Birmingham and Solihull Integrated Care System
Caring about healthier lives

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28 April 2023

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PRIVATE AND CONFIDENTIAL

Mrs Louise Hunt
Senior Coroner
Birmingham and Solihull Areas
The Birmingham and Solihull Coroners Court
Steelhouse Lane
Birmingham, B4 6BJ

Dear Ms Hunt

Leroy Patrick Hamilton - Response to Regulation 28 report to prevent future deaths

I write in response to the Regulation 28 Report dated 11th January 2023 which was issued following the inquest on the death of Mr Leroy Patrick Hamilton in December 2021. I note the narrative conclusion of the inquest was 'drowned whilst suffering an acute psychotic relapse' and that a Regulation 28 Report to Prevent Future Deaths has been issued in respect of this incident. I extend my sincere condolences to Mr Hamilton's family and loved ones.

You raised five matters for concern, three specifically relating to the provision of services by Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT), NHS Birmingham and Solihull ICB and University Hospitals Birmingham NHS foundation Trust (UHBFT) and two related to West Midlands Police.

Please accept this letter, authored by Birmingham and Solihull ICB in conjunction with both BSMHFT and UHBFT, in response to the concerns identified. The issues identified during the above inquest into Mr Hamilton's death, regarding the provision/resourcing of health care to acutely unwell people requiring mental health support are complex and the subject of significant review at both a national and regional level consequent to the current unprecedented demand for mental health services.

Lack of inpatient mental health beds and lack of Psychiatric Decisions Unit (PDU) spaces. Consideration is needed urgently to fund further mental health beds and PDU spaces to ensure patients are not kept unattended in extremely busy emergency departments.

This cohort of vulnerable people often, through necessity, initially attend at acute hospital Emergency Departments (ED) when in crisis. Initial assessment and subsequent placement into an appropriate therapeutic environment can take several hours resulting in the person waiting within the ED, which is busy and unsettling. This is a pathway of access into care that we as an ICS recognise does not provide a suitable experience for a person with an acute mental health (MH) crisis. It reflects the widely recognised need for further acute bedded capacity for the Birmingham and Solihull system; it is unfortunately usual

for the ICS to have many patients placed in beds out of area and managed within the community whilst awaiting access to a bed.

A Mental Health Provider Collaborative was formed April 2023 within Birmingham and Solihull ICS with responsibility for designing and delivering appropriate mental health services across the ICS. This collaborative is leading on the strategic cases to establish further bedded capacity, but we recognise that this will take time. The developing health infrastructure strategy for the local NHS will highlight additional inpatient mental health facilities as a priority for any bids for national capital.

As an ICS we, therefore, recognise the need to place significant focus on pathways for people with acute MH crisis to, whenever possible, ensure direction to the most appropriate pathway of care at first contact, thus avoiding the ED, and once within an ED to progress to definitive care as soon as possible.

Over this winter period the ICB have commissioned additional beds to aid flow through bedded capacity to enable step down ahead of discharge and to facilitate return into the system from out of area placement. There is also a considerable focus on flow through all MH bedded capacity, with a focus on overcoming delays in discharge of stable patients to maximise productivity of available capacity.

For patients known to MH services, support is already provided through their community teams, the crisis and home treatment teams with work in progress to further strengthen these support mechanisms. In addition there are plans to extend the Street Triage team and a focused project with West Midlands Ambulance Trust has introduced 'call before you convey' giving direct access to MH advice diverting people away from the ED to more appropriate pathways wherever possible. BSMHFT have recently appointed a Director of Urgent Care Transformation to lead all pathway changes.

The Psychiatric Decision Unit (PDU) based at Oleaster Unit in BSMHFT, has been commissioned for patients who have capacity, are able to consent to attend the PDU and who are assessed as "low risk". It is an ambulant assessment area which provides a calming environment for the assessment and development of treatment and pathway plans. As such it is not an admission area; it does not have beds within it. Like ED, there are no powers of detention for individuals accessing the PDU. There are six spaces (three male, three female) in the PDU. Processes implemented by the ICS help to divert suitable people to the PDU capacity rather than attendance at ED and the capacity is used regularly to take people from ED who meet the relevant criteria. However, it is recognised that review of the current PDU service is required; we need capacity that provides care for people with higher acuity of MH need, with clear pathways for access and onward care. As part of the review we will also be looking at the clinical support for PDU. As a system we recognise accessing help prior to coming to ED or PDU will be best for many patients.

Despite efforts to offer alternatives to people with known mental health issues, and to proactively support those in crisis, it is not possible to completely prevent attendance of people with acute MH crisis to the ED; personal behaviour will direct health seeking behaviour, and some people require assessment and treatment of physical health and MH needs (the latter through the embedded psychiatric liaison teams) before transfer to MH care. Where the person presents to the ED a system focus is applied to ensure that they are moved to the most appropriate environment as capacity allows in the shortest possible time.

Within the EDs, nursing staff complete a triage on all patients. When a patient presents with a MH issue, staff will complete an additional assessment, the 'Threshold Assessment Grid'. During this assessment, additional questions are asked to understand the risk of the patient to both themselves and others. Where a significant MH need is identified, this will be escalated to the nurse in charge for consideration of a high visibility cubicle and need for enhanced observation including the need for the request for a mental health nurse to 'special' the patient. Ongoing observations are then performed and level of risk is also escalated as needed to the liaison psychiatry team for an urgent assessment.

Initial assessment is performed by the liaison psychiatry team. The liaison psychiatry team aim to review all patients in ED within one hour of referral. If a suitable placement is available the person is moved to this as soon as possible.

Where admission or further assessment is required and there is no immediate admission destination available the person will sometimes remain in the ED whilst this is progressed. The care of such a person is escalated to the ICS Urgent and Emergency Care meetings which are held three to four times per day and discussed within BSMHFT bed meetings held twice daily. People may be transferred to the PDU during this period of waiting for a suitable placement if considered appropriate.

We recognise as an ICS that even with the introduction of the significant focus on pathways for individuals described above, the care for this group of people must remain a priority for us all. We have therefore established a system wide clinical oversight group to lead together this piece of work. This emphasizes joint ownership of care and pathways and will be a single liaison point with external agencies. Through the Mental Health Collaborative we are also ensuring that all work in this area is being streamlined and joined up under one programme linking clinical and operational elements along the whole pathway across all provider organisations. The clinical work programme includes an immediate adoption of jointly owned care standards across the pathway, with audit and learning against provided care, and exploration of different PDU models to meet ICS need. This group will report to ICS quality governance into the ICB Quality Committee as well as into individual provider quality oversight.

Consideration should be given to setting up a safe space where patients can wait for a bed or PDU space which is able to cater for their special needs and keep them safe.

We feel that the creation of a physical safe space, that is not a psychiatric hospital, where a person is admitted either informally or under Part 2 or Part 3 of the MHA 1983, within the ICS would not prevent a person in Mr Hamilton's circumstances from leaving the premises of an acute hospital.

In this context, however, we recognise the need to keep people safe within the environment we have. The actions outlined above focus on ensuring where possible, ED is avoided. When a person does present to ED, a structured process of care assesses an individual's need and provides care to this need when the person remains in the department. This time within the department is minimised by system ownership of the need to progress the person to a more suitable place of care as a matter of urgency within jointly owned care standards and regular escalations to progress onward care placement. This will remain a crucial focus whilst bedded capacity is expanded to meet the local need. We also ensure all system partners will communicate with each other as needed when our patients leave PDU or ED to provide maximum safeguards for our patients.

Multiagency protocol for informal missing patients.

BSMHFT and UHB both have Missing Patients Policies in place. These are single agency policies and it is recognised that there will be significant potential benefit in establishing a consistent system wide protocol across urgent care services for mental health patients who go missing, consistent with the National Framework Document ('The multi-agency response for adults missing from health and care settings' (Updated August 2021). A multi-agency agreement of this type defines roles and responsibilities, allows for consistency across services, and includes clear escalation pathways. This work will be led by the Mental Health Provider Collaborative with input from all system stakeholders.

I trust that the actions outlined above will provide the assurances you seek in respect of the matters of concern. We recognise that there is considerable work to be done and some of the aspects of this work will require input at a national level. We are conscious, therefore, that we have not been able to provide an action plan with detailed timelines. As an ICS we are, however, utterly committed to working together

to own jointly the pathways of care for patients with acute mental illness and ensure we use our currently available capacity as effectively as we can for individuals and the population.

Yours sincerely

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Chief Executive