# Independent Investigation

# into the

# Care and Treatment Provided to Mr. X

# by the

# Avon and Wiltshire Mental Health Partnership NHS Trust

# Commissioned by

# NHS South West Strategic Health Authority

## *Executive Summary*

**Independent Investigation: HASCAS Health and Social Care Advisory Service**

**Report Author: Dr Len Rowland**

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## Brief overview of Mr. X's contact with the Avon and Wilshire Mental Health Partnership NHS Trust

Mr. X had contact with the Children's Mental Health Services from around the age of six. On one occasion he was admitted to a paediatric ward for assessment following an overdose.

In 2005 Mr. X presented to the Accident and Emergency Department at his local hospital on two occasions following him taking overdoses. He was diagnosed as suffering an adjustment disorder and was discharged to the care of his GP. The Community Mental Health Team (CMHT) contacted Mr. X suggesting that he make contact with them. He did not respond to this offer.

In 2006 Mr. X was detained on a Section 136 of the Mental Health Act (1983) following an argument at his grandmother's house. Mr. X said that he had been drinking alcohol but the custody sergeant reported that he did not appear to be drunk. He was assessed at the local police station and found not to have a mental illness serious enough to warrant a hospital admission. He declined offers of support and was discharged.

Mr. X was again detained on 26 March 2008 following an argument at his grandmother's house. His grandmother had been frightened by his behaviour and called the police. When Mr. X was assessed he reported that he regularly drank heavily and used illicit drugs, particularly cannabis. He also reported that his grandmother had suggested that he was hearing voices but he denied that this was the case. It was concluded that Mr. X was not showing any evidence of mental illness. He was discharged and given the contact details of the drug counselling service.

On 31 March 2008 Mr. X contacted the Adult Mental Health services. He said that he was concerned that his use of drugs and alcohol had damaged his mental health and he feared that he was suffering from schizophrenia. He was seeking support to prevent his mental health deteriorating. Mr. X reported that he was abstaining from drugs and alcohol at that time.

Mr. X was displaying a number of symptoms consistent with a diagnosis of psychosis and it was concluded that he was suffering from a drug induced psychosis or hypomania. The Community Psychiatric Nurse (CPN) who assessed Mr. X discussed his formulation with Mr. X's GP and with the Community Mental Health Team (CMHT) and arranged to see him again a week later to assess if his mental state had improved as the effects of the drugs and alcohol wore off. A risk assessment was carried out and Mr. X was rated as not posing a risk to others, though it was noted that he had had problems in controlling his anger in the past.

Mr. X was again detained by the police on 2 April 2008. He was described as expressing bizarre and psychotic type thoughts. He attended his review appointment on 8 April 2008 accompanied by his grandmother. The CPN and the Mental Health Team Leader, who assessed Mr. X on this occasion, concluded that Mr. X's mental state was much improved. This improvement in Mr. X's mental state appeared to support the diagnosis of a drug induced psychosis and Mr. X was discharged. Mr. X's grandmother's opinion of his mental state and behaviour was not sought.

At this time Mr. X was living with a friend, Mr. C, who was to be Mr. X's victim. Mr. X told the CPN that he was having problems with Mr. C and created the impression that he was being exploited by him.

On 12 April 2008 Mr. X was arrested on suspicion of murder. He was assessed at Salisbury police station. A preliminary drug screen was carried out which suggested that Mr. X had been smoking cannabis. He reported that he had been drinking heavily on 11 April. The conclusion of the assessment was that Mr. X was suffering from a drug induced psychosis and was not fit to be interviewed by the police.

Mr. X was assessed again on 14 April and though his mental state had improved it was felt that he was still not fit to be interviewed. When he was assessed on 15 April 2008 it was concluded that Mr. X had an eccentric way of expressing himself but that he was not, at that time, mentally ill and was fit to be interviewed by the police.

On 24 April 2008 the Regional Laboratory for Toxicology reported that the urine sample that had been taken from Mr. X on 12 April 2008 was negative for all the drugs they had tested for, including cannabis.

Mr. X was remanded to HMP Reading where he continued to display symptoms consistent with a diagnosis of psychosis and was prescribed anti-psychotic medication. He was transferred to HM Young Offenders Institution Feltham on 18 April 2008 where he remained until 30 June 2008. During this time his mental state gradually stabilised. However, Mr. X was transferred to a medium secure unit on 30 June 2008 on Section 48/49 of the Mental Health Act. A forensic report prepared in August 2008 concluded that Mr. X was suffering from a bipolar affective disorder (manic type). A further report in October 2008 also identified bipolar affective disorder as the most probable diagnosis but also identified drug and alcohol dependency misuse and a personality disorder as possible differential diagnoses. This report noted that it was possible that Mr. X's illness was continuing to develop and that he might develop a psychotic illness such as schizophrenia.

Mr. X was convicted of manslaughter on the grounds of diminished responsibility at Winchester Crown Court in November 2008. He was sentenced to be detained for an indeterminate period under sections 37/41 of the Mental Health Act (1983).

## Terms of Reference for the Independent Investigation

The Terms of Reference for the Independent Investigation were set by NHS South West, the Strategic Authority (SHA). They are as follows:

**1. The overall objectives of the Independent Investigation of the Case of Mr. X**

to evaluate the mental health care and treatment including risk assessment and risk management;

- to identify key issues, lessons learnt, recommendations and actions by all directly involved in health services;
- assess progress made on the delivery of action plans following the Internal investigation;
- identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies.

**2. Terms of Reference**

1. Review the assessment, treatment and care that Mr. X received from the Avon & Wiltshire Mental Health Partnership NHS Trust.
2. Review the care planning and risk assessment policy and procedures.
3. Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment.
4. Review the documentation and recording of key information.
5. Review communication, case management and care delivery.
6. Review the Trust's Internal Investigation of the incident to include timeliness and methodology to identify:
    - whether all key issues and lessons have been identified;
    - whether recommendations are appropriate and comprehensive and flow from the lessons learnt;
    - review progress made against the action plan;
    - review processes in place to embed any lessons learnt.

8. Review any communication and work with families of victim and perpetrator.

9. Establish appropriate contacts and communications with family/carers to ensure appropriate engagement with the Internal Investigation process.

## 3. Outcomes

1. A comprehensive report of this investigation which contains the lessons learnt and recommendations based on evidence arising from the Investigation.

## The Independent Investigation Team

The Investigation Team was comprised of individuals who worked independently of the Avon and Wiltshire Mental Health Partnership NHS Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

**Investigation Team Leader and Chair**

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|---|---|
| Dr. L.A. Rowland | Director of Research, HASCAS Health and Social Care Advisory Service. Clinical Psychologist Member |

**Investigation Team Members**

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| Dr. A. Johnstone | Chief Executive Officer, HASCAS Health and Social Care Advisory Service. Nurse Member |
| Mr. I. Allured | Director of Mental Health, HASCAS Health and Social Care Advisory Service. Social Worker Member |

**Support to the Investigation Team**

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|---|---|
| Mr. C. Welton | Investigation Manager, HASCAS Health and Social Care Advisory Service |
| Fiona Shipley Transcriptions Ltd | Stenography Services |
| Independent Legal Advice | Kennedy's Solicitors |

## Findings

### The Care Programme Approach: Assessing Needs and Planning Care

Sound assessment is the foundation upon which good care is based. Each time Mr. X presented to the Mental Health services he was appropriately assessed; on most occasions the Trust Core Assessment form was completed.

However, despite the Trust policy identifying the importance of involving the service user's family in the assessment of his/her needs Mr. X's family were consulted on only one occasion. This failure to involve Mr. X's family did not reflect best practice, however it would not be reasonable to conclude that it had a direct causal relationship with the events of 11 /12 April 2008.

### Risk Assessment and Management

On three of the four occasions that Mr. X was assessed by Trust staff, the Trust's confidential screening tool was used. On two of these occasions it was concluded that he did not pose a risk to others. It was noted that Mr. X coped poorly with his anger and he was provided with details of stress and anger management courses.

Mr. X was detained by the police on at least three occasions. However, when he was assessed by Mental Health staff they concluded that he was not suffering from a significant mental health problem. The result of this was that Mr. X was passed between agencies without any co-ordinated approach being adopted. These were missed opportunities.

Good practice suggests that the assessment of risk should be ongong, accretitive and, where appropriate, multi-agency. Had this approach been adopted in Mr. X's case a different view might have been taken of the risk he posed and how this might have been responded to. However, given the brief and transient nature of Mr. X's contact with mental health services it would not be reasonable to conclude that there was a direct and causal association between the approach adopted by the mental health services and the events of 11 /12 April 2008.

**Diagnosis and Formulation**

When Mr. X was assessed in 2005 he was diagnosed as suffering from an adjustment reaction/disorder. In 2006 it was concluded that he was not suffering from a mental illness. On 31 March 2008 he was diagnosed as suffering from a drug induced psychosis. The possibility of his suffering from a personality disorder was also raised.

Differential diagnosis: It is good practice to consider explicitly alternative explanations of an individual's behaviour. Entertaining a range of possible formulations forces one to consider a range of possible interventions and adds clarity to the assessment. Although Mr. X had several different diagnostic labels were applied to him during his contact with the Avon and Wiltshire Mental Health Services there is no evidence in Mr. X's notes that differential diagnoses were considered.

Corroboration and the reliability of information: It was known that the information Mr. X provided was often unreliable. However corroboration of his drug and alcohol use was not sought prior to his arrest in April 2008.

Availability of information: The clinical staff who assessed Mr. X were under the impression that he had no history of mental health problems. However, Mr. X had been in contact with various mental health services from at least 1994 when he was six/seven years old. It would have been good practice to have the clinical notes from Mr. X's childhood available to those assessing him.

**Treatment**

Mr. X was referred to the Crisis Team, the CMHT and the Drug and Alcohol services. He was given the contact details of a drug counselling service and a stress and anger management course and it was recommended that he saw his GP to discuss referral to a primary care counsellor. There is no evidence that Mr. X availed himself of any of these services.

The Trust's Dual Diagnosis policy and national guidance suggest that where both mental health needs and substance misuse problems are present the individual should be treated in a holistic manner, normally, within mainstream Mental Health services. It would have been

good practice to have considered how these inter-related problems might have been addressed, rather than discharging Mr. X as soon as his mental state appeared to improve. However, given that there were only three days between Mr. X's review appointment and the events of 11 and 12 April 2008 it is unlikely that any intervention would have had a significant impact on Mr. X's health and well-being.

**Safeguarding Adults**

From his first contact with Adult Mental Health services in May 2005 it was noted that Mr. X had a difficult relationship with his family. This manifested itself in outbursts of anger which he found difficult to control. His grandmother found Mr. X's behaviour frightening. He stole money from her. He introduced his friends into her home, where they drank alcohol and used illicit drugs. He argued with his grandmother and damaged her property. On a number of occasions the police were called to Mr. X's grandmother's home because of his behaviour. It seems that Mr. X had little insight into the effects of his behaviour.

Given the information available it would have been good practice to have formally assess the risk Mr. X posed to his grandmother and to consider to what degree, if any, she met the criteria of being a vulnerable adult. It would have been good practice to include Mr. X's grandmother in these deliberations and, in consultation with her, a plan should have been put in place to address any identified issues.

**Service user Involvement in Care Planning**

Given his brief and episodic contact with the Adult Mental Health services there was limited opportunity to demonstrate Mr. X's involvement in his assessment and care planning. On two of the three occasions, prior to his arrest in April 2008, when the Trust's core assessment form was completed the section for recording the user's views was completed. This was good practice. However, on only one occasion is it indicated that a letter regarding Mr. X's presentation was copied to him. It would have been good practice to copy all relevant correspondence to Mr. X.

Following most assessments Mr. X was given information about relevant services or was referred to relevant services. There is no evidence that he availed himself of these services.

**Involvement of the Family**

On a number of the occasions Mr. X reported that his distress was the result of conflict with his family. On at least two occasions Mr. X's family called the police for assistance and on one occasion Mr. X's grandmother felt frightened by his behaviour. On a number of occasions it was noted that Mr. X was not a reliable historian. Given these circumstances it would have been good practice to have consulted his family to corroborate his account of events and to understand better how he might have been helped. However prior to his arrest there is only one record of an attempt to involve Mr. X's family being made.

**Communication**

Although Mr. X was seen on only seven occasions as an adult there is evidence of good and consistent communication between the Mental Health services, Mr. X's GP and the out of hours Emergency Duty service.

The Emergency Duty service (EDS) electronic records system did not speak to the Avon and Wiltshire Mental Health Partnership NHS Trust's electronic system. The EDS, therefore, had to fax information to the CMHT when they had contact with a service user out of hours. This interface was a point of weakness in the communication system.

There was a local electronic records system, as well as a paper clinical record used only by the community teams in Salisbury. This was a point of weakness in the communication system.

A third point of weakness in the communication and record keeping system was that records of multi-disciplinary team discussion were not available in Mr. X's case notes.

A Trust-wide electronic record system is currently being put in place. This will address some of the concerns noted here. However, access to and inputting of information when an assessment is undertaken out of hours and away from Trust premises remains an issue to be addressed; the out of hours EDS will continue to have a separate electronic system which will not speak to the Trust system and this remains a point of weakness in the communication system.

Only notes relating to Mr. X's contacts with adult services were available to clinicians, however, Mr. X had been seen by the Children's Mental Health services. If clinical staff are to undertake sound assessments it is important that they have timely access to all relevant information.

If assessments are to be robust and reliable then it is important that all relevant clinical information is available to those undertaking the assessment. This information should be readily accessible and available in a timely manner. Because of the systems of recording and storing information in place at the time, the details of Mr. X's presentation, his behaviour and the fact that his grandmother was sufficiently afraid to call the police, was not available to the CPN when he undertook his assessment on 31 March 2008. This was a significant weakness in the communication and record keeping system however it can not be reasonably concluded that that this failure had a direct causal relationship with the events of 11/12 April 2008

**The Management of Mr. X's Care**

Because of the manner of Mr. X's presentation and because he was only briefly and infrequently in contact with the service, there was no explicit plan for the management of his care. Mr. X was referred to the Crisis Team[1], to the CMHT[2] and to the Drug and Alcohol Services.[3] However there was no mechanism in place to monitor whether Mr. X took advantage of these referrals.

It was consistently noted that Mr. X misused drugs and alcohol to the detriment of his psychological well-being. Good practice indicates that where substance misuse impacts on an individual's mental health s/he should be assessed and offered intervention by mainstream Mental Health services, with appropriate support from the specialist substance misuse service to address these inter-related difficulties. Such a service was not offered to Mr. X.

Mr. X's care was not planned and co-ordinated. This was because he presented infrequently and in crisis. However, where an individual presents in crisis on a number of occasions, good practice suggests that the assessment should go beyond the immediate presentation and

[1] Clinical Records p.167
[2] Clinical records p. 147
[3] Clinical records p. 124

address the question of what need is being made manifest by repeated crisis presentations. The Trust together with the clinicians who undertake assessments might reflect on how this might be built into both routine and emergency assessments.

## Conclusion

Mr. X presented to Adult Mental Health services on three occasions and was detained by the police on a further three occasions between 2005 and 2008. On each occasion that the Mental Health services were asked to assess Mr. X they responded promptly and usually completed the Trust's core assessment schedule and the Trust's risk assessment form. When Mr. X presented himself to the "wrong" part of the service in March 2008 the service showed appropriate flexibility and a duty worker travelled to Mr. X to assess him immediately. This was good practice.

Prior to Mr. X approaching the Mental Health services on 31 March 2008 the consistent opinion of those who assessed him was that he was not suffering from a major mental illness. However given his presentation on 31 March and his reported use of alcohol and illicit drugs it was hypothesised that he was suffering from a drug induced psychosis. Given the information available this was a reasonable hypothesis. The Community Psychiatric Nurse (CPN) who assessed Mr. X discussed his formulation with Mr. X's GP and with the multi-disciplinary team. He also arranged to see Mr. X a week later, together with the Team Manager, to monitor his mental state. Again this was good practice.

Mr. X's mental state appeared to have improved by the time of his review appointment. This was taken as confirmation of the diagnosis of drug induced psychosis and Mr. X was discharged from the service.

Overall Mr. X received prompt and appropriate care. However there are lessons to be learnt from Mr. X's case. Mr. X consistently reported friction with his family, on a number of occasions his family called the police because of his behaviour and on at least one occasion Mr. X's grandmother, with whom he lived, reported that she was afraid of him. It was also noted that Mr. X was a poor historian and the information he provided was not always reliable. Despite this Mr. X's family were not involved in the assessment of his needs or the risks he posed, or in planning his treatment. The fact that Mr. X's grandmother had summoned the police and had reported that she was afraid of him did not prompt an

assessment of the risk she might be exposed to. Best practice suggests that Mr. X's family should have been consulted.

The utility of assessments rests on the availability and reliability of information. In general there was good communication between the Mental Health services, Mr. X's GP, and the Emergency Duty Service (EDS). However, because the EDS's electronic records system could not communicate with the Trust's electronic system, a cumbersome system of printing information, faxing, and either filing this within the paper clinical records or scanning it onto the electronic record was employed. While this usually worked well, this was a point of weakness in the communication system. In Mr. X's case it was unclear whether, because of the inherent delays in the system of faxing information, important information was unavailable when he was assessed on 31 March 2008.

Assessment, particularly the assessment of risk, relies on historical information being available. Mr. X had been seen by the Children's Mental Health services however this information and the clinical notes relating to this period were not available to those assessing him. This was a weakness in the communication system.

During the time Mr. X was in contact with the Trust, Mr. X was referred to the Crisis Team, to the CMHT and to the Drug and Alcohol service. He was given the contact details of a local anger management course and a drug counselling service and advised to consult his GP about being referred to a primary care counsellor. Mr. X did not avail himself of any of these opportunities. Because he was not retained in the Mental Health services there was no mechanism for monitoring his compliance with the advice given to him. When Mr. X was re-assessed on 8 April, and his mental state appeared to have improved significantly, he was discharged from the care of the Mental Health services. However, as on previous occasions, the question why Mr. X kept presenting and why he was using drugs and alcohol to such damaging effect was not asked. As Mr. X was discharged from secondary Mental Health services no mechanism was put in place to monitor his mental state. The combination of drug misuse and mental health problems is a common one in the Mental Health service. Both national guidance and the Trust's Dual Diagnosis policy recommend that when an individual presents with both drug mis-use and mental health problems s/he should be assessed and cared for within mainstream Mental Health services. If this is not done there is the danger that the focus will be on the aetiology of the immediate presenting problem and the individual

will be passed between the criminal justice system, Drug and Alcohol services and Mental Health services. In Mr. X's case it would have been good practice for the Mental Health services to have taken the lead in managing his care instead of discharging him as soon as his mental state appeared to have improved.

As noted above, given the information available to the CPN the hypothesis that he had experienced a drug induced psychosis was not an unreasonable one. However subsequent events have thrown doubt on this diagnosis. In June 2008 Mr. X was transferred from prison to a medium secure unit on Section 48/49 of the Mental Health Act (1983). Subsequently two forensic reports concluded that Mr. X was suffering from a serious mental illness, the most probable diagnosis being bipolar affective disorder. The Court, taking note of these reports, accepted Mr. X's plea of guilt to manslaughter on the grounds of diminished responsibility and he was sentenced to be detained for an indeterminate period under sections 37/41 of the Mental Health Act (1983).

Given the nature of Mr. X's conviction and the fact that he was detained under the Mental Health Act the question arises whether any acts or omissions on the part of the staff of the Avon and Wiltshire Mental Health Partnership NHS Trust had a direct, causal, relationship with the events of 11 / 12 April 2008.

Mr. X's contacts with the Trust's Mental Health services were brief and episodic and, until March 2008, it was concluded that he did not suffer from a serious mental illness. When Mr. X's symptomatology appeared to be more serious the service responded in a prompt and flexible manner and arrived at a not unreasonable hypothesis as to the nature of his problem.

It has been pointed out that Mr. X's family might have been more closely involved in his assessments and it would have been good practice for the Mental Health service to have taken the lead in providing a holistic assessment and package of care for Mr. X. However, given the very brief gap between him being reviewed and the events of 11 / 12 April 2008 it would not be reasonable to conclude that any intervention would have had a significant effect on his behaviour or mental state within that time scale and there were no evident grounds for detaining Mr. X under the Mental Health Act (1983) at that time.

The Independent Investigation, therefore, concluded that while there are lessons that can be learned to improve the care are treatment received by other service users it would not be reasonable to conclude that there was any causal relationship between the actions or omissions of the staff of the Trust and the events of 11 / 12 April 2008.

## Recommendations

**Recommendation 1: The Care Programme Approach: Assessing Needs and Planning Care**

Training:

- the Trust must ensure that all clinical staff receive training, which is updated on a regular basis, on working with and involving families and carers of service users in the assessment of needs and planning of care of the service user;
- where appropriate the '*Working in Partnership with Families and Carers'* workshop should continue to be offered as part of this training;
- the Trust Care Programme Approach (CPA) and Risk Management training should continue to use Carer Trainers to model partnership working;
- a mechanism to disseminate good practice in this area should be put in place.

Practice:

- the **expectation** that, wherever possible and appropriate, families and carers should be involved in the assessment of needs and planning of care of the service user should be enshrined in Trust policy and procedure;
- that this best practice is being followed should be reviewed on a regular basis in supervision;
- the Trust should ensure that there is easy access to advice and support in this area of clinical practice.

Monitoring and assurance:

- the Trust should put in place mechanisms, including regular audits, to assure itself that its policies and protocols in this area are being consistently implemented;
- building on the good practice the Trust has already developed, carers should be involved, appropriately, in these assurance exercises;
- the Trust should put in place a mechanism, for example audits and surveys, to assure itself that the involvement of carers and families is meeting the identified needs of this policy of improving the care and treatment of service users and appropriately involving carers and providing them with relevant information and support;

- the Trust should continue its good practice of consulting carers; it should obtain the views of carers and families on how they can most efficiently and effectively be involved in the planning and delivery of care for those they care for. This information should be used in the development of future policies and protocols.

**Recommendation 2: Risk Assessment and Management**

The Trust is currently concluding the review of its Risk Procedures.

Policy and Protocols:

The Trust should ensure that the new policy and associated procedures:

- promote robust risk assessment in line with the best practice guidance (e.g. Department of Health *Best Practice in Managing Risk,* 2007);
- as in previous Trust policies the revised policy should emphasise that risk assessment is an ongoing exercise, builds on previous assessments and historical information, wherever possible is multi-disciplinary and, where appropriate, is a multi-agency exercise;
- wherever possible and appropriate corroboration should be sought;
- the risk assessment should result in a clear formulation which enables all those providing care, treatment and support to make informed decisions;
- following a risk assessment a risk management plan should be drawn up:
    - this should set out how the identified risks are to be responded to and managed;
    - this plan should be more than a list of actions and more than a list of people who should be contacted in times of crisis;
- As the Trust is now employing the RiO electronic records system it must ensure that any changes in policy and protocols are reflected in the RiO system;
- following the updating of the risk management policy and protocols the Trust must ensure that all clinical staff are provided with appropriate training in a timely manner and this training should be repeated on a regular basis;
- the Trust might consider continuing its established good practice and involving carers in this training.

Practice:

- The Trust must ensure that families and carers are appropriately involved in both the risk assessment and risk management planning and that they are appropriately informed of risk management plans;
- the Trust should consider putting in place mechanisms to ensure that risk assessments and risk management plans are carried out on a planned and regular basis as well as at times of crisis and at points of change in the service user's life;
- the Trust should ensure that risk management plans are disseminated in a timely manner.

Monitoring and Assurance:

- The Trust should put in place mechanisms to assure itself that its policies are being implemented in a consistent manner, this might include surveys of service users and carers and others involved in the care of service users e.g. GPs, as well as clinical audits;
- the assurance exercises should address issues of quality, of assessment and planning, as well as the occurrence of assessment and the recording of plans;
- risk assessment and planning should be regularly addressed in supervision and clinical staff should have ready access to advice and support in this area.

**Recommendation 3: Diagnosis and Formulation**

- The Trust should ensure that all clinical staff receive regular, up-dated training addressing the assessment of substance misuse and dual diagnosis;
- the Trust should put in place a mechanism to assure itself that its policies relating to the assessment of substance misuse and dual diagnosis are being implemented in a consistent manner; this exercise should included an evaluation of the quality of the assessments as well as identifying that relevant information is recorded;
- The Trust should ensure that staff in Adult Mental Health services have ready access to advice, consultation, and support from Specialist Substance Misuse services and that protocols are in place and being employed to foster joint working to address the needs of the service user.

**Recommendation 4**

If clinicians are to conduct robust and reliable assessments of risk and need it is essential that they have access to all relevant historical information. Given that the Trust does not provide

CAMH services it cannot, on its own, put in place a protocol or mechanism to ensure that information relating to a services user's contact with CAMH services is readily available.

Commissioner

- The commissioner should ensure that:
    - there are protocols in place to ensure that clinicians have timely access to historical information from Child and Adolescent Mental Health Services (CAMHS) and other relevant services;
    - that there are relevant information sharing protocols in place;
    - that service providers work in a collaborative manner with the aim of ensuring that service users receive the best possible care and treatment.
- These protocols might build on the protocols already in place relating to the transition from CAMHS to Adult Mental Health services.

The Trust

- The Trust must ensure that, at least, as part of the initial assessment of each service user:
    - information regarding the individual's mental health as a child is sought;
    - relevant, corroborative information is sought and, where appropriate, access to clinical notes, assessments and plans is obtained.

Monitoring and Assurance

The commissioners in collaboration with the Trust and other relevant service providers should put in place appropriate mechanisms to ensure these protocols are being implemented in a consistent fashion.

**Recommendation 5**

The Trust should ensure that:

- clinical staff have appropriate training in formulation and diagnosis;
- that all patients have a clear formulation of their needs, including a working diagnosis, which informs intervention and treatment, following their initial period of assessment;
- it puts in place a mechanism to assure itself that this policy is being adhered to in a consistent manner, and that diagnostic practices and formulations are of an acceptable quality.

**Recommendation 6: Treatment**

The Trust should put in place mechanisms to assure itself and its commissioners that those service users who have been identified as having a substance misuse or Dual Diagnosis problem are having their needs appropriately addressed, in line with the Trust's recent initiatives and policies.

- As part of this assurance exercise the Trust might conduct an annual audit of discharge CPA paperwork for those service users who have been identified as having Dual Diagnosis issues to ensure that substance misuse issues have been addressed as part of discharge planning.

**Recommendation 7: Safeguarding Adults**

- The Trust should ensure that its policy on Safeguarding Adults is reviewed:
  - with reference to the South West Safeguarding Adult Threshold Guidance;
  - to enshrine emerging locally agreed best practice and ensure that it employs language that is consonant with local multi-agency guidance, policies and protocols.
- The Trust should ensure that clinical staff have regular training on Adult Safeguarding and that advice and consultation are readily accessible.
- The Trust should put in place mechanisms to assure itself, its commissioners and other local agencies that its policies and the local Adult Safeguarding Guidance are being implemented in a consistent manner.

**Recommendation 8: Communication**

- The Trust should agree a protocol with the Local Authority, which provides the out of hours emergency duty system, to ensure that assessments undertaken out of hours are forwarded in a timely manner to Mental Health teams who will ensure that these assessments are uploaded on to the Trust's systems within an agreed timescale.
- The Trust should put in place a mechanism to assure itself that information from out of hours assessments is available to clinicians in a timely manner;
- The Trust together with its Local Authority partners should put in place a mechanism to assure themselves and their commissioners that those undertaking out of hours assessments have ready access to relevant clinical information, assessments and plans.

**Recommendation 9: The Management of Care**

The Trust should:

- complete its development of a its Early Warning Trigger tool in a timely manner;
- ensure that this device and/or associated protocols, together with relevant training, enable particularly those undertaking emergency assessments to understand and formulate why an individual is repeatedly presenting in crisis;
- consider putting in place a protocol to assess and address the needs of those who present in this manner;
- together with commissioners undertake a review of the needs and subsequent care required by such individuals to inform future service development and effective practice.

**Recommendation 10: Commissioning**

NHS Wiltshire should ensure that it has in place policies and procedures which ensure that:

- they are informed of any serious adverse incident in a timely manner;
- standards for the quality and time-scale of investigations are in place;
- the role of NHS Wiltshire is identified in assuring that the recommendations of the investigation are translated into meaningful and effective action plans which are consonant with the quality standards identified for the commissioned services;
- the role of NHS Wiltshire in assuring that the action plan is implemented in a timely manner is identified;
- all relevant staff in NHS Wiltshire are aware of the policy and protocol;
- that information concerning serious adverse incidents is fed into the governance and quality and performance monitoring structures in such a way that it can assure itself that local Mental Health services are safe and of an acceptable quality;
- it conducts regular assurance exercises, including audits, to assure itself that its policies are being implemented in a consistent and effective manner.