Response to recommendations from independent investigation 2011/21879 (Miss K)

Recommendation 1

The three Trusts and commissioning groups involved in Ms K's care at the time should develop robust, collaborative, patient-centered plans, to guide staff who care for individuals presenting with complex needs and who move between geographical, commissioning, or service boundaries on a regular basis, with a view to ensuring continuity of care, and which minimise disruption of therapeutic relationships.

Care Trust (BDCFT) Response

- BDCFT has developed a robust collaborative care plan that has been embedded into their new patient record database, SystmOne. This was developed through BDCFT's wide and extensive carer and service user involvement forums and has a clear focus on recovery from a strengths-based approach.
- The care plan has an easy read version and can be readily printed off and shared with the service user or other services when required.

Recommendation 5

Ms K was a complex individual who posed a challenge for services to engage with. In addition, Ms K may have attracted some unhelpful 'labels'. 'Labelling' in a clinical context always opens the possibility of the clinical significance of some of her behaviours, particularly in relation to engagement, being missed.

Strategies to secure her engagement were not always reviewed, and, as a result, the ethos of the Care Programme Approach was not always adhered to in relation to her care. Accordingly, the Independent Investigation Team recommends that:
5a. LYPFT and BDCT review their engagement strategies with complex individuals to ensure that a properly formulated analysis and action plan is included when the issue of non-engagement is recognised, particularly in relation to safeguarding.

BDCFT Response

- All BDCFT staff are trained in relation to adult safeguarding roles and responsibilities and are aware of the safeguarding procedures that should be implemented when a concern arises.
- All Adult Community Mental Health Teams (CMHT's) in BDCFT are integrated Health and Social Care teams therefore have Safeguarding Coordinators embedded in the management structure so that all staff can access immediate Safeguarding support and advice when needed.
- All safeguarding plans consider non-engagement issues for whatever reason on a case by case basis.
- BDCFT has specific teams such as the Assertive Outreach Team that are dedicated in dealing with individuals that don't engage with traditional mental health services. They review individual service users non-engagement issues on a daily basis and are focused on developing imaginative strategies that will enhance service user engagement.

Recommendation 5

The Independent Investigation Team also recommends that:
5b. LYPFT and BDCT review their Care Programme Approach and training programmes in order to highlight the philosophical purpose behind Care Programme Approach, rather than focusing on adherence to administrative policies and procedures, important though this is, to ensure that care co-ordination is approached in a reflective manner.

BDCFT Response
BDCFT's Care Programme Approach Policy was reviewed in July 2018. The policy has the following principles embedded:

- To provide a holistic, integrated and consistent approach to care management across all services and with our key healthcare providers (social care, primary care and other secondary healthcare providers).
- All service users receiving treatment, care and support will receive quality care based on an individual assessment of their health and social care needs including risk and vulnerability, an evaluation of their strengths, and identification of their goals, aspirations and choices.
- Assessment, care planning and review will focus on improving outcomes for service users and their families across their life domains, helping them to achieve the outcomes that matter to them.
- The approach to assessment, care planning and review will be collaborative, placing the service user and their family at the centre of care in order to maximise their involvement and supporting the principle 'No decision about me without me'.
- Ensuring that the service users' needs are regularly reviewed and kept up to date whilst minimising duplication and repetition.
- Ensuring clear accountability for care planning with a single person who has overall responsibility for care co-ordination.
- Recognising the need to plan and provide care which is sensitive to the individual, recognising diversity in relation to race, faith, age, gender and sexual orientation and other characteristics that the service user may have in order to ensure equitable and appropriate access to services, interventions and information.
- BDCFT has also reviewed Care Co-ordinator training in relation to Rec 5b. The Trust is satisfied that the range and depth of material covered in the training package demonstrates that training is focusing on the principles and philosophy behind the Care Programme Approach, emphasizing collaboration and involvement, encouraging client-orientated goals and focus.

Recommendation 6

6a. The Independent Investigation Team would encourage the three Trusts involved in Ms K's care to consider reviewing the approach which they adopt in providing the families of those involved in incidents with information and support. A significant issue in this case was lack of communication between the various agencies involved in her care including social services who continued to have contact with Ms K following her arrest. The concern of the Independent Investigation Team is that if organisations are focused on who is 'responsible' for an investigation (i.e. whose team saw an individual most or, indeed, last)

then there is a danger that the bigger picture will be missed as organisations fail to come together.

BDCFT Response

In 2016 the Care Quality Commission (CQC) produced the report Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.

It showed that in some organisations learning from deaths was not being given sufficient priority and that valuable opportunities for improvements were being missed. Importantly the CQC also point out that there is much more we can do to engage families and carers and recognise their insights and experiences are vital to our learning.

The National Quality Board (NQB) guidance on Learning from Deaths (2017) was the starting point to initiate a standardised approach across the NHS to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning.

It is the right thing to do to review and investigate deaths where care and service delivery problems occurred so that we can learn and prevent recurrence.

BDCFT has stated its intention to make it a priority to work more closely with families and carers of patients who have died and to ensure meaningful support and engagement with them at all stages, from the notification of the death of their loved one right through to actions taken following from an investigation (if deemed appropriate).

The Trust fully supports the approach it has developed with other mental health trusts in the north of England as part of our collaborative approach to learning from deaths. The trusts participating are:

- Bradford District Care NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust
- Humber NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Sheffield Health & Social Care NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust

The BDCFT Learning from death policy sets out the principles that guide our work and how we will implement them.
This policy works alongside other BDCFT policies listed below

- Being Open Policy
- Serious Incident Policy
- Incident Reporting and Management Policy
- Analysing, Learning From and Responding To, Inspections, Guidance and Internal/ External Reports Policy
- Investigation of Incidents, Complaints and Claims Policy

Recommendation 6b.

The Trust's review their approach to undertaking investigation when more than one organisation is involved to ensure that a collaborative approach is considered and if appropriate adopted with a view to maximising the learning for each individual organisation.

BDCFT Response
BDCFT works in line with the Serious Incident Framework 2015 which gives guidance on how to investigate collaboratively when more than one organisation is involved in the section titled, Involvement of multiple providers.

The Serious Incident Framework states that "often more than one organisation is involved in the care and service delivery in which a serious incident has occurred. The organisation that identifies the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.

All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate.

Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

Commissioners themselves should provide support in complex circumstances. Where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process.

Often in complex circumstances separate investigations are completed by the different provider organisations. Where this is the case organisations (providers and commissioners and external partners as required) must agree to consider cross boundary issues i.e. the gaps in the services that may lead to problems in care. The contributing factors and root causes of any problems identified must be fully explored in order to develop effective solutions to prevent recurrence. Those responsible for coordinating the investigation must ensure this takes place. This activity should culminate in the development of a single investigation report. Development, implementation and monitoring of subsequent action plans by the relevant organisations must be undertaken in line with guidance outlined in part three of this Framework".

BDCFT is part of a Federation of NHS Trusts within West Yorkshire with Bradford District Care NHS Foundation Trust (BDCFT), Leeds & York Partnership NHS Foundation Trust (LYPFT) and South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) who have agreed to work collaboratively to deliver the West Yorkshire suicide prevention strategy across the West Yorkshire area, working across geographical and organisational boundaries in WY to deliver WY suicide prevention strategy, and to discuss serious incidents to include:

- Developing actions in response to strategic objectives
- Sharing good practice
- Pooling resources and develop business cases

- Learning lessons from each other’s experience