Independent Investigation Action Plan for AB Reference: 2020/5846

A statement from West London NHS Trust said:

"We extend our deepest condolences to family, friends and all of those impacted by this tragic case. Since this tragic incident we have addressed a number of issues to improve clinical practice in order to avoid incidents like this one happening again. This includes increasing the focus of our Integrated Network Teams on supporting people's mental health at the same time as their physical health and social care needs. "We will continue to work closely with other health, care and local authority sector agencies to make sure the recommendations made in this independent investigation are addressed and implemented".

Statement from NHS North West Integrated Care Board(ICB)

"NHS North West London Integrated Care Board is deeply saddened by this tragedy and wish to extend our condolences to the families, friends and all who have been affected by this incident. We are working with West London Trust to ensure that lessons from this report are fully embedded in their processes in order to reduce the likelihood of an incident like this happening again".

Statement from Ealing Social Services

"We would like to extend our sincerest condolences to all impacted by the events that led to such tragic conclusions. In the time that has passed since this incident, there have been a number of refinements made to our internal process - specifically as it pertains to information triangulation, contact and referral screening, and the appointment of a dedicated MASH Mental Health Advisor - to assist with our threshold application and decision making for children whose primary carers are, or may be neurodivergent or have mental health conditions. The effectiveness and governance of these endeavours will be independently overseen within our MASH Strategic Subgroup - which is a multiagency forum and extension of our Ealing Safeguarding Children Partnership. We are dedicated to working collaboratively with our stakeholders to ensure that the recommendations and learning generated by this investigation are essential priorities for our partnership"

Report published: 18 October 2023

Rec No.	Organisation	Recommendation	Actions to achieve recommendation	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
1	West London NHS Trust	WLT should examine the question as to whether a service user similar in presentation to AB might still fall into a gap between services. That is, the nonurgent pathway of care between the GP, Mental Health Integrated Network Team (MINT), Improving Access to Psychological Therapies (IAPT) and any other relevant service identified by WLT should be robustly tested, and any residual gaps identified.	To review the non-urgent pathway of care between the GP, MINT, IAPT et al, by considering a) the non-urgent waiting times for MINT services, and b) accessibility to MINT services	Clinical Director (CRMHS) and Clinical Director (PMS)	Commenced April 2022. With all of the CQC 'Should Dos' completed and 4 of the 7 CQC 'Must Dos' completed. The remaining Must Do actions, are all in motion and progressing well.	CQC MINT Action Plan MINT Services: - specifically good progress towards improved triaging and Single Point of Access services, resulting in better directing of individuals into appropriate care pathways; improved joint working between Primary Care Level - IAPT and Secondary Mental Health services within the MINT model (allowing increased number of touch points and interfacing); system and process in place to enable to identify individuals who have fallen off waiting lists/ follow-ups. Improved interface meetings between services now address threshold concerns. We have increased monitoring of incidents and related information related to MINT to identify areas for further review. The Trust has engaged RW Health, a consultancy firm with expertise in process improvement & business information, to improve the timeliness of referral to treatment commencing. The work streams include: • Stratification of risk & complexity • Managing unplanned care – improving our existing provision for patients contacting the service for support through an acute exacerbation of their condition. Increasing the speed of response and ensuring short term therapeutic interventions are linked into their long term care plan. This work includes digital solutions, like the testing of a new telephony system that allows callers to request a 'ring back', rather than waiting in a queue. • Improving triage processes – improving the triage process to ensure patients are directed to the right care first time. • Brief interventions – increasing the suite of therapeutic interventions that are available to patients, including additional group capacity for	Trust CQC Workgroup Meeting (bi-monthly); Trust Clinical Governance Group (Six monthly); Trust Quality Committee Annual 'Deep Dive' Reviews (last reviewed June 2023). Also, pathways of care / transitions are one of the Trust's Quality Priorities, including for both CRMHS and PMS.

						those who will benefit from it. There has also been significant work increase the proportion of patients who receive a clinical risk assessment, with 70% now having one in place and further work ongoing to improve the quality of safety plans to empower the patient to take action during acute exacerbations of their condition. Long term action plan to sustainable which started in April 2022, which will be completed - closely monitored by CQC and commissioners. The last progress report was provided to the CQC in October 2023.	
2	West London NHS Trust	WLT already have a CQC action plan in place that covers patient safety concerns in relation to non-urgent waiting times and access to MINT services. We are content for WLT to avoid duplication, and to reference progress against the relevant items of the CQC action plan in their action plan in response to this serious incident investigation.	To deliver the ongoing CQC MINT Action Plan, with specific focus on: Recruitment and Retention; Operational Delivery; Digital Improvement; Risk Mitigation and Referral To Treatment Pathways. The action is aligned directly with the ongoing transformation work taking place in partnership with system partners, including the local authority.	Clinical Director (CRMHS) and Clinical Director (PMS)	Commenced April 2022. With all of the CQC 'Should Dos' completed and 4 of the 7 CQC 'Must Dos' completed. The remaining Must Do actions, are all in motion and progressing well .	CQC MINT Action Plan. Specific progress already made on referral to treatment and quality improvement; electronic patient records and recording; and managing complex referrals. SystmOne Flags have been developed to expedite triage, assessment and prioritise intervention. This has enabled the service to have a more rigorous, assertive and pro-active case management system for users with complex or higher risk presentations. We have also updated relevant dashboards and trackers; Improved data capture on medical record systems and databases; Amended operational processes; Aligned MINT Operational Policy across teams; Reviewed DNA Policy / SOP; and Improved process to assess patient's appointment needs; along with Follow Up processes improvement. We have achieved an increased flow through services, allowing access to a wider range of community-based services and support. The electronic patient record systems allow improved visibility of our performance, including caseloads and waiting times. The MINT service has gone from a baseline of 200 WTE in July 2022 to over 300 currently, creating significant additional capacity for patient care. A task and finish group that reports into the Trust's Recruitment & Retention Board continue to support a reduction in the vacancy rate to further increase the capacity for patient care. We have already appointed key staff including a dedicated Associate Director for MINT, Lead Nurse for Quality and Safety, and new Head of Performance. We have also fully recruited to all Band 7 Mental Health Acute Response Service roles - 100% of Primary Care Networks. Work is underway to develop pathways for Complex Emotional Needs and review the role and activity within Complex Psychosis / Rehabilitation pathways. Recovery and Wellbeing College was relaunched and is now accepting self-referrals.	Trust CQC Workgroup Meeting (bi-monthly); Trust Clinical Governance Group (Six monthly); Trust Quality Committee Annual 'Deep Dive' Reviews (last reviewed June 2023).Note: Pathways of care / transitions are one of the Trust's Quality Priorities, including for both CRMHS and PMS.

3	**Ealing Social Services and West London NHS Trust**	ESS should work in partnership with WLT to ensure that information sharing and communication between the two agencies is robust, particularly in terms of ESS staff being confident in when and how to communicate concerns.	The implementation of a robust mechanism, created collaboratively with West London NHS Trust colleagues to support social workers and multiter managers with evidence based threshold application and inclusive planning for vulnerable children where primary carers have presenting mental health diagnoses or acute concerns about their emotional well-being. This pilot post will sit within Ealing's MASH, be referred to as the Designated MASH Metal Health Advisor, and go-live in August 2022 to bolster our holistic thinking about supporting vulnerable primary carers with mental health presentations. **Key Responsibilities of the MASH Mental Health Advisor:** Conduct research on health records for mostly Amber MASH referrals, but some Red and Green referrals may also be included. To advocate for children's and parents' mental health by sharing knowledge, analysis, and recommendations. Conduct research for updates and missing demographic/relationship information as requested by partner agencies. This ensures that referrals are completed correctly by other agencies, which is of great mutual benefit and allows for higher quality intelligence. Attending the 'High Risk' MASH meetings several times per week, depending on how many referrals come through the 'Front Door'. To attend operational MASH partner agency meetings. Attend strategy meetings or, if unable to, conduct research and provide it to the requesting manager via email. Attend monthly West London safeguarding meetings, face-to-face meetings, and other ad hoc meetings as needed. Gather evidence and data to prepare reports for the line manager.	Assistant Director - ECS Head of ECIRS MASH Mental Health Advisor	Completed: August 2022	**ESS** ESS were mentioned in the trust Loop newsletter; article 'Pilot of Mental Health Advisor role is proving a success' in the December 12th, 2022 issue. Furthermore, the mental health advisor pilot was highlighted as innovative and forward-thinking during our recent Ofsted Focused Visit in November 2022 inspection. In one case, the mental health advisor was able to provide information that resulted in the issuance of a court order to protect a child/family. Feedback from partner agencies continues to be incredibly positive, common themes include; -The information provided by the mental health advisor has quantifiably improved risk assessments for Ealing children and families - evidence through audit activity and performance reporting. -The quality, depth, and timeliness of mental health reports received by partner agencies has been widely praised and valued. -It has also been recognised that the pilot could serve as a model for other local authorities looking to improve their risk assessment and thus protect children outside of Ealing. There is improved collaborative working between WLT and ESS with a Revised Memorandum of Understanding in regards to information sharing between both organisations where joint responsibilities apply; and improved governance and escalation processes are now business as usual. The Independent Chair from Ealing Safeguarding Board has acknowledged that there has been positive improvements in multi-agency working through the Multi Agency Safeguarding Hub forums.	Robust multiagency audit activity and reciprocal feedback loops with families, lead professionals, and external stakeholders will assist us with evaluating the effectiveness of our approach to supporting primary carers with mental health presentations. Quarterly assurance reports will continue to be compiled by our MASH Mental Health Advisor, informed by performance reporting, to highlight the impact of the post on service delivery, multiagency planning, and holistic support for children whose primary carers have mental health needs. There will continue to be robust oversight of the function and purpose of the MASH Mental Health Advisors post by our ESCP Independent Chair and Scrutineer to ensure that there is impartial oversight of our arrangements.