Report of the Strategic Director Adult and Community Services to the meeting of the Social Care Improvement Committee to be held on the 20 January 2010

O

Subject: **Independent review into three serious untoward Incidents and subsequent developments in the learning disability services in Bradford.**

Summary statement:

Yorkshire and the Humber Strategic Health Authority (YHSHA) commissioned an independent review in association with City of Bradford Metropolitan Council (CBMDC), NHS Bradford and Airedale (BAPCT) and Bradford District Care Trust (BDCT) to identify themes and learning from the individual investigations into the deaths of three people who were users of the learning disability services provided by BDCT. The review includes reviewing three unexpected deaths of people receiving learning disability services from Bradford District Care Trust, the actions taken and progress made as a consequence of the Care Quality Commission inspection reports of Highfield Unit and Weaver Court.

The review was also asked to consider whether that the new Commissioning Strategy for people with learning disabilities required any amendment as a consequence of the review findings.

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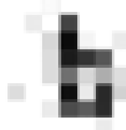
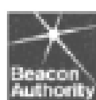
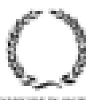
Overview and Scrutiny Area:
Social Care







1. **Summary**

1.1 Yorkshire and the Humber Strategic Health Authority (YHSHA) has commissioned an independent review in association with City of Bradford Metropolitan District Council (CBMDC) , NHS Bradford and Airedale (BAPCT) and Bradford District Care Trust (BDCT) to identify themes and learning from the investigations into three serious untoward incidents involving people who were receiving learning disability services provided by BDCT. The review includes reviewing three unexpected deaths of people receiving learning disability services from BDCT. The actions taken and progress made as a consequence of the Care Quality Commission inspection reports of Highfield Unit and Weaver Court.

The review was also asked to consider whether the new Commissioning Strategy for people with learning disabilities required any amendment as a consequence of the review findings.

2. Background

2.1 On 13 May 2009 the Committee resolved to receive a report on the unexpected deaths of residents at Weaver Court from the Strategic Director of Adult and Community services. The Strategic Health authority has included a review of an unexpected death of a patient in the Highfield Unit in this independent review. In the past 18 months three other Weaver Court residents have died and after thorough review are not classed as unexpected by the Coroner therefore they are not included in this report.

2.2 This independent review report has included an assessment of the actions and progress made as a consequence of the Care Quality Commission (CQC) inspection reports into Highfield Unit and Weaver Court. On 13 May 2009 this Committee also resolved to receive a report on the CQC inspection reports on Weaver Court, the reports were presented to the Committee on the 16 July 2009.

2.3 The Independent reviewer has reviewed Bradford District's learning disability commissioning strategy "Changing lives through real partnership" to identify any additional actions as a consequence of the independent review. The reviewer has endorsed the implementation of the Commissioning Strategy and recommended that implementation is accelerated and performance managed by the Council and NHS Bradford and Airedale.

The Committee received a progress report on the learning disability programme at the 16 September 2009 meeting and resolved to support the establishment of the Learning Disability Programme and receive regular progress reports. Councillor McPhee was nominated to act as link member to the programme.

2.4 The Social Care Improvement Committee has received reports on the "Changing lives through real partnership", learning disability change programme. The most recent 16 September 2009.

2.5 Three unexpected deaths occurred during 2008 of people who were receiving learning disability services provided by Bradford District Care Trust (BDCT).These incidents were individually reported to NHS Yorkshire and the Humber , the

Strategic Health Authority (SHA) and each has been the subject of an individual investigation report and action plan.

2.6 In March 2009 the Healthcare Commission (HCC) and the Commission for Social Care Inspection (CSCI) now merged into the Care Quality Commission undertook an unannounced visit to BDCT learning disability services. Following this a series of performance management meetings commenced in April 2009 to respond to the issues raised. The Strategic Health Authority also undertook a further joint review of the three unexpected deaths.

2.7 NHS Bradford and Airedale, the Council and Bradford District Care Trust asked the SHA to commission this independent review. The full report is attached as Appendix 1.

2.8 The report was not received until Friday 8th January 2010. There has not been sufficient time to include written individual responses from the agencies or an action Plan although representatives will be attending the Committee. Work is underway between all agencies to develop the Action Plan and will be available for Committee to comment on.

3 Conclusions of the Independent Review

3.1 The key driver for the report into the deaths was to identify any system failures, learn lessons and ensure subsequent plans in place such as the learning disability commissioning strategy was sufficient or would need additional actions as a result of the review.

3.2 The HCC, CSCI and CQC inspection reports had identified substandard care, but a lot of work has already taken place to address those issues as has been recognised by CQC with the closure of the case by the investigating team and the change in quality rating.

3.3 In the three serious untoward incidents investigation (SUI) reports the reviewer has stated that there are some outstanding questions which have been identified within this report with actions identified in the recommendations. A full reinvestigation of these cases now may not produce any further information to answer the outstanding questions as the initial investigators had access to what information was available and did not identify the answers. Although the SUIs were reported by BDCT the investigations raised issues for primary care, community care and acute care as well as BDCT. The action plans that have been produced deal with the system issues, the reduction of risk for other service users and lessons to be learnt. All action plans are and continue to be performance managed to completion by the agencies involved and overseen by the Commissioners.

3.4 The Care Quality Commission reports identified poor practice in the Highfield Unit and Weaver Court but it has been acknowledged by the Care Quality Commission and the author of this report that a lot of work has already taken place to address those issues. The commissioners, the Council and BAPCT now have a joint quality review group to monitor the quality of services provided by BDCT and this is included in the revised Section 75 Partnership agreement which is to be submitted for comment to this committee at a future meeting.

3.5 The author concludes that if the existing learning disability commissioning strategy "Changing lives through real partnership" is fully implemented over the next two years as planned then there is the potential to avoid the system risks evident in the SUI reports and CQC reports. It recommends that implementation of the strategy is performance managed. The Committee has resolved at the 16 September 2009 meeting to receive regular progress reports.

4. Independent Review Recommendations

4.1 **NHSB&A** should ensure that holistic care assessments and appropriate documentation is used by all providers, including Primary Care services, in the care of all people with learning disabilities.

4.2 **NHSB&A** should continue to performance manage all relevant providers (BDCT, Bradford Teaching Hospitals Foundation Trust, Bradford and Airedale Community Health Services) to completion of the combined action plans arising from all three SUIs and then audit subsequent impact.

4.3 **NHSB&A** should ensure commitment to agreed standard clinical processes based on the best evidence around the management of PEG feeds, and ensure that this is delivered through the contracting process.

4.4 **CBMDC and NHSB&A** should ensure that the arrangements are in place to performance manage the introduction of the Learning Disability Commissioning Strategy as rapidly as possible so that the system risks and safeguarding issues identified are reduced.

4.5 **CBMDC and NHSB&A** should use the local 'Valuing People' Board to ensure that lessons learnt are spread throughout the services in Bradford and the 'Valuing People Now' and 'Healthcare for All' strategies are introduced.

4.6 **CBMDC and NHSB&A** should raise the profile of the commissioned Independent Mental Capacity Advocate services to ensure that providers of services seek their involvement when dealing with vulnerable people that may have capacity issues.

4.7 **CBMDC and NHSB&A** should ensure through the commissioning process that adult safeguarding is a high priority within all partner organisations within the Bradford district. The organisations should adhere to joint safeguarding procedures set out in the commissioning process, and practice should be regularly monitored.

4.8 **NHSB&A and YHSHA** should ensure that investigations that take place across multiple organisations are resourced and supported appropriately by the organisations involved so that the investigating teams have an appropriate membership and mix of skills and have access to appropriate records and staff to produce robust investigating reports following the NPSA guidance and root cause analysis.

4.9 **YHSHA and ADASS** (Association of Directors of Adult Social Services) should use the Healthy Ambitions Learning Disability Pathway Group, Yorkshire and Humber ADASS and the Valuing People Support Team to spread best practice for Learning Disability Service Users throughout the region.

4.10 **YHSHA and ADASS** should raise the profile of adult safeguarding across the region and ensure that SUIs that raise safeguarding issues are referred to the relevant multiagency adult protection processes.

4.11 **YHSHA** should consider for closure the SUI 2008/2958.

4.12 **YHSHA** should use the Healthy Ambitions Delivery Board to ensure that the care pathways being developed take into account the needs of vulnerable adults to meet the physical health needs and maintain the well being of people with learning disability.

4.13 **YHSHA** should publish this independent review and share with the organisations involved so that their own governance arrangements can address the necessary changes. Further, it should ensure learning from these events is facilitated across the region. It should also share a copy with the Care Quality Commission and National Patient Safety Agency.

4.14 **YHSHA's** Internal Review Panel should consider this independent review and take a view on the need for further investigation and the recommendations made.

5. Options

5.1 That the Social Care Improvement Committee receives regular updates on progress made in implementing the Learning Disability Programme this will ensure the social care elements of improvements are reported to the committee.

5.2 The Health Improvement Committee receive regular updates on the progress made in implementing the Healthier Lives project which is within the overall programme this will include specific updates on the action plans arising from the review that relate to health.

5.3 Regular reports from the Safeguarding Board should be presented to the Committee.

6. Financial Appraisal

6.1 There are no financial implications arising out of the recommendations in this report. Any financial implications arising out of the implementation of the recommendations will be considered when the action plans are prepared.

7. Legal Appraisal.

7.1 There are no legal implications arsing out of the recommendations in this report. Any legal implications arising out of the implementation of the recommendations will be considered when the action plans are prepared.

8. Other implications

8.1 There are no specific equal rights, sustainability, community safety or human rights action implications arising out of the recommendations in this report. Any such implications arising out of the implementation of the recommendations will be considered when the action plans are prepared.

9. **Trade Union**

9.1 The Trade Union, Unison, have and will continue to be engaged throughout the process.

10. Contribution to corporate priorities

10.1 The learning disability programme links into the Personalisation programme which is one of the corporate programmes for 2009/10 and contributes to the Big Plan supporting the health and well being objective. In addition it supports the Dignity agenda for Adult Social Care.

11. Recommendations

11.1 That the Social Care Improvement Committee receives regular updates on progress made in implementing the Learning Disability Programme.

11.2 The Social Care Improvement Committee receive a further report with agency responses including the action plan derived from the report and subsequent progress on the action plan.

11.3 The Health Improvement Committee receive regular updates on the progress made in implementing the Healthier Lives project which is within the overall programme.

11.4 Regular reports from the Safeguarding Board should be presented to the Committee

12. Background documents

"Changing lives through real partnership "commissioning framework for learning disability services 2007-2012.

Report of the Programme Director, Learning Disabilities to the meeting of the Social Care Committee held on 16 September 2009.

13 Not for publication documents

None.

14. Appendix

Independent Review into three serious untoward incidents and subsequent developments in the learning disability services in Bradford.

Author Paul Farrimond RGN RMN MBA Dip HSM.

P.F. Consultancy Ltd

INDEPENDENT REVIEW INTO THREE SERIOUS UNTOWARD INCIDENTS AND SUBSEQUENT DEVELOPMENTS IN THE LEARNING DISABILITY SERVICES IN BRADFORD

COMMISSIONED BY:

YORKSHIRE AND HUMBER STRATEGIC HEALTH AUTHORITY

IN ASSOCIATION WITH:

CITY OF BRADFORD METROPOLITAN DISTRICT COUNCIL
NHS BRADFORD AND AIREDALE
BRADFORD DISTRICT CARE TRUST

PAUL FARRIMOND
RGN RMN MBA DipHSM
4th January 2010

CONTENTS

		Page
1.	INTRODUCTION	3
2.	EXECUTIVE SUMMARY	4
3.	TERMS OF REFERENCE	7
4.	DOCUMENTS REVIEWED	8
5.	SERIOUS UNTOWARD INCIDENT 2008/2958	9
6.	SERIOUS UNTOWARD INCIDENT 2008/5265	11
7.	SERIOUS UNTOWARD INCIDENT 2009/2860	15
8.	HEALTHCARE COMMISSION and CARE QUALITY COMMISSION REPORTS	20
9.	A COMMISSIONING FRAMEWORK FOR LEARNING DISABILITY SERVICES (2007-12)	24
10.	DISCUSSION	27
11.	CONCLUSION	33
12.	RECOMMENDATIONS	34
13.	APPENDIX A: GLOSSARY OF TERMS	36

1. INTRODUCTION

In March 2009, the Healthcare Commission (HCC) with the Commission for Social Care Inspection (CSCI) undertook an unannounced visit to services within the Bradford District Care Trust (BDCT) learning disability services. Following this visit and the resulting report a series of performance management meetings commenced in April 2009 to respond to the issues identified in the report. The Strategic Health Authority also reviewed the previously reported Serious Untoward Incidents (SUIs) for the previous 18 months and identified three SUIs that occurred in 2008 involving the deaths of three people who were service users of the learning disability services provided by BDCT. These SUIs had previously been the subject of an individual investigation report and action plan, but it was decided to revisit these three SUIs together as a potential cluster.

Yorkshire and the Humber Strategic Health Authority (YHSHA) has commissioned this independent review in association with City of Bradford Metropolitan District Council (CBMDC), NHS Bradford and Airedale (NHSB&A) and BDCT to draw out the themes and learning from the investigation reports and three SUIs as set out in the terms of reference below.

This report is a review of the previous SUI investigation documentation, the HCC, CSCI and Care Quality Commission (CQC) reports and in light of those reviews a consideration of the current district commissioning strategy. In producing this review the independent reviewer has not interviewed anyone including the relatives, staff involved in the events themselves or staff involved in the production of the investigatory reports. The independent reviewer has based this report upon the documentation made available and these documents are listed in Section 4. Any information that is taken directly from those reports is set out in *italics* throughout the independent review report. This is not intended to be a re-investigation of the previous investigations and as such is reliant upon the content of the previous investigations. The organisations involved have been given the opportunity to amend factual points in this review. The independent review was written to inform the discussions of the existing internal review panel set up by YHSHA.

I would like to thank Heather Raistrick Strategic Lead Adult Services YHSHA, Dr Peter Dickson Medical Director NHSB&A, Lyn Sowray Joint Programme Director CBMDC and NHSB&A, and Nick Morris Director of Strategy and Nursing BDCT for their help and support in locating reports and information to allow this independent review to be completed in a short timescale.

The abbreviations used in this report are set out in Appendix A.

2. EXECUTIVE SUMMARY

In March 2009, the HCC with CSCI undertook an unannounced visit to part of the BDCT learning disability services. Following this, a series of performance management meetings commenced in April 2009 to respond to the issues raised. The Strategic Health Authority also revisited the serious untoward incidents (SUIs) reported over the previous 18 months. This review identified three SUIs that occurred during 2008 involving the death of three people who were users of the learning disability services provided by BDCT. These incidents were individually reported to Yorkshire and the Humber Strategic Health Authority (SHA) and each had been the subject of an individual investigation report and action plan.

The Strategic Health Authority, in association with CBMDC, NHSB&A and BDCT, commissioned this independent review to draw out the themes and learning from the regulators' reports and the three SUIs, to identify any additional learning points and make recommendations as appropriate. As part of the independent review, consideration was given to the existing Learning Disability Commissioning Strategy to identify any additions that may be required in light of the independent review.

The existing Learning Disabilities Commissioning Strategy once fully implemented has the potential to avoid the system risks evident in the SUI reports and the HCC, CSCI and CQC reports. However, risks remain during this implementation phase and the performance management of its implementation should be progressed as rapidly as possible by CBMDC and NHSB&A.

The Care Quality Commission came into being on 1st April 2009 and brought together the three inspection organisations the Healthcare Commission (HCC), The Mental Health Act Commission (MHAC) and the Commission for Social Care Inspection (CSCI).

The HCC, CSCI and CQC inspection reports had identified substandard practice, but a lot of work has already taken place to address those issues as has been recognised by CQC with the closure of the case by the investigating team and the improvement in quality rating. The action plans need to be performance managed to completion by BDCT and the commissioners. The lessons learnt from these reports should be shared widely to ensure that other organisations can also put in place systems that improve the care for the learning disability service users.

In the three SUI investigation reports we were left with some outstanding questions and these have been identified in the report and specific actions identified in the recommendations below. However, a full reinvestigation of these cases now may not produce any further information to answer these outstanding questions as the initial investigators had access to what information was available and did not identify answers. It should be noted that although the SUIs were appropriately reported by BDCT the investigations raised issues for primary care, community care and acute care as well as BDCT. The action plans that have been produced deal with the system issues, the reduction of risk for other service users and lessons to be learnt. All action plans should be performance managed to completion.

The recommendations of this independent review are:

1. **NHSB&A** should ensure that holistic care assessments and appropriate documentation is used by all providers, including Primary Care services, in the care of all people with learning disabilities.

2. **NHSB&A** should continue to performance manage all relevant providers (BDCT, Bradford Teaching Hospitals Foundation Trust, Bradford and Airedale Community Health Services) to completion of the combined action plans arising from all three SUIs and then audit subsequent impact.

3. **NHSB&A** should ensure commitment to agreed standard clinical processes based on the best evidence around the management of PEG feeds, and ensure that this is delivered through the contracting process.

4. **CBMDC and NHSB&A** should ensure that the arrangements are in place to performance manage the introduction of the Learning Disability Commissioning Strategy as rapidly as possible so that the system risks and safeguarding issues identified are reduced.

5. **CBMDC and NHSB&A** should use the local 'Valuing People' Board to ensure that lessons learnt are spread throughout the services in Bradford and the 'Valuing People Now' and 'Healthcare for All' strategies are introduced.

6. **CBMDC and NHSB&A** should raise the profile of the commissioned Independent Mental Capacity Advocate services to ensure that providers of services seek their involvement when dealing with vulnerable people that may have capacity issues.

7. **CBMDC and NHSB&A** should ensure through the commissioning process that adult safeguarding is a high priority within all partner organisations within the Bradford district. The organisations should adhere to joint safeguarding procedures set out in the commissioning process, and practice should be regularly monitored.

8. **NHSB&A and YHSHA** should ensure that investigations that take place across multiple organisations are resourced and supported appropriately by the organisations involved so that the investigating teams have an appropriate membership and mix of skills and have access to appropriate records and staff to produce robust investigating reports following the NPSA guidance and root cause analysis.

9. **YHSHA and ADASS** should use the Healthy Ambitions Learning Disability Pathway Group, Yorkshire and Humber ADASS and the Valuing People Support Team to spread best practice for Learning Disability Service Users throughout the region.

10. **YHSHA and ADASS** should raise the profile of adult safeguarding across the region and ensure that SUIs that raise safeguarding issues are referred to the relevant multiagency adult protection processes.

11. **YHSHA** should consider for closure the SUI 2008/2958.

12. **YHSHA** should use the Healthy Ambitions Delivery Board to ensure that the care pathways being developed take into account the needs of vulnerable adults to meet the physical health needs and maintain the well being of people with learning disability.

13. **YHSHA** should publish this independent review and share with the organisations involved so that their own governance arrangements can address the necessary changes. Further, it should ensure learning from these events is facilitated across the region. It should also share a copy with the Care Quality Commission and National Patient Safety Agency.

14. **YHSHA's** Internal Review Panel should consider this independent review and take a view on the need for further investigation and the recommendations made.

The Learning Disability Services in Bradford and Airedale have improved greatly since the SUI investigations were instigated. There are still areas for improvement and the outstanding action plans should be performance managed to conclusion. The Commissioning Strategy has the potential to ensure the system risks are removed and that the services provided are of a high quality. It should be recognised that change has been achieved and that the effort should be focused on implementing the commissioning strategy rather than past events.

3. TERMS OF REFERENCE

The independent reviewer of the investigations was commissioned by the SHA to work with the existing review panel to produce a report covering the following areas.

1. Review the three individual SUI reports and accompanying action plans to assess the robustness of the action plans against the investigation findings.

2. Review the actions taken and progress made as a consequence of the HCC and CQC inspection reports in relation to Highfield Unit and Weaver Court.

3. In the light of the above to:
    a. Identify causes of any system failure
    b. Identify lessons learnt
    c. Identify any additional actions for organisations in the health and social care economy

4. Review the District's existing strategic plan for learning disabilities and identify any additions to be included as a consequence of the above findings.

The three SUIs are:

SUI Reference	Place of service user's residence	Date reported to SHA	Details
2008/2958	Highfield Unit	9.4.2008	Death of service user - choking incident
2008/5265	Weaver Court	23.6.2008	Death of service user who had required emergency bowel surgery
2009/2860	Weaver Court	Watching Brief: 17.2.2009 SUI reported: 27.3.2009	Death of service user with complex health needs.

4. DOCUMENTS REVIEWED

SUI 2008/2958

- STEIS report 2008/2958 (9.4.2008)
- Investigation report 2008/2958 (16.5.2008)
- Investigation action plan 2008/2958 (no date)
- SHA review of SUI 2008/2958 investigation report and action plan (19.11.2008)
- Coroner's narrative 2008/2958 (no date)
- BDCT action plan 2008/2958 (August 2008)

SUI 2008/5265

- STEIS report 2008/5265 (23.6.2008)
- Investigation report 2008/5265 (3.9.2008)
- Investigation action plan 2008/5265 (no date)
- SHA review of SUI 2008/5265 investigation report and action plan (9.12.2008)
- Response from BDCT to questions raised by SHA review of SUI 2008/5265 (no date)
- Consultant Pathologist report SUI 2008/5265 (20.8.2008)
- BDCT action plan 2008/5265 (October 2008)

SUI 2009/2860

- STEIS report 2009/2860 (27.3.2009)
- Investigation report 2009/2860 (7.9.2009)
- Combined investigation action plan 2009/2860 (26.8.2009)
- SHA review of SUI 2009/2860 investigation report and action plan (27.10.2009)

Reports and Notes of Meetings

- HCC letter following unannounced visits on 12th and 13th March 2009 (16.3.2009)
- BDCT: Terms of Reference for examination of recent deaths reported to SHA within the last 18 months (no date ?April 2009)
- CQC random inspection report – Weaver Court and Branwell Lodge(17.6.2009)
- CQC Key Inspection Report – Weaver Court (19.10.2009)
- Terms of reference for the independent review of SUIs over the last 18 months in Learning Disability Services in Bradford District Care Trust. (no date)
- Notes/actions of meeting held on 6.4.2009 between SHA, NHS Bradford and CCBMDC (City of Bradford Metropolitan District Council)
- Notes of meeting between SHA, NHS Bradford, BDCT and Bradford MDC on 3.6.2009
- Review panel meetings 15.6.2009, 8.9.2009 and 9.9.2009.
- Bradford Learning Disability Notes 30.6.2009
- Bradford Learning Disability Notes 11.9.2009
- Amalgamated action plan and updates for weaver Court Part A and Branwell Lodge Part B (version 7 updated 6.11.2009)
- HCC easy read report on Highfield Unit (no date)
- Changing lives through real partnership, a commissioning framework for learning disability services – a model [2007-12]. Published November 2007.
- Changing lives through real partnership action plan updated October 2008
- Update Highfield action plan February 2008
- BDCT Service Governance committee minutes for 7th march 2008
- CQC letter closing the case dated 16th July 2009

5. SERIOUS UNTOWARD INCIDENT 2008/2958

The incident occurred on 4.4.2008 when a 39 year old male learning disability service user choked on his evening meal at the Highfield Unit, a Learning Disability Inpatient unit. The unit staff, ambulance staff and A&E staff were unable to resuscitate the service user.

The Coroner's Narrative report at the inquest stated:

> *"(The service user) died on the 4th April 2008 at Lynfield Mount Hospital, Bradford of Asphyxia due to Inhalation of Food, a contributory factor being Down's Syndrome. He had developed a propensity to choke on food, which risk had been recognised in the Care Plan devised to minimise that risk. On the day he died as soon as he began to eat, and before action could be taken to prevent it, he inhaled mashed potato to such a degree that all efforts to save him failed."*

The incident was reported to the SHA via the STEIS system on 9.4.2008 and an internal investigation was commenced by Bradford District Care Trust. The investigation was completed in May 2008 and an action plan was produced. The investigation report and action plan was clinically reviewed by the SHA in November 2008.

The investigation report followed National Patient Safety Agency (NPSA) root cause analysis recommended processes and produced recommendations that were related to the actual incident and to the general improvement in care and safety for all service users. During the internal investigation the report notes that the next of kin were contacted and the investigation was discussed with them. The next of kin contribution can be seen in the report and they are reported as thinking highly of the staff involved in the service user's care and were well aware of the risks his behaviour produced. The timeline in the internal investigation report only runs until 25th March 2008 and there is then a gap from then until the incident on 4th April 2008. The internal investigator stated that the timeline is only a summarised chronology of relevant events in the report. The reader of the report is left to assume from this approach that nothing significant happened in the days from 25th March to the incident. The internal investigation report does not describe the actual incident and actions taken in one place in the report. The reader of the report has to search through the report to find out what happened. In the *'introduction'* the choking incident and resuscitation attempt was mentioned. It is some 8 pages later that one finds, under the section entitled *'dietary management'*, that the service user was being supported with his meal and another 2 pages later, under the section entitled *'route cause'*, that one finds out that the service user choked on one of the first mouthfuls of his meal. Fortunately all of this was brought together for the Coroner's benefit, allowing him to make the narrative report set out in the box above.

The internal investigation report made recommendations to deal with the issues identified. These covered dietary management, equipment, staff training, communication, staff issues, risk assessment and service issues. The YHSHA clinical reviewer recommended strengthening the recommendations and questioned why an Ambulance Technician from Yorkshire Ambulance Service (YAS) had attended the emergency call rather than an Ambulance Paramedic. Ambulance Emergency Medical Technicians are trained in the emergency management of choking and where they are the nearest available resource they will be dispatched to an emergency choking incident. They are able

to request Paramedic back-up if more advanced clinical skills are required. This is consistent with the practice in other English ambulance services.

BDCT produced an action plan in response to these strengthened recommendations and all of them have now been completed.

Review Conclusion

The Coroner made a narrative report, which is a factual statement of the events causative of death. The conclusion was that this service user tragically inhaled his food on the first mouthful as soon as he began to eat (rather than this being a choking incident) and despite all the consequent efforts by the different staff he was unable to be resuscitated and died. The narrative report concludes that the service user died at the Highfield Unit rather than later at the A&E. Also the Coroner saw that the risk of choking was recognised and dealt with in the risk assessment and care plan for this individual. The action plan and lessons to be learnt from this incident for the care and safety of other service users have been put in place by BDCT. The SHA can now consider this case for closure.

6. SERIOUS UNTOWARD INCIDENT 2008/5265

This incident concerned a male service user of 50 years of age, who was resident at Weaver Court, a residential care home. On 15th June 2008 he collapsed and was admitted to Bradford Royal Infirmary (BRI). On 18th June 2008 he underwent surgery during which the large bowel was removed and two surgical gloves were found in his rectum. His condition deteriorated and he was artificially ventilated. The artificial ventilation was discontinued on 22nd June 2008 and he died on the 23rd June 2008.

The Consultant Pathologist's report on 20.8.2008 stated:

> *"Examination of the colectomy specimen (reference BH08-9606) shows features of a pseudomembranous colitis, suggestive of an infective/toxic aetiology.*
>
> *Histology of post mortem lung tissue shows oedema, hyaline membrane formation, and pneumocyte hyperplasia, consistent with adult respiratory distress syndrome or shock lung. Histology of the liver shows centrilobular and necrosis of liver cells.*
>
> ***Comments:*** *Significant findings at the post mortem examination were previous proctocolectomy with residual small intestine and stoma, no evidence of peritonitis or perforation of an abdominal organ, and airless oedematous lungs suggestive of adult respiratory distress syndrome. Mr x also had significant ischaemic heart disease, with evidence of an old septal infarct.*
>
> *Subsequent histological examination of tissues including the colectomy specimen has shown a pseudomembranous colitis, complicated by multiorgan failure including adult respiratory distress syndrome (or shock lung) and changes in the liver consistent with circulatory failure or shock.*
>
> *The findings indicate that Mr x died of complications of pseudomembranous colitis complicated by a significant degree of ischaemic heart disease and there was no evidence at post mortem examination that the surgical operation (colectomy) played any part in his death.*
>
> *There was also no evidence at autopsy that the foreign bodies in the rectum (surgical gloves and a piece of wire) played any part in the cause of the pseudomembranous colitis or any part in his death."*

N.B. The piece of wire mentioned above was later identified as a part of the rim of the glove by the histopathology report.

The Coroner's Inquest on 23rd September produced a verdict of death by natural causes.

The incident was reported to the SHA via the STEIS system on 23.6.2008 and Bradford District Care Trust commenced an internal investigation. The investigation was completed in September 2008 and an action plan produced. The investigation report and action plan was clinically reviewed by the SHA in December 2008.

The investigation report followed National Patient Safety Agency (NPSA) root cause analysis recommended processes and produced recommendations that were related to the actual incident and to the general improvement in care and safety for all service users. The internal investigation raised a number of issues that were specific to this case and for general learning for BDCT, the General Practitioner (GP) and Bradford and Airedale Community Health Services (BACHS). Weaver Court is a residential care home and at that time was not staffed by qualified general nurses and as such relied on the input from the GP and District Nurse for health related matters. The service user was an unstable insulin dependent type 1 diabetic and was visited twice a day by a District Nurse to administer his insulin. He was also visited by a Diabetic Specialist Nurse. The question of whether the service user was suitably placed in a non-nursing environment was considered in the internal investigation. However, the internal investigator found this difficult to assess given the absence of up to date care plans and a health assessment. The internal investigator noted in the report that one of the District Nurses who was involved in the care of the service user was interviewed. However, it does not mention in the report what the District Nurses, attending the Service User twice a day, knew about the frequent episodes of loose stool or that the service user was accessing the clinical waste bin.

The internal investigation identified "*Key Care and Service Delivery Problems*" at the time:

1. *In the case of the care and treatment of the service user, the Investigating Officer found that his care was compromised by the teams failure to comprehensively record what they observed on a daily basis. Examples of this include, accessing clinical waste bins, and the absence of completed incident reports. Observations of loose stools, with no documentation to support how his care was altered. On occasions laxative medication was not omitted and on others it was.*
2. *The team failed to evaluate on the service user's clinical presentation and after thirteen months of sporadic episodes of loose stools a GP was finally contacted about this specific problem.*
3. *The team failed on twelve occasions out of the recorded thirteen to complete an incident report, identifying that the service user was accessing clinical waste bins. On the one incident report completed, the manager identifies an alternative bin should be sought in June 2007, yet the bin remains the same at the time of his death. The service do use gloves which are discarded in the clinical waste bins. And this is a possible hypothesis of how (service user) accessed the gloves found during surgery.*
4. *The investigating officer identifies that between January 2007 and July 2007 there was thirteen episodes of accessing clinical waste bins. No preventative action was taken on any of these occasions. Then there was a ten month gap when the service user is not reported to access the bins. The officer concludes it is more likely that the incidents were not reported rather than the behaviour ceased. This conclusion is drawn from the following observations made; the bin remained in the same place for all of that time, observations of the service user were not increased, risk assessments were not implemented and care plans were not in place to minimise or eradicate the opportunity of accessing the area.*
5. *The care plans and risk assessments in place for the service user were written in 2005 and reviewed in 2006, ranging between eighteen months and two years out of date. The staff team interviewed were not aware of the content of care plans for the service user. There is no recorded evaluation of care delivery at any time. The overall standard of record keeping is poor, not every observation is timed, the observation is made with no intervention identified or evaluations of planned care.*
6. *The documents were reviewed by a senior staff member three times in one year, but there was no acknowledgement of the documented risks identified in the daily observation records. It was also not recognised that IR1's had been omitted.*

The internal investigation at the time recognised *“Key Contributing Factors”:*

1. *Information about the service user was not accurately and consistently reported on a daily basis.*
2. *There is no evidence of a systematic assessment, plan, implementation, or evaluation method for any of the issues the service user presented.*
3. *There was a lack of follow up care/ intervention to assess the service users physical needs based on his regular presentation of loose stools.*

The internal investigation at the time identified *“Root Causes/Causal Factors”:*

1. *The service user was known to access clinical waste bins, he was never observed eating the contents of the clinical waste bin, but it is clear that when he is found by the staff team the contents of the bag are regularly emptied all over the floor .*
2. *The team record regularly that he requires a shower after emptying clinical waste bags indicating that he is soiled from faeces and urine from other service users pads.*
3. *There is evidence that the service user has swallowed two gloves, which suggests that he had the potential to ingest faecal matter. It is possible that the regular loose stools encountered by the service user are linked with him accessing clinical waste bins and the potential for him to contract other infections is highly likely given his behaviour.*
4. *The surgeon clearly reports that the service users death was not caused by the gloves in his bowel.*

When the SHA clinical reviewers considered the investigation report and action plan they questioned the involvement of the GP and District Nurse. This was outside the remit of the BDCT investigator and fell to the PCT to investigate. It appears that the question asked was solely related to a visit of a GP to the service user on the 15th June, rather than the longer-term issue of knowledge and action around the frequent loose stools. The PCT have identified that a GP was asked to look into the issue of the GP visit on 15th June at 21.00 when a diagnosis of gastroenteritis was made and paracetamol prescribed. The investigating GP reported that: “*case notes were reviewed and conclusion was that GP had not been made aware of loose stools or events leading up to the final episode and therefore gastroenteritis was a reasonable diagnosis given the information available to them at the time*”. This outcome was apparently made verbally available to the BDCT internal investigator at the time of the report.

The investigating GP comments do not cover the previously reported contacts with one or more GPs. It is unfortunate that the investigation report does not differentiate between GPs and it is difficult to ascertain which GP was involved. On 29th May the duty officer contacted a GP as the service user was unwell and had loose stools. The duty officer took advice from that GP with regard to omitting dairy products, offering plenty of drinks and checking the blood glucose levels more frequently. Later that day it was noted that a specimen of faeces was obtained, but no record is made of what if any investigation was undertaken with the stool specimen. On 30th May the service user was seen by the District Nurse, Diabetic Support Nurse and Clinical Intervention Team, also telephone discussions took place with a GP and an emergency GP (unable to say whether these are the same GP or not) with regard to controlling his blood glucose. The record does not show any discussion taking place with regard to the frequency of loose stool and its possible impact on his blood glucose control.

The SHA clinical reviewers also questioned if further pathology examination of the colon had occurred to identify how the service user contracted Pseudomembranous Colitis as the SHA clinical reviewers recognised that: “*Pseudomembranous colitis is almost always caused by overgrowth of*

Clostridium difficile. This is usually precipitated by antibiotic use but may also be caused by ingestion of a large amount of spores or bacteria. Rarely, other organisms may be involved."

No further pathology results have been made available and it is recorded in the investigation report that the service user was not taking any antibiotics during this time to cause the overgrowth of Clostridium difficile. It therefore must remain as a hypothesis that the Pseudomembranous Colitis was caused by the ingestion of spores or bacteria whilst the service user was accessing the clinical waste bins. It is also recorded on an IR1 form that the service user wandered into the garden and greenhouse area where he fell over. He may have accessed other sources of infection than the clinical waste bin. The investigating officer recorded interviewing the infection control lead as part of the investigation. However, it was not clear from the investigation report what the view was of the infection control lead or if any audit had identified Clostridium difficile contamination.

The BDCT investigating officer recommendations included:

- *A full audit of all service user records be undertaken to ensure risk assessments and care plans are up to date and relevant with a monthly evaluation of care provision to be completed by the manager or nominated deputy. Monthly audit of service user records to review the process.*
- *Training of the staff team to ensure they are aware of when an incident is a reportable incident and when to complete and IR1. The importance of following up 'actions identified' from the IR1 reporting mechanism.*
- *Raising the awareness of the staff team when to elect the support of a clinician or GP to treat or review illnesses.*
- *The Trust should ensure that all learning disabled service users in its care have an annual health needs assessment undertaken by the Primary Care Team consistent with DH policy.*
- *The service manager should ensure that all staff are aware of the requirements for detailed, relevant documentation consistent with trust Policy that is completed at least every shift and includes the date, time and signature of the author.*
- *The service needs to buy bins appropriate to the needs of the group.*

The recommendations are related to BDCT only and this leaves a gap with regard to the primary care and community services. Also no mention is made of the lack of referrals to safeguarding or any involvement of advocacy for a service user that has no next of kin. The safeguarding and advocacy issues raised in the CQC reports have now been dealt with. The action plan for the above recommendations from a BDCT point of view has been completed. The annual health needs assessments for Weaver Court service users have been completed and this is being progressed with the facilitation of the PCT to all the service users living in long stay residential services.

<u>Review Conclusion</u>

The Coroner has recorded that the service user died from natural causes. There remains a lack of clarity about what caused the Pseudomembranous Colitis and how this was contracted by the service user. Given the lack of pathology testing results for the service user's colon or stool sample this is unlikely to be identified. If it was caused by Clostridium difficile we do not know the source of infection. There is still the outstanding question of what was known by the GP and District Nurses involved in this case and what action, if any, that they took and this should be followed up by YHSHA with NHSB&A. This should then allow YHSHA to consider this case for closure.

7. SERIOUS UNTOWARD INCIDENT 2009/2860

This SUI concerns a 62 year old female service user who was resident at Weaver Court from June 2003 until her death in 2008. She died at Bradford Royal Infirmary in November 2008. She was a quadriplegic requiring the use of a wheelchair and had a history of chronic chest problems and chronic gastrointestinal problems. The service user was admitted to Weaver Court, a residential care home with no nursing staff on the establishment, when a nursing home closed down. This was intended as a transitional move prior to moving on to another nursing home. This move onwards never happened although a referral for an assessment of the continued suitability of a residential home was made by the Weaver Court manager to the Community Team for Learning Disabilities (CTLD) in March 2008. Unfortunately this wasn't acted upon by CTLD until November 2008 due to capacity issues.

The internal investigation report noted that the delay in reporting this incident to YHSHA was due to the service manager at BDCT thinking that because the incident had occurred at BRI that they would report it. This incident was classified as a 'watching brief' when first notified to the SHA in February 2009. It was reclassified as a SUI on the STEIS system in March 2009, in the light of further information. BDCT commenced an internal investigation which was completed in September 2009. Given the number of organisations involved in this case the internal investigation report was signed off by BDCT, BTHFT, BACHS and NHSB&A. A combined action plan was produced that is performance managed by NHSB&A. The internal investigation and combined action plan was clinically reviewed by the SHA in October 2009.

The internal investigation noted that the service user had 10 admissions to the BRI from October 2007 that involved care and treatment from different hospital/medical teams. The internal investigation report covers the timeline from October 2007 to November 2008. In October 2007 the service user was admitted to Bradford Royal Infirmary with abdominal pain, following an ultra sound it was identified that she had gallstones. There is no record of any active treatment of the gallstones, and the surgeons have stated that they were not relevant in terms of the management of this patient. Following concerns about aspirational inhalation and pneumonia risks a Speech and Language Therapist (SLT) assessment was undertaken and after discussions with the service user, an Independent Mental Capacity Advocate (IMCA), the Weaver Court Manager and the Acute Hospital team, a Percutaneous Endoscopic Gastrostomy (PEG) tube was inserted in November 2007 and PEG feeding initiated. The care team at Weaver Court undertook training and were supported by the Dietician and Abbott Nurse (a specialist nurse who is expert in the use of feeding tubes and nutrition) for the care of somebody with a PEG feed device. In January 2008 during discharge planning discussions after one of her admissions to BRI a District Nurse raised concerns about the continued placement at Weaver Court. However, it was decided to discharge the service user back to Weaver Court with support from the Dietician and District Nurse. The SLT gave advice to the care team at Weaver Court about oral feeding alongside the PEG feeding and warned them to maintain a Nil by Mouth regime at any sign of intolerance. The internal investigation report noted that this was not always understood by the care staff and on occasion oral feeding took place when it should not have done and that larger quantities of food were given than recommended by the SLT.

It was noted in the internal investigation report that in March and again in April 2008 the service user was assaulted by a fellow resident and whilst Incident Record Form 1 (IR1 forms) were completed the incidents were not reported to adult protection as required by policy and an examination by a doctor was not undertaken. In June 2008 Weaver Court staff reported possible faeces in the PEG feeding tube and whilst this was reported to the BTHFT junior medical staff on admission it would appear that this information was never passed on to the consultant surgical staff.

This is probably the first indication that the PEG tube had moved from the service user's stomach to her colon and therefore the service user was not receiving the nutrition she required.
The internal investigation report noted that in July 2008 the District Nurses instituted a triage system with Weaver Court to attempt to reduce the number of admissions to BTHFT. The service user was not admitted again until October 2008 and whilst this was probably done with the best intent it prevented any further opportunity for medical staff at the BTHFT to recognise the deterioration in her condition. From June to October it appears that she lost 7.1kgs in weight (just over a stone) and was recorded to be complaining of feeling hungry. Weaver Court did not have the correct weighing equipment required to weigh this individual on site and this was undertaken at Shipley Resource Centre and Stoney Ridge. It was noted in the report that some of Weaver Court staff continued to give the service user oral meals which may have improved her nutritional status, but increased the risk of aspirational pneumonia. During her last admission to the BRI the Trust's Adult Protection Liaison Officer was informed of her admission, but not of her previous admissions or history. It was recognised that the PEG tube was displaced and alternative methods of feeding were discussed with the Service User, but before these could be put in place her condition deteriorated and she died on 16th November 2008. The cause of death was recorded on her death certificate as Chest Infection and Heart Failure.

The internal investigation report makes a number of recommendations, including:

- *BTHFT should examine its processes on the Surgical Assessment Unit for handover of information to senior medical staff during handovers/ward rounds to ensure a complete picture of the patient's presentation is available for review.*
- *BTHFT should ensure that medical records are maintained to ensure that appropriate information is communicated across the medical teams of the Trust relating to an individual service user. Specialist teams who have been involved in the patient care should be involved where appropriate.*
- *A) Staff at Weaver Court, the District Nurses and the staff at BRI involved in the service users care should be reminded of the importance of maintaining accurate physical healthcare details on admission and during subsequent periods once it has been identified that they play an important role in care planning and monitoring. These should include as examples where the service users condition requires it:*
    - *Regular weight monitoring*
    - *Fluid balance monitoring*
    - *Accurate monitoring of bowel activity*
    - *Nutritional intake*
- *B) In particular – all service users at Weaver Court should have in place a health assessment and a health plan which is undertaken by registered nurses.*
- *The Primary Care (BACHS) and BDCT should review the arrangements for identification of the personal care co-ordinator of people with long-term conditions. Primary Care responsibility for health surveillance and management of people registered with general practices needs to be clear whilst recognising the role of specialist practitioners from secondary care providers who may have some responsibility for specialist interventions.*
- *BDCT should review the staffing establishment for Weaver Court to address the concerns raised by staff.*
- *BDCT and its commissioners should review the CTLD capacity to ensure that all service users can have a comprehensive assessment in place and that this would be reviewed at least annually.*
- *BDCT should ensure that staff at Weaver Court are aware of the policies relating to Safeguarding adults and can use the Adult protection procedures.*

- *BDCT and NHS Bradford and Airedale (the PCT) should review the decision taken to 'triage' access to the GP/Hospital re admissions.*
- *BTHFT has signed up to the Safeguarding adults multi-agency policy for the care of vulnerable adults and:*
    - *Will ensure that staff across the Trust are aware of it.*
    - *Will continue to train ward staff to ensure they activate appropriate support for such patients via their Matrons – supported by the lead practitioner for Vulnerable Adults.*
- *BDCT should review the record keeping systems at Weaver Court to ensure staff comply with BDCT policy.*
- *BDCT/BTHFT and the NHS Bradford and Airedale should establish a 'task and finish group' to review the current procedures for follow up of assessments and tests, (e.g. CT scans) to ensure all service users have such tests thoroughly followed up whether they were instituted in the hospital of from the community. This group should also review the adequacy of the discharge communications, (letters and summaries) and identify any improvements that should be made.*
- *BDCT should ensure the outcomes of its review of the delay in the reporting of this SUI are addressed and communicated to all staff via the care group management systems.*
- *BDCT should develop the management arrangements for weaver Court to ensure there is a growing sense of collaboration between the local managers and the staff in the unit. Development work should aim to ensure that staff recognise the legitimacy of the line management systems, but remain aware of processes for seeking support should the line-management communications breakdown, e.g. use of the 'Hearing the concerns of workers policy'.*
- *BDCT should ensure the availability of appropriate weighing equipment for the needs of the staff and the care planning arrangements of the service users*.

These recommendations and a further one relating to BACHS reviewing the PEG feeding policy and guidelines have been incorporated into a combined action plan that is owned by all of the organisations involved in this SUI. The SHA clinical review of the SUI investigation report and action plan raised a number of issues to strengthen the action plan and to ensure that the outcomes could be evidenced. If this strengthened action plan is performance managed appropriately by NHSB&A that should deal with the outstanding issues.

The internal investigation report was based on all the case files, with a detailed examination of the files relating to the timeline from October 2007. Interviews took place with mainly BDCT staff. The only other member of staff interviewed was the BTHFT Dietetic Manager. The District Nurse and Abbott Nurse submitted timelines, BTHFT submitted a review report and timeline that was prepared in line with the BTHFT SUI policy, and the minutes from the multi-disciplinary case review were used. The BTHFT submitted report included relevant staff providing statements and discussions regarding the potential issues identified within the Directorate and with the Medical Director and Chief Nurse. Appendix 3 of the SUI investigation report sets out a Primary Care Summary and indicates the frequent contact with the GP practice and community staff. This included multi-disciplinary team meetings in January and July 2008 when concerns were raised about the suitability of her placement at Weaver Court and the increasing number of hospital admissions. This led to the decision to try and undertake appropriate clinical assessments (triage) before admission to hospital. The investigation quotes Consultant staff from BTHFT about the lack of handover information on the possible faecal matter in the PEG tube. BTHFT have clarified that they have not been able to identify which junior doctors had briefed the Consultants as it was the Consultant who had dictated a note to the medical records following the ward rounds not the junior doctor. Due to the delay in the investigation being undertaken it was not possible to identify the junior doctors who had been

present. However, the implementation of the recommendations has been applied to all medical staff.
The internal investigation report when considering the timeline identified that:

"However, there was a lack of full multi-agency/multi-disciplinary team (MDT) meetings re 'A's needs. It appears that care from individuals was being given, but there was a lack of co-ordination across staff teams in order to produce a clear and consistent plan agreed by all parties. This conclusion was also reached by the multi-disciplinary team when it reviewed 'A's care after her death in December 2008, where the need for an overall 'coordinator' was identified in such complex cases involving many staff teams (Appendix 1). The Author notes that 'A' lived in a Residential Care Home where staff expertise would have been limited as regards multi-agency care management. Residents are registered with a General Practice and there is an expectation that the lead for specific healthcare management should be from this primary care service. However, as a long term service user with a learning disability, responsibility for annualised assessment of need and ongoing co-ordination of social care support falls to the Community Team for Learning Disability. Confusion re this should be addressed to improve quality of future care planning arrangements for such complex care arrangements. Additionally 'A' received care from a number of medical and ward teams whilst being cared for at the BRI. It is not clear that details from each admission and the care delivered by a team were passed on to successive teams on re-presentation. Hence it is not certain that secondary care teams had a full understanding of the history of management over the full year of care."

The internal investigation reached the following conclusions:

- *A had developed symptoms towards the end of 2007 that represented a significant risk to her physical health status. She had a developing history of progressive deterioration in her gastrointestinal disturbance and her swallowing reflex. In November 2007 she was fitted with a PEG feeding device to reduce the risk of aspiration pneumonia.*
- *It is considered likely that the original PEG placement will have transfixed the colon on initial placement, a recognised complication of the procedure. At a later stage, the PEG is likely to have been pulled or migrated through into the colon. Although it is difficult to ascertain when this happened, it is likely this was the situation when she was admitted to the BRI in June 2008.*
- *The presence of material in the PEG tube which could be faeces was noted. BRI did not recognise the problem and it was therefore not dealt with. Staff in the community and at Weaver Court continued to try to find solutions to the nutritional problems and the emerging weight loss – however the original assessment that the PEG was now mis-placed did not feature in on-going care monitoring.*
- *The staff continued to feed her orally which would have helped with her nutritional needs but may also have masked the problem that the PEG was no longer delivering nutrition to her.*
- *In November 2008, when it was recognised that the PEG tube had migrated into the colon, appropriate measures were taken to establish an alternative form of nutrition. This was poorly tolerated and the tube had to be replaced on more than one occasion. Additional approaches were considered but unfortunately her condition deteriorated and she wasn't well enough for any further procedures.*
- *It is of the opinion of the Consultant Colorectal/General Surgeons who have reviewed 'A's medical records, that if they had been certain of faeces in the PEG tube in June 2008 then a CT Scan/PET Scan would have been undertaken and this would have identified the mis-sited PEG tube and provided a solution to her nutritional needs.*

- *'A's care was complex and involved a number of agencies and disciplines of staff. Comprehensive care coordination did not emerge despite the significant efforts of all the staff engaged with her to try and meet her on-going needs.*

In this SUI the staff appear to have acted independently, in what they considered to be the best interests of the service user for a part of her care. It was also noted in the internal investigation that some staff at Weaver Court distrusted the instructions about nil by mouth and considered that the service user hadn't wanted the PEG tube inserted despite the involvement of IMCA. This distrust and lack of communication led them to provide more oral food for the Service User than had been advised by the SLT, which possibly increased her risk of aspirational pneumonia and possibly hid the weight loss. Perhaps the access to an advocate would have helped to ensure that staff understood better what the service user herself wanted and what decisions she was making for her own care. The District Nurses for the best of reasons managed to reduce the admissions to BRI by providing a 'triage' service but this potentially delayed the identification that the PEG tube was displaced. The admissions to BRI were not achieving a resolution to the service user's problems and were very distressing for her.

This shows that the lack of an overall care co-ordinator was key to the outcome. A care co-ordinator would have been able to bring together the multidisciplinary aspects of the service Users care. If all the staff involved had been able to discuss the case together and all the interlocking aspects of the care were discussed in one place then a better service could have been achieved. Also the placement at Weaver Court was only meant to be temporary and yet five years later there appeared to be no assessment of need or plan to ensure that this service user was in the most appropriate accommodation for her needs. It is possible for carers at home and staff in residential homes with professional support to deliver PEG feeding, so this in itself was not a reason to place her elsewhere. However, the needs of the individual appear to have been considered in isolation rather than as a whole as identified in the internal investigation report.

<u>Review Conclusion</u>

A Coroner's Inquest was not undertaken and the cause of death on the service user's death certificate was given as 1a) Chest Infection and 1b) Heart Failure. It is not possible from the investigation reports to say how the Chest Infection occurred and as the internal investigator had access to all the files and clinical reports it is unlikely that this could ever be identified. The service user was placed temporarily at Weaver Court for five years and given her health needs she may have been better placed in a Nursing Home, but no assessment was undertaken. The lack of a handover of a key piece of information from the junior doctor in the BRI to the Consultant meant that the opportunity to deal with the misplaced PEG feeding tube was missed.

The overall lack of care co-ordination and multi-disciplinary working also meant that key pieces of information were not shared and the different aspects of the service users needs were treated in isolation. There was also a lack of advocacy and involvement of safeguarding that could have assisted the service user in identifying her own wishes and needs. This case was complex and no individual issue could be seen as causal. It highlights the need for health checks, to be held annually at a minimum, and health action plans that consider all health issues together to be organised for all Learning Disability service users. The Combined Action Plan identifies the actions required to address the issues identified in the internal investigation and by the YHSHA clinical reviewers. This will be performance managed by NHSB&A to ensure that the case can then be considered for closure.

8. HEALTHCARE COMMISSION AND CARE QUALITY COMMISSION REPORTS

The Healthcare Commission (HCC) wrote to BDCT and CBMDC on 16th March 2009 following an unannounced visit to BDCT on the 12th and 13th March 2009. During this visit the inspection team was made up from HCC and CSCI staff and visited Weaver Court and Branwell Lodge. This was a visit to assess the Trust's implementation of recommendations made in a letter to the Trust dated 7th August 2008. There was a Key Inspections visit made to Weaver Court on 23rd and 24th April and the quality rating was 'zero stars poor service'. Also following this a random inspection of Weaver Court was undertaken on 17th June 2009 by the Care Quality Commission. An unannounced Key Inspection Report visit was made to Weaver Court on 19th October 2009 and resulted in a change in the quality rating for this residential care home to 'one star adequate service'.

The HCC had originally raised concerns regarding the Learning Disability service that included:

- A lack of trust engagement with service users and carers
- A lack of patient-centred planning
- A lack of reporting and learning from incidents

March 2009

During the unannounced visit on 12th and 13th March 2009 further issues were raised with BDCT. For Weaver Court the investigation team raised issues around the stark nature of the environment, the unsuitable mix of the service users, the apparent lack of staffing levels, safeguarding issues, communication issues, and a staff reported difficulty in getting GP home visits. The HCC raised immediate action that was required:
"*The trust needs to take action to ensure the immediate safety of the people who live at Weaver Court, and treat the observations made above as referrals to the council's safeguarding team. In addition the trust and the commissioners need to ensure themselves and the HCC that services across the trust are safe."*

For Branwell Lodge the investigation team recognised some improvements had been made with an improvement in the atmosphere. Staffing levels had remained the same although eight people had been resettled elsewhere. The care plans were greatly improved, containing more thorough information and were clearly person-focused. However, two service users raised concerns for the investigation team. The first lady was blind and required a proper assessment of her sensory needs alongside improvements in her care plan, an annual health check and a health action plan. The HCC raised immediate action that was required: "*A review and assessment of this service users needs should be undertaken as a matter of urgency. The HCC requires the trust to provide evidence of what action will be taken to address the concerns highlighted*". The second service user was a gentleman that raised safeguarding concerns and his care plan required attention. The HCC raised immediate action that was required: "*A review and assessment of this service user's needs and circumstances should be undertaken as a matter of urgency, primarily to ensure his safety. The HCC requires the trust to provide evidence of what action will be taken to address concerns highlighted*".

The HCC required a joint formal response from the Trust and commissioners of the service detailing the action to be taken by the 20th March 2009. This letter was copied to the SHA and led to the performance management meetings that then reviewed the SUIs resulting in death reported by the Learning Disability service of BDCT over the previous 18 months. This led to the identification of the three SUIs for further investigation and review, discussed above.

June 2009

The random inspection report describes the findings following the CQC visit to Weaver Court on the 17th June 2009. This was a follow-up to the key inspection visit on 23rd and 24th April, at which seventeen requirements and six recommendations were made. The quality rating for the home on 23.4.2009 was zero stars and a poor service. Weaver Court has 22 places and at the time of this visit 19 people were resident with very different needs, some of which are not compatible with living together. Since the last visit 14 people have had an assessment of their needs and if appropriate other more suitable accommodation to meet their needs was being sought. Care plans had been improved and staff showed that they had a good awareness of the people's needs and mainly followed the care plan information. Risk plans had been reviewed and updated, but still required further work on identification of actual risk for individuals at risk from other resident's behaviour. There remained a lack of clarity about the reporting of incidents and this required further work to ensure that incidents are properly reported and reviewed.

A far greater range of activities are now available with them being more tailored to the individual resident's needs. Staffing levels have been improved and this has reduced the risk of incidents of conflict between people in the home. Meals are better organised and it is more of a social occasion. Health action plans have been developed which allow staff to support individuals health needs and it is noted that the number of health appointments with a range of health practitioners has increased. Independent Mental Capacity Assessments have also been undertaken when there were concerns around capacity to consent to medical treatments or interventions. Staff supervision and training have improved. A new medication system was in place and further training is being undertaken with staff. However, the inspection team found one medication not signed for and received a notification of a medication error, so this system needs further monitoring and review. The environment continues to be unsuitable to most residents' needs, but some improvements have taken place. Fire training and procedures have been reviewed and planned improvements continue to be made. The recruitment process records show that this is now being handled correctly by the home.

Following this random inspection visit the CQC made one statutory requirement and three recommendations. The statutory requirement was that: *Current staffing levels must be maintained and any reductions in staffing levels must be discussed with the commission before they are implemented. This is to make sure peoples needs continue to be fully met"*.

The three recommendations included:

- *The support plans and risk assessments need to be reviewed and updated on a regular basis*
- *The medication system needs to be regularly monitored and reviewed*
- *The reporting and review of serious incidents needs clarification*

Overall this random inspection report showed a great improvement at Weaver Court but the CQC felt that they could do better: "*Weaver Court has improved as a result of the increased number of staff and increased skills and the increased level of support and management. To enable the improvements to continue and to protect people this must be maintained until people move from Weaver Court".*

I have been unable to access the HCC full report on the Highfield Unit and I have had to review the easy read report on the Highfield Unit. This raised similar issues and suggested changes in that:

- person centred planning should be used,
- review needs assessments should be regularly undertaken,
- annual health checks undertaken,
- the medication system should be reviewed,

- service users and carers should be involved in the care planning with interpreters involved if required,
- access to and from the unit by keypad should be facilitated,
- service users should be assisted in keeping in contact with carers, in undertaking activities and with handling their finances,
- advocacy services should be available,
- staff should have training that includes safeguarding
- BDCT needs to develop a system of audit and monitoring to ensure all of the above is actioned

October 2009

The latest unannounced Key Inspection Report visit to Weaver Court took place on 19th October 2009 and the written report from that visit has just been made available by the CQC. This report recognises the improvements made at Weaver Court and changed the quality rating for the home from zero star poor service to one star adequate service. In fact from the eight outcomes assessed 5 were rated as adequate and 3 as good, which means that they are getting close to achieving a quality rating of 2 stars. None of the statutory requirements or recommendations raised in the random inspection visit on 17th June 2009 were repeated in this report. No immediate requirements or statutory requirements were made at the visit in October 2009. Seven recommendations were made as a way of improving the service.

The seven recommendations included:

- *The terms and conditions of residency in the home need to be updated as they are not in an accessible format. In order that the terms and conditions of residency in the home contain all the right information, they need to be reviewed against the guidance produced by the Office of Fair trading on fair contracts.*
- *The use of recognised person centred planning techniques would further enhance the ways in care planning is undertaken.*
- *Opportunities should be created for people to develop their cooking and meal preparation skills the provision of a dedicated kitchen would facilitate this.*
- *Consideration on how the premises can be enhanced so as to provide a homely and comfortable environment should be made.*
- *People should have sufficient usable floor space to meet their individual needs and requirements.*
- *The management team needs to ensure that the use of inappropriate and disrespectful terminology to describe people living at the home is not used by the staff.*
- *Any changes to the staff team needs to be managed effectively and efficiently so as to ensure people's needs are consistently meet.*

Three of the recommendations relate to the environment of the home and may require capital investment. The last recommendation refers to the mix and level of staffing at the home as currently the staff mix includes nursing staff. Given the changes in the mix of residents and their needs the staffing levels and staff mix will be revisited and the commissioners will need to consider this as part of the quality and cost elements of the contract.

The CQC wrote to CBMDC and BDCT on 16th July 2009 covering the visits and investigations undertaken with the Learning Disability services provided by BDCT. This letter states that:
"In summary, we recognise that the concerns raised in our correspondence of 16 March 2009 and 8 April 2009 have been taken seriously and immediate action to address the concerns have been taken.

Furthermore, detailed action plans have been undertaken and progress has been made against a considerable number of the actions. As such, the investigations team have come to the decision that we will not be having any further involvement with the Trust as we are satisfied with the action taken and the case will be closed."

The CQC will continue to monitor the service through the Local Area Manager and will require regular updates on the key priorities for action listed below:

- *Weaver Court – We request that the trust continues to provide the Local area manager with progress made at Weaver Court. Including details of further visits to the trust and updated action plans.*
- *Inappropriate Accommodation – We request that the trust continues to provide the Local Area Manager with information pertaining to the revised Section 75 and any decisions made in relation to service provisions. Furthermore, we request that the trust provides a copy of the plans in relation to the accommodation project upon completion.*
- *Rolling Programme – We request that the trust continues to provide the Local Area Manager with information pertaining to the rolling programme and details of any concerns that arise as part of this process.*
- *Adult Protection Referral – We request that the trust continues to provide the Local area Manager with updates in relation to the adult protection referral including details of meetings that have taken place with the Adult Potection Unit and subsequent actions taken.*

Review Conclusion

The issues originally raised in these reports mirror issues raised in the SUI reports with questions about staffing levels, staffing mix, lack of up to date care plans, communications, the health input, health checks and health action plans, the poor environment, advocacy and safeguarding. However, major improvements have been made since the original HCC and CSCI visit and the latest CQC report recognises these changes. This has led to the letter from the CQC stating that the investigation team has closed the case. The commissioners will now have to take on the responsibilities of monitoring the service and ensuring that the quality of the service continues to improve. The question over the suitability of the accommodation and environment will need to be addressed as part of a consideration of the capital requirements to support the commissioning strategy.

9. A COMMISSIONING FRAMEWORK FOR LEARNING DISABILITY SERVICES (2007-12)

As part of the terms of reference of this investigation, the District's existing strategic plan for learning disability was reviewed and any additions identified to be included as a consequence of the findings from the review of the three SUIs and the HCC, CSCI and CQC reports. The strategic plan entitled "changing lives through real partnership, a commissioning framework for learning disability services – a model 2007-12" was published in November 2007.

The strategic plan set out the visions and values as a critical foundation for the strategy and against which all the proposed implementations and changes should be judged. The vision and values included:

- *The right to be full and included members of the communities.*
- *Have the ability to make a contribution to the communities in which they are engaged.*
- *The right to be listened to and to be taken seriously.*
- *Have the right to be treated as citizens.*
- *Have the rights to health and wellbeing.*

The strategy goes on to identify critical enablers that need to be implemented by CBMDC and NHSB&A so that the model can be realised and sustained. It then identifies the critical next step changes required; comments upon the need to improve the health outcomes for these people in health and wellbeing and outlines the key messages from the evidence-based practice and research.

It then addresses the current commissioning arrangements and I have listed the findings below in full:

The following findings can be made arising from the above:

> *· There is a distinct absence of appropriate commissioning arrangements i.e. needs analysis, trends, best value and methodology……….The agreement which sought to place these responsibilities with the BDCT failed to recognise the potential conflicts of interest arising from its provider role and its commissioning responsibilities. It ensures a self perpetuating model of service rather than allows for the shaping and flexibility necessary to contemporise the service. As a result, where this is attempted, it becomes 'ad hoc' and opportunistic and small scale.*
>
> *· There is no strategic plan for the learning disability service, a vision and aspiration for achieving 'Valuing People' and no consensus around which diverse stakeholders can gather.*
>
> *· An absence, over the significant past, of a robust methodology for specification, quality, performance and outcome monitoring of contractual arrangements. It is arguable that the processes for proper procurement have not been undertaken because of the construct of the previous reprovision procedures and then, subsequently, the setting up of the BDCT.*
>
> *· The CTLD are operating a workload-management system in order to ensure that there is a process for ranking allocation, given their current capacity. As a result there are currently 75 referrals, which include 25 priority cases not being appropriately assessed, dating back to February 2007 (as at April 2007). This situation continues to worsen. Three vacancies are 'frozen', reducing the hours available even further.*
>
> *· The model of CTLD care/case management differs between Bradford and Keighley, particularly with regard to the access arrangements for clinical support from a range of other professionals (psychology, physiotherapy, OT), creating inequality of access and inconsistent pathways. This is because historically the Airedale/Bradford models were commissioned/developed by different NHS economies (PCT's) in conjunction with Social Care.*

· There is an underdevelopment of the use of community support workers in the teams, and no workforce strategy associated with this.
· Current approaches do not, any longer, reflect the wider commissioning agenda for learning disability regarding prevention, health inequalities, access etc, which are corporate/generic partnership issues. Development activity is provider-driven without operating in the wider system change context.
· There is a single designated 'transition' worker; which does not reflect the collective (Education/NHS/DASS) responsibility for properly undertaking person centred planning, assessing, resource identification and then procuring appropriately for those in transition. There are other staff within the Children with Disabilities and Complex Health Needs Team who undertake transition planning.
· There is no evidence of the necessary long-term housing needs database for those with a learning disability that can either identify future needs/style of housing provision, nor that seeks to target those most at risk of crisis (i.e. ageing carers), and that links the development of life skills and future "independent" placement.
· There is a significant number of 'older' persons (over 65 and over 75) in the learning disability service who urgently require assessment for needs and appropriate service planning as part of transition planning.
· The absence of a significant and sustainable application of person centred planning, which is neither the subject of an implementation strategy by the statutory organisations, nor targeted at the most vulnerable people (lifestyle, complexity, carer frailty).
· That operational commissioning is constrained by the need to 'purchase' placements and responses to individual need within the context of what is mainly available within the BDCT rather than the system as a whole creating a danger of 'shoe-horning';
· That costs rather than quality and cost dominate the contracting process and indeed that no 'outcomes' framework is in place to judge the effectiveness of purchasing;
· That there are no effective links between the 'intelligence' emerging from the operational commissioning function and the strategic market shaping and development functions;
· That there exists an implicit acknowledgement by almost all parties that both the strategic and operational commissioning responsibilities are not appropriately located in the BDCT, and are not therefore 'fit for purpose';
· That the development of convergent housing, leisure, education, employment commissioning is not active and present and hence lacks the drive and focus for the necessary market development. This does not sit within a wider partnership arrangement that is developing social inclusion and diversity approaches to ensure equality of access;
· The Section 31 Agreement was developed in such a way as to have the impact of significantly shifting the financial risk from the Council to BDCT. It has been a transactional contract arrangement rather than being based on partnership principles of shared risk, though distinct arrangements over such elements as reductions in income, eligibility variation, capital improvement and has served to restrain and destabilise the service.

The strategy goes on to identify the lack of information and information systems to support an 'intelligent commissioning' approach. The strategy then moves on to delivery by identifying the priorities for development and suggests that the re-alignment of commissioning should take place so that CBMDC and NHSB&A should take over the strategic and operational commissioning function from BDCT by 1st April 2008.

The strategy identified five key commissioning priorities and I have listed these below:

1. People as individuals – person centred planning, direct payments, individual budgets, care management (CTLD), greater choice of providers, integrated commissioning and developing advocacy.

2. Fulfilling lives (including having a good day) – more paid and voluntary work, explore social enterprise schemes, and developing sport and leisure activities.

3. Health and well-being – access to mainstream services, support in accessing specialist services that meet particular needs, improved access to primary care, access to therapy services, making hospital a better experience and develop treatment pathways for people with a dual diagnosis of Learning Disability and Mental Health.

4. A suitable place to live – establish the housing needs, work with the Strategic Housing Partnership, commission a range of services, help people to move, integrate respite provision and explore imaginative alternatives.

5. Community leadership – revise the role and function of the Valuing People Board, predict future need, monitor the strategy, support the workforce and manage the money.

The CBMDC and NHSB&A recognised the degree of change required to deliver this strategy and appointed a joint Director of Change to lead the day to day implementation process. An action plan was developed that took the five key commissioning priorities listed above and put in place the action required to deliver them. The action plan is now incorporated into the Learning Disability programme and highlight reports on progress are reported to the Sponsor Group.

Review Conclusion

The vision, values and direction of travel of the Commissioning Framework for Learning disability Services – A Model (2007-12) are to be supported and welcomed. The emphasis on health and wellbeing, access to primary care and acute care, care co-ordination, care planning including person centred care, multi-disciplinary approach, accommodation that meets needs, advocacy, the role and capacity of CTLD to assess needs and the approach to commissioning for outcomes all resonates with the issues arising from the three SUIs and HCC, CSCI and CQC reports.

The strategy findings set out above includes the recognition in 2007 of a lack of person centred care planning, a lack of a health and wellbeing approach, people placed inappropriately to meet their needs and with a poor mix of people. The lack of capacity in the CTLD team to assess and commission appropriately was recognised yet the assessment of residents in residential care homes and the mix of service users was not included in the five key commissioning priorities in the strategy. The risk in BDCT acting as commissioner and provider was recognised, plus the way that the section 31 arrangements shifted the financial risk onto BDCT. The Learning Disabilities Programme Director came into post in June 2008 and the strategic commissioning contracting and performance were transferred to CBMDC in October 2008, with the operational commissioning being transferred to CBMDC in April 2009, rather than in April 2008 as initially planned. Considering the strategy was published in November 2007 with a tight timescale for implementation this shows a willingness to progress the implementation of the commissioning strategy. The completion of the section 75 agreement will enshrine this position. If possible it would be useful to see the timetable accelerated to ensure the vision and values are delivered for the Learning Disability community and their carers. However, one must recognise that these arrangements take time with the culture change taking the longest. It would be useful to use this independent review to support the implementation of the commissioning strategy and to ensure that its implementation is performance managed by CBMDC and NHSB&A so that the implementation is achieved as quickly as possible.

10. DISCUSSION

This independent review has followed the terms of reference set out above and has been based on the documents provided (listed in Section 4). Since the review commenced and the first draft a further ten documents have been provided which has led to changes in the review report as new facts have come to light. Also the organisations involved have been given the opportunity to comment on factual content and this has produced further factual information that has been taken into account. This has been a review not a re-investigation of the original cases. The reviewer has therefore to be careful not to speculate as direct investigation and questioning was not part of the methodology.

The commissioning strategy published in 2007, the three SUIs in 2008, and the HCC, CSCI and CQC reports in 2009 all identify similar issues. There are some overarching themes that arise from these various reports that the whole system was required to consider and find ways of addressing them at the time that they were published, including:

- Lack of a strategic plan for learning disability services
- Lack of appropriate strategic and operational commissioning to meet needs
- The lack of capacity and different model of work for CTLD
- Lack of planning and assessment for appropriate accommodation
- Lack of appropriate placement of service users to meet their needs
- The inappropriate mix of service users in accommodation
- Lack of care co-ordination and/or case management
- Absence of person centred planning
- The Section 31 agreement shifting financial risk led to restraint and destabilising the service
- Improved access to and treatment from health mainstream services and specialist services
- Lack of care planning, risk assessments, annual health checks and health action plans
- Poor record keeping including not using IR1 forms
- Staffing levels and mix of staff not set to support the assessed needs
- Staff training not planned to ensure skills meet assessed needs
- Lack of multidisciplinary case management
- Not using safeguarding appropriately
- Absence of independent advocacy and accessing IMCA
- Primary care leadership with health needs in residential settings

Many of these issues have been dealt with or are part of ongoing actions to address them with the introduction of the commissioning strategy, the action plans with the Care Quality Commission and the revised action plans following the three SUIs.

I cannot say if the commissioning strategy had been introduced earlier whether the later SUI incidents could have been avoided. The residential homes such as Weaver Court were not seen as the first priority for action in the five key commissioning priorities in the commissioning strategy. Also as explained on page 27, the NPSA advises that the risks of hindsight bias and outcome bias which have to be considered. However, now that the issues are recognised and the commissioning strategy is seen as a means of addressing many of these issues then there is a collective responsibility to proceed with the implementation of the commissioning strategy as quickly as possible. This should be jointly led by CBMDC and NHSB&A to performance manage the implementation.

NHSB&A also has a role in ensuring that the health elements of these issues are addressed, so that annual health checks, health action plans and health input to residential care is in place. There is also a wider commissioning role with the health providers to ensure that care pathways take into account the needs of vulnerable adults including the learning disability service users.

The Coroner has jurisdiction to inquire into violent or unnatural death, sudden deaths when the cause is unknown, and deaths in prison. An inquest is an inquiry to examine witnesses on oath who can give any relevant evidence or information in order to establish who the deceased was, and how and where the deceased came by their death. The inquest is an inquiry in order to establish material facts not criminal or civil liability. There are a number of potential common conclusions as to death. For example, natural causes, industrial disease, accident or misadventure, suicide, and unlawful killing. A Coroner can also return a narrative conclusion which is a factual statement of the events causative of death. In the SUI 2008/2958 the Coroner gave a narrative conclusion, in 2008/5265 the Coroner gave a verdict of death by natural causes and in 2009/2860 an inquest was not considered necessary.

SUI investigations are undertaken following the occurrence of serious events and near misses. It is expected that the investigators will use National Patient Safety Agency (NPSA) guidance that includes Root Cause Analysis (RCA) methods to identify the underlying causes. The purpose of the investigation is to understand what happened, who it happened to, when it happened, where it happened, how it happened and why it happened including to identify any system failures that need to be addressed and then to share the learning wider. The SHA clinical reviewers will not close a SUI investigation until they are satisfied that the investigation report and action plan are appropriate. The whole approach recommended by the NPSA is to ensure openness rather than blame in order to reduce further risk and to stop defensive practices. This does not mean that disciplinary action is not taken when appropriate, but that is not the purpose of the SUI investigation. Potential disciplinary issues should be investigated by the individual organisations separately to the SUI investigation.

The NPSA also warn that: "*It is important when analysing investigation findings to be aware of, and to try and avoid hindsight bias and outcome bias*" in producing and reading reports.

Hindsight bias

Hindsight bias is the tendency for people with the 'benefit of hindsight' to falsely believe, once all the facts become clear, that the actions that should have been taken to prevent an incident seem obvious, or that they could have predicted the outcome of an event.

Although considered a serious pitfall in investigation terms, hindsight bias has been documented as a potentially useful mechanism in terms of the specific focus of learning from incidents. Hoffrage et al argue that it is a by-product of an adaptive mechanism that can make human memory more efficient. The basic idea of this 'RAFT' model (reconstruction After Feedback with Take the Best) is that any feedback or correct information received (in this case in the form of a now know, but previously unpredicted, incident outcome) is used to automatically update a person's knowledge base.

It is important to remember, however, that failure to recognise hindsight bias in incident investigation can result in misinterpretation of findings and may ultimately mask the real lessons to be learned.

Outcome bias

Outcome bias is the tendency to judge a past decision or action by its success or failure, instead of based on the quality of the decision made at the time. No decision maker knows for sure whether or not the future will turn out for the best following any decision they make.

Individuals whose judgements are influenced by outcome bias can hold decision makers responsible for events beyond their control.

Similarly, if an incident leads to death it is often considered very differently and critically, compared to an incident that results in no harm, even where the incident or error is exactly the same.

When people are judged one way when the outcome is good, and another when the outcome is poor, accountability levels become inconsistent and unfair.

To avoid the influence of outcome bias, one should evaluate the decision or action taken at the time it was taken and given what was known or going on at that time, irrespective of the success or failure of the outcome.

The YHSHA and NHSB&A have policies for the undertaking of SUI investigations. This includes the following of the National Patient Safety Agency (NPSA) guidance, ensuring that investigators or investigating teams have the skills and experience appropriate for the case, investigate appropriately, produce suitable recommendations and action plans to deal with the issues raised. The investigation report and action plan are then considered by independent clinical reviewers to assess the suitability and appropriateness of the approach. Any concerns raised by the clinical reviewers have to be met before the case can be considered for closure. All three of the SUIs investigated followed this policy approach.

Case 2009/2958

For SUI 2009/2958 the Coroner made a narrative report, which is a factual statement of the events causative of death. The conclusion was that this service user tragically inhaled his food on the first mouthful as soon as he began to eat, rather than this being a choking incident as originally reported and despite all the consequent efforts by the different staff he was unable to be resuscitated and died. The narrative report concludes that the service user died at the Highfield Unit rather than later at the A&E. Also the Coroner saw that the risk of choking was recognised and dealt with in the risk assessment and care plan for this individual. The action plan and lessons to be learnt from this incident for the care and safety of other service users have been put in place by BDCT. The SHA can now consider this case (2009/2958) for closure.

Case 2008/5265

For SUI 2008/5265 the Coroner has recorded that the service user died from natural causes. There remains a lack of clarity about what caused the Pseudomembranous Colitis and how this was contracted by the service user. Given the lack of pathology testing results for the service user’s colon or stool sample the cause is unlikely to be identified. If it was caused by Clostridium difficile we do not know the source of infection.

The Health Protection Agency Clostridium difficile fact sheet (13.2.2009) states that: "*Clostridium difficile is a bacterium that can be found in people's intestines. However, it does not cause disease by its presence alone, it can be found in healthy people, about 3% of adults and two-thirds of babies with no symptoms. It causes disease when the normal bacteria in the gut, with which C. difficile competes are disadvantaged, usually by taking antibiotics, allowing the C. difficile to grow to unusually high levels. This allows the toxin they produce to reach levels where it attacks the intestine and causes symptoms of disease."* ... "*Clostridium difficile causes diarrhoea (mild to severe) and, unusually , life-threatening inflammation of the intestines. Other symptoms can include fever, loss of appetite, nausea and abdominal pain or tenderness." ... "Another person may acquire C. difficile disease by ingesting the bacteria through contact with contaminated environment or patient." ..."Because Clostridium difficile is able to produce a form of cell that is highly resistant to chemicals (spores), hand washing using soap and water rather than alcohol is recommended"....*

The spores are very resistant and can live on surfaces or in soil for months. The Service User was known to access the clinical waste bin, he was reported to wander in the garden and greenhouse and he may have come into contact with a person carrying the spores due to poor hygiene. He was never reported as having been seen to eat anything from the clinical waste bin and despite a pair of surgical gloves being found in his rectum we cannot say if they came from the clinical waste bin. It was reported that surgical gloves where used in Weaver Court.

There is still the outstanding question of what was known by the GP and District Nurses involved in this case and what action, if any, that they took and this should be followed up by NHSB&A. This should then allow YHSHA to consider this case (2008/5265) for closure.

Case 2009/2860

For SUI 2009/2860 a Coroner's Inquest was not undertaken and the cause of death on the service user's death certificate was given as 1a) Chest Infection and 1b) Heart Failure. An inquest is not undertaken for every death as explained above. In this instance I do not know why one was not undertaken. However, because the Service User's identity and cause of death were known an inquest may not have been considered necessary. It is not possible from the internal investigation report to say how the Chest Infection occurred and as that internal investigator did have access to all the files and clinical reports at the time it is unlikely that this could be identified now. The service user was placed temporarily at Weaver Court for five years and given her health needs she may have been better placed in a Nursing Home, but no assessment was undertaken. The lack of a handover of a key piece of information from the junior doctor in the BRI to the Consultant meant that the opportunity to deal with the misplaced PEG feeding tube was missed. However, clearly a misplaced PEG feeding tube would not cause a chest infection.

The overall lack of care co-ordination and multi-disciplinary working also meant that key pieces of information were not shared and the different aspects of the service users needs were treated in isolation. There was also a lack of advocacy and involvement of adult safeguarding that could have assisted the service user in identifying her own wishes and needs. This case was complex and no individual issue could be seen as causal. It highlights the need for annual health checks and health action plans that consider all health issues together to be organised for all Learning Disability service users. The combined action plan identifies the actions required to address the issues identified in the internal investigation and by the YHSHA clinical reviewers. This will be performance managed by NHSB&A to ensure that the case (2009/2860) can then be considered for closure.

In conclusion:

These three SUIs raise questions for YHSHA and NHSB&A to make sure that future complex SUI investigations have the correct mix of investigators with the skills and experience to address the issues or the ability to access appropriate advice. This is normally checked by the clinical reviewers at the end of the process and investigating organisations need to be reminded of this requirement so that it is considered at the start of the investigation. When the complex SUI investigation involves a number of organisations the investigator or investigating team need to be able to ensure that the investigation report is informed by direct access to relevant documents and staff in each of the organisations involved. This could be achieved by each of the organisations appointing an investigator to work with the lead investigator and using the multi-organisation SUI investigation checklist which has now been introduced by the SHA. Whilst the three SUIs cannot be seen as a cluster of incidents there are similar issues identified for Weaver Court in the two SUI and the HCC, CSCI and CQC reports. These similar issues raised questions about staffing levels, staffing mix, lack of up to date care plans, communications, the health input, health checks and health action plans, the poor environment, advocacy and safeguarding.

Wider regulator reports

The HCC, CSCI and CQC reports highlighted substandard care in the learning disability service following visits to the Highfield Unit, Weaver Court, and Branwell lodge in March 2009. The action plans produced by BDCT and follow-up visits by the CQC have reported a marked improvement. A letter from CQC dated 16th July 2009 stating that the investigating team has closed the case. In the case of Weaver Court which was also involved in two of the SUI cases the CQC revisited the residential care home on 19th October 2009 and increased the quality rating to one star adequate service. The commissioners have taken on the responsibilities of monitoring the service and ensuring that the quality of the service continues to improve with the commissioning strategy.

National reports: Considerations for Bradford and Airedale

In January 2009 the Department of Health launched 'Valuing People Now' as a three year strategy for people with Learning Disability. I have set out the key themes from this strategy that are relevant to this report:

- *The fundamental principle that people with learning disabilities have the same human rights as everyone else.*
- *Commitment to giving people more independence, choice and control through high-quality and personalised services.*
- *Better health for people with learning disabilities is a key priority.*
- *The NHS Next Stage Review sets out the vision for the NHS that it will 'deliver high quality care for* ***all*** *users of services in all aspects'.*

In March 2009 the Local Government Ombudsman and the Parliamentary and Health Service Ombudsman published "Six lives: the provision of public services to people with learning disabilities". This publication was the investigation by the two Ombudsmen into complaints made by Mencap on behalf of the families of six people with learning disabilities, all of whom died between 2003 and 2005 while in NHS or local authority care. The complaints were made following Mencap's report, Death by indifference, published in March 2007. This led to the setting up of the

Independent Inquiry into Access to Healthcare for People with Learning Disabilities and the inquiry's report, Healthcare for All, which was published in July 2008.

I mention the Six Lives report here not only because it led to the publication of Healthcare for All, but because it includes lessons to be learnt for people undertaking SUI investigations. The ombudsmen reached decisions that the Local Authorities and NHS organisations had failed in some of the aspects of the cases, but not all. The logic they applied to their decision making and the weight they applied to Coroner's Inquest findings in two cases should be useful for investigating staff undertaking future SUI investigations.

It is important that we consider the position today following the action taken after the SUI investigations and HCC, CSCI and CQC reports rather than what was the position when they were first investigated. There were weaknesses in the SUI internal investigation reports, but despite that the action plans have addressed the system issues and changes that were required to reduce further risks and to learn lessons and this is the purpose of the NPSA approach. There do remain some questions following the SUI investigations, but whether any further investigation now will address them requires further discussion by the Internal Review Panel. In 2008/5265 we do not know what was known by the GP and District Nurses about the frequency of loose stool and how the service user contracted the Pseudomembranous colitis. In 2009/2860 we do not know why the key information about the possible faecal matter in the PEG feeding tube was not conveyed by the junior doctors to the Consultant at the BRI. The HCC, CSCI and CQC reports have shown a marked improvement in the service provision with the investigating team having closed the case and in the case of Weaver Court changed the quality rating accordingly. Many of the system issues identified in the investigations are being addressed by the implementation of the commissioning strategy and that should be supported and progressed.

11. CONCLUSION

The terms of reference for this independent review required the reviewing of the three SUI reports and action plans to assess their robustness and to also review the actions taken following the HCC, CSCI and CQC inspection reports. Following that the independent review was to identify any system failures, lessons learnt and any additional actions required. Finally a review of the existing commissioning strategy was to be undertaken to identify any additions required as a consequence of this independent review. I have set out the independent review report to follow the order in the terms of reference to ensure that the independent review has followed its commission. The independent review was aimed at informing the discussion of the existing internal review panel set up by YHSHA.

The HCC, CSCI and CQC inspection reports had identified substandard care, but a lot of work has already taken place to address those issues as has been recognised by CQC with the closure of the case by the investigating team and the change in quality rating. The action plans need to be performance managed to completion by BDCT and the commissioners. The lessons learnt from these reports should be shared widely to ensure that other organisations can also put in place systems that improve the care for the learning disability service users.

The three SUI investigation reports were investigated using NPSA guidance, including root cause analysis. However, we were left with outstanding questions in two of the SUI and the other SUI report (2008/2958) relied upon the Coroner report to bring together the events. In 2008/5265 we do not know what was known by the GP and District Nurses about the frequency of loose stool and how the service user contracted the Pseudomembranous colitis. It is unlikely that we will ever know how the service user contracted the Pseudomembranous colitis, but YHSHA should request NHSB&A to investigate what was known and any action undertaken by the GP and District Nurses about the frequent loose stools and accessing the clinical waste bin. In 2009/2860 we do not know why the key information about the possible faecal matter in the PEG feeding tube was not conveyed by the junior doctors to the Consultants at the BRI and we do not know how the chest infection was contracted. However, reinvestigating these cases now may not produce any further information to answer these outstanding questions and this requires further discussion by the Internal review Panel. The action plans have been produced do deal with the system issues, the reduction of risk for other service users and lessons learnt. The combined action plan for 2009/2860 should be performance managed to completion by NHSB&A.

The existing Learning Disabilities Commissioning Strategy once fully implemented has the potential to avoid the system risks evident in the SUI reports and the HCC, CSCI and CQC reports. However, risks remain during this implementation phase and the performance management of its implementation should be progressed as rapidly as possible by CBMDC and NHSB&A.

Healthcare for All and Valuing People Now provide clear support and good practice for the improvement of services for Learning Disability service users. The lessons learnt from this independent review, the SUI investigations and the inspection reports should be shared widely to support improved practice for all Learning Disability service users. The local Valuing People Board, the Healthy Ambitions Learning Disability Pathway Group, ADASS and the Healthy Ambitions Delivery Board have responsibilities to performance manage the development of Healthcare for All and Valuing People Now.

12. RECOMMENDATIONS

1. **NHSB&A** should ensure that holistic care assessments and appropriate documentation is used by all providers, including Primary Care services, in the care of all people with learning disabilities.

2. **NHSB&A** should continue to performance manage all relevant providers (BDCT, Bradford Teaching Hospitals Foundation Trust, Bradford and Airedale Community Health Services) to completion of the combined action plans arising from all three SUIs and then audit subsequent impact.

3. **NHSB&A** should ensure commitment to agreed standard clinical processes based on the best evidence around the management of PEG feeds, and ensure that this is delivered through the contracting process.

4. **CBMDC and NHSB&A** should ensure that the arrangements are in place to performance manage the introduction of the Learning Disability Commissioning Strategy as rapidly as possible so that the system risks and safeguarding issues identified are reduced.

5. **CBMDC and NHSB&A** should use the local 'Valuing People' Board to ensure that lessons learnt are spread throughout the services in Bradford and the 'Valuing People Now' and 'Healthcare for All' strategies are introduced.

6. **CBMDC and NHSB&A** should raise the profile of the commissioned Independent Mental Capacity Advocate services to ensure that providers of services seek their involvement when dealing with vulnerable people that may have capacity issues.

7. **CBMDC and NHSB&A** should ensure through the commissioning process that adult safeguarding is a high priority within all partner organisations within the Bradford district. The organisations should adhere to joint safeguarding procedures set out in the commissioning process, and practice should be regularly monitored.

8. **NHSB&A and YHSHA** should ensure that investigations that take place across multiple organisations are resourced and supported appropriately by the organisations involved so that the investigating teams have an appropriate membership and mix of skills and have access to appropriate records and staff to produce robust investigating reports following the NPSA guidance and root cause analysis.

9. **YHSHA and ADASS** should use the Healthy Ambitions Learning Disability Pathway Group, Yorkshire and Humber ADASS and the Valuing People Support Team to spread best practice for Learning Disability Service Users throughout the region.

10. **YHSHA and ADASS** should raise the profile of adult safeguarding across the region and ensure that SUIs that raise safeguarding issues are referred to the relevant multiagency adult protection processes.

11. **YHSHA** should consider for closure the SUI 2008/2958.

12. **YHSHA** should use the Healthy Ambitions Delivery Board to ensure that the care pathways being developed take into account the needs of vulnerable adults to meet the physical health needs and maintain the well being of people with learning disability.

13. **YHSHA** should publish this independent review and share with the organisations involved so that their own governance arrangements can address the necessary changes. Further, it should ensure learning from these events is facilitated across the region. It should also share a copy with the Care Quality Commission and National Patient Safety Agency.

14. **YHSHA's** Internal Review Panel should consider this independent review and take a view on the need for further investigation and the recommendations made.

APPENDIX A: GLOSSARY OF TERMS

Organisations involved in this report

BDCT	Bradford District Care Trust
CBMDC	City of Bradford Metropolitan District Council
YHSHA	Yorkshire and Humber Strategic Health Authority (NHS Yorkshire and Humber)
NHSB&A	NHS Bradford and Airedale
BACHS	Bradford and Airedale Community Health Services (part of NHSB&A)
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust
BRI	Bradford Royal Infirmary (part of BTHFT)
YAS	Yorkshire Ambulance Services NHS Trust

Abbreviations

CQC	Care Quality Commission
HCC	Healthcare Commission
CSCI	Commission for Social Care Inspection
SUI	Serious Untoward Incident
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
ADASS	Association of Directors of Adult Social Services
STEIS	Strategic Executive Information System
A&E	Accident and Emergency
SLT	Speech and Language Therapist
PEG	Percutaneous Endoscopic Gastrostomy - a feeding tube placed directly into the stomach so that liquid food can be given when an individual cannot swallow properly
NICE	National Institute for Health and Clinical Excellence
RCA	Root Cause Analysis
AED	Automatic External Defibrillator
PaSA	Purchasing and Supply Agents
GP	General Practitioner
CTLD	Community Team for Learning Disabilities
IR1	Incident Record Form 1
IMCA	Independent Mental Capacity Advocate