NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Assurance Statement

Publication date: 31 August 2022

Assurance statement by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) in response to an independent investigation into the care and treatment of Mr F

Firstly, and most importantly. our thoughts are with everyone affected by this tragic incident, in particular the victim and their family. We recognise the lifelong impact on the lives of Mr F's family and Mr F himself. From the external review commissioned by NHS England it was established that the Trust can show it has acted on all the action points set down in the action plan constructed following its own internal investigation, and have developed an improvement plan to achieve the areas of learning identified in the investigation conducted by Consequence UK Ltd. The external review also notes that there are no indications that the violent act that occurred was influenced by Mr F's mental health disorder, nor by any act or omission by those responsible for the delivery of his mental health care.

Introduction - the configuration of Kirklees Community Mental Health Services

South West Yorkshire Partnership NHS Foundation Trust is a specialist NHS foundation trust providing community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees, and Wakefield.

We also provide medium secure services for West Yorkshire and local low secure services. We are the lead provider for the West Yorkshire secure services provider collaborative and the lead for the South Yorkshire secure services collaborative.

Kirklees Community Mental Health Services is composed of two main teams:

- Enhanced teams – these deliver interventions to people under the care programme approach (CPA) with high risk and complexity. There are two enhanced teams per Kirklees locality (two in the North and two in the South).
- Core teams – these deliver time limited interventions to people with severe mental ill-health and include functions such as ongoing medication management and monitoring and psychological and occupational therapies. There is one core team per Kirklees locality (one in the North and one in the South).
- Early Intervention in Psychosis – these teams deliver interventions to people with a diagnosis of psychosis as well as those at risk of developing psychosis.

There is one team per Kirklees locality (one in the North and one in the South).

This structure has been in place since a service transformation in 2017, although systems and processes have evolved to further enhance the transition points and flow of service users between the teams.

Type of investigation

This incident met the Serious Incident Framework (SIF) (Appendix 1) criteria for an independent investigation. NHS England commissioned this learning and quality assurance review in line with the Serious Incident Framework for England 2015, which reflects the health circular guidance HSG 94/27 dated 10 May 1994, 'Guidance on the discharge of mentally disordered people and their continuing care in the community.'

An organisation called 'Consequence UK Ltd' was commissioned by NHS England to conduct the independent investigation.

The report was concluded in August 2022, and the Trust received and accepted the final version of the investigation. The investigation report was published on 31 August 2022.

Overall, the independent team concurred with the findings and recommendations of the Trust's internal review, led by an external colleague, Professor Jenny Shaw. The Trust can show that it has acted on all the action points set down in its action plan agreed following this internal investigation.

SWYPFT's response to the recommendations that arose from the external review commissioned by NHS England

It is important to reiterate that many of these concerns were already addressed prior to these recommendations being received and that NHS England and Consequence UK Ltd have agreed with South West Yorkshire NHS Foundation Trust to develop an improvement plan to achieve the recommendations, to enable the Trust to continually work to improve the experience and outcomes for service users, their families, and carers.

Report recommendations

The final report from Consequence UK Ltd contains three recommendations.

Recommendation 1:

What is required:

Where a service user is actively supported by a carer/family member or close friend, and those individuals are relied on by the service user for their wellbeing and stability, the care team must provide the opportunity for those individuals to share information with the care team on an 'as needed' basis. The service user must be aware of this facility and its necessity and be reassured that the care team will not divulge information they hold about the service user with friends/family without the express

consent of the service user. How this situation can be reliably achieved requires the engagement of service users, families, and frontline practitioners to participate in the process design, so it works, and the culture change necessary to achieve it, is achieved.

Recommendation 2:

What is required:

The Trust is tasked with designing an audit approach that enables it to test out the improvements it wanted to achieve because of the safety improvements initiated because of what happened with Mr F. The key areas that must be tested are:

- the impact of the Trust's approach to Formulation Informed Risk Management (FIRM), the new approach to risk assessment, risk management and safety planning
- how all care teams communicate with and engagement with families and carers of service users.

Such an audit must deliver a systems wide assessment and include the following types of activity:

- Focus groups of professionals, service users and families
- Peer review of record keeping assessing content and quality of what is written
- Individual exploratory conversations (interviews) to explore in-depth the experience of staff, patients, and families particularly:
  - Design of risk reduction / safety plans and service user and family involvement
  - The confidence families have to contact a service user's care team
  - The ease with which the family/carers of a service user can contact the care team
  - The responsiveness of the care team as experienced by the family/carer

Recommendation 3:

What is required:

It is commendable that the Trust is developing the role of a family liaison officer to work with families and be a named point of contact through an incident investigation process. However, we recommend that the Trust ensures it embraces the principles of restorative practice after harm into the family liaison officer role and seeks the advice and input of emerging thoughts leaders in these field, and registered practitioners and facilitators in restorative practice before finalising its approach.

Trust actions

Overall, the independent team concurred with the findings and recommendations of the Trust's own internal review. The Trust can show that it has acted on all the action points

set down in its action plan constructed following this internal investigation. The recommendations identified in the investigation commissioned by NHS England seek to address what Consequence UK Ltd considers to be outstanding issues, and/or the need for auditable assurance that the actions already taken have delivered the improvements they were designed to achieve. An improvement plan has been developed and regular review will take place to ensure these recommendations are embedded in our daily ways of working.

Governance and Oversight

Regular reports and updates have been provided to the Trust Board and Clinical Governance & Clinical Safety Committee regarding the incident and progress of the investigations since 2019. Going forward, progress against the actions from this report will be overseen by the Clinical Governance & Clinical Safety Committee.

The executive summary of the independent investigation and Trust response can be accessed on our website and is being made available to all directors.

For further information please contact the Trust communications team on comms@swyt.nhs.uk or 01924 316391.