NHS England Yorkshire &Humber (Y&H) assurance statement in response to the Independent Investigation into the care and treatment of MB

The Independent Investigation in relation to the care and treatment of MB was commissioned in line with NHS England's Serious Incident Framework 2015 (SIF). A proportionate approach to the investigation was agreed through the associated Terms of Reference given the potential limitations due to the historical nature of the incident.

The resulting report and recommendations are due to be published shortly and the response from Tees Esk and Wear Valley NHS Foundation Trust (TEWV) which outlines the actions that they have taken to date in order to address the learning from the investigation report is recognised and accepted.

The decision not to progress a formal action plan due to limitations of the findings and subsequent recommendations is also fully recognised and accepted, specifically the recommendation aimed towards TEWV who were not the providers of care at the time of the incident. However, it is also accepted that the findings from the investigation identifies the potential for further learning and NHS England Yorkshire & Humber will use existing and appropriate mechanisms to share this in order to influence system learning and improvement. We also welcome the finding from the investigation which outlines that '*a significant amount of learning which has been identified in relation to the care of MB has already been addressed in the considerable legislative changes and changes in the structure and manner in which care is now delivered by the NHS'.*

NHS England Y&H mechanisms and systems for learning from investigations

In line with the 2015 NHS England SIF, where a serious incident indicates issues that have significant implications for the wider healthcare system (learning), or where an incident may cause public concern, the relevant commissioner must consider the need to share information throughout the system i.e. with NHS England Sub-regions and other partner agencies. This includes findings from Independent Investigations commissioned by NHS England.

National guidance outlines that commissioners should share information through Quality Surveillance Groups (QSGs), which brings together different parts of the system to proactively share intelligence and to influence learning and improvement with an aim to prevent recurrence.

https://www.england.nhs.uk/publication/quality-surveillance-groups-national-guidance/

A mechanism to enable this learning and sharing is fully established within the remit of the three QSGs which meet on a bi-monthly basis. There is also an established

escalation mechanism to ensure intelligence is appropriately shared across the wider QSG network.

Where it is deemed appropriate, learning will additionally be shared through the NHS England Y&H Safeguarding Forum for Safeguarding Designated Professionals which would specifically consider the findings if there are any implications for improving multi-agency safeguarding pathways.

The associated learning from the Independent Investigation into the care and treatment of MB will be shared via this forum following publication (during May 2018), in the form of a dedicated agenda item and a learning and sharing report. This will specifically outline tragic circumstances of this incident and the findings from the independent investigation, the learning and the associated themes such as discharge planning, record management and the sharing of data for investigative processes in line with the 2015 Serious Incident Framework and legislative duties.

A recommendation will be made for commissioners and providers of healthcare to consider the learning from this investigation for assurance and scrutiny of existing pathways across mental health services and to influence any local actions for system improvement.

An additional mechanism for ensuring robust and wider oversight and assurance in relation to NHS England commissioned Independent Investigations is through direct representation and membership of the North Regional Independent Investigation Regional Group (IIRG).

The IIRG function is to maintain governance, oversight of Independent Investigations and their progression, ensuring that NHS England has a contemporary process for commissioning high quality Independent Investigations, which supports learning and aims to reduce the likelihood of recurrence and improve mental health services.