

<p>Yorkshire and the Humber Strategic Health Authority</p> <p>BOARD MEETING</p>	 <p>Yorkshire and the Humber</p>
<p>Date: 2 September 2008</p>	<p>Report Author: Prof. Sue Proctor</p>
<p>Title of paper: Report of the Independent Investigations Committee</p>	
<p>Actions Requested:</p> <ul style="list-style-type: none"> <i>i) Receive the minutes of the meeting of 23 July 2008</i> <i>ii) Approve the closure of SUI Ref 2005/2100 (subject to suitable audit)</i> <i>iii) Note the report on incidents which predated 1 July 2006</i> <i>iv) Approve the proposal that an extraordinary Board meeting be held on 4 November 2008 to receive the reports of five independent investigation cases</i> 	
<p>Governance Requirements</p>	
<p>SHA Objectives supported by this paper: <i>Objective 1: Delivering an improved health system</i></p>	
<p>Risk Management: <i>Potential risk: failure to ensure learning from key national and local incidents/inquiries implemented in practice in PCTs and Trusts.</i></p>	
<p>Board Assurances:</p> <ul style="list-style-type: none"> <i>• This paper confirms that the Health Authority is undertaking its statutory obligations to investigate incidents and that a Board Committee is providing assurance that the processes are being observed.</i> <i>• The Independent Investigations Committee minutes attached provide assurance that the incidents are being investigated and that the action plans from the incidents are being implemented.</i> 	
<p>Risk Assessment:</p> <ul style="list-style-type: none"> <i>• A risk assessment has been carried out. Existing controls will be sufficient to handle the risks arising from the issues identified in the paper.</i> <i>• The risks arising from these issues are being pursued through operational risk registers</i> 	

Communication (including public and patient involvement):

Not applicable

Resource Implications:

Not applicable

Legal Implications:

Not applicable

Equality and Diversity:

Learning from independent investigations may be used to improve services for vulnerable people.

Yorkshire and the Humber Strategic Health Authority

2 September 2008

Report of the Independent Investigations Committee

- 1 Attached at appendix 1 are the minutes of the meeting of the Independent Investigations Committee held on 23 July 2008.
- 2 The Committee reviewed the Action Plan arising from the investigation into SUI reference 2005/2100. As this indicated that all actions had been taken it was agreed to recommend to the Board that this investigation be closed subject to a suitable audit.
- 3 In July 2007 the Chief Executive of the NHS wrote to all SHA Chief Executives asking them to assure themselves of the local processes for identifying cases for independent investigation. Since this letter was first issued the Department of Health has informally requested SHAs to publish the list of the serious untoward incidents that required independent investigation as at 1 July 2006.
- 4 On 23 July 2008, the Independent Investigations Committee received a paper relating to these "legacy cases", how they were identified and how the Integrated Governance Team have been dealing with this backlog. A revised and final version of this paper is attached at appendix 2.
- 5 As most of the independent investigations into these incidents were commissioned towards the end of last year or early this year it is anticipated that there will be a significant number of reports ready for publication towards the end of this calendar year. In Yorkshire and the Humber such reports have always been presented to the Board in public session. This is considered to be good practice by the Department of Health. To facilitate such publication of these "legacy cases" the Independent Investigation Committee proposes that an extraordinary Board meeting be held on 4 November 2008 following the Board development session.
- 6 The Board is asked to :-
 - i) **Receive** the minutes of the Independent Investigations Committee;
 - ii) **Approve** the closure of SUI reference 2005/2100
 - iii) **Note** the paper on the incidents which occurred prior to 1 July 2006.
 - iv) **Approve** the proposal to hold an extraordinary Board meeting on the afternoon of 4 November 2008.

Professor Sue Proctor
Director of Patient Care and Partnerships

Yorkshire and the Humber Strategic Health Authority

Minutes of the Independent Investigations Committee held on 23rd July 2008 in Board Room C, Blenheim House.

Present:	Jayne Jack	Non Executive Director (Chair)
	Rachel Gregson	Associate Director of Integrated Governance
	Sue Proctor	Director of Patient Care and Partnerships
In Attendance:	Wendy Ambler	Integrated Governance Manager
	Caroline Radford	Senior Media and Communications Manager
	Fiona Forbes	Integrated Governance Programme Manager.

	Action/ Responsibility
08/30 Welcome and introductions	
The Chairman welcomed Mrs Fiona Forbes, Integrated Governance Programme Manager, to the meeting.	
08/31 Minutes of the meeting of 5 February 2008	
The minutes of the meeting of 23 April 2008 were approved.	
08/32 Matters arising	
It was noted that all of the matters arising from the minutes of the previous meeting were covered on the agenda.	
08/33 Cases to be commissioned	
<p><i>a) SUI ref. 2004/2230 and 2007/9994 NYYPCT</i></p> <p>The committee was advised that the contracts for these independent investigations were in the process of being let to Consequence UK.</p> <p><i>b) SUI ref. 2007/4506; SUI 2007/12661; SUI 2007/13546</i></p> <p>The committee was informed that the judicial process in these cases had been completed and independent investigations were required. It was noted that there were a limited number of investigators for independent investigations and this has resulted in delays in the investigation process in the past. This had been identified as a national issue. The committee discussed approaches taken in other SHAs.</p> <p>The committee agreed that:</p> <p>Contact would be made with the North East and North West SHAs to discuss the possibility of pooling arrangements and that the matter would be raised</p>	

<p>The committee was informed that the contract for these independent investigations had been awarded to Caring Solutions. The investigation had already begun and the first draft of the report into 2005/95 was anticipated by the end of October 2008. The timetable for presentation to the Board would be agreed once the first draft had been received.</p>	
<p>08/37 Cases to be closed</p>	
<p><i>b) SUI ref.2007/806 - SWYMHT</i></p> <p>It was noted that the service user accused of having committed a murder in this case had not been subject to a CPA (Care Programme Approach) within the previous 6 months. The incident was therefore removed from the list of investigations to be commissioned.</p>	<p>FF</p>
<p>08/38 Review progress</p>	
<p><i>a) SUI ref. 2005/2100 – SWYMHT</i></p> <p>The committee considered the updated action plan for this case, copies of which had been previously circulated. It was agreed that the evidence on the action plan indicated that all actions had been taken and therefore the committee would advise the Board to close this case subject to an appropriate audit</p> <p><i>b) SUI ref. 2005/2081 – SWYMHT</i></p> <p>The committee considered the updated action plan for this case, copies of which had been previously circulated. Concerns were raised that timescales were not included for all the actions. The committee asked that an update on the progress of the action plan was brought to the next committee meeting to provide assurance.</p>	<p>WA</p>
<p>08/39 New Cases</p>	
<p>No new cases had been reported since the previous meeting.</p>	
<p>08/40 Legacy Cases</p>	
<p>The committee received a report detailing the investigations from the predecessor SHAs. The committee noted an amendment to the report – draft to be removed from the last sentence of paragraph 3 on page 2 of the report.</p> <p>The final report (including its Appendix) would be published on the SHA's website in line with advice from the Department of Health.</p>	
<p>08/41 Process to receive Legacy Cases</p>	
<p>The committee discussed the process for receiving the final independent investigation reports for the legacy cases which were in production. It was proposed that the Board be asked to hold an extraordinary Board meeting held in public with a dedicated agenda be convened in late October/early November to receive the reports and action plans to respond to</p>	

<p>recommendations. In addition to those investigations previously discussed, the reports which were still in process and would need to be reported to the Board over the coming months included two from Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust and three from Leeds Partnerships NHS Foundation Trust.</p> <p>It was agreed to liaise with the Secretary of the Board to organise the extraordinary meeting.</p>	<p>FF</p> <p>WA</p>
<p>08/42 Child and adolescent psychiatry</p>	
<p>It was noted that Child and Adolescent Mental Health Services were identified in the SHA's Healthy Ambitions document as a key area of development. Sue Proctor agreed to liaise with the Children Services Lead and the Child and Adolescent Mental Health Service Lead to ensure that a combined approach was developed.</p>	<p>SP</p>
<p>08/43 Workshop on Communications and Independent Investigations</p>	
<p>It was noted that a workshop for SHAs run by the Department of Health on communications aspects of independent Investigations was to take place on 16 October 2008. Venue to be announced.</p>	<p>CR/FF/RG</p>
<p>08/44 Date, time and place of next meeting</p>	
<p>It was agreed that the meeting that had been arranged for 21 October 2008 at 2pm in Blenheim House would be cancelled and be replaced by the extraordinary Board meeting.</p> <p>An outline timetable of dates for the new year were to be circulated with the minutes.</p>	<p>FF</p> <p>FF</p>

Yorkshire and the Humber Strategic Health Authority

Independent Investigations into serious adverse events in mental health

In 1994 the NHS Executive issued “Guidance on the discharge of mentally disordered people and their continuing care in the community” which included, in paragraph 34 “In the case of homicide it is always necessary to hold an inquiry which is independent of the providers involved.” Further guidance was produced in June 2005 including the criteria for when independent investigations should take place:-

- When a homicide has been committed by a person who is or has been under the care i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the three months prior to the event
- When it is necessary to comply with the State’s obligations under Article 2 of the European Convention on Human Rights (where an agent of the State is, or may be responsible for a death)
- Where the SHA determines that an adverse event warrants independent investigation

This guidance also clearly stated that Strategic Health Authorities were responsible for commissioning independent investigations. On 1 July 2006 Yorkshire and the Humber Strategic Health Authority became responsible for any outstanding investigations from the three predecessor organisations. This report covers the work arising from the first criterion only.

As organisations began to consider this issue it became clear that in some areas there was either little information available about the number of outstanding investigations or a significant backlog of investigations to be commissioned. In July 2007 the Chief Executive of the NHS, Mr David Nicholson, wrote to all SHA Chief Executives asking that they assure themselves of local processes to identify cases and ensure robust investigations.

At Yorkshire and the Humber SHA the staff of the Integrated Governance team already had a list of Serious Untoward Incidents (SUIs) which would require an independent investigation. The three predecessor organisations had implemented the national electronic incident reporting system, known as STEIS, which enabled NHS organisations across the region to record their incidents. To ensure that this list was accurate the first step was to interrogate the STEIS system, identifying all incidents which included the word “homicide”. Each incident that was identified in this manner was then scrutinised to see if it met the criterion for a “mental health” independent investigation. When a list had been prepared from this source, each Chief Executive of the organisations providing specialist mental health services was written to with a list of the cases from their organisation asking them to verify the list. Each Chief Executive responded that the list was complete.

A list of the investigations which the SHA picked up on 1 July 2006 is shown at Appendix A. This list has been shared with the National Confidential Inquiry into Suicides and Homicides (NCISH). This organisation receives its data through

different routes and uses different definitions (lifetime contact as opposed to within the six months prior to the offence) so a direct comparison with information from that organisation is not currently possible.

At the beginning of July 2006 there had been seventeen incidents which required independent investigation, of which one was identified during the checking process and another was reported late (in 2007) by a Trust following contact by NCISH. Four investigations had already been commissioned and two were in the process of being commissioned. Seven reports have been presented to the Board since 1 July 2006. Of the ten remaining cases, it is planned that eight reports will be submitted between the end of July and the end of December.

In addition to identifying the outstanding investigations, the Integrated Governance team has worked on ensuring that the commissioning of the investigations is transparent, and that the remit of the investigators is clear. All of the mental health investigations have been put out to tender. The tender documentation also includes guidance on the content of the investigation report and a confidentiality agreement form. The investigations have been grouped by organisation so that an investigator can develop a clear understanding of the organisation and can comment on how the organisation has changed since the incidents have occurred. This approach also enables some economies of scale, both for the provider organisation and for the commissioners which fund the investigations. Common themes and issues can also be drawn out for the provider organisation to consider. This approach should allow investigations to be commissioned and reported more quickly than previously allowing organisations to benefit from the findings and implementing change within a reasonable timescale.

The key reason why these investigations are conducted is to ensure that lessons are learned. In July 2007 the SHA produced a list of the issues/recommendations from the reports which had been produced and the action plans were still being monitored. These were:-

- Care planning and the application of the Care Programme Approach;
- Compliance with treatment, including medication;
- Poor record keeping and transfer of records;
- Communication between professionals, sectors and carers;
- Risk assessments including documentation;
- Management of patients with dual diagnosis;
- Access to services.

These are very similar to those identified elsewhere in the country.

Three key themes from this list have been identified to be taken forward through the Mental Health and Learning Disabilities Patient Safety Forum (MH/LD Forum) so that learning can be shared the across Yorkshire and the Humber. These are:

- Improving service users' engagement and compliance with all aspects of treatment;
- Communications;

- Assessing, managing and documenting risk.

Provider organisations will be asked to identify the action that they are taking in relation to each of these themes, how they are collaborating with their stakeholders in delivering improvement and how they plan to evaluate the impact of their changes. These will be fed back through the Mental Health and Learning Disabilities Patient Safety Network.

The commissioners of services will also be asked to pick up key issues. The Mental Health Pathways section of “Healthy Ambitions”, the Yorkshire and the Humber response to the Darzi review, identifies a number of issues. Of these, improving the clarity of referral routes, ensuring better access to psychological therapies and closer working with social care could help reduce the risk of these tragic events occurring.

W.M. Ambler
Integrated Governance Manager

Yorkshire and the Humber Strategic Health Authority

Independent investigations into adverse events in mental health

Incidents occurred prior to 1 July 2006

SUI Reference	Status of Investigation
2003/827	Investigation complete, published December 2006. Update now on website
2003/1578	Investigation commissioned
2004/282	As 2003/827 (joint report published)
2004/487	Investigation in progress
2004/680	Investigation in progress
2004/1904	Investigation complete, published September 06. Board to be asked to close following review of actions
2004/1964	Investigation complete, published 1 December 2006.
2004/2230	Investigation to be re-commissioned
2004/3403	Investigation in progress
2005/95	Investigation commissioned
2005/2081	Investigation complete, report published May 2008
2005/2100	Investigation complete, published June 2007
2005/2579	Investigation in progress
2005/2880	Investigation in progress
2005/3404	Investigation complete, published June 2007. Board to be asked to close following review of actions
2006/1787	Investigation in progress
2007/9994	To be commissioned – reported late as Trust was not aware of incident until National Confidential Inquiry into Suicides and Homicides requested information