Assurance Report: Somerset Partnership NHS Foundation Trust

NHS England independent investigation Mr S 2013/23705

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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 This paper sets out the assessment for Somerset Partnership NHS Foundation Trust's (SOMPAR) action plan assurance following an independent investigation into a homicide by a service user (serious incident identification number 2013/23705). The purpose of this is to test whether the Trust has completed every action, embedded the changes and can demonstrate each action's impact or effectiveness.

1.2 NHS England South commissioned Niche Health & Social Care Consulting Ltd (Niche) to conduct an independent investigation into the care and treatment of Mr S by Somerset Partnership NHS Foundation Trust, which was undertaken by Grania Jenkins, Lead Investigator for Niche and published in August 2016.

1.3 In September 2012 Mr S had been under the care of Somerset Partnership NHS Foundation Trust and at the time of the incident Mr S was in the care of his GP. The incident occurred on 6 August 2013 in the accommodation of Ms G and her partner. Mr S, Ms G and her partner all originated from Sri Lanka. The exact nature of their relationship remains unclear. At approximately 8:15 pm two women arrived in the parking area. One of the women got out of the car and saw Ms G at the window, with her arms outstretched, shouting "Help me". She reported that a male, who was subsequently identified by the police as Mr S, dragged Ms G away from the window. The police were called. Whilst waiting for the police to arrive, the woman looked through the window and saw Ms G lying on the floor with Mr S crouching over her. He was moving his right arm in what she described as mechanical up and down movements. Police arrived at the scene at 8:25 pm. When they entered the flat they found Ms G on the floor with multiple stab wounds. Mr S had blood on his clothes, hands and face and was holding a knife. The pathologist reported that the cause of death was stab wounds to the left-hand side of Ms G's neck, which had severed her carotid artery and jugular vein; she had in the region of 50 to 100 other stab wounds. On 4 March 2014 Mr S was found guilty of the murder of Ms G. He is currently serving a life tariff with a minimum term of 18 years in prison. 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.

1.4 This evidence based review has been carried out by Donna Eldridge, Practitioner, Investigator, Reviewer for Niche, and has been peer reviewed by Carol Rooney, Deputy Director at Niche. The draft report was sent for comment to Somerset Partnership NHS Foundation Trust and NHS Somerset CCG.

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

Criteria for assessment

1.6 We agreed with the Trust on the 20 June 2017 that we would be testing actions for completeness, embeddedness and impact. Therefore, the criteria for each action is as follows.

Is there evidence that the action has been completed?

- policy,
- procedure,
- training
- guidance
- job descriptions
- terms of reference
- is there documentary evidence to support its embeddedness? I.e.
- attendance records,
- activity reports (tableau, Ulysses)
- minutes
- Is there evidence of impact/effectiveness?
- audit & analysis reports

Where actions have not progressed is there evidence of intervention where improvements are needed?

Selection of the actions

1.7 We established that the action plan contained several cross cutting actions that related to more than one recommendation. In addition, some of the actions were repeated. We took the approach to review all the recommendations on the action plan to ensure that they had been embedded within the organisation but to group them together in themes for ease of reporting into seven assessment areas.

1.8 We communicated to the Trust that all fifteen recommendations would be reviewed, prior to the first assessment and site visit and had requested further documentation against each action. It was noted that the action plan was multi-agency but ownership lay with the Trust.

Methodology for the Assurance Audit

1.9 The review process comprised of a review of Trust documents and interviews based on a set of questions developed from the Trust's action plan. Feedback on the CCG's oversight of the Trust serious incident management process was also reviewed. The assurance in respect of the recommendations and associated actions was assessed by the triangulation of these sources of information.

1.10 A full list of all documents reviewed is referenced in (Appendix A).

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

- Director of Strategy and Corporate Affairs
- Head of Safeguarding
- Head of Corporate Business
- CMHT Manager
- Operational Service manager CMHT West Somerset (by telephone)
- Consultant Clinical Psychologist – Dual Diagnosis, Adult Psychological Therapies Service
- Deputy Service Director for Mental Health and Learning Disabilities
- Head of In-patient and Urgent Care Services (by telephone)
- Head of Patient Safety and Risk Management – Somerset CCG (by Telephone)
- I discussed the issues with the Head of Patient and Risk Management at NHS Somerset Clinical Commissioning Group, who provided evidence on the oversight of the action plan and serious incident process.

Analysis of the Action Plan

1.12 The Trust implementation of each of the 15 recommendations made by the independent investigation is discussed in turn as well as the evidence and assurance for its implementation. I was informed that the governance of the action plan was signed off by the SIRI and Mortality Review Group and has gone through the Board and the Quality & Performance Committee and presented to the CCG Governance Committee by the CEO for the Trust.

1.13 Following the independent investigation there were different action plans developed one by the Trust, and one by Somerset Drug and Alcohol Service (SDAS). These have now been incorporated to have one unified action plan and agreed by the CCG. (Appendix B). It was also agreed at the CCG Governance Committee that actions in relation to primary care would be considered and taken forward by the CCG.

Recommendation 1

When assessing and providing support to patients whose first language is not English, primary and secondary care services must always consider the option of utilising an interpreting service

1.14 SOMPAR indicated that this action was completed on the 31st July 2016. The evidence submitted was the interpreting, translating and accessible

information policy 2013 V3. This policy has since been reviewed and updated to reflect template changes; new appendices and further guidance on BSL Interpreting in January 2017. The policy is monitored through the Patient and Public Involvement Group.

1.15 SOMPAR's action was also to regularly review the use of interpreting services across services. I was informed that this is completed on a weekly basis by the Head of Corporate Business and that the budget is significantly overspent. The usage is sent through directly to the Head of Corporate Business and fed back to the operational practice groups. A quarterly report to Patient and Public Involvement Group is produced which also gives a clear breakdown on the languages required for interpretation.

1.16 Within the Action plan SOMPAR was to ensure information regarding access to interpreting services, 24hrs a day is readily available for all staff. I was informed that there is a detailed page on the Trust's intranet page giving staff the information on how to obtain an interpreter and forms are available for completion.

1.17 One piece of evidence submitted was the staff 'What's On' magazine. As part of the action plan the Trust was to remind staff of the Interpreting service. On review of this evidence there was no mention of interpreting services within it. I questioned this and was informed that it was the wrong piece of evidence submitted but was then subsequently informed that this had not been in the 'What's On' for 'a couple of years'.

1.18 I had the opportunity to visit a CMHT and discuss the use of interpreters. The process was said to be clear and understandable and I was told that there was a robust intranet page. The Team Manager stated that there had never been a problem identified in relation to obtaining an interpreter if required.

1.19 **Partially complete** due to further communication with staff across the Trust being required through 'What's On' as required on the action plan.

Recommendation 2

Where it is known that a patient is experiencing financial or housing issues secondary mental health services should be identifying, as part of the patient's care planning, details of the relevant advocacy and support services and supporting them in accessing such service.

1.20 SOMPAR indicated that this action was completed on the 30th September 2016. The first area was to review the recommendation within the CMHT best practice group. Evidence was received where the assessment documentation was revised to include financial and housing issues.

1.21 The second area was to review the Trust's clinical risk training to ensure that these elements are included within the training. I was informed that the Trust has reviewed the Training and has recently procured 45 places on a two-day

RCA training from an external organisation. Within the RCA training there are several scenarios that discuss elements of this case for staff to work through. These were reviewed and accepted as assurance.

1.22 Lastly the final action was to share the review and recommendations with social care colleagues in light of new mental health social worker arrangements and incorporate into transition plans for new models of service delivery. I was informed that although social care colleagues are no longer integrated into teams, they still share some of the buildings. There are daily conference calls in relation to risk which incorporate housing and financial issues. Evidence for this was submitted and reviewed.

1.23 I was informed that the risk module on RIO (the electronic notes system) has been enhanced to ensure that housing and financial issues are captured. The screenshot submitted as evidence did not show that housing and financial issues are captured but it could possibly be that the wrong screenshot was submitted. Due to this I was unable to accept assurance.

1.24 **Partially complete** due to lack of evidence in relation to RIO risk assessment including financial and housing elements.

Recommendation 3, 7 & 8

Where static long-term and acute risk factors have been identified as being significant, they must continue to be assessed and documented at this level until it can be evidenced that there has been a significant change in a patient or that there are new robust protective factors in place.
Somerset Partnership NHS Foundation Trust's Risk Assessments and Recovery Care Plans should have a section to indicate if a patient has been involved in the process. The form should also indicate if a patient has agreed with the assessment and if not, it should be documented. Also, the assessment and plan should indicate if the patient has been asked if they would like a copy.
Somerset Partnership NHS Foundation Trust's Risk Assessments and Recovery Support plans should always identify and consider 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 and support.

1.25 I was informed that the current risk screens have been reviewed within RIO by the CMHT 'best practice' group. This is an ongoing review and spot audits will be taking place although no date has been set yet.

1.26 I requested the current CMHT caseload reviews to check the process is embedded as per the action plan and although I was informed that this does take place no evidence was received.

1.27 The Trust was asked to ensure that a section within RIO identifies patient involvement in the development of the care/crisis plan. Currently there is a tick box within RIO to state that the patient has agreed to the care but there is no evidence that the patient has disagreed with the plan of care. However, through the patient user groups printable care plans have been developed which have been received positively. A copy of the care plan was received but there is no area for the patient to sign to say that they agree or not. This requires further development.

1.28 An audit of personalisation of care plans was completed in January 2017. Although some very positive results were identified the area of concern remained to be that patients were not being given a copy of their care plans as this only stood at 35%.

1.29 In discussion with the Deputy Service Director for Mental Health and Learning Disabilities it was acknowledged that the audit did not capture the issues around patient's agreement and disagreement of their plan of care and this will be enhanced.

1.30 **Partially complete** due to further work being required on the person centre care planning process, ensuring that service users are engaged.

Recommendation 4

For the safety and protection of both patients and staff, the RIO Physical Health Examination pro forma should include a body map that is used, with the patient's permission, to record any injuries, scars, bruises etc. on a patient's body

1.31 I was informed that all in-patient areas use a paper based body map. Evidence has been submitted to say that the body map in RIO is currently under development and is being tested but this is not currently being used.

1.32 In discussion with CMHT, they would not use a body map upon assessment but only when the patient was accepted within the team. The Team Manager stated that unless a patient was on clozapine or a depot their physical health would not be assessed and a body map would not be used.

1.33 There is a shortfall in physical health assessments and the CHMT manager stated that they would like to run a well-being clinical but due to staffing demands this has not been possible

1.34 **Partially complete** due to the work continuing in obtaining the body map on RIO.

Recommendation 5, 6 & 9

Both Somerset Partnership NHS Foundation Trust and the re-commissioned Somerset Drug and Alcohol Service (SDAS) need to consider developing a specific policy, which includes consideration of the

psychological, accommodation and social needs in the provision of services to refugees. Such a policy should include NICE guidelines on supporting such patients with PTSD.
Somerset Drug and Alcohol Service (SDAS) and Somerset Partnership NHS Foundation Trust must agree a formal information-sharing protocol.

1.35 It is evident that there has been a great deal of working taking place around the issue of dual diagnosis within the organisation as well as with SDAS and the CCG.

1.36 There is a robust joint working protocol which was developed and has been taken through SDAS and the CCG. The joint working policy now has the refugee status incorporated.

1.37 A dual diagnosis policy has been developed and updated as part of a multi-agency approach linking the local Safeguarding Board. The reviewed policy will be going for ratification in August 2017 and has been updated to include people with complex needs.

1.38 The dual diagnosis service only consists of a part time clinical psychologist and an administrator. The clinical psychologist is part-time and term time only. In discussion, it was stated that for the amount of referrals that the service receives, the amount of staff is a significant shortfall.

1.39 There appears to be a good working relationship with SDAS and the Dual Diagnosis service and joint agency supervision groups are held where cases and action plans are discussed.

1.40 In discussion with a CMHT manager, she describes the Trust's dual diagnosis services as good and knows that she can always have discussion by phone on any cases. The manager endeavours to attend the Trusts alcohol best practice group as feels that this is extremely useful.

1.41 Currently there is an intranet page being developed for dual diagnosis but this is taking a bit of time due to time constraints.

1.42 In discussion with the clinical psychologist it was felt that the service could easily expand with another four workers, possibly at a Band 6 to enhance the service provision. There are "link Workers" across the Trust but unfortunately these are not always given the dedicated time to attend supervision groups or training which would again enhance the service.

1.43 A joint working protocol has been developed and disseminated which includes all NICE guidance. This has also been sent to the Safeguarding Board.

1.44 The clinical psychologist provides 4 days of training per year and will try to complete bespoke training for teams where time allows. It was discussed that it would be useful to have some e-learning for staff but this would have to be developed at a later stage.

1.45 A bi-annual audit will be undertaken for the dual diagnosis service and working with SDAS.

1.46 There appear to be good links with Primary Care for dual diagnosis and this has been incorporated into the policy and joint working protocol.

1.47 **Recommendation 6** within the investigation report has not been included within the action plan. The recommendation is as follows: "The **primary care service** involved in this case should familiarise themselves with NICE guidelines regarding the provision of health care to refugee patients". A newsletter from the CCG went to all GP practices in relation to this recommendation and it has been confirmed by the GP practice that this is now complete.

1.48 **Evidence of completeness** received against the action plan although this is ongoing work.

Recommendation 10, 11, 13, 14 & 15

Authors of Serious Incident Reports must include evidence within their reports of the methodology that is being utilised within their investigations, for example Root Cause Analysis, a fishbone diagram, 5 Whys
Somerset Partnership NHS Foundation Trust should adopt a universal action plan proforma and ensure that the relevant STEIS incident number is clearly documented on the original and on subsequent action plans.
Authors of Serious Incident Reports must ensure that they are referring to all the relevant NICE guidelines that were in place at the time of the incident
To ensure that all the action plans that have arisen out of this Serious Incident Report have been fully implemented, Somerset Partnership NHS Foundation Trust should undertake an immediate audit of each recommendation.
In order to evaluate the effectiveness of the new information-sharing systems introduced since this incident, Somerset Partnership NHS Foundation Trust should consider undertaking an audit exercise of a number of cases, involving similar complex patients, where there is both internal and external multi-agency involvement.

1.49 A revised template has been developed which incorporates the methodology used. There is also external training taking places for RCA's as discussed under recommendation 2.

1.50 A revised SIRI template has been developed and implemented and a reminder to use NICE guidance within the template. The serious incident identification (STEIS) number has also been added onto the template.

1.51 The audit in relation to the recommendations and the multi-agency audits are currently being considered but have not yet taken place.

1.52 **Partially complete** received against the action plan although this is ongoing work.

Recommendation 12

Somerset Partnership NHS Foundation Trust's Safeguarding Adults at Risk Policy should direct practitioners to consider a patient's culture and ethnicity as being significant and interconnecting factors to both their vulnerabilities and their potential risks of being abused.

1.53 SOMPAR have a clear Safeguarding policy which has been updated to reflect cultural factors which are clear and concise. The new policy is going for ratification in August 2017.

1.54 There are clear intranet pages for staff for Safeguarding with all the relevant forms available. In discussion with CMHT staff they are aware of the processes for safeguarding and where to find the relevant information.

1.55 Safeguarding training is mandatory for all staff but at varying levels dependent on their role. Within the training culture and ethnicity issues are raised.

1.56 There is a safeguarding steering group which is multi-disciplinary which feeds into the clinical governance group/integrated governance and the Trust Bboard. All relevant information goes to the Safeguarding Boards with good attendance from the Trust.

1.57 Safeguarding is a regular feature in the 'What's On' magazine for staff information.

1.58 **Evidence of completeness and embeddedness** received for this recommendation.

Assessment against the Recommendations

1.59 For our assessment, we have summarised our findings against themes and against individual actions. We have graded these and explanation of each grading is set out in the table below.

criteria
A-Evidence of completeness and embeddedness and impact
B-Evidence of completeness and embeddedness
C-Evidence of completeness
D-Partially complete

E-Not enough evidence to say complete
U- Yet to check

2 Findings

2.1 It is acknowledged that a lot of work has been undertaken to address the recommendations of the action plan and in the period from the publication of the report to completion of this audit, there have been significant changes both in national policy relating to the investigation of serious incidents and within the Trust's approach to personalised care planning that have, to some extent, superseded the original actions identified. However, in relation to the specific actions within the action plan there is a lack of evidence forthcoming in some areas. The CCG has yet to close the action plan and does have some concerns in relation to the lack of evidence.

2.2 I found that there was only partial assurance for all recommendations apart from recommendations five, nine and twelve. This was mainly due to the lack of evidence to back up the interviews that were undertaken.

2.3 I found that one item of evidence submitted for recommendation one (What's On) had no relevance to that action and was informed that this had not taken place.

2.4 I found evidence of completeness and embeddedness for recommendation twelve with good governance structures in place.

2.5 Although there was evidence for completeness against recommendations five, six and nine this work is ongoing.

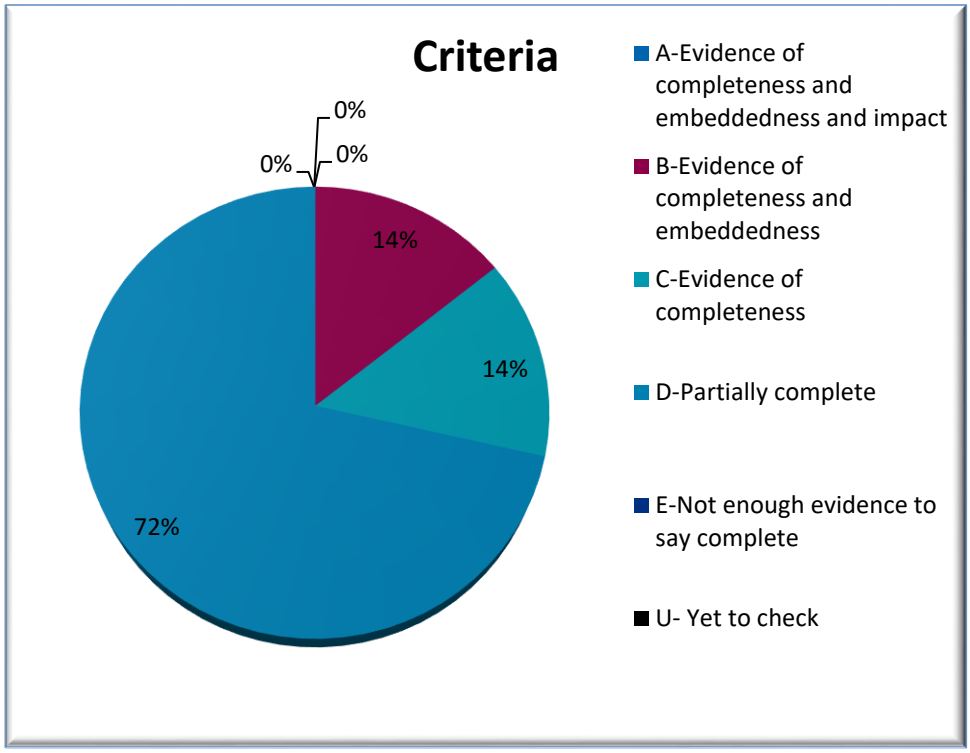
2.6 I found that recommendation six from the original investigation had not been included within the action plan as this related to primary care and has been completed.

Overall Assessment by action

2.7 The table below outlines the grading against each action as follows:

criteria	number	percentage
A-Evidence of completeness and embeddedness and impact	0	0
B-Evidence of completeness and embeddedness	1	14
C-Evidence of completeness	1	14
D-Partially complete	5	72

E-Not enough evidence to say complete	0	
U- Yet to check	0	



3 NHS Somerset Clinical Commissioning Group feedback

CCG Feedback on NHS England Action Plan Mr S Case 3 May 2017

3.1 On the 3 May 2017 NHS Somerset Clinical Commissioning Group held their Governance Committee where discussion took place around the extraordinary governance committee held in July 2016 on the Independent investigation into the care and treatment of Mr S.

3.2 It was highlighted that recommendation 14 from the SOMPAR action plan, which was in relation to Serious Incident action plans being in place and monitored has not been concluded. It was noted that the recommendation had been signed off in June 2016 by the Trust, but no evidence was given to the CCG to provide any assurance for this.

3.3 In respect of recommendation 15, it was suggested that the response provided was inadequate in saying that the Trust would only consider undertaking an audit to evaluate the effectiveness of information sharing systems introduced since the incident.

3.4 It was agreed it would be helpful to discuss with SOMPAR which actions should be prioritised. It was suggested the dual diagnosis issue was of importance and the policy from the SOMPAR action plan could be implemented in different ways.

3.5 The combined Action Plan to go to the next meeting in July 2017 for further scrutiny.

3.6 The Action Plan remains open to the CCG.

4 Areas for the Trust to focus on

4.1 Further communication with staff across the Trust required through 'What's On' on the use of interpreters.

4.2 Risk assessments and person-centred care/crisis plans to be addressed which ensure that the service user agrees or disagrees with the plan of care and are engaged in the process.

4.3 Physical health assessments on RIO to include the body map. Work is underway but needs to move on. It would also be useful for the physical health agenda to be taken forward more robustly within CMHTs in alignment with the national agenda.

4.4 The issue of the Dual diagnosis service to be addressed with the CCG.

4.5 The CCG to have further robust oversight/monitoring of the Action Plan.

4.6 A further review of the Action Plan to take place in 3 months' time.

Appendix A documents reviewed

Interpreting and Translation Policy v3

- Revised LAP template
- Safeguarding Adults at Risk Policy 2015
- Equality Delivery System EDS2 Self-Assessment May 2016
- Equality Delivery System EDS2 Self-assess Report May 2015
- SIRI Policy Feb 2017
- SIRI Policy November 2012
- SIRI Improvement Action V1.10
- SIRI Internal Audit Action Plan V1.0
- Interpreting and Translation Policy 2013
- Interpreting and Translation Policy 2017
- What's on @ sompar 1613 8 July FINAL
- Screenshot of staff intranet page for Interpreting services
- Trust Governance Structure May 2016
- Clinical Assessment and Management of Risk of Harm to Self and Others Policy V5
- Routine Appointment Assessment Report template
- Minutes (extract) Countywide Services Divisional Meeting 31 October 2016
- Joint Working Protocol March 2017
- Audit of Personalised Care Planning for Hospital Based Patients
- RCA template
- Documentation for review Interviews
- Draft DD policy approved BPG version June 2017
- Dual Diagnosis Policy V1. November 2012
- Interview schedule for Niche Assurance review re GV
- Joint working protocol reviewed January 2017- FINAL

- RE SIRI Action Plan Recommendation
- Safeguarding Adults at Risk Policy V5.1 June 2017 fv2 watermark
- Notes clinical review of RIO 310717
- Revised Care Plan rev 16 01 17
- Mental Health project board action notes 26.05.16
- Copy of Care Plan
- Draft Project board ToR v1.1
- Mental Health operating model group action 13.07.16
- Weekly conference call details
- Progress update on CMHS review
- MHSC Workshop 1.2.17
- SCCG GC Minutes 3.5.17
- Patient and Carer involvement group Report Q4
- Risk Training case studies

Appendix B Trust action plan

ORGANISATIONAL ACTION PLAN

SIRI (StEIS) 2013/23705- DATIX 18964
Client Mr S, Private location

Recommendation Identified in Overarching Report Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible Initials	Target Date for Completion	RAG Rating See Key	
Specific	**Measurable**	**Specific and Achievable**	**Realistic**		**Timebound**		
Recommendation 1 When assessing and providing support to patients whose first language is not English, primary and secondary care services must always consider the option of utilising an interpreting service	For all patients whose first language is not English, the option of the use of an interpreting service will be considered If not used the rationale for this will be documented	Regular review of the use of interpreting services across services	The interpretation budget is already significantly overspent	AS	31 July 2016		
		Ensure information regarding access to interpreting services, 24hrs a day is readily available for all staff	None	NJ	31 July 2016		
		Remind staff of the access to this service through What'sOn	None	AS	31 July 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)* • Interpreting and Translation Policy  Interpreting and Translation Policy v3. • What'sOn  what's on @ sompar 1613 8 July FINAL.pd							
Recommendation 2 Where it is known that a patient is experiencing financial or housing issues secondary mental health services should be	Financial and housing issues are considered as an integral element of the risk assessment and where these are considered a risk, details of the support	Review the recommendation within the CMHT best practice group	None	TC	31 July 2016		
		Review the Trust's clinical risk training to ensure that these elements are included within the training	None	NJ/JY	31 July 2016		

Recommendation Identified in Overarching Report Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible Initials	Target Date for Completion	RAG Rating See Key	
identifying, as part of the patient's care planning, details of the relevant advocacy and support services and supporting them in accessing such service	including advocacy will be included and agreed within the patients care plan	Share the review and recommendations with social care colleagues in light of new mental health social worker arrangements and incorporate into transition plans for new models of service delivery	None	NJ (CS from SCC)	30 Sept 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)* • Clinical Assessment and Management of Risk Policy  Clinical Assess and Management of Risk • Assessment report document for CMHT's updated  Taunton Assessment REPORT UPDATED 2							
Recommendation 3 Where static long-term and acute risk factors have been identified as being significant, they must continue to be assessed and documented at this level until such time as it can be evidenced that there has been a significant change in a patient or that there are new robust protective factors in place	This practice is supported by the mandatory Risk training Carry out county wide and local peer reviews to ensure this practice is embedded and consistent	Consider use of this case for reflection within the clinical risk training	None	NJ/JY	31 July 2016		
		Review of the current risk screens within RIO by the CMHT best practice group.	None	TC	31 July 2016		
		Utilise the current CMHT caseload reviews to check the process is embedded	None	TC/PM	30 Sept 2016		
		Share the recommendations from this review with Mental Health staff through Divisional Governance and best practice groups	None	NJ/JY	30 Sept 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							

Recommendation Identified in Overarching Report Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible Initials	Target Date for Completion	RAG Rating See Key	
List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)* • Recommendation 3 – Minute Extract for CW Division		 COUNTYWIDE Divisional Meeting - 3					
Recommendation 4 For the safety and protection of both patients and staff, RIO's Physical Health Examination pro forma should include a body map that is used, with the patient's permission, to record any injuries, scars, bruises etc. on a patient's body Somerset Partnership NHS Foundation Trust should introduce the appropriate guidelines regarding the use of body maps	For an agreed body map to be included within the "Physical Health Examination" on RIO. Guidance to be produced for staff for its use	Review the use of body maps within other mental health services	None	PMi/TY	30 Sept 2016		
		Develop a body map with the clinical skills and RIO team that can be used where appropriate	Will be dependent on the delivery of a technological solution – body map option now available in RIO	PMi/TY	30 Sept 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							

Recommendation Identified in Overarching Report Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible Initials	Target Date for Completion	RAG Rating See Key	
List of Evidence: *(Embed evidence of actions detailed above –* *click on insert, object, create from file, browse, select document and click on display as icon)* • Update re introduction of body map onto RIO. Enquiries have concluded that some other mental health trusts are using body maps as part of clinical records. • The initial technical obstacles have now been overcome and a suite of maps have been developed. The next stage to determine where to configure this within the RIO so it is functional for clinical services.  RE SIRI Action Plan Recommendation.msg							
Recommendation 5 Both Somerset Partnership NHS Foundation Trust and the recommissioned Somerset Drug and Alcohol Service (SDAS) need to consider developing a specific policy, which includes consideration of the psychological, accommodation and social needs in the provision of services to refugees. Such a policy should include NICE's guidelines on supporting such patients with PTSD.	Clear multi-agency protocol/policy for PTSD in line with NICE guidance	Review the requirements for support of patients with Dual Diagnosis and PTSD working with Turning Point and other organisations	Will rely on engagement of SDAS and other agencies	HB	~~30 Sept 2016~~ 31 December 2016		
		Develop a policy or working protocol as part of a multi-agency approach linking with the local Safeguarding Board	As above	HB	31 December 2016		
	Review the existing treatment and governance, for the provision of services to refugees (and other potentially traumatised people, arriving in Somerset) for each of the provider organisations that constitute SDAS.	Existing policies for the governance of equality and diversity reviewed and include protection of people with protected characteristics; this includes refugees and or/misplaced peoples. Local practice already embedded, to offer person-centred treatment, such as interpreter services.		Dr A /AC / CB /KM			
	Review each organisations (the providers of SDAS and SOMPAR) existing treatment and governance, in the provision of services to people with PTSD	Existing policies for the governance and management of mental health conditions have been reviewed within SDAS and amended where necessary, to incorporate the action detailed above.		Dr A / AC / CB /KM / Sompar			

Recommendation Identified in Overarching Report Issue/ Driver/ Gap/ Objective requiring action	Monitoring/ Progress Measure of success. How will you know the actions have resolved the issues identified	Actions Stated clearly and concisely	Resource demand/ constraints	Person Responsible Initials	Target Date for Completion	RAG Rating See Key	
	Discuss/review the local need for policies (policy amendments) and/or guidance on the above, within the Dual Diagnosis Best Practice Group.	Tabled for discussion at the Dual Diagnosis meeting between Sompar and SDAS on 9 May 2017.		AC / CB /KM	30 May 2017		
	Develop the actions documented above, as part of a multi-agency approach to joint action-planning	In progress		Dr A / AC / CB /KM / Sompar	30 May 2017		
	Escalate to Senior Clinical Governance team within the provider organisations that constitute SDAS for sign-off	Action to be taken, if amendments are needed and once all associated actions detailed above have been realised.		AC / CB / KM			
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)* • Joint working protocol revised		 Joint working protocol reviewed Jar	•				
Recommendation 7 Somerset Partnership NHS Foundation Trust's Risk Assessments and Recovery Care Plans should have a section to indicate if a patient has been involved in the process. The form should also indicate if a patient	All patients are involved in care planning or the reasons they are not, or a disagreement with the plan are documented It can be documented on RIO where a patient has been included within the	Incorporate a section with RIO to identify patient involvement in development of the care plan	None	NJ	30 Sept 2016		
		Incorporate section to identify any patient disagreement with the care plan	None	NJ	30 Sept 2016		

Recommendation Identified in Overarching Report Issue/ Driver/ Gap/ Objective requiring action	**Monitoring/ Progress** Measure of success. How will you know the actions have resolved the issues identified	**Actions** Stated clearly and concisely	**Resource demand/ constraints**	**Person Responsible** Initials	**Target Date for Completion**	**RAG Rating** See Key	
has agreed with the assessment and if not it should be documented what are their reasons. Also the assessment and plan should indicate if the patient has been asked if they would like a copy.	development of the Care plan	Audit personalisation of care plans	None	NJ	31 March 2017		

How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:

List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)*

• Audit completed January 2017	 248 Personalised Inpatient Care Planni		

Recommendation 8 Somerset Partnership NHS Foundation Trust's Risk Assessments and Recovery Support plans should always identify and consider 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 and support.	Financial and housing issues are considered as an integral element of the risk assessment and where these are considered a risk, details of the support including advocacy will be included and agreed within the patients care plan.	Review the Trust's clinical risk training to ensure that these elements are included within the training	None	TC	31 July 2016		
		Share the review and recommendations with social care colleagues in light of new mental health social worker arrangements and incorporate into transition plans for new models of service delivery	None	NJ/JY	31 July 2016		
		Share the review and recommendations with social care colleagues in light of new mental health social worker arrangements and incorporate into transition plans for new models of service delivery	Will rely on engagement of SCC and other agencies	NJ (CS from SCC)	30 Sept 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above –* *click on insert, object, create from file, browse, select document and click on display as icon)*							
• Clinical Assessment and Management of Risk Policy and training		Clinical Assess and Management of Risk	•				
Recommendation 9 Somerset Drug and Alcohol Service (SDAS) and Somerset Partnership NHS Foundation Trust must agree a formal information-sharing protocol.	Confirmation that there is an information sharing protocol in place	Confirm that SDAS are signatories to the first tier information sharing protocol	Will rely on CCG and SDAS engagement	AC / CB / KM /SOMPAR	31 December 2016		
		Dual diagnosis lead to confirm that there is a second tier information sharing protocol in place and review to ensure it is effective.	Will rely on SDAS engagement	HB	30 September 2016		
	SDAS partner organisations to escalate sign off of the above, to a signatory member of the organisations Senior Governance team			AC / CB / KM /SOMPAR			
	Signed copies of the Information Sharing Protocol to be collated and			AC / CB / KM /SOMPAR			

	stored by each participating organisation within SDAS.						
	Amend the Dual Diagnosis policy to include people with multiple complex needs, including but not exclusive to people with refugee status/ displaced people.	People with complex PTSD have been written in to the Dual Diagnosis policy: Figure 2, page 8		AC / HB			
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)* • Working protocol (under further review see 5 above) includes information sharing provisions. • Some agencies involved in SDAS are signatories to the first tier information sharing agreement but not all. Somerset CCG is pursuing this issue		 Joint working protocol reviewed Jar					
Recommendation 10 Authors of Serious Incident Reports must include evidence within their reports of the methodology that is being utilised within their investigations, for example Root Cause Analysis, a fishbone diagram, 5 Whys	Guidance for completion of investigations relating to use of tools is embedded in the RCA template	Revise template	None	MC	30 June 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)* • Copy of RCA template		 New RCA template May 2016.docx					

Recommendation 11 Authors of Serious Incident Reports must ensure that they are referring to all the relevant NICE guidelines that were in place at the time of the incident.	Reminder re NICE guidance to be embedded in RCA template	Revise SIRI template	None	MC	30 June 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)*							
• Copy of RCA template as above.	As above						
Recommendation 12 Somerset Partnership NHS Foundation Trust's Safeguarding Adults at Risk Policy should direct practitioners to consider a patient's culture and ethnicity as being significant and interconnecting factors to both their vulnerabilities and their potential risks of being abused.	Policy effectively directs practitioners to consider these elements	Review existing wording and references to consideration of protected characteristics and cultural factors to make sure these are sufficiently clear	Long term staff sickness resulting in safeguarding lead undertaking significant level of operational work.	RP	~~30 Sept 2016~~ 31 December 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above – click on insert, object, create from file, browse, select document and click on display as icon)*							
• Safeguarding Adults at Risk Policy	 Safeguarding Adults at Risk Policy 2015 v5						
Recommendation 13 Somerset Partnership NHS Foundation Trust should adopt a universal	Template available for use that has space to add STEIS number for both RCA and Action plan	Review RCA and Action plan templates	None	MC	30 June 2016		

action plan proforma and ensure that the relevant STEIS incident number is clearly documented on the original and on subsequent action plans.							
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above –* *click on insert, object, create from file, browse, select document and click on display as icon)*							
• Copy of RCA template and Action plan template • (Plse see above for RCA template)		 Revised LAP template updated 03	•				
Recommendation 14 In order to ensure that all the action plans that have arisen out of this Serious Incident Report have been fully implemented, Somerset Partnership NHS Foundation Trust should undertake an immediate audit of each recommendation.	All Serious Incident Reports have updated action plans in place and these are effectively monitored	Review monitoring process for implementation of action plans	None	MC/VW	30 June 2016		
		Review monitoring process for implementation of action plans	None	MC	30 June 2016		
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							
List of Evidence: *(Embed evidence of actions detailed above –* *click on insert, object, create from file, browse, select document and click on display as icon)*							
•			•				
Recommendation 15 In order to evaluate the effectiveness of the new information-sharing	New information systems improve the effectiveness of inter-agency working and patient safety across the	Consider multi-agency audit with partner organisations involved in the Multi-agency Safeguarding Hub (MASH)	Will rely on engagement from other agencies.	RP	30 Sept 2016		

systems introduced since this incident, Somerset Partnership NHS Foundation Trust should consider undertaking an audit exercise of a number of cases, involving similar complex patients, where there is both internal and external multi-agency involvement.	county, reducing serious incidents arising from poor information sharing		Multi-agency audit with partner organisations involved in the Multi-agency Safeguarding Hub (MASH) currently being considered by SSAB Quality Assurance sub-group. Limited value in separate work from Sompar on this				
How (and to whom) have the lessons learnt relating to the recommendation above been disseminated:							

Key to RAG Rating:

Green	**Green**	Achieved
Green	**Amber**	Work is in progress in line with target date
Amber	**Amber**	Initial work has commenced appropriate to target date
Amber	**Red**	Minimal or no work has commenced in this area due to the long lead time
Red	**Red**	Actions have not been achieved by the target date
Grey	**Grey**	Responsibility allocated to agencies outside of the Trust