Independent Investigation Assurance Review Greater Manchester Mental Health NHS Foundation Trust (GMMH).

STEIS: 2016-29151

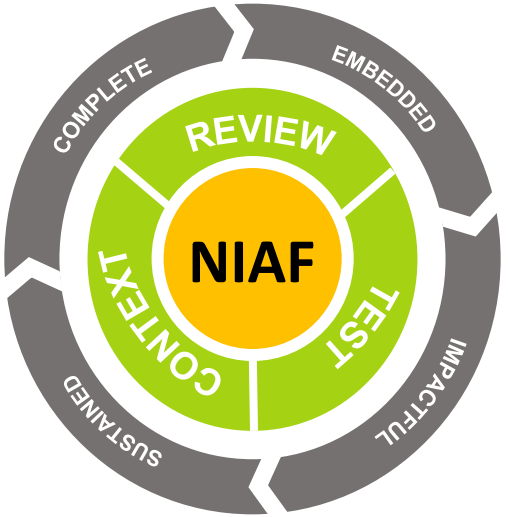
Final Report

Private and confidential

April 2021

insight integrity impact

Niche Investigation Assurance Framework



Report author: Sue Smith
Lead Partner: Nick Moor

Niche Health and Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

NHS England and NHS Improvement
Quarry House, Leeds

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Final Report has been written in line with the terms of reference for our Independent Investigation into the Care and Treatment of a Mental Health Service User ('Service User A'). This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date.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

This is a confidential Report and has been written for NHS England alone under agreed contractual terms. No other party may place any reliability whatsoever on this report as this report 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, approved version of this Report, the 'Final Report' should be regarded as definitive.

Nick Moor, Partner

Telephone: 0161 785 1000
Email: enquiries@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

insight integrity impact

Contents

1. Executive summary and additional recommendations

Background to the initial event

In October 2017 NHS England commissioned Niche Health and Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Mr A) by the Greater Manchester Mental Health NHS Foundation Trust (GMMH, 'the Trust'), previously known as Greater Manchester West Mental Health NHS Foundation Trust, following the homicide of a member of the public, Mr O, in October 2016.

Context for this review

The final report from Niche was published in 2019 and included 11 recommendations intended to support the Trust in taking learning forward and improving services and practices.

The Terms of Reference for the independent investigation required Niche to undertake an assurance follow up review after report completion. This was to provide an assessment of the implementation of the organisation's resultant action plans against the Niche Investigation Assurance Framework (NIAF).

This is a high level report on progress to NHS England and NHS Improvement North West, undertaken on the basis of a desktop review only, without further site visits or interviews.

We would like to thank the staff at GMMH for their engagement throughout the review.

Independent internal investigation and implementation of recommendations

Recommendations were used as the basis for action planning.

The action plan submitted by GMMH against the recommendations showed the due dates for completion of all recommendations as April and May 2019, and was RAG rated as green. However, much of the evidence submitted to Niche for this assurance report had been written in 2020.

There were named individuals in the Trust action plan who were assigned to take the actions forward. It was not noted however, when the specific actions were completed and mapped against the due dates.

Review method and quality control

Our work has comprised a review of documents. It is important to note that we have not reviewed any patient records because there is no element of re-investigation contained within the assurance review terms of reference. We used information from GMMH, Central Manchester Clinical Commissioning Group (CCG), and Salford Royal NHS Foundation Trust (SRFT) to complete this review.

At Niche we have a rigorous approach to quality standards. We are an ISO 9001:2015 certified organisation and have developed our own internal single operating process for undertaking independent investigations. Our final reports are quality assured through a Professional Standards Review process (PSR) and approved by an additional senior team member to ensure that they have fully met the terms of reference for review.

2. Summary assessment on progress

The Niche Investigation Assurance Framework

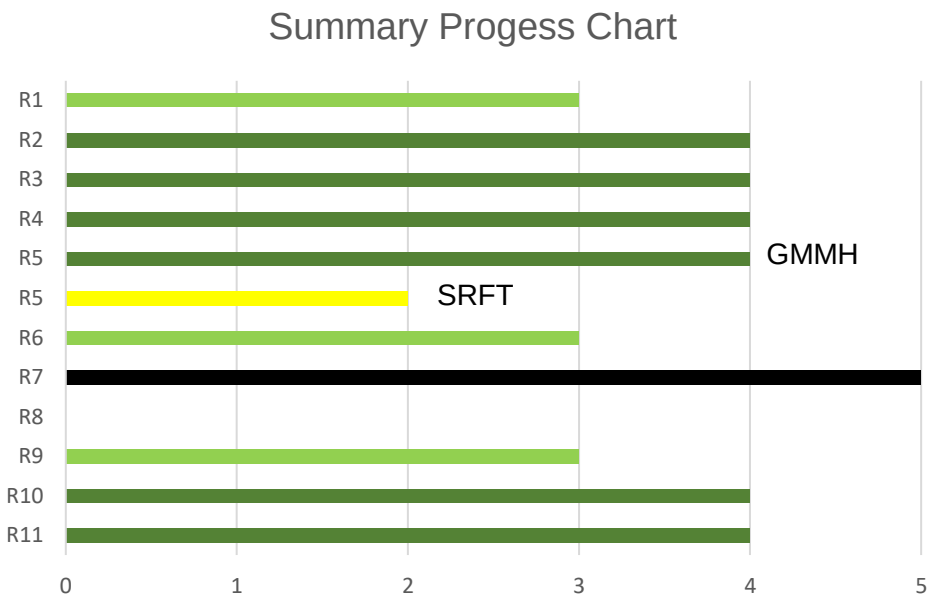
Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be constructive and evaluative, rather than punitive and judgemental. We adopt a useful numerical grading system to support the representation of 'progress data'. We deliberately avoid using traditional RAG ratings, instead preferring to help our clients to focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and in response to the original recommendation.

Our measurement criteria includes:

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 and embedded
5	Can demonstrate a sustained improvement

This assurance review has focussed on the subsequent actions that have been progressed and their implementation in response to the recommendations made in the original report.

In relation to progression of actions which have been agreed from the 11 recommendations made, we have rated the findings which are summarised below:



Summary

The Trust has made good progress in relation to most actions, but we have received limited information to be able to assess the progress of Recommendation eight (R8).

Further evidence is required from Salford Royal NHS Foundation Trust (SRFT) to demonstrate the progress of Recommendation five (R5).

Assurance review findings

Detailed assurance review of the Trust's actions

Recommendation 1: The Trust must ensure that clarity is provided to early intervention team staff about what approach to take when there is diagnostic uncertainty (either within a single team or between teams involved in a patients' care and treatment).		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
Trafford Senior Leadership Team (SLT) facilitated a multidisciplinary Positive Learning Event attended by the Early Intervention (EI) staff and teams from other areas of the Trust. Reflecting on the review findings staff were made aware that there must be a full multidisciplinary team(MDT) discussion, including presence from the medical representative, when deciding to discharge someone from EI services. This is regardless of whether the rationale for discharge is due to diagnostic uncertainty or the end of the expected pathway.	The Trust held the Positive Learning Event on 24/4/2019. The minutes were submitted as evidence and reflected the Trust's plan to include professionals across multiple services, including those external to the Trust (e.g. Greater Manchester Police). There was a detailed account of the discussions that were undertaken between the various agencies and an exercise carried out whereby the outcomes of this shared learning were documented.	The minutes are comprehensive and identify those that attended and their roles. The minutes lack action dates or identified personnel to take issues forward. The Trust indicated in their action plan that further events on a smaller scale are planned across the Trust. These events, if they have taken place, have not been evidenced. There is no further evidence that this way of working has continued – it may be useful to have this format as a standing item for local business meetings.
The EI Team Operational Procedure has been revised to highlight to teams the process for referral to forensic services for clinical opinion/risk management guidance where a service user is not responding to treatment for a period of time and where risks are escalating.	The EI Operational Policy submitted was ratified on 17/12/2020 and has comprehensive content regarding the management of varying levels of risk and guidance for staff on how to seek specialist support/intervention. The policy is due for review in January 2022.	Operational policy provided. Point 11 – 11.8 sets out clearly steps to be taken if concerns around risk are raised.

Recommendation 1: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The EI Operational Policy has been strengthened to highlight to staff whereby difference of opinions within teams regarding the use of the Mental Health Act (MHA). Initial resolution of any conflicting opinions will take place within multidisciplinary meetings that are recorded on Paris. AMHPs within the team are involved in such discussions.	The EI Operational Policy identifies clearly in Point 27.1.1 the way in which differences of clinical opinion are to be managed.	The policy is comprehensive and outlines in detail how the pathway works, and identifies in a user friendly way how people should proceed when engaged in managing diagnostic variances.
	The specific professional groups who need to be involved in discussion about the above are listed for clarity – minutes provided.	The policy is long and inclusive with a number of references - a short "Policy on a Page" version would be useful for practitioners to enable quick reference.
Learning from Mr A in relation to the recommendations made by Niche has been shared through the Trust wide Early intervention Steering Group and through a dedicated Trafford Homicide Action review meeting.	A meeting of the EI Steering Group was held in June 2019 where it was agreed there that the EI Policy would be updated to reflect the Niche report's recommendations – minutes provided.	The revised policy includes additions which reflect learning from the incident – Point 26.

NIAF review rating (RR): The meetings and workshop held reflect the Trust's willingness to meet the recommendation. The comprehensive updated EI Policy outlines clearly what the service provides and how it needs to be delivered in a collaborative, focussed way.

Overall review rating for this recommendation: 3

Recommendation 2: The Trust must ensure that clarity is provided to the Early Intervention Team about the process for seeking a 2nd opinion and/or formal consultation with another clinician or team (in particular the forensic team) when a patient has not responded to treatment for a prolonged period of time and where risks are escalating.		
Trust action plan	**Trust response and evidence submitted**	**Niche comments and gaps on assurance**
The EIT Operational procedure has been strengthened to provide further clarity to staff in relation [to] the process for seeking a second opinion and/or formal consultation with another clinician or team (in particular the forensic team) when a patient has not responded to treatment for a prolonged period of time and where risks are escalating. The Trust commissioned a Greater Manchester collaborative pilot programme - development of a Specialist Community Forensic Team (SCFT) with the aim of providing expert advice and support to Community Teams across GM to safely manage patients with a known forensic risk.	This learning was also shared through business meetings, Trust EIT Steering Group meetings and a Local and Trust wide Multidisciplinary Positive Learning Event as referred to in recommendation 1 above. Emails from colleagues working in community Health and Justice services describing joint working and collaboration with EI teams submitted. Document detailing multiagency support submitted. The SCFT pilot proposal paper outlining the workforce requirements and staffing model, key milestones and timeline March 2020 – March 2021 start and finish was submitted.	The evidence for this part of Recommendation 2 was a duplicate of that submitted for Recommendation 1. The minutes of the EI business meeting held on 21/05/2019 which included the names and roles of attendees, demonstrates that the team are aware and working towards strengthened clarity with regard to consultation with other teams. The pilot SCFT is to work alongside generic teams in an advisory capacity. The proposal identifies two desired outcomes: • Prevention of relapse through timely assessments and interventions. • Accelerated discharge back to the community via enhanced engagement with local services. The Trust has given an evaluation date of the service as March 2021. We have not been provided with detail of how the team was set up or evidence to demonstrate the service it delivers.

Recommendation 2: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The service will provide expert advice, responsive consultation and a liaison service to other mental health services and relevant stakeholders in the management of patients with mental disorders who have offended or are at risk of offending/reoffending. In 2018 the GMMH Adult Forensic Referral Flow chart was developed to support teams across the trust where they require a second opinion and/or formal consultation with another clinician or team in particular from the forensic team when a patient has not responded to treatment and where risks are escalating.	A series of documents and emails which describe how SCFT will provide ongoing mental health assessment, formulation and treatment to promote recovery and manage risk during and after transition to and from inpatient services were provided. The flowchart identifying in a simple and clear way how to make a referral to Forensic Services was submitted as evidence, as was a screen shot showing it displayed on the Trust intranet.	The Trust has met this action with a pilot SCFT set up and due for evaluation in March 2021. This action meets the requirement of the recommendation. The Forensic Referral flowchart is a practical, helpful guide for not only the EI team, but teams across the Trust as it is accessible through their intranet.

NIAF review rating (RR): The Trust has progressed a number actions to meet this recommendation. The implementation and review of the new SCFT team demonstrates an improvement in practice.

Overall review rating for this recommendation: 4

Recommendation 3: The Trust and relevant local authorities must ensure that where systems do not already exist: • when there are doubts or differences of opinion about the use of the Mental Health Act (MHA), a formal discussion that involves an Approved Mental Health Professional (AMHP) takes place and is properly recorded; • the AMHP teams on duty during normal working hours and out of hours have a system to record all requests for Mental Health Act assessments, even when it is expected that a clinical team will contact the next shift.		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
AMHP referrals continue to go through a single point of access across the 24-hour period. The referral tracker remains in place to cover the 24-hour period and all referrals entered on the PARIS records. The full-time AMHPs are proactive in maintaining an overview of both incoming referrals and the tracker. The importance of complying with the AB action plan is raised through the Emergency Duty Team (EDT) management structure.	Compliance with the MHA and AMHP related matters are monitored via the Trust's Mental Health Act and Mental Capacity Act Compliance Committee (MHACC). Minutes of the MHA & MCA Quality Improvement Group (MCAQ) held in March, May and July 2020 submitted. Formal discussion regarding the use of the MHA is recorded either on the relevant tracker if a screened-out referral or on the Paris notes. Referral trackers, MHA assessment reports x3 and PARIS training attendance submitted as evidence.	The MHACC group discussed the AB case in detail. The use of referral trackers and the entering of these onto PARIS was agreed and minuted. The implementation of the referral trackers demonstrates a system whereby broad monitoring of the MHA journey of a service user is documented, with clarity regarding personnel involved. The EDT PARIS training attendance records which set out names of staff, was well attended, and was logged onto the Trust's Education and Training site for CPD.

NIAF review rating (RR): The evidence submitted demonstrates that the Trust has progressed this action and demonstrates a significant improvement in practice and monitoring.

Overall review rating for this recommendation: 4

Recommendation 4: The Trust must ensure that all clinical teams follow Trust Safeguarding policies when they are made aware of safeguarding concerns about children or adults, and that appropriate referrals are made to the relevant social care department.		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The Trust's suite of Safeguarding Policies and Procedures developed by the Safeguarding Team ensures that the Trust complies with relevant legislation and guidance on the safeguarding of its service user population. These policies are supported by a comprehensive Mandatory Training programme in order to raise awareness on how staff can raise a safeguarding referral where service users may be at risk.	Compliance of staff accessing safeguarding training is monitored by the Trust Safeguarding Team, and Trust Learning & Development department. Audits of compliance provided. Internal audits of staff awareness of safeguarding policies and processes submitted as evidence The Trust's Safeguarding intranet page has been updated to provide tools and resources for all staff to access. Divisional/service safeguarding leads are in place to provide local advice and guidance within teams with clear direction on multiagency referral (MARAC) processes. Screenshots provided.	Audits completed in 2018/2019 demonstrates the Trust target of 90% of awareness of resources in both adult and children safeguarding has been achieved. The audits also included the uptake of PREVENT training. Action plans have been formulated to take work forward and audits are underway for 2020/21. Trust staff are aware of Safeguarding policies via a safeguarding newsletter, a Trust intranet site which gives detailed guidance on a variety of safeguarding issues, the safeguarding pathway, a list of local leads, their contact details and helpful resources. Mandatory training strategy 2018-2020 sets out clearly the roll out of training in terms of professional background and role, method of delivery and compliance targets. The risk procedure is a practical and comprehensive what to do guide for practitioners.

Recommendation 4: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
	Safeguarding Adults at Risk procedure & Safeguarding training strategy submitted. The Trust updated Supervision Policy (September 2020) submitted as evidence. The Trust Biannual Datix Safeguarding Audit Quarter 3 2020/21 submitted. The audit is used by the Safeguarding team to provide assurance staff are following the correct safeguarding processes and that referrals are appropraite.	Discussion of safeguarding is a standing item in clinical and managerial supervision. The audit is an inclusive review of incidents, actions taken and agencies alerted. Part of the audit criteria is whether the referral was appropriate.

NIAF review rating (RR): The Trust has provided extensive evidence that Safeguarding policies, guidance and resources are available to staff, and that there is monitoring of adherence to Safeguarding process through audit.

Overall review rating for this recommendation: **4**

Recommendation 5: The Trust and Salford Royal NHS Foundation Trust must ensure that when recording that a patient is being treated under the Deprivation of Liberties Safeguards (DoLS) framework the appropriate documentary detail is in place to apply the Mental Capacity Act lawfully.		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
GMMH: The Trust now has a Mental Capacity Act and DoLS policy that provides clear guidance for staff in terms of the legal frameworks, assessment documentation and recording processes. A centralised email address has been established to ensure that DoLS applications are received centrally to facilitate oversight and monitoring of the authorisation processes and ensure that supervisory bodies are regularly contacted in regards to statutory timescales and assessments.	Contact with supervisory bodies is now recorded in the clinical record to evidence that authorisations are being pursued. New legal categories relating to DoLS have been added to the clinical record system to ensure that the legal framework is accurately recorded. Notifications to the CQC for authorised DoLS are also completed centrally within the Trust. Evidence of the Best Interest decision tree, copies of Bullet briefings which go out via the intranet out to all clinical staff in the Trust submitted. This document had no date. Minutes of Trust and CCG Quality & Performance meeting held on 4/03/2020.	In June 2020 the Trust carried out a comprehensive audit across staff groups of adherence to policies and use of the additional tools/frameworks in practice. The audit showed 75% compliance. An audit of compliance - not dated - with Trust mandatory training around the MHA, Mental Capacity Act (MCA) and DoLS showed 80% compliance against the Trust target of 82%. The Trust Annual Report January 2019 included a section on numbers of DoLS applications made demonstrating transparency. Standing item on Quality & Performance agenda.

NIAF review rating (RR): GMMH - this recommendation has been completed and testing has evidenced that it is generally embedded in practice, and is monitored through the Trust and CCG Quality & Performance mechanism. In order to fully meet the recommendation the Trust should demonstrate long term improvements to practice through regular audit.

Overall review rating for this recommendation: 4 * This score is GMMH only (see over for SRFT).

Recommendation 5: **The Trust and Salford Royal NHS Foundation Trust must ensure that when recording that a patient is being treated under the Deprivation of Liberties Safeguards (DoLS) framework the appropriate documentary detail is in place to apply the Mental Capacity Act lawfully.**		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
Salford Royal NHS Foundation Trust (SRFT) stated "Processes have been improved and staff are more confident in recognising when there is a need for DoLS and MCA. MCA and DoLS training is mandatory for all clinical staff and compliance with training is consistently high".	The SRFT Deprivation of Liberty Safeguards Policy ratified 25/08/2020, review date 25/08/2025 was submitted as evidence.	The policy is comprehensive and user friendly. It has a helpful guide for families and carers embedded within it.
	An example of a completed DoLS request which sits in the electronic patient record submitted along with the DoLS review form that is now in use. They both have a user guide attached for clinicians to follow for completeness.	The request and review forms demonstrate that the Trust has appropriate documentation in place that can be located easily from within the electronic record. The embedded user guides confirm that clinicians are assisted in appropriately using the system.
"Mandatory Level 3 training in line with the intercollegiate document 2018 is now delivered across SRFT by the Adult Safeguarding team. This details the legislation, background and application of DoLS."	Quarter 3 Safeguarding Adult Activity Report 2020/21 submitted – identified improved uptake of Safeguarding training indicating that compliance met the Trust's standard	The activity report recorded improvements in Safeguarding training however, there was a reduction in DoLS training uptake falling below the Trust standard.
	Salford Core Organisation Adult Safeguarding Highlight Report March 2021submitted.	There are plans in place to make improvements in this area but there was insufficient evidence to demonstrate that these were having an impact. The Trust noted that some of the work they had been doing was interrupted due to the Covid 19 pandemic.

[Detailed assurance review of the Trust's actions continued]

Recommendation 5: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
	Salford Core Organisation Safeguarding Adults Group due to commence in April 20201 Terms of Reference submitted as evidence.	Safeguarding Adults Steering Group chaired by the Director of Governance in order to regularly monitor compliance and training including DoLS and MCA but it is yet to take place.

NIAF review rating (RR): The Trust has provided evidence of policy and templates to facilitate the recording of appropriate documentary detail, under the DoLS framework, but we have not seen specific evidence of their application**.**

Overall review rating for this recommendation: 2 *SRFT only.

Recommendation 6: The Trust must assure itself and its commissioners that when actions are implemented there is sufficient evidence of the effectiveness of the outcome or change in practices.		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The Trust has in place both a Serious Incident Review Panel (SIRP) and a Post Incident Review Panel (PIRP) chaired by the Medical Director and Director of Nursing & Governance. These monitor progress against action plans that support internal reviews and action plans supporting NHS England Independent Investigation reports. Quarterly Quality and Performance meetings with Trust commissioners also provide opportunity for discussion and presentations by the Trust around assurance on progress on quality work streams supporting the learning from internal reviews and serious incidents.	PIRPs and SIRPs take place monthly and monitor action plans – outstanding actions are escalated with named responsible individuals and completion dates. Multi-Disciplinary Positive Learning Events take place after Serious incident Reviews and service managers leading these events provide feedback to the Trust PIRP using a positive learning event feedback template regarding how learning has been shared. In January 2020 Manchester Commissioners invited GMMH to present at a Learning from Serious Incidents workshop attended by all commissioners. This was an opportunity for the Trust to demonstrate work undertaken with regard to patient safety implemented by the Trust. The Trust received positive feedback from commissioners following this event.	This additional layer of assurance and the dissemination of the minutes to the various responsible managers with clear timelines to respond meets the recommendation. We have seen evidence of minutes and action plans for four review panels (see document list slide 24). The Positive Learning Events are multidisciplinary and supported by extensive guidance notes and list of attendees names and roles. All staff are encouraged to complete a reflection document and the results of the events are discussed in the PIRP meetings. The System Learning Workshop slides submitted highlighted a number of patient safety issues showcased including ligature care plans for both staff and service users, suicide prevention eLearning for staff, suicide prevention hotlines and a self harm audit undertaken in 2018.

NIAF review rating (RR): GMMH has adequate systems in place internally to assure that action plans are monitored and progress has been made but not yet tested. Evaluation of embedding actions into practice could not be demonstrated.

Overall review rating for this recommendation: 3

Recommendation 7: The Trust must ensure that it fulfils its responsibilities under Duty of Candour and that appropriate guidance and oversight is provided to staff to enable them to execute the responsibility appropriately.		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The Trust Being Open and Duty of Candour (DoC) Policy is clear in highlighting staff roles and responsibilities in relation to the Trust meeting its statutory obligations in accordance with Duty of candour. The policy has been further strengthened following the Niche Review in relation to how review teams engage with carers/families.	Being Open policy 2017 updated with specific points made regarding engaging with carers/families is evidenced on pp9-13. Being Open & Duty of Candour Clinical Audit report 2017/2018 submitted as evidence. Audit demonstrated the understanding of staff across a wide range of roles about their obligations under DoC. The audit of DATIX showed there has been an improvement in communication with service users and carers.	Strengthened policy reviewed with amendments ratified in November 2020 due for review in 2022. These amendments meet the recommendation. These audits demonstrate that the Trust has met the recommendation.
In 2018 an external training company 'Patient Safety Science' were commissioned by the Trust to raise awareness to staff around the principles of Being Open and Duty of Candour as part of the Trust internal review process.	Anonymised letters from investigators to the families of victims and perpetrators submitted. Four Awareness Raising workshops were delivered to Senior Leadership Teams across divisions in relation to Being Open and Duty of Candour requirements. The Trust used learning splash screens and 7 minute briefings to raise awareness to staff around their roles and responsibilities for engaging with families when incidents occur.	DoC letters are now sent to both victims and perpetrators families as part of routine practice. The attendance register for the workshops held on 30 and 31 January 2018 identifies the names, roles and teams of the attendees.

Recommendation 7: Continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
Trust Root Cause Analysis (RCA) training continues to be reviewed and strengthened to incorporate the learning for serious incidents. The Trust SIR guidance is undergoing further review. In December 2018 GMMH introduced a provisional Bereavement Liaison role responsible for supporting service users, families/carers and included in that staff who have been affected or bereaved following a serious incident resulting in a sudden unexpected death.	The Trust RCA training slides have been revised to raise awareness to staff around the roles and responsibilities of review leads with respect to Duty of Candour when engaging with families/carers when incidents occur. Training slides submitted as evidence. This role enhances how GMMH executes its statutory Duty of Candour in a timely manner. Paper outlining the purpose of the role, implementation and evaluation submitted. Those affected by a Serious Incident are invited to participate in the Trust internal review process and are provided with a copy of the final investigation report and formal apology from the Trust where care delivery concerns have been identified.	Training well attended across the Trust between 2019 and 2020 - attendance list with numbers of staff who attended submitted. Due to the Covid-19 pandemic 50% of the training was delivered via TEAMS. The Bereavement Liaison role has significantly enhanced the Trust's governance offer to the families/carers of service users who have died as a result of serious incidents. Evaluation of this Band 7 role concludes it is now permanent and embedded in the Trust's commitment to Duty of Candour. A second post is being considered which strengthens this endorsement. A survey of the impact of the role on those who had been bereaved identified encouraging outcomes.

NIAF review rating (RR): The Trust has made progress in strengthening its Duty of Candour policy, has held a number of workshops, and disseminated information via the intranet to various staff groups. The audits, Bereavement Liaison role becoming substantive, and the communication by investigators demonstrate a sustained improvement in the application of Duty of Candour as part of its serious incident process.

Overall review rating for this recommendation: 5

Recommendation 8: The Trust must ensure that an appropriate prescribing plan is developed and implemented when patients are at risk of becoming homeless or not registered with a GP.		
Trust action plan	**Trust response and evidence submitted**	**Niche comments and gaps on assurance**
The Trust is a key partner in the Manchester Homelessness Task Group which feeds into the GM Homelessness Action Network.	The Trust have developed pathways that address the specific prescribing/dispensing plans for this vulnerable group of individuals who are at risk of becoming homeless. The Trust described efforts in place to enable patients to register with a GP as part of the pathway for those homeless or vulnerable of becoming homeless. Prescribing to individuals who are homeless or at risk of becoming homeless is now built into care planning of this service user group. CPA policy submitted as evidence. Six case studies were submitted as evidence of multi agency working.	The CPA policy gives guidance on the way in which service users should be managed who are homeless or without a GP, however there is no evidence that refers to specific prescribing plans. This is noted in the EI and CPA policies submitted. We did not see evidence of the care plans into which prescribing plans are embedded. The case studies, whilst an indication of good practice, did not provide evidence of prescribing plans.

NIAF review rating (RR): We have not received adequate evidence that this recommendation has been progressed. The Trust provided the following statement: "GMMH Medicines Management Committee is leading this action and the Trust are implementing a dedicated task and finish group who will be taking this work forward across the whole organisation."

Overall review rating for this recommendation: 0

Recommendation 9: The Trust must ensure that when care plans are developed patients and their carers are given the opportunity to contribute to the content, in accordance with Trust policy.		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The Service User Engagement & Carers Family and Friends Strategy highlights how working collaboratively with service users and carers to develop meaningful care plans that support recovery is fundamental.	There are a number of initiatives to promote collaborative care planning including training led by peer mentors through the Recovery Academy. Care plans are audited quarterly by all teams to demonstrate where these are completed collaboratively with services users and carers. Several care plan audits completed across Community and Inpatient services included as evidence. The most recent is a Community Care Plan audit looking at data between October-December 2019. It showed: • Service User involvement in care planning - 79% • Carer involvement - 54% This is against 85% Trust compliance standard.	There is evidence that the Trust is committed to improving engagement with Service Users and Carers. These include: • Carers information sharing form. • Combined Carer and Service User. • Carers & Confidentiality Guide. The Service User & Carer Engagement Strategy provided is not dated – we did not receive evidence to demonstrate how it is working in practice.

NIAF review rating (RR): The Trust has made a number of steps to meet this recommendation, however, there is a need for repeated audits to improve compliance and provide assurance this is embedded in practice.

Overall review rating for this recommendation: 3

Recommendation 10: The Trust and their commissioners must be assured that the investigation, management and oversight of serious incidents is appropriately undertaken.		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
Monitoring and oversight of Serious Incidents and supporting action plans takes place through the Trust monthly Trust Post Incident Review Panel which is chaired by the Medical Director and Director of Nursing and Governance. Escalation reports are provided to the panel and divisional Associate Directors for action taken in response to outstanding actions recommended in serious investigation reports.	Monthly meetings take place with commissioners where GMMH Patient Safety practitioners attend the CCG Serious Incident Oversight Panels (SIOP) to review completed reviews and enable the Trust and Commissioners to agree closure of serious incidents reported through the STEIS system. Minutes of meetings described and action logs submitted.	The Trust has a number of mechanisms which ensure that the management and monitoring of Serious Incidents and the resultant actions are robust. Monthly meetings are held jointly with the Trust Executive Directors and the CCGs which allow for detailed scrutiny of Serious Incidents, their investigation and management. The evidence reviewed demonstrates Serious Incident reports are subject to challenge and scrutiny.

NIAF review rating (RR): This recommendation has been completed and on going compliance is monitored at senior levels.

Overall review rating for this recommendation: 4

Recommendation 11: The Trust must assure themselves that when patients are entered into a clinical trial there is evidence to indicate that they are an appropriate candidate for that trial.		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
Eligibility for service users being involved in research and research trials is highlighted in the Trust's RDSOP04 procedure for identification of potential participants in research studies and delegation of clinician responsibility. The Research Delivery Team highlights the standards to be implemented to ensure that each study or clinical trial carried out complies with current legislation and guidance for research involving GMMH staff, patients and/or patients' data.	The Trust Research & Innovation Standard Operating Procedure 2017 incorporated into this policy also provides clear guidance in relation to the appropriateness of individuals involved in any Trust research or trial. Research and Innovation (R&I) policy updated 10/2020 and operating procedures for identification of potential candidates submitted, as was: • RDSOP04 dated 23/10/2020 sets out procedures with regard to identification of participants. • RDSOP03 dated 18/08/2020 submitted which outlines the responsibilities of the Principle Investigator in Delegation and Oversight of a research project. Eligibility process/criteria and management of service users with clinicians' support submitted as evidence. Extracts from patient records demonstrating checking research trial eligibility.	The R&I policy and Standard Operating Procedures (SOP) outline with clarity the standards that need to be met. The policies and SOPs were all updated in 2020 with review dates in 2023. This recommendation has been implemented, the role of Principle Investigator in ensuring that service users are an appropriate fit for clinical trials affords assurance. There is rigour in the process to ensure that appropriate/eligible candidates are entered into clinical trials, and if they become ineligible for any reason this is managed.

NIAF review rating (RR): The policies and procedures have been updated, and there is evidence of staff checking patient eligibility for a research trial.

Overall review rating for this recommendation: 4

Appendices

Documents reviewed

Documents reviewed CCG	
Corporate Policy for Performance Management of Serious Incidents & Never Events within commissioned services October 2017	Serious Incident Standard Operating Procedure (SOP) March 2020
Serious Incidents & Investigations Final report 2016/2017 Dated 10/1/2017	GMMH & CCG Serious Incident Workshop Pack GMMH & CCG Quality & Performance Meeting Minutes 24/06/2020
Documents reviewed GMMH Trust	
Homicide Action Plan Review Meeting Minutes 24/06/2019	Screenshot Forensic Referral Process 05/2020
EIS Steering Group Minutes 14/05/2019	Community Health & Justice Support Service assistance to GMMH paper (Undated)
EIS Business Meeting Minutes 21/05/2019	Emails re Forensic Team Proposal 26/02/2019
EI Operational Policy 17/12/2020	Mental Health Act and Mental Capacity Act Quality Improvement Group Minutes 4/03/2020
Positive Learning Group Social Care & Mental Health Minutes 22/10/2020	CQC DoLS notifications X 6, DoLS eLearning data
Positive Learning Event Feedback Template	Bullet Briefing re MHA & MCA Interface x 2 (Undated)
Proposal for Forensic Community Team (Undated)	Salford safeguarding Highlight Report 1/10/2020
Forensic Referral Flowchart (Undated)	Trust wide Audit of Clinical Standards of Record Keeping 06/2020

Documents reviewed

Documents reviewed GMMH Trust (cont.).	
CPD MHC learning event & Safeguarding Level 3 training packs	Patient Case studies x 6
PIR Meeting minutes 16/02/2017,15/11/2017, 18/07/2018, 5/11/2020	Inpatient & Community care Plan audit results x 4
SIRP Meeting minutes 13/10/2020	Service User & Carer Assessment tool
Being Open Policy 26/06/2017	Carers Information and Confidentiality guides
Being Open Workshops content and flyers	RDSOP03 & RDSOP04 policies re research.
Root Cause Analysis workshops content and flyers	Duty of Candour Audits 2016/17 & 2017/18
Guidance for Serious Incident Investigators	Suicide prevention training and associated documents.
CPA Policy 30/04/2019	Bereavement Liaison Band 7 workforce paper.
Biannual Datix Safeguarding Audit Q3 2020/21	Referral tracker June-Aug 2020

Documents reviewed

Documents reviewed GMMH Trust (cont.).	
EDT MHA assessments	Training registers and compliance figures
Safeguarding guidance	Guidance on facilitating learning events
Extracts from patient records	Research and innovation strategy 2017-2021
Link for monitoring Good Clinical Practice (GCP) certificates	COMP001 Pre-screening checklist and referral form

Documents reviewed

Documents reviewed SRFT.
DoLS training guide - undated
DoLS request form - undated
Deprivation of Liberty Safeguarding Policy 25/08/2020
MCA Virtual training guide - undated
MCA Audit process - undated
Q3Safeguarding Audit Activity Report 2020/21
Terms of Reference Salford Core Organisation Safeguarding Adults Steering Group beginning April 2021
Salford Core Organisation Adult Safeguarding Highlight Report March 2021

Glossary

AMHP	Approved Mental Health Practitioner	**SIRP**	Serious Incident Review Panel
CCG	Clinical Commissioning Group	**SLT**	Senior Leadership Team
CPA	Care Programme Approach	**SRFT**	Salford Royal NHS Foundation Trust
DoLS	Deprivation of Liberty Safeguards		
EDT	Emergency Duty Team		
EIT/S	Early intervention Team/Service		
GMMH	Greater Manchester Mental Health NHS Foundation Trust		
MCA	Mental Capacity Act		
MDT	Multidisciplinary Team		
MHA	Mental Health Act		
PARIS	Electronic patient notes system		
PIRP	Post Incident Review Panel		
RAG	Red amber green – a traffic light scoring system		
RCA	Root Cause Analysis – an investigatory process		
RDS	Research Design Standards		
R&I	Research and Innovation		
SCFT	Specialist Community Forensic Team		
SIOP	Serious Incident Oversight Panel		

Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Tel: 0161 785 1000

www.nicheconsult.co.uk

Niche Health and Social Care Consulting Ltd is a company registered in England and Wales with company number 08133492.

niche
HEALTH & SOCIAL CARE CONSULTING