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HEALTH & SOCIAL CARE CONSULTING

Independent Quality Assurance Review
Cornwall Partnership NHS Foundation Trust
NHS Kernow Clinical Commissioning Group

StEIS 2016/6113

Final Report March 2022

insight integrity impact

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16 March 2022

Independent Quality Assurance Review, Cornwall Partnership NHS Foundation Trust and NHS Kernow Clinical Commissioning Group

Please find attached our Final Report of 16 March 2022 in relation to an independent quality assurance review of the implementation of recommendations resulting from the independent investigation into the care and treatment of a mental health service user Mr M in Cornwall (dated February 2019).

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 Events which may occur outside of the timescale of this review will render our report out of date.

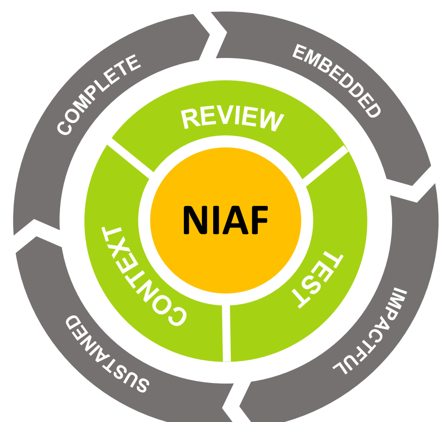
Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

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

Niche
Investigation
Assurance
Framework



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1. Method

1.1 Background and context for this review

NHS England and NHS Improvement commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake an assurance review using the Niche Investigation Assurance Framework (NIAF). This is intended to provide an assessment of the implementation of the actions developed in response to recommendations from the Niche independent investigation into the care and treatment of a mental health service user Mr M in Cornwall (dated February 2019 and accessed via: **https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2019/02/final-report-2016-6113-v3.2.pdf**).

1.2 Review method

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

Our work comprised a review of documents provided by Cornwall Partnership NHS Foundation Trust ('the Trust' or 'CPFT)', and NHS Kernow CCG ('the CCG'). These included action plans, policies, procedures, audits, meeting minutes and staff communications. We have not reviewed health care records because there was no requirement to re-investigate this case in the review terms of reference. The information provided to us has not been audited or otherwise verified for accuracy.

1.3 Implementation of recommendations

The Niche independent investigation made nine recommendations which are summarised below and opposite.

1	The Trust must ensure that it fully executes its Duty of Candour (DoC) responsibilities and that where there are parallel investigations by other agencies advice is only sought from senior staff about the most appropriate methods of communicating with affected parties.
2	If it has not already been actioned, the Trust must ensure that appropriate audits are undertaken regarding the effectiveness of the new protocol for the Complex Care and Dementia Team, taking any remedial action required if the effectiveness is found to be lacking.
3	The Trust must provide assurance that the expectations of the clinical record keeping policy are met.
4	The CCG must ensure that the policy covering the management of serious incidents includes a requirement for oversight of provider investigation action plans, and appropriate and documented dialogue between the commissioner and relevant provider/s.
5	Outlook South West must consider what actions it can take to mitigate the risk of patients choosing not to share relevant clinical information with their therapist, now that therapists no longer have access to the GP clinical record system.
6	The Trust must ensure that SBARD (Situation, Background, Assessment of individual, Recommendation, Decision) is introduced to community mental health teams, ensuring that relevant learning from implementation in inpatient services is transferred.
7	The Trust must ensure that staff are able to identify and recognise the different types of supervision set out in the Supervision Policy ratified in March 2016, in order that staff can use supervision sessions appropriately.
8	The Trust must ensure that staff explore patients' literacy abilities and then communicate information in a way that is accessible and personalised.
9	The Trust and NHS Kernow Clinical CCG must assure themselves that the therapy strategy sufficiently addresses the provision and use of qualified therapy staff across the Trust, ensuring that gaps in access to appropriate therapy are properly addressed.

2. Assurance summary

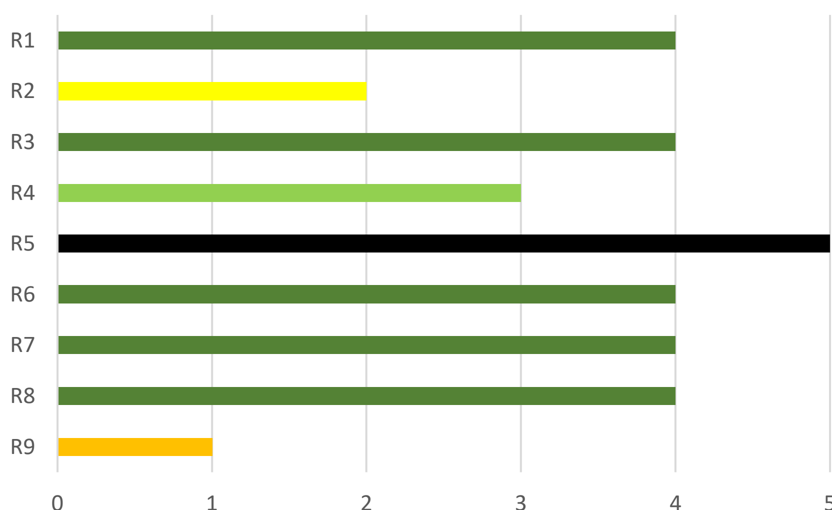
Scoring criteria key

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 the steps they need to take to move between the stages of completed, embedded, impactful and sustained.

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

Implementation of recommendations

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



Summary

Clear progress has been made in relation to a number of recommendations; however, in some areas, evidence to support progression is more limited. We have provided examples of further assurance which is required to demonstrate actions are complete, tested, embedded and/or sustained as appropriate.

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

2. Assurance summary (continued)

Recommendation 1

The Trust must ensure that it fully executes its Duty of Candour responsibilities and that where there are parallel investigations by other agencies advice is only sought from senior staff about the most appropriate methods of communicating with affected parties.

Niche assurance rating for this recommendation	**4**

Key findings:

The Trust's Duty of Candour (DoC) Policy was updated in December 2021. It is clear on DoC responsibilities, training requirements, oversight and audit of compliance with the Policy. The current Policy also directs staff to the prompt identification of the 'Named Lead' for DoC. It includes that where there are circumstances of multi-agency input or concurrent investigations, a senior lead should be identified, and consideration given to the requirement for DoC to be completed with a coordinated approach to communicating with patients and/or families/carers. This aspect of the Policy has not yet been tested but other audits of DoC compliance have been undertaken; although the most recent December 2021 Internal Audit Report gave limited assurance that the Policy was being consistently applied. This was confirmed in a report to the Trust Board which highlighted that the Trust continues to experience challenges in embedding DoC processes.

While we have seen no evidence of compliance with training requirements, an action from the Internal Audit Report included that refreshed training and guidance to all staff was required.

Residual recommendations:

- The Trust should continue to monitor DoC action plan progress at team level with oversight through reporting to the Quality Committee and Board.

Recommendation 2

If it has not already been actioned, the Trust must ensure that appropriate audits are undertaken regarding the effectiveness of the new protocol for the Complex Care and Dementia Team, taking any remedial action required if the effectiveness is found to be lacking.

Niche assurance rating for this recommendation	**2**

Key findings:

In May 2021 the Trust undertook an audit of ten cases to assess if patients had an allocated care coordinator prior to commencing Cognitive Analytic Therapy (CAT) and the Trust reported positive audit results. However, the audit approach was unclear and did not test all aspects of the new protocol.

The Trust has advised that further audits are not deemed necessary as the CAT therapist is now part of the Psychology Team; we were told regular supervision and audit is undertaken for this team. The Trust provided evidence of supervision being undertaken with discussion of key aspects of the new protocol but evidence of audits was not provided.

Residual recommendations:

- The Trust should continue to undertake periodic audits to test the effectiveness of the new protocol for the CAT under the revised team structures.

2. Assurance summary (continued)

Recommendation 3	
The Trust must provide assurance that the expectations of the clinical record keeping policy are met.	
Niche assurance rating for this recommendation	**4**

Key findings:

Over the last two years, the Trust has maintained a focus on improving the standard of record keeping as a quality improvement priority. The Trust has developed specific tools and training around the SBARD (Situation, Background, Assessment of individual, Recommendation, Decision) approach to record keeping although audits undertaken to date indicate that this is not yet embedded and training roll-out was delayed due to the Covid pandemic.

Supervision processes also cover record keeping, prompted by the supervision record template which includes a section on compliance with the requirements of the electronic patient record system (RiO). Individual compliance reports can be generated from RiO but we have seen no outputs from these.

Clinical record keeping audits and performance reporting (to the relevant quality governance forums) are referenced in policy and quality reports but, again, we do not have sight of this evidence.

Residual recommendations:

- The Trust should prioritise the roll-out of the revised record keeping approach through training, with continued monitoring of compliance through audits and performance reporting to highlight hotspots.

Recommendation 4	
NHS Kernow Clinical Commissioning Group must ensure that the policy covering the management of serious incidents includes a requirement for oversight of provider investigation action plans, and appropriate and documented dialogue between the commissioner and relevant provider/s.	
Niche assurance rating for this recommendation	**3**

Key findings:

The Serious Incident (SI) Policy is out-of-date (2017) but references the processes required for oversight of provider investigation reports and action plans. It does not specifically reference the local forums to be used for dialogue between commissioners and relevant providers although there is evidence of system-wide SI meetings and patient safety forums where action plans are discussed. Prior to the homicide, an internal audit in 2018 also indicated that weekly meetings took place with individual providers but we have seen no evidence of further testing to ensure compliance with the SI Policy. The Policy is currently being revised to reflect the Patient Safety Incident Response Framework (PSIRF) and required oversight/monitoring mechanisms.

Residual recommendations:

- The CCG should ensure that the terms of reference for the various commissioner/provider forums in place for discussion of serious incidents and resultant action plans avoid duplication and provide clarity on the respective roles of each forum.

2. Assurance summary (continued)

Recommendation 5	
Outlook South West (OSW) must consider what actions it can take to mitigate the risk of patients choosing not to share relevant clinical information with their therapist, now that therapists no longer have access to the GP clinical record system	
Niche assurance rating for this recommendation	**5**
Key findings: At the time of the incident, OSW were not part of the Trust but joined in 2020. They now have access to the RIO patient record system where they can view relevant clinical information about a patient and they also send letters/updates to GPs when a client is on their pathways. This recommendation has therefore been superseded by organisational changes.	
Residual recommendations:	
Not applicable	

Recommendation 6	
The Trust must ensure that SBARD (Situation, Background, Assessment of individual, Recommendation, Decision) is introduced to community mental health teams, ensuring that relevant learning from implementation in inpatient services is transferred.	
Niche assurance rating for this recommendation	**4**
Key findings: The SBARD approach to record keeping has been implemented across the Trust during 2019/20 and 2020/21 and the template is embedded in the RiO clinical information system. The implementation in adult community mental health teams was initially delayed due to the Covid pandemic, however, the Trust confirmed in February 2021 that the approach had been established across all teams. The Trust has developed specific training resources to support staff learning on the approach, but we did not see the training content so are unable to confirm how this captures learning from the implementation in other services. The Trust did not provide details of training attendance to date. The Trust undertook audits during 2020/21 in two community nursing teams; we did not see the learning from these audits but the Trust states in the Quality Report for 2020/21 that these highlighted a need for more training on the SBARD approach.	
Residual recommendations:	
• See recommendation 3.	

2. Assurance summary (continued)

Recommendation 7	
The Trust must ensure that staff are able to identify and recognise the different types of supervision set out in the Supervision Policy ratified in March 2016, in order that staff can use supervision sessions appropriately.	
Niche assurance rating for this recommendation	**4**

Key findings:

The Trust's Clinical Supervision Policy has been regularly refreshed and provides comprehensive guidance for effective clinical supervision. Staff are required to record all episodes of clinical supervision on an electronic system (HARP) and the Policy states that compliance is monitored quarterly through reports to the Clinical Cabinet and Quality and Governance Committee. The Trust provided a recent example of reporting; the October 2021 report showed that compliance had been low over the previous five months, at 45% for the Trust overall. This is a helpful analysis, but it does not provide commentary on the reasons for underperformance, and it was unclear if this forms the basis for reporting to relevant governance forums.

It was also unclear how assurance is gained on the quality of supervision sessions as we did not see any reports to relevant committees on this. While training is available to supervisors and supervisees to support the quality of supervision, the Trust did not provide evidence of its uptake.

The Trust undertook an audit for a small sample of staff to test awareness of supervision processes and results were positive in terms of awareness and engagement. The name of the team that had been audited was not stated or when and if further audit was planned.

Residual recommendations:

- The Trust should continue to obtain periodic feedback from staff on the quality of their clinical supervision through team discussions and further audit/surveys, with reporting on findings to relevant governance forums.

Recommendation 8	
The Trust must ensure that staff explore patients' literacy abilities and then communicate information in a way that is accessible and personalised.	
Niche assurance rating for this recommendation	**4**

Key findings:

Accessible communications and personalised care have been Trust quality priorities over the last two years and the Trust has focused plans in these areas. Patient and staff surveys have been undertaken to understand areas for improvement. Monthly audits have also been undertaken on this topic for adult community nursing teams, but these have provided limited assurance.

Based on an update in July 2021, progress appears to have been impacted by capacity pressures due to the Covid pandemic and work still needs to be done to ensure the clinical system is used effectively by staff to record patients' communication needs.

Residual recommendations:

- The Trust should implement the roll-out of training for staff on accessible communication and recording needs in the clinical system and undertake further surveys and regular audit.

Recommendation 9	
The Trust and NHS Kernow Clinical CCG must assure themselves that the therapy strategy sufficiently addresses the provision and use of qualified therapy staff across the Trust, ensuring that gaps in access to appropriate therapy are properly addressed.	
Niche assurance rating for this recommendation	**1**
Key findings: We have been told that the Therapy Strategy is reviewed through CCG and Trust quality and governance routes; however, we have seen no evidence to support this monitoring or that appropriate types of therapy are offered to patients and that resourcing and response times are within required standards.	
Residual recommendations:	
• The Trust and CCG should ensure that delivery of the Therapy Strategy is monitored through routine performance reporting and contract mechanisms.	

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1

The Trust must ensure that it fully executes its Duty of Candour responsibilities and that where there are parallel investigations by other agencies advice is only sought from senior staff about the most appropriate methods of communicating with affected parties.

Key evidence submitted	Niche review
Being Open and Duty of Candour Policy and Process, February 2019	The Trust provided its Duty of Candour (DoC) Policy which had been updated and ratified (by an individual rather than relevant committee) in February 2019. The Policy was to be disseminated to all staff through Clinical Quality Operational Groups and clinical forums. We did not see evidence of this dissemination. The Policy requires that the 'Named Person' (for liaison on behalf of the Trust with the patient/family/carer) should be at Clinical Services' Manager level and would normally be a senior clinician. The Policy is clear that the 'Named Person', *" should be senior enough or have sufficient experience and expertise in relation to the type of patient safety incident."* The Policy refers to the ongoing liaison required between the serious incident investigating officer and the 'Named Person' but does not refer to how communication is co-ordinated with affected parties when other parallel investigations are ongoing. The Policy does state that when a safeguarding alert has been made in relation to a patient safety incident, the Safeguarding Team should manage DoC communications. The Policy refers to the training available to staff including e-learning on the risk management system and a Being Open and DoC e-learning package which had been developed. Audit requirements are clearly stated in the Policy and include a quarterly audit of record keeping relating to the DoC process. The Trust's action plan refers to two internal audits having been undertaken since 2016 and positive assurance having been received (see further below), but the Trust has not provided evidence of the audits referenced. There is also reference to the Quality and Governance Committee receiving reports on compliance with the Policy but we have not seen an example of this reporting.
Duty of Candour Policy and Process, August 2021	The DoC Policy was refreshed in August 2021. It refers to the oversight by the Quality Assurance Committee and Trust Board through reporting on DoC compliance. It highlights DoC as essential training. The Trust did not provide training content or evidence of compliance with training requirements. The Policy recognises multidisciplinary team input and that usually the most appropriate team member to undertake DoC communications will be the lead clinician. The Policy is not specific on requirements when there are concurrent investigations, however, it clearly directs staff to the prompt identification of the 'Named Lead' at the commencement of the process.

Appendix 1: Evidence review (continued)

Recommendation 1 (continued)	
Key evidence submitted	**Niche review**
Mr M Final Combined Action Plan, not dated	The action plan provided for our review states that there had been an internal audit of DoC Policy compliance in Quarter 4 of 2018/19. The action plan also refers to a previous audit (date not provided but indicates post-2016). The Trust did not provide further evidence of these audits.
Email from Trust, 12.02.21, Update from JW re actions	The Trust's update on the action plan of February 2021, states that a robust system is in place with monthly reporting on open cases for DoC through a performance meeting by Team Managers. The update states that all actions are up-to-date. The Trust did not provide examples of monthly reporting by Team Managers or evidence of the associated action plan on DoC.
Integrated Compliance and Performance Report, October 2021 (accessed from Trust website)	The report to the Trust Board (Section 3) provides detail on the number of DoC cases and provides a commentary on performance. The October 2021 report highlighted that DoC processes are not yet fully embedded and significant support continues to be required from the Trust DoC Lead to support teams in this regard.
Patient Safety Incident Response Plan (PSIRP) 2021/22, October 2021	The Trust has developed a PSIRP for 2021/22 as an 'early adopter' of NHS England's new Patient Safety Incident Response Framework (planned to replace the Serious Incident Framework in Spring 2022). In developing this plan, the Trust has estimated the resource required for family liaison with a view to understanding capacity to support patient safety investigations from this perspective. The plan demonstrates more of a focus on a multi-agency approach to the response to patient safety incidents.
Duty of Candour Policy and Process, December 2021	This refreshed document includes that where there are circumstances of multi-agency input or concurrent investigations, a senior lead should be identified, and consideration should be given to the requirement for DoC to be completed with a coordinated approach to communicating with patients and/or families/carers. This aspect of the Policy has not yet been tested.
Final Internal Audit Report: Duty of Candour, December 2021	This internal audit on DoC demonstrated limited assurance. It concluded that while roles and responsibilities of various staff groups across the organisation appeared to be understood, there continued to be an over reliance on the Governance Team and DoC Lead. The findings of this report also highlighted areas of poor record keeping within the Trust, which combined with previous audit reports, highlights this as a cultural weakness across the whole Trust. An associated action plan includes action owners and deadlines for completion by the end of March 2022.

Appendix 1: Evidence review (continued)

Recommendation 2	
If it has not already been actioned, the Trust must ensure that appropriate audits are undertaken regarding the effectiveness of the new protocol for the Complex Care and Dementia Team, taking any remedial action required if the effectiveness is found to be lacking.	
Key evidence submitted	**Niche review**
Pilot of 10 random cases on PPT caseload receiving CAT, not dated	The Trust undertook an audit in the Psychology and Psychological Therapies Team (PPT) of a random sample of ten cases to assess if the patient had an allocated care coordinator prior to commencing Cognitive Analytic Therapy (CAT). The Trust confirmed that this audit took place in May 2021. Although a small sample size, the audit results were positive - out of the ten records reviewed, nine had a care coordinator assigned prior to CAT commencing. We were unable to confirm whether the audit had specifically tested whether a different care coordinator was assigned when the CAT practitioner was the patient's existing care coordinator. The action from the audit was for *"Managers to remind all staff in their business meetings of the importance of a care coordinator being allocated prior to CAT commencing if this is the treatment plan agreed."* The Trust did not provide evidence of this communication in relevant meetings. There was no evidence provided of the other aspects of the protocol being tested, i.e. eligibility criteria, minimum frequency of CAT supervision sessions and the recording of supervision sessions in the electronic patient record as non-face-to-face contact.
Email from Trust, 12.02.21, Update from JW re actions	The Trust advised that further specific audits (after May 2021) were not considered necessary as the CAT therapist became part of the PPT within the Complex Care and Dementia (CCD) Team, for which regular supervision, audit and service reviews take place. The Trust did not provide evidence of audits undertaken as part of the standard audit programme for PPT which cover the recommendation.
Completed Supervision Record Sheet, May 2021	This is the record for the CAT Therapist and clearly states that the CAT Therapist does not care-coordinate their own caseload and evidences discussion of referral protocols as part of supervision.
Supervision notes CAT Therapist, 18 October and 17 November 2021	The Trust provided two examples of monthly supervision notes for the CAT Therapist dated October and November 2021 as evidence of supervision taking place under the new team structure.
PPT Team Structure, not dated	The team structure provided showed the CAT therapist as part of the PPT but this was not dated so it was unclear when structures changed.
1524_001	This document evidences positive patient and carer feedback regarding the 'Sparkle' service for dementia patients.

Appendix 1: Evidence review (continued)

Recommendation 3	
The Trust must provide assurance that the expectations of the clinical record keeping policy are met.	
Key evidence submitted	**Niche review**
Clinical Record Keeping Policy, July 2018	This Policy aims to ensure that the Trust meets its obligations in respect of clinical record keeping and refences a range of associated Trust Policies and documents on this subject. It also asks staff to consider use of SBARD as this aids clear, structured and concise communications. Monitoring arrangements are included in the Policy with reports to be submitted to the Information Governance Steering Group which incorporates data quality information with regards to record keeping (evidence of these have not been provided). Also, that clinical supervision within individual teams will incorporate record keeping standards.
Email from Trust, 12.02.21, Update from JW re actions	This stated that record keeping is discussed and managed through the supervision process on a four to six- weekly basis, with monthly reporting at performance meetings. The Trust did not provide evidence of monthly reporting on record keeping for relevant meetings.
Supervision Record Sheet	This contains a section on compliance with the electronic patient record system and refers to a RiO Compliancy Report. The Trust advised that individual compliance reports are available through RiO but did not provide an example to confirm this or summary reporting on compliance.
Mr M Final Combined Action Plan, not dated	The action plan refers to planned roll-out of the SBARD approach. The action plan states that annual and local operational audits are undertaken to review the standard of record keeping. The Trust did not provide evidence of the audits undertaken for the CCD or other teams.
Quality Priority 4 Record Keeping, not dated	This summary plan for Quality Priority 4 (2019/20 to 2020/21) was submitted as evidence of the focus on record keeping and the use of the SBARD approach. The plan referred to the development of specific tools and training for this purpose as well as a defined audit approach which included a baseline audit of 100 clinical records to be undertaken in Quarter 2 and Quarter 4 of 2019/20. The Trust did not provide evidence of these.
Quality Report, 2020/21	Record keeping was described as a quality improvement priority in the Trust's externally audited Quality Report for 2020/21 with a focus on the SBARD approach. It states that SBARD had been implemented in some services during 2019/20 with plans to introduce it to community teams in 2020/21. Training roll-out had been delayed due to the Covid pandemic but was anticipated to restart during 2021/22. The Trust did not provide evidence of training undertaken and uptake. The Quality Report referred to an audit undertaken during 2020/21 in two community nursing teams which indicated the need for further training on the incorporation of the SBARD approach in record keeping.

Appendix 1: Evidence review (continued)

Recommendation 4

NHS Kernow CCG must ensure that the policy covering the management of serious incidents includes a requirement for oversight of provider investigation action plans, and appropriate and documented dialogue between the commissioner and relevant provider/s.

Key evidence submitted	Niche review
Kernow CCG, Serious Incident Policy, 2017 (accessed from CCG website)	The Serious Incident (SI) Policy on the CCG's website is out-of-date. It sets out the procedures for oversight of provider reported SIs and review of SI root cause analysis reports. The Policy does not set out audit requirements to monitor compliance with this process and does not refer to meetings with providers as part of required governance arrangements. We were unable to access through the website the associated policy, Reporting and Learning from Serious Incidents Requiring Investigation. The SI Policy is currently being revised to reflect the Patient Safety Incident Response Framework (PSIRF) and required oversight/monitoring mechanisms.
Assurance Review of Serious Incidents, Final TIAA Audit, 2018	An internal audit of serious incident processes took place in November 2018. This gave 'reasonable assurance' and found that the CCG adhered to the national Serious Incident Framework and local policy. Key actions related to timeliness of provider reporting, duplication with partners and a need to clarify roles and responsibilities. The audit indicated that weekly meetings took place with each provider. We have no evidence of a review since 2018 or that the actions taken by the CCG as noted on the action plan were overseen through appropriate governance channels and whether they have had the required impact.
Mr M Final Combined Action Plan, not dated	The action plan states that the CCG hosts a Cornwall-wide serious incident forum which brings together providers to share learning (see terms of reference below). This forum links into the South West Community of Practice network for wider learning.
Terms of Reference - Systemwide SI Weekly Meeting, April 2020	The terms of reference (ToR) for the system-wide SI forum indicates weekly meetings which aim to share learning and improve processes in relation to SIs. The ToR do not state which organisations attend this forum; the CCG confirmed that CPFT and OSW are members. The ToR refer to reporting to the CCG's Quality Committee but do not specify the nature of such reporting; examples of minutes or reporting were not provided for review.
Agenda, Draft Minutes and Action Tracker for the Cornwall system patient safety meeting, 5 May 2021	The CCG provided evidence of dialogue on SIs with providers (CPFT and the local acute Trust) through the minutes of a patient safety meeting chaired by the Head of Clinical Quality for the CCG. The minutes indicate that the meeting occurs bi-monthly. Reviews of incidents, shared learning and quality improvement are discussed. There is an associated action tracker for the meeting.

Appendix 1: Evidence review (continued)

Recommendation 6	
The Trust must ensure that SBARD (Situation, Background, Assessment of individual, Recommendation, Decision) is introduced to community mental health teams, ensuring that relevant learning from implementation in inpatient services is transferred.	
Key evidence submitted	**Niche review**
Email from Trust, 12.02.21, Update from JW re actions	The Trust's update stated that SBARD is now used and recorded in all multi-disciplinary team (MDT) meetings on a weekly basis and embedded on RIO as a triage document with some staff using the approach to format their progress notes.
MDT SBARD form	The Trust provided a screenshot of the SBARD form used by MDTs which showed that this was embedded into the RiO clinical information system. The Trust advised that use of this form was approved by the relevant governance forum in December 2019.
Quality Report, 2020/21	The Trust's Quality Report for 2020/21 describes in some detail the implementation of the SBARD approach. It states that the SBARD had been implemented for mental health, learning disabilities, complex care and dementia, children and adolescent mental health services (the Quality Report did not indicate if these were inpatient or community teams). It was to be introduced to adult community services in 2020/21 but this was impacted by the Covid pandemic. The Trust developed an SBARD training video and other resources to support training. The Trust did not provide details of the content of the training provided during 2021/22 and the level of attendance by community teams. As referred to in recommendation 3, the Quality Report referred to an audit undertaken during 2020/21 in two community nursing teams which indicated the need for further training on the incorporation of the SBARD approach in record keeping (the audit reports were not provided)

Appendix 1: Evidence review (continued)

Recommendation 7

The Trust must ensure that staff are able to identify and recognise the different types of supervision set out in the Supervision Policy ratified in March 2016, in order that staff can use supervision sessions appropriately.

Key evidence submitted	Niche review
Clinical Supervision Policy, July 2018	The Policy was refreshed in 2018 (we noted it was ratified by an individual rather than relevant committee). It set out the types of supervision and how these were to be applied to different staff groups (see further detail below as described in the 2020 version of the Policy). The Policy required all supervision activity to be recorded on the 'e-hub' system. It included a clinical supervision record and agreement templates for both parties to agree and sign.
Clinical Supervision Policy, October 2020	The Clinical Supervision Policy was updated in October 2020. The Policy was ratified in December 2020 by an individual rather than the relevant committee. The Policy details formal supervision requirements and the different types of supervision including clinical, professional, line management, caseload and safeguarding. Informal supervision is also encouraged, and the Policy describes other forms of support such as coaching. It describes the formal supervision approaches for each professional group and clearly sets out the roles and responsibilities of individuals and includes a supervision agreement template. Staff are required to record all episodes of clinical supervision on a system called 'HARP' (see below) and that compliance with this is reported monthly by the Education and Training Team, with quarterly monitoring reports to the Clinical Cabinet and Quality and Governance Committee. The Trust did not provide examples of reports to relevant governance forums. Evidence of dissemination of the Policy to staff and training (non-mandatory) was also not provided.
Supervision audit, not dated	The Trust undertook an audit (date not stated) to assess staff's awareness of supervision processes. Analysis showed that of the ten staff sampled all were aware and engaged in supervision processes. One person fed back that they would like to have more clinical supervision and another that it can be challenging from a capacity perspective to take part in all the forums. While these results are positive, the sample size was small and it was unclear which team had been audited, when and if further audit was planned.

Appendix 1: Evidence review (continued)

Recommendation 7 (continued)	
Key evidence submitted	**Niche review**
HARP	The Trust provided a screenshot of the HARP web application which is required to be used by healthcare professionals (excluding medical staff) for the recording of clinical supervision.
Supervision Compliance Report, 25 October 2021	The Trust provided an example of reporting on supervision compliance. This is a statistical analysis generated by the HARP system and shows the number and percentage of staff by team and in summary who have complied with supervision requirements. As at October 2021, compliance was low at 45% for the Trust overall (736 out of 1637 staff had complied). For the CCD directorate, compliance was 44% (43 out of 98 staff). The report contains a trend analysis from January to October 2021 for each team. A summary for the last five months shows a continued underperformance at 45% compliance for the Trust overall. This is a comprehensive and helpful analysis but does not provide commentary on the reasons for underperformance. It is unclear if this forms the basis for reporting to relevant governance forums.
Supplementary information received	DOPMH Dashboard and supervision evidence (100% compliance with 'supervision – any' April-October 2021)

Appendix 1: Evidence review (continued)

Recommendation 8	
The Trust must ensure that staff explore patients' literacy abilities and then communicate information in a way that is accessible and personalised.	
Key evidence submitted	**Niche review**
Quality Report, 2020/21	Accessible communication was a quality improvement priority in the Trust's externally audited Quality Report for 2021/22 as this had been a key theme in incidents and a recognised area where the Trust should improve as part of personalised care planning. It was also a priority in 2020/21. Training for staff was referenced in the report but there were no details of the training undertaken or uptake, and whether this was mandatory. The Quality Report stated that the Friends and Family Test (FFT) would include questions to allow improvement in this area to be monitored but we have seen no evidence of this being enacted. There was also reference to planned audits (minimum five case records per team), interviews with patients/families and carers and a bi-annual staff survey to gather intelligence on performance against the required standards (see below).
Email from Trust, 12.02.21, Update from JW re actions	The Trust confirmed that easy read and formatted literature is available for staff to access. Also, that patient literacy abilities are recorded in RiO and included in the initial assessment process. We did not see an extract of RiO to evidence this.
Accessible Communication Records Audit Template	The Trust provided the audit template for a programme of planned audits of case records on accessible communication. The template indicates that these are undertaken monthly but evidence to support these being undertaken was not provided.
Personalised care planning charts, April 2021	This is an analysis of monthly audits, undertaken in Adult Community Nursing teams, on personalised care planning over the period October 2019 to February 2021. Accessible communication is covered within this. The analysis shows that results are variable, and that limited assurance can be taken from this data. Mean sample size was relatively small (18 participants).
Progress against the priorities. Priority 1: accessible communication, not dated [July 2021 indicated]	This document sets out progress against the quality improvement priority for providing accessible communication. Comments against this document indicate that a training needs analysis had been undertaken but that training modules were not in place as at July 2021 with work on RiO at the planning stage. An audit template had been developed (see above) and patient and staff surveys were live.
Accessible communication survey links, not dated [implied May 2021]	The Trust provided links to the live patient and staff surveys on accessible communication which we were able to access (also see over leaf).

Appendix 1: Evidence review (continued)

Recommendation 8 (continued)	
Key evidence submitted	**Niche review**
Easy Read Patient Communication Survey, May 2021	The patient survey is available in an easy read version.
Accessible communication baseline surveys report, not dated	This report presented a comprehensive analysis of the staff survey; 102 members of staff took part, representing 37 clinical teams. It was unclear at what date this baseline had been established. The survey findings were positive in terms of staff managing appropriately and confidently communication needs with patients. Areas for improvement included recording communication needs and the need for further training and alerting systems for additional communication needs. There was no indication of when the next survey would be taken to compare against the baseline results and no action plan indicated as part of next steps.
Accessible communication patient survey results, July 2021	The patient survey results were reported for the period February to July 2021. This was a small sample of seven respondents. There were some positive messages - six respondents said they had not received information from the Trust that they found difficult to understand, and five were aware of their right to ask for accessible information. However, respondents indicated that communication needs were not always considered when information was sent to them. Next steps were not indicated, for example, follow-up surveys.
Quality Priority 3. Care Plans, not dated	This document sets out a plan for achievement of this quality priority including an objective for the 'patient voice' to be reflected in care plans.
Personalised care planning - progress summary, 2019-2021, April 2021	This document summarises progress on the quality priority for personalised care planning. It highlights challenges in the RiO system functionality to easily pull through information into an Easy Read care plan (needed to meet the literacy needs and the Accessible Information Standard); a paper template had been created for testing. Planned audits and patient interviews on care planning had been delayed due to the Covid pandemic.
Flash report Quality Priority 1 Accessible Communication, December 2021	The Trust provided a summary highlights report on progress against the quality priority for accessible communication. This indicated that work had been undertaken on communication alerts in RiO and that training and audit materials were ready but had not yet progressed; Covid pressures on capacity were noted as the key risk to delivery of the plan.

Appendix 1: Evidence review (continued)

Recommendation 9	
The Trust and the CCG must assure themselves that the therapy strategy sufficiently addresses the provision and use of qualified therapy staff across the Trust, ensuring that gaps in access to appropriate therapy are properly addressed.	
Key evidence submitted	**Niche review**
A Therapy Strategy for Cornwall and the Isles of Scilly. The contribution of Therapy services to transforming the delivery of Health Care in Cornwall and the Isles of Scilly, September 2016	This includes the purpose, objectives, scope, ownership and responsibilities, risks, implementation and action plan. Resources are listed as a theme and the need to ensure that efficient use is made of the therapy resources across the county to underpin service transformation. An action plan is listed in the document as are reporting mechanisms. There is also reference to the Strategy needing to be reviewed yearly in line with annual business planning processes. However, we have seen no evidence of reporting or the reviews described.
Mr M Final Combined Action Plan, not dated	The action plan update confirms that the Therapy Strategy has been revised and implemented in 2017. The action plan also refers to the growth in the PPT team and additional expertise from a Professor from Exeter University. The action plan refers to implementation of the strategy being reported to the CCG Quality Review meeting but examples of this monitoring were not provided for our review.
Email from Trust, 12.02.21, Update from JW re actions	The Trust advised that as part of the Therapy Strategy a psychological and psychological therapies (PPT) team has been developed over the previous four years (this includes a CAT therapist). The Trust/CCG provided no information on other therapy services incorporated within this team.
PPT Team Structure, not dated	The team structure was provided but this was not dated so it was unclear when this changed.

Appendix 2: Glossary of terms

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CAT	Cognitive Analytic Therapy
CCD	Complex Care and Dementia
CCG	Clinical Commissioning Group
CPFT	Cornwall Partnership NHS Foundation Trust
DoC	Duty of Candour
MDT	Multi-Disciplinary Team
NIAF	Niche Investigation Assurance Framework
OSW	Outlook South West
PPT	Psychology and Psychological Therapies
PSIRP	Patient Safety Incident Response Plan
SBARD	Situation, Background, Assessment of individual, Recommendation, Decision
SI	Serious Incident
ToR	Terms of Reference

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