Independent Quality Assurance Review

Dorset HealthCare University NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
NHS Dorset Clinical Commissioning Group

StEIS 2016/21910

Highly private and confidential

Final Report April 2022

insight integrity impact

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12 April 2022

Independent Quality Assurance Review, Dorset HealthCare University NHS Foundation Trust, Cornwall Partnership NHS Foundation Trust, and NHS Dorset Clinical Commissioning Group

Please find attached our Final Report of 12 April 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 P, in Dorset.

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 Events which may occur outside of the timescale of this review will render our report out of date.

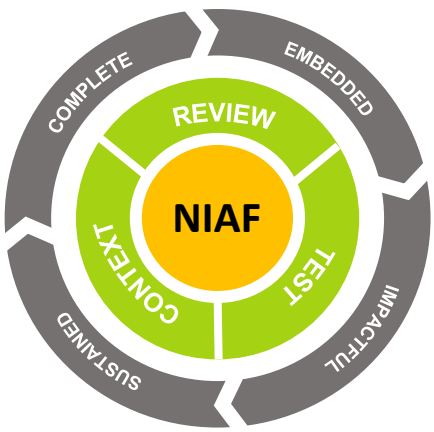
Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

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

Niche Health and Social Care Consulting Ltd



Niche Investigation Assurance Framework

insight integrity impact

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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 P, in Dorset.

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 Dorset HealthCare University NHS Foundation Trust (DHUFT), Cornwall Partnership NHS Foundation Trust (CPFT), and NHS Dorset Clinical Commissioning Group (CCG). 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 Niche independent investigation made ten recommendations to the above-named organisations; these are listed opposite and on the next page.

1	The Trust (DHUFT) must ensure that all serious incident reports comply with the standards set out in the NHS England Serious Incident Framework so that: • root causes to incidents are clear in cases where they are identified; • appropriate learning can be identified and shared; • findings can be shared in an open and transparent way with affected parties.
2	The NHS Dorset CCG must ensure that provider serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework, that there is an audit trail of assessment of serious incident reports, and that appropriate action is taken when this is not the case.
3	The NHS Dorset CCG must ensure that: • provider action plans properly address recommendations in the associated serious incident reports; • provider action plans are appropriately monitored, and that evidence is assessed to provide assurance that the required actions are in place; and • when actions are not completed within the agreed timeframe, the provider is required to explain the delay.
4	The Trust (DHUFT) must ensure that patients are provided with appropriate information about medicines in order for them to be able to make an informed decision about consenting to accept the medicine. This is even more important when a medicine is prescribed off licence.
5	The Trust (DHUFT) must ensure that the forensic team is clear about all current and previous diagnostic formulations, particularly where there have been substantial periods of care in multiple settings, in order to ensure that assessment and treatment plans are relevant and appropriate.

1. Method (cont.)

6	The Trust (DHUFT) and its commissioners must ensure that the relevance of previous post-traumatic stress disorder diagnoses and of potential current post-traumatic stress disorder symptoms should be routinely considered, and appropriate guidance followed where relevant.
7	Agencies involved in managing individuals through the MAPPA process must ensure that information about risks and management of those risks is passed to other areas when an individual moves to the jurisdiction of another MAPPA group. The Trusts involved in this case must review their existing MAPPA policies with this recommendation and associated findings in mind.
8	NHS England must ensure that secure services provide all relevant clinical information within progress reports, correspondence and discharge documents so that future clinical teams have a complete picture of a patient's diagnosis, risk and treatment history.
9	The Trust (DHUFT) must also ensure that HCR-20s (risk assessments) are kept up to date with relevant information, particularly when responsibility for the patient's care and treatment is being transferred from another provider.
10	The Trust (DHUFT) must ensure that all communications executing their Duty of Candour responsibilities (including when acting in the spirit of Regulation 20) fulfil all of the requirements of the Regulation.
11	Cornwall Partnership NHS Foundation Trust must ensure that when a patient is discharged to the care of an originating team a full summary of the patient's care and treatment whilst in Cornwall is provided to the receiving team.

2. Assurance summary

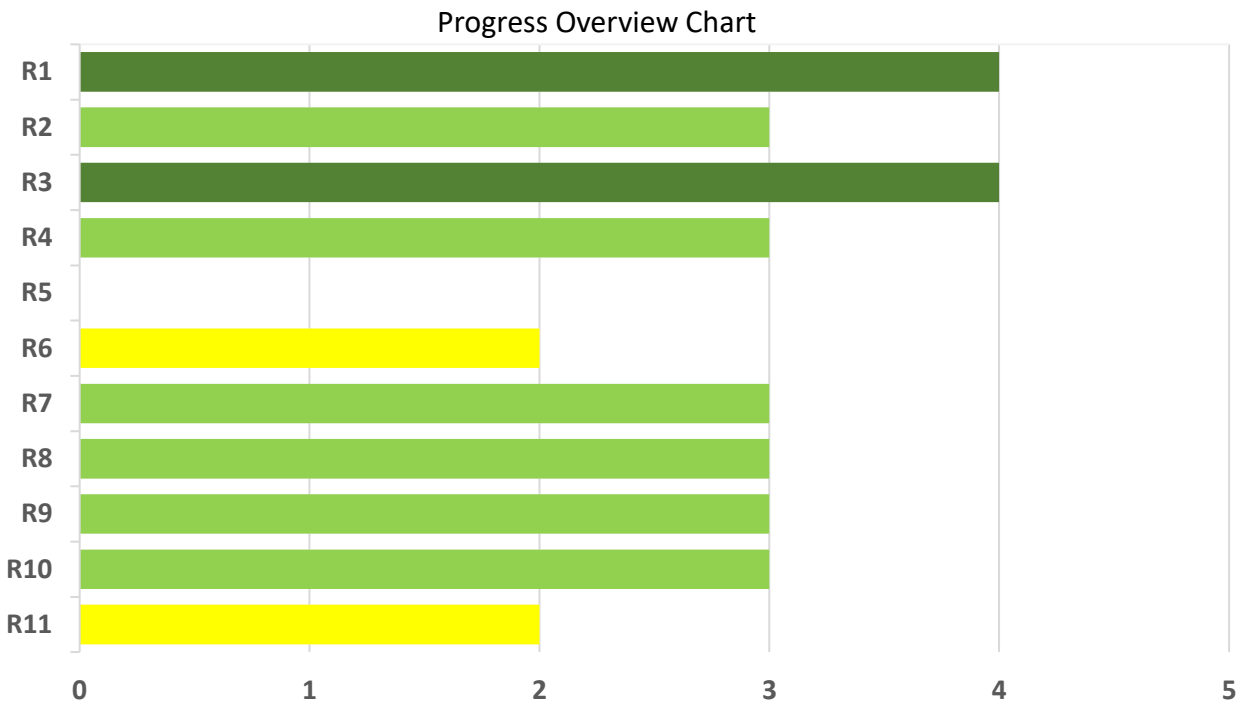
Scoring criteria key

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 complete, tested, but not 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

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

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

2. Assurance summary (cont.)

Recommendation 1

The Trust must ensure that all serious incident reports comply with the standards set out in the NHS England Serious Incident Framework so that:

- root causes to incidents are clear in cases where they are identified;
- appropriate learning can be identified and shared;
- findings can be shared in an open and transparent way with affected parties.

Niche assurance rating for this recommendation **4**

Key findings: Serious incident investigations are now reported on a standardised template (this is used by all local providers) which is aligned to the requirements of the Serious Incident Framework. The quality assurance tool and closure checklists are good practice, as are the learning bulletins which are circulated to Trust staff. Recommendations and learning from serious incidents are discussed in a range of Trust and service meetings and the monthly reports to the CCG also include recommendations and lessons learned. However, these processes need to be further tested as we have seen examples of investigation reports which do not indicate that they have been shared with affected parties, including the families of the service users involved.

Residual recommendations:

Complete the audit cycle and seek further assurance on the sharing of learning from serious incident investigations with affected parties, including families of the service users involved.

Recommendation 2

The NHS Dorset Clinical Commissioning Group must ensure that provider serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework, that there is an audit trail of assessment of serious incident reports, and that appropriate action is taken when this is not the case.

Niche assurance rating for this recommendation **3**

Key findings: The new Investigation Report Template has been shared with all Dorset NHS organisations and is used by local trusts. Audits have been undertaken to test compliance with aspects of the Serious Incident Framework and the progression of action implementation; however, several areas of non-compliance have been identified by the CCG and further testing is required to ensure required standards are being upheld.

Residual recommendations:

Complete the audit cycle to demonstrate embeddedness and sustained improvement.

2. Assurance summary (cont.)

Recommendation 3

The NHS Dorset Clinical Commissioning Group must ensure that:

- provider action plans properly address recommendations in the associated serious incident reports;
- provider action plans are appropriately monitored, and that evidence is assessed to provide assurance that the required actions are in place; and
- when actions are not completed within agreed timeframes, the provider is required to explain the delay.

Niche assurance rating for this recommendation	4

Key findings: The CCG has initiated a number of processes which allow the quality of recommendations and action plans resulting from serious incident investigations to be scrutinised and challenged and we have seen examples where this has happened in practice. The CCG has oversight of provider action plan implementation and barriers to progress through monthly tracking. There is also an annual audit cycle which includes self-assessments submitted by each of the providers followed by deep dives for all independent reviews and selected serious incidents. However, some provider actions remain outstanding (also as evidenced by this report) and the CCG needs to ensure that their processes are sufficient to gain assurance that actions are fully implemented and having the required impact.

Residual recommendations:

Complete the audit cycle and seek further assurance that provider actions are appropriate, fully implemented and having the required impact.

Recommendation 4

The Trust must ensure that patients are provided with appropriate information about medicines in order for them to be able to make an informed decision about consenting to accept the medicine. This is even more important when a medicine is prescribed off licence.

Niche assurance rating for this recommendation	3

Key findings: Guidance and information is available for patients about their medications in a variety of formats, and the Trust has implemented a range of website analytics to monitor visits to the website and leaflet downloads. The need for consent (including for medicines which are prescribed off licence) is reflected in Trust policies; however, we have seen no evidence of the required audits or monitoring to check compliance with these.

Residual recommendations:

Complete the audit cycle to demonstrate embeddedness and sustained improvement.

Recommendation 5

The Trust must ensure that the forensic team is clear about all current and previous diagnostic formulations, particularly where there have been substantial periods of care in multiple settings, in order to ensure that assessment and treatment plans are relevant and appropriate.

Niche assurance rating for this recommendation	0

Key findings: Operational policies are available for the Forensic Team and there is guidance on referral and assessment processes but references to diagnostic formulation are limited. We have seen no evidence of the framework or audits to ensure that assessment and treatment plans are relevant and appropriate, particularly where there have been substantial periods of care in multiple settings.

Residual recommendations:

Evidence to support progression of this recommendation is required.

2. Assurance summary (cont.)

Recommendation 6

The Trust and its commissioners must ensure that the relevance of previous post-traumatic stress disorder (PTSD) diagnoses and of potential current post-traumatic stress disorder symptoms should be routinely considered, and appropriate guidance followed where relevant.

Niche assurance rating for this recommendation	2

Key findings: NICE PTSD pathways clearly depict the assessment requirements for service users and the therapeutic interventions that should be considered once accepted onto the pathway. The Trust has a policy on the management of NICE guidance implementation and progress is tracked at the NICE Assurance Group; however, compliance with the 42 PTSD recommendations relevant to the Trust varies across the service from four to 38.

Residual recommendations:

Evidence to support increased compliance with PTSD NICE guidance is required.

Complete the audit cycle to demonstrate embeddedness and sustained improvement.

Recommendation 7

Agencies involved in managing individuals through the MAPPA process must ensure that information about risks and management of those risks is passed to other areas when an individual moves to the jurisdiction of another MAPPA group. The Trusts involved in this case must review their existing MAPPA policies with this recommendation and associated findings in mind.

Niche assurance rating for this recommendation	3

Key findings: An independent review of MAPPA arrangements (April 2021) identified areas where improvements could be made including in relation to the governance structure, policy and guidelines. An action plan was agreed and implementation is being monitored by the Mental Health/Learning Disability Directorate Management Group. The Trust's MAPPA Policy has been revised in response to this review and includes actions to be taken when high risk MAPPA offenders are transferred or discharged to a different MAPPA area. MAPPA training stalled through the pandemic but is now being provided to a range of Trust staff and audits of this refreshed Policy have commenced. MAPPA arrangements are reported through the Trust's Clinical Governance Group and Integrated Safeguarding Group, and MAPPA meetings have been subject to multi-agency audits to determine whether cases are appropriately managed.

Residual recommendations:

Actions resulting from the independent review need to be fully implemented and assurance gained that changes are having the required impact.

Targeted auditing of high risk MAPPA offenders who have been transferred or discharged to a different location would provide further assurance about compliance with this recommendation.

2. Assurance summary (cont.)

Recommendation 8	
NHS England must ensure that secure services provide all relevant clinical information within progress reports, correspondence and discharge documents so that future clinical teams have a complete picture of a patient's diagnosis, risk and treatment history.	
Niche assurance rating for this recommendation	**3**

Key findings: Service specifications for secure services include requirements for handover and information sharing on transfer and discharge to other teams. Commissioner quality assurance mechanisms are in place, and we have seen evidence of meeting minutes and site visits to provider services which help to identify whether contract standards are being met. Compliance with discharge and care planning requirements are included in monthly Contract Quality Review Meeting reports although we have seen no specific reference to handover and information sharing on transfer or discharge to other teams.

Thames Valley & Wessex Adult Secure Provider Collaborative are the responsible commissioners who currently sub-contract the medium secure unit where the mental health service user, Mr P, received care. They have committed to undertaking an audit of discharge information in Quarter 1 2022-23.

Residual recommendations:

Complete the audit cycle to demonstrate embeddedness and sustained improvement.

Recommendation 9	
The Trust must also ensure that HCR-20s (risk assessments) are kept up to date with relevant information, particularly when responsibility for the patient's care and treatment is being transferred from another provider.	
Niche assurance rating for this recommendation	**3**

Key findings: The requirement for up to date risk assessments is written in policy and there have been audits to test compliance; however, these audits identified occasions where assessments were not complete or updated within required timeframes. Further testing is required to determine whether HCR-20s are being updated at each Care Programme Approach (CPA) meeting (these should occur on a six monthly basis) and to assess the quality of risk assessments being undertaken.

Residual recommendations:

Complete the audit cycle to demonstrate embeddedness and sustained improvement.

2. Assurance summary (cont.)

Recommendation 10	
The Trust must ensure that all communications executing their Duty of Candour responsibilities (including when acting in the spirit of Regulation 20) fulfil all of the requirements of the Regulation.	
Niche assurance rating for this recommendation	**3**
Key findings: Statutory Duty of Candour requirements, roles and responsibilities are written in policy. Training has been available to staff, although it is not clear how many or which groups of staff this has been delivered to. There are examples where Duty of Candour requirements have been met following serious incidents but also some cases where full assurance could not be given; compliance will therefore need to be tested further.	
Residual recommendations:	
Complete the audit cycle to demonstrate embeddedness and sustained improvement.	

Recommendation 11	
Cornwall Partnership NHS Foundation Trust must ensure that when a patient is discharged to the care of an originating team a full summary of the patient's care and treatment whilst in Cornwall is provided to the receiving team.	
Niche assurance rating for this recommendation	**2**
Key findings: The process for the transfer of care has been described via flowcharts, and requirements for information sharing with the new team are also reflected in the CPA Policy (although this expired in 2020). However, we have seen no evidence of 'a full summary of care and treatment' being required, how these guidance documents have been communicated to staff or of any audits to ensure compliance with the processes described.	
Residual recommendations:	
Update the CPA Policy to include requirements for full summary of care to be provided when transferring to originating or other service. Complete the audit cycle to demonstrate embeddedness and sustained improvement.	

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1

The Trust must ensure that all serious incident reports comply with the standards set out in the NHS England Serious Incident Framework so that:

- root causes to incidents are clear in cases where they are identified;
- appropriate learning can be identified and shared;

findings can be shared in an open and transparent way with affected parties.

Key evidence submitted[1]	Niche review
Policy for Reporting and Management of Incidents Including Serious Incidents	The Trust Policy (October 2017) is aligned to the Serious Incident Framework (SIF) and covers root cause analysis, sharing of lessons learned.
Investigation Report Template	The Report Template (agreed by the CCG and used by all local providers) reflects the requirements of the SIF including the identification of root causes, care and service delivery problems, contributory and human factors, lessons learned, arrangements for sharing lessons learned, sign-off and action planning. [We have been told that staff who undertake SI investigations have received training in root cause analysis (RCA) methodology; however, we have seen no evidence to confirm this].
Two anonymised Full and Final Investigation Reports (2021-1994 and 4898)	These example reports have used the Report Template that was agreed with the CCG and have been written in accordance with this; however, in one example there is no indication that the report had been shared with the service user's family or learning distributed from the Serious Incident Review Group, and in the other the arrangements for sharing learning have not been included in the required section.
DHUFT Incident Investigation Toolkit 2021	This includes information about incident escalation, review and investigation process and provides templates and guidance for the same.
Serious Incident Review – Panel Summary	This checklist includes the requirements for closure of the Serious Incident and these are aligned to the SIF.
Incident Investigation Quality Assurance Tools Template	This template is used by the Trust for internal assurance for investigation reports. Sections within the tool include set up, gathering and mapping, action planning and sharing the learning.
Two completed Incident Investigation Quality Assurance Tools	These examples ((2021-1994 and 4898) evidence use of the Quality Assurance Tool although, for both examples, action planning and learning were left blank.
Patient Safety Incident Report to the Clinical Governance Group – September 2021	This report includes the number of incidents by type, harms and distribution across the clinical directorates. Trend analysis is included and also lessons learned from the prior month.
CCG SI Reports, August and October 2021	These include a summary of serious incidents for mental health and learning disabilities services with recommendations, lessons learned and application of Duty of Candour.
Learning from Serious Incident Reviews	Monthly learning bulletins include brief details of cases, recommendations and learning.
Supplementary information received	• Example Next of Kin letter offering opportunity to discuss review findings

Appendix 1: Evidence review (cont.)

Recommendation 2
The NHS Dorset Clinical Commissioning Group must ensure that provider serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework, that there is an audit trail of assessment of serious incident reports, and that appropriate action is taken when this is not the case.

Key evidence submitted[1]	Niche review
Action Plan for Response to NHS Improvement Review of Dorset Never Events September 2019, updated 9 March 2020 (although entries include up to December 2020).	The review identified an inconsistent quality of serious incident reports, inconsistent application of Duty of Candour (DoC) requirements in Serious Incident investigations, variations in training and report writing skills across organisations, variations in routine involvement of other organisations in patient safety investigations, the requirement to improve thematic analysis of learning as a system and to include evidence of the review of actions and their effectiveness as part of the investigation and review processes as themes. Actions (more than 25) to address these are included within the action plan and all marked as complete (other than DoC audit report to the Quality Surveillance Group meeting pending and one action moved to new project action plan). The action plan references a number of audits (including DoC, Annual Action Plan completion audits – see letters below).
Letter to Dorset County Hospital from NHS Dorset CCG (undated) regarding provider audit for patient safety alerts, DoC and action plans for Q4 2020/21	Results for DoC gave moderate assurance that statutory duties were being exercised (from a small sample size) with good assurance that actions from serious incidents were being reported and monitored via Datix. Four recommendations resulted from these audits.
Letter to DHUFT from NHS Dorset CCG (undated) regarding provider audit for patient safety alerts, DoC and action plans for Q4 2020/21	Results for DoC gave poor assurance that statutory duties were being exercised (from a small sample size of three, none was deemed applicable) and good assurance that actions in response to serious incidents were captured and monitored.
Incident Investigation Report Template v2 10.10.2020. This is used by all Dorset provider Trusts.	The Report Template reflects the requirements of the SIF including the identification of root causes, care and service delivery problems, contributory and human factors, lessons learned, arrangements for sharing lessons learned, sign-off and action planning.
NHS Dorset Procedure for the Management of Serious Incidents	This outlines the reporting, investigation and closure processes for serious incident for provider Trusts and the CCG. It also includes the roles and responsibilities of the CCG in quality assuring the robustness of serious incident investigations and in the development and implementation of effective actions to prevent recurrence of similar incidents.
DHUFT Incident Investigation Toolkit 2021	This toolkit includes information about the incident escalation, review and investigation process and also provides templates and guidance for the same.

Appendix 1: Evidence review (cont.)

Recommendation 2 (continued)	
Key evidence submitted[1]	**Niche review**
DHUFT Incident Investigation Toolkit 2021	This toolkit includes information about the incident escalation, review and investigation process and also provides templates and guidance for the same.
Dorset County Hospital NHS FT catch up meeting notes June 2021	Meeting notes include a discussion about the Serious Incident template and the requirement for DCH to use the one issued by the CCG (‘over a year ago’).
NHS Dorset CCG Quality Surveillance Group Minutes July 2021	Minutes include that the Mental Health Homicide and Never Event Action Plans have been closed.
NHS Dorset CCG Quality Surveillance Group Duty of Candour Report July 2021	Report regarding DoC processes on patient safety investigations and an update on improvement work relating to the quality of investigation reports. Q4 audits of the provider organisations gave moderate assurance that statutory DoC is exercised in an effective and timely way by Provider organisations for those moderate incidents which are not subject to external scrutiny. However, it was acknowledged that the number of incidents within scope was too small to draw too many conclusions; therefore, the next audit will include incidents closed in both Quarter 2 and Quarter 3 2021/22.
Various minutes and papers from Patient Safety and Quality (Leads) meetings.	Evidence that meetings take place with commissioners where processes are agreed, reports and some actions plans following serious incidents reviewed, and learning identified (including themes). We note that attendance varies from 6 to 18 members.

Appendix 1: Evidence review (cont.)

Recommendation 3
The NHS Dorset Clinical Commissioning Group must ensure that provider serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework, that there is an audit trail of assessment of serious incident reports, and that appropriate action is taken when this is not the case.

Key evidence submitted[1]	Niche review
CCG Serious Incident Panel – Terms of Reference	These include the CCG's responsibility in relation to the scrutiny of investigations and action plans from provider organisations following serious incidents.
NHS Dorset CCG Patient Safety and Risk Team SI Panel standing agenda, 8 June 2021.	This includes action plans and which, if any, need to be added to the action plan or DoC audit.
Blank action plan self-audit tool for Serious Incident, Never Event and Independent Investigation Action Plans of NHS Providers in Dorset Q3.	Self-audit tool. Part 1 focuses on the action plans of five serious incidents closed during 2020 which have been selected by the CCG prior to the self-audit. Additional questions include processes and barriers to completing actions in required timeframes and the number which remain open and overdue as a Trust.
Dorset County Hospital Self-audit Action plan - extracted section of excel spreadsheet Q3 2020-21	This includes the processes which the hospital has in relation to checking due and overdue actions, barriers to completion of action plans within pre-agreed timeframes, and the number of overdue actions from serious incidents (13), Never Events (0) and Independent Investigations (0).
Dorset County Hospital Final Formal Audit Tool Q4 2020-21	Audit tool indicating that seven actions were overdue from serious incident investigation, with two from Never Events and none from independent investigations.
DHUFT Quality Catch Up – notes May 2021	These notes include reference to audits following a serious incident and dashboards for monitoring compliance.
Serious Incident Review – Panel Summary May 2021	This checklist includes whether the recommendations made by the investigators of serious incidents are appropriate and action plans robust. It also includes the outcome of the panel review and whether any further follow-up actions are required. In the example given, there was a challenge by the CCG about the strength of actions.
Serious Incident Review – Panel Summary July 2021	(As May 2021 above). In the example given there was challenge by the CCG in relation to DoC and completion of the action plan.
NHS Dorset Clinical Commissioning Group Quality Surveillance Group Patient Safety and Mortality Report January 2021	This includes a thematic and trend analysis of all incidents reported to the CCG.
Supplementary information received	NHS Dorset Clinical Commissioning Group Quality Surveillance Group minutes - various System Quality reports – various Dorset Quality Surveillance Group Action Tracker September 2020

Appendix 1: Evidence review (cont.)

Recommendation 4	
The Trust must ensure that patients are provided with appropriate information about medicines in order for them to be able to make an informed decision about consenting to accept the medicine. This is even more important when a medicine is prescribed off licence.	
Key evidence submitted:	**Niche review**
Prescribing Unlicensed and 'Off-Label' Medicines Policy v3 June 2020	This Policy details the Trust's approach to the use of unlicensed medicinal products and medicinal products used outside the terms of their licence. It requires patients (or their relatives when relevant) to be given a full (documented) explanation and patient consent must be obtained and documented wherever possible. The Policy states that the prescribing of unlicensed medicines will be reviewed based on the receipt of unlicensed medicines usage forms; however, we have seen no evidence of this being undertaken.
Policy For Non-Medical Prescribing v16.1 February 2018	This provides guidance to non-medical prescribers. It requires the reason for choosing the medication to be documented in the medical records and for the patient or client to agree to the prescription in the knowledge that the medicine is unlicensed. Senior managers and the Director of Nursing are responsible for reviewing compliance against this Policy and agreeing recommendations for changes required for effective and cost efficient compliance; however, we have seen no evidence of this being undertaken.
Medicines Management Policy Statement October 2018	This document introduces an integrated suite of procedural documents aimed at addressing areas of medicines management referred to as the Medicines Management Policy Framework. This states that compliance will be monitored through regular audit as part of the Trust's clinical and internal audit strategy and plans. Also that non-compliance and trends in variance from agreed standards will be measured through monitoring of incident reporting with respect to medicines management; however, we have seen no evidence of this being undertaken.
Medicines Control Policy June 2020	This Policy forms part of a suite of policies written to instruct staff within the Trust on aspects of medicines including their prescribing, handling, and storage. It includes that compliance will be monitored via pharmacy weekly and monthly checks and self-assessment via the Medicines Management Quality Checklist; however, we have seen no evidence of this being undertaken.
Clozapine Policy: Prescribing, Monitoring and Supply February 2021	This document states that the purpose of the Policy is to clarify the roles and responsibilities of all healthcare professionals involved in the management of clozapine (prescribing, monitoring, administration, procurement, supply), and to ensure that there are processes in place that aim to minimise risk and deliver a service of consistent quality. It includes that adherence to this policy is monitored by the Medicines Management Team and by the High Dose Antipsychotic Therapy audit; however, we have seen no evidence of this being undertaken.

Appendix 1: Evidence review (cont.)

Recommendation 4 (continued)	
Key evidence submitted:	**Niche review**
Unlicensed Medicines Handy Fact Sheet	This two page fact sheet provides patients with information about prescribed unlicensed medicines, what to expect and how to get more information if required.
HR 2016/21910 evidence extract from email box to 'all prescribers and pharmacy' Subject: FW: Unlicensed Medicines - action	Email following 'a review that resulted in learning around unlicensed medicines, to ensure that all prescribers are aware of/reminded of best practice with regard to unlicensed medicines and licensed medicines that are prescribed off-licence'.
Screen shot of the Trust's Pharmacy homepage: 'Find out more about mental health conditions, treatments and medications'	Website which allows patients/relatives to search for information about a condition or a medication
Various examples of analytics for the Pharmacy service June 2020 – May 2021	Audience overview of visits to the website and leaflet downloads.

Recommendation 5	
The Trust must ensure that the forensic team is clear about all current and previous diagnostic formulations, particularly where there have been substantial periods of care in multiple settings, in order to ensure that assessment and treatment plans are relevant and appropriate.	
Key evidence submitted:	**Niche review**
Operational Procedural Guidance For The Forensic Inpatient Service On Twynham Low Secure Unit August 2020	This document describes the operational arrangements for the Forensic Inpatient Service. It includes that on admission to Twynham Ward the Consultant Psychiatrist, alongside the MDT, will review a patient's diagnosis and formulate a treatment plan. It also states that regular compliance audits will be undertaken by reviewing incident reports, complaints and audit data, and that this will be reviewed on an annual basis with any non-compliance reported to Quality, Clinical Governance and Risk Committee; however, we have seen no evidence of these activities being undertaken. There is also reference to a SOP/guidance for diagnostic formulation (e.g. for the 5Ps formulation framework) but we have not been provided with a copy of this.
Dorset Forensic Team Operational Policy August 2020	This document describes the operational arrangements for the Dorset Forensic Team (DFT). It includes a section on risk assessment and management and requires that all referrals will need to remain open until the assessment and formulation is complete. It states that the Forensic Team will regularly audit care plans, CPA and risk management requirements; however, we have seen no evidence of these audits being undertaken.

Appendix 1: Evidence review (cont.)

Recommendation 5 (continued)	
Key evidence submitted:	**Niche review**
Example of Clinical Review Day -Twynham January 2020	Case review of all patients. This includes reason for admission, who should be involved, how often each service user should be reviewed and long term plans.
Example of Dorset Forensic Services (DFS) case load lists - April 2021	This includes a reminder of date and details of last discussion for each service user.
Example of DFS Weekly MDT Meeting agenda and notes – April 2021	This includes discussion summaries of new referrals and all patients on the current caseload.
Referrals and assessment audit – September 2018-August 2019	This includes data relating to date of referral and assessment to the DFT although a number of fields are left blank. Findings indicate that, on average, 61.8% of referrals were assessed within four weeks of receiving the referral and 57.7% of assessments carried were fed back to the MDT within 2-4 weeks of carrying out the initial assessment.
Various Quality Assurance Checks of Dorset Forensic Services – March 2017, May 2018, August 2018, July 2019, May 2021	The purpose of these visits is to assess the Forensic Team's compliance with a sample of fundamental standards and Mental Health Act Code of Practice requirements. These vary in the examples given but include care plans, risk assessments, record keeping and patient involvement although the number of patients' case notes reviewed was low.
Dorset Forensic Service Criteria for Referral (Appendix B)	This requires NHS mental health providers referring patients to Dorset Forensic Services to keep the patient open to their service until the forensic assessment, formulation and conclusion are complete. Also that services should not discharge patients from their caseload until formal transfer of care has been agreed and arranged.
Dorset Forensic Services Referral Pathway (Appendix C)	This flow chart depicts the routine and urgent referral processes and includes requirements for assessment.
Dorset Forensic Services Low Secure and Community Forensic Directorate Care Programme Approach April 2018 (Appendix E)	This includes a section on the assessment of needs and requires staff to undertake a review of previous care plans and risks. It also states that patients who are being admitted to the community forensic services who have been on a CPA pathway with another service should have a CPA review as part of their discharge/transfer from their current service to the community forensic services
Supplementary information received	Inpatient Service Review Report - November 2019 Royal College of Psychiatrists Quality Improvement Report - Twynham Ward May 2019

Appendix 1: Evidence review (cont.)

Recommendation 6	
The Trust and its commissioners must ensure that the relevance of previous post-traumatic stress disorder diagnoses and of potential current post-traumatic stress disorder symptoms should be routinely considered, and appropriate guidance followed where relevant.	
Key evidence submitted:	**Niche review**
DHUFT Contractual Quality Report June 2019	NICE compliance was a requirement of commissioner quality monitoring and in this report there is reference to implementation of NG 116 (PTSD) which was due in April but extended to June 2019. Normal contract monitoring was, however, paused for the pandemic in March 2020 and the current contract and finance guidance states that the standard NHS contract applies nationally and there has been no requirement to re-start local agreement of quality schedules; update reports have therefore not been received formally. The CCG is now working towards the development of a quality dashboard that draws from national datasets and is outcomes focussed to reduce the burden of reporting.
PTSD Service User Fact Sheet, July 2019	This factsheet has information about the symptoms and causes of PTSD. It explains who might develop PTSD and what treatment is available.
NICE Clinical Guideline No: NG116 PTSD (Mental Health Inpatient Service) Published: December 2018	This baseline assessment document (dated September 2019) confirms that 42 recommendations were relevant to the Trust with full compliance for 24. Evidence for compliance status is not included and there are no residual actions for the areas of non-compliance.
NICE Clinical Guideline No: NG116 PTSD (Adult Psychology Services)	This baseline assessment document (dated April 2020) confirms that 42 recommendations were relevant to the Trust with full compliance for 38. There are no residual actions for the areas of non-compliance.
NICE Clinical Guideline No: NG116 PTSD (LD Service)	This baseline assessment document (dated August 2020) confirms that 42 recommendations were relevant to the Trust with full compliance for 16. There are no residual actions for the areas of non-compliance.
NICE Clinical Guideline No: NG116 PTSD (MIUs & UTCs)	This baseline assessment document (dated August 2020) confirms that 42 recommendations were relevant to the Trust with full compliance for 4. There are no residual actions for the areas of non-compliance.
Clinical Effectiveness Group Part 1 NICE Assurance Group Agenda and Matters Arising 6 August 2020	This agenda includes Completed action plans (Trust Compliant) for NG116 PTSD (MIUs & UTCs) and also a progress report for NG116 PTSD (Learning Disabilities/Autism). The Matters Arising document includes action taken in relation to the progress reports (updated 3 September 2020).
DHUFT NICE Guidance Management Policy June 2021	This Policy describes the agreed process for the assessment, implementation and monitoring of NICE guidance. The policy aims to ensure there is an internal system of control in place to ensure that the Trust meet the expected standards and that relevant NICE guidance is implemented in a timely manner.
Mental Health Pathway-PTSD and Complex PTSD	This includes inclusion and exclusion criteria for assessment and the range of therapeutic interventions which should be considered for service users.
Supplementary information received	DHUFT Quality Account 2020/2021 MH&LD NICE Guidance Action plans spreadsheet - November 2021

Appendix 1: Evidence review (cont.)

Recommendation 7
Agencies involved in managing individuals through the MAPPA process must ensure that information about risks and management of those risks is passed to other areas when an individual moves to the jurisdiction of another MAPPA group. The Trusts involved in this case must review their existing MAPPA policies with this recommendation and associated findings in mind.

Key evidence submitted:	**Niche review**
MAPPA Training – 1 and 22 August 2020	A list of 47 staff attenders. A new blended training package of face to face and e-learning has been developed jointly by the Trust, Police and MAPPA Co-Ordinator. This is being rolled out to relevant staff groups; 92 staff have signed up to the training that is being delivered in November with further dates being added.
MAPPA Audits – various (December 2020, January 2021, April 2021)	Individual case audits which include a review of risk management plans, recording of circumstances of transfer/admission and information/liaison with other agencies/police. Liaison evident in all cases.
MAPPA File Audit Q3 2020-2021	Five MAPPA meetings were audited remotely by five auditors from Dorset Police, Dorset Youth Offending Service, Dorset Healthcare, MAPPA Lay Adviser and MAPPA Coordinator. They found that four cases had been managed “very well” and one case “well enough”. No material concerns were identified by the auditors.
Dorset MAPPA KPI Quarterly Performance Comparison Table Q1- Q4 2020-2021	Green (>90%) ratings given for 10 KPIs including reviews within 8/16 weeks for Level 3/2 MAPPA cases and attendance by named agencies at MAPPA meetings.
MAPPA Annual Report 2020-2021	This included that the Trust has a MAPPA work stream group to address any gaps in provision in meeting its responsibilities and areas of work that had been addressed through this forum. It also stated that an action plan was being developed following an external review commissioned by the Trust (see Independent Review of DHC MAPPA systems and processes below).
Independent Review of DHC MAPPA systems and processes – (and also Executive Summary), April 2021	This report provided some positive assurances in relation to MAPPA case management, contributions to audit activity and attendance at key meetings. However, there were also several areas where improvements were required including a review of the governance structure, MAPPA policies and associated guidance, representation at Level 2 meetings, recording Level 1 clients on RiO, provision of awareness training for wider staff groups and a central site for staff to access MAPPA related information. An action plan was agreed (see below).
Action plan from the Independent Review of DHC MAPPA systems and processes – April 2021	The action plan includes the 12 recommendations from the independent review (see above). Four were marked complete with eight still in progress. Evidence of effective implementation/assurance [e.g. audit] is a requirement of the template but only included for two of the completed actions.
MAPPA Training Meeting June 2021	Meeting to discuss delivery of MAPPA training for staff in various forms including face to face and virtual/e-learning.

Appendix 1: Evidence review (cont.)

Recommendation 7 (continued)	
Key evidence submitted:	**Niche review**
Multi-Agency Public Protection Arrangements - April 2021	The MAPPA Policy includes action to be taken when high risk MAPPA offenders are transferred to external treatment facilities or are to be discharged to a different MAPPA area. We have been told by the Trust that the plan was to audit 10 MAPPA cases against the standards from the Trust MAPPA Policy after six months. This work has commenced and the report will be presented to the Mental Health & Learning Disability Directorate Management Group in December 2021 and the Clinical Governance Committee in January 2022.
Clinical Governance Group Safeguarding Service Reports Q2, Q4 2020-2021, Q1 2021-2022	These include information on MAPPA (activity, ongoing reviews etc.)

Recommendation 8	
NHS England must ensure that secure services provide all relevant clinical information within progress reports, correspondence and discharge documents so that future clinical teams have a complete picture of a patient's diagnosis, risk and treatment history.	
Key evidence submitted:	**Niche review**
Adult Low Secure Services including Access Assessment Service and Forensic Outreach and Liaison Services (FOLS), March 2018	This service specification covers the provision of low secure inpatient services for adults. Appendix 1 includes a section on discharge and transition. It identifies the need for a discharge care plan focusing on transition and engagement with the next service along and also effective handover when transferring care to another team.
Adult Medium Secure Services including Access Assessment Service and FOLS, March 2018	This service specification covers the provision of medium secure inpatient services for adults. Appendix 1 includes a section on discharge and transition. It identifies the need for a discharge care plan focusing on transition and engagement with the next service along and also effective handover when transferring care to another team.
Provider Monthly Reports for NHS England for Specialised Services, various, August 2020	These reports include safeguarding information, incidents and causal groups, compliance with operational standards (7 day follow-up, CPA, Delayed Transfers of Care, HCR-20 assessment and review)
Quarterly Exception Report to Provider Collaborative CQRM for Adult Secure Services, October 2020	This report includes safeguarding, inpatient activity and operational standards, 7-day follow-up and incident data.
Forensic Services Provider Collaborative Contract Quality Review Meeting Notes, various (June, August, November 2020)	Sample of Contract Quality Review Meeting (CQRM) notes. Provider Quality Assurance Updates are included and cover a range of key performance indicators with some evidence of incidents, delayed discharges and care planning being discussed.

Appendix 1: Evidence review (cont.)

Recommendation 8 (continued)	
Key evidence submitted:	**Niche review**
Allied Healthcare Professionals Adult Forensic and Learning Disabilities Quarterly Quality and Safety Report, January 2021	This report includes a trend analysis of incidents, actions being taken, other patient safety information and the results of external inspections. Risk assessments are noted as 100% compliant across all forensic services.
Service specification: High secure mental health services (Adult), February 2021	This specification covers the provision of high secure services for adults aged 18 years and over in England and Wales and the high secure service for women in Scotland and Northern Ireland. Appendix 1 includes a section on the discharge pathway. It states that the service will share a discharge summary and the most recent risk assessment and management plan.
Quarterly Key Performance Indicator Reports, Southfield, Quarter 1 and 3 2020-21	These spreadsheets list activity, KPI and compliance information including in relation to discharge and care planning (compliance rates for these aspects of care noted to be high in Quarter 3).
Case Manager Quality Report, Thames Valley and Wessex Forensic Network, Quarter 3 2020-21	Case Manager report for Ashford Unit, Southfield and Ravenswood House submitted prior to CQRM. This includes: themes and trends for incidents, safeguarding, Care Quality Commission inspections etc; actions taken for any escalated concerns; outcomes from quality visits; and service user feedback.
Dorset HealthCare University NHS FT (DHUFT) and Southern Health NHS FT (SHFT) CQRM Meeting Minutes, various (May, August, November 2021)	These include patient stories and deep dives into identified areas of concern such as ligature management, Triangle of Care, safeguarding, complaints management, infection prevention and control. Learning from incidents, provider quality assurance, Case Manager and contract updates are also given with compliance visit action plans discussed.
Extract of statement from NHS England South East (NHSESE) Specialised Commissioning, March 2022	This states that a Specialised Commissioning Nursing and Quality Team was established in April 2020. Also that this team: monitors and quality assures providers' performance via a number of mechanisms such as attendance at Clinical Quality Review Meetings and Quality Surveillance Groups/ System Quality Groups; works with regulators; and undertakes quality assurance visits to providers routinely. The Thames Valley & Wessex Adult Secure Provider Collaborative are now the responsible commissioners who sub-contract Ravenswood House medium secure unit.

Appendix 1: Evidence review (cont.)

Recommendation 9	
The Trust must also ensure that HCR-20s (risk assessments) are kept up to date with relevant information, particularly when responsibility for the patient's care and treatment is being transferred from another provider.	
Key evidence submitted:	**Niche review**
Managing Clinical Risk in Mental Health Policy July 2021	This Policy was refreshed in July 2021 and emphasises the importance of accurate and recent risk assessments of the individual and their social context. It also confirms the requirement for a risk assessment to be undertaken when there is any change in the patient's clinical condition, presentation and circumstances (discharge from a service, admission and discharge from an inpatient ward, at the point of transfer between Trust services and any other change in circumstances identified).
Quality Assurance Check – Twynham Ward May 2021	The report includes a summary of findings using the five questions which the CQC ask of all care services; 'are we safe, effective, responsive, caring and well-led?' The records of four detained patients were checked with evidence of HCR-20 risk assessments being '*regularly undertaken'.* This sample size is small and the report does not include whether the assessments were up to date.
Realtional Security Presentation - 2018	Training presentation on relational security and the tools available to staff and the steps to be taken to keep people safe.
HCR-20 Audit Report - March 2021 (annual summary of monthly audits, samples of which were also supplied)	An audit of all inpatients and community patients on the DFS caseload between April 2020 to March 2021. This found that (including both inpatient and community caseloads), the average monthly performance of HCR-20 completion was 90%, of which 77% had been updated within the last six months of each audit date. This preliminary data was discussed at the Clinical Governance meeting in April 2021 and it was agreed that HCR-20s should be updated at each six monthly CPA meeting.
Twynham Ward Forensic MDT Initial Assessment Audit – February 2020	Audit of six patients with 10 KPIs (assessment by members of the MDT within stated timeframes). Results indicate overall compliance of 51% (8/10 KPIs red rated).
Dorset Forensic Services Low Secure and Community Forensic Directorate CPA – April 2018 (Appendix E)	This includes that Inpatient and Community Forensic patients on CPA pathway will have a review of whether a HCR-20 V3 risk assessment should be completed by the clinical team during their first CPA review. A lead clinician will be allocated to coordinate the HCR-20 risk assessment.
Twynham Low Secure Unit Trial HCR-20 (Risk Assessment) Process (Appendices K and L)	This requires the Inpatient Care Coordinator to ensure that referring services provide the Dorset Forensic Services with an updated HCR-20 prior to/on admission (as part of admission checklist) for all new patients and describes the processes for HCR-20 assessments and meetings.

Appendix 1: Evidence review (cont.)

Recommendation 10	
The Trust must ensure that all communications executing their Duty of Candour responsibilities (including when acting in the spirit of Regulation 20) fulfil all of the requirements of the Regulation.	
Key evidence submitted:	**Niche review**
Duty of Candour presentation 2016	DoC training slides for staff. Training numbers of staff who have received this training have not been made available.
Being Open (Duty of Candour Policy (DoC)) July 2014 (ratified 2017)	This Policy recognises that patients and/ or carers should receive an apology as soon as possible after a patient safety incident has occurred. It includes that all Trusts have a contractual and statutory duty to inform patients when moderate or serious harm has been or could have been caused by their services (DoC).
Duty of Candour (DoC) Template Letter	This is aligned to statutory and professional requirements for DoC. It includes an apology, that an investigation into the incident will occur and that the person/family can be involved.
Examples of DoC letter sent to family – February, April and June 2021	Examples of DoC letter sent using the Trust template pre and post incident investigation and aligned to statutory and professional requirements.
Examples of DoC dates due and dates the 10 day letters were sent	Extract of table showing the dates that 10 day DoC letters were due and sent for eight serious incidents for a named DoC Lead. All were sent within the required timeframe.
Incident Investigation Template	Template used by authors of investigations, This reflects the requirements of the SIF including DoC arrangements (and the rationale if Duty of Candour has not been applied).
Serious Incident Report to the Quality Governance Committee - May 2021	This report provides summary details of significant events occurring during March and April 2021 and gives updates on DoC and any key issues relating to ongoing incidents.
Annual Serious Incident Report to Quality Governance Committee - September 2020	This report provides an overview of serious incident themes and trends with an update on recent activity. It includes a section on DoC and states compliance with this requirement for all reported serious incidents.
Extract from Serious Incident Tracker (for StEIS Ref 2021)	10 incidents with details of dates and types of incident and date DoC sent.
Letter to DHUFT from NHS Dorset CCG (undated) regarding provider audit for patient safety alerts, DoC and action plans for Q4 2020/21	Results for DoC gave poor assurance that statutory duties were being exercised (from a small sample size of three, none were deemed applicable).

Appendix 1: Evidence review (cont.)

Recommendation 11	
Cornwall Partnership NHS Foundation Trust must ensure that when a patient is discharged to the care of an originating team a full summary of the patient's care and treatment whilst in Cornwall is provided to the receiving team.	
Key evidence submitted:	**Niche review**
Transfer of Care out of area – non CPA v2 flowchart (undated)	This flowchart describes the transfer of care process that is required when a patient moves out of area. This requires teams to agree a transfer date with the new Care Co-ordinator and to update the care plan, risk assessment and crisis plan.
Transfer of Care out of area via CPA v2 flowchart (undated)	This flowchart describes the transfer of care process that is required when a patient moves out of area. This requires teams to support the patient to register with a new GP if required, agree a transfer date with the new Care Co-ordinator and to update the care plan, risk assessment, cluster assessment and discharge CPA review. There is also reference to the consideration of joint working for a period of three months to minimise risk of destabilisation post move.
CPA Policy	This expired in December 2020 but requires information to be shared with all appropriate agencies on discharge or transfer including the latest care plan, completed contingency plans, and relevant copies of correspondence or events from the electronic and paper record.

Appendix 2: Glossary of terms

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CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CPA	Care Programme Approach
CQRM	Contract Quality Review Meeting
DHUFT	Dorset HeathCare University NHS Foundation Trust
DoC	Duty of Candour
MAPPA	Multi-Agency Public Protection Arrangements
NIAF	Niche Investigation Assurance Framework
PTSD	Post-traumatic stress disorder
RCA	Root Case Analysis
SIF	Serious Incident Framework
SOP	Standard Operating Procedure

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