Assurance report: Solent NHS Trust

NHS England independent investigation Mr C (2013.14158)

September 2017

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Niche Health & 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.

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1 Introduction

1.1 NHS England South commissioned Niche Health & Social Care Consulting Ltd (Niche) to conduct an independent investigation into the care and treatment of Mr C by Solent NHS Trust, which was undertaken by Grania Jenkins, Lead Investigator for Niche and published in June 2016. The terms of reference for this investigation included the requirement to carry out an evidence based review of whether the independent report recommendations have been fully implemented.

1.2 The focus of this evidence based review is with Solent NHS Trust (to be referred to as the Trust hereafter). Mr C was under the care of Portsmouth Assertive Outreach; this team no longer exists in the new Trust structure, therefore the focus of the review was on the Portsmouth North Recovery team, which cares for an equivalent patient group.

1.3 This evidence based review has been carried out by Carol Rooney, Deputy Director for Niche, and has been peer reviewed by Nick Moor, Partner for Niche. The draft report was sent for comment to NHS Portsmouth CCG and Solent NHS Trust.

1.4 NHS England South have maintained oversight of the action plan implementation and review process.

1.5 Summary information has been taken from the independent investigation to provide an overview and context to this review.

1.6 The review comprised a review of Trust documents and interviews based on a set of questions developed from the key lines of enquiry. Feedback on the CCG's oversight of the Trust serious incident management process was requested. The assurance in respect of the recommendations and associated actions was assessed by the triangulation of these sources of information.

1.7 A full list of all documents reviewed is referenced is at Appendix A.

1.8 As part of the evidence based review I met with:

- Quality and Standards Lead Adult Mental Health (AMH) & Substance Misuse Services (SMS)
- Associate Director – Quality & Safety
- Team Managers Portsmouth South and North CMHT
- Staff Nurse Portsmouth North Recovery team

1.9 I discussed the issues with the Clinical Quality Manager, NHS Portsmouth Clinical Commissioning Group, who provided a report on the oversight of the action plan and serious incident process.

1.10 There is an AMH Governance & Essential Standards Group (GESG) held monthly, which is attended by service managers and team leaders from across the adult mental health services. The function of this meeting is to provide a focus on how standards are maintained; actions are taken to address quality and standards issues including issues from serious incidents, and this group also reviews the AMH risk register and action plans.

1.11 Learning notes from serious incidents are now disseminated to management meetings through a 'Serious Incident (SIRI) and High Risk Incident (HIRI) learning report'.

1.12 A 'learning messages' document is communicated across the Trust when key learning points from incidents need to be conveyed across the services.

Structure of the evidence based review

1.13 Section 2 provides a summary of the findings of the independent investigation with the recommendations.

1.14 Section 3 provides the evidence based review with information on the progress made by the Trust against each recommendation and their associated action plans.

1.15 Section 4 provides the overall summary.

2 Summary of case

Past psychiatric history

2.1 Mr C first began to exhibit mental health symptoms at the age of 17 when he was an army cadet and undertaking basic training. This appeared to have coincided with reports that he had begun to use illegal drugs. On 29 July 1993 Mr C was first admitted, initially on an informal basis, to a psychiatric inpatient unit. He reported that he had been experiencing increasingly intrusive thoughts. During this admission Mr C was involved in two serious incidents which involved knives. A forensic risk assessment that was completed at the time reported that Mr C had become 'more disturbed and more dangerous'.

2.2 He had a long history of inpatient care, including five years in a medium secure unit.

2.3 At the time of the incident (11 May 2013), Mr C was 40 years old and had a diagnosis of treatment-resistant paranoid schizophrenia with co-morbid substance misuse. Historically Mr C had also been given several other mental health diagnoses, including bipolar disorder, depression and a personality disorder.

2.4 In July 2012 Mr C relocated to the Solent area. During the transition the Southern Health NHS Foundation Trust Assertive Outreach Team (AOT) supported him until January 2013, at which point his mental health care was transferred to Solent NHS Trust. In order to provide continuity of care during this transitional period, Southern Health's AOT supported Mr C until January 2013. During this period there were three hospital admissions following incidents of self-harm and overdosing.

2.5 On 29 January 2013 Mr C presented in a psychotic state in a public place and he was admitted as an informal patient to the local acute mental health inpatient unit for a 20-day admission. He was discharged back to Solent's AOT (19 February). Mr C was readmitted two days later, having taken an overdose of prescribed medication. This admission was for 11 days and he was again discharged to the care of the AOT. The AOT documented that they were experiencing difficulty engaging Mr C and that his parents were voicing their concerns about their son's increasingly chaotic behaviour.

2.6 Mr C's last hospital admission was on 4 April 2013 when he was detained under a section 2 of the Mental Health Act (1983). During this 21-day admission Mr C's behaviour was documented as being erratic and there were five reported episodes of violence towards other patients. After Mr C's discharge he was seen by his care coordinator from the AOT on two occasions, on both occasions it was assessed that he was stable and compliant with his medication.

2.7 On the evening of 11 May 2013 Mr C telephoned the police to report that someone was dead in his flat. He had repeatedly stabbed Mr D, who was an acquaintance he had been spending time with.

2.8 At a subsequent Crown Court hearing (12 March 2014), Mr C was found unfit to plead and was subsequently detained on under Section 37/41 of the Mental Health Act 1983.

Recommendations and action plan

2.9 The independent report produced 11 recommendations, and Solent NHS Trust developed an action plan which grouped the recommendations into themes or issues, based on our recommendations.

2.10 The action plan implementation has been overseen by the adult mental health Quality and Standards Lead, and evidence was provided for each issue. The action plan was commenced before the publication of the report by NHS England, and was rag rated 'green' in March 2016, as all actions had been completed.

2.11 The Trust action plan is at Appendix B.

Issue 1: CPA

2.12 Following a CPA review if there are any significant changes in a patient's risk management, support needs or medication the care coordinator should arrange as soon as possible to meet with the patient's primary care service so that the patient's records can be updated and any plans implemented.

Issue 2: transfer and handover

2.13 Where there is a planned transfer of a patient between NHS Trusts the responsible clinician must ensure, wherever possible, that the transfer of medical records is completed before they accept responsibility for the patient's care.

2.14 A full review of a patient's historical medical notes must be undertaken by both inpatient and community services as part of their initial clinical and risk assessment.

2.15 In order to evaluate the effectiveness of Solent NHS Trust's Protocol for Receiving and Referring Transfers of Care an audit should be undertaken of a number of individual cases where this protocol has been utilised.

Issue 3: Risk assessment

2.16 Solent NHS Trust revised risk assessment form should have separate sections for historical, current and ongoing risk factors. Each risk factor identified should be cross-referenced in the narrative section. Triggers and protective and contributory factors should be clearly identified for every area of risk.

2.17 Risk information should only be documented in one location within Solent NHS Trust's patient records system.

Issue 4: personal budgets

2.18 Consideration should be given during discharge and CPA planning to apply for Personalised Budgets or Direct Payments to fund additional care and support needs.

Issue 5: Housing

2.19 Risk assessments and support plans should always be identifying and considering a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention.

Issue 6: Serious incident management and reporting

2.20 Serious Incident Review authors should always utilise and demonstrate within their report the underpinning investigative methodology that they are using, e.g. a Fishbone analysis of contributory factors.

2.21 Serious Incident Review reports must fully comply with guidelines outlined in the National Patient Safety Agency's RCA Investigation Evaluation Checklist.

Recommendation for NHS England

2.22 A further recommendation was made that NHS England should consider providing a copy of the report to Southern Health NHS Foundation Trust.

3 Evidence based review

Issue 1 CPA

3.1 **Following a CPA review if there are any significant changes in a patient's risk management, support needs or medication the care coordinator should arrange as soon as possible to meet with the patient's primary care service so that the patient's records can be updated and any plans implemented.**

Trust actions agreed:

This learning to be discussed with staff at the team meeting, to ensure staff are aware of this consideration following any changes where complexity may warrant a follow up call/meeting to GP who may not have attended.

To be raised as and where appropriate with Individual staff in caseload supervision. To be an added component for managers to consider in supervision.

3.2 The CPA and Standard Care Policy (version 5) and Clinical Risk Assessment and Management Policy and Procedure (version 8) have been amended to include the requirement to ensure primary care services are informed of any changes. These changes were discussed at the Business meetings of the North and South Mental Health Recovery teams in January and February 2016.

3.3 Examples of 'learning messages' communicated after these meetings from after March 2016 were seen and these are disseminated through team meetings and supervision.

3.4 This was discussed at the Adult Mental Health Governance & Essential Standards Group (GESG) meeting on 24 March 2016 to reinforce this learning.

3.5 It was noted that the focus on CPA and communication overlaps with work on the Trust action plan following a CQC report published on 17 November 2016. The relevant section is: the Trust should ensure that staff clearly document communication between partner agencies, particularly around care planning. For this item an audit was planned for January/February 2017, but has not taken place yet. Actions agreed in February 2017 were that care plans using a partnership approach are recorded on the clinical notes on a weekly or fortnightly basis with clear actions allocated to named workers within the partnership.

3.6 NHS Portsmouth CCG feedback on the Trust's implementation of serious incident action plans was reviewed, showing that this element of the action plan had been completed.

3.7 A 'straw poll' of embeddedness from conversations with GPs where there have been changes in risk was presented, and examples of positive feedback given.

3.8 The Trust has changed its electronic case note record provider, and this is now on SystmOne. Where permissions have been given, the GP and Trust can both view the patient's primary and secondary care records on SystmOne, which was reported to be very helpful in aiding communication across both services.

3.9 Two patient care issues regarding physical health and medication were presented, which had been solved through close co-operation with GPs.

3.10 There is a monthly Trust wide 'Risk Panel' which has been in place for over two years. Care coordinators can request to attend this panel, which is chaired by the Quality and Standards Lead. Staff can bring issues to present, reflect on risk, and the panel give considered thoughts on management and care planning, and may suggest multiagency or multi-professional meetings. The suggestion of attending a Risk Panel to discuss a patient may come from an MDT meeting or through supervision. The aim is to allow space to discuss risks and risk management, with senior clinical staff. A summary and suggested actions are sent to the individual/team after the risk panel discussion. Team Managers confirmed that this was used as a helpful forum by staff, and evidence of feedback from the meeting with a summary and suggestions was observed.

3.11 Sample 'learning messages' documents for March 2016 were seen.

3.12 Service Managers oversee and audit the requirements for staff supervision in AMH. In the Recovery team there are clear structures in place to plan and carry out the requirements of monthly supervision. A Trust template is in place to provide structure to the supervision, which includes a section on staff wellbeing. The monthly audits show compliance with supervision between 70 and 100% between May and October 2016, with reasons given for non-attendance and follow up plans in place.

3.13 Staff interviewed confirmed that supervision occurs regularly as planned, and there is a clear culture of expectation that staff will attend and engage. The wellbeing questions were appreciated by staff, because it is a busy service with many challenges working in the community.

3.14 Appropriate assurance is therefore available in respect of this recommendation.

Issue 2: Transfer and handover

3.15 **Where there is a planned transfer of a patient between NHS Trusts the responsible clinician must ensure, wherever possible, that the transfer of medical records is completed before they accept responsibility for the patient's care.**

3.16 **A full review of a patient's historical medical notes must be undertaken by both inpatient and community services as part of their initial clinical and risk assessment.**

3.17 **In order to evaluate the effectiveness of Solent NHS Trust's Protocol for Receiving and Referring Transfers of Care an audit should be undertaken of a number of individual cases where this protocol has been utilised.**

Trust actions agreed:

Protocol to be adjusted to reflect completion of medical records prior to accepting responsibility.

Staff to be informed further that this refers to the responsibility of overview of notes and history be part of initial clinical and risk assessment. Protocol to further reflect this.

Random audit of a sample of transfers over first year of protocol in place to ensure compliance.

3.18 An amended transfer protocol has been written and agreed with Southern Health, and an audit developed to include transfers in and out to Southern Health.

3.19 This protocol has been used directly with transfers to and from neighbouring Southern Health, although it has also been applied in adapted form to transfers from further afield. A 'learning message' was sent out to all staff referencing the protocol to be used.

3.20 The protocol advises checking that all the information is available before accepting at Solent.

3.21 Face to face CPA handover meetings are carried out where possible, including with both CCOs and patient, although it was acknowledged that this can be more challenging if the patient is further afield.

3.22 There is evidence of discussion and actions at GESG in December 2015.

3.23 The audit tool has been formulated with the safeguarding lead, and a sample tool was available in the action plan. An audit was carried out in February 2017 in conjunction with Southern Health. Nine records were audited, five of which were transferred into Solent and four were transferred out to SH during 2015 and 2016. The audit results showed that the transfer standards had been implemented, and where there was variation in a small number of cases, there was a contingency in place. The report was discussed at GESG and actions agreed.

3.24 Appropriate assurance is therefore available in respect of this recommendation, although we suggest that the transfer protocol is dated and formally linked to a Trust policy.

Issue 3: Risk assessment

3.25 **Solent NHS Trust revised risk assessment form should have separate sections for historical, current and ongoing risk factors. Each risk factor identified should be cross-referenced in the narrative section. Triggers and protective and contributory factors should be clearly identified for every area of risk.**

3.26 **Risk information should only be documented in one location within Solent NHS Trust's patient records system.**

Trust actions:

To ensure Risk Formulation currently required from staff, captures historical overview as well as current risks.

To ensure staff are informed of the requirement to link narrative around risks to appropriate 'Risk Node' section.

All staff to be informed of process for recording risk formulation on SystmOne.

3.27 The Trust has introduced 'risk champions' in each service, who have received additional training and provide support to colleagues around risk themes of suicide, self-harm and harm to others.

3.28 A new user guide for the completion of risk documentation in SystmOne is in place. An audit of risk documentation that was carried out in October 2015 recommended that current audit standards should be adjusted for SystmOne functionality, and that a standardised progress notes format should be implemented.

3.29 The team managers conduct a monthly nine-point audit on risk documentation, which includes checking whether additions have been completed, the presence of a risk formulation, and whether risks are linked to the care plan. Team Manager audits are reviewed in the GESG meeting every month, and focus for actions are agreed.

3.30 Following two years of Team Manager audits, five sets of notes were audited; with the results comparing results from May-Sept 2016 with results from May-Sept 2015.

3.31 Compliance improvements were noted, risk formulation & crisis & contingency plans had increased from September 2015 to 66% (although leaves from PICU had decreased in number). There was an increase in progress note entries linked to risk.

3.32 In the community, advance directives were still lower but every other area was over 90%.

3.33 Following the change to SystmOne last year (5 Dec 2016), the risk section was changed to an easier format, which included a section for formulation, and it became easier to write up the risk assessment and include feedback from clinicians.

3.34 Recommendations from the March 2016 risk audit results included:

- To reinforce use of notes format through service.
- Training to reflect whole approach to Recovery planning in risk management.
- Crisis and Contingency plan to include Advance Directive components to help inform plan and better involvement of service user in managing crisis situations.

3.35 A Band 7s group has reviewed the quality of risk assessments and ensures these are discussed in supervision. Peer audits of the quality of risk assessments take place across CMHTs, with feedback forms to Team Managers. A format for risk formulation has been developed that has been disseminated across CMHTs. This includes an acronym -NERD- that is used to highlight the key points or changes where a new risk assessment should be conducted. NERD stands for New, Escalation, Review, and Discharge). In inpatient environments ‘5C’s’ has been introduced as a basis for risk assessment before leave; Circumstances, Clothing, Consideration of risk, Current mental state, Contingency.

3.36 The approach to risk assessment and management training has been completely changed; one day training commenced in 2015, with development to two days risk training rolled out in 2016. A training matrix has been developed by Clinical Services Manager and Clinical Managers detailing which staff should attend, and this is then conveyed through supervision and appraisal. In the first two years of the training around risk to self we trained 77% of staff. Staff turnover (large numbers of new starters) during 2016/17 has reduced this to 54% of current staff having risk management training. Six further two day training sessions are planned in 2017/18 to address this.

3.37 The training plans and content was reviewed; it is delivered by the Quality & Standards Lead and a consultant psychiatrist. The training focusses on risk to self and risk to others, and is based around an interpersonal theory of suicide.[1]

3.38 The training content incorporates issues highlighted by the care of Mr C such as housing, transfers, risk assessment and formulation, and uses a case study approach. There is a session on 'safety planning' delivered by a peer support worker who brings lived experience to the training.

3.39 We saw staff feedback from the training which showed they felt increased skills and confidence after attendance.

3.40 Appropriate assurance is therefore available in respect of this recommendation.

Issue 4: Personal budgets

3.41 **Consideration should be given during discharge and CPA planning to apply for Personalised Budgets or Direct Payments to fund additional care and support needs.**

Trust actions:

Staff to be reminded of the need to consider personalised budgets through discussion and being recorded at team meetings.

Issue to be raised where appropriate within individual caseload supervision.

3.42 Since the implementation of the Care Act where care needs are assessed as needing further support Social Workers within the community services facilitate the most appropriate ways forward in addressing these including direct payments or personalised budgets. These are also monitored by Portsmouth Council.

3.43 Where personal budgets are accessed these are incorporated into care plans and monitored. Within the Recovery service the majority of care packages are used for housing, and can be taken to the complex needs meeting or risk panel for discussion.

3.44 A recent review of care packages showed that 4 out of a sample of 15 patients were in receipt of direct payments and had social care assessments carried out. An example of a care plan where the individual lacked capacity and was using substances harmfully was reviewed to illustrate how care was planned using a personal budget with appointeeship.

[1] *Van Orden, K.A., Witte, T.K., Cukrowicz, K.C., Braithwaite, S.R., Selby, E.A. and Joiner Jr, T.E., 2010. The interpersonal theory of suicide. Psychological review, 117(2), p.575.*

3.45 Appropriate assurance is therefore available in respect of this recommendation.

Issue 5: Housing

3.46 **Risk assessments and support plans should always be identifying and considering a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention**.

Trust actions:

Learning message to be discussed and recorded in Team Meetings.

Discussed and recorded in caseload supervision as appropriate.

Current risk Acronym to clarify Housing as a key factor in reviewing risk.

3.47 'Learning messages' were circulated in December 2015 referencing housing in the 'NERD' acronym, and in March 2016 focusing on personalised budgets and direct payments. These were evidenced as discussed in Business meetings across AMH and at GESG meetings.

3.48 Revision of the risk formulation standard and NERD, and incorporation into revised training are discussed above at 3.35 to 3.39.

3.49 Example cases where housing was raised as a risk issue within an MDT and resolved by planning with the housing provider were discussed.

3.50 Appropriate assurance is therefore available in respect of this recommendation

Issue 6: Serious incident management and reporting

3.51 **Serious Incident Review authors should always utilise and demonstrate within their report the underpinning investigative methodology that they are using, e.g. a Fishbone analysis of contributory factors.**

3.52 **Serious Incident Review reports must fully comply with guidelines outlined in the National Patient Safety Agency's RCA Investigation Evaluation Checklist**.

Trust actions:

Review existing root cause analysis template to include a section for the methodology.

Review existing root cause analysis template to ensure it is compliant with the NPSA guidance.

Serious incidents requiring investigation (SIRI) are now managed by the Clinical Risk and Safety team. The new Associate Director of Quality & Safety has been in post since September 2016, and amendments to the SIRI template have been made, and further changes are planned, to emphasise how contributory and service delivery factors are identified and recorded. Resources for the investigation of incidents have been increased, and a local 'bank' of experienced investigators is kept, and the process is managed by the SIRI facilitator. The Trust reported that fewer queries are received from the CCG at their SIRI quality group. Ensuring that all incidents are recorded appropriately is also included in the Trust CQC action plan and monitored accordingly.

3.53 There are twice monthly SIRI Panels chaired by the Chief Nurse, and a Mortality Review group is in place. The terms of reference (dated February 2015) describes clear roles, responsibilities and lines of accountability. Minutes of SIRI Panel meetings on 7 February and 22 February 2017 were reviewed, and there was evidence of senior staff attendance, in depth discussion about each SIRI report, and actions agreed and followed up.

3.54 The most recent SIRI template and two sample reports were reviewed, which showed evidence of use of the NPSA contributory factors framework which were described and shown as a fishbone analysis.

3.55 Staff interviewed were able to describe how information and learning from SIRIs is cascaded down through 'learning messages', team meetings and supervision.

3.56 GESG produces a list of learning points relevant to AMH, which is talked through at the meeting and evidenced in minutes.

3.57 Minutes of 24 November 2016 seen (describe contents/issues reviewed etc)

3.58 A 'risk action tracker' is maintained and the Panel produces themed reports – such as MHA/SIRI/HIRI learning, mortality report, audit reports, incidents, Sussex themed homicide report, results of suicide audit, audit programme, section 136 mobilisation plan, and a research report.

3.59 Appropriate assurance is therefore available in respect of this recommendation.

Recommendation for NHS England

3.60 It was confirmed by the Head of Investigations (Mental Health Homicides) NHS England South that this has been completed.

4 NHS Portsmouth CCG feedback April 2017

Management of Serious Incidents

4.1 NHS Portsmouth Clinical Commissioning Group (PCCG) has had oversight of Solent NHS Trust (Solent) serious incidents (SIs) since 2014. The SI

management process has evolved over the past three years with continued support from PCCG. During this time there have been several workforce changes to the Trust's risk team which delayed progress. However, since the Trust substantively appointed a new Head of Patient safety in December 2015 significant progress has been made and continues in working towards the National SI Framework standards.

4.2 It should be acknowledged that there has been a huge amount of work required to resolve the impact of a substantial back-log of un-submitted SI reports which, in addition to the current SI workload demanded further assurance from the Trust prior to closure by the CCG.

Process

4.3 PCCG has worked closely with Solent to support the resolution of challenges and to promote an environment of openness and transparency. The positive working relationship between the two organisations continues to grow and there is confidence that the provider will continue to alert PCCG to any potential situation as a matter of course, regardless of whether, following further investigation the incident is confirmed as an SI or not.

4.4 PCCG continue to challenge the provider as and when appropriate and over the past 12 months several actions have taken place as a result;

4.5 The Trust's risk department workforce position was monitored via PCCG quality and safeguarding register of concerns; however following assurance with the stabilisation of this workforce this concern is now closed with evidence that processes are being embedded within both the team and service lines.

4.6 Incidents are reported onto STEIS in a timely way and rationales for exceptions are provided where previously there were delays at times. This is monitored by both PCCG and the Trust.

4.7 The management of SIs in line with national guidance has been discussed with the provider on several occasions both informally and formally at Clinical Quality Review Board (CQRB) meetings. PCCG Clinical Quality Manager (CQM) meets monthly (previously this was fortnightly but reduced when improvements were noted) with the Solent's Head of Patient Safety to review the current position. This includes any SIs breaching the 60 day target and SIs that require further feedback or a more updated action plan to demonstrate actions taken.

4.8 The Trust provided PCCG with an action plan and trajectory to improve its position and progress which was monitored closely by the CQM. Significant progress has been made but the high number of pressure ulcer incidents reported has previously skewed the data somewhat as these are grouped and reviewed at provider SWARM panels. Decisions are made to undertake a full RCA or not. PCCG have worked closely with the Trust to streamline the management of pressure ulcer SIs to ensure this process is timely, efficient

and proportionate. A pilot commenced on 1st April 2017 and there is a planned review in six weeks' time.

4.9 PCCG on occasions as deemed necessary will formally notify Solent highlighting any re-occurring themes and trends this has included in the past; Staff awareness of Mental Capacity, contingency plans for the switch from one electronic recording system to another, Joint working across single point of access, multi-disciplinary working across agencies, record keeping and care coordination. Solent is responsive and engages with PCCG on actions taken to address these issues.

4.10 PCCG have seen an improvement in the quality of RCAs submitted and this is thought partly due to the provider's improvement in its internal processes for sign off and the investment in bank investigators to undertake investigations. Due to the back-log and late submissions PCCG have for some time been working with RCAs completed several months ago, but as Solent embeds its processes and systems Trust wide PCCG are now beginning to see RCAs submitted within the 60 day timeframe. Extensions for deadlines are only granted in exceptional circumstances and not as a result of poor internal planning and monitoring.

4.11 Where necessary individuals are invited to PCCG SI panels to support presentation and assist commissioners in making well informed decisions about closure of cases. This has proved particularly successful for both PCCG and the Trust as it allows a greater understanding of complex cases face to face meaning that any questions can be resolved at the time.

4.12 Numbers of SIs per month and breaches are monitored as part of the monthly quality scorecard with themes and trends noted at SI panels. As per the quality contract Solent are obliged to submit quarterly reports around lessons learned and the organisation learning report which triangulates learning from all sources is submitted bi-annually. A progress check on past action plans can be sought via this route as well.

SI Panels

4.13 PCCG CQM maintains a comprehensive log of all SIs raised and monitors progress in accordance with national guidelines. SI panels to review RCAs are held monthly, chaired by PCCGs Deputy Director of Quality & Safeguarding. Additional SI panels are also convened dependant on demand to ensure timely closure. RCAs submitted by the provider are distributed on receipt to the CCG panel members for an initial review and further feedback from the provider is sought (prior to panel) if it is felt that a decision to close the RCA is not possible without additional information.

4.14 The panel reviews and discusses the RCA and will make one of the following decisions to;

- Close
- Close with questions back to the provider

- Open with further questions and representation at panel

4.15 In addition to panels, the CQM is undertaking informal visits within the Portsmouth care group to gain a better understanding of the services, seeking assurance that changes to practice have occurred as a result of lessons learned. This provides an opportunity to talk to staff and follow up on some of the actions and learning at the point of direct care delivery.

4.16 On a monthly basis the CQM along with PCCGs Deputy Director of Quality & Safeguarding also holds a SI review panel which looks at;

- requests for de-escalations (when it has been established by the provider following further investigation that the incident does not meet the SI criteria)
- Information requested to provide additional assurance on previously reviewed SIs
- Updated action plans
- Themes and Trends – areas of concern

Summary

4.17 Overall Solent has made significant progress since 2014. The improvement to processes and SI management within the organisation has evolved albeit slowly but there is a definite proactive approach to not only attaining high standard of SI management but to work alongside PCCG where once it was more of a reactive approach. Incident reporting has increased due to what is believed to be the promotion of a positive reporting culture and further work is being undertaken jointly to ensure incident management is effective and responsive. Work continues to ensure lessons learned are shared both across and outside of the organisation.

CCG Feedback on NHS England Action Plan Mr C Case

Issue 1

4.18 The CCG has received feedback from GPs that they are being updated in a timely way by the mental health teams.

Issue 2

4.19 An audit was completed after a reflective practice review of another case. The audit demonstrated that practice had improved but more work was needed regarding transfers of care from/to Trusts further away.

Issue 3

4.20 There have been improvements to the risk assessment form and documentation and work continues to ensure this is embedded into everyday processes across the service.

Issue 4

4.21 Work is ongoing to look at innovative support options as an alternative to registered care, including the use of personal budgets it appropriate

Issue 6

4.22 PCCG agree that the SI reports are now of a much better standard and comply with national guidance.

5 Summary

5.1 It is clear that the lessons learned from this independent investigation have been actively implemented, and evidence based assurance of implementation has been sought by senior management.

5.2 The action plan is considered complete, with one suggestion to incorporate the new transfer protocol into formal policy.

Appendix A documents reviewed

Solent NHS Trust documents

- CPA and Standard Care Policy (version 5)
- Clinical Risk Assessment and Management Policy and Procedure (version 8)
- Protocol for transfers
- Mental Health Recovery Team South Business meeting 17 February 2016
- Mental Health Recovery Team North Business Meeting 26 January 2016
- Mental Health Recovery Team North Business Meeting 19 April 2016
- Mental Health Recovery Team North Business Meeting 14 June 2016
- Adult Mental Health Governance & Essential Standards Group (GESG) meeting 24 March 2016
- AMH & SMS Governance & Essential Standards Group 27 October 2016
- AMH & SMS Governance & Essential Standards Group 24 November 2016
- AMH & SMS Governance & Essential Standards Group 15 December 2016
- AMH & SMS Governance & Essential Standards Group 26 January 2017
- Minutes of SIRI Panel meetings on 7 February and 22 February 2017
- Audit of Transfer of patients from Southern Health to Solent Mental Health Services against transfer protocol standards 2015/2016
- Risk formulation standard
- NERD acronym
- Risk training packs- risk to self and others, Joiner's interpersonal model, Lived experience risk training pack
- Solent action plan following CQC report dated November 2016

Other documents

- CQC report dated November 2016
- Portsmouth CCG feedback on the Trust's implementation of serious incident action plans dated March 2017

Appendix B Mr C Action Plan

Organisation Name:	Solent NHS Trust	**Individual Completing Action Plan:**	Richard Webb
Service Area:	Adult mental Health	**Phone:** **Email Address:**	023 92682520 Richard.webb@solent.nhs.uk
Action Plan Title:	NHS England Homicide Review for Mr C		
Start Date:	Dec 15	**Finish Date**:	Apr 16
The aim of this Action Plan is to:	To address recommendations outlined in the independent report carried out by NHS England into Homicide in 2013		
Evidence Base / Rationale for undertaking this Action:			

Green – complete / in action; Amber – on time but not yet started / missed target but action in place to resolve ; Red – missed target with no action to resolve)

Issue 1 (Recommendation 1)	Action Required	Start Date	Finish Date	RAG	Action Owner	Outcome / Target	
Following a CPA review if there are any significant changes in a patient's risk management, support needs or medication the care coordinator should arrange as soon as possible to meet with the patient's primary care service so that the patient's records can be updated and any plans implemented.	This learning to be discussed with staff at the team meeting, to ensure staff are aware of this consideration following any changes where complexity may warrant a follow up call/meeting to GP who may not have attended. To be raised as and where appropriate with Individual staff in caseload supervision. To be an added component for managers to consider in supervision.	Dec 15 Dec 15	Jan 16 Mar 16		Community Services Manager and Team Managers	GPs to be fully informed of any care changes (via phone call or meeting) in complex and high risk cases where felt appropriate.	The Risk Assessment and CPA Policy have had additional statements inserted in relation to this recommendation. This has been discussed at our Governance meeting 24.3.16 to reinforce this learning. Addition to Risk Policy Email.msg FW Revised CPA Policy Attached.msg

Issue 2 (Recommendation 2,3,10)	Action Required	Start Date	Finish Date	RAG	Action Owner	Outcome / Target	
Where there is a planned transfer of a patient between NHS Trusts the responsible clinician must ensure, wherever possible, that the transfer of medical records is completed before they accept responsibility for the patient's care. **A full review of a patient's historical medical notes must be undertaken by both inpatient and community services as part of their initial clinical and risk assessment.** **In order to evaluate the effectiveness of Solent NHS Trust's Protocol for Receiving and Referring Transfers of Care an audit should be undertaken of a number of individual cases where this protocol has been utilised.**	Protocol to be adjusted to reflect completion of medical records prior to accepting responsibility.	Nov 15	Dec 15		Quality and Standards Lead.	Protocol adjusted and shared with all staff.	 Transfer of Patient Amended 2015.doc
	Staff to be informed further that this refers to the responsibility of overview of notes and history be part of initial clinical and risk assessment. Protocol to further reflect this.	Nov 15	Dec 15		Quality and Standards Lead.	Protocol adjusted and shared with all staff.	 GESG Minutes 17.12.15.doc
	Random audit of a sample of transfers over first year of protocol in place to ensure compliance.	Nov 15	Jan 16		Community Services Manager	Audit to demonstrate adherence to transfer protocol.	 Tranfer of Patients Audit v1.xlsx
Issue 3 (Recommendation 4,5)	**Action Required**	**Start Date**	**Finish Date**	**RAG**	**Action Owner**	**Outcome / Target**	**Evidence of Completion**
Solent NHS's Trust's revised risk assessment form should have separate sections for historical, current and ongoing risk factors. Each risk factor identified should be cross-referenced in the narrative section. Triggers and protective and contributory factors should be clearly identified for every area of risk.	To ensure Risk Formulation currently required from staff, captures historical overview as well as current risks.	Nov 15	Nov 15		Team Managers	All staff to be informed through formal meetings with minutes. Risk audit to demonstrate compliance to reporting risk procedure.	Message disseminated to staff via Learning messages and contained within the Risk Policy (see above)

Risk information should only be documented in one location within Solent NHS Trust's patient records system.	To ensure staff are informed of the requirement to link narrative around risks to appropriate 'Risk Node' section.	Nov 15	Jan 16		Team Managers	System One Risk process guide available. Risk audit to demonstrate compliance to reporting risk procedure.	S1CRS MH Risks FINAL.docx Risk Documentation Audit Q1+2 final - Oc Risk Documentation Audit Q3 + 4 Final Ma
	All staff to be informed of process for recording risk formulation on System One.	Nov 15	Jan 16		Team Managers	Communication to all staff re expectation around risk. Risk audit to demonstrate compliance to reporting risk procedure.	S1CRS MH Risks FINAL.docx
Issue 4 (Recommendation 6)	**Action Required**	**Start Date**	**Finish Date**	**RAG**	**Action Owner**	**Outcome / Target**	**Evidence of Completion**
Consideration should be given during discharge and CPA planning to apply for Personalised Budgets or Direct Payments to fund additional care and support needs.	Staff to be reminded of the need to consider personalised budgets through discussion and being recorded at team meetings. Issue to be raised where appropriate within individual caseload supervision.	Dec 15	Mar 16		Team Managers	Service able to provide examples of where personalised budgets have been used.	Since the implementation of the Care Act where care needs are assessed as needing further support Social Workers within the community services will facilitate the most appropriate ways forward in addressing these including direct payments or personalised budgets. Currently a small number of individuals within the service are in receipt of personalised budgets or direct

							payments. This is also monitored by PCC.
	Message to be shared through Learning Messages poster.	Dec 15	Jan 16		Quality and Standards Lead	Further dissemination of learning message.	SIRI Learning February and March 2
Issue 5 (Recommendation 7)	**Action Required**	**Start Date**	**Finish Date**	**RAG**	**Action Owner**	**Outcome / Target**	**Evidence of Completion**
Risk assessments and support plans should always be identifying and considering a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention.	Learning message to be discussed and recorded in Team Meetings. Discussed and recorded in caseload supervision as appropriate.	Dec 15	Mar 16		Team Managers	Risk Assessments recording housing issues and plans around this where appropriate.	Risk Panel runs within service where complex risk cases are discussed and issues identified for further exploration. Panel includes representation by current lead in service, involved in reviewing accommodation and housing needs in city. SIRI Learning February and March 2 SIRI Learning December 2015.docx
	Current risk Acronym to clarify Housing as a key factor in reviewing risk.	Dec 15	Jan 16		Quality and Standards Lead	Clarity of housing issues initiating a risk review.	SIRI Learning December 2015.docx

Issue 6 (Recommendation 8,9)	**Action Required**	**Start Date**	**Finish Date**	**RAG**	**Action Owner**	**Outcome / Target**	**Evidence of Completion**
Serious Incident Review authors should always utilise and demonstrate within their report the underpinning	Review existing root cause analysis template to include a section for the methodology.	7/12/15	10/01/16		Clinical Risk and Safety Manager	Revised Root Cause Analysis template in use.	Solent NHS TRUST SIRI Report Template

investigative methodology that they are using, e.g. a Fishbone analysis of contributory factors. **Serious Incident Review reports must fully comply with guidelines outlined in the National Patient Safety Agency's RCA Investigation Evaluation Checklist.**	Review existing root cause analysis template to ensure it is compliant with the NPSA guidance.	7/12/15	10/01/16		Clinical Risk and Safety Manager	Revised Root Cause Analysis template in use.	Solent NHS TRUST SIRI Report Template

Group signed off:	
Sustainability for this Action Plan:	
Action Plan completed:	