NHS
Somerset
Clinical Commissioning Group

ACTION PLAN
StEIS Reference: 2017/15440

Root cause/contributory factor (please number each one following the example given below)	Recommendation	Specific actions (SMART- specific, measurable, achievable/action-related, relevant, time-specific) **Please consider where and how local** actions will be monitored and if the actions require measures (i.e. audit/spot checks) to ensure changes have been embedded.	Responsible person (include job titles)	By when	Date complete	Evidence of Completion (embedded or appendix)
Lack of evidence that original Clinical Commissioning Group investigation was followed up after initial Serious Incidents Requiring Investigation meeting held 09/02/2018.	1. Somerset Clinical Commissioning Group must ensure that the quality assurance of investigation reports and associated actions plans are consistently completed and evidenced, and that a process is in place that ensures reports are picked up at future Review Learn and Improve meetings	1. Create a process for Quality Reviews, ensuring all investigations are reviewed once a provider has submitted their final report.	Quality Improvement Facilitator – Patient Safety and Quality Leads	01/11/2019	01/11/2019	Quality Reviews are saved down into each electronic serious incident folder – quality review template saved in folder.
		2. Internal investigations to be added to monthly Review Learn Improve report template.	Quality Improvement Facilitator – Patient Safety	15/06/2020	26/06/2020	Serious incident review meetings report and minutes. Complex case sign off process mapped into the Standard Operating Procedure (SOP) - SOP and flow charts saved in folder.

		3. Recommendations & actions added to the Clinical Commissioning Group's tracker and followed up at appropriate date to ensure embedded learning has occurred.	Quality Improvement Facilitator – Patient Safety	15/06/2020	01/06/2021	Evidence on tracker, monthly meetings with providers, evidenced from actions – tracker is available to view on request, will require anonymising.
		4. All complex serious incidents such as mental health homicide incidents will be monitored through the Review, Learn, Improve Meeting, Patient Safety and Quality Assurance Committee and final reports for complex serious incidents and mental health homicides sign off will be at the Governing Body Meeting.	Director of Nursing, Deputy Director of Nursing and Assistant Quality Manager	18/11/2021	18/11/2021	Standard operating procedure (SOP), evidence from minutes of meetings – SOP saved in folder.
The Clinical Commissioning Group believes that the reason a full and detailed action plan was not developed is the result of an administrative error, because the wrong Clinical Commissioning Group action plan (for a different case) was logged to the case record. This error was not identified by the Clinical Commissioning Group until we requested the relevant documents for our investigation. This is the second stage at which there is a risk that key	2. Somerset Clinical Commissioning Group must ensure that a system is in place to check that recommendations in investigation reports are fully reflected in associated action plans.	1. Quality Leads and Commissioners will undertake a quality review process for all serious incidents. This will include a requirement to ensure recommendations and actions are SMART (specific, measurable, achievable/action-related, relevant, time-specific). Serious Incidents will not be closed until action plans have been received and reviewed.	Quality Improvement facilitator – Patient Safety and Quality Leads	15/06/2020	15/06/2020	Quality Reviews are saved down into each electronic SI folder – quality review template saved in folder.

findings from the investigation have not been addressed.		2. Current tracker to include action plans received date, action plan complete.	Quality Improvement facilitator – Patient Safety and Quality Leads	15/06/2020	15/06/2020	Tracker is active and a working document – tracker is available to view on request, will require anonymising.
		3. Overdue action plans will be added to the Review, Learn, Improve report monthly, to enable Quality Leads to escalate.	Quality Improvement facilitator – Patient Safety	15/06/2020	01/01/2021 Delay due to other work commitments (COVID)	Review, Learn, Improve report and minutes of meeting – all filed on system and available to see upon request, will require anonymising.

We have seen evidence that the clinical commissioning group was monitoring the implementation of the recommendations set out in the Trust action plan. In addition, we can see that the Trust provided the clinical commissioning group with evidence that the actions set out in the Trust plan had been completed. However, there is no evidence that either the clinical commissioning group or the Trust sought assurance that the actions had resulted in beneficial changes to patients or health and social care colleagues.	3. Somerset Clinical Commissioning Group must assess the impact to relevant stakeholder of the actions completed by the Trust	1. Standard Operating Procedure to be created to include: • Quality Lead responsible for the named contract to undertake visits to the Trust (regularity to be confirmed) with the Quality Improvement Facilitator, to check that selected actions from previously completed action plans have been embedded and request evidence of completed actions in order to gain assurance. • All complex serious incidents such as mental health homicide incidents will be monitored through the Review, Learn, Improve Meeting, Patient Safety and Quality Assurance Committee and final reports for complex serious incidents and mental health homicides sign off will be at the Governing Body Meeting.	Quality Improvement Facilitator – Patient Safety	31/07/2020	Complete, Standard Operating Procedure has been updated and is regularly reviewed whenever iterative changes are identified.	Standard Operating Procedure has been discussed at our internal Review, Learn, Improve Meeting and shared with all necessary. Standard Operating Procedure is saved in folder. Minutes of meetings.
		2. A review template to be created and ratified at Review, Learn, Improve meeting to include: • Evidence of action completion • Evidence of audit/ongoing monitoring of action	Quality Improvement Facilitator – Patient Safety	31/07/2020	Action tracker template is complete.	Tracker is available to view on request, will require anonymising.

We can see that the intentions to improve service provision and patient experience are present in the documents we have received from the Clinical Commissioning Group. The Clinical Commissioning Group has also acknowledged that they are in the early stages of embedding the changes. However, we have not been able to get a sense of how these changes are actually improving patient or stakeholder experiences. We heard from the GP practice involved in Mr K's case that their perspective is that it is just as difficult to secure an urgent assessment today as it was in 2016. The Clinical Commissioning Group should seek assurance that the service response to urgent requests for Mental Health Act assessments is much improved.	4. Somerset Clinical Commissioning Group must work with stakeholders to assess the impact of service changes on all groups of stakeholders, specifically patients and their families, and GPs. Particular attention must be given to evidencing an improvement in access to urgent Mental Health Act assessments.	Somerset's Community Mental Health services have been transformed over recent years. Including the establishment of a whole new, nationally recognised 'trailblazer' model of Community Mental Health Care supported by more than £13m additional investment in Community Mental Health Support Services. Evidence of the transformation of Mental Health Services in Somerset can be seen by the recent award Somerset Foundation Trust received. The prestigious HSJ Mental Trust of the Year award 2021. The Home Treatment Team and crisis services have significantly expanded and benefit from peer support workers working alongside registered staff. 11 new step up/step down beds have been created to avoid admissions to hospital and support the discharge process. An all age, 24/7 telephone support line has been created, delivered in partnership with Voluntary, Community and Social Enterprise partners. Crisis support safe spaces have established in four localities in the County. Both of the County's acute hospitals benefit from Psychiatric Liaison services. A	Deputy Director of Commissioning – Mental Health, Autism & Learning Disabilities (Somerset Clinical Commissioning Group) Director of Mental Health & Learning Disability Care, Somerset Foundation Trust Quality Lead, Mental Health Services (Somerset Clinical Commissioning Group)	Sept 2021		Health And Wellbeing Briefing report – Sept 2021 – saved in folder. Presentation to the Health and Wellbeing Board Sept 2021 – saved in folder.

		Recovery College has been established to better support people with mental health needs in a more accessible and less stigmatising context. All the above service improvements are elements of the new Open Mental Health service offer that has an ethos of 'no wrong door' in terms of access and is delivered in partnership with 10 Voluntary, Community and Social Enterprise partners. At every stage in both the design and the delivery of the new model of care people with lived experience have been active partners in its development. Each of the thirteen Primary Care Networks in the County have been involved in the development of this new model and every surgery in the County has improved access to mental health support for their patients from both the Trust and specialist Voluntary, Community and Social Enterprise providers. This has been evidenced by a decrease of GP complaints and an increase in positive feedback that has been received in relation to GPs having access to support, along with ongoing positive				

		engagement with GPs and Primary Care Networks as they have developed. A successful two-year programme of public engagement and formal consultations was undertaken in relation to the new model of support and the consolidation of adult inpatient beds the results of which can be seen at this link for the Fit For My Future website. In September 2021 a formal update on Adult Community Mental Health Services was presented to the County's Health and Wellbeing Board which was very positively received by all members.				

We are concerned at the reducing low conversion rate and the lack of information about the outcomes for those people who have not been detained.	5. NHS Somerset Clinical Commissioning Group must work with local authority partners and the Trust to understand the reasons behind a reducing number of Mental Health Act assessments and to understand more fully what happens to those people who are assessed but not detained under the Mental Health Act, and how their mental health needs are being met.	The new model of support delivering community mental health services as described above has transformed how people are supported. This includes improved access to mental health support in primary care settings and a wider range of Voluntary, Community and Social Enterprise partners – including peer support from people with lived experience. This enables a range of ongoing support in community settings for those people who are assessed under the Mental Health Act but not appropriate for detention. The Clinical Commissioning Group is working with the Local Authority and the Trust have developed a reporting tool from the Trust's clinical electronic patient recording system that is beginning to allow integration of activity and outcome data of Mental Health Act referrals. This is an interactive tool that is being further refined and allows regular reports to be presented, analysed, and discussed at the Trust's Mental Health Act Committee meeting on a regular basis (attended by Clinical Commissioning Group and Local Authority officers).	Deputy Director of Commissioning – Mental Health, Autism & Learning Disabilities (Somerset Clinical Commissioning Group) Director of Mental Health & Learning Disability Care, Somerset Foundation Trust Quality Lead, Mental Health Services (Somerset Clinical Commissioning Group)	23rd March 2021		

		The draft Niche Report and its recommendations were discussed in the Trust's Mental Health Act Committee meeting in March 2021. This group continue to monitor the Mental Health Act assessment referral and conversion rates. However, it was also felt that at the current time of 2021 (as opposed to 2017) substantial new investment in mental health services in Somerset that is driving improved provision of support helps to mitigate the risks of a low conversion rate. Furthermore, the benefits of least restrictive interventions that whilst supporting community and individual safety are recognised.				

The Approved Mental Health Practitioners service should have been clear when their assessment had ended and that there would need to be a new referral to get them involved again. Until they had done this the responsibility remained with the Somerset County Council Approved Mental Health Practitioners service.	6. Somerset Clinical Commissioning Group must work with local authority partners to gain assurance that the Approved Mental Health Practitioners service working practices comply with the Mental Health Act Code of Practice.	The Trust's Mental Health Act Committee discussed this aspect of the report in March 2021. The group recognised that system working had significantly changed since 2017 – as evidenced in part by the fact partner agencies are invited to, and now attend, this group. There is no statutory mechanism for the Clinical Commissioning Group to ensure compliance of the Local Authority for their statutory duties in relation to the Code of Practice. However, as a system the Clinical Commissioning Group and the Trust are assured that the Local Authority, and specifically the Approved Mental Health Practitioners Hub are clear in their responsibilities and duties and fulfil them appropriately. In 2018, Somerset County Council's Approved Mental Health Practitioners Hub issued clear guidance to GPs and its own staff as a direct response to this specific case, including the need to inform GPs of the outcome of any decisions made even if the decision is that it is not appropriate to assess or detain an individual under the Mental Health Act. This guidance remains in place.	Deputy Director of Commissioning – Mental Health, Autism & Learning Disabilities (Somerset Clinical Commissioning Group) Director of Mental Health & Learning Disability Care, Somerset Foundation Trust Quality Lead, Mental Health Services (Somerset Clinical Commissioning Group)	23rd March 2021		Guidance for GPs and Approved Mental Health Practitioners staff in relation to assessments under the Mental Health Act – saved in folder. Trust action plan from their initial investigation – saved in folder. Mental Health Act assessment request flow chart – saved in folder. Home treatment team operating procedure – saved in folder. Protocol for management of telephone referrals and face to face assessment for home treatment services – saved in folder.

		The Somerset Mental Health system as a whole is now far more integrated in terms of ways of working across both the commissioning and provider functions as well as health and social care provision in relation to delivery. This governance framework will be further enhanced as we move towards an Integrated Care System in the coming months.				