Berkshire Healthcare
NHS Foundation Trust

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[redacted]

8th July 2024

Sir Adrian Fulford PC
His Majesty's Judge Coroner

Dear Sir

Inquests arising from the deaths in the Forbury Gardens terror attack of 20 June 2020; James Furlong, Joseph Ritchie-Bennett and David Wails

Regulation 28 Response – Berkshire Healthcare NHS Foundation Trust

I write on behalf of Berkshire Healthcare NHS Foundation Trust ("BHFT") further to the above inquests which took place between 15 January 2024 and 23 February 2024, and the Factual Findings delivered on 26 April 2024. I have set out below BHFT's response to the Regulation 28 Report dated 20 May 2024.

Introduction

BHFT acknowledges the Findings and Conclusions of the Inquests and has carefully reflected upon any failings or areas of concern that were highlighted. BHFT is grateful that Sir Adrian noted in his Regulation 28 report the promising changes made by our organisation since the events in July 2020. BHFT shares the view that it is of utmost importance that the effectiveness of the services and those changes are rigorously and regularly assessed.

As described by [redacted] in the written and oral evidence on behalf of the Trust, there has been a wholesale change in the framework for delivery of community mental health services and necessarily this is an evolutionary process. I wanted to therefore provide an update on the matters relevant to BHFT's services since February 2024 which demonstrate that BHFT continues to drive forward and monitor these improvements.

As an initial comment, the actions described herein are included in the BHFT audit programme where a review of progress on key topics is audited by an externally commissioned partner.

One Team / Care Coordination / Communication with other agencies

BHFT have continued the development of the One Team model as described in February and helpfully summarised in the Regulation 28 report. This is an ongoing and gradual roll out of associated changes to service delivery. There are monthly team updates and a number of engagement events that have taken place with BHFT staff, external stakeholders (such as local authorities in Berkshire, Primary Care Networks,

Voluntary, Community and Social Enterprise (VCSE) events, and local communities (including service users and carers)) to socialise the changes and take feedback from interested parties to influence the approach we are taking. The changes noted in the Regulation 28 evidence remain a clear focus and evaluating the impact of service changes will be measured over time.

The One Team model is being implemented in stages and the new One Assessment and multidisciplinary team post assessment place-based meetings (MDT) will be implemented with a gradual transition starting on July 8th 2024 with full roll out in August 2024. The One Assessment has been developed in response to feedback relating to referrals bouncing between services and was noted in the KS case where there were referrals between CPE, CRHTT, BTSS, CMHT, with no clear plan at times. The One Assessment is carried out by the local team. This is a full mental health assessment which captures all the details any team/ service may need to know. The assessment is available for all teams to access to prevent the patient from having to retell their story to each person they interact with.

This central assessment will provide the basis, and each time it's revisited, up-to-date information can be added. The post assessment review will have a range of professionals from Health, Adult Social Care and increasingly our (VCSE) sector and Lived Experience Practitioners (LExP) colleagues to help staff identify the most suitable interventions to address the assessed need. All mental health teams within a locality will work jointly for people in their area so the patient won't feel like they are bouncing between the teams. This puts the patient at the centre and the professionals come to them rather than the other way around. This could include how to support with stabilisation prior to any structured psychological intervention being able to commence.

For example, the PFD evidence described how Elmore Community Services had been commissioned by BHFT to provide community support (non-mental health treatment) for adult residents in Berkshire, with significant and/or enduring complex mental health needs, often associated with a diagnosis of personality disorder. The post assessment review would formalise a plan to engage with Elmore, potentially supported by a community connector.

Since February the Peer Support Network (LExPs) has been established and this would be an additional support that could help to engage the individual with short term stabilisation working towards a longer-term plan around more formal treatment interventions (e.g. trauma therapy).

The MDT will identify a named worker when agreeing individual plans for those referred into services. The named worker will be assigned to anyone who is opened to services and receiving treatment, and a named worker will be assigned to people awaiting treatment held on waiting lists. A workstream dedicated to defining the elements of the named worker role is established and the named key worker role will be formally rolled out in September 2024. As set out in the national guidance, there will be a named key worker for all service users open to BHFT services with a multidisciplinary team approach at Place (i.e. geographical locality) taking overall responsibility for coordinating care - this will be integrated with social care and VCSE and an example is offered above.

There will be a streamlined, holistic, personalised care and support plan, co-produced between the service user and the named key worker and regularly reviewed. A new risk form went live on 15 June 2024, and this is a more streamlined record of risk assessment that is easier to navigate for all clinicians involved.

More focus within this assessment has been given to risk to others. Alongside this more contemporary risk assessment is a new care plan format which will complement the risk assessment and is due to be launched in July 2024.

The MDT described above will agree a clear formulation which will help inform the care plan, as well as identify the best person to lead on the plan of care using the named key worker approach. Where mental health services are not indicated, a clear rationale will be communicated to referrers and any other relevant parties. Risk training has been reviewed and a new programme of risk training has started which will encapsulate elements discussed within this response and case studies based on real clinical cases will help to inform this training.

The direction of the changes will ensure that people referred back into services are considered in a timely manner and that would include the MDT decision around CMHT input. Our mental health services are moving away from the potential for a 'catch 22' dilemma as described in the Regulation 28 report, rather they will use the resources available to them to help support stabilisation, working closely with partners such as drug and alcohol services to maximise opportunities to support people to reach the stability required to engage in more formal therapies.

These changes offer more robust communications with other organisations such as sharing plans for patients that are offered care coordination as well as a clear rationale where CMHT decline care coordination. Multi-agency and multi-disciplinary forums will ensure information is not lost or misunderstood and holistic, trauma informed care plans are collaboratively created. This mechanism will also ensure needs are being met by the most appropriate service and expectations are realistic and clearly communicated.

In addition, BHFT Drug and Alcohol Lead chairs a COMAD (Co-occurring mental health, alcohol and drug) forum which is a cross agency group and includes all drug and alcohol service providers from the six localities in Berkshire alongside mental health services, including CMHTs. This forum has a shared learning focus, provides opportunity to discuss particular cases, and has helped to facilitate a shared understanding of each other's services and which services are, or are not, involved in a particular individual's care.

Escalation of differences between professionals

An escalation Standard Operating Procedure was produced for the Judge Coroner at the Inquests. Since the Inquests, escalation processes have been further aligned with the new One Team model. The MDT described above will enable shared decision making and where agreement cannot be reached this will be escalated to Heads of Service. An enhanced MDT can be arranged to support this process. On the rare occasion that the Head of Service decision and enhanced MDT is challenged, this will be escalated to the Clinical Director who will make the final decision regarding the plan. In addition to the Positive Risk Panel referred to in the inquest proceedings, an additional 'Harm to Others' MDT risk panel is being established. This is in recognition of the increasing awareness of vulnerable individuals who may not fit neatly into a forensic pathway but carry a level of risk. This panel will be made up of clinicians with experience of managing people with a risk of harming others and can offer expertise to inform care planning for this group. The Harm to Others MDT Risk Panel will be effective from July 2024.

BHFT Mental Health Service Dashboard

A Mental Health Service Dashboard will monitor impacts of the changes described through One Team in addition to existing national and internal processes, such as waiting list monitoring. A method of flagging cases that are referred into BHFT on more than three occasions over a year on the RIO system is being explored. These processes will allow Place level managers and performance managers to see what is working and what isn't to allow increased focus on any gaps. The new One Assessment means that CPE will manage any urgent responses if needed or short term need and those put through for a Place one assessment (routine) will now be subject to a collaborative MDT discussion straight after the assessment clinic (or within 1 working day) where rather than bounce around services to consider at another allocation meeting for teams, there will be representatives from all disciplines who can make a decision on that day, as described above. This should support an appropriate offer of something being agreed and avoiding the potential for exclusion. A monthly schedule of reviews has been designed to monitor impacts more broadly. Any risks that may emerge will be managed through existing processes escalating through Heads of Service, to Director, to Executive if necessary.

The Service User Network

The Service User Network (SUN) has been reviewed and data from 2020 to June 2024 indicates that there has been a 20.3% reduction in appointments with the crisis team, a 21.2% reduction in appointments at emergency departments, and a reduction of inpatient admission by 60.1% for this particular patient group. This suggests that the SUN model is effective and a more helpful approach to working with people who experience some of the personality difficulties and distress that KS experienced when he touched BHFT services.

Nurse Consultant Network

Our Nurse Consultant Network has expanded, and this has allowed for an enhanced focus on supporting our teams to improve clinical effectiveness across our inpatient and community services. The evidence presented at the Inquests described a pilot project between Probation and BHFT using Nurse Consultants as a conduit to offer a layer of decision-making where conflict arises. This project has now been evaluated. Recommendations have been made to Probation and BHFT are building upon the learning that has come from the Pilot. The Nurse Consultants will continue to offer this additional support to Probation colleagues, and the learning sessions delivered by the Nurse Consultants to Probation will continue twice yearly. Internally, BHFT sessions have been reviewed to reflect the findings of the project alongside the learning from these Inquests. Twice yearly ‘harm to others’ sessions will continue to facilitate ongoing learning and refresh for our staff, alongside shorter bespoke sessions for individual teams. The feedback from the Probation and BHFT sessions has been positive and has helped both to gain a better understanding of each other’s ways of working. The increased escalation processes that have come about following the early release scheme described below will also supplement these processes.

Reconnect Service & ECSL

Our Reconnect service has seen increasing numbers of service users over time and are playing a valuable role in bridging the gap between leaving prison and accessing the best community support to meet the needs of vulnerable people. Reconnect offers the bridge between prison, probation and health, and we have good evidence of those workers playing a key role in engaging prisoners prior to leaving prison, or soon after, with community services that best support their needs. For example, supporting people to attend housing appointments or drug and alcohol appointments. We have noted below the additional challenges that early release may bring alongside mitigations agreed with Probation colleagues. BHFT will be closely monitoring impacts and escalating concerns locally and nationally as they arise.

It should be noted that the End of Custody Supervised License (ECSL) and Probation reset which has been implemented since the Inquest proceedings, has been an additional driver to increase scrutiny of communications regarding people released from prison with mental health vulnerabilities. BHFT are engaged locally and nationally as the impact of these changes evolve. While these changes are not directly related to this case, it has provided an opportunity to double down the focus on inter-agency communication. To this end BHFT are working closely with Probation and Prison colleagues to establish additional escalation processes for this client group. A weekly multi-agency forum, chaired by Probation and attended by a range of partners including drug and alcohol providers and VCSE, has allowed for concerns to be raised in a timely way and share examples for learning across organisations. Probation colleagues have been responsive to working closely with us and agree shared escalation processes.

'Harm to Others' Steering Group

A 'Harm to Others' Steering Group has been set up internally within BHFT to focus specifically on this agenda and will supplement the work that was shared in PFD evidence presented at the inquest. Objectives of the steering group in include –

i) To agree areas of priority related to the harm to others agenda;
ii) To identify key data sources to identify gaps and measure progress;
iii) To agree any workstreams that need to support the work of this group (e.g. early release, probation pilot work, MAPPA processes/standard work);
iv) To oversee the progress and outputs of workstreams; and
v) To ensure effective communication to relevant stakeholders, internally and externally.

A quarterly oversight group has also been set up with senior Probation and Prison colleagues to continue this focus and allow for shared decision making, shared learning and consider together risks across organisations.

Strategic Planning

A broader piece of work, led by our Director of Specialist Mental Health Services, has reviewed data from a range of sources more recently to help inform strategic planning. This review has identified that there is a

cohort of men in Berkshire (predominantly Slough and Reading) who are affected by multiple inequalities (lack of stable housing, higher levels of deprivation, diagnosed serious mental illness) who also have overlaps with the criminal justice system and increased detention under the Mental Health Act. A case study has been developed by our Criminal Justice Liaison & Diversion (CJLD) service to highlight how early intervention can improve these health outcomes at an earlier stage, supporting engagement with support services, and improving life outcomes. This work will be built upon and conversations with other partners (e.g. the Police) to consider this particular cohort in terms of future early intervention work.

Entry / navigation between services

In addition to the community connector roles described in the Regulation 28 evidence, we now have an additional resource in our Common Point of Entry (CPE) by way of mental health Care Navigator roles. These workers help people to navigate the complex variety of support on offer within the community for people with mental health vulnerability.

The role of these practitioners is to support individuals that have been referred to mental health services, to access VCSE and external partner agencies where they may be best placed to support an individual's primary presenting problems or where there might not be an appropriate treatment pathway within BHFT. This includes access to services such as Drug and Alcohol support, debt advice and housing support. Where an individual requires more intensive support than the navigators can offer, they will bridge the individual into appropriate local services such as Berkshire Mind, Wokingham CAB project, drug and alcohol services, or the East Berkshire wellbeing service. This role has expanded within CPE and there are now 4 full time navigators. The support offer is also increasing with the Trust introducing direct access to non-clinical CBT programmes such as sleep, money worries and stress modules. This means the navigators can provide direct access to individuals using silver cloud which is a platform providing online CBT modules. Work is also underway to develop a trust wide service directory and social prescribing software that will mean clinicians across Berkshire will more easily be able to refer individuals to VSCE and partner agencies to support their psychosocial or low level psychological and engagement needs. The care navigators have supported over 500 people to access support since they started. That is primarily with just 2 of them as another 2 have just recently joined us. As a core role in CPE the navigators can escalate cases directly to clinicians where there are concerns of risk or escalating mental health needs.

A Peer Support Network is now established which aims to offer support to vulnerable people from others who have lived experience of mental health problems. The service is led by a team of Lived Experience Practitioners (LExPs). LExPs use their own lived experience of mental distress, alongside their training and professional experience of supporting others, to help service users achieve their personal recovery goals. All LExPs receive ongoing training and supervision to make sure that they are confident and competent in their role.

In addition, the Let's Connect service has also been established in Berkshire and is hosted by BHFT. Let's Connect is a social network to support the wellbeing of citizens over the age of 18 by connecting with each other, with organisations and services and with the many opportunities in our community. Those who join the network will bring their own strengths as well as gaining from the support of others, based on their own personal choices.

Transition between community / custody

Where individuals move between the community and custody, there will be greater proactive engagement with Prison and Probation colleagues both principally and on a case-by-case basis. Where someone receives a short sentence, it would be important to maintain CMHT input and involvement in planning for post release. For more lengthy sentences requiring ongoing mental health input in custody, they will transition from community (e.g. CMHT) to Prison Mental Health Services. In such situations, the named worker in the community will ensure that a handover takes place with prison colleagues. The Reconnect roles, as described above, will allow for easier transition back into CMHT's on release if required. Where CMHT input is not indicated, a clear rationale will be shared between relevant parties and our teams will support other organisations, such as probation, to understand the rationale and help them to navigate other more appropriate services if necessary. Clarity around responsibilities will be made explicit for all cases.

In addition, an option to include an automatic flag for people that have been referred into services over three times in a year is being explored with our RIO (electronic records) team. This would be an additional way to flag a review of these cases. Where these cases are flagged, an additional review of the case could be undertaken by Head of Service/MDT to ensure that all options have been fully explored.

Information sharing

BHFT recognises that we play a key role in sharing communications particularly around risk. While we are not responsible for the organisation of MAPPA meetings, we are committed to supporting these processes, ensuring that the right people attend the meetings and that we continue to have named representatives from each CMHT within BHFT. This attendance includes contributing to discussions/providing advice to MAPPA case discussions for those that may not be under CMHT. In addition, those named workers will act in a liaison role for inpatients and CRHTT. CRHTT and inpatient teams are less likely to be in a position to attend MAPPA, particularly at short notice, and CMHT representatives are best placed to communicate into and out of MAPPA where inpatient or CRHTT may have been involved in a case. We are active participants in a range of mental health collaboratives where other partners, including VCSE, people with lived experience, and carers, can escalate concerns, working together to inform strategy and direction, and agree priorities across Berkshire.

Within BHFT our Mental Health Transformation Board is chaired by our Director of Transformation and our Director of Strategic Planning oversees our partnership work. A recent VCSE workshop had 81 attendees to consider a shared vision of co-production. A commitment to regular meetings and a forum which will supplement existing collaboratives has been made.

We are disappointed that [redacted] on behalf of the British Red Cross did not feel that progress had been made regarding the impact of changes that are in progress, and we acknowledged in our evidence that it is early days in terms of transformational changes that will take place over a period of time. We have reached out to [redacted] to try and get a better understanding of the particular concerns of British Red Cross and hope that will help inform the broader range of ongoing work that we are undertaking with our VCSE partners. To date he has not responded to an initial approach. BHFT Director of Strategic Planning has advised that British Red Cross were included as a member in the BHFT VCSE task and finish group that

ran throughout 23/24 with oversight of the development of the BHFT VCSE strategy. She reports that they engaged in the first few meetings and then dropped out of attending. They would have continued to receive papers and would have been invited to attend the above VCSE conference however we do not have a record of them attending the conference. We will continue to reach out to British Red Cross as part of our wider VCSE engagement described above.

The Regulation 28 evidence outlined BHFT input into MAPPA processes as well as monitoring of key performance indicators which includes CMHT attendance. An escalation process is in place where any concerns around MAPPA attendance can be raised up to Director level. For example, a recent case was escalated where it was not clear that the named worker would be attending a MAPPA meeting. It was established that the worker had the meeting in his calendar and was intending to attend the meeting. This example suggests that escalation processes are working effectively.

Summary

BHFT takes the matters raised throughout the proceedings, the Judge Coroner's Findings and Regulation 28 report extremely seriously and is continuously working to improve its practice to provide the highest possible standard of care. Representatives from Berkshire Healthcare were present in court throughout the inquest to ensure that the learning from this matter was captured understood and disseminated.

The substantive changes and introduction of new services aim to promote the inclusive nature of mental health assistance in Berkshire and seek to avoid the *'not for our team'* exclusionary response perhaps illustrated in KS's case. Such offerings are to enable service users such as KS to build up better community links and support, which in turn may help to improve mental health stability to be in a position to be able to engage in the therapies relevant to addressing underlying difficulties and mitigating potential risks.

I hope that this response provides some measure of reassurance to HM Judge Coroner and the families of James Furlong, Joseph Ritchie-Bennett and David Wails.

Yours sincerely

[redacted]

[redacted]
Chief Executive