Firstly, and most importantly our thoughts are with the families, and everyone affected by these tragic incidents. From this external review which has been commissioned by NHS England, there are identified areas of learning in our care, for which we offer our sincere apologies.

1. Introduction

In 2014 two mental health service users were involved in domestic homicides. Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) completed internal reviews of care and treatment for both service users, in line with the requirements of the NHS Serious Incident Framework (March 2013).

These resulted in findings and recommendations for BSMHFT. Birmingham Community Safety Partnership commissioned a Domestic Homicide Review (DHR) to be carried out in both cases to establish what lessons could be learned.

These DHRs were completed, and reports were written and shared with stakeholders, but they were not published. Although both incidents met the threshold for commissioning an independent mental health homicide investigation, they were not commissioned at that time.

In 2021 the NHS England Midlands & East (NHSE) Regional Investigations Review Group decided it would be proportionate to commission a review of how the current systems might respond to a similar situation.

Niche were commissioned by NHSE to complete an examination of the present-day situation to answer one fundamental question:

"If a service user accessed services today with a similar history/problem – what would change/be different"?

The final report from Niche contains seven learning points. Our progress against these is described within the following text.

2. Report Learning Points

Learning Point 1: Community Treatment Orders

Discussions taking place with service user subject to a CTO regarding the decision to recall with them and informing them of their legal status.

To provide assurance of compliance with the Mental Health Act, the Trust has a monthly audit programme in place, the identified learning points have been integrated into the existing audit programme, enhancing its oversight.

Since the introduction improvements have consistently been shown over time with compliance a 100%.

Learning Point 2: Care Planning

The number of service users with an up-to-date care plan.

Acknowledging the significance of care plans to our service users, monthly audits and undertaken in the service areas which involve sampling from caseloads. These audits encompass various quality domains, and serve as a proactive measure to uphold and enhance the quality and effectiveness of care plans.

In the last audit, over 75% of care plans were found to be in date.

These results are shared regularly with the teams and relevant quality forums to provide oversight and support if needed.

Learning Point 3: **Risk Assessment**

Compliance with the Trust policy expectations regardin risk assessment and management

A Risk Management Group has been set up to look at our risk assessment processes, which is being led by our Deputy Medical Director for Quality and Safety.

To introduce sustainable change and improvement in quality, a proposal was commissioned by the group which lays out plans for a thorough review of our risk management processes. It focuses on defining information needs, conducting a data review, consulting stakeholders and mapping processes. The quality of the information and the effectiveness of our risk assessment training, using improvement methodologies to guide our approach, which has identified key resources for this to succeed.

Learning Point 4: Risk Assessments

Staff can pull through information from previous risk assessments when completing a review. If there has no new risk identified during the review period, they are not required to make an entry in the risk assessment. Therefore, it is difficult to determine if a risk review has been completed or if it is simply a change of date.

The group mentioned in point 3 have also supported the comprehensive review of the Clinical Risk Assessment and Management policy, the identified updates were included and this policy was ratified by the Clinical Governance Committee.

Learning Point Five: Domestic Abuse

We were unable to identify a Trust process that allows the risk of domestic abuse to be easily identifiable in the service user's clinical record.

The Domestic Abuse policy has undergone enhancements and has been ratified through our Clinical Governance Committee. The updated policy now includes detailed guidance on how to document instances of domestic abuse, which are recorded in Alerts within the clinical record keeping system.

Additionally the Safeguarding Team have been collaborating with the Learning and Development team to incorporate a scenario focusing on Think Family to be incorporated into Clinical Risk Assessment and Management training, which will necessitate the creation of a safeguarding alert.

To improve the quality of record keeping the Safeguarding Team are working to create alert standards to provide guidance for staff.

Furthermore there is a plan in place to conduct a comprehensive review of all safeguarding documentation within the clinical record keeping system, with the goal to enhance record keeping practices overall.

Learning Point Six: Keeping Safe Plans

We were unable to identify a clear process for developing 'keeping safe' plans for family members who may be at risk of domestic abuse.

As per point 4 and 5

Learning Point 7: **Carers Engagement**

There is no evidence that 48% of carers were offered the opportunity to complete a carer engagement tool.

The services recognises that carers are experts by experience and there are a number of strategies and initiatives to actively engage and involve families and carers across services.

- Family Engagement Awareness sessions are conducted in collaboration with a carer. These sessions are designed to raise awareness and provide relevant information to all staff. By involving a carer in the facilitation, we ensure firsthand experiences and insights are shared, enhancing the relevance and impact on the sessions.
- Services have a dedicated lead for family and carer engagement, providing vital support and connections. These leads offer various interventions, including practical and emotional support, tailored to carers needs. Their efforts strengthen relationships between service providers and carers, improving the quality of care and support provided.
- We are reviewing and enhancing our Family Engagement Tool to ensure that it is meaningful and effective. By incorporating feedback from all stakeholders and refining our approach, we aim to strengthen our engagement efforts and reflect how we value the voice of family and carers.

The Trust recognises the deficits in care identified in the independent investigation and we again offer our sincere apologies for these deficits. Regular review will take place to ensure these recommendations are embedded in our daily ways of working,

The executive summary of the independent investigation and Trust response can be accessed on our website and is being made available to all.

The BSMHFT action plan to address the lessons identified will be overseen by the Clinical Governance Committee.