NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

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Date: 4 September 2023

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Mr James Bennett
Area Coroner for Birmingham and Solihull
Steelhouse Lane,
BIRMINGHAM B4 6BJ

Dear Mr Bennett,

RE: Prevention of Future Deaths Report for Mr Peter Fleming (deceased)

Further to the Prevention of Future Deaths Report dated 14th July 2023, the Trust has now had an opportunity to review the Matters of Concern you have raised within the same. I would first like to begin by offering my sincere condolences to the Family of Mr Fleming for his very sad loss. As a Trust we have taken your concerns very seriously and have aim to act on these issues as quickly as possible to ensure lessons are learned to benefit other patients in the future. I will respond to each issue in turn;

1. **A continuing lack of resources to treat seriously mentally ill patients in Birmingham and Solihull**

As you will be aware, the Trust received a previous Prevention of Future Deaths report into this matter by Mrs Louise Hunt, which was responded to in April 2023. I attach a copy of this to set out the joint work that is currently being carried out alongside the Integrated Care System.

In addition to this we can highlight other areas where we are trying to assist with this as follows:

I. Places of Safety

Whilst it is best practice that a service user presenting with a mental health concerns is taken to a mental health Place of Safety, this could not be achieved on the particular day in question as all the mental health Places of Safety within the Trust were taken. However, Mr Fleming was conveyed to the Accident & Emergency Department at Heartlands Hospital which is an appropriate Place of Safety and indeed there are a number of A&E departments across the Birmimgham and Solihull area where service users can be taken too as Places of Safety. In terms of its own provision the Trust has three Places of Safety available across the organisation. The pressure on these facilities is multi-factorial. Work is ongoing in this area with the Police to streamline the s.136 process.

II. Care Coordinators

The Care Programme Approach (CPA) has had a central role in the planning and delivery of secondary care mental health services for the past 30 years. There is a recognition that principles were sound when initially introduced and implemented. It was associated with resource allocation, clinical care delivery and planning whilst being closely associated with risk management. The two main aspects of a CPA package of care involved allocation of a care coordinator and development of a care plan. It was also used as an overarching framework to join up health and social care assessments.

The CPA has been superseded by The Community Mental Health Framework (2019) which proposed replacing the CPA for community mental health services while retaining the sound theoretical principles of good care coordination and high-quality care planning**.** The focus is on shifting away from generic care coordination to a more meaningful intervention-based care. For there to be a named key worker with a clearer Multi Disciplinary Team approach, with a high quality co-produced, holistic personalised care and support planning. The Framework also focuses on better support for and involvement of carers and a more accessible, responsive and flexible system.

The use of a Dialog Plus Care Planning tool will be the foundational component of the framework to ensure the holistic identification of needs with allocation of the appropriate clinician within teams to support those needs to be met, to liaise with other professionals who need to input into care and to ensure the Action Plan is reviewed in a timely manner.

From March 2023 to April 2024 the Trust is in a transition phase of implementing the new Dialog Plus Care planning tool. Once this is completed, the required/recommended changes to the CPA Framework, will be reviewed (with learning from other organisations as part of the process) in line with NHS England Guidance and implementation.

The Local Authority will be addressing separately the point around Approved Mental Health Professionals.

2. Communication between specialist mental health teams is not effective and this caused delays

In preparation for our transition to the Patient Safety Incident Response Framework we have undertaken an analysis of data from various sources, with aim of looking for opportunities for improvement, areas where gaps in care and treatment/or incident types remain a concerns. As part of our Incident Response Plan we are proposing that fragmented working and poor communication is a safety priority for the organisation. It is anticipated that the Response Plan will be approved in October 2023.

By way of a general update on the Trust's management of PFDs going forward, the Associate Director of Nursing and Governance is currently undertaking a deep dive review of the last 2 years of Regulation 28 Reports. This will facilitate a detailed thematic review and learning exercise.

This work will subsequently feed into an overarching piece of work the Trust has already commenced pulling a variety of patient safety data sources together including SIs, Safeguarding Reviews, Complaints, Legal Claims, CQC, and Local Investigation information. This rich dataset will be formed into themes, and a QI approach taken to addressing the bigger and most impactful areas of required improvement.

Anticipated timelines for this work are below:

- The thematic review of PFDs will be completed in 8 weeks.
- The overarching review of multiple patient safety datasets and subsequent forming into themes and trends will be completed in 16 weeks.
- Formulation of the major QI workstreams will commence in 18 weeks' time.

3. Carbamazepine management indicating a problem with process and systems

A review of the RiO notes and discussions with the SI review lead and others highlighted that the patient has not been under a shared care arrangement and was discharged by BSMHFT back to their GP following non-attendance in 2012. The specialist advised the GP to prescribe carbamazepine in line with locally agreed practice, a letter was sent to the GP and acknowledged as received, but the GP stopped prescribing carbamazepine for reasons unknown. BSMHFT Home Treatment team re-started prescribing carbamazepine when the patient was admitted into their service.

Carbamazepine is on the Birmingham and Solihull IMOC formulary as an AMBER medicine, meaning that once a specialist has advised initiation of this medicine, any prescriber can prescribe it. There is no requirement for a shared care agreement for carbamazepine and there has never been a template for one. Communication is evidenced via clinical correspondence.

4. Communication between different health organisations is not as effective as it could be causing important information to be missed and delay in treatment occurring

Following the introduction of the shared electronic system across Birmingham, Sandwell and Solihull areas through Your Care Connected some years ago, the Trust could access some clinical information from primary care services. However, in the last 12 months this has been enhanced, and is now known as the Shared Care Platform. This allows a number of different organisations to access different clinical information across the system, including investigation results, thus improving the exchange of clinical information and thus improving patient care.

5. GP's are not able to proactively check patients are collecting prescribed medication due to excessive patient lists as a consequence of a lack of resources at a national level

The Trust cannot respond to this point and will leave this to others to respond to. If a patient is open to BSMHFT, our staff will regularly speak to the patient about all aspects of their care, including medication.

Yours sincerely,

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Chief Executive