

Yorkshire and the Humber Strategic Health Authority

1 May 2007

Independent Inquiries – Update on Action Plans

1. Purpose

The purpose of this paper is to update the Board on the progress made by Trusts on the implementation of action plans arising from independent inquiries, into the care and treatment of users of mental health services convicted of homicide.

2. Background

On 1 July 2006 the SHA inherited responsibility for monitoring a number of action plans arising from independent inquiries that had been commissioned by, or on behalf of the predecessor Strategic Health Authorities. Action plans have been completed for all open and closed cases and progress is noted below.

3. Progress on Action Plans & Recommendations

2001/91 – Bradford District Care Trust (Appendix 1)

Inquiry into the homicide by a service user of the Trust, first presented to the Board of West Yorkshire SHA in December 2005. Actions for this incident are not yet complete. Staff now dealing with this case are new in post, all original recommendations are being re-examined to ensure that they have been completed in the spirit of the original report. There are a significant number of references to the Aire/Wharfe operational policy. The development of a central, co-located team is seen as a major step towards improving services in the Aire/Wharfe area covered by Bradford District Care Trust.

2003/1015 – Barnsley PCT (Appendix 2)

Inquiry into homicide by a service user of the PCT, first presented to the Board of South Yorkshire SHA in September 2005. The action plan does not indicate that the actions have been completed. However, the Complaints, Serious Untoward Incidents and Claims sub-group at Barnsley PCT, which has been monitoring this action plan, agreed in January 2006 that all of the actions had been completed. The PCT has agreed to review the action plan again to ensure that this is the case.

It is recommended that the action plans in respect of inquiries 2001/191 and 2003/1015 be reviewed in two months time with a view to final closure.

2003/827 and 2004/282 – Sheffield Care Trust (Appendix 3)

The inquiry into homicides by service users of Sheffield Care Trust were first presented to the Board of Yorkshire and the Humber SHA in December 2006. The joint action plan for 2003/827 and 2004/282 originally had thirteen primary actions with ten actions still outstanding. The new plan shows eighteen primary actions taken and a further nine to be completed. The actions have increased as

the Trust has worked through the plans and part completed the work or identified appropriate follow up work to ensure that good practice is embedded.

2004/1964 – Sheffield Care Trust

The inquiry into homicide by a service user of Sheffield Care Trust was first presented to the Board of Yorkshire and the Humber SHA in December 2006 at the same time as the above. The principal recommendation of that report was that the Royal College of Psychiatrists be contacted with recommendations about developing guidance on the structure and content of psychiatric assessments. A letter has been sent to the President of the Royal Psychiatrists with this recommendation.

2004/1904 - Bradford District Care Trust (Appendix 4)

The inquiry into homicide by a service user of the Trust was first presented to the Board of Yorkshire and the Humber SHA on 26 September 2006. The action plan shows that of the twenty five original recommendations, twenty one have been completed or actions built in to the on-going activity of the organisation. One of the key issues arising from this report was the working between the Local Authority and the Trust. Whilst plans have been prepared for the transfer of responsibilities from the Local Authority to the Trust there has been no final agreement on the transfer of staff and finances.

It is recommended that the action plans for inquiries 2003/827, 2004/282 and 2004/1904 be reviewed in four months time.

It is recommended that the Board note the action taken following the inquiry into incident number 2004/1964

2002/867 – Leeds Mental Health Teaching NHS Trust (Appendix 5)

Inquiry into homicide by a service user of the Trust. First presented to the Board of West Yorkshire SHA in November 2004. The action plan for this incident has now been completed and it is recommended that the Board approves the closure of the file.

The Board is asked to note and agree the recommendations set out in this report.

**Dr Sue Proctor
Director of Nursing and Patient Care**

Bradford District Care Trust**Independent Inquiry 2001/191 Homicide Review Action Plan – Progress update April 2007**

Ref	PROPOSED ACTION	PROGRESS UPDATE	ACTION STATUS	DATE COMPLETION EXPECTED/REVIEW
6.1 Primary Care				
6.1.1	Provide feedback to GP about primary care issues from this incident.	A further briefing for all GP's is to be distributed by the end of May 2007.	Complete	N/A
6.1.2	Review of current implementation of NICE guidelines for depression in primary care.	A review was undertaken in 2002 and action plan created to include;- <ul style="list-style-type: none"> • Training • Creation of a primary care mental health team • Creation of posts for GP's with special interest in mental health. Currently being revisited as part of a cross district review.	Complete	N/A
6.1.3	Review mental health referral pathways between primary and secondary care using outcomes to inform GP training programme.	Referral pathways have been revised and changes to service made including the establishment of gateway workers as a point of access and crisis resolution services. GP's are trained and updated on an ongoing basis by primary and secondary care mental health services.	Complete	N/A
6.2 Secondary Care				
6.2.1	All staff members interviewed for this investigation to receive a copy of the report.	Staff received a copy of the report.	Complete	N/A

6.2.2	Review of CMHT Operational Policy to include;-			
	<ul style="list-style-type: none"> Criteria for access 	Detailed in Appendix 1 of the Aire-Wharfe Operational Policy 2007.	Complete	N/A
	<ul style="list-style-type: none"> Recording of referral meeting/clinical discussions (decision making process) 	<p>This is detailed on pages 5-7 of the Aire-Wharfe Operational Policy 2007. Also detailed in Appendix 3 (Link Liaison Policy), Appendix 4 (A&E Liaison Policy), Appendix 6 (Caseload Management Guidelines).</p> <p>There is insufficient clarity regarding the requirement to document decisions taken and the reasons for them. Further action required.</p>	Incomplete	May 2007
	<ul style="list-style-type: none"> Standard letter format with reason for referral, purpose of initial assessment in the operational policy 	The Trust Referral form is attached to the Aire-Wharfe Operational Policy as Appendix 2.	Complete	N/A
	<ul style="list-style-type: none"> Criteria for access to establish rationale for acceptance onto caseload 	This is detailed in Appendix 1 of the Aire-Wharfe Operational Policy 2007.	Complete	N/A
	<ul style="list-style-type: none"> Eligibility of standard/enhanced CPA 	<p>This is detailed on page 7 of the Aire-Wharfe Operational Policy 2007. This is in greater detail in Section 10 of the BDCT Care Co-ordination Policy (January 2007).</p>	Complete	N/A
	<ul style="list-style-type: none"> Outcomes of assessment letters to include areas of disagreement between staff and service user 	<p>This is detailed on page 6 of the Aire-Wharfe Operational Policy. Further work required with regard to standard letter template.</p>	Incomplete	May 2007
	<ul style="list-style-type: none"> Giving accurate information to patients about their personal responsibilities and lifestyle choices 	Further clarification required before including in the Aire-Wharfe Operational Policy.	Incomplete	May 2007
	<ul style="list-style-type: none"> Review of caseload management and supervision records policy, to include keeping ongoing records of each discussion 	This is detailed in Appendix 6(Caseload Management Guideline) of the Aire-Wharfe Operational Policy.	Incomplete	May 2007

		Further work to include record keeping in caseload management and frequency of supervision.		
	<ul style="list-style-type: none"> Process for allocation of referrals to care co-ordinators 	This is detailed on pages 6-7 and Appendix 6 of the Aire-Wharfe Operational Policy 2007.	Complete	N/A
	<ul style="list-style-type: none"> Discharge Policy with template for discharge letter to include progress, interventions and remaining problem areas (cross reference with CPA policy) 	<p>Page 9 of the Aire-Wharfe Operational Policy requires that discharge should be in accordance with the Trust CPA Policy (Care Co-ordination Policy, January 2007). It is noted that the discharge letter should include information on progress, interventions and remaining problem areas.</p> <p>Further work to include template discharge letter and to address discharge from secondary care community services within the Care Co-ordination Policy.</p>	Incomplete	May 2007
6.2.3	CPN Link/Liaison Policy to be implemented across Aire Valley.	This is detailed in Appendix 3 of the Aire-Wharfe Operational Policy 2007.	Complete	N/A
6.2.4	Review caseload management guidelines to include advice to staff regarding information for GP's and service users on completion of assessment. e.g. outcome letters.	Further clarification required. It is unclear what this recommendation related to and how it was anticipated that it would be completed. The Trust would wish to review records and determine in more detail what this relates to.	Incomplete	May 2007
6.2.5	Development of educational packs for service users that are to be sent outcome letters. Service improvement Group to consider the most appropriate way of getting information to patients.	Further clarification required. It is unclear what this recommendation related to and how it was anticipated that it would be completed. The Trust would wish to review records and determine in more detail what this relates to.	Incomplete	2007
6.2.6	Review of Community Drug & Alcohol team Operational Policy to reflect current service provision.	A draft Drug & Alcohol service model has been issued for consultation and is in the process of being implemented by the Trust. This includes full pathways and liaison with primary care and CMHT's.	Complete	N/A
6.2.7	Review Record Keeping Policy to include;-	The Records Policy was reviewed and a new version introduced in January 2007. It will be reviewed annually.	Complete	N/A

	<ul style="list-style-type: none"> Practitioners must record date & time of next appointment 	<p>The Records Policy does not contain this requirement, although it is common practice.</p> <p>Further work is needed to address this requirement in the Records Policy.</p>	Incomplete	Policy review due December 2007.
	<ul style="list-style-type: none"> Recognised abbreviations 	This is addressed in The Records Policy, as a requirement not to use abbreviations.	Complete	N/A
	<ul style="list-style-type: none"> Printed surname, signature & designation. 	This is covered in the Records Policy.	Complete	N/A
6.2.8	Electronic Records to be developed in line with the NHS National Programme for IT.	A multi-disciplinary single patient file is under development. A Pilot has been completed and will be rolled out across all service areas pending progress with NPfIT.	Ongoing	To be reviewed through Information Governance Group and Service Governance Committee quarterly until completed
6.3 Multi-agency issues				
6.3.1	Review of Information Sharing Policy with the Police & other agencies and share findings/actions with other agencies, through appropriate partnership arrangements.	The overarching Bradford Health & Social Care Partnership Interagency Protocol for Sharing Information was approved in November 2003. Revision of this document and a number of issue specific protocols is expected to be completed by July 2007.	Pending	July 2007
6.3.2	Review of Emergency Duty team record keeping with reference to personal notes, in line with policy.	Out of hours service provision and the interaction between CRHT and EDT is currently under consideration, pending the transfer of adult EDT responsibilities to BDCT.	Complete	N/A
6.3.3	Staff briefing and written information about how the information sharing protocols work and how they can be accessed and the process required to access. Staff briefing to follow publication of report.	<p>A PCT Officer has been appointed to work with general practices on the application of these protocols. Further training and development will be addressed within the PCT's risk management planning.</p> <p>BDCT email sent to confirm that staff were given a copy of the report and debriefing took place.</p>	Complete	N/A

BARNSELY PCT
INDEPENDENT INQUIRY 2003/1015
ACTION PLAN

RECOMMENDATION 1

The assessment and exploration of jealousy amongst persons receiving mental health services from primary care services in Barnsley needs to be clarified and clear guidance provided to staff as to indicators that suggest referral and assessment by a consultant psychiatrist is required.

ACTIONS REQUIRED	DEADLINE FOR COMPLETION	RESPONSIBLE PERSON
To include interpersonal jealousy on new risk assessment documentation	Sept 05	Wendy Beresford
To include jealousy in mandatory 3 day risk/CPA training programme	August 05	Wendy Beresford
Each clinical area to receive training on jealousy	March 06	Gary Foley
Contact Rampton to request if they have any additional guidance	October 05	Marie Knott

RECOMMENDATION 2

Whilst the psychology department has made a significant impact on the previous waiting times for access to psychology services for primary care clients, it is essential that there is ongoing monitoring of effectiveness for this service

ACTIONS REQUIRED	DEADLINE FOR COMPLETION	RESPONSIBLE PERSON
Rollout stress-pac initiative across all 4 sectors	September 05	Linda Matthews
Monitor effectiveness of stress-pac and send report to community clinical governance	April 06	Linda Matthews Steve Kellett
Process map the system to clarify waiting time and measurements	To be agreed	Paul Foster
Establish system to measure waiting time for psychological therapies which becomes part of performance management system	To be agreed	Paul Foster

RECOMMENDATION 3

Barnsley PCT needs to assess the robustness of its induction and orientation arrangements for doctors in training and doctors appointed on a locum basis.

ACTIONS REQUIRED	DEADLINE FOR COMPLETION	RESPONSIBLE PERSON
Talk to Dr Courtney/Dr Chari	On Going	Dr. Courtney

ADDITIONAL RECOMMENDATION 1

The Trust needs to assess the level of compliance, and the effectiveness of, systems and processes it believes to be in place to support the induction and development of new and existing staff who are appointed to more senior nursing positions within the Trust. In undertaking such an assessment, the Trust may wish to consider undertaking a survey of staff who have been promoted within the Trust in the last 36 months to find out if Trust policy and systems have been followed and to ascertain what support and development would have assisted the transition of these staff to their more senior post.

ACTIONS REQUIRED	DEADLINE FOR COMPLETION	RESPONSIBLE PERSON
Review procedures in place for induction of professionally qualified staff (non medical)	Sept 05	Marie Knott
Review procedures in place for induction of medical staff		Mary Courtney
Preceptorship pilot	On Going	Marie Knott
Audit of effectiveness of procedures	June 06	Marie Knott
Implement any changes required as a result of the audit		Marie Knott

ADDITIONAL RECOMMENDATION 2

The current operational policy in adult services does not contain all of the expected key elements, e.g. details of case-load, discharge and transfer arrangements. These gaps need to be addressed and the policy document made complete.

ACTIONS REQUIRED	DEADLINE FOR COMPLETION	RESPONSIBLE PERSON
Review operational policy alongside CPA policy which already contains these elements. To consider merging or cross referencing these documents	December 05	Ian Noble

ADDITIONAL RECOMMENDATION 3

The Trust needs to develop a strategy for how it communicates with families of patients and other persons adversely affected as a result of an adverse incident involving a Trust client. In developing such a strategy the inquiry team recommends that this is progressed on multi-agency basis working in partnership with

- The local Police Force
- The local Coroner and the Coroner's officers
- Local statutory and non-statutory victim and mental health support groups

Further more, the Trust is encouraged to liaise with the National Patient Safety Agency, which is to launch national guidance on the investigation of serious mental health incidents such as homicide. A key component of this guidance is communication with families of mental health service user and the family of the victim.

ACTIONS REQUIRED	DEADLINE FOR COMPLETION	RESPONSIBLE PERSON
Develop guidelines using National Patient Safety Agency (NPSA) guidance		Sue Bentley

ADDITIONAL RECOMMENDATION 4

The Trust needs to reflect on how it currently provides stability in leadership where a Community Mental Health Team is without its substantive leader for a significant period of time and the effectiveness of its current policy and approach. The Trust is encouraged to seek the views of staff who have been without their appointed leader for a period of time as an integral component of any audit that may be undertaken to ascertain the effectiveness of current policy.

ACTIONS REQUIRED	DEADLINE FOR COMPLETION	RESPONSIBLE PERSON
Establish senior social work posts within each sector team. Job description to include cover for team leader	July 05	Jill Jinks
Review what actually happened in these cover arrangements	Oct 05	Marie Knott
Establish set of principles for covering workloads and test these out	Oct 05	Gill Jinks



**INDEPENDENT INQUIRY SI / S2
(SUI REFS: 2003/827 AND 2004/282)**

ACTION PLAN

UP-DATES AS AT 16 APRIL 2007

INTRODUCTION

Sheffield Care Trust Mental Health and Wellbeing NHS Trust and Sheffield Primary Care Trust, the lead commissioning body for mental health services in the city, accepted the findings of the Independent Inquiry Investigations (SUI 2003/827 and SUI 2004/282) commissioned by the former South Yorkshire Strategic Health Authority. The Independent Inquiry Investigation Team was thanked for its work in producing the reports.

This action plan addressed the recommendations from the Independent Inquiry Investigation reports, and was published alongside the reports. The action plan is a jointly owned document of Sheffield Care Trust Mental Health and Wellbeing NHS Trust and Sheffield Primary Care Trust. These organisations are committed to ensuring that the learning from the Independent Inquiry Investigations is thoroughly implemented in practice.

NHS Yorkshire and the Humber and Sheffield Primary Care Trust will monitor implementation of the action plan.



Kevan Taylor
Chief Executive
Sheffield Care Trust



Simon Gilby
Acting Chief Executive
Sheffield Primary Care Trust

INDEPENDENT INQUIRY INVESTIGATION - ACTION PLAN

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
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NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
1.	<p>PRIORITY RECOMMENDATION</p> <p>THE WEST CONTINUING NEEDS SERVICE HAS COMMENCED WORK TO AGREE A DRAFT PROTOCOL/PATHWAY FOR MANAGING CLINICAL DISPUTES BUT THE STATUS OF THIS PROJECT NEEDS TO BE ELEVATED SO THAT IT IS ADOPTED AS AN ADULT SERVICES WIDE PROJECT WITH DEFINED TIMESCALES AND DELIVERABLES THAT ARE MONITORED BY THE TRUST OR SERVICE GOVERNANCE COMMITTEE.</p>	<ol style="list-style-type: none"> 1. New guidance was implemented 1 November 06 by the Executive Directors and issued to all practitioners within Sheffield Care Trust, which instructed staff to follow a stepped model approach to resolving clinical disputes. 2. Directors within the Operational Management Group have taken personal responsibility and ensured that the guidance has been disseminated and discussed through their senior management teams. 3. The Chief Executive, in his regular letter to all staff, has highlighted the issue of clinical disputes and drawn attention to the guidance. 4. The Chief Executive has raised the issues of clinical disputes within Sheffield Care Trust's Leadership Forum. The new guidance forms a critical part of Sheffield Care Trust's Team Manager Development Programme. 	<ol style="list-style-type: none"> 1. Clinical Directors have confirmed compliance. Sheffield Care Trust, Patient Experience and Practice Development Directorate, will audit the implementation of the clinical disputes guidance, as part of the Sheffield Care Trust annual clinical audit plan for 2007 - 2008. 	<ol style="list-style-type: none"> 1. Tina Ball Director of Patient Experience and Practice Development 	<ol style="list-style-type: none"> 1. 31 May 07

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
1.	<p>PRIORITY RECOMMENDATION CONTINUED ...</p> <p>THE WEST CONTINUING NEEDS SERVICE HAS COMMENCED WORK TO AGREE A DRAFT PROTOCOL/PATHWAY FOR MANAGING CLINICAL DISPUTES BUT THE STATUS OF THIS PROJECT NEEDS TO BE ELEVATED SO THAT IT IS ADOPTED AS AN ADULT SERVICES WIDE PROJECT WITH DEFINED TIMESCALES AND DELIVERABLES THAT ARE MONITORED BY THE TRUST OR SERVICE GOVERNANCE COMMITTEE.</p>	<p>5. Sheffield Care Trust has developed a protocol/pathway in order to ensure that use of the guidance on clinical disputes will include a feed-back system to clinicians.</p> <p>6. Guidance has been circulated to Clinical and Service Directors on monitoring and reporting incidents.</p>			

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
2.	<p>Priority Recommendation</p> <p>Sheffield Care Trust needs to undertake a number of developments in relation to the clinically focused risk assessment process and training delivered to its staff.</p>	<ol style="list-style-type: none"> 1. An Executive and two Clinical Directors have been identified. They have overall responsibility for ensuring the effective implementation of a validated risk assessment tool. 2. A working group, involving external consultants from ARW Consultants with Clinical Directors for adults of working age, produced an action plan as at 31 October 06. 3. Standardised risk assessment tools are being evaluated. Implementation will be based on currently validated risk assessment tools. 4. A training trainers two day event was booked for 18/19 December 06 and was attended by 20 identified trainers. 	<ol style="list-style-type: none"> 1. Monitoring of the implementation process over the period 30 November 06 to 30 November 07. 2. Commencing at the end of January 07, the Head of Practice Development if reviewing the risk assessment and management programme, with a view to improving the content as it roles out to other Directorates. Reports have been produced on the number of training days completed each month and a register of all staff who have completed training is being maintained. An up-date will be presented to the Executive Directors Group, following agreement by 1 May 2007. 3. Application of the risk assessment tool will be subjected to a case notes audit, to identify the quality of application by staff who have completed the training. 	<ol style="list-style-type: none"> 1. Pam Stirling Executive Director Dr Katy Kendall and Dr Rachel Warner Clinical Directors 2. Eva Rix Head of Practice Development 3. Tina Ball Director of Patient Experience and Practice Development 4. Tina Ball Director of Patient Experience and Practice Development 	<ol style="list-style-type: none"> 1. 30 November 07 2. 01 May 07 3. 31 May 07 4. 30 November 07

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
2.	<p>Priority Recommendation continued ...</p> <p>Sheffield Care Trust needs to undertake a number of developments in relation to the clinically focused risk assessment process and training delivered to its staff.</p>	<p>5. Between January and August 07, 10 training days per month have been booked. It is anticipated that between 90 – 200 staff per month will be trained in the use of a standardised assessment tool. This will result in the whole of the work-force having been systematically trained in the application and implementation of an accredited risk assessment tool.</p>	<p>4. Similar audits will be applied at three monthly intervals, in order to maintain confidence in the application across the organisation.</p>		

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
3.	<p>Priority Recommendation</p> <p>Sheffield Care Trust must establish the baseline information it considers essential to the effective assessment of Service Users detained under the Mental Health Act. In identifying this SCT must ensure that its practice is commensurate with any relevant national guidance and good practice standards.</p>	<ol style="list-style-type: none"> 1. Most recent audits July/August 06 on clinical records showed that there was a consistently high level of completed assessments. Seven areas were audited, five in-patient wards and two community teams. Six units achieved 100% completion of assessments and care plans. One unit scored 96%. 2. In all cases the current bench-mark threshold for all components of the audit is 75%. All units achieved significantly higher scores on the full audit. 3. 100% of detained patients to have completed assessments, identified diagnosis and management plan. 4. Planned audits have been undertaken to ensure that a diagnosis is recorded at the end of the assessment period, for patients detained under the Mental Health Act. This has been submitted to Clinical and Service Directors. 	<ol style="list-style-type: none"> 1. Following the audit of records ensuring recording of diagnosis at the end of the assessment period, an action plan will be produced by Clinical Directors. 2. Following audit reporting of Section 17 leave approval, an action plan will be produced by the Clinical and Service Directors. 	<ol style="list-style-type: none"> 1. Dr Katy Kendall and Dr Rachel Warner Clinical Directors 2. Dr Katy Kendall and Dr Rachel Warner Clinical Directors 	<ol style="list-style-type: none"> 1. 30 April 07 2. 30 April 07

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
3.	<p>Priority Recommendation continued ...</p> <p>Sheffield Care Trust must establish the baseline information it considers essential to the effective assessment of Service Users detained under the Mental Health Act. In identifying this SCT must ensure that its practice is commensurate with any relevant national guidance and good practice standards.</p>	<p>5. Section 17 Leave approved by Registered Medical Officer and audit findings reported to Clinical and Service Directors.</p>			

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
4.	<p>Priority Recommendation</p> <p>The Operational Policy for the Continuing Needs Service needs to be updated so that it becomes a valuable and practical document for staff.</p>	<ol style="list-style-type: none"> 1. The Continuing Needs Service has reviewed and up-dated the operational policies for the team. This includes clear guidance for staff on engaging with service users from black minority and ethnic communities and covers the range of internal and external resources available to support effective engagement with service users and recommends communication pathways. 2. The Service Director for Recovery and Rehabilitation submitted a report to the Executive Director, confirmation successful implementation of the operational policies. 3. At their January 07 meeting, the Acute Community Care Forum developed an action plan with time-scales to review operational policies in acute and community settings. 	<ol style="list-style-type: none"> 1. The application of operational policies for continuing needs teams will be reviewed. 2. The action plan developed by the Acute Community Care Forum will be implemented and monitored. 	<ol style="list-style-type: none"> 1. Pam Stirling Executive Director Guy Hollingsworth Service Director 2. Richard Bulmer Service Director 	<ol style="list-style-type: none"> 1. 30 June 07 2. 31 August 07

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
	<p>Secondary Recommendation</p> <p>Care Programming Approach</p>	<ol style="list-style-type: none"> 1. The Care Programme Approach Manager was commissioned to review and action the recommendations highlighted by the Independent Inquiry Investigation Team. 2. The Information Technology Department now produces a monthly report for each team, highlighting overdue care programme approach reviews. 3. Team Managers and Care Co-ordinators are ensuring that information received regarding delayed reviews is treated as a matter of priority. 4. Further audits of delayed care programming approach reviews have been under-taken. The findings of such audits have been reported to Team and Governance meetings. Reports will continue to be submitted to Team and Governance meetings on a monthly basis. 	<ol style="list-style-type: none"> 1. Continue to submit monthly reports to Team and Directorate Governance meetings. 2. Sheffield Care Trust's Care Programme Approach policy will be further up-dated to include a protocol on medicines management which will be agreed with GPs in Sheffield Primary Care Trust and will cover communication of non compliance of medication by service users. If there are any recommendations arising from the forthcoming national review on Care Programming Approach, these will also be taken into account in the update; however, further guidance is currently awaited. 3. An audit of the care programming approach will include an evaluation of the effectiveness of the above protocol. 	<ol style="list-style-type: none"> 1. Tina Ball Director of Patient Experience and Practice Development Steve Jones Care Programming Approach Manager 2. Dr Katy Kendall Dr Rachel Warner Clinical Directors Steve Jones Care Programming Approach Manager 3. Dr Katy Kendall Dr Rachel Warner Clinical Directors Steve Jones Care Programming Approach Manager 	<ol style="list-style-type: none"> 1. Monthly on-going 2. 30 June 07 3. 31 December 07

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
	<p>Secondary Recommendation</p> <p>Clinical Records: Quality of information included in records.</p>	<ol style="list-style-type: none"> 1. Audits of records in five inpatient areas and two community teams have taken place in July/August 2006. The results demonstrated a high standard, as referred to in recommendation 3 (action taken to date) page 4 of this action plan. 2. Clinical Directors for Recovery and Rehabilitation, and Acute, Community and Primary Care, have produced the audit information required to effectively audit the quality of information contained within the records. There is specific focus on care plans reflecting the needs of patients, including - risk assessment, management of care, containment and contingency in the event of poor compliance 	<ol style="list-style-type: none"> 1. Draw up and implement an audit of clinical records including action plan with time-scales, to respond to any recommendations arising. 2. Further audit cycles to be agreed. 	<ol style="list-style-type: none"> 1. Dr Katy Kendall Dr Rachel Warner Clinical Directors Jim Chapman Audit and Knowledge Management Manager 2. Dr Katy Kendall Dr Rachel Warner Clinical Directors Jim Chapman Audit and Knowledge Management Manager 	<ol style="list-style-type: none"> 1. 30 April 07 2. 31 May 07

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
	<p>Secondary Recommendation</p> <p>Supervision of Practitioners/Clinicians within Sheffield Care Trust</p>	<ol style="list-style-type: none"> 1. The Supervision Policy for Practitioners and Clinicians within Sheffield Care Trust has been subjected to a complete review and been ratified by the Human Resources Sub Committee. 2. Implementation of the new consultant contracts and the use of 360° assessments of consultants' performance has resulted in improved supervision. 3. An implementation and training plan was produced as at 31 December 06. 	<ol style="list-style-type: none"> 1. Implementation of the Supervision Policy across Sheffield Care Trust has commenced. 2. An audit will be under-taken following implementation, to ensure that supervision is consistently available within Sheffield Care Trust, for all professional groups. 3. Further audit cycles to be agreed. 	<ol style="list-style-type: none"> 1. Eva Rix Head of Practice Development 2. Eva Rix Head of Practice Development Jim Chapman Audit and Knowledge Management Manager 3. Eva Rix Head of Practice Development Jim Chapman Audit and Knowledge Management Manager 	<ol style="list-style-type: none"> 1. 31 July 07 2. 30 September 07 3. 31 May 08

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
	<p>Secondary Recommendation</p> <p>Medicines Management</p> <p>Maintaining Medication Compliance within the Community</p>	<p>Dr Katy Kendall and Dr Rachel Warner have met with Dr Paul Harvey, to discuss a protocol for managing medicines compliance within the community.</p>	<ol style="list-style-type: none"> 1. The care programming approach policy up-date will include a protocol with GPs on medicines management, compliance and communicating non compliance. 2. This will be agreed with Sheffield Primary Care Trust. 3. An audit of the Care Programme approach will include an evaluation of the effectiveness of this protocol. 	<ol style="list-style-type: none"> 1. Dr Katy Kendall Dr Rachel Warner Clinical Directors Dr Paul Harvey Professional Executive Committee Mental Health Lead Sheffield Primary Care Trust 2. Dr Katy Kendall Dr Rachel Warner Clinical Directors Dr Paul Harvey Professional Executive Committee Mental Health Lead Sheffield Primary Care Trust 3. Steve Jones Care Programming Approach Manager 	<ol style="list-style-type: none"> 1. 30 June 07 2. 30 June 07 3. 31 December 07

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
	<p>Secondary Recommendation</p> <p>Interface with South Yorkshire Police Force</p>	<ol style="list-style-type: none"> 1. Through the Executive Director for Adult Services, a high level meeting with senior officers of South Yorkshire Police has secured agreement that, as part of the Safer Neighbourhoods City Initiatives, a training and implementation plan is being developed to support awareness of mental health issues at a community level. 2. Furthermore, agreement has been reached to explore and understand mental health systems and to help identify ways of improving communication and information sharing relevant to the needs of mental health clients, who for whatever reason, are in contact with South Yorkshire Police. 3. Executive Director for Adult Services and Nominated Lead from South Yorkshire Police Force have agreed a protocol for sharing information and improving communication. 	<ol style="list-style-type: none"> 1. Strategic partners to agree an implementation plan. 2. Continue work with the newly established liaison group. 3. Review the pilot training for police officers, in mental health issues. 	<ol style="list-style-type: none"> 1. Pam Stirling Executive Director and Nominated Lead from South Yorkshire Police Force 2. Lenny Fairhall Assistant Service Director Acute and Community Mental Health 3. Liz Johnson Head of Patient Experience, Inclusion and Diversity Bob Levesley Trainer Neighbourhoods and Community Care 	<ol style="list-style-type: none"> 1. 31 July 07 2. On-going 3. 31 May 07

NO	RECOMMENDATION	ACTION Taken to date	FURTHER ACTION TO BE TAKEN	LEAD(S)	TIMESCALE
	<p>Secondary Recommendation</p> <p>Interface with South Yorkshire Police Force</p>	<p>4. Strategic partnership established with Executive Director for Adult Services and Nominated Lead from South Yorkshire Police Force, for Sheffield Care Trust and the South Yorkshire Police Force. Now working towards application of joint memorandum of understanding.</p> <p>5. A liaison group has been established with Safer Neighbourhoods, involving Sheffield Care Trust, Sheffield City Council and the South Yorkshire Police Force.</p> <p>6. A pilot site has been identified to explore and implement support training, in mental health issues, to police officers,</p>			

INDEPENDENT INQUIRY 2004/1904
ACTION PLAN: PROGRESS REPORT
March 2007

BRADFORD DISTRICT CARE TRUST
BRADFORD METROPOLITAN DISTRICT COUNCIL
BRADFORD & AIREDALE TEACHING PCT

Summary

Within the Action Plan there are 7 key recommendations comprising 25 individual key actions. At the time of this update report, the overall position for progress on these items can be summarised as follows:

Completed	21
On target:	N/A
Extended timescale	0
Target date not due	4

RECOMMENDATIONS	PROPOSED ACTION	LEAD ORGANISATION	TARGET DATE	PROGRESS
Care and Treatment				
1. Communication with the Responsible Medical Officer				
To ensure that the responsible medical officer is Informed of any significant changes in circumstances or a patient's condition, an audit should be conducted on at least an annual basis of all patients admitted to hospital over a defined period to record the time of identification of a defined risk threshold and the time senior medical input was requested and delivered.	1. Audit tool developed and agreed 2. An initial audit to be conducted 3. The requirement to audit annual this to be built into the operational policy	BDCT, with input from BMDC	1. Done 2. 30 Nov 2006 3. 31 Jan 2007	2. Audit completed; results being analysed 3. To be built into Audit Plan for 2007 - 08.
2. Roles and responsibilities of members of the Assertive Outreach Team (AOT), Crisis Resolution and Home Treatment Team (CRHT) and the Emergency Duty Team (EDT)				
(a) There should be a joint agreement signed by the chief officers of the Trust and Social Services to specify the roles and responsibilities of all members of the AOT, the CRHT and the EDT.	1. Clarity of roles of EDT, AOT and CRHT to be set out and agreed. 2. Joint agreement to be signed.	BMDC, with input from BDCT	1. 24 Oct 2006 2. 31 Oct 2006	1. Completed 2. Achieved

<p>(b) There should be an agreed, documented operational policy on how the three teams work to best meet the needs of patients and carers, including specific reference to how cases are prioritised and how contact is made with patients and carers</p>	<p>1. Operational policy to be developed and documented. This will set out the standards against which these services will be audited through an annual review.</p> <p>2. Produce a project plan to ensure that by 30 June 2007 BMDC safely hands over responsibility for out-of-hours Mental Health Act (MHA) assessments from its Emergency Duty Team to BDCT, which will then provide an integrated MHA assessment service 24 hours per day, seven days per week; update operational policy to reflect interim ways of working</p> <p>3. Revise operational policy when project aim achieved</p>	<p>1. BMDC, with input from BDCT</p> <p>2. BMDC, with input from BDCT</p> <p>3. BDCT, with input from BMDC</p>	<p>1. 31 Oct 2006</p> <p>2. 31 Oct 2006</p> <p>3. 30 June 2007</p>	<p>1. Achieved (Interim)</p> <p>2. Plan remains for June implementation. EDT activity analysed & resource requirement to run out of hours service sent to BMDC for discussion at JCG. Project plan drafted ready for when agreement on resources reached.</p> <p>3. On target: wider review of MH response arrangements for early 2007.</p>
<p>(c) There should be training for all staff on their roles and responsibilities and the operational policy</p>	<p>1. Provide joint training for all staff on their roles and responsibilities in line with the operational policy.</p> <p>2. Liaise with PCT Medical Director, to ensure PCT mental health leads are aware of and engaged in the implementation of training.</p> <p>3. Individual staff will have training needs assessed and delivered through Review of Achievement and Development (ROAD) and the Professional Development Planning (PDP) processes.</p> <p>4. Provide training to all staff on their new roles and responsibilities when new system for out of hours MHA assessments is introduced (ref: 2(b)2).</p>	<p>1. BDCT, with input from BMDC</p> <p>2. BDCT</p> <p>3. BDCT, with input from BMDC</p> <p>4. BDCT</p>	<p>1. 30 Nov 2006</p> <p>2. 31 Oct 2006</p> <p>3. 1 Mar 2007</p> <p>4. 31 July 2007</p>	<p>1. Joint training event held on 12 January 2007</p> <p>2. PCT Medical Director to be involved in developing the revised MH response.</p> <p>3. Further training to be linked to implementation of integrated out of hours response arrangements.</p> <p>4. Linked to revised operational arrangements.</p>

(d)	The working of the teams should be subject to annual review and the outcome of this review should be reported to the chief officers of the Trust and Social Services.	Annually review the working of the teams through a formal presentation to the Joint Co-ordinating Group.	BDCT, with input from BMDC	31 Mar 2007	Process for annual evaluation to be agreed at JCG once integrated out of hours system agreed and implemented.
3. Record Keeping					
(a)	The Trust should formally adopt the standards for record keeping required by the relevant national standards for the disciplines working at the AOT	<p>1. The Trust will reissue the record keeping policy (incorporating the relevant national standards) to the teams</p> <p>2. Provide training in the requirements of good professional record keeping to the teams</p> <p>3. Local induction for staff to include record keeping requirements</p>	<p>1. BDCT</p> <p>2. BDCT</p> <p>3. BDCT</p>	<p>1. 30 Sept 2006</p> <p>2. 31 Oct 2006</p> <p>3. Commence Oct 2006 and thereafter at monthly induction</p>	<p>1. Achieved</p> <p>2. Provided at the training event on 12 January 2007.</p> <p>3. Commenced review of record keeping and standards Trust wide for implementation at Trust and local induction.</p>
(b)	Monitoring standards of record keeping and compliance with nationally recommended standards should form part of the clinical audit programme of the Trust	As part of the annual audit programme in the Trust, record keeping will be included and will include a minimum 10% of records in Assertive Outreach	BDCT	Dec 2006 and annually thereafter	More frequent Trust wide audit process under consideration for 2007-08.
Management of Untoward Incidents and Internal Reviews					
4. Involvement of staff in internal reviews					

<p>(a) When undertaking an internal review, all staff involved should be identified, the extent of their involvement identified and they should be given the opportunity to comment on that involvement.</p>	<p>1. Trust to recognise and agree that the terms of reference for internal reviews once set may need to be reviewed to ensure that all appropriate parties to the review are included</p> <p>2. The terms of reference of any review will state that all efforts possible will be made to identify all staff involved, ascertain the extent of their involvement and give them the opportunity to comment on their involvement</p>	<p>1. BDCT</p> <p>2. BDCT</p>	<p>1. With immediate effect</p> <p>2. With immediate effect</p>	<p>1. Achieved. Detailed further review of SUI management underway as part of Trust's governance development work.</p> <p>2. As 1 above.</p>
<p>5. Involvement of service commissioners</p>				
<p>A representative of service commissioners should be invited to attend appropriate post incident reviews carried out by provider organisations.</p>	<p>1. To ensure that the appropriate joint commissioners for Bradford District and the Primary Care Trust (PCT) Medical Director (or lead commissioner for Craven and other relevant commissioners) are notified and invited to attend post incident reviews for any incidents involving suicides, attempted suicides and homicides</p> <p>2. The Service Level Agreement monitoring Board meetings will monitor serious untoward incidents on a quarterly basis</p>	<p>1. BDCT</p> <p>2. Bradford South & West Primary Care Trust</p>	<p>1. With immediate effect</p> <p>2. Commencing Nov 2006 and three monthly thereafter</p>	<p>1.Completed</p> <p>3. Agreed at JCG to provide Trust Board report to the PCT in lieu of LDP meetings whilst 2007-08 SLA negotiation process underway. Future process will be agreed when new PCT LDP monitoring is implemented.</p>

6.	Incident Management Policy and adoption of SMART criteria for recommendations				
	The Trust should redraft its Incident Management Policy to ensure clarity of goals and processes to be followed, including the adoption of SMART criteria for the recommendations of any future service inquiries and reviews. The amended policy should be approved by the Trust Board and an audit should be done on an annual basis to review how the policy is working in practice.	1. The Trust will redraft its Incident Management Policy to ensure clarity of goals including adoption of SMART criteria 2. The amended policy will be approved through the Trust governance structures to the Trust Board 3. The annual policy review will include an audit of the effectiveness of the policy	1. BDCT 2. BDCT 3. BDCT	1. 30 Nov 2006 2. 31 Dec 2006 3. Apr 2007 and annually thereafter	1. Completed. Revised policy prepared for CNST inspection. 2. Approved 3. To be considered as part of the follow up arrangements post CNST visit.
7.	Monitoring of Action				
	The Joint Co-ordinating Group should be considered as the group for monitoring the implementation of recommendations affecting complementary services provided by the Trust and Social Services.	The Joint Coordinating Group will amend its terms of reference to specifically state that it is the monitoring group	BMDC	30 Sep 2006	Completed. Progress updates reported at regular meetings.

Key: BDCT: Bradford District Care Trust
BMDC: Bradford Metropolitan District Council

2002/867 ACTION PLAN – MARCH 2007

ISSUES	ACTION	BY WHEN	COMMENTS	BY WHOM
Risk Management	A proactive method that screens for potential for harm to others in a systematic and inclusive way (and which integrates data from routine clinical assessment alongside that from formalised risk assessment tools) should be added to the process of all clinical assessment particularly where the issue of morbid jealousy has been concerned and plays an important part in the individuals presentation.	April 2004	FACE risk profile in use throughout the Trust which includes sufficient trigger points for assessing the impact of morbid jealousy. COMPLETED	Medical Director AMD's Director of Nursing & Clinical Governance
Diagnosis & Treatment	Where medication is being reduced or discontinued more rapidly than might be advised, then the patient (and where appropriate and with necessary permission their family or carer(s)) are given full information regarding the risks and benefits of this course of action. Practitioners should document that this information has been given.	April 2004	All drug information leaflets for patients have been reviewed and include benefits, risks and alternatives. There are clear medicines management policies covering both switching of drugs and reduction regimes. COMPLETED	Medical Director AMD's
Involvement of family members including the wife	All clinical teams assertively pursue the involvement of family members and particular the spouse in these types of cases.	April 2004	Adjustments have been added to the SUI policy and procedure which includes an intention to involve patients and their loved ones as much as is possible and appropriate at the time. COMPLETED	Medical Director Director of Nursing & Clinical Governance
The use of the overspill rota	Where an overspill situation occurs that the clinical teams involved pay particular attention to the communication and the handover of the care of the patient. Any patient in an overspill situation should be treated with the same level of care and attention that a local sector patient would receive. It is imperative that the clinical team equally engage and involve fully family members and significant others in the patients care were that is consented to.	April 2004	Since the implementation of the functional model in acute adult services and the centralisation of acute in-patient beds at the Becklin centre overspill has not been an issue. All 4 wards operate as a "single unit" hence no overspill. COMPLETED	Associate Director Adult Mental Health Services

ISSUES	ACTION	BY WHEN	COMMENTS	BY WHOM
The Care Programme Approach	<p>On admission to an inpatient ward a CPA Care Coordinator is identified immediately at that the appropriate CPA documentation is completed following a CPA review prior to discharge.</p> <p>The Intensive Home Treatment Team use the CPA approach as the basis for the planning of care and subsequent discharge.</p>	January 2004	<p>The CPA process has been reviewed and standards set for wards and departments. CPA co-ordinators are identified within 2 days and appropriate reviews take place during the patients stay.</p> <p>All services user CPA unless they only offer an initial screening/assessment.</p> <p style="text-align: center;">COMPLETED</p>	Associate Director Adult Mental Health Services
Locum Medical Staff Cover	Clarify the need for clear documentation through CPA, clear risk assessment using a standardised risk profile and strong care coordination so that care can be handed over from individual to individual.	April 2004	<p>The CPA process has been strengthened and supported by electronic care planning. These have impacted positively on the communication between services. Locum medical staff receive a local induction with the appropriate Associate Medical Director which includes the use of CPA and the FACE risk profile.</p> <p style="text-align: center;">COMPLETED</p>	Medical Director AMD's
The involvement of General Practitioners	Discussions with PCT's through the Mental Health leads regarding GP engagement and via the LMC liaison meetings.	April 2004	<p>LMC discussions have taken place regarding involvement and engagement. Clinical teams and lead clinicians are locally engaging with GPs in order to improve links and liaisons.</p> <p style="text-align: center;">COMPLETED</p>	Deputy Chief Executive