

**ACTION PLAN POST INDEPENDENT INVESTIGATION - PUBLISHED ON WEBSITES**

<b>Serious Incident Review Proforma</b>			
<b>Patient ID/Other</b>	<b>Date of Incident</b>	<b>Service</b>	<b>StEIS Number</b>
Patient I	03.07.10	Adult ADHD Service	2010/8656
<b>Summary of Incident:</b> Male outpatient killed a man following a fight at a party. He was subsequently sentenced to nine years for manslaughter.			
<b>Recommendations following Independent Investigation</b>		<b>Actions Undertaken / Planned</b>	<b>Lead / Timescale / Date Completed</b>
<b>1. Risk Assessment</b> When a risk assessment tool is to be used, there should be clear guidance as to when a more detailed risk assessment is triggered. This should include when and how such information is shared between various agencies.		<b>This recommendation is for the Local Authority and Youth Offending Team</b>	
<b>2. Data Sharing</b> It would be of great assistance if all agencies involved with a young person such as patient I had access to all relevant records via an electronic system. This would present a more rounded picture of		<b>Policy and Procedure</b> NTW invested significant resources in the initial work relating to becoming a pilot site for 'Contact Point': a shared multi agency data system prior to its National implementation. Unfortunately due to a change in government policy this initiative was cancelled at National level.  All Trust services, including Children and Young Peoples' Services (CYPS), use an electronic health record system called RiO to input and store	Completed

<p>the particular individual to the professional involved. Further this would allow a more thorough risk assessment which, in turn, would make the identification of any appropriate services more straightforward. Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion and could be supported by more effective data sharing.</p>	<p>information about patients. The Trust and its Local Authority partners recognise the value of sharing records via electronic systems and have undertaken work to facilitate this.</p> <p>The current position is that in Northumberland and Newcastle there is an overnight exchange of key clinical information between the Trust's electronic health record system and two Local Authority systems. In other localities there are reciprocal arrangements in place to have 'read only' access to electronic records. These processes support effective verbal and written communication between professionals but are not seen as a substitute.</p> <p>Difficulty sharing information led to the government commissioning a second review of information governance by Dame Fiona Caldicott . The review reinforced the six original Caldicott principles and made one addition which should help with sharing information in future.</p> <p><b>Information Sharing</b> The added principle is:</p> <p><i>“The duty to share information can be as important as the duty to protect patient confidentiality”.</i> The Review highlights that for health professionals to act in a patient's best interest, they need to have all the available information about the patient to do so. However, it is acknowledged that current information governance provisions (or at least the interpretation of them) have led to information not being shared when it should be. Accordingly, Recommendation 2 of the Review specifically states that:</p> <p>“for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual.”</p> <p>The advent of the Common Assessment Framework has provided a</p>	
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	<p>framework to support multiagency working utilising the Team Around the Child/family approach. This supports robust multiagency working and the sharing of information. NTW CYPS staff participate fully in this process.</p>	
<p><b>3. Health Care Treatment of Patient I as a Child</b></p> <p>Where treatment is being offered to a child such as was offered to patient I, such treatment should be evidenced based and should comply with the appropriate NICE guidelines. In addition there should be a clear written care plan in relation to that treatment.</p>	<p>The Trust, as does the Panel, recognise that requirement at both a National and local level have developed since Patient I was offered treatment as a child.</p> <p>The young person was seen and assessed in Child and Adolescent Mental Health Services (CAMHS) and given a diagnosis of ADHD. He was prescribed medication in accordance with prescribing procedures and NICE guidance and the ongoing care and treatment was monitored by a community paediatrician as was common practice at the time. This young person was also offered other forms of interventions to address behavioural issues such as support from a nursery nurse.</p> <p>As mentioned under recommendation 2 above, The advent of the Common Assessment Framework has provided a framework to support multiagency working utilising the Team Around the Child/family approach. This supports robust multiagency working and the sharing of information and would be reflected in an associated care plan.</p> <p>Since its formation in 2006, the Trust has had clear policy statements regarding all young people having a care plan which should be cognisant of and build on any Team Around The Child care plan in place. The current policy NTW(C)48 is compliant with Department of Health guidance. Refocusing CPA (2008) sets out that for young people who do not have complex needs such that they meet the criteria for CPA, the care plan can be recorded as a clinical letter, meeting the following standards:</p> <ul style="list-style-type: none"> <li>○ Should be written using language / terms that the young person / parents / carers (if appropriate) are able to understand as much as it is practicable.</li> </ul>	<p>Completed</p>

	<ul style="list-style-type: none"> <li>○ The care plan should clearly contain: <ul style="list-style-type: none"> <li>○ The date of contact / clinic / visit;</li> <li>○ The current plan of intervention / care / treatment agreed with the young person / and their parent/carer (if appropriate) and who is providing this, the goals of the intervention including those determined by the young person;</li> <li>○ Indicate the circumstances in which the young person may need extra help and the associated crisis arrangements;</li> <li>○ The outcome of the assessment of risk.</li> </ul> </li> </ul>	
<p><b>4. Formal Assessment of a Child Moving Through Special Needs Provision</b></p> <p>Patient I was never subject of a psychological assessment of his cognitive ability even though the issue of a potential learning disability was raised on a number of occasions. It is recommended that it would be appropriate for there to be a formal assessment of any learning issues of a child moving through special needs provision to ascertain whether he or she has a learning disability or difficulty to aid with the identification of appropriate services.</p>	<p><b>This recommendation is for the Local Authority.</b></p> <p>Assessment of cognitive ability due to concerns expressed regarding the patient’s educational attainment would have been the responsibility of the Educational Psychology Department and not the Trust at that time.</p> <p>Since then, the NTW Children and Young Peoples Service has remodelled and has prioritised integration of its young peoples community services to bring together what was previously CAMH and LD to improve assessment and recognition of mental health and learning issues within the interagency framework.</p>	<p>Completed</p>
<p><b>5. Core Group/Team Around the Child</b></p> <p>It is clear that school attempts were</p>	<p><b>Policy and Procedure</b></p> <p>At the time that this young man was in high school, the school was a leader in the city in developing a multiagency forum for partners to meet to discuss children and young people of concern in order to plan a coordinated</p>	

<p>made to involve all relevant agencies in discussions on a regular basis about the various presenting problems which patient I exhibited. A system which involves health, YOT, education, police, social care is clearly of benefit. A more rigorous and regularised protocol for carrying this into effect needs to be agreed and appropriately resourced. It is clear that such a system has particular application in larger schools whose catchment area includes pupils with higher than average levels of YOT involvement and social problems.</p>	<p>approach to their management and support.</p> <p>In recent years this has been replaced by the Team Around the Child Approach as part of the Common Assessment Framework, as outlined above in recommendation 2 and 3.</p>	<p>Completed</p>
<p><b>6. Transitional Planning</b></p> <p>It is recommended that the transition from child to adult healthcare should be set at the statutory school leaving age. School leaving age was 16. It is due to become age 17 in 2013 but will be at age 18 from 2015 onwards. Transition has been a longstanding issue and it would make practical common sense for all agencies to work to one age. There are examples of best practice within the region. One example given to the panel was for services relating to children with disabilities and how the</p>	<p><b>Policy and Procedure</b></p> <p>The Trust recognises the risks from a lack of standardisation across agencies in relation to age however this recommendation stands outwith current National policy guidance that recommends children and young people's services should be provided to those up to the age of 18 years.</p> <p>The Trust is compliant with regard to National Service Framework Standard 9 and the Newcastle Children's Trust Board arrangements also adopt age 18 years as being the threshold for transition to adult services. An increase in the school leaving age will further support this arrangement.</p> <p>The Trust CPA policy states an age of 18 years for transition and has developed a Practice Guidance Note specifically with regard to managing the issues arising from the transition from children to adult mental health services.</p>	<p>Completed</p>

<p>transition from childhood to adulthood was managed within that sphere. Clearly a formula which brings together services to assess an individual's ongoing needs and to identify any services required as that person moves into adulthood.</p>		
<p><b>7. Adult ADHD Service</b></p> <p>Despite discussions being instigated in 2008 about an adult ADHD service, the service remains an interim one and a final commissioning decision is yet to be taken. It is clear the demand for the service is significant. The panel recommends that such a service is commissioned. In any event, a decision on whether or not the service is commissioned should be taken as a matter of urgency. Any service which is commissioned should comply with NICE guidelines. This should include the creation of a clear prescribing protocol with application across the region. The absence of a clear commissioning decision runs the risk that the service which patients receive will not meet their overall needs as envisaged by the care programme approach.</p>	<p><b>This recommendation is for Commissioners.</b></p> <p>There remains no service currently for young people aged 18 years and over who have an existing diagnosis of ADHD. The pilot service in Newcastle is for new cases only where no diagnosis exists.</p> <p>Trust Specialist Service Managers submitted a comprehensive business case to commissioners regarding the risks arising from this group of patients and the amount of funding required to provide an appropriate service in the summer of 2013. This is currently under consideration however changes in commissioning arrangements have delayed decisions on this case.</p> <p>In the meantime those accessing CYPS who reach 18 years are being retained in the CYPS service under a duty of care arrangement as GPs are unwilling to take on the prescribing and monitoring of medication without mental health service support. This is having a significant impact on this group of young people many of whom have other co morbid mental health issues that are untreated as well as the impact on CYPS who are treating young people that should not be in their service. This is causing pressures on waiting times and diverts resources from formally agreed and contracted activity.</p>	