

APPENDIX 1: TERMS OF REFERENCE

The East of England Strategic Health Authority (SHA) outlined The Terms of Reference, the expectations in regard to the Investigation Team, the proposed method of working, the output and reporting arrangements and the timetable. The Terms of Reference were divided into two stages, stage one and stage two.

Stage One

Following the review of clinical notes and other documentary evidence:

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Agree with the Strategic Health Authority any areas (beyond those listed below) that require further consideration.

Stage Two

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of his offence.
- Compile a comprehensive chronology of events leading up to the incident.
- Review the appropriateness of the treatment, care and supervision of the mental health service user in the light of any identified health and social care needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and his family.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations, including the Mental Health Act assessment process where applicable.
- Examine the adequacy of the collaboration and effectiveness of communication between the service teams, other agencies, who may have been involved in the care and treatment.
- Consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence.
- Provide a written report to the Strategic Health Authority that has clear implementable recommendations for the local health community.

THE INDEPENDENT INVESTIGATION TEAM

The East of England SHA asked that: members of investigations team will need to be properly appointed with formal appointment letters and from the outset one member of the independent investigation team will need to be the designated lead for the investigation process.

In order to create independence and avoid any conflict of interest, no member of the independent investigation team should be in the employment of the organisation(s) or should have had any clinical involvement with the victim or the perpetrator, subject to investigation.

The skills and expertise of the independent investigation team appointed should include:

- Relevant clinical, social care and managerial expertise;

- Other expertise where appropriate, for example housing or probation;
- Expert investigation skills, such as RCA or similar;
- Excellent report writing skills;
- Interviewing and communication skills; understanding of the independent investigation process;
- The treatment of witnesses.

Other specific skills or experience may be required depending on the nature of the case and the findings of the internal investigation report.

METHOD OF WORKING

The team will examine all appropriate documentation pertaining to the care of JMcf and seek evidence from those involved in his care, in order to properly carry out its investigation.

The team will agree appropriate communication arrangements with family members and give an opportunity to the families of the victim and of JMcf to contribute to the Investigation, as the team feels necessary.

The team will consider, if appropriate, recommendations from similar independent mental health investigation reports so that any significant common factors can be identified.

The team will conduct its work in private.

OUTPUT AND REPORTING ARRANGEMENTS

The team will provide a report with recommendations to the Strategic Health Authority on its findings.

The SHA will make the findings and the recommendations of the investigation public.

TIMETABLE

The panel is asked to complete the Investigation and report within six months of commencing the Investigation. Whilst the team were committed to completing and reporting this investigation within the six month time frame this was not possible due to the delay in receiving vital documents for review.

APPENDIX 2: TABLE OF RECOMMENDATIONS

RECOMMENDATIONS IN RELATION TO:	
NATIONAL LEARNING	
1.	Providers should consider the implementation of national policies to ensure that they do not inhibit access to multiple services where that is necessary.(linked to recommendation 39)
2.	Attention should be paid to the content of what is posted in texts and on social networking sites. The fact that the communication is at arm's length should not diminish the content and the actions that may be required.
MULTI-AGENCY WORKING/ORGANISATIONAL BOUNDARIES	
INTERFACE BETWEEN HEALTH AND SUFFOLK POLICE FORCE	
3.	A high level discussion between the SHA and Suffolk Police needs to take place to avoid delays in the investigation process in the future.
4.	All parties should work together as suggested by the <i>Memorandum of Understanding as per national guidance</i> to ensure that parallel investigations are not compromised.
INTERFACE BETWEEN HEALTH AND SOCIAL CARE	
5.	There should be an immediate review of the Section 75 agreement as to its current and future utility, with a new agreement developed in a more appropriate form that makes explicit the respective roles, responsibilities, required resources and outcome measures for each party.
6.	Social work and social care, beyond that of the AMHP role, should be given a higher profile throughout the Trust with bespoke support, forums, training and Key Performance Indicators for all social care staff who work within the MDT context.
7.	We recommend that the core panel facilitate a combined learning event for all agencies where the opportunity could be taken to draw up a multi-agency action plan. It is a recommendation that the core panel monitor progress against the actions identified.
COMMUNICATION BETWEEN ACUTE AND MENTAL HEALTH TRUST	
8.	An operational policy should be developed by and agreed between West Suffolk Hospital and Suffolk Mental Health Partnership NHS Trust regarding caring for patients who have presented with mental health problems in the Accident & Emergency Department, West Suffolk Hospital. This should include: <ul style="list-style-type: none"> ■ Minimum standards for response times by mental health professionals ■ A clearly agreed framework of responsibility for the care and welfare of patients with mental health problems during their time in A&E ■ Clarity around the clinical responsibilities for staff working in each Trust ■ How information about the patient can be accessed ■ How information about the patient will be recorded ■ Reporting arrangements and management structure ■ How to contact senior staff for advice
9.	The standards set out in the operational policy should be monitored and reported to the Accident & Emergency Psychiatric Liaison Meeting
10.	An audit of a random sample of patient records to establish the response times of mental health professionals should be undertaken and reported on twice a year.

11.	All staff working in Accident & Emergency should receive training on key considerations in respect of their duty to care, the initial assessment and observation of patients presenting with mental health problems
ORGANISATIONAL , GOVERNANCE AND SERIOUS UNTOWARD INCIDENT INVESTIGATION PROCESS	
12.	COMMISSIONERS: External Scrutiny by Commissioners should continue to ensure that the recommendations from this and other independent investigations/reviews around organisational governance and implementation of patient safety are closely monitored.
13.	The Commissioners reviewing Trust reports of Serious Untoward Incidents should: <ul style="list-style-type: none"> ■ Quality check the content and ensure it conforms to national and local guidance. ■ Ensure that investigations in relation to mental health are reviewed by a professional with the appropriate mental health and patient safety experience. ■ Early thematic analysis should occur which could identify any common themes and trends which would facilitate opportunities for learning and preventing reoccurrence.
14.	SUFFOLK MENTAL HEALTH PARTNERSHIP TRUST: The Trust should strength its leadership and co-ordination of the management of Serious Untoward Incidents. The Trust should: <ul style="list-style-type: none"> ■ Ensure that patient safety is a Trust Board priority and consider having a Non–Executive Director with responsibility for patient safety as well as an Executive Director. ■ There is appropriate and careful engagement and communication with families affected ■ Ensure that the Medical Director has responsibility for assisting in the medical peer review of Serious Untoward Incidents and the ongoing learning arising through a planned audit approach.
15.	The Trust should ensure that there are processes in place to quality check the outcome of Serious Untoward Incident Investigation.
16.	The Trust Serious Untoward Incident investigation should be robust and thorough with identified learning points, a robust action plan that is carefully monitored by the Trust Board.
17.	The Trust Board should confirm and challenge the outputs from the reports and the actions arising.
18.	Recommendations made should be risk assessed; those which are difficult to implement and/or require additional resources should be included on the Trust Board Assurance Framework and Risk Register.
19.	The Trust Board should closely monitor the implementation plan with an Executive Director holding ultimate responsibility for implementation.
20.	The Trust needs to update its Serious Untoward Incident Policy in line with national policy and recommendations. Including revising its guidance on statement writing for the purposes of Serious Untoward Incidents.
21.	Increased number of staff should be trained in the investigation technique, Root Cause Analysis and report writing with an increase in the associated administrative support.
22.	All staff should receive training in regard to the process of the management of Serious Untoward Incidents and the expectations of them.
23.	All complaints received by Trust staff should be dealt with via the Trust policy on managing complaints. Staff should receive the necessary training in the management of complaints.

CARE PATHWAY-OPERATIONAL POLICIES	
REFERRAL PROCESS	
24.	The Community Mental Health Team Operational Policy should state how all referrals to the team will be managed. The policy should provide staff with guidance around how quickly referrals should be seen and by whom.
25.	Where a patient is known to have a past psychiatric history, attempts should be made prior to the assessment to obtain a discharge summary from the service which has previously assessed the patient and access previous mental health records. Enclosures with referrals should be documented and a proactive approach should be adopted in requesting previous records
26.	Draft a protocol to support clinical staff in relation to how new referrals for assessment are allocated to team members.
27.	Ensure that there is a system in place to record receipt of all letters/documents which have been received by the CMHT
28.	Where a referral is received by the CMHT from a GP for an assessment by a Consultant Psychiatrist, the referral should be brought to the attention to the Consultant Psychiatrist and agreement reached regarding who should assess the patient.
29.	If the Consultant Psychiatrist agrees that it is appropriate for other team members to assess a new referral, the staff who subsequently assess the patient should ensure that they feed back the outcome of their assessment to the Consultant Psychiatrist and the rest of the multi disciplinary team via the Team Meeting including the GP. The outcome should be documented.
30.	Ensure that there is a robust system in place for staff to feed back the outcome of any new referrals and outcome of any new assessments undertaken to the team, the referrer and the service user.
31.	Ensure that there are standards in place to monitor how soon an emergency, urgent and routine referral should be seen.
CRISIS RESOLUTION HOME TREATMENT TEAM.	
32.	A Key Worker/Care Co-ordinator system should be introduced within the CRHTT with a view to enhancing continuity of care and supporting the development of a therapeutic relationship between patients on the team case load and named workers within the CRHTT
33.	The importance of having an up to date, comprehensive care plan for all patients on the CRHTT case load should be highlighted to clinical staff working in the team. A copy of the care plan should be given to the service user.
34.	Through the Key Worker/Care Co-ordination system within the CRHTT, ensure that there is continuity of care to avoid patients being assessed and reviewed by several different clinicians.
35.	Staff within the CRHTT should make attempts to contact other health and social care professionals involved in the care of any patient they have on their caseload. The patient's consent should be secured in writing prior to doing so, in exceptions, verbal consent should be documented clearly in the patient's records.
36.	A Did Not Attend Policy is now said to be place but this needs to be regularly audited to check for compliance.
ACCESS TO PSYCHOLOGICAL THERAPIES	
37.	We recommend that a patient's wishes regarding accessing psychological therapies be taken into consideration when deciding whether to offer treatment and which treatment to offer.
38.	We recommend that the professional opinion of mental health professionals who have recently assessed any patients being assessed by IAPT is considered when deciding what treatment to offer the patient.

39.	Improved formal communications between secondary care services and the IAPT service need to be agreed and protocols for patients being able to access both secondary care and primary care mental health services simultaneously when required/requested.
40.	We recommend that the Trust makes available appropriate accommodation for clinical supervision to take place and that the supervisor and supervisee should record supervision notes.
PRIVATE THERAPY	
41.	Communication amongst all health professionals involved in the care and treatment of a patient should be considered, subject to the agreement of the patient, whether the professionals are working inside the NHS or in the private or independent sector.
42.	All health professionals should ensure that recognised standards of documentation and record keeping are maintained.
RISK ASSESSMENTS	
43.	The Trust conducts a training needs analysis of all staff and ensure this complies with the National Health Service Litigation Authority Risk Management Standards for Acute, Community and Mental Health Trusts 2011/2012 Standard 2 criterion five and six.
44.	All relevant staff to access mandatory training and regular supervision on undertaking risk assessments including assessing harm to self and others
45.	All staff are fully aware of the amended version of the risk profile amended 5 th August 2009.
46.	The risk to children could be further strengthened by asking the question. Does the user have contact with or access to children?
47.	The Trust Policy should explicitly address the issue of risk to self and others with clear cross referencing from one relevant policy to another.
48.	A formal system should be introduced for the Team Manager to monitor the quality of assessments, including risk assessments being conducted by each individual member of all clinical teams.
49.	That all mental health assessing staff within the Trust and Local Authority receive up to date risk Assessment and safe-guarding training on at least a yearly recurring basis. As a minimum we would expect at least a full day on each subject domain.
50.	That all current and future AMHPs receive intensive risk assessment training that stresses the importance of previous history, appropriate alternative interventions and their responsibilities, and the need to consider homicide as well as suicide when considering harm to self and/or others.
DATA COLLECTION/EQUIPMENT	
51.	We recommend that the Trust improves both the quality of the data it collects in terms of staffing levels, (e.g., sickness, absences, training commitments, staff grades, on and off duty records,) and the means of collection, (e.g., it should be electronic rather than paper-based).
52.	We recommend that mental health teams are provided with the technology to access the electronic patient record system (ePex) when on-call and out of hours.

APPENDIX 3: NHS SUFFOLK SERVICE SPECIFICATION

SUMMARY FINDING

This appendix presents in summary form the evidence presented to the Investigation Team in relation to the performance and allocation of resources in the build up to the events of the May Bank Holiday weekend in 2009. The ultimate question it seeks to ask and address is *“did the availability or otherwise of resources (beds and staff numbers) impact upon the decision making process as to whether to admit or not admit JMcF over that fateful weekend?”*

The short answer to that question is that on the evidence that we have received and assessed we have no reason to conclude that the decision made was made on any other basis other than clinical grounds.

The process of coming to this conclusion is mirrored in the structure of this appendix. First we benchmarked at a macro level the total numbers of beds proportionate to the population. We then incrementally narrowed our focus to where the beds were, what their normal levels of occupancy were, what the gender split was, what were the normal staffing, sickness and observations levels on the wards for the preceding six months, before focusing in more detail on the weeks and days immediately before the May Bank Holiday weekend 2009.

It should be noted the data that we received from the Trust was incomplete or not of sufficient quality to infer a definitive finding on a number of these questions. For example, 1) we do not know what the incident or levels of enhanced observations were on the wards for the specified period, 2) though we have the names of those on duty we do not know their levels of skills, capability and training levels, 3) having the diagnosis code or MHA status of patients on the ward at that time tells us nothing of the level of support they require (and therefore demand on nursing staff). Notwithstanding these caveats we have no reason to conclude that the May Bank Holiday Weekend 2009 was in any way more or less pressured than the ‘normal’ and ongoing challenges in managing that particular inpatient psychiatric unit.

Our findings are that over the weekend in question there were sufficient numbers of staff on duty (though we cannot determine their grade and skill mix) and there were sufficient beds in the unit as a whole to admit JMcF if he was deemed to be clinically appropriate to do so – whether formally or informally.

The analysis is based upon the data supplied by the Trust Information Department unless otherwise stated.

DID SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST HAVE ENOUGH BEDS?

We compared the average daily number of available mental health beds for Suffolk Mental Health Partnership and other NHS providers within the East of England SHA area.¹⁵³ The number of daily beds available merely records what is supplied not what is required. A more useful measure compares the number of available beds in relation to the adult working age population, weighted for mental health need.

Trusts, unlike PCTs and Local Authorities, do not have defined populations since a PCT may commission services from multiple NHS providers. All we can say for definite is that a Trust may be the dominant or prime provider of inpatient services for that PCT. We have used information from financial mapping to produce “indicative” mental health populations for each Trust.

Average Daily Available Mental Health Beds in East of England SHA 2009/10

	Adult Short Stay	Adult Long stay	All MH Beds	Weighted MH WAA Pop	Trust Indicative Weighted Population per bed	
					per Adult Short Stay bed	per Adult Long Stay bed
Bedfordshire And Luton Mental Health And Social Care Partnership NHS Trust	78	58	254	353,869	4,537	6,101
Suffolk Mental Health Partnership NHS Trust	99	16	164	294,523	2,985	18,408
Norfolk And Waveney Mental Health NHS Foundation Trust	108	45	399	504,354	4,650	11,295
North Essex Partnership NHS Foundation Trust	118	63	391	487,940	4,135	7,721
South Essex Partnership University NHS Foundation Trust	122	64	492	402,115	3,296	6,296
Cambridgeshire And Peterborough NHS Foundation Trust	123	48	358	414,385	3,366	8,633
Hertfordshire Partnership NHS Foundation Trust	173	64	483	177,671	1,025	2,755
East of England SHA	822	358	2539			
Average of East of England NHS Trust providers	117	51	363		3,428	8,744

Suffolk Mental Health Partnership Trust had fewer available adult short stay beds on average per day (99) compared to the East of England SHA area as a whole (117) but when compared to the likely demand as measured by the Weighted MH population per available bed, was the second best provided Trust for short stay beds with 2,985 population per available bed compared to 3,428 for the East of England SHA area. On the other hand, Suffolk Mental Health Partnership fared comparatively badly for long stay adult mental health beds where the weighted population per bed at 18,408 was the highest of all the 7 providers in the East of England SHA area. For the purposes of this investigation it was the short term beds that we were concerned to benchmark and so we concluded their bed levels (for short stay/assessment purposes) were of an acceptable level.

Comparative bed occupancy figures are not available at specialty level for individual trusts. Normally this information is published nationally at specialty level, or at trust level but not at Trust specialty level. We attempted to use the nationally available figures to calculate bed occupancy by using the daily available

¹⁵³ Source of Information: DH Hospital Activity Statistics 2009/10. Weighted Populations for mental health: These are based upon the ONS Mid 2008 resident population for the PCT weighted for mental health need, which have then been mapped on to individual Trusts dependent on the degree of provision supplied by the Trust to the PCTs. Please note that Trusts, unlike PCTs and Local Authorities do NOT have defined populations since a PCT commission services from more than one Trust provider. These Trust weighted populations and populations per bed, can only be indicative and not absolute and this should be borne in mind when looking at them.

beds. However, the resultant figures were not sufficiently reliable to use within the final published patient safety report, as the figures can only be based on all adult MH episodes and not just adult short stay and the bed occupancy figures were extremely and unrealistically low.

HOW MANY BEDS WERE NORMALLY AVAILABLE?

The Trust, for the locality in question, had access to up to 4 wards:

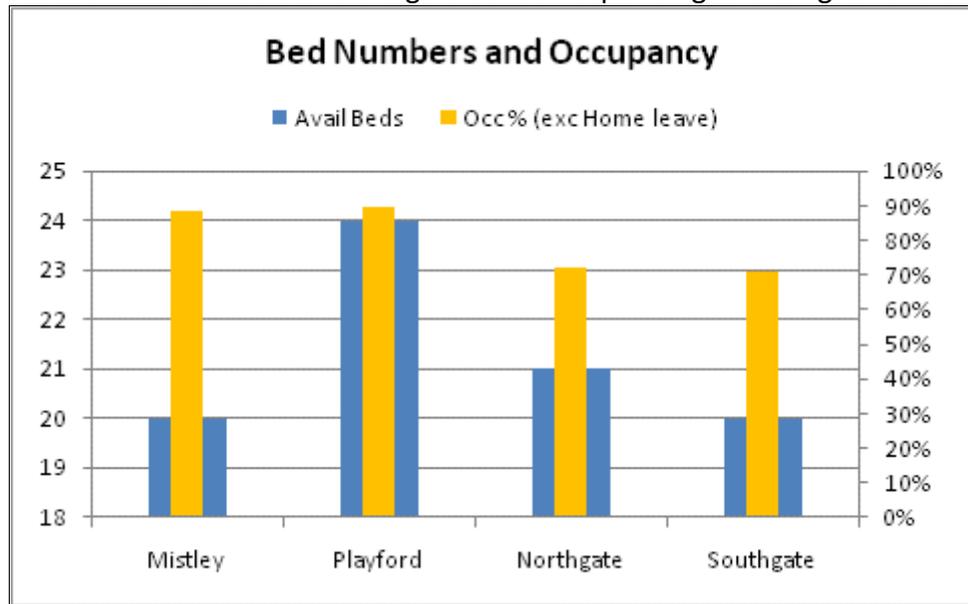
- Northgate -21 beds
- Southgate - 20 beds
- Mistley - 24 beds
- Playford - 24 beds

We understand that if JMCF were to have been admitted he would have been placed on Northgate Ward. However it is not unusual when managing beds on a psychiatric unit for people to be moved between wards for a range of clinical and operational reasons. Therefore we wherever possible looked to the data on all four wards rather than merely Northgate to ensure we achieved a more rounded view. Our analysis was completed in three levels of detail as follows.

1. High Level Overview of Inpatient Data Dec 2008 – May 2009
2. Summary of Individual Monthly Inpatient data Dec 2008 – 20th May 2009
3. Detailed analysis of April and May 2009 Inpatient data

HIGH LEVEL OVERALL INPATIENT DATA DEC 2008/JAN 2009 – MAY 2009

The table below illustrates the average number of beds that were available between December 08 and May 09 with the blue bars corresponding to the left axis of bed numbers and the gold bar corresponding to the right hand side relating to the occupancy level as a % figure.

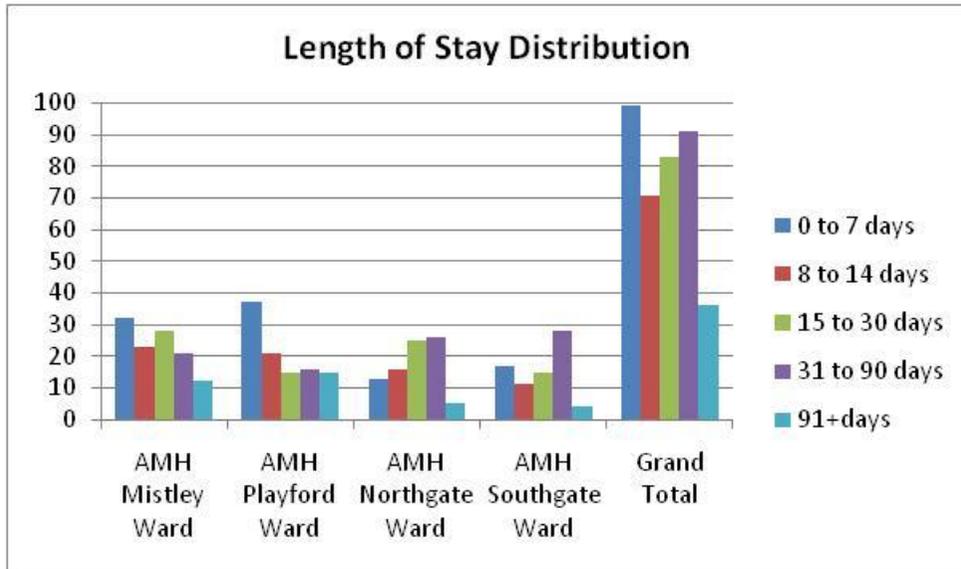


Bed occupancy levels overall spanning the period varied from 70% to 91% averaging out at 80%.

There is no universal measure of what an acceptable level of bed occupancy is. The Royal College of Psychiatrists set the acceptable rate at 85%, (Royal College of Psychiatrists, 1988, *Psychiatric Beds and Resources: Factors Influencing Bed Use and Service Planning*. Gaskell), but the National Service Framework for Mental Health, (1999, Department of Health) set as a milestone quality standard of 95%.

We have taken the middle line of 90% as being the pragmatic maximum comfortable level.

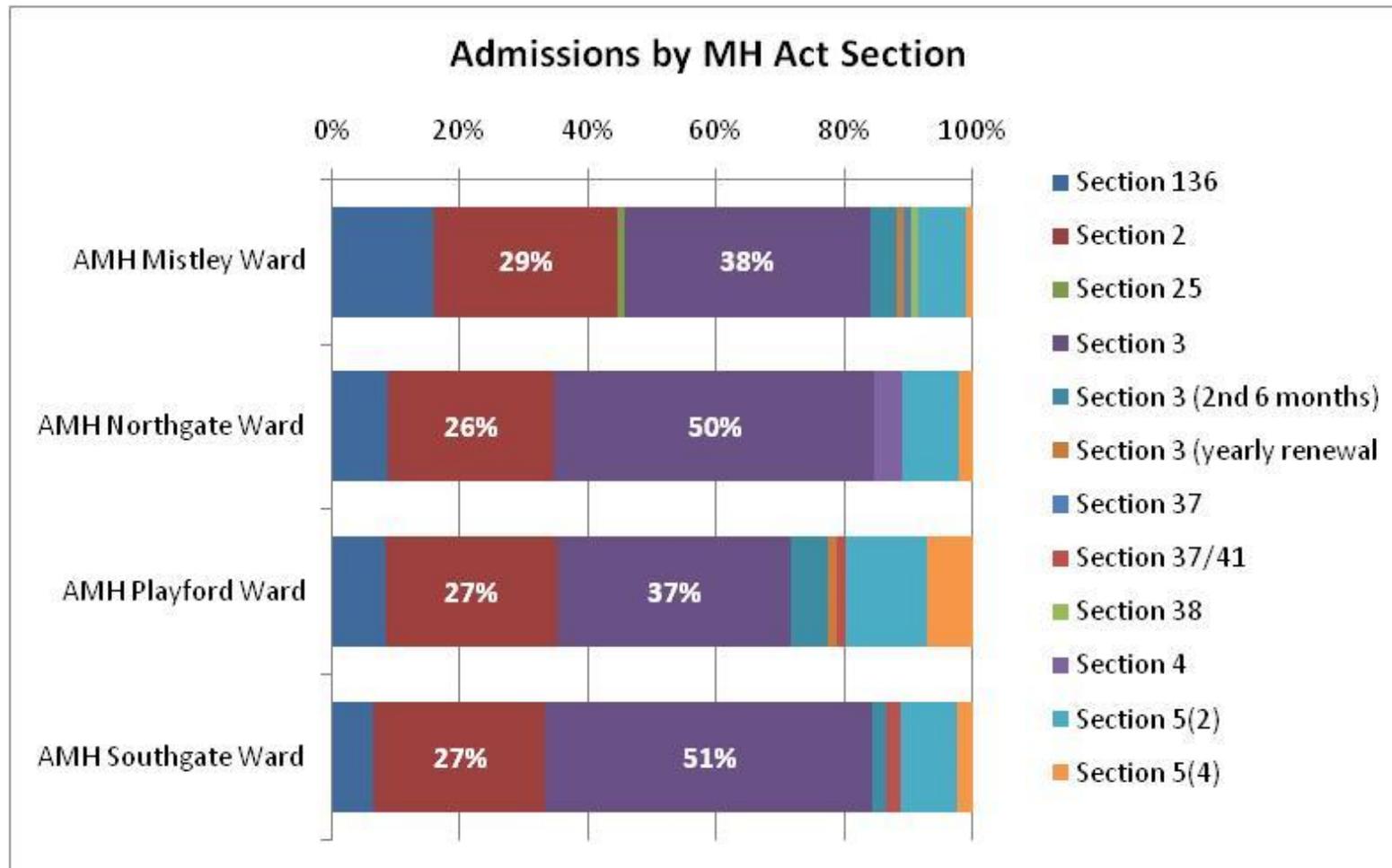
Therefore by this standard even the busiest ward was within an acceptable limit.



Mistley and Playford wards have a generally lower average length of stay. Northgate and Southgate wards have generally longer LOS distribution patterns.

For all of these wards, the largest proportion of admissions under the Mental Health Act was for Section 3.

Interestingly, the wards with generally lower LOS (–Mistley and Playford Wards) have a lower proportion of admissions for Section 3 (37% and 38%) compared to Northgate and Southgate wards at 50% to 51%.



The above provides an overview of the inpatient wards for the period up to the end of May 2009 in relation to the breakdown of Mental Health Act 1983 admissions as percentage figures.

SUMMARY OF INDIVIDUAL MONTHLY INPATIENT DATA DEC 2008 – 20TH MAY 2009

We only received data on individual patients on the ward regarding occupancy, gender and periods of authorised absence from the ward. We can make no comment on the adequacy or otherwise of staffing levels or their skill levels apart from staff absence rates as the ward staffing rotas were not provided.

How many unoccupied beds were there on the wards?

In April 2009, the number of unoccupied beds varied from 1 -8 with average for the month of 5 unoccupied beds.

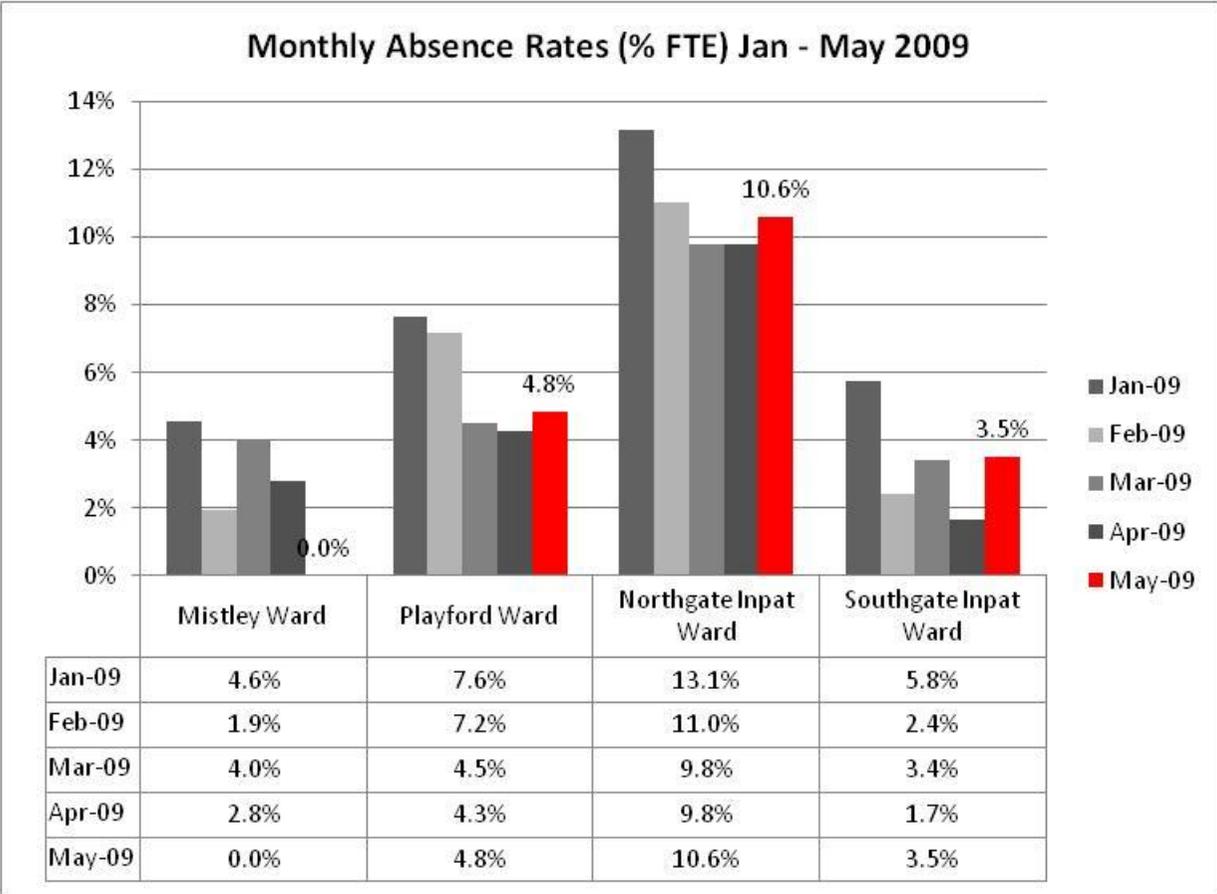
Monthly Unoccupied Beds by Ward - Occupied beds -less Authorised Leave

Beds	Ward	Dec			Jan			Feb			Mar			April			up to 20th May		
		Avg	Min	Max	Avg	Min	Max	Avg	Min	Max									
21	Northgate	4	1	8	8	8	8	6	3	7	7	4	13	5	1	8	5	1	9
20	Southgate	5	2	9	7	7	7	5	2	12	6	1	9	2	-1	5	1	-2	3
24	Mistley	2	-3	6	1	1	1	3	-2	6	1	-2	6	1	-2	5	3	-2	7
24	Playford	3	0	6	2	2	2	2	0	6	5	1	10	3	-1	5	5	1	9

The above suggests that there was at least one bed available on Northgate Ward in April and early May although it is not known whether this was suitable for a male or a female patient.

Staff absence rates on the wards

The absence rates as reported by the Monthly Board analysis a relatively declining absence rate.



Of the wards, Northgate ward reported the highest absence rates in each month. This is of concern and may be indicative of other phenomena occurring on the ward at that time but we do not have sufficient information to make a comment beyond this.

What was the gender mix on the wards?

The monthly bed usage for each ward is tabled below.

Northgate Monthly Beds by Gender - Occupied beds -less Authorised Leave - 21 bedded ward

Ward	Dec			Jan			Feb			Mar			April			up to 20th May			5th May 2009
	Avg	Min	Max	Avg	Min	Max	Avg	Min	Max										
Male	6	4	9	4	4	4	5	4	7	7	3	11	8	6	10	9	8	11	10
Female	11	8	12	9	9	9	10	8	13	8	4	12	8	5	11	7	4	10	9
Unoccupied beds	4	1	8	8	8	8	6	3	7	7	4	13	5	1	8	5	1	9	2

This shows that on Northgate Ward, the patients were mostly female until March 2009, equally split in April, and mostly male in May 2009.

Southgate Monthly Beds by Gender - Occupied beds -less Authorised Leave -20 bedded ward

Ward	Dec			Jan			Feb			Mar			April			up to 20th May			5th May 2009
	Avg	Min	Max	Avg	Min	Max	Avg	Min	Max										
Male	7	5	9	5	5	5	6	4	7	8	4	12	12	10	14	12	10	14	12
Female	8	5	11	8	8	8	9	4	12	6	3	10	6	3	8	7	6	9	7
Unoccupied beds	5	2	9	7	7	7	5	2	12	6	1	9	2	-1	5	1	-2	3	1

Mistley Monthly Beds by Gender - Occupied beds -less Authorised Leave - 24 bedded ward

Ward	Dec			Jan			Feb			Mar			April			up to 20th May			5th May 2009
	Avg	Min	Max	Avg	Min	Max	Avg	Min	Max										
Male	8	6	12	7	7	7	7	5	8	4	1	8	4	3	6	5	2	7	6
Female	10	6	14	11	11	11	11	8	14	14	11	17	15	11	18	12	11	16	16
Unoccupied beds	6	1	10	5	5	5	7	2	10	5	2	10	5	2	9	7	2	11	2

Playford Monthly Beds by Gender - Occupied beds -less Authorised Leave - 24 bedded ward

Ward	Dec			Jan			Feb			Mar			April			up to 20th May			5th May 2009
	Avg	Min	Max	Avg	Min	Max	Avg	Min	Max										
Male	5	3	8	6	6	6	6	5	8	4	1	7	6	4	9	3	2	5	5
Female	16	14	18	16	16	16	16	13	18	15	10	18	16	14	17	16	13	19	17
Unoccupied beds	3	0	6	2	2	2	2	0	6	5	1	10	3	-1	5	5	1	9	2

DETAILED ANALYSIS OF APRIL AND MAY 2009 DATA

The following tables show the daily figures for each ward from the period 1st April 2009 to 20th May 2010 displayed in the following format.

	Northgate				Southgate				Mistley				Playford			
	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F
01/04/2009	71%	6	60%	40%	90%	2	67%	33%	100%	0	15%	85%	83%	4	25%	75%
02/04/2009	67%	7	57%	43%	85%	3	71%	29%	110%	-2	18%	82%	83%	4	20%	80%
03/04/2009	62%	8	62%	38%	75%	5	80%	20%	100%	0	15%	85%	83%	4	25%	75%
04/04/2009	67%	7	57%	43%	80%	4	75%	25%	105%	-1	19%	81%	83%	4	20%	80%
05/04/2009	67%	7	57%	43%	80%	4	75%	25%	100%	0	20%	80%	83%	4	20%	80%
06/04/2009	71%	6	47%	53%	95%	1	68%	32%	105%	-1	24%	76%	79%	5	21%	79%
07/04/2009	71%	6	40%	60%	105%	-1	62%	38%	90%	2	22%	78%	83%	4	20%	80%
08/04/2009	67%	7	43%	57%	100%	0	70%	30%	95%	1	26%	74%	88%	3	24%	76%
09/04/2009	67%	7	57%	43%	105%	-1	62%	38%	90%	2	28%	72%	92%	2	23%	77%

Please note the following:

- % Occupancy = Occupied beds exclude Patients on Authorised Absence/Total Beds on ward
- Unoccupied beds = Total beds on ward less (actually occupied beds + authorised absences)
- % M = Percentage of actually occupied beds who are male in gender
- % F = Percentage of actually occupied beds who are female in gender
- Figures in RED reflect reported occupancy over 100%. This *may* in part be the result of limitations in the reporting mechanisms regarding when during the day patients go and return from authorised leave.

The key findings are

- **The bed occupancy levels on the 3rd May, when the key MHA assessment was made, were 90%, 90%, 100 and 96% respectively for the four wards. Net bed availability for the 4 wards as a whole was 5 available beds.**
- **Although these figures are higher than the 85% RCP acceptable levels they are just below the NSF milestone levels of 95%**
- **If there was a clinical need to admit JMcF – whether informally or via a section of the Mental Health Act 1983 – there were sufficient beds to do so.**

	Northgate				Southgate				Mistley				Playford			
	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F
01/04/2009	71%	6	60%	40%	90%	2	67%	33%	100%	0	15%	85%	83%	4	25%	75%
02/04/2009	67%	7	57%	43%	85%	3	71%	29%	110%	-2	18%	82%	83%	4	20%	80%
03/04/2009	62%	8	62%	38%	75%	5	80%	20%	100%	0	15%	85%	83%	4	25%	75%
04/04/2009	67%	7	57%	43%	80%	4	75%	25%	105%	-1	19%	81%	83%	4	20%	80%
05/04/2009	67%	7	57%	43%	80%	4	75%	25%	100%	0	20%	80%	83%	4	20%	80%
06/04/2009	71%	6	47%	53%	95%	1	68%	32%	105%	-1	24%	76%	79%	5	21%	79%
07/04/2009	71%	6	40%	60%	105%	-1	62%	38%	90%	2	22%	78%	83%	4	20%	80%
08/04/2009	67%	7	43%	57%	100%	0	70%	30%	95%	1	26%	74%	88%	3	24%	76%
09/04/2009	67%	7	57%	43%	105%	-1	62%	38%	90%	2	28%	72%	92%	2	23%	77%
10/04/2009	62%	8	54%	46%	80%	4	63%	38%	95%	1	26%	74%	83%	4	20%	80%
11/04/2009	67%	7	57%	43%	80%	4	63%	38%	100%	0	25%	75%	79%	5	21%	79%
12/04/2009	67%	7	57%	43%	80%	4	63%	38%	100%	0	25%	75%	88%	3	29%	71%
13/04/2009	67%	7	57%	43%	95%	1	63%	37%	105%	-1	24%	76%	92%	2	32%	68%
14/04/2009	62%	8	46%	54%	100%	0	65%	35%	100%	0	20%	80%	88%	3	33%	67%
15/04/2009	71%	6	40%	60%	90%	2	72%	28%	100%	0	20%	80%	96%	1	35%	65%
16/04/2009	76%	5	44%	56%	100%	0	70%	30%	110%	-2	18%	82%	92%	2	36%	64%
17/04/2009	76%	5	44%	56%	95%	1	68%	32%	90%	2	22%	78%	92%	2	27%	73%
18/04/2009	76%	5	44%	56%	85%	3	71%	29%	95%	1	21%	79%	88%	3	33%	67%
19/04/2009	76%	5	44%	56%	90%	2	67%	33%	95%	1	21%	79%	92%	2	36%	64%
20/04/2009	76%	5	44%	56%	95%	1	63%	37%	100%	0	20%	80%	96%	1	39%	61%
21/04/2009	90%	2	47%	53%	95%	1	68%	32%	100%	0	20%	80%	104%	-1	32%	68%
22/04/2009	95%	1	45%	55%	100%	0	65%	35%	100%	0	30%	70%	100%	0	29%	71%
23/04/2009	90%	2	42%	58%	85%	3	71%	29%	90%	2	22%	78%	92%	2	27%	73%
24/04/2009	81%	4	47%	53%	80%	4	69%	31%	90%	2	22%	78%	88%	3	24%	76%
25/04/2009	76%	5	50%	50%	80%	4	69%	31%	90%	2	22%	78%	88%	3	24%	76%
26/04/2009	76%	5	50%	50%	90%	2	67%	33%	90%	2	22%	78%	88%	3	24%	76%
27/04/2009	76%	5	50%	50%	90%	2	67%	33%	95%	1	21%	79%	92%	2	27%	73%
28/04/2009	90%	2	47%	53%	105%	-1	62%	38%	85%	3	18%	82%	92%	2	23%	77%
29/04/2009	95%	1	50%	50%	85%	3	71%	29%	90%	2	28%	72%	88%	3	24%	76%
30/04/2009	90%	2	53%	47%	100%	0	60%	40%	75%	5	27%	73%	92%	2	23%	77%

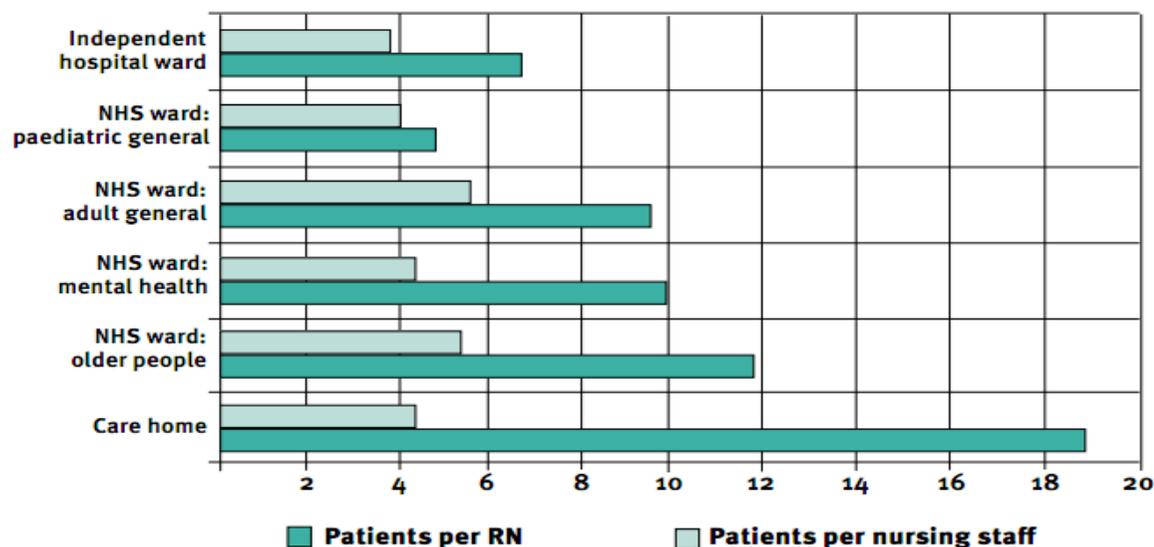
	Northgate				Southgate				Mistley				Playford			
	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F	% Occ	Unoccupied beds	% M	% F
01/05/2009	95%	1	50%	50%	90%	2	61%	39%	85%	3	35%	65%	96%	1	22%	78%
02/05/2009	90%	2	53%	47%	85%	3	65%	35%	95%	1	37%	63%	92%	2	18%	82%
03/05/2009	90%	2	53%	47%	90%	2	67%	33%	100%	0	35%	65%	96%	1	22%	78%
04/05/2009	90%	2	53%	47%	90%	2	67%	33%	100%	0	35%	65%	96%	1	22%	78%
05/05/2009	90%	2	53%	47%	95%	1	63%	37%	110%	-2	27%	73%	92%	2	23%	77%
06/05/2009	95%	1	55%	45%	105%	-1	62%	38%	95%	1	32%	68%	92%	2	18%	82%
07/05/2009	86%	3	56%	44%	85%	3	59%	41%	95%	1	32%	68%	88%	3	19%	81%
08/05/2009	86%	3	56%	44%	90%	2	56%	44%	90%	2	33%	67%	96%	1	17%	83%
09/05/2009	86%	3	56%	44%	90%	2	56%	44%	90%	2	33%	67%	79%	5	21%	79%
10/05/2009	81%	4	59%	41%	100%	0	60%	40%	90%	2	33%	67%	83%	4	25%	75%
11/05/2009	90%	2	53%	47%	100%	0	60%	40%	100%	0	35%	65%	83%	4	20%	80%
12/05/2009	81%	4	59%	41%	110%	-2	64%	36%	80%	4	25%	75%	71%	7	18%	82%
13/05/2009	76%	5	63%	38%	110%	-2	59%	41%	75%	5	20%	80%	67%	8	13%	88%
14/05/2009	71%	6	60%	40%	100%	0	65%	35%	75%	5	20%	80%	67%	8	13%	88%
15/05/2009	67%	7	64%	36%	100%	0	65%	35%	70%	6	14%	86%	67%	8	13%	88%
16/05/2009	57%	9	67%	33%	95%	1	63%	37%	70%	6	14%	86%	67%	8	13%	88%
17/05/2009	57%	9	67%	33%	95%	1	63%	37%	70%	6	14%	86%	67%	8	13%	88%
18/05/2009	57%	9	67%	33%	100%	0	65%	35%	75%	5	20%	80%	67%	8	13%	88%
19/05/2009	57%	9	67%	33%	95%	1	63%	37%	70%	6	14%	86%	67%	8	13%	88%
20/05/2009	57%	9	67%	33%	90%	2	61%	39%	65%	7	15%	85%	63%	9	13%	87%

Staffing Levels on the Ward

The number of staff on each of the wards for the weekend in question were within acceptable levels of operation but we do not have sufficient data to determine whether they were registered or unregistered nurses and therefore the respective grade and skill levels.

The means by which we came to our conclusion was as follows. Before assessing the staffing numbers on the respective wards we considered the national standards. RCN Guidance notes that on average across the nation there are 4.1 mental health patients per nursing staff across all shifts (of which 50% were registered nurses) at an average occupancy of 88%.¹⁵⁴

Figure 5.2 Number of patients per registered nurse/nursing staff by care setting



Source: Employment Research/RCN 2009

The RCN also quoted the 1998 Royal College of Psychiatrists Statement:

¹⁵⁴ RCN 2010 Guidance on Safe Nurse Staffing Levels in the UK - Tables 5.2 and 5.3

'It is unlikely that a ward of 15 acute patients could be safely managed with less than three registered nurses per shift during the day and two at night, irrespective of other staff available.'

With this guidance in mind we reviewed the staffing levels at the Trust as follows.

Average Numbers of Reported Staff on Trust Wards Jan 2009 – 20th May 2009

Ward						5th May
	Jan	Feb	Mar	April	May	2009
Northgate - Early Shift	6	6	6	6	6	6
Northgate - Late Shift	5	5	5	6	5	5
Northgate - Nights	3	4	4	3	3	3
Northgate - Total Day Staff	11	11	11	11	11	11
Monthly Occupied beds	13	15	14	16	16	14
Patients per day staff	1.2	1.4	1.3	1.4	1.5	1.3
Patients per night staff	3.9	4.4	4.0	4.5	4.8	4.7

Northgate Ward on 3-5th May the overall staffing numbers wise, was within the RCP 1998 minimum guidelines of 3 staff during the day and 2 at night – however, we don't know if these were registered or un registered nurses and we were unable to ascertain this from the data available .

Ward						5th May
	Jan	Feb	Mar	April	May	2009
Southgate - Early Shift	5	6	5	6	6	7
Southgate - Late Shift	5	5	5	6	5	5
Southgate - Nights	3	4	4	4	4	4
Southgate - Total Day Staff	10	11	10	12	10	12
Monthly Occupied beds	13	15	14	18	19	16
Patients per day staff	1.2	1.4	1.4	1.6	1.9	1.3
Patients per night staff	3.7	4.2	4.0	4.9	5.1	4.0

Southgate Ward on 3-5th May the overall staffing numbers wise, was within the RCP 1998 minimum guidelines of 3 staff during the day and 2 at night – however, we don't know if these were registered or un registered nurses and we were unable to ascertain this from the data available .

<u>Ward</u>	5th May					
	Jan	Feb	Mar	April	May	2009
Playford - Early Shift	6	5	5	6	6	6
Playford - Late Shift	5	5	5	5	6	5
Playford - Nights	4	4	4	4	4	4
Playford - Total Day Staff	11	11	11	11	12	11
Monthly Occupied beds	22	22	19	21	19	15
Patients per day staff	2.0	2.1	1.8	1.9	1.6	1.4
Patients per night staff	5.4	5.8	4.7	5.3	4.3	3.8

Playford Ward on 3-5th May the overall staffing numbers wise, was within the RCP 1998 minimum guidelines of 3 staff during the day and 2 at night – however, we don't know if these were registered or un registered nurses and we were unable to ascertain this from the data available.

<u>Ward</u>	5th May					
	Jan	Feb	Mar	April	May	2009
Mistley - Early Shift	5	7	5	5	5	5
Mistley - Late Shift	5	5	5	5	5	5
Mistley - Nights	4	4	4	3	4	3
Mistley - Total Day Staff	10	12	10	10	10	10
Monthly Occupied beds	23	21	23	23	21	13
Patients per day staff	2.3	1.8	2.3	2.3	2.1	1.3
Patients per night staff	5.5	5.2	6.4	7.3	5.8	4.3

Mistley Ward on 5th May the overall staffing numbers wise, was within the RCP 1998 minimum guidelines of 3 staff during the day and 2 at night – however, we don't know if these were registered or un registered nurses and we were unable to ascertain this from the data available.

APPENDIX 4: ACCESS TO PSYCHOLOGICAL THERAPIES

National Context The Improving Access to Psychological Therapies (IAPT) programme began with wave one sites in October 2008 as part of a three year programme in England.

Background to IAPT

Recommendations by the National Institute for Clinical Excellence¹⁵⁵ have led the government to invest significantly in the Improving Access to Psychological Therapies programme¹⁵⁶. In October 2007, it was announced by the Secretary of State for Health that £173 million would be invested in IAPT by 2010/11¹⁵⁷. The aim of this government initiative was to provide training for 3,600 therapists, mainly in Cognitive Behavioural Therapy (CBT) based interventions, and open 350 dedicated therapy centres for the treatment of depression and anxiety¹⁵⁸. Evolved from the NICE guidelines¹⁵⁹ and Lord Layard's¹⁶⁰ paper, the IAPT programme aims to reduce the human and societal costs of depression and anxiety. Layard¹⁶¹ argued that improving the provision of psychological therapies would positively impact on the number of people who are fit to work.

The IAPT implementation plan¹⁶² focused on the recruitment and training of a new workforce of psychological therapists trained in CBT. This was because CBT had the strongest evidence base, according to the NICE guidelines, and also because it had the biggest deficits in terms of the availability of a suitably trained workforce. In November 2008, the Department of Health issued a statement¹⁶³ that IAPT would develop from a core CBT workforce to include the full range of NICE-approved therapies (<http://www.iapt.nhs.uk/2008/12/statement-of-intent-november-2008>).

Treatment success and fidelity to IAPT service model

A recent review reported data from the first full year of operation of the 32 IAPT sites that were rolled out following pilot work in Doncaster and Newham¹⁶⁴. This study reported wide variations across the 32 sites in the way services were set up, treatments were delivered, and outcomes recorded (p.37). The study found that the sites that displayed fidelity to the IAPT service model, as recommended in the national implementation plan for the IAPT programme¹⁶⁵ reported the better outcomes. The number of treatment sessions per patient was found to be surprisingly low in comparison to NICE guidelines (p.3) with significant differences across sites. The patterns of treatments that patients received in different sites varied widely. For example, counselling, which is recommended by NICE as a fall-back treatment for patients with depression who are unwilling to agree to other approaches, was used for around 95% of patients receiving high intensity care in two sites and none in two more (p.37).

¹⁵⁵ National Institute for Health and Clinical Excellence (2009) *Depression: The treatment and management of depression in adults* (update) [CG 90]

¹⁵⁶ Department of Health (2007) *Improving Access to Psychological Therapies: Specification for the commissioner-led pathfinder programme*

¹⁵⁷ Department of Health (2010) *Realising the Benefits: IAPT at full roll out*. p 19

¹⁵⁸ Layard, R. (2006) The case for psychological treatment centres. *British Medical Journal*, 332, pp 1030-1032

¹⁵⁹ *Ib id*

¹⁶⁰ *Ib id*

¹⁶¹ *Ib id*

¹⁶² Department of Health (2008) *Improving Access to Psychological Therapies Implementation Plan: National guidelines for regional delivery*

¹⁶³ Department of Health (2008) IAPT Statement of Intent

¹⁶⁴ Glover, G., Webb, M., Evison, F. (2010) *Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll out year*. North East Public Health Observatory. <http://www.wmrhc.org.uk/silo/files/iapt-year-1-sites-data-review-final-report.pdf>

¹⁶⁵ *Ib id*

By 2010/11, the IAPT programme is aiming for a recovery rate of 50% for patients who have completed treatment¹⁶⁶. A recovery rate is defined as the proportion of patients with case level symptom ratings (rated on outcome scales, such as the PHQ-9 or GAD-7) at the start whom did not have case level symptoms at the end of treatment. Glover et al¹⁶⁷ reported an average recovery rate of 37% across the sites, however, “the effectiveness of treatment varied substantially between sites”. This led the authors to conclude that “while much was in line with NICE guidelines, much was not”.

IAPT Workforce

The New Ways of Working initiative has helped to direct and implement the development of the IAPT workforce¹⁶⁸. The ‘New Ways of Working for Everyone’ report¹⁶⁹ emphasised a ‘skill-mix approach’ where services are designed specifically with service users in mind, with a focus on creating a new competence-based workforce.

Services within the IAPT programme deliver a system of stepped care, and are staffed by high and low intensity workers. There are 1,500 people working and training in IAPT services, and a further 750 recently recruited trainees¹⁷⁰. Low intensity workers, now known nationally as psychological wellbeing practitioners, work at step 2. High intensity (HI) workers deliver treatment at steps 3 and 4, and usually deliver up to 20 face-to-face sessions of a therapy recommended by the NICE guidelines¹⁷¹. The national implementation plan for the IAPT programme recommended a ratio of high and low intensity therapists in a ratio of roughly 3:2¹⁷². However, the report by Glover et al¹⁷³ reported wide variations between sites with extremes from 13% to 100% of high intensity workers. Turpin et al¹⁷⁴ reported that, at that time, there were 571 workers and 349 trainees.

A recent study¹⁷⁵ reported that the qualified HI IAPT workforce is currently predominantly made up of counsellors, clinical psychologists, counselling psychologists, nurses, and CBT therapists. By contrast, trainees recruited in 2009 reflect nursing, counselling and graduate workers with applied psychologists and psychologists appearing to be less well-represented. This was identified as a possible barrier to IAPT obtaining optimum clinical outcomes from its workforce. Turpin, Clarke, Duffy, & Hope¹⁷⁶ reported that estimates by Boardman & Parsonage (2005) and Lavender & Paxton (2004) of the optimal professional mix for a high intensity team were approximately 50% psychologists, 42% nurses and CBT therapists, and 8% graduate workers. Turpin et al¹⁷⁷ argued that appropriately training and supporting the workforce is one of the key challenges in the success of the IAPT programme. Turpin et al¹⁷⁸ stated that “a quality

¹⁶⁶ Ib id.

¹⁶⁷ Ib id.

¹⁶⁸ Turpin, G., Clarke, J., Duffy, R., Hope, R. (2009) A new workforce to deliver IAPT: A case study. *Journal of Mental Health Training, Education and Practice*, 4(2), pp 37-46

¹⁶⁹ Department of Health (2007) *New Ways of Working for Everyone: A best practice implementation guide*

¹⁷⁰ Department of Health (2010) *Realising the Benefits: IAPT at full roll out*

¹⁷¹ Glover, G., Webb, M., Evison, F. (2010) *Improving Access to Psychological Therapies: A review of the progress made by sites in the first roll out year*. North East Public Health Observatory. p 23 <http://www.wmrhc.org.uk/silo/files/iapt-year-1-sites-data-review-final-report.pdf>

¹⁷² Department of Health (2008) *Improving Access to Psychological Therapies Implementation Plan: National guidelines for regional delivery*. p 5

¹⁷³ Ib id

¹⁷⁴ Turpin, G., Clarke, J., Duffy, R., Hope, R. (2009) A new workforce to deliver IAPT: A case study. *Journal of Mental Health Training, Education and Practice*, 4(2), pp 37-46

¹⁷⁵ Ib id

¹⁷⁶ Turpin, G., Clarke, J., Duffy, R., Hope, R. (2008) Delivering the IAPT programme. *Healthcare Counselling and Psychotherapy Journal*, April 2008, pp 2-7

¹⁷⁷ Ib id

¹⁷⁸ Ib id

psychological therapy service is not just dependent on the competences of its therapists, but also individuals who can offer clinical leadership, provide aspects of clinical governance, service development and research and development.” The following section is taken from the IAPT website and describes the model of service delivery, in particular the stepped care approach aligned to NICE guidelines, ascribed in the policy.

Treatments

National Institute for Health and Clinical Excellence (NICE) recommends a range of psychological therapies to treat people with depression and anxiety disorders and bring them to recovery. It also recommends these therapies are used to provide a system of stepped care, shown in the diagram below. Stepped care has two principles:

1. Treatment should always have the best chance of delivering positive outcomes while burdening the patient as little as possible.
2. A system of scheduled review to detect and act on non-improvement must be in place to enable stepping up to more intensive treatments, stepping down where a less intensive treatment becomes appropriate and stepping out when an alternative treatment or no treatment become appropriate.

Step 3 High Intensity Service	Depression Mild, Moderate and Severe	CBT , IPT behavioural activation
	Depression Mild-Moderate	Counselling , couples therapy
	Panic Disorder	CBT
	Generalised anxiety disorder (GAD) mild- moderate	CBT
	Social Phobia	CBT ,
	Post Traumatic Stress Disorder (PTSD)	CBT , eye movement desensitisation and reprocessing (EMDR)
	Obsessive Compulsive Disorder (OCD)	CBT
Step 2 : Low Intensity Service	Depression Mild-Moderate	cCBT , guided self-help , behavioural activation , exercise
	Panic Disorder Mild -Moderate	cCBT , guided self-help , pure self help ,
	Generalised anxiety disorder (GAD) mild- moderate	cCBT , guided self-help , pure self help , psychoeducation groups
	OCD mild - moderate	Guided Self-Help
Step 1 : Primary Care/ IAPT Service	Recognition of Problem	Assessment / Watchful Waiting

Staffing

Two types of psychological therapy practitioners are required:

- High Intensity therapists trained in cognitive behavioural therapy for people with moderate and severe depression and anxiety disorders
- Low intensity therapy workers trained in cognitive behavioural approaches for people with mild to moderate anxiety and depression. These approaches include guided self help and delivering psycho-educational groups. Services will also have administrative staff, employment advisors, a GP advisor and links with other services such as housing, drugs advice and benefits

Choice

It is important that people have a say in what kind of treatment they receive. This helps ensure the best health outcome for them. Clinicians should explain which treatment they are recommending and why they think it is suitable for the patient.

Access

Some people will refer themselves to the service but most will be referred for therapy by their GP or a member of the practice team. The team and their patients should have clear information about local services and the treatment choices available.

Outcomes

IAPT services routinely measure people’s health outcome. This charts their progress and has therapeutic benefit. It is part of ongoing, collaborative service evaluation too, providing feedback on elements of treatment that are helpful or unhelpful.

NHS Suffolk
Service Specification

IMPROVED ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

Version Control	Date	Main changes
V1	29 July 2008	Incorporated in 2009/10 contract
V2	18 January 2010	Specification reformatted into standard template by NHS Suffolk

Period; Three year contract 2010/11 to 2012/13

Review: NHS Suffolk propose to review the operation of the IAPT service during 2010/11. It is anticipated that national IAPT requirements may change during 2010/11 and the specification may have to be amended to reflect these.

1. PURPOSE

1.1 Strategic Context

NHS Suffolk has five Strategic Goals:

1. Improve the overall experience of healthcare services for all people in Suffolk;
2. Improve the health and sense of well being for all people in Suffolk;
3. Reduce inequalities in health within and between our communities;
4. Increase joint working between NHS organisations, partners and other sectors across Suffolk;
5. Develop our organisation to achieve world-class commissioning on behalf of all people in Suffolk;

Suffolk County Council’s strategic priorities are:

1. Protect vulnerable people and reduce inequalities
2. Transform learning and skills in Suffolk
3. A strong and dynamic jobs market
4. Be the Greenest County
5. Deliver great services at exceptional value

For the IAPT service these goals will be achieved through:

- An improved experience of the service as reported by service users in the annual national Mental Health Service Users Survey, local Patient Recorded Outcome Measures (PROMS) and other outcome measures in development
- Personalisation of care which ensures that the service an individual receives is based on their needs and wishes, leading to recovery
- Helping people with depression and anxiety disorders
- Giving them a choice of treatments for the first time
- Using evidence based therapies
- Enabling equity
- Measuring people's recovery

These areas are covered in more detail in the detailed specification.

1.2 Aims

The purpose of the service is to provide early access to and delivery of psychological therapies in primary and community settings for people who suffer from common mental health disorders which are suitable for treatment with such therapies. As a proportion of Suffolk's total at-risk, served population, the size of the population of the age range from which people might access this service is 69,650. (Suffolk PCT Needs Assessment June 2008).

The service will offer the following key benefits to the population served by Suffolk PCT:

1. Improved health and wellbeing
2. Improved service user and carer experience and satisfaction
3. Improved choice and access of clinically effective psychological therapy services
4. Improved inclusion and employment status, including:
 - Maintaining people in work and involvement in activities of daily living
 - Supporting people in returning to work and participating in activities of daily living

The service will:

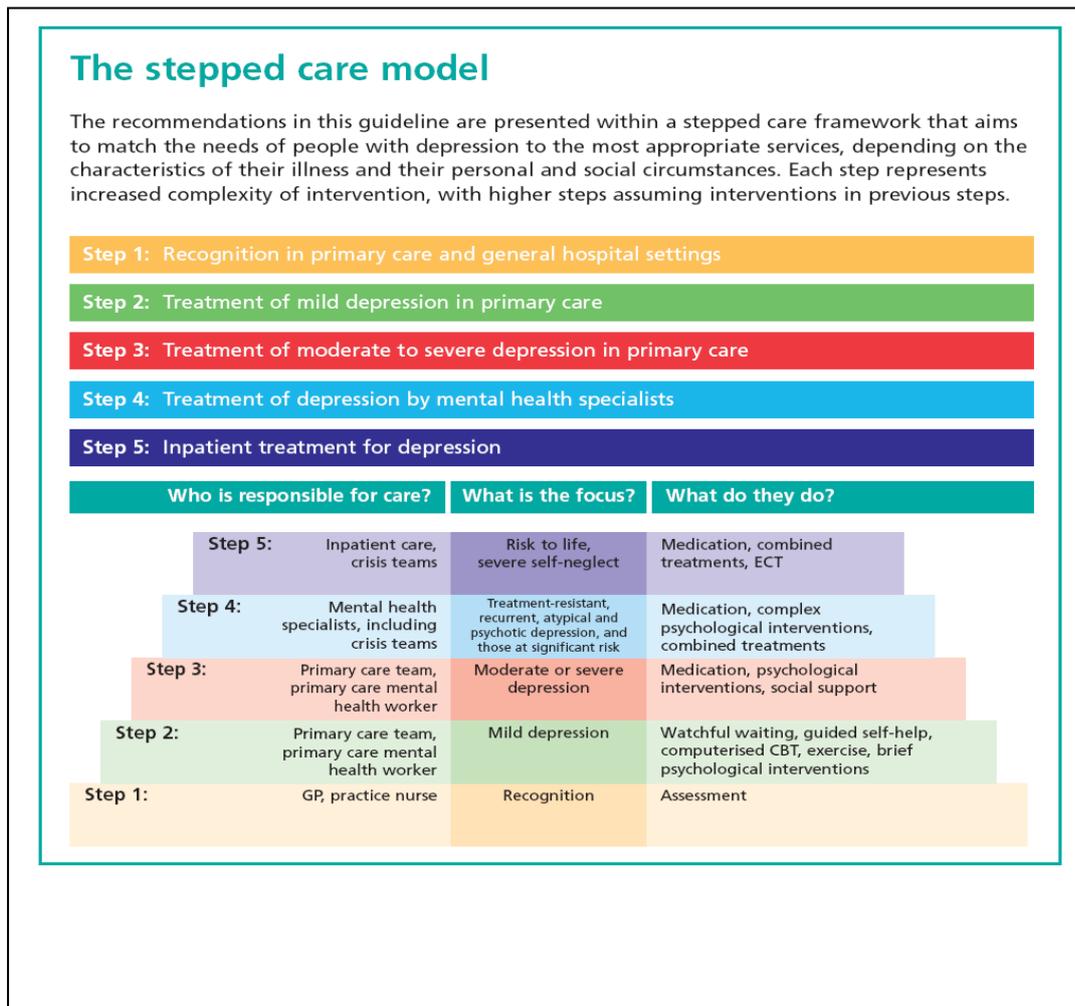
- Focus on the provision of low and high intensity therapy services in the early steps (2-4) of the stepped care model (figure 1).
- Improve early access to, and delivery of, psychological therapies in primary and community settings.
- Provide an evidence - based service that represents value for money through a continuing emphasis on high volume, low cost throughput
- Provide access to information and signposting to other support arrangements for people who are referred, but who may not be eligible for the service.

1.3 Policy Context

National IAPT policy requires that the service:

- Provides a range of NICE approved psychological therapy services in a stepped care process of care for those conditions where risk stratification and varying intensity of interventions is appropriate and approved by NICE.
- Promotes a collaborative approach to case management where the stepping handles varying intensities of intervention and displays also appropriate, stratified risk assessment and management approaches. The model for this service is shown below in figure 1. This service will treat clients at steps 2 – 4.
- Uses a data collection system which can support the core requirements of the IAPT minimum data set capable of verifying that IAPT results in an increase of evidence based and informed choice by people using the IAPT service
- Increases access to a range of evidence based treatment options. New trainees for the IAPT service must attend a nationally accredited IAPT training programme at an approved Higher Education Institute. Those working as High Intensity Workers in the IAPT service must attend the above training, or have BABCP accreditation.

Figure 1: The Stepped Care Model



2. SERVICE SCOPE

2.1 Service user groups covered

The Service will be provided to all people meeting the criteria for steps 2 -4 to the stepped care model and for whom referral to secondary mental health services is not deemed appropriate.

The Service will treat patients experiencing;

- Depression
- Panic Disorder
- Generalised Anxiety Disorder
- Phobias
- Post-traumatic Stress Disorder
- Obsessive-compulsive Disorder – including body dysmorphic disorder
- Those with Medically Unexplained symptoms, initially also suffering with the above conditions

Individuals who also have a diagnosis of a Learning Disability, Personality Disorder or Substance Misuse problem should not be automatically excluded from treatment for the conditions listed above.

2.2 Geographical population

The population to which this service specification applies is the population served by Suffolk PCT population over 16 years of age.

2.3 Service description

2.3.1 Assessment

All patients will initially be offered an assessment/screening which will focus on the presenting problem, a basic risk assessment and referral on to other agencies, if appropriate. This will include the following elements:

- Prior to the start of treatment all patients should receive a comprehensive 'patient centred' assessment that clearly identifies the full range and impact of their mental health problems and any linked employment, social and physical health issues.
- Risk (suicide, harm to others, etc) should be assessed at initial contact and at each contact thereafter.

All patients must have their clinical, work and social outcomes assessed using standardised measures that are appropriate to the conditions being treated. Key measures should be given at each treatment session so that a clinical end point is available even if patients finish treatment early

2.3.2 Care Planning

Treatment will be planned by using the stepped care approach (Figure 1). The patient journey around the blocks of services must offer quick access and seamlessness through true integration of care pathways. Care must be planned to ensure that patients are able to experience smooth, uncomplicated transitions between mental health service modalities.

2.3.3 Interventions

Step 2 service

This is generally a low-intensity service and will include the components below. It can be provided through individual and group sessions (when these are recommended by NICE Guidance) and will include both brief, face-to face, contact and telephone support. The key elements are: -

- Use of interventions detailed below (1-6 sessions, average 4 sessions):
 - ✓ Education
 - ✓ Bibliotherapy
 - ✓ Behavioural activation
 - ✓ Signposting, which should include follow up to ensure that the signposting has been effective, rather than 'signpost and forget'
 - ✓ Guided cognitive-behavioural self-help
 - ✓ Problem-Solving
 - ✓ Guided self-directed exposure therapy
 - ✓ Referring to various services including social services and exercise referral
 - ✓ Introduction to services - this will require the worker to accompany the client to the required service if support is needed.
 - ✓ Computerised CBT (8 sessions)
- Concomitant medication advice and support for patients receiving antidepressant medication

- Telephone ‘collaborative care’ support for patients on antidepressant medication
- Individual CBT sessions with a Worker (6-8 face-to-face sessions, average 7 sessions)

Steps 3 & 4 service

This level is generally a high-intensity service and includes the following components:

- Individual CBT (8-20 sessions, average of 12 sessions over 6 months)
- Group CBT (6-10 people, up to 12 x 2hr sessions)
- Therapy sessions should be supplemented by guided self help when appropriate materials are available.
- Concomitant medication advice and support for patients receiving antidepressant medication
- Telephone ‘collaborative care’ support for patients on antidepressant medication

3. SERVICE DELIVERY

3.1 Location of service

IAPT treatment services need to be easily accessible to service users from a full range of local sites which do not necessarily have to be NHS owned.

3.2 Days/hours of operation

Working hours will be 9 to 5 weekdays with flexibility for specific out of hours requirements.

3.3 Referral and discharge process

3.3.1 Referral

The service will accept referrals from primary care, secondary mental health services and self referral. Detailed pathways should be available to service users explaining how to enter the service, receive therapy be stepped up or down within the service and also leave the service.

3.3.2 Discharge

The model for IAPT services expects that interventions for people will be limited

- for low intensity therapy up to 6 sessions
- for high intensity therapy up to 20 sessions

3.4 Response times

Response times should meet the standards set out by East of England SHA in Towards the Best Together Pledge 2:

- Initial assessment for psychological therapy within 10 days of referral
- For step 2 psychological therapies 10 day maximum wait
- For step 3 psychological therapies 28 day maximum wait

3.5 Care pathways

A diagram of the care pathway is attached at annexe 1.

3.5.1 Partnerships

The philosophical underpinning of IAPT is that it is a service which is both initiated and controlled by primary care. Close partnership with GPs and other members of the primary care team is therefore essential.

In addition, links with other organisations which can contribute to addressing those factors which may be contributing to the mental health of the service user should be established. Whilst not an exclusive list, these will include:-

- Primary Care Counselling Services
- Citizens Advice Bureau
- Debt and Financial Advice Services
- Department of Health and Pensions
- Statutory and Voluntary Sector Providers

3.5.2 Transition and interfaces

The IAPT service is responsible for case management and communicating with the service user's GP when required, including referral to higher steps (specialist services outside the IAPT service, CMHTs, in-patient care).

3.5.3 Subcontractors

No part of the IAPT service should be subcontracted to another provider without the agreement of the commissioners.

3.6 Staffing

The service will be delivered by a multi-disciplinary team:

1. At step 2 (depending on the specific interventions recommended by the relevant NICE guideline), low-intensity interventions will be delivered by a mix of workers with appropriate training, supported and supervised by professionals with the relevant competencies.
2. At steps 3 and 4 (depending on the specific interventions recommended by the relevant NICE guideline), high intensity interventions will be delivered by professionals competent in the delivery of CBT and other evidence based interventions.
3. The team will be supported at all steps by access to employment/housing/benefit advisors or services and by input from GPs who have developed a special interest in mental health. The role of such GPs is to provide appropriate medication advice to the members of the team, and to primary care, along with facilitating liaison and education within primary care. The provider is responsible for ensuring that Doctors with such an interest who are appointed are appropriately experienced, and have the capabilities for providing appropriate clinical supervision. GPs will expect to be accredited according to Department of Health guidelines.

3.7 Staff Training and Education

All staff providing the service will have appropriate training and be regularly updated to meet best practice requirements.

Supervision and Leadership Arrangements

All members of clinical staff have clear arrangements for clinical and managerial supervision, clinical leadership will ensure that time is available for supervision and opportunities are taken up
Low intensity workers must have regular weekly clinical supervision from a clinician who is fully trained in the relevant intervention(s). For high intensity workers weekly clinical supervision should not be necessary, but arrangements must be in place for them to have access to supervision as required.

4. QUALITY INDICATORS

The service should deliver the access and outcome standards defined in the IAPT Outcome and Data Collection framework. Performance will be assessed against these standards on a monthly basis as required by national key performance indicator reporting.

Reporting requirements are set out in contract schedule 5. In addition continuation and development of current quarterly report on activity by GP practice/PBC consortia.

5 ACTIVITY PLAN

Trajectory toward

4200 completed High Intensity Treatments a year

16000 completed Low Intensity Treatments a year

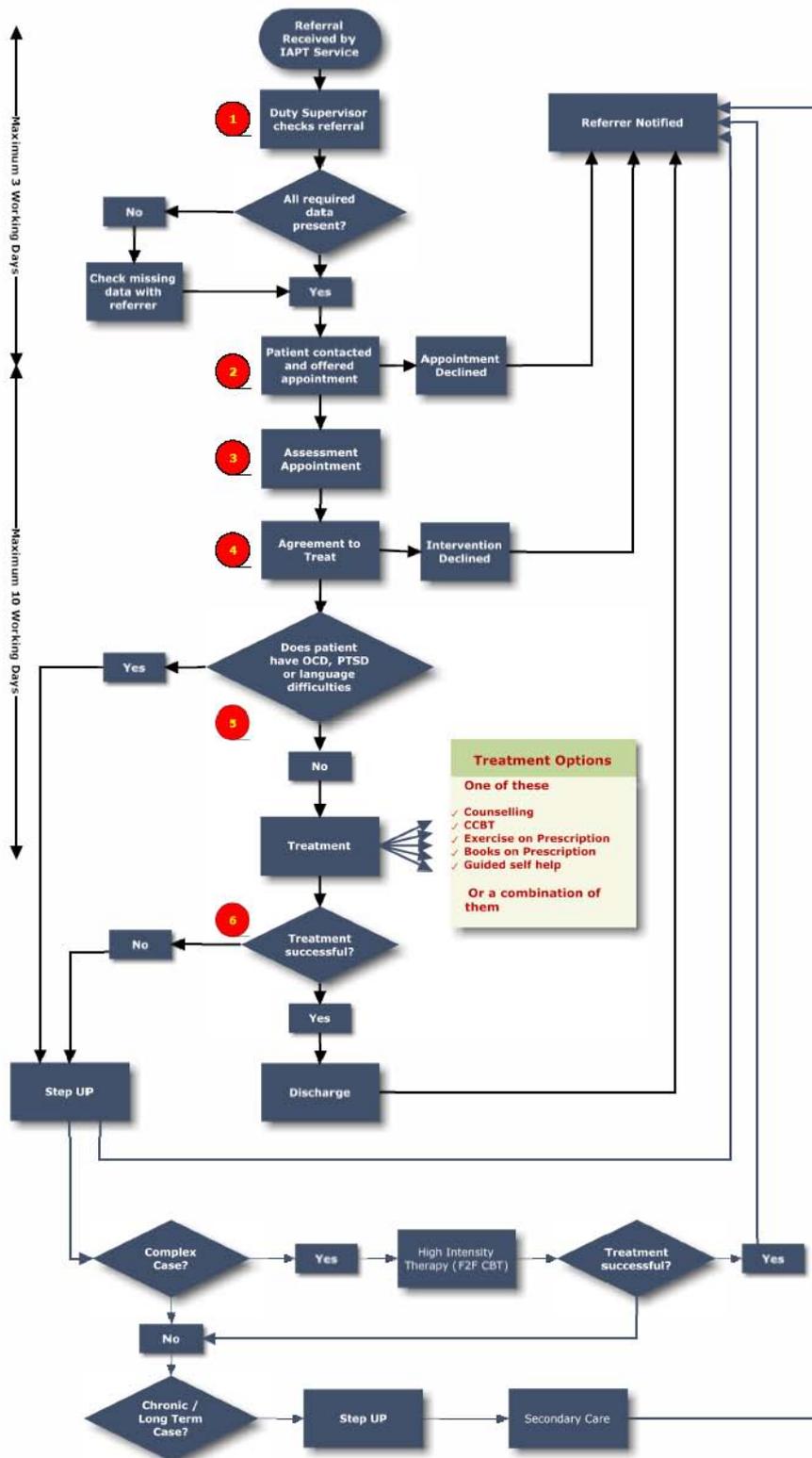
With a resulting 60% improvement in depression or anxiety scores (measured by PHQ9 or GAD7 as appropriate)

6 PRICES AND COSTS

£ 5.5 million

Illustrative pathways

Flow Chart 3. IAPT Process



Notes

- All referrals are checked by a duty supervisor to ensure essential information is present. Where information is missing the supervisor rings the referrer and obtains the missing information
- Once essential information is present the patient is contacted and offered an assessment appointment. Where the patient declines to be seen the duty supervisor or administrator contacts and informs the referrer.
- At the assessment appointment baseline data including the PHQ9 and GAD7 is taken and a treatment programme agreed
- Once essential information is present the patient is contacted and offered an assessment appointment. Where the patient declines to be seen the duty supervisor or administrator contacts and informs the referrer.
- Treatment by Low Intensity methods is the choice for all cases except where serious PTSD or OCD are present or the person requires an interpreter to engage in treatment. Such cases step up to High Intensity Automatically.
- Where Treatment is successful the patient is discharged and the referrer notified. However where treatment is unsuccessful the patient may be referred for High Intensity (Face-to-Face) Therapy and the referrer notified.

APPENDIX 5: CRITERIA FOR DETENTION

For supporting background information it is worth noting the options available to the various clinicians who were assessing JMCF in A&E.

JMCF had been offered a bed in the mental health inpatient unit if he wished to take it. He declined this offer. Therefore the question was rightly raised as to whether he should be formally detained against his wishes under the terms of the Mental Health Act 1983.

The criteria for detention are quite clear and a number of conditions must be met depending upon which section of the Mental Health Act is used. In the circumstances presenting themselves to clinicians, the most appropriate sections of the Act relating to detention were either a Section 2, for assessment, or a Section 3, for treatment. In either instance it would have been the Approved Mental Health Professional (AMHP, previously an ASW – Approved Social Worker) who would have made the formal application for detention. However before this application is made a number of conditions would have to have been fulfilled including the following.

1. The person has a mental disorder as defined in section 1 of the Mental Health Act – or in the case of a Section 2 detention sufficient evidence of one to warrant further assessment.
2. The person poses a risk to themselves, his or her own health or safety, or for the protection of others.
3. The person would not be admitted voluntarily, i.e., they have refused or lack capacity to decide to be admitted to hospital for the assessment or treatment identified.

For either a Section 2 or 3 application the AMHP must assure themselves that each of the above criteria has been met and have two signed medical opinions to the effect that point one has been met and that they agree points two and three have also been met.

It is important to note that ‘Mental Disorder’ as defined in Section 1 of the Mental Health Act 1983 is a legal rather than clinical term. A person must have a medical diagnosis (or sufficient evidence to warrant further assessment in the case of a Section 2) to be defined as a mental disorder. Having a psychiatric diagnosis is necessary but not in itself sufficient to meet the requirements for detention as for both Section 2 and Section 3 detentions there is the requirement of the disorder being “...of a nature or degree...” to warrant detention.

In the case of JMCF he was assessed by two experienced doctors in A&E who both formed the view that at that time he did not meet the criteria for detention in terms of having a mental disorder as defined in Section 1 of the Mental Health Act 1983. That is to say he did not have a diagnosable mental disorder, was not of arrested or incomplete development of mind, did not have a psychopathic disorder or any other disability of mind. Or it was not of a nature or degree, to warrant his formal detention, and or that his assessed level of risk at that time to himself or others were not perceived to be sufficiently high to warrant detention.

Therefore the AMHP **could not** make an application for detention even if he had wanted to (which he in fact did not as he concurred with the medical opinion).

APPENDIX 6: GLOSSARY

Approved Mental Health Professional (AMHP) –

In 2007 amendments to the Mental Health Act 1983 abolished the role of Approved Social Worker (ASW) and created Approved Mental Health Professionals (AMHP). The role is broadly the same but can be undertaken by a wider range of professionals – registered social workers, psychiatric nurses, registered occupational therapists and chartered psychologists

Approved Social Worker (ASW) –

Approved Social Workers were mental health social workers who were involved in the assessment and detention process of mentally ill people. In 2007 amendments to the Mental Health Act 1983 abolished the role of Approved Social Worker (ASW) and created Approved Mental Health Professionals (AMHP)

Care Programme Approach (CPA) –

The CPA is a standardised way of planning a person's care, it is a multidisciplinary approach that includes the service user, and, where appropriate, their carer, to develop an appropriate package of care that is acceptable to health professionals, social services and the service user

Care Quality Commission's (CQC) –

Independent regulators of health and social care in England

Chlorpromazine –

Antipsychotic drug

Cognitive Behavioural Therapy (CBT) –

CBT is a psychological treatment that can help to change how a person thinks and behaves. It encourages people to talk about how they think about themselves, the world and other people and how what they do affects their thoughts and feelings. Instead of focusing on the causes of a person's distress or symptoms in the past, it focuses on the present and looks for ways to improve their state of mind now. CBT is useful for dealing with a number of issues, including depression, anxiety and phobias

Community Mental Health Nurse (CMHN) –

A mental health nurse working in the community providing treatment, care and support for people with emotional, mental and behavioural problems

Community Mental Health Team (CMHT) –

A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and the community

Community Psychiatric Nurse (CPN) –

CPNs are registered nurses working with people with mental health issues in a variety of settings in the community such as GP surgeries, clinics or health centres or in a client's own home. They provide practical advice, ongoing support with problems, supervise medication and help with counselling

Consultant Psychiatrist –

A Consultant Psychiatrist is a trained mental health doctor with additional specialist training in psychiatry. The consultant is medically responsible for the care of people receiving mental health services

Crisis Resolution/Home Treatment Team (CRHTT) –

CRHTTs provides intensive support for people in mental health crises in the community with the possibility of offering comprehensive acute psychiatric care at home until the crisis is resolved, and usually without hospital admission

Dothiepin –

Tricyclic antidepressant with sedative properties

Fluoxetine –

Selective serotonin reuptake inhibitor (SSRI) antidepressant

Flucloxacillin –

An antibiotic

Homicide –

The crime of killing somebody intentionally

Improved Access to Psychological Therapies (IAPT) –

The IAPT programme was launched in 2007 to improve the availability of psychological therapies, especially relating to people with depression or anxiety disorders

Independent Police Complaints Commission (IPCC) –

The IPCC is guardian of the police complaints system and investigates the most serious complaints and allegations of misconduct against the police in England and Wales

Lofepamine –

Tricyclic antidepressant

Mental Health Act 1983 –

The Mental Health Act 1983 is largely concerned with the circumstances in which a person with a mental disorder can be detained for treatment for that disorder without his or her consent. It also sets out the processes that must be followed and the safeguards for patients, to ensure that they are not inappropriately detained or treated without their consent

Mental Health Act 2007 –

The Mental Health Act 2007 made amendments to the Mental Health Act 1983 including the definition of mental disorder, the criteria for detention and it broadened the group of practitioners who can take on the functions previously performed by the approved social worker (ASW) and responsible medical officer (RMO)

Metronidazole –

Antibiotic drug

NHS Litigation Authority (NHSLA) –

The NHSLA handles negligence claims and works to improve risk management practices in the NHS. They are responsible for resolving disputes between practitioners and primary care trusts, giving advice to the NHS on human rights case law and handling equal pay claims on behalf of the NHS

Primary Care –

Primary care is the care that you will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers

Primary Care Trust (PCT) –

A PCT is a type of trust that provides primary services, or commissions them from other providers, and is involved in the commissioning of secondary care

Procyclidine –

An anticholinergic drug

Psychiatric Assessment –

Assessment happens when a person first comes into contact with mental health services, information is collected in order to identify the person's needs and plan treatment

Psychological Therapies –

Psychological therapies generally fall into three categories. These are behavioural therapies, which focus on cognitions and behaviours, psychoanalytical and psychodynamic therapies, which focus on the unconscious relationship patterns that evolved from childhood, and humanistic therapies, which focus on self-development in the 'here and now'

Psychotic –

A severe mental disorder in which there is extreme impairment of ability to think clearly, respond with appropriate emotion, communicate effectively, understand reality and behave appropriately

Risk Assessment –

A formal process to determine a patient's risk behaviours

Root Cause Analysis (RCA) –

A systematic approach to get to the true root cause of a problem

Schizophrenia –

Schizophrenia is a major psychiatric disorder, or cluster of disorders, characterised by psychotic symptoms that alter a person's perception, thoughts, affect, and behaviour

Secondary Care –

Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional

Serious Untoward Incident (SUI) –

A serious incident or event which led, or may have led, to the harm of patients or staff

Stepped Care Model –

A stepped care recovery model seeks to treat service users at the lowest appropriate service tier in the first instance, only 'stepping up' to intensive/specialist services as clinically required

Strategic Health Authority (SHA) –

SHAs manage the NHS locally and provide an important link between the Department of Health and the NHS. They are responsible for developing plans for improving health services in their local area, making sure local health services are of a high quality and making sure national priorities are integrated into local health service plans

Talking Therapies –

Broad term covering a range of therapeutic approaches including counselling, cognitive behavioural therapy (CBT), psychoanalysis and psychodynamic therapies

Temazepam –

Temazepam is in a group of drugs called benzodiazepines and is used to treat insomnia symptoms and occasionally to reduce anxiety

Trazodone –

A serotonin antagonist and reuptake inhibitor (SARI) antidepressant

Venlafaxine –

A serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant

Zopiclone –

Non-benzodiazepine hypnotic drug used to treat insomnia

Zuclopenthixol –

Antipsychotic drug

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Written statement from Supervisor CBT One, Qualified Cognitive Behavioural Psychotherapist 31st January 2011

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Police Statement from Consultant Psychiatrist Two 21st May 2009

Police statement from CRHTT Nurse One dated 29th June 2009

Police statement from CRHTT Nurse Two dated 22nd July 2009

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Transcript from interview with Friend One conducted on 8th November 2010

All transcripts were accessed of all staff interviewed for the purposes of this investigation

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Referral letter written by GP One to Consultant Psychiatrist, West Suffolk Hospital dated 13th August 2008

Letter from Team Leader One, Clinical Team Manager to GP One dated 19th August 2008

Letter to JMcF from Social Worker One, ASW dated 19th September 2008

Referral letter from GP One, GP to Consultant Psychiatrist, Bloomfield House dated 25th November 2008

Acknowledgment of receipt of referral letter. Letter sent by Team Leader One, Clinical Team Manager to GP Two dated 2nd December 2008

Letter from Consultant Psychiatrist One to GP One dated 14th January 2009

Undated letter from JMcF to IAPT Worker One. Stamped as being received on 3rd March 2009

East of England letter dated 8th May 2009 to PCT and SMHT from EOE

INTERVIEWS

Interview with Friend One on 8th November 2010

Interview with IAPT Worker One on 8th November 2010
Interview with Consultant Psychiatrist One on 9th November 2010
Interview with CRHTT Nurse One 9th November 2010
Interview with CPN One on 9th November 2010
Interview with CRHTT Nurse Three on 9th November 2010
Interview with Social Worker One on 16th November 2010
Interview with CRHTT Nurse Two on 16th November 2010
Interview with Consultant Psychiatrist Two on 17th November 2010

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Discharge Summary dated 8th March 1993
Initial Assessment conducted by [REDACTED] dated 21st October 2000
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APPENDIX 8: LIST OF INTERVIEWEES

TITLE
Friends
Friend of JMcf and MG & a trainee Clinical Psychologist
Husband of above and Friend of JMcf
Other Contacts
JMcF ex Employer
JMcF ex Employer
Farm Manager
Private CBT Therapist
GP One
GP Two
A&E Consultant One(Statement only) no direct contact with JMcf, assisted the Investigation Team as Clinical Lead for the department.
Psychologist
Trust Staff At the time of the offence
Chief Executive
Deputy Chief Exec, Director of Nursing
Retired Medical Director of the Trust
Head of the Centre for Service Excellence
Consultant Psychiatrist
Consultant Psychiatrist
Section 12 Doctor
Section 12 Doctor
Director Health & Social Care
Head of Mental Health Services
Social worker & team manager
CPN
ASW
AMHP
Case Manager IAPT
Team Manager/CRHTT Nurse(give feedback on MHA assessment)
Modern Matron
CRHTT Nurse
Senior Manager
IAPT
Acting Service Manager
Primary Care Trust
Director Patient Safety & Clinical Quality

LEONARD WILSON

MA DipClinPsychol AFBPsS

Chair

Associate Director Niche Health & Social Care Consulting Ltd

Len is a chartered clinical psychologist by background and, prior to a move into full-time management posts, he was in clinical practice in the NHS. He spent a number of years in developing and delivering specialist mental health care and in training other professionals. He served on the Mental Health Act Commission from 1987 until 1995 and subsequently remained a member of the Commission's Section 57 (consent to psychosurgery) Panel.

Len has been chief executive of two NHS Trusts, one a community, mental health and learning disabilities services Trust and the other a specialist mental health Trust.

Following his early retirement from the NHS in 1998, he began to work as an Associate Director with Mental Health Strategies and has completed a number of training, service planning and development projects across the country. He commits time also to his role as Chair of the Board of Trustees of a mental health charity delivering a range of services for people with mental health problems in a number of localities across England and working in partnership with NHS Trusts to provide increased access to psychological therapies.

Brief Career History:

- Associate Director, Mental Health Strategies - from 1999
- Chief Executive, South Durham NHS Trust - 1996-1998; mental health, learning disabilities, community hospitals and general community services
- Chief Executive, SW Durham Mental Health NHS Trust - 1993-1996; specialist hospital and community mental health services (and Project Manager for Trust merger Project 1995-96)
- Unit General Manager, SW Durham Mental Health Unit - 1992-1993 (and Third Wave Trust Project Manager)
- Assistant General Manager (Planning and Business Development) - 1989-1992; responsible for developing business planning and contracting approaches to local mental health service delivery
- Community Hospital Manager - 1988-1989
- Coordinator for Community Mental Health Services Planning and Development - 1987-1988
- District Clinical psychologist, SW Durham Health District - to 1988

Additional Experience and Achievements:

- Interim Director posts in not-for-profit and independent sector health and social care provider organisations - 2006-09
- Delivery (with Nick Moor) of Mental Health Law and Policy training programme for Graduate Mental Health Workers
- Mental Health Act Commissioner - Feb 1987 to Oct 1995
- Member of the Mental Health Act Commission Section 57 Panel.
- Contributor, Executive Development Programme, HSMU, University of Manchester
- Assessor, General Management Training Scheme, HSMU, University of Manchester
- Former coordinator and contributor, BPS Division of Clinical Psychology Management Training Course for clinical psychology services managers

Siân Wicks

Masters in Medical Law and Legal Practice,
Capsticks Diploma in Risk Management,
RGN



Deputy Director Patient Safety & Quality Niche Health & Social Care Consulting

Siân is a Graduate in Medical Law and Legal Practice (LLM Cardiff), an experienced senior nurse with 25 years experience in the NHS, ten years of which has been spent in leading Governance & Patient Safety, in a London Teaching Hospital, District Hospital and a Foundation Trust which gives her the foundation and wealth of experience to make a difference in patient safety, investigations and healthcare regulatory work.

She has broad experience with the ability to meet the needs of all stakeholders: families, commissioners, providers, regulatory bodies and the Coroner.

She is fully conversant with the Memorandum of Understanding (2006) and works within Department of Health Guidelines. Siân has led on three National Health Service Litigation Authority assessments. She understands the complexities of running parallel investigations. She has extensive experience in multi-agency working: Health, Social care, Police, IPCC and the prison service.

A passion for excellence and the drive to make a difference are the qualities that underpin Siân's work in the complex arena of patient safety, investigations and healthcare regulation.

Siân is a fellow of The Royal Society of Medicine and lead member of The Patient Safety Sub section at the RSM. She has been invited to judge the National Patient Safety Awards for Mental Health for three consecutive years.

Current and past work:

- Lead Investigator and report author for two Type A Homicide investigations
- Oversight responsibilities for category B and C investigations.
- Investigation following an unexpected death during a surgical procedure
- Governance review of Acute Hospital department
- Thematic look back exercise following suicides
- Investigations into care and treatment following suicides
- Investigation into a cluster of deaths in provider arm of PCT
- Audit at the interface between primary and secondary care in mental health.
- CQC compliance
- Trust Investigations reports submitted to HM Coroner

Key Skills

- Chair, Lead Investigator and Project Manager for complex HSG investigations, SUI Investigations with specialist skills in report writing and root cause analysis. Investigations range from Homicide, Suicide, look backs of a cluster of deaths, Child deaths, acute patient deaths and maternal death.
- Sensitive communicator with families and all stakeholders.
- Support to Boards on the implementation of recommendations arising from complex investigations and governance processes.
- Project management of NHSLA Risk Management Standards Acute and Maternity to level 3 standard.
- CQC Compliance

Tim Cate

BSc Ma MSc Grad Dip

Registered Psychologist
Associate Niche Health & Social Care Consulting Ltd

EMPLOYMENT HISTORY

Employer	Position Held	Date from/to
2 day week secondment Clinical Director, Mental Health Matters	Clinical Director	January 2010
Tees, Esk and Wear Valleys NHS Trust	Associate Director of Psychology	January 2008
Tees, Esk and Wear Valleys NHS Trust/ Division of Clinical Psychology (DCP)	Associate Director of Psychology Chair of DCP	April 2006 December 2007
Tees & North East Yorkshire NHS Trust Division of Clinical Psychology (DCP)	Head of Psychology	April 2005
	Trust Strategic Lead on Psychological Therapies	April 2006
Tees & North East Yorkshire NHS Trust	Head of Psychological Health Service	February 2001
Tees & North East Yorkshire NHS Trust	Acting Head of Psychological Health Service	27 Nov 2000 February 2001
Tees & North East Yorkshire NHS Trust	Consultant Clinical Psychologist and Head of Adult Psychological Health Service	Jan 2000 to 27 Nov 2000
South Tees Community & Mental Health NHS Trust	Consultant Clinical Psychologist Forensic Learning Disabilities Service. Divisional Manager for Adult Mental Health and Special Needs Psychology	May 1996 to Jan 2000
South Tyneside Health Care Trust	Consultant Clinical Psychologist Head of Learning Disabilities	June 1994 to April 1996
South Tees Community & Mental Health NHS Trust	Manager of Specialist Support Team and Clinical Psychologist	March 1992 to May 1994

South Tees Health Authority Community Unit	Chartered Clinical Psychologist Community Support Team	October 1989 February 1992
South Tees Health Authority Community Unit	Trainee Clinical Psychologist	October 1987 September 1989
South Lincolnshire Health Authority Mental Handicap Service	Psychology Technician	March 1985 to October 1986
South Lincolnshire Health Authority	Care Assistant	October 1984 March 1985

Associate Director of Psychology, Clinical Director Mental Health Matters 2010

- Professional lead for Psychology for Trust
- Regional Advisor SHA IAPT Steering Board
- Chair Psychological Therapies Governance Group
- Member National Workforce Planning Group
- Chair BPS workforce Planning group
- Clinical Director for Mental Health Matters (2 day a week secondment)
- Organisational change and leadership strategy locally and nationally
-

Associate Director of Psychology and Chair of the Division of Clinical Psychology (ended December 2007)

- Professional lead for Psychology for Trust
- Regional Advisor SHA IAPT Steering Board
- Lead for Depressive Complaints Pathway for Trust
- Chair Psychological Therapies Governance Group
- Reviewing Challenging Behaviour Services
- Project managing training developments in Challenging Behaviour
- Member of Lean Project Management Team
- Organisational development work on Change and Transition
- National Executive Lead for Professional Body
- National Lead New Ways of Working for Psychologists "Leading and Organising Services" work stream
- Member of Improving Access to Psychological Therapies National Workforce Sub Group

**Head of Psychological Health Service (February 2001-April 2006)
(Trust Strategic Lead for psychological therapies)**

- Integrated and aligned Psychological Health Service and completed by April 2003
- Effective and improved Professional and operational line management of services
- Expansion of management role to cover all specialties
- Strategic Lead for Trust in delivering psychological therapies including developing workforce plans, training and governance
- Development of career framework for psychological therapist (produced locally in 2005 and now used in IAPT commissioning framework published 2008)
- As part of wider team developed care pathways
- Continuation of Clinical work in Learning disability, forensic and generic services

Head of Adult Psychological Service (January 2000-February 2001)

- Coordinating and managing all Specialty Heads in Adult Services
- Strategic Planning and delivery of new Specialist Mental Health Services

- Reconfiguration of existing services

Consultant Clinical Psychologist, and Divisional Manager, Adult Mental Health and Special Needs (May 1996 – January 2000)

- Development of Learning Disability Forensic Service
- Development of high level clinical skills pertaining to client group
- Effective management of the service with Psychiatry and Nursing colleagues
- Professional and management responsibilities within the former Psychology and Counselling Agency

Head of Learning Disabilities, South Tyneside (June 1994 – April 1996)

- Established Clinical Psychology Services for People with Learning Disabilities
- Liaison across three Trust Directorates, Social Services, and Independent Sector
- Responsible for resettlement programme (provider role)
- Attended the Northern and Yorkshire Region Leadership Development Programme (Chief Executive sponsored attendance)

Team Manager, Specialist Support Team (March 1992 – May 1994)

- Commissioned Team including selection and training of staff
- Establishment of the Team through the contracting process
- Management of budget of £115,000 per annum
- Ensured that the Team fulfilled operational criteria
- Evaluation of work undertaken and production of annual report
- Liaison with colleagues in developing resettlement services
- Member of the Divisional Management Team

Clinical Psychologist – Community Support Team (October 1989 – February 1992)

- Responsible for the provision of Clinical Psychology Services in Langbaugh
- Responsible for pediatric referrals for the Middlesbrough area
- Development of therapeutic skills working with families
- Service evaluation of the intensive support team approach to Challenging Behaviour

PUBLICATIONS AND PAPERS

- Invited by the British Association of Behavioural Psychotherapy (BABP) to organise a symposium on Challenging Behaviour for the 25th BABP Annual Conference (Oxford University 1991). This included presenting the findings of our own project.
- Challenging Behaviour Project Team – Mental Handicap, June 1993 Vol. 212 BIMH Publications.
- BILD Conference, Scarborough 1994 “Evaluation of Specialist Support Team – User Satisfaction”
- Annual National Vacancy survey papers 2003 onwards, Clinical Psychology Forum

OTHER ACTIVITIES

- Director, Psychology in Organisations Ltd (now ceased trading)
- Director Healthwise Fitness and Leisure Ltd
- National representative for the North East Region Clinical Psychologists on the OAC 1991 – 1993
- Chair and founder of National Managers Faculty of the Division of Clinical Psychology 2002-2004

Dr Mark Potter

B Med Sci 11 (1)BM,BS MRCPsych

Consultant Psychiatrist Associate Niche Health and Social Care Consulting Ltd

Mark was appointed as a Consultant Psychiatrist in November 1991 and is also an Honorary Senior Lecturer in the Department of Psychiatry, St George's Hospital Medical School, examiner for the MRCPsych, and member of the Royal College of Psychiatrists.

Mark is currently the Consultant Psychiatrist and clinical leader for a Community Health Team serving a population of 45,000 in an inner city area in south west London with significant pockets of deprivation. The service has a clear focus on serving the needs of the long term mentally ill, and Mark has worked hard to forge strong links with services that interface with specialist mental health services. Marks responsibilities include providing leadership and direction to the clinical team to manage the care of patient with complex and serious mental health problems, and has led the development of protocols for the management of depression between primary and secondary care.

As Clinical Leader and Consultant Psychiatrist Mark has significant experience in working with management to ensure that community mental health services are organised to provide care which safe, effective and efficient. He has been closely involved with the development of Clinical Governance within his Trust and was Chair of the Risk Assessment and Management Committee. He led the Risk Assessment Review Group arising from the Anthony Joseph Inquiry and helped develop revised pro forma and practice based on best practice guidance, which has now been implemented throughout his Trust.

He has a special interest in supporting SUI investigations using root cause analysis, and has worked on over 12 investigations, including suicides and 3 homicides.

Mark also has research interests in the areas of the genetics of mental illness and in court diversion schemes, and has published widely on these subjects.

Marks recent achievements include:

- Assessor for the Health Service Ombudsman.
- Advisor to complaints for the Health Care Commission.
- Chair of Trust Section 136 review group
- Chair of the Dual Diagnosis Strategy Group.
- Assessor for the National Clinical Assessment Service (NCAS) undertaking clinical performance assessments in cases where the NCAS has judged a full assessment necessary. Mark has been fully trained in the use of NCAS assessment methods.
- 2005 Panel Member – PM External Homicide Inquiry. First such inquiry undertaken in Northern Ireland under DHSSPS Guidance of May 2004.

Medical Protection: Medical Defence Union
Membership Number 170879

GMC Number: 2579823

PUBLICATIONS

1. Sherringham,R., Brynolfsson,J., Petursson,H., Potter,M., Duddleston,K., Barraclough,B., Wasmuth,J., Dobbs,M., Gurling,HMD. (1988) Localisation of susceptibility ;locus for schizophrenia on chromosome 5. Nature 336:164 – 167.

2. Gurling,HMD., Sherrington,R., Brynjolfsson,J., Potter,M., McInnis,M., Petursson,H., Hodgkinson,S. (1988) Molecular genetics and heterogeneity in manic depression. *Molecular Neurobiology* 2: 1 – 7.
3. Gurling,HMD., Sherrington,R., Brynjolsson,J., Read,T., Curtis,D., Mankoo,B., Potter,M., Petursson,H. (1989) Recent and future molecular genetic research into schizophrenia. *Schizophrenia Bulletin* 15: 373 – 382.
4. Gurling,HMD., Sherrington,R., Brynjolfsson,J., Wells,R., Hodginson,S., Barracloch,B., Potter,M. (1988). Genetic linkage studies of schizophrenia using minisatellite and chromosome 5 DNA polymorphisms. *Schizophrenia Research* 1(2-3) 130 – 131.
5. Gurling,HMD., Sherrington,R., Brynjolfsson,J., Wells,R., Hodginson,S., Barracloch,B., Potter,M. (1988). Genetic linkage studies of schizophrenia using the M13, 33.15 and 33.6 hypervariable DNA polymorphisms. In: *A genetic perspective for Schizophrenia and Related Disorders*. Eds. Smeraldi,E., Kidd,K., Edi-Hermes,Milan, 43 – 48.
6. Joseph,P.L.A., Potter,M. (1990) Mentally disordered offenders – diversion from custody. *Health Trends* 2: 51 – 53
7. Stansty,D., Potter,M. (1991) Alcohol abuse by patients undergoing methadone maintenance programmes. *British Journal of Addiction* 86: 307 – 310.
8. Gurling,HMD., Read,T., Potter,M. (1991) Genetic linkage studies of schizophrenia. In: *The New Genetics of Mental Illness*. Eds. Murray,R.M., McGuffin,P., Butterworth-Heinemann Medical Books, Oxford UK, 98 – 111.
9. Joseph,P.L.A., Potter,M. (1991) Munchausen AIDS in a Bomb Hoaxer. *Medicine, Science and the Law* Vol 31, No.3: 259 – 260
10. Joseph,P.L.A., Potter,M. (1993) Diversion from Custody. 1: Psychiatric Assessment at the Magistrates Court. *British Journal of Psychiatry* 162: 325 – 330.
11. Joseph,P.L.A., Potter,M. (1993) Diversion from Custody. 2: Effect of Hospital and Prison Resources. *British Journal of Psychiatry* 162: 330 – 334.
12. Chaplin,R., Potter,M., Tardive Dyskinesia: screening and risk disclosure.
13. McGowan,I., Potter,M., George,R., Michaels,L., Sinclair,E., Scaravilli,F., Miller,R. HIV Encephalopathy Presenting as Hypomania *Genitourinary Medicine* 1991: 67: 420 – 424

SUBMITTED

Temporal Lobe Abnormalities in First-episode Psychosis – to *American Journal of Psychiatry* Sumich,A., Chitnis,X., Fannon,D., Doko,V., Marshall,N., Matthew,V., Potter,M., Sharma,T.

Dr IAN CUMMINGS

Consultant Forensic Psychiatrist Associate Niche Health & Social Care Consulting

Ian is a Consultant in General Adult Psychiatry & Forensic Psychiatry. Ian has been employed by the NHS since 1998. He currently leads a multidisciplinary team based at HMP Belmarsh which he has developed since the partnership between Oxleas and HMP Belmarsh began in December 1998. Ian is also part of the forensic directorate at Oxleas NHS Trust. His post involves a heavy clinical commitment in providing the care and delivery of mental health services at HMP Belmarsh. Ian is a core component of the management team within the partnership between HMP Belmarsh and Oxleas.

Education and Qualifications:

- The Middlesex Hospital Medical School, Mortimer Street, London W1.
- MB BS 1988
- Fully registered with The General Medical Council (3359202)
- Membership of The Royal College of Psychiatrists – MRCPsych (1992)
- CCST General Adult Psychiatry – December 1998 (Subspeciality Substance Misuse)
- Statement of eligibility for practice as a consultant forensic psychiatrist by The Royal College of Psychiatry – 2007
- Elected to the Executive of the Faculty of Forensic Psychiatry, Royal College of Psychiatrists – May 2006
- Elected Fellow of The Royal College of Psychiatrists – 2009

Further Professional Training:

- United Medical and Dental Schools of Guy's and St Thomas's Psychiatry Training Scheme : October 1989 – August 1991 (Senior house officer)
- United Medical Schools of Guy's and St Thomas's and The South East Thames Regional Health Authority, Registrar Rotational Training Scheme in Psychiatry : August 1991 – September 1993 (Registrar)
- Clinical Research Fellow in Forensic Psychiatry – The Bracton Centre and HMP Belmarsh – September 1993 – November 1995
- UMDS/South East Thames Higher Training Scheme : November 1995 – October 1998 (Senior Registrar)

Key Responsibilities and achievements:

Ian's areas of specialism and expertise are in mental health services in prisons, Forensic psychiatry, general adult psychiatry and substance misuse. He regularly lectures to students, psychiatrists, government officials and other professionals on aspects of mental health services in prison. He has lectured at the Royal College of Psychiatry Annual Conference, the Forensic Faculty and internationally in Russia, The United States and Israel.

He is one of the leading experts in prison psychiatry in England and Wales. He is well known and respected within the forensic psychiatry community and in 2006 he was elected to the executive of the faculty of forensic psychiatry at The Royal College of Psychiatry. His knowledge and experience of prison psychiatry is based upon 11 years of clinical work at HMP Belmarsh and the forensic directorate in Oxleas NHS Trust; he has visited many prisons in the UK and has a comprehensive knowledge of psychiatric services and prison regimes. He has written and edited a textbook on prison psychiatry which is due to be published this year.

He has recently been appointed to be an advisor on prison psychiatry issues and criminal justice for NHS London and also an advisor on prison issues to The Sainsbury Centre for Mental Health one of the leading 'think tank' agencies in the United Kingdom.

He has extensive experience in the preparation of medicolegal reports and within civil and criminal spheres. Ian has prepared reports for the defence, court and crown prosecution service and in all types of cases and offences including those charged with murder, terrorism and serious sexual offending. He has been involved in many high profile and difficult cases that have been to court.

Ian has been employed by various Government agencies to undertake prison related psychiatric reports and inquiries. He is the clinical lead for psychiatric court diversion and liaison services at four Magistrates Courts in London; in 2008 Ian developed an innovative liaison service at The Central Criminal Court and he works there one day a week to address and manage mental health issues that impinge upon the case management of the court.

DR PAUL ALFORD

GP

Associate
Niche Health & Social Care
Consulting

Roles and Responsibilities

Present substantive role	-	GP Principal – Morden Hall Medical Centre
2010 - Present	-	Co-chair of Clinical Management Board for Assura Wandle GP Company
2009 - Present	-	Chair of Mental Health Interface Prescribing Forum
2009 - Present	-	Chair of Mental Health Clinical Quality Review Committee
2009 - Present	-	Clinical Management Board GP member for Assura Wandle GP Company
2008 - Present	-	Nelson Health Limited Director
2008 - 2010	-	Merton Professional Delivery Committee GP member
2006 - Present	-	Nelson Commissioning Performance Group member
2005 - Present	-	Nelson Commissioning Group Management Team Practice Representative
2005 - Present	-	GP Appraiser
2005 - Present	-	Joint prescribing lead for Merton
2004 - 2007	-	GP member Professional Executive Committee, Sutton and Merton PCT
2004 - Present	-	Associate Clinical Director in Education
2003 - Present	-	GP Trainer
2002 - Present	-	Local Medical Committee representative
2001 - Present	-	Membership of CHD clinical priority group and then NSF implementation group
2001 - 2004	-	Prescribing lead for Nelson and West Merton PCT
2001 - 2004	-	GP forum co-chair for Nelson and West Merton locality and combined GP forum
2001 - 2044	-	Membership of Mental Health clinical priority group and then NSF implementation group

Recent Qualifications

2008 -	Fellowship of Royal College of General Practitioners
2005 -	Professional Certificate in Management
2003 -	Certificate of Education in Primary Care
1999 -	DFFP
1998 -	MRCGP
1992 -	MBBS

Paul has a keen interest in health service management with over 10 year's experience. This profession development has allowed him to understand the functioning of teams, small organisations, large organisations and their complex interactions in an ever-changing world. His future lies in developing and managing health service provision at all levels – practice, community and other health service providers. He has a keen interest in prescribing and special expertise in understanding clinicians' and practices' performance generally.

SUE SALAS

RGN,RMN,BSc(Hons),MSc, MSc

Senior Consultant Niche Health & Social Care Consulting



Sue has a BSc (Hons) Psychology and an MSc Occupational Psychology both from Birkbeck College, University of London. She is also a qualified general and psychiatric nurse. She also has an MSc Culture & Mental Health from University College London. Prior to joining us she was a Service Manager at Camden & Islington Mental Health & Social Care Trust, London, where she managed a range of inpatient and community services.

Sue has fourteen years experience of management in both the NHS and private sector. She has considerable experience of working in partnership with service users, academics, religious leaders, local authority and voluntary sector colleagues on a wide range of projects. She has worked with service users from diverse backgrounds and with a wide range of needs. Sue has won awards for innovative practice in the past.

Sue is experienced in managing complex projects within agreed timescales. She is committed to and interested in making the link between research evidence, good practice guidance and clinical practice. She is also an experienced researcher and has undertaken projects on Islam & mental health plus return migration, reintegration and mental health.

Sue's previous work includes:

- Conducting a Mental Health Needs Assessment of foreign national prisoners at HMP Canterbury
- Conducting a Community Needs Assessment with so called "hard to reach" groups focusing on ascertaining their views on housing, employment, education, leisure and access to mental health services.
- Undertaking a review of Alcohol Services.
- Undertaking a review of Drug, Alcohol & Dual Diagnosis Services
- Devising a Dual Diagnosis Strategy
- Undertaking a CMHT review
- Conducting a review of specialist Mental Health Services.
- Devising and delivering Equality & Diversity interactive workshops for healthcare professionals.
- Conducting a review of Psychiatric Liaison Services
- Acting as Mental Health Nurse Lead on a "Look Back" exercise and on a detailed SUI investigation
- Creating, appointing, and supervising the UK's only Cross cultural Nurse on a Psychiatric Intensive Care Unit.
- Conducting a baseline review of the extent to which Bedford District Care Trust is meeting the Delivering Race Equality vision for 2010.
- Creating an "Equality & Diversity Champions" initiative and devising and delivering a Training Programme for two cohorts, Cumbria Partnership NHS Foundation Trust.

Publications

Keaney, F, Salas, S & Wilson, C. (2006). Working with NHS managers: Finding a common language. *British Journal of Medicine*, 332, pp 63 – 64.

Salas, S & Jadhav, S (2004): Meeting the needs of Muslim service users. *Professional Nurse*, Sept 2004, vol 20, no 1, 22-24.

Salas, S & Jadhav, S (2004): Sensitising Mental Health Professionals to Islam. In Shaw, T and Saunders, K (Eds) *Foundation of Nursing Studies Dissemination Series*, Vol 2, No 5.

Salas, S & Jadhav, S (2003): Islam & Mental Health. *Proceedings of the Trans-cultural Nursing & Healthcare Association Annual Conference*.

Wanigarante, S, Salas, S & Strang, J. Culture & Substance Misuse (2007) In Bhugra, D & Bhui, K (Eds). *Textbook of Cultural Psychiatry*. Cambridge University Press.

Book Reviews

Salas, S. (2009). A history of the U.S Army Nurse Corps by Mary Sarnecky (1999). *Anthropology & Medicine*, Vol 16, 2, pp 211-212

ANDREW KEEFE

DipSW, MA (econ), Crime, Law & Society, MBA

Principal Consultant
Niche Health & Social Care Consulting



Andrew is a Registered Social Worker and a Principal Consultant with us. His career in health and social care began in the mid 1980's when he moved to the then West Germany to establish and run an independent sector 'drop in' centre for homeless young people. Since returning to the UK he has worked in a range of statutory Health and Social Care environments including both community and inpatient facilities as both a practitioner and a manager.

After completing his social work training in 1995 he went on to complete his ASW training whilst working within Tameside's joint Mental Health Services – working in their Ethno-sensitive Mental Health Unit. In 1998 he moved to work at Ashworth High Secure Hospital, initially as a Senior Social Worker within the Personality Disorder Service, working with some of the UK's most challenging and high profile cases, before moving in 2000 to work exclusively within Ashworth's Women's Service as a senior manager. In both roles he was closely involved in and led many Quality, Risk and Governance Forums and Serious Untoward Incident Case Reviews. As the Clinical Manager of the Women's Service he was also closely involved in the re-provision of care away from High Secure Services and the closure of the Women's Service at Ashworth.

In 2003 joined NIMHE North West (later CSIP) as the Service Improvement Lead for the region with specific responsibility for the Access, Booking and Choice agenda as well as being the NIMHE NW's Substance Misuse Lead for the Region and the Client Manager for two mental health provider trusts. Andrew joined Mental Health Strategies in the spring of 2005 and since then – as well as completing his MBA – he has led a wide range of projects spanning the domains of: mental health and wellbeing; learning disabilities; alcohol and substance misuse services; and employment services.

These projects include:

- numerous commissioning strategies across each of the above domains – including complex care/dual diagnosis strategies
- whole system, service, and care pathways reviews across the health and social care spectrum
- many service improvement and service redesign projects
- stakeholder engagement and formal public consultation projects
- complex option appraisals all completed in an inclusive manner whilst achieving decisive outcomes
- fulfilling the role of commissioner on an interim basis for a City PCT
- providing bespoke client focused projects include the development of a joint communication strategy, a joint workforce plan, market assessments, business cases and marketing plans (for both statutory and independent sector providers), and many team and organisational development projects

Andrew also contributes to the teaching on postgraduate mental health programmes at the University of Manchester (School of Nursing, Midwifery and Social Work). He has an engaging and inclusive manner with a strong emphasis on improving services from the service user and their carer's viewpoint. From this value base he brings his creative and critical mind to engaging commissioners and service providers in improving their performance and outcomes. He is married, lives in Stalybridge, and has two adult children.

TONY INGHAM

CMS MMS

Consultant Analyst Mental Health Strategies



Tony has concentrated on information type projects since 1985 when he was a key member of a multi-disciplinary team which successfully implemented a PAS for 18 health authorities. Concentrating on mental health information since 1996, his experience in projects at national, regional and local level includes specifying, implementing and evaluating systems.

A firm believer in “information first.. technology second”, Tony was one of the authors of the Mental Health Information Strategy published by the Information Unit of the NHSE in March 2001. “Solution orientated”, he specialises in converting large amounts of data into user friendly relevant information.

Working with service users and professionals, he developed the pioneering mental health benchmarking system commended in the NSF, covering services for adult acute, older people and child and adolescent mental health services.

Tony's experience includes:

- Key member of the team who wrote the Mental Health Information Strategy and has participated in subsequent projects to establish the NHS's capacity and capability to deliver the Strategy.
- Technical development and reporting on the Autumn Comprehensive Review of Adult Mental Health Services for the Department of Health. Tony has been instrumental in the National “Traffic Light” LIT Self Assessment of mental health services 2000 - 2005 and the National Finance Mapping exercises for 2001-2009. His involvement ranged from initial design work, designing mechanisms to collect data, web site support, through to client liaison and the development and production and presentation of national, regional and local LIT reports.
- The collection, analysis and reporting of healthcare provision in English prisons in 2007, 2008 and 2009. Now on the second year of collection, Tony was central to providing the first comprehensive comparative picture of prison healthcare provision in England at individual prison, SHA, PCT and National levels.
- Undertaking Information Technology Training Needs Assessment of Healthcare staff for H.M. Prison Service. The project highlighted staff knowledge and attitudes on several key issues. His contribution included database and report design and producing 124 prison specific reports.
- Design and development of a dashboard information reporting system for PCT and Mental Health Trust use. Commencing with actual information needs identification for clinicians and managers, agreeing realistic and practical indicators, it delivered an easy to use and understand, pragmatic and low cost solution to client needs.
- A key player in the design and delivery of the mental health chapter in the World Class Commissioning (WCC) project in support of healthcare commissioners for both 2008 and 2009 collections.
- Participating in several multi aspect service reviews covering adult, child and adolescent mental health and drug/alcohol services
- Market assessments for a number of NHS and private healthcare organisations. Projects for 2009 included core mental health needs assessment for a large London PCT seeking a detailed and up-to-date understanding of the mental health needs of the local population (including epidemiological projections for

the main mental disorders, local factors influencing mental health needs and the relationship between epidemiology and service utilisation data) and detailed market analysis for a large independent healthcare provider.

- Research for several clients into the prevalence of mental health disorders, forecasting the likely demand on services.
- Developed several mental health specific benchmarking initiatives in the adult acute, child and adolescent and older people mental health and primary care fields. These were developed with multi agency and disciplinary groups (including health, social services and education).
- Prepared system and reporting specifications for clinically relevant mental health information systems and a strategic review of mental health information provision in an NHS trust.
- Project managing a major site for the Mental Health Minimum Data Set with particular attention to clinical outcome measures for contract monitoring.
- Several years experience in implementing and post implementation reviews of a variety of NHS health care acute and community computer systems concentrating on benefits realisation, reporting capabilities and needs.