usions and recommendations from the:-

Report of the Inquiry into the treatment and care of 5 individual patients by Oldham N.H.S. Trust Mental Health Services commissioned by the West Pennine Health Authority

West Pennine Health Authority

Contents

1. Introduction

In January 1996 West Pennine Health Authority established an Independent Review of the treatment and care provided by the Oldham National Health Service Trust for four individual patients during the period of September 1994 to 22 November 1995 and to produce a report and recommendations. In July 1996 the Health Authority asked the Review Team to include in this review the treatment and care provided for a further individual who was also under the care of the Oldham NHS Trust.

The members of the Independent Review Team who were appointed following consultation with the Mental Health Act Commission and the National Health Service Executive were:-

Mr. J Sedgman, Solicitor, *Chairman*

Mr. M Graham MBE, RMN

Mr. J Moran CQSW, MSc

Dr. J Wilkins BSc, MBBS, MRCPsych

The terms of reference of the Inquiry and the procedure adopted by the Team are attached at appendices A and B.

The Inquiry Team are grateful to and express their gratitude to all witnesses of fact for their attendance, co-operation and frankness during a crisis that was for them, at times, stressful and upsetting.

The members of the families involved for their help and contribution to their deliberations in circumstances that were understandably often distressing for them.

The Legal Union and other representatives for their helpful and professional contribution to the work of the inquiry. All those who appeared as expert witnesses before the inquiry, for there time, expertise and special contribution.

The Officers, Managers and Board Members of both West Pennine Health Authority and The Oldham NHS Trust, who gave their time and expertise in providing evidence and background information on a variety of matters involved including, in particular, matter of policy and administration.

To take forward the Inquiry recommendations. The Health Authority and Oldham Trust have produced a timetabled action plan to address the issues raised by the Team.

2. General Conclusions and Recommendations

TRUST SERVICES

(i) Policies and Procedures

(ii) Throughout the period covered by this Report, there is evidence of some poor drafting of policies, procedures and protocols, of considerable and unnecessary delay in the consideration of and approval of draft documents and of delay in the implementation of agreed policies. There has been a lack of multidisciplinary, (including clinical) input into the preparation of these policies, procedures and protocols and a lack of overall responsibility for and ownership of the same.

(iii) **Recommendation:** That the Trust should provide for full multidisciplinary input into the drafting and approval of all appropriate policies, procedures and protocols; should set down timescales during which the same shall be approved and implemented; should arrange for clear ownership and monitoring of the working of such, and should establish overall responsibility for all such in one senior officer of the Trust. The Trust should provide all appropriate publicity for and training in such policies, procedures and protocols.

(i) Training

(ii) There is a lack of co-ordination of training in the Mental Health Directorate. A number of useful initiatives and examples of good practice were apparent but, overall, training received an insufficient priority and was poorly planned.

(iii) **Recommendation:** That the Trust should develop an overall strategy for the training of all staff and, that this should be the responsibility of one senior officer accountable to the Clinical Director. Such strategy should include training in, amongst other areas, resuscitation techniques, CPA, Care and Responsibility, observation policy, MDT working, clinical supervision, discharge planning, the duties of key workers and named nurses, risk assessment and the working of alarm systems. The responsible officer should, in addition to overseeing the implementation of such training, also monitor the position and identify any un-met training needs from time to time.

(i) Resuscitation Policy

(ii) Some staff were unclear as to when to cease cardio-pulmonary resuscitation once begun, and under what circumstances the "Crash Team" should be called.

(iii) **Recommendation:** That the Trust should, as a matter of urgency, develop and promulgate a policy which should comply with good practice in this area. It should introduce a training programme for all staff, together with regular refresher courses in this field.

(i) Staff Supervision

(ii) Supervision of staff appeared to be poorly organised, managed and monitored.

(iii) **Recommendation:** That supervision throughout the Directorate should be reviewed by the Trust and a suitable management tool developed to provide appropriate supervision of staff at all grades.

(i) Night Staffing Levels

(ii) Optimum night staffing levels of two qualified to one unqualified member of staff are not being met on approximately 60% of occasions.

(iii) **Recommendation:** That the Trust should draw up and implement a nursing strategy to address this matter and, in conjunction with the Health Authority, provide appropriate funding there for.

(i) Nurse Observation Policy

(ii) During the period May 1995 - June 1995 when two of the incidents, the subject of this Report, took place the draft Nursing Observation Policy had failed to be agreed, adopted and implemented, despite the question of Observation having been raised by the Mental Health Act Commission ("MHAC") in both September 1994 and September 1995.

(iii) **Recommendation:** That the Trust should revisit the current adopted Nurse Observation Policy in the light of the Recommendations contained in this Report and keep the same under review.

(i) Observation Levels

(ii) Whilst we have no reason to believe that recommended observation levels were ever not complied with as a result of resource implications, there was some uncertainty as to the method of imposition, review and maintenance of observation levels.

(iii) **Recommendation:** That the Trust should clarify the rules regarding the setting of observation levels, by whom these should be set, and by whom reviewed, altered and cancelled.

(i) Shift Handovers

(ii) There were some deficiencies found in the arrangements for shift handovers.

(iii) **Recommendation:** That the Trust should urgently review current policy in this area and issue clear instructions to all appropriate members of staff as to content and manner of conveying information from one shift to the next, including all necessary documentation.

(i) Risk Assessment

(ii) There is little evidence of any systematic policy on risk assessment.

(iii) **Recommendation:** That the Trust should set up a systematic approach to Risk Assessment in all branches of clinical activity, and in compliance with good practice, and that the same should be subject to regular monitoring and audit.

(i) Building Provision

(ii) The Mental Health Directorate, particularly in regard to its provision of in-patient facilities, has been functioning heretofore in totally inadequate and potentially hazardous accommodation.

(iii) **Recommendation:** That the Trust should immediately carry out a detailed safety audit of existing facilities in order to obviate, as far as possible, potential hazards.

(i) Hazard Analysis on the New Build

(ii) The Inquiry did not, as part of its Terms of Reference, concern itself with any potential hazards or risks that may be present in the new-build provision when completed.

(iii) **Recommendation:** That the Trust should carry out a risk analysis as to any potential hazards to staff, patients or others in the new-build provision.

(i) Testing of Equipment

(ii) In one case considered by this Inquiry, equipment had not been tested regularly and staff were confused as to its operation. In another case, faulty equipment, whilst having been reported, had not been rectified.

(iii) **Recommendation:** That the Trust should provide adequate facilities, for the reporting of faulty equipment and for the rectification of reported faults. That it should develop and implement an overall system of planned preventative maintenance throughout its premises. In particular it should arrange for the regular testing of alarms and other similar equipment, and for the training of staff in the use thereof.

(i) Monitoring of External Reports

(ii) There was evidence of failure by the Trust to act upon the Reports of certain external agencies, such as the MHAC, and of no adequate system to monitor whether appropriate action had been taken in the light of such Reports.

(iii) **Recommendation:** That the Trust should set up a system to consider recommendations contained in external agency Reports, to act upon such and to monitor that appropriate action has been taken.

(i) Internal Reports into Untoward Incidents and Reviews Thereof

(ii) The Internal Reports into the five untoward incidents, the subjects of this Report, were, in the main, poorly done. In significant respects, they failed to involve the family and/or carers. There was some improvement in the format and content of the last Report.

(iii) **Recommendation:** That the Trust, when conducting Internal Inquiries and producing Reports, should comply with current Government guidance, involve carers and family from the outset, and set out clear recommendations with timescales. Regard should be had to guidance provided at paragraph 5.1.3 of the Health of the Nation guide "Building Bridges" - 1995.

(i) Executive Reviews following Internal Inquiries.

(ii) There is evidence that the Executive Reviews undertaken in certain of the cases, the subject of this Report, were not sufficiently exhaustive.

(iii) **Recommendation:** That the Trust produce and implement clear guidance for the conducting of Executive Reviews following Internal Inquiries.

(i) Staff Support

(ii) There is little evidence of a co-ordinated approach to the question of staff support and counselling following traumatic untoward incidents. Such support as was offered in the cases the subject of this Report, appeared to be on a somewhat ad hoc basis. One common theme that came through strongly was that in many cases the best counselling available was felt to be the ability for staff involved to be able to talk to colleagues who had been involved in similar occurrences. However, there is also a need for a more structured approach by the Trust. There was the ability in a number of cases to access the services provided by Mediscreen and, in one case, facilities offered by Rochdale Hospital psychological services. The whole matter, though, seemed to be conducted in a rather haphazard manner and also not to have been followed through in any co-ordinated way. A number of witnesses made it clear that their needs arose some time after the incident and continued for a considerable time. There was also, the necessity for more specific counselling and support for staff who were required to give evidence subsequently at the Coroners' Inquests.

(iii) **Recommendation:** That the Trust should develop and implement a policy for the support of staff following untoward incidents. It should be a managerial responsibility to ensure that sufficient steps are taken to organise appropriate support for staff which, while taking into account their individual needs, should not be intrusive. A non-executive director could perhaps be assigned to this co-ordinating and monitoring role. Care should be taken to include all staff, including those working in the community. Such support should continue for so long as may be necessary and include support in connection with Inquests, if appropriate

(i) Audit and Monitoring of Mental Health Services

(ii) There is no sufficient structured internal monitoring or audit of clinical services provided by the Trust in the hospital and the community. Hitherto, contact with the Health Authority over audit has been poor. There appears to have been little collaboration in determining audit priorities.

(iii) **Recommendation:** That the Trust should set up a structured approach, at all levels of service delivery, to multidisciplinary audit, with the Clinical Director being ultimately responsible. Better links with the Health Authority need to be developed in order to determine audit priorities.

(i) Key Worker and Named Nurse

(ii) The roles of Key Worker and Named Nurse were poorly understood, and at times poorly undertaken and supervised by Trust personnel.

(iii) **Recommendation:** That the Trust should provide adequate training for and supervision of Key Workers and Named Nurses.

(i) Care Programme Approach

(ii) There was evidence that the Care Programme Approach ("CPA") was poorly understood and implemented within the Trust.

(iii) **Recommendation:** That the Trust should continue with its current review of the CPA and produce an agreed Action Plan with timescales in the near future. This Action Plan should identify a senior officer of the Trust as being responsible for the monitoring of the efficient running of the CPA. The current 1991 CPA document needs to be updated. Appropriate training in the philosophy and implementation of the CPA should be provided by the Trust for all relevant personnel on a multidisciplinary basis.

(i) Liaison between Mental Health In-Patient Facilities and the Accident and Emergency Department

(ii) A number of patients access the mental health services via the A & E Department of the hospital, particularly out of hours. This is inevitable and should be recognised. There would appear to be a lack of liaison however between the A & E Department and the mental health services provided in other parts of the hospital and in the community.

(iii) **Recommendation:** That the Trust should address its attention to the lines of communication between the A & E Department and the mental health in-patient and community facilities, particularly out of hours. It should consider the provision of Mental Health Directorate personnel in the A & E Department. This might be provided by the presence of Registered Mental Nurses in a triage capacity, thus reducing the necessity for junior mental health medical staff to physically attend the Department for casual referrals.

(i) Consultant Recruitment

(ii) There have been long-standing difficulties in the recruitment of Consultant staff in the Mental Health Directorate.

(iii) **Recommendation:** That the Trust should, in conjunction with the Health Authority and the local University Department, draw up an Action Plan to address the problem by, for instance, linking the Directorate with the University Department. It should develop a recruitment strategy and seek to enhance the attractiveness of the employment package.

(i) Information Systems

(ii) The Trust appeared to have no overall information technology strategy and the Mental Health Directorate have no sufficient system available whereby authorised personnel may immediately access all necessary patient information. There is some software facility in the area of CPA/Section 117 cases.

(iii) **Recommendation:** That the Trust should identify and purchase and or develop an appropriate information technology package, to include an accessible patient information system. Such system should include, in addition to clinical information, details relating to Supervised Discharge, The Supervision Register, and Section 117 and CPA cases.

(i) Mental Health Services Funding

(ii) In common with mental health services generally, the funding available to the Mental Health Directorate for the provision of mental health services in the area does not appear to have received the priority in the allocation of funds that the mental health needs of the area would warrant.

(iii) **Recommendation:** That the Trust, together with the Health Authority, should re-visit policy on budget provision and reassess the needs and requirements of the mental health services provided in the area and the appropriate level of funding there for.

(i) HAS Manual on "Suicide Prevention"

(ii) The HAS Manual "Suicide Prevention" third impression 1996, appeared to be little known amongst the staff of the Mental Health Directorate. It was brought to the attention of the Trust in May 1996 by the Inquiry Team, a group was set up to produce a policy and procedure in the light of the recommendations made in the Manual but we found no evidence some nine months later that this group had produced any such policy or procedure or that the guidance contained in the document had been taken note of.

(iii) **Recommendation:** That the Trust should take account of the HAS Manual "Suicide Prevention" and draft and implement, within an agreed timescale, appropriate policies and procedures in the light of its recommendations.

(i) Health of the Nation Targets

(ii) There appeared to be little policy or planning directed towards achieving the Health of the Nation targets.

(iii) **Recommendation:** That the Trust, together with the Health Authority, should take note of the Health of the Nation targets and produce an appropriate policy and procedure directed towards achieving these targets within an acceptable timescale. Compliance should be monitored, perhaps by a non-executive director of the Trust.

(i) Medical and Nursing Notes

(ii) There is evidence that on occasions the maintenance of separate medical and nursing notes may have led to some confusion and or missed instructions.

(iii) **Recommendation:** That the Trust should consider introducing integrated multidisciplinary notes.

(i) CPN Care Plans

(ii) There is evidence that Care Plans were poorly constructed, written up and implemented.

(iii) **Recommendation:** That the Trust review its Care Plan documentation generally and monitor CPN Care Plans by appropriate clinical supervision.

HEALTH AUTHORITY

(i) Socio-economic Deprivation

(ii) The area served by the Trust has particular problems of social deprivation.

(iii) **Recommendation:** That the Health Authority should bear these particular needs in mind when assessing their purchasing priorities and the services to be provided.

(i) Organisation of Mental Health Services in the Oldham Area

(ii) The provision of mental health services is essentially different in character from that of other services provided by an acute health Trust. There are other examples in the country where mental health services have not received the priority, particularly in funding, that the health requirements of an area demanded. In many areas the provision of mental health services has been found to be better provided by a specialised mental health Trust. Any reorganisation in this regard would necessarily involve the mental health services provided by other local acute services Trusts.

(iii) **Recommendation:** That the Health Authority, with the Trust, and in consultation with other local Trusts and the OMBSSD should consider whether the provision of mental health services might better be provided by a specialised mental health Trust in the area.

(i) Monitoring of Mental Health Services

(ii) There has been limited audit or monitoring of the mental health services purchased, in the light of the five incidents, the subject of this Report.

(iii) **Recommendation:** That the Health Authority should increase its monitoring of the mental health services purchased, particularly in the light of the five incidents the subject of this Report, and in the knowledge of the conclusions and recommendations contained herein. It should utilise the advice given in the North West Regional Health Authority's, "A Health Service Strategy for Suicide Prevention in the North West Region" March 1996 and the HAS Manual "Suicide Prevention" third impression 1996, in any such monitoring and audit.

(i) Action Plan and Monitoring of Recommendations in this Report

(ii) This matter is outwith our Terms of Reference but it is felt that a reference thereto is appropriate. The Inquiry team will be available to assist as necessary.

(iii) **Recommendation:** That the Health Authority may wish to negotiate with the Trust an Action Plan in connection with some or all of the recommendations contained in this Report.

THE SERVICES TOGETHER

(i) Inter-Agency Working

(ii) There is evidence of deficiencies in inter-agency working such as, for instance, that between the in-patient and the community based services in the field of Admissions and Discharge Planning.

(iii) **Recommendation:** That the Trust and the OMBCSSD should negotiate and implement an agreed joint policy in all areas of common interest, including in particular the areas of Admissions, Discharge Planning (including CPA), care management an needs assessment.

(i) Joint Planning, Joint Working

(ii) There appears to be a lack of joint planning and working together between the Trust and OMBCSSD.

(iii) **Recommendation:** That the Trust and the OMBCSSD should look at the potential for joint purchasing, joint management, joint funding, joint recording, joint training and joint audit.

(i) Joint Working of Trust and Primary Health Care Services

(ii) Contact between the Trust and the Primary Health Care Services is poor. GPs seem unaware of the services provided by the Trust and how to access them. Each has remained substantially uninvolved in developing services provided by the other. In all cases, the subject of this Report, there was only a limited involvement of the Primary Health Care Services, and in particular of GPs, by the mental health team from the point of admission through to death or discharge; nor, it seems, was there an involvement of GPs in after care arrangements when being set up at Discharge and CPA meetings.

(iii) **Recommendation:** That the Health Authority should facilitate better liaison between the Trust and the Primary Health Care Services as, for instance, by involving GPs in co missioning decisions. The Trust should facilitate its Clinical Director's attendance at local LMC and other Primary Health Care meetings, and GPs attendance at ward rounds, Discharge and CPA meetings. The Health Authority should monitor the extent to which the Trust adheres to this recommendation.

(i) Multidisciplinary Review of Patients

(ii) There was evidence to show that there is no agreed policy or procedure whereby patients in the community are reviewed on a regular basis by the multidisciplinary team using CPA/care management as the framework.

(iii) **Recommendation:** That the Trust should discuss with the OMBCSSD development of a policy providing for regular multidisciplinary review of community based patients' cases in accordance with CPA/care management guidance and good practice

(i) Out of Hours Service

(ii) There appear to be deficiencies in the out of hours and crisis services provided in the area, together with considerable ignorance and confusion in the publics' mind as to how to access the same.

(iii) **Recommendation:** That the Health Authority, OMBCSSD and the Trust should together consider ways of developing an out of hours service for the use of those with mental health problems. Such a service should be set up involving all other relevant agencies, (including Primary Medical Health Care Services), and arrangements should be made to publicise the service and give information to potential users as to how the service may be accessed. The service could incorporate a 24 hour telephone helpline.

(i) Community Mental Health Teams

(ii) There is a lack of properly integrated multidisciplinary community mental health teams in the area. At the moment the service is organised along "functional" lines. This has tended to lead to a confusion of priorities and a distortion in the profile of services provided by the Trust in the community, together with some isolation of personnel.

(iii) **Recommendation:** That the Trust, the Health Authority and OMBCSSD should discuss together and jointly set up and develop within a specified timescale and with the involvement, as necessary, of GP fundholding practices, properly integrated and jointly managed multidisciplinary community mental health teams in line with good practice. This will involve an element of joint commissioning, joint financing and joint record keeping.

(i) Service Information to the Public

(ii) There is limited information available to the public as to the mental health services provided, and as to the means of access thereto.

(iii) **Recommendation:** That the Health Authority, the Trust and the OMBCSSD should consider and implement the recommendations in this regard contained in "The Way Forward" and generally act to publicise facilities in the field of mental health available in the area and the means of access thereto by the public.

SOCIAL SERVICES

(i) Access to Services and Information by Carers and Families

(ii) There is a lack of knowledge in users, carers and families as to the services provided in the field of mental health by the Trust and OMBCSSD and as to the means of access to the same. This includes information as to the provision of out of hours services and as to rights and responsibilities under the Mental Health Act 1983.

(iii) **Recommendation:** That the OMBCSSD should discuss with the Trust and GP fund holding practices the publicising of services offered and the methods of access thereto. Such publicity could include the setting up of a 24 hour helpline and the production and dissemination of information by leaflets, notices and other means.

FAMILIES AND CARERS

(i) Reporting Absence

(ii) In one case with which we dealt there was confusion as to next of kin/nearest relative and in another there had arisen a question relating to the reporting of a patient's absence to the police. The reporting of absence is a difficult question, particularly where the patient is informal. Nevertheless, as clear guidance as it is possible to give should be given to staff in respect of such matters.

(iii) **Recommendation:** That the Trust should obtain and keep readily available to responsible staff clear details of next of kin and nearest relative in all cases. Guidance as to the reporting of absences of patients should also be available to all staff.

(i) Involvement in Care and Discharge Planning

(ii) There appeared to be little, if any, agreement on the degree of involvement of users, carers and families in the planning of care, including attendance at ward rounds, and in Discharge Planning.

(iii) **Recommendation:** That the Trust should develop and implement a procedure for the involvement in care and discharge planning of users, carers and families as appropriate and in accordance with good practice. Staff should be fully acquainted with such arrangements, as should users, carers and families themselves.

(i) Knowing Who To Talk To

(ii) One of the repeated comments made to us by witnesses was that though the care provided to loved ones may well have been excellent, carers and families were constantly frustrated by not knowing who they could contact directly for information as to their family member.

(iii) **Recommendation:** That the Trust should develop a procedure whereby carers and families are provided with a named member of staff who they can contact if necessary at short notice, and with whom they can discuss matters connected with the care of their family member.

(i) Advocacy Services

(ii) There appeared to be little evidence of the presence of advocacy services within the in-patient facility. Organisations such as MIND operate in the community but only, it seems, to a limited extent, if any, within the hospital.

(iii) **Recommendation:** That the Trust should encourage the development of advocacy services within the in-patient facility.

(i) Service Information

(ii) There is little immediate provision of information on in-patient services and facilities provided to new patients on some wards. There is no reason to suppose that staff on the wards were not kind, helpful, understanding and sympathetic to new patients, but there is little by way of written information available.

(iii) **Recommendation:** That the Trust should review the availability of written information to new patients on the wards, and produce and disseminate to all such, brief details of services provided and information as to ward life generally.

(i) Involvement in Internal Inquiries Following Untoward Incidents

(ii) There appeared to us to have been little involvement of carers and families in the Internal Reviews following the five incidents with which this Report is concerned, nor in the drafting of the Reports of such Reviews. Neither did there seem to be any clear directive as to the informing of users, carers and families of the contents of the Reports and the recommendations, when produced.

(iii) **Recommendation:** That the Trust should incorporate into the procedure for such Internal Reviews, and the preparing of Reports following the same, the involvement of users, carers and families at an early date, and the informing of all relevant parties so far as is appropriate of the contents of such Reports when produced.

(i) Support and Counselling

(ii) There was little formalised procedure for the support and counselling of carers and families following incidents such as those with which this Report is concerned.

(iii) **Recommendation:** That the Trust should develop and adopt a procedure whereby there is provision for appropriate support, in accordance with good practice, for carers and families following traumatic and untoward incidents. Such support should be provided as desired by the carers and families, and should be co-ordinated by a named officer of the Trust.

NHSME and NHSE

(i) Suicides and Homicides by the Mental Ill.

(ii) There is evidence that the National Health Service Executive (NHSE), at both national and regional level, is addressing the issue of suicides and homicides by the mentally ill. The matter is addressed in Chapter 12 of this Report.

(iii) **Recommendation:**

(a) That the Confidential Inquiry into Homicides and Suicides by Mentally Ill People should be available to advise in connection with the setting up of Independent Inquiries.

(b) That the Confidential Inquiry should hold a database of qualified chairmen and members available to sit on such Inquiries.

(c) That the Confidential Inquiry should provide guidance on appropriate procedure and powers for such Inquiries and on the format and standard of presentation of the Reports of such Inquiries.

(d) That the Confidential Inquiry should be allocated the task of monitoring all such Independent Inquiry Reports nationally, of collating recommendations made therein, and disseminating in digest form such recommendations as may have a general relevance.

(e) That the North West NHSE should agree an Action Plan with the Health Authority in connection with the North West NHSE Suicide Prevention Strategy, March 1996.

(f) That the draft Mental Health Inquiry Checklist be completed, supported and funded.

3. Action already taken by Oldham NHS Trust

The five separate incidents with which this Inquiry is concerned took place between 28th September 1994 and 21st May 1996. In the course of our investigations, it has been possible to observe.certain lessons having been learned as a result of these events and to note action taken as a result thereof. Such action has included:-

i) A range of policies and procedures introduced and/or updated.

ii) An improvement in the quality and standard of Internal Reports into untoward incidents.

iii) An improvement in policies and procedures relating to records and nursing observation.

iv) An improvement in support to staff and families following untoward incidents.

v) An improvement in the understanding and implementation of the Care Programme Approach.

vi) A clearer identification of the Named Nurse and of their role and responsibilities.

vii) The introduction of formal ward audits.

viii) A more structured approach to clinical supervision.

ix) An agreed training programme for all nursing staff in resuscitation techniques together with annual refresher courses.

x) Senior Officers of the Trust immediately visiting the site of untoward incidents and providing support for staff.

xi) Testing of the 'Alarm System' in a more structured manner.

4. The Way Forward

The Conclusions and Recommendations contained in the Report provide an opportunity to further develop and enhance the Mental Health Services in Oldham.

As a matter of urgency Senior Officers from the Trust, Health Authority and N.H.S. Executive North West, will be meeting to produce a strategy and agreed action plan on delivering the Conclusions and Recommendations outlined in the report. This strategy will involve a series of time limited task groups to review the Conclusions and Recommendations of the report to produce a positive response to these issues.

The Task Groups will enable the clinical staff the opportunity to build upon the work undertaken to date in the Directorate and outlined in the report under Section 2 of this briefing.

The timescale for these actions will be as follows:-

1. Strategic Direction Produced	**29 August 97**
2. Task Groups established	**1 September 97**
3. Reports reviewed from Task Groups	**1 November 97**
4. Action plan with agreed implementation timetable produced	**1 December 97**

The Oldham NHS Trust is embarking on a number of innovative initiatives to improve the Mental Health Services both for service users and their carers.

A new in-patient unit is at an advanced stage of construction on the Royal Oldham Hospital site, and will provide 66 single en-suite bedrooms. A second community-based Mental Health Resource Centre will be established in association with the Social Services department, clients currently in Westwood ward will be transferred to community-based accommodation which is more appropriate to their needs, and the further development of the Care Programme Approach are planned. Positive working relationships exist between The Health Authority, The Trust, The Local Authority, Social Services, and the Voluntary Sector and these will be further developed. The constructive recommendations in the Inquiry Teams Report will provide a framework for the continued development of The Mental Health Services in Oldham.

Appendix A

West Pennine Health Authority

1. TERMS OF REFERENCE

Inquiry into the Care and Treatment of 5 clients of The Oldham Mental Health Services

1. To undertake an independent review of all the circumstances surrounding the treatment and care of 5 clients of the Oldham National Health Service Trust and in particular as to:-

(a) the quality and scope of health care, social care and risk assessments;

(b) the appropriateness of their hospital treatment and in-patient care and supervision and as to their subsequent support, supervision and after care in the community as appropriate and more particularly as to:

(i) their assessed health and social care needs;

(ii) their assessed risk of potential harm to themselves and others;

(iii) any previous psychiatric history;

(iv) the number and nature of any previous Court convictions;

(v) the number and nature of any previous violent incidents, self harm and/or suicide attempts;

(c) the extent to which the care of these clients corresponded to statutory obligations, relevant guidance from the Department of Health (including HC(90)23, LASSL(90)11, HSG(94)27) and local operational policies;

(d) the extent to which their prescribed care plans were:

(i) effectively delivered, and

(ii) complied with by each client;

(e) the history of their medication and compliance therewith.

Appendix A Cont.

2. To examine the adequacy of the collaboration and communication between:

(a) the agencies involved in the care of these clients and in the provision of services to each of them;

(b) the statutory agencies and the clients' families.

3. To prepare a Report and make recommendations to the West Pennine Health Authority and, if appropriate, Oldham Social Services Department.

Appendix B

INDEPENDENT INQUIRY - MENTAL HEALTH SERVICES

PROCEDURE TO BE ADOPTED BY THE INQUIRY

1. Every Witness of Fact will receive a letter in advance of appearing to give evidence informing them:

a. Of the Terms of Reference and the Procedure to be adopted by the Inquiry.

b. That when they give all evidence they may raise any matter they wish and which they feel might be relevant to the Inquiry.

c. That they may bring with them a friend or relative, Member of a Trade Union, Lawyer or Member of a Defence Organisation or anyone else they wish to accompany them with the exception of another Inquiry witness.

d. That it is the witness who will be asked questions and who will be expected to answer.

e. That their evidence will be recorded and a copy sent to them afterwards for them to sign.

2. Witnesses of Fact will be asked to affirm that their evidence is true.

3. Any points of factual criticism will be put to a Witness of Fact, either verbally when they first give evidence, or in writing at a later time and they will be given a full opportunity to respond.

4. Representations will be received from any professional body and other interested parties as to present arrangements for persons in similar circumstances to those the subject of the Inquiry and as to any recommendations they may have for the future.

5. Those professional bodies or interested parties may be asked to give all evidence about their views and recommendations.

6. Anyone else who feels they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

Appendix B Cont.

7. All sittings of the Inquiry will be held in private.

8. Findings of the Inquiry and any recommendations will be made public.

9. The evidence which is submitted to the Inquiry, either orally or in writing, will not be made public by the Inquiry save as is disclosed within the body of the Inquiry's final report.

10. Findings of fact will be made on the basis of the evidence received by the Inquiry, comments which appear within the narrative of the report and any recommendations will be based on those findings.

J Sedgman
Chairman, Inquiry Panel

14 May 1996