An independent external quality assurance review in respect of mental health service users Mr A and Mr B in Birmingham

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Niche Health & Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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Contents

1   Executive summary

1.1   In 2011 and 2012 two individual homicides occurred, perpetrated by male service users who will be referred to as Mr A and Mr B, from Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT).

1.2   Both men suffered with a psychosis that involved persecutory or paranoid beliefs. In both cases, each mother was the main carer, and was killed by the service user. In each case the mother had raised concerns with the teams caring for the service users immediately prior to their death.

1.3   They were investigated as Domestic Homicide Reviews (DHR) for the Birmingham Community Safety Partnership (BCSP), and BSMHFT completed Independent Management Reviews (IMR) of the care and treatment of each individual.

1.4   NHS England Midlands & East commissioned Niche Health & Social Care Consulting to undertake an external quality assurance review, specifically of the outcomes of BSMHFT's IMR's and the BCSP DHR investigations following the two homicides, to ensure that the recommendations and actions identified have been implemented and are being sustained. The terms of reference for this investigation are given in full in Appendix A.

1.5   Niche is a specialist safety and governance organisation undertaking investigations into serious incidents in healthcare. Sue Denby, Practitioner, Governance and Investigations for Niche carried out the external quality assurance review, with expert clinical advice provided by Dr Ian Davidson. The investigation team will subsequently be referred to in the third person in the report. The report was peer reviewed by Carol Rooney, Deputy Director, Niche.

1.6   Since the homicides occurred, BSMHFT is no longer the sole provider of adult mental health services in the area, and Forward Thinking Birmingham (FTB)[1] is now commissioned by the three Birmingham clinical commissioning group (CCG) to provide mental health services for people up to 25 years and early intervention services for people up to 35 years of age. FTB combines the expertise of Birmingham Children's Hospital, Worcestershire Health and Care NHS Trust, the Priory Group, Beacon UK and the Children's Society. The FTB service model is attached at Appendix B.

1.7   Additionally, since the homicides occurred, BSMHFT has implemented new models of service as part of a transformation project called New Dawn. The New Dawn service model description is attached at Appendix C.

1.8   The external quality assurance review has focused on the following key lines of enquiry:

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[1] FTB combines the expertise of Birmingham Children's Hospital, Worcestershire Health and Care NHS Trust, the Priory Group, Beacon UK and the Children's Society.

- The DHR process of oversight and quality assurance of the final report.
- Bed management.
- Access to Approved Mental Health Professionals (AMHPs).
- Transitions.
- The care programme approach (CPA) and crisis plans.
- Medication concordance and risk assessment.
- Carer's assessments, involvement and engagement.
- Record keeping and information sharing.
- The role of the nearest relative and police powers of entry.
- Structures for learning lessons following serious incidents.

1.9 The external quality assurance review commenced in February 2016 and was completed in October 2017. Between June and October 2017 a review of further progress was undertaken. Evidence initially provided for the external quality review was therefore updated where appropriate. A second progress review is planned in six months after publication.

1.10 The external quality assurance review comprised of the triangulation of interviews with clinical and managerial staff from FTB and BSMHFT, meetings with users and carers and a review of documents and policies. Staff interviewed are attached at Appendix D. Documents and policies reviewed are attached at Appendix E. We have graded our findings using the following criteria:

Grade	Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

1.11 Two of the key lines of enquiry do not correspond to recommendations made. These are the DHR process of oversight and quality assurance of the final report and structures for learning lessons. We have therefore summarised our findings in respect of these in the respective narrative sections of the report without assigning a grade.

1.12 We consider that, in respect of the bed management and lack of clarity about the provision of AMHPs, if a similar incident or circumstances such as outlined in the DHR for Mr A occurred today that the current systems would potentially not prevent a reoccurrence.

1.13 We believe there are two areas in which if a similar incident or circumstances, such as outlined in the Mr A DHR, occurred today that the current systems would potentially not prevent a reoccurrence.

1.14 Firstly, against the recommendation that the bed management policy is sufficiently robust, understood and implemented by clinicians and senior managers in a way that keeps people safe. This is due to the fact that the

operational management of beds in BSMHFT and FTB does not include the critical safety metric of no delay in accessing an inpatient bed once it is deemed necessary.

1.15 BSMHFT told us that they are committed to the provision of an inpatient bed as a priority, and their view is that this should be considered within the national shortage of beds and the challenges this can pose in enabling ready access to beds at the point of the decision to admit.

1.16 We note the approval of a business case to provide a further 27 beds from commissioners comprising two new wards (15 beds for female admissions) and (12 beds for male pre-discharge patients). The beds will accommodate 16 BSMHFT and 11 FTB patients. Discussions were taking place with FTB regarding the provision of the 11 beds and how they would be operationalised in Autumn 2017.

1.17 We also note the level and pace of change in BSMHFT and FTB and the range of bed management initiatives in place, however these do not at present provide the assurance that the DHR recommendation action has been implemented in a way which keeps people safe.

1.18 Secondly, against the recommendation for the City Council, is to ensure that the new AMHP service is implemented as soon as possible and enshrined in training and policy with guidance, we concluded that although Birmingham City Council have implemented a new service, the staff and BSMHFT and FTB remain confused about the service and are still to feel the benefits.

1.19 We have not made recommendations in respect of our findings, as the further review planned in 2018 will assess progress against the key lines of enquiry, the IMR and DHR recommendations and the grades as outlined below.

#	Key Line of Enquiry	Recommendation		Grading FTB
1	Bed Management.	The bed management policy is to be reviewed and a clear monitoring process put in place.		B
2	Bed management.	The bed management policy is sufficiently robust, understood and implemented by clinicians and senior managers in a way that keeps people safe.	D	D
3	Access to Approved Mental Health Professionals (AMHPs).	Birmingham City Council is to ensure that the new AMHP service is implemented as soon as possible and enshrined in training and policy with guidance.	C	C
4	Transitions.	Ensure that teams are complying with the transfer and transition policy and there is a detailed handover meeting for a service user transferring to another team for longer term care, involving relevant agencies and engaging with as wide a range of family members as reasonable.	C	C
5	The care programme approach (CPA) and crisis plans.	Ensure that crisis plans are built into CPA care planning and followed.	B	C
6	The care programme approach (CPA) and crisis plans.	Put in place procedures and monitoring arrangements to ensure that the assessment for specialist mental health services involves includes all significant others living with and involved in the life of the service user and include meaningful contact with the patient in order to establish their mental state and degree of risk before being considered complete.	C	C
7	The care programme approach (CPA) and crisis plans.	Put in place procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carer's assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually.	A	C

	Key Line of Enquiry	Recommendation	Grading BSMHFT	Grading FTB
8	The care programme approach (CPA) and crisis plans.	Ensure that each assessment includes all relevant information from family, friends, carers and others but must include meaningful contact with the patient in order to establish their mental state and degree of risk before being considered complete.	C	C
9	Medication concordance and risk assessment.	Ensure that staff recognise poor concordance with medication as an indicator of risk and that non-concordance is incorporated into the risk management plan of the CPA.	B	D
10	Medication concordance and risk assessment.	Implement a clear protocol for monitoring medication concordance for people who are considered to require sustained (long-term) treatment with antipsychotic medication that can review actions and risk against concordance.	B	D
11	Medication concordance and risk assessment.	Risk assessment training to consider risk in its broadest sense, and ensures all practitioners can consider potential as well as actual risk to the individual as well as to those around them.	D	E
12	Medication concordance and risk assessment.	Ensure that all staff are complying with clinical and management supervision policies ensuring that the management of clinical risk is imbedded in multi-disciplinary meetings, with emphasis on the role of the carer and family members.	C	B
13	Carer's assessments, involvement and engagement.	Families and carers, and where a significant other is offering a caring role, are to be made aware of their right to a carers assessment. The offer must be clearly documented, with reasons provided if not accepted, and a date set to revisit this with the carer. Carers assessments are to lead to care plans, which are to be followed, informed by the family's or carer's wishes.	C	E
14	Record keeping and information sharing.	Jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer.	D	D
15	The role of the nearest relative and police powers of entry.	West Midlands Police to provide practice guidance for mental health practitioners about police officers power of entry and search of premises without a warrant, to save life and limb or prevent serious damage to property as per Section 17 Police and Criminal Evidence Act 1984	B	B

2   External quality assurance review

Contact with the perpetrators and victim's family

2.1   We offered the opportunity to both Mr A and Mr B to meet with us prior to publication of the report. In consultation with the responsible clinicians (RC), the service users were not interviewed as part of this process due to their mental state and capacity.

2.2   Mr A did not wish to meet with us, however we met with his RC on the 20 October 2017 to feedback the findings of the investigation so that he is in a position to provide support to Mr A at publication.

2.3   We met with Mr B on the 22 January 2018 to feedback the findings of the investigation. He commented it was important to understand that with some people there is a possibility of relapse even if they are compliant with medication. Additionally, from a carer's perspective he reminded that they may be mistrustful of mental health services and need support to engage.

2.4   Mr B's family had previously indicated that they did not wish to be involved in this independent investigation.

2.5   Contact was made with the sister of Mr A's victim. In the meeting held on 13 December 2016 she clearly indicated that she was seeking an apology from BSMHFT. We were informed by BSMHFT that an apology and sincere condolences was provided on 16 November 2017.

2.6   The victim's sister was not involved in the internal investigation undertaken by BSMHFT. She feels as though the family of the victim don't seem to matter and that BSMHFT want the family to move on and forget. She stressed the crucial importance of communication with the family about subtle changes and to keep them informed even if there is nothing to report.

2.7   She told us that she had no offer of support from BSMHFT after the homicide although has had support via Victim Support which is ongoing. She wanted to stress the traumatic impact on the whole family even now. Discussions about the potential leave arrangements for Mr A are proving so traumatic that the family are thinking of moving.

2.8   She explained how her sister initially thought she could manage Mr A and felt it was her responsibility to get him to take the medication. Disagreements between them were always about the medication. When her sister couldn't manage him she felt not enough support was offered to her.

2.9   She said that because Mr A was paranoid, sending different people to visit him at home was not helpful. Medication was posted through the letter box on two occasions and food and drink left for Mr A was untouched upstairs which the team knew about.

2.10   She asked why Mr A had not been prescribed a long acting injection (depot medication). Both the IMR and the DHR refer to the fact that Mr

A was agreeing to take his medication and that his mother was supporting him to take it.

2.11 Both the IMR and DHR for Mr A made recommendations about medication concordance. Medication and risk assessment is discussed in detail in section 11 of the report.

2.12 She told us how she felt that Mr A had been let down and asked if a private bed had been found for him would it have made a difference and prevented the homicide. The issue of bed management is discussed in detail in section 7 of the report.

2.13 We offered her the opportunity of providing a victim impact statement to the external quality assurance review.

3 Summary of the care and treatment of Mr A and Mr B

Mr A

3.1 Mr A was referred to the BSMHFT home treatment team (HTT) on 20 March 2012 by his GP, after a change in his behaviour over the past year. He had become verbally abusive to his mother, paranoid and suspicious, and was possibly hearing voices.

3.2 He had previously been seen by the GP and prescribed medication which his family had supervised. However, his mother had seen the GP alone in February and expressed her and her husband's concern. Apparently Mr A was talking to himself and staring in the mirror for long periods.

3.3 A was assessed and found to be socially withdrawn, poorly motivated and believing his mother was possessed by demons. He had ringing in his ears, and is reported to believe that he could change the weather and that certain music had a specific meaning for him. He was diagnosed with prodromal (early signs) of schizophrenia.

3.4 The initial plan was that the HTT would visit daily and administer the medication as prescribed. Visits were to be in the evening to also have contact with his mother. After the first day he refused further medication for four days.

3.5 It is understood that Mr A also told his mother that if she let another person visit the home he would leave. Admission to hospital was discussed, but at that time his mother was keen to keep him at home.

3.6 From the end of March Mr A took his medication supervised by the HTT. His mother took over this supervision on 11 April. HHTT would continue to visit Mr A, but earlier in the day, to spend more time with him. He was referred to the early intervention service (EIS), improved, and HTT reduced visits to alternate days from 19 April.

3.7 The EIS assessed him on 26 April 2012. He refused to allow his father to be in the room at the same time, though he was spoken to afterwards. He was

found to have delusions of persecution, control, references, and grandeur. He denied any thoughts of self-harm or violence to others. He was allocated a care coordinator, and the plan was to engage with his mother for a more comprehensive history.

3.8 Mr A refused his medication on 15 May 2012, although a supply was left with his mother. He became very angry with his mother when she pointed out the changes in him and whilst she tried to persuade him to take the medications. From then he was reported to be intermittently needing persuasion to take the medication.

3.9 By 7 June 2012 it appears he was not taking his medication regularly, and HTT were re-engaged to assist with medication and supervision. He needed a lot of persuasion, and stopped and started his medication frequently. Admission was again discussed. By 20 June he refused to be seen at all, and would leave the house if staff visited. He had stopped taking medication on or around 16 June.

3.10 He was assessed under the mental health act (MHA) on 26 June 2012, but was not seen as detainable, although he would not stay for the assessment and left the house. The agreed plan was for HTT and EIS to jointly visit daily for one week to see if he could be persuaded to take medications. The risk to self or others was described as 'low'.

3.11 By the 28 June 2012, his mother reported that he was going out to avoid professionals, and that he was starting to smell and not eating. The MHA assessment process was restarted, and, according to the process for admission under detention, the medical recommendations were completed. Mr A was placed on the bed list as a priority but there was no bed available, and no Approved Mental Health Professional (AMHP) to complete the application for admission on 29 June.

3.12 He avoided EIS staff when they visited on the 29 June 2012. His mother now agreed admission was needed, though she suggested that no one visit on the Sunday (1 July) as the visits increased Mr A's agitation. EIS and the HTT stayed in touch over the weekend and attempts were made to find a bed for him.

3.13 On 2 July 2012, the EIS staff explained to the EIS consultant psychiatrist about Mr A's deterioration, and he made moves to arrange a bed for admission of Mr A. At 4pm, with a bed now available, the AMHP and the doctor went to his house but there was no reply. Attempts had also been made to contact his mother, but again there had been no reply. On 3 July 2012 the HTT were informed that Mr A had been arrested for killing his mother. Mr A had no previous contact with the criminal justice system.

Mr B

3.14 Mr B had been known to mental health services since 1999. For the first ten years of his contact with mental health services he was hard to engage with and poorly compliant with his medications. He had ten admissions between 2002 and 2009, six of these between 2002 and 2003.

3.15   Mr B had two convictions between the ages of 16 and 20 years of age for drunken driving and making obscene gestures in public with no sentence passed.

3.16   Since an admission under Section 2[2] of the MHA in March 2009 his engagement with services seemed to change. Immediately prior to this admission he had relapsed after not taking his medication.

3.17   On discharge in April 2009 he received initial follow up from the HTT and then from a range of professionals within the community mental health team (CMHT) including consultant psychiatrist, community psychiatric nurse (CPN), clinical psychologist and psychotherapist.

3.18   He had attended a 'Mood on Track' course to help him understand his illness and signs of relapse. He also received input from a dietician as he had problems with weight gain from the medication. He liked to have control of his medication and there were negotiations about dosage. It was also noted that his use of alcohol increased when unwell.

3.19   He had the same consultant psychiatrist and CPN for around eight to ten years. He was then seen every two to four weeks, as well as sometimes in between, for support to go to the housing department or when he came to collect his medication. He was sometimes seen at home, the CMHT base or another community venue. There were no concerns about risk of harm to other people.

3.20   On the 1 July 2011 his CPN made her final visit before retiring after having worked with him for ten years, and told him who his new CPN would be. According to the IMR, there was no handover or transition period with joint visits to allow B and his new CPN to get to know each other.

3.21   His mother made a concerned telephone call to the CMHT on 18 July 2011, and she attended the base with him to see the consultant psychiatrist on the following day. Although he was unwell and had not been taking his medication for several weeks, he stated he was now taking it again, and would be staying with his mother.

3.22   According to the DHR no one asked his mother what her concerns were. An appointment was made to see him in two days' time.

3.23   In the early hours of 20 July Mr B 'phoned the emergency services and said he had killed his mother. After he was arrested Mr B is reported to have said that he had killed the "*she-devil*" and that she had "*shape-changed*" into a demon, and that his rage had come from the voices telling him to hurry and kill the devil. He had been drinking alcohol prior to killing her.

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[2] Section 2 is part of the civil sections under the Mental Health Act. It provides for someone to be detained in hospital under a legal framework for an assessment and treatment of their mental disorder.
http://www.legislation.gov.uk/ukpga/1983/20/section/2

4   IMR and DHR recommendations

Mr A

4.1   The IMR made six recommendations:

- Families and carers to be made aware of their right to a carers assessment.

- Carers assessments to lead to care plans, informed by the family's or carer's wishes, which are to be followed.

- Risk assessment training to consider risk in its broadest sense, and ensures all practitioners can consider potential as well as actual risk to the individual as well as to those around them.

- Develop a protocol for monitoring medication in line with the policy, that can review actions and risk against concordance.

- Bed management policy to be reviewed and a clear monitoring process put in place.

- Review the partnership working and processes between BSMHFT and the local authority with regards to Mental Health Act 1983 assessments.

4.2   The DHR made eight recommendations:

- Care coordinators must ensure (as part of their organisation of care) that all carers are advised of their right to a carer's assessment. The offer must be clearly documented. If the offer is not accepted the reasons should also be clearly documented and a date set to revisit this with the carer.

- Ensure that staff recognise poor concordance with medication as an indicator of risk and that non-concordance is incorporated into the risk management plan of the care programme approach.

- Ensure that teams are complying with the transfer and transition policy and there is a detailed handover meeting for a service user transferring to another team for longer term care, it should involve relevant agencies and engage with as wide a range of family members as reasonable.

- Each assessment needs to include all relevant information from family, friends, carers and others but must include meaningful contact with the patient in order to establish their mental state and degree of risk before being considered complete.

- Ensure that all staff are complying with clinical and management supervision policies ensuring that the management of clinical risk is imbedded in multi-disciplinary meetings, with emphasis on the role of the carer and family members.

- West Midlands Police to provide practice guidance for mental health practitioners about police officers power of entry and search of premises without a warrant, to save life and limb or prevent serious damage to property as per Section 17 Police and Criminal Evidence Act 1984[3].

- The bed management policy is sufficiently robust, understood and implemented by clinicians and senior managers in a way that keeps people safe.

- Birmingham City Council adults and communities service (adult social care), to ensure that the new AMHP service to be introduced is implemented as soon as possible and enshrined in training and policy with guidance.

4.3 The DHR for Mr A discusses at length how he could have been removed from the family home using police powers under Section 17 of the Police and Criminal Evidence Act (PACE), instead of using the powers under Section 135[4] of the MHA.

Mr B

4.4 The IMR made four recommendations:

- CPA Audit for involvement of carers and significant others.

- Development of medication monitoring protocol.

- Transfer of care process within and between teams.

- To ensure that crisis plans are built into CPA care planning and followed.

4.5 The DHR made nine recommendations:

- Put in place procedures and monitoring arrangements to ensure that the assessment for specialist mental health services involves and includes all significant others living with and involved in the life of the service user.

- Put in place procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carer's assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually.

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[3] https://www.legislation.gov.uk/ukpga/1984/60/section/17 Section 17(1)(e) of PACE gives the police the power to enter and search premises without a warrant, in order to 'save life or limb' or prevent serious damage to property. However, it is not enough that the police should have a general welfare concern about somebody in order to use this power of entry, which may only be used in cases of emergency, not general welfare.
[4] http://www.mentalhealthlaw.co.uk/MHA_1983_s135 Section135 is a warrant authorising any constable to search for and remove patients if need be by force, from any premises specified in the warrant in which the person is believed to be and if thought fit to remove him to a place of safety with a view to the making of an application in respect of the person under Part II of the Act, or of other arrangements for the persons treatment and care.

- Put in place procedures and monitoring arrangements to ensure that a carer's assessment is always offered where a significant other is offering a caring role, even if this is at specific times only.

- Jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer.

- Put in place processes that ensure that relatives or significant others contacting services to express concerns about a patient's mental state are given the opportunity to share their concerns with the care coordinator or responsible clinician.

- Put in place processes to ensure that care plans are followed.

- Implement a clear protocol for monitoring medication concordance for people who are considered to require sustained (long-term) treatment with antipsychotic medication.

- Implement a procedure for the transfer of care from one practitioner to another.

- Improve record keeping procedures to ensure that information is available to all members of the team.

4.6   The IMR and DHR both note that apart from a concerned 'phone call on 18 July, there is only one other mention in the notes of communication and involvement of his mother, which was during the 2009 admission. This seems to be despite a tacit understanding that his mother stepped in as a carer when he was unwell. Both the DHR and IMR also note that his mother was never considered at risk, although the risk assessments (and other care planning documentation) were not complete or up to date.

4.7   Where it seemed reasonable we put recommendations together as themes and reviewed assurance against 13 recommendations in total (see 1.12).

The DHR oversight and quality assurance

4.8   Neither the IMR's or DHR's made recommendations in respect of DHR oversight and quality assurance, and we have not therefore provided an assessment grading. However, on review we found anomalies in the DHR for Mr A which we have investigated further.

4.9   In the DHR for Mr A the chronology is completely different to that in the IMR, describing a period of contact with mental health services of approximately 14 months, and with different dates of the homicide.

4.10   The DHR coordinator and DHR review manager were interviewed regarding the anomaly with the date, and explained that prior to the DHR being made

public a risk assessment meeting was held, as per the usual process, which included legal advice and consultation with the responsible clinician for Mr A.

4.11   It was felt that Mr A could be identified without a redaction strategy however the level of redaction required would have made reading and understanding the investigation difficult. As a result, a decision was taken to alter the dates in the DHR by six months with the intention of protecting the identification of Mr A in the media.

4.12   The decision taken to alter the dates in the DHR was an operational decision made by the DHR team and the Chair of the DHR Steering Group. We consider the fact that this decision was not recorded, in a way that would inform the agencies and the family involved, to be an omission, and does not provide adequate governance of the process.

4.13   We believe the decision to alter the dates in the chronology was poor practice and would not normally be supported, although we note that this was a legally informed decision and it was clearly felt at the time to be in the best interests of Mr A.

4.14   The BCSP has a clear DHR process flow chart and in terms of the scope of the DHR, the process would be to collate scoping requests from each organisation for the panel to decide. The DHR coordinator and manager explained that the scope needs to be relevant and up to date, needs to reflect the life of the service user up to that point and include key episodes.

4.15   Terms of reference are drawn up by the independent chair and DHR panel members. The current practice is to ensure that family members are asked to input into the terms of reference where appropriate.

4.16   As a result, the IMR for Mr A went back to the first GP referral to mental health services however the DHR went back further to look at GP involvement. We therefore felt that the DHR scoping decision was a reasonable judgment to make.

4.17   The DHR coordinator and manager explained that governance of IMR's begins with the understanding of the DHR panel that the IMR has already had sign off in the organisation through the strategic lead, including the correction of any inaccuracies, at the point of submission to the panel. This view was supported by the CCG and BSMHFT at interview and we feel this is an appropriate governance structure.

4.18   The overview report is ratified at the DHR steering group and following this the independent chair then presents the overview report to the responsible authorities of Birmingham community safety police and crime Board (BCSPCB). The BSMHFT representative on this Board is BSMHFT chief executive.

4.19   Further to this, the report is subject to the Home Office quality assurance panel for DHRs. If the Home Office is satisfied, and the report is adequate

then the report is returned. The DHR coordinator and manager report that all DHR reports have been assessed as adequate by the Home Office to date.

4.20   The action plan for the DHR is implemented and reviewed quarterly by the Birmingham DHR steering group until completed and multiagency learning events are held.

4.21   The DHR action plans are publicly available on the BCSP website. We found the format of the action plans to be clear and well structured. Both Mr A and Mr B action plans are 'RAG' rated as green for all items, however the final BCSP quality assurance column indicates that the recommendations are awaiting verification by the commissioners.

4.22   The DHR coordinator and manager informed us that evidence and assurance is provided but not in a way that can be audited, indicating the difficulty of holding agencies to account given their different governance processes. They felt that at the present time there was more informal learning than audit. The view of the CCG as commissioners is that the DHR panel should have a process whereby they revisit recommendations every year.

4.23   We were informed by BCSP staff at interview that the BCSP has developed a new quality assurance framework, which challenges the BCSP to secure evidence that DHR's have delivered a desired change in frontline services. The principles of this framework were reported to be well received by the Home Office and would ensure reporting back to families about the changes that have been made as a result of each review.

4.24   We were also informed that the BCSP had plans to commence peer reviews and recruit reviewers to undertake thematic reviews from September 2016. This is noted and adds to the narrative for multiagency learning.

4.25   We found recent evidence of excellent multiagency training facilitated by the BCSP called 'Learning from Domestic Homicide Reviews Safeguarding and Domestic Violence', using actual cases with family permission, specifically in the area of domestic violence and coercive control using multiagency trainers to assist with this from a former police lead and women's aid.

4.26   We were informed that further targeted DHR training will commence in November 2016 and encompass adult safeguarding taking into account the Association of Directors of Adult Social Services (ADASS) guidance Adult Safeguarding and Domestic Abuse.[5]

4.27   However, there was no evidence that multiagency training specifically related to either the themes arising or recommendations in the Mr A and Mr B homicides have been facilitated by the BCSP and we feel there is scope to further develop the multiagency training aspect of the BCSP.

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[5]ADASS Adult Safeguarding and Domestic Abuse guidance can be found at:
http://www.local.gov.uk/c/document_library/get_file?uuid=5928377b-8eb3-4518-84ac-61ea6e19a026&

Bed Management

Recommendation	Grading BSMHFT	Grading FTB
The bed management policy is to be reviewed and a clear monitoring process put in place.	B	B
The bed management policy is sufficiently robust, understood and implemented by clinicians and senior managers in a way that keeps people safe.	D	D

4.28   The IMR and the DHR for Mr A both recommended that BSMHFT review the bed management policy and that the implementation was monitored. The DHR recommendation asks that the Medical Director assures the BCSP that the policy is sufficiently robust, understood and implemented by clinicians and senior managers in a way that keeps people safe.

4.29   To ensure that the policy is understood by clinicians and managers, and to understand the monitoring mechanisms BSMHFT and FTB has put in place to assure itself (and the BCSP) of its implementation we have interviewed staff, users and carers to understand how this works in practice and to review if there are any ongoing problems with bed allocation within BSMHFT and FTB. We have also reviewed minutes of meetings, communication and the quality performance metrics put in place.

BSMHFT

4.30   BSMHFT has a clinical bed management policy with the aim of ensuring consistency in arrangements for ensuring that service users are appropriately prioritised in obtaining inpatient treatment. The policy was recently reviewed in January 2017 with a further review date of January 2020.

4.31   BSMHFT recognised that they had a problem with bed capacity and that they often sent people to inpatient beds out of area, disconnecting them from family, friends and carers and also from local services. The staff we interviewed were all engaged, committed, very aware and concerned about the problems with providing beds locally when patients required inpatient admission and working hard to find solutions.

4.32   BSMHFT also recognised that there were delays in patients seeing experienced clinicians, especially at weekends or out of hours, with patients in inpatient beds for too long. Additionally, BSMHFT often could not find accommodation or the right kind of support for on-going care. Clearly this is dependent on working closely with other agencies.

4.33   To address these concerns, it is commendable that in July 2015 BSMHFT embarked on a major transformation programme called New Dawn to address these issues. The model was co-designed and co-produced with service users, carers, staff, partners and commissioners.

4.34 The New Dawn model expectation was an attempt to mitigate the impact of a reduction of inpatient beds, the aim being that more service users would be treated at home with teams centrally located around a number of clinical hubs, and teams would work in partnership with third sector providers to deliver respite and housing services.

4.35 As part of the model, we were informed that BSMHFT implemented a single consultant for HTT's and a single consultant for each of the inpatient wards in November 2016 to manage bed capacity and to ensure that patients are seen quickly. We see this as positive, and standard practice now across many mental health trusts, but do not believe that this step alone addresses the issue of capacity for inpatient beds.

4.36 Staff interviewed at a clinical level in teams were able to tell us how the bed management policy worked in practice and the process of referrals for inpatient beds.

4.37 The policy states that admission for in-patient treatment will rest on a clinical decision approved by a consultant psychiatrist following consultation and assessment. The clinical decision reached will be that there is no viable alternative to in-patient admission.

4.38 The patient must have been reviewed by a psychiatrist on the day the referral is made. The decision to admit is made by the responsible medical team assessing the patient based on clinical risk and where there is no alternative pathway is suitable. The patient should be in need of assessment or treatment for deterioration in mental health, and be cared for under CPA.

4.39 Medical staff must assess a service user within 24 hours of making a decision to admit. A request will then be made to the bed management team by the relevant HTT (or assertive outreach team after liaison with HTT and documented on the electronic care record).

4.40 All patients must have an up to date health and social care assessment and risk assessment with a clear risk management plan in place.

4.41 If there is a delay in admitting a patient, they should be reassessed within 24 hours and the risk assessment updated every 48 hours. The policy states that this should continue until the bed is accessible and the patient transferred.

4.42 When there is a delay in admission, it is the responsibility of the referring team or clinician to maintain the safety of the patient while still in the community and to record how this is to be managed in a care plan within the electronic care record. Assurance on this will be sought from the referring team at the point the referral is made and referring teams will be reminded of the requirement for them to continue to provide a safe and appropriate plan and level of support in line with trust Policy.

4.43 The policy has a section on bed allocation and process for prioritisation for beds. Referrals are 'RAG' rated green to red with red being imminent risk to self

or others associated with use of the MHA. Red referrals would be admitted to any (or next) available bed in BSMHFT, regardless of whether it is the persons' usual ward for admission.

4.44   To illustrate the current procedures, the policy states that the bed management team in conjunction with support of the relevant consultant and service manager will put significant effort into creating a bed if one is not available. If exceptional circumstances arise where there are several red referrals requiring admission, which exceed available bed numbers, then the Clinical Director or the designated deputy will serve as the 'bed referee' and advise the bed management team on priorities within the group for admission and support efforts to generate further capacity for admission. Out of hours the duty consultant is to be called for advice and support.

4.45   Amber referrals are admitted as next priority, with amber being the presence of an active psychiatric disorder that can either be more efficiently treated, or treated to more rapidly decrease the patient's suffering, or a need for acute psychiatric interventions.

4.46   Amber referrals are admitted to any available adult acute bed in BSMHFT. If circumstances arise where there are a number of amber referrals exceeding capacity (and all red referrals are placed), the Clinical Director where the bed is available will assist the bed management team in establishing priorities for admission.

4.47   All other referrals are classed as green and these await a bed in the usual ward serving their home area and may only be admitted once all red and amber referrals have been accommodated. In the event of a number of green referrals for a particular ward, admissions will be on the basis of first referred to be first admitted.

4.48   We were informed that the CXlinical Director now goes through the referrals for inpatient beds list daily to clinically prioritise and to check whether the patient has sufficient input to support them whilst waiting. This is a new element of the process and clinical staff interviewed felt that this process is working well.

4.49   We strongly recommend that the critical safety metric is that once an inpatient bed is deemed necessary then there should be no delay to accessing that bed. If the gatekeeping assessment finds that home treatment is adequate, then there is no need to rag rate the referrals.

4.50   We were also informed that at weekends an on call consultant reviews all admissions and that the Clinical Directors are also responsible for the development of action plans to reduce the length of stay.

4.51   Clinical staff interviewed indicated that the HTT is stretched, especially since the loss of the 0 - 25 years of age contract and the associated resources to FTB. This was based on an expected lowering of referral rates to HTT.

4.52   We heard from a Clinical Director that there are a lot of 'inappropriate' referrals to HTT and that there is pressure on HTT because they have no rights of

refusal from the routes of referral such as from the rapid assessment, interface and discharge team (RAID), street triage and place of safety and when they take on a patient they have a responsibility to ensure they are seen within twenty hours of the referral and ensure the patient has a medical review every week. The chief operating officer told us that the response times for HTT were under review as part of the single point of assessment guidelines.

4.53   Both the HTT and the inpatient consultant expressed their views that the system is under pressure. The HTT consultant felt that although BSMHFT has undertaken a lot of work to increase the throughput, if a bed was needed today for a patient needing admission under the MHA the chances are that a bed would not be available. Other clinical and managerial staff interviewed expressed similar views. We felt this was a very serious position and are concerned that people with a serious level of risk, that are willing to be admitted, may be even less likely to obtain a bed when clinically necessary.

4.54   Another Clinical Director felt that there is increased acuity, increased demand and insufficient beds in the system. We were told that the bed situation is not helped by pressure in other parts of the system, as an example, with local authority cuts and changes to housing benefit.

4.55   It was felt by staff interviewed, that overall there is not enough resource in the system to support people with mental health problems so the distress and suicidality may increase leading to a potential admission. However, on a positive note we heard that there is an awareness of the pressure points in the system and a willingness on the part of BSMHFT and other agencies such as the local authority to work through them together.

4.56   BSMHFT saw unprecedented demand for services, especially adult acute mental health inpatient services in 2015 to 2016. Their occupancy levels in adult acute inpatient wards and psychiatric intensive care units exceeded 90 per cent in each month of 2015 to 2016 and has averaged over 94.8 per cent in the last three years.

4.57   The NHS network mental health benchmarking 2015 review (based on 2014 to 2015 data), showed that BSMFT had an average adult acute bed occupancy of 95.5 per cent against a mean level for all trusts in England and Wales of 91.1 per cent. In 2014/15, BSMHFT had the second lowest number of beds per 100,000 weighted population, and in 2015/16 had the fifth lowest number of beds per 100,000 weighted population with 13.3 adult acute beds.

4.58   Coupled with the increase in overall demand, BSMHFT feels that the acuity of the inpatients admitted appears to be increasing if measured by the use of the Mental Health Act.

4.59   The annual report for BSMHFT 2015 to 2016 reports positively that the number of delayed transfers of care in 2015 to 2016 reduced considerably as a result of close joint working with social care colleagues and commissioners. This changed from 34 at the beginning of April 2015, rising to a peak of 52 in July and then reducing to 23 by the end March 2016, an almost 50 per cent reduction from the peak.

4.60 In terms of capacity, we were informed that the new models being introduced through New Dawn will ensure there is flexibility to undertake assessments, for example, there is now a separation of assessment and home treatment functions although these service still work closely together.

4.61 Operational management of bed capacity has included using the 'perfect week[6]' national initiative and challenge for delayed discharges. This initiative aims to rapidly improve patient flow to produce significant improvements in performance, safety and patient experience.

4.62 As part of operational management, the chief operating officer receives a daily bed management report which looks at the out of area admissions, the length of time patients have been on the bed list, the date of the medical review and the alternative package to admission. The chief operating officer also looks at other sources of information to triangulate, including the length of stay on the inpatient wards, the patients in Psychiatric Decisions Unit (PDU), HTT and activity in A&E.

4.63 There is a BSMHFT wide bed management weekly meeting which includes representatives from the local authority and commissioners, and BSMHFT matrons and discharge coordinators. The meeting looks at the length of stay and challenges the plan as appropriate. In addition, the rehabilitation services have a weekly referrals meeting. The throughput in rehabilitation services has improved and assessments are now undertaken in 72 hours.

4.64 To support the operational management of beds further, we were informed about an opportunity BSMHFT took when they found that they couldn't fill the nursing posts on the inpatient wards to recruit an increased number of occupational therapists focusing on recovery towards discharge. These posts are assisted by a health care support position on each ward to focusing on physical health needs, carers support and the discharge plans.

4.65 Additionally, BSMHFT has a PDU which works closely in conjunction with RAID and street triage to ease pressure on A&E targets. Patients who have been assessed by RAID in A&E or in the street triage team and still need further assessment are informally transferred to the PDU. The annual report for BSMHFT 2015 -16 reports that since the introduction of the PDU, admissions to psychiatric inpatient units through RAID has gone down by 39 per cent and admission to A&E through street triage has gone down by 26 per cent, which appears to be a positive development.

4.66 At a strategic and operational level, BSMHFT is involved in several initiatives to better manage inpatient capacity. One if these is the 'RAIDplus' integrated mental health urgent care test bed. This is a partnership including a commercial partner, Birmingham community healthcare trust, the joint commissioning team, the strategy unit hosted by Midlands and Lancashire commissioning support unit, West Midlands academic health Science Network, West Midlands ambulance service and West Midlands police. This project was later identified as an example of good practice in the CQC inspection report August 2017.

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[6] https://www.england.nhs.uk/2015/12/vincent-connolly/ and http://www.ecip.nhs.uk

4.67   The project will provide patients with access to digital tools such as improved online support, risk assessments and crisis intervention plans that will enable care professionals to better support patients to manage their conditions in the community. Training will be designed and delivered to partner organisations, patients and their carers to assist them in identifying the early warning signs of a mental health crisis.

4.68   The work BSMHFT is undertaking will develop analytics for risk prediction. In terms of demand for beds, this will look at, for example, how many assessments are being undertaken in high risk situations via the police, street triage and RAID team assessments plus how many discharges are due that day. The system will be able to pull out key words from the electronic care record to compile a clear picture of risk in order to prioritise for admission. We found this to be an innovative piece of work and very promising, however there is no evidence of impact to date.

4.69   The system aims to track patients through a clinical utilisation tool with an established discharge date to ensure that tasks are actioned as appropriate every day. The system tracks where days are lost, why, what needs to be done and by whom.

4.70   In September 2015, NHS England and its national partners announced a new type of new care model 'vanguard'. The Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) vanguard aims to share best practice and create replicable models for long-term clinically and financially sustainable specialist mental health services. They will work together to solve efficiency, workforce, equality and policy implementation challenges.

4.71   The MERIT vanguard commenced in BSMHFT in December 2015 and is a partnership between BSMHFT, Black Country Partnership NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Coventry and Warwickshire Partnership NHS Trust.

4.72   MERIT will focus on seven day working in acute services, crisis care and reduction of risk, and recovery and rehabilitation. In these areas better integration across organisations will aim to increase quality and improve efficiency rapidly while reducing variations and spreading best practice.

4.73   There is a quality assurance work stream for the MERIT vanguard, which reports regularly to the Board, and this group agreed to establish a mock Care Quality Commission (CQC) inspection process called 'A Time to Shine'. Colleagues from the four partner organisations have looked and evaluated a range of tools and have agreed on a tool to be piloted during June to September 2016 so that any modifications can be made to the final version. Due to the delivery timescales we have not had the opportunity to review these as part of the investigation process.

4.74   The vanguard includes plans to build an urgent care centre within Solihull Hospital as part of a health and wellbeing campus to support patients and carers, reducing pressure on hospital services. This will provide GP out of hours, urgent walk-in and minor injuries services, some primary care led beds, improvements to community and social care teams as well as a new primary care centre and improved access to diagnostics and specialists.

4.75   The partners will build on existing mental health and community services so that patients know where to go for help before a problem escalates. Those people who are most likely to have complex health issues, particularly frail patients aged 75 and over, will be given more support in the community.

4.76   To provide information and assurance to the Board, the challenges associated with managing the bed capacity was evident in the operational escalation reports to the Board in April and May 2016 and provided information on a delayed transfer of care meeting held to escalate the issues relating to delays in residential care placements with the local authority for Birmingham. The May report provided information on a task and finish group established with the CCG and Local Authority to improve capacity of social workers, patient flow and minimise delays.

4.77   The May 2016 report to the Board also indicated that out of area admissions remain a significant issue within BSMHFT and at the time of writing the May report, BSMHFT had nine out of areas for patients over 25 years of age which was seen as a significant improvement.

4.78   It is positive to note that in August 2016 we were informed that BSMHFT had five out of area patients. There are discussions going on via commissioners with local mental health services in Dudley and Walsall about purchasing beds so patients can be treated locally rather than a bed a long way from the community in which the patient usually resides.

4.79   We note the Chief Operating Officers report to the Board in May 2017 indicating that the demand for male beds remained high with a total of eight patients in out of area placements. The report detailed that a joint operational group between FTB and BSMHFT had been established to make significant improvement in assessment, access to beds and discharge to home treatment and improvements in care pathways bringing clarity to both organisations around roles, responsibilities and service response times.

4.80   We also note the June 2017 board minutes stating that Birmingham City Council will be increasing the availability of nursing home dementia beds by 70 beds, and that Solihull would also be commissioning more nursing home beds.

4.81   We note that MERIT signed off standard operating procedures for bed management in June 2017 and will be developing supporting information systems and an approach for capturing the views of patients and carers regarding the new bed management processes.

4.82   We were informed that the trust urged the commissioners to commission an independent review of bed demand and capacity for mental health services in Birmingham. As a result, Mental Health Strategies[7] were commissioned in February 2016 and reported to the Board in July 2017. The conclusion of the review was that significant action on clinical redesign, new service models and new investment would be required to achieve balance in capacity and demand over the coming years and reported that:

"*Much has already been done to mitigate the effects of bed pressures. Both RAID and Home Treatment services appear to be offering very good levels of diversion from inpatient admission. However, there is a continuing trend of high use of overspill beds, wards occupied at over 100%, and long waits to access a local bed. This includes a 'waiting list' for patients who have been assessed as requiring admission under section 2 of the Mental Health Act, a practice which should not be permitted to continue at all. Failure to ensure admission of a patient in this situation (who has been lawfully assessed as requiring admission for their health or safety or that of other persons) should be regarded as a 'never event'. The transfer of services to FTB is not yet producing the hoped-for reduction of demand on beds; the trend so far has been in the opposite direction*".

4.83   The CQC inspection report published in August 2017 found that between December 2015 and November 2016, 164 patients were placed out of area. Post inspection the trust provided figures which showed that the range of out of area placements between October 2016 and February 2017 was between two and six, showing a good improvement. Carers told the CQC that they were very concerned about the shortage of beds and the impact this had for their relatives and themselves in terms of travel time for visiting.

4.84   The CQC inspection August 2017 found that staff reported that waiting to access inpatient beds was routine, particularly for informal patients who were not detained under the MHA. In the period December 2015 to November 2016, the trust recorded 110 incidents of delayed admissions to inpatient beds.

4.85   The CQC inspection reported that crisis resolution home treatment teams stored completed medical recommendation forms for admission under the MHA when an admission bed was not immediately available. Staff recalled occasions when medical recommendations had expired prior to an admission bed being found; a period of 14 days. However, the trust did not record the number of times that medical recommendations expired because of waits to access inpatient beds.

4.86   We note that the trust has now received approval of a business case to provide a further 27 beds from commissioners comprising two new wards (15 beds for female admissions) and (12 beds for male pre-discharge patients). The beds will accommodate 16 BSMHFT and 11 FTB patients. Discussions

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[7] Mental Health Strategies provide a range of bespoke consultancy services to mental health providers.

are currently taking place with FTB regarding the provision of the 11 beds and how they will be operationalised for the Autumn 2017.

4.87 We have therefore graded the IMR recommendation to review and monitor the bed management policy as B which indicates that the action is completed and embedded. We concluded that due to the fact that the operational management of beds in BSMHFT does not include the critical safety metric of no delay in accessing an inpatient bed once it is deemed necessary, we have graded the DHR recommendation to ensure that the bed management policy is sufficiently robust and understood by clinicians and senior managers in a way that keeps people safe as D which indicates that the action is partially complete.

4.88 BSMHFT told us that they are committed to the provision of inpatient bed as a priority when required, and their view is that this should be considered within the national shortage of beds and the challenges this can pose in enabling ready access to beds at the point of the decision to admit.

4.89 We note the level and pace of change in BSMHFT and the range of bed management initiatives in place however these do not at present provide the assurance that the DHR recommendation action has been implemented in a way which keeps people safe.

FTB

4.90 The commissioned contract for FTB provides 21 beds for adult patients between the ages of 18 and 25 years of age plus a further five intensive care beds. Inpatient and intensive care mental health beds are provided by the Priory.

4.91 The development of a bed management policy, key metrics report, the demand and capacity review and the review session to improve pathways are all key elements of assurance regarding bed capacity and management in FTB.

4.92 The FTB bed management policy was issued to staff on 21 June 2017 and has a review date of 21 June 2020. The policy is clear on the process including escalation via the serious incident policy. We found that staff interviewed were able to explain the bed management process.

4.93 The bed management policy has a section on utilising a triage system to create a priority list in order to consistently place those service users in most need of inpatient care should a situation arise when beds are not available.

4.94 Categories are rated red, amber and green with red being the highest priority. There is explanation of the process for admission associated with these however there is no clinical description of the categories.

4.95 To support bed management, FTB have developed a utilisation management (UM) system (undated) which supports consistent clinical decision making through the use of level of care criteria (LoCC), ensuring that people receive

the right care, from the right service at the right time. Generic LoCC were developed and agreed by all partners prior to 'go live'.

4.96   The UM lead and FTB partner leads have localised the LoCC to individual team/service-specific entry and exit criteria. The aim is to have frontline provider clinicians use these agreed and standardised criteria sets in order to:

- Reduce variation in clinical decision making thus improve equity of access to services.
- Ensure young person's access the most appropriate and least restrictive service for their clinical needs.
- Improve active discharge planning by reviewing all cases at an agreed review date against the exit criteria ('managing the back door').
- Improve overall system 'flow' in the service.
- Reduce waiting times and length of stay (monitored by data dashboards).

4.97   The inpatient criteria states that one of the following must be present:

- Serious active suicidal ideation with plan and means available, a prior history of significant suicide attempts and a lack of protective factors that would support a community based intervention.
- Indication of significant risk of harm to others, with a documented history of violence.
- Suicidal ideation accompanied by severely depressed mood, severely elevated mood, significant losses and, or continuing intent to hurt self.
- Homicidal ideation with indication of actual or potential danger to others.
- Delusions or hallucinations that increase the risk of potential violence to self or others or are very distressing and cannot be managed at home.

4.98   Criteria are also available for admission to and discharge from a 72-hour clinical decision bed, a psychiatric intensive care unit bed (PICU), inpatient rehabilitation bed, home treatment team, crisis team, eating disorders, learning disability, complex hub team, attention deficit disorder (ADHD) team, children in care service and improving access to psychological therapies team (IAPT).

4.99   A checklist of the questions a bed manager must ask prior to inpatient admission is also available.

4.100 We were told that the current bed capacity is not meeting the demand and so FTB have a high proportion of out of area beds. They have had to use beds as an example as far away as London, Manchester, Essex and Sussex although the beds have been found quite quickly.

4.101 FTB staff reported to us that since April 2016 the demand for acute beds has increased and doesn't match the data provided by the commissioners. As a result, an audit of demand and capacity is ongoing including a tracking system for the use of out of area beds and the conveyancing of patients.

4.102 We were informed that beds for patients under the age of 18 years of age are very difficult to find and that if beds are required for this age group, it is the responsibility of NHS England to locate them. There are no intensive care beds in Birmingham for this group of patients. The perception of the clinical staff is that the clinical view of the urgency for admission doesn't appear to match the service specification that NHS England work to and so patients needing admission have to wait much longer for a bed and may be sent to an inpatient service a long way from the community in which they normally reside.

4.103 The FTB bed management team receive most of their requests for admission from RAID on a trusted assessment model (where the team is appointed to undertake the assessment on behalf of FTB, using agreed criteria and protocols) and medical staff then authorise admission.

4.104 To assist with capacity, FTB has a partnership with an organisation called Beacon who offer mental health case management, system-wide pathway coordination, and insightful analytics that improve the delivery of care. The Beacon service undertake rapid reviews and intensive case management looking at any delays, length of stay and will undertake any work required to progress the care and treatment plan.

4.105 Staff explained, and we could clearly see, that this model of working would not be possible with patients in out of area beds and so it is positive that staff are exploring innovative ways of working, such as the use of skype consultations about care planning with out of area placements. However, the use of skype will not assist with the issue of out of area bed capacity if FTB are not able to manage the beds they currently have based at The Priory.

4.106 FTB staff told us that they are hampered with being able to discharge people as there are different discharge systems for patients under and over 25 years of age. The urgent care pathway for patients over 25 years sits with BSMHFT and the under 25 years sits with FTB. Additionally, there are historical problems with the care pathway and patients are staying longer than the recommended three years in the early intervention service. The length of time in early intervention services needs further clarification between commissioners and providers.

4.107 The concern about bed capacity in FTB was raised appropriately through their governance structure at the Birmingham children's hospital key issues and quality concerns committee who then appraised the Birmingham children's hospital Board of Directors in June 2016 with detail about the emerging bed management issues.

4.108 The Birmingham children's hospital key issues and assurance report from the quality committee 21 June 2016 noted that the FTB new urgent care service

commenced on 6 June 2016 and were experiencing operational issues due to an unprecedented spike in demand and higher patient acuity than expected, with an inability of the current service to flex provision to meet this, particularly at the weekend. This led to concerns raised externally by the police and others, particularly regarding place of safety and delays in accessing urgent care.

4.109 The key issues and quality concerns committee requested a range of key metrics in the next report to enable performance to be appropriately monitored and measured to include the numbers of concerns raised with the patient advice and liaison service (PALS), formal complaints and also sought additional assurance regarding resilience of the senior management and clinical teams in dealing with these issues.

4.110 Additionally, the CCG is leading a review session with FTB and wider partners to improve pathways and learn from case studies.

4.111 The request for additional assurance regarding the resilience of the senior management and clinical teams in dealing with these issues is very positive. We saw an engaged and committed staff group, aware of the service problems working very hard to rectify them at the same time as developing new ways of working in a new model and service. However, the service provision for patients needing an inpatient bed is currently inadequate.

4.112 The February 2017 Birmingham children's hospital Board report indicated concern about the out of area bed costs and signalled that this remained an on-going risk for the Board to note. The Board discussed the concerns from both a quality and financial perspective and was assured that further scrutiny is taking place alongside conversations with commissioners regarding funding and a review of the original demand and workforce model.

4.113 We note that in June 2017 the MERIT Board invited FTB to join with the consequence of access to beds being managed across the whole geographical area. We view this as a positive development.

4.114 Mental Health Strategies was commissioned in February 2016 to review the large increase in admission rates under FTB, in contrast to BSMHFT. This was initially viewed as possibly representing a response to demand which had always been latent in the local system, the consequence of separation out of a distinct pool of resources, a 'bedding in' problem of a new system, or a longer-term systemic change.

4.115 The conclusion of the review in July 2017 was that significant action on clinical redesign, new service models and new investment would be required to achieve balance in capacity and demand over the coming years. The report also commented on the practice of and risks associated with having a waiting list (see 4.82).

4.116 In August 2017 Mental Health Strategies was further commissioned to review the patterns of activity which have developed, to compare them with the original plans, and to propose an updated activity plan for the remainder of

the FTB contract. The project was due to report in October 2017 and will provide a body of evidence to inform local discussions, and independent recommendations as to specific actions which could be taken.

4.117 Further to this, we note that a business case has been approved to provide a further 27 beds from commissioners comprising two new wards (15 beds for female admissions) and (12 beds for male pre-discharge patients). The beds will accommodate 16 BSMHFT and 11 FTB patients. Discussions are currently taking place with FTB regarding the provision of the 11 beds and how they will be operationalised for the Autumn 2017.

4.118 We have therefore graded the IMR recommendation to review and monitor the bed management policy as B which indicates that the action is completed and embedded. We concluded that due to the fact that the operational management of beds in FTB does not include the critical safety metric of no delay in accessing an inpatient bed once it is deemed necessary, we have graded the DHR recommendation to ensure that the bed management policy is sufficiently robust and understood by clinicians and senior managers in a way that keeps people safe as D, which indicates that the action is partially complete.

4.119 We note the level and pace of change in FTB with the range of bed management initiatives, including entry and exit criteria, however these do not at present provide the assurance that the DHR recommendation action has been implemented in a way which keeps people safe.

Access to AMHPs

Recommendation	Grading
Birmingham City Council ensures that the new AMHP service is implemented as soon as possible and enshrined in training and policy with guidance.	C

4.120 The DHR for Mr A does not consider that within the provisions of the MHA, the nearest relative could have applied for admission. Secondly it appears to have missed the statutory obligation on the local authority to ensure there are enough AMHPs to provide a 24-hour service, and that the referral for an AMHP should have been passed to the emergency duty team.

4.121 An AMHP is the person necessary to apply for the admission after receipt of two medical recommendations for admission. The DHR for Mr A notes the lack of an AMHP leading to a delay in detaining Mr A.

4.122 Local authorities are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the MHA, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, local authorities should have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs.

4.123 There is a specific duty on local authorities to arrange for an AMHP to consider the case of any patient who is within their area if they have reason to believe that an application for detention in hospital may need to be made in

respect of the patient. Local authorities must make such arrangements if asked to do so by (or on behalf of) the nearest relative.

4.124   The AMHP must consult the nearest relative for application for admission under Section 3 of the Mental Health Act 1983, unless 'such consultation is not reasonably practicable or would involve unreasonable delay.

4.125   Instead the DHR makes a recommendation that the City Council ensure that the new AMHP service is implemented as soon as possible and enshrined in training and policy with guidance.

4.126   Feedback in our interviews from BSMHFT and FTB clinical and managerial staff indicate that the AMHP service is stretched. However, some clinical staff felt that there had been an improvement in services especially with the speed of response in terms of the MHA Section 2 and 3 requests.

4.127   The AMHP day team manager was interviewed and reports an increase in MHA assessments and suggests it may be that the thresholds for maintaining people in the community, the ability to manage risk in the community and the level of skilled and experienced staff in the HTT and CMHTs are a factor.

4.128   The bed problems have a significant impact on the AMHP assessment capacity. If there is no bed, then repeated AMHP assessments are required. This can prove difficult for both BSMHFT and the AMHP service if BSMHFT needs to look for an out of area bed and requires an assessment to progress.

4.129   The 'go live' with a new AMHP team and service was 1 October 2015. The day team manager described the new AMHP model as being about setting the tone and providing a professional service in response to Mental Health Act Assessment (MHAA) work. BSMHFT and FTB staff told us they are not yet feeling the benefits of the new system and the out of hours' team manager interviewed felt that BSMHFT and FTB had little understanding of AMHP needs and priorities.

4.130   The day time service operates from 8.45am to 5.15pm Monday to Thursday and Friday from 8.45am to 4.15pm. There is one new post holder working 3pm to 11pm to support the work flow coming in later in the day. It has been a struggle to recruit to a further post for the 3pm to 11pm shift; it is thought that this is due to the hours rather than the pay provided.

4.131   The new model is organised in three separate bases in the north, central and south of Birmingham to facilitate local responses and is now able to provide cross cover. If cover is problematic due to unexpected sickness or leave, then the senior practitioner would negotiate with the community mental health teams to seek cover. When a referral comes into the AMHP team and if it is already allocated to an AMHP as a case, the AMHP team senior practitioner would raise that there was an AMHP shortfall and alert the AMHP team manager who would liaise with the local community team managers for an AMHP if it was agreed this was needed.

4.132   Following service reviews and concerns raised there is a new current interim agreement that day time managers, do one week on call for the emergency duty team (now called the out of hours' team), from 5.15pm to 12.00 midnight

each week night and then 9.00am to 12.00 pm on the Saturday and Sunday.

4.133 The AMHPs undertaking these shifts are day time AMHPs who put themselves forward to be on the out of hours' team rota which is managed separately to the day time rota. There is current recruitment underway for an out of hours' team manager (who will work half time as an AMHP), and three dedicated out of hours' team AMHPs. It is expected that these posts will be recruited to substantially within the next three months, however there will still be rota back-ups required to support sickness and holiday cover and in the interim agency staff will be recruited. The AMHP service is currently looking at what would constitute core hours for the out of hours' service. They are considering, as an example, with the use of the place of safety, PDU and A and E whether there would be a need for urgent assessments between the hours of 3am and 8.45am.

4.134 The Birmingham and Solihull AMHP service is launching an electronic survey in line with the West Midlands AMHP leads network, to seek information about issues in the assessment process. Additionally, the June 2016 national AMHP Survey via the local authorities and the AMHPs lead networks will provide very useful national AMHPs information.

4.135 The AMHP service is in discussion with BSMHFT about their obligation to provide an urgent assessment bed under section 140 (a) of the Mental Health Act 1983. BSMHFT is in discussion with the Local Authority on whether they should hold a bed for assessment purposes on each ward. Clinical staff told us that the AMHP service will not undertake the assessment until a bed was made available, however the AMHP day and out of hours' managers explained that requests for assessment by an AMHP will always require careful thought in terms of risk and logistics and that this may not always be understood by BSMHFT and FTB clinical staff.

4.136 Section 140 (a) places a duty on NHS CCGs (transferred from PCTs by the Health and Social Care Bill 2011) to notify Local Social Services Authorities (LSSA) about the hospitals to which their patients can be admitted in cases of exceptional urgency where there is no identified bed.

4.137 The Department of Health Mental Health Act 1983: Code of Practice[8] states that commissioners should, in partnership with providers, ensure that alternative arrangements to meet the person's needs pending the availability of a bed are accessible, and they should communicate those arrangements to the local authority. The local authority should ensure that AMHPs are aware of these arrangements.

4.138 We were informed by the out of hours' team manager that the view of the clinical staff that Section 140 (a) means that unless they have a secured bed for admission the AMHP will not undertake the assessment is not correct and that the part of the MHA this refers to is about exceptional circumstances, for example, if a nurse was severely injured by a patient, and a bed was required in a different hospital. As a result of the confusion surrounding this, the out of hours' team manager is developing a policy for clarity on this issue.

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[8] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

4.139 The AMHP team manager reported that the crisis part of BSMHFT's New Dawn transformation will have more ability to support the AMHP service although BSMHFT is still working these changes through. When undertaking an assessment, we were told that the AMHP needs a member of the HTT to accompany them in terms of both the gatekeeping function and managing the risk. We were informed by the out of hours' team manager that this tends to be a problem at night.

4.140 The AMHP team manager told us her view was that the key to managing the mental health issues is through the crisis care concordat[9] document ensuring that agencies have robust partnership arrangements in place, with each agency accountable for its role in delivering on this and if not then challenged appropriately within the governance structures. FTB are not currently part of these arrangements.

4.141 FTB and BSMHFT are not integrated services with social services so there are no AMHPs in the teams. When they had social workers as part of the integrated service FTB and BSMHFT staff felt they were the mental health act experts. Staff told us that they felt that not having their expertise in the teams has led to problems with accessing and organising AMHPs for assessments through the HTT, and that they feel that the process for obtaining warrants for a Section 135 of the MHA is more difficult to manage. In general, staff told us that they believe the AMHP services to be very poor and told us they can be waiting up to 48 hours for an assessment to take place.

4.142 FTB staff also told us that it is difficult to contact the emergency duty team. The unqualified person taking the call won't commit to where they are in the 'queue' or when the assessment will take place. The urgent care lead has submitted a letter of concern about the lack of clarity about the times the out of hours' AMHP service operate.

4.143 We were informed that the AMHP service has strived to put together a much more seamless service (between day & evening). The adult service now has an emergency duty team, with a full-time manager, plus five dedicated AMHP's. We were informed that the service is more confident in the availability, risk management and quality of the service.

4.144 However, clinical and managerial staff felt confusion and concern about the out of hours' service and were not feeling the benefits of the new service provision. We were informed that a position statement has been sought from the AMHPs service and is currently being drafted.

4.145 Our view is, that although the new service has been operational from October 2015, and the action against this recommendation is therefore complete, there is no adequate assurance that the new service is embedded and having a positive impact. We have therefore graded this recommendation as C.

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[9]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

Transitions

Recommendation	Grading BSMHFT	Grading FTB
Ensure that teams are complying with the transfer and transition policy and there is a detailed handover meeting for a service user transferring to another team for longer term care, involving relevant agencies and engaging with as wide a range of family members as reasonable.	C	C

4.146 BSMHFT's CPA policy states that the care coordinator is responsible for ensuring that CPA information remains current and relevant by reviewing and updating the assessment summary, risk assessment and CPA care plan prior to any transition/transfer including in patient/home treatment teams.

4.147 BSMHFT also has a discharge and transfer policy with the aim of ensuring that discharge from, or transfer within BSMHFT is safe, effective and consistent. BSMHFT has identified a lead to review and update the discharge and transfer policy which was due for review in June 2015.

4.148 A Clinical Director informed us that although there is a transfer and discharge policy in BSMHFT, transitions remain a theme in incidents with variable practice in the transition process between HTTs, Improving Access to Psychological Therapies (IAPT) and the CMHTs. The head of investigations told us that transitions do come up from time to time, and at present the issue of transitions is greatest between BSMHFT and FTB.

4.149 We were told that there is a greater awareness of transition risk and how to mitigate risks especially from EIS to HTT although with the new models there are more interface points with FTB. BSMHFT has a memorandum of understanding in place with FTB for EIS and HTT services and BSMHFT and FTB meet weekly to discuss transitions.

4.150 There is no specific BSMHFT or FTB protocol for managing the transition from one CPN to another but team based clinical staff in both BSMHFT and FTB told us that in practical terms there is a face to face handover and joint visits (this may take place over a period of time).

4.151 We note a November 2013 BSMHFT learning lessons bulletin provided useful information to staff about transitions. It notes that feedback received from quality audits and serious incident reviews highlighted cases where internal transfers of care are made without appropriate risk assessments or care plans being produced or communicated.

4.152 BSMHFT state in the learning lessons bulletin that this is a significant risk and is frequently cited as a root cause of serious incidents. The bulletin reminds staff that it is important for clinical teams to reinforce the requirement of the care management policy which highlights the need for receiving teams to be assured that all relevant risk information has been recorded and communicated to them before taking on any case. The responsibilities

defined in the care management policy for transfers of care are highlighted for staff.

4.153 We were told that volume of work may hamper the process of transition, as may staff leaving the service. If this is the case, then the process of transition is started early with the patient's care handed over to an established team member to minimise disruption. We understand from staff that there have been a couple of complaints about transitions but we also heard a very positive personal account from a service user of how a transition was managed.

4.154 BSMHFT has assurance in respect of the recommendation in that there is a trust transition policy, however this requires review and needs to include transition from one member of staff to another. However, we were concerned to hear from one interviewee that there may be a theme of transition in incidents and recommend that the actions arising and learning from these incidents continues to be shared widely to prevent recurrence.

4.155 We note the FTB transitions policy which states that a quarterly joint transition group has been established between FTB and BSMHFT and that young adults' views on the transition process will be assessed by using a service user satisfaction questionnaire or by other appropriate means. Given that at present the issue of transitions is greatest between BSMHFT and FTB we therefore view the action as complete but not yet embedded in practice and have graded action against this recommendation as C.

FTB

4.156 The FTB Care Management and CPA Policy January 2016 has a detailed section on transferring patients and the role of the care coordinator, including guidance on consulting service users and carers and having contingency and crisis plans in place specifying who to contact if additional support is needed.

4.157 In FTB the transfer of patients from BSMHFT to the new service took place over two weeks in June 2016. A lot of planning had gone into this beforehand with lots of information provided to users and carers about FTB highlighting how the new service provision would specifically meet their needs.

4.158 We were told that a lack of capacity and the sheer volume of patients being transferred had not allowed the FTB staff to undertake the usual face to face handover. Staff felt that going forward they needed a better transition policy with time limits on the process, and to build capacity to respond to people, as organising two to three face to face handover meetings can be a lengthy process.

4.159 The FTB CPA policy states that dates for transfer of care should be agreed within four weeks of the transfer request. However, this does not appear to be working in practice. To illustrate the issue with the 'flow' and transition of patients through the EIS care pathway to another service, staff told us that for some time they have had a delayed discharge level of 15 per cent for patients that have been in the service for three years or more and one patient has been in the service for fourteen years.

4.160 We were informed that this was because BSMHFT do not have the capacity

to take patients back although FTB transitions start at 24 and a half years of age to provide appropriate time to do so. Additionally, there is a large cohort of patients with a diagnosis of ADHD requiring transfer from FTB to BSMHFT however an ADHD pathway has not been developed as yet.

We were told that capacity in the service was stretched and that discussions were ongoing with senior managers in the service and with commissioners. In terms of capacity we understand that Health Education England will shortly make available a workforce planning tool to support commissioners and providers to plan the EIS capacity and skill mix required locally to ensure sustainable delivery of high-quality, National Institute for Health and Care Excellence (NICE) recommended care.

4.161 The final stages of taking the transferred cases from BSMHFT to FTB was by end of September 2016. Many EIS staff transferred over from BSMHFT and FTB took the decision to transfer staff, with their caseloads, to minimise the disruption to clients on CPA, so that patients would still have the same care coordinators. However clients not subject to CPA and care coordination may have felt the disruption more.

4.162 FTB appear to have managed a challenging process of transition to the new service with careful thought given to minimising disruption for patients. Going forward, it will be important to work with commissioners to understand and plan the EIS capacity, skill mix and the length of stay for patients in the EIS care pathway.

4.163 FTB implemented a transitions policy in January 2017 with a three-year review date to ensure that the transition of young adults with mental health problems between FTB and BSMHFT is planned and implemented consistently and safely to occur with as little disruption to the young adult's care as possible and in support of the care programme approach framework.

4.164 The policy states that every effort should be made to involve the young adult and their family in the transition process with a joint handover meeting arranged. The policy contains a section on handover arrangements and states that the requirement for the care coordinator is to invite all agencies involved in the case to the transitions meeting.

4.165 The policy provides guidance on transfer of patient care from one practitioner to another within teams, and between teams. A detailed handover meeting should take place for a service user transferring to another team for longer term care, and should involve the relevant agencies and family members.

4.166 In order to facilitate smooth transition, appropriate joint working arrangements and to monitor the implementation of the policy, a quarterly joint transition group has been established between FTB and BSMHFT and will include commissioners. Young adults' views on the transition process will be assessed by using a service user satisfaction questionnaire or by other appropriate means.

4.167 We note that a quarterly joint transition group has been established between FTB and BSMHFT and that young adults' views on the transition process will be assessed by using a service user satisfaction questionnaire or by other

appropriate means. Given that at present the issue of transitions is greatest between BSMHFT and FTB we therefore view the action as complete but not yet embedded in practice and have graded action against this recommendation as C.

CPA and crisis plans

Recommendation	Grading BSMHFT	Grading FTB
Ensure that crisis plans are built into CPA care planning and followed.	B	C
Put in place procedures and monitoring arrangements to ensure that the assessment for specialist mental health services involves includes all significant others living with and involved in the life of the service user and include meaningful contact with the patient in order to establish their mental state and degree of risk before being considered complete.	B	C
Put in place procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carer's assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually.	A	C

4.168 The Mr B IMR made a recommendation that CPA audit should include whether carers and or significant others had been involved and asked BSMHFT to ensure that crisis plans are built into CPA care planning and followed. The DHR for Mr B asks BSMHFT and the Council to put in place procedures and monitoring arrangements to ensure that the assessment for specialist mental health services involves and includes all significant others living with and involved in the life of the service user.

4.169 A further recommendation of the DHR for Mr B asks BSMHFT and the Council to put in place procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carer's assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually.

4.170 These recommendations echo the Mr A DHR where BSMHFT is asked to ensure that each assessment includes all relevant information from family, friends, carers and others but must include meaningful contact with the patient in order to establish their mental state and degree of risk before being considered complete.

BSMHFT

4.171 BSMHFT has a robust Care Management, Care Programme Approach (CPA) and Care Support Policy 2016 to 2019, a trust wide annual audit programme of the quality of the CPA and a CPA quality group overseeing both CPA concordance and quality. The Care Quality Commission (CQC) commented positively on the systems and processes for CPA and risk assessment in their 2014 report for the adult community teams.

4.172 BSMHFT CPA policy was approved in February 2016 and contains a section on how to deliver high quality CPA reviews and best practice for risk assessments. Care planning standards within the policy have been updated in line with changes to Mental Health Act code of practice and there has been strengthening of care support standards.

4.173 BSMHFT CPA policy addresses the recommendation to ensure that crisis plans are built into CPA care planning by stating that the care plans should include a crisis plan which identifies early warning signs, individual coping strategies, and actions to be taken by the service user, family, carers, and/or the wider care system in a crisis or, if a service user's mental health deteriorates, contact details for the care coordinator or lead clinician and information about 24-hour access to services.

4.174 In terms of crisis plans, as part of the work BSMHFT has undertaken for the national audit of schizophrenia, the crisis plan section of the CPA has been added to the risk assessment which will support improved crisis planning for patients who are routine users of the emergency services but not taken onto caseload. The chief operating officer informed us that BSMHFT has appointed a crisis plan lead to formulate minimum standards for crisis care plans within six months including who to contact in and out of hours, advice and guidance to the patient and their carer with contact details and any advance directives.

4.175 BSMHFT signed up as a partner to the Mental Health Crisis Care Concordat in 2014. This is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis

4.176 BSMHFT contribution to concordance with the Mental Health Crisis Care Concordat is the development of the integrated urgent care services pathway and this pathway includes the following trust services:

- Place of Safety
- Psychiatric Decisions Unit (PDU)
- Street Triage
- Crisis House
- Rapid Assessment Interface and Discharge (RAID)
- NHS 111
- Crisis Assessment
- British Transport Police Psychiatric Liaison Team
- Self or carer referral

4.177 BSMHFT has developed partnerships with all of the acute hospitals in Birmingham and Solihull, plus the police, West Midlands Ambulance Service and third sector organisations in order to deliver the urgent care pathway.

4.178 The urgent care pathway development is part of BSMHFT transformation plan called New Dawn. BSMHFT recognised that it was not always clear to service users or carers where or who to turn to in a crisis, meaning that they still had high numbers of known service users going to A&E, or via an emergency call, and with many of their service users not having clear crisis plans. The vision for the pathway is to open up referral routes for those in crisis across the 24-hour time span.

4.179 The urgent care pathway has been designed to meet the needs of those patients who are in crisis and presenting with a high level of risk due to their clinical presentation. The pathway includes a range of access points for service users.

4.180 All referrals for urgent assessments within BSMHFT are undertaken across the urgent care teams. The teams work together to provide in-depth assessment of need in order to ensure patients are referred on wards to the appropriate pathway. The operational policies for the new services are currently being reviewed, consulted upon and will be available early 2017.

4.181 Under the crisis care CQUIN[10] BSMHFT has commenced a clear programme related to ensuring all service users have crisis plans and reference to family where appropriate and linked to service users' choices and decision making.

4.182 BSMHFT Board approved a suicide prevention strategy in December 2015 and a one-year action plan with outcome measures was taken to the Board in February 2016 to embed a new working culture to prevent suicides and to establish clear crisis plans within care plans with service user input. A new set of training modules, through e-learning, had been established and is now being rolled out and a suicide prevention hotline run by the British transport police is advertised in BSMHFT.

4.183 The BSMHFT quality account 2016 -17 states there has been a concerted effort to ensure that service users have crisis plans in their CPA or care support care plans. The completion of care plan documents monitored weekly by the chief operating officer, but their quality is also considered as part of clinical audit.

4.184 The quality account also notes that actions delivered by the service user feedback, intelligence and actions task group include reinforcing what to do in a crisis. This work was organised as a priority in the urgent care pathway. The quality account notes that an audit of CPA has shown a large majority of care plans do include information on dealing with a crisis however BSMHFT will

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[10] The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.

continue to reinforce the need to offer crisis cards to both the service user and to their carer.

4.185 The BSMHFT quality strategy 2017- 2020 has quality goals to ensure that all service users have crisis care plans that they co-produce, have access to and ensure that they understand how to use these plans if their presentation escalates, to engage families and carers in coproduction of care plans and crisis plans, with service user agreement and to conduct co-produced workshops focusing on crisis plans for colleagues, service users, families and carers.

4.186 The May 2017 quality update to the Board reports that all service users are encouraged to identify a carer or family member to be proactively included in care planning. A series of sessions titled 'caring in a crisis' are being run at the recovery college and this has been well received by carers.

4.187 The CQC inspection report August 2017 reports that they reviewed 12 care records from the crisis resolution home treatment teams. The CQC saw that staff updated the risk assessments of inpatients at the acute hospital and that staff had created crisis management plans in 90 percent of the records reviewed.

4.188 BSMHFT CPA policy states that subject to the service users' agreement, the assessment may include contributions from carers, relatives, friends or an advocate; however, the person's views may be overridden where there is significant risk and the assessment will identify and take into account the views and needs of any informal carers.

4.189 BSMHFT CPA policy addresses the DHR recommendation that a CPA review should be undertaken at least annually by stating that the care coordinator is responsible for scheduling and organising CPA reviews at least every six months but as a minimum standard must be annually unless clinical presentation or local service standards recommend more frequent review periods.

4.190 To support the implementation of BSMHFT CPA policy, and to provide appropriate Board level assurance that the policy is being put into practice, the Director of Nursing reports on CPA in the regular quality report to the board. This report informs the Board that BSMHFT wide CPA steering group monitors the completion of the essential documents for people on CPA.

4.191 The quality report to the Board confirms that a CPA quality audit commenced in January 2016 to determine the extent to which documentation and CPA processes meet the quality standards needed. CPA quality standards is now also a commissioner target for BSMHFT requiring quarterly reporting.

4.192 The quality report also provides assurance on the action to improve the quality of CPA reviews as part of the national audit of schizophrenia confirming that the quality of CPA reviews will be added to the 2016/17 audit programme in April 2016.

4.193 In addition, BSMHFT utilises a balanced scorecard forming part of the Board assurance framework (BAF) reflecting operational practice, while directing attention to trust strategy and tracking its implementation. This is produced using measures set against a variety of domains, weighting and thresholds. It includes domains for CPA concordance. The scorecard results are reported quarterly to the executive team and also shared with service areas during their quarterly review meetings

4.194 The balanced scorecard for quarter four in 2015 to 2016 indicates delivery of targets for completeness of health and social care assessment, care plan and risk assessment with plans to further improve the target for CPA reviews in the last 6 months from 81 per cent to the target of 85 per cent concordance. Identified lessons for where the targets were not met are reported as being incorporated into a 2016 to 2017 planning process with quarterly reviews by exception.

4.195 The quality account section on CPA indicates that the CPA team delivers a two-hour CPA session on the trust's induction programme for all new clinical staff. This session covers CPA policy requirements and care planning quality standards. The CPA team also delivers a half day training session for all newly qualified staff as part of the trust's preceptorship programme. This includes nursing, occupational therapy, and other allied health professional staff.

4.196 In conjunction with the clinical governance team and information team electronic reporting mechanisms have been developed. These reports measure compliance for all CPA core documentation including CPA, inpatient and care support plans. Reporting is providing evidence of continuous and sustained improvement in the number of service users who have a current care plan.

4.197 We found that clinical staff at team level were knowledgeable about CPA. They were able to tell us, and we were provided with information about the integrated care record which links into 'mydashboard' to which the clinical service managers have an overview.

4.198 'MyDashboard' has been developed in BSMHFT to provide a range of clinically based staff with improved access to the information they require to work effectively. Clinical staff, team and ward managers and administrators can easily see an individually focused list of actions needed to ensure key clinical pathway steps are met, and patient records are accurate, timely and complete. It includes CPA, risk assessment, and health and social care assessments. There is an integrated care records lead and together with the team manager they audit the quality by looking at sample cases.

4.199 We found that BSMHFT CPA policy and target was well understood by staff interviewed however the quality of the CPA care plan was recognised as an area for improvement. Some users told us that they were either not aware they could have a copy of their care plan or receiving a copy of their care plan was not consistent. Carers we interviewed felt that the involvement of carers

is an area that needs further development, particularly in situations where they have information about risk.

4.200 Our view is that the work BSMHFT has undertaken to ensure that crisis plans are built into CPA care planning and followed is complete and embedded in practice and is therefore graded as B.

4.201 Although the BSMHFT CPA policy assessment section addresses the DHR recommendation to ensure that the assessment for specialist mental health services involve and includes all significant others living with and involved in the life of the service user and that the CPA review process includes the views of the service user and their family or carers, given the views expressed by service users and carers we have graded the action against this recommendation as C being complete but not yet embedded in practice.

4.202 We believe BSMHFT has adequate assurance against the recommendation to put in place procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carers' assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually. Given that the quality account 2016 -17 states that the national mental health indicators show that 98.6 percent of CPA patients have had a formal review in past 12 months against a national threshold of 95 percent we have graded the action against this recommendation as A being complete, embedded in practice and having an impact.

FTB

4.203 FTB have a new, clear CPA policy from January 2016 setting out the framework for use across the services. It is designed to support effective clinical care as well as service user and carer involvement and recovery.

4.204 The FTB CPA policy states that a CPA review is expected to take place at least every six months but as a minimum standard the review must be annually unless operational policy recommends more frequent review periods. At each formal review consideration should be given to the on-going need for support under CPA.

4.205 In terms of risk, the FTB CPA policy usefully states that it is not intended to obstruct or delay urgent action where this is necessary to ensure safety or the effective provision of services, which should take priority if there is any conflict with the procedural arrangements.

4.206 The FTB CPA policy describes the care plan as a written document identifying who is involved, setting out agreed plans for meeting the person's needs, managing risk and a crisis and contingency plan setting out ways of responding if some of the care plan cannot be delivered or if there is a crisis.

4.207 The FTB CPA policy details that a formal comprehensive multidisciplinary care plan should include relapse and risk management plans, a contingency plan and contact details for the care co-coordinator and contact numbers for

help out of hours or in a crisis. It states that a risk assessment is a continuous process and an essential part of the assessment.

4.208 FTB also has a clinical risk management policy which states that risk assessments and risk management plans should be completed in partnership with service users and carers in the same way as other assessments. They should normally be shared with service users unless doing so would increase risks to the service user or others. They should also be shared with carers where appropriate and with the agreement of the service user.

4.209 It goes on to say that contingency plans should specify what should happen if something specified in the care plan is not available, for instance if the care coordinator is not available or a day service closed. This aims to prevent a crisis developing by providing contact details for sources of interim support and identifying who will be involved in trying to make alternative arrangements.

4.210 In terms of crisis plans the FTB CPA policy states that they should set out details of early warning signs or relapse indicators, potential risks and identify action to be implemented if there is a crisis, for instance if the service user's mental health deteriorates. Action should take account of previous experience, the views of carers and advance decisions where relevant. Crisis plans should include:

- Services available and how they can be accessed in a crisis, including out of hours.
- Anyone the service user might be responsive to and how to contact them.
- Previous strategies which have been successful.
- Who should be involved in deciding next steps.

4.211 The FTB CPA policy states that monitoring concordance with and the effectiveness of the policy will be reviewed as the FTB service becomes fully operational. Any changes to the policy will be approved by the FTB risk and quality group meeting and the Birmingham children's hospital policy review group. The monitoring process is very clear and includes:

- Concordance with use of care planning documentation (quarterly).
- Monitoring of the quality of care plans (annual audit).
- Seven day follow up following discharge (monthly).
- CPA reviews (monthly).
- Regular contact with the care coordinator.
- Care plan within twelve months.

- Allocation to care co-ordination within seven days.

4.212 The CPA systems and processes are relatively new in FTB and staff told us that they had focused on making sure all transferred patients were recorded on CaseNotes initially but were now working on a quality tool for CPA.

4.213 We were informed that the quality of care plans, risk assessments and record keeping, adherence to the mental health act where applicable, safeguarding and patient experience are to be audited via a planned quality metrics initiative.

4.214 We have noted the draft FTB audit forward plan 2017 - 18 which includes record keeping, crisis plans, care plans and risk assessments. We were provided with some CPA audit data (undated) which looked at the date of the CPA care plan review, evidence of other CPA review, date of CPA review, date of CPA risk review, date of individualised care plan and the date of the mental health care plan. The data indicates that further improvements are required.

4.215 Our view is therefore that the work FTB has undertaken to ensure that crisis plans are built into CPA care planning and followed is complete but not yet embedded in practice and is therefore graded as C.

4.216 The FTB CPA policy assessment addresses the DHR recommendation to ensure that the assessment for specialist mental health services involve and includes all significant others living with and involved in the life of the service user and that the CPA review process includes the views of the service user and their family or carers.

4.217 However, some users told us that they were either not aware they could have a copy of their care plan or receiving a copy of their care plan was not consistent. Carers we interviewed felt that the involvement of carers is an area that needs further development, particularly in situations where they have information about risk. Given this, we have graded the action against this recommendation as C being complete but not yet embedded in practice.

4.218 We believe FTB has adequate assurance through their policy against the recommendation to put in place procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carers assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually. However, at the current time, we do not believe there is adequate assurance to ensure the process is embedded. We have therefore graded the actions against this recommendation as C.

Medication concordance and risk assessment

Recommendation	Grading BSMHFT	Grading FTB
Ensure that staff recognise poor concordance with medication as an indicator of risk and that non-concordance is incorporated into the risk management plan of the CPA.	B	D
Implement a clear protocol for monitoring medication concordance for people who are considered to require sustained (long-term) treatment with antipsychotic medication that can review actions and risk against concordance.	C	D
Risk assessment training to consider risk in its broadest sense, and ensures all practitioners can consider potential as well as actual risk to the individual as well as to those around them.	B	E
Ensure that all staff are complying with clinical and management supervision policies ensuring that the management of clinical risk is imbedded in multi-disciplinary meetings, with emphasis on the role of the carer and family members.	C	B

4.219　The DHR for Mr A recommends that BSMHFT ensures that its staff recognise poor concordance with medication as an indicator of risk and that non- concordance is incorporated into the risk management plan of the CPA

4.220　The recommendations from both the Mr A and Mr B DHR's included implementing a clear protocol for monitoring medication concordance for people who are considered to require sustained (long-term) treatment with antipsychotic medication and develop a protocol for monitoring medication in line with the policy, that can review actions and risk against concordance.

BSMHFT

4.221　BSMHFT CPA Policy 2016 to 2019 reflects the requirements of national guidance in managing risk. In 2014 the CQC found that that risk assessments and care plans were updated and reviewed. Clinical staff interviewed expressed the view that in terms of assessing risk professional curiosity is needed and staff need to dig a bit deeper and ask difficult questions.

4.222　On entry to secondary mental health services BSMHFT CPA policy requirements are that all service users will receive a comprehensive assessment of their health and social care needs including risk and the care plan will be based on the assessed needs, including risks and vulnerabilities. It states that in preparation for a CPA review, the care coordinator should review and update the assessment summary and appropriate risk assessment.

4.223 BSMHFT CPA policy also provides staff with guidance and a checklist for the effectiveness of treatment and interventions, including medication and psychological therapies and asks staff to consider if all evidence based interventions for the pathway been considered or offered and must cover the effectiveness of treatment and interventions, including medication. BSMHFT CPA policy asks staff to consider whether the patient:

- Is aware of their medication, what it is for and what side effects might they experience.
- Has capacity to make decisions about their medication?
- Feel involved in decisions about their medication?
- Has made choices about their medication?
- Has had choice and medication leaflets made available to them.

4.224 To support BSMHFT CPA policy requirements, BSMHFT has a medication management 5-day module as part of an overall package of training for nurses and other professional staff within BSMHFT.

4.225 BSMHFT also has a clinical risk management policy (RS 01) approved November 2015. This policy refers to clinical risk, the use of clinical risk assessment tools and the CPA policy.

4.226 BSMHFT clinical risk management policy states that the Director of Nursing (on behalf of the Chief Executive) is the Executive Director responsible for coordinating the management of clinical and non-clinical risk and for ensuring that risks are escalated through the risk management governance structure. The Medical Director and the Director of Nursing have joint delegated responsibility for clinical risk management.

4.227 BSMHFT clinical risk management policy also states that clinicians and practitioners will provide safe clinical practice, maintain professional registration with the relevant governing professional bodies, adhere to relevant professional codes of practice, maintain and keep records to evidence up to date competencies, skills and knowledge and assess clinical risk using trust approved clinical risk assessment tools.

4.228 Additionally, BSMHFT Medicines Code Policy and Procedures for Managing Clinical Risks 2015 to 2018 associated with medicines has a section and a detailed appendix developed to assist clinical staff in adopting a more consistent and collaborative approach with service users to apply a range of strategies to maximise concordance. The policy refers to the NICE clinical guideline number 76 medicines adherence[11] issued January 2009.

4.229 To respond specifically to the issues of risk identified in homicide investigations BSMHFT has established an integrated clinical risk committee

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[11] https://www.nice.org.uk/guidance/cg76

led by the Medical Director and has appointed a clinical risk management lead for BSMHFT. This committee reports to BSMHFT clinical governance committee and integrates the clinical risk working group and acute care pathway crisis plan group.

4.230 We were informed that as a result, BSMHFT is reviewing their clinical risk management training programme, and reviewing their clinical risk management policy. Risk training in BSMHFT is mandatory every three years. Staff were not able to tell us if it addressed the issue of carers involvement in the risk assessment process but were able to tell us about learning on this issue arising from another serious incident.

4.231 Producing a clinical risk management strategy and policy, undertaking a comprehensive review of clinical risk training and developing risk assessment tools for use within the electronic care record are Trust priorities. Short life working groups were established in August 2016 by the integrated clinical risk committee to progress the clinical risk management policy and strategy by November 2016 and to report on initial progress in November 2016; for clinical risk training with a new package to be developed by February 2017 and implemented by April 2017; and to finalise the clinical risk assessment tools by November 2016.

4.232 Clinical staff at team level told us that to ensure that risk assessments are up to date and in place, a snapshot of cases are looked at in monthly supervision and the clinical information system flags up where this hasn't been completed to assist them. BSMHFT is now looking at the quality of risk assessments and team managers receive regular feedback through the annual CPA audit.

4.233 Issues of risk are taken to the multidisciplinary team meeting every week and in HTT every patient is discussed every week. Care plans are updated weekly after the review. If risk is escalating quickly an urgent review is undertaken at every shift handover to ensure all staff are aware and they have the option of bringing forward the medical review.

4.234 BSMHFT does not have a protocol for monitoring medication concordance for people who are considered to require sustained (long-term) treatment with antipsychotic medication. Clinical staff interviewed understood this aspect of care and treatment to be covered in the risk assessment process.

4.235 There is a section in the risk assessment on the electronic care record system on medication concordance and it is covered in the risk assessment training. The staff we interviewed felt that the use of clinical skills and professional curiosity are important aspects of the day to day clinical role in respect of medication concordance.

4.236 We were told that to underline the specific importance of medication concordance it should be discussed in the weekly HTT meetings or in complex cases discussions. In addition, the use of blood tests, long acting medication (depots), checking the right number of tablets have been taken (although this is thought to be better for chaotic rather than overtly psychotic patients) can be utilised.

4.237 A new clinical guideline has been developed for BSMHFT electronic care record system alerts. The guideline provides instruction for the correct use of the new alerts system for highlighting any significant risk posed by service users.

4.238 Through the pharmacological therapies committee (PTC), the associate Medical Director for pharmacological therapies is working on specific recommendations around non-concordance of clozapine (an antipsychotic used to treat schizophrenia) as well as the management of abrupt cessation of clozapine. This includes investigating capillary testing for clozapine blood monitoring to improve concordance with blood monitoring and prescribed clozapine therapy.

4.239 BSMHFT is also reviewing clozapine guidance specifically if clozapine is stopped abruptly. BSMHFT sent an alert to clinical staff highlighting the importance of appropriate risk management with regard to rapid cessation of clozapine. The new guidance is scheduled for this year and updated guidance is to be ready by September 2016.

4.240 We therefore believe there is adequate assurance that BSMHFT ensures that staff recognise poor concordance with medication as an indicator of risk and that non-concordance is incorporated into the risk management plan of the CPA. We have graded the action against this recommendation as B being complete and embedded in practice.

4.241 We believe that BSMHFT have addressed the issues of risk associated with medication concordance in their CPA, risk and medicines code policies. We do not believe BSMHFT needs a separate protocol for monitoring medication concordance. We have graded the action against this recommendation as B being complete and embedded in practice.

4.242 A Clinical Director expressed a view that in HTTs sometimes the burden placed on carers is too much especially with medication supervision and that it isn't ideal to expect relatives to supervise medication. The Clinical Director felt that this needs to be put on the HTT agenda and that this may be a HTT team cultural issue.

4.243 Other clinical staff interviewed told us that carers may be asked to prompt with medication but nothing more as it puts pressure in the relationship. If there are overt concerns, then medication can be administered via pharmacy and staff can check on this. In the home staff told us they need to pick up on early signs and work with the service user.

4.244 The May 2017 Medical Director report to the board reported that a proposal for a revised risk summary form was agreed by the integrated risk meeting and procedures to take this through wider consultation and clinical governance are underway. We note that a draft revised clinical risk management policy has been developed and is out for consultation.

4.245 The report details that the training group agreed that a multi-dimensional approach to supporting good practice in assessing and managing risk is

required. This will include e-learning, face to face training, web-based resources such as good practice guidance, literature, case examples, team-based practices which mentor and support good practice and an audit programme.

4.246 We believe that these risk training developments will provide the assurance against the recommendation that risk assessment training will consider risk in its broadest sense, and ensures all practitioners can consider potential as well as actual risk to the individual aND to those around them. Given the stage of development of the training, we have graded the action against this recommendation as D being partially complete.

4.247 The CQC inspection report August 2017 reviewed 12 crisis team and four RAID care records. All contained a two-part risk assessment from the Trust's electronic record system that staff had completed with patients at admission. The first part was a screening tool and the second allowed staff to make a more detailed assessment of risk. The CQC saw examples of staff communicating specific or high level risks using alerts on electronic records.

4.248 However, carers we interviewed felt that the involvement of carers is an area that needed further development, particularly in situations where they have information about risk. Carers views were that issues of confidentiality got in the way of this, particularly with the medical staff.

4.249 As a result, we believe that the action against the recommendation to ensure that all staff are complying with clinical and management supervision policies ensuring that the management of clinical risk is imbedded in multi-disciplinary meetings, with emphasis on the role of the carer and family members is complete but not embedded in practice. We have therefore graded this as C.

FTB

4.250 The FTB Care Management and CPA Policy January 2016 only mentions medication and side effect monitoring as one aspect of the assessment process in planning care. It does not specifically address medication concordance.

4.251 We were told that in FTB concordance risks with medication form part of the risk assessment process and are flagged in the multidisciplinary team meeting weekly with a joint plan formulated in the meeting.

4.252 If the lack of concordance with medication is leading to a deterioration in the persons' mental health, then the service would look at further support to the patient with the provision of HTT urgent care and consideration of practical options more appealing to the patient such as prescribing either monthly depot medication or weekly oral medication. Carers and users interviewed told us that the structured approach taken by EIS services to medication concordance was very positive.

4.253 Despite good feedback from carers on the EIS structured approach, and the obvious practical expertise of the staff we interviewed, we DO not believe there is

adequate assurance that FTB has addressed the issues of risk associated with medication concordance in their CPA policy. We have therefore graded the recommendation as D being partially complete.

4.254 Although we do not believe that FTB needs a separate protocol for monitoring medication concordance we would expect to see the specific issues of risk associated with medication concordance in their CPA, risk and medicines code policies. The FTB CPA policy does however state that a risk assessment is a continuous process and an essential part of the assessment and the FTB clinical risk management policy states that risk assessments and risk management plans should be completed in partnership with service users and carers in the same way as other assessments. Given this, balanced with the positive feedback from staff and carers, and we have graded this as D being partially complete.

4.255 In terms of risk assessment training in FTB, staff transferred across with their mandatory risk training from BSMHFT. FTB are creating a new statutory and mandatory list of training, have just completed a training needs analysis and risk assessment training is a priority. Access to training records was initially a problem but is now resolved, however unfortunately previous training hasn't transitioned across.

4.256 We have therefore graded the recommendation that risk assessment training will consider risk in its broadest sense, and ensures all practitioners can consider potential as well as actual risk to the individual as well as to those around them as E as there is not enough evidence at this stage.

4.257 Given the feedback from staff on how they manage risk associated with medication and the positive feedback from carers on the structured approach used by EIS we have graded the action against the recommendation to ensure that all staff are complying with clinical and management supervision policies ensuring that the management of clinical risk is imbedded in multidisciplinary meetings, with emphasis on the role of the carer and family members as B being complete and embedded in practice.

Carers assessments, involvement and engagement

Recommendation	Grading BSMHFT	Grading FTB
Families and carers, and where a significant other is offering a caring role, are to be made aware of their right to a carers assessment. The offer must be clearly documented, with reasons provided if not accepted, and a date set to revisit this with the carer. Carers assessments are to lead to care plans, which are to be followed, informed by the family's or carer's wishes.	C	E

4.258 The executive summary of the DHR for Mr A asks BSMHFT to ensure that its staff fully engage with relatives and family members and carers when assessing patients and to offer carers assessments.

4.259 The DHR for Mr A echoed the recommendations made of BSMHFT in the Mr B DHR which required a strengthening of assessments and management of risk for service users, their carers and significant others. In particular, the DHR required that the trust put in place procedures and monitoring arrangements to ensure that the assessment for specialist mental health services involves and includes all significant others living with and involved in the life of the service user.

BSMHFT

4.260 BSMHFT CPA policy is robust in stating that regardless of the care management arrangements anyone who is identified as giving care to the service user on a regular and substantial basis must be told of their right to an assessment of their caring, physical and mental health needs by the care coordinator or lead clinician within the first six months of the persons care and annually thereafter.

4.261 We were told that there have been issues with sharing information with carers and so BSMHFT has a policy regarding confidentiality to assist staff. Staff interviewed felt that BSMHFT is better now at hearing from carers but haven't really progressed carers assessments, however they felt that carers are involved quite routinely in the collection of collateral information.

4.262 However, this view was not shared by the carers we interviewed. They felt that the involvement of carers is an area that needed further development, particularly in situations where they have information about risk. Carers views were that issues of confidentiality got in the way of this, particularly with the medical staff.

4.263 Users we interviewed felt concerned about how the level of support offered may impact on their recovery, as an example, if their carer became ill. The issue of needing an interpreter when carers attended appointments for their relative was also raised as an issue for consideration by BSMHFT.

4.264 Carers also felt that listening is one thing however the information provided doesn't appear to make a difference, and feedback on any action taken is not forthcoming. Carers interviewed shared their stories to illustrate this and felt that this is the main issue of concern and the area BSMHFT should focus on, explaining that they felt a cultural change is needed and not just a ticking box exercise. They also expressed the view that the support they need is with this rather than direct support for themselves.

4.265 BSMHFT has several initiatives to support carers including the meridian family programme which trains and supervises staff to work effectively with families and relatives of people experiencing severe mental health problems. This service produced a website for carers focusing exclusively on the recovery of carers with the intention that it will encourage families and friends to consider their own needs and wellbeing so that they are better able to cope and contribute to supporting the person who is unwell.

4.266 We have noted that BSMHFT has developed interactive training jointly between BSMHFT and the meridian family programme with the aim of reflecting upon sharing information with family and friends to introduce good practice strategies for working with service users, their families, friends and significant others.

4.267 BSMHFT is a member of the Triangle of Care.[12] This is a working collaboration, or 'therapeutic alliance' between the service user, professional and carer that promotes safety, supports recovery and sustains wellbeing. It was initially developed to improve mental health acute services by adopting six principles. The trust and carers have worked together to achieve the triangle of care stage one award, celebrating a growing awareness of the needs of carers and families. BSMHFT is to focus further on this in 2016 to 2017.

4.268 There are many examples of BSMHFT information for carers, including a carer and family charter, a leaflet asking for information so that BSMHFT can keep in touch with carers via a database, and a new app called MyCare developed by the meridian family programme in partnership with families and carers of people who live with a mental health condition and is designed to help carers and families take good care of themselves.

4.269 In addition, BSMHFT celebrates carers week annually, facilitated by BSMHFT family and carers lead, with an awareness campaign that is designed to highlight the challenges carers can face and to recognise the contribution that they make while helping people with poor physical and mental health to live well.

4.270 BSMHFT had already identified that services users and carers were not always involved in care planning and goal setting and work was underway via the New Dawn transformation programme to address these issues in the design of a new community hub service.

4.271 However, in February 2016 the quality report informed the Board that the parliamentary health services ombudsman (PHSO) partially upheld a complaint from a family member of a former service user who was receiving care from the services in 2008 and who sadly committed suicide in November 2008.

4.272 Failings related to the adequacy of BSMHFT's arrangements for offering carers assessments to people caring for those in regular contact with mental health services and whether BSMHFT are signposting complainants to other organisations where appropriate. Carers and users interviewed told us a similar story.

4.273 BSMHFT reviewed this with senior clinical and operational colleagues and with their systems teams who facilitate recording and monitoring the activity, and concluded that there are improvements to be made in both routine

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[12] https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf

practice (offering and undertaking carers assessments as mandatory part of practice) and in their ability to demonstrate that they have undertaken this.

4.274 BSMHFT has commissioned a piece of work to oversee the response to the PHSO finding and the action plan is being developed. The action plan is intended to fully address the importance of this area and BSMHFT considers that this requires widespread discussion and consideration prior to sharing with the PHSO upon completion.

4.275 BSMHFT is placing an increased focus on the role of carers and how it consistently approaches carers assessments. The delivery of carers assessments was identified as a risk in the Board assurance framework in May 2016 with an action to support staff in this area. There is no current trust key performance indicator or target for carers assessments, as the statutory responsibility for this lies with Birmingham City Council who have commissioned Stoneham housing association to deliver this piece of work.

4.276 There is good assurance through BSMHFT governance structure to indicate the progress in this area. BSMHFT clinical governance committee approved a task and finish group to be led by the head of patient experience and recovery to review recording of carers, provision of information, implementation of the triangle of care and the support offered to families and carers following a very serious incident including suicide. This task and finish group is developing the action plan in response to the PHSO. As part of these development training is to be delivered to ensure that confidentiality and the policy on sharing information with families is fully understood.

4.277 Progress on the family and carer work stream was subject to a report to the integrated quality committee in May and August 2016. The May report provides a clear programme structure reporting to the integrated quality committee with the family and carer work stream as part of this and the priorities detailed as being to:

- Set the strategic direction.
- Set work plan emergent from themes from homicide /suicide/ complaint and PHSO reports.
- Set the work plan regarding carers assessments.
- Review of ways in which we engage carers and families routinely in co design and co-production.
- Confirm ways of working with other providers of services for carers and families.
- Reviews training for staff.
- Link to recovery agenda.

- Recovery College.

4.278 The first meeting of the task group took place on 8 August 2016. The minutes of this meeting describe good attendance, enthusiasm and a positive start. The group discussions focused on carers assessments and support to families and noted a forthcoming meeting with the chief executive of Birmingham Carers to discuss carers assessments. The committee discussed staff training for carers assessments and felt that this training should also link other elements of risk management and the current review of risk management led by the Medical Director.

4.279 The task group reports to the overarching patient experience recovery programme committee held 26 August 2016. This meeting provided an overview on the key issues associated with carers from the Mr A and Mr B homicide including assessments of risk, noting that BSMHFT did not always adequately engage families and carers, and engaging family in elements of care for example giving medication or taking a role in keeping the service user safe.

4.280 The August report from the overarching patient experience recovery programme to the integrated quality committee informed them that the patient experience and recovery programme committee had met and determined key priorities to be scoped out further so that the work plans are clear including carers assessments. The report also provided information about the development of commissioner quality targets in the first quarter for 2016 to 2017 for the identification of carers and providing information to carers.

4.281 The Birmingham commissioners have identified the need to improve consistent access to high quality information for service users and carers within the community hubs. The commissioners have has asked BSMHFT to take a benchmark of what is in each hub or centre, seeking to move to a consistent view on what needs to be routinely available.

4.282 The Solihull Solar commissioners have identified the need for early work to define a potential approach to routinely seeking to identify carers and family members for all service users, irrespective of CPA status, and the potential, where identified, to provide a standardised set of information as a routine first line action to identified carers.

4.283 BSMHFT is cognisant of the need to change the culture with regards to carers' assessment, involvement and engagement. This was the area the carers interviewed felt strongly about. Further new initiatives included BSMHFT opening their recovery college in June and July 2016 offering a range of co- produced sessions developed with and for people who have been affected by mental health issue including carers.

4.284 BSMHFT delivers training through the recovery college including co-produced courses with carers i.e. training that should change practice. In their 6-week prospectus there are sessions on caring in a crisis, caring for carers, carers and recovery and mental health first aid. Over 450 slots have been offered to users, carers and staff to date.

4.285 BSMHFT has also gone live with a recovery e-learning package for all clinicians where personal safety planning, joint risk planning, advance statements and crisis care are all covered as they relate to the service user, and also who to or not to involve and how in managing a phase of acute illness. Out of a total group of 2788 clinical staff, 1461 staff have successfully completed the training, meaning 1461 staff are now well orientated to recovery and supporting the cultural change BSMHFT seeks within the workforce.

4.286 The May 2017 quality update to the Board provides information about positive developments to encourage service users to identify a carer or family member to be proactively included in care planning.

4.287 A project manager has commenced a programme to institute carers' assessments fully across the organization and the NHS families and friends test postcards to identify specific comments from families and friends has been improved.

4.288 We have heard about and seen lots of initiatives and the development work BSMHFT is undertaking is noted. The governance structure for the task group development work is clear and there is appropriate assurance to evidence the group's development and progress.

4.289 BSMHFT is clearly committed to improvement in the area of carers' assessments, involvement, engagement and the provision of information for carers and feels that things have improved but that there is work still to do. However, it is early days for the development work to report positively on outcomes and it is unfortunate that the carers we interviewed are saying there is no real change from their perspective as yet.

4.290 We also note that the CQC inspection August 2017 reported that patients had concerns about the way in which teams delivered services, their involvement in the care planning process, and the involvement and support provided to family member or carers.

4.291 We have therefore graded progress against these recommendations as C being complete but not embedded in practice.

FTB

4.292 FTB staff interviewed felt that carers concerns are treated differently now. The service sees families and carers as being central to the recovery of young people experiencing psychosis for the first time, and recognise that they too need support in addition to offering family interventions. FTB has a number of carers' groups run by their staff in the evenings, allowing people to share their experiences and support each other.

4.293 FTB staff told us that carers are consulted as part of an ongoing assessment process for the service user although some do not have carers, some have fragmented families and sometimes the service user does not give consent for their carer to be consulted. FTB are now looking to set new standards for

family work. Each team has a person that oversees the family process and sees that carers assessments have been done

4.294 FTB have a January 2016 CPA policy which is due for review in July 2016 according to the policy front sheet, although we were informed that this is not correct by FTB and it is valid for a year. This policy sets out the framework for use across the services. It is designed to support effective clinical care as well as service user and carer involvement and recovery. The policy states that carers form a vital part of the support required and that their needs should be also recognised and supported.

4.295 The policy endorses working collaboratively and maximising the involvement of the service user and carers through clear communication and engagement and indicates that care, risk assessment and management plans should be developed in collaboration between users, carers and professionals. This echoes the NICE guidelines about the key components of a high quality EIS service from the perspective of service users and carers and families. Care coordinators undertake the initial assessment and then refer to Stoneham Housing organisation.

4.296 A five-year participation strategy is being developed and has been shared with the commissioners. This strategy highlights the parent and carers strategy which is further being developed.

4.297 The strategy states that FTB will engage with parents and carers through the carers support group, engaging with parents and carers and through supporting hub and pathway participation champions to develop specific support and engagement groups for parents and carers of children and young people who use FTB services.

4.298 The parent and carers strategy development has a carer involved with the work. Carers assessments are included in the carers strategy and quality standards are being developed around these and a framework for a carers risk assessment. There is an alert and a flagged free text capability in the electronic CareNotes system for carers risk.

4.299 We were informed that FTB provide a regular weekly Saturday morning drop in session at the Pause centre for parents and carers.

4.300 This new parent organisation are looking at further work for carers with Stoneham housing association including a support service for young people over sixteen years. An audit of the pathways, the amount and quality of carers assessments completed and a survey to test out the impact is also planned.

4.301 This joint work and the development of the carers strategy is very positive however at this point it is too early to assess the assurance within FTB as to whether the specific recommendation that families and carers, and where a significant other is offering a caring role, are made aware of their right to a carers assessment, clearly documented, even if not accepted and a date set to revisit this with the carer.

4.302 We have therefore graded the action against this recommendation as E as there is not enough evidence to indicate this is complete.

Record keeping and information sharing

Recommendation	Grading BSMHFT	Grading FTB
Jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer.	D	D

4.303 In 2011, when Mr B killed his mother, it was noted that his care team were using multiple, paper based clinical records, and that no one person held all the information about Mr B and his care, or knew about his relationship and contact with his mother. Since then BSMHFT has implemented a new electronic care record system.

4.304 We sought to understand if this has made the difference it was intended to, and how its use affects clinical practice within the teams.

BSMHFT

4.305 BSMHFT uses an electronic care record system called RiO. We were not informed of any problems with the use of or access to the system in BSMHFT and the Clinical Director for community services told us that the system has a useful link to historical notes. BSMHFT has however recognised some issues with regards to information sharing.

4.306 BSMHFT has an information sharing protocol for the exchange of Information between health and justice agencies within Birmingham & Solihull approved November 2014 but this requires updating as it was due for review in November 2014. This policy relates to:

- BSMHFT.
- Birmingham City Council.
- Solihull Metropolitan Borough Council.
- West Midlands police.
- The Crown Prosecution Service.
- West Midlands ambulance service.
- South Birmingham PCT, learning disability services.

4.307 The May 2016 BSMHFT Trust Board received the information governance annual report for 2015 to 2016. This report identified that a number of Trust projects were likely to require significant information governance involvement and expertise to ensure BSMHFT has assurance and meets its information governance responsibilities, for example with the MERIT vanguard and the Test Beds projects.

4.308 The report indicated that a critical area of this work will be the production and agreement of information sharing agreements which safeguard all partners and ensure concordance with data protection and national standards.

4.309 We note the May 2017 chief operating officer report provides a Board update regarding access to patient records and the need for clinical staff in urgent care for both BSMHFT and FTB to have read and data entry right. The report states that work is underway through the MERIT vanguard to incorporate FTB as part of the access to records programme.

4.310 We have therefore graded the action against the recommendation to jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer as D, being partially complete.

FTB

4.311 FTB uses an electronic care record system called CareNotes. Both BSMHFT RiO system and FTB CareNotes systems should have access to each other. There is a business intelligence platform aligned to the CareNotes system which is designed to provide:

- A single electronic patient record (EPR) system
- Remote and offline access (where 3G or Wi-Fi are not available) to the EPR system from mobile devices for community based staff available 24 hours of the day.
- Seamless transfer of data to adult providers at the age of 25 years, where appropriate.
- An access centre equipped with innovative telephony to allow robust management of calls.
- Co-working and integration with national and regional information sharing projects such as 'Your Care Connected'.
- A patient portal allowing young people and their families access to and the ability to contribute to their own clinical information and care planning for the first time, where they can set goals and review their care plans. They aim to have this in place by late 2016.
- Digital health solutions, such as SilverCloud online, to complement face to face interactions with online psychological therapies.

4.312 The new electronic patient record system launched in 2016 (with some functionality being introduced at a later stage) and will be used by all clinical care delivery partners.

4.313 The system supports the integrated approach by ensuring that all clinical documentation relating to a patient will be immediately accessible to clinicians. Community based staff will be equipped with mobile devices to enable more flexible and efficient working practices.

4.314 At present having access to information is a problem as there is no access to care notes for patients under the age of 25 years, needing the services of HTT but still in BSMHFT CMHT, until they have been transferred to FTB.

4.315 The CareNotes system in FTB and BSMHFT electronic care records RiO system don't currently 'talk' to each other. We were informed that ten RiO access licenses have been issues to FTB via BSMHFT however the FTB staff feel this is not enough. Additionally, we were told that the CareNotes system does not have a section for identifying the nearest relative.

4.316 The staff are therefore looking at operational workarounds to ensure they can always access RiO should they need it. This represents a risk because at present the staff in FTB cannot access risk assessments and need to see patient related activity, for example activity in A&E or RAID for patient's over the age of 25 years receiving services from HTT and EIS is required.

4.317 The contingency plan is that each team's licenses have been transferred to the urgent care shift coordinators who work 24 hours so there is always one person on duty that can access the notes. We have been informed that the inpatient service has access to electronic Carenotes, and access for community staff to in-patient records is in progress.

4.318 Additionally, the CareNotes system for inpatients have a slightly different form to the community CareNotes system and don't 'talk' to each other. Staff did not appreciate that this would be a problem and are looking for workaround opportunities.

4.319 We note the May 2017 BSMHFT Chief Operating Officer report provides an update to the BSMHFT Board regarding access to patient records so that all clinical staff in urgent care for both BSMHFT and FTB have read and data entry rights in the electronic patient record. The report states that work is underway through the MERIT vanguard to incorporate FTB as part of the access to records programme.

4.320 We have therefore graded the action against the recommendation to jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer as D, being partially complete.

The use of the MHA and police powers of entry

Recommendation	Grading BSMHFT	Grading FTB
West Midlands Police to provide practice guidance for mental health practitioners about police officers power of entry and search of premises without a warrant, to save life and limb or prevent serious damage to property as per Section 17 Police and Criminal Evidence Act 1984	B	B

4.321 The DHR for A notes that there appeared to be a lack of appreciation at that time that where there are reasonable grounds to believe that a person is at risk of harm, the Police can use Section 17 PACE to force entry to save life and limb, so entry could have been gained without the use of Section 135 (1) MHA 1983.

4.322 Case law and guidance (including the MHA Code of Practice) are clear that life must be at risk, and that concerns for an individual's welfare are not sufficient grounds to circumvent the process of applying for a warrant under Section 135 (1) MHA 1983. At that time there was no concern that anyone's life was at risk.

4.323 The DHR should perhaps have more accurately reported the law as it stands and clarified this point. However, the DHR coordinator and DHR manager told us that they rely on the expertise of the DHR panel to advise appropriately and these comprise of senior members of each organisation plus the voluntary sector and women's aid.

4.324 The DHR multiagency statutory guidance for the Conduct of Domestic Homicide Reviews 2013 states that the review panel can either have a fixed, standing membership or be created on a bespoke basis for the purposes of undertaking a particular DHR but does not offer any further guidance.

4.325 The A DHR panel comprised:

- BSMHFT lead nurse.
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- Senior strategic commissioning manager NHS.
- Birmingham City Council senior service manager.
- 'Face to Face Channel', Birmingham City Council.
- Detective sergeant, West Midlands police.
- Senior service manager for 'Violence Against Women', Birmingham community safety partnership.

4.326 The following two members joined the panel as from 24 January 2013:

- Designated nurse for safeguarding adults and children.
- Mental capacity act lead, Solihull clinical commissioning group, acting as health advisor to the panel.
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- Operations manager, Birmingham MIND.

4.327 We note that in the DHR there appears to be a lack of clear understanding of the roles of nearest relatives and the duties and responsibilities of AMHPs to inform the nearest relative or consult with the nearest relative. In this instance, the nearest relative could have applied for admission under Section 2. The

Section 12 approved doctors making the recommendation should have known this.

4.328 It is also not clear if Mr A's mother was in fact the nearest relative, as the law is clear that the nearest relative is the elder of the two relatives of 'equal rank' (for example father and mother or son and daughter). If the nearest relative was the father it is possible that he may have been more willing to apply for admission than his mother.

BSMHFT and FTB

4.329 Whilst we understand that the police have not specifically provided practice guidance to staff, we met with medical staff and received information from the MHA and mental capacity act training leads to review their understanding of the MHA with particular reference to the roles of nearest relatives and had the opportunity to review the training syllabus and schedule.

4.330 There is a rolling programme (multiple times a year) of teaching on the MHA for all doctors. The courses are multidisciplinary, including teaching by service users, AMHPs, solicitors and staff as well as doctors.

4.331 The courses and speakers are approved independently by the MHA approvals panel for the Midlands and East of England and quality assured by them. The courses follow the syllabus set by the panel and include training associated with the role of the nearest relative.

4.332 The courses have received good feedback (80% of attendees giving the course the highest rating). Further courses took place June and October 2016, and January and April 2017; and the training is now provided on a rolling monthly or bi monthly basis.

4.333 FTB staff felt that more work is required in relation to liaison with the police to ensure they have the support they need from the police as every neighbourhood is different. The police attend the weekly urgent care operational meeting, the staff meet the police at a liaison and diversion board and meet regularly with regards to the prevent agenda, however staff still feel more work is needed.

4.334 We believe there is adequate assurance in BSMHFT and FTB to ensure that staff gain a good understanding of the role of the nearest relative. We found from the interviews with staff that there was no confusion about the powers of police to force entry. We have therefore graded the action against this recommendation as B, being implemented and embedded in practice.

5 Structures for Learning Lessons

BSMHFT

5.1 Without exception all staff interviewed in BSMHFT were aware of the two IMR and DHRs and the associated learning. Staff were engaged and keen to take

forward both existing and new developments to promote learning in BSMHFT, and aware of areas where more work was required. Staff were able to tell us that learning is shared in BSMHFT through the clinical governance forums they attend.

5.2   We note that the CQC inspection report August 2017 found that the electronic incident recording system included 'It Takes 3', a serious of short films sharing learning from incidents across the trust with staff.

5.3   The CQC found that staff working in the acute care pathway were able to provide examples of changes to practice as a result of serious incident investigations.

5.4   Staff in the acute care pathway told the CQC that they met to discuss feedback from incidents at handovers, multidisciplinary meetings and supervision. The CQC saw examples of staff meetings, where learning from incidents was discussed and recorded. If absent, staff could access the minutes of team meetings on their return.

5.5   The Birmingham Cross City CCG staff member interviewed told us that they have a good relationship with BSMHFT and find them open and very responsive. We were informed that this culture has been maintained despite changes at executive level. When the CCG undertake assurance visits they find that the staff in the teams and wards understand the key messages and learning from incidents

5.6   BSMHFT Board received a homicide review paper in November 2015 providing an update on the current position of any outstanding reviews, key escalation matters relating to on-going or impending independent reviews, lessons learnt and wider governance matters. The paper indicated that BSMHFT was currently assessing the extent to which recommendations from the IMR's and DHRs for Mr A and Mr B have been implemented across BSMHFT.

5.7   BSMHFT Board were informed that the Associate Director of Governance was leading an exercise to revisit all recommendations arising from homicide cases in the past three years. This this exercise was completed by February 2016 with findings reported to the integrated quality committee.

5.8   The Director of Nursing informed the Board that learning lessons remained a challenge but BSMHFT was on a journey of improvement in terms of these processes and there was now a more robust system wide mechanism for sharing lessons and much improved audit processes.

5.9   We note the department of health learning lessons league which has been drawn together by scoring providers based on the fairness and effectiveness of procedures for reporting errors; near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their trust.

5.10   We were informed that BSMHFT has piloted a range of methods for learning over an 18-month period. BSMHFT now produce a serious incident 'it takes

three' podcast where the serious incident themes and changes as a result are aired and may include interviewing a member of staff, a carer or users. This approach has been received well by staff who can view this at their desk when convenient for them.

5.11 The revised approach also includes the development of a Trust database which provides oversight, identifies the homicides, the IMR, DHR cases and the recommendations. Assurance testing of actions commenced in October 2015 and updates are made to this database on an ongoing basis. A quarterly report on progress is submitted to the integrated quality committee and Trust Board. BSMHFT is also conducting a review of themes from serious incidents, complaints and national incidents.

5.12 The BSMHFT Associate Director of Governance, with direct support from the head of investigations, govern the implementation and tracking of recommendations. Action plans arising from homicides are specific, measurable, agreed upon, realistic and time-based (SMART) and we were informed that consideration will always be given to trust wide and locality based learning.

5.13 Staff interviewed were able to tell us about lessons they had learnt both from the IMR and DHRs and from other serious incidents. There was also a view expressed that improvements could be made to Trust wide learning. This indicates that the work BSMHFT is undertaking is in its early stages of implementation and has not yet embedded

5.14 BSMHFT has an integrated quality committee which is a subcommittee of the Board, chaired by a non-executive director, with two further non executives, the chair of the Board of Directors, the Director of Nursing, the Medical Director, Chief Operating Officer and the Chief Executive on the membership. The committee receives a quarterly safeguarding report and a quarterly report on learning from homicides and suicides.

5.15 Reporting to the integrated quality committee is a clinical governance committee chaired by the Director of Nursing. The terms of this committee have been revised and the membership now includes the safeguarding lead.

5.16 Reporting to the clinical governance committee there are sub groups for safeguarding, clinical governance, infection control and health and safety, together with service area local clinical governance groups which are chaired by Clinical Directors. In November 2016 the head of safeguarding undertook a strengthening learning presentation to the clinical governance committee

5.17 BSMHFT annual report 2015-16 confirmed that to ensure openness and transparency of reporting including learning from incidents it intends to take the following actions:

- Incident reporting training.
- Learning lessons webinars.

- Development of integrated quality and incident reports at local service area levels.
- Thematic reviews of incidents.

5.18 In May 2016 the BSMHFT Board indicted that the MERIT partners had agreed to a common approach in holding mock CQC inspections using a model developed by Coventry and Warwickshire called 'Time to Shine'. This initiative is to contribute to how lessons are being communicated to staff.

5.19 As a result, unannounced visits had taken place across services and the results discussed in detail at the executive team and integrated quality committee. The executive team had agreed that a letter should be issued to all ward managers outlining their results, areas of good practice and areas requiring improvement, with a view to increasing local clinical ownership.

5.20 The Birmingham Cross City CCG has also been undertaking assurance visits to wards and teams. The CCG staff member interviewed told us that the CCG undertakes assurance visits for the following reasons:

- They may have picked up an issue.
- To gain additional assurance.
- To follow up on issues, for example, policy changes.

5.21 If they find BSMHFT is generally not delivering on actions, then this would be flagged up either directly with the Chief Nurses (BSMHFT and CCG Chief Nurses meet monthly) or through the Clinical Quality Review Group. The CCG can set targets and use contractual levers which could ultimately lead to financial penalties.

5.22 Outside of contractual levers there would be a debate on what action to take and this may result in the CCG undertaking a themed review where a team go into the services as per the assurance visits and also ask for supporting additional information. The CCG may also seek an independent view via professional bodies to support a themed review.

5.23 Specifically, for DHR actions not being delivered the CCG would discuss with the other CCGs and the BCSP. Actions may include taking the issue to the Quality and Safety Committee, NHS England or to hold a Board to Board meeting.

5.24 We have observed several initiatives and structures for learning lessons being developed in BSMHFT with further suites of more engaging and interactive mechanisms for learning lessons being developed. We note that lessons learnt are reported to the Board on a regular basis through the regular Director of Nursing report.

5.25   The May 2017 Director of Nursing report to the Board on quality goals includes a goal to complete a review of the trust's approach to quality improvement and compare this to best practice models by the end of July 2017.

5.26   This review will develop a best practice framework for quality improvement and approval to this framework will be sought by the end of September 2017. Work has commenced on evaluating a range of quality improvement frameworks in order to determine the most effective model for incorporation in the trust. A paper detailing preferred options and methodology will be submitted to the executive team during June 2017.

BCSP

5.27   In September 2014 the West Midlands strategic police and crime Board took a report as an update on the DHR research project to enhance collaborative practice across agencies and reduce the number of deaths occurring; through learning lessons from the DHR's undertaken since April 2011. On the 2 July 2014, a regional dissemination of findings event was held with over 90 representatives from agencies across the West Midlands.

5.28   Follow up engagement and learning events for the dissemination of findings in each of the seven local police and crime Board areas where required were planned. The heads of community safety across the seven areas were to develop an action plan arising from the report to be monitored through the quarterly heads of community safety meeting, and the meetings of the strategic policing and crime Board.

5.29   Community safety partnerships have had statutory responsibility for undertaking domestic homicide reviews since 13 April 2011 and a duty to decrease crime and disorder in the area.

5.30   The local authority violence against women and children steering group is a sub-group of the BCSP and part of it's purpose is to ensure that lessons concerning domestic violence that emerge from DHRs are fully addressed and that action is taken as requested by BCSP's executive Board on specific issues.

5.31   A summary of progress against the DHRs is contained within the domestic homicide review annual report to Birmingham City Council social cohesion and community safety overview and scrutiny committee in February 2015.

5.32   The DHR coordinator and manager told us about two learning projects which have been agreed through the strategic police and crime Board.

5.33   The first project will be a learning into practice project to support agencies to implement an evidence based learning tool and an internal quality assurance cycle. It is an appreciative enquiry model where organisations adopt a culture of learning.

5.34   The second project is to ensure DHRs are part of the existing audit framework and integrate DHRs into existing quality and governance processes.

However, although dissemination of any learning is to take place through the link with the other local authority strategic Boards, individual organisations still need systems in place to disseminate learning.

5.35   We were informed that the community safety partnership has facilitated a programme of evidenced based multi-agency training 'Learning from Domestic Homicide Reviews Safeguarding & Domestic Violence'. Over 1,000 delegates from different professional backgrounds have attended the training. The evaluation evidenced that the training specifically achieved the learning outcomes in enhancing knowledge and understanding of coercive control in changing attitudes and responses of the workforce

5.36   Further targeted DHR training will commence in November 2016 and encompass adult safeguarding taking into account the ADASS[13] guidance for adult safeguarding and domestic abuse.

5.37   We were also informed that the community safety partnership has now developed a quality assurance framework, which has been well received by the Home Office, to provide genuine accountability, and to secure evidence that DHRs have delivered a desired change in frontline services.

5.38   This also ensures reporting back to families about the changes that have been made as a result of each review. Peer Reviews are beginning to evidence the impact of DHRs are commencing from Autumn 2016.

FTB

5.39   Without exception all staff interviewed in FTB were aware of the two IMR and DHR's and the associated learning. Staff were engaged and keen to take forward both existing and new developments to promote learning in FTB, and aware of areas where more work was required.

5.40   It is early days for FTB in terms of structures for learning lessons. However, staff told us that although there are currently no formal learning structures in place they were able to tell us that the usual process is the hub managers attend the operational governance meetings to bring the learning back to the teams and learning is then communicated through the weekly newsletter.

5.41   Quality governance structures for FTB are clear. Each of the partners' report to the operational governance meeting which in turn reports to the risk quality governance meeting. This reports to the FTB Board and the Birmingham children's hospital Trust clinical risk and quality assurance committee. This reports to the Birmingham children's quality committee and then to the Birmingham children's Trust Board.

5.42   Minutes of the August 2016 risk quality meeting indicate that learning from both complaints and serious incidents form part of the agenda with evidence that FTB is following up actions and disseminating learning across the

[13] ADASS Safeguarding Adults Policy Network Guidance June 2016 https://www.adass.org.uk/media/5414/adass-guidance-inter-authority-safeguarding-arrangements-june-2016.pdf

partnership. The main points of the Birmingham children's hospital governance report and monthly quality and safety dashboard are discussed. We have seen a schedule of governance meetings going forward.

5.43 We were informed that learning processes are in place through the clinical governance group and that a continual review of serious incidents is in place to ensure actions are complete, and themes are not recurring.

5.44 We have viewed the terms of reference for this group and note that one of the aims is to ensure that the service has consistent mechanisms and processes for sharing learning across all services and teams.

5.45 Appropriate routes of assurance are in place with the group reporting to the FTB quality partnership meeting quarterly, the monthly clinical quality review group with commissioners monthly and quarterly through the Birmingham children's hospital clinical governance meetings.

6   Summary

6.1   Two of the key lines of enquiry do not correspond to recommendations made. These are the DHR process of oversight and quality assurance of the final report and structures for learning lessons. We have therefore summarised our findings in respect of these in the respective narrative sections of the report without assigning a grade.

BSMHFT

6.2   Out of the 15 IMR and DHR recommendations we have graded BSMHFT as follows:

Grade	Criteria	Total
A	Evidence of completeness, embeddedness and impact.	1
B	Evidence of completeness and embeddedness.	5
C	Evidence of completeness.	6
D	Partially complete.	3
E	Not enough evidence to say complete.	0

6.3   BSMHFT had one action scored A with evidence of completeness, embeddedness and impact against the recommendation to have procedures and monitoring arrangements to ensure that all health and social care assessments, risk assessments and carer's assessments are regularly reviewed and up-dated as directed by the CPA process, and at a minimum annually. The BSMHFT quality account 2016 -17 states that the national mental health indicators show that 98.6 percent of CPA patients have had a formal review in past 12 months against a national threshold of 95 percent.

6.4   BSMHFT had partially completed actions against three recommendations and scored D in these areas. Firstly, against the recommendation that the bed management policy is sufficiently robust, understood and implemented by clinicians and senior managers in a way that keeps people safe. This is due to the fact that the operational management of beds in BSMHFT does not include the critical safety metric of no delay in accessing an inpatient bed once it is deemed necessary.

6.5   We note that the Trust has now received approval of a business case to provide a further 27 beds from commissioners comprising two new wards (15 beds for female admissions) and (12 beds for male pre-discharge patients). The beds will accommodate 16 BSMHFT and 11 FTB patients. Discussions are currently taking place with FTB regarding the provision of the 11 beds and how they will be operationalised for the Autumn 2017.

6.6   We note the level and pace of change in BSMHFT and the range of bed management initiatives in place however these do not at present provide the assurance that the DHR recommendation action has been implemented in a

way which keeps people safe. We consider that, in respect of bed management, if a similar incident or circumstances such as outlined in the Mr A DHR occurred today that the current trust policies and procedures would potentially not prevent a reoccurrence.

6.7 Secondly against the recommendation that risk assessment training will consider risk in its broadest sense, and ensures all practitioners can consider potential as well as actual risk to the individual as well as to those around them due to the stage of risk training development in BSMHFT. However, this is balanced by the fact that issues of risk embedded in practice through discussion at the multidisciplinary team meeting every week and in HTT every patient is discussed every week. Care plans are updated weekly after the review. If risk is escalating quickly an urgent review is undertaken at every shift handover to ensure all staff are aware and they have the option of bringing forward the medical review.

6.8 Lastly against the recommendation to jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer. We note that in May 2017 the BSMHFT Chief Operating Officer reported that work is underway through the MERIT vanguard to incorporate FTB as part of the access to records programme.

FTB

6.9 Out of the 15 IMR and DHR recommendations we have graded FTB as follows:

Grade	Criteria	Total
A	Evidence of completeness, embeddedness and impact.	0
B	Evidence of completeness and embeddedness.	3
C	Evidence of completeness.	6
D	Partially complete.	4
E	Not enough evidence to say complete.	2

6.10 FTB had partially complete actions against four recommendations and scored D in these areas. Firstly, against the recommendation that the bed management policy is sufficiently robust, understood and implemented by clinicians and senior managers in a way that keeps people safe. This is due to the fact that the operational management of beds in BSMHFT does not include the critical safety metric of no delay in accessing an inpatient bed once it is deemed necessary.

6.11 We note that approval of a business case has now been received to provide a further 27 beds from commissioners comprising two new wards (15 beds for female admissions) and (12 beds for male pre-discharge patients). The beds will accommodate 16 BSMHFT and 11 FTB patients. Discussions are currently taking place with FTB regarding the provision of the 11 beds and

how they will be operationalised for the Autumn 2017.

6.12   We note the level and pace of change in FTB and the range of bed management initiatives in place however these do not at present provide the assurance that the DHR recommendation action has been implemented in a way which keeps people safe. We consider that, in respect of bed management, if a similar incident or circumstances such as outlined in the Mr A DHR occurred today that the current trust policies and procedures would potentially not prevent a reoccurrence.

6.13   Secondly, against the recommendation that risk associated with medication concordance is in their CPA policy. This was despite good feedback from carers on the EIS structured approach, and the obvious practical expertise of the staff we interviewed.

6.14   The third area in which FTB scored D as being partially complete was against the recommendation to have a separate protocol for monitoring medication concordance. Although we do not believe that FTB needs a separate protocol, we would expect to see the specific issues of risk associated with medication concordance in their CPA, risk and medicines code policies.

6.15   We note that the FTB CPA policy does however state that a risk assessment is a continuous process and an essential part of the assessment, and the FTB clinical risk management policy states that risk assessments and risk management plans should be completed in partnership with service users and carers in the same way as other assessments. We balanced this with the positive feedback from staff and carers to arrive at our conclusion.

6.16   We have graded the recommendation that risk assessment training will consider risk in its broadest sense, and ensures all practitioners can consider potential as well as actual risk to the individual as well as to those around them as E as there is not enough evidence at this stage.

6.17   Lastly, the fourth area in which FTB scored D as being partially complete was against the recommendation to jointly review the information sharing and record sharing protocol to ensure that records are integrated to enable effective sharing of records across the two agencies when both are involved in supporting a service user and their carer. We note that in May 2017 the Chief Operating Officer reported that work is underway through the MERIT vanguard to incorporate FTB as part of the access to records programme.

6.18   FTB had two areas in which there was not enough evidence. In terms of risk assessment training in FTB, staff transferred across with their mandatory risk training from BSMHFT. FTB are creating a new statutory and mandatory list of training, have just completed a training needs analysis and risk assessment training is a priority. Access to training records was initially a problem but is now resolved, however unfortunately previous training hasn't transitioned across.

6.19   We have therefore graded the recommendation that risk assessment training will consider risk in its broadest sense, and ensures all practitioners can consider potential as well as actual risk to the individual as well as to those around them as E as there is not enough evidence at this stage.

6.20   Secondly against the recommendation that families and carers, and where a significant other is offering a caring role, are to be made aware of their right to a carers assessment. The offer must be clearly documented, with reasons provided if not accepted, and a date set to revisit this with the carer. Carers assessments are to lead to care plans, which are to be followed, informed by the family's or carer's wishes. Despite positive joint work and the development of a carers strategy FTB had action with not enough evidence to indicate that action was complete in one area.

Birmingham City Council

6.21   We have graded the action against the DHR recommendation for Birmingham City Council as follows:

Grade	Criteria	Total
C	The City Council is to ensure that the new AMHP service is implemented as soon as possible and enshrined in training and policy with guidance.	1

6.22   We concluded this because although Birmingham City Council have implemented a new service, the staff and BSMHFT and FTB remain confused about the service and are still to feel the benefits. We consider that, in respect of this, if a similar incident or circumstances such as outlined in the DHR for Mr A occurred today that the current systems would potentially not prevent a reoccurrence.

Appendix A - Terms of reference

Both of these cases have been the subject of a Domestic Homicide review, by the Birmingham Community Safety Partnership, with resulting recommendations for the health economy. This external quality assurance review is intended to be a review of the outcomes of the investigations, from an NHS perspective, to ensure that the recommendations and actions identified have been implemented and are being sustained. The focus of the combined investigation will be on present day services and current processes.

- Quality assure the recommendations and action plans from both the internal investigations and the Domestic Homicide Reviews.

- Review the progress that the NHS has made in implementing the recommendations and the learning from the internal investigations and Domestic Homicide Reviews.

- Consider if the recommendations are embedded in all the current processes within the relevant organisations.

- Consider if similar incident/circumstances occurred today whether the current trust policies and procedures would prevent a reoccurrence.

- Review the appropriateness of the treatment of the service users in light of their identified health needs and access to services.

- Examine the effectiveness of the service users care plans including the medication management.

- Review the involvement of the service users and their families and examine the current processes of involving relative's in the service user's care.

- Involve the families of both the victim and the service users as fully as is considered appropriate.

- Consider if the incidents were either predictable or preventable.

- Provide a written report to NHS England that may include measurable and sustainable recommendations.

- Assist NHS England in undertaking a brief post investigation evaluation

Appendix B - FTB model

The service combines the expertise of Birmingham Children's Hospital, Worcestershire Health and Care NHS Trust, the Priory Group, Beacon UK and The Children's Society.

Worcestershire Health and Care NHS Trust includes services provided to children, adolescents, adults and older people who are supported in both community and inpatient settings. Services are also designed to ensure effective transition between services including ensuring that the transition between children's mental health and adult mental health is as seamless as possible.

Beacon UK are managed care leaders in mental health, specialising in helping people achieve and sustain recovery in community settings. Beacon UK does not provide care, but organises multiple services so that support is tailored to the individual. Beacon offers mental health case management, system-wide pathway coordination, and insightful analytics that improve the delivery of care. Its mission is to help people with mental health problems live life to their fullest potential.

The Children's Society deliver frontline support services and campaign for change. It works closely with a wide range of community and voluntary organisations to tackle poverty and neglect and is a lead researcher in the field of children's emotional well-being. Its experience and approach has been proven to build bridges in communities and improve the mental resilience of young people. It has formed a partnership with Birmingham City Council to bring the voices of children and teenagers into the future of the city.

Priory Group purpose is to make a real and lasting difference for everyone it supports. Priory Healthcare runs the largest network of mental healthcare hospitals and clinics in the country, providing treatment for addictions and conditions including depression, self-harming, and eating disorders. It treats 20,000 patients a year at more than 50 sites. In Birmingham, the Priory's Woodbourne Hospital has a team of psychiatrists, psychologists and therapists treating adults and children. The service is based around raising the profile of mental health and challenging stigma in the community to help prevent problems from developing in the first place.

Appendix C - New Dawn Model

Primary care and prevention

The aim is to always see people close to home as possible. Patients have the ability to self-refer back into the system without having to revisit the GP to ensure speedy access to services, early intervention, promoting mental health within schools. Supporting GPs with training and development, providing tools and guidance on BSMHFT website.

Integrated community teams in hubs

A single point of access and support, staffed by administration and clinical staff with opportunities for self-referral with simplified access, booking and transitions service to access the best assessment with a choice of location, team or clinician, time and date. Fast track appointments without any need for re-referral with a 2-week referral to treatment for people with psychosis. Standardised, consistent, high quality mental health service within the community mental health teams local in focus and global in standard. Appointments in 'appropriate' settings, which could be at the integrated hubs, GP surgeries or at the service user's own home with staff having technology for mobile working. The initial assessment will be holistic and carers will be involved and supported whenever possible. Flexible appointments that service users choose. Interventions offered on pathways based on needs not age. More options for having needs met away from mental health setting. Recovery focus, to meet outcomes and personal goals. Community based assessment, interventions and support, mainly needing specialist and multi-disciplinary team approach, bringing together all services for ages over 25 located in main 'hub' bases, reaching out into a range of venues to make access easier and closer to home

Urgent care services

Includes:

- Psychiatric Decisions Unit (PDU)
- Place of safety
- Street Triage
- Crisis House
- Rapid Assessment Interface and Discharge (RAID)
- NHS 111
- Crisis Assessment
- British Transport Police Psychiatric Liaison Team
- Self and, or carer referral

These services will form part of all integrated urgent care pathway. All referrals for urgent assessments within BSMHFT are undertaken across the urgent care teams. The teams work together to provide in-depth assessment of need in order to ensure patients are referred on wards to the appropriate pathway. The pathway is integral to

BSMHFTs contribution to concordance with the Mental Health Crisis Care Concordat.

Acute services

Includes these services which form part of an integrated pathway:

- Acute inpatient wards including specialist beds for people with dementia or organic mental illness
- Psychiatric Intensive Care Units (PICU)
- 7-day recovery or 'day' services
- Respite beds
- Home Treatment and Community Enablement Recovery Team (known as CERT) for older people.

Assertive outreach in community and inpatient and community rehabilitation

The rehabilitation pathway is whole system approach to recovery from mental illness, and strongly focusses on maximising a person's chances, getting the right support and interventions to enable them to live as fulfilling a life as possible. Includes specialist rehabilitation inpatient facilities geared up to provide active rehabilitation services to people over the age of 25 with a long term mental health conditions. Assertive outreach services continue to work in conjunction with other partners and agencies to ensure that some of the most vulnerable people and those with the most complex needs can live in the community.

Appendix D - People Interviewed

Designation	Date and type of Interview
Deputy chief nurse and quality officer Birmingham cross city CCG	Telephone interview 5 July 2016
Associate director of governance	15 July 2016
Head of investigations	15 July 2016
Associate director of operations	10 August 2016
Head of patient experience and recovery	18 August 2016
Clinical services manager	18 August 2016
BCSP DHR coordinator	12 August 2016
BCSP Violence Against Women strategic lead and domestic homicide review manager	12 August 2016
FTB associate director of nursing	12 August 2016
FTB lead for quality and governance	12 August 2016
AMHP lead	7 August 2016
EDT lead	30 September 2016
Consultant psychiatrist inpatient services and clinical director community	10 August 2016
Consultant psychiatrist HTT and clinical director urgent care services	Telephone Interview 7 September 2016
Medical director	18 August 2016
Chief operating officer	Telephone Interview 7 September 2016
Executive director of nursing	Telephone interview 4 October 2016
CMHT team manager	Group Interview 5 September 2016
Deputy team manager HTT	Group Interview 5 September 2016
HTT team manager	Group Interview 5 September 2016
EIS pathway lead	Group Interview 5 September 2016
EIS CPN	Group Interview 5 September 2016
EIS senior practitioner	Group Interview 5 September 2016
FTB deputy head of nursing	Group Interview 5 September 2016
Family and carer engagement lead	Group Interview 5 September 2016
Service user, carer and public engagement lead	Group Interview 5 September 2016
N/A	Group Interview 5 September 2016
N/A	Group Interview 5 September 2016
N/A	Telephone Interview 5 September 2015

Appendix E - Documents reviewed

1	Document	Date
2	Key clinical documents for A	2012
3	Key clinical documents for B	2010 - 2011
4	IMR and DHR for A	2012 and August 2013
5	IMR and DHR for B	October 2012 and May 2013
6	New Dawn service model	July 2015
7	FTB service model	No date - website
8	BSMHFT review of homicides	February 2016
9	BSMHFT learning from homicides	April 2016
10	BSMHFT quarterly update – learning from homicides	August 2016
11	BSMHFT homicide review board paper	September 2016
12	BSMHFT organisational learning	April 2016
13	BSMHFT learning lessons proposal	April 2016
14	BSMHFT identifying, investigating, learning from serious incidents	No date – power point presentation
15	BSMHFT and commissioners 'dare to share' presentations	No date – powerpoint presentation
16	BSMHFT Annual Report	2015 - 16
17	Report to Social Cohesion and Community Safety Overview and Scrutiny Committee Domestic Homicide Reviews	February 2015
18	DHR lessons review details	2014
19	DHR lessons – police and crime board	2014
20	DHR review of homicides learning research – police and crime board	2014
21	DHR multiagency training	requested
22	BSMHFT patient experience integrated quality committee report	April and August 2016
23	BSMHFT patient experience clinical governance committee report	July 2016
24	BSMHFT patient experience recovery committee notes	August 2016
25	BSMHFT patient experience and recovery programme structure	August 2016
26	BSMHFT crisis care concordat	April 2015
27	BSMHFT MERIT vanguard	No date
28	BSMHFT bed management policy	April – October 2014
29	BSMHFT crisis resolution and home treatment operational policy	April 2007 – April 2008
30	BSMHFT medicines code	April 2015 – April 2018
31	BSMHFT clinical supervision policy	December 2014 – December 2017
32	BSMHFT discharge and transfer policy	June 2012 – June 2015

33	BSMHFT care records management policy (Electronic and Manual)	April 2016 – April 2019
34	BSMHFT care management and CPA/care support policy	February 2016 – February 2019
35	BSMHFT carers strategy	2012
	BSMHFT Clinical Risk Assessment and Management Policy version 1	22 June 2017
36	BSMHFT community mental health team operational policy	April 2008 – March 2009
37	BSMHFT protocol for the exchange of information between health and justice agencies within Birmingham & Solihull	November 2012 – November 2014
38	BSMHFT information governance annual report	May 2015
39	BSMHFT MyDashboard user guidance	No date
40	BSMHFT integrated clinical risk committee terms of reference and minutes	August 2016
41	BSMHFT medication management in mental health learning outcomes	April 2013
42	BSMHFT learning lessons bulletins	November 2012 – February 2015
43	FTB quality governance structure	No date
44	FTB risk quality governance meeting draft minutes	August 2016
45	FTB CPA policy	January b2016
46	FTB schedule for risk quality governance meetings	No date
47	FTB complaints learning and actions	No date
48	FTB memorandum of understanding with BSMHFT for patients 25 to 35 years under EIS requiring urgent care services from BSMHFT	April 2016
49	FTB bed management policy version 3	21 June 2017
50	FTB utilisation management system	undated
51	FTB entry and exit criteria version 12	undated
52	FTB bed managers checklist	undated
53	FTB transitions policy	January 2017
54	FTB clinical governance group terms of reference	undated
55	FTB forward audit plan	2017 - 2018
56	FTB risk register entry 2314	18 June 2016
57	Birmingham children's hospital board of directors minutes	June – July 2016
58	BSHMFT integrated quality committee minutes 18 January 2017 with themes	January 2017
59	NHS benchmarking network inpatient and community mental health benchmarking	2016
60	Mental Health Strategies simulation modelling project report	April 2017

Appendix F - Glossary

1	BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust
2	DHR	Domestic Homicide Reviews
3	BCSP	Birmingham Community Safety Partnership
4	IMR	Independent Management Reviews
5	FTB	Forward Thinking Birmingham
6	CCG	Clinical Commissioning Group
7	AMHP	Approved Mental Health Professionals
8	CPA	Care Programme Approach
9	RC	Responsible Clinicians
10	HTT	Home Treatment Team
11	EIS	Early Intervention Service
12	MHA	Mental Health Act
13	CMHT	Community Mental Health Team
14	CPN	Community Psychiatric Nurse
15	BCSPCB	Birmingham Community Safety Police and Crime Board
16	PDU	Psychiatric Decisions Unit
17	MERIT	The Mental Health Alliance for Excellence, Resilience, Innovation and Training
18	CQC	Care Quality Commission
19	UM	Utilisation Management
20	LOCC	Level of Care Criteria
21	PICU	Psychiatric Intensive Care Unit
22	ADHD	Attention Deficit Disorder
23	IAPT	Improving Access to Psychological Therapies Team
24	PALS	Patient Advice and Liaison Service
25	MHAA	Mental Health Act Assessment
26	LSSA	Local Social Services Authorities
27	NICE	National Institute for Healthcare Care Excellence
28	RAID	Rapid Assessment Interface and Discharge
29	CQUIN	The Commissioning for Quality and Innovation
30	PTC	Pharmalogical Therapies Committee
31	PHSO	Parliamentary Health Services Ombudsman
32	EPR	Electronic Patient Record
33	PACE	Police and Criminal Evidence Act
34	SMART	Specific, Measurable, Agreed upon, Realistic and Time-based