Our Ref:

NHS
Bradford District Care
NHS Foundation Trust

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29 April 2025

Dear Ms Brocklehurst

I set out below the Trust's response to your Prevention of Future Deaths notice arising from the Inquest into the death of Andrea Mann.

Matters of concern

1. **That during the period of [the deceased's] involvement with the Community Mental Health Trust between the period 25/04/2023 and 04/12/2023 the care given to the deceased was limited to 2 appointments only within which she was referred back to her GP for medication adjustment which had been seen to be ineffective, and referral to Psychological therapy sessions which had a waiting period of 6 months despite an earlier private consultation having been proved ineffective.**

   That the frequent requests of the deceased and her family for a Psychiatric appointment had not been provided to her, with the result that the deceased had to seek a private consultation.

2. **That no evidence of any overarching management tool existed to provide scrutiny of the care given to the deceased, or measure the success or efficacy of such care, and as such there were many lost opportunities to provide to the deceased and her family sufficient, consistent, controlled, and bespoke care.**

Trust response

Bradford District Care NHS Foundation Trust have taken the following actions to prevent future deaths:

1. A routine re-referral process has been developed and implemented from April 2025 to ensure management oversight of any service user re-referred to Community Mental Health Services within 6 months. This includes:

    I. Identification of those re-referred within 6 months.
    II. Review of the case by the Assessment Team Manager.
    III. Contact made by the Assessment Team Manager within 5 days of screening.
    IV. Intelligence gathering to understand service users ongoing needs and identify the best course of action. This should include the voice of the individual and their family.
    V. Prioritisation of assessment based on the needs of the individual and level of risk identified.
    VI. Previous reasons why recommendations were not successful to be explored on assessment and further recommendations made.
    VII. Clear description of what the service user/family/carer are requesting needs to be considered and documented.
    VIII. Clear rationale for next steps should be recorded and plan outlined.
    IX. 2nd assessment to be discussed with wider Multi-Disciplinary Team for assurance.
    X. All feedback should be recorded clearly in a letter to both the service user and their GP and/or referrer as appropriate.

2. Weekly monitoring of re-referrals is now undertaken by the Community Mental Health Service Clinical Managers. This includes the number of re-referrals received, the outcome of the re-referral process, analysis of trends and themes and the dissemination of learning. This information is reviewed by the Community Mental Health Service Manager and shared by exception in the Deputy Director's weekly report out to ensure senior oversight.

3. Weekly oversight of discharges is now undertaken by the Community Mental Health Service Clinical Managers. This includes a dip sample audit of discharges every week to ensure that the Transition of Care Policy, the Care Programme Approach Policy, and the Section 117 Policy have been adhered to, and to confirm that the discharge was safe and appropriate. The outcome of this review is shared with the Service Manager and reported by exception to the Deputy Director's weekly report out to ensure senior oversight.

4. A review of the Community Mental Health Assessment Team was undertaken in 2024/25 to support an understanding of the problems and identification of ideas and solutions to address and improve access, waits and experience. It was identified that an increase in waits was attributable to a number of factors including capacity of the workforce within the pathway, the process of screening and administering an assessment through the electronic patient record and unwarranted variation in how this was done. By identifying the problems, we were able to identify opportunities to improve both the process and in turn release clinical time to provide more direct clinical time to delivering assessments to those that need it.

5. Improvement activities were agreed and a timebound recovery plan created to stabilise, mitigate and improve waits into the Community Mental Health Assessment Team. This included:

    I. A demand and capacity analysis to understand the workforce gap.
    II. Use of bank shifts and agency workers to increase clinical capacity in the short term.
    III. Increased administrative capacity to support with booking appointments and freeing up clinical time.
    IV. A review and streamlining of the process and associated clinical administration to eliminate any non-value-added steps in the process and release clinical time to care.

6. In addition, direct referral pathways were created to reduce the number of assessment points in the pathway and reduce unnecessary waste in the process:

    I. Where a service user has been supported by the Intensive Home Treatment Team and requires ongoing care and treatment from the Community Mental Health Team, these referrals are now directed to CMHT Team Managers for review/allocation negating the need for the Assessment Team to screen or assess.
    II. First Response Service referrals, where a mental health practitioner has undertaken a face to face assessment, are now directed to CMHT Team Managers

for review/allocation negating the need for the Assessment Team to screen or assess.

III. Where a service user is transferring into Bradford District and Craven from another area, their transfer of care request is now directed to the relevant CMHT Manager group for review and decision, further reducing the demand on the Assessment Team.

7. For those referrals that have been assessed as requiring an appointment with a consultant psychiatrist, this will be booked by the admin team. At present, routine appointments are being booked 4-6 weeks in advance however the urgency of the appointment is based on the formulation of risk based on the assessment findings and a Multi-Disciplinary Team discussion. If it is felt that the individual needs to be seen more urgently, medics have urgent appointment slots for this purpose.

8. We are committed to continuous improvement utilising BDCFT quality improvement methodology to improve the timeliness of support available, and a programme of work has been established, commencing April 2025, to ensure that people are able to access a meaningful intervention within four weeks of referral.

I hope the information within this response has provided you with the assurance that you were seeking in relation to further learning. Should you require any further clarification on the details within this letter, please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]

Director of Nursing, Professions and Care Standards, DIPC, Deputy Chief Executive, Director of Nursing and Quality for Bradford District and Craven Health and Care Partnership