Independent Quality Assurance Review
Somerset NHS FT
NHS Somerset Integrated Care Board

StEIS 2017/15440

Final report
April 2023

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3 April 2023

Independent Quality Assurance Review, Somerset NHS FT and NHS Somerset Integrated Care Board

Please find attached our final draft report of 3 April 2023 in relation to an independent quality assurance review of the implementation of recommendations resulting from the independent investigation into the care and treatment of a mental health service user, Mr K in Somerset.

This report is a limited scope review and has been drafted for the purposes as set out in the terms of reference for the independent investigation alone and is not to be relied upon for any other purpose. The scope of our work has been confined to the provision of an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF). Events which may occur outside of the timescale of this review will render our report out of date.

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

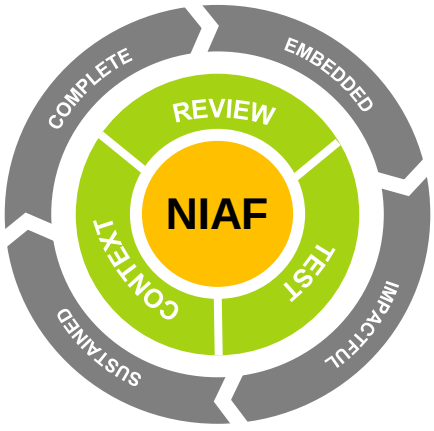
This report is for the attention of the project sponsor and stakeholders. No other party may place any reliance whatsoever on this report as it has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only this final signed version of this report should be regarded as definitive.

James Fitton

Partner

Niche Health and Social Care Consulting Ltd

Niche Investigation Assurance Framework



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1. Method

1.1 Background and context for this review

NHS England commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake an assurance review using the Niche Investigation Assurance Framework (NIAF).

This is intended to provide an assessment of the implementation of the actions developed in response to recommendations from the Niche independent investigation into the care and treatment of a mental health service user in Somerset.

1.2 Review method

This is a high-level report on progress to NHS England, undertaken through desktop review only, without site visits or interviews. The assurance review focusses on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report.

Our work comprised a review of documents provided by Somerset NHS FT and NHS Somerset Integrated Care Board (ICB). These included action plans, policies, procedures, meeting minutes and staff communications.

We have not reviewed any health care records because there was no requirement to re-investigate this case in the review's terms of reference. The information provided to us has not been audited or otherwise verified for accuracy.

The ICB was previously known as NHS Somerset CCG, or 'the CCG'. Our original recommendations referred to the CCG, and we have kept this naming convention when stating our original recommendations in this report.

1.3 Implementation of recommendations

The Niche independent investigation made six recommendations to the above-named organisations which are listed opposite here.

1	NHS Somerset Clinical Commissioning Group must ensure that quality assurance of investigation reports and associated action plans is consistently completed and evidenced, and that a process is in place that ensures reports are picked up at future Serious Incident Review Group meetings.
2	NHS Somerset Clinical Commissioning Group must ensure that a system is in place to check that recommendations in investigation reports are fully reflected in associated action plans.
3	NHS Somerset Clinical Commissioning Group must assess the impact to relevant stakeholders of the actions completed by the Trust.
4	NHS Somerset Clinical Commissioning Group must work with stakeholders to assess the impact of service changes on all groups of stakeholders, specifically patients and their families, and GPs. Particular attention must be given to evidencing an improvement in access to urgent Mental Health Act assessments.
5	NHS Somerset Clinical Commissioning Group must work with local authority partners and the Trust to understand the reasons behind a reducing number of Mental Health Act assessments and to understand more fully what happens to those people who are assessed but not detained under the Mental Health Act, and how their mental health needs are being met.
6	NHS Somerset Clinical Commissioning Group must work with local authority partners to gain assurance that the AMHP service working practices comply with the Mental Health Act Code of Practice.

2. Assurance summary

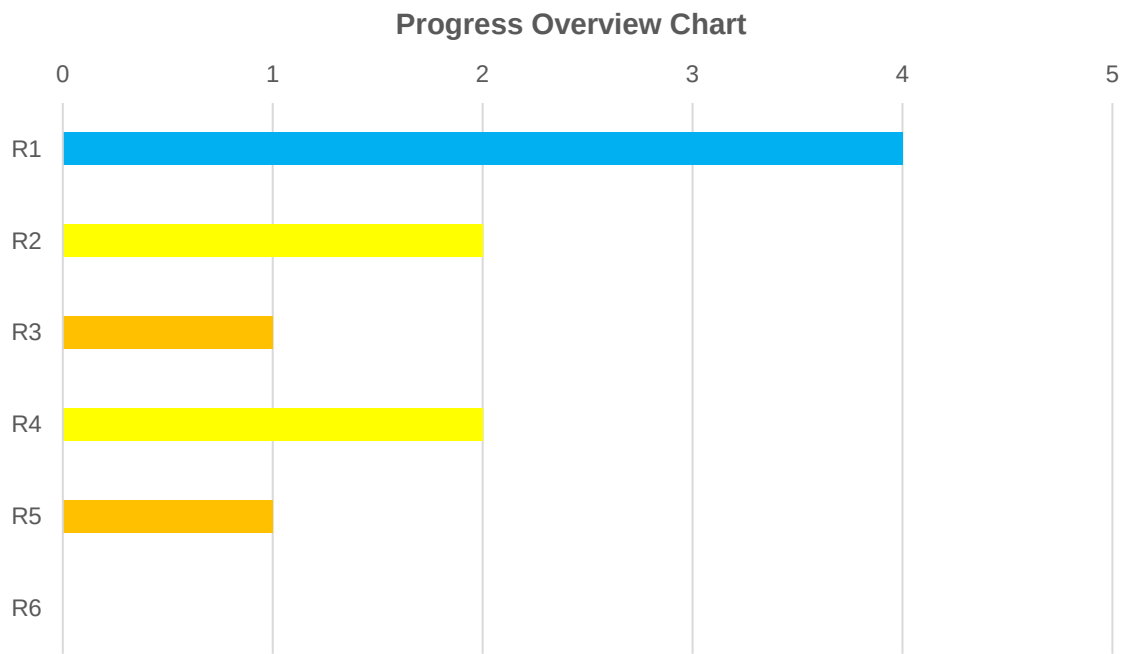
Scoring criteria key

We use a numerical grading system to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained. 3 is regarded as a good score as it reflects action completion. Scores of 4 and 5 are harder to achieve due to the cycle of testing that is required to demonstrate sustained improvements being achieved (for at least 12 months).

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action completed, tested, but not yet embedded
5	Can demonstrate a sustained improvement

Implementation of recommendations

We have rated the progress of the actions which were agreed from the recommendations made. Our findings are summarised in the progress overview chart below:



2. Assurance summary (cont.)

Summary

Since the index incident in 2017 which was investigated by Niche, there have been significant changes to the commissioning and provision of mental health services in Somerset. These have been described to us, in detail, in the ICB's and Trust's action plans.

That said, this review has returned limited assurance across some recommendations made in our original report. In some cases, this is because recommendations made in the report have not been fully accepted by the Trust and / or ICB. Partly as a result of this, it appears that there has not been the usual rigour we would expect to see in terms of establishing and implementing an action plan which is clearly linked to the recommendations made, to ensure that changes are made and sustained in practice.

The key limitations of the evidence with which we were provided included:

- Information submitted in some cases was mostly an update on strategic changes made across Somerset, with little focus on specific changes to practice made following the index incident.
- There was an absence, in some cases, of data to support assertions made about improvements (such as access to urgent Mental Health Act referrals).
- Where actions have been completed (for example, Recommendation 1) there was a lack of evidence of testing of actions to assess their impact. This point has been recognised by the ICB.

Throughout this report, we have provided examples of further assurance which is required to demonstrate actions are complete, tested, embedded and sustained. Some headline commentary to support these ratings has been provided in the following pages, and Appendix 1 (Evidence Review) provides a more detailed assessment against each piece of evidence which has been submitted to Niche.

2. Assurance summary (cont.)

Recommendation 1

NHS Somerset Clinical Commissioning Group must ensure that quality assurance of investigation reports and associated action plans is consistently completed and evidenced and that a process is in place that ensures reports are picked up at future Serious Incident Review Group meetings.

Niche assurance rating for this recommendation	4

Key findings

There is a rigorous process in place, documented in the Standard Operating Procedure (SOP), to quality assure the content of SI reports. This includes checking that providers have incorporated all feedback from the ICB into the investigation report. The SOP expired in August 2022, and should also be reviewed, particularly in view of the Patient Safety Incident Response Framework (PSIRF). We understand that this work is now underway.

SI investigation reports are reviewed by the Review, Learn, Improve (RLI) Group, which has replaced the former Serious Incident Review Group. This forum has a clear focus on service improvement, and using quality intelligence to drive changes in practice. The submissions from Mental Health and Learning Disability services are detailed and identify actions that need to be taken by the ICB resulting from adverse events and patient feedback. This forum appears to have a large remit, and it is important that there is sufficient time for the group is able to do justice to the information received within its scope. We have been told that meeting discipline remains a key focus (e.g. prior preparation and focus on highlights and escalation) and this remains under review by the ICB.

New recommendation

Update this SOP (which has expired) and consider the impact of the PSIRF in doing so.

Recommendation 2

NHS Somerset Clinical Commissioning Group must ensure that a system is in place to check that recommendations in investigation reports are fully reflected in associated action plans.

Niche assurance rating for this recommendation	2

Key findings

In August 2021, the ICB introduced a new Quality Review template to support the quality assurance checks of SI reports. This had omitted the need to check that action plans align to recommendations made, but this has recently (February 2023) been corrected. (A prior template used had historically captured this information). Quality reviewers are also trained to check for this matter, and we have seen evidence of reviewers challenging the quality of action plans.

SI actions are recorded on a tracker within the ICB. Action assurance is undertaken via email every six months, although some are chosen for ‘dip testing’ every three months where more assurance is required. The SI Quality Visit process outlined by the ICB (which is intended to assess the impact of actions taken in the Trust following an SI) has not taken place to date, due to system and Trust-level pressures. We understand that one was scheduled for late March 2023.

We were also told via email from the Trust that the number of outstanding SI actions is not routinely captured by their Patient Safety team.

2. Assurance summary (cont.)

Recommendation 2 (continued)

Residual recommendations:

Test compliance with the quality review checklist, to ensure that recommendations made within SI reports are translating appropriately into action plans.

Recommendation 3

NHS Somerset Clinical Commissioning Group must assess the impact to relevant stakeholders of the actions completed by the Trust

Niche assurance rating for this recommendation	**1**

Key findings:

The ICB has shared examples of where it has visited Somerset NHS Foundation Trust (SFT) services, for example, in relation to Ockenden-related assurance seeking in Maternity Services. We have also been told that the ICB Quality Lead for Learning Disabilities, Mental Health and Community Services undertakes ward quality visits within SFT. There is no evidence, however, to suggest that the ICB has systematically assessed the impact of actions taken by the Trust following the index incident investigated by Niche. There is, however an SFT Mental Health Homicide Subgroup, which is attended by the ICB Mental Health Quality Lead to gain assurance into the implementation of actions following a mental health homicide within the Trust.

The intention to undertake SI quality visits is positive; in our view this would be a direct way of assessing, in the clinical environment, what changes to practice have been made.

Residual recommendations:

Seek assurance that all actions relating to the index incident in this case have been sustained, and that actions have had their intended impact.

2. Assurance summary (cont.)

Recommendation 4

NHS Somerset Clinical Commissioning Group must work with stakeholders to assess the impact of service changes on all groups of stakeholders, specifically patients and their families, and GPs. Particular attention must be given to evidencing an improvement in access to urgent Mental Health Act assessments.

Niche assurance rating for this recommendation	**2**

Key findings:

There have been significant changes made to service provision in Somerset since 2019. A significant wealth of evidence has been shared with us, showing how major service changes in Somerset have been co-designed with service users, the public and the voluntary and community sector. Much of this took place during the Covid-19 pandemic, and the system should be commended for the scale of its public engagement activities during this challenging time for the health and care sector.

While the Trust and the ICB have outlined the various improvements in access to mental health services in recent years, no specific evidence has been provided to show an improvement in access to urgent Mental Health Act (MHA) assessments. We have, therefore, been unable to score this recommendation as a 3 ('action complete').

Residual recommendations:

Complete this recommendation.

Recommendation 5

NHS Somerset Clinical Commissioning Group must work with local authority partners and the Trust to understand the reasons behind a reducing number of Mental Health Act assessments and to understand more fully what happens to those people who are assessed but not detained under the Mental Health Act, and how their mental health needs are being met.

Niche assurance rating for this recommendation	**1**

Key findings:

A small audit (10 recent cases) has been undertaken to understand what happens to patients who are assessed but not detained under the MHA. We have been told that this returned positive assurance, but have not seen the outcomes of this work.

The ICB and Trust have explained in detail on their respective action plans the scale of transformation in mental health services in Somerset since the time of this index incident. They state that this improved provision mitigates the risk of low conversion rates (from MHA assessment requests to detentions), although this has not been quantified in any of the evidence submitted.

2. Assurance summary (cont.)

Recommendation 5 (continued)	
Niche assurance rating for this recommendation	**1**

Key findings:

We have been told that the ICB is working with the Local Authority and Trust to develop a reporting tool to integrate activity and outcome data of MHA referrals. This work was due to be completed in March 2021 although the tool has not been shared with us.

Residual recommendations:

Complete this recommendation.

Recommendation 6	

NHS Somerset Clinical Commissioning Group must work with local authority partners to gain assurance that the AMHP service working practices comply with the Mental Health Act Code of Practice.

Niche assurance rating for this recommendation	**0**

Key findings:

In discussions and communications with leaders in the system, it has emerged that this recommendation was not fully accepted, and work to implement it has therefore been limited. The Trust's (and its partners') rationale for this has been provided at Appendix 1 (Recommendation 6).

Residual recommendations:

We accept the reasoning given for this recommendation being addressed only in the ways described. There are therefore no residual recommendations here

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1
NHS Somerset Clinical Commissioning Group must ensure that quality assurance of investigation reports and associated action plans is consistently completed and evidenced, and that a process is in place that ensures reports are picked up at future Serious Incident Review Group meetings.

Key evidence submitted	Niche review
Standard Operating Procedure (SOP) for: Serious Incident Process V2.8, August 2021	This SOP outlines how SIs should be handled by the ICB. It includes details of the process for: • Documenting the recommendations and actions arising from an SI investigation onto the ICB's action tracker. This includes any themes identified in the report; • How quality review templates should be completed, documented and communicated back to the provider to assure the quality of investigation reports; and • The process for checking that the provider has incorporated the ICB's comments into the updated investigation report. An incident can be closed on the Strategic Executive Information System (StEIS) once the Quality Lead within the ICB is "assured by the report and action plan". This is accepted in the Serious Incident Framework (SIF). This SOP was due for review in August 2022.
SI process flow chart V2.3 (undated)	This chart describes the end-to-end process of how SIs are handled by the ICB, from notification to closure on StEIS. At least one Quality Lead in the ICB is expected to comment on the investigation terms of reference. Cases are closed in StEIS once the action plan has been received by the provider, and signed off by the ICB.
Simplified process: Quality reviewing a serious incident investigation report (undated)	New SIs reported to the ICB are sent to the Review, Learn and Improve (RLI) meeting, alongside other forums in the ICB. The RLI meeting has replaced the former Serious Incident Review Group. Details of closed SIs are also reported to RLI meeting (and other forums, where appropriate).
RLI Report examples (August 2022 and November 2022)	This report contains information on patient feedback, including new and closed complaints, Patient Advice and Liaison Service (PALS) cases, and SIs. For the latter, emerging themes are reported. There is a section outlining the learning from recent SIs, in which commonly reported contributory factors and root causes are identified, as well as actions which have been undertaken as a result of this analysis.

Appendix 1: Evidence review (cont.)

Recommendation 1 (continued)	
Key evidence submitted	**Niche review**
RLI Report examples (August 2022 and November 2022) (continued)	Each sector of the ICS (planned care, primary care, mental health etc) reports on the following elements: • *What is quality information reported telling us?* • *What are why [sic] learning from it, and how does it triangulate with themes seen elsewhere?* • *What role does the ICB have in response to this?* • *What are we doing about it, and what service improvement opportunities exist?* • *How will we know that what we are doing is effective, and are there any exceptions to escalate?*
72 Hour Report - Review & Terms of Reference Template	This template prompts the Quality Lead within the ICB to: • Assess whether the provider has put the necessary immediate actions in place to prevent recurrence of the patient safety incident; and • Assess whether the provider has considered safeguarding concerns when reviewing the incident.
Quality review template-V2.4	This document provides a checklist which should be used by those reviewing reports to assure their quality. It reflects some of the SI closure requirements in the Serious Incident Framework, although does not require that care and service delivery problems are identified, nor that recommendations are aligned to any root causes identified. Following the ICB's review of the draft version of this report (in February 2023), this matter has since been addressed. Some of the content of this checklist is reflective of the PSIRF's ethos (including promoting an ethos of learning, a need to carry out Duty of Candour, and patient and family engagement). Now that the PSIRF is being implemented nationally, there is a need to update the template to ensure it aligns fully to the PSIRF's expectations.
Narrative from ICB	Both the Trust and the ICB have confirmed that they do not routinely report on the number of outstanding actions arising from SIs. The ICB, as part of its quality review process, intends to sample actions from specific SI action plans to assess for evidence of completion and impact. This process has not been used within SFT to date.

Appendix 1: Evidence review (cont.)

Recommendation 2

NHS Somerset Clinical Commissioning Group must ensure that a system is in place to check that recommendations in investigation reports are fully reflected in associated action plans.

Key evidence submitted	Niche review
Quality review template-V2.4	The Quality Review template (introduced in August 2021) requires that actions are "robust, SMART and include clear plans to support implementation". It does not require the reviewer to check that they align to the recommendations made.
Quality review template-V2.5	This updated version of the above was amended in February 2023, following Niche highlighting the gap above. This has now been addressed, and this updated version reviewed as part of the factual inaccuracy checking process.
Quality Review Subject Matter Experts - Contacts and training log	This is a log of all available subject matter experts available for completing quality reviews. There is a checklist of points to cover in the training of these individuals, which includes that "*reports must… draw suitable conclusions, produce appropriate recommendations and that these must translate into appropriate actions."*
Email correspondence demonstrating scrutiny of SI action plans (May 2022)	This email shows correspondence between staff in the CCG's (now ICB) Patient Safety team, with one member of staff stating that an action plan pertaining to Somerset NHS FT was rejected as it did not sufficiently reflect recommendations made following an investigation by the Healthcare Safety Investigation Branch.
Review, Learn, Improve (RLI) Meeting Terms of Reference – January 2022	Part of the purpose of this group is to: "*To monitor providers' performance against their Serious Incident investigations and ensure they are completing them in line with the Serious Incident Framework*…", and to "*ensure that relevant learning is captured from completed/closed investigations… and shared across the Somerset system*." The group reviews all SI reports, recommendations and accompanying action plans.

Appendix 1: Evidence review (cont.)

Recommendation 2 (continued)	
Key evidence submitted	**Niche review**
SI and action tracker	This action plan tracker is used to document: • Whether there are outstanding actions on the action plan; • The root cause, recommendation and 'service delivery issue'; • Action, update and evidence; • If the Quality Lead has requested that a specific action be followed up; and • Provider updates upon follow-up. All actions arising from never events, mental health homicides and maternity-related events are reviewed for progress on a monthly basis by the ICB. Other SI actions are 'dip tested' at the quality reviewer's discretion. We have been told that this translates to around a third of actions currently held on the tracker (for incidents originating from Somerset NHS FT). The ICB has shared examples of assurance it has received from the Trust via this 'dip testing' process. These have included: audits, surveys, KPI reporting, evidence of changes to equipment and pathway reviews.
Action plan narrative	The action plan states that "*Overdue action plans will be added to the Review, Learn, Improve report monthly, to enable Quality Leads to escalate*." This is no longer the intention as the role of the RLI forum has changed from one of oversight to a focus on thematic analysis and learning. As a result there is currently a gap in the ICB's assurance about action completion; typically this is reported to Quality Committee level on a routine basis.

Appendix 1: Evidence review (cont.)

Recommendation 3	
NHS Somerset Clinical Commissioning Group must assess the impact to relevant stakeholders of the actions completed by the Trust.	
Key evidence submitted	**Niche review**
Standard Operating Procedure for undertaking Quality Visits to Providers in respect of Serious Incidents- August 2021	The purpose of these quality visits is, in part, to audit actions arising from SI investigations and to "gain assurance that learning has been embedded in practice". The SOP explains how commissioners should choose an SI to audit on a quality visit. A template to structure the quality visit is provided in the SOP, and prompts the reviewer to assess: • What has changed since the incident occurred; • What evidence is available that learning has been embedded; • What learning should be shared across the wider system; • Feedback from staff about the changes; • Any further areas for improvement; and • Whether, overall, the recommendations and actions from the investigation have been implemented. Findings should be shared with the provider and, in some cases, can lead to a follow-up visit or requests for further assurance. These visits have not yet been implemented.
Governance Matters newsletter (January – November examples)	This is a bulletin which is produced by SFT's mental health services' governance team. It outlines recent learning from SIs and complaints.
Email narrative from Quality Lead for Learning Disabilities, Mental Health and Community Services, NHS Somerset ICB	NHS Somerset ICB undertakes regular quality visits to SFT wards. The outputs and outcomes of these visits have not been shared with us.

Appendix 1: Evidence review (cont.)

Recommendation 4

NHS Somerset Clinical Commissioning Group must work with stakeholders to assess the impact of service changes on all groups of stakeholders, specifically patients and their families, and GPs. Particular attention must be given to evidencing an improvement in access to urgent Mental Health Act assessments.

Key evidence submitted	Niche review
Our vision for mental health services - Somerset Integrated Care System	This is the website setting out the process for how mental health services have been and are being redesigned in Somerset. It describes the vision for the changes and how stakeholders (including people with lived experience of mental health issues, their carers, doctors and other health and care professionals, and local community and voluntary organisations) have been involved in contributing to this. The process was led by Somerset CCG (as was) from 2018.
Mental Health - Somerset Integrated Care System	This is the website through which the public could access the formal consultation about the future locations of acute mental health beds for working age adults. The outcome of this consultation led to the expansion of the Home Treatment Teams and the psychiatric liaison service, the appointment of peer support workers, crisis safe spaces being created, and an all-age 24 hour crisis helpline (Mindline). We have been told that all of these initiatives were developed alongside people with lived experience of using mental health services, as well as an alliance of voluntary and community sector partners (collectively known as Open Mental Health).
A new mental health model of care - Somerset Integrated Care System	Website to access and contribute to the consultation for service development of mental health services in Somerset.
Further opportunities to have your say on community health and care services - Somerset Integrated Care System	Website outlining public engagement sessions; These took place as part of the Fit for My Future engagement programme (2020), which saw around 60 public events take place to support stakeholder engagement in mental health service changes in Somerset.
Mental Health Virtual Feedback Sharing Event FAQs - Sep 2020	This document sets out the details of a virtual, live event (which took place in September 2020) to feedback the outcomes of the mental health service development public consultation which took place in 2020.
Somerset Community Mental Health Transformation Evaluation – 2019.	This is a report following an evaluation undertaken by the University of Plymouth, which assessed Somerset's work as an early implementer of the NHS Community Mental Health Framework for Adults and Older Adults.

Appendix 1: Evidence review (cont.)

Recommendation 4 (continued)	
Key evidence submitted	**Niche review**
Community Adult Mental Health briefing paper for the Somerset Health and Well Being Board – September 2021	In 2019, the Somerset mental health system was awarded £14m investment (to be drawn down over three years) from NHS England for the transformation of its adult community mental health services. This has resulted in various initiatives, including: • The development of a network of local VCSE organisations, through which anyone (individuals, but also GPs and pharmacists for example) can contact the Open Mental Health hub for an assessment of what help may be available; • Specific men's mental health resources, including suicide prevention; • Four short term crisis prevention teams across the county; and • The Somerset Recovery College, which promotes positive mental health. The paper states that, in Somerset, there are lower waits for psychological therapies appointments, recovery rates are significantly higher than the national average, there are no waiting times for care co-ordinators in most localities, and that the county has some of the lowest out-of-area placements for beds in the country. We have not seen performance data to support these statements.
Email from Associate Director of Mental Health & Learning Disability Care, Somerset FT	The Trust is developing a ward accreditation process, and as part of this, will be asking 'experts by experience' to visit one ward per month to seek their perspective on the ward visited. The timeframes regarding this initiative are unclear.
Narrative from NHS Somerset ICB	The ICB has confirmed that they have not received any evidence or assurance from SFT that there has been an improvement in access to urgent MHA assessments.

Appendix 1: Evidence review (cont.)

Recommendation 5
NHS Somerset Clinical Commissioning Group must work with local authority partners and the Trust to understand the reasons behind a reducing number of Mental Health Act assessments and to understand more fully what happens to those people who are assessed but not detained under the Mental Health Act, and how their mental health needs are being met.

Key evidence submitted	Niche review
Action plan narrative	Action plan commentary for this recommendation underlines the scale of service transformation since the time of this index incident. It states that the improved provision of mental health services since 2017 mitigates the risk of low conversion rates (from MHA assessment requests to detentions). There is no reference to the volume of MHA assessments, how these are increasing/decreasing over time and why this might be the case. It is stated that there is a wider range of support in community settings for people who are assessed, but not detained, under the MHA. The CCG (now ICB) is working with the Local Authority and Trust to develop a reporting tool to integrate activity and outcome data of Mental Health Act referrals. The timescale for this work recorded on the action plan is March 2021, although this task is RAG-rated as green.
Mental Health Act Committee terms of reference - approved October 2022	This SFT committee is also attended by representatives from the Somerset County Council's AMHP service and the Somerset ICB. The Trust told us via its factual accuracy response to the draft version of this report that the Committee has agreed that "*avoiding the use of the MHA where this was not required and the use of least restrictive interventions was more of a positive than a negative aspect of the local care delivery*."
Minutes - Mental Health Act Committee - 14 June 2022, 21 September 2021 and 13 December 2022.	This meeting minutes show discussion and engagement with the County Council and other partners around MHA assessments.
Narrative from SFT received through factual accuracy checking process	The Trust recently undertook an exercise of checking 10 recent AMHP reports completed in the last five days, where the patient was not detained under the MHA. All described the follow up actions with respect to the person's mental health. Three remained as informal inpatients (i.e. not detained), five were offered and accepted follow up care from home treatment teams, one was discharged back to comprehensive CAMHS care provision, and in one case, police were advised to pursue a criminal justice route. These reports were not made available to Niche due to their containing patient identifiable information.

Appendix 1: Evidence review (cont.)

Recommendation 6

NHS Somerset Clinical Commissioning Group must work with local authority partners to gain assurance that the AMHP service working practices comply with the Mental Health Act Code of Practice.

Key evidence submitted	Niche review
Memo from AMHP Professional Lead (Somerset County Council) to GP practices and AMHP staff	This is a briefing note reminding GPs and AMHP staff of the process involved in arranging a MHA assessment. It states that If the AMHP decides that an assessment under the MHA is not appropriate, they should record their rationale for that decision, and inform the GP that an assessment is not going to proceed.
Action to be taken by Mental Health Professionals on Receipt of an External Request for a Mental Health Act Assessment	This is a joint process chart, held by the Local Authority and Somerset FT. It is undated, and refers to the legacy Trust (Somerset Partnership NHS FT) which suggests that it is an old document. It is unclear if this process is still in place, and how widely it is adhered to by relevant staff.
Narrative provided by SFT via the factual accuracy checking process of the draft report	*The Approved Mental Health Professional (AMHP) Service is operated by the Local Authority and responsibility for ensuring that the Service's working practice comply with the Mental Health Act Code of Practice (MHA Code of Practice) lies with the Local Authority rather than with the Somerset CCG/ICB.* *At the time of the service user's referral to mental health services in Somerset in 2016, the current MHA Code of Practice had been available for approximately a year, and was still in the process of being embedded in practice. Since that time, training commissioned for Approved Mental Health Professionals in all aspects of the use of the MHA includes focus on the guidance in the Code. AMHPs have become much more familiar with the guidance in the Code of Practice and now refer to it routinely, a change over the course of the six years that have elapsed since the original referral in 2016.* *Since 2020 there has been a shift in culture and communication style between the Somerset NHS Foundation Trust and Somerset County Council AMHP Service, with representatives from SCC being invited to join meetings dealing with issues relating to compliance with the MHA Code of Practice and joint working objectives agreed. During the last year regular meetings have been scheduled to discuss practice and compliance issues arising both in the AMHP Service and Somerset Foundation Trust. The AMHP Lead and Mental Health Act Lead discuss specific issues and agree appropriate actions and information sharing.*

Appendix 1: Evidence review (cont.)

Recommendation 6 (continued)	
Key evidence submitted	**Niche review**
Narrative provided by SFT via the factual accuracy checking process of the draft report (continued)	*Although this isn't a formal scrutiny of the AMHP Services compliance with the Code of Practice it does raise specific points and issues which are taken forward in AMHP Individual and Peer Supervision, and Training Sessions both within the AMHP service and SFT. These issues have included: the discharge of S5(2) holding powers; completion of AMHP Outline reports; proposed discharge of S.117 aftercare; potential application of S5(2) post tribunal discharge; S.136 detention of CAMHS patients; timely requests for Mental Health Act assessments and the need for doctors to provide timely requests to AMHPs when seeking CTO renewals in order to ensure they are able to comply with the MHA Code of Practice.* *In hindsight we feel this recommendation is not worded as well as it could have been. We appreciate that the terms of reference for the investigation did not include the scope to give recommendations to the Local Authority and the AMHP Service directly and so this was directed to the CCG.* *There is no legal framework where a CCG can hold to account the autonomous (and highly regulated) AMHP service for their own statutory duties.* *Also, the wording referencing the whole of the Code of Practice is too wide and not specific enough for this particular case.* *What we can do, and have done regularly, is to have open and meaningful discussions formally at the multi-agency Mental Health Act Committee with the Trust, the ICB/CCG and the LA all in attendance. This is equally pertinent between all partners in relation to our respective roles and duties.*

Appendix 2: Glossary of terms

Appendix 2: Glossary of terms

CCG	Clinical Commissioning Group
AMHP	Approved Mental Health Professional
CCO	Care Coordinator
ICB	Integrated Care Board
MAT	Multiagency Team
MDT	Multidisciplinary Team
MHA	Mental Health Act
NIAF	Niche Investigation Assurance Framework
PALS	Patient Advice and Liaison Service
PSIRF	Patient Safety Incident Response Framework
RLI	Review, Learn, Improve Meeting
SIF	Serious Incident Framework
SIRI	Serious Incident Requiring Investigation
SMI	Serious Mental Illness
SFT	Somerset NHS Foundation Trust
SOP	Standard Operating Procedure
StEIS	Strategic Executive Information System

Our address is:
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