



## **Independent Homicide Investigations**

**The National Confidential Inquiry into Suicide and Homicide by People with  
Mental Illness**

**April 2008**

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## **REPORT SUMMARY**

In 1994 the Department of Health issued guidance for the independent investigation of serious patient safety incidents in mental health services (Department of Health circular HSG (94)27 and LASSL (94)4). The criteria for conducting such investigations were revised in June 2005 and in February 2008 the National Patient Safety Agency published additional “Good Practice Guidance” for the independent investigation of adverse events.

Since the autumn of 2006 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Inquiry) has been working with the National Patient Safety Agency (NPSA) to research the independent investigation process with regard to homicides. The first phase of this work was reported in May 2007. The current report presents the results of the second phase of this work. The aims were to:

- identify the number of independent investigations carried out for patients in England and Wales who had committed a homicide between 1 January 2002 and 31 December 2005, particularly where perpetrators were under enhanced CPA and within 6 months of contact with mental health services,
- compare the characteristics of Inquiry cases who did and did not receive an independent homicide investigation,
- examine the recommendations in all available independent homicide investigation reports.

During the study period the Inquiry were notified of 2,053 homicides in England and Wales. Of these, 201 were in contact with mental health services in the year prior to the offence. Fifty perpetrators were under enhanced care programme approach and in contact with services during the six months prior to the offence. Fifteen (30%) of these fifty cases were not subject to an independent investigation. Few differences were noted between those offenders who did not receive an investigation and those who did. Although not significant, those who did not receive an investigation were more likely to have received a prison sentence, were more likely to have been compliant with medication and less likely to have killed a stranger or a female.

Thirty-nine independent investigation reports relating to 40 homicide incidents were collected during the study period and a thematic analysis was conducted on all the recommendations from these reports. The categories into which these themes were grouped were developed and refined through a series of consensus meetings with senior Inquiry clinical staff. These were then further refined into the following fifteen key recommendations using the same process.

1. Review the application of CPA policy to ensure that it reflects both the Department of Health guidance and best practice within mental health services nationally.
2. Risk assessment should be regularly reviewed and should include the use of relevant risk management tools. Such information should be easily available and accessible.
3. Clear guidelines and procedures should be in place for granting leave. In particular, patients on home leave need risk assessment prior to leave, and regular monitoring of value of leave for the patient.
4. Appropriate services for dual diagnosis including adequate senior medical input and training should be developed.
5. Training in the assessment of personality disorder should be provided. Specialist personality disorder services should be developed, if necessary, and available for advice and support to psychiatric services and external agencies.
6. Problems resulting from offenders who change their name and move between geographical boundaries need to be addressed at both local and national levels.
7. Decisions about whether to conduct home visits and by whom, including lone workers, should be based on careful consideration and recent risk assessment.

8. Trusts need to develop policies to help reduce 'do not attend' rates and find ways of working more flexibly with those patients reluctant to access or engage with services.
9. Referral pathways should be free from unnecessary obstacles and should be as direct as possible. The appropriateness of an 'opt-in' system for referrals should be reviewed.
10. Discharge planning should be conducted by multidisciplinary teams, including liaison between health and social care services and housing agencies and should be clearly documented. Future care plans and discharge summaries should be shared with all relevant professionals.
11. There should be consideration of whether patients who commit very serious offences and are made subject to restriction orders (Section 41) should remain under supervision for the rest of their lives and of the legal and procedural issues relating to the readmission to hospital of conditionally discharged patients.
12. Where possible services should avoid relying on high levels of agency staff. When using agency staff they must be provided with sufficient induction training, access statutory and mandatory training and appropriate supervision.
13. Health and social care services need to ensure they have developed clear policies and procedures for sharing relevant information both internally and with external agencies. This should include accident and emergency departments, criminal justice professionals, multi agency public protection arrangements (MAPPA) agencies and any other relevant professionals.
14. Health and social care services need to work with domestic violence and child protection agencies to ensure adequate risk assessment and management of patients in contact with partners and children who may be at risk.

15. Serious untoward incident reviews should be open and independent, with adequate support provided to the staff and families/ carers involved. They should occur without unnecessary delay and recommendations should be acted upon.

## 1. INTRODUCTION

### 1.1. Background

The importance of a rigorous investigation following any serious untoward incident for patients was made clear in two major Department of Health reports: ‘An Organization with a Memory’ (2000) and ‘Building a Safer NHS’ (2001). Both reports emphasized that a modern health service must have processes in place to monitor, investigate and learn lessons from adverse patient events in order to reduce the risk of similar events occurring in the future. National reporting systems have since been implemented through the National Patient Safety Agency (NPSA) for both health professionals and the public to report patient safety incidents.

In 1994 the Department of Health issued guidelines regarding the discharge and continuing community care of mentally disordered persons (Health Service Guidelines [94]27 & Local Authority Social Services Letter [94]4). In paragraph 34 the Health Service Guidelines stated that, *“In cases of homicide it will always be necessary to hold an inquiry which is independent of the providers involved”*. This guidance was updated in June 2005 and the amended criteria for strategic health authorities (SHA) to consider when deciding which incidents required an independent investigation were as follows:

- when a homicide has been committed by a patient under the care of specialist mental health services, subject to standard or enhanced care programme approach (CPA), in the 6 months prior to the homicide,
- when it is necessary to comply with the State’s obligation under Article 2 of the European Convention on Human Rights,
- when the SHAs determine that an adverse incident warrants an independent investigation.

However, there has been much criticism of the independent homicide investigations process. Peay (1996) questioned whether investigations provide the best platform for learning lessons, as they are essentially case reports. Although investigation reports all make recommendations for service development, this information is poorly disseminated and there are few opportunities for wider learning. Investigations have also been labelled inefficient, costly, misleading and potentially unjust (Eastman,

1996) and by not adopting a common methodology this has limited their usefulness (Petch & Bradley, 1997).

## **1.2. Independent homicide investigation studies 2005-2008**

In 2005, the National Patient Safety Agency (NPSA) carried out a pilot study of independent homicide investigations. The aims of the study were to:

- identify the number of independent homicide investigations commissioned in each SHA in 2005,
- identify the number of such investigations completed in 2005 which were commissioned before January 2005,
- examine the details of the investigations that were currently underway and the date they were due to be completed,
- report the details of any cases where it was known that an independent investigation would be commissioned in the future.

The results of this study suggested that fewer than expected independent investigations had been notified to the NPSA. The NPSA therefore commissioned the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Inquiry) to carry out a comprehensive study examining the homicide investigations process. This work has been carried out in two phases.

The first phase of the Inquiry study into homicide investigations was reported in May 2007. The aims of the study were to:

- estimate the number of independent investigations undertaken for patients convicted between 2002-2004,
- collect and examine a sample of reports,
- compare the characteristics of cases against the Inquiry database,
- provide an overview of the independent homicide investigation report contents,
- determine the time course of the independent homicide inquiries.

The findings indicated there was wide variation in the time taken to conduct an independent investigation, and in the publication of the report. Recurring themes in the reports included:

- a need for improvement in staff training,

- › service development, particularly the use of Care Programme Approach (CPA),
- › regular assessment of the quality of the services provided to patients,
- › improving the process of independent investigations.

The current report presents the findings of the second phase of the Inquiry homicide investigations study. The aims were to:

- › identify the number of independent investigations carried out for patients in England and Wales who had committed a homicide between 1 January 2002 and 31 December 2005, particularly where perpetrators were under enhanced CPA and within 6 months of contact with mental health services,
- › compare the characteristics of Inquiry cases who did and did not receive an independent homicide investigation,
- › examine the recommendations in all available independent homicide investigation reports.

## **2. METHOD**

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Inquiry) is a UK-wide case series of all people who have been convicted of homicide and had recent (within 12 months of the offence) or any lifetime contact with secondary mental health services. The method of the Inquiry is described fully elsewhere (Appleby et al., 2006). In brief, there are 4 stages to data collection: i) data on all perpetrators is provided by the Home Office Homicide Index, ii) information on perpetrators is sent to administrative contacts within each Trust nationally, to identify those perpetrators who had been in contact with services within 12 months of the offence, iii) information on previous offences is collected from police forces and the National Crime Operations Faculty, iv) detailed socio-demographic and clinical data is collected via questionnaires sent to the clinician who had been caring for the patient at the time of the offence. The response rate for questionnaire data is over 95% complete.

### **2.1. Cases**

Cases were all convicted homicide perpetrators in England and Wales reported to the Inquiry whose date of offence was between 1 January 2002 and 31 December 2005. This time period was chosen because it allowed enough time for the case to have been processed by the Inquiry. Further, it allowed sufficient time from the date of conviction for an independent investigation to have been carried out by the Strategic Health Authority (SHA).

Overall, the response rate for the homicide Inquiry is 95% (1996-2005). For the time period of this report (2002-2005) the response rate is 85%. Earlier years of the homicide Inquiry are more complete than more recent years, ranging from 100% to 50%; the final year of the Inquiry (2005) is the least complete at 50%. Decreasing completeness in the most recent year of the Inquiry is a result of delays in receiving data from the Home Office Homicide Index. Data collection for cases occurring in 2005 is still ongoing and is expected to be complete by 2008.

## **2.2. Data collection**

Data were collected from two sources. Detailed socio-demographic and clinical characteristics of Inquiry cases were collected via questionnaires completed by the consultant or member of the mental health team caring for the patient at the time of the offence. Second, all available independent homicide investigations carried out by the SHA were examined. Where an independent investigation could not be obtained, the trust in which the homicide perpetrator last had contact with services was contacted. For each case it was determined whether an independent investigation had been carried out and if so, what the status of the investigation was.

## **2.3. Analysis**

The characteristics of Inquiry cases are presented in the tables as valid percents (i.e. cases for whom the relevant data was available) with 95% confidence intervals. The confidence intervals indicate the accuracy of each percentage by showing the range of values within which the true figure is likely to lie. For sub-group comparisons we used chi-squared tests of association with statistical significance set at 5%.

Thematic analysis was carried out on all recommendations reported in the independent homicide investigation reports. The recommendations of all homicide investigations were collated and organised into six broad themes; additional sub-themes were identified where appropriate. The categories into which these themes were grouped were developed and refined through a series of consensus meetings with senior Inquiry clinical staff.

### **3. RESULTS**

The findings of the study are presented in two parts. The numbers and characteristics of homicide perpetrators are reported first. The thematic analysis of the homicide investigation recommendations is reported second.

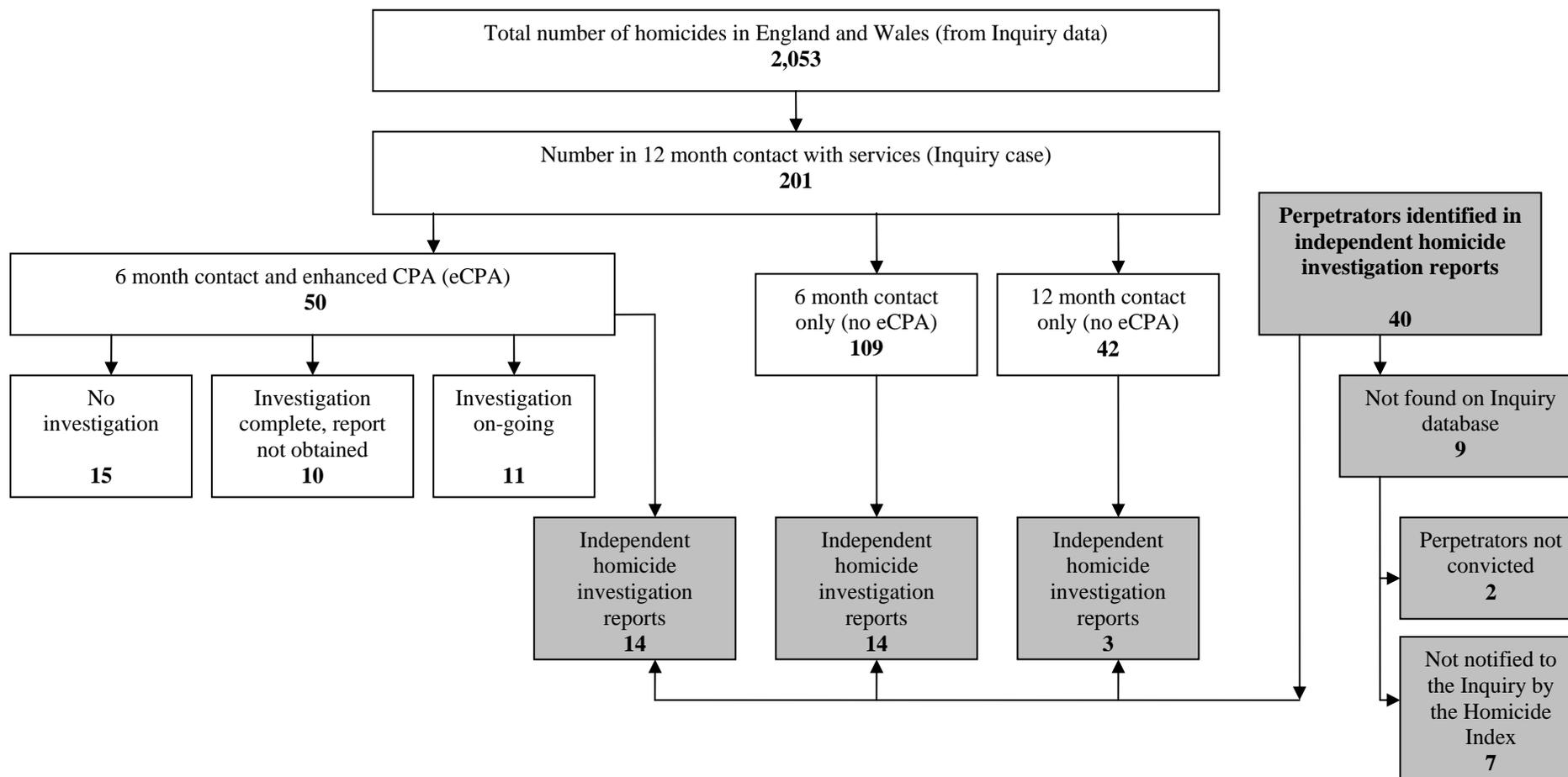
#### **3.1. INQUIRY HOMICIDE PERPETRATORS**

##### **3.1.1. Number of homicide cases and independent investigations**

During the study period there were 2,053 people who committed homicide in England and Wales. Of these, 201 were in contact with mental health services in the year prior to the offence (Inquiry cases). One-hundred and fifty-nine perpetrators were in contact with services during the six months prior to the offence, 50 of whom were also under enhanced CPA at the time of the offence (Figure 1).

Thirty-nine independent investigation reports were collected during the study period. These reports cover the investigations of 42 homicide incidents. One report investigated two homicides committed between 2002 and 2005. A second report investigated three homicides, one of which was committed within the time frame of the current study (2002-2005). However, the other two homicide incidents investigated in this report were committed in 2001 and were therefore excluded from the current study. In total, the 39 independent homicide investigations included in the current study relate to 40 homicide incidents.

Figure 1: Details of Inquiry cases and independent investigation homicide cases occurring between 1 January 2002 and 31 December 2005.<sup>1</sup>



<sup>1</sup> The boxes shaded in grey refer to the 39 investigation reports reviewed. One report covered two homicide cases during the study period (see page 8).

### **3.1.2. Characteristics of homicide perpetrators**

There were fifty perpetrators identified by the Inquiry who had been under enhanced CPA at the time of offence and who had been in contact with mental health services in the 6 months prior to the offence. These cases comprised:

- 14 Inquiry cases for whom an independent homicide investigation report was obtained,
- 11 cases in which a report was not obtained because the investigation was on-going,
- 10 cases where an investigation had been carried out, but had not been obtained by the Inquiry,
- 15 cases where an independent homicide investigation had not been carried out.

The 15 cases (30%) for whom no investigation had been carried out were compared to the remaining 35 Inquiry cases (70%) for whom: 1) a report had been obtained, 2) for whom an investigation was on-going, 3) a report had been carried out but not collected by the Inquiry. The key characteristics are shown in table 1.

There were few differences between those offenders who did not receive an investigation and those who did. Although not significant, those who did not receive an investigation were more likely to have received a prison sentence than those who were the subject of an investigation (60% vs. 34%); they were more likely to have been compliant with medication (86% vs. 53%) and less likely to have killed a stranger (8% vs. 19%) or a female (40% vs. 60%).

Table 1: Characteristics of Inquiry cases who were in 6 month contact and under enhanced CPA who did and did not receive an independent homicide investigation.

	<b>No Investigation (N =15)</b>	<b>95% CIs</b>	<b>Investigation (N =35)</b>	<b>95% CIs</b>
<b>Male</b>	11 (73%)	(51 – 96)	31 (89%)	(78 – 99)
<b>Ethnicity</b>				
White	11 (73%)	(51 – 96)	28 (80%)	(67 – 93)
Black (African/Caribbean)	2 (13%)	(0 – 31)	3 (9%)	(0 – 18)
Indian/mixed race/other	2 (13%)	(0 – 31)	4 (11%)	(1 – 22)
<b>Marital status</b>				
Single	8 (53%)	(28 – 79)	19 (54%)	(38 – 71)
Married/co-habiting	4 (27%)	(4 – 49)	9 (26%)	(11 – 40)
Divorced/separated/widowed	3 (20%)	(0 – 40)	7 (20%)	(7 – 33)
<b>Employment status</b>				
Employed	1 (7%)	(0 – 19)	3 (9%)	(0 – 18)
Unemployed/long term sick	12 (80%)	(60 – 100)	27 (77%)	(63 – 91)
Housewife/husband/retired/student	2 (13%)	(0 – 29)	5 (14%)	(3 – 26)
<b>Living circumstances</b>				
Alone	7 (47%)	(21 – 72)	14 (40%)	(24 – 56)
With parents	3 (20%)	(0 – 40)	8 (23%)	(9 – 37)
Spouse/partner/kids	4 (27%)	(4 – 49)	12 (34%)	(19 – 50)
Other shared	1 (7%)	(0 – 19)	1 (3%)	(0 – 8)
<b>Method</b>				
Sharp instrument	8 (62%)	(35 – 88)	19 (59%)	(42 – 76)
Poisoning	2 (15%)	(0 – 35)	0	
Strangulation	0		3 (9%)	(0 – 19)
Blunt instrument	0		4 (13%)	(1 – 24)
Hitting/Kicking	0		2 (6%)	(0 – 15)
<b>Primary diagnosis</b>				
Schizophrenia/delusional disorder	9 (60%)	(35 – 85)	23 (66%)	(50 – 81)
Bipolar affective disorder	1 (7%)	(0 – 19)	4 (11%)	(1 – 22)
Depressive illness	0		2 (6%)	(0 – 13)
Adjustment disorder	1 (7%)	(0 – 19)	0	
Alcohol misuse/dependence	0		1 (3%)	(0 – 8)
Personality disorder	4 (27%)	(4 – 49)	3 (9%)	(0 – 18)
<b>Abnormal mental state at offence</b>	6 (86%)	(60 – 100)	20 (100%)	(100 – 100)
<b>Missed last appointment</b>				
Yes	4 (27%)	(4 – 49)	21 (68%)	(51 – 84)
No	11 (73%)	(51 – 96)	9 (30%)	(13 – 45)
Inpatient	0		4	
<b>Non-compliant with medication</b>				
Yes	2 (14%)	(0 – 33)	14 (47%)	(29 – 65)
No	12 (86%)	(67 – 100)	16 (53%)	(35 – 71)

Table 1: Characteristics of Inquiry cases who were in 6 month contact and under enhanced CPA who did and did not receive an independent homicide investigation. (cont'd)

	<b>No Investigation (N =15)</b>	<b>95% CIs</b>	<b>Investigation (N =35)</b>	<b>95% CIs</b>
<b>Victim details</b>				
Female	6 (40%)	(36 – 97)	21 (60%)	(44 – 76)
Family (kids/partner/parents)	7 (58%)	(30 – 86)	15 (58%)	(39 – 77)
Known to the perpetrator	4 (33%)	(7 – 60)	4 (15%)	(2 – 29)
Prostitute	0		2 (8%)	(0 – 18)
Stranger	1 (8%)	(0 – 24)	5 (19%)	(4 – 34)
<b>Outcome</b>				
Murder	7 (47%)	(21 – 72)	11 (33%)	(17 – 49)
Manslaughter (section 2)	0		8 (24%)	(10 – 39)
Other manslaughter	8 (53%)	(28 – 79)	14 (42%)	(26 – 59)
<b>Disposal</b>				
Imprisonment	9 (60%)	(35 – 85)	12 (34%)	(19 – 50)
Hospital order with/without restriction order	4 (27%)	(4 – 49)	18 (51%)	(35 – 68)
Unfit to plead	1 (7%)	(0 – 19)	4 (11%)	(1 – 22)

The Inquiry identified a further 17 independent investigation reports for perpetrators who had not been under enhanced CPA. The characteristics of these cases are presented in table 2. Of these, 14 had been in contact with services in the six months prior to the offence; three had been in contact with services between six and twelve months. There were no distinguishing characteristics of these cases to indicate why an investigation was carried out.

A further nine independent investigation reports were identified but could not be matched to the Inquiry's homicide database (see figure 1). In one case, the perpetrator became the victim in a second homicide prior to their conviction. In a second case, the perpetrator died by suicide prior to conviction. The remaining seven homicide cases had not yet been notified to the Inquiry at the time of reporting. However, from the homicide investigation reports it was established that three of these perpetrators were under enhanced CPA and within six month mental health contact, five were in six month contact only and one perpetrator was in contact in the seven to twelve months before the offence.

Table 2: Characteristics of Inquiry cases who were in 6 month contact and 12 month contact but not under enhanced CPA, who received an independent homicide investigation

	<b>6 month contact (N =14)</b>	<b>95% CIs</b>	<b>12 month contact (N =3)</b>	<b>95% CIs</b>
<b>Male</b>	10 (91%)	(74 – 100)	3 (100%)	(100 – 100)
<b>Ethnicity</b>				
White	9 (82%)	(59 – 100)	2 (100%)	(100 – 100)
Black (African/Caribbean)	1 (9%)	(0 – 26)	0	
Indian/mixed race/other	1 (9%)	(0 – 26)	0	
<b>Marital status</b>				
Single	4 (36%)	(8 – 65)	2 (67%)	(13 – 100)
Married/co-habiting	3 (27%)	(1 – 54)	0	
Divorced/separated/widowed	4 (36%)	(8 – 65)	1 (33%)	(0 – 87)
<b>Employment status</b>				
Employed	3 (30%)	(16 – 58)	0	
Unemployed/long term sick	6(60%)	(30 – 90)	3 (100%)	(100 – 100)
Housewife/husband/retired/student	1(10%)	(0 – 29)	0	
<b>Living circumstances</b>				
Alone	5 (45%)	(16 – 75)	1 (33%)	(0 – 87)
With parents	2 (18%)	(0 – 41)	1 (33%)	(0 – 87)
Spouse/partner/kids	3 (27%)	(1 – 54)	0	
Other shared	1 (9%)	(0 – 26)	1 (33%)	(0 – 87)
<b>Method</b>				
Sharp instrument	10 (77%)	(62 – 100)	1 (33%)	(0 – 87)
Hitting/kicking	1 (8%)	(0 – 24)	0	
Strangulation	1 (8%)	(0 – 24)	1 (33%)	(0 – 87)
Blunt instrument	0		0	
Drowning	0		1 (33%)	(0 – 87)
<b>Primary diagnosis</b>				
Schizophrenia/delusional disorder	4 (36%)	(8 – 65)	1 (33%)	(0 – 87)
Bipolar affective disorder	0		1 (33%)	(0 – 87)
Depressive illness	1 (9%)	(0 – 26)	0	
Adjustment disorder	1 (9%)	(0 – 26)	0	
Alcohol misuse	1 (9%)	(0 – 26)	0	
Personality disorder	3 (27%)	(1 – 54)	1 (33%)	(0 – 87)
<b>Abnormal mental state at offence</b>	6 (86%)	(60 – 100)	1 (50%)	(0 – 100)
<b>Missed last appointment</b>				
Yes	4 (40%)	(10 – 70)	2 (67%)	(13 – 100)
No	6 (60%)	(30 – 90)	1 (33%)	(0 – 87)
Inpatient	1		0	
<b>Non-compliant with medication</b>				
Yes	1 (10%)	(0 – 29)	1 (33%)	(0 – 87)
No	9 (90%)	(71 – 100)	2 (67%)	

Table 2: Characteristics of Inquiry cases who were in 6 month contact and 12 month contact but not under enhanced CPA, who received an independent homicide investigation (cont'd)

	<b>6 month contact (N =14)</b>	<b>95% CIs</b>	<b>12 month contact (N =3)</b>	<b>95% CIs</b>
<b>Victim details</b>				
Female	7 (54%)	(27 – 81)	1 (33%)	(0 – 87)
Family (kids/partner/parents)	8 (64%)	(46 – 99)	1 (33%)	(0 – 87)
Known to the perpetrator	1 (9%)	(0 – 26)	1 (33%)	(0 – 87)
Prostitute	1 (9%)	(0 – 26)	0	
Stranger	1 (9%)	(0 – 26)	0	
<b>Outcome</b>				
Murder	6 (46%)	(19 – 73)	0	
Manslaughter (section 2)	4 (31%)	(6 – 56)	0	
Other manslaughter	3 (23%)	(0 – 46)	3 (100%)	(100 – 100)
<b>Disposal</b>				
Imprisonment	7 (54%)	(27 – 81)	1 (33%)	(0 – 87)
Hospital order with/without restriction order	6 (46%)	(19 – 73)	2 (66%)	(13 – 100)
Unfit to plead	0		0	

## **3.2. INDEPENDENT HOMICIDE INVESTIGATION REPORT RECOMMENDATIONS**

Recommendations were divided into six broad themes. During the process of analyzing the recommendations it emerged that all the recommendations could have national learning points. As such, the recommendations are not further divided into national and local learning points.

The number of recommendations made in the reports ranged from four to over thirty. The key recommendations have been summarised below. A full list of the recommendations can be found in appendix 1.

### **3.2.1. Clinical Practice**

A total of 36 independent investigation reports included 171 recommendations relating to clinical practice issues. These were further categorised into seven sub-categories:

- › Care Programme Approach (CPA)
- › Assertive outreach/ crisis service
- › Risk assessment and management
- › Treatment, particularly inpatient treatment
- › Patients with a dual diagnosis/ substance misuse and personality disorder

#### *3.2.1.1. Care Programme Approach (CPA)*

- › The application of local CPA policy should be reviewed to ensure that it reflects both the Department of Health (1999) Guidance and the experience of best practice within mental health services nationally. This should include regular audit of CPA practice, comprehensive and clear care plans, contributions from carers and multi-agency involvement.
- › Systematic needs assessment of children of patients under enhanced CPA needs to take place, addressing a full range of needs, not solely child protection issues.

**Key Recommendation 1: Review the application of CPA policy to ensure that it reflects both the Department of Health guidance and best practice within mental health services nationally.**

*3.2.1.2. Assertive outreach / Crisis services*

- Trusts should review the operation of, and development if required, of assertive outreach and crisis assessment and treatment services. There should be adequate information sharing between external agencies including A&E and primary care and consider as to whether A&E liaison services should be part of an integrated crisis service.

*3.2.1.3. Risk assessment and management*

**Key Recommendation 2: Risk assessment should be regularly reviewed and should include the use of relevant risk management tools. Such information should be easily available and accessible.**

*3.2.1.4. Treatment*

- Prescribing practice should be reviewed and guidelines/ policies developed regarding prescription and monitoring of medication, patient compliance with medication and covert administration of medication.

*3.2.1.5. In-patient treatment*

**Key Recommendation 3: Clear guidelines and procedures should be in place for granting leave. In particular, patients on home leave need risk assessment prior to leave, and regular monitoring of value of leave for the patient.**

*3.2.1.6. Dual diagnosis / Substance misuse*

- Policies should be developed on monitoring substance misuse including randomised drug screening, consideration of the use of police sniffer dogs on inpatient units and a clear management plan of monitoring and action if substance misuse occurs, with case review.

**Key Recommendation 4: Appropriate services for dual diagnosis including adequate senior medical input and training should be developed.**

### *3.2.1.7. Personality disorder*

**Key Recommendation 5: Training in the assessment of personality disorder should be provided. Specialist personality disorder services should be developed, if necessary, and available for advice and support to psychiatric services and external agencies.**

### **3.2.2. Clinical procedures**

A total of 37 independent investigation reports made 187 recommendations relating to clinical procedure issues. These were further categorised into six sections:

- Communication
- Information and record keeping
- Work practice/ policy
- Failure to attend appointment
- Assessments and reviews, referrals and discharge.

#### *3.2.2.1. Communication, information sharing and record keeping*

- Health care services should move towards adopting a system of integrated record keeping. This may be best achieved by developing electronic records systems.
- Referral/ transfer and discharge summaries should be written and sent to relevant professionals (e.g. General Practitioners) and should include information such as diagnosis, medication, results of any assessments, follow up arrangements, risk assessment, risk factors, relapse indicators, contingency and crisis management and plans/ advice for future management.

**Key Recommendation 6: Problems resulting from offenders who change their name and move between geographical boundaries need to be addressed at both local and national levels.**

#### *3.2.2.2. Work practice and policies*

**Key Recommendation 7: Decisions about whether to conduct home visits and by whom, including lone workers, should be based on careful consideration and recent risk assessment.**

*3.2.2.3. Failure to attend appointments*

**Key Recommendation 8: Trusts need to develop policies to help reduce ‘do not attend’ rates and find ways of working more flexibly with those patients reluctant to access or engage with services.**

*3.2.2.4. Assessment and reviews*

- There should be increased flexibility, particularly out of hours, in general and Mental Health Act assessments. Community patients should receive regular out patient reviews not just CPA reviews. Independent reviews should be considered in cases where the patient has been receiving long term care from a team and there has been little change to their condition.
- Those caring for patients should be made aware of their formal status as carers and should always be offered an assessment of their own needs. The effectiveness of carer needs assessments should be audited.

*3.2.2.5. Referrals*

**Key Recommendation 9: Referral pathways should be free from unnecessary obstacles and should be as direct as possible. The appropriateness of an ‘opt-in’ system for referrals should be reviewed.**

*3.2.2.6. Discharge*

- Discharge care plans should be prepared by multidisciplinary teams. Reasons for decisions to discharge patients should be clearly documented along with a clear plan of action to follow if a patient fails to comply with the conditions of their discharge.
- Health and social care services need to liaise with housing agencies to carefully consider the housing arrangements (independent and supervised) and needs of patients being discharged.

- › The Home Office should carefully review all tribunal reasons/ decisions for discharging restricted patients. If the Home Secretary disagrees with a decision to discharge a patient he/she should consider being represented at the tribunal.
- › The Home Office should consider whether additional guidance is required in relation to the legal and procedural issues of readmitting conditionally discharged patients to hospital.
- › The Department of Health and Home Office should commission research into the effect of absolute discharge on patient compliance, rates of recidivism and relapse. There should also be consideration of whether patients who commit very serious offences and are made subject to restriction orders (Section 41) should remain under supervision for the rest of their lives and if they are to be given an absolute discharge whether this should be undertaken by the Home Secretary or Mental Health Review Tribunal.

**Key Recommendation 10: Discharge planning should be conducted by multidisciplinary teams, including liaison between health and social care services and housing agencies and should be clearly documented. Future care plans and discharge summaries should be shared with all relevant professionals.**

**Key Recommendation 11: There should be consideration of whether patients who commit very serious offences and are made subject to restriction orders (Section 41) should remain under supervision for the rest of their lives and of the legal and procedural issues relating to the readmission to hospital of conditionally discharged patients.**

### **3.2.3. Service management and support**

A total of 30 reports included 102 recommendations relating to service management and support issues. The key points from these recommendations are as follows.

- Trusts should ensure effective performance management arrangements are in place and that there are clear line management structures for clinical and managerial staff.
- Trusts should review clinical supervision policies and practice to ensure that they are sufficiently robust. All staff should have access to regular appraisals. Trusts should ensure that they have appropriate support structures in place for staff, particularly for those 'acting up'.
- Consultant psychiatrists should be appropriately qualified and should not work/cross cover beyond their speciality. Their workloads need to allow for the clinical education and supervision of junior doctors.
- Trusts should review staffing levels and work/case loads to ensure that there are sufficient resources so that junior staff do not work beyond the expectation of their grade and to cover shift patterns, on call procedures, staff sickness and holidays.
- Trusts should be aware of the diversity of the communities they serve and provide suitable representation throughout the organisation. They should also develop and regularly review equality and diversity action plans and strategies to monitor their effectiveness.

#### **3.2.4. Training**

A total of 21 reports included 41 recommendations about the training of health care professionals. An additional eight recommendations (from six reports) related to training issues involving external agencies such as the police or probation service. These have been discussed in section 3.2.5. Key points relating to the training recommendations are as follows.

- Health and social care staff should be provided with training on the use of the Mental Health Act and doctors (especially GPs) should be encouraged to become Section 12(2) approved.

- Health and social care staff should be provided with training to improve their understanding of working with carers/ families, particularly with regard to sharing information and issues of confidentiality. Such training should be provided with input from relevant voluntary sector organisations and carer/ family workers.

**Key Recommendation 12: Where possible services should avoid relying on high levels of agency staff. When using agency staff they must be provided with sufficient induction training, access statutory and mandatory training and appropriate supervision.**

### **3.2.5. External agencies**

The recommendations in this category address issues arising from health and social care services working with external agencies specifically police, probation, prison services and domestic violence organisations. A total of 12 reports included 29 recommendations in this area. The key points are as follows.

- Multi-agency training/ workshops should be developed for criminal justice and health and social care professionals to improve their knowledge of issues such as risk assessment, domestic violence, child protection and the organisation and function of MAPPA, knowledge of mental health conditions, the Mental Health Act, Care Programme Approach and relevant service contact points.

**Key Recommendation 13: Health and social care services need to ensure they have developed clear policies and procedures for sharing relevant information both internally and with external agencies. This should include A&E departments, criminal justice professionals, MAPPA agencies and any other relevant professionals.**

**Key Recommendation 14: Health and social care services need to work with domestic violence and child protection agencies to ensure adequate risk assessment and management of patients in contact with partners and children who may be at risk.**

### 3.2.6. Serious untoward incidents

A total of 21 reports included 60 recommendations relating to serious untoward incidents. Key points from these recommendations are as follows.

- Serious untoward incident reviews/ investigations should identify the staff involved, establish their level of involvement and staff should be provided with copies of all relevant notes. Staff should be given the opportunity to comment on their involvement/ evidence and should not face adverse action or blame.
- Serious untoward incident procedures should adopt an open approach when helping staff and families/ carers involved in the incident. A senior member of staff should be given the responsibility of ensuring that the family/ carers of both the patients and victims are fully informed throughout the investigation process, are offered appropriate support, care and counselling and are provided with a copy of the investigation report and given the opportunity to discuss its contents.
- Strategic Health Authorities and Trusts are responsible for ensuring that both internal and external investigations take place without unnecessary delay and that potential learning is disseminated as soon as possible. All resulting conclusions, recommendations and action plans should be considered and acted upon and progress should be monitored.

**Key Recommendation 15: Serious untoward incident reviews should be open and independent, with adequate support provided to the staff and families/ carers involved. They should occur without unnecessary delay and recommendations should be acted upon.**

## REFERENCES

<b>Report</b>	<b>Year Published</b>	<b>Commissioners</b>
The report of the independent inquiry into the care and treatment of MH	2003	Blackburn with Darwen PCT
Independently chaired review into the care and treatment of a client of Buckinghamshire mental health NHS trust	2003	Buckinghamshire Mental Health NHS Trust
Independent inquiry into the care and treatment of a patient known as X	2004	South West Peninsula SHA
The independent inquiry into the care and treatment of a patient known as P	2004	South West Peninsula SHA
Independent external review into a homicide at Prestatyn, Wales on 25th March 2003	2004	Cardiff Local Health Board
Report of the independent inquiry pursuant to health service guideline (94) 27 into the care and treatment afforded to DP	2005	Leicestershire, Northamptonshire & Rutland SHA
Report of the independent panel reviewing the care and treatment for RS between May and July 2002	2005	Essex SHA
Independent review into the care and treatment of AH	2005	North Central London SHA
Report of the independent inquiry into the care and treatment of DF	2005	North East London SHA
Report to Northumberland, Tyne & Wear SHA of the independent inquiry panel into the health care and treatment of TG	2005	Northumberland, Tyne & Wear SHA
Report of an independent inquiry into the care of CK by mental health services in Lancashire	2005	Cumbria & Lancashire SHA & Chorley & South Ribble PCT
External independent review into the care and treatment of DC	2005	Cheshire & Merseyside SHA
Report of the review of mental health services in the Surrey Hampshire Borders area in relation to the care & treatment of AB, CD & EF	2005	Hampshire & the Isle of Wight SHA & Blackwater Valley & Hart PCT
Report of the independent inquiry team into the care and treatment of M	2005	Surrey & Sussex SHA
Panel report from the inquiry into the care and treatment of RK	2005	Norfolk & Waveney Mental Health Partnership
Report of the independent inquiry into the care and treatment of SSW	2006	North East London SHA
Report of the independent inquiry into the care and treatment of MM	2006	North East London SHA
Report of the external review of John Meyer Ward following the death of EC	2006	South West London SHA
Report of the independent inquiry into the care and treatment of JB	2006	South West London SHA
Report of the independent inquiry into the care and treatment of GL	2006	County Durham & Tees Valley SHA

<b>Report</b>	<b>Year Published</b>	<b>Commissioners</b>
Report to Northumberland, Tyne & Wear SHA of the independent inquiry panel into the health care and treatment of CS	2006	Northumberland, Tyne & Wear SHA
Independent review into the care and treatment of MC	2006	Cheshire & Merseyside SHA
Independent mental health inquiry into the care and treatment received by E	2006	Thames Valley SHA
Independent mental health inquiry report into the care and treatment of H	2006	Surrey & Sussex SHA
Independent inquiry into the care and treatment of MN	2006	Avon, Gloucestershire & Wiltshire SHA
Report of the inquiry into the care and treatment of a patient known as J	2006	South West Peninsula SHA
W Investigation. Report of the independent investigation team	2006	Birmingham & the Black Country SHA
The report of the independent investigation into the care and treatment of OS	2006	West Midlands South SHA
The report of the independent investigation into the care and treatment of PW	2006	West Midlands South SHA
Independent investigation report reference SUI 2003/827 and SUI 2004/282	2006	South Yorkshire SHA
Report of the independent homicide inquiry reference SUI 2004/1904	2006	West Yorkshire SHA
Independent inquiry into the care and treatment of RL	2006	Medway PCT & Medway Council
Report to the North East SHA of the independent inquiry into the health care and treatment of SC	2007	Northumberland, Tyne & Wear SHA
Report of the independent inquiry reference SUI 2005/2100	2007	West Yorkshire SHA
Report of the independent inquiry reference SUI 2005/3404	2007	West Yorkshire SHA
Report to the North East SHA of the independent inquiry into the health care and treatment of GT	2007	Northumberland, Tyne & Wear SHA
The report of an independent mental health inquiry into care and treatment received by P	2005	Surrey & Sussex HA
Independent external review into the homicide and suicide in Llangadog on 27th February 2003	2005	Carmarthenshire Local Health Board
Serious case review report in respect of TB formerly known as TKC	2006	NSPCC

Appleby, L., Shaw, J., Kapur, N., Windfuhr, K., Ashton, A., Swinson, N., While, D., Lowe, R., Bickley, H., Flynn, S., Hunt, I., McDonnell, S., Pearson, A., Da Cruz, D., Rodway, C., Roscoe, A., Saini, P., Turnbull, P., Burns, J., Hadfield, K., Stones, P. Avoidable Deaths, Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London: Stationery Office (2006).

Department of Health. (1994) Guidance on the discharge of mentally disordered people and their continuing care in the community. NHS Executive HSG(94)27 & LASSL(94)4. London.

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Peay, J. (1996) Inquiries after Homicide. London: Duckworth.

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## **Appendix 1: Homicide investigation report recommendations**

### **1. Clinical Practice**

#### **Care Programme Approach**

1. Review the application of the local CPA policy; to ensure that it reflects both the Department of Health (1999) Guidance, and the experience of Best Practice within Crisis services, nationally.
2. Review the application of the local CPA policy to ensure that it reflects both the Department of Health (1999) Guidance, and the experience of best practice within mental health services nationally. This should include: a) The development of a system which ensures that all information relating to the care and treatment of a person in contact with services is available to all the practitioners involved. It should be accessible across all disciplines and equally applicable to Health & Social Care. b) Work to ensure that the CMHTs in Rugby work to a proper multidisciplinary model, and that all staff involved in a patients care are involved in key decisions, such as discharge and demonstrate their working together through the use of a shared clinical record.
3. The use of existing processes, in particular the care programme approach, should facilitate appropriate information exchange. The inquiry panel recommends that mental health services should ensure that the care programme approach is utilised in appropriate cases, particularly for those patients suffering from mental illness and who are engaged with other agencies.
4. East London and The City Mental Health NHS Trust (now incorporating Newham community mental health services) should 1) review the implementation of its CPA policy with a view to establishing the reasons why the referrals of PC to the East Newham CMHT in 2002 and 2003 did not occur and/or were delayed, 2) review the definitions and inclusion criteria of standard and enhanced CPA.
5. Barnet, Enfield and Haringey and East London and The City Mental Health NHS Trusts should a) review the application of CPA principles, and b) ensure that the Barnet MDO team reviews its allocation of cases and application of CPA to all cases that are open but not active.
6. Barnet, Enfield and Haringey Mental Health NHS Trust and East London and The City Mental Health NHS Trusts should review all forensic patients with an element of care in another locality to ensure the application of CPA principles and follow-up.
7. Random audits of the Trust CPA/ECC policy should be conducted at intervals to ensure that it is being implemented correctly. It is noted that the Trust CPA/ECC policy is robust and compliant with all Department of Health guidance.
8. **CPA:** The team manager should have responsibility for ensuring that the Care Programme Approach is fully implemented in respect of every patient, including those treated only as outpatients. The Trust should ensure that this function is performed effectively through appropriate supervision and audit.
9. The omissions in the trust's current CPA policy document are remedied. The current policy does not specify the role/ responsibility of the executive director leading the implementation of the CPA policy, it makes no reference to MAPPAs or equivalent, it makes no reference to the transfer of patients on CPA outside trust borders, there is no reference to training for staff, requirement 12 of the Laming Report has not been incorporated into the document and there is no cross reference to transfer arrangements between child & Adolescent services.
10. The SHB Trust should ensure that the responsibilities of the Executive Director (the Interim Director of Operations) responsible for CPA are outlined in the job description for that post as soon as possible.

11. We recommend that the Trust reviews the CPA policy and its best practice guidance to include who should chair the meeting, where they should and should not be held, and how confidentiality is maintained.
12. **Current CPA policy and procedures should be amended to take into account the following. a. Change of eligibility criteria:** The characteristics of people on CPA may change – for example a person on standard CPA may become eligible for enhanced CPA. The policy should explicitly deal with this and should contain guidance about reviewing each patient’s status.
13. **Current CPA policy and procedures should be amended to take into account the following. b. Dispute resolution:** The possibility of dispute between professionals about applying eligibility criteria for CPA and other CPA-related areas, for example the contents of care plans, should be explicitly recognised and the policy should contain procedures to resolve disputes.
14. **Current CPA policy and procedures should be amended to take into account the following. c. Multi-agency working and public protection:** The policy should contain clear information about MAPPAs. There should be specific and explicit references in the CPA documentation to the involvement of other agencies, including both the police and probation services and to MAPPAs where appropriate. For example: CPA 1 screening information should include involvement with other agencies and should specify agencies involved. The tick-box should include reference to MAPPAs. CPA 2 information, under the forensic heading, should again specify agencies involved.
15. **Current CPA policy and procedures should be amended to take into account the following. g. Service shortfall:** The need to identify service shortfall should be given greater prominence in the policy and the purpose of completing CPAs should be clarified.
16. **CPA:** An amendment is needed to appendix 3 of the trust’s current CPA policy. In this appendix NHS direct and the Samaritans phone number were listed as 24 hour access numbers for mental health service users. The panel suggested that consider more local options, e.g. crisis team, local support groups, out of hours PCT/ GP numbers.
17. In addition to the current review of the Trust's CPA Policy, a review of CPA practice in the Trust should be undertaken and completed as a high priority to: identify areas for further improvement and consistency; develop an action plan; deliver improvements and ensure that a robust process is in place to monitor implementation. Particular attention should be paid to the seamless continuation of CPA and engagement of care coordinators, when patients are admitted to hospital or transferred between inpatient wards.
18. The Trust should consider appointing a trust-wide C.P.A. coordinator to continue the drive to improve C.P.A practice and compliance across the trust. This officer should be of suitable seniority.
19. **Process issues:** The Mental Health Trust has to ensure, as a matter of urgency, that the national and local CPA processes are in place and followed effectively, so that all practitioners, and components of the mental health service are aware of newly developing services, and effectively interface with these, to the benefit of the person in receipt of mental health services.
20. **Management of out of area admission (Clarifying RMO, clinical and CPA responsibility):** The Trust should ensure that together its ICPA Policy and its Good Practice in the Transfer of Service User Care Between Mental Health Districts includes; Clear guidance on where consultant responsibilities lie when there is out of area admission and detention under the MHA with s17 leave. The guidance should refer to the following consultant responsibilities: i. RMO, ii. day-to-day clinical supervision, iii. organising of CPA in hospital, iv. ensuring there is a care co-ordinator managing CPA in the community, v. arranging hospital re-admission and a bed should it be needed. A requirement that these various responsibilities be recorded in CPA documentation by or on behalf of the consultant responsible for CPA. Good practice guidance that every effort should be made to avoid arrangements which are confusing and have gaps or lack continuity.

21. **Ensuring a functioning Trustwide CPA register:** The Trust should ensure that relevant policies and procedures require that CPA care plans and risk assessments are • completed for all users accepted by the Trust, • recorded on paper in the form required by the Trust ICPA Policy, • for patients subject to both standard and enhanced CPA, entered electronically in the Trust MHIS (Mental Health Information System).
22. **Making a public commitment to CPA:** The Trust should give public commitment to CPA as the main framework for delivery of treatment and care throughout the Trust and in association with local Primary Health Care and Social Services providers.
23. **Ensuring that patients detained for treatment under the MHA are on enhanced CPA:** the Trust should, with immediate effect, amend its ICPA Policy to make it clear that patients who are liable to be detained for treatment under the MHA, whether or not subject to s17 leave, must always be placed on an enhanced level of CPA. The presumption should be that patients discharged from such detention and therefore subject to s17 aftercare will remain on enhanced level CPA until s17 ceases to apply. During this period any alteration in CPA level should be agreed only after a review involving the patient, carers and other agencies involved in the patient's regular support.
24. **Ensuring co-ordinated planning of CPA services and records (The SHA should ensure that all PCTs commissioning services from the Trust co-ordinate service specifications):** Co-ordinate their planning and services specifications within the requirements of national CPA guidance, so that patients moving across PCT boundaries are not put at risk of becoming lost within the network of service delivery systems in the greater Bristol area.
25. **Standards:** Quality of CPA for all psychiatric patients, whether subject to an order or not, should be a key element in the standards based system of assessment for mental health providers and therefore CPA should be at the heart of the annual health check/performance assessments for health and social care organizations.
26. **Accountability:** The Secretary of State should clarify where within the NHS Chief Executive's office responsibility lies for delivery of mental health services based on CPA.
27. **Accountability:** The Secretary of State should make it a clear responsibility of Strategic Health Authority Chief Executives that they ensure through performance management that provider/PCT Chief Executives are accountable for ensuring that CPA processes are properly in place across health and social care.
28. **Accountability:** Ensure that all registered private and voluntary health and social care providers are accountable for ensuring that CPA processes are properly in place and where applicable clinical governance arrangements take into account the requirements of CPA.
29. **Accountability:** The Department of Health should state firmly in 'Standards for Better Health' that CPA is an essential component of the core standards.
30. **Contracts of employment:** In line with CPA policy the contracts of employment for all practitioners should include the explicit requirement that practitioners working with adults of working age should use the CPA as the basis for delivering mental health treatment and care. This requirement should be reflected in practitioners' job plans and compliance should be monitored in annual appraisals, thus facilitating the identification and review of the requisite managerial, administrative infrastructure support for practitioners.
31. **Confirming commitment to CPA:** In the light of the weight of evidence seen and heard by this Inquiry, the DOH should re-assert that CPA still constitutes the main national guidance on operational standards in mental health services for all providers and the professional staff employed by them.
32. **CPA and patients detained for treatment:** The Department of Health should ensure that national and local operational guidance on CPA clearly states that persons who are liable to be detained for treatment under the MHA, notably those on s17 leave or receiving aftercare under s17, should always be placed on an enhanced level of CPA. Any ambiguity of advice to staff contained in local practice policies should be amended with immediate effect.

33. **Amended legislation and associated guidance:** The Department of Health should ensure that patients subject to compulsory supervised treatment in the community under any amended mental health legislation are placed on an enhanced level of CPA, and their care plans reviewed or at least considered when any Tribunal hears an appeal or automatic referral of their continued compulsory treatment in the community.
34. **Accountability:** Upon any amendment of the Mental Health Act the Department of Health should consider what further national guidance is needed to ensure that the Care Programme Approach is comprehensively operated as the main framework for mental health treatment and social care provided under the NHS. All relevant primary and secondary legislation and guidance, namely statutory aftercare, requirements of clinical supervision, matters to be considered by Tribunals, national CPA guidance and MHA Code of Practice should be linked together to create one unambiguous and unified CPA care planning system.
35. **Detained patients and CPA standards:** The Mental Health Act Commission should ensure that in the current biennial review period, the standards for CPA incorporated in the MHA 1983 Code of Practice are systematically reviewed on every Commission visit, incorporated in each visit report and given appropriately full account in the Biennial Report.
36. A system of clear and effective care co-ordination should be introduced similar to that found with the adult CPA process whereby there is effective communication and care management via a keyworker between the various agencies involved in a young person's care. This process should facilitate the young person's progress through the care pathway, enhance risk assessment and improve the effectiveness of risk reduction measures.
37. Undertake a comprehensive audit and review of the operation of CPA to include the role and effectiveness of care coordinators.
38. The audit of CPA practice should incorporate periodic audits of the data entered into care notes by the CPA facilitators for accuracy. This will probably be best accommodated as a component of peer review audit and of necessity will need to involve the care coordinators who made the original documentation of the electronic records included in such an audit.
39. It is recommended that CPA audit is closely monitored by the Lancashire care trust. This should include the distribution of copies of the completed CPA. It is particularly important that a copy is sent to all agencies actively involved with the patient's care, including the GP.
40. **Performance management:** East London and The City Mental Health NHS Trust, in partnership with the London Borough of Tower Hamlets and Tower Hamlets Primary Care Trust, should review the Trust's performance management systems to satisfy themselves that those systems are sufficiently robust to ensure compliance with the Care Programme Approach and its requirements. Learning and changes in practice and in culture should be acknowledged and reflected at all levels within the organization.
41. **Ensuring a functioning Trustwide CPA register:** The Trust should audit compliance and publish figures for the numbers of patients on the CPA register.
42. **Ensuring a functioning Trustwide CPA register:** The Trust should provide regular reports to the Trust Board on the implementation of CPA.
43. **Reviewing CPA standards in the Trust:** The Trust should set up a comprehensive, systematic review of the way CPA is applied across services in the Trust's area. The Trust review should: (1) consider the extent to which CPA for detained patients meets the standards set out in the MHA Code of Practice guidance (referred to at paragraph 6.3 of this report) bearing in mind the areas of failure in MN's case listed (a) to (g) in this report's commentary under paragraph 6.15.7 & (2) consider the extent to which Standards Four and Five of the *National Service Framework for Mental Health (1999)* are satisfied, bearing in mind that these Standards apply equally to patients on standard and enhanced CPA.
44. **Standards:** The Health Care Commission and Commission for Social Care Inspection should jointly review the way in which they assess the effective implementation of CPA and develop key indicators that will more effectively measure performance in this area. Key indicators should include • Progress towards operation of electronic mental health information systems •

Evidence of an administrative infrastructure to support professionals in their operation of CPA

- Arrangements for training of professionals in CPA.

45. **Review and study of the effectiveness of CPA:** The Department of Health should commission a comprehensive review of the Care Programme Approach to establish conclusively; that all health service commissioners have specified its standards as the basic requirement for delivery of mental health treatment and care, the extent of the adoption of CPA as the main operational tool for delivery of mental health care by all health and social services providers nationwide & that the guidance provides clear and unambiguous definitions around the eligibility criteria for CPA. The Department of Health should consider commissioning a national study of the effectiveness of CPA, with the purpose of indicating weaknesses and how they can be rectified.
46. **Discharge from hospital:** It is recommended that Care Plans contain full information on contingency and crisis plans and that the Trust audits this on a regular basis.
47. **Contact with CMHT:** It is recommended that the allocation of a care coordinator is carefully recorded and that the professional and their role is clearly understood by his/her colleagues, the patient, carer and other relevant agencies.
48. **CPA:** Every patient in an acute admission ward should have a ward round on a weekly basis, as a minimum, attended by all relevant clinical staff including consultants and patients' care co-ordinators. Carers and others involved in patients' care should be invited to attend.
49. **CMHT:** The in-patient care planning process should be reviewed to enable easier transfer of care between community care and hospital episodes.
50. **Use of the CPA process:** The inquiry panel recommends that when a patient subject to enhanced CPA is being transferred to another clinical team within the trust, the consultant psychiatrist taking over their care is present at the CPA transfer meeting ensuring that they take the lead in the patient's care plan.
51. **Use of the CPA process:** The inquiry panel recommends that where there is more than one patient in a relationship this needs to be addressed through the application of the CPA process. The focus is to promote an appreciation of the needs of each person as an individual and also as an individual in a relationship with another person who has needs of their own.
52. **Current CPA policy and procedures should be amended to take into account the following.**
  - h. Change of care co-ordinator – enhanced CPA:** The policy should explicitly deal with the circumstances where there is to be a change of care co-ordinator for a person on enhanced CPA. There should preferably be a face-to-face transfer meeting involving a CPA review. The policy should take into account that when workers leave it is not always possible to re-allocate the case straight away. Sometimes there will have to be temporary cover to deal with emergencies regarding a case before a definitive transfer can be made.
  - i the extent to which D prescribed care plans were effectively drawn up, delivered and complied with by D;** 8.4.1 A review of the summary of the joint care plan is required for the purpose of developing a Care Plan Approach.
54. **Process issues:** The Mental Health Trust has to ensure, as a matter of urgency, that the national and local CPA processes are in place and followed effectively, so that people in receipt of mental health services are placed firmly and unequivocally at the centre of a collaborative and regularly reviewed Care Plan, which is acted upon.
55. **Diagnosis & CPA (Recording of diagnosis and treatment in CPA care plans):** The Trust should review its ICPA Policy to ensure that each Care Plan describes the diagnosis and differential diagnosis if there is one, and includes a clear treatment and management plan, unless there is a clinical reason not to do so which is noted in the medical records. Where consent is needed for disclosure of information this should be recorded.
56. **Consistency of nursing and CPA care plans:** The Trust should ensure that overarching CPA care plans make reference to any other contemporaneous care plans, such as nursing or psychology, attaching copies of them to the patient's CPA document where possible.

57. **Ensuring a care co-ordinator is always appointed:** The Trust should review its ICPA Policy as necessary and give a commitment that under no circumstances will a service user be deprived of a care co-ordinator under CPA. If it is assessed that care cannot be delivered safely for any reason, alternative care or supervision options and appropriate referral should be considered. This should be explained to the service user and carer(s) and recorded in ICPA documentation.
58. **Ensuring co-ordinated planning of CPA services and records (The SHA should ensure that all PCTs commissioning services from the Trust require the involvement of service users and carers in care planning):** Require care planning and delivery under CPA to involve patients and carers so that their status as participants as well as recipients is fully acknowledged.
59. Ensure that the contributions of carers are fully integrated into CPA.
60. Where CPA arrangements are in place, all documentation specified in the CPA policy should be completed, and full adherence to the CPA policy should be verified by audit. In the present case, this may have identified the fact that separate psychiatric outpatient appointments had ceased, and that no risk and relapse plan had been drawn up. Consideration should also be given to a more effective method for GPs to make input to the CPA review process, for example by requesting them to submit a note of recent contacts of the patient with the GP practice.
61. **Current CPA policy and procedures should be amended to take into account the following. f. Process of risk assessment:** This section of the policy should be amended to refer to MAPPA. It should contain a brief explanatory note about the function of MAPPA and about local routes to the MAPPPs.
62. **CPA:** Where multiple agencies are engaged in supporting a service user then early consent is sought for involving these persons in CPA. Also CPA process must ensure that it supports the involvement of the multi-agency parties in the CPA process. If INSIGHT does not already accommodate the recording of other agencies involvement with the service user incorporation of the facility for this may be useful.
63. The SHB NHS Trust should review the arrangements for scheduling CPA meetings to allow for a longer period of notice of the meeting time and date for those invited to attend.
64. We recommend that the Trust regularly reviews the outcome of CPA meetings to ensure that the actions are carried out and that a nominated person is accountable for the follow up of any interventions.
65. **CPA:** The current system for alerting team managers to overdue CPA reviews is enhanced by the CPA coordinator having invested authority to ask for the reason for delayed CPA reviews & to raise any ongoing delay with the directorate manager and clinical director.
66. **CPA:** Data on delayed CPA reviews including the reasons for delays should be incorporated into the existing audit process for CPA. The analysed data should be made available to each CNS for discussion & action planning at service governance meetings. Aggregate data should also be presented at the service governance forum for the directorate of acute & community.
67. **Ensuring a functioning Trustwide CPA register:** The Trust should use the CPA register to trigger CPA reviews.
68. **CPA review upon change in legal status under the MHA:** The Trust should include within its ICPA Policy a requirement that upon and preferably before, any change in a patient's legal status, a CPA review meeting be held, so that legal implications for the patient and nearest relative can be fully explained and amendments to CPA arrangements made if necessary.
69. The SHB Trust should examine ways of forging closer links between CPA and the patient risk management process. Particular attention should be given to the need to build in appropriate risk assessment tools to the CPA process. This should aim to ensure that risk assessment is confirmed as an integral part of CPA and may help to overcome any remaining views of CPA as a "bureaucratic paper exercise".

70. In terms of his mental health problems, prior to coming to Lincolnshire, more serious consideration could have been given to placing TB on a Care Programme Approach much earlier than was the case, which could have afforded a degree of monitoring of his whereabouts.
71. **Diagnosis & CPA (Consideration of an independent opinion):** The Trust should provide good practice guidance in its ICPA Policy to the effect that where, in the context of a CPA assessment of health and social care, it becomes apparent that there is dispute or uncertainty about a diagnosis, consideration should be given to the appointment of an independent expert to provide an opinion.
72. **Ensuring s117 aftercare planning takes place:** The Trust should review its ICPA and section 117 policies, and work with local authorities to ensure that the responsibilities of the Trust and social services to carry out a s117 aftercare assessment before any extended leave of absence are explicitly addressed and incorporated into CPA care planning. A multi-agency audit of the use of this policy should be included in the Trust and Local Authority annual audit cycle.
73. **CPA:** In respect of every patient on the enhanced CPA there should be a systematic assessment of the needs of any children associated with the patient and a plan for meeting their needs in accordance with the Trust's child care policies. Such assessment should not be limited to child protection issues but should embrace the full range of the children's needs in accordance with the Framework for the Assessment of Children in Need and Their Families.

### **Assertive Outreach / Crisis Services**

74. Review the operation of the AOT to ensure compliance with national policy guidance, with a particular emphasis on engagement.
75. **Contact with CMHT:** It is recommended that the eligibility criteria for access to the Assertive Outreach Team is reviewed and that if the six month guidance remains then professionals seeking support for their patients/clients who are not accepted should be able to have an opportunity to discuss the case with the team and mechanism for dealing with unresolved referrals between the teams should be developed.
76. **CMHT:** The community services should focus on those with severe and enduring mental illness, with the development of early intervention and assertive outreach services.
77. Ensure that the Crisis Service, across North Warwickshire and Rugby, is consistent with the aspirations and requirements of the Mental Health Policy Implementation Guidance (PIG), 2002 – and is a model that is agreed with the Commissioners of the service.
78. **Crisis assessment & treatment service:** The strategic health authority is recommended to ensure that benchmarking of the crisis assessment and treatment service is commissioned.
79. **Crisis assessment & treatment service:** The strategic health authority is recommended that staff are reminded of the Nursing and Midwifery Council guidelines regarding record keeping.
80. **CMHT:** The crisis response team should be re-focussed to give emphasis to those known to the service and subject to the care programme approach, so as to ensure appropriate crisis response as outlined in standard four of the NSF.
81. **Leadership:** The newly formed Crisis Home Treatment Team (CHTT) service policies and procedures are reviewed to ensure that they are consistent with the overall Trust strategy: - *that a system is implemented whereby the team formally reviews all case formulation, care plans and multi-disciplinary care review.* - *That a review of the handover process is undertaken to ensure that all decisions are documented in the individual's notes and that an ongoing team log of the handovers and review meeting is completed.* - *That a clearer process is established for the allocation and coordination of each case.*
82. **Primary care:** ART members did not appear to routinely access primary care and other related records. We believe that both, in the case in question, and more broadly that the team would benefit from access to and use of this information. We recommend that crisis services

routinely access primary care and other available health and social care information within 24 hours.

83. **A&E:** We found that in this case there was not a clear handover of information between the A&E service and ART. We recommend that a protocol for handover of clients is developed urgently, which contains information to ensure the safe transfer of patients to ongoing services and includes all patient documentation. That the Trust should consider whether A&E liaison service should be part of an integrated crisis service.
84. **Clinical psychology:** We found that there was a lack of proactive use of Clinical Psychology by the ART, in order to address this we would recommend that Clinical Psychology input is sought by team members to assist with the formulation of care plans and to participate in multi-disciplinary case reviews.
85. **Roles and responsibilities of members of the AOT, Crisis Resolution and Home Treatment Team and the EDT:** There should be a joint agreement signed by the chief officers of the Trust and Social Services to specify the roles and responsibilities of all members of the AOT, the CRHT and the EDT. There should be an agreed, documented operational policy on how the three teams work to best meet the needs of patients and carers, including specific reference to how cases are prioritised and how contact is made with patients and carers. There should be training for all staff on their roles and responsibilities and the operational policy. The working of the teams should be subject to annual review and the outcome of this review should be reported to the chief officers of the Trust and Social Services.
86. **Crisis Resolution & Home Treatment Team (CRHT):** The practice of the CHRT for the recording of incoming calls and requests should be reviewed.
87. **ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.12 Extra training for all staff in recognising and responding to psychiatric emergencies, especially learning when to increase resources to affect patient management.

## **Risk Assessment & Management**

88. Develop and implement effective arrangements for clinical risk management that are subject to regular audit and review.
89. **Initial referral to mental health services:** It is recommended that risk assessment and management becomes an integral part of care planning and management and is regularly audited by the Trust.
90. In relation to risk assessment and risk management, there should be mechanisms in place to ensure that risk factors are explicitly identified, with rigorous reviews of risk at appropriate stages in the care of a patient, particularly where steps such as conditional discharge or discharge of S.117 arrangements are being planned. Where patients have committed serious offences, risk assessment should take account of the risk of re-offending as well as the risk of deterioration in mental state.
91. We recommend that some further work on improving risk assessment procedures should be undertaken. The Panel recommends that the Trust monitor and review the efficacy of its current risk management strategy.
92. That the Trust should ensure that it has a clear Risk Assessment policy and supporting literature in mandatory use by its staff throughout its area.
93. A system of clear and standardised risk assessment should be included in a young person's care plan. Risk assessment should then be carried out at regular intervals at locations that are appropriate and the process documented as such in order to achieve maximum risk mitigation.
94. **Nursing records:** Risk profiles should be completed sequentially and regularly, wherever possible, by the same staff to encourage comparison, consistency, and to highlight change.

95. **Risk assessment & management:** All Trusts should ensure that information directly relevant to risk management is easily available and easily accessible (for example, by storing such information in a specifically designated part of the clinical records). The design of electronic patient records must allow for this also.
96. **Risk assessment & management:** Trusts should review their risk assessment forms to determine whether improvements can be made so that forms can contribute optimally to assessment and appraisal of risk. This should include consideration of a facility to record estimated levels of prediction and certainty – rather than omitting a risk because it is uncertain. Recording it in the risk assessment should help the multi-professional team to focus on any further evidence relevant to that risk that becomes available after the risk assessment has been completed.
97. The SHB Trust and the new Surrey and Borders Partnership NHS Trust should be aware of and approve the use of all risk management tools. All risk management tools in use should be subject to regular review to ensure their continuing fitness for purpose.
98. The Blackwater Valley and Hart PCT should support Health Visiting and Midwifery services in reviewing their risk assessment processes for patients presenting with a previous history of severe mental illness. The reviews should aim to ensure that clear guidelines are in place to support staff in assessing risk, using appropriate risk assessment tools and in taking decisions about onward referral to mental health services, within an appropriate clinical supervision framework.
99. When a risk assessment identifies significant risk factors to the patient or to others procedures should ensure that the risk assessment is regularly reviewed, particularly at the point of discharge & post discharge follow-up.
100. If a patient is re-admitted, however soon after previous discharge, a fresh assessment, including a risk assessment, should be completed to identify any change to presenting features.
101. **Governance & risk management:** East London and The City Mental Health NHS Trust must establish a governance and risk assurance structure which distributes expertise across its senior staff and makes use of Non-Executive Directors.
102. **To examine the quality and scope of the assessments made of D health and social care needs from 24th October 2002 to 27th February 2003.** 8.1.2 Reviews of clinical risk assessment and management plans should be repeated at significant stages in order to gain an on-going and up to date reflection of risk assessment.
103. **The nature of the risk assessment of potential harm to D and others.** 8.2.1 Risk management plans, when completed, should be made available to all clinical staff, and plans to deal with each risk factor identified should be spelled out and linked to named individuals. These plans should be updated at each formal clinical assessment, i.e. ward round, team meeting, etc.
104. **The nature of the risk assessment of potential harm to D and others.** 8.2.4 Consideration should be given to teaching and adopting more widely the concept of threat assessment rather than standard risk assessment as it is more clearly focused on the individual, whereas risks are largely statistical concepts.
105. **The nature of the risk assessment of potential harm to D and others.** 8.2.5 Assessments of either kind should always lead to a plan for management.
106. **iii to examine the adequacy of collaboration and communication between agencies involved in the care of D, the provision of service to him and between the statutory agencies involved;** 8.4.19 Scores on risk assessment scales should not be used in isolation for clinical or operational purposes, but only in the context of a full clinical evaluation in the case of a psychiatric patient.
107. The Trust should review its arrangements for managing health and safety systems and consider appointing a Health and Safety manager to strengthen its overall structure for risk management.

108. The Trust should continue to roll out and evaluate the zoning pilots for risk assessment with a view to expanding the use of zoning across the Trust as a whole.
109. Work should be commissioned to realise the opportunity to embed zoning into the Trust's CPA policy and procedures.
110. Implementation of zoning on John Meyer Ward and elsewhere should be developed as a team process. It should be developed on John Meyer Ward as an action research project and be evaluated perhaps as part of the Trust's Practice Development programme.
111. **Reporting on risk:** We recommend that the standard question on the patient's current risk to others be changed.
112. **Assessing and recording risk:** The Trust should review its ICPA and risk assessment policies to ensure that when risk is assessed, any risk associated with a differential diagnosis is taken fully into account & that CPA reviews always record risk assessment, even if it is to note that there is no risk.
113. **Responding quickly when threats of serious violence are made:** The Trust and Social Services should require that any member of staff who receives direct threats of serious violence immediately report those threats to the psychiatrist responsible for the service user's care and the police, so that risk can quickly be assessed and a clear contemporary record established there and then. All CPNs and ASW's should be provided with mobile telephones.
114. **Local service's work with M & L:** The inquiry panel recommends that the trust develop processes for regularly auditing the quality and usage of information gained through risk assessments and that this is reported within the clinical governance process of the trust.
115. **iv to examine and comment on the nature of any risk assessment and the management of identified risk presented by D to himself or others;** 8.4.24 When dealing with a patient in the community, efforts should be made by mental health staff to conduct some sessions without other family members present, in order to gain a more accurate assessment.
116. **Lack of specific & measurable relapse indicators. The RCA Team recommends that the utilisation of the list of relapse indicators in terms of clinical management needs to be more clearly specified to avoid ambiguity. To achieve this the investigative team recommends:-** That guidelines are produced by Bro Morgannwg and Cardiff and Vale NHS Trusts for detailing the way in which individual relapse indicators are translated into clinical actions. This will reduce the potential for human error. The RCA team consider it would be good practice when listing the relapse indicators to indicate the strength each indicator should be considered as a sign of relapse and to specify the action to be taken. It is recognised that clinical judgement must be allowed to vary the action at the discretion of the practitioner.
117. **Lack of specific & measurable relapse indicators. The RCA Team recommends that the utilisation of the list of relapse indicators in terms of clinical management needs to be more clearly specified to avoid ambiguity. To achieve this the investigative team recommends:-** That both of the aforementioned Trusts should review all relapse indicators presently in use with high-risk patients, to assess their ease of interpretation in terms of clinical actions and their applicability in the environmental setting.
118. Enable all practitioners to work to an appropriate Domestic Violence Strategy.
119. **The nature of the risk assessment of potential harm to D and others.** 8.2.2 In any situation involving an actual or alleged sexual partnership which is going wrong, a diagnosis of morbid jealousy should always be considered.
120. Information regarding TB's Schedule 1 status, his offending history and his mental health problems that was communicated to Healthcare professionals, prior to him coming to Lincolnshire, should have triggered the need for assessment and management of the potential risk he posed to females and children.
121. Prior to her meeting TB, Mrs. X's husband was serving a sentence for offences against children, and whilst he was in Prison it came to the attention of Social Services in 2001 that

Mrs. X was accommodating another man who had committed offences against children. Thus, TB was the third man to have a Schedule 1 offence who moved into Mrs. X's household. When referrals are received within Social Services (now Social Care) about such families, more rigorous checks should be carried out when such background information is known.

## Treatment

122. **Crisis assessment & treatment service:** The strategic health authority is recommended to review prescribing practice in light of the guidance provided in 'patient group directives' (Department of Health, 2005).
123. **Therapeutic options:** The Trust should ensure that the NICE51 guidelines on schizophrenia as to the allocation of resources between medical and other forms of treatment are implemented.
124. Guidelines for the prescription and monitoring of lithium should be developed. This should include clear details of where the principle responsibility lies for monitoring lithium and should be clear that consultant psychiatrists must retain responsibility for deciding what action to take if serum lithium levels outside agreed targets are reported.
125. We recommend that the Trust reviews its policy on the administration of depot injections.
126. **Medication:** Previous non-compliance with medication should be identified in care plans and risk assessments to encourage medication usage checks to be carried out.
127. **Medication:** The use of rating scales to assess psychotic symptoms would improve the assessment of mental state and assist in decisions about compliance.
128. **Failure to ensure medication compliance whilst in hospital:** That Cardiff and Vale NHS Trust ensures there are robust mechanisms in place to monitor the compliance of conditionally discharged patients in taking oral medication.
129. **Medicines management:** The directorate for acute, community & primary care mental health services needs to open a dialogue with the local PCT and GPs to try to establish a workable system to enable mental health workers to be made aware at an early stage if a service user has not been collecting their medication.
130. Develop and implement a policy on covert administration of medication.
131. **Evidence based practice:** In order to ensure best practice which is evidence based, the strategic health authority is recommended to review the interventions which are offered to mental health patients and to consider the benefits that are offered by such interventions.
132. **Therapeutic options:** The Trust should increase the availability of psychological and other therapeutic interventions across the community mental health teams and on the wards.
133. **Ward staffing:** The range of therapeutic activities available for younger adults in the wards should be broadened by the involvement of a planned programme of weekly activities, coordinated by occupational therapists and psychologists.

## Inpatient Treatment

134. Review the role and function of Dene Ward with a view to developing an effective operational policy in line with current national policy guidance.
135. The Trust should take the opportunity to refine the John Meyer Ward Operational Policy, building on the good work to date, in preparation for the move to the new purpose-built PICU.
136. We recommend that consideration be given to the circumstances in which ward doors can be shut to safeguard patients, but without thereby creating locked wards.

137. We recommend the Trust reflect on the ward related difficulties highlighted in this report. The Trust may benefit from undertaking an audit of the work that General Adult psychiatry wards are expected to undertake against their capacity, to ensure a safe supportive and therapeutic environment for patients.
138. Pending the completion of the new purpose-built PICU, the Trust should consider further short-term improvements to the existing ward, for example through the use of colours, light and space. (The King's Fund "Enhancing the Healing Environment" programme and the NHS Estates "Art of Good Health" series offer some useful advice).
139. The Trust should audit and review response times from its Estates Department to requests for repairs in areas where patients may be at high risk.
140. **Patient records:** Pre-admission information should be an integral part of hospital care planning. It should therefore be checked and explored as the opportunity arises with carers and others who were involved with the patient before his/her admission.
141. It is recommended that the PCT monitor the use of Section 4 by the trust for the compulsory admission of patients.
142. A care coordination admission meeting should be held in accordance with CMHT procedure as soon as possible after admission to the ward. If a patient is unknown to mental health services this meeting should be within 7 days of admission.
143. Senior medical involvement with a patient should take place at least on a weekly basis & should be documented.
144. The John Meyer Ward team should continue efforts to improve services in the light of the patient experience survey findings. Particular emphasis is needed to find ways of improving the range of activities for patients, particularly at evenings and weekends.
145. **Home leave:** Nursing staff should assess the value of leave taken by patients on their return before further leave is planned, with a positive leave assessment acting as the main consideration for further leave.
146. **Home leave:** Home leave should be part of a planned programme of care that is monitored through home visits by a named care coordinator together with feedback from a number of different sources.
147. Panel commended clear guidelines & procedures regarding the granting of leave. Decisions to grant leave need to be documented in accordance with these procedures. Training should be provided to ensure that all staff understand the decision making process regarding leave, factors that should be considered in granting leave and how decisions are made. Decisions to grant leave should be supported by ongoing risk assessments.

## Dual Diagnosis / Substance Misuse

148. **Service delivery (overall dual diagnosis strategy):** The PCT and partnership agencies should develop mutually agreed a strategy to oversee the development of dual diagnosis services. This should be performance managed by the Strategic Health Authority.
149. **Service delivery (overall dual diagnosis strategy):** The Trust should appoint a 'local champion' to lead on the implementation of a jointly agreed strategy.
150. **Dual diagnosis:** It is recommended that staff are provided with training on the impact that substance misuse can have on a person with a mental illness and that local Dual Diagnosis Strategies are developed and implemented.
151. **Substance misuse:** The trust should support the care team in dealing with inpatient substance misuse by producing a robust policy to deal with the issue. The policy should recognise that: i. previous substance misuse or excessive alcohol consumption, should always act as an indicator of a potential for disturbed behaviour and be identified on care plans; ii. continued

substance misuse should trigger a case review by the care team and appropriate action should be taken to both reduce it and modify future care plans; iii. all patients suspected, or with a history of, misusing substances should be subjected to automatic drug testing on return from leave however short.

152. Using the DoH good practice guide in dual diagnosis, the trust needs to map the skills & competencies currently available, identify clinical leadership and draft a strategy that will assure service development appropriate to local services. This can best be achieved by the appointment of appropriate clinical leaders in dual diagnosis to develop the strategy, support good practice, commission/ provide training & promote service development. The panel recommends the trust consider the appointment of a nurse consultant in dual diagnosis & at least 2 sessions of a consultant psychiatrist with specialist interest in dual diagnosis.
153. To establish clear policy & agreements for the new assertive outreach function in the CMHT on dual diagnosis & up to date training for newly appointed staff.
154. **Patients with dual Diagnosis:** The London Borough of Tower Hamlets, East London and The City Mental Health NHS Trust and Tower Hamlets Primary Care Trust should review their strategy and operational policy for the provision of services to those with a dual diagnosis, i.e. a substance misuse problem co-morbid with mental illness or a clinically significant personality disorder. In particular, the Trust needs to define and develop a coherent approach to services for people with dual diagnoses in conjunction with the London Borough of Tower Hamlets and the Tower Hamlets Primary Care Trust, thereby seeking to ensure that its dual diagnosis service is fully integrated within mainstream mental health services.
155. **Illicit Drugs:** After taking appropriate advice, the Trust should consider and develop policies (if possible) to address the problem which the use of illicit drugs carries to mental health care service users, in particular, those suffering from schizophrenia.
156. **The alcohol issue:** Current guidance is set out in the Alcohol Needs Assessment Research Project, 2005 and endorsed in Alcohol Misuse Interventions (Department of Health, 2005). The strategic health authority is recommended to consider these publications and implementation.
157. **Admission to hospital:** The inquiry panel recommends that the inpatient unit review their processes to ensure that: • Where a person continues to misuse substances then a more active management of these problems should be undertaken either by a referral to specialist services or through the adult service with support from the specialist service • The contribution of carers is recognised and encouraged • Preparation for discharge is commenced on admission including the identification of appropriate housing needs where relevant • Meaningful therapeutic activities are available within the unit.
158. Ensure that appropriate senior clinical psychiatric input is provided to the CDAT. The panel noted that the trust currently has no consultant psychiatrist in substance misuse and this should be remedied as soon as possible, but with the caveat that the team must receive appropriate consultant psychiatric input which the panel understands is currently only provided on a “grace & favour” basis from a locum.
159. **Day services:** The London Borough of Tower Hamlets, East London and The City Mental Health NHS Trust and Tower Hamlets Primary Care Trust should conduct a comprehensive review of the adequacy of day services they make available to patients with multiple morbidities as part of their care package. That review should not be limited to considering the provision of facilities at the proposed day centre at Mile End Hospital. As part of the review, the Trust should assess the services available on a trust-wide basis from both statutory and non-statutory agencies and their efficacy at, for example, building better social networks for patients and achieving a return to employment.
160. **Day services:** Upon completion of the strategy review recommended, the London Borough of Tower Hamlets should seek to ensure that the Trust is held accountable for delivering against their key objectives and reporting mechanisms between the two must be well established. For example, the Performance Assessment Framework and Referral, Assessment and Packages of Care Requirements should be delivered within mental health and substance misuse services.

161. **Day services:** As part of their reporting mechanisms, the London Borough of Tower Hamlets should establish formal quarterly reviews with East London and The City Mental Health NHS Trust. Those reviews should monitor the Trust's progress and achievements in the delivery of mental health and substance misuse services which have been delegated to it pursuant to the National Health Service and Social Care Act 1999. Those reviews should examine qualitative matters such as carer and service user experience and progress on findings from serious incidents, and enable the Council to assess the Trust's impact on the Council's Comprehensive Performance Assessment.
162. **Failure to monitor substance misuse as a condition of discharge:** There should be a low threshold for tolerance of substance misuse in the community, where it has any impact on the risk of dangerousness and a clear management plan where substance misuse occurs, should be specified in the care plan.
163. **Failure to monitor substance misuse as a condition of discharge:** That the care plans of patients who currently fall into this category should be reviewed by all NHS Trusts with this advice in mind.
164. **Substance misuse:** The trust should, in partnership with the police, consider the use of acute wards as training areas for police sniffer dogs, to reduce the supply of illicit substances.
165. **Substance misuse:** The police should be requested to consider formal warnings to patients found to be in possession of illicit substances.
166. Substance misuse testing must be routinely considered when substance misuse issues are complicating mental health – e.g. drug related disorders & dual diagnosis.
167. **Failure to monitor substance misuse as a condition of discharge:** the RCA team recommends that Bro Morgannwg NHS Trust should ensure that protocols exist for screening to continue to occur once patients are transferred to the care of other Trusts. The RCA Team understands that staff at Caswell Clinic have now introduced randomised drug screening when supervising conditionally discharged patients in the community.
168. **Failure to monitor substance misuse as a condition of discharge:** That all patients discharged from secure care with a history of alcohol or drug abuse/misuse should be routinely, regularly and randomly tested for illicit drugs and alcohol use. This could be applied with urine testing, hair testing and breathalysing. It should be considered and specified in the care plan.

## Personality Disorder

169. **Personality disorders:** Within the review recommended at (1) above, East London and The City Mental Health NHS Trust should also give consideration to the development of a specialist personality disorder team to provide consultation and support to staff working:- Within its adult mental health teams; More widely across the Trust (e.g. to Child and Adolescent Mental Health Services and Accident & Emergency Departments); To external agencies (e.g. to social services, primary care and the National Offender Management Service). The Trust should look at developing skills and resources in those of its staff who work with personality disordered people and at the range of treatment interventions available.
170. **Personality disorder:** General psychiatry teams in every Trust should have liaison with a specialist service offering advice and support (that is, not exclusively a consultation service) in the treatment of people with mental disorder in whom personality is considered to be an important element in their care.
171. **Personality disorder:** Psychiatrists and other mental health professionals should receive further training in understanding and describing features of personality, independent of the specific process of diagnosing particular personality disorders.

## **2. Clinical Procedure**

### **Communication, Information Sharing & Record Keeping**

- 172.**Service delivery (future service reconfiguration):** Future changes in the configuration and process of services should be communicated to stakeholders in a timely fashion.
173. We recommend the Trust ensure that their strategic intentions are communicated to, understood by, and owned by all staff groups.
174. Engage with primary care in Sunderland in order better to understand the concerns of GPs regarding the provision of specialist mental health services.
175. The SHB Trust should initiate work to check the degree to which its core internal communications are received and understood. This could include an evaluation of the effectiveness of team briefing in conveying corporate messages, inviting and receiving feedback and briefing teams of staff on more local issues and developments.
176. The SHB Trust and its successor should consider and examine ways to improve communications with its partner organisations and the public about the key issues, opportunities and challenges it faces.
- 177.**Service delivery (information sharing):** Where a patient has sought care and treatment from non-NHS sources through the GP, the GP should encourage them to share that information with the NHS in cases where the NHS is responsible for the provision of ongoing care.
- 178.**Service delivery (information sharing):** The Strategic Health Authority should write to the British Psychological Society and the Council for the Regulation of Health Care Excellence to raise concerns regarding the guidance in respect of sharing of clinical information.
- 179.**Recording & communication issues:** The strategic health authority is recommended to remind practitioners of the guidelines of the Nursing and Midwifery Council – communication / record keeping.
180. It is recommended that the Trust puts into place more robust systems for acquiring and coordinating available information:-
- An explicit policy and operational guidance is required on the process of acquiring, collation and recording pertinent information.
  - In each case the responsible team should identify a designated named person to carry out this task.
  - In order to avoid a partial consideration of the person and their history which regards each new context as a stand alone episode.
181. Clear guidelines need to be developed to guide written communications with a service users GP by medical staff in particular. In discussing such guidelines consideration might be given to the following; clarity of diagnosis, instructions regarding monitoring medication, criteria for re-referral if a patient is being discharged/ having outpatient appointments reduced, reasons for discharge and any expectations of primary care services.
182. A protocol should be developed with partner organisations for the sharing of information about patients at risk of harming themselves or others. This will require agreement from clinicians across the Trust to ensure a consistent approach.
183. Hampshire County Council Social Services Department should work with the Mother and Baby Unit on developing an information sharing protocol which could be shared and agreed with the Local Authority Social Services Departments in the catchment area served by the MBU.
- 184.**Communication:** The Trust policies on communications from Community Mental Health Team to Acute Wards and vice versa must be followed. It is inevitable when there is a shortage of beds that patients may be admitted to wards which do not serve their geographical area. In these circumstances both teams must pay particular attention to communication.
- 185.**CMHT:** While it remains important to all concerned that voluntary sector resources are independent of the local mental health service, all CMHT's should meet with their local

voluntary sector resources to develop protocols for regularly recording and sharing information about individuals in contact with them, especially that relevant to risks to the patient or others. This is particularly relevant when Mental Health Services refer patients to voluntary sector resources as part of their care plan, and/or fund such placements.

186. The inquiry panel recommends that mental health services in Sunderland work actively with primary health care and partner organisations to set and monitor appropriate standards of clinical information exchange. This should occur within a multi-agency protocol for information sharing. The inquiry panel recommends that procedures be put in place to monitor the quality of clinical information communicated between primary and secondary care services. The need for effective communication between professionals involved in the care of patients such as SC is universally accepted, but improvement may be most effectively managed through systematic auditing. This should also ensure that accurate diagnostic information is contained in all correspondence from mental health services to general practitioners.
187. In relation to any service user subject to in-patient care under the Mental Health Act (1983), it is essential to ensure that all correspondence, including that relating to the decision of Mental Health Tribunals and failure to attend routine out-patient appointments, be copied to the General Practitioner in order to advise them on the status and care requirements of the service user.
188. The Primary Care Trust should emphasise to General Practitioners the importance of providing feedback should any concerns be perceived on the clinical status of service users who are known to be in contact with mental health care services.
189. That where a person currently in receipt of mental health services has involvement from other statutory agencies the mental health services should take a proactive role in establishing contact with those agencies to facilitate appropriate sharing of information.
190. We recommend that, in taking steps to improve record-keeping, the Trust also endeavours to secure improvements in communication and team-working and, in particular in the sharing of necessary information between hospital-based and community-based workers.
191. **Service management:** Closer links should be developed between the forensic and general adult services to strengthen relationships, foster good practice and improve the use of the trust's resources.
192. **General communication issues.** We list below some of the communication issues that have been raised in this report. We recommend that the Mental Health Trust consider gathering data and identifying solutions to the following problems: a. Primary health care: We were told that it was sometimes difficult for a GP to obtain feedback if his /her patient had been in contact with either community or inpatient psychiatric services. b. Inpatient teams, the CMHT, and vice versa: We noted difficulties in communicating information from inpatient to community teams on a patient's admission and discharge. For example a patient taking their own discharge against medical advice could result in a delay in the transfer of relevant information. Likewise, we were told of communication difficulties from the care co-ordinator to hospital based staff in the event of a patient experiencing problems in the community. c. Probation service: Communication between the probation and mental health services should be clarified, in relation to a person on either standard or enhanced CPA and subject to a probation order.
193. The new Surrey and Borders Partnership NHS Trust should discuss with its partner organisations, for example Housing Authorities and PCT's, opportunities for naming "link workers" to facilitate inter agency liaison and improve understanding of respective roles. For example a member of the Health Visitor team could attend meetings of the CMHT on a regular basis and visa versa. This could also be achieved by promoting shadowing or secondment arrangements between agencies.
194. **The role of psychology in relation to D health needs.** 8.3.1 Views of individual professionals should be shared amongst all clinical staff, and articulated and reviewed at each formal clinical assessment, i.e. ward round, team meeting, etc.
195. **ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.10 For more

effective communication, particularly in fraught and stressful situations, informal discussions with other knowledgeable staff should take place.

- 196.**ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.16 The panel notes that the Caswell unit at Bridgend now has audio-visual communication technology which could be linked to west Wales, which would assist in achieving some of the other recommendations made here and may even act as an interim partial solution to the staffing shortage.
- 197.**Interagency co-operation:** it is recommended that Turning Point, the mental health trust and the PCT work together to jointly agree a care pathway which incorporates the Sanctuary service into the wider mental health services in order to ensure a shared value base between all parties, identify key staff to liaise between provider services and ensure co-ordinated care planning and delivery & that the Sanctuary funding is reviewed to ensure adequate resourcing to meet the significant demands placed upon them.
- 198.**Learning:** The Mental Health Trust should ensure that all the different professional groupings within the MDT commit to meeting together regularly. This will enable the sharing of key information concerning patient care, the resolution of complex problems, the formulation of strategic care plans and contingency arrangements, the processing of new referrals, the sharing of achievements and difficulties & administrative staff to provide documented evidence of cases reviewed and reasons for the decisions made.
- 199.**Forensic & general psychiatry:** General psychiatry teams in every Trust should liaise with a multi-professional forensic specialist service offering ongoing advice and support regarding clinical management, in addition to a basic consultation service. It would be helpful to pair particular forensic and general psychiatric teams.
- 200.Information-sharing between Healthcare professionals, and with other agencies, needs to be reviewed and improved to ensure that vital information is not lost.
- 201.**Communication:** The Mental Health Trust needs to review its mechanisms for communication, to ensure that prescribing practitioners ensure that they clearly record medication regimes and if changes occur, the reasons for it. Ref: Guidance on Good Practice, RPS of Great Britain.
- 202.The new Surrey and Borders Partnership NHS Trust should, as an early priority, ensure that internal communications across the new Trust are reviewed and evaluated and that efficient and effective internal communication processes are put in place, building on the strengths of the systems it inherits.
- 203.A system for quickly flagging and updating risk information on psychiatric patients under community care, and assessed as emergency cases in A&E, should be developed and deployed.
- 204.The Project Board for the formation of the new Surrey and Borders Partnership NHS Trust should flag up the need for a multi agency approach to risk management to reflect the partnership working needed for the delivery of comprehensive, modern services for people with mental health problems.
- 205.The fact that TB changed his name when he came into Lincolnshire (except in relation to GP registration) is indicative of a wider national problem of offenders who change their names and cross geographical boundaries, and this needs to be addressed at national as well as local level.
- 206.**Communication with the RMO:** To ensure that the RMO is informed of any significant changes in circumstances or a patient's condition, an audit should be conducted on at least an annual basis of all patients admitted to hospital over a defined period to record the time of identification of a defined risk threshold and the time senior medical input was requested and delivered.
- 207.**To examine the quality and scope of the assessments made of D health and social care needs from 24th October 2002 to 27th February 2003.** 8.1.1 Patient history taking should

include other sources of information particularly where there are public protection concerns, in order to ensure that an accurate assessment can be gained and appropriate interventions can subsequently be undertaken.

208. TB's Schedule 1 status should not have been lost sight of. It should have been communicated and followed through by all agencies with whom he came into contact and who knew about it, since 1995.
209. That when the care of patients is transferred from forensic services to local secondary care mental health services, a transfer summary should accompany them and be copied to the GP. The summary should detail the outcome of the assessment by the forensic services and include, as a minimum, sections on diagnosis, risk assessment and advice on future management.
210. **Information sharing:** The Trust should conduct a clinical audit of compliance with minimum standards for communication with referrers which ensures they are aware of the disposal of referrals.
211. **Recording & communication issues:** The strategic health authority is recommended to develop a transfer protocol for primary care mental health service users.
212. When discharging patients to the psychiatric care of a GP, the discharge letter should give full information with regard to the future management of the patient, including a review of significant issues of which to be aware, all relevant risk factors that may trigger relapse, steps to take in case of relapse, and advice about review of medication and treatment.
213. **Assessment of patients (discharge summaries):** East London and The City Mental Health NHS Trust must ensure that a patient's GP and any other agency providing care to him is informed promptly of his discharge from inpatient care and is given full details of the contingency and crisis plans formulated for that patient.
214. **i the extent to which D prescribed care plans were effectively drawn up, delivered and complied with by D;** 8.4.4 Discharge information in discharge summaries should be enhanced by a narrative using simple words and language which can be understood by all intended recipients.
215. **Review of discharge summaries:** The Trust should review the way in which discharge summaries are written, both when a patient leaves hospital on S17 leave, and on subsequent discharge from Section. The summary should show the detailed decision as to why discharge became appropriate. It should specify the arrangements for follow up treatment and care, with particular reference to the review of clinical factors which have not been fully defined in the period of assessment and treatment, particularly any factor which may involve risk for the patient or others.
216. **Current CPA policy and procedures should be amended to take into account the following. d. Inpatients:** The use of the phrase 'the transfer of relevant information' from hospital team to community-based staff should be re-evaluated. Consideration should be given to itemising information to be made available where a patient is being discharged from an inpatient setting.
217. It is recommended that all staff receive guidance to encourage and facilitate the gathering of information from carers and significant others, (recognising the confidentiality issues), which should be incorporated into the assessment and care planning process.
218. In accordance with guidance to effective care coordination, carers/ important others should be involved in planning & delivery of care. Where appropriate and with patient consent, carers should be invited to care coordination meetings & reviews. Their involvement should be documented.
219. **iv to examine and comment on the nature of any risk assessment and the management of identified risk presented by D to himself or others;** 8.4.25 Opportunities should be taken by mental health staff to engage with patients' friends and relatives when visiting the ward in order to gain a more complete assessment.

220. **Making a commitment to carers (History taking):** Relevant family history should be investigated comprehensively and form part of each service user's record. Immediate family members should be involved in this information gathering and their contribution identified for appropriate use in treatment and care planning, including risk assessment.
221. **Making a commitment to carers (Prioritisation):** The Trust should give a commitment in public to all service users and carers that they will prioritise partnership working with them, and will make this clearly evident throughout the whole ICPA Policy.
222. **Management of out of area admission - Explaining arrangements to service users and carers:** Where responsibility is shared or unclear the service user and carer should be told who to contact if they have a concern.
223. **Making a commitment to carers (Carers must be involved in care):** Guidance should be issued to all staff that carers and other family members must be involved in care, treatment and risk assessment, and their views established and recorded when CPA plans are made and reviewed.
224. **Making a commitment to carers (Providing public information about services):** The Trust should publish an organisational chart that is kept up to date to ensure that service users and their carers know where different services are located and how they link together. This, the Patient Information Booklet, information about confidentiality, the MHA, the Trust ICPA Policy and other relevant policies should be available to the public on the Trust website in easy to read format as well as in full, with guidance on how to understand them.
225. The questions of when and in what circumstances, information should be released to carers or other third parties, how this should be decided and by whom, should be considered by the mental health services and partner agencies.
226. **Service delivery (record retention):** The Trust should develop and implement a policy for the safe retention of records, including diary and message books.
227. Ensure that all clinicians are familiar with local Trust policy and procedure regarding record keeping and with documents relating to their own profession e.g. Clinical Psychology and Case Notes: Guidance on Good Practice (Division of Clinical Psychology, British Psychological Society, 2000). Supervision records should be kept and discussions recorded. There should be entries made in the clinical notes when clients have been discussed in supervision.
228. The inquiry panel recommends that the commissioners of primary care services utilise appropriate clinical governance arrangements to promote detailed record keeping in general practice so as to facilitate continuity of patient care.
229. We recommend that concerted action be taken to improve the quality of record keeping by means of review of all policies and procedures and staff training and audit of activity.
230. **Nursing records:** Nursing care plans and records should be a key reference document for the team.
231. Where there may be subsequent need for psychiatric support, it is important that an accurate forensic history is recorded which does not colour the judgement of those involved in the care of the patient. It is recommended that CK's clinical case records are corrected with reference to the forensic history.
232. **Assessment of patients (diagnostic discipline):** There should be a clear record in a patient's medical notes of the diagnosis for that patient once it has been made, and the reasons why that particular diagnosis has been reached for that patient. That diagnosis should inform the treatment plan for the patient.
233. **Clinical records:** A designated audit tool should be developed to support the peer review of clinical records (does the care plan reflect the needs of the patient & set out clearly the intended management plan, is there a clearly documented risk containment & contingency plan, do the progress records contain a clear & accurate description of the care coordinators assessment of the service users mental health state).

234. **Record keeping:** The Trust should formally adopt the standards for record keeping required by the relevant national standards for the disciplines working at the AOT. Monitoring standards of record keeping and compliance with nationally recommended standards should form part of the clinical audit programme of the Trust.
235. **Record Keeping:** All staff are reminded that Trust policies on record keeping are to be complied with. It is also important that staff adhere to Professional Standards for records and record keeping.
236. **Written record of the tribunal's decisions:** We recommend that the regional chairmen remind presidents and tribunal staff of this requirement.
237. **Using records effectively (Good practice in record-keeping):** The Trust and social services should ensure through suitable training, monitoring, management and audit processes, that practitioners consistently maintain accurate and relevant records which fulfil standards of good practice under CPA.
238. **Management of out of area admission - Location of healthcare records:** The ICPA Policy should make it clear where the healthcare records must be located.
239. **Ensuring a functioning Trustwide CPA register:** The Trust should make it clear who is responsible for entering information onto MHIS and provide any necessary training.
240. **Ensuring a functioning Trustwide CPA register:** The Trust should establish the MHIS information as the basis of the Trust CPA register, which should satisfy the Department of Health requirement for central records on all those in contact with services as described at paragraph 6.2.7 of this report.
241. **Assessing nursing and social work skills and record keeping:** The Trust should audit its nursing records and managers should monitor audit findings as part of their regular performance management process.
242. **Assessing nursing and social work skills and record keeping:** Social work records should be similarly audited by social services staff.
243. **Using records effectively (Healthcare records should follow the patient):** Wherever and whenever a service user is seen within the Trust the full healthcare record should be made available to the psychiatrist responsible for their care and treatment as soon as possible and at least within five working days.
244. **Service delivery (information sharing):** When a patient is known to have received services from another mental health provider, the previous clinical records should be obtained to enable as full a picture to inform clinical care and decision making. This should be monitored through clinical audit.
245. Ensure that all telephone calls requesting help should be noted and professionals made aware of clients asking to see them. The decision as to whether someone needs to be re-referred should be made on an individual basis by clinicians who know them and are aware of the risks. It is possible that if either clinician had been aware of his telephone call they would have fast-tracked an appointment.
246. When meetings are convened in schools, it is important to identify and record all attendees.
247. Implement a unified system of clinical records and undertake an audit of the quality of clinicians record keeping.
248. Ensure that in its development of integrated multi-disciplinary teams clinicians work with a shared clinical record.
249. Review the use of the electronic record. EPEX should be used to communicate between professionals rather than simply be used to collect activity data. The Trust should provide training for all staff in the use of EPEX.

250. **Communication between & within teams:** The inquiry panel understands that the Trust, together with its partner agencies, is reviewing and developing an electronic data system, which can be used by the multi-disciplinary team. It is further recommended that the Trust: • Reviews the implementation of integrated records to ensure that the transition to this new system is in place as soon as possible. • Take into consideration duty rotas when allocating a team of professionals to one individual patient/client.
251. **CMHT:** There should be a single record of service contact that covers both community and hospital care.
252. **Communication, transferring & sharing information between & within teams:** The inquiry panel recommends that the trust scrutinises its existing systems for storing, transferring and sharing information. Inpatient settings should have a person responsible for ensuring that information contained in patient case files is presented to the wards decision making forum. Notes from all disciplines should be held in the same file and scrutinised for presentation in this way and the introduction of eCPA should be seen as an opportunity for clear & definite records of information, decisions and care planning.
253. Trust should move toward creating integrated medical & nursing records. They should also review whether use of new care coordination documentation in tandem with the tidal model nursing assessment does not duplicate documentation and whether documentation can be further rationalised.
254. **i the extent to which D prescribed care plans were effectively drawn up, delivered and complied with by D;** 8.4.3 The current system for integrating records should be reviewed with the objective of taking into account the rural nature of the service. Computerised patients notes with desk top machines at strategic points could prove particularly useful in addressing some of the technical problems in rural areas. If notes were updated locally, soon after each intervention, then all team members would be appraised of what was happening to patients at any given time. Other key staff, such as GP's, could also be given access to patients' notes via a password.
255. **Communication:** The Mental Health Trust needs to review its mechanisms for communication, to ensure that practitioners involved in the provision of care and treatment have access to, and make use of, a unified and integrated health and social care recordkeeping system. This could be ePEX or any other system adopted in the future, which ensures that contemporaneous information on which to base sound clinical decisions is consistently available.
256. **Communication:** The Mental Health Trust needs to review its mechanisms for communication, to ensure that the record is created and controlled by the practitioners involved, regardless of who enters the information onto the system.
257. **Communication:** The Mental Health Trust needs to review its mechanisms for communication, to ensure that irrespective of how multi-disciplinary (and multi-agency) teams are structured and located, mechanisms are in place to ensure that all practitioners can utilise the above system.
258. **Using records effectively (Integrating records):** Separate systems of medical, nursing and other records are discontinued, so that patient healthcare records are fully integrated.
259. **Ensuring a functioning Trustwide CPA register:** The Trust should ensure the MHIS central electronic repository is readily accessible wherever the Trust provides care other than in domiciliary settings.
260. **Ensuring a functioning Trustwide CPA register:** The Trust should prepare for a link between the CPA register and national computerisation of health care records.
261. **Ensuring co-ordinated planning of CPA services and records (The SHA should ensure that all PCTs commissioning services from the Trust ensure operational systems are shared):** In conjunction with local Social Services require that all treatment and care plans, including those shared with primary health care providers, are based on the same operational principles and systems, particularly with regard to electronic records and documentation, so that the risks of losing essential information and divergent actions are minimised.

262. **Electronic information systems for mental health services:** The DOH should ensure that the final specifications of the National Care Records System pay adequate attention to the requirements of mental health services and in particular that they support CPA.

## **Staff Work Practice / Policy**

263. **Clinical practice & culture:** The Trust should ensure that there is an increased amount of consultant time spent within the community mental health teams, the assertive outreach team, home treatment team and other community teams. This should include; implementing the proposals for consultant time spent in community teams proposed by the Medical Director in “The Review of Teams in Adult Mental Health Services in Newham, Tower Hamlets and City and Hackney”; once those proposals have been implemented, further increasing consultant time spent within the community teams with a view to doctors moving their offices from the hospitals and into community mental health team premises; holding medical outpatient clinics on community mental health team premises.
264. **Service management:** It is our recommendation that Primary Nursing is fully established, and appropriate documentation used.
265. **Service management:** It is our recommendation that the process for nursing handover be reviewed to provide a more systematic approach to individualised patient care, which will ensure that the nursing staff are able to fulfil their role within the multi-disciplinary team.
266. **Training & development:** It is our recommendation that the nursing strategy should be brought up –to date in light of the particular needs of mental health nursing and their policies and procedures, and taking account of changes in Nursing Practice.
267. Trust should review the way the tidal model nursing assessment & the primary and allocated nurse system operate. The panel believes that the tidal model has many strengths, but the process can become mechanistic & clinically ineffective if it does not produce a clear care plan which should involve a more pro-active approach for those who are less likely to engage with services.
268. **Management of out of area admission - Maintaining inpatient care standards:** Trust good practice guidance should stress the importance of maintaining nursing standards when a patient is cared for out of area. This should be reviewed through regular clinical audit.
269. That, as certain of the Trust's officers whom we met told us that staff working in one part of the Trust's area, for example Chelmsford, did not know about the practices applying in another part of the area, such as Colchester, the Trust should ensure that, wherever possible, its working practices are unified throughout the whole of its area and are known to and understood by all staff, as unified practices greatly facilitate the delivery of services to the clients of the Trust.
270. **CMHT:** In some instances, the decision not to see a patient at home may be justifiable, but this decision needs to be based on careful and documented consideration, and regularly reviewed as part of his care plan. The threshold for avoiding all home visits should be high, because in many instances, seeing the home (and the individual in his/her home setting) can give valuable clues regarding the person's functioning and mental state.
271. **CPA:** Regular clinical audits of the work of CMHTs should include their effectiveness with regard to child protection and welfare.
272. **Forensic & general psychiatry:** Complex reports involving consultation about, or specialist assessment of, patients should be prepared according to a timescale agreed in advance. Failure to meet a deadline should always require those preparing the report to contact the person who commissioned it to discuss the delay and agree a revised deadline.
273. Consideration should be given to the appointment of a Community Resources Development Officer for NE Hampshire and NW Surrey or a number of locality based community development posts.

274. **The Clinical and Practice Review Action Plan.** Given our comments about the sufficiency and relevance of this plan, we recommend that the plan is jointly reviewed and updated in the light of our analysis and these recommendations.
275. **Failure to inform the HO of the admission to hospital in April 2002:** That Cardiff and Vale NHS Trust and Cardiff Council review their policies and procedures for both medical and social supervisors to ensure clarity and compliance with reporting requirements.
276. **Handover:** The Trust should establish clear protocols for the handover from one clinician to another.
277. The Trust should examine all policies and procedures to ensure that they are up to date. Reviews of policies and procedures that are overdue or necessary should be completed as soon as possible. A system should be put in place to ensure that an up-to-date portfolio of the Trust's policies and procedures is readily accessible for all services, wards and teams and that it is regularly updated. Consideration should be given to a standardised format for all policies and procedures whether Trust wide or local with a standardised front sheet providing information on policy number, author, date of publication and review date.
278. It is recommended that all policies are dated when introduced and that the date for review is included on the document. When policies are withdrawn the date of withdrawal should be stated and a copy should be retained.
279. **Multidisciplinary working:** A policy for multi-disciplinary working should be developed and all staff should comply with it. The policy should require that, amongst other things: i. the roles of the multi-disciplinary team members are defined. ii. records of attendance at ward rounds and discharge planning meetings are kept; iii. key discussion points and any disagreements about care and treatment decisions are accurately recorded.
280. **CMHT:** When more than one member of a family is involved with services, the role of the care coordinators should be clarified and agreed.
281. **CMHT:** The role of the trust grade psychiatrist in the care team should be defined.
282. **iii to examine the adequacy of collaboration and communication between agencies involved in the care of D, the provision of service to him and between the statutory agencies involved;** 8.4.21 Carmarthenshire Local Health Board and Pembrokeshire & Derwen NHS Trust to have clear protocols and guidelines in place for access to general medical services out of hours.
283. The west continuing needs services has commenced work to agree a draft protocol/ pathway for managing clinical disputes but the status of this project needs to be elevated so that it is adopted as an adult services wide project with defined timescales & deliverables that are monitored by the trust or service governance committee.
284. The operational policy for the CNS service needs to be updated so that it becomes a valuable & practical document for staff.
285. **Professional Conduct:** It is essential that all staff understand and accept that all elements of an agreed care plan should be adhered to unless changed following review. If, as in this case, it had been agreed that no single team member should visit Richard King on their own, then all team members should comply with this. The elements of poor practice set out in Section 5.0.6 should be the subject of discussion, evaluation and practice advice by the Training & Appointments Board for Approved Social Workers and the Service Improvement Board.
286. **Clinical practice & culture:** The Trust should undertake a full investigation into Doctor F's work within the Trust and review his position. The investigation should encompass his clinical practice & whether and, if so, the extent to which his practice in relation to M is symptomatic of his practice more generally.
287. **Service management:** Disciplinary action should be considered in appropriate cases.

## Failure to Attend Appointments

288. **Service delivery (do not attend for services):** The Trust should review methods of reducing DNA rates of both new and follow up patients.
289. **Initial referral to mental health services:** It is recommended that the Trust develop a Policy on Managing DNA or Cancelled Appointments as detailed on the internal review's recommendation to ensure that there is an effective follow up of people who do not attend for appointments. It is further recommended that once the Policy is implemented that its operation and effectiveness is audited.
290. The inquiry panel recommends that mental health services in Sunderland develop a strategy which recognises the need to engage those individuals who are reluctant to access services. Within such a strategy, policies and procedures should be put in place, which allow the identification of those unwilling to work with services and the utilisation of more flexible approaches to encourage engagement. In this context it is particularly important that the process of managing those patients who fail to respond to offers of appointments should be reviewed.
291. It is recommended that the Trust audit the operation and effectiveness of the policy on Managing DNA or Cancelled Appointments implemented in the Autumn 2005. This is to ensure that there is an effective follow up of people who do not attend for appointments.
292. Review & management of service users on enhanced CPA who do not attend their outpatient appointments. The accountability and responsibility for identifying those DNA service users for discussion at the next team allocation and review meeting is clarified and made explicit within the respective operational policies. The notes for those service users brought for discussion are available where possible at the team allocation and review meeting so that decisions made can be recorded directly into the case notes. There is a designated agenda item for the discussion of DNAs that is either separate to, or a distinctly identifiable component of, discussions around 'cases of concern'.
293. **Communication:** The Mental Health Trust needs to review its mechanisms for communication, to ensure that where non-attendance (DNA) occurs, it is brought to the attention of the care co-ordinator, who will risk assess the relevance and develop a carefully thought through strategy to address this, with colleagues if necessary and preferably in discussion and agreement with the individual concerned.
294. **Home visits following missed appointments:** The Trust should ensure that its ICPA Policy, its Outpatient Non-Attendance and Failure of Patients to Keep to Home Visit Arrangements Policy, and its home visiting protocols for CPN's and ASW's, together state in clear terms that there must be a CPA review and risk assessment, urgently undertaken if necessary, before a home visit is made to a patient who has missed appointments, not been assessed for some time and whose mental state is unknown.

## Assessments & Reviews

295. Provide the necessary arrangements that will enable people to be assessed in their own homes and the community, including out-of-hours, if necessary, without there having to be a formal Mental Health Act (1983) Assessment process.
296. Increase the flexibility of out-of-hours Mental Health Act Assessment procedures. This should enable better continuity, so that cases can be assessed routinely during the evening or at weekends if they begin during the working day, without recourse to 'emergency systems'.
297. It is recommended that all Approved Section 12 doctors liable to make recommendations within the Trust's catchment area are written to and reminded of the requirement to complete a written record of an assessment under the Mental Health Act 1983, and that this correspondence is also sent to the Local Medical Committee and Primary Care Trust.
298. That the Trust should review the procedure for arranging assessments under, and for the purposes of, the Mental Health Act 1983 ("MHA assessments"), to ensure both that the

process is as efficient as it reasonably can be and that it is clearly understood and applied by all officers involved in arranging MHA assessments.

299. That the Trust should review its procedures for the transmission of a patient's previous history and supporting documentation to an approved doctor and social worker making an MHA assessment, in order to ensure that the doctor and social worker have before them all the information that they may need to carry out their statutory tasks properly, and should ensure that those procedures are fully understood and implemented by all officers concerned. Where, as in this case, the patient is already receiving in-patient treatment in a surgical or medical ward, those procedures need to take account of the fact that the records from that ward may be of assistance to the officers carrying out an assessment.
300. Approach the Local Authority with a view to conducting a detailed review of the ASW service to ensure effective operation, compliance with the MHA Code of Practice, and that there are opportunities to learn lessons from case reviews.
301. The social services department should ensure that social workers are reminded of the need to ensure a detailed history which includes previous contact with social services. This is particularly important where a patient may be new to the Lancashire services.
302. **Childhood & adolescence:** It is recommended that previous contacts with other services are included in assessments undertaken by the adult services, taking into account full background information about the person's previous psychiatric history and social circumstances.
303. **Assessment of patients (joint assessments):** East London and The City Mental Health NHS Trust should develop, and adhere to, clear policies on joint assessments for patients which are aimed at achieving effective discharge planning including contingency and crisis planning and a designated care co-ordinator. Those policies should seek to ensure that all agencies or services involved in a patient's care and treatment participate in the joint assessments and are fully aware of the outcome of the assessments.
304. SCT must establish base line information essential to the effective assessment of service users detained under the MHA. In identifying this SCT must ensure that its practice is commensurate with any relevant national guidance/ good practice standards. As a minimum the team recommends that the Directorate for acute, community & primary care MHS undertakes a case note audit of a percentage of service users who have been detained under the MHA to ascertain how many of these have a clearly documented diagnosis at the end of their period of compulsory admission, how many had a clearly defined & documented management plan & the frequency with which service users present significant challenges to containment for inpatient staff and where no referral is made to intensive support services.
305. Where CPN's attend a service user in the community following discharge from hospital they should be empowered with the full clinical history in order to further establish an accurate assessment of their mental health.
306. Where patients have been receiving long term care from a multi disciplinary team, and where there has been little apparent change in the condition of the patient, the team should consider whether there would be benefit in a periodic independent review in order to avoid complacency or a purely reactive approach becoming established.
307. Patients who are being treated in the community should receive regular reviews in psychiatric outpatients (which in the case of well stabilised patients could be limited to three or four appointments per year). Contact in the context of CPA reviews or other larger meetings is no substitute for a psychiatric outpatient appointment.
308. Review and ensure that the arrangements for carer assessments are effective.
309. **Carers:** It is recommended that the following is taken into account and audited by the Trust: -
- The assessment process must include information gained from carers without compromising the individual's right to confidentiality.
  - That carers are offered a Carers Assessment and that their support needs are recognised.
  - That the services should establish better links with the Carers organisations in Buckinghamshire.

310. **Carers assessments.** We pointed out on a number of occasions throughout this report that L was entitled to receive a carer's assessment. We were told that these assessments are now being regularly undertaken. We suggest that the effectiveness of the carers' assessments be audited. In particular we question whether primary health care practitioners are aware that some of their patients may be entitled to such an assessment, and we suggest therefore that an audit may help to publicise the benefits of these assessments to this group.
311. **Boundaries:** The Mental Health Trust must ensure that wherever carers are actively involved, their statutory rights to a separate assessment of needs should be respected and met.
312. **Making a commitment to carers (Carers and communicators):** Carers should be told that they have formal status as 'carers' and that they are entitled to a Carers Assessment of their Needs. The identity of carers should be recorded on ICPA documentation and there should be agreement over who will this person may not always be the main carer. Where carers are relied upon to observe the patient, describe behaviour or symptoms and express opinions upon risk, they should be provided with written contact details and all the necessary information about diagnosis and medication so that they are able to undertake this task, and it should be recorded that this has been done. Carers should be supported in their own right.
313. Barnet, Enfield and Haringey, and East London and The City NHS Mental Health Trusts, should review the implementation of CPA policy to ensure compliance with current guidance relating to the needs of carers.
314. **Family support:** It is our recommendation that the Trust should ensure that all carers are positively involved in the CPA process, and should discuss their needs and how they relate to the task of caring for the patient. A care worker should be appointed to assess the carer's needs for ongoing support and respite care, if and when necessary, and to enable carers to become positively engaged in the CPA process in line with the NSF for mental health, standard 6. Carers should have their own Care Plan, including names of key professionals and how to contact them. A handbook describing the CPA process and all available services should be written and distributed to all new clients' families/carers of people in touch with mental health services.

## Referrals

315. **Initial referral to mental health services:** In line with good practice a timescale of response to referrals should be agreed between primary and secondary care and the referring agency should develop a system for tracking when referrals are made and the response received.
316. Pathways of care should be free from unnecessary obstruction. The referral of cases to consultant psychiatric staff should not be unduly restricted, particularly for those patients already in contact with mental health professionals. The inquiry panel recommends that mental health services put in place protocols which allow the direct referral of cases from non medical mental health professionals to senior medical staff. Furthermore, there should be a more direct route of referral available, for appropriate cases, from primary care to the community mental health service.
317. The inquiry panel recommends that clearly defined processes for the referral of urgent cases to mental health services should be developed with the participation of primary care and secondary acute health services. Health services in Sunderland should determine and agree appropriate standards of information required for the referral of urgent cases. This should include jointly agreed criteria for assessing risk and clinical urgency, upon which mental health services can then appropriately prioritise resources.
318. Review the rationale for asking people to go back to their GP in order to be re-referred. Where the development of a trusting relationship is seen as a vital protective factor, there should be a more direct route back for certain people.
319. Individuals with mental health needs commonly attend acute hospital services, particularly accident and emergency departments. The inquiry panel recommends that effective arrangements should be in place to enable ready access to mental health professionals in these circumstances. This would facilitate not only appropriate referral of cases to mental health

services, but also more effective communication of any concerns identified in the course of such contacts.

320. A liaison psychiatric referral policy or care pathway for use by A&E medical staff should be developed.
321. The RCA team recommends that the Trust conducts a review of its referral process to assess whether the 'opt in' system is the most appropriate arrangement for both new and existing service user populations. It should consider whether non-attendance is an appropriate indicator for 'case closure' or whether a more proactive contact is required before it is agreed that this should occur.
322. **The role of psychology in relation to D health needs.** 8.3.2 Formal protocols to be followed for referrals for social assessments when significant social issues are raised.
323. **Inter-Service Referrals:** The discussion currently taking place between the Norfolk & Waveney Mental Health and the Learning Disabilities service about the protocols for referrals between services should be brought to a conclusion and monitored by the Service Improvement Board.
324. **The role of psychology in relation to D health needs.** 8.3.3 Arrangements for accessing forensic psychiatry assessments/opinions in a timely manner, to be in place.
325. The Trust should consider the delivery of a more responsive CAMH Service to patient's such as DC. The RCA team recommends that a review is conducted by the Trust of the demands and resources within CAMHS to ensure they are meeting the requirements of service users and other clinicians. In particular, the review should consider how and on what basis referrals are prioritised. A care pathway should be identified as appropriate to facilitate a young person's entry into contact with specialist services such as CAMHS. The findings of the review should be reported to the Trust Board together with a plan to address any issues identified as requiring action. The findings should also be fed into the clinical audit process to ensure regular monitoring occurs.

## Discharge

326. **Discharge from hospital:** It is recommended that where patients are discharged to unfurnished accommodation staff support clients to obtain adequate furniture and domestic equipment.
327. **Discharge:** The frequency of follow up appointments for recently discharged patients should be prescribed.
328. **Discharge:** Discharge care plans should be prepared by the multi-disciplinary care team, and should take into account all care history and contact with the service.
329. **Discharge:** More frequent use should be made of s.25 when high risk patients who have enduring mental illness are discharged.
330. **Housing:** Contact with the Housing Department should be with a named individual whose post (a) gives him/her the responsibility to be the key contact within Housing, and (b) is at a sufficiently senior level to allow him/her to represent all elements of the Housing Department in liaising with Mental Health Services.
331. **Housing:** As with risk assessment, all information relevant to decisions about a patient's placement needs to be shared in a timely manner between all those involved with the patient.
332. **Housing:** Good practice would indicate that discharge planning (including housing) should begin at admission.
333. **MHA:** While hospital managers retain the power to discharge patients from detention, they should have access to legal advice on the conduct of hearings and the formulation of reasons for their decisions.

334. The decision to discharge a patient should be informed through a multi-disciplinary process, with the ultimate responsibility lying with senior medical staff. These decisions should be clearly documented. They must be based on up to date risk assessments. The discharge notification procedure should be changed so that the CMHT & the ward have a copy of the full form and can see the diagnosis & comments section.
335. **In terms of Supervision and Placement the RCA team recommends:** - That Bro Morgannwg NHS Trust and Cardiff and Vale NHS Trust give careful consideration to whether patients conditionally discharged into the community can be adequately managed in fulltime independent living or whether they should remain in supervised hostel accommodation. This is particularly the case where the required relapse indicators and missing person rules may be practically difficult to apply in the situation of fully independent living.
336. **In terms of Supervision and Placement the RCA team recommends:** - Where patients are suitable for transfer to independent living, both Trusts should give careful consideration to determining how long those should remain in supervised settings before transfer and what continued day care facilities may be required as part of their aftercare.
337. **In terms of Supervision and Placement the RCA team recommends:** - That Social Services Departments ensure adequate and appropriately staffed 24 hour supervised hostel accommodation is made available.
338. **In terms of Supervision and Placement the RCA team recommends:** - That where 24 hour supervised care is specified in the conditions of discharge and cannot be met, the matter should be brought to the attention of Local Health Boards/ Health Commission Wales to ensure this requirement is properly applied.
339. **In terms of Supervision and Placement the RCA team recommends:** - That where patients need to be discharged into 24 hour supervised hostel accommodation, the length of time in supervised care is specified by MHRTs in the conditions of discharge and the discharge plan in advance.
340. **In terms of Supervision and Placement the RCA team recommends:** - That Local Health Boards and Health Commission Wales be made responsible to monitor compliance with the conditions specified for discharge.
341. **Failure to inform the HO of the admission to hospital in April 2002:** That all NHS Trusts and Social Services Departments ensure that a clear action plan for any problems occurring during the period of supervised care should be specified in advance and that all staff are fully conversant with it.
342. **Failure to apply the agreed 12 hour missing rule as required by the care plan by the CMHT:** That Cardiff and Vale NHS Trust and Cardiff Social Services Department ensure that clear care and social services plans exist for all patients currently conditionally discharged and under supervision. In addition, all staff should be familiar with the contents and conditions identified within the clinical notes prior to communicating or taking any action relating to patients or relatives making contact to discuss clinical problems.
343. **Role of the MHRT:** That Local Health Boards (prior to the amendment of any legislation) undertake an independent monitoring role to ensure compliance with the imposed conditions of discharge and ensure that a duty of care is met to the patient and the public.
344. **Role of the MHRT:** That MHRTs (prior to any Legislative amendment) exercise their powers to ensure that problems are addressed at an early date when they are made aware that they exist, or may occur.
345. **Role of the HO. The RCA team identified that the Home Office has a substantial role to play in such management processes and would emphasise the following:** That Medical Supervisors have a statutory responsibility (Mental Health Act, Section 41 (6)) to comply with Home Office Mental Health Unit reporting requirements. Reports submitted should be comprehensive, timely and identify any issues of concern.

346. **Role of the HO. The RCA team identified that the Home Office has a substantial role to play in such management processes and would emphasise the following:** That the Home Secretary is responsible for the management of conditionally discharged patients within the community. Supervising psychiatrists and social supervisors should fully cooperate with the Mental Health Unit of the Home Office in order to ensure that any risks are minimised as far as possible.
347. **The tribunal's written reasons:** We recommend that the Home Office should scrutinise the reasons in every case where a restricted patient is discharged. In those cases where they are considered inadequate but it is decided not to apply for judicial review, the Home Office should make representations to the regional chairman of the tribunal about the quality of the written reasons.
348. **The Home Secretary's role in the proceedings:** Where, as in this case, the Home Secretary is strongly opposed to a discharge which is supported by the multi-disciplinary team responsible for the patient, we recommend that consideration should always be given to the Home secretary being represented.
349. **HO oversight of tribunal conditions:** We recommend a change to the reporting format to require that the conditions imposed by a tribunal on discharging the patient, and their implementation, be included in all reports on conditionally discharged patients.
350. **Re-admission of conditionally discharged patients:** We recommend that the Home Office should consider whether further guidance is needed on the law and procedure relating to the readmission of conditionally discharged patients to hospital.
351. **Re-admission of conditionally discharged patients:** We recommend that whenever the Home Office becomes aware of an admission of a conditionally discharged patient which was not reported by the psychiatric supervisor a letter be sent to the psychiatric supervisor requesting an explanation of the circumstances.
352. **The thoroughness of the hearing:** We recommend that JB case, even if it is not representative, should be reviewed by the Department for Constitutional Affairs with a view to improving tribunal procedures in restricted cases.
353. **The Home Secretary's role in the proceedings:** We recommend that the Home Office, in consultation with the tribunal, reviews the format of statements it prepares in restricted cases.
354. **Reporting on restricted patients:** We recommend that the Home Office should insist that annual statutory reports are signed, or countersigned, by the RMO.
355. **Reporting format:** We recommend that the Home Office's standard reporting format should be mandatory for both psychiatric and social supervisors.
356. **Role of the HO. The RCA team identified that the Home Office has a substantial role to play in such management processes and would emphasise the following:** It is further recommended that the Home Office Mental Health Unit should require all NHS Trusts to review relapse indicators presently in use with conditionally discharged patients, to assess their ease of interpretation in terms of clinical actions and their applicability in the environmental setting.
357. **Consideration should be given at policy level in Government to two alternative issues.** First, whether patients who have committed a very serious offence and who have received restriction orders under the provisions of S.41 of the Mental Health Act 1983 should remain under supervision for the rest of their lives. Second, if such patients are to be absolutely discharged, whether this should be undertaken only by a Mental Health Review Tribunal rather than by administrative action taken by the Home Secretary, as a tribunal would have the benefit of its own more independent assessment compared with what is available to the Home Secretary, who is dependent on information obtained almost wholly from the team caring for the patient.
358. **The Home Office and Department of Health should jointly commission research into the effects of an absolute discharge on compliance with supervising teams, rates of recidivism and relapse.**

### **3. Service Management & Support**

359. That the strategic health authority should require the trust to establish a service improvement team, with appropriate external representation, to bring about a fundamental change of attitude in the Sunderland area, to modernise mental health services in line with the eleven principles for reform contained in the mental health national service framework and to ensure that there is commitment to such reform at all levels. The actions of this team and the responses of professionals to it will need to be monitored in such a way as to assure the trust board and SHA that effective action has been taken.
360. The inquiry panel recommends that service development in mental health should be supported and robustly monitored to ensure progress in line with national priorities. In particular alternative models which may aid the treatment of patients such as C, including crisis intervention, early intervention in psychosis and assertive outreach teams should be prioritised and the efficacy of their development closely monitored. This is a joint responsibility between mental health service providers and the commissioners of services.
361. Notwithstanding the Trust reconfiguration, the new Surrey and Borders Partnership NHS Trust should continue to regard the replacement of Acorn accommodation at Frith Cottage as a very high priority.
362. **Urgent need for ‘early intervention in psychosis’ services:** The Trust, jointly with its commissioning colleagues, should make a public statement on the progress being made towards the establishment of Early Intervention Services throughout the Trust area. Development of these services should now be considered urgent. It should be based on the highest national standards set for such services since 1999: The service should be publicised, its ethos should be that early intervention in psychosis is of such potential benefit to service users and carers that they must be entitled to early assessment, treatment, care and information, acceptance criteria should be broad, with diagnostic uncertainty being acceptable, indeed desirable until full assessment has taken place, recognising that some individuals will not go on to develop psychosis & the Trust must provide sufficient specialist staff trained in ‘first episode of psychosis’ approaches and ‘family interventions in psychosis’ to ensure that: • service users with possible signs of an emerging psychosis are fully assessed and monitored, • service users with a first episode of psychosis are followed up, • assessment always includes a family history • families are routinely involved in the planning of treatment and care • information about psychosis, advocacy services and carer support is provided to families.
363. **In terms of Supervision and Placement the RCA team recommends:** - That Health Commission Wales reviews its requirement in terms of medium secure provision and identifies any bed shortages that may exist.
364. It is essential that the re-provision of the PICU on the Springfield Hospital site is commissioned and completed as soon as possible.
365. The Trust should produce a cohesive organisational development plan to clarify and share its vision for developing the organisation, building on the range of initiatives already underway. An executive director of the Trust should be given responsibility for this.
366. **SW London & St George’s MH NHS trust:** We recommend that a service improvement team, taking a national perspective, work with the Trust and the Forensic Service to turn around the performance of the Service, to identify failings and put in place systems and processes that are robust and effective with regular monitoring to ensure safe and effective patient care.
367. The inquiry panel recommends that a mentally disordered offender strategy is developed within Sunderland which both fosters inter-agency working and supports the provision of mental health services for mentally disordered offenders. There is an urgent need to provide a service which allows access to those within the criminal justice system who may have mental health needs, outwith the traditional referral pathways. This service should include both a liaison service to the courts and the probation service and a model of health care delivery to offenders in the community.
368. Prior to the finalisation the Forensic Liaison Service’s Revised Operational Policy (2005) the PCT facilitates an objective assessment of how the current model for the provision of the FLS

is working and its terms of reference. Such as assessment should include an assessment of the capacity of the FLS against the demands currently placed upon it.

369. **ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.9 Mid & West Wales should develop a low secure forensic psychiatry and forensic community service. A new post in forensic psychiatry dedicated to West Wales and linked to Bridgend for peer support should be considered.
370. **Management of out of area admission - Prevention:** In line with National Service Framework guidance, the Trust should work in partnership with Commissioners to ensure that the capacity of local mental health services is sufficient to minimise the risk of individuals being admitted to inpatient care away from the usual inpatient unit for the area.
371. The Blackwater Valley and Hart PCT, Guildford and Waverley PCT and Surrey Heath and Woking PCT should open discussions, as soon as possible, with the Surrey and Hampshire County Councils' Social Services Departments to explore and reach agreement on the future arrangements for commissioning mental health and social care services in the NE Hampshire and NW Surrey area. Such arrangements should essentially continue to recognise the needs of locality populations and the diversity of provision required to meet those local needs. They should also recognise the need for a consistent overview of the mental health and social care needs of the whole population of the catchment area and how those needs should be met in the future. Commissioning arrangements should continue to build on the success of the LIT in engaging a wide range of views and expertise in the service planning process.
372. In the meantime the existing commissioners should continue to work with the SHB Trust and the new Surrey and Borders Partnership NHS Trust and other health and social care providers, to produce a strategy for the development of a wider range of community resources to supplement and support mental health services in the area.
373. We recommend that the Trust clearly demonstrates that the role of commissioning is separated from that of providing services.
374. **Resources:** Commissioners have to ensure that mental health service investment is grounded in an evidence-based strategy which ensures the provision is adequate to meet the assessed health and social care needs of a population.
375. **Resources:** Commissioners have to ensure that mental health service investment is grounded in an evidence-based strategy which enables the resident population to access contemporary services in a timely manner, not influenced by geographical location.
376. The SHB Trust and/or its successor should work to ensure a more consistent degree of service user and carer engagement across the Trust. This should be achieved while allowing scope for local initiative and identifying opportunities for learning lessons across services from what works well and what does not.
377. The PCT's, Social Services Departments and the SHB Trust and /or its successor should develop a strategic framework aimed at facilitating improvement in the engagement of service users and carers in the service planning and commissioning processes. This should be linked to work on exploring and agreeing future commissioning arrangements for NE Hampshire and NW Surrey.
378. **In terms of Supervision and Placement the RCA team recommends:** - That NHS Trusts always formally bring difficulties in obtaining appropriate aftercare facilities to the attention of their commissioning authorities.
379. The Trust should continue its work developing and implementing its business-planning process.
380. We recommend that the PCT, through the Local Implementation Team (LIT), should ensure the provision of an inpatient and community mental health advocate service, which is able to represent service users where appropriate at care and treatment forums in the service.
381. Review the effectiveness of PALS, complaints processes and access to advocacy services.

- 382.**Making a commitment to carers (Supporting advocacy services):** The Trust should consider how it might support advocacy services across the Trust, reporting on the options available.
- 383.Ensure that there are effective performance management arrangements in place for service managers and clinical teams.
- 384.**Skills sharing:** The Trust should ensure that all newly appointed managers are provided with sufficient support and training.
- 385.The Trust Board need to satisfy themselves that all doctors in consultant positions are aware of and have clear lines of clinical and managerial responsibility and accountability.
- 386.**Clinical practice & culture:** The Trust Board must immediately ensure the effectiveness of clinical and managerial leadership of the Tower Hamlets area, including putting in place appropriate remedies.
- 387.**Service management:** The trust and the local authority should agree a single line management structure that reflects the needs of the care groups for whom they are responsible, and provides clear lines of managerial responsibility and accountability.
- 388.**ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.6 A review of the working of the community mental health team should be undertaken to examine qualifications and leadership.
- 389.**ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.8 A review of the capacity of local senior management to provide support and leadership for the mental health service teams.
- 390.**Leadership:** To secure improved performance, it is recommended that the managers of the service ensure that plans and clear service standards are developed and implemented in the following areas that match the overall strategic direction of the Trust (Supervision, Care Programme Approach, Clinical governance, Staff Development, Cross team working & Case review).
- 391.**Performance management:** During the period under review, management of mental health services in this locality was in transition. From the evidence before us, despite the best efforts of practitioners and managers the performance management framework both within and between agencies appeared to lack coherence. We recommend that The Strategic Health Authority, County Council and other relevant health bodies satisfy themselves that arrangements for performance management now in place meet the requirements of statute and best practice.
- 392.The Trust should ensure that the corporate framework within which devolved management and clinical leadership can thrive is developed to allow for local variations to meet local needs but within agreed parameters.
- 393.**Leadership:** The Mental Health Trust has to ensure, as a matter of urgency, that clear and unambiguous clinical and managerial leadership is demonstrated at all levels of the organisation, so that practitioners have access to consistent support mechanisms such as clinical and managerial supervision, mentorship, appraisal and appropriate learning and development opportunities.
- 394.**Leadership:** The Mental Health Trust has to ensure, as a matter of urgency, that clear and unambiguous clinical and managerial leadership is demonstrated at all levels of the organisation, so that multi-disciplinary teams are encouraged to consider a range of evidence driven treatment and care intervention options.
- 395.**Leadership:** The Mental Health Trust has to ensure, as a matter of urgency, that clear and unambiguous clinical and managerial leadership is demonstrated at all levels of the

organisation, so that practitioners and multi-disciplinary teams are required consistently to follow policies and processes for high quality evidence-driven interventions.

396. **Completing integration of health and social care:** The Trust and South Gloucestershire Council should ensure that significant progress continues to be achieved in the operational integration of mental health and social care adult mental health services in South Gloucestershire, by implementing single management arrangements for adult mental health teams no later than 31 March 2007.
397. The new Surrey and Borders Partnership NHS Trust should consider the scope for broadening the role of Non-Executive Directors to provide more opportunities for their interface with front line staff and partner organisations, perhaps by introducing “lead” or “special interest” roles.
398. **Review of Community Mental Health Teams:** The Trust should review the composition, management and effectiveness of Community Mental Health Teams to ensure: (1) there is a framework for allocating and reviewing patients’ care using the full range of professional resources of the team , (2) all team members and managers have a clear understanding of their roles, duties and responsibilities in terms of management, leadership and decision making & (3) consultant psychiatrists play a full part in hospital and community multidisciplinary teams.
399. Now the appointment of a substantive consultant psychiatrist to share the clinical leadership of John Meyer Ward with the ward manager has been confirmed. Further development of the ward team should now be undertaken using an appropriate tool, for example the "Creating Capable Teams" toolkit developed by the Sainsbury Centre for Mental Health and the National Institute for Mental Health in England (NIME).
400. **Local service’s work with M & L:** The inquiry panel recommends that the manager of the team responsible for the care of the patient is given the authority to ensure adherence to quality standards set by the board of the trust. These would include designated time periods and quality standards for risk assessment, the scrutiny and incorporation of information gained into care plans and its communication to relevant professionals involved in the patient’s care.
401. **Leadership & clinical accountability:** The inquiry panel recommends that as part of the trust’s clinical governance process specific guidance is drawn up as a priority to identify issues and concerns relating directly to patient care for presentation to the trust’s senior management executive team & the trust board.
402. The Trust should review its arrangements for managing security, including designating a local security management specialist (LSMS).
403. Undertake an audit of clinical supervision in order to ensure that robust systems are in place.
404. **Leadership & clinical accountability:** It is recommended that the Trust ensures appropriate professional support and supervision structures are in place for all clinical staff and that this is monitored.
405. **Crisis assessment & treatment service:** The strategic health authority is recommended to ensure that supervision arrangements are reviewed for personal advisors service trainees and junior staff.
406. A supervision policy for newly appointed SHO’s in psychiatry by senior staff should be developed/ reviewed. This should include supervision in outpatients and supervision of written communication, in particular during the management of patients with a severe and enduring mental illness.
407. **CMHT:** The supervision of community mental health workers should be strengthened by carrying out independent external audit checks of their practice.
408. **Training & development:** It is our recommendation that the ‘*A Supervised Led Approach to the Supervision of Clinical Practice*’ policy is formally implemented with a separate training programme for supervisors and supervisees. The Trust Board should discuss the resource implications and agree a suitable budget to introduce meaningful supervision.

409. We recommend that the Trust revises its Clinical Supervision Policy and implements a more structured approach to supervision in order that; • aims and objectives are agreed for each case, • supervision notes are passed on to new supervisors, • notes are agreed and countersigned by both supervisor and supervisee, and • the Care Co-ordinator is identified.
410. We recommend that the Trust implements a programme of evaluation to ensure that clinical supervision fits into the clinical governance framework.
411. The CMHT will re-establish protected time for discussion, reflection, education & clinical governance issues.
412. **Supervision.** We were told about the development of joint management/supervision arrangements for members of the CMHT and about 'professional' or 'clinical' supervision for various disciplines. We did not discuss arrangements for supervision or support for senior medical staff and we suggest that further consideration is given to developing methods of peer support for this group of professionals.
413. **ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.7 A review of local clinical leadership and supervision to ensure that this is properly being addressed.
414. **Professional supervision:** The Independent Inquiry found that arrangements for supervision were inadequate for meeting the needs of both service users and developmental needs of staff. It is recommended that a more structured process for supervision is developed to ensure that there is a formal review of care plans for all members of the team including CPNs and psychiatrists as well as developing a multi-disciplinary team based approach to review cases. At these reviews it would be advisable to include other professionals such as substance misuse and housing.
415. **Supervision:** The revised approach to supervision within SCT needs to ensure that it enables; staff to receive a copy of the supervision record, that staff are aware of people who can provide specialist supervision & on what basis, that there is an assessment of the effectiveness of individual case management & the quality of documentation and there is a balance between the responsibility of the individual to seek out supervision & the organisation to ensure that it is provided and that the maximum period between sessions is stipulated.
416. The Trust should ensure as a high priority that regular clinical supervision and appraisal for all staff is consistent across all locations and services and that it is regularly monitored and audited.
417. The Trust should consider urgently the resources devoted to and structure of the Clinical Audit Team to offer career progression and to improve retention of staff.
418. The Trust should review the capacity of its Human Resources (HR) function to ensure that adequate support is provided for front-line managers and supervisors to deliver effective appraisal and clinical supervision for staff. Staff also will need 'protected time' then to be able to participate effectively in both the appraisal in clinical supervision process. A wider ranging review of HR capacity to achieve its strategic aims and business plan objectives, including contributing to organisational development and cultural change is also needed.
419. **Line Management:** Line Managers must ensure there is regular appraisal and that clinical supervision is undertaken according to Trust standards. The Trust should assist them by establishing adequate information systems to be able to oversee and evaluate the work of those for whom they are responsible. The line management arrangements for Consultant medical staff should be clarified and understood by all Locality Managers.
420. **Learning:** The Trust must ensure that there are robust supervision arrangements, consistently applied.
421. **Learning:** The Mental Health Trust should support robust procedures allowing consultants to meet in peer groups on a regular basis for the purposes of peer supervision. If records are not kept, it would be advisable to do so to ensure targets for CPD are agreed and met.

422. **Process issues:** The Mental Health Trust has to ensure, as a matter of urgency, that the national and local CPA processes are in place and followed effectively, so that all practitioners should receive regular and effective clinical supervision, and have access to a mentor if appropriate.
423. **Risk assessment & management:** Trusts should review their supervision procedures concerning patient care to ensure that (a) regular clinical/professional supervision happens and (b) it gives staff the opportunity to reflect on concerns about individual patients and to formulate these concerns into risks that can be monitored and that can be incorporated into care plans.
424. **Risk assessment & management:** Ward rounds have become increasingly complex, and the aims they attempt to meet have increased. Every team should try to make dedicated time to reflect (probably once a year) on how their ward rounds and other meetings are used, and on changes that might improve the team's work.
425. Ensure that, as part of the clinical governance policy, medical staff, within the service in Rugby, have sufficient time to meet with their peer group regularly for managerial and educational activities, and that such attendance should be monitored.
426. We recommend that the Trust reviews the human resource support to the mental health services Directorate.
427. We recommend that the Trust give consideration to how it can more effectively empower staff.
428. Support all medical practitioners, at a grade lower than Consultant, to provide optimum quality patient care.
429. **Staff Support:** Where staff are "acting up" to a higher post than their normal grading justifies, line managers must provide, for an appropriate period, suitable monitoring and support.
430. **To prepare a report with recommendations to Carmarthenshire Local Health Board and Welsh Assembly Government.** 8.5.2 Staff should be given support structures and advice to enable them to move on with confidence if the standards of mental health care in Carmarthenshire are not to fall.
431. We recommend that the CPNs working in the Inner City should meet regularly with other CPNs providing primary care liaison in order to develop a better understanding of their workload pressures and provide peer support.
432. We recommend that the Trust appoints a further Nurse Consultant in the Mental Health and Learning Disability Directorate to take a lead on community based practice in order to: a) Identify opportunities for ongoing professional development for all nursing staff and support nurses in new areas of working, b) Advise the Director on these as they impact on patient care, c) Work with members of the multi-disciplinary healthcare team in furthering the Trust's Clinical Governance programme.
433. We recommend that the Director of Mental Health and Learning Disability services establishes a nursing forum, jointly chaired by the Nurse Consultants, which will be the focus for professional and clinical practice development and advise the Trust Board through him.
434. **Training & development:** It is our recommendation that all staff have access to annual appraisal, when training plans can be discussed and individual nurse's performance measured against agreed objectives.
435. **Assessing nursing and social work skills and record keeping:** As part of their individual appraisal system, all professionally qualified staff should be assessed to ensure they have the appropriate skills, knowledge and competencies required to: build effective therapeutic relationships with each patient; use interviewing skills to elicit information relevant to diagnosis; obtain a comprehensive clinical and social history; and engage with the family and other carers.

436. **Specifying staff operational responsibilities for CPA:** The Trust should ensure that the roles and responsibilities of staff involved in the operation of CPA, (medical, nursing, therapists and operational support staff) are clearly specified, understood by them and included in performance reviews of all staff members concerned, particularly bearing in mind the past and present operational problems of CPA described in paragraphs 6.7 and 6.12 of this report.
437. Ensure that clinical psychologists are able to allocate enough time per client for reflection, note writing, report writing and planning.
438. The operational policy for the CMHT needs to be revised to include clear guidance on optimal caseload sizes, clear expectations of the CMHTeam leaders, active case file audit as an integral part of management supervision, more detail about transfer of care arrangements – referencing to CPA policy, clear expectations about the training & development CMHT staff should be undertaking and the roles/ responsibilities of consultant psychiatrists in leadership of CMHTs, prioritisation of clinical resources etc.
439. We recommend that the Trust specifically review CPN caseloads, workload and staffing levels.
440. We recommend that the Trust carries out an audit of the workload of the CPNs working in the Inner City PCLT on an annual basis.
441. We recommend that the Trust reviews the roles and responsibilities of all qualified nurses in the PCLTs so that more junior nurses are not working beyond the expectation of their grade.
442. The nursing skill-mix on inpatient wards including the PICUs should be regularly reviewed in line with evidence-based practice and service developments.
443. **Service management:** It is our recommendation that the Trust reviews nursing models, shift patterns and the skill mix within the nursing establishment on the acute admission ward at Longreach.
444. **Ward staffing:** The staffing levels on Darwen ward should be reviewed to reflect the need for planned therapeutic activity.
445. Arrangements should be put in place to ensure that the inpatient work load of a particular consultant psychiatrist is not excessive. The consultant's job plan should be designed to allow for sufficient time for clinical & educational supervision of junior doctors.
446. We recommend that those consultants who lead clinical services are appropriately qualified i.e. forensic psychiatry is a specialty which should be led by a forensic psychiatrist. We recommend that the Trust not allow consultants to cross cover beyond the remit of their specialty.
447. The trust is creating a post of lead consultant for ward 21, who will provide administrative lead for medical issues. This post should have responsibility for ensuring there is adequate consultant psychiatrist & junior doctor cover for patients within CMHTs and that the system is flexible enough to allow for cover to be provided in the event that a particular consultant psychiatrist has an excessive work load.
448. **Medical input:** We found the medical input to the team and the medical leadership of the team to be both limited and reactive. In order to improve this situation we recommend that the team has sufficiently resourced Consultant Psychiatrist input.
449. **Service management:** It is our recommendation that Clinical Improvement groups are convened to discuss the effect on the quality of patient care of the current shift pattern, sickness and staff shortages & changes in the delivery and management of acute care to ensure effective service user involvement.
450. **ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.5 Efforts should be made to ensure staffing (to include medical, nursing, psychology, and occupational therapy) in the mental health field is up to establishment level and that the establishment level

is sufficient. This could take the form of a brief research programme to evaluate the causes of any deficiencies.

451. **iii to examine the adequacy of collaboration and communication between agencies involved in the care of D, the provision of service to him and between the statutory agencies involved;** 8.4.20 Funding arrangements should be put in place to ensure that PRISM is able to cover critical holiday periods such as Christmas.
452. **ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.11 The medical on call cover system should be strengthened and formalised in order that there are clear cover arrangements and formal handover for staff on leave, including accessibility to all clinical notes. Staff off-duty or on leave should have cover which will embrace at some point in the chain a person of similar rank and position to the one on leave. No junior member of staff should ever have any doubt as to the means of contacting a senior member of staff.
453. We recommend that the Trust continue to keep the medical staffing issue under review.
454. **Equality & diversity:** The Trust should explore and support the development of cultural mediation services to be deployed in the most effective way.
455. **Equality & diversity:** The Trust should ensure that the Equality and Diversity Action Plan includes concrete, measurable actions and that it is implemented within the set timescales, with sufficient resources allocated in order to do so. The Trust should ensure that a Board level director's post has explicit overall responsibility for ensuring the implementation of the Plan throughout the Trust.
456. **Equality & diversity:** The Trust must monitor on a regular basis whether and how the Action Plan affects the nature, quality and effectiveness of services to patients.
457. **Equality & diversity:** The Trust should ensure appropriate representation at every level of the organisation to reflect the diversity of the community that it serves, including at Board and top management level.
458. The MBU and Hampshire Social Services child protection services should meet to discuss the issues of cultural and ethnic sensitivity of their respective services. The outcomes could form the basis of an action plan to identify and implement improvements within Hampshire which could be shared with other Social Services Departments in the MBU's catchment area.
459. The Trust should review as soon as possible its strategy and Action Plan for equality.
460. The Trust should build on evidence from "The Experience of Adult Inpatient Care" to explore further the reasons for the variances in levels of satisfaction with the service between people defining themselves as black or black British and their white or Asian/Asian British counterparts. The outcomes of this further work could help to address the reasons for dissatisfaction and inform the Trust's Equality Strategy.

#### **4. Staff Training**

461. **ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.14 The amount of training available to all professional staff should be increased with the main focus on general psychiatry (especially history taking and diagnostic skills) and psychiatric nursing. As a new dimension, forensic psychiatry training should also be included. Forensic psychiatry reviews and case presentations should take place on a regular basis with other service providers and disciplines as part of a local training scheme.
462. **ii to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.15 Mental health professional training should include experience of work outside the trust e.g. by attending courses elsewhere, by exchange schemes, and by frequent use of visiting speakers.
463. **Agency staff:** The Independent Inquiry found that whilst acknowledging the difficulties in employment and retention of staff, to have such a high percentage of agency staff working in a crisis team such as Access & Response Team was unacceptable. This was accentuated by the lack of induction and access to training and supervision for this staff group. It is recommended that all agency staff receive proper induction and access to statutory and mandatory training and that a care coordination system is systematically implemented which clarifies the role.
464. It is essential that professionals from all agencies have a common understanding as to the available and appropriate care pathways between services. The inquiry panel recommends that enhanced priority should be given to establishing and maintaining a programme of education designed to ensure that this objective is met.
465. **Care Programme Approach:** Ensure all relevant staff are trained as a matter of urgency in the underpinning philosophy and the practice of: Leadership, Communication, Historical service user information from Health & Social Care, Risk assessments, Chairing meetings / CPA reviews, Care Planning – there is a need for full discussion and sharing of information by team members with the service user at all times. There are indications that this did not take place with K, Carer's Assessments. Such training to include clarifying the function and role of the Care Co-ordinator.
466. **Training & development:** It is our recommendation that the Trust implements a multi-disciplinary training programme for all staff who are involved in the CPA process and ensures that CPA is included in the induction programmes for newly appointed clinical staff.
467. The SHB Trust should ensure that the training of medical staff in assessment, through their participation in CPA training, is implemented as soon as possible.
468. **Use of the CPA process:** The inquiry panel recommends that the trust should extend the CPA training programme to include provision of clear guidance on the participation of consultant psychiatrists in enhanced CPA meetings. Participation of all disciplines working in the CMHT, inpatient and day hospital settings should be mandatory. Joint risk assessment training should be incorporated in CPA training with multidisciplinary teams. The message is strongly delivered that CPA is the central process & that it is not acceptable to consider it as an adjunct to other decision making methods. CPA audit processes are used regularly & satisfy the trust board that day to day CPA documentation is regularly monitored to confirm that all disciplines contribute, the adequacy of care plans, their quality and that progress from one review to the next is followed up & documented. Determinants for using standard and enhanced CPA are set out more clearly in the trusts policy and operational guidelines. When a patient is on enhanced CPA greater clarity is provided about the consultant psychiatrist's continuing responsibility and the GPs responsibilities. The trust should consider incorporating a management plan for the person's medication as part of the CPA care plan.
469. **Leadership & clinical accountability:** The inquiry panel recommends that the trust; secures clear and sustainable lines of accountability for the practice of the assessment & referral team, ensures the CPA process is unequivocally adopted by the consultant psychiatrists and that attendance at CPA training & CPA processes is mandatory for all relevant staff, utilises appraisal processes to ensure staff comply with mandatory training and can demonstrate essential competencies and ensures appropriate professional supervision structures are in place for all clinical and non clinical staff and this should be monitored.

- 470.i **the extent to which D prescribed care plans were effectively drawn up, delivered and complied with by D;** 8.4.2 Training programmes to be put in place to teach care management and key worker roles.
- 471.ii **to examine the appropriateness of the competencies of the team (professional qualifications) and the experience of those involved in the care of D.** 8.4.13 Training programmes to be put in place to teach key worker and team leader roles.
472. Panel commented upon the lack of clarity in applying CPA in TG's case. Trust should ensure that all members of staff understand the care coordination process & how it should be documented.
473. **CMHT:** Those who are appointed as care coordinators should receive training in the role and function of the post.
474. That the Trust continues to promote the improvements in clinical accountability and practice already underway but with a greater emphasis on ensuring that doctors at all levels are incorporated into the training arrangements and required to attend risk assessment and CPA multidisciplinary practice development events.
475. The PCT needs to undertake a training needs analysis within its Mental Health Directorate targeting CPA & risk assessment practice and develop a planned programme of training to address any skill/ knowledge deficits identified.
476. **Training:** As we believe is now to be done – all training should be determined after assessment of personal and professional needs by appraisal. Training in core competencies should not be optional and necessary resources should be allocated to provide the required training. Risk assessment and CPA should be mandatory for all staff working with service users.
- 477.iv **to examine and comment on the nature of any risk assessment and the management of identified risk presented by D to himself or others;** 8.4.22 Further training for mental health staff on public protection issues should be provided.
- 478.iv **to examine and comment on the nature of any risk assessment and the management of identified risk presented by D to himself or others;** 8.4.23 Formal training required on incident reporting processes.
479. Ensure that all staff of all disciplines, including Consultant Psychiatrists, participate in an externally provided training with regard to risk assessment and risk management, including evaluation of the impact of such training on individual clinicians competence in these areas.
480. The effectiveness of training in risk assessment for all clinical staff should be reviewed. This should include the need to adequately document risk in the clinical notes and communicate such to all those staff involved with the ongoing care of the service user (E.g General Practice clinical staff).
481. CIAG & the Directorate Risk Management Group should consider developing a risk management bulletin (Quarterly) where anonymised summaries of incidents, pertinent reflection and learning points and actions taken could be shared with all staff.
482. **Risk assessment & management:** All mental health staff should have training in translating implicit into explicit knowledge. It would be appropriate for this to be considered specifically in training and supervision.
483. The SHB Trust, through the Risk Management Committee, should consider ways of clarifying the threshold for reporting “near misses”, perhaps through a workshop involving staff and managers from different levels and a cross section of the Trust's services.
484. **Assessment of patients (risk assessments):** As has been recommended by earlier Independent Inquiries, East London and The City Mental Health NHS Trust ought to address its training for risk assessment and management and emphasize the importance of good information gathering and sharing.

485. **The nature of the risk assessment of potential harm to D and others.** 8.2.3 Training programmes should be in place to teach clinical risk assessment techniques.
486. **Clinical psychology:** Overall the quality of the risk assessment and risk management was considered by the panel to be very limited, superficial and fragmented. In order to avoid this situation recurring we recommend that this is reinforced to team members and Agency staff and that a mandatory annual training session on the formulation of active and dynamic Care Plans from Risk Assessments is introduced.
487. The SCT needs to undertake a number of developments in relation to the clinically focused risk assessment process & training delivered to staff. Specifically the trust should make its current risk assessment training programme available to inpatient staff. It should also implement a unified baseline risk assessment documentation tool of inpatient and community use. The trust should also make financial provision for refresher training every three years for all qualified staff.
488. **Risk assessment:** Ensure all clinical staff and managers are trained in this discipline as a matter of urgency. Such training should emphasise that risk assessment is a team process and must be an integral element of care planning.
489. The effectiveness of induction training for newly appointed SHO's in psychiatry should be reviewed. Induction training should include an emphasis on risk assessment processes and when to access and seek advice from senior clinical staff in particular during circumstances where service users are known to be at risk of harm to themselves and others during non-compliance with medication.
490. **Skills sharing:** The statutory and voluntary sector agencies in Kirklees should develop and implement joint training in dual diagnosis for staff which must be financially supported by the Primary Care Trust and partnership agencies.
491. **Substance misuse service:** There were a number of indicators both in the medical records and in the client's history where clues about alcohol misuse were apparent. In order to improve the quality of responses by the ART to potential substance misuse we recommend that a member of the team be identified to receive training in substance misuse from the DAAT, and that they provide a continuing structured link between the DAAT and the CHTT.
492. We recommend that induction and up-date training on the use of the Mental Health Act, particularly with regard to policy on when and how it should be used, be reviewed.
493. **MHA:** Clinicians need further training to improve their understanding of the criteria used in decision making by Managers' Hearings and Mental Health Review Tribunals.
494. It is recommended that the PCT encourage doctors, in particular GPs, to become Section 12(2) approved.
495. We recommend that the Trust invites its Solicitors to deliver a training programme that covers the legal obligation to keep appropriate records, especially as more records are being kept electronically.
496. **Assessing nursing and social work skills and record keeping:** Where poor standards of nursing records are identified, the Trust and social services should provide training to improve those standards.
497. We recommend that Staff from all the teams are trained to 'peer review' their written records in addition to the audits required by the Dept of Health.
498. **Communication, transferring & sharing information between & within teams:** The inquiry panel recommends that the trust ensure that within its training programme, sessions specifically designed to promote; a stronger understanding of the importance of multidisciplinary sharing of information, effective ways of identifying & recording behaviours and statements that give cause for concern in the context of specific situations and the development of a care plan, planning & reviewing processes which utilise such information in their consideration of the person's needs, treatment & care and an understanding that

information gained should be considered in the context of the known history, characteristics & behaviours of individual patients.

499. **Training & development:** It is our recommendation that the voluntary sector be involved in, or at least consulted in relation to, the content of the training programme being prepared, together with any associated printed material available for families/ carers.

500. **Making a commitment to carers (Training):** Trust and social care providers' staff induction programmes should always include a presentation from a carer and a family worker, in order to develop practitioners' understanding of family work and how to work collaboratively with carers.

501. **Making a commitment to carers (Understanding confidentiality):** The Trust and social services should ensure their health and social care staff undergo training to understand that: • they need information from carers to provide effective psychiatric care and carers have a right to provide such information. There are no issues of confidentiality involved in this communication and carers should be told this. • confidentiality issues arise only when personal information about the service user's mental condition is provided to carers. Under these circumstances consent should be sought from the service user unless there is an issue of risk, when consent is not needed and carers and family should be informed. Whether consent is given or withheld should be recorded.

## **5. External Agencies**

- 502.**MAPPA:** Every Trust should have a protocol for Trust liaison with the Multi Agency Protection Panel, including referrals and seeking advice.
- 503.**MAPPA:** Under such circumstances, the Multi-Agency Protection Panel (MAPP) is the most appropriate forum to discuss the risks of a person to others. Trusts and MAPPs need to agree procedures to determine how a case like this could best be brought to MAPP.
- 504.**MAPPA. c. The CPA:** The mental health services should review existing CPA guidance and procedures to ensure that: All CPA meetings routinely question MAPPA registration. CPA documentation, including risk assessment pro-formas, is amended to incorporate MAPPA status. CPA policy and procedures is amended to include guidance on those circumstances which might indicate a need to make a referral to the responsible authority (police and probation) in order to prompt a MAPPA review.
- 505.**MAPPA. g. Procedures and information systems:** Mental health services should develop clear policies and procedures relating to their interface with MAPPA. Mental health services may consider developing systems to ensure that without breaching confidentiality, patients known to both mental health and probation services can be identified and so managed safely.
- 506.**MAPPA:** MAPPs should use this case as an example to explore how multi-agency consideration of the risks within the MAPP would contribute to their management.
- 507.**MAPPA. a. Health involvement in MAPPA:** A senior mental health service manager should attend all level 2 meetings. We understand that a consultant forensic psychiatrist attends all level 3 meetings. The attendee should have received appropriate training in the interface between psychiatry and the criminal justice system, and must be senior enough to commit resources. The function of the manager at level 2 is threefold: to screen and identify the appropriate specialism to whom further communication should be directed, for example CAMHS, forensic, general, drugs and alcohol; to liaise with the forensic services attending level 3 meetings and to act as a conduit for all referrals to MAPPA by mental health services.
- 508.**MAPPA. e. MAPPA Reviews:** When a person on any level of MAPPA is arrested for a further offence, an urgent review should take place. If the offence is of a violent or sexual nature, a MAPPP meeting should be convened, with full multi-disciplinary involvement, to allow appropriate sharing of information and to enable risk assessment/ management plans to be developed. When an offender is described as high risk, and his/her probation order is to end, a MAPPA review should be initiated.
- 509.**MAPPA. h. CMHTs:** Forensic ASWs or other specialist professionals working with mentally disordered offenders who work with or for CMHTs should have dedicated time allocated in order to deal with and develop links with MAPPA organisers.
- 510.**iii to examine the adequacy of collaboration and communication between agencies involved in the care of D, the provision of service to him and between the statutory agencies involved;** 8.4.18 Multi-agency public protection arrangements (MAPPA) were in place at the time of the incident (with a mental health representative on the steering group) and continue to be in place in Carmarthenshire. In the panel's view, these should involve a consultant psychiatrist with forensic psychiatry experience or interest and should follow the Royal College of Psychiatrists guidelines.
- 511.**MAPPA. b. Police:** In collaboration with mental health services, the police should promote the role of the Public Protection Officer to mental health services. The purpose of this is to advertise the role of this officer as a resource and conduit into MAPPA.
- 512.**MAPPA. f. Guidelines:** The Trust should develop guidance relating to the duty to cooperate and the circumstances in which information can be shared. Staff should be provided with training relevant to their roles and responsibilities in this area.
513. The SHB Trust and its successor should work with MAPPA and other key agencies to develop a clearer understanding of their respective individual and multi agency roles and perceptions, including: Individual organisations' and multi agency roles, thresholds for services and how to access respective services · Communications – Identifying problems and opportunities in

communications between agencies, including sharing of information about risks posed to others by dangerous or potentially dangerous individuals · Identifying groups of people who do not fit neatly into existing thresholds or criteria for mental health, public protection, or “Supporting People” services and agreeing how those people can be supported.

514. We recommend that the Devon and Cornwall Probation Area Service and their constituent Health and Social Services should introduce a protocol and an agreed ‘template’ to improve communication and the sharing of information, leading to a better understanding of the role played by each agency.
515. **Current CPA policy and procedures should be amended to take into account the following. e. Difficult to engage/out-of-contact, vulnerable, at-risk clients:** Where this part of the policy refers to communication with other agencies, the probation service should be included in the list of agencies to be considered.
516. **iii to examine the adequacy of collaboration and communication between agencies involved in the care of D, the provision of service to him and between the statutory agencies involved;** 8.4.17 Robust liaison mechanisms should be established between the police and the mental health services to involve regular meetings with doctors and managers from both, in order that an appreciation of each others role and a full exchange of information when passing clients from one agency to another, can be gained.
517. It is imperative that the Police, Probation and Prison Services, and where relevant, Healthcare professionals, liaise closely regarding risk assessment and planning for the management of offenders, especially prior to the release from Prison of offenders who have mental health problems and who potentially pose a risk to females and children.
518. The new Surrey and Borders Partnership NHS Trust should consider encouraging the development of a “leadership forum” with colleagues from social services, MAPPA, courts service, PCTs, housing and other relevant services, to meet occasionally, for workshop type sessions in which broader leadership and organisational issues such as culture change could be considered and shared, away from the everyday service planning or service delivery agendas.
519. **Interface with the police force:** The panel acknowledged the work that has gone into developing trust & police joint operational procedures & guidelines. Once the protocol/ information sharing agreement has ‘bedded in’ there should be further development of this work to establish a more effective communication system between these professionals when a service user is taken into custody & released on bail. It may also be beneficial to establish guidance for forensic examiners (police surgeons) regarding the appropriate route of contact with mental health services if information regarding the mental health history of a person is required.
520. It is recommended that the Lancashire care trust, social services & the probation services should formalise a protocol of arrangements for joint working and shared information as soon as possible.
521. **Current CPA policy and procedures should be amended to take into account the following. i. Training:** The training of police and probation officers to enhance their knowledge of the CPA should be considered.
522. **Police:** Training should be offered to police officers to: i. improve their recognition of mental health conditions; ii. enhance their familiarity with the appropriate sections of the Mental Health Act to improve their confidence in its usage; iii. provide them with knowledge of the most suitable contact points with the service.
523. **Notable practice:** The Panel commends this new training programme for probationer officers and suggests that this should be a reciprocal arrangement between partner agencies with the aim that members of staff of all agencies develop a mutual respect for each other’s ways of working. An avoidance of jargon including medical terminology to be encouraged.
524. Enable all practitioners to work to an appropriate Domestic Violence Strategy, having undertaken a multi-agency training programme taking into consideration the Warwickshire Constabulary policy.

525. As a first step, a case study based, multi agency workshop should be commissioned jointly the SHB Trust or its successor, MAPPa and Hampshire County Council Social Services Department. The workshop could examine opportunities and challenges in the interface between MAPPa, adult mental health services, housing and child protection services.
526. We recommend that the Devon and Cornwall Probation Area Service, as part of the multi-agency Public Protection arrangements, should participate in a mental health awareness training programme which takes account of the findings and recommendations of this report for practitioners and their managers.
527. **MAPPa. d. Training:** In conjunction with the responsible authorities for MAPPa, mental health services should devise a programme of multi-disciplinary training for health staff and other agencies. The purpose of this training would include describing the organisation and function of MAPPa and the processes for sharing information between police, probation and health services. All disciplines involved in the delivery of mental health services should be encouraged to participate in this training.
528. **Training. A programme to be developed which:** i. Builds on existing risk assessment/management training by including relevant details from our report. ii. Provides training concerning MAPPa for all agencies, involving key stake holders for MAPPa - police, prison and probation service, and mental health services.
529. **Domestic violence:** In view of this and other cases that the independent inquiry is aware of where harm has come to a former partner following the breakdown of a relationship we recommend that the mental health services should develop protocols with wider Domestic Violence services to assist in supporting and protecting ex partners.
530. When the Police attend an incident involving a male who is spreading alarming information about what could happen to children, and given that some school staff at child B's school were concerned about TB generally, more rigorous enquiries should be made about such individuals.

## **6. Serious Untoward Incidents**

531. **Management of untoward incidents & internal reviews (involvement of staff in internal reviews):** When undertaking an internal review, all staff involved should be identified, the extent of their involvement clarified and they should be given the opportunity to comment on that involvement prior to the publication of the report.
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533. **Management of untoward incidents & internal reviews:** Involvement of staff in internal reviews. When undertaking an internal review, all staff involved should be identified, the extent of their involvement identified and they should be given the opportunity to comment on that involvement.
534. **Management of untoward incidents & internal reviews (involvement of service commissioners):** A representative of service commissioners should be invited to attend post incident reviews carried out by provider organisations.
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536. **Management of untoward incidents & internal reviews:** Involvement of service commissioners. A representative of service commissioners should be invited to attend appropriate post incident reviews carried out by provider organisations.
537. We recommend that when a serious incident is being investigated all notes are photocopied and a complete set given to the relevant practitioners involved in the case.
538. We recommend that in any investigation which necessitates interviewing staff the notes of the meeting are taken by a confidential transcriber.
539. **Post Incident Reviews.** We were concerned that mental health services were not involved in either of the police or probation service reviews which took place following the homicide committed by RL, and that mental health services did not include police or probation services in their review. Post-incident reviews and/or Serious Untoward Incident reviews/inquiries should include representation from all agencies involved with an individual patient. Current Serious Untoward Incident policies should be amended accordingly.
540. **To prepare a report with recommendations to Carmarthenshire Local Health Board and Welsh Assembly Government.** 8.5.1 It is particularly important that the staff, who have been the focus of this investigation, should not be singled out for adverse action and blame.
541. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that future Inquiries should give consideration to the value of a preliminary 'stakeholder' meeting, involving senior officers of the agencies most likely to be providing evidence.
542. We recommend that the Trust, with the Strategic Health Authority, continue to implement and improve internal reviews based on sound investigative and issue-interpretation procedures, notably root cause analysis and other tools and approaches as recommended by the National Patient Safety Agency of the NHS.
543. The responsibility for ensuring an external review takes place in a timely fashion rests with the SHA. We hope that this is given urgent and due consideration.
544. It is recommended that internal reviews of serious incidents are only undertaken by those trained to do so and who do not have a potential conflict of interest in the review.
545. We recommend that any serious investigation is carried out by a team of senior staff, including an independent chairperson.

546. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that the Trust has up-to-date SUI (and other) policies, which all managers and members of staff understand and follow without deviation.
547. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that members of staff who have been involved in the events immediately prior to an Incident should not be asked to undertake the formal internal review process.
548. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that future discussion regarding the conduct of 'Internal' and 'Independent' reviews should not result in an undue delay before potential learning is shared.
549. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that the role of Independent (Homicide) Inquiry Panel members is clear and unambiguous, including any expectations of a facilitation and leadership role.
550. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that the recently issued revised national expectations for Independent Inquiry Panels to use RCA techniques will be incorporated within future Independent (Homicide) Inquiries.
551. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that arrangements for the attendance of expert assistance to Panels must be considered in advance, and agreed with Panel members.
552. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that there must be a clear and direct line of communication between the Panel and witnesses called.
553. **Involvement & support for carers:** The Trust should ensure that the family of patients involved in serious incidents are contacted to establish their possible care and support requirements.
554. Comprehensively review its SUI processes to take account of a more open approach to help staff and families.
555. Comprehensively review its Serious Untoward Incident processes to take account of a more open approach to help staff and families. This will ensure that: a) a senior person makes contact with families who are the victims of serious incidents; b) staff take account of the sensitive nature of support required, seeking guidance from and including the various voluntary agencies such as Victim Support in the preparation of the training programme; c) the level of competence and confidence of staff, when dealing with serious untoward incidents is enhanced; d) a supportive framework is provided - which includes counselling if necessary, adequate time for briefing and the opportunity to receive feedback as well as full discussion about any action plan which has to be implemented.
556. **Support provided to families after the homicide:** It is recommended that the Trust should identify a senior manager to coordinate both informal and formal support to families after a homicide as set out in the "Building Bridges" and the National Patient Safety Agency guidance for "Supporting Families".
557. Any revisions to the trust policy regarding reporting and investigating SUIs considers the NPSA's Safer Practice Notice 10 & briefing paper "Being open saying sorry when things go wrong". In addition to these documents it is essential that the trust develop a clear communication strategy so that the families of victims as well as the families of service users are appropriately communicated with. Recommendation suggests that this be done with multi-

agency input with local police, coroners & other statutory and non-statutory victim and mental health support groups.

558. **Service management:** The trust should consider supporting the families of victims whenever serious untoward incidents occur.

559. **Family support:** It is our recommendation that the Trust should appoint a senior person to make and maintain contact with the family until the independent inquiry has been appointed. This individual should be responsible, amongst other things, to: a) keep the family informed and up to date in relation to all investigations and proceedings consequent upon the event, including internal investigations, court hearings, and the possibility of an external independent inquiry; and b) arrange access for the family to appropriate care, support and counselling services.

560. **Family support:** It is our recommendation that all contacts with the victim's family, including telephone contacts, are recorded in the Serious Untoward Incident report prepared for the Trust Board and the Health Authority. If no such contacts have taken place at the time of the report, then senior management will be alerted to the need to ensure that appropriate offers of support are then made. Details of contacts and offers of support made subsequent to the preparation of the Serious Untoward Incident report should be forwarded to the Trust representative responsible for the preparation of the Serious Untoward Incident report.

561. **Family support:** It is our recommendation that the Trust identify an appropriate strategy for providing families affected such incidents with support and for putting them in touch with relevant organisations.

562. It is recommended that a copy of the independent investigation report is given to CK & K and that she be given the opportunity of discussing it with relevant organisations if she wishes.

563. **Management of untoward incidents & internal reviews (recommendations of reports):** The Trust should ensure that it implements its current Untoward Incident Management Policy to ensure clarity of goals and processes to be followed, including the adoption of SMART criteria for the recommendations of any future internal reviews. An audit of the policy should be done on an annual basis to review how the policy is working in practice.

564. **Management of untoward incidents & internal reviews (recommendations of reports):** The Trust should ensure that it implements and monitors its current Incident Management Policy to ensure clarity of goals and processes to be followed, including the adoption of SMART criteria for the recommendations of any future internal reviews.

565. **Management of untoward incidents & internal reviews:** Incident Management Policy and adoption of SMART criteria for recommendations. The Trust should redraft its Incident Management Policy to ensure clarity of goals and processes to be followed, including the adoption of SMART criteria for the recommendations of any future service inquiries and reviews. The amended policy should be approved by the Trust Board and an audit should be done on an annual basis to review how the policy is working in practice.

566. Consider all the comments made in this Report; regarding aspects of the interactions between PW, Colette and their respective families with all statutory agencies - particularly during the critical period of 1st to 3rd February 2005 and to amend their practices and processes accordingly.

567. Consider all the comments made in this Report and amend Trust practices and processes accordingly.

568. **Serious untoward incidents:** The Trust must establish procedures for ensuring that learning arising from each serious untoward incident is translated into effective change, in particular in service delivery. The Trust must be able to demonstrate such change with concrete evidence.

569. The DCGG should undertake an audit of the action points recommended by CIAG & DRMG after the internal investigation of the incident with W to determine if there are any issue that need to be incorporated into the existing audit programmes.

570. We recommend that the Trust continue its efforts to improve organisational memory.

571. **Service management:** It is our recommendation that the Director of Nursing considers the appointment of a clinical nurse specialist or nurse consultant post based at Longreach to take forward the recommendations in this report which relate to Longreach, and to provide clinical leadership.
572. **Training & development:** This Inquiry team is invited back to review the implementation of the recommendations of this inquiry and those of the two previous inquiries which relate to the Trust & to assess the progress made through the Trust's ongoing action plan.
573. It is recommended that the recommendations from this report are reported to the Lancashire Care trust board together with an action plan which identifies those responsible for implementation, and the timescales applicable for the implementation of the recommendations. The implementation must be reviewed by the board as part of its governance arrangements.
574. The SHB Trust's SUI Scrutiny Panel should, at the earliest opportunity, highlight each agreed action not yet addressed or partially completed. The Panel should formally agree a timetable, responsible organization and responsible officer for each "non-completed" action to be implemented with a target date for completion. Any difficulties in meeting agreed timetables should be discussed by the Scrutiny Panel chairman with the Chief Executive of the responsible organisation.
575. The SHB Trust and the new Surrey and Borders NHS Partnership Trust should review policy for the dissemination of internal and external inquiry and SUI review reports and associated action plans. This should aim to ensure that their use for shared learning, within and beyond the trust, can be maximised. Particular attention should be paid to agreeing with partner agencies the actions they will take to disseminate information to relevant groups of staff and their managers and how they will account for the implementation of actions they have agreed to take.
576. The SHB Trust should consider auditing the effectiveness of feedback to managers and staff teams concerning untoward incidents.
577. We recommend that in the event of all future serious incident investigations all reports are shared in full with the clinicians who were responsible for providing care.
578. We recommend that the findings, conclusions and recommendations of internal investigation reports and this report, with their action plans, are used to debrief staff and are the focus for an in-depth training programme for all staff in the Adult Mental Health Directorate.
579. **Serious untoward incidents:** East London and The City Mental Health NHS Trust should carry out a review of the recommendations of all of the Independent Inquiries in which it has been involved and which have reported since 2001, and of the resulting action plans, to monitor its progress since then. An audit programme should be in place to manage the changes implemented by the Trust in a coherent and consistent manner. Key areas of weakness that need constant monitoring are assessments (including risk assessments), care planning and record-keeping.
580. **SUIs:** The 2003/04 Trust annual report highlighted the need to improve Serious Untoward Incident processes and systems. We recommend that the Trust reviews the process of dealing with Serious Untoward Incidents to ensure that the SUI policy is implemented consistently and comprehensively; that lessons are learned and cascaded effectively through the Trust; that audit systems are put in place to ensure that recommendations are implemented and that lessons from SUIs are considered by the Trust Board as part of overall Clinical and wider Governance structures.
581. The Trust should consider the gaps and issues for debate in the internal inquiry report identified in this review to establish whether they have been addressed since the internal inquiry and, where they have not, ensure that appropriate action is taken.
582. The Trust should consider adding a column to its format for Action Plans to record evidence of completed actions. Further improvements are needed to the format to ensure that Action

Plans are effective monitoring tools to enable the recording and continuous review of actions until they are signed off, with evidence of completion recorded.

583. **Management of untoward incidents & internal reviews:** Monitoring of action. The Joint Co-ordinating Group should be considered as the group for monitoring the implementation of recommendations affecting complementary services provided by the Trust and Social Services.

584. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that issues identified within the Internal process are acted upon, as a matter of urgency across the Trust.

585. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that all stakeholders should consider how to disseminate the learning from this report.

586. **SUI processes:** The Mental Health Trust and the SHA have to ensure that the conduct of internal and independent Inquiry processes into SUIs follows best practice and stated policy, so that in addition to the formal scrutiny to be undertaken by the SHA, those stakeholders with actions arising from this report should consider inviting representatives of the Panel to independently evaluate achievements in 12 months time.

587. **Reviewing progress on recommendations:** The Trust together with PCT's and local social services should keep under review the progress made on the recommendations contained in this Inquiry's report, the Lessons Learned and associated Recommendations of the Multi-Disciplinary Audit completed in February 2003, reporting back to this Inquiry in six months' time. In particular the following subjects should be examined: Out of area admissions, Non attendance for patients on CPA, Transfer of documentation (section papers and medical notes), Changing a diagnosis in early psychosis, Discharge summaries, Co-ordinated risk assessment, risk management plans, documentation, communication and reviews & The engagement of patients and carers.

588. **Review of these recommendations:** The organisations listed in these national recommendations should review progress on them and report to this Inquiry in six months time so that the Inquiry can comply with its Terms of Reference.

589. **Training & development:** It is our recommendation that, following the external review of policies and procedures, the implementation of such recommendations that are made is accompanied with an in-service training programme, and audited within one year of the implementation.

590. We recommend that the Trust implements a development programme for the Inner City PCLT, facilitated by an impartial trainer, which takes account of the changes in personnel and the outcome of the internal investigation. The outcome of this programme should; a) establish ground rules for acceptable behaviour in the working environment, e.g. responsibility to each other and working with other teams, b) develop operational policies into agreed practical procedures, c) identify opportunities if staff wish to work in other teams, and d) develop working arrangements at the interface with other services in order to achieve 'conflict resolution'.