NHS
Birmingham and Solihull
Clinical Commissioning Group

NHS Birmingham and Solihull CCG: Response to the Birmingham and Solihull Coroner's Regulation 28 reports to prevent future deaths

1. Introduction

1.1 This report provides a response to the Birmingham and Solihull Coroner, in respect of the seven Regulation 28 reports issued to NHS Birmingham and Solihull Clinical Commissioning Group (the CCG). These reports relate to the deaths of:

[redacted]

1.2 The CCG has taken the opportunity, as part of this investigation, to review its broader quality assurance processes and identify any learning outside the scope of the Regulation 28 reports. The CCG is aware that there are a number of other unexplained deaths/potential suicides, since the reports were received from the Coroner, which will be included into our analysis and further recommendations for action but which are excluded from this report.

2. Background and context

2.1 On 05 October 2018, the CCG received seven Regulation 28 Reports to Prevent Future Deaths from the Birmingham and Solihull Coroner. These deaths occurred over a four month period, between May and August 2018. One of the deceased had been under the care of services provided by Forward Thinking Birmingham (FTB) at the time of their death, with the other six being under the care of services provided by Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT).

2.2 The Regulation 28 reports were accompanied by letters from the medical directors of BSMHFT and Birmingham Women's and Children's NHS Foundation Trust on behalf of FTB. The letter from FTB highlighted pressures in mental health services, which they felt were caused by demand for services, coupled with a lack of funding. However, the letter from BSMHFT was explicit that they did not feel that funding was a contributing factor in these incidents.

2.3 The CCG commissions a range of health services for the population of Birmingham and Solihull. For mental health, this includes tiers one, two and three mental health services for children and young people aged under 25, and tiers one, two, three and four for adults.

2.4 The CCG commissions mental health services from both FTB and BSMHFT. FTB provides mental health services for people aged under 25 years old through a consortium of providers, with the CCG holding a contract with Birmingham Women's and Children's NHS Foundation Trust as the main provider of these services. BSMHFT provides mental health services for people aged 25 years old and over.

2.5 NHS England directly commissions specialised tier four inpatient mental health services for children and young people, specialised mental health services (e.g. eating disorders and services for the deaf), adult medium and high secure services, perinatal mental health, services for prisoners and services for the military and military veterans[1].

3. Contract management

3.1 The CCG commissions services from FTB and BSMHFT through NHS standard contracts. The standard contract sets out the required operational standards, as well as national and local quality requirements.

Contracts and provider performance are monitored by the CCG through a range of reports and meetings which include:

3.1.1 Monthly contract review meetings, which include oversight of performance, activity and quality.

3.1.2 A range of contractual key performance indicators and monthly and/or quarterly reports, which include data relating to patient experience, patient safety and clinical effectiveness.

3.1.3 In accordance with the NHS England Serious Incident Reporting Framework (2015), the reporting of serious incidents to the CCG within two days of the provider becoming aware that a serious incident has occurred.

3.1.4 Quarterly reporting from providers regarding their systems and processes for learning from deaths, as set out in the National Quality Board Publication: National Guidance on Learning from Deaths (2017).

[1] https://www.england.nhs.uk/commissioning/who-commissions-nhs-services/nhs-england/

3.1.5 In response to a Care Quality Commission (CQC) inspection report in February 2018 which found the FTB service to be inadequate[2], a Quality Improvement Board was established to oversee and provide assurance on the delivery of their CQC Improvement Action Plan and also the System Improvement Plan.

4. Quality monitoring

4.1 The CCG's approach to the management of quality is set out in the Birmingham and Solihull Quality Strategy 2017-2018, which was approved in July 2017.

4.2 Serious incidents that are reported to the CCG are collated into a weekly report which is reviewed for trends and issues that require escalation. Matters that need to be addressed are raised through the monthly contract review meetings; thereafter any urgent concerns are raised with the relevant provider, as a matter of priority, at a senior level.

4.3 In addition to the direct monitoring of contracts, the CCG reports on the contract meetings through Quality and Safety Committee and Finance and Performance Committee, both of which are sub-committees of the CCG Governing Body and have Governing Body membership. The Quality and Safety Committee routinely receives a quality and safety integrated report. This report analyses a number of quality indicators, including serious incidents, and highlights any areas of concern for discussion and escalation if required.

4.4 The CCG is a member of the NHS England West Midlands Quality Surveillance Group, covering Birmingham and the Black Country. The Group brings together different health and care partners, including the Care Quality Commission, NHS Improvement and Healthwatch. NHS England also operate a mortality leads meeting, which is attended by a representative of the CCG.

4.5 The CCG's independent internal auditors undertook a review of quality assurance mechanisms, which they reported in January 2018. This audit specifically reviewed the provider quality and performance review meetings in order to provide assurance that there were effective mechanisms in place to share recommendations, lessons learned and to monitor trends. The review concluded that there was 'significant assurance' that the mechanisms were appropriate and working effectively.

5. Understanding and responding to capacity and demand

5.1 Since 2016, the CCG (both in the current form and as three former CCGs, prior to the Birmingham and Solihull CCG merger on 01 April 2018) has taken a

[2] Available at https://www.cqc.org.uk/provider/RQ3/inspection-summary#mhchildrenandyoung

number of steps, with partner organisations, to understand and respond to concerns about capacity and demand within the local mental health system.

5.2 The CCG is committed to establishing and maintaining a mental health system which facilitates timely access to inpatient care for those who need it, whilst ensuring that community-based provision is adequately resourced to support recovery in the most appropriate environment. Part of this approach involves the CCG being an active partner in the Birmingham and Solihull Sustainability and Transformation Partnership (the STP), and the Mental Health Programme Delivery Board. The ambition of the STP is to achieve sustainability, through a strong focus on prevention and recovery.

5.3 The Mental Health Programme Delivery Board's plan of action includes a range of initiatives to deliver measurable changes for mental health services. This includes reducing the number of patients being placed in inpatient units that are out of the local area to zero by 2021. The plan is jointly owned by the CCG, Birmingham Women's and Children's NHS Foundation Trust, BSMHFT, Solihull Metropolitan Borough Council and Birmingham City Council. A 'zero suicide' ambition has been committed to, which is led by the local authorities' respective public health teams. This ambition will be supported by evidence based, preventative action and high-quality crisis support, as well as reducing stigma around mental health and improving access through early intervention services.

5.4 To date, the CCG's response to the increase in demand for mental health services has included:

5.4.1 An independent system simulation modelling exercise, which was jointly commissioned with FTB and BSMHFT, to develop an informed response on the best solutions to address the demand and where investment should be prioritised. This followed a sharp increase in demand for inpatient beds in 2016.

5.4.2 An independent review of patients' journeys into and out of inpatient mental health beds was commissioned by the STP. The review considered whether alternatives to admission could have been used and whether patients stayed in hospital longer than necessary. The review found that in both cases, improvements could be made to help avoid unnecessary admissions and reduce the time taken to discharge patients.

5.4.3 Supporting operational initiatives to reduce delayed transfers of care, where CCG funding of individual packages of care under Section 117 (jointly funded packages of health and social care) are required to facilitate discharge from hospital.

5.4.4 Weekly, and daily peak period, delayed discharge escalation calls with providers and local authority social work teams, in order to escalate any delays and for swift resolution.

5.4.5 Continuing to support the use of admissions to other NHS mental health trusts within the MERIT Vanguard[3] and to independent hospitals, where no locally commissioned beds are available, and an admission is deemed necessary.

5.4.6 Using evidence and data analysis to inform investment and approach.

5.4.7 Recognising that capacity is impacted by a wide range of factors and encouraging action at all levels across the mental health care pathway.

5.4.8 In 2017/18 providing additional investment in mental health services above the contract value amounting to £4,611,000 for BSMHFT (3.7% increase) and £6,235,000 for FTB (22.6% increase).

5.4.9 In 2018/19 providing additional investment in BSMHFT amounting to £3,117,000 (2.4% increase) and FTB amounting to £2,881,000 (9.3% increase).

5.4.10 This reflects growth of 3.03% in core mental health budgets, in accordance with the CCG's investment standard, which is above the national growth standard of 2.85%. See annexes one and two for further information.

5.5 There are many further initiatives underway, which are underpinned by performance monitoring, to make real improvements to local services. These include:

5.5.1 A number of discussions have taken place at contract level with FTB, regarding pressures on services and more patients accessing the service, and specifically the effect that this has had on inpatient care. As a result, there has been investment in the service over-and-above the contracted level, as detailed above.

5.5.1 The issue of funding was formally raised by FTB when they issued an activity query notice[4] on 14 September 2018, after the initial £1.4million that was invested by the CCG at the start of the year had been spent. This notice set out concerns about demand and capacity, in community (+10%) and inpatients (+1%). This resulted in a meeting taking place on 20 September 2018 and an action plan being jointly developed.

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[3] The MERIT Vanguard was supported through the Department of Health New Models of Care Programme. It is a partnership between four NHS mental health providers in the Midlands (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. The Vanguard has sought to improve crisis care through a more flexible use of bed stock across the region and by seeking to embed 'recovery principles' in practice.

[4] This is a formal contractual clause in the NHS contract that is used when there are significant changes to activity planning and management processes, which require either party to alert the other if there have been unusual changes in activity or referrals and allow for either party to issue an activity query notice, leading to a joint activity review, activity management plan or utilisation review.

5.5.2 It is acknowledged, through contract review meetings, there have been informal decisions with BSMHFT about funding and capacity. However, this has not been raised formally with the CCG.

5.5.3 In October 2018 BSMHFT developed a proposal for funding, via the Solihull Local Transformation Plan fund, for additional investment in the Solihull Early Intervention Team. This is currently being progressed.

6. Response to serious incident management

6.1 Serious incidents are managed in accordance with NHS England's serious incident reporting framework and are reported to the CCG by all providers, including FTB and BSMHFT, in accordance with the framework and their contractual requirements.

6.2 Reports are shared with key CCG staff, in real time, and considered through the CCG's Serious Incidents Group. Following the initial notification, the CCG can request an update at 72 hours on the immediate actions taken by the provider, and will be doing this for all reported deaths in the future.

6.3 Following initial management of the incident, the provider is required to submit a full root cause analysis (RCA) investigation report of the incident within 60 working days. Each RCA is quality assured by the CCG, through a multidisciplinary panel review, before being signed off. To improve the quality of RCAs and learning from adverse events the CCG will convene a second tier panel, with specialist clinical input, for review of serious incidents requiring clinical expertise.

6.4 To further strengthen the process for managing RCAs the CCG will produce a weekly serious incident report, which will be circulated to a wider group of nominated CCG clinicians and senior staff.

6.5 The CCG was aware of all of the seven deaths highlighted by the Coroner. All had been reported as serious incidents by FTB or BSMHFT. To date, the CCG has received four RCAs, which were received within the required timescales. However, two of the RCAs have been referred back to the provider for additional work to be carried out, as the CCG was not satisfied that all of the learning opportunities had been identified to prevent a recurrence. The remaining RCA reports are scheduled to be received by the CCG in November 2018, and will go through the same quality assurance process.

6.6 On 25 September 2018, the CCG's Quality and Safety Committee received the integrated quality and safety report, as part of its regular oversight of provider performance. The Committee identified there were a number of unexplained deaths/potential suicides, prior to receipt of the Coroner's letter and Regulation 28 reports. The Committee raised questions as to whether BSMHFT was an outlier in the region. The Committee will continue to monitor the situation and make recommendations, as appropriate, in response to any quality issues or concerns.

Should the investigation of these deaths reveal either a theme that needs to be addressed, or safety issues arising from the individual investigations, the Committee will consider the specific problem and identify any required actions.

6.7 In addition to the deaths that are the subject of the Regulation 28 reports, the CCG has become aware of a number of additional unexplained deaths/potential suicides, which are subject to current investigation. In response to this, the CCG's Medical Director and Chief Nurse held a meeting with the Medical Director of BSMHFT on 05 November 2018 to discuss BSMHFT's understanding of this and to also learn more about their oversight of risk assessments and care planning for patients who are not detained under the Mental Health Act.

7. Conclusion

7.1 The CCG aspires to there being no avoidable deaths in Birmingham and Solihull and takes every reported unexplained death very seriously. The CCG is continuously working with providers to improve the quality and safety of services, as well as looking at new and innovative ways to improve all mental health services.

7.2 The CCG has taken this opportunity to review the processes for managing serious incidents, but to also consider whether a shortage of funding may have contributed to these untimely deaths. The CCG has been unable to identify any correlation between funding and these deaths, but has recognised the need to continually improve its quality monitoring function and to also improve processes for learning from deaths at the earliest opportunity.

7.3 The CCG recognises the need to take a multiagency approach to the prevention of deaths, including creating robust partnerships with mental health support services e.g. substance abuse services, community intervention and crisis management. The CCG must also ensure that inpatient beds are maximised and available for those who need them.

7.4 There is a system wide recognition of the need to improve access to early intervention in mental health services to prevent mental health difficulties escalating, to reduce pressure on crisis services and to improve flow through the system thereby freeing up capacity. Equally, there needs to be improvement in the mechanisms for transfer of patients from crisis care to community support and care.

7.5 The system wide mental health commissioning strategy should be revisited and updated to ensure that resources are focussed on early intervention and support, as well as supporting those transferred to or being treated within community services.

7.6 The CCG will continue to keep under review the pressures on mental health services and the need to develop new initiatives to manage patient flow and improve services.

7.7 The CCG will analyse the outstanding RCAs that will be received in the near future, in relation to these deaths, to ensure that all necessary actions are implemented.

7.8 It is noted from the Coroner's letter and the Regulation 28 reports that under funding may be a contributing factor to these deaths. The CCG is still awaiting detailed investigation reports into all of the deaths. However, at this stage there is no evidence that a lack of funding contributed to the deaths of the individuals concerned. This has been confirmed by BSMHFT in their letter to the Coroner, dated 28 September 2018.

7.9 Notwithstanding this, the CCG recognises that there has been increased demand for mental health services since 2016, and has responded to this additional pressure with increased funding and through working with the FTB, BSMHFT and the STP to look at different ways of working throughout the system. The CCG will monitor the situation to ensure that all partnership working across Birmingham and Solihull is focussed on improving access and the quality of care.

7.10 The CCG has processes in place for monitoring and responding to individual serious incidents, as well as emerging trends and themes, which might indicate an underlying issue. It is recognised, however, that there is always a need to continually learn and improve. As a result of this investigation the CCG has made a number of recommendations in relation to its monitoring systems, which are detailed in section eight.

7.11 The CCG has identified a number of reported unexpected deaths/potential suicides in the period since the Regulation 28 reports have been issued, and is actively working with FTB and BSMHFT to understand the root causes of these deaths and any contributory factors. In addition, the CCG will work to improve the broader understanding of the local area's position, in terms of performance against comparable organisations, allowing for early identification of emerging changes in performance.

7.12 As part of this review into the seven Regulation 28 reports, the CCG has identified a number of areas where processes can be improved and these have been incorporated into the recommendations below. These recommendations incorporate system wide improvements, beyond the immediate situation and reports, and are consistent with our aims for improving the quality and safety of services.

7.13 The recommendations in this response should form part of the system's immediate response and longer term planning.

8. Recommendations

8.1 We intend to improve our learning from all mortality by implementing the following recommendations:

8.1.1 A comprehensive review of the CCG's serious incident reporting policy, including how the CCG manages serious incidents from reporting through to the close down of actions. This is to ensure that all actions to bring about improvements are implemented and there are clear early warning signs for director-led intervention.

8.1.2 Increasing primary care (general practice) reporting, with clear guidance on when there should be escalation through the CCG's serious incident process. This is to ensure that any deaths that occur outside of mental health services form part of the learning and review processes.

8.1.3 Undertaking an urgent review of the CCG's operational processes to ensure that appropriate and robust quality assurance mechanisms are in place.

8.1.4 Continuing to work with all providers, to address any deficiencies in RCA reports.

8.1.3 Improved scrutiny and challenge of learning from provider deaths processes.

8.1.5 Quantifying and understanding trends in mortality data and ensuring that there is a system in place for early identification of significant variation, which can be reported through the CCG's quality reports.

8.1.6 Ongoing monitoring of statistical data, which allows comparison with other similar organisations, in order to identify outliers.

8.1.7 Triangulation, with qualitative reviews, of mortality undertaken by individual organisations.

8.1.8 Improving communication and information sharing with oversight and regulatory bodies, to ensure that all relevant sources of information are used for early identification of emerging issues. This will include closer working with the Coroner, NHS England, Care Quality Commission, NHS Improvement and Health Education England.

8.1.9 Working with partners to help address challenges in recruiting and retaining staff, to ensure services are appropriately resourced.

8.1.10 Updating the system wide mental health commissioning strategy, including developing plans to reduce fragmentation of services and to ensure care is delivered in the most appropriate setting.

8.1.11 Working with our Local Authorities to ensure a suicide prevention strategy and plan is approved and implemented.

8.1.12 Ensuring action plans relating to learning from deaths and improvement plans for managing demand and capacity are incorporated into contracts as service delivery improvement plans.

8.1.13 The CCG, BSMHFT and FTB will work with the National Mental Health Support Team to undertake a diagnostic review of early help and intervention services, and thereafter develop a plan to address any issues raised.

Annex 1: Key milestones - July 2016 to October 2018

July 2016	Paper discussed at Mental Health System Strategy Board- this set out the issues in relation to capacity in the mental health system and proposed the joint commissioning an independent system simulation modelling exercise, to develop an informed response on the best solutions to address the demand and where investment should be prioritised.
Oct 2016	Mental Health Strategies are commissioned to undertake the system simulation modelling exercise.
Feb 2017	Interim report produced by Mental Health Strategies. £420,000 investment in community based personality disorder service, provided by BSMHFT.
May 2017	Final report produced by Mental Health Strategies, including key recommendations.
May 2017	Programme of work initiated, in response to recommendations.
July 2017	Additional inpatient bed capacity commissioned (investment of £2.44million BSMHFT and £2.56million FTB).
Nov 2017	Additional 32 bed capacity is mobilised via BSMHFT, for adults aged 18+.
Dec 2017	Changes to the Code of Practice to reduce detention under Section 136 of the Mental Health Act from 72 to 24 hours.
Jan 2018	£312,000 per annum recurrent investment in FTB to fund new pathway for people with a diagnosis of personality disorder and included funding for a clinical lead for personality disorder.
Feb 2018	CQC report published on FTB.
April 2018	Additional £700,000 invested in FTB community provision and further £1.4million investment above contract value in 2018/19. £60,000 invested recurrently in BSMHFT, to appoint a clinical lead for personality disorder. £110,000 non-recurrent investment across BSMHFT and FTB to test a model of primary care liaison to reduce referrals into secondary care.
June 2018	BSMHFT raise concerns about capacity verbally at Contract Review Group meeting (CRG). No further action taken by BSMHFT.
Sept 2018	CCG identify funds to increase staffing ratio in 'step up – step down' provision with Servol (voluntary care service) to accept a wider range of patients.

Sept 2018	Report to Programme Delivery Board detailing limited progress in relation to some key recommendations of system simulation report.
Sept 2018	FTB issue Activity Query Notice (AQN). CCG meet with FTB to discuss AQN.
Oct 2018	BSMHFT submit request for additional investment of £325,000 in Solihull Early Intervention Service per annum, via CRG meeting on 26 October 2018.

Annex 2

Increase in funding for BSMHFT

BSMHFT	**£000's**	**Increase**
Baseline 2017-18 (inc CQUIN)	124,885	
Inpatient Capacity	2,119	1.7%
Other Investments	2,492	2.0%
Total Investment 2017-18	**129,496**	**3.7%**

Baseline 2018-19 (inc CQUIN)	128,654	
Inpatient Capacity	1,633	1.3%
Other Investments	1,484	1.2%
Total Investment 2018-19	**131,771**	**2.4%**

Increase in funding for FTB

FTB	**£000's**	**Increase**
Baseline 2017-18 (inc CQUIN)	27,586	
Inpatient Capacity	4,254	15.4%
Other Investments	1,981	7.2%
Total Investment 2017-18	**33,821**	**22.6%**

FTB	**£000's**	**Increase**
Baseline 2018-19 (inc CQUIN)	30,889	
Inpatient Capacity	0	0.0%
Other Investments	2,881	9.3%
Total Investment 2017-18	**33,770**	**9.3%**