Assurance statement

Publication date: 18 December 2018

Assurance statement in response to two independent investigations into the deaths of Ken Godward and Roger Lamb, and the care and treatment of Harry Bosomworth, by Leeds and York Partnership NHS Foundation Trust (LYPFT) and Leeds Teaching Hospitals Trust (LTH)

This statement has been produced in response to two investigation reports.

- A report by David Curtis jointly commissioned by LYPFT and LTH which reviewed the care and treatment provided to Harry Bosomworth, published in April 2016
- A report commissioned by NHS England entitled “An independent investigation into the care and treatment of Harry Bosomworth by Leeds and York Partnership NHS Foundation Trust and Leeds Teaching Hospitals Trust” published on 18 December 2018. This report has also been published on NHS England’s website.

This statement is split into three sections.

1. The configuration of LYPFT’s Adult Liaison Psychiatry Service, how this service was structured around the time of the deaths of Mr Godward and Mr Lamb in February 2015 and how it was evolving and has developed since then as part of our ongoing commitment to improve our services.
2. LYPFT's response to the recommendations that arose from the review that was jointly commissioned by LYPFT and LTH produced by David Curtis
3. LYPFT’s response to the external review commissioned by NHS England, in so far as those recommendations relate to LYPFT.

Many of the actions in response to the recommendations in both reports were already underway prior to February 2015 and, in large part, completed or well progressed prior to the recommendations contained in NHS England’s report being made.

1. Overview of LYPFT's Liaison Psychiatry Services

Prior to late 2015, Adult Liaison Psychiatry Services were split between an older people's service (65+) and a working age service (18-65). Those services were further split according to the setting in which they were provided; i.e. in the Emergency Department and the remainder of LTH. The older people's service was provided 9-5pm seven days per week, with nursing staff providing the service at the weekend. Out of hours service provision was provided 5pm-9am by the on-call psychiatry team, which was comprised of a junior doctor who had access to an on-call Registrar and Consultant.

The older people's service was a consultant led service. It operated on the basis of receiving referrals (via a duty worker system) which were triaged and allocated according to priority. Meetings took place each weekday morning at the start of the shift to review the workload and allocate staff to undertake assessments and reviews. Every lunch time (except Wednesday) a multidisciplinary team (MDT) meeting was held at which the reviews that had taken place that day were considered and plans made for any ongoing management. On Wednesday mornings a longer MDT meeting was held, to discuss patients on the case load in detail.

Adult Liaison Psychiatry Services have developed significantly from late 2015 onwards, in accordance with both local and national initiatives which were already in inception at the time of the incident.

As part of its commitment to ongoing service review and improvement, LYPFT carried out a review of its Adult Liaison Psychiatry Services in early 2016, in partnership with LTH and the commissioners of the service (Leeds CCG). Following that review, the Trust identified ways in which its provision of Adult Liaison Psychiatry Services could be improved. Prior to this, in December 2015, LYPFT had submitted a bid to NHS England (as part of a national development programme) for additional funding to implement a planned expansion of the service to provide a 24/7 all age service within the Emergency Department in accordance with the national "core 24" initiative. LYPFT's bid was successful and funding was received in April 2016.

The funding enabled the Trust to implement the planned expansion, and five Specialist Practitioners were put in post to provide out of hours emergency mental health assessments for adolescents and provide onsite out of hours cover to the whole of LTH for acute mental health need. As indicated above, between the hours of 5pm and 9am, provision was provided by on-call doctors who often had demands within other parts of the Trust's services as well as attending to requests for patients that, during the daytime, would come under the Older Age Liaison psychiatry services.

These practitioners provided a more continuous service, and in particular access to immediate on-site advice for the care and management of patients exhibiting mental health need.

One of the challenges of providing liaison psychiatry services is providing mental health care in a different (acute) setting. Liaison psychiatry services are best provided by individuals who are familiar with the setting within which they are providing these services. Therefore, the Specialist Practitioners are based in the acute hospital which enables them to integrate with, and better understand, the workings of LTH. The Specialist Practitioners provide advice and support as required on wards at LTH, and may also support mental health assessment work in the Emergency Department when able to do so.

A gap in service provision (and associated funding) was identified between 5-8pm (the time between the end of the day shift and the Specialist Practitioners coming on duty in the evening). The funding gap was filled by Leeds CCG in 2017 and a further bid to NHS England from April 2018, which allowed LYPFT to increase the number of Specialist Practitioners within the Liaison Psychiatry Service and the number of nurses within the in-reach service (which work into the LTH wards).

From June 2018, LYPFT has provided liaison psychiatry services for adults on a 24/7 basis within LTH. Liaison services are therefore now provided by a multi-disciplinary team during core working hours (9am-5pm, Monday to Friday), and nursing and social work staff (including the specialist practitioners) between 5pm-9am on weekdays and throughout the weekend.

To further improve the provision of mental health liaison services, LYPFT submitted a bid to NHS England in late 2017 for funding to provide additional nursing resource within the Accident and Emergency department at LTH to achieve a target of reviewing all patients with mental health needs within one hour of their arrival at A&E. This was successful, and has been in place since June 2018.

Patients referred to Liaison Psychiatry Services are categorised in accordance with the urgency with which they need to be reviewed:

- Routine – review within 24 hours
- Urgent – review within 6 hours

'Open' referrals are also sent to the Liaison Psychiatry Services. In these circumstances, they undertake regular reviews within appropriate timescales based on clinical needs. The Service can also deploy staff to actively support the nursing care of patients on wards (for example, by visiting the ward on a number of occasions throughout the day and supporting the delivery of care) but this is rarely required.

More often the Service will provide advice and guidance to ward staff on how to manage a patient and will attend the ward to carry out ongoing assessments as deemed appropriate. This is similar to the approach adopted with patients in a community setting.

Liaison Psychiatry Services have seen a significant increase in the volume of activity in recent years. In particular, the service is receiving more referrals for older people from both of Leeds' emergency departments, and referrals are frequently increasingly complex and

involve Mental Health Act work. In order to meet the anticipated demand, LYPFT is currently looking to increase resource further in the Liaison Psychiatry Service, although in reality this is more about meeting an anticipated future increase in demand for such services.

LYPFT's own internal review of the Liaison Psychiatry Service highlighted an issue surrounding multiple entries in patient records. This had come about as a result of the various and differing patient record systems in place within LYPFT and LTH, which meant that the Service had to potentially make up to four separate clinical entries. This issue has been explored at length between LYPFT and LTH and has in part been addressed by the introduction of digital tablet devices, which allow the Service to make an entry in the LTHT electronic records and then cut and paste it into the LYPFT electronic records. This enables information to be shared more easily across the two organisations.

Whilst the LYPFT records remain the predominant mental health record, it is important that the LTH team treating patients has access to the necessary information in terms of assessment, treatment, care and risk. The Liaison Psychiatry Service will therefore provide an overview of key aspects of their review (e.g. risk assessment summary, medication and management guidance) in the LTH records to enable the patients mental and physical health needs to be treated in conjunction with one another.

2. Recommendations set out in David Curtis' report published April 2016

As referred to above, LYPFT and LTH jointly commissioned a review of the care and treatment provided to Mr Bosomworth. The subsequent report by David Curtis was finalised in April 2016 and included ten recommendations. LYPFT's response to those recommendations is set out below.

Recommendation 1: "Where patients admitted to acute medical wards have diagnosed serious mental illness or are prescribed antipsychotic medication, acute medical staff should, as part of the care pathway, access the early opinion of a Consultant Psychiatrist or liaison team to consider the impact of planned physical health treatment regimes as they would from a Consultant specialising in physical health problems."

LYPFT Response

LYPFT and LTH established a joint partnership group in 2016 to oversee the implementation of the recommendations and strengthen effective partnership working, in order to improve joint care delivery. In conjunction with LTH, LYPFT developed a full new Standard Operating Procedure (SOP) in 2016 relating to the admission of patients to an acute hospital with identified mental health needs. This was updated and ratified in October 2018 due to service changes. The SOP sets out information in relation to referral, assessment, recording and carer involvement. However, referral to the Liaison Psychiatry Service is a clinical decision rather than a prescriptive process and the decision to refer a patient to the Service remains a matter of clinical judgment.

The clinical teams will, if unsure about making a referral to the Liaison Psychiatry Service, will make initial contact with the Liaison Psychiatry Service to discuss whether a formal referral is needed.

As part of the development of the service, a number of activities have been undertaken within LTH to raise the profile of the Liaison Psychiatry Service, explain its role and advise on how referrals to the service should be made. These have included written communications (from September 2016 onwards), attendance at meetings within LTHT (such as the ward manager and matron forum), co-location of the specialist practitioners with site coordinators, attending handovers within LTH, and significantly increased visibility of the liaison staff.

Recommendation 2: "All mental health assessments and in particular risk assessments undertaken by LYPFT older peoples liaison team should be shared

with, and made available for, the respective acute medical team and ensure that historical and current risks are being consistently documented and appropriately assessed."

LYPFT response

This recommendation has been discussed with LTH in a series of operational meetings. The feedback from the acute medical staff at LTH is consistently that they do not want the full mental health risk assessment to be included in the patient's acute medical records; rather they want a summary of the risk(s) identified and any appropriate guidance on how to manage identified risks on the acute ward.

This information is routinely included in the medical entries made by members of the Liaison Psychiatry Service. Whilst this was the case prior to late 2015, we believe we now have a more standard and specific approach to this.

Recommendation 3: "Primarily for LTHT but also LYPFT should review how families are involved in the care and treatment of their family members; how they can support the care processes; inform both risk assessments and support plans and how services can respond to their needs."

LYPFT response

David Curtis' report acknowledges that this recommendation applies more to LTH than LYPFT. However, the Liaison Psychiatry Service recognises the important of involving patient's families and carers (when appropriate) in the care and treatment it provides to patients and routinely does so.

However, we recognise that family and carer engagement can always be improved and in light of this recommendation, this was discussed in team meetings and staff were reminded of the importance and need to involve family members and / or carers in patient's care and treatment. It is also specifically included as a section in the Operating Policy for the hospital mental health team (revised November 2018).

Recommendation 4: "Overall clinical leadership and accountability for patients in the acute hospital beds lies with the responsible consultant. Mental health services providing input to the care and treatment of medical patients also hold that same responsibility for their actions. Therefore the Trusts should review how a more integrated approach could be developed between the two specialities."

LYPFT response

A Liaison Operational Delivery Group was jointly set up in 2016 by LYPFT and LTH, which oversees the operational delivery and development of the liaison service, including any

actions/learning points that may arise from serious incident investigations and/or complaints. It is also responsible for overseeing the implementation of the new model that was developed from the review in 2016. The Liaison Delivery Group functions at an operational and clinical level and includes members from both Trusts. The Group meets approximately every six weeks and discusses how the LYPFT and LTH can best work together; including what works well and what aspects of service delivery may require improvement/refining.

However, prior to the creation of the Liaison Delivery Group in 2016 there was a longstanding history of good communication between LYPFT and LTH. For example, if a referral was made to the Liaison Psychiatry Service prior to 2016, there would generally have been a discussion between the specialities involved. Whilst these discussions took place, it was recognised that these were often carried out on an informal basis and it was agreed that it would be mutually beneficial to formalise the means of communication between the Trusts.

This led to the implementation of the Liaison Delivery Group, as referred to above. However, notwithstanding the creation of the Liaison Delivery Group, discussions will still take place across specialities at a clinical level as and when appropriate.

Recommendation 5: "Acute hospital based staff would benefit from further training in mental health issues including assessment and appropriate responses. LTHT should review its current postgraduate training for all staff to include this additional mental health training, with the local mental health services being commissioned in delivering that training".

LYPFT response

LYPFT and LTH recognise that patients' mental health and physical health needs should not be managed in isolation and vice versa. In light of this, the Trusts have jointly developed a Training and Education Group, which sets an agreed curriculum of training that is rolled out to LYPFT and LTH staff as appropriate. Prior to this, there was a long history of irregular involvement of LYPFT psychiatry staff in the training of LTH staff.

As a result, a rolling programme of joint training sessions have been developed and delivered between LTH and LYPFT. This includes sessions by the Psychiatric Liaison Service on how to assess patients with mental health needs and manage immediate risks, how to engage with such patients and how and when to obtain additional specialist support and advise from the Psychiatric Liaison Service. The aim of this training session was to give the acute staff at LTH sufficient information and understanding to identify when an individual has mental health needs that require additional specialist input and how to obtain that specialist input.

In return, mental health staff have received training from LTH staff on the assessment and management of physical health issues. LYPFT and LTH are also working together to provide a more coordinated approach to Mental Health Act management and training.

Recommendation 6: "The mental health liaison service currently operated by LTHT and LYPFT reflects national best practice guidelines that was [sic] planned and introduced many years ago. Since that time there has been a change in the dynamics/presentation of people into acute settings and the demands placed upon both Trusts that has not been reflected by a change in the commissioning of liaison services. Both Trusts [sic] together with NHS commissions should undertake a collaborative review of the Hospital Mental Health For Older People Service to ensure that it is responding to the changing needs of patients, is in line with current practice and builds on the aims and objectives described in the LYPFT Liaison Psychiatry for Older People, Hospital Mental Health Team for Older People 2014."

LYPFT response

As outlined above, LYPFT carried out a full review of its Adult Liaison Psychiatry Services in 2016. That review highlighted ways in which the service could be improved and in light of it, a revised/expanded service model was submitted to the CCG for funding consideration.

Following the Trust's successful bid, funds have been provided over time to implement the revised model. Whilst the service delivery model has been revised, the purpose and core clinical model remains essentially the same i.e. it is for the provision of mental health services within an acute Trust.

As outlined above, the changes have included increased hours to provide a 24/7 service, increased access to nursing assessment and support, the development of an all age out of hours service on site, and additional members of staff to safely implement the expanded service.

Recommendation 7: "Currently communications between the two clinical teams is not well defined. Both Trusts should review with the respective clinicians how effective communications can be pragmatically managed and improved"

LYPFT response

As referred to above, the Liaison Delivery Group has been established to formalise the communication, delivery model and shared learning between LYPFT and LTH, and this is supported by operational procedures and a joint partnership approach between the two trusts. However, there is a longstanding history of communication and collaborative working between acute medical and psychiatric staff that pre-dates the creation of the Liaison Delivery Group and the incident involving Mr Bosomworth.

Recommendation 8: "The current physical and mental health assessment documentation reflects a separate approach to care. The Trusts should review these assessments to enable a more integrated physical and mental health assessment process"

LYPFT response

As outlined above, discussions have been held between LYPFT and LTH with regards to the mental and physical health documentation/record keeping and much work has been undertaken in this area, recognising the challenges of different patient record systems.

In addition, as outlined above the Trust's Liaison Delivery Group works to ensure information sharing and shared learning outcomes, which assists and enables the Trusts to work together and provide a more integrated approach for the provision of physical and mental health care and treatment, and a specific subgroup focusses on documentation and recording.

Recommendation 9: "The review has identified multiple patient clinical information formats and systems. The Trusts should agree a collaborative approach to information recording and sharing that is in an accessible and single format"

LYPFT response

As above, LYPFT and LTH have discussed how information recording and sharing can be made more accessible across both organisations despite the different electronic patient record systems in place at each Trust. As outlined above, the Liaison Psychiatry Service has been provided with digital tablet devices which enable them to copy and paste (in whole or in part) their entries between LTH electronic patient record and the LYPFT electronic patient record. This is to be rolled out more widely.

Recommendation 10: "The review has identified a number of issues in relation to case mix and the environment of ward J19. Both Trusts should jointly review the suitability of caring for patients with primary mental health issues on an acute medical ward"

LYPFT response

This recommendation has been discussed on a number of occasions at operational and clinical level between LYPFT and LTH, recognising some potential advantages especially for people with dementia. The result of those discussions to date is that it would not be safe or practicable to create one single ward for all patients with concurrent physical and mental health needs.

The reason for this is that physical health input would be needed from a wide range of specialities and there would be practical difficulties in clinicians attending patients on an outlying ward. In addition, physical health wards are often specifically set up to meet the physical health needs of their patients, in terms of specialist equipment and nursing staff. Patients on an outlying ward would not have the benefit of these specialist resources and as a result, the care and treatment provided to them in respect of their physical health needs would not be as good as it would be on a dedicated, specialist ward.

It is our view currently that it is preferable for patients with concurrent mental and physical health needs to be treated on the specific ward for their physical health needs and for mental health input to be provided by way of liaison psychiatry services.

3. Recommendations set out in external report commissioned by NHS England, published December 2018

NHS England commissioned its own external review, which includes a number of recommendations. We have set out LYPFT's position in respect of those recommendations below, in so far as they apply to LYPFT (as opposed to LTH) and are not addressed elsewhere in this assurance statement. It is important to reiterate many of these matters were already being addressed prior to the recommendations being made.

- **The mental health needs of patients are properly addressed when they are admitted to an acute general ward**

The first recommendation made is that the LTH and LYPFT ensure that the mental health needs of patients are properly addressed when they are admitted to an acute general ward.

It has been recommended that mental health diagnoses and medications are included in the admission information and that for those patients diagnosed with schizophrenia there is an MDT discussion regarding their care. This recommendation primarily rests with LTH as the acute Trust responsible for the admission of patients to the acute general wards.

However, as outlined above, LYPFT and LTH have jointly reviewed and revised the SOP relating to the admission of patients to acute general wards who have identified mental health needs. The SOP has been developed and agreed across both organisations and sets out the circumstances in which a referral to Liaison Psychiatry Services should be made as well as the process for making such a referral.

Notwithstanding the implementation of the revised SOP, the report is inaccurate in its suggestion that in 2015 the Trusts were operating in silos; discussions would routinely be held amongst the treating clinicians across organisations. For example, with particular regard to the care and treatment provided to Mr Bosomworth, it is evidenced in the medical records that the Liaison Psychiatry Service had discussions with his treating medical team on 23 and 26 February 2015.

- **LTH and LYPFT should work together to improve the application of risk assessments and risk management in the acute hospital environment**

The second recommendation is that LTH and LYPFT should work together to improve the application of risk assessments and risk management in the acute hospital environment. It has been recommended that this work should include training for staff leadership and role modelling from clinical leaders with regular audit to demonstrate improvement. Further, it is

recommended that risk assessments and management plans for mental health patients in the acute hospital setting should be included in the clinical audit programme.

LYPFT often carries out local audits of aspects of care delivery – such as audits of clinical documentation, recording or referral processes. As an example, we have recently carried out a small audit relating to process we use to assess and plan the transporting of patients with mental health needs from LTH to mental health units.

- **LYPFT and LTH work together to ensure that there is clarity about where decisions regarding patients who are receiving treatment from both Trusts are recorded**

As outlined above, entries are made in the patient records for both Trusts. Whilst this results in some duplication, it ensures that information is readily available to staff within LYPFT and LTH. This has been supported by the development of a written procedural guide.

- **The process for undertaking future Level 2 Investigations**

Recommendation 17 relates to the process for undertaking future Level 2 Investigations. Usually, the terms of reference include a version control. Unfortunately, this did not happen in this case for reasons which are unclear. However it is submitted that this small oversight has not adversely affected the quality or scope of the investigation undertaken by David Curtis.

Following the publication of David Curtis' report in April 2016, the families raised further issues. Had those issues been raised during the investigation stage, they would have been considered and it would have been determined whether they fell within the scope of the agreed terms of reference within David Curtis' review and addressed within the resulting report.

In the circumstances, it was not possible to include the additional queries raised by the family as they were raised post-publication. It should also be mentioned that the respective families met with David Curtis and had the opportunity to input into the terms of reference of his review prior to the start of his investigation. The draft and final report were also shared with the respective families.

- **Complex Level 2 investigations team to be comprised of professionals with specialist knowledge in the clinical areas to be investigated**

The report comments that complex Level 2 investigations are to be conducted with an investigation team that is comprised of professionals with specialist knowledge in the

clinical areas to be investigated. David Curtis has the requisite specialist knowledge of acute mental health and liaison psychiatry services. Where he felt it was necessary to obtain specialist input (for example in relation to pharmacy), he sought an opinion from appropriate individuals within the relevant speciality who had not been involved in the care and treatment provided to Mr Bosomworth.

- **LYPFT and LTH consider how best to ensure that all learning from the incident that occurred on 28 February 2015 is captured**

As outlined above, the Trusts have jointly set up a Liaison Delivery Group which implements shared learning and action points arising from serious incident investigations and / or complaints. The Liaison Delivery Group meets regularly to oversee implementation of any accepted recommendations, and this is overseen by a senior partnership group at director level to provide monitoring and assurance of progress.

In addition, with regards to this specific incident, David Curtis met with the Older People's Liaison Psychiatry Service to go through his report and findings and to provide them with feedback and learning points following his detailed review.

- **LYPFT and LTH should report their progress to the Local Safeguarding Adults Board to ensure openness and to share learning**

The final recommendation that has any application to LYPFT is that LYPFT and LTH should report their progress to the Local Safeguarding Adults Board to ensure openness and to share learning. The report states that the rationale for this is that the incident has wider safeguarding implications than within the local CCG.

It is usual practice to share any learning with the safeguarding board once the outcome of an inquest has been concluded and any external commissioned report published. The directors of LYPFT, LTH and the CCG will ensure this is tabled at a future meeting.

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About Leeds and York Partnership NHS Foundation Trust:
Leeds and York Partnership NHS Foundation Trust provides specialist mental health and learning disability services to the people of Leeds and across Yorkshire and the Humber.
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