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NHS England

70 YEARS OF THE NHS 1948 - 2018

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Mr A. J. A. Rebello OBE
Senior Coroner
Liverpool and Wirral Coroner Area
Gerard Majella Courthouse
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24th May 2018

Dear Mr Rebello

Re: Report to Prevent Future Deaths (Regulation 28) concerning the death of Mr Anthony Paine, who died at HMP Liverpool on 19th February 2018.

Thank you for your letter and Regulation 28 Report ("Report") issued on Friday 23rd March 2018 which was received on Tuesday 27th March 2018 following the inquest into the death of Anthony Paine. I would like to express my deep sympathy to Mr Paine's' family.

In your report you raised concerns regarding:

1. The mental healthcare provision of HMP Liverpool provided by Lancashire Care NHS Foundation Trust, as being inadequate and insufficient and is not in parity with the provision in the community.
2. That Her Majesty's Prison and Probation Service (HMPPS), the Ministry of Justice ("MoJ") and NHS England are aware of this as evidenced by the number of fatal incident investigations that have occurred over the last few years.
3. When a prisoner experiences an enduring mental health illness for which he has a community mental health care plan, you ask, why there was not a Mental Health Act assessment and transfer to a secure mental health facility to keep him safe.

The provider of healthcare services in HMP Liverpool at the time of the incident was Lancashire Care NHS Foundation Trust ("LCFT") who served notice on their contract and are no longer providing services in HMP Liverpool with effect from 31st March 2018.

A procurement process has taken place and the contract has been awarded to Spectrum Community Health CiC ("Spectrum"), who currently provide healthcare across six prisons in the North of England. This contract commenced on 1st April 2018. Spectrum have subcontracted the Mental Health provision in HMP Liverpool to Mersey Care NHS Foundation Trust, who are also the current providers of the local community services for mental health and also the Liaison and Diversion service in Liverpool, ensuring a consistent approach to the continuity of care for people entering and leaving the criminal justice system.

NHS England (North) has reviewed the fatal incidents that have occurred in HMP Liverpool over the previous two years and are currently working with the new provider Spectrum to ensure that learning for health is evident from these deaths. The remedial action plans for previous deaths in custody are reviewed and managed as part of the quarterly contract review meetings. In the previous two years there have been twelve deaths in HMP Liverpool of which six have been considered as self-inflicted. Each death is regrettable and NHS England acknowledges are also potentially preventable.

In addition to the above, NHS England (North) has regular clinical quality visits which supports health commissioners to obtain assurance that all the recommendations from action plans have been adhered to and that, where required, practice has changed or improved. This will be evidenced by reviewing policies, procedures, reviewing practice and service delivery.

The NHS England Health and Justice Nursing and Quality Leads meet on a quarterly basis and review the learnings from deaths in custody reports. Once the independent investigation has been concluded into this death the report will be shared at the next meeting, following the report and action for national learning will be agreed and implemented. There are also opportunities within NHS England to share the learning from this report with other healthcare commissioners.

NHS England (North) currently have a multi-agency project board in place to oversee the smooth transition of change of the healthcare provider. Patient safety is a core feature of the project plan, which is monitored monthly by the project board. In addition, patient safety is embedded in the quality framework, which is reviewed and monitored quarterly as part of the quarterly contract review process, supported by quality assurance visits of the healthcare provision. The management of recommendations from previous death in custody reviews and Regulation 28 Prevent Future Death Reports will continue to be managed within the quality framework with the new provider, ensuring that they are accountable for the safety of patients within their care, and that learning from previous deaths is shared across the organisation.

NHS England (North) are awaiting the outcome of the independent investigation to determine whether the care provided to meet Mr Paine's mental healthcare was in accordance with his assessed need.

Nationally NHS England and its partners Ministry of Justice ("MoJ"), HMPPS, Public Health England ("PHE") and the Department of health and Social Care ("DHSC") have signed up to a revised National Partnership Agreement[1] (NPA) covering 2018 – 2021 for healthcare services in prisons. The partnership agreement on prison healthcare has been in place since 2013 and supports the commissioning and delivery of healthcare in English prisons. The revised NPA sets out our commitment to working together and sharing accountability for delivery through linked governance structures and core objectives and priorities for 2018 – 2021. Priority one is to continue to work collaboratively to improve

[1] https://www.gov.uk/guidance/healthcare-for-offenders

practice and reduce incidents of self-harm and self-inflicted deaths in the adult secure estate by strengthening multi-agency approaches to managing prisoners at serious risk of harm and further embedding shared learning.

Collectively, the partnership objectives are to improve health and reduce health inequalities; support rehabilitation and reduce reoffending, and enable continuity of care across health and justice care pathways.

Nationally NHS England is completing a programme of work to refresh all health and justice service specification, which the regional health commissioners procure services against. The mental health service specification refresh has been completed and published in March 2018. This refresh entailed redesigning the structure of the specifications to allow them to be more easily adapted to the defined needs of the individual prison population. The new provider, Spectrum has reviewed the new specifications and are currently benchmarking against them as part of the new model development work ongoing with partners at HMP Liverpool. We anticipate that this work will be completed by the end of June 2018.

In addition to the work NHE England is undertaking in partnership with HMPPS and PHE to improve and redesign services for people in prison with mental health needs we are revising the approaches to secure hospital transfers ensuring when a person needs to be in a hospital setting for their mental health needs this is done in a coherent, timely and appropriate manner. As part of this, a comprehensive ten-point plan "Right Care, Right Place, Right Time" for the transfer and remission of prisoners under the Mental Health Act is being developed.

I hope the information above addresses the concerns you have raised within your Report and provide you with assurances that NHS England is working with our healthcare providers to make improvements to the provision of healthcare in HMP Liverpool, and the wider prison estate.

Yours sincerely,

Professor Stephen Powis
National Medical Director
NHS England