Derbyshire Healthcare
NHS Foundation Trust

24 July 2017
Press statement

Independent investigation into the care and treatment of Ms Z: Response from Ifti Majid, Acting Chief Executive at Derbyshire Healthcare NHS Foundation Trust

On behalf of Derbyshire Healthcare NHS Foundation Trust, I offer my sincere condolences to all individuals affected by this case. The victim was a much loved mother, grandmother and friend and I am aware that many lives have been changed forever by the tragic events of December 2013.

I apologise for the missed opportunities identified in the independent report published today. The report highlights a number of areas where we could and should have provided better and more joined up care. I am sorry for these missed opportunities and I am sorry for the family's loss.

I also apologise to Ms Z and her family for the omissions in our care. I am sorry that we let Ms Z down and I deeply regret the terrible impact this has had on her family.

The tragic events of 2013 have significantly affected the Trust over the last few years. In 2014 the Trust undertook a thorough internal investigation into the care and treatment of Ms Z prior to December 2013. This investigation identified a number of areas where the Trust could learn lessons, continually improve the quality and effectiveness of our services, and minimise the possibility of a reoccurrence of similar events.

A formal action plan was developed and I can confirm that all recommendations have been completed, in full. The services provided by the Trust today are very different to those that were in place in 2013. The improvements we have made in response to the learning identified by this tragic set of circumstances have transformed our services and made Derbyshire a safer place than it was in 2013.

We fully accept the recommendations made in the independent investigation report and are committed to delivering them in full. A robust action plan has been developed in response to the recommendations made and we will continue to learn from this case and make ongoing improvements to our services.

Today the Trust works with an electronic patient record, which provides all staff working across mental health services with immediate access to notes regarding a patient's care and their clinical presentation. We have also ensured wider connectivity to other clinical records for those in support of drug and alcohol services and to extend this access to GPs and hospital staff.

In 2014 we introduced a new family liaison service, to support families experiencing difficult and tragic events such as these. This has transformed the way we work with families immediately after an incident and beyond.

We have developed a new, innovative communication tool that enables families and friends to safely share information about an individual with our staff.

We have also changed the way we identify carers, to enable anyone with close contact with a service user to receive support. We have also looked at new and innovative ways for people to share insight or concerns about an individual with a healthcare professional. Our use of the SBARD communication tool is an initiative that is being introduced in other similar Trusts as a result of the benefits it has brought to our services for engaging families.

We are taking a new approach to keeping service receivers and others safe from harm, working side-by-side with service users so that they are encouraged to be the authors of their own 'safety plan'. This is something that helps us to better understand our patients as individuals, and empowers them to think about how they can keep themselves safe.

A new, multi-agency safeguarding hub has been established through a partnership approach by the Trust, the Police and social care colleagues. Here the multidisciplinary team work together in the same location; providing immediate support and response to criminal justice teams, connecting our care.

The Trust has also invested in key safeguarding roles and developed a new model to safeguard those in our care.

We have made a number of improvements to the different elements of care that combine to form the Care Programme Approach (CPA) and we have committed to capturing these improvements in the development of a new CPA policy.

We will continue to provide greater training, using the recommendations of this report for Trust-wide learning. We will also conduct regular audits to check adherence to the CPA policy, which will include guidance on family inclusive practice.

We have engaged with all staff who were involved in the care and treatment of Ms Z prior to the tragic events of 2013 and sought to offer appropriate support. We have held a number of focused events for our staff to learn from these tragic circumstances, understand the changes required and the reasons behind them.

A 'buddy' system has been introduced to ensure staff who experience such very serious incidents receive appropriate support.

We are committed to continuing to improve our practices, procedures and services and we will support all our staff to work together and learn as much as we can from these tragic events.

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A copy of the independent investigation report into the care and treatment of Ms Z can be accessed through NHS England's website at: https://www.england.nhs.uk/mids-east/our-work/ind-invest-reports/

The Trust's action plan, developed in response to the report can be accessed at http://www.derbyshirehealthcareft.nhs.uk/standards/performance/improvement-plans/