South West Yorkshire Partnership NHS Foundation Trust

Assurance Statement

9 February 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 A following the death of his stepfather.

Firstly, and most importantly our thoughts are with the family and everyone affected by this tragic incident. From our internal serious incident review and the report by Sancus Solutions, it is clear that there were deficits in our care, for which we offer our sincere apologies.

This statement is split into three sections.

1. The configuration of SWYPFT's forensic services, how these services were structured around the time of the death of Mr A's stepfather in 2017 and how they are evolving and have developed since that time.

2. SWYPFT's response to the recommendations that arose from the internal Serious Incident Review, which concluded in March 2018.

3. SWYPFT's response to the external review commissioned by NHS England, published in February 2022. Many of the actions in response to the recommendations in the internal Serious Incident Review reports were in large part, completed or well progressed prior to the recommendations contained in the Sancus Solutions Report being made.

1. The Configuration of SWYPFT's Forensic Services at the time of the incident

South West Yorkshire Partnership NHS Foundation Trust provides mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield, and community health services to Barnsley. We also provide low and medium secure forensic services to the whole of Yorkshire and the Humber.

The community forensic outreach team

The specialist forensic outreach team provides a community based service to service users who are still under the care of specialist forensic psychiatry. The team is based

at the Bretton Centre at Fieldhead Hospital in Wakefield and covers the Kirklees and Calderdale areas.

The service is commissioned to provide specialist outreach for service users discharged from secure mental health services into the community and to provide advice and act as a consultation service to reduce the need for admission to secure services. Clients offered a service are those individuals with a clearly identifiable mental illness with a high-risk profile of risk to others.

The service monitors health and social welfare as well as mental health and potential risk. It offers practical support with housing, benefits, activity and employment. The service is staffed by both health and social care staff.

Care is based on the Care Programme Approach (a particular way of assessing, planning and reviewing someone's mental health care needs) and service users and carers are included in the planning process from the outset.

The objectives of the team are to improve mental health, manage and reduce risk, improve physical health, improve functional capacity, prevent relapse, develop skills and support transition to local generic mental health services.

Support offered includes:

- Risk monitoring and management
- Medical treatment
- Health screening
- Family work
- Recreational activity
- Self-care
- Social skills
- Group work
- Onward referral to other services which may be able to help further

Bretton Centre – low secure forensic service

The Bretton Centre is a low secure inpatient service which provides care for 38 men in 3 wards, based at Fieldhead Hospital in Wakefield. The wards are supported by a therapy centre and community teams. This provides the low secure part of the secure pathway.

The Bretton Centre admits people whose care cannot be appropriately provided in prisons and local generic mental health services. The centre also cares for people who no longer need to be in medium secure psychiatric services.

The function of the service and pathway is the assessment, treatment and rehabilitation of service users with severe mental health problems who require management in low secure conditions as a result of their risk to others. All wards

have a rehabilitative function and aim to develop service users' maximum level of functioning to support their rehabilitation potential.

Changes to service since the incident took place

Since the incident took place in 2017, the community forensic service provision has changed, with significant work in collaboration with mainstream services to establish clear forensic pathways. A comprehensive service review has been completed and outcomes and a future forensic vision have been presented to the Forensic Provider Collaborative Board that oversees service development. Regular updates will be provided to the Trust's Operational Management Group in the form of a monthly report offering more detailed assurance at strategic operational level. Changes will continue to be made following evaluation and feedback on this service to ensure safe, high quality care continues.

The team has been renamed to reflect greater emphasis on transition functions and is now known as the Forensic Community Transition Team.

2. Recommendations set out in the SWYPFT internal Serious Incident Review, concluded in March 2018

Based on the findings of the Trust internal investigation, the analysis and the conclusions reached, the SWYPFT internal investigation team recommended the following:

Recommendation 1: *Documentation and care planning should be in place to evidence what actions have been taken to address potential safeguarding and the issues raised by family members and to ensure that these are explored*

The overarching emphasis in achieving this recommendation was to improve safeguarding awareness and practice in the team. This was principally supported by establishing more robust and effective multi-disciplinary team reviews of all service users on the team caseload, supported by a weekly review template, which prompts the identification of safeguarding concerns and allows for discussion on clinical management and use of the current safeguarding policy and frameworks.

For completeness, a full review of the existing caseload was undertaken to understand if there were any missed opportunities for safeguarding activity, care planning and risk management.

Safeguarding awareness was further improved by raising awareness of opportunities for information sharing of concerns across teams, improved acknowledgement of

family concerns, improved opportunities for safeguarding supervision and the development of a safeguarding toolkit to support decision making for practitioners.

Recommendation 2: *When risks are identified, including information received from third parties, reassessment and formulation of the risk should be documented*

Through regular multi-disciplinary review, and discussions around risk assessment, the team have the opportunity to review risk and develop formulation through evaluation of professional observation and any other third-party information received, which is then documented.

Recommendation 3a) *The inpatient multi-disciplinary team ward summary template to be reviewed to ensure that risk assessment and risk formulation is recorded at each multi-disciplinary team ward review held*

Improvements were made to the ward-based summary documents, including sections which described risk assessment and formulation to support clinical review discussions and continuous and responsive risk management processes.

3b) *The low secure inpatient service to review the risk assessments of all their caseload to ensure that the HCR-20 and RAMP is completed and where it isn't, these should be completed immediately*

The service undertook a full review of the completion of risk assessments and action was clinically driven to ensure that all service users had an appropriate risk assessment in place to meet their needs. The Trust policy was updated to mandate the use of the Historical Clinical and Risk Management (HCR-20) tool for all community patients in forensic services and work was undertaken to develop risk assessments for all service users on the caseload. This continues to be monitored through robust governance frameworks within the service and high levels of compliance continue to be achieved.

The Trust has more recently introduced a Formulation Informed Risk Management approach (FIRM) which is a universal risk assessment tool with risk formulation for implementation for all service users. It was launched in October 2020 across the forensic services. All service users in both in-patient and community teams have a FIRM risk assessment developed on admission / allocation to a community caseload, and there is also a robust governance framework in place to monitor continued practice and quality improvement processes.

3c) *Clinical staff to be identified to receive appropriate training in the completion of HCR-20 version 3*

A programme of training for all registered staff was established to support the knowledge and skills required for the completion of the HCR-20 V3 risk assessment. The service achieved high levels of attendance on the training programme. A continuous rolling programme of training has been established to ensure that all registered staff attend this training to support their practice. This recommendation has been achieved.

Recommendation 4: *When a service user is in an informal or formal caring role this should be fully explored with them and the outcome documented.*

A full review was undertaken of the existing caseload at the time to identify whether any service users had identified caring roles. Information from this review was then used where appropriate to inform ongoing care plans and support to service users and their families. Ongoing assurance is achieved through the inclusion of carer issues via the multi-disciplinary team review template, to support a continued focus on carers and their challenges and ensure appropriate support and assessment and documentation through the clinical record.

Recommendation 5: *Assurance to be provided that record keeping standards are reinforced*

The serious incident investigation process highlighted a number of issues relating to the clinical record keeping standards within the forensic community transition team. This recommendation has been addressed by a series of record keeping improvement activities. A new programme of audit and review was established, alongside practical support to the team to improve record keeping practices. All members of the community team attended a bespoke record keeping training session and cycles of audit and action planning remain in place. Significant improvements are evident, continued quality improvement activity is ongoing as part of standard business processes and is being monitored through governance frameworks in the service.

Recommendation 6: *Discharge planning meetings should be planned as soon as possible and will include obtaining information from all relevant parties in a timely manner*

A full audit of all discharged service users in a 12 month period was undertaken to assess whether the team was aligned with policy and guidance. The outcomes of this audit review and suggestions for improvements were circulated across the forensic services. A re-audit process conducted in November 2020 indicated that improved practices had embedded, and outcomes were aligned with policy.

Recommendation 7: *The low secure community service to review their multi-disciplinary team discussion process*

A dedicated review meeting was established for this team to allow for more detailed review of all cases. This was supported by the development of a multi-disciplinary team template, which has been highlighted above, as a method to support wider, more comprehensive, clinical discussions of each individual and subsequent review of additional concerns, risks, support networks, information sharing and risk management and care planning processes in the team.

Recommendation 8: *The service to determine the frequency of management supervision for clinicians working in the community team with assurance that this has been implemented*

The Trust has ensured that community services have developed a framework of supervision, with different formats of supervision and standards expected across the service in line with the Trust supervision policy. All clinicians are offered appropriate supervision, and this is monitored via governance frameworks within the service. The community team is also now managed under a single community service management structure.

Recommendation 9: *The operational philosophy and policy should be updated to reflect current community service provision and where this sits in the overall forensic pathway*

A comprehensive operational procedure was developed for the team and implemented. The findings of a recent service review will further inform future changes, and these will be included in the current review of the procedure.

Recommendation 10: *To ensure the learning is shared from this investigation across the teams and the Business Delivery Unit*

Three formal learning events have been held, where learning was shared from the outcomes of the internal investigation at team level across the forensic service. These also included other Trust services considering the broader focus on safeguarding in the Sancus investigation.

3. Sancus Solutions Report – Independent Mental Health Homicide Investigation, published January 2022

Introduction

The internal investigation, commissioned in 2017 and concluded in 2018, was shared with the external investigation team. The external investigation was commissioned in 2018 from an organisation called Sancus Solutions, who were externally sourced by NHS England to investigate the mental health homicide, and the care and treatment

of the service user involved in this serious incident. The following statement describes our approach to the nine recommendations made in the final executive summary prepared by Sancus Solutions and published by NHS England.

Independent Investigation

This incident met the Serious Incident Framework (SIF) Appendix 1 criteria for an independent investigation. It was agreed by the Community Safety Partnership (CSP) that the incident also met the criteria for a Domestic Homicide Review (DHR). In line with the SIF, the CSP and NHS England agreed to complete one review, which meets the requirements of both statutory reviews.

Sancus Solutions were commissioned by NHS England to conduct the independent investigation. The start-up meeting of all stakeholders was held on 8 February 2018.

Sancus Solutions engaged with family members and the Trust during 2019 as they conducted their investigation. The first draft report was received into the Trust in December 2019 and our feedback regarding factual accuracy was submitted to NHS England in January 2020.

Information was received from NHS England that the Sancus Solutions report had been shared with the family in December 2020 to provide them with the opportunity to comment on the investigation. Several factors outside the control of the Trust, impacted on the significant delay of the report being published.

The Trust Board received and accepted the final version of the investigation in November 2021. Despite the delay in receipt of a final version, clinical teams had been working on earlier recommendations from Sancus Solutions where there was clear evidence for potential learning in practice or changes required to improve quality and safety.

The final executive summary of the investigation was published on 9th February 2022.

There are a number of recommendations set out in the Sancus Solutions Report, and we have set out the Trust's response in respect of these recommendations as follows. It is important to reiterate that many of these concerns were already being addressed prior to these recommendations being received.

Report Recommendations

The final report from Sancus contains nine recommendations. Our progress against these is described within the following text. Several of the recommendations refer to a planned quality assurance review. This assurance review is an opportunity for the Trust to provide evidence of our progress against the report recommendations to

Sancus so that this can be independently assessed. Sancus Solutions have taken into account the work already completed as a result of the serious incident investigation and additional work carried out as their findings unfolded over time. This is acknowledged within the wording of their recommendations.

Recommendation 1: *At Sancus Solutions' quality assurance review SWYPFT should provide an updated report on the implementation of HCR-20 assessments in both the forensic inpatient unit and forensic community service.*

Recommendation 2: *SWYPFT to provide evidence at Sancus Solutions quality assurance review from an audit of the use of FIRM in their forensic community and inpatient services.*

These first two recommendations acknowledge the work completed in the service to improve roll out and compliance with the HCR-20 and the FIRM risk assessments. We welcome their recommendation to provide an updated report to their quality assurance review within the coming weeks to demonstrate that this work has been embedded. The Trust has made strong progress with both of these and has a process to maintain oversight of this progress.

Recommendation 3: *SWYPFT to consider developing a version of FIRM assessment for its forensic services*

Sancus is recommending that we consider a version of FIRM for our forensic services. Further work is underway with the authors of FIRM to ensure that this recommendation is given detailed consideration and the Trust's decision will be discussed and detailed through our governance structures.

Recommendation 4: *At Sancus Solutions' quality assurance review SWYPFT should have completed a further audit of the forensic community service and be able to evidence that they have considered the following Sancus Solutions' recommendations:*

a) *the introduction of rehabilitation outreach forensic psychologist and psychiatrist posts*
b) *the allocation of administrative and dual diagnosis practitioner support*

Sancus have recognised the work undertaken to fully review the forensic community transition team. This is substantially complete and includes a clinical review of all service users in the team. A report was presented in the Trust at the end of November 2021 and was re-presented in January 2022, following further consideration and development of actions going forward. The future forensic vision has been presented to the forensic collaborative Board. In the interim, the forensic service will use temporary resources where they are available to provide the posts recommended by Sancus.

Recommendation 5: *Potentially Dangerous Person awareness training should be a core requirement for all practitioners in SWYPFT's forensic low secure unit and the forensic community transition team. SWYPFT should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.*

Potentially Dangerous Persons (PDP) is a police mechanism to manage people who might be a risk to others who do not fall under any of the three multi-agency public protection arrangements (MAPPA) categories. The Trust has excellent links with the police via MAPPA, and Sancus Solutions are requesting that the Trust should also include PDP processes in our training. This has been accepted, will be incorporated into existing Mental Health Act Training, and will be further included within the MAPPA training that is currently in development. Contact has been made with the West and South Yorkshire police forces to confirm we have the most up to date approach.

Recommendation 6: *SWYPFT should provide guidance in their Safeguarding Adults at Risk Policy on the identification and assessment of domestic violence in the elderly patient group.*

The Safeguarding Policy has been updated to include the identification and assessment of domestic violence in the elderly patient group.

Recommendation 7: *A member of SWYPFT's safeguarding team should regularly attend the inpatient and community elderly care mental health services multidisciplinary team meetings. SWYPFT should provide evidence at Sancus Solution's quality assurance review that this recommendation has been implemented*

This has been established. In addition, significant work has also been carried out internally to improve the monitoring of service users in the community who are under restrictions.

Recommendation 8: *SWYPFT's elderly community and inpatient mental health services should be provided with training on the Mental Health Act 1983. SWYPFT should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.*

This is mandatory training for colleagues in these teams and compliance is monitored on a monthly basis. Ongoing monitoring will be via the mandatory training dashboard, and performance will be presented at Sancus Solutions quality assurance review.

Recommendation 9: *SWYPFT's forensic services and West Yorkshire Police Authority should agree a protocol in relation to the management of patients in the locality who are under Section 37/41 of the Mental Health Act 1983. SWYPFT should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.*

Sancus recommended that joint work is undertaken with the police to agree a shared protocol in relation to the joint monitoring and care of this group of people. Given that the Trust covers both West and South Yorkshire policy areas, contact has been made with the two Chief Constables' offices and conversations have taken place about the operationalisation of this recommendation into practice. We will be able to demonstrate evidence of this joint protocol in the quality assurance review.

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 2018. As commissioners of SWYPFT care services for Kirklees residents, the Clinical Commissioning Group will also be monitoring progress against the action plan. Upon production of the final Sancus report, further detail has been provided to all Board members including progress against the recommendations included in the report.

Summary

The Trust recognises the deficits in care identified in the independent investigation conducted by Sancus Solutions and we again offer our sincere apologies for these deficits in care. The recommendations made by both our own internal investigation and that conducted by Sancus Solutions have been accepted and are largely complete. Regular review will take place to ensure these recommendations are embedded in our daily ways of working. Further exploration of embedded learning will be gained through the Trust's internal Quality Monitoring Visits. Additional assurance will be provided to Kirklees Safeguarding Adult Board in the form of a report outlining the key facts and actions.

A detailed 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.