Yorkshire and the Humber Strategic Health Authority **BOARD MEETING**	NHS Yorkshire and the Humber
Date: 2 June 2009	**Report Author**: Professor Sue Proctor, Director of Patient Care and Partnerships

Title of paper: Independent Investigations into SUI 2005/2579, SUI 2005/2880 and 2006/4924

Actions Requested:
The Board is asked to:-

i) Receive the executive summaries of the three individual reports from the independent investigators who have reviewed the care and treatment of three users of mental health services provided by Leeds Partnerships NHS Foundation Trust. Two of these individuals committed homicide and one attempted to commit homicide.

ii) Receive the action plans developed by Leeds Partnership NHS Foundation Trust in association with NHS Leeds and other provider organisations in response to the recommendations in the individual reports and

iii) Approve the publication of the independent investigation reports following their presentation to and scrutiny by the Independent Investigation Committee.

Governance Requirements

SHA Objectives supported by this paper:
Improving and assuring quality

Risk Management:
Risk 1.1 on 2008/9 assurance framework - Patients not treated as safely as possible in Yorkshire and the Humber

Board Assurances:
The Executive summaries and action plans are assurance to the Board that there has been appropriate action in the commissioning of the independent investigations and the action plans give assurance that the Trust and NHS Leeds are taking forward the recommendations from the investigation report.
The Independent Investigations Committee will review and monitor the action plans regularly and recommend closure when there is clear assurance that all of the actions have been taken.

Risk Assessment:
The reports have been shared with solicitors acting for the SHA and it has been concluded that the risk to the SHA is low.

Communication (including public and patient involvement):
Where possible the investigation reports have been shared with the families of the victims, the victim in 2005/2880, the service users and their families.
The full investigation reports will be made available to the public through the SHA web site once the SHA has approved the executive summaries.

Resource Implications: Any additional resource implications arising from the reports will be met by the Foundation Trust and the third sector organisations providing services in Leeds with support from NHS Leeds.
Legal Implications: All of these reports have been reviewed by solicitors acting for the SHA and any action identified by them has been taken. In publishing the reports into these incidents the SHA is discharging its statutory duty under HSG(94)27, as amended
Equality and Diversity: Poor mental health is known to have a significant impact upon the health, lifestyle and life chances of the sufferer and their close family. These reports and the associated action plans have been prepared to ensure that the learning from such tragic incidents is taken forward to help improve the care and treatment of people with mental illness and subsequently their life chances.

Yorkshire and the Humber Strategic Health Authority

2 June 2009

Independent Investigations into SUI Ref 2005/2579, SUI Ref 2005/2880 and 2006/4924

- At the Independent Investigation Committee meeting of 13 May 2009 three reports were presented by the lead investigator for Consequence UK. Copies of the Action plans accompanying these reports were also considered.

- Consequence UK had been commissioned to review and comment on two reports which had been prepared on behalf of Leeds Partnerships NHS Trust following a homicide and an attempted homicide by service users in the care of the Trust. They had also been asked to carry out a full review of the care and treatment of a third service user who had committed a homicide.

- Attached at appendix 1 (enclosure B) is the executive summary and action plan for the independent investigation into SUI Ref 2005/2579.

- Attached at appendix 2 (enclosure C) is the executive summary and action plan for the independent investigation into SUI Ref 2005/2880.

- Attached at appendix 3 (enclosure D) is the executive summary and action plan for the independent investigation into SUI Ref 2006/4924.

- All three reports relate to incidents involving patients using services provided by Leeds Mental Health NHS Trust (now Leeds Partnerships NHS Trust). There were no common features between these incidents identified by the investigators.

- Following consideration at the 13 May meeting the Independent Investigations Committee recommends the publication of these reports.

- The Chief Executives of Leeds Partnerships NHS Foundation Trust and NHS Leeds will attend the Board meeting to present the action plans.

- The Board is asked to:-
  i) Receive the executive summaries of the independent investigations;
  ii) Receive the action plans developed by Leeds Partnerships NHS Foundation Trust with NHS Leeds in response to the recommendations in the independent investigation reports and
  iii) Approve the publication of the three independent investigation reports.

Professor Sue Proctor
Director of Patient Care and Partnerships
2 June 2009

Independent Investigation into SUI 2005/2579
Executive Summary
JUNE 2009

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This independent investigation was commissioned by Yorkshire and the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.
This requires an independent investigation of the care and services offered to mental health service users involved in incidents of homicide where they have had contact with mental health services in the six months prior to the incident, and replaces the paragraphs in "HSG (94)27" which previously gave guidance on the conduct of such enquiries.

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Dr Maureen Devlin, Independent Healthcare Consultant and Associate Consequence UK Ltd
- Mr Mike Foster, Assistant Director of Nursing Oxfordshire and Buckinghamshire Mental Health NHS Trust
- Dr Mark Potter Consultant Psychiatrist South West London Mental Health NHS Trust

Acknowledgements:

The Investigation Team wish to thank the mother of the MHSU, also the wife of the deceased and his brother and sister for sharing with them their recollections of the weeks leading to the death of the MHSU's father.

The Investigation Team also wish to thank:

- all of the staff at Leeds Partnerships NHS Foundation Trust who gave willingly of their time to assist us in understanding the full context of the care and management of the mental health service user involved in the homicide on 10 July 2005.
- the General Practitioners in Leeds who participated in our on-line survey.
- the independent investigation team appointed by Leeds Mental Health Teaching Trust in 2005 for their cooperation with this investigation.

EXECUTIVE SUMMARY

Intention

On 10 July 2005 a patient of Leeds Mental Health Trust stabbed his father to death in his bed where he lay next to his mother. He was remanded to HMP Leeds on 12 July and subsequently transferred to a high secure hospital for urgent treatment under section 48 of the mental health act on 17 January 2006. He remains an in-patient at this hospital**.**

This report sets out the findings of the independent Investigation Team following its analysis of the internal investigation report written by the independent investigators appointed by Leeds Mental Health Teaching Trust to assess the care and management of mental health service user MHSU 2579 (the MHSU), meetings with the family of the MHSU, and exploration of key issues relevant to the care and management of the MHSU with staff currently working for Leeds Partnerships NHS Foundation Trust.

Purpose

The terms of reference for the work commissioned were to:

- Undertake an analysis of the MHSU's mental health clinical records and to identify any significant care management concerns that would require investigating as part of this independent investigation.
- Undertake an assessment of the internal investigation undertaken by Leeds Mental Health Teaching Trust to determine the extent to which it provides reasonable analysis and explanation of the care management concerns identified by the Independent Investigation Team.
- Undertake further analysis of the care management concerns in the MHSU's case where appropriate and necessary.
- To ascertain, if at all possible, the validity of the LMHTT Internal Investigation finding that the attack on the Service Users Father was not foreseeable or preventable by the mental health services at that time.

Outline of the review process

To deliver the above the following activities occurred:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A critical appraisal of the Trust's internal investigation report
- A meeting with the mother of the MHSU (wife of the deceased), and an aunt and uncle of the MHSU (brother and sister of the deceased).
- The use of a semi-structured survey instrument.
- A survey of GP's via the Leeds Local Medical Committee (LLMC)

Main conclusions
Before addressing the specific conclusions arising from this investigation the Investigation Team wish to make clear that the systems and processes underpinning the delivery of safe and effective care to mental health service users in Leeds have developed and improved considerably since 2005. It is the view of the Investigation Team Leader that the system failures that occurred in relation to the care and management of this MHSU would not occur today.

With regards to this MHSU it is clear that there were a number of missed opportunities to assess the MHSU following his referral by his GP in February 2005. The preventability of this incident will therefore always remain a possibility even though the act itself was not foreseeable. The Investigation Team draw this conclusion on the basis of information obtained from an analysis of the MHSU's medical record, the Trust's own internal investigation report, discussion with the independent investigation team leader appointed by Leeds Mental Health Teach Trust in 2006 and from information provided by the MHSU's family about how he was in the weeks and days leading to the incident.

The factors that might have made the difference are:

- A full assessment of the MHSU by an experienced member of the Sector 1 CMHT, (inc Consultant Psychiatrist), who was cognisant of the MHSU's past history and relapse behaviours, followed by regular community follow up and a reinstatement of enhanced CPA status. This would have provided the opportunity for a mental health professional to assess the MHSU and to determine whether or not he was relapsing and instituted an appropriate care plan.
- Although the MHSU's mother and father are reported to have become increasingly concerned about their son they did not feel able, at the time, to ask the GP to initiate an assessment under the mental health act (1983). A whole range of complex family factors underpinned this which are completely understandable.
- The wider family being aware that they could have approached the GP about their concerns and asked this person to consider whether or not assessment under the MHA was possible.

In stating the above the Investigation Team attributes no blame to the family of the MHSU, for what happened. Caring for someone with a severe mental illness can be traumatic and difficult. The impact of the experiences the MHSU's parents had with their son between 1994 and 2005 cannot be under-estimated. It is very understandable that they would not have wanted to have put at further risk, or further worsened, the fragile nature of the relationship between father and son.

The family members of the deceased, who met with the investigation team leader on 18 April 2009, accept the findings and conclusions of the Investigation Team. They do however believe that LMHTT let their nephew down regardless of whether or not the death of their bother was preventable. The Investigation Team agrees with this.

Main Recommendations
The Investigation Team have a number of recommendations for Leeds Partnerships NHS Foundation Trust,

Recommendation 1

The operation policy for the Community Mental Health Teams is more structured that that in place in 2004 – 2005, and now sets out the process for reviewing referrals and the time scales within which a response must be made. When its content is reviewed it is suggested that the following are considered for inclusion:

- A clear definition of the roles of clinical and managerial leaders.
- A clear definition of the roles and responsibilities of individual team members (to include clarity of differentiation between the bands of community psychiatric nurses (CPNs)).
- Case load allocation and case mix.
- Collective CMHT caseload size and the maximum case load for each team member.
- CMHT's relationship with general practitioners (e.g. at least twice a year one or more of the CMHT members will meet with the GP practice to look at issues of concern, referral patterns etc, meeting more frequently if required).
- Systems for preceptorship and induction of new staff (to include how different grades of staff are managed and supported).
- Handover arrangements when a care coordinator leaves, or where care coordination responsibility is transferred between services.

Recommendation 2

Although the response rate from GP's to the survey questionnaire circulated to all GP practices in Leeds (150 practices approx 300 GP's) was very disappointing (13%), a number of key issues emerged from the responses that were received. These were:

- That 50% of respondents to the survey said that they 'sometimes' felt that their concerns were respected when an urgent referral is made to mental health services.
- 50% of respondents had concerns about the usefulness of information sent to GP's from the specialist mental health service in Leeds following initial assessment and at the point of discharge.
- 32% of respondents had concerns about the overall quality of information sent to GPs from specialist mental health services.

The Investigation Team does not believe it is appropriate to make substantive recommendations on the basis of the above information i) because of the low response rate and ii) because variables such as the geographical placement of a GP practice, interpersonal relationships between CMHT members and staff at a GP practice / Health Centre could alter the results of the survey considerably.

However, neither is it appropriate to ignore the messages collated as a result of the survey. Therefore the Investigation Team suggests that the Directorate of Adult Services consider how they can further explore these issues on a sector by sector basis. In addition to aiding effective communications between primary care and specialist mental health services further exploration of the stated concerns should inform the development and design of current and future electronic documentation.

Recommendation 3

It is recommended that the Trust ensures that its regular audits of record keeping incorporate the audit of the quality and clinical usefulness of the documentation and do not focus solely on whether or not particular sections of a documentation tool are populated.

With regards to the audit of documents such as letters to GP following an assessment of a service user, or after discharge back into the community, clearly GP's will need to have an active stake in this process.

Leeds Partnerships NHS
NHS Foundation Trust

Independent Inquiry SUI ref: 2005:2579
Action Plan:

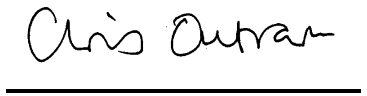
To be presented to the Board of Yorkshire and the Humber Strategic Health Authority

Introduction

Leeds Partnerships NHS Foundation Trust and NHS Leeds, the lead commissioning body for mental health services in the Leeds, accept the findings of the Independent Inquiry Investigations (SUI 2005/2579). The Independent Investigation was commissioned by Yorkshire & the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance titled "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.

This action plan addresses the recommendations from the Independent Inquiry report, and is published alongside the reports. The action plan is an owned document of Leeds Partnerships NHS Foundation Trust and NHS Leeds. Our organisations are committed to ensuring that the learning from the Independent Inquiry is thoroughly implemented in practice.

The implementation of this action plan will be monitored by NHS Leeds and by Yorkshire & the Humber Strategic Health Authority.



On behalf of
Chris Butler
Chief Executive
Leeds Partnerships NHS Foundation Trust

Chris Outram
Chief Executive
NHS Leeds

Independent inquiry Action Plan – Serious Untoward Incident Reference 2005.2579 – Final Draft

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
1.	When the content of the community mental health teams operational policy is reviewed it is recommended that certain areas are clarified and made explicit. • A clear definition of the clinical and managerial leadership • A clear definition of the roles and responsibilities of individual team members • Case load allocation and case mix • Collective CMHT caseload size and the maximum case load for each worker by Band and profession • The relationship between CMHTs and GPs and contact and communication between teams and GPs • Systems for preceptorship and induction for new staff • Caseload transfer arrangements when a care coordinator leaves or care coordinator responsibility transfer within a team or between teams.	The local working instructions were reviewed by the Clinical Service Manager (CMHTs) in January 2009. The local working instructions for the Community Mental Health Teams is more structured that that in place in 2004 – 2005, and now sets out the process for reviewing referrals and the time scales within which a response must be made. The Directorate is in the process of undertaking a significant review of CMHTs which began in August 2008. The review was based on demand for CMHT services including levels of referral and activity for CMHTs and Out Patients, Numbers of referrals to acute community services and admission to in patient care. The focus of the review is related to equalizing capacity and demand and reducing variation in this across the city specifically relating to workload, skill mix and introduction of New ways of working. The Lead Nurse and Head	1. Agreement of future configuration of CMHT services based on demand and capacity analysis previously undertaken on which the configuration proposal was based by Leeds Partnerships NHS Foundation Trust Board. 2. Agreement of the level of engagement required by NHS Leeds prior to any change process being implemented to move to new configuration of CMHTs by Leeds Parternships Foundation Trust. 3. To undertake a review of the current CMHT local working instructions and update this to make explicit the points defined within the recommendation. 4. Local working instructions will be ratified within the Directorate Business Meeting. 5. Use staffnet and Trust wide communication bulletin to publicise changed instructions and ensure this places on all team meeting agendas within the Directorate. 6. Identify areas in changed local working instructions which impact on current CPA training and revise training accordingly to reflect new	Clinical Services Manager, (Community mental health teams) Associate Medical Director, AMH Lead Nurse, AMH Head Occupational Therapist, AMH Directorate Support Manager, AMH	August 2009 September 2009 June 2009 July 2009 July 2009 December 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
		Occupational Therapist have undertaken a review of mentorship and preceptorship for new staff within the Directorate.	instructions. 7. Variance against agreed caseload to be monitored through Paris information system and Cognos business intelligence software reports via the capacity management group. 8. Lead Nurse and Head Occupational Therapist to finalise recommendations of the review of preceptorship arrangements and table for consideration within the Directorate's clinical governance council. Once agreed Lead Nurse and Head OT to implement recommendations with clinical governance leads and annually review the effectiveness of the preceptorship programmes. 9. Associate Medical Director to annually monitor the views of GPs via his attendance at the Leeds medical committee. 10. Use Paris information system to annually audit that transfer CPA meetings are held to enable caseload transfer.		July 2009 March 2010 March 2010 March 2010

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
2	Identify with colleagues in primary care how information sent from the Directorate can be made more useful to them.	Audits of discharge summary content and timeliness undertaken within the Directorate leading to standardisation in the format of discharge summaries. 'Copying correspondence' guidance implemented within the directorate to ensure service users who wish to receive information sent to GPs about them are able to have this. Each CMHT has a link liaison worker aligned to each GP practice in Leeds.	1. Undertake audit of GPs to assess overall satisfaction with regard to written communication received from clinical members of community mental health teams using 'Sheffield Assessment Instrument for Letters' (SAIL) 2. Identify areas of good practice within directorate as assessed by GP colleagues 3. Based on feedback from GPs develop minimum standard for communication with GPs and service users in conjunction with staff in CMHTs 4. Develop standards for use by clinical staff in CMHTs on Paris information system 5. Monitor effectiveness and satisfaction of standards with staff in CMHTs including medical staff GP colleagues and service users after 6 months and review 6. Annual review of agreed standards in use by clinical staff and amend PARIS information system as required.	Directorate Support Manager, AMH Associate Medical Director, AMH	September 2009 September 2009 April 2010 April 2010 October 2010 April 2011 and ongoing

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
3	The Trust ensures that as part of its regular audits of record keeping the activities undertaken to achieve this and the design of the audit tools incorporate the audit of the quality and clinical usefulness of the documentation and not solely whether or not particular sections of a documentation tool are populated	There is currently an audit cycle in place to audit clinical records within all Directorates The CPA audit tool used in January 2009 in all Directorates who use CPA was designed to include both quantitative and qualitative measures.	1. With colleagues from clinical audit department review all documentation audit tools currently in use in the Trust. 2. Assess to what extent documentation audit tools measure qualitative and quantitative aspects of record keeping 3. Develop reports using Paris and Cognos information tools to replicate measures of quantitative aspects of current audits. 4. Develop quality and clinical usefulness indicators and measures to be used and audit tools for capturing these and share with colleagues in all directorates. 5. Set and monitor audit cycles for each Service Directorate. 6. Development, if required, of action plans to be monitored through clinical governance structure	Head of Clinical Audit Head of Mental Health legislation & CPA	May 2009 May 2009 September 2009 July 2009 July 2009 Ongoing

Appendix 2

Independent Investigation into SUI 2005/2880
Executive Summary
June 2009

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This independent investigation was commissioned by Yorkshire and the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.
Page 2 of this guidance enables Strategic Health Authorities (SHA's) to commission independent investigations where a SHA deems that an independent analysis of a service user's care and treatment is warranted. In this case the victim of an unprovoked attacked by an in-patient at Leeds Mental Health Teaching Trust was lucky not to lose her life. It was this near death experience that prompted the SHA to call for an independent investigation in this case.

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Mr Mike Foster, Assistant Director of Nursing Oxfordshire and Buckinghamshire Mental Health NHS Trust
- Dr Maureen Devlin, Independent Healthcare Consultant and Associate Consequence UK Ltd
- Dr Mary Jackson, Consultant Clinical Psychologist and Associate Consequence UK Ltd
- Dr Mark Potter – Consultant Psychiatrist South West London and St Georges Mental Health Trust

Acknowledgements:

The Investigation Team wish to thank:

- West Yorkshire Police
- Staff at Leeds Partnerships Foundation NHS Trust
- The Service User
- The Voluntary Agencies in Leeds who met with the Investigation Team
- The independent investigation team appointed by the former Leeds Mental Health Teaching Trust

who all assisted in the completion of the investigation conducted. .

EXECUTIVE SUMMARY

Intention

On 20 December 2005 a patient (the MHSU) of Leeds Mental Health Trust (LMHTT) was convicted with wounding with intent on 27 July 2005, by stabbing a female who was unknown to him. The MHSU was transferred from HMP Leeds to a high secure hospital facility on 11 January 2006, detained under section 48 of the mental health act for urgent treatment of his mental illness. He remains an inpatient at this hospital.

This report sets out the findings of the independent Investigation Team following its analysis of the independent internal investigation report commissioned by Leeds Mental Health Teaching Trust (LMHTT) into the care and management of MHSU 2880 (the MHSU), meetings with a number of key voluntary agencies working with mental health service users in Leeds, and exploration of key issues relevant to the care and management of the MHSU with staff currently working for Leeds Partnerships NHS Foundation Trust (LPFT).

Purpose

The terms of reference for the work commissioned were to:

- Undertake an analysis of the MHSU's mental health clinical records and to identify any significant care management concerns that would require investigating as part of independent review.

- Undertake an assessment of the internal investigation undertaken by Leeds Mental Health Teaching Trust to determine the extent to which it provides reasonable analysis and explanation of the care management concerns identified by the Independent Investigation Team.

- Undertake any further analysis of the care management concerns in the MHSU's case where appropriate and necessary.

Outline of the review process

To deliver the above the following activities occurred:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A critical appraisal of the Trust's internal investigation report
- The use of a semi-structured survey instrument.
- Focus group meetings with three voluntary agencies

Main conclusions

The Independent Investigation Team supports the findings and main conclusions of the LMHTT Internal Investigation Report (June 2006) in every respect except for its assertion that the attack that occurred was predictable and preventable.

However both this Independent Investigation Team, and the original LMHTT Investigation Team believe that had any one or a combination of factors occurred then it is possible that the unprovoked attacked on the victim may have been prevented.

However, the Independent Investigation Team does not believe that one can assert with any certainty that the incident was preventable had the assessment and management of the MHSU been better. Our reasoning for questioning absolute preventability is the variables that could have still enabled the MHSU to have left the ward unnoticed even if his management had been optimal.

These variables were:

- The open door policy at the time. This means that the ward was unlocked and even if the MHSU had been on more closely timed observations he still could have left the clinical area unnoticed and been back on the ward before he was missed.
- The period of time the MHSU was absent from the ward for. It is significant that he was only absent for a period of eight minutes. For staff to have known where the MHSU was at all times would have required 'within eyesight', or 'within arm's length' observation. Even with optimal management this MHSU would not have attracted this level of observation.
- The MHSU was an informal patient and technically was free to leave the ward.

With regards to the question "could the incident occur in LPFT today?" One would be foolish to assert that a service user will not ever leave a ward and harm another again. However, if LPFT

- ensures that the standard of 'no ground leave' in the first 72hrs following admission is robustly upheld in all inpatient areas,
- continues with a more robust approach to risk assessment training,
- continues to undertake meaningful analysis of absconding incidents,
- continues with its commitment to develop effective and healthy working relationships with third sector agencies which includes the respect of their time served experience and knowledge of a service user,

then an incident with similar features should not occur again.

LPFT has made considerable investments in the security of its acute inpatient building, numbers of staff employed and staff skill mix as well as in embedding strong governance arrangements. The models and approaches to care are significantly different to those in place in 2005 across the whole of the adult services directorate. Ward 1 as it was in 2005 no longer exists and the new Ward 1 has effective and dynamic leadership. In spite of the horror of this incident for the victim who continues to live with her injuries today the Trust does deserve recognition for the commitment it has made to improving its service.

Main Recommendations

For LPFT

Recommendation 1: LPFT is encouraged to explore the potential for named third sector agencies to be awarded direct referral rights to CMHTs without having to go via the GP. If this suggestion is considered at all feasible LPFT is encouraged, with the support of Volition[1], to run a pilot project over a defined period of time for example 6 months, with clear auditable outcomes.

Recommendation 2: For Adult Services Directorate, LPFT, Volition and Supporting People[2] to explore the feasibility of having named individuals at a sufficiently senior level to act as the central conduit of information relating to the availability of beds within the voluntary sector.

Recommendation 3: It is recommended that the Director of Service Delivery – Chief Nurse and the Chief Officer of Volition meet to discuss the findings of this investigation and develop a detailed action plan, preferably utilising a multi-pronged approach, to achieve further improvement in the grass root relationships between LPFT staff and third sector agencies working substantially with mental health service users. It is expected that addressing the reported ineffectiveness of the current shadowing arrangements will form part of the action implementation plan.

Any plan agreed must be shared with the SHA and commissioners and have measurable objectives so that the impact of the agreed action implementation plan can be monitored in the short, medium and long term.

Recommendation 4: As LPFT develops PARIS[3], and its Care Programme Approach (CPA)[4] and FACE[5] risk assessment tools the

[1] Volition - Leeds is an alliance of voluntary sector organisations that either provide mental health services for or work with people who have mental health needs.
[2] The Supporting People Programme was launched in 2003 to support vulnerable people to live more independently and maintain their tenancies. It provides housing related support to over 1.2 million people.
[3] PARIS is an electronic documentation package.
[4] CPA see glossary

Trust needs to look at how information about third sector agencies, who are providing a service to 'the' service user can be best incorporated so that:

- the degree of their involvement is clear
- the contact details of the key worker are readily available,
- the wishes of the service user with regards to information that can be shared with the voluntary agency are recorded
- whether or not they are to be invited to CPA discharge planning and CPA meetings generally is stated.

Recommendation 5: The training provided to LPFT Care Coordinators needs to highlight the valuable role of the third (voluntary) sector in supporting the provision of an effective mental health service.

For Volition and Commissioners Of Mental Health Services To Progress

Recommendation 6: All third sector agencies registered with Volition who work on a regular basis with LPFT should be using the FACE risk assessment. Ideally where possible these third sector agencies need to fund their staffs attendance at LPFT's risk assessment training workshops.

Recommendation 7: There needs to be a clear pathway to enable workers in the voluntary sector to be able to access relevant specialist mental health services appropriately. It is recommended that LPFT and Volition work jointly with commissioners to achieve this.

Recommendation 8: Commissioners of mental health services in Leeds need to consider the value to the delivery of safe and effective services of supporting financially the development of, and delivery of, a single training programme for risk assessment of mental health service users across the secondary and third sectors. Clearly should such an initiate be considered sensible then careful consideration will need to be given to which third sector agencies should be included as a matter of course, and those for whom automatic training provision is not considered an appropriate use of the training resource.

Recommendation 9: To assist appropriate information sharing between third sector agencies and the specialist mental health service in Leeds. It is recommended that the Chief Officer of Volition initiate a meeting with those third sector agencies who work most closely with specialist mental health services and assess the feasibility of using a common design, or content specification, of consent form. This form would not only seek the consent of third sector clients to share appropriate information with specialist mental health services where both sectors are engaged in care and management, but also the

[5] FACE is a model of risk assessment used to determine the risks a service user poses to him or herself and the risks posed to others.

consent of the client for the third sector agency to receive information from specialist mental health services in relation to:

- the treatment plan
- CPA
- Risk Assessment

In the interests of completeness the validity of the consent should be checked periodically. The Investigation Team suggests that the advice of the legal advisors to NHS Leeds or Yorkshire and the Humber SHA should be sought regarding pragmatic time periods for this.

Leeds Partnerships NHS
NHS Foundation Trust

Independent Inquiry SUI ref: 2005:2880
Action Plan:

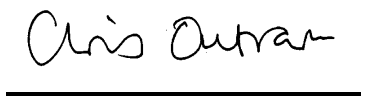
To be presented to the Board of Yorkshire and the Humber Strategic Health Authority

Introduction

Leeds Partnerships NHS Foundation Trust and NHS Leeds, the lead commissioning body for mental health services in the Leeds, accept the findings of the Independent Inquiry Investigations (SUI 2005/2880). The Independent Investigation was commissioned by Yorkshire & the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance titled "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.

This action plan addresses the recommendations from the Independent Inquiry report, and is published alongside the reports. The action plan is an owned document of Leeds Partnerships NHS Foundation Trust and NHS Leeds. Our organisations are committed to ensuring that the learning from the Independent Inquiry is thoroughly implemented in practice.

The implementation of this action plan will be monitored by NHS Leeds and by Yorkshire & the Humber Strategic Health Authority.



On behalf of
Chris Butler
Chief Executive
Leeds Partnerships NHS Foundation Trust

Chris Outram
Chief Executive
NHS Leeds

Independent inquiry Action Plan – Serious Untoward Incident Reference 2005.2880– Final draft

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
1.	Leeds Partnerships NHS Foundation Trust is encouraged to explore the potential for named third sector agencies to be awarded direct referral rights to CMHTs without having to go via the GP. If this suggestion is considered at all feasible Leeds Partnerships NHS Foundation Trust is encouraged, with the support of Volition, to run a pilot project over a defined period of time for example 6 months, with clear auditable outcomes.	Referral criteria in the recently revised CMHT local working instructions specify that referrals can be accepted directly from non-statutory agencies. Paris information system is currently configured to allow for referral source of voluntary sector to be made to CMHT.	1. To undertake a review of the current CMHT local working instructions and update this to make explicit that appropriate 3rd Sector agencies can refer directly to CMHT's. 2. Process mapping for CMHTs to be undertaken in April and May 2009 to identify any variance in referral pathways between teams. 3. CMHTs will adhere to a single service pathway. Variance tracking against this pathway will be undertaken using information reports generated via the COGNOS business information tool based on data from the PARIS clinical information system. Causes of variance will need to be understood to decide whether these constitute predictable and clinically appropriate variance. 4. Review of variance tracking information on a 6 monthly basis by CMHT clinical governance team to review service pathway and	Clinical Services Manager, Community Mental Health Teams Acting Associate Director, Adult Mental Health	June 2009 May 2009 June 2009 December 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
			implement change processes as necessary. 5. Local working instructions will be ratified within the Directorate Business Meeting. 6. Use staffnet and Trust wide communication bulletin to publicise changed instructions and ensure this places on all team meeting agendas within the Directorate. 7. Audit of numbers of referrals received from voluntary sector and numbers accepted by the CMHT compared with average of total referrals accepted. Reports to be produced using Cognos business intelligence software. 8. Acting Associate Director and Associate medical Director to meet with Volition lead and review output of audits on quarterly basis.		July 2009 July 2009 November 2009 onward November 2009 onward
2	For Adult Services Leeds Partnerships NHS Foundation Trust, Volition and Supporting People to explore the feasibility of having named individuals at a sufficiently senior level to act as the central conduit of information relating to the availability of beds within the third sector. The third	Review of existing pathways for accessing vacancies in the third sector has been completed as part of wider Accommodation Pathways Project, providing clear evidence of the benefits of a single point of access and	1. Work with Leeds City Council Housing Solutions Service and Supporting People Providers and Commissioners to implement a single point of access within the Housing Solutions Service and a central system for identifying and	Acting Associate Director Care Pathways and Performance Lead	April-December 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
	sector agencies are convinced that such a system would improve communications and optimise bed usage.	central system for identifying vacancies. This project is a significant piece of partnership improvement work between Leeds PFT, Local Authority, Volition and NHS Leeds. The project has applied systems improvement methodology in reviewing current systems, including process mapping across all agencies involved and has identified many opportunities to improve the process and significantly reduce delays for service users in accessing accommodation.	allocating vacancies in the 3rd sector. 2. Once an agreed protocol has been introduced this will be monitored via the accommodation pathways project board. 3. The adult Directorate Delayed Discharge panel will continue to monitor any reductions in delayed transfers of care as a result of improvements in the allocation of bed usage in the third sector.		December 2009 onward December 2009 onward

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
3	It is recommended that the Director of Service Delivery - Chief Nurse and the Chief Officer of Volition meet to discuss the findings of this investigation and develop a detailed action plan, preferably utilising a multi-pronged approach, to achieve further improvement in the grass roots relationships between Leeds Partnerships NHS Foundation Trust staff and third sector agencies working substantially with mental health service users. It is expected that addressing the reported ineffectiveness of the current shadowing arrangements will form part of the action implementation plan. Any plan agreed must be shared with the SHA and the commissioners and have measurable objectives so that the impact of the agreed action implementation plan can be monitored in the short, medium and long term.	None.	1. Meeting to be organised between the Director of Service Delivery - Chief Nurse and the Chief Officer of Volition to agree a detailed action plan designed to bring about further improvement in the grass roots relationships between Leeds Partnerships NHS Foundation Trust staff and third sector agencies working substantially with mental health service users. This will include a review of the effectiveness of the current shadowing arrangements and any necessary improvements will form part of the action implementation plan. The resulting plan will be shared with the SHA and commissioners with timescales for implementation and clear, measurable objectives set out along with arrangements for monitoring delivery of these.	Director of Service Delivery – Chief Nurse	July 2009
4	As Leeds Partnerships NHS Foundation Trust develops PARIS, and its CPA and FACE risk assessment tools the Trust needs to look at how information about third sector agencies, who are providing a service to 'the' service user can be best incorporated so that: • the degree of their involvement is clear	Information sharing agreement in place between Leeds Partnerships NHS Foundation Trust and Community Links. Leeds Partnerships NHS Foundation Trust have agreed to set Aspire as a team on Paris Reviewing the software	1. Review of PARIS to assess if this information is currently being recorded adequately. 2. As part of the current review of the CRHT Holistic Assessment tool in preparation for adopting this as the standard assessment to be used by all clinicians within the Directorate – ensure that this information is	Directorate Support Manager, Adult Mental Health Clinical Services Manager, Community Mental Health Teams	June 2009 June 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
	• the contact details of the key worker are readily available, • the wishes of the service user with regards to information that can be shared with the voluntary agency are recorded • Whether or not they are to be invited to CPA discharge planning and CPA meetings generally.	requirements for Aspire staff to directly access Paris system from their team base.	collected in the initial assessment process. 3. Assess the current CPA care plan documentation within PARIS and amend to collect this information. 4. To include the revised documentation and process in CPA training 5. To specifically include this in future CPA documentation audits. 6. The Directorate has begun to discuss with Aspire (Early Intervention Service) ways by which their staff can have direct access to the Paris information system.	Head of Mental Health Legislation	August 2009 December 2009 January 2010 October 2009
5	The training provided to Leeds Partnerships NHS Foundation Trust Care Coordinators needs to highlight the valuable role of the third (voluntary) sector in supporting the provision of an effective mental health service.	Discussions underway with Aspire (early Intervention Service) for their staff to have direct access to Paris in order that they can record CPA information relating to service users they care coordinate. Volition representatives attend the city wide care coordination steering group.	1. Revise CPA training to ensure that this aspect of care coordinator responsibility is highlighted in the Trust's training for care coordinators and within any general training workshops. 2. To specifically include this in future CPA documentation audits.	Acting Associate Director Head of Mental Health Legislation	December 2009 January 2010
6	All third sector agencies registered with Volition who work on a regular basis with Leeds Partnerships NHS Foundation Trust	Contracts with third sector providers of services for people with complex needs (where	1. Review with Leeds Partnerships NHS Foundation Trust and third sector providers of services for	Director Development & Commissioning	End October 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
	should be using the FACE risk assessment. Ideally where possible these third sector agencies need to fund their staffs attendance at Leeds Partnerships NHS Foundation Trust's risk assessment training workshops.	there is a regular interface with acute in patient care) specify that a) appropriate risk assessments measures are used and b) that providers are responsible for ensuring the provision of a safe responsive service including having staff that are appropriately trained. A PAN Leeds Information Sharing Agreement is in place.	people with complex needs the potential to develop interface protocols including risk assessment.	Priority Groups Strategic Development Manager	
7	There needs to be a clear pathway to enable workers in the voluntary sector to be able to access relevant specialist mental health services appropriately. It is recommended that Leeds Partnerships NHS Foundation Trust and Volition work jointly to achieve this.	NHS Leeds works jointly with Leeds Partnerships NHS Foundation Trust and the third sector to ensure that joint working aids the process of managing clear care pathways. An example of this has been NHS Leeds, as a commissioner, co-ordinating a project between in patient wards, the housing department and the third sector to facilitate timely and safe discharge. In addition, all contracts state that service providers are responsible for the quality of services.	1. The possibility of joint training in relation to risk management procedures will be reviewed with Leeds Partnerships NHS Foundation Trust and Volition.	Director Development & Commissioning Priority Groups Strategic Development Manager	End October 2009
8	Commissioners of mental health services in Leeds need to consider the value to the delivery of safe and effective services of supporting financially the development of, and delivery of, a single training	Contracts with both Leeds Partnerships NHS Foundation Trust and third sector providers of services for people with complex needs include the	1. In light of work on interface protocols (recommendation 6) review with providers consideration of a single training programme.	Director Development & Commissioning Priority Groups	End March 2010

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
	programme for risk assessment of mental health service users across the secondary and third agencies. Clearly should such an initiative be considered sensible then careful consideration will need to be given to which third sector agencies should be included as a matter of course, and those for whom automatic training provision is not considered an appropriate use of the training resource.	requirement for staff to be appropriately trained and to maintain their competency. Training costs are included within the contract sum.		Strategic Development Manager	
9	To assist appropriate information sharing between third sector agencies and the specialist mental health service in Leeds. It is recommended that the Chief Officer for Volition initiate a meeting with those third sector agencies who work most closely with specialist mental health services and assess the feasibility of using a common design or content specification of a consent form. This form would not only seek the consent of third sector clients to share appropriate information with specialist mental health services where both sectors are engaged in care and management but also the consent of the client for the third sector agency to receive information from specialist mental health services in relation to: • The treatment plan • CPA • Risk assessment	This issue has been raised through the Becklin Discharge Project work mentioned in recommendation 7 and there is recognition from third sector providers that, whilst difficult to achieve, there is great need for common systems and processes in the important areas of risk assessment and information sharing.	1. Volition to set up a meeting of those third sector agencies who work most closely with specialist mental health services and assess the feasibility of using a common design or content specification of a consent form. 2. Volition to explore the systems used between statutory organisations and together with the relevant third sector organisations, Leeds Partnerships NHS Foundation Trust and commissioners devise a suitable format for third sector organisations. 3. Leeds Partnerships NHS Foundation Trust and third sector organisations to pilot the form, should this be agreed, and ensure that this is modified as appropriate and that widespread roll out is achieved.	Chief Executive Volition	End October 2009

Appendix 3

Independent Investigation into SUI 2006/4924 Executive Summary June 2009

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This independent investigation was commissioned by Yorkshire and the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.
This requires an independent investigation of the care and services offered to mental health service users involved in incidents of homicide where they have had contact with mental health services in the six months prior to the incident, and replaces the paragraphs in "HSG (94)27" which previously gave guidance on the conduct of such enquiries.

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Dr Michael Clarke, Consultant Psychiatrist, Assertive Out Reach
- Mr Jess Liversley, Commissioning & Development Manager (mental health/learning disability), NHS East of England Public Health Directorate
- Dr Mary Jackson, Consultant Clinical Psychologist and Associate, Consequence UK Ltd

Acknowledgements:

The Investigation Team wishes to thank all of the staff at Leeds Partnerships NHS Foundation Trust who gave willingly of their time to assist us in understanding the full context of the care and management of the mental health service user involved in the homicide on 25 July 2006.

EXECUTIVE SUMMARY

Intention

This report sets out the findings of the independent Investigation Team following its analysis of the care and treatment of a mental health service user (MHSU), who was involved in an incident of homicide on 25 July 2006 and subsequently sentenced on 13 December 2006 to life imprisonment with a stipulation that he serve seventeen years before being eligible for parole.

Purpose

The purpose of the work commissioned was to assess:

- The care and treatment the MHSU was receiving during the period leading up to the incident and at the time of the incident (that is, from February 2006 to 25 July 2006).
- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs.
- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies.
- The adequacy of the risk assessment and care plan and their use in practice.
- The exercise of professional judgment and clinical decision making.
- The interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs.
- The extent of services' engagement with carers and the impact of this.
- The quality of internal investigation and review.

Outline of the review process

To deliver the above the following activities occurred:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A series of interviews with the NHS, probation and voluntary sector staff (from the charity Touchstone) who had been engaged in the care and management of the MHSU, or were responsible for the provision of services.

- A round-the-table discussion with a selection of staff working in in-patient services.
- A semi-structured survey of staff.
- Analysis of the interview data using the qualitative research methodology of content analysis and affinity mapping[6].

Main conclusions

As a result of this review the main conclusions are:

- That the incident that occurred on 25 July was neither predictable nor preventable by the mental health services nor any other agency who had had involvement with the MHSU.
- Between 2002 and May 2006 the MHSU's care was of a reasonable standard.
- Between 16 May and 6 June 2006 there was a breakdown in communication between the mental health service, the court liaison service and the prison service which resulted in the MHSU not receiving the mental healthcare he should have whilst in custody between 16 May and 5 June and then in prison between 6 June and 14 July 2006.
- That on discharge from prison back into the community, as far as the Investigation Team has been able to ascertain, the MHSU was not discharged back into the care of a care coordinator. He was an enhanced care programme approach (CPA) patient when he was discharged from hospital services in May 2006, and he should have had a designated care coordinator who followed him up while in prison. This individual should have been aware of his discharge date so that community mental health services could be reinstated.
- At the time of the MHSU's final contact with mental health services on 19 and 20 July 2006 the decision not to admit him to hospital was reasonable.
- The non-communication by the Crisis Resolution and Home Treatment Team (CRHT) to the MHSU's care coordinator following his assessment in A&E, whilst constituting a slip in practice, did not (in the opinion of the Investigation Team) contribute in any way to the events that subsequently occurred. The CRHT had referred the MHSU to the Leeds Addiction Service (LAU), and had provided the MHSU with all of the necessary contact details for this service. There is no record that the MHSU made independent contact with the LAU.

[6] Affinity mapping is a way of sorting large amounts of data into logical groups. Consequence UK uses it to map interview data content against the main care concerns identified in an investigation.

Main recommendations

The Investigation Team has five recommendations for Leeds Partnerships NHS Foundation Trust, and one for NHS Leeds (formerly Leeds PCT).

Recommendations for Leeds Partnerships NHS Foundation Trust.

- When a service user is arrested and a custodial sentence is passed it is important that the specialist mental health service ensures that the responsible prison healthcare team is aware of any relevant mental health history, including the care plan and risk assessments. This responsibility is held regardless of the location of arrest, e.g. hospital or community.

  The challenge for the specialist mental health service is how it becomes aware of the arrest and subsequent custodial disposal so that it can discharge its duty of care to the service user.

- Cases will continue to arise where more than one agency is involved with a service user (such as probation, voluntary agencies and secondary mental health services), and a decision is being taken by a mental health care coordinator, following an initial referral assessment, as to whether input by the community mental health team (CMHT) is required. In such cases this professional must ensure that he or she has a complete understanding not only of the engagement of the other agencies, but also of the degree of engagement of the service user with these agencies, and the communication strategy should significant changes in the service user's circumstances arise.

- The trust does need to achieve a position where all staff responsible for assessing whether or not an individual requires specialist mental health services also consider whether the individual ought to be referred to other services, for example to the local authority for a Section 47 Assessment.

- This recommendation is inextricably linked to recommendation 1.

  From time to time service users receiving active input from the trust will be arrested and placed in custody at the direction of the courts pending trial, or as a result of trial and/or sentencing. Where the trust is aware of a service user being awarded a custodial sentence, in such cases the trust needs to ensure that all staff who carry care coordination responsibility understand that it is their responsibility to continue to oversee the delivery of any required mental health service to the service user, and ensure continuity of care planning arrangements.

- All CMHTs, regardless of directorate, are required to maintain clear and auditable minutes of their weekly team meetings.

Recommendations for NHS Leeds Prison Health Services

- The head of prison healthcare must ensure that the current approach to the monitoring and audit of documentation is reviewed. The Investigation Team suggests that a peer-review approach is considered to enable health staff to reflect on the quality of their documentation and whether or it accurately portrays:
  - care and treatment given;
  - the names, positions and agencies of persons providing third party information; and
  - information relayed to third parties.

- It is recommended that NHS Leeds prison healthcare services reconsider the current design of the form it issues to general practitioners seeking health based information about new inmates.

  The current form is not particularly directive and does not state clearly the importance of the information provided to enabling the provision of appropriate healthcare to a new inmate.

Leeds Partnerships NHS
NHS Foundation Trust

Independent Inquiry SUI ref: 2006:4924
Action Plan:

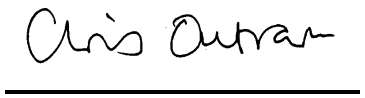
To be presented to the Board of Yorkshire and the Humber Strategic Health Authority

Introduction

Leeds Partnerships NHS Foundation Trust and NHS Leeds, the lead commissioning body for mental health services in the Leeds, accept the findings of the Independent Inquiry Investigations (SUI 2006/4924). The Independent Investigation was commissioned by Yorkshire & the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance titled "Independent Investigation of Adverse Events in Mental Health Services" issued in June 2005.

This action plan addresses the recommendations from the Independent Inquiry report, and is published alongside the reports. The action plan is an owned document of Leeds Partnerships NHS Foundation Trust and NHS Leeds. Our organisations are committed to ensuring that the learning from the Independent Inquiry is thoroughly implemented in practice.

The implementation of this action plan will be monitored by NHS Leeds and by Yorkshire & the Humber Strategic Health Authority.



On behalf of
Chris Butler
Chief Executive
Leeds Partnerships NHS Foundation Trust

Chris Outram
Chief Executive
NHS Leeds

Independent inquiry Action Plan – Serious Untoward Incident Reference 2006:4924 – Final Draft

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
1	When a service user is arrested and a custodial sentence is passed it is important that the specialist mental health service ensures that the responsible prison healthcare team is aware of any relevant mental health history, including the care plan and risk assessment. This responsibility is held regardless of the location of arrest e.g. hospital or community. The challenge for the specialist mental health service is how it becomes aware of the arrest and subsequent custodial disposal so that it can discharge its duty of care to the service user.	The Prison In reach team for Leeds are currently on the Paris information system used by all clinical services in the Adult MH Directorate since November 24th 2008. The system allows for referrals between services and the opportunity for all services involved with a client to be informed of any change in circumstances for a service user. The Leeds prison in-reach team have existing links with other in-reach teams on a regional basis which allows teams to share information between themselves regarding service users in prison in one area but originating from another Adult Mental Health Directorate Lead Nurse (formerly Clinical Services Manager for Community Mental Health Teams) disseminated learning through CMHT management and governance structures in	1. Develop a central system for Prison healthcare services contacting the Trust to confirm whether prisoners have had an ongoing or previous contact with Trust services. Determine if this service is best placed with the existing 'access to health records service' managed by Annette Booth. 2. Inform all prison in-reach teams nationally of the new arrangements for accessing information relating to possible service users with the Leeds Partnerships NHS Foundation Trust. 3. Develop systems and time limits for care coordinators to agree the sharing of CPA, FACE risk assessment and other appropriate clinical information. Any cases where agreement for sharing information is not given by care coordinator should be agreed by the Information Governance officer / Caldicott guardian through existing information governance and sharing processes and policies in place within the Leeds	Directorate support manager, AMH Medical records Manager Associate Medical Director, AMH	April 2009 April 2009 April 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
		May 2007. Risk assessment and management training has commenced for all clinical staff within the Adult MH Directorate. Court liaison/Diversion provided by the prison in-reach mental health service providing advice and support in court and to link offenders with mental health services as appropriate.	Partnerships NHS Foundation Trust. 4. Ensure secure arrangements in place for sending of clinical information either electronically where this is available or as hard copy in line with existing information governance policies and protocols within the Leeds Partnerships NHS Foundation Trust. This system will be reviewed within the information governance sub group of the IM&T committee. 5. Highlight to primary care colleagues the opportunity for proactive notification to mental health services by the service user's GP when they receive requests for health information about the service user from a prison.		April 2009 May 2009
2	Cases will continue to arise where more than one agency is involved with a service user e.g. probation, voluntary agencies and secondary mental health services, and a decision is being taken by a mental health care coordinator, following an initial assessment, as to whether input by the CMHT is required. In such cases this professional must ensure that he/she has a complete understanding not only of the engagement of the other agencies but also the degree of engagement of the service	The directorate has identified the need to have a single initial assessment tool which is being developed by clinical staff within the directorate. Use of CPA throughout CMHTs ensures that all agencies involved in service users' care are noted in the CPA documentation.	1. To include a specific question on the standardised initial assessment which asks about other agencies involved in the service users care and the level of engagement with these agencies. 2. Inclusion of the template and detail relating to delivery of this formalised in the CMHT operational policy. 3. Implement use of standardised	Clinical Service Manager, CMHTs Directorate Support Manager, AMH	June 2009 June 2009 July 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
	user with these agencies, and the communication strategy should significant changes in the service users circumstances arise.		assessment tool across all service areas. 4. Develop audit process to measure use of template, completion and quality of recording. NB this could be linked in to Paris and Cognos to allow automatic tracking and audit of completion of template. Review template at least annually or as indicated by variance tracking information. 5. Include question on CPA audit tool regarding completion of agencies involved in service users care on CPA documentation against that recorded in clinical notes. Repeat CPA audit.		September 2009 January 2010

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
3	The Trust does need to reach a position where all staff responsible for assessing whether or not an individual requires specialist mental health services consider the individual's eligibility under Fair Access to Care, and clearly documents their decision in relation to this.	The directorate has identified the need to have a single initial assessment tool which is being developed by clinical staff within the directorate. Use of CPA throughout CMHTs ensures that all agencies involved in service users' care are noted in the CPA documentation.	1. Discuss with Head of Mental Health Legislation how the Fair Access to Care requirements could be incorporated in to the CPA training. 2. Ensure that clinical service managers understand requirements of Fair Access to Care by asking Social Care manager to attend business meeting and discuss with management team. 3. Once understood by management team produce communication and training strategy to deliver training to staff in CMHTs 4. Deliver training to CMHT staff 5. Review single assessment tool currently under development to assess whether Fair Access to Care should be included in this tool. 6. Progress recruitment into CPA development post.	Clinical Service Manager, CMHTs Directorate Support Manager, AMH Head of Mental Health Legislation & CPA	May 2009 June 2009 September 2009 June 2009 September 2009 June 2009
4	From time to time service users receiving an input from the Trust will be placed in custody at the direction of the courts	The Directorate has a 'lessons learnt' cascade system in place which can be used to ensure	1. The Trust is in the process of recruiting a CPA development post with responsibilities for the provision	Head of Mental Health Legislation &	October 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
	pending trial, or as a result of trial and/or sentencing. Where the Trust is aware of a service user being awarded a custodial sentence, in such cases the Trust needs to ensure that all staff who carry care coordination responsibility understand that it is their responsibility to continue to oversee the delivery of any required mental health service to the service user, and ensure continuity of care planning arrangements.	that good practice or areas where practice can be improved are shared with staff within the Directorate and beyond. Prison in-reach team policy regarding CPA care coordination transfer in place stating that care coordination will only be transferred for sentenced prisoners and that CMHT staff should retain CPA care coordination for prisoners on remand.	of training. The former post left the organisation recently and the job description has been reviewed and sent for banding. 2. Revise the CPA policy document and the CPA paperwork (electronically on Paris) to reflect these responsibilities clearly and unambiguously. 3. Revise CPA training to ensure that this aspect of care coordinator responsibility is highlighted in the Trust's training for care coordinators and within any general training workshops. 4. Notify staff of these changes using the 'lessons learnt' system for cascade throughout the Adult Directorate and share with other directorates. 5. Review effectiveness of the lessons learnt cascade system through development of an audit tool to measure staffs understanding of the lessons learnt system and specific lessons cascaded.	CPA Directorate Support Manager, AMH Associate Medical director, AMH	 October 2009 December 2009 April 2009 October 2009
5	All CMHTs regardless of directorate are required to maintain clear and auditable minutes of their weekly team meetings.	All CMHTs hold a weekly team meeting where clients who are 'of concern' are discussed.	1. Develop standard template for use by CMHTs in team meetings to record minutes and actions arising from team meeting to include points	Clinical Service Manager, CMHTs Directorate	April 2009

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
		All team members receive clinical and caseload supervision where they can discuss any concerns with regard to any service user with a senior colleague. Draft minutes template produced by Jim Woolhouse to be discussed with Francis Denning and Clinical Team Managers in CMHTs.	specified in recommendation 5 of this report. 2. Ensure with CTMs that minutes are held securely and are available for audit. 3. Write to all team members to remind them of their responsibility to ensure that all discussions relating to a service user are recorded in the appropriate clinical record 4. Share template with colleagues in other Directorates	Support Manager, AMH	 April 2009 April 2009 April 2009
6	The investigation therefore recommends that the Head of Prison Healthcare reviews the current approach to the monitoring of and audit of documentation. We suggest that a peer review approach is considered to enable health staff to reflect on the quality of their documentation and whether it accurately portrays - care and treatment given - the names, positions and agencies of persons providing third party information and - information relayed to third parties. We also suggest that the review of documentation is a core activity within the context of clinical and management	Annual documentation audit in place, acknowledged and reported through HCC standards process Clinical supervision in place (September 2008)	1. Peer Review to be designed 2. Quarterly Peer review of clinical records 3. Provide annual report on findings and recommendations following peer audit	Head of Prison Healthcare	July 2009 September 2009 September 2010

No.	Recommendation	Action taken to date	Further action to be taken	Lead(s)	Time-scale
	supervision.				
7	It is recommended that NHS Leeds prison healthcare service reconsider the current design of the form it issues to general practitioners seeking health based information about new inmates The current form is not particularly directive and does not state clearly the importance provided to enabling the provision of appropriate healthcare to a new inmate With regards to information pertaining to the mental health needs of an individual the following minimum data set should be requested: does the individual have a mental health diagnosis; is the individual on CPA; what is the name of the individuals consultant and care coordinator	Pilot telephone contact with new patients' GP for confirmation regarding health status begun January 2009	1. Complete pilot of telephone contact 2. Incorporate recommended questions into telephone contact tool 3. Evaluation of pilot 4. Mainstream tool and process following audit 5. Improve communication with in-reach team and develop a recorded handover system with information from GP practice. 6. Provide documented evidenced of handover of information in patient's notes.	Head of Prison Healthcare	May 2009 April 2009 May 2009 June 2009 June 2009 June 2009