



**An independent quality assurance  
review following the independent  
investigation into the care and  
treatment of P in the West Midlands**

**November 2018**

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Niche Health and 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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# 1. INTRODUCTION

## The incident

- 1.1 On 7 March 2013 shortly after 5.00am P boarded the number 9 bus (the bus) close to Birmingham city centre and went to the upper deck of the bus. Shortly after 7.25am after a passenger informed the bus driver that P was asleep, the driver went to the upper deck and saw P, but he took no action.
- 1.2 Christina boarded the bus at approximately 7.30am and sat on her own in a seat on the upper deck of the bus. Within seconds of Christina sitting down P got up and moved forward three seats and sat down. CCTV evidence showed P taking a knife from his bag and then hiding it between his hands and thigh. P then stood up and walked towards Christina, stabbed her and then disembarked from the bus. Emergency services attended the scene but Christina was declared dead at about 8.00am.
- 1.3 Christina and P were not known to each other.

## Summary of care and treatment

- 1.4 P had been in contact with, and assessed by, several different mental health services from between 2005 and 2013, but had never fully engaged with or received consistent mental health care and treatment for his emerging severe mental illness.
- 1.5 P was last in contact with mental health services whilst in HMP Birmingham, when he was seen jointly by the Consultant Psychiatrist and his nurse key worker on 12 December 2012.
- 1.6 At that time P denied hearing voices but was difficult to engage. He was not presenting with any active or acute mental health problems nor any immediate risk of self-harm or suicide. The plan was to refer P to Birmingham and Solihull NHS Foundation Trust (BSMHFT) Homeless Team on his release. It was the consultant psychiatrist's intention to review P's notes from HMP Hewell but this did not happen before he was released.
- 1.7 P was released from HMP Birmingham custody the next day (13 December 2012). The healthcare team were not informed that P was being released.
- 1.8 It is not known where P lived from December 2012 up to the incident in March 2013. It is thought he was homeless.

## The independent investigation

- 1.9 NHS England, (Midlands and East) commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of P, a mental health service user in the West Midlands, who had received care and treatment from Black Country Partnership NHS Foundation Trust (BCPFT) and prison health care services in HMP Hewell

(then provided by Worcestershire Health and Care NHS Trust and now provided by CareUK) and HMP Birmingham (provided by BSMHFT).

- 1.10 The independent investigation report was published in June 2017.
- 1.11 Niche is a consultancy company specialising in patient safety investigations and reviews.
- 1.12 This investigation was chaired by Kiran Bhogal who is a partner and Head of Healthcare (London) at Hill Dickinson LLP.<sup>1</sup> She has extensive experience of advising the health and public sector on medico-legal issues including mental health law, the law relating to children, child protection, complaints handling, complex and sensitive inquests, clinical and corporate governance, serious untoward incidents (including homicide inquiries) and human rights.
- 1.13 Grania Jenkins was the senior investigator and report author. Grania is a senior mental health care, performance and quality professional who has worked in primary, secondary and third sector organisations. She has extensive experience of undertaking investigations into critical incidents, unexpected deaths and suicides.
- 1.14 Dr David Ndegwa was the clinical advisor in forensic psychiatry. Dr Ndegwa is a consultant forensic psychiatrist in the NHS with considerable experience of all aspects of psychiatric services. He has been a clinical director for more than 16 years and has led and developed services in a part of London which is culturally diverse with high psychiatric morbidity and rates of violent crime.
- 1.15 Bill Abbott, OBE, provided advice on criminal justice and secure mental health services policy issues. He has been a prison governor, and advised on criminal justice and security with the North West Secure Commissioning Team. He later became the senior policy adviser to Department of Health Secure Services Policy Team.
- 1.16 Dr Jane Winstone provided the expertise in management of adult offenders with mental health needs within a multi-agency environment. She has extensive experience in the interface between these services, and has worked as a youth and adult probation officer in community and secure settings, before moving to the University of Portsmouth to develop and lead the qualification in probation training and more recently the Professional Doctorate in Criminal Justice.
- 1.17 Nick Moor, Partner, Investigations and Reviews, Niche Health and Social Care Consulting was co-chair and focused on reviewing governance arrangements for the initial investigation report and testing the evidence supplied by organisations as assurance for the implementation of their action plans developed in response to the recommendations. He provided additional project management support and editing of the final report.

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<sup>1</sup> LLP – Limited Liability Partnership

- 1.18 The independent investigation follows the NHS England Serious Incident Framework (March 2015)<sup>2</sup> and Department of Health guidance on Article 2 of the European Convention on Human Rights<sup>3</sup> and the investigation of serious incidents in mental health services.
- 1.19 The main purpose of the independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.20 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.
- 1.21 The independent investigation report was published in June 2017. The independent investigation made 25 recommendations for the agencies involved to address in order to further improve learning from this tragic incident.

## Recommendations arising from the independent investigation

- 1.22 Where appropriate throughout the report we have made 25 recommendations to improve practice. These have been given one of three levels of importance:
- Priority 1: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems/process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.
  - Priority 2: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems/process objectives. The area of concern does not compromise the safety of patients, but identifies important improvements in the delivery of care required.
  - Priority 3: the recommendation addresses areas that are not considered important to the achievement of systems/process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.
- 1.23 We made 10 Priority One recommendations, 13 Priority Two recommendations, and two Priority Three recommendations. The following list shows the recommendations in priority order. In Appendix B we present the recommendations in numerical order.

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<sup>2</sup> NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

<sup>3</sup> Department of Health Guidance ECHR Article 2: investigations into mental health incidents. <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incident>

## **PRIORITY 1**

### **HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**

Recommendation 8: Staff undertaking the initial Care Programme Approach Plan must ensure that they liaise with all agencies who have been involved with the prisoner, in the community and/or during the court process, in order to obtain an accurate profile of their needs and risks to themselves and others.

### **Department of Health, NHS England, CCGs and local Police and Crime Commissioners**

Recommendation 11: To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services.

### **NHS England Specialised Commissioning Health and Justice commissioners, prison health care providers and Ministry of Justice**

Recommendation 15 : The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services.

### **NHS England and Ministry of Justice**

Recommendation 18: To consider what protocols if any, within the current legislative framework can be developed and implemented to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs.

### **HMP Hewell and HMP Birmingham, BCPFT, BSMHFT, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG, West Midlands Councils, West Midlands Ambulance Service, the Crown Prosecution Service.**

Recommendation 19: The named partner agencies should work collectively to 'sign off' the information sharing protocol as soon as possible, ensuring wider membership as much as practicable across the West Midlands public sector so long as this does not delay completion.

### **NHS England Specialised Commissioning Health and Justice commissioners, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).**

Recommendation 21: The above to seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release

**Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)**

Recommendation 22: Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community.

**Forward Thinking Birmingham and NHS Birmingham CrossCity CCG**

Recommendation 23: To ensure that the recommendations and lessons learnt from this incident continue to inform the development of services for vulnerable young people in contact with mental health and criminal justice services.

**All local and national organisations involved in this case and the implications of the recommendations (BCPFT, Care UK/ HMP Hewell (Healthcare), BSMHFT (PICU and HMP Birmingham (Healthcare), Forward Thinking Birmingham, West Midlands Police, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG Sandwell Social Services, Birmingham Safeguarding Adults Board, NHS England and HMP's Hewell and Birmingham.**

Recommendation 24: There should be a local 'lessons learned' day, as soon as practicable, for each organisation to share with others an update on the progress made on the implementation of their action plans, seek clarification and share experiences. We also recommend that the outcome of the 'lessons learned day' is a shared understanding and agreement of how oversight of the recommendations made in this independent investigation will be taken forward, and which body is best placed with the appropriate authority to do this.

**NHS England**

Recommendation 25: Should provide clear guidance for the 'ownership', commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries, so that local responsibilities are very clear.

**PRIORITY 2**

**Black Country Partnership NHS Foundation Trust**

Recommendation 1: The Child and Family Service Operational Policy must provide clear guidance on how CAMHS clinicians are to work with other partner agencies and the young person's family in the assessment and support planning processes.

**Black Country Partnership NHS Foundation Trust**

Recommendation 2: The Trust's revised Record Keeping Policy must include reference to the importance of documenting the details and the involvement of other involved agencies.

### **Black Country Partnership NHS Foundation Trust**

Recommendation 3: Black County Partnership NHS Foundation Trust should ensure that the CAMH services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family.

### **NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practices.**

Recommendation 4: NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practice members should share the learning from the initial investigation and roll out the enhanced safeguarding practices now implemented in Ps final GP practice.

### **NHS Sandwell and West Birmingham CCG and their member GP practices**

Recommendation 5: NHS Sandwell and West Birmingham CCG and its member GP practices should review the systems they have in place to identify and support parents of children who have mental health problems to ensure that they are providing them with appropriate levels of support, including referral for a carer's assessment.

### **West Midlands Police**

Recommendation 6: Before the decision is made by the police to remove safety and alert equipment from a victim of domestic violence West Midlands Police should ensure that a full risk assessment is undertaken to inform this decision. All relevant agencies and the victim should be involved in this assessment and decision.

### **HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**

Recommendation 7: Healthcare staff at both HMP Hewell and HMP Birmingham who are undertaking CPA and risk assessments should familiarise themselves with the Home Office 'Adolescent to Parent Violence and Abuse Guidance for Practitioners' (2015) and be categorising incidents of violence by children on a parent and/or carer as incidents of domestic abuse.

### **Black Country Partnership NHS Foundation Trust**

Recommendation 9: The new EHR must facilitate the recording of other agencies involvement and contact details.

### **Black Country Partnership NHS Foundation Trust**

Recommendation 10: The Trust should assure itself that the new DNA/ No Access Visit policies are complied with.

**HMP Hewell (Healthcare) and NHS England's Health and Justice Commissioning Team (North Midlands).**

Recommendation 12: NHS England's Health and Justice Commissioning Team (North Midlands) should discuss the findings of the original Trust report with the new provider of healthcare at HMP Hewell to ensure that implementation is still progressing and that lessons learnt are continuing to inform practices and policies.

**Birmingham and Solihull Mental Health NHS Foundation Trust**

Recommendation 14: The Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units.

**HMP Birmingham (Healthcare) and Birmingham and Solihull Mental Health NHS Foundation Trust**

Recommendation 16: HMP Birmingham (Healthcare) should provide assurance to the Trust and their commissioners that the issues with SystmOne (accessing prisoner's full medical notes from the point of admission) have been resolved.

**West Midlands Police**

Recommendation 20: West Midland's Police should formalise the involvement of family and carers within their policies and protocols, relating to information sharing.

**PRIORITY 3**

**HMP Hewell and HMP Birmingham**

Recommendation 13: Both HMP Hewell and HMP Birmingham introduce a requirement, supported by guidance, that all prison staff, including the governor's office and pastoral care services, should document any contact, either written or verbal, with prisoners' families in a prisoner's P-NOMIS record.

**NHS England Specialised Commissioning Health and Justice commissioners, prison health care providers, G4S and Ministry of Justice**

Recommendation 17: to consider what action can be taken to allow healthcare teams in prisons to have access to the prison records P-NOMIS.

## Structure of the report

- 1.24 Section 2 describes the process of the review, and Section 3 reviews in detail the actions planned in response to the independent investigation, and the progress the organisations have made in implementing the recommendations and embedding change. We have reported by organisation.
- 1.25 Section 4 sets out our overall analysis and conclusions.

## Summary of findings of this assurance review

- 1.26 The external quality assurance review comprised of meetings and interviews with senior managerial staff from the above organisations and a review of documents and policies provided by responsible people in the organisations, as evidence of completion.
- 1.27 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.

- 1.28 The overall conclusion of the review is that 72% of the recommendations (18 out of 25) are complete.
- 1.29 We are able to give full assurance of completion, embeddedness and impact (i.e. Grade A) for two recommendations, Recommendation 11 (Department of Health, NHS England, CCGs and local Police and Crime Commissioners to work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services); and Recommendation 14 (Birmingham and Solihull Mental Health NHS Foundation Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units).
- 1.30 Eleven recommendations are complete and embedded (Grade B), and five recommendations are graded as complete (Grade C).
- 1.31 We have identified that seven recommendations (6, 7, 8, 13, 20, 21, and 25) are partially complete.
- 1.32 However, we also recognise that many of the actions will take more time to complete than the six months after publication, and that for some of the actions it will take even longer for the actions to become embedded and have

the desired impact. We note that the process of addressing all the recommendations is well under way and we anticipate that many of the other recommendations will shortly be complete.

- 1.33 However, the overarching concern of the independent investigation report was that prisoners with ongoing mental health needs who were released early might not be able to access coordinated mental health care upon release.
- 1.34 We note the significant efforts of all concerned with this action plan, and especially the new programme of work being undertaken in partnership with the Ministry of Justice. Despite this work, this still remains a concern.

## Grading of implementation of actions

### All

Recommendation 19	Grade
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#### All organisations involved in the West Midlands

The named partner agencies should work collectively to ‘sign off’ the information sharing protocol as soon as possible, ensuring wider membership as much as practicable across the West Midlands public sector so long as this does not delay completion.

**Priority 1.**

Recommendation 24	Grade
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#### All organisations involved

There should be a local ‘lessons learned’ day, as soon as practicable, for each organisation to share with others an update on the progress made on the implementation of their action plans, seek clarification and share experiences.

We also recommend that the outcome of the ‘lessons learned day’ is a shared understanding and agreement of how oversight of the recommendations made in this independent investigation will be taken forward, and which body is best placed with the appropriate authority to do this.

**Priority 1**

### Black Country Partnership NHS Foundation Trust

Recommendation 1	Grade
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#### Black Country Partnership NHS Foundation Trust

The Child and Family Service Operational Policy must provide clear guidance on how CAMHS clinicians are to work with other partner agencies and the young person’s family in the assessment and support planning processes.

**Priority 2.**

Recommendation 2	Grade
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**Black Country Partnership NHS Foundation Trust**

The Trust's revised Record Keeping Policy must include reference to the importance of documenting the details and the involvement of other involved agencies. B

**Priority 2.**

Recommendation 3	Grade
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**Black County Partnership NHS Foundation Trust** should ensure that the CAMH services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family. B

**Priority 2.**

Recommendation 9	Grade
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**Black Country Partnership NHS Foundation Trust**

The new EHR must facilitate the recording of other agencies involvement and contact details. B

**Priority 2.**

Recommendation 10	Grade
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**Black Country Partnership NHS Foundation Trust**

The Trust should assure itself that the new DNA/ No Access Visit policies are complied with. B

**NHS Sandwell and West Birmingham CCG and NHS Birmingham Cross City CCG**

Recommendation 4	Grade
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**NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG** and their GP practice members should share the learning from the initial investigation and roll out the enhanced safeguarding practices now implemented in Ps final GP practice. B

**Priority 2.**

Recommendation 5	Grade
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**NHS Sandwell and West Birmingham CCG** and its member GP practices should review the systems they have in place to identify and support parents of children who have mental health problems to ensure that they are providing them with appropriate levels of support, including referral for a carer's assessment. B

**Priority 2.**

**West Midlands Police**

Recommendation 6	Grade
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**West Midlands Police**

Before the decision is made by the police to remove safety and alert equipment from a victim of domestic violence West Midlands Police should ensure that a full risk assessment is undertaken to inform this D

decision. All relevant agencies and the victim should be involved in this assessment and decision.

**Priority 2**

**Recommendation 20** **Grade**

**West Midlands Police** should formalise the involvement of family and carers within their policies and protocols, relating to information sharing. D

**Priority 2**

**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**

**Recommendation 7** **Grade**

**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**  
Healthcare staff at both HMP Hewell and HMP Birmingham who are undertaking a Care Programme Approach Plan (CPA) and risk assessments should familiarise themselves with the Home Office 'Adolescent to Parent Violence and Abuse Guidance for Practitioners' (2015) and be categorising incidents of violence by children on a parent and/or carer as incidents of domestic abuse. D

**Priority 2**

**Recommendation 8** **Grade**

**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**  
Staff undertaking the initial Care Programme Approach Plan must ensure that they liaise with all agencies who have been involved with the prisoner, in the community and/or during the court process, in order to obtain an accurate profile of their needs and risks to themselves and others. D

**Priority 2**

**Recommendation 16** **Grade**

**HMP Birmingham (Healthcare) and Birmingham and Solihull Mental Health NHS Foundation Trust**  
HMP Birmingham (Healthcare) should provide assurance to the Trust and their commissioners that the issues with SystemOne (accessing prisoner's full medical notes from the point of admission) have been resolved. C

**Priority 2**

**Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)**

**Recommendation 22** **Grade**

**Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)**  
Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community. B

**Priority 1**

Recommendation 23	Grade
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<b>Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)</b> Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community. <b>Priority 1</b>	B
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### NHS England Health and Justice Commissioners

Recommendation 12	Grade
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NHS England's Health and Justice Commissioning Team (North Midlands) should discuss the findings of the original Trust report with the new provider of healthcare at HMP Hewell to ensure that implementation is still progressing and that lessons learnt are continuing to inform practices and policies. <b>Priority 2</b>	C
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Recommendation 15	Grade
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<b>NHS England Specialised Commissioning Health and Justice commissioners, prison health care providers and Ministry of Justice.</b> The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services. <b>Priority 1.</b>	B
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Recommendation 17	Grade
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<b>NHS England Specialised Commissioning Health and Justice commissioners, prison health care providers, G4S and Ministry of Justice.</b> To consider what action can be taken to allow healthcare teams in prisons to have access to the prison records P-NOMIS. <b>Priority 3.</b>	C
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Recommendation 18	Grade
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<b>NHS England and Ministry of Justice</b> To consider what protocols if any, within the current legislative framework can be developed and implemented to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs. <b>Priority 1</b>	C
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Recommendation 21	Grade
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**NHS England Specialised Commissioning Health and Justice commissioners, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).** D

The above to seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release.

**Priority 1**

### HMP Hewell and HMP Birmingham

Recommendation 13	Grade
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Both HMP Hewell and HMP Birmingham introduce a requirement, supported by guidance, that all prison staff, including the governor's office and pastoral care services, should document any contact, either written or verbal, with prisoners' families in a prisoner's P-NOMIS record. D

**Priority 3**

### Department of Health, NHS England, CCGs and local Police and Crime Commissioners

Recommendation 11	Grade
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To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services. A

**Priority 1**

### Birmingham and Solihull NHS Foundation Trust

Recommendation 14	Grade
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The Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units. A

**Priority 2**

### NHS England

Recommendation 25	Grade
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**NHS England** D  
Should provide clear guidance for the 'ownership', commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries, so that local responsibilities are very clear.

**Priority 1**

## 2. ASSURANCE REVIEW

### Approach to the review

- 2.1 The external quality assurance review has focused on the action plans developed by the organisations involved following publication of the report in June 2017.
- 2.2 The external quality assurance review commenced in February 2018 and was completed in September 2018, and was carried out by:
  - Nick Moor, Partner, Investigations and Reviews, Niche Health and Social Care Consulting
- 2.3 As part of the terms of reference (provided in full at Appendix A) for the independent investigation there was an expectation that the action plan arising from the investigation would be reviewed within six months of the publication of the independent investigation report to provide NHS England with independent assurance on the implementation of the agreed action plan.
- 2.4 The expectation was that written feedback of this independent assurance review would be provided to the reviewer highlighting areas of good practice and measurable improvement or areas of concern.
- 2.5 The external quality assurance review has focused on the implementation of the recommendations in the action plans developed by:
  - Black Country Partnership NHS Foundation Trust (BCPFT);
  - HMP Hewell prison healthcare;
  - HMP Birmingham prison healthcare;
  - NHS England Health and Justice Commissioners, West Midlands region;
  - Birmingham and Solihull NHS Foundation Trust (BSMHFT);
  - West Midlands Police;
  - NHS England Birmingham and Solihull CCG (successor organisation to NHS Birmingham Cross City CCG) and NHS Sandwell and West Birmingham CCG;
  - NHS England West Midlands Direct Commissioning Organisation (DCO); and
  - NHS England.
- 2.6 The external quality assurance review comprised of meetings and interviews with senior managerial staff from the above organisations and a review of

documents and policies provided by responsible people in the organisations, as evidence of completion.

2.7 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.

### 3. ACTION PLAN PROGRESS

- 3.1 The independent investigation was published in June 2017.
- 3.2 It was agreed that an assurance review of the implementation of the action plan would be carried out within six months of publication. The relevant section of the terms of reference is:
- 3.3 “Undertake a six month review of implementation of recommendations detailed in the report and produce a summary for the families.”
- 3.4 It is acknowledged that this homicide has had far reaching effects on mental health services in the West Midlands. There have been wide ranging programmes of work that have been focussed on addressing many of the underlying problems around access to mental health services and information sharing that were identified in the internal and subsequent independent investigation.
- 3.5 The intention was that the learning from this tragic event should become embedded in everyday practice. In the following section we review the implementation of actions by each organisation, or group of organisations.

#### Recommendations made for all organisations

- 3.6 There were two recommendations made for all organisations to respond to. Because information sharing was such a key feature of this incident, the first of these concerned the development and ‘signing off’ of an information sharing protocol by all partner agencies.

Recommendation 19	Grade
<b>All organisations involved in the West Midlands</b> The named partner agencies should work collectively to ‘sign off’ the information sharing protocol as soon as possible, ensuring wider membership as much as practicable across the West Midlands public sector so long as this does not delay completion. <b>Priority 1</b>	B

- 3.7 The above recommendation was made for:
- “HMP Hewell and HMP Birmingham, BCPFT, BSMHFT, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG, West Midlands Councils, West Midlands Ambulance Service, the Crown Prosecution Service.”
- 3.8 The expected outcome was:
- A new information sharing protocol that is agreed and ‘signed off’ by all partner agencies and organisations in the West Midlands Public sector

- 3.9 The expected evidence of this implementation was:
- A new agreed information sharing protocol in place.
  - Evidence of dissemination of the protocol including copies of communications/ emails/ notes of meetings and attendance where it was discussed.
  - Evidence of assurance that the protocol is embedded and operational, and any obstacles to progress are brought to the attention of senior management for resolution.
- 3.10 We have seen that there are robust information sharing protocols in place across the West Midlands in respect to both Adult Safeguarding and Children's Safeguarding. In Birmingham and Sandwell these information protocols are signed up to by all relevant local agencies including NHS provider trusts, NHS commissioners, Local Authorities, West Midlands Police, Staffordshire and West Midlands Probation, the Care Quality Commission, West Midlands Fire Service, West Midlands Ambulance Service.
- 3.11 We have been provided with copies of these protocols. We have seen some evidence that these protocols are embedded. We are aware of the significant efforts being made with new Service Transformation Programmes in the West Midlands and the MERIT programme.
- 3.12 Therefore we can grade this as B (evidence of completion and embeddedness).
- 3.13 With respect to information sharing we have also been told that there has been significant work undertaken across the West Midlands, for example the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT, a 'Vanguard' initiative supported by NHS England<sup>4</sup>) has a focus on three priority areas: crisis care and reduction of risk, recovery and rehabilitation, and every day services. The vanguard aims to rapidly improve service quality, and increase efficiency, by adopting an IT system where clinical information can be accessed and shared across organisational boundaries around the region. Currently there are 4 partners within the vanguard: Birmingham and Solihull Mental Health NHS Foundation Trust, Black Country Partnership NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Coventry and Warwickshire Partnership NHS Trust, who together cover a population of 3.4 million people.
- 3.14 We discuss later (with regard to Recommendation 9) how the planned procurement of the Electronic Health Record (EHR) in Black Country Partnership NHS Foundation Trust has not yet been completed. However, once this has happened, each of the four NHS mental health providers in the West Midlands will be using the same information system for EHR, which will

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<sup>4</sup> In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguards' for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View (published October 2014) and supporting improvement and integration of services. Integrated primary and acute care systems join up GP, hospital, community and mental health services, whilst multispecialty community providers move specialist care out of hospitals into the community. Enhanced health in care homes offer older people better, joined up health, care and rehabilitation services.

facilitate the sharing of information. This will clearly be of significant assistance to aid information sharing.

Recommendation 24	Grade
<p><b>All organisations involved</b></p> <p>There should be a local ‘lessons learned’ day, as soon as practicable, for each organisation to share with others an update on the progress made on the implementation of their action plans, seek clarification and share experiences.</p> <p>We also recommend that the outcome of the ‘lessons learned day’ is a shared understanding and agreement of how oversight of the recommendations made in this independent investigation will be taken forward, and which body is best placed with the appropriate authority to do this.</p> <p><b>Priority 1</b></p>	C

3.15 The above recommendation was made for:

“All local and national organisations involved in this case and the implications of the recommendations (BCPFT, Care UK/ HMP Hewell (Healthcare), BSMHFT (PICU and HMP Birmingham (Healthcare), Forward Thinking Birmingham, West Midlands Police, NHS Birmingham South Central CCG, NHS Birmingham CrossCity CCG, NHS Sandwell and West Birmingham CCG Sandwell Social Services, Birmingham Safeguarding Adults Board, NHS England and HMP’s Hewell and Birmingham.”

3.16 The expected outcome was:

- A local ‘lessons learned’ day with widespread involvement and engagement of the attendees.
- A shared understanding and agreement of how oversight of the implementation of recommendations made in the independent investigation will be taken forward, including identification of the body which is best placed, with appropriate authority to do this.

3.17 The expected evidence of this implementation was:

- Evidence of the local ‘lessons’ learned day.
- Evidence of a clear output regarding oversight and leadership to take forward oversight of the recommendations and implementation.
- A nominated individual to be responsible for coordinating and collating action plan responses, within an organisation agreed to be responsible for oversight.
- Evidence of ongoing oversight and monitoring of the oversight of recommendations.

- 3.18 NHS England West Midlands DCO hosted a learning lessons day on 6th September 2017 in the Midlands Art Centre, Cannon Hill Park, Birmingham, and shared work that has progressed locally to address the recommendations and to share wider learning from this case. The Right Honourable Norman Lamb, MP was a keynote speaker at this event.
- 3.19 Attendees included senior level representatives of all organisations involved in this case. Attendees received presentations from the investigation team, and stakeholders describing the progress made with the initial investigation findings.
- 3.20 We have also seen evidence that following the ‘lessons learned’ day in September, NHS England has provided two further workshop/ conferences, with the first aimed at the information governance issues arising from this case, and the second on 1 March 2018 dealing with safeguarding issues which in part this case has touched upon.
- 3.21 We have been provided with significant evidence of how the lessons learned from this incident and the day itself have been shared within partner organisations. This aspect of the recommendation is therefore complete.
- 3.22 We have asked the agencies concerned how they were involved in the coordination and oversight of the action planning. We were told that the NHS England West Midlands had requested an update of progress of implementation of recommendations in December 2017, then monthly thereafter.
- 3.23 NHS England West Midlands DCO have taken on the role of coordinating the oversight of the actions. This has led to the development of an ‘action planning tracker’ which identifies who is responsible within each organisation for implementing the recommendation as a key contact, and the state of implementation of the action. We note this has been updated monthly from January 2018 until June 2018, then again in September 2018.
- 3.24 This has now led to the establishment of a NHS England West Midlands Mental Health Homicide Oversight Group. The purpose of the Mental Health Homicide Oversight Group (MHHOG) is to systematically bring together the different parts of the system (NHS and where relevant other agencies and statutory bodies) to share information and oversee delivery of actions following a Mental Health Homicide (MMH) investigation or review. We have seen the terms of reference for this group and observed the inaugural and second meetings. This group will now provide the necessary oversight and coordination of the actions arising, completing the actions required in the recommendation.
- 3.25 We have also heard that the NHS England Midlands and East Region Independent Investigation Review Group has maintained a significant interest in this independent investigation and the implementation of actions, and the case and the progress made in implementation has been discussed and minuted on four occasions. We have been provided with the agenda’s for

these meetings, and the relevant extract from the minutes which demonstrate oversight and assurance of completion of actions.

- 3.26 Alongside this we have been told that NHS England West Midlands DCO has reported regularly about this case to the NHS England Regional Safeguarding Steering Group meetings, which in turn reports to the National Safeguarding Steering Group. These meetings were on 21 September 2017, 24 January 2018 and 28 February 2018. We have been provided with copies of the relevant minutes of the meetings (redacted). The September meeting noted the lessons learned day event, and the January and February meetings noted the commencement of the assurance review.
- 3.27 We have been told that Birmingham Safeguarding Adults Board have also been interested to understand how the implementation of the recommendations from this investigation and the governance of these has been overseen. The current Chair of the Safeguarding Adults Board and the two previous chairs have written to NHS England West Midlands office, to both discuss the implementation of this recommendation and also requesting assurance that this action has been completed.
- 3.28 It is clear that the sharing of lessons learned day in September was significantly beneficial to all concerned, and that the recommendations arising from the investigation into P's care and Christina's death has remained under some scrutiny.
- 3.29 It is also clear that this case has had impact upon or led to a significant range of other work streams to develop mental health services in the West Midlands, and also to support the further development of access to mental health services nationally for people in contact with criminal justice services and who have mental health needs (for example further development of the street triage programme, and also the establishment of a group of experts to look at the pathway for individuals who are experiencing poor mental health who enter the justice system).
- 3.30 We have seen the evidence that the action plan tracker has been routinely updated, and that oversight of this action will now fall to the newly established Mental Health Oversight Group, which will act as the central co-ordinator for oversight and implementation of actions.
- 3.31 Because of this, we believe this aspect of the recommendation is now completed, and is graded as C accordingly (complete but not yet embedded or delivering impact).

## Black Country Partnership NHS Foundation Trust

- 3.32 BCPFT received five recommendations which are detailed below. All of these recommendations were Priority 2. The underpinning theme of the recommendations was for the Trust to ensure that families and other agencies were involved in the assessment and care planning process, that services were sensitive to the needs of families from different cultural backgrounds, and that systems were in place to support the recording of involvement of families and other agencies, and that the DNA/ No Access policy was complied with.
- 3.33 The Trust has provided us with an action plan which details each recommendation, and 45 items submitted as evidence for implementation of the actions embedded in the plan.

Recommendation 1	Grade
<p><b>Black Country Partnership NHS Foundation Trust</b>            The Child and Family Service Operational Policy must provide clear guidance on how CAMHS clinicians are to work with other partner agencies and the young person's family in the assessment and support planning processes.  <b>Priority 2.</b></p>	B

- 3.34 The expected outcome was:
- A revised and updated Child and Family Service Operational Policy with clear guidance, that has been disseminated to all staff, is understood and implemented, and the organisation can provide assurance that this revised practice is now 'business as usual'.
- 3.35 The expected evidence of this implementation was:
- The Child and Family Service Operational Policy is updated to reflect the changes.
  - Evidence of dissemination of the guidance including copies of communications/ emails/ notes of meetings and attendance where it was discussed.
  - Evidence of assurance that the guidance is embedded and operational. For example, audits and case sampling done to provide assurance, examples of any reports sent to Board quality sub-committee or other quality monitoring and oversight meetings.
- 3.36 A revised and updated Child and Family Service Operational Policy with clear guidance on how clinicians are to work with partner agencies and families in assessment process has been developed. This Operational Policy describes the objectives of the policy (to enable families, carers and other professionals to positively support children and young people, by providing them with the appropriate strategies and skills to improve their mental health).

- 3.37 The policy goes on to describe how families and children need to be partners in their care, including in the assessment process, and how services and clinical staff need to ensure they involve other local networks in the assessment and care planning process.
- 3.38 This policy is version 3, and was revised in May 2018. Prior to this, version 2 was revised in July 2016. The policy has identified operational accountabilities, and the committee structure responsible for governance and approval (Children, Young People and Families Quality and Safety Group).
- 3.39 This policy is supported by BEAM, the Sandwell Emotional and Well-being Service, which supports partnership working, within an open access mental health and welfare service.
- 3.40 There are new assessment processes which include within them key text to guide the assessor into ensuring they assess for involvement of other agencies from the outset when a first assessment is undertaken for all new referrals. These assessments are:
- CAMHS Initial Assessment form (version 7 dated February 2018);
  - Care Programme Approach (CPA) Common Assessment Tool (undated); and
  - CPA Single Assessment Process (version 1.0 dated October 2015).
- 3.41 We have been shown a poster which lists all the changes made to the CAMH service since 2005 when P was first in contact with mental health services. These are listed as follows:
- The recommendations arising from the investigation and action tracking have been discussed regularly in divisional and Trust Board meetings. We have seen minutes of the Children's, Young Peoples and Families Patient Safety and Risk Management meetings, dated 3 July 2017, 7 August 2017 and 4 September 2017. These all detail how the independent investigation report findings were fed back to the division, and what the key recommendations and actions required were.
  - Similarly the Mental Health Division Quality and Safety Meeting held on 9 November 2017 identified actions to be undertaken. This detailed that there was to be a further review of the action plan attached in January 2018:
    - To confirm methodology in addressing actions.
    - What have the Trust done well.
    - What mechanisms are in place to assure themselves they have achieved the actions?
    - Focus on record keeping an involvement of other agencies.

- 3.42 We have seen that the Trust Quality and Safety Committee meeting on 8 June 2017 were provided with an update report from the Director of Nursing on the pending publication of the independent investigation report.
- 3.43 Also, the Trust Board of Directors were provided with progress reports and updates on the independent investigation report and its publication on 29 March 2017 and 26 July 2017 (both public and private sections of the Board of Directors meetings).
- 3.44 This tells us that the Trust Board of Directors, and the divisional quality governance structures have been providing oversight for the implementation of actions arising and the findings of the independent investigation report.
- 3.45 We were told that regular audits are carried out to check implementation of the policy and monitored through the quality and safety structure within the Trust. Examples of this in practice include:
- Current assessment paperwork takes into account the family’s needs, and the operational policy recognises that the Trust is utilising Choice And Partnership Approach (CAPA) as a process.
- 3.46 Letters are sent out to schools and partner agencies as active engagement. The service works together in the Electronic Common Assessment Framework (ECAAF), Team Around the Family, Care Programme Approach, Child in Need and Child Protection and SEN processes.
- 3.47 We have not been provided with evidence that the new policy has been audited to ensure implementation, or that the Board of Directors has been made aware of assurance of the implementation of the new policy. However we have been told that operational policies are not routinely audited. They are devised for information and reference for new and existing staff to provide an overview and to explain the function of the service. While important for operational staff, they do not hold the same status as a Trust policy.
- 3.48 Because of this, we believe this recommendation is completed and embedded, and is graded as B accordingly.

Recommendation 2	Grade
<p><b>Black Country Partnership NHS Foundation Trust</b>            The Trust’s revised Record Keeping Policy must include reference to the importance of documenting the details and the involvement of other involved agencies.  <b>Priority 2</b></p>	B

- 3.49 The expected outcome was:
- A revised and updated Record Keeping policy which identifies that recoding involvement of other agencies is a key requirement, and that services now routinely record this involvement.

- 3.50 The expected evidence of this implementation was:
- Copy of the revised record keeping policy with reference to documenting details and involvement of other agencies.
  - Evidence of dissemination of the revised guidance.
  - Evidence of assurance that the guidance is embedded and operational (for example, any audits and case sampling done to provide assurance).
  - Examples of any reports sent to Board quality sub-committee or other quality monitoring and oversight meetings.

3.51 We have been provided with a copy of the BCPFT Clinical Record Keeping Standards policy, version 2.1 dates April 2017. Paragraph 4.2.23 in particular highlights the importance of documenting details and involvement of other external agencies. It also explain why it is important that these details are recorded.

- 3.52 This states:
- “Records must document the involvement of other external agencies as part of collaboration with or partnership working in the care of the service user.
  - Staff must ensure they document the details and involvement of any other external agencies involved in the care of the service user.
  - This may be as a result of collaboration or partnership working to improve outcomes for service users, or to evidence where people with complex needs require and receive support from multiple agencies.
  - The name of each agency (avoid abbreviations) and the contact details of each agency involved in the care of the service user must be clearly recorded.
  - Followed by a summary of the involvement the service has had with each external agency in the care of the service user. Documenting the name and position of the person from an external agency involved in the care of the service user is helpful while recognising that this is likely to change over a period of time.”

3.53 We have also seen the Trust poster (mentioned earlier) and the relevant information for Recommendation 2 is as follows:

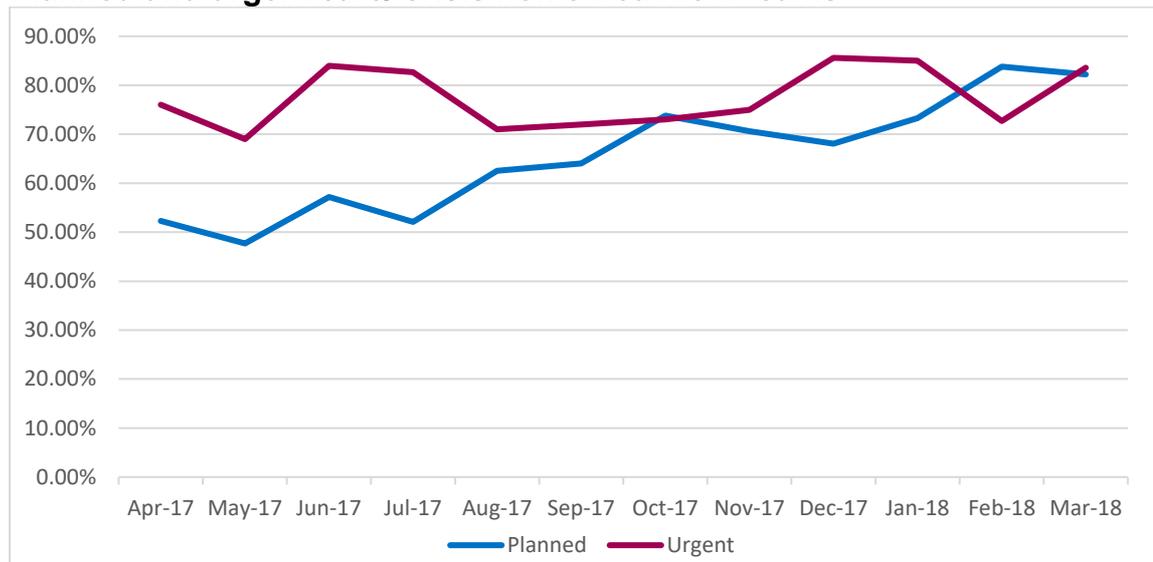
“Actions from the meeting held in November in readiness for the review in January 2018 are:

- Review record keeping policy to ensure this includes involvement with other agencies.
- Review the record keeping audits template to include involvement with other agencies.
- Letters to patients following consultation with services needs to be addressed. This was also picked up in the National Service User Survey.

- Equality and Inclusion to be added to the Quality and Safety agenda.
  - Remind staff to access the migrant health resource on intranet.
  - Audit compliance against DNA Policy/ SOP.
  - Evidence to be collated within divisions in readiness for review.
  - Ensure action plan is on the agenda of Quality and Safety to monitor progress against above actions.
  - Feedback from workshop held on Prison Healthcare and Community Mental Health service to be shared by Service Manager at Quality and Safety meeting.
- 3.54 We were told that Managers/ Team Leaders e-mail policies around the team for them to read when they come out. Policies that directly affect teams on a day to day basis are discussed in team meetings. We have not seen evidence of such communication, or evidence of how this policy was disseminated.
- 3.55 We have been provided with a copy of the 'The Children's Services' Record Keeping Dashboard 2017/18' (undated). We were told that from Quarter 2 in 2017/18 (i.e. September onwards) the audit introduced an additional question "Have contact details of all other agencies involved in the person's care been recorded?"
- 3.56 On the audit provided, of the 23 teams audited, two teams hadn't answered the question, two teams had used the old audit tool, nine teams had less than 100% compliance (ranging from 20% to 60%) and the remaining ten teams achieved 100% compliance. This shows that within Children's Services, compliance with the new policy is being routinely monitored, and that it is becoming routine practice, but that it is not yet fully embedded as routine practice in all teams.
- 3.57 We have seen three examples of minutes of meetings of the Specialist Mental Health Clinical Effectiveness Group where the record keeping dashboard was discussed. However, although the meetings clearly discuss the dashboard and performance, the examples provided did not show clear evidence of discussion or monitoring of "reference to the importance of documenting the details and the involvement of other involved agencies".
- 3.58 In addition, we were told that adult mental health services undertake record keeping audits across their Urgent and Planned care teams, and that all audit tools used have been reviewed to check that they audit third party involvement.
- 3.59 We have been provided with examples of the blank audit tool for Mental Health Care records Audit (v4.1). At section 3i, it states "Does the CAT, or SAP, or Needs Assessment or other primary assessment document identify any third parties involved in providing care or treatment for the patient? (Note: this question is not included in scoring but is for reference information)".

- 3.60 The 'Weekly Records Audit Tool for Crisis/ HTT/ RAS (v1.4.1)' also includes the same question at line 2d, and the Planned Care Community Teams Records Audit Tool (v1.2) include the question at line 2c.
- 3.61 We have seen evidence of the results of using this audit tool to demonstrate compliance. These show that routine compliance with this audit record is now above 80%. The results were as follows:

**Third party involvement - Weekly audit findings April 2017 to March 2018: Planned and urgent care/ crisis home treatment teams**



- 3.62 This demonstrates clearly that the implementation of the revised record keeping policy is being regularly monitored, and such practice is now routinely embedded in practice. We have graded this as B, complete and embedded.

Recommendation 3	Grade
<p><b>Black County Partnership NHS Foundation Trust</b> should ensure that the CAMH services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family.</p> <p><b>Priority 2</b></p>	B

- 3.63 The expected outcome was:
- CAMH Services are able to demonstrate how they are culturally sensitive to the needs of patients and families, and they are able to recognise and understand the potential impact of immigration.
- 3.64 The expected evidence of this implementation was:
- Copy of any guidance provided.

- Dissemination of the guidance. Copies of communications/ emails/ notes of meetings where it was discussed and any training days (where, when, who provided it, attendance) etc.
- Evidence of assurance that the guidance is embedded and operational (i.e. any audits and case sampling done to provide assurance).

3.65 We have been provided with an example of the 'BCPFT CAMHS Initial Needs Assessment Form (V7)' dated February 2018. This is a comprehensive 24 page assessment tool. Page 1 of the assessment tool requires that the assessor clearly identify ethnic origin, religion, and first language. However, whilst there is a further section in the assessment tool which outlines 'Contextual information', which includes prompts for the assessor to consider:

#### **Family**

- Genogram (Inc. household composition, physical health, MH incidence).
- Who lives in the household?
- Relevant family dynamics now and historically.
- Extended family support and protective factors.
- Major family transitions and events (bereavements, house moves, relationship breakdowns).
- Familial incidence of stress, mental health (mental health issues in parents?).
- Living conditions and financial resources as appropriate.

3.66 Whilst this is helpful, there is now a clear prompt to guide the assessor to consider immigration status, although it may be a factor in several of the areas listed.

3.67 We have also been shown that the Trust has set up a Migrant Health Project on its intranet to support staff in understanding the asylum and refugee process as it relates to health and care services provided within the Trust. The links to this and other information for supporting migrants has been disseminated. We have seen two recent emails (14 March and 11 April), sent to all CAMHS and Children and Family's professionals, which outlined how staff can access the intranet Migrant Health resources. The 11 April email also listed several other key sources of useful information, including Migrant Help, Refugee Council, Black Country and Birmingham Refugee and Migrant Centre. We have not seen evidence which demonstrates if this information is being accessed, or the impact this may be having.

3.68 We have been provided with the Trust response to the Equalities Act 2014, which is called 'Play Fair'. This is a strategy document which outlines how the organisation will address equalities issues around gender, sexual orientation,

disabilities, and different religious and ethnic backgrounds so as to ensure service users and their families aren't discriminated against.

- 3.69 Linked to this the Trust has four equalities objectives. However, three of these are specifically linked to workforce issues of representation and non-discrimination. Only one objective relates to non-staff members, which is Equalities Objective Four: "Improve the amount and quality of information we gather relating to the personal protected characteristic of sexual orientation, to improve the experience of people who use our services, and as part of the national NHS Sexual Orientation Monitoring Standard (SOMS)".
- 3.70 Since this covers sexual orientation it cannot be applied to cultural sensitivity regarding different cultural backgrounds.
- 3.71 We have been provided with a copy of the Trust employee induction scheme, which also includes inducting new employees in to the single equalities scheme within 'Play Fair'.
- 3.72 The Trust has made significant efforts with regard to Equalities and Diversity. All Trust staff must attend Equality and Diversity Training as part of their Trust induction and thereafter as part of mandatory training every three years. We have been provided with a copy of the three yearly Mandatory Training Subjects, and the Mandatory Training staff handbook contents, which both identify this training.
- 3.73 The Trust has an Equality and Inclusion Board (EIB) where representatives from all groups within the Trust report back on areas of good practice and developments, and areas where there may be potential challenges in providing services. This includes feedback from the Children Young People and Families (CYPF) representative to all service leads including CAMHS.
- 3.74 We have been provided with the minutes of the EIB meetings for 20 September 2017, 15 November 2017, 17 January 2018 and 21 March 2018. Although much of the information contained within was concerned with workforce and approaches to Equality and Diversity, we did see some evidence that issues affecting cultural sensitivity and the impact of immigration were being considered:
- **"Migrant Health and Mental Health:** The Trust Intranet resource was developed. Wolverhampton Commissioners have agreed that a CPN should be based at the Refugee and Migrant Centre supervised by Healthy Minds. This has happened. A fantastic development. This is primarily to support the Syrian resettlement families but will also be a resource more generally." (17 January 2018).
  - **"Public Sector Equality Duty:** The Spiritual Care Team co-produce workshops at the Recovery College around culture, ethnicity, LGBT issues, faith and beliefs and cultural festivals to help understand our neighbours in the Black Country and the area that we live in. We have a duty to foster good relations between people of different characteristics so this contributes towards this." (21 March 2018)



between cultures, but not assigning values to the differences (better or worse, right or wrong).”<sup>5</sup>

- 3.82 Diagnosing a psychiatric disorder or other type of illness can be influenced by many different factors. In clinical interactions between patients and clinicians, differences in age, gender, socioeconomic status, as well as ethnicity can cause barriers in communication, and this can also happen during the diagnostic process.
- 3.83 There is a significant range of information on cultural issues in mental health, including guidance on cultural formulation and assessment in mental health<sup>6</sup> and a wide range of training available.
- 3.84 We note the meeting minutes of the EIB (21 March 2018) and the EIB Annual Report does tell us about “workshops at the Recovery College around culture, ethnicity, LGBT issues, faith and beliefs and cultural festivals to help understand our neighbours in the Black Country”.
- 3.85 We note that the new assessment form includes identifying ethnicity, religion and language, and that the underpinning issues within the section on context could include reference to immigration. We also have received detail of the Play Fair programme. The Equality Act 2010 stipulates in section (149) Public Sector Equality Duty clause (5): Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard in particular to the need to (a) tackle prejudice and (b) promote understanding. In response to this and to demonstrate due regard Play Fair (a) tackles prejudice by advancing anti-discriminatory practice (b) promotes understanding through inclusive practice that takes into account cultural inclusion and sensitivity.
- 3.86 Cultural sensitivity can only have an impact when the focus is on anti-discriminatory practice. It is not possible to deliver appropriate, responsive care and foster good relations if staff are not culturally sensitive to the needs of the patient and the communities they serve. The vehicle used to ensure this takes place is the focus on anti-discriminatory practice.
- 3.87 We believe that this answers the specific detail of the recommendation, which was to “ensure that the CAMH services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family”. Therefore we have graded this action as B, evidence of completion and embeddedness.

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<sup>5</sup> “Cultural Competence and Spirituality in Community Building” <https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/culturally-competent-organizations/main>

<sup>6</sup> Ayonrinde O. (2003). Importance of cultural sensitivity in therapeutic transactions: considerations for healthcare providers. *Dis Manage Health Outcomes*, 11, 233–48

Recommendation 9	Grade
<p><b>Black Country Partnership NHS Foundation Trust</b>  The new EHR must facilitate the recording of other agencies involvement and contact details.  <b>Priority 2</b></p>	B

- 3.88 The expected outcome was:
- The new EHR facilitates the recording of other agencies involvement.
- 3.89 The expected evidence of this implementation was:
- Demonstration that the new EHR provides the facility to record other agencies involvement and contact details.
  - Evidence of audit of sample of cases to assure that this is being used and is now operational.
  - Examples of any reports sent to Board quality sub-committee or other quality monitoring and oversight meetings.
- 3.90 The Trust has not yet procured a new EHR. However, BCPFT in close collaboration with Dudley and Walsall Mental Health NHS Trust are in the final stages of jointly procuring and implementing a shared Black Country Electronic Patient Record (EPR) for Mental Health, Learning Disabilities and Children, Young People and Families.
- 3.91 There is a preferred supplier, and it is intended that it will lead to a common EHR system across the wider midlands Mental Health and Community services. A programme board with joint representation from both Trusts met on the 8 June, 2018 and in future will be responsible for ensuring the programme is clinically driven.
- 3.92 Due to financial difficulties, the Trust has spent the last two years preparing to be taken over by Birmingham Community Healthcare NHS Foundation Trust. In such circumstances, inevitably large capital projects such as the move to EHR were put on hold. Only in February 2018 was the decision made that the takeover would not proceed. This can be independently verified by NHS Improvement, the regulator for NHS foundation trusts.
- 3.93 Since then the Board has moved quickly to work in partnership with Dudley and Walsall Mental Health NHS Trust to jointly implement EHR as the report states. The intention is this will take place in 2018/19.
- 3.94 Despite all this significant work undertaken, unfortunately there is no EHR system yet in place.
- 3.95 However, we also note that within existing systems and policies the Trust has mandated the recording of other agency involvement in service user's care. Since this was the intention of the recommendation, this has been graded as B, evidence of completion and embeddedness.

3.96 We also recognise that some of the recommendations in the independent investigation report will take much longer to complete, including for example the procurement of a major Electronic Health Record, and we anticipate that once the EHR is fully procured and implemented this grading will change again.

Recommendation 10	Grade
<p><b>Black Country Partnership NHS Foundation Trust</b> The Trust should assure itself that the new DNA/ No Access Visit policies are complied with.</p>	B

3.97 The expected outcome was:

- The Trust can provide assurance that the DNA/ No Access Visit policy is complied with.

3.98 The expected evidence of this implementation was:

- Copy of the new DNA/ No Access Visit policy.
- Dissemination of the revised policy. Copies of communications/ emails/ notes of meetings or training days and attendance (who and as percentage of total staff) where it was discussed
- Evidence of assurance that the guidance is embedded and operational (i.e. any audits and case sampling done to provide assurance)
- Examples of any reports sent to Board quality sub-committee or other quality monitoring and oversight meetings.

3.99 We have been provided with copies of both the Trust DNA No Access Visit policy (Version 2, dated February 2018), the DNA Process and Flowchart Version 4 Dated 19 June 2018 and the Standard Operating Procedure (SOP) for the Children, Young People and Families DNA / No Access Visits (Version 1, dated July 2017).

3.100 We have seen evidence of how this policy was communicated and introduced to staff, including workshop agenda from 12 June 2018, draft Terms of Reference for the DNA Task and Finish Group dated 10 February 2017 we have also seen the meeting minutes dated 6 May 2018 of the 'Text Messaging Task and Finish Group' with responsibility for implementing the new procedure for texting service users and carers (for CAMHS). We have seen evidence that the policy is being planned to be audited for implementation.

3.101 We have therefore graded this action as B, complete with embeddedness.

## NHS Sandwell and West Birmingham CCG and NHS Birmingham Cross City CCG

- 3.102 We have taken the recommendations for the Clinical Commissioning Groups (CCGs) together.
- 3.103 It is important to note that NHS Birmingham Cross City CCG is now called NHS Birmingham and Solihull CCG.
- 3.104 There was one recommendation made directly for NHS Sandwell and West Birmingham CCG alone and one recommendation for NHS Birmingham Cross City CCG (now NHS Birmingham and Solihull CCG) and NHS Sandwell and West Birmingham CCG together.

Recommendation 4	Grade
<p><b>NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG</b> and their GP practice members should share the learning from the initial investigation and roll out the enhanced safeguarding practices now implemented in Ps final GP practice.</p> <p><b>Priority 2</b></p>	B

- 3.105 The expected outcome was:
- Increased learning of the issues identified in the initial investigation and roll out of the safeguarding practices identified in the independent investigation.
  - Enhanced safeguarding practices amongst GPs for vulnerable children.
- 3.106 The expected evidence of this implementation was:
- The CCGs can provide assurance that they and their member GP practices have shared the learning concerning the initial investigation and have rolled out the safeguarding practices.
  - Evidence of the process of sharing the learning.
  - Evidence of dissemination of information to improve practice in safeguarding, especially with regard to families with children with mental health problems.
  - Assurance that enhanced safeguarding practices are now established in GP practices.
- 3.107 We have been told that learning from this case and the initial investigation in 2014 was shared widely across the health economy within Birmingham and Sandwell West Birmingham CCGs, including GP practices. Additionally the full initial investigation report, executive summary document and family statements were made available electronically on the then NHS Birmingham CrossCity CCG website.

- 3.108 To promote awareness within GP Practices we were told that a Safeguarding Bulletin which made specific reference to this case was circulated in January 2015 and November 2015.
- 3.109 GPs have had ready access to attend regular scenario based Safeguarding Training events, and general learning lessons sessions from Serious Case Reviews (SCRs) which are informed by the key messages from this case.
- 3.110 To support enhanced safeguarding within primary care there are GP Safeguarding Champions in post who work directly with GP Practices to support the delivery of best practice.
- 3.111 We have seen significant evidence of the steps taken by the CCG to share the learning from the initial investigation and roll out enhanced Safeguarding practices, including:
- Wider training for all CCG staff and GPs, practice nurses and staff.
  - The leaflet “Questions for exploring vulnerabilities and risk when talking to patients and carers about mental health”.
  - The information resource “Supporting Carers of Individuals with Mental Health Needs: Useful Resources”.
  - QSC Safeguarding Report (Birmingham) November 2017 which identifies that “Identification and Referral to Improve Safety (IRIS) programme, delivered in 50 GP practices across the BCC/BSC footprint. IRIS is now in its third year. IRIS is a practice based identification and referral system which allows patients experiencing DVA direct access to specialist services. Over 500 women who would otherwise perhaps not have been identified have received help and support to escape abusive relationships.”
  - CCG Governing Body papers detailing Safeguarding Practice leads workshops and evidence that Safeguarding Champions are in place.
  - CQC Report “Review of health services for Children Looked After and Safeguarding in Birmingham” 2015.
- 3.112 This supports the assurance that this action has been completed.
- 3.113 However within some of the external assurance provided there is evidence that some concerns remain. These include:
- The CQC Report “Review of health services for Children Looked After and Safeguarding in Birmingham” identifies that CAMHS Supervision was an area for development; and
  - The QSC Safeguarding Report November 2017 identifies that “Oversight of DVA arrangements in the large commissioned services is developing, but is not currently as embedded as other areas of the safeguarding agenda”.
- 3.114 Therefore we are grading this as B, evidence of completeness and embeddedness but not yet evidence of impact.

Recommendation 5	Grade
<p><b>NHS Sandwell and West Birmingham CCG</b> and its member GP practices should review the systems they have in place to identify and support parents of children who have mental health problems to ensure that they are providing them with appropriate levels of support, including referral for a carer’s assessment.</p> <p><b>Priority 2</b></p>	B

3.115 The expected outcome was:

- Improved recognition of and support for parents with children who have mental health problems, including referrals for carer’s assessments.

3.116 The expected evidence of this implementation was:

- The CCG can provide assurance that they and their member GP practices have reviewed systems they have in place to identify and support parents of children who have mental health problems to ensure that they are providing them with appropriate levels of support, including referral for a carer’s assessment.
- Evidence of the process of review (meeting minutes, email, other communication).
- Evidence of an output from the review (revised or new policies and or guidelines).
- Evidence of dissemination of information to improve practice in the identification of families with children with mental health problems.
- Assurance that any revised/ new policy or guidance is embedded and operational (i.e. any audits, case sampling or similar undertaken to provide assurance that practice has changed).
- Examples of any reports sent to CCG Board quality sub-committee or other quality monitoring and oversight meetings.

3.117 We have been informed of the considerable work undertaken to actively encourage frontline staff to become more aware of carers and the need to support carers within their caring role. Additionally work has been undertaken to promote carers to make themselves known to services so that they might receive appropriate support. For example, nationally there has been significant work to promote carer support, and this has included the development of Carers Registers within GP Practices. We have not seen evidence of the local work undertaken.

3.118 Additionally the Royal College of General Practitioners has produced a range of Carer Support resources for GP practices, including Carer Support for those carers caring for an individual with mental health needs. We have not seen how this has been cascaded.

3.119 GP Safeguarding Champions continue to promote the issue of carer identification and support, and encourage Carer’s Assessment referrals within

local GP practices. We would like to have seen identification of the GP Safeguarding Champions.

- 3.120 In Sandwell and West Birmingham it is a requirement of the Primary Care Commissioning Framework for every GP practice to have a Carers Lead, and this is monitored through regular meetings and visits. It would have been helpful to have been provided with copies of minutes of such meetings as evidence.
- 3.121 In respect to raising awareness regarding adolescent to parent violence and abuse, the Joint Safeguarding Team, which links with all the local CCGs, has included the key messages from the Home Office Information guide: adolescent to parent violence and abuse (APVA) within local scenario based training which has been delivered to GPs.
- 3.122 This guidance is also covered in the nationally approved Identification and Referral to Improve Safety programme (IRIS) training delivered to GP practices. IRIS is a general practice based domestic violence training and support programme that it endorsed by a number of organisations including the Royal College of Psychiatrists. All Birmingham and Sandwell CCGs are actively involved with IRIS. Again we would prefer to have seen evidence that this training has been delivered, including dates and practices covered.
- 3.123 The 2013 government definition of Domestic Violence has been shared with GPs via training, bulletins, newsletters, GP forums and Practice Nurse Forums.
- 3.124 We also heard that having reflected on the final version of this report NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG initially agreed to form a short term working group that would work with relevant parties to develop:
- A short flowchart for Primary Care focusing on what to do when concerns are raised by a relative or significant other that an individual may be experiencing mental health issues.
  - 10 top questions to enable frontline staff to have a better sight of risks and safeguarding concerns.
  - Additional guidance for Primary Care concerning how best to raise concerns and risks related to patients with mental health needs.
- 3.125 These resources would then be cascaded across GP practices over Birmingham and Sandwell, and shared with NHS England for sharing more widely.
- 3.126 Further discussion by the CCGs identified that local primary care services already had access to relevant referral processes where they could raise concerns relating to any individual with mental health needs. There were also clear systems in place for both GP Practices and patients/families to raise concerns should they consider that these processes are not working effectively. Currently these referral processes appear to work well and support both patients and carers.

- 3.127 A poster has been developed detailing a number of simple questions for enabling frontline staff to have a better sight of risks and safeguarding concerns which could be impacting onto a patient and/or carer.
- 3.128 Further guidance has been developed and circulated regarding carers and mental health concerns. These resources also contain links to on-line training and national best practice toolkits, where appropriate.
- 3.129 Good practice guidance developed by the RCGP in respect to confidentiality and information sharing has been circulated to promote effective communication of risks.
- 3.130 These national and local resources have been circulated across Sandwell and BSOL via the shared Safeguarding route as well as through CCG bulletins.
- 3.131 We have been told that these additional resources were showcased at the NHSE Learning Lessons event held in September 2017, and have been shared with NHSE for wider circulation as appropriate.
- 3.132 In addition we have also seen that the CCGs have shared 'Practice News' which is an information bulleting aimed at GP practices and members to increase awareness of issues and matters arising that will impact on practice.
- 3.133 Practice News - Issue 226: 22 December 2017 provides resources for promoting working with carers, professional curiosity and understanding mental health, and provides "Questions for exploring vulnerabilities and risk when talking to patients and carers about mental health". We have seen copies of these questions/ guidelines and also an additional resource "Supporting Carers of Individuals with Mental Health Needs: Useful Resources".
- 3.134 Practice News - Issue 226: 22 December 2017 also provided further information resources for GPs to guide them in understanding how they can help patients who have caring responsibilities.
- 3.135 Practice News - Issue 215: 6 October 2017 invited GPs to a networking event on 26 October at Birmingham City Football Club to find out more about what services are available for carers across Birmingham, and how they could influence the development of new and existing services. Topics included integrated pathways, improving access to support and improving carers' experience of services.
- 3.136 We fully recognise that the above has taken place. However, in the absence of further evidence we are unable to give Assurance that this action is now complete. In order to grade this as complete we would need to see further evidence of the training sessions, information shared, revised guidelines, identification of Safeguarding Champions etc. It would be even better if there was evidence of improved practice with regard to safeguarding.
- 3.137 We have received significant evidence that this action is now complete. We have been provided details of training sessions, information shared, revised

guidelines, identification of Safeguarding Champions and evidence of improved practice with regard to safeguarding and DVA.

3.138 Therefore we have graded this as B, evidence of completion and embeddedness.

## West Midlands Police

Recommendation 6	Grade
<p><b>West Midlands Police</b>            Before the decision is made by the police to remove safety and alert equipment from a victim of domestic violence West Midlands Police should ensure that a full risk assessment is undertaken to inform this decision. All relevant agencies and the victim should be involved in this assessment and decision.</p> <p><b>Priority 2</b></p>	D

3.139 The expected outcome was:

- A risk assessment is undertaken before removal of safety and alert equipment from a victim of domestic violence, with relevant multi-agency involvement.

3.140 The expected evidence of this implementation was:

- Revised or new guidance or policy.
- Dissemination of the revised or new guidance or policy. Copies of communications/ emails/ notes of meetings or training days and attendance (who and as percentage of total staff) where it was discussed.
- Evidence of assurance that the guidance is embedded and operational (i.e. practice as usual) such as audits, case sampling or similar.
- Examples of any reports sent to senior level meetings to provide assurance.

3.141 A new domestic abuse alarm system (Tecsos) was introduced by West Midlands Police in April 2016. These personal alarms are mobile, allowing them to be carried by anyone at risk, and therefore not necessarily limited to one per household. The alarms are trackable and linked directly to the Force's Control Centre, allowing a fast response to the correct location. Numerous officers and staff have been trained to give out the alarms to avoid delay or risk to victims and training is regularly refreshed.

3.142 We also understand that the force are planning to purchase and roll out a web application or 'app' that can be downloaded on to a victim's mobile phone to replace the personal alarm. A major advantage of this app is that it is unobtrusive and can be safely removed when no longer required.

- 3.143 We were told that deployment of the alarms is frequently reviewed and before the decision is made by police to recall safety equipment such as Tecsos alarms or remove the access to app based products on victims own phone such as the Tecsos App version, then a risk assessment is undertaken to inform this decision.
- 3.144 Also that WMP domestic abuse (DA) policy adheres to Authorised Professional Practice (APP) as defined by the College of Policing. All WMP personnel receive regular training in respect of DA which includes the learning from all statutory reviews. The DA policy requires high risk victims of DA to be referred to MARAC to ensure enhanced safeguarding and risk is appropriately considered within a multi-agency information sharing forum. Enhanced safeguarding can include the use of Texos devices, a mobile phone type personal panic alarm that can be carried at all times by a high risk victim of DA. MARAC actions are reviewed on a monthly basis with any on-going risk fully assessed by all relevant partners to ensure that subsequent decision making is appropriately informed.
- 3.145 We have also been told that the domestic abuse alarm system has been superceded by the roll out of a personal safety alarm which is downloaded onto smartphones. This provides rapid and unobtrusive access to an alarm system for potential victims that will ensure the police are contacted when the potential victim perceives they are at increased risk.
- 3.146 Although we have been informed of these changes, we have not yet seen evidence that this is the standard practice employed across the force, or evidence of policy and the implementation of the alarm system. For these reasons this is graded as D, partially complete.

Recommendation 20	Grade
<p><b>West Midlands Police</b> should formalise the involvement of family and carers within their policies and protocols, relating to information sharing.</p> <p><b>Priority 2</b></p>	D

- 3.147 The expected outcome was:
- Enhanced information sharing with families and carers from police officers, with specific regard to young people with mental health problems, being mindful of the balance to be struck between confidentiality and managing risk.
- 3.148 The expected evidence of this implementation was:
- Copy of any new or revised policies and guidelines.
  - Dissemination of these. Copies of communications/ emails/ notes of meetings or training days and attendance where it was discussed.
  - Evidence of assurance that information sharing is now 'practice as usual'.

- Examples of any reports providing assurance that the practice is embedded.
- 3.149 We have been informed how West Midlands Police borders a large number of agencies and information sharing is essential to prevent crime, protect people and help those in need. The decisions about how much information to share, with whom and when, can have a profound impact on individuals.
- 3.150 West Midlands Police works with carers, family and friends of individuals to help them get the care and support they need. Sharing information with these people is generally done with the consent of the individual. There may be occasions when a decision to share information is made with individuals in response to an imminent threat or risk of significant harm. This may be done without consent in specific circumstances using a number of available legislative options.
- 3.151 We have been told that WMP regularly review and update force policies, and is currently revising the force policy on mental health. Part of this process includes consultation with relevant partner agencies to ensure that information from families and carers are adequately considered when discussed within an information sharing arena. In respect of DA, this includes Birmingham local authority, Women Acting in Today's Society (WAITS) and Birmingham City Housing.
- 3.152 In relation to people within mental health crisis, if the person lacks the mental capacity to make a decision about sharing information with key people, then the Mental Capacity Act is followed to ensure each decision to share information is in the person's best interests. Decisions and reasoning are recorded.
- 3.153 The force also follows the guidance from the National College of Policing on 'mental health and dealing with vulnerable people with mental illness'.<sup>7</sup> This has very clear guidance on seeking and providing information to families and carers of people with mental health problems. One example of the guidance contained describes that "where possible, the police should seek the views and consent of the individual in question to interact with their parents, carers, family and associates. Police officers and contact management staff should be aware that the people providing information may also require support and advice about what is happening and why, and what they can expect from the whole process".
- 3.154 We understand the WMP are now establishing routine recording of such interactions to enable future audit to evidence further implementation of this recommendation.
- 3.155 We have graded this recommendation as D, partially implemented.

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<sup>7</sup> <https://www.app.college.police.uk/app-content/mental-health/mental-vulnerability-and-illness/#information-from-parents-carers-family-and-associates>

## HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)

3.156 The independent investigation made three recommendations for the prison healthcare services (recommendations 7, 8, and 16).

Recommendation 7	Grade
<p><b>HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)</b>            Healthcare staff at both HMP Hewell and HMP Birmingham who are undertaking a Care Programme Approach Plan (CPA) and risk assessments should familiarise themselves with the Home Office 'Adolescent to Parent Violence and Abuse Guidance for Practitioners' (2015) and be categorising incidents of violence by children on a parent and/or carer as incidents of domestic abuse.</p> <p><b>Priority 2</b></p>	D

3.157 The expected outcome was:

- Staff are familiar with the above guidance, and incidents of violence of child on parent or carer are categorised and recorded where appropriate.

3.158 The expected evidence of this implementation was:

- Copy of any new or revised policy or guidance.
- Dissemination of the revised policy. Copies of communications/ emails/ notes of meetings or training days and attendance (who and as percentage of total staff) where it was discussed.
- Evidence of any training days, including dates, percentage of staff attending, and programme, related to the guidance.
- Evidence of assurance that the guidance is embedded and operational (i.e. any audits and case sampling done to provide assurance).
- Examples of any reports sent to quality monitoring and oversight meetings.

### HMP Hewell (Healthcare)

3.159 The Home Office guidance has been circulated in June 2017. We have seen the evidence that the guidance was circulated by email, twice, by the Trust (South Staffordshire and Shropshire NHS foundation Trust (SSSFT) on 9 June 2017.

3.160 A risk assessment template has been constructed on SystemOne. We have not been provided with an example of this.

3.161 Practitioners have attended Violence Risk Assessment and Clinical Risk Management Training. We have not seen the evidence of the training days and attendance.

- 3.162 Adolescent to Parent Violence and Abuse Guidance for Practitioners is part of the mandatory training for staff. We have not seen the curriculum or evidence that staff attend this training.
- 3.163 The Head of Healthcare confirmed to the commissioners on the 23 March 2018 that this is part of the mandatory training module for SSSFT staff. We have not seen the evidence that this was confirmed or that staff have been trained.
- 3.164 We were also told that the Deputy Regional Manager updated the information provided to include that all staff at HMP Hewell who are involved in any part of the CPA process have to complete both Vulnerable Adult Safeguarding training and Safeguarding Children training as part of their mandatory trust or organisational training, and that records of training are available. We have not seen the training records.

### **HMP Birmingham (Healthcare)**

- 3.165 We were told that the Home office guidance has been circulated via email 11th April 2017.
- 3.166 We understand that the Trust (Birmingham and Solihull NHS Foundation Trust) Domestic Violence lead was facilitating a study session within the prison, covering all areas of Domestic Violence. The original event was postponed and we were told that this then took place on 18 December 2017.
- 3.167 We were also informed Safeguarding training has now taken place to those involved in CPA and risk assessment, and that the Head of Healthcare has confirmed on the 27 March 2018 that this is now part of the mandatory adult and children safeguarding training, which must be received by staff every three years.
- 3.168 We have been told that Safeguarding/Domestic Abuse Lead within HMP Birmingham has confirmed that training took place in the Prison on this guidance, and that confirmation has also been received from the Head of Healthcare at HMP Birmingham. We have not seen evidence of any records of training attendance.
- 3.169 We have not seen evidence that the guidance was circulated, nor any information concerning the study session on Domestic Violence. We have not been provided with copies of the policy which would mandate the Safeguarding training, nor evidence of the staff receiving this training.
- 3.170 For these reasons we believe this recommendation is partially complete and have graded this recommendation as D.

Recommendation 8	Grade
<p><b>HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)</b>  Staff undertaking the initial Care Programme Approach Plan must ensure that they liaise with all agencies who have been involved with the prisoner, in the community and/or during the court process, in order to obtain an accurate profile of their needs and risks to themselves and others.</p> <p><b>Priority 2</b></p>	D

3.171 The expected outcome was:

- Staff are liaising with all agencies involved with the prisoner in the community and during the court process, and are developing accurate profiles of needs and risks.

3.172 The expected evidence of this implementation was:

- Copy of any new or revised policy or guidance.
- Dissemination of the revised policy. Copies of communications/ emails/ notes of meetings or training days and attendance (who and as percentage of total staff) where it was discussed.
- Evidence of any training days, including dates, percentage of staff attending, and programme, related to the guidance.
- Evidence of assurance that the guidance is embedded and operational (i.e. any audits and case sampling done to provide assurance that this practice is now 'business as usual').
- Examples of any reports sent to quality monitoring and oversight meetings regarding assurance of implementation.

### **HMP Hewell (Healthcare)**

3.173 We were told that GP records are routinely requested, and previous records on SystemOne are reviewed to identify service involved in the patient's care and where onward referrals were signposted to on previous release and every effort is made to contact previous agencies dependent on whether the details re known. Where patients present as acutely unwell (psychotic) it is not always clear which service patients have been in contact with unless information is sent from the community.

3.174 We have not seen any guidance concerning this procedure, communication and dissemination about the practice, records of training, or evidence of audit or case samples to establish this is now routine practice.

## **HMP Birmingham (Healthcare)**

- 3.175 We were told that staff liaise closely with all external agencies when undertaking the CPA plan. Mental Health staff have good links with local Liaison and Diversion services and utilise information for CPA reviews.
- 3.176 A 'dip audit' of CPA care plans to demonstrate multi agency assessment and care planning was intended to be completed in October 2017. However, due to staffing shortages this audit was delayed until April 2018. This will be presented at the May clinical effectiveness committee.
- 3.177 We have not seen any guidance concerning these practices, communication and dissemination about the practice, records of training, or evidence of the audit to establish this is now routine practice.
- 3.178 We also heard that for both prison healthcare teams that performance will be assessed as part of the NHS England annual prison clinical quality visit process. We have not seen the evidence of this performance assessment.
- 3.179 We were also told that the new prison clinical information technology functionality will connect prisons to the national spine when rolled out (12 months from go live) which will facilitate improved clinical information sharing on reception and on discharge. This is a national programme, which affects all prison healthcare services. The Personal demographics service (PDS) will roll out from October 2018 to April 2019, GMS Registration and GP2GP data transfer will roll out from July 2019 to February 2020, and ERS, EPS, SCR will roll out from April to October 2020.
- 3.180 PDS allows registration on the Spine, and allows healthcare providers to retrieve the correct NHS number. GMS registration will allow the clinical record to follow the patient. ERS is the electronic referral service, previously known as "Choose and Book". EPS is the electronic prescribing service, and will allow safer medicines management on release. SCR is the summary care record, which providers can already access via a web browser, but in future it will be integrated with SystemOne. This enhanced functionality will significantly improve the ability to obtain and share information across healthcare agencies, and will hopefully address some of the underlying issues within this case. However, because this will obviously take longer to implement, we have not yet seen evidence of this change.
- 3.181 Because the above information shows only partial evidence of completion, we have graded implementation of this recommendation as D, partially complete.

Recommendation 16	Grade
<p><b>HMP Birmingham (Healthcare) and Birmingham and Solihull Mental Health NHS Foundation Trust</b>  HMP Birmingham (Healthcare) should provide assurance to the Trust and their commissioners that the issues with SystmOne (accessing prisoner’s full medical notes from the point of admission) have been resolved.  <b>Priority 2</b></p>	C

3.182 The expected outcome was:

- HMP Birmingham (Healthcare) are able to fully access prisoners’ medical notes within SystmOne. Staff are familiar with the above guidance, and incidents of violence of child on parent or carer are categorised and recorded where appropriate.

3.183 The expected evidence of this implementation was:

- Evidence of meetings to discuss the issues, with agreed actions to resolve them.
- Evidence of full access to SystmOne by healthcare staff.

3.184 We were told that this action was to be discussed formally at the Commissioner - provider meeting.

3.185 We were also told that staff working HMP Birmingham (Healthcare) have access to SystmOne but will not have access to the person’s full medical notes. Given the nature of HMP Birmingham and the significant number of prisoners coming through reception (we were told 30 – 50 a day) the staff have a limited amount of time to complete a health history.

3.186 We were told that all NHS staff have access to SystmOne but do not have access to all GP information as not all GP practices use SystmOne so the prison healthcare team can never be fully compliant. However, on reception all prisoners are asked to sign a consent form so the healthcare team can access medical notes and these are received and scanned onto SystmOne.

3.187 Reception screening is also just a brief overview with a more detailed full health screening using medical history taken in the ‘well man’ assessment. The new first night screening templates are much more detailed, although the high numbers of new receptions can impact on time. In reception there are 2 qualified nurses (RGN/RMN) and 1 HCA who completes the physical observations and urine testing. Medicine reconciliation is also part of screening which picks up issues re medication.

3.188 For prison to prison transfers the full SystmOne record is available if access rights and patient administration is appropriately completed. North East London CSU has produced a brief user guide regarding access rights and administration which was shared with providers on 28 April 2017.

- 3.189 The annual prison quality assurance visit process run by NHS England Health and Justice Commissioners considers this as part of the assurance process.
- 3.190 We note that implementation and development of new information systems and protocols can take several years to develop and implement. We also note the systemic difficulties mentioned above in that not all prisoners GPs are on SystemOne. We also note the difficulties posed by the significant number of reception screenings required for prisoners.
- 3.191 However, the recommendation was solely focussed on HMP Birmingham (Healthcare) staff having full access to SystemOne.
- 3.192 We have graded this as C, action complete.

### Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)

- 3.193 The independent investigation made two recommendations involving prison healthcare and Forward Thinking Birmingham (FTB). These were recommendations 22 and 23.

Recommendation 22	Grade
<p><b>Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).</b> Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community.</p> <p><b>Priority 1</b></p>	B

- 3.194 The expected outcome was:
- The referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community.
- 3.195 The expected evidence of this implementation was:
- Evidence of meetings to discuss the issues, with agreed actions to resolve them.
  - Dissemination of any outputs to establish any new practices.

### Forward Thinking Birmingham

- 3.196 We were told there is a referral pathway for prison leavers under the age of 25, which sees the extended triage with a senior clinician in 'Access'. We have seen a copy of this algorithm/pathway (FTB Prison Process V4). In order to raise awareness of this referral pathway Forward Thinking Birmingham Access and Utilisation and Intensive Case Management (UICM) lead have

attended the monthly Midlands Governance meeting for Prison Mental Health Care and followed up the referral process in writing.

- 3.197 Following the 'lessons learned' event hosted by NHS England West Midlands in September last year, it was fed back that FTB needed a process to ensure these young people did not fall through gaps in the service (hence the development of the FTB Prison Process).
- 3.198 It was also noted that the risk to family indicates an increased risk to others so the Intensive Case Management (ICM) team needed to be aware of this when managing the most complex young people in FTB. This was to be picked up in 1:1 supervision as appropriate. It was also reported that FTB felt able to share more information if significantly concerned. The information guidance prepared by Mills and Reeve from the previous workshop was sent to the UICM team and summarised verbally in the UICM team meeting. We have been provided with a copy of this information sharing guidance.
- 3.199 We have been provided with copies of the workflows 'Prison release from FTB process' (current v4 and old versions) and 'Item 5 Young person open to FTB receives custodial sentence process' that have been developed and signed off through Clinical Strategy and Governance meetings for the FTB Prison Process.
- 3.200 There is also an analysis of the ICM intervention with the prison release cases since June 2017 which identified the rationale for changing the process to v4 as the data showed that these young people were requiring extended triage rather than assertive clinical outreach.
- 3.201 Other developments we have been told of include the ICM lead attending a Prison pathway Design day (Oct 17) and the Access lead to attend a Prison pathway Design day (to be arranged from Feb 2018). There is a meeting between Liaison and Diversion lead, Deputy Director of Nursing and Access Centre lead to be arranged to ensure this group within current FTB processes.
- 3.202 There is a Youth Offending Service provided by FTB. We have a copy of the service model which describes the rationale for the service. This includes the following text:

"Literature in relation to children and young people in the Youth Justice System suggests that these populations are at an increased risk of multiple health inequalities and poor life chances and, as such, are a key target group for health services charged with narrowing the gap in outcomes between the highest and lowest achieving children (Khan and Wilson, 2010). Barriers to progress include higher than average, a) mental health vulnerabilities, b) neuro-developmental difficulties, c) compromised levels of learning disabilities, d) speech and communication needs, e) health inequalities and f) increased rates of problematic drug and alcohol use.

Research indicates that these young people are less likely to have their needs identified early in primary care, school settings or in the wider health provisions. It also appears that their needs remain unidentified and only

supported after entry into the Youth Justice System (Khan and Wilson, 2010). Research also suggests that these young people often face persistent problems accessing support from mainstream specialist health and social care services. This appears due, in large part, to an inflexible exclusion criteria, failure to recognise multiple safeguarding needs, and poor design of services that are not experienced by young people as accessible or engaging (Khan and Wilson, 2010).”

- 3.203 Currently the Youth Offending Service (YOS) support all the Multi Agency Public Protection Arrangements (MAPPA) meetings across the City which means FTB facilitate any discharges of ‘risky patients’ under 18. FTB are currently looking at expanding this to the over 18s.
- 3.204 YOS are firmly integrated with the under 18 Youth Offending Service which means that there is a nurse in each of the Youth Offending Teams that supports the team with all the mental health concerns. The nurses deal directly with all mental health referrals. We have been told there is dedicated access to Psychiatrist.
- 3.205 FTB offer an early identification screening to all young people that attend the YOS, and do not operate a waiting list. All cases are reviewed and monitored via the overall FTB case management system. Every young person going through YOS is offered a mental health screening.
- 3.206 We have been provided with copies of minutes of the monthly YOS team meetings for September, October, November and December 2017 and January and April 2018, which discuss referrals and aspects of case management and service quality.
- 3.207 The service has secured, and regularly uses its access to the BSMHFT patient records system, Rio, for which it has 50 licences. Additionally, allocated staff have access to the Woodbourne Priory notes system, Carenotes. This enhances information sharing across the BSMHFT footprint.
- 3.208 Because of the quantity of supporting evidence concerning the Birmingham system involving FTB and HMP Birmingham, we have graded this recommendation as B, evidence of completeness and embedding. It is noted that the service is much more embedded in Birmingham and that more work is ongoing with regard to HMP Hewell.

### **HMP Birmingham (Healthcare)**

- 3.209 We were told that HMP Birmingham (Healthcare) have recently developed links with FTB and they are now attending the prison to keep in contact with anyone under the age of 25 they are providing a service to.
- 3.210 FTB and the mental health team at HMP Birmingham have regular communication and FTB will attend the prison and provide follow up where appropriate. Most communication is via email/phone, although the service is encouraged to come into the prison. Resettlement team attend weekly bed

management meeting for wards 1 and 2. Discussions also includes complex patient where concerns have been raised on the wings.

### HMP Hewell (Healthcare)

3.211 HMP Hewell is not a local prison to FTB. The patient catchment area for FTB is for those with a Birmingham registered GP only.

Recommendation 23	Grade
<p><b>Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)</b>            Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community.  <b>Priority 1</b></p>	B

3.212 The expected outcome was:

- Young offenders released into the community access the referral and homeless pathways and receive appropriate support.

3.213 The expected evidence of this implementation was:

- Evidence of how this incident has continued to help shape services, and specifically access to mental health services for young people in contact with criminal justice services.
- Descriptions of new services.
- Examples of new services, and guidelines for referral
- Audits of effectiveness – how many young people are now accessing such services? Any other metrics of improvement – young people now receiving care, reductions in young people going into criminal justice service, crime reduction etc?

### HMP Hewell (Healthcare)

3.214 We understand that stronger links have yet to be established between FTB and HMP Hewell (Healthcare).

### HMP Birmingham (Healthcare)

3.215 We have been told that FTB and the MH team at HMP Birmingham have regular communication and FTB will attend the prison and provide follow up where appropriate, and that the Resettlement team attend weekly bed management meeting.

## Forward Thinking Birmingham

- 3.216 We have been provided with the Professional guidelines and information: Multisystemic Therapy (MST) provided by FTB.
- 3.217 The Multisystemic Therapy (MST) team works alongside other agencies to support young people with complex emotional, social and academic needs.
- 3.218 Based in the community, the service is funded by Birmingham City Council as part of the Think Family programme but operates as part of FTB to support children aged 11 to 17 on the 'edge of care' to avoid out of home placements, reduce offending and encourage engagement in education. MST is a family-focused, evidence-based treatment programme, which has proven to be both clinically and cost-effective.
- 3.219 The emphasis in MST is to work with the young person's family, school, police and other agencies, rather than the young person in isolation. The team usually delivers a therapeutic intervention over three to five months, providing approximately three sessions per week within the family home, as well as a 24/7 on-call service for crisis advice.
- 3.220 We have seen the information about Pause, a city centre drop-in service in Birmingham. Pause, provides young people with advice and support with any concerns related to mental and emotional well-being. Pause is a recently launched drop-in facility in Birmingham city centre. The aim is to provide young people aged up to 25 with advice, sign posting, and support with any concerns related to mental and emotional wellbeing. Pause is part of the service offered by Forward Thinking Birmingham and is run by The Children's Society.
- 3.221 We have also seen information concerning the Living Well consortium which provides accessible support for young people with emotional and mental health problems amenable to psychological interventions.
- 3.222 We have seen the evidence of the On-line crisis team and its referral form.
- 3.223 Other recent developments include:
- Opened access to services through self-referral and 24-hour crisis support. Parents and carers can also receive support or make a referral to FTB through the Access Centre.
  - Commissioned services from voluntary and community organisations which provide culturally relevant support to children, young people and young adults. This includes psychotherapy and counselling services with expertise in engaging BME young men, as well as mental health support for BME prison leavers.
  - Pause Computer Club launched – 1 ½ hr workshop each week for migrants aged 12-18 to reduce isolation, build confidence and develop valuable skills.

- 3.224 We have seen ten case studies that evidence the process and impact that the new ICM pathway for ex-offenders is having which are reported into FTB.
- 3.225 We have discussed previously the development of the Youth Offending Service and its relationship with criminal justice services in our discussion regarding recommendation 21.
- 3.226 Because of the range of supporting evidence and assurance that the lessons learned from the incident are continuing to support the development of services in FTB, we have graded this recommendation as B, evidence of completeness and embeddedness. Further evidence over time will need to be supplied to provide evidence of impact.

## NHS England Health and Justice Commissioners

- 3.227 The independent investigation made four recommendations that applied to NHS England Health and Justice Commissioners. These were recommendations 12, 15, 17, and 21. In addition to these recommendations, the NHS England Health and Justice Commissioning Team for the North Midlands have also taken on the implementation of recommendation 18.

Recommendation 12	Grade
<p>NHS England's Health and Justice Commissioning Team (North Midlands) should discuss the findings of the original Trust report with the new provider of healthcare at HMP Hewell to ensure that implementation is still progressing and that lessons learnt are continuing to inform practices and policies.</p> <p><b>Priority 2</b></p>	C

- 3.228 The expected outcome was:
- Implementation of the internal investigation findings is continuing with the change of prison healthcare provider.
- 3.229 The expected evidence of this implementation was:
- Records of discussion with HMP Hewell healthcare provider to discuss findings of report. The commissioners and the new healthcare team at HMP Hewell can provide evidence of these discussions (dates, venue, noted), and the evidence to demonstrate monitoring of implementation.
- 3.230 We were told that the new provider of healthcare in HMP Hewell, CareUK, has reviewed the original report and produced an updated action plan which will be reviewed every 2 months with NHS England Health and Justice Commissioners. We have not seen the dates and minutes of these reviews, but we have seen evidence that there is a regularly updated action plan tracker from HMP Hewell, which also includes some evidence of the implementation of the nine recommendations that applied to HMP Hewell (Healthcare).
- 3.231 We have graded this as C, evidence of completeness.

Recommendation 15	Grade
<p><b>NHS England Specialised Commissioning Health and Justice commissioners, prison health care providers and Ministry of Justice.</b></p> <p>The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services.</p> <p><b>Priority 1</b></p>	B

3.232 The expected outcome was:

- Improved discharge planning for prisoners released earlier than planned, who have mental health problems.

3.233 The expected evidence of this implementation was:

- Records of discussion between Health and Justice Commissioners, prison healthcare providers and the Ministry of Justice to work together to improve discharge planning and improved access to mental health.

3.234 This recommendation, alongside the improvements to information seeking and sharing lie at the heart of the findings in the independent investigation.

3.235 We were told the following details concerning implementation of this recommendation.

3.236 Prison Service Instruction (PSI) 72/ 2018<sup>8</sup> outlines the requirements of all prisoners who are to be released. Paragraph 2.47 states 'All prisoners must be examined by a healthcare practitioner during the 24 hours prior to discharge.' This was completed in June 2017.

3.237 NHS England Health and Justice Commissioners and Her Majesty's Prison and Probation Service (HMPPS) are working together to consider ways of assuring compliance with this PSI. They are exploring in partnership the scenarios under which issues of continuity of care can arise from unexpected events or decisions and consider what more can be done to provide assurance that risks are well managed as people transition from custodial care to care in the community.

3.238 NHS England Health and Justice central team have undertaken work to develop a national set of clinical templates for SystmOne which includes pre-release planning and release/ transfer templates. These templates have been fully endorsed by the NHS England Health and Justice Clinical Reference Group and are reflective of NICE Guidelines and PSI 72/2011. A pilot of these

<sup>8</sup> <https://www.justice.gov.uk/downloads/offenders/psipso/psi-2011/psi-72-2011.doc>

templates took place in August 2017 with full training and full roll-out anticipated during 2018.

3.239 NHS England Health and Justice central team have developed a national mental health and learning disability service specification which went for a 30 day consultation (23rd October – 22nd November).

3.240 Objective 3 of this service specification is to ensure continuity of care through the gate and within prison through a programme of service improvement initiatives, e.g. evidence of:

- patients are aware of and engaged with their local community mental health services, learning disability services and/or any other required care services upon release or discharge;
- they have a robust discharge plan and their support needs feature in their resettlement plan; and
- support is provided through the gate to enable patients to navigate local services and access appropriate wider services e.g. housing which will support their recovery.

3.241 This was published March 2018 and will be mobilised during 2018 and 2019. We have been provided with a copy of this specification, and note in particular the following standards:

- An identified key worker and/or responsible clinician from the receiving service are invited to discharge/release planning CPA meetings.
- Referrals to community mental health services are made for those patients who require continued care and follow-up support following release.
- On discharge from the team, patient information is provided to the receiving primary care or mental healthcare service.
- The team carries out a follow-up interview with the patient and/or the new care co-ordinator/service provider within 14 days of release/transfer from prison. *Guidance: This includes communication in person, by telephone, email or in writing.*

3.242 We also note the following question posed at Prime Ministers Question Time on 13 September 2017 by the Rt Hon Norman Lamb MP:<sup>9</sup>

“Four years after teenager Christina Edkins was tragically killed by Philip Simelane, a man who was acutely ill with psychosis and had only recently been released from prison, the chair of the independent panel has expressed extreme concern about the fact that vulnerable prisoners are still being released without adequate support. Will the Prime Minister make it an urgent priority to ensure that we guarantee that there is proper support, proper continuity of care, and the sharing of information between prisons and mental health services to reduce the risk of another tragedy taking place?”

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<sup>9</sup> <https://hansard.parliament.uk/Commons/2017-09-13/debates/942D3785-A42F-4393-86EB-90FC2658B4B9/PrimeMinister>

3.243 We also note the Prime Ministers reply:

“The right hon. Gentleman has raised a very important matter. He has campaigned long and hard on mental health issues, and has made a huge contribution in doing so. The issue of the relationship between health services and prisons is long-standing. Efforts have been made, and there has been some progress in improving that relationship—in the context of the responsibilities of the Department of Health and the national health service in prisons—to ensure that cross-cutting action of exactly that sort can be taken; but we will, of course, continue to look at the issue.”

3.244 A meeting was convened with Phillip Lee Under-Secretary of State at the Ministry of Justice to discuss the national issues of vulnerable prisoners being released without adequate support into the community. It was discussed that West Midlands, who are already working to address this issue, are given a status that enables them to work closer with the Ministry of Justice to develop a model pathway for a coordinated safe release. A Task and Finish group was to meet in April 2018 to progress this work, however, this had to be cancelled at short notice, and a new date for this meeting is being sought. We have seen the correspondence to support the arrangement of this meeting, the agenda and purpose and the attendees.

3.245 The March 2018 update of the action plan tracker identified that a Multiagency workshop was held in October 2017. We have not seen attendances or outputs other than those listed below. The Output of this workshop was:

- Prisoner Escort Record (PER) Orange sticker pilot in Coventry and Warwickshire Partnership NHS Trust. This is a bright orange sticker applied to the front of the prisoner records to ensure that Liaison and Diversion (L&D) information flows into prison healthcare.

**Seen by Coventry Liaison and Diversion:**  
**024 7696 1214, for further info contact:**

**Name:** \_\_\_\_\_

**Tel:** \_\_\_\_\_

**Immediate risks:** \_\_\_\_\_

**NHS**  
Coventry and  
Warwickshire Partnership  
NHS Trust

- Her Majesty’s Court and Tribunal Service (HMCTS) staff to pilot court lists being published earlier.
- Sharing across the pathway specific contacts e.g. all Prison duty system contacts shared with all L and D teams and all contact details for L&D staff shared.
- High level directory of services developed and shared with prison healthcare and mental health services to support awareness and referrals.

- Exploration of ‘sharing diaries to set reminders’ around remand. We have not seen any further elaboration on this.
  - The regional L&D forum hosted a day focusing on information exchange /flow with colleagues from prison healthcare and police healthcare custody staff. This was held on Friday 19th January 2018 at Jury’s Inn, 245 Broad Street, Birmingham. The session included a presentation by Jill Weston (Mills-Reeves) on information sharing. We have seen copies of the agenda, the presentation, and have been provided with draft versions of an information sharing card guide.
  - The commissioners are in the process of developing a short term sentence pilot with the Birmingham L&D service and HMP Birmingham healthcare team. Will include recruiting a Band 7 clinician and a support worker (Lived experience preference) they will follow any individuals seen by L&D in custody/court who are given a 12 week or less sentence. The work will include visiting, meeting at the gate and short term interventions on release to connect the individual with appropriate community resources and support both individual and their social network to improve health and social care outcomes and also impact on reducing reoffending. We have been provided with a copy of the draft service specification.
- 3.246 HMPPS and NHS England Health and Justice Commissioners coordinated and delivered a multiagency workshop on the ‘Prison/ Community Mental Health Pathway’. Around 40 people attended, from NHS, HMPPS and HMCTS organisations from around the West Midlands. The presentation outlining the background to the event outlined the underpinning themes arising from the independent investigation. We have been provided with copies of the agenda, the presentation and list of attendees. A follow up workshop was being arranged for June 2018, and we have seen the prepared agenda, but this review took place before the event.
- 3.247 We have seen the Health and Justice Indicators of Performance (HJIPs) Adult Secure Estate: User Guide 2018-19 and the HJIP Data Template 2018-19. We note the significant number of performance indicators linked to ensuring that prisoners with mental health needs are assessed and identified, and that plans of care are made accordingly with follow up and medication on release.
- 3.248 We have also been provided with a copy of the national partnership agreement<sup>10</sup> between the Ministry of Justice, Her Majesty’s Prison and Probation Service, Public Health England, the Department of Health and Social Care, and NHS England. This partnership agreement identifies how the partners can work together to improve data and evidence so that they can better understand the health needs of people in custody and the quality of health and social care services delivered to people in prisons. In particular we note the objective “to support access to and continuity of care through the prison estate, pre-custody and post-custody into the community” and also the objective “Work together to improve the mental health and wellbeing of our

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<sup>10</sup> HM Government, NHS England. “National Partnership Agreement for Prison Healthcare in England 2018-2021”

population, securing timely and appropriate assessment, treatment and transfers of care, and to focus appropriately on the mental health needs of those with protected characteristics.”

- 3.249 Following discussion at the Local Criminal Justice Board in January this year and also with the West Midlands Mental Health Alliance, it was proposed to establish a group of experts to look at the pathway for individuals who are experiencing poor mental health who enter the justice system. The purpose of this programme will be to seek to review the pathway from home throughout the whole Criminal Justice System, from police contact, court, and prison and then back into the community.
- 3.250 On 4th July this year Mental Health and Justice inaugural meeting took place, to carry forward this work on improving access to mental health services for prisoners.
- 3.251 Although it is early days yet a clear output from this group has been the development of a draft pathway for ‘unplanned release of prisoners with mental health needs’. This pathway is called “Mental Health Act Assessments for Prisoners on or Approaching Release from Prison”.
- 3.252 We note that much of the work identified above will require a much longer timescale to have the desired impact. However, because of the significant amount of work done at all levels (local and national) and the evidence provided we are able to grade this as B, evidence of completeness and embeddedness.

Recommendation 17	Grade
<p><b>NHS England Specialised Commissioning Health and Justice commissioners, prison health care providers, G4S and Ministry of Justice.</b> To consider what action can be taken to allow healthcare teams in prisons to have access to the prison records P-NOMIS.</p> <p><b>Priority 3</b></p>	C

- 3.253 The expected outcome was:
  - Working within current legislation, there would be consideration by the named organisations of how to facilitate some access to prison records for prison healthcare teams.
  - Consideration of risks v benefits, and data protection issues and how these could be overridden if necessary or if not, why not.
- 3.254 The expected evidence of this implementation was:
  - Evidence of discussions between representatives of the organisations involved.
  - Output of the discussions, communicated to appropriate bodies.

- 3.255 We were told that it will not be appropriate to grant healthcare staff full access to prisoner records on PNOMIS, nor would it be appropriate for custodial staff to access clinical patient records. However, NHS England Health and Justice and HMPPS are working together to consider a system whereby healthcare staff can access appropriate and relevant information on P-NOMIS, alongside work to promote better multi-disciplinary working. We have not seen evidence of any output of this collaboration directly, although we note the National Partnership agreement mentioned earlier.
- 3.256 Alongside this we also note the efforts made by the Health and Justice Commissioners to address the issue. We have seen the agenda for the workshop hosted by NHS England Health and Justice Commissioners in Birmingham on 19 January, and the agenda item devoted to discussion of information sharing between agencies and the presentation on this subject provided by Mills and Reeves. We have not seen attendances for this day. We also note the Information Sharing guide card produced in draft as an output from this day.
- 3.257 We have seen evidence of email conversations between regional Health and Justice Commissioners where they are discussing the feasibility of transferring prisoner healthcare records held on SystmOne between prison healthcare providers.
- 3.258 We have been told that the Information Sharing best Practice Guidelines have been shared with RCGP Secure Environment Group, HMPPS and RCN with a request for endorsement prior to communicating to all prison operational staff.
- 3.259 NHS England is reviewing the National Information Sharing Protocol for all national partners to agree and sign. A template Information Sharing Agreement will be shared for local multiple partner agreements to be agreed and implemented. This will support both the requirement for all partners to understand their roles and responsibilities in information sharing and ensure they are compliant with the imminent new GDPR requirements.
- 3.260 We have graded this as C, evidence of completeness.

Recommendation 18	Grade
<p><b>NHS England and Ministry of Justice</b>            To consider what protocols if any, within the current legislative framework can be developed and implemented to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs.  <b>Priority 1</b></p>	C

- 3.261 The expected outcome was:
- Working within current legislation, there would be consideration by the named organisations of what protocols if any, within the current legislative framework, can be developed and implemented to share

relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs.

- Consideration of risks v benefits, and data protection issues and how these could be overridden if necessary or if not, why not.

3.262 The expected evidence of this implementation was:

- Evidence of discussions between representatives of the organisations involved.
- Output of the discussions, communicated to appropriate bodies.

3.263 We note that this recommendation implementation has merged significantly with the previous recommendation 17. Both recommendations consider the difficulties of information sharing within the current frameworks, and will be supported by the Information Sharing guidance.

3.264 We note the Health and Justice Commissioner efforts through the above mentioned workshop of 19 January 2018, the presentation on information sharing, and the draft guidance card produced. We were also told that compliance of Mandatory and Statutory Training (MAST), which includes knowledge and understanding of Information Governance and the Data Protection Act, is included in the contract and quality performance and assurance process between Health and Justice Commissioners and healthcare providers.

3.265 NHS England are reviewing the current Quality Schedule for the 2018/19 contract and will include specific assurance of IG training and staff understanding of information sharing relating to the learning from this case, and NHS England Nursing and Quality Leads are intending to include specific assurance around MAST and Information Governance compliance in the 2018/19 Quality Schedule as part of the contract for all prison healthcare providers.

3.266 The prison healthcare Quality Schedule that sits within the NHS Standard Contract, for 2018/19 has been agreed with the NHS England Health and Justice Nursing and Quality leads. This schedule includes healthcare providers to assure commissioners that there is an annual MAST plan with monitoring in place.

We also note the Service Specification: Integrated Mental Health Service For Prisons in England (final version dated January 2018), section 1.9 Information Sharing and Record Keeping, which states: "Clinicians are required to keep appropriate, comprehensive and contemporaneous Inmate Medical Records utilising the healthcare clinical IT system in line with information governance and data protection legislation. Clinicians are required to share information where relevant and appropriate (in-line with information governance expectations) to ensure patient safeguarding. The patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this must be recorded in the patient record".

3.267 We have graded this as C, evidence of completeness.

Recommendation 21	Grade
<p><b>NHS England Specialised Commissioning Health and Justice commissioners, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).</b></p> <p>The above to seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release.</p> <p><b>Priority 1</b></p>	D

3.268 The expected outcome was:

- Prisoners with mental health problems have access to appropriate mental health care after release.

3.269 The expected evidence of this implementation was:

- Evidence of meetings to discuss the issues, with agreed actions to resolve them.
- Dissemination of any outputs to establish any new practices.

3.270 In the West Midlands, CCGs commission appropriate services for ex-offenders with mental health problems. Work is being undertaken by the current provider Forward Thinking Birmingham and NHS England Health and Justice Team to ensure that health services in prisons are fully aware of the available services and pathways and they have clear referral routes for under 25 year olds. We have seen the pathway provided by FTB. We have also seen evidence of the FTB Youth Offending Service work with young offenders.

3.271 We have been told that assurance relating to this will be sought by NHS England through CCG assurance meetings, but we have not seen this assurance.

3.272 We have also been told that NHS England Health and Justice will also work with HMPPS, the prison operators, mental health providers, prison health providers and the CCGs to review processes into these services for unplanned releases. We note the workshops delivered and planned concerning Prison/ Community Mental Health Pathway Workshop in October and again in June 2018 and have seen the agenda and attendance list for the earlier event.

3.273 We have also been provided with a Directory of Services which identifies mental health services across Birmingham and Worcestershire which are available to offenders and ex-offenders.

3.274 We have been told that the NHS England Health and Justice commissioning team is piloting a prison discharge post being developed with the 2 L&D services. The focus will be on short sentences and the intention is to go live in the first quarter of 2018/19. However we have not seen evidence of this pilot post being in place.

- 3.275 We also note that the issue of early release prisoners and supporting access to mental health services is an ongoing and national problem.
- 3.276 We discussed earlier the question put to the Prime Minister by the Rt Hon Norman Lamb MP, and the meeting convened with Phillip Lee, Under-Secretary of State at the Ministry of Justice, to discuss the national issues of vulnerable prisoners being released without adequate support into the community. We mentioned that West Midlands, who are already working to address this issue, are given a status that enables them to work closer with the Ministry of Justice to develop a model pathway for a coordinated safe release. A Task and Finish group was to meet in April 2018 to develop this but the meeting has been postponed.
- 3.277 We also understand through wider conversations that this issue is very much at the heart of developments to improve access to mental health services for offenders and ex-offenders. The Local Criminal Justice Board (LCJB) Mental Health and Justice meeting has now started meeting regularly and alongside the West Midlands Mental Health Alliance are involved in the development of the model pathway with input from experts in the field.
- 3.278 We recognise that many of these longer term systemic changes are going to take much longer to develop and implement and that significant effort is being expended at national and local levels to take forward the development of new pathways and services.
- 3.279 In recognition of the work being undertaken, and by virtue of this work that the system is not yet assured that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release, and also being aware that it will not be possible for some time to say this action is complete we have graded this recommendation as D, partially complete. However, we are also aware that this is a nationally recognised problem, and that the development of the pilot and pathway in West Midlands by the LCJB Mental Health and Criminal Justice meeting should start to address some of these problems.

## HMP Hewell and HMP Birmingham

- 3.280 The independent investigation made one recommendation that applied to HMP's Hewell and Birmingham.

Recommendation 13	Grade
<p>Both HMP Hewell and HMP Birmingham introduce a requirement, supported by guidance, that all prison staff, including the governor's office and pastoral care services, should document any contact, either written or verbal, with prisoners' families in a prisoner's P-NOMIS record.</p> <p><b>Priority 3</b></p>	D

- 3.281 The expected outcome was:

- Documented contact with prisoners families in P-NOMIS.
- 3.282 The expected evidence of this implementation was:
- Internal discussions with the prison system to discuss implementation of this recommendation.
  - Copy of guidance developed.
  - Copies of dissemination or communication method to introduce guidance.
  - Evidence of checking guidance implemented (e.g. sampling files, case audits).
- 3.283 We were told that NHS England has shared the report with the Ministry of Justice as the Government department responsible for prisons. Their response to this recommendation is awaited and will be included in this improvement plan when received.
- 3.284 We are also aware that HM Prison Service is governed by a set of national instructions (Prison Service Instructions<sup>11</sup> or PSI's) which guide national standards. These PSI's cover a wide range of issues to guide prison officer's and prison practice. The most relevant guidance is Records, Information Management and Retention Policy PSI 04/2018. This provides clear guidance on what information to record and store, and for how long. It does not provide guidance on what to record.
- 3.285 We have seen a copy of a 'Notice to staff' produced by HMP Hewell which has just been developed (November 2018) which asks "can all staff please ensure that they document any contact they have with prisoner's families on P-NOMIS. This is then easily accessible to all". This guidance is issued as a local instruction with the expectation that staff now practice in this way.
- 3.286 Similarly, HMP Birmingham have also produced clear guidance 'Recording Family Concerns' (Instruction number 230/2018). This instruction reminds staff "of the importance of recording any contact, either written or verbal, with a prisoner's family on their NOMIS record. This instruction follows an incident where a family raised concerns and these were not recorded or actioned. This same prisoner was later involved in a serious incident of harm".
- 3.287 These local instructions now need to be disseminated amongst staff, and checked for implementation to complete and embed this action.
- 3.288 Until the establishment of the West Midlands MHHOG, there had been limited engagement of HMP's Hewell and Birmingham in the implementation of actions at a local level. Now that they are members of this group it is anticipated that local implementation of this recommendation will be taken forward through this group.
- 3.289 We have graded this as D, not enough evidence to say complete.

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<sup>11</sup> <https://www.justice.gov.uk/offenders/psis>

## Department of Health, NHS England, CCGs and local Police and Crime Commissioners

Recommendation 11	Grade
<p>To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services.</p> <p><b>Priority 1</b></p>	A

3.290 The expected outcome was:

- Further development and extension of the Street Triage service.

3.291 The expected evidence of this implementation was:

- Records of discussions between NHS England, CCGs and other stakeholders relating to implementation of this recommendation.
- Agreements, and funding for further roll out of street triage.
- Copy of guidance developed.
- Copies of dissemination or communication to introduce further street triage services.
- Evidence of checking service implemented (e.g. sampling files, case audits) and impact (prisons and court contacts with in-reach and L&D services for example).

3.292 We were told that West Midlands Police established with Birmingham and Solihull Mental Health NHS Foundation Trust and West Midlands Ambulance Service a Street Triage programme in January 2013. This programme initially funded by the Department of Health, has been rolled out as a 'business as usual' across the West Midlands Police footprint with three schemes now being delivered. The service has its own Twitter site (@TriageWMP).

3.293 The benefits of having these three organisations together and sharing information for the benefit of the patient and wider safety of our communities has been realised and supported an improved quality of care and support.

3.294 There is substantial evidence prior to the publication of the report that the pilot approaches in Birmingham had saved money and had significant local impact.<sup>12</sup>

3.295 According to recent evidence from West Midlands Police, there has been further impact. No-one detained by police under the Mental Health Act has

<sup>12</sup> <https://www.bbc.co.uk/news/uk-england-birmingham-25666605>

<https://www.westmidlands-pcc.gov.uk/transparency/bob-jones-archive/2014-bob-jones-news-archive/police-and-crime-commissioner-supports-mental-health-street-triage-pilot/>

Street Triage cuts detentions under Mental Health Act <https://www.birminghampost.co.uk/news/regional-affairs/street-triage-cuts-detentions-under-9527075>

been taken to a police cell in the last two years which has helped to reduce the strain on police resources.

- 3.296 We were told that progress in other areas was still to be confirmed with the National Mental Health Programme.
- 3.297 Although we have not seen evidence of the planning and developmental discussions, we have graded this as A, evidence of completeness, embeddedness and impact for the West Midlands, because it is clear that it exists and is having an impact in the West Midlands. It is much harder to assess progress across the country.

## Birmingham and Solihull NHS Foundation Trust

Recommendation 14	Grade
<p>The Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units.</p> <p><b>Priority 2</b></p>	A

- 3.298 The expected outcome was:
- Referrers understand the guidance for referral to PICU within the Trust, so that referrals for assessment are appropriately responded to.
- 3.299 The expected evidence of this implementation was:
- Records of internal discussions within the Trust to implement the recommendation.
  - Evidence of development of guidance.
  - Copy of guidance developed.
  - Evidence of checking guidance implemented (e.g. sampling files, case audits).
- 3.300 We were told that the Trust and HMP Birmingham Healthcare team have kept this recommendation under regular review. We have been provided with extracts of the minutes of the local HMP Birmingham Healthcare Local Clinical Governance Committee which demonstrates this oversight of actions.
- 3.301 We have seen the audits and re-audits of the implementation for the recommendations arising from the initial investigation. We have been provided with the Trust issued PICU guidelines to all prison healthcare services that have referred to BSMHFT PICU units in the past 3 years.
- 3.302 For these reasons this recommendation is graded A, evidence of completion, embeddedness and impact.

## NHS England

Recommendation 25	Grade
<p><b>NHS England</b> Should provide clear guidance for the ‘ownership’, commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries, so that local responsibilities are very clear.</p> <p><b>Priority 1</b></p>	D

3.303 The expected outcome was:

- Clear guidance available for organisations that clearly explains the commissioning and oversight of future very serious incident investigations that cross organisations and agency boundaries.

3.304 The expected evidence of this implementation was:

- Records of internal discussions within NHS England concerning this recommendation.
- Evidence of development of guidance (meetings, sharing of draft versions for comment etc).
- Copy of guidance developed.
- Evidence of dissemination and communication regarding this recommendation.

3.305 We were told that the NHS England Serious Incident Framework (SIF) (revised and published by NHS England in March 2015)<sup>13</sup> describes the process and procedure to help ensure Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. This framework includes clear guidance for the ownership, commissioning and oversight of all serious incident investigations.

3.306 We have also discovered that this recommendation should now be made for the patient safety team at NHS Improvement.

3.307 With regards to the SIF, we have concerns that it does not adequately and clearly describe the guidance for the ‘ownership’, commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries.

3.308 Page 24 , Section 2 of the guidance states:

<sup>13</sup> <https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incident-framework-upd2.pdf>

## **“2. ACCOUNTABILITY**

*The primary responsibility in relation to serious incidents is from the provider of the care to the people who are affected and/or their families/carers.*

*The key organisational accountability for serious incident management is from the provider in which the incident took place to the commissioner of the care in which the incident took place. Given this line of accountability, it follows that serious incidents must be reported to the organisation that commissioned the care in which the serious incident occurred.*

### **2.1. Involvement of multiple commissioners**

*In a complex commissioning landscape where multiple commissioners may commission services from multiple providers spanning local and regional geographical boundaries, this model (i.e. where providers report incidents to the commissioner holding the contract who then assumes responsibility for overseeing the response to the serious incident) is not always practicable so a more flexible approach is required. Commissioners must work collaboratively to agree how best to manage serious incidents for their services.*

*In all cases, a RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model should be agreed in relation to management of serious incidents (see Appendix 5 for further details). This will ensure that it is clear who is responsible for leading oversight of the investigation, where the accountability ultimately resides and who should be consulted and/or informed as part of the process. This allows the ‘accountable commissioner’, i.e. the commissioner holding the contract to clearly delegate responsibility for management of serious incident investigations to an appropriate alternative commissioning body, if that makes sense. It should be noted that this does not remove the overall accountability of the commissioner who holds the relevant contract.*

*The RASCI model supports the identification of a single ‘lead commissioner’ with responsibility for managing oversight of serious incidents within a particular provider. This means that a provider reports and engages with one single commissioning organisation who can then liaise with other commissioners as required. This approach is particularly useful where the ‘accountable commissioner’ is geographically remote from the provider (and therefore removed from other local systems and intelligence networks) and/or where multiple commissioners’ commission services from the same provider. It facilitates continuity in the management of serious incidents, removes ambiguity and therefore the risk of serious incidents being overlooked and reduces the likelihood of duplication where there is confusion regarding accountability and/or responsibility and general management of the serious incident process.*

### **2.2. Involvement of multiple providers**

*Often more than one organisation is involved in the care and service delivery in which a serious incident has occurred. The organisation that identifies the serious incident is responsible for recognising the need to alert other*

*providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.*

*All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate.*

*Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. Commissioners themselves should provide support in complex circumstances. Where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process.*

*Often in complex circumstances separate investigations are completed by the different provider organisations. Where this is the case organisations (providers and commissioners and external partners as required) must agree to consider cross boundary issues i.e. the gaps in the services that may lead to problems in care. The contributing factors and root causes of any problems identified must be fully explored in order to develop effective solutions to prevent recurrence. Those responsible for coordinating the investigation must ensure this takes place. This activity should culminate in the development of a single investigation report. Development, implementation and monitoring of subsequent action plans by the relevant organisations must be undertaken in line with guidance outlined in part three of this Framework.*

3.309 The relevant part of Section 3 states:

*“Commissioning organisations have a responsibility to work together to determine how best to manage oversight of serious incidents in all the services they commission, particularly where multiple commissioners commission services from the same provider and/or where commissioning teams may be geographically remote. Commissioners should establish a RASCI (‘Responsible, Accountable, Supporting, Consulted, Informed,’) model for the management of serious incidents in their commissioned services as set out in Appendix 5. A ‘lead commissioner’ role should be agreed in relation to serious incident management in providers with multiple commissioners in order to provide a clear communication channel between the provider and commissioning system.*

*As previously described, commissioners will typically manage serious incidents by overseeing investigations that are actually led and resourced by the provider(s) of care in which the serious incident occurred. However, in complex situations where multiple providers are involved or where the provider requires support with the investigation, commissioners may need to take a more hands-on approach to the investigation process itself”.*

3.310 This incident involved services commissioned by local CCG commissioners and NHS England Health and Justice Commissioners. It also crossed

organisational and jurisdictional boundaries, from NHS England to the Ministry of Justice.

- 3.311 Whilst the above guidance does say that “Commissioning organisations have a responsibility to work together to determine how best to manage oversight of serious incidents in all the services they commission” it does not clarify how oversight of national recommendation and those concerning other agencies and jurisdictions should be taken forward.
- 3.312 We are aware that the ownership of this action has been taken on by the Homicide lead for NHS England (Midlands and East) who is taking this action through the national Independent Investigation Governance Committee to link into the review of the Serious Incident Framework.
- 3.313 For these reasons we have graded this recommendations D, partially complete.

## 4. OVERALL ANALYSIS OF ACTION PLAN

- 4.1 The overall conclusion of the review is that nearly three quarter (72%) of the recommendations (i.e. 18 out of 25) are complete, and seven are partially complete.
- 4.2 We are able to give full assurance of completion, embeddedness and impact (i.e. Grade A) for two recommendations, Recommendation 11 (To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services); and Recommendation 14 (Birmingham and Solihull Mental Health NHS Foundation Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units).
- 4.3 Eleven recommendations are complete and embedded (Grade B), and seven recommendations are graded as complete (Grade C) and we have identified that seven recommendations (6, 7, 8, 13, 20, 21, and 25) are partially complete.
- 4.4 Of the ten Priority 1 recommendations, eight are complete (with one grade A, fully complete, embedded and with evidence of impact, and three complete and embedded) and two are partially complete. Eleven of the Priority 2 recommendations out of 13 are complete, with one grade A, and one Priority 3 recommendation is complete and one partially complete.
- 4.5 We also recognise that many of the actions will take much more time to complete than the six months after publication, and that for some of the actions, because they require wider multi-agency system changes, it will take even longer for the actions to become embedded and have the desired impact. We note that the process of addressing all the recommendations is well under way and we anticipate that many of the other recommendations will shortly be complete, embedded and with evidence of impact.
- 4.6 We note that all recommendations which only involve local NHS providers or commissioners are complete (with some being embedded and 2 with evidence of impact). However, those recommendations that must involve liaison with, and the cooperation of, other statutory bodies for completion (such as West Midlands Police, HM Prison Service or the Ministry of Justice) appear to require longer timescales to ensure cooperation and ownership of actions, which may account for more of these recommendations being partially complete. Notwithstanding this, progress is being made to address the outstanding issues and will be monitored through the MHOG, but this demonstrates some of the complexities involved in implementation of recommendations that cross organisational and jurisdictional boundaries.
- 4.7 This links directly to the final recommendation that is partially complete, Recommendation 25 which concerns the need for guidance around complex multi-agency investigations. This being addressed through a review of the NHS England Serious Incident Framework.

- 4.8 The overarching concern of the independent investigation report was that prisoners with ongoing mental health needs who were released early might not be able to access coordinated mental health care upon release.
- 4.9 We note the significant efforts of all concerned with this action plan, and especially the new programme of work being undertaken in partnership with the Ministry of Justice which has led to the development of the draft pathway.
- 4.10 However, despite this valuable work, this problem still remains a concern.

## *Appendix A: Table of Recommendations*

### **Black Country Partnership NHS Foundation Trust**

Recommendation 1: The Child and Family Service Operational Policy must provide clear guidance on how CAMHS clinicians are to work with other partner agencies and the young person's family in the assessment and support planning processes.

**Priority 2**

### **Black Country Partnership NHS Foundation Trust**

Recommendation 2: The Trust's revised Record Keeping Policy must include reference to the importance of documenting the details and the involvement of other involved agencies.

**Priority 2**

### **Black Country Partnership NHS Foundation Trust**

Recommendation 3: Black County Partnership NHS Foundation Trust should ensure that the CAMH services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family.

**Priority 2**

### **NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practices.**

Recommendation 4: NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practice members should share the learning from the initial investigation and roll out the enhanced safeguarding practices now implemented in Ps final GP practice.

**Priority 2**

### **NHS Sandwell and West Birmingham CCG and their member GP practices,**

Recommendation 5: NHS Sandwell and West Birmingham CCG and its member GP practices should review the systems they have in place to identify and support parents of children who have mental health problems to ensure that they are providing them with appropriate levels of support, including referral for a carer's assessment.

**Priority 2.**

### **West Midlands Police**

Recommendation 6: Before the decision is made by the police to remove safety and alert equipment from a victim of domestic violence West Midlands Police should ensure that a full risk assessment is undertaken to inform this decision. All relevant agencies and the victim should be involved in this assessment and decision.

**Priority 2**

### **HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**

Recommendation 7: Healthcare staff at both HMP Hewell and HMP Birmingham who are undertaking CPA and risk assessments should familiarise themselves with the Home Office 'Adolescent to Parent Violence and Abuse Guidance for Practitioners' (2015) and be categorising incidents of violence by children on a parent and/or carer as incidents of domestic abuse.

## **Priority 2**

### **HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**

Recommendation 8: Staff undertaking the initial Care Programme Approach Plan must ensure that they liaise with all agencies who have been involved with the prisoner, in the community and/or during the court process, in order to obtain an accurate profile of their needs and risks to themselves and others.

#### **Priority 1**

### **Black Country Partnership NHS Foundation Trust**

Recommendation 9: The new EHR must facilitate the recording of other agencies involvement and contact details.

#### **Priority 2**

### **Black Country Partnership NHS Foundation Trust**

Recommendation 10: The Trust should assure itself that the new DNA/ No Access Visit policies are complied with.

#### **Priority 2**

### **Department of Health, NHS England, CCGs and local Police and Crime Commissioners**

Recommendation 11: To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services.

#### **Priority 1**

### **HMP Hewell (Healthcare) and NHS England's Health and Justice Commissioning Team (North Midlands).**

Recommendation 12: NHS England's Health and Justice Commissioning Team (North Midlands) should discuss the findings of the original Trust report with the new provider of healthcare at HMP Hewell to ensure that implementation is still progressing and that lessons learnt are continuing to inform practices and policies.

#### **Priority 2**

### **HMP Hewell and HMP Birmingham**

Recommendation 13: Both HMP Hewell and HMP Birmingham introduce a requirement, supported by guidance, that all prison staff, including the governor's office and pastoral care services, should document any contact, either written or verbal, with prisoners' families in a prisoner's P-NOMIS record.

#### **Priority 3**

### **Birmingham and Solihull Mental Health NHS Foundation Trust**

Recommendation 14: The Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units.

#### **Priority 2**

### **NHS England Specialised Commissioning Health and Justice commissioners, prison health care providers and Ministry of Justice**

Recommendation 15 : The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve

discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services.

**Priority 1**

**HMP Birmingham (Healthcare) and Birmingham and Solihull Mental Health NHS Foundation Trust**

Recommendation 16: HMP Birmingham (Healthcare) should provide assurance to the Trust and their commissioners that the issues with SystemOne (accessing prisoner's full medical notes from the point of admission) have been resolved.

**Priority 2**

**NHS England Specialised Commissioning Health and Justice commissioners, prison health care providers, G4S and Ministry of Justice**

Recommendation 17: to consider what action can be taken to allow healthcare teams in prisons to have access to the prison records P-NOMIS.

**Priority 3**

**NHS England and Ministry of Justice**

Recommendation 18: To consider what protocols if any, within the current legislative framework can be developed and implemented to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs.

**Priority 1**

**HMP Hewell and HMP Birmingham, BCPFT, BSMHFT, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG, West Midlands Councils, West Midlands Ambulance Service, the Crown Prosecution Service.**

Recommendation 19: The named partner agencies should work collectively to 'sign off' the information sharing protocol as soon as possible, ensuring wider membership as much as practicable across the West Midlands public sector so long as this does not delay completion.

**Priority 1**

**West Midlands Police**

Recommendation 20: West Midlands' Police should formalise the involvement of family and carers within their policies and protocols, relating to information sharing.

**Priority 2**

**NHS England Specialised Commissioning Health and Justice commissioners, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).**

Recommendation 21: The above to seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release.

**Priority 1**

**Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)**

Recommendation 22: Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and homeless pathways are effectively utilised to identify and support young offenders being released into the community.

**Priority 1**

**Forward Thinking Birmingham and CrossCity CCG**

Recommendation 23: To ensure that the recommendations and lessons learnt from this incident continue to inform the development of services for vulnerable young people in contact with mental health and criminal justice services.

**Priority 1**

**All local and national organisations involved in this case and the implications of the recommendations (BCPFT, Care UK/ HMP Hewell (Healthcare), BSMHFT (PICU and HMP Birmingham (Healthcare), Forward Thinking Birmingham, West Midlands Police, NHS Birmingham South Central CCG, NHS Birmingham Crosscity CCG, NHS Sandwell and West Birmingham CCG Sandwell Social Services, Birmingham Safeguarding Adults Board, NHS England and HMP's Hewell and Birmingham**

Recommendation 24: There should be a local 'lessons learned' day, as soon as practicable, for each organisation to share with others an update on the progress made on the implementation of their action plans, seek clarification and share experiences. We also recommend that the outcome of the 'lessons learned day' is a shared understanding and agreement of how oversight of the recommendations made in this independent investigation will be taken forward, and which body is best placed with the appropriate authority to do this.

**Priority 1**

**NHS England**

Recommendation 25: Should provide clear guidance for the 'ownership', commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries, so that local responsibilities are very clear.

**Priority 1**

## *Appendix B: Terms of reference*

This case has been the subject of a Birmingham and Black Country wide Multi Agency Review, with resulting recommendations for the whole health economy and partner organisations. This Independent Investigation is intended to be a review of the outcomes of the multi-agency review, from a NHS perspective, to ensure that the recommendations and actions identified have been implemented and are being sustained.

The focus of the investigation will be on the present day services and current processes:

- Review the progress that the local NHS services have made in implementing the recommendations and the learning from the multiagency investigation.
- Review the progress of the national recommendations across partnership organisations and NHS England.
  - Review the care, treatment and services provided by the NHS from the service user's first contact with services to the time of their offence.
  - Review the appropriateness of the treatment of the service user in light of any identified health needs.
  - Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
  - Examine the effectiveness of the service user care plan including the involvement of the service user and the family.
  - Examine the referral arrangements and discharge procedures of the prison health services into the wider NHS services.
  - Review and assess compliance with local policies, national guidance and relevant statutory obligations.
  - Involve the families of both the victim and the perpetrator as fully as is considered appropriate.
  - Establish if this incident was predictable and preventable.
  - Provide a written report to NHS England that includes measurable and sustainable recommendations.
  - Assist NHS England in undertaking a brief post investigation evaluation.
  - Undertake a six month review of implementation of recommendations detailed in the report and produce a summary for the families.