NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Assurance Statement

Publication date: 11th May 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 G following the death of Beth.

Firstly, and most importantly our thoughts are with Beth's family, and everyone affected by this tragic incident. From the external reviews commissioned by NHS England and the Kirklees Community Safety Partnership, there are identified areas of learning in our care, for which we offer our sincere apologies.

This statement has been produced in response to the two investigation reports:

- Independent review of the care and treatment of Mr G between 2014 and 2019.
- Kirklees Communities Board (Incorporating the Statutory Community Safety Partnership) Domestic Homicide Review

This statement is split into three sections:

1. The configuration of SWYPFT's Kirklees Community Mental Health Services, how these services were structured around the time of the death of Beth in 2019 and how they are evolving and have developed since that time.
2. SWYPFT's response to the recommendations that arose from the external review commissioned by NHS England (Independent review of the care and treatment of Mr G between the time of 2014 and 2019) which concluded in November 2021.
3. An update on the progress of the external review commissioned by Kirklees Community Safety Partnership.

1. The configuration of Kirklees Community Mental Health Services

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

Kirklees Community Mental Health Services composed of two main teams:

- Enhanced services – these teams deliver interventions to people under the care programme approach (CPA) with high risk

With **all of us** in mind.

and complexity. There are two enhanced teams per Kirklees locality (two in the North and two in the South).

- Core services – these teams 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 (on in the North and one in the South).

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

2. SWYPFT’s response to the recommendations that arose from the external review commissioned by NHS England

Introduction

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 two reviews; the NHS England independent investigation (which would also serve the purpose of providing an Independent Management Review IMR into the Domestic Homicide review) and the Domestic Homicide Review.

An organisation called ‘Consequence’ was commissioned by NHS England to conduct the independent investigation.

The report was concluded in December 2021. The Trust received and accepted the final version of the investigation in January 2022. The clinical team had been working on earlier recommendations from Consequence where there was clear evidence for potential learning in practice or changes required to improve quality and safety.

The final report and executive summary of the investigation was published on 11th May 2022

There are several recommendations in the Consequence report, and we have set out the Trust’s response in respect of these recommendations as follows in the following pages. It is important to reiterate that many of these concerns were already addressed prior to these recommendations being received.

Report recommendations

The final report from Consequence contains four recommendations. Our progress against these is described within the following text.

Recommendations of the report

Recommendation 1: Learning event

The Director of Nursing and Quality at the trust is tasked with organising and facilitating an Oxford Model1 learning event to ensure that the widest reflection and learning is achieved across adult services from this case.

A learning event was initially planned to take place at the SWYPFT Safeguarding conference in February 2022. However, due to the COVID-19 government guidance and the current demands on the front-line teams who we would want to engage in this event, this conference has been rescheduled for July 2022.

Recommendation 2: The Care Programme Approach and care pathways

2.1: The trust must determine the extent to which there is a gap in service provision for those service users meeting Care Programme Approach criteria, to ensure that it is aware of its risk management position in relation to this gap, and to have a clear plan for mitigating its impact.

The service has undertaken a review of its caseload and introduced a Complex Case Forum multi-disciplinary meeting, where cases that may need stepping up or require a more enhanced package of care are discussed. This will identify any gap in being able to increase provision and identify a clear plan to mitigate the impact of any gap. In addition, the Trust is currently reviewing its approach to the Care Programme Approach criteria in line with emerging national and place guidance, and Kirklees senior managers are fully engaged in this process.

2.2: For all service users identified as meeting Care Programme Approach criteria, the trust must ensure that there is an auditable and defendable approach to determining which of them are accepted onto the Care Programme Approach as a matter of priority once capacity is released.

As above, and as part of clarifying our baseline position, all cases open to the Core mental health team have been reviewed to ensure that their care and treatment is appropriate to their identified needs. Additionally, caseload management and clinical supervision provide a structure to discuss and determine who is accepted on to the Care Programme Approach. There is a route of escalation from the team managers to the senior leadership team where there are delays to transfer or where there is disagreement around the correct service

2.3: The trust has implemented a complex case forum, and other initiatives, for service users who may meet the threshold for enhanced care but cannot be accommodated on the enhanced care pathway, as well as service users who are presenting as more complex than the Core team can accommodate. The trust must audit the usage and effectiveness of the safety nets provided and provide assurance that the avenues to achieve a more enhanced and intensive

package of support are being used as intended and to identify those service users for whom an enhanced care package must be achieved.

An audit is planned of cases discussed at the North Kirklees Inter Pathway Meeting which is the multi-disciplinary team meeting to transition cases between Kirklees Community Teams in Q2 2022/23.

2.4: Where it is identified clinically that enhanced care must be delivered to a service user and the range of safety nets is not sufficient to deliver an effective or safe package of care, there must be tangible and measurable steps in the care pathway design to enable this to be escalated via the trust's risk/patient safety committees and brought to the attention of the commissioners.

The service offer has been further strengthened following this review and as part of the standard operating procedure if a service user required an enhanced package of care, the service would increase the service offer. This could include an increased number of visits, additional support from support workers or other professionals, and intensive home-based treatment or hospital admission would also be considered. Should this approach for whatever reason not be possible, escalation from the team manager to the senior leadership team would take place and oversight would be maintained through team meetings, Business Development Unit meeting, and meetings with commissioners.

2.5: The Trust Board should receive quarterly reports detailing the number of adult service users who meet the threshold for the Care Programme Approach but are not receiving this level of care package and explaining why not. Assurance regarding the delivery of safe and effective care will also be required.

This is captured as part of the Business Development Unit Risk Register, which is overseen by the operational management team. It is also discussed within the monthly local governance meetings and the service level meetings where the risk is reviewed and monitored. Any escalations of risks are discussed at the Executive Management Team meeting. The Trust is reviewing how to provide the requested quarterly reports to Board.

Recommendation 3: Risk assessment

The development team for the trust's revised approach to risk assessment and the trust's Safeguarding Lead are tasked with ensuring that:

3.1: The revised FIRM model facilitates the consistent capture and consideration of information relating to the spectrum of domestic abuse (emotional, psychological, financial, physical). This must encompass risk posed by the service user to others, not only risks to the service user. Reasonable expectations are that assessed risk will include known episodes of police and/or probation involvement in relation to such behaviours. A reasonable expectation is that the risk assessment process will triangulate what a service user reveals with these agencies where it is clear that the service user has had contact/involvement with them.

The FIRM (formulation informed risk management) risk assessment has been updated in December 2021 to reflect this action. This change has also been included in the refreshed FIRM training programme and in the Trust safeguarding training.

3.2: Information captured via FIRM that highlights safeguarding concerns for adults, adults at risk and vulnerable adults, such as domestic abuse, should trigger a force field alert for the assessing professional to consider whether a referral to adult safeguarding, or a domestic abuse agency, is necessary. If it is determined that no action is required, the system must require the professional to record their rationale for this.

As above, fields have also been made mandatory to ensure that their decision-making rationale is included.

Recommendation 4: Carer's assessments

A situation must be achieved where individuals/informal carers providing significant emotional, physical, or day-to-day living support to a service user are routinely offered a carer's assessment, and are provided with a carer's passport, by the team responsible for the care and management of the service user.

The service recognises that carers are experts by experience with regards to the person for whom they provide day to day support. The service now provides information on carer support for those who are providing significant support to a service user accessing mental health services (available via Adult social care and health | Kirklees Council and Carers' passport - South West Yorkshire Partnership NHS Foundation Trust. The Trust is continuing work to ensure it maintains oversight and assurance with regards to the offer of a carer's assessment and a carer's passport.

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.

Summary

The Trust recognises the deficits in care identified in the independent investigation and we again offer our sincere apologies for these deficits. Regular review will take place to ensure these recommendations are embedded in our daily ways of working,

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

3. **An update on the progress of the external review commissioned by Kirklees Community Safety Partnership**

The Domestic Abuse Review met for the sixth time on the 18th January 2022, version two of the draft report was reviewed, comments and updates suggested (including contacting the

independent author of the mental health homicide investigation to ensure that the executive summary is the final version for Appendix A). The family have been in receipt of the Domestic Homicide Review.

The SWYPFT action plan to address the lessons identified will be overseen by the Business Development Unit Serious Incident meeting, the Trust Safeguarding Strategic Board, Kirklees Clinical Commission Group (CCG) and the Kirklees Domestic Abuse Panel (where a challenge event will be arranged within the next 12 months and an updated report will be produced by the Domestic Abuse Panel to share with family members.

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