Agenda Item No: 5

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Report to Cambridgeshire Health Committee

Follow – up to 16th January 2018 meeting regarding the Health Service Ombudsman's report into the death of Averil Hart

1.	**INTRODUCTION / BACKGROUND**
	The Health Committee requested a follow up report after the January 2018 meeting where the findings of the Health Service Ombudsman's Report regarding delivery of services by CPFT was discussed.
2.	**BODY OF REPORT**
	The Committee has requested an update in the following areas: • Progress on the internal CPFT Action Plan which was being implemented to identify risks and how they were being mitigated • Discuss CPFT policy around closer working with Universities • Update on why the anonymised case study had been withdrawn from the Marsipan Guidelines • Update on how the CEO was being informed of the service pressures within the Eating Disorder services. • Progress made against Ombudsman recommendations • Communications with Mr Hart
2.1	**Progress on the internal CPFT action plan**
	The action plan has been implemented. Many of the areas of action were considered by the CQC whilst undertaking their recent inspection of eating disorder services within the Trust. There are areas of the action plan that continue to be further developed, mainly as part of quality improvement work across the Trust. The impetus for these developments has come directly from reviews of serious incidents and feedback from families and carers. These areas include: • Continued work to develop and improve the care planning approach used in the Trust • Development of the centralised human resources management system to include records of staff supervision so that adherence to supervision requirements can be monitored • Introduction of mandatory training for all clinical staff on involving families and carers as partners in care

	• A family liaison officer has been appointed to support carers/ relatives following the death of a person in our care • Complaints management timelines are being monitored and reviewed to improve the timeliness of complaints responses • The Serious Incident process has been revised as part of work with the Royal College of Psychiatrists. Improvements include the involvement of carers / relatives in the review process. In addition the Trust has led work with NHSI and the CCG to ensure that any serious incidents that involve patients under the care of the Trust Eating Disorders Services and other providers, such as acute trusts, will be declared once as a Serious Incident, and investigated once on behalf of all organisations involved. NHSI, NHS England and the CCG are involved in work to establish these investigations as they are needed. In this way we are ensuring that the learning from Mr Hart regarding multiple investigations and complaint handling is remedied going forwards. The CCG has taken the local co-ordinating lead for this. In early Autumn the Trust will lead a regional seminar regarding safe and effective care for patients with severe anorexia nervosa, focussed on where care is shared with GPs and where patients present with acute physical ill health. We will use good practice learning and development between the Norfolk Community Eating Disorders Services and the Norfolk and Norwich Hospital to lead this seminar. We will also have a clear focus on the need for acute staff to recognise how seriously vulnerable ents to life threatening physical ill health patients with anorexia are as a result of extreme frailty not usually seen in younger people. The regional eating disorders network are also going to assist with the planning of this event.
2.2	**Discuss CPFT Policy regarding closer working with Universities**
	The protocol for the Norfolk community service to work with the local University was developed in 2014. This is currently being revised and updated. The protocol sets out steps to be taken especially over the long summer vacation. It includes ensuring arrangements are made for medical monitoring, for psychological support, and, particularly for high risk patients, transfer to a local specialist service over the vacation if it is not feasible to retain direct management by the community service. The importance of involving families in the care planning is explicit within the protocol. The service has also provided teaching and training to the UEA Counselling Service and also to ARU Counselling Services. When young people in the care of eating disorder services move to our area to start University, the CPFT service liaises with the transferring service, and consults with the university / college nurses, support services and students GPs. For students leaving our area, we make contact with their University Wellbeing Services and the GP.
2.3	**Update on why the anonymised case study was withdrawn from the Marsipan guidelines**

	The Marsipan guidelines are national guidelines. The author of the guidelines made the decision to remove the case study from the appendix. This was not a decision taken by the Trust.
2.4	**Update on how the CEO was being informed of the service pressures within the Eating Disorder services.**
	It is not possible for me to report on how the CEO was being informed of service pressures in 2012. The current arrangements for keeping me informed of service pressures include: • Monthly directorate performance and risk meetings with the executive team, chaired by the Chief Executive, where issues relating to service pressures, risk and delivery for each service in the Trust are escalated. Eating Disorder services are considered and discussed in these meetings. • Attendance of the Chief Executive at the Quality, Safety and Governance subcommittee of the Board where issues with quality and safety in any service is discussed. • Reports to the Executive Committee (chaired by the Chief Executive) for decision making in response to service pressures. This applies for all services and has been utilised by the eating disorder services when necessary. These meetings are reported to the Trust Board in the Chief Executives report bi-monthly. • Stop the Line processes exist for any staff member to highlight direct to the executive is service pressures need to be addressed immediately. • All staff are notified of the Freedom to Speak up process – which reports to the Director of Nursing and Quality, the Chief Executive and to the Quality and Safety and Governance sub committee of the board • In addition I visit services and report to the Board on these visits, I also have direct meetings with staff from services in order to support them with service delivery, with making the case for additional resources and with managing the delivery of high quality services. This has included a visit to the eating Disorders ward, to the Children and Young People eating Disorder unit and attendance at a high risk patients monitoring meeting to observe first hand how the policy is implemented in practice. • The Trust has a system of operational risk registers for each service. These risks are assessed, actions to mitigate documented, and risks reassessed at regular intervals. The service operational risk registers are compiled and reviewed at the service directorate level, and then corporately. The high level risks are reflected in the Board Assurance Framework. These risk management registers are reviewed at the above executive and board meetings and sub committee meetings to ensure risk is recognised and managed.
2.5	**Progress made against Ombudsman recommendations**
	The Ombudsman asked CPFT to: • Apologise in writing to Mr Hart and his family for the injustice they suffered as a result of the failings the Ombudsman found • He asked that we send the letters to Mr Hart within one month of the report and that the letters were copied to the Ombudsman • They asked that CPFT pay Mr Hart £3000 compensation and write to the Ombudsman to confirm this • The Ombudsman asked that each organisation (and therefore CPFT) write to Mr Hart to explain what they have done with regard to lessons learned and actions taken.

	These actions have been complied with and the Ombudsman has written to say that they are satisfied that CPFT has complied with their recommendations. In addition the Trust is developing a seminar for the East of England Region for early Autumn as described above.
2.6	**Communications with Mr Hart**
	The Trust has communicated with Mr Hart as described above in relation to the request of the Ombudsman. There is also a piece of work in progress to seek to find answers to the questions Mr Hart continues to have regarding the service his daughter received. I have kept this work under close review and this is almost complete. Once complete this will be shared with Mr Hart. Mr Hart and myself have agreed that a meeting with the team would be beneficial. However we need to ensure that the facilitator of this meeting has the confidence of the staff as well as the confidence of Mr Hart. Unfortunately a letter sent by Mr Hart by post was not received by the Trust so there has been a delay in arranging this meeting. The most recent proposal is that a member of the Health Committee undertake this role of facilitator, and this seems like a very satisfactory way forwards.
3.0	**Report from CQC regarding CPFT Eating Disorder Services – June 2018**
	As stated above the Trust received the CQC report in June 2018. The CQC inspected ten core services including specialist mental health services for people with an eating disorder. The Trust also had an inspection of the 'Well-led' domain. The eating disorders service was rated as 'good'. The summary report findings are as follows: " Our rating of the service stayed the same. We rated it as good because: • There was a culture of learning to ensure improvements were made and maintained in this service. Staff were encouraged to report incidents and received timely feedback. There was evidence of learning from incidents, which was shared across the service. Staff used appropriate governance frameworks, risk management strategies and quality monitoring measures to improve patient care, safety and outcomes. There were effective processes in place to assess and escalate deteriorating patients. • Staff provided care and treatment in line with national guidance and good practice. The service monitored the effectiveness of care and treatment through local and national audits. • The multidisciplinary team worked in partnership with patients, families and carers. Staff interacted with patients and their carers in a caring, polite and friendly manner. They were aware of the need to provide emotional support for patients, families and carers. This included providing a variety of therapeutic approaches. There was a range of information and support available for patients, families and carers. • Senior managers were visible, approachable and supportive. Staff were supported to develop their knowledge and skills whilst working in this service. However: • Staff at the Phoenix centre did not have access to suitable equipment for searching patients" The safety domain was assessed as 'requires improvement' due to drawing pins being used on noticeboards and drawing pins and a stapler being available in the resource room. Also the CQC were concerned that in the Phoenix unit patients had hair straighteners and there was a comb with a spiked handle. They were also concerned that patients might be able to construct a ligature from pipe cleaners (used for art work). All these issues have been addressed.

	There is also a recommendation that Phoenix Unit has its own metal detector rather than borrowing one from the adjacent ward to search patients. The report found that risks are well managed, that the risks posed by staffing levels are managed well, and that there is good senior management support and visibility. Phoenix Unit was identified as having outstanding practice in relation to activities for patients. There are recommendations to ensure that staff recruitment and training efforts continue to be actively managed and monitored. All of these areas are included in the trust CQC action plan (currently under development in response to the report.) I
4.0	**Conclusion**
	The Trust recognises the failings established in the Ombudsman's Report and is sorry for the tragic death of Averil Hart. The Trust has responded with seriousness to the findings, and has put the action plan in place with good rigour. Anorexia has a high mortality rate and our patients are often classified as high risk. They are also vulnerable to physical ill health and there is more to do to ensure wider understanding of this. The Trust will continue to ensure the actions are embedded and built on; that the learning is shared across the Trust and to other providers; and that we continue to develop eating disorder services to ensure they deliver good outcomes and that they are services that staff choose to work in.

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Date: 4th July 2018