Leeds and York Partnership NHS Foundation Trust

Assurance Statement

In response to recommendations from IODEM Independent investigation report into the care and treatment of Ms K

Reference No: 2011/21879

Introduction

NHS England commissioned an independent investigation report to elicit learning from a serious incident which occurred in October 2011, which led to the death of Mr DE. A young woman (Ms K), who had a six year history of involvement with mental health services in the period leading up to the incident was, at Leeds Crown Court, found to have inflicted stab wounds upon Mr DE and she was subsequently made subject to a Hospital Order under Section 37 of the Mental Health Act 1983, together with a Section 41 Restriction Order.

The Independent Investigation concluded that this tragic incident was neither predictable nor preventable. Significant learning points have been identified and a number of recommendations made to improve future practice and service delivery.

Following a meeting in September 2018, with services involved in the care and treatment of Ms K up to the period of the incident, it was agreed that each service would provide an assurance statement, outlining how they have developed working arrangements and practice in response to the recommendations of the report.

Recommendation 1: Encouraging collaborative working between services

The Independent Investigation Team recommends that:
The Trusts and commissioning groups involved in Ms Ks care at the time develop robust, collaborative, patient centred plans, to guide staff who care for individuals presenting with complex need 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.

LYPFT Response:

At Leeds and York Partnership NHS Foundation Trust we are fully committed to delivering coordinated, patient centred care, utilising the framework of the Care Programme Approach (CPA). The CPA is targeted at ensuring the most complex of individuals receive coordinated care which pays particular attention to points of transition, be that from in patient to community services or from one team to another. We have made a significant investment in

recent years in training and developing the practice of our staff and teams and this work is led by a full time dedicated Trust wide CPA Lead Practitioner.

Our teams are regularly audited regarding CPA performance and practice and we include within our CPA procedure, clear instructions and safeguards which need to be applied in the event of a service user moving from our Leeds based services to another city or area.

Our CPA statement of values and principles are highlighted on our staff intranet pages as follows;

- The approach to individuals care and support puts them at the centre and promotes social inclusion and recovery
- Services should be organised and delivered in ways that promote and coordinate helpful and purposeful mental health practice, based upon fulfilling therapeutic relationships and partnerships between the people involved.
- These relationships involve shared listening, communicating, understanding, clarification and organisation of diverse opinions to deliver valued, appropriate equitable and coordinated care.
- The quality of relationship between the service user and care coordinator is one of the most important determinants of success in care.
- Care planning is underpinned by long term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting agencies, not just the planned occasions when people meet for reviews.

We are determined to ensure that our services support service users to manage safely points of transition in their care and utilise best practice in line with the requirements of the Care Programme Approach.

Recommendation 2 – Aspire Early Intervention in Psychosis service

No response is required from LYPFT for this recommendation.

Recommendation 3 – Prescription of sodium valproate by LYPFT:

The Independent Investigation Team recommends that:

1. The prescription of sodium valproate by clinicians should follow the recommendations within the British National Formulary, and the guidance from the Medicines and Healthcare Products Regulatory Agency, with respect to women of childbearing age.
2. In the event of the exceptional circumstances arising in which sodium valproate may be an appropriate treatment in such patients, those patients should be fully informed, both verbally and in writing, and must have the capacity to provide informed consent. This should include information regarding the expectation of the duration of treatment, and the risks associated with discontinuation of treatment once it is established.

3. In the event that a patient lacks capacity prior to using sodium valproate, or loses capacity during treatment with sodium valproate, it should be established that this is, or remains, in the patient's best interests with reference to the Mental Health Act 1983 and the Mental Capacity Act 2005.
4. The Trust should perform an audit to confirm compliance with this recommendation.

LYPFT Response:

The prescription of sodium valproate is discussed in the Medicines Optimisation Group. This topic has also been robustly discussed at the Senior Medical Council, whereby the Lead Clinical Pharmacist attended and presented what was expected from prescribers.

A number of in house pro formas and guidance documents have been produced regarding this matter which can be submitted as evidence if required, including:

- Treatment with Valproate/Topiramate preparations for female patients: Checklist for patients and prescribers
- Treatment with Valproate preparations for female patients: Checklist for patients and prescribers
- Lessons Learnt – Valproate Prescribing
- Shared care document
- Flow chart designed by Primary care

National Audit: During September 2015, fifty-five specialist mental health Trusts within the UK, including LYPFT, participated in the baseline audit of this quality improvement programme to address the prescribing of valproate in people with bipolar disorder.

The Trust has also conducted local audits on this matter.

Recommendation 4 - **Multi-disciplinary Discussion regarding disagreements**

Crisis Resolution and Home Treatment teams have had a positive impact upon the numbers of individuals admitted to hospital. However, a key challenge faced by the Crisis Resolution and Home Treatment model of care is the potential for it to achieve close integration with other services involved with the patient in order to deliver continuity of care from a multidisciplinary perspective and not in isolation from other services or agencies in which the patient might be involved. In order to ensure that, in cases where there is a difference of opinion in relation to the decision to admit, a mechanism is developed and implemented by the three Trusts involved in Ms K's care to ensure a multi-disciplinary team discussion takes place to review the individual patient's options for care. It is recommended that the mechanism includes the following criteria:

1. If no admission is to occur, and home-based treatment is indicated, then all clinicians need to have collaboratively reached this conclusion.

   However,

2. If one assessing clinician diagnoses a mental disorder and feels admission is needed, then admission should occur, in order to assess more fully the risk.

LYPFT Response:

Our Crisis Resolution Service is responsible for gatekeeping access to inpatient beds and should be involved in all cases where an admission is being considered. We encourage multidisciplinary discussion and reflection and seek to adhere to best practice evidence and nationally developed CORE Fidelity standards. The standards specify that the Crisis Resolution Team should have a fully implemented gatekeeping role, assessing all patients before admission to acute psychiatric wards and deciding whether they are suitable for home treatment. It should not be the case that a single individual makes this decision, but rather a collaborative approach should be taken involving the multidisciplinary team, service users and their carers.

Recommendation 5 - Review of engagement strategies

The Independent Investigation Team recommends that:

1. 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.
2. 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 coordination is approached in a reflective manner.

LYPFT Response:

At LYPFT we have in place a guidance document for staff working with service users where poor engagement or disengagement is a factor. The guidance reinforces the need to make sensible and timely decisions and advises any unsure staff to seek advice from their clinical supervisor, clinical lead or safeguarding team as appropriate. (Doc ref SG – 0008)

Our CPA Practice Lead oversees comprehensive training programmes across all of our clinical services which focus upon the relational aspects of CPA in practice. Our recently revised audit focused upon person centred care which involved service users and their family/carers. We continue to place great importance on CPA as a central component in delivering safe and effective care.

Recommendation 6 – Review of internal investigation processes

The Independent Investigation Team recommends that:

1. The Trusts involved in Ms K's care at the time to consider reviewing the approach which they adopt in providing the families of those involved in incidents such as the death of Mr Edeson with information and support.

2. The Trusts 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.

LYPFT Response:

We have a robust process for our SI investigations whereby contact is made to the families at the earliest opportunity, first contact initiated by the care team offering condolence and support. The second contact is a letter to the family from the Deputy Director of Nursing. This letter details the investigation process and a request for the family to contribute to the review and includes a formal apology.
When it has not been possible to identify the next of kin we make contact with the Coroner's office to assist in forwarding a letter on behalf of the Trust.
Throughout the SI process the SI investigator meets with families and in addition shares the finding of the report. The trust attends the regional mortality meeting led by NHS Improvement and through this forum is working towards developing duty of candour guidance for all mortality reviews not only those that are identified as serious incidents.

In Sept 17 we developed a maturity matrix to identify our current position in relation to how we support bereaved families and friends. The matrix has four progress levels: 1 – Early Progress in development, 2- Firm Progress in development, 3 – Results achieved, 4 – Exemplar. In Sept 2017 we were at level 2 - Firm Progress moving to level 3 - Results achieved by March 2018. The Trust is working towards achieving exemplar in this area.

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