VERITA

IMPROVEMENT THROUGH INVESTIGATION

A thematic review of six independent investigations

A report for

NHS England, North Region

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Verita is a management consultancy that works with regulated organisations to improve their effectiveness and levels of service. It specialises in conducting independent investigations, reviews and inquiries.

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1. Introduction

During the period March 2007 to June 2011 there have been six homicides committed by service users who had received care and treatment from South West Yorkshire Partnership NHS Foundation Trust.

External investigations have been carried out for all six cases three by The Health and Social Care Advisory Service (HASCAS) and three by Verita. The independent investigations followed the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-36 issued in June 2005.

Verita were also commissioned to consider any thematic similarities between the six cases and this thematic review considers the similarities highlighted in the following reports:

- Verita reports for Mr J, Mr L and Mr N; and
- The Health and Social Care Advisory Service (HASCAS) reports for Mr X, Y and Z.

1.1 Overview of the Incidents

All six service users committed a homicide and had received care and treatment from South West Yorkshire Partnership NHS Foundation Trust.

Mr J aged 29, was arrested on 29 July 2010 for attacking and killing a member of the public. He was found guilty of murder and sentenced to life imprisonment with a minimum term of sixteen years.

Mr L stabbed and killed his partner on the 9 June 2011. He was arrested and charged with murder. He pleaded guilty to murder and was sentenced to life imprisonment with a minimum of 12 years.

Mr N robbed and assaulted an 89-year-old woman on 18 June 2011 which resulted in her death. He was convicted of manslaughter and two counts of robbery.

Mr X and his wife were found dead at their home, in 2008. The coroner's inquest found that Mr X had taken his own life while the balance of his mind was disturbed and was responsible for the unlawful killing of his wife.

Mr Y was convicted, in 2008, of manslaughter on the grounds of diminished responsibility.

Mr Z was convicted alongside two others, in 2007, of the murder of a vulnerable man.

The Trust developed 6 action plans to take forward the recommendations. These actions plans were monitored and signed off by the Yorkshire and Humber Strategic Health Authority[1] in January 2012.

We have reviewed these action plans and highlighted the similarities and differences between the Verita and HASCAS independent investigations.

[1] The Health Authority that commissioned the 3 HASCAS independent investigations.

2. Common Themes

We have identified the common themes as being areas that fell below good practice arose in two or more of the case investigated by HASCAS and Verita.

- Diagnosis and Treatment
- Pathway of Care
- Non compliance with care programme approach policy
- Lack of risk assessment and management
- Personality Disorder/NICE Guidelines
- Safeguarding of Adults and Children
- Working with people with substance misuse problems (Not Dual Diagnosis)
- Record Keeping

The table below summarises where elements of care and treatment fell short of good practice.

2.1 Table A – Elements of care and treatment falling below good practice

	Mr J	Mr L	Mr N	Mr X	Mr Y	Mr Z
Diagnosis and Treatment	V				•	
Pathway of Care		•	• V		•	
CPA	•	•	•	•	•	•
Risk Assessment		•	•	•	•	•
Personality Disorder/ NICE Guidelines			V		•	
Safeguarding of Children and Adults	V	V	• V		•	•
Clinical Supervision				•		
Working with people with substance misuse (not DD)		•	•		•	
Dual Diagnosis Policy			V			
Safe accountable practice			•			
Serious Incident Policy-Feedback process				•		
Quality Review of electronic system				•		
Record keeping/ Retrieval of archived notes	•		•			
Physical well being			•			
Intervention in situations that involve firearms			•			
Involvement of Carers		•				
Domestic Abuse Policy to include service users as perpetrators		•				
Communication with service users by mobile, text and email			•			
Communication between Primary and Secondary Care					•	
Equality and Diversity					•	
Spiritual Care					•	
Family Intervention					•	
Housing					•	

• Issues identified in previous investigations
V Additional Issues identified in Verita investigations

2.2 Diagnosis and Treatment

HASCAS and Verita found issues relating to diagnosis and treatment in two cases. These were:

1. Mr J - there was insufficient evidence to suggest that Mr J suffered from a mental disorder which needed support from secondary mental health services

2. Mr Y - there was no evidence that psychological interventions had been considered to address the dynamics of his family life.

2.2.1 Current position in the Trust.

The Trust has told us that it is unable to locate an operational policy for the CMHT that was in place at the time of the incident. However, we have reviewed an undated draft policy which describes the inclusion criteria, regular review of progress against the care plan and discharge planning.

We have made the following recommendation to help further this work:

> "The Trust should take steps to ensure that patients are reviewed by the multidisciplinary team on a regular basis so that timely discharge and relapse plans are put in place."

Since the incident and as part of its transformation programme the Trust has developed The Community Therapies Pathway. This encompasses all Psychological therapy Services and provides a broad spectrum of psychological interventions, ranging from the IAPT services through to complex cases.

2.2.2 Conclusions

The Trust has further developed the inclusion criteria and carries out regular reviews and our recommendation will further enhance this work.

The Trust has developed a broad range of psychological services to meet the needs of services users.

2.3 Pathway of Care

Issues with the Pathway of Care were identified in three of the cases as follows:

1. Mr L – A nurse placed Mr L in the wrong clustering tool. Mr L was placed in the non-psychotic (moderate severity), with an associated low risk to self instead of the cluster for a psychotic crisis. This was done whilst Mr L was being assessed in A&E

2. Mr N - utilisation of evidence based documentation and assessment and evaluation tools particular to Early Intervention service specialist assessments

3. Mr X - an audit of referral and discharge policies to consolidate new policies.

2.3.1 Current position in the Trust

At the time of these incidents the A&E department could not access the RiO system. This issue has now been rectified. Systems have been put in place to ensure the A& E department is able to access the system.

The Trust has revised the CPA policy to provide advice on arrangements for referral and discharge. The RiO system now provides information for staff on the specialist assessments available. These form part of the service user record

2.3.2 Conclusion

The Trust has developed services appropriately to further develop pathways of care and ensure that the RiO system can be accessed in the A & E department

2.4 CPA

CPA was identified as falling below good practice in six of the cases although the issues were different. These are outlined below:

- Mr J
  CPA reviews were not adhered to in accordance with Trust policy and were not recorded as having taken place. Liaison with the appropriate prison services should take place as soon as is possible in order to ensure continuity of care takes place.

- Mr L
  CPA status and discharge arrangements for inpatients who have had a brief admission to hospital and 7 day follow-up process, including the rationale for this and how it should be implemented.

  No opportunity for carers to have a discussion with the inpatient MDT in the absence of the service user.

- Mr N
  Clarification of expectations, roles, responsibilities and purpose when planning case transfers between teams.

- Mr X
  The take up of CPA training.

- Mr Y
  There did not appear to be an effective mechanism in place to ensure best practice with respect to CPA was followed at practitioner or team level.

- Mr Z
  Non-adherence to the CPA policy which led to MR Z remaining in secondary mental health services.

2.4.1 Current position within the Trust

Managers from the Trust told us in the interviews that there is now a revised CPA Policy in place. We have received a copy of the policy and have examined it.

The Trust undertakes an annual audit of CPA and reports performance to Monitor[1] and to commissioners. The Trust is subject to a CQUIN[2] target of 95% of patients, cared for under the CPA, having had an annual review of their care. The Trust has a process by which it assures itself that all clinical areas adhere to CPA standards, including completion of risk assessments, and is actively subject to a performance monitoring process. This process utilises team dashboards to display performance at business delivery unit level down to individual team level. The approach empowers all tiers of management to engage proactively with the service improvements in this area.

Within the CPA process there is a module to review carers' needs. When identified, the information is used to inform the wider care plan. The carers' needs module is subject to an annual review along with the rest of the care plan.

The Kirklees service uses a family therapist to help improve the quality of carers' engagement. Within the wider trust, carers' involvement is supported by the strategy 'Our Commitment to Carers', the implementation of which is led by a dedicated resource, a carers' development officer. Within each team there are carers' networks and team champions. Carers' engagement is further supported by the provision of training workshops on their involvement and the use of patient experience questionnaires. On acute wards, the Trust runs regular carers' meetings.

2.4.2 Conclusion

We are satisfied that the Trust has improved CPA policy and procedures and has good governance arrangements in place for monitoring and improving performance where necessary.

2.5 Risk Assessment

Risk assessment and risk management was identified in five of the cases as follows:

- Mr L - completion of a Level 2 risk assessment

[1] Monitor is the sector regulator for health services in England; Monitor's job is to make the health sector work better for patients.
[2] The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

- Mr N - use of the Sainsbury Level 1 and Level 2 Risk Assessment and take up of risk assessment training

- Mr X - compliance with the risk assessment policy

- Mr Y - the risk assessment tool was not employed to assess Mr Y's risk

- Mr Z - risk assessments were not carried out in line with Trust policy.

2.5.1 Current position within the Trust

We reviewed all the evidence from the action plans to find out what progress has been made. We found that the Trust have implemented the Sainsbury Level 1 and Level 2 risk assessment tool. The Trust has a process by which it assures itself that all clinical areas adhere to the completion of risk assessments, and this is subject to a performance monitoring process. We also heard that for complex cases a process of Complex Cases Discussions are held to be clear about key responsibilities and responses to different circumstances that may arise across different teams. The Trust also has good relationships with the police and involvement in multi-agency public protection agreement (MAPPA), multi-agency risk assessment conference (MARAC) and anti-social behaviour order (ASBO) panels

2.5.2 Conclusion

We have found that there is evidence showing that all the actions plans have been embedded in current practice.

2.6 Personality Disorder

Personality Disorder was identified as an area requiring action in two of the cases

- Mr Y - no available service for assessment, treatment and advice for personality disorders.

- Mr N - The Trust should audit the compliance with NICE *Guidance in the treatment and management of personality disorder*

2.6.1 Current position within the Trust

A significant proportion of the Trust's day-to-day clinical business is with individuals with varying degrees of personality disorder. The Trust recognises this and since these incidents has deployed expertise within the psychological therapies service. The Trust has demonstrated an ongoing ability to manage individuals with personality disorder through services such as assertive outreach, crisis resolution, the early intervention in psychosis (EIP) team and the CMHT. Staff within these services have been supported by a training programme and supervision from the

psychology team, clinical support from the dual diagnosis resource and by good medical leadership.

Personality disorder is managed through the Trust clinical record system, RiO, and incorporates the CPA. Within this there is a risk assessment module. Clinical teams describe a recovery model which promotes independence, autonomy and social inclusion. Teams use crisis plans and care delivery with the framework of the CPA.

2.6.2 Conclusion

We found that the Trust has developed services in order to meet the needs of people with personality disorder and is compliant with all aspects of NICE *Guidance in the treatment and management of personality disorder*. We have however made a recommendation as a result of our investigation into the care and treatment of Mr N that assurance should be provided to the commissioners through an audit process.

2.7 Safeguarding

Adult and Child Safeguarding featured in three of the cases and Verita has made a further recommendation relating to electronic systems to support the Trust in further developing the work that has already been undertaken.

- Mr N - child protection issues were not incorporated into the service users care plan
- Mr Y - was not identified as being a vulnerable adult despite being the victim of exploitation
- Mr Z - the victim was not assessed for his vulnerability

2.7.1 Current position within the Trust

Since these incidents, there has been a national drive to promote adult and child safeguarding. The Trust works closely with local authorities to ensure that safeguarding issues are identified and addressed and national and local policies and procedures are adhered to. The Trust has improved capacity to support safeguarding. There is a named doctor for safeguarding along with six clinical safeguarding advisors and eight practice governance coaches who support safeguarding at clinical level.

Safeguarding is an inherent process to risk assessment and the CPA process. The Trust is currently trialling a new two-stage mental health assessment process which incorporates assessing and managing risk and safeguarding issues.

We also heard that the Trust assures itself of its performance through an annual audit of cases open to clinicians to ensure compliance with policy. The Trust offers, and ensures that staff attend, training in safeguarding at basic awareness level 1 for

all staff within the Trust and basic awareness training level 2 for staff in direct contact with service users.

Managers and clinicians from the Trust told us during interviews that safeguarding is an evolving agenda shared between and the Trust, local authority colleagues. We heard that significant progress has been made since this incident in improving staff awareness of issues and of joint working with other agencies.

When we met with staff they told us that further integration of electronic record systems between the local authority and the Trust would be helpful. This would improve the efficiency of administration and give advance warning of safeguarding issues. Several areas of good practice were also identified in the individual reports.

2.7.2 Conclusions

The Trust now works closely with local authorities to ensure that safeguarding issues are addressed and that policies and procedures are adhered to.

The Trust has increased grade and skill mix so that there is better capacity to meet the safeguarding agenda

2.8 Working with People with Substance Misuse

Working with people with substance misuse featured in two of the cases:

- Mr L - lack of provision of information on treatment and support options to people who experience drug and alcohol problems

- Mr N - review of EIP to working with people with substance misuse issues who do not present with dual diagnosis but who may have needs in this area

- Mr Y - the relevant support, training and advice was not available to staff as outlined in the DoH Good practice Guidance on Dual Diagnosis

2.8.1 Current position within the Trust

The Trust maintains capacity to ensure a response to individuals presenting with a dual diagnosis of mental illness and substance misuse. The Trust has run training programmes for front-line clinicians in mental health services and local drug and alcohol services to ensure clinical competence and confidence.

The Trust has a dedicated dual diagnosis practitioner and a dual diagnosis consultant who work closely with the drug service Lifeline, the alcohol service On Track and the mainstream mental health services. They provide support in assessment, supervision and treatment options and deliver training programmes. There is evidence of clinical confidence in the management of dual diagnosis within the crisis resolution and home treatment teams. There is widespread awareness of this capacity throughout the Trust and it is greatly valued. However, given the size of

the Trust and the prevalence of dual diagnosis, the current resource may not be adequate to meet the needs for face-to-face clinical assessment, provision of clinical supervision and focused training relating to dual diagnosis.

The Trust assessment tool includes specific questions that seek to establish service users' relationship with substances, their pattern of use and their associated behaviour as a result both of use and of efforts to obtain the substances. This information is used within the wider risk assessment process and informs the care plan.

2.8.2 Conclusion

We found that the arrangements for delivering substance misuse services have been improved. We have, however, made a recommendation as a result of our investigation into the care and treatment of Mr N that the Trust should review its dual diagnosis policy and capacity to ensure appropriate access to specialist knowledge and drug screening when services are responding to presentations that include both a mental disorder and active substance misuse.

2.9 Record Keeping

Record keeping featured in two cases:

- Mr J - the Trust were unable to retrieve the archive notes for the internal investigation
- Mr N - timely and comprehensive entries in the electronic recording system including those of psychology practitioners.

2.9.1 Current position within the Trust

A procedure for archiving paper records has been developed but the implementation of RiO the electronic records system will minimise the need for archiving paper records in the future. Psychology records are now included on RiO notes.

2.9.2 Conclusion

The Trust has implemented these two recommendations. The Trust continues to make improvements in record management by further developing their electronic system.

3. Overall conclusion

The Trust has undergone a major restructure as part of its transformation programme. This has resulted in services being re arranged into Districts. These are coterminous with local authorities, and have improved accountability via District Directors. There are now clinical and managerial partnerships and a comprehensive governance structure in place. The Creative Minds strategy was developed in 2011. Since then, the Trust has supported staff, voluntary organisations and community groups to deliver creative activities as part of healthcare interventions. This includes alternatives to traditional forms of support by signposting people into community based systems and working in partnerships with voluntary organisations and community groups.

Appendix A

Recommendations from the six investigation reports

In this section we set out the list of recommendations from the six individual reports undertaken by the Trusts and the three reports undertaken by Verita.

Mr J	**Trust report** The Trust's Crisis Resolution and Community Mental Health Team services should satisfy themselves that: • The systems and support in place to ensure regular Care Programme Approach reviews take place are adhered to in accordance with Trust policy. • When Care Programme Approach reviews are recorded as having taken place, the reviews take place in accordance with the Trust's Care Programme Approach policy and guidance. • For those individuals subject to Care Programme Approach who are arrested and subsequently held in prison, liaison takes place with the appropriate prison services as soon as is possible in order to ensure continuity of care takes place. In addition to the above recommendations, the Trust should ensure that: • The processes in place to retrieve externally archived manual clinical notes and associated records are fit for purpose. **Verita Report** *Recommendation 1* The Trust should take steps to ensure that patients are reviewed by the multidisciplinary team on a regular basis so that timely discharge and relapse plans are put in place. *Recommendation 2* The Trust should consider the options available to refine and develop its electronic record systems in order to ensure greater integration of safeguarding, care planning and care delivery systems.
Mr L	**Trust report** 1. "The CRHTT, or equivalent service, needs to ensure that for people who have ongoing contact with the services there is a system by which following assessment the appropriateness of cluster of the patient and other key decisions are audited and confirmed." 2. "The CRHTT, or equivalent staff, should make routine enquiries with A&E staff at the time of the initial assessment to ensure that as full a history and risk profile as possible is obtained."

3. "The Inpatient Service Manager should ensure that the ward MDT understands the requirements for formally completing the required risk assessments and that there are appropriate systems in place to facilitate this."

4. "Staff at each interface or transfer to a new service throughout the patient journey will review the existing assessment and finish the parts not completed previously. This applies to both risk assessment and other parts of the assessment process."

5. "Ward staff should routinely seek further criminal information from the police in relation to inpatients if the person had indicated during assessment that they had a criminal history."

6. "The CRHTT should obtain contact and other key information about patients prior to discharge."

7. "Ward staff should provide information on treatment and support options to people who experience drug and alcohol problems as a routine intervention and a system should be in place to support this."

8. "All carers of people on inpatient wards should be given the opportunity to have a discussion with members the MDT in the absence of the patient."

9. "CPA and discharge policies should be reviewed to clarify the following:

    - CPA status and discharge arrangements for inpatients who have had a brief admission to hospital.

    - The 7 day follow-up process including the rationale for this and how it should be implemented."

10. "Trust policy requirement to complete a Level 2 risk assessment for all inpatients should be reviewed with specific reference to short admissions."

11. "Trust policy should be amended to include 'Domestic Abuse Policy – service users' guidance for staff in relation to service users as perpetrators of domestic abuse."

12. "Information relating to domestic abuse and support should be readily available on the wards for service users and for carers."

Verita Report

The Trust should consider the options available to refine and develop its electronic record systems and thereby ensure greater integration of systems in regard to safeguarding, care planning and care delivery.

Mr N	**Trust report** 1. When working with service users, the EIP team should fully utilise the range of specialist assessments which are readily accessible on the RiO system and form part of the service user electronic patient record; they are thus available to all practitioners and support the safe and effective management of care and risk. 2. The EIP team should review its discharge process and practice to ensure that the administrative caseload record is an accountable and accurate reflection of clinical caseload at all times. 3. Clear guidelines and specific timeframes on the use of the Sainsbury level 1 and level 2 risk assessment should be embedded in the CPA policy and the clinical risk assessment, management and training policy. Team managers should review practitioners' understanding of these requirements and ensure the appropriate use and consistency with the required standards thus promoting best practice and providing the opportunity to review risk and draw together various professional perspectives. 4. Practitioners in EIP could benefit from the opportunity to reflect upon and review their approach to working with people with substance misuse issues who do not present with dual diagnosis but who may have needs in this area which, if openly established, could be receptive to intervention to preclude antisocial or illegal behaviour. Reflection and review may also promote staff safety and wellbeing when working with such service users and could form part of a team development session or be facilitated by the Trust's dual diagnosis specialists or nurse consultants. 5. Where child protection issues exist and practitioners agree to take responsibilities and actions, these should be incorporated into the service user's care plan with explicit, specific and timed actions underpinned by a shared risk assessment which clarifies each agency's expectations and thresholds for action. All issues regarding the wellbeing of children and potential risk should be included in the Sainsbury risk assessment and passed on to the appropriate agencies immediately and a record made of this in accordance with the appropriate trust and inter-agency policies and procedures relating to safeguarding. 6. There should be clarification of expectations, roles, responsibilities and purpose when planning case transfers between teams. This should be achieved by the effective delivery of the principles, practice and processes of CPA. Team managers should be reminded of the need to ensure that transfers between teams are effective and purposeful. 7. Appropriate access to the APTS for service users in EIP should be clarified and any pathway issues or barriers to individuals having the opportunity to receive a suitable service for their needs should be addressed. 8. Guidance should be provided to practitioners in relation to intervention in and management of situations where service users have weapons,

	including the safe and accountable removal, storage and disposal of weapons. A trust-wide protocol is currently being developed to inform practice in relation to service users who are known to own or have access to firearms; this should be made available to all teams. 9. The EIP team should review the process regarding the offer of carers' assessments. All eligible carers should be offered a carer's assessment and a carer's plan if appropriate, and a record of this having been done should be made. This record and associated documentation should form part of the service user electronic patient record to ensure optimum and effective communication of service user need and risk. 10. The EIP operational policy should include clear standards for ongoing monitoring of service users' physical wellbeing and the side-effects of medication. 11. The EIP operational policy in its reference to expectations around blurring professional boundaries should be reviewed and its wording offer a safe and accountable framework for practice. 12. Consideration should be given to producing practice guidance for communication with service users by mobile phone and by text, and should incorporate the disclosure of individual's numbers and the safety and accountability implications of this. This could also include email communication. 13. Practitioners should be reminded of the Trust's expectations with regard to record-keeping standards and the need for timely and comprehensive entries to be made in the electronic patient record. All processes and interventions around the service user pathway should be fully recorded and reflected including those of psychology practitioners. **Verita Report** To ensure the efficacy of the EIP team and the appropriateness of care delivery to patients, the Trust should routinely audit case files to ensure that the EIP team is focused on those patients with psychosis, or at risk of psychosis. Those patients with a presentation suggestive of personality disorder should be transferred to other trust services such as the CMHT or psychological therapies. The trust should seek further to refine and develop its electronic record systems to ensure greater integration of systems in regard to safeguarding, care planning and care delivery. The Trust should review its dual diagnosis policy and capacity to ensure appropriate access to specialist knowledge and drug screening when services are responding to presentations that include both a mental disorder and active substance misuse. The Trust should seek to provide assurance to commissioning bodies of compliance with NICE *Guidance in the treatment and management of personality disorder* (appendix C) through an audit process.

	The Trust should maintain and improve on current performance in delivery of psychological therapies to ensure that 18 weeks is the maximum waiting time rather than, as at present, the average.
Mr X	**HASCAS Report** The Trust in conjunction with its commissioning bodies should conduct as part of its ongoing clinical audit programme an audit to consolidate the implementation of all of its new policies and procedures. The audit should be conducted either one year following the policy implementation changes, or within six months of the publication of this report, whichever comes first. The audit should include: • the take up of CPA and risk assessment training across all disciplines; • compliance with the risk assessment policy; • the effectiveness of referral and discharge processes; • clinical supervision compliance; • the quality of clinical supervision processes; • a compliance and quality review of the new electronic clinical record system; and • a feedback process from all staff who have been involved in serious untoward incident procedures.
Mr Y	**HASCAS Report** *Recommendation 1 – The Care Programme Approach: Assessing needs and planning care* In line with current CPA guidance and the Trust's own current CPA policy the Trust should undertake regular quality audits to ensure that: • all those referred to its secondary mental health services have a comprehensive assessment of their needs; • there is a clear formulation of the individual's difficulties and needs; • care plans are informed by appropriate assessment and formulation; • all clear plans have clear goals or outcomes; • service users and, with their consent, their families and carers, are involved in the assessment of need, the planning of care, and any changes to either the care plan or the care co-ordinator; • the agreement of families and carers is obtained before care plans are finalised which involve actions on their part; • families and carers, with the agreement of service users, are provided with current care plans, including crisis management plans; and • where there is multidisciplinary or multi-agency involvement all those involved in delivering care and support are appropriately involved in the assessment and planning process with the knowledge and consent of the service user.

	Recommendation 2 – Risk Assessment Having revised its risk assessment, management and training policy the Trust should institute a regular quality audit to ensure: • that the formulation of the individual's problems and needs informs the understanding of his/her risk; • that robust and meaningful care plans are put in place; • that the service user and other relevant individuals are involved in the assessment and planning process; and • that the risk management plan is appropriately disseminated. *Recommendation 3 – Personality Disorders / NICE Guidance* South West Yorkshire Partnership NHS Foundation Trust should review, with its commissioners, the provision of services for individuals with a diagnosis of personality disorder. This review should identify how a comprehensive service, complying with the relevant NICE guidelines, will be established. Any plans should ensure that there is equity of access to services for individuals from all the localities served by the Trust. In line with the Trust's current plans there should be an ongoing audit, agreed with the Trust's commissioners, to ensure that the Trust is complying, or moving towards compliance in a planned and agreed manner, with the relevant NICE guidelines on personality disorders. *Recommendation 4 - Treatment* In line with the recent developments in the provision and delivery of Psychological Therapies in the Trust, together with its commissioners, the Trust should review this provision to ensure that it complies with the recommendations of relevant NICE guidelines. In particular the Trust should ensure that those individuals with more serious, complex and enduring mental health problems have access to psychological interventions in a timely manner as recommended by the relevant NICE guidelines. Having agreed appropriate standards with its commissioner, the Trust should institute a regular cycle of audits to establish that, especially, those individuals with serious, complex and enduring mental health problems have appropriate access to Psychological Therapies. *Recommendation 5 - Substance Misuse* The Trust has identified that progress has been made in the delivery of substance misuse services. It should now put in place a system, including an audit cycle, to assure itself and its commissioners that these developments are realizing the intended and identified outcomes. The Trust has identified a number of issues which need to be addressed. Together with its partner organizations, the Trust should agree an action plan to address the issues it has identified and put it place a monitoring system to assure itself and its commissioners that the identified actions have been completed and the agreed goals realized. An audit cycle should be put in place to ensure the ongoing improvements of these services.

	Recommendation 6 – Equality and Diversity South West Yorkshire Partnership NHS Foundation Trust should ensure that the aims of its Equality and Diversity policy are translated into practice in the clinical arena by: Ensuring that cultural and religious issues are included in the assessment of need in a routine manner; Ensuring that staff receive appropriate training to enable them to address cultural and religious issues as part of the assessment process; Ensuring that staff receive appropriate and regular supervision in this area; Undertaking regular audits to monitor the implementation of the Trust's Equality and Inclusion Strategy in clinical practice. *Recommendation 7* South West Yorkshire Partnership NHS Foundation Trust should take action to ensure that the Spiritual and Pastoral Care Team, or another suitable resource, is available to raise awareness of cultural and religious issues within the clinical arena and that clinical staff have timely access to appropriate advice, consultation and supervision on these matters. *Recommendation 8 – Vulnerable Adults and Safeguarding* The Trust should assure itself and its Local Authority partners that the Safeguarding policies and procedures which it has put in place and supported with training are being implemented. It should include audits of compliance with its Safeguarding policies in its regular audit cycle. *Recommendation 9 – The Family* Access to appropriate family interventions should be available to service users under the care of the CMHT. CMHT Staff should receive training and supervision in appropriate family work and interventions. The Trust should monitor the provision of this service, including using regular audits, to ensure that those individuals who might benefit from family interventions are able to access them in a timely fashion. *Recommendation 10* The PCT should put in place a system to ensure that there is timely communication between primary care and secondary care services. *Recommendation 11* Given that new protocols have now been put in place, the local Housing Associations, the Trust and the commissioners of mental health services should institute a monitoring system to ensure that: • the proper roles and responsibilities of these organisations are adhered to; • the protocol for sharing information is adhered to; • staff are properly trained and supported to carry out their agreed roles; and • there is a clear mechanism for identifying unmet need.

Mr Z	**HASCAS Report** *Recommendation 1* In line with current CPA guidance and the Trust's own current CPA policy the Trust should undertake regular quality audits to ensure that: • all those referred to its secondary mental health services have a comprehensive assessment of their needs; • there is a clear formulation of the individual's difficulties and needs; • care plans are informed by appropriate assessment and formulation; • all clear plans have clear goals or outcomes; • service users and, with their consent, their families and carers, are involved in the assessment of need, the planning of care, and any changes to either the care plan or the care co-ordinator; • the agreement of families and carers is obtained before care plans are finalised which involve actions on their part; and • families and carers, with the agreement of service users, are provided with current care plans, including crisis management plans. Where there is multidisciplinary or multi-agency involvement all those involved in delivering care and support are appropriately involved in the assessment and planning process with the knowledge and consent of the service user. *Recommendation 2 – Risk Assessment* Having revised its risk assessment, management and training policy the Trust should institute a regular quality audit to ensure: • that the formulation of the individual's problems and needs informs the understanding of his/her risk; • that robust and meaningful care plans are put in place; • that the service user and other relevant individuals are involved in the assessment and planning process; • that the risk management plan is appropriately disseminated. *Recommendation 3 – Vulnerable Adults and Safeguarding* The Trust should assure itself and its Local Authority partners that the Safeguarding policies and procedures which it has put in place and supported with training are being implemented. It should include audits of compliance with its Safeguarding policies in its regular audit cycle