Improvement Plan in response to recommendations outlined in the Independent Investigation into the Care and Treatment of P

28 November 2018

This is an update to an existing action plan which was produced following the publication of the independent investigation into the care and treatment of P. The investigation made 25 recommendations to improve practice. These have been given three levels of importance and priority and are graded from A-E is accordance to their completeness.

Individual organisations will be responsible for providing and publishing updates to their recommendations on their own websites in the future.

Grade	Criteria
A	Evidence of completeness, embeddedness and impact
B	Evidence of completeness and embeddedness
C	Evidence of completeness
D	Partially complete
E	Not enough evidence to say complete

Priority 1	The recommendations is considered fundamental in that it addresses issues that are essential to achieve systems/process objectives and without which, the delivery of safe and effective clinical care would in our view, be compromised.
Priority 2	The recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems/process objectives. The area of concern does not compromise the safety of patients but identifies important improvements in the delivery of care required.
Priority 3	The recommendation addresses areas that are not considered important to the achievement of systems/process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

	RECOMMENDATION	DCO/Health and Justice/CCG OVERSIGHT	ACCOUNTABLE LEAD	BY WHEN	PROGRESS as of 14 June 2017	GRADING as at 28 November 2018	FOLLOW UP ACTION REQUIRED post Quality Assurance Review	BY WHEN
1	**Black Country Partnership NHS Foundation Trust**							
	The Child and Family Service Operational Policy must provide clear guidance on how CAMHS clinicians are to work with other partner agencies and the young person's family in the assessment and support	Local Overseen by NHS Sandwell and West Birmingham	Joyce Fletcher Director of Nursing, Black Country Partnership NHS Foundation Trust	Completed August 2016	The Child and Family Service (CAFS) Operational Policy was last updated August 2016 and provides clear guidance to clinicians and staff who work within the services for children and young people on how they should work in	B	The results of these audits are now reported at the CYP Divisional Quality and Safety Group each month. Results of Q1 18/19 showed 97% compliance, which is evidence that this is implemented in practice Where results identify sub-optimal practice for any month, follow up	Complete and ongoing

	planning processes. Priority 2	CCG			partnership with the young person, their families and partner agencies. Regular audits are carried out to check implementation of the policy and monitored through the quality and safety structure within the Trust. Examples of this in practice include: • Current assessment paperwork takes into account the family's needs, and the operational policy recognises that the Trust is utilising Choice And Partnership Approach (CAPA) as a process. • Letters are sent out to schools and partner agencies as active engagement. The service works together in the Electronic Common Assessment Framework (ECAF), Team Around the Family, Care Programme Approach ,Child in Need and Child Protection and SEN processes.		action is taken through staff meetings, supervision and training offered as necessary for staff. In this way the Trust is able to demonstrate and evidence not only completeness, but embeddedness and impact.	
2	**Black Country Partnership NHS Foundation Trust**							

	The Trust's revised Record Keeping Policy must include reference to the importance of documenting the details and the involvement of other involved agencies. Priority 2	Local Overseen by NHS Sandwell and West Birmingham CCG	Joyce Fletcher Director of Nursing, Black Country Partnership NHS Foundation Trust	Completed October 2016	The Clinical Record Keeping Standards Policy was updated in October 2016 and is aligned to statutory, organisational and professional legislation and standards. The policy gives clear direction as to what information should be recorded and in what format, and clarifies responsibilities for confidentiality, setting out the principles governing the sharing of information. The policy also clarifies for staff the importance of documenting the details and the involvement of other involved agencies. Record Keeping audits are undertaken to check the implementation of the policy and reported through the Quality and Safety Structure within the Trust.	B	The results of these audits are now reported at the CYP Divisional Quality and Safety Group each month. Results of Q1 18/19 showed 97% compliance which is evidence that this is implemented in practice Where results identify sub-optimal practice for any month, follow up action is taken through staff meetings, supervision and training offered as necessary for staff. In this way the Trust is able to demonstrate and evidence not only completeness, but embeddedness and impact.	Complete and ongoing
3	**Black Country Partnership NHS Foundation Trust**							
	Black County Partnership NHS Foundation Trust should ensure that the CAMHs services are culturally sensitive to the needs of a patient and their families, and that they recognise and understand the potential impact of immigration on the family. Priority 2	Local Overseen by NHS Sandwell and West Birmingham CCG	Joyce Fletcher Director of Nursing, Black Country Partnership NHS Foundation Trust	Completed	There is a current Fairplay Strategy which incorporates the Equality, Diversity and Inclusion agenda. All staff attend Equality and Diversity training as part of Trust induction. Additionally: • The Trust identify if there is a language/interpreting need if indicated at pre-assessments and extended sessions are offered to support this need. Interpreters are booked as	B	The Trust's Equality and Inclusion Board will oversee the completion of audits to provide evidence that all Trust services are culturally sensitive to the needs of a patient and their families that they recognise and understand the potential impact of immigration on the family and this is fully embedded and operational. The results of these audits will be reported to the Trust's Equality and Inclusion Board.	31 March 2019

					necessary • The Trust has an Equality and Inclusion Board where representatives from all groups within the Trust report back on areas of good practice and developments, and areas where there may be potential challenges in providing services. This includes feedback from the Children Young People and Families (CYPF) representative to all service leads including CAMHs. • Members of the Equality and Inclusion Team attend the groups Quality and safety meetings to ensure diversity is embedded within the group and this will form part of the Quality and Safety agenda moving forward. • The Trusts Equality and Inclusion Board have set up a migrant Health Project Resource on the intranet to support staff in understanding the asylum and refugee process as it relates to health and care services that are provided within the Trust. This is available on the Intranet and staff have been alerted to this. • Regular ethnicity audits are carried out to ensure		Where results identify sub-optimal practice, follow up action is taken through staff meetings, supervision and training offered as necessary for staff. In this way the Trust will be able to demonstrate and evidence not only completeness, but embeddedness and impact	

					access to the service is representative of the population and this is built into the Divisional audit cycle.			
4	**NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practices.**							
	NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG and their GP practice members should share the learning from the initial investigation and roll out the enhanced safeguarding practices now implemented in Ps final GP practice. Priority 2	Local Overseen by NHS England West Midlands DCO	Michelle Carolan Deputy Chief Officer – Quality, NHS Sandwell and West Birmingham CCG Elaine Thompson Associate Chief Nurse and Quality Officer, NHS Birmingham CrossCity CCG	Completed January 2015	Learning from this case and the initial investigation in 2014 was shared widely across the health economy within Birmingham and Sandwell West Birmingham, including GP practices. Additionally the full initial investigation report, executive summary document and family statements were made available electronically on the NHS Birmingham CrossCity CCG website. • To promote awareness within GP Practices a Safeguarding Bulletin which made specific reference to this case was circulated in January 2015 and November 2015. • GPs have had ready access to attend regular scenario based Safeguarding Training events, and general learning lessons sessions from Serious Case Reviews (SCRs) which are informed by the key messages from this case. • To support enhanced safeguarding within primary care there are GP Safeguarding Champions in	B	Birmingham and Solihull CCG (formerly Birmingham Cross City CCG**)** will strengthen external evaluation of safeguarding processes within GP practices. This will involve the completion of the BSOL CCG Safeguarding (adults and children) Assurance Tool, engagement with lessons learnt arising from safeguarding case reviews and educational activity required to ensure the practice is fully compliant with the new legislation and guidance for safeguarding which will be required by all practices to comply with in the forthcoming year. Sandwell and West Birmingham CCG commission safeguarding expertise through BSol CCG to ensure a systematic and joint approach to safeguarding across Birmingham and will be subject to the completion of assurance tool, engagement with lessons learnt and educational activity as described above. GP safeguarding champions in post who work directly with GP practices continue to share learning and support best practice.	By March 2020 Complete and ongoing

					post who work directly with GP Practices to support the delivery of best practice.			
5	**NHS Sandwell and West Birmingham CCG and their member GP practices,**							
	NHS Sandwell and West Birmingham CCG and its member GP practices should review the systems they have in place to identify and support parents of children who have mental health problems to ensure that they are providing them with appropriate levels of support, including referral for a carer's assessment. Priority 2	Local Overseen by NHS England West Midlands DCO	Michelle Carolan Deputy Chief Officer - Quality, Sandwell and West Birmingham CCG	Completed In progress, to be completed October 2017	• Nationally there has been significant work to promote carer support, and this has included the development of Carers Registers within GP Practices, additionally the Royal College of General Practitioners has produced a range of Carer Support resources for GP practices. • GP Safeguarding Champions continue to promote the issue of support for carers, and encourage Carer's Assessment referrals within local practices. • In Sandwell and West Birmingham it is a requirement of the Primary Care Commissioning Framework for every GP practice to have a Carers	B	Sandwell and West Birmingham CCG Primary Care Commissioning Framework requires every GP practice to have a carers lead. This requirement is monitored via regular meetings and commissioning assurance visits.	Complete and ongoing

					Lead, and this is monitored through regular meetings and visits. • In respect to raising awareness regarding adolescent to parent violence and abuse, the Joint Safeguarding Team, which links with all the local CCGs, has included the key messages from the Home Office Information guide: adolescent to parent violence and abuse (APVA) within local scenario based training which has been delivered to GPs. • This guidance is also covered in the nationally approved Identification and Referral to Improve Safety programme (IRIS) training delivered to GP practices. IRIS is a general practice based domestic violence training and support programme that it endorsed by a number of organisations including the Royal College of Psychiatrists. All Birmingham and Sandwell CCGs are actively involved with IRIS. • The 2013 government definition of Domestic			

					Violence has been shared with GPs via training, bulletins, newsletters, GP forums and Practice Nurse Forums. • However despite all this positive work that has taken place to raise this locally, there is currently no comprehensive national electronic system in place to identify when either an individual is a parent, or indeed that they are a parent of a child with mental health problems. • Having reflected on the final version of this report NHS Sandwell and West Birmingham CCG and NHS Birmingham CrossCity CCG have agreed to form a short term working group that will working with relevant parties to: o Develop a short flowchart for Primary Care focusing onto what to do when concerns are raised by a relative or significant other that an individual may be experiencing mental health issues. o Develop 10 top questions to enable frontline staff to have a better sight of			

					risks and safeguarding concerns. ○ Develop additional guidance for Primary Care concerning how best to raise concerns and risks related to patients with mental health needs. These resources will then be cascaded across GP practices over Birmingham and Sandwell, and shared with NHS England for sharing more widely.			

6	**West Midlands Police**							
	Before the decision is made by the police to remove safety and alert equipment from a victim of domestic violence West Midlands Police should ensure that a full risk assessment is undertaken to inform this decision. All relevant agencies and the victim should be involved in this assessment and decision. Priority 2	Local Overseen by the Police and Crime Commissioner	Superintendent Sean Russell West Midlands Mental Health Commission	Completed April 2016	Since April 2016 a new domestic abuse alarm system has been introduced by West Midlands Police. The personal alarms are mobile, allowing them to be carried by anyone at risk, and therefore not necessarily limited to one per household. The alarms are trackable and linked directly to the Force's Control Centre, allowing a fast response to the correct location. Numerous officers and staff have been trained to give out the alarms to avoid delay or risk to victims and training is regularly refreshed. Deployment of the alarms is frequently reviewed and a full risk assessment in liaison with MARAC partners is carried out when an alarm is removed, in consultation with the victim.	D	This is well embedded practice within West Midlands Police. An audit will be undertaken to evidence the practice and to assure that all relevant agencies and the victim is involved in the assessment and decision.	31 March 2020
7	**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**							
	Healthcare staff at both HMP Hewell and HMP Birmingham who are undertaking a Care Programme Approach Plan (CPA) and risk assessments should familiarise themselves with the Home Office 'Adolescent to Parent Violence and Abuse	Local Overseen by NHS England Midlands and East.	Health and Justice Commissioners NHS England North Midlands Sarah Forrest, Head of Health and Justice Commissioning (NHS England	Completed June 2017	HMP Hewell: The Home Office guidance has been circulated. Practitioners have also attended violence risk assessment and Clinical Risk Management Training.	D	<u>HMP Hewell</u> Evidence of policy being re-shared to update existing staff and new employees Evidence of clinical risk management, safeguarding children training and safeguarding adult training content supplied	30 November 2018 Complete

	Guidance for Practitioners' (2015) and be categorising incidents of violence by children on a parent and/or carer as incidents of domestic abuse. Priority 2		North Midlands)	Due by October 2017	HMP Birmingham: The Home Office guidance has been circulated. In addition a study event by the Domestic Violence (DV) lead, covering all areas of DV, will be held before 30 September 17		Copy of mandatory training policy Quality return mandatory training statistics reviewed monthly. September data provided as evidence <u>HMP Birmingham</u> Evidence of policy being re-shared with staff to update existing staff and new employees Evidence of clinical risk management, safeguarding children training and safeguarding adult training supplied. Evidence of mandatory training policy supplied Quality return mandatory training statistics reviewed monthly. September data provided as evidence	Complete Ongoing 30 November 2018 30 November 2018 30 November 2018 Ongoing
8	**HMP Hewell (Healthcare) and HMP Birmingham (Healthcare)**							
	Staff undertaking the initial Care Programme Approach Plan (CPA) must ensure that they liaise with all agencies who have been involved with the prisoner in the community and/or during the court process, in order to obtain an accurate profile of their needs and risks to themselves and others. Priority 1	Local Overseen by NHS England Midlands and East	Health and Justice Commissioners NHS England North Midlands Sarah Forrest, Head of Health and Justice Commissioning (NHS England North Midlands	Completed	HMPs Hewell and Birmingham: Staff liaise with known external agencies when undertaking CPA plans. Performance will be assessed as part of the NHS England annual prison clinical quality visit process.	D	<u>HMP Hewell</u> CPA policy/guidance supplied 2018/19 Clinical quality visit report available with CPA considered 2019/20 visit report will include CPA review	30 November 2018 Complete 31 March 2020

				To be completed by Autumn 2018	NHS England Midlands and East – North Midlands: The new prison clinical IT functionality will connect prisons to the national spine when rolled out (12 months from go live) which will facilitate improved clinical information sharing on reception and on discharge. This is a national programme with roll out expected to commence in 2017.		<u>HMP Birmingham</u> CPA policy/guidance supplied 2018/19 Clinical quality visit report available with CPA considered 2019/20 visit report will include CPA review NHS England commission review of practice across Midlands prisons HMP Birmingham scheduled to go live HMP Hewell scheduled to go live	30 November 2018 Complete 31 March 2020 30 June 2019 31 March 2019 14 May 2019
9	**Black Country Partnership NHS Foundation Trust**							
	The new electronic health record (EHR) must facilitate the recording of other agencies involvement and contact details. Priority 2	Local Overseen by NHS Sandwell and West Birmingham CCG	Joyce Fletcher Director of Nursing, Black Country Partnership NHS Foundation Trust	Estimated timeframe - October 2017- October 2019	• The Trust has a system in place to ensure we record the involvement of other agencies in all clinical records. This process is audited through our quality and safety processes. We are currently piloting the electronic health record (EHR) and the move to an	B	The first server is scheduled to go live in May 2019 with all servers live by December 2019. Thereafter the Trust will be able to fully demonstrate the new electronic health record (EHR) is able to facilitate the recording of other agencies involvement and contact details.	31 January 2020

					EHR will enhance these systems. • The Criminal Justice Team is piloting the EHR, they are recording entries within all clinical notes, letters and assessments now onto the electric health records system which includes details of any additional agencies involved. All correspondence is scanned onto the system with electronic records and notes available to anyone using the system. • The EHR Pilot scheme is being overseen by Estates and Information Management and Technology Steering Group. As part of Transforming Care Together (TCT) there will be a review of the electronic systems to be used as a priority it must have the capacity to record the involvement of other agencies and contact details. Programme of EHR whole system development is planned to commence in Q3 17/18 and extend for 2 years subject to the aforementioned TCT arrangements.			
10	**Black Country Partnership NHS Foundation Trust**							

	The Trust should assure itself that the new DNA/ No Access Visit policies are complied with. Priority 2	Local Overseen by NHS Sandwell and West Birmingham CCG	Joyce Fletcher Director of Nursing, Black Country Partnership NHS Foundation Trust	Completed April 2017	Several DNA policies across the Trust Divisions have been introduced for both adults and children's services.: • Local systems have been introduced so services can monitor compliance with operational policies, this includes the use of performance packs/dashboards. For example Consultant DNA performance data sets across Sandwell CAMHS on a monthly basis. • There are regular reviews and communications from service managers /Matrons to staff via various means to ensure the policy is complied with and staff understand their role and how to apply the policy in practice. Regular reminders are circulated via local team meetings. • Compliance with policy forms part of workforce supervision as relevant to individual cases; including documentation of agreed actions.	B	Audits to be completed to provide evidence that the DNA Standard operating procedure is embedded and operational. The results of these audits will be reported at the CYP Divisional Quality and Safety Group. Where results identify sub-optimal practice for any month, follow up action is taken through staff meetings, supervision and training offered as necessary for staff. In this way the Trust will be able to demonstrate and evidence not only completeness, but embeddedness and impact	31 March 2019
11	**Department of Health, NHS England, CCGs and local Police and Crime Commissioners**							
	To work in partnership to roll out and further develop the street triage service to reduce the impact of mental health crises on local police and emergency services.	Local Overseen by NHS England West Midlands	CCGs/Local Police and Crime Commissioners	Completed January 2014	West Midlands Police established with Birmingham and Solihull Mental Health NHS Foundation Trust and West Midlands Ambulance Service a Street Triage	B	BSOL CCG – Street Triage performs a key role with the BSOL Mental Health Urgent Care Pathway. The CCG is working with partners to redesign the pathway to become age inclusive, to improve the experience	March 2020

	Priority 1	DCO			programme in January 2013. This programme initially funded by the Department of Health, has been rolled out as a business as usual across the West Midlands Police footprint with three schemes now being delivered. The benefits of having these three organisations together and sharing information for the benefit of the patient and wider safety of our communities has been realised and supported an improved quality of care and support.		of people in crisis and to make available a range options for people finding themselves in this position.	
12	**HMP Hewell (Healthcare) and NHS England's Health and Justice Commissioning Team (North Midlands).**							
	NHS England's Health and Justice Commissioning Team (North Midlands) should discuss the findings of the original Trust report with the new provider of healthcare at HMP Hewell to ensure that implementation is still progressing and that lessons learnt are continuing to inform practices and policies. Priority 2	Local Overseen by NHS England Midlands and East.	Health and Justice Commissioners NHS England North Midlands Sarah Forrest, Head of Health and Justice Commissioning (NHS England North Midlands)	Completed March 2017	The new Healthcare Provider at HMP Hewell has reviewed the original report and produced an updated action plan which will be reviewed every 2 months with NHS England.	C	Evidence of report being shared and discussed Schedule of remaining action plan updates Latest action plan update	Complete Complete 30 November 2018
13	**HMP Hewell and HMP Birmingham**							
	Both HMP Hewell and HMP Birmingham introduce a requirement, supported by guidance, that all prison staff, including the governor's office and pastoral care services,	Local Overseen by NHS England Midlands and East.	Ministry of Justice	Outstanding	NHS England has shared the report with the Ministry of Justice as the Government department responsible for prisons. Their response to this recommendation is awaited and will be included in this	D	HMP Hewell has communicated guidance around this recommendation to its staffing group via a Notice to Staff, issued in November 2018. This states "can all staff please ensure that they document any contact they have	Complete

	should document any contact, either written or verbal, with prisoners' families in a prisoner's P-NOMIS record. Priority 3	National Implications			improvement plan when received.		with prisoner's families on P-NOMIS. This is then easily accessible to all". Prior to this there had been no formal communication around this issue, but ad-hoc checks demonstrated that this was taking place prior to this Notice to Staff.	
14	**Birmingham and Solihull Mental Health NHS Foundation Trust**							
	The Trust should discuss their PICU guidance with all the prison health care services who refer to their PICU units. Priority 2	Local Overseen by NHS Birmingham CrossCity CCG	Sue Hartley Director of Nursing, NHS Birmingham CrossCity CCG	Completed May 2017	The Trust has issued PICU guidelines to all prison healthcare services that have referred to BSMHFT PICU units in the past 3 years.	A	Actions complete. No further actions required.	Complete
15	**NHS England Specialised Commissioning Health and Justice commissioners, Prison Healthcare Providers and Ministry of Justice**							
	The specialist health and justice commissioners, prison healthcare providers and the Ministry of Justice should work together to improve discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned, and produce clear guidelines for all healthcare staff to refer to other mental health services. Priority 1	National Implications to be progressed by NHS England Health and Justice National Team	Kate Davies, Director of Health and Justice, Armed Forces and Sexual Assault Services Commissioning Ministry of Justice	In progress - date to be agreed with MoJ	Prison Service Instruction (PSI) 2011/72 outlines the requirements of all prisoners who are to be released. Paragraph 2.47 states '*All prisoners must be examined by a healthcare practitioner during the 24 hours prior to discharge.'* NHS England Health and Justice and HMPPS are working together to consider ways of assuring compliance with this PSI. We will explore in partnership the scenarios under which issues of continuity of care can arise from unexpected events or decisions and consider what more can be done to provide assurance that risks are well managed as people transition from custodial care to care in the community.	B	Agenda, attendance and slides from Nov 2018 housing workshop Primary care workshop arranged Prison discharge pilot commenced at HMP Birmingham Commence prison discharge pilot at HMP Hewell Review pilot progress every 3 months New national prison mental health service specification rolled out across HMPs Birmingham and Hewell – includes new requirements for discharge and follow up	Complete 30 March 2019 Complete 31 June 2019 31 March 2020 31 April 2019

					NHS England Health and Justice central team have undertaken a piece of work to develop a national set of clinical template for SystmOne which includes pre-release planning and release/ transfer templates. These templates have been fully endorsed by the NHS England Health and Justice Clinical Reference Group and are reflective of NICE Guidelines and PSI 2011/72. A pilot of these templates will be taking place in August 2017 with full training and roll-out is anticipated in 2017.			
16	**HMP Birmingham (Healthcare) and Birmingham and Solihull Mental Health NHS Foundation Trust**							
	HMP Birmingham (Healthcare) should provide assurance to the Trust and their commissioners that the issues with SystmOne (accessing prisoner's full medical notes from the point of admission) have been resolved. Priority 2	Local Overseen by NHS England Midlands and East.	Health and Justice Commissioners NHS England North Midlands Sarah Forrest, Head of Health and Justice Commissioning (North Midlands)	Completed April 2017	• For prison to prison transfers the full SystmOne record is available if access rights and patient administration is appropriately completed. • North East London CSU has produced a brief user guide regarding access rights and administration which was shared with providers on 28 April 2017. • The annual prison quality assurance visit process run by NHS England considers this as part of the assurance process.	C	SystmOne user guide supplied 19/20 annual assurance visit report includes review HMP Birmingham dip audit completed	30 November 2018 31 March 2020 31 December 2019
17	**NHS England Specialised Commissioning Health and Justice commissioners, Prison Healthcare Providers, G4S and Ministry of Justice**							
	To consider what action can be taken to allow healthcare	National Implications to	Kate Davies, Director of Health	In progress - date to	It will not be appropriate to grant healthcare staff full	C	Agree information sharing template with MoJ and HMPPS	1 April 2019

	teams in prisons to have access to the prison records P-NOMIS. Priority 3	be progressed by NHS England Health and Justice National Team	and Justice, Armed Forces and Sexual Assault Services Commissioning Ministry of Justice	be agreed with MoJ	access to prisoner records on PNOMIS, nor would it be appropriate for custodial staff to access clinical patient records. However, NHS England Health and Justice and HMPPS are working together to consider a system whereby healthcare staff can access appropriate and relevant information on P-NOMIS, alongside work to promote better multi-disciplinary working.		Roll out of information sharing agreement across all Health and Justice commissioning teams	31 December 2019
18	**NHS England and Ministry of Justice**							
	To consider what protocols if any, within the current legislative framework can be developed and implemented to share relevant healthcare information about prisoners at risk of mental health problems who refuse consent to share information with GPs. Priority 1	Local Overseen by NHS England Midlands and East.	Health and Justice Commissioners NHS England North Midlands Sarah Forrest, Head of Health and Justice Commissioning (North Midlands) Kate Davies, Director of Health and Justice, Armed Forces and Sexual Assault Services Commissioning and MoJ	Completed December 2016	This issue relates to staff training and awareness rather than legislation and protocols. HMP Hewell: Training in confidentiality and information sharing was completed on the 2/3 November 20 16 and 1/2 December 2016 for all mental health staff. This is in addition to mandatory IG training HMP Birmingham: Staff participate in information governance training as part of their mandatory training. In addition data is discussed at local induction and in team meetings.	C	2018/19 IG compliance report provide by HMP Hewell and HMP Birmingham healthcare providers IG mandatory training checked during annual clinical quality visit Information sharing guides produced and shared with healthcare teams	30 April 2019 31 March 2020 31 March 2019
19	**HMP Hewell and HMP Birmingham, BCPFT, BSMHFT, NHS Birmingham South Central CCG, NHS Birmingham CrossCity CCG, NHS Sandwell and West Birmingham CCG, West Midlands Councils, West Midlands Ambulance Service, the Crown Prosecution Service.**							

	The named partner agencies should work collectively to 'sign off' the information sharing protocol as soon as possible, ensuring wider membership as much as practicable across the West Midlands public sector so long as this does not delay completion. Priority 1	Local NHS England Midlands and East, and NHS England West Midlands DCO Caldicott Guardian.	HMP Hewell and HMP Birmingham, BCPFT, BSMHFT, NHS Birmingham South Central CCG, NHS Birmingham CrossCity CCG, NHS Sandwell and West Birmingham CCG, West Midlands Councils, West Midlands Ambulance Service, the Crown Prosecution Service.	Completed October 2013 via Birmingham Safeguarding Adults Board and March 2017 via West Midlands Safeguarding Children's Procedures	There are robust information sharing protocols in place across the West Midlands in respect to both Adult Safeguarding and Children's Safeguarding. In Birmingham and Sandwell these information protocols are signed up to by all relevant local agencies including NHS provider trusts, NHS commissioners, Local Authorities, West Midlands Police Staffordshire and West Midlands Probation, the Care Quality Commission, West Midlands Fire Service, West Midlands Ambulance Service. With respect to information sharing there has been significant work undertaken across the West Midlands, for example the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT) is an initiative supported by NHS England has a focus on three priority areas: crisis care and reduction of risk, recovery and rehabilitation, and every day services. The vanguard aims to rapidly improve service quality, and increase efficiency, by adopting an IT system where clinical information can be accessed and shared across organisational boundaries	B	Information sharing protocols in place Once the electronic health record in BCPFT has been implemented each of the 4 mental health providers in the West Midlands will use the same information system which will further facilitate information sharing. The first server is scheduled to 'go live' in May 2019 with all servers live by December 2019	Complete 31 January 2020

					around the region. Currently there are 4 partners within the vanguard: 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, who together cover a population of 3.4 million. In relation to the involvement of the Crown Prosecution service and prison services, it is recognised that this is an issue greater than the local services and requires further national debate.			
				In progress completion date to be agreed nationally by Ministry of Justice and CPS				
20	**West Midlands Police**							
	West Midland's Police should formalise the involvement of family and carers within their policies and protocols, relating to information sharing. Priority 2	West Midlands Police	Sean Russell Superintendent West Midlands Police Mental Health Lead Information Governance Team	Completed March 2015 Triage February 2016 Alarm policy	• The work of West Midlands Police borders a large number of agencies and information sharing is essential to prevent crime, protect people and help those in need. The decisions about how much information to share, with whom and when, can have a profound impact on individuals. • West Midlands Police works with carers, family and friends of individuals to help them get the care	D	There is an approved Professional Practice policy (which is a national policy). This has been adopted into local practice. This practice will be audited to evidence implementation into practice.	31 March 2020

					and support they need. Sharing information with these people is generally done with the consent of the individual. There may be occasions when a decision to share information is made with individuals in response to an imminent threat or risk of significant harm. This may be done without consent in specific circumstances using a number of available legislative options. • In relation to people within mental health crisis, if the person lacks the mental capacity to make a decision about sharing information with key people, then the Mental Capacity Act is followed to ensure each decision to share information is in the person's best interests. Decisions and reasoning are recorded.			
21	**NHS England Specialised Commissioning Health and Justice commissioners, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare).**							
	The above to seek assurance that the current pathway for released prisoners with mental health problems ensures that those in need have access to appropriate mental health care after release Priority 1	Overseen by NHS England Midlands and East Regional Team	NHS England North Midlands Health and Justice Commissioners NHS England North Midlands DCO	In progress to be completed by July 2017	In the West Midlands CCGs commission appropriate services for ex-offenders with mental health problems to access. A piece of work is being undertaken by the current provider Forward Thinking Birmingham and NHS England Health and Justice	D	This is currently a national challenge however locally there is significant focus on this. It was agreed as part of the Local Criminal Justice Board (January 2018) and wider regional NHS Mental Health Alliance (March 2018) with support from the Minister that a group of experts would be established to look at the pathway	Ongoing during 2018 and 2019

			Sarah Forrest		Team to ensure that health services in prisons are fully aware of the available services and pathways and they have clear referral routes for 0-25 year olds. Assurance relating to this will be sought by NHS England through CCG assurance meetings. NHS England Health and Justice will also work with HMPPS, the prison operators, mental health providers, prison health providers and the CCGs to review processes into these services for unplanned releases.		for individuals who are experiencing poor mental health who enter/exit the justice system. A multiagency group with leadership from the West Midlands Combined Authority has been formed to review the justice pathway for individuals with mental health conditions The group undertook an appreciative enquiry exercise at their first meeting on 4th July 2018 and identified from this four task and finish groups: stakeholder/journey mapping and service directory design; co-location; experts by experience network; learning lessons approached. This work continues.	
22	**Forward Thinking Birmingham and HMP Birmingham (Healthcare) and HMP Hewell (Healthcare)**							
	Forward Thinking Birmingham, HMP Birmingham (Healthcare) and HMP Hewell (Healthcare) should review the new service provision, to ensure that the referral and pathways are effectively utilised to identify and support young offenders being released into the community. Priority 1	Local Overseen by Birmingham CrossCity CCG	Elaine Kirwan Deputy Director of Nursing, Forward Thinking Birmingham HMP Hewell and Birmingham Healthcare	In progress to be completed by July 2017	• In respect to Birmingham patients, Forward Thinking Birmingham have developed, and are following, a referral pathway way for 0-25 year old prison leavers, which sees the allocation of an Intensive Case Manager from the onset. • In order to raise awareness of this referral pathway Forward Thinking Birmingham are writing to all prison providers to alert them to the pathway and its content.	B	Meeting to be arranged with FTB and HMP Hewell to review pathway and service offer. Joint audit with FTB to be completed to review of a number of cases to ensure compliance with pathway to be undertaken – to be undertaken by YOS team	31 December 2018 30 September 2019

23	**Forward Thinking Birmingham and NHS Birmingham CrossCity CCG**							
	To ensure that the recommendations and lessons learnt from this incident continue to inform the development of services for vulnerable young people in contact with mental health and criminal justice services. Priority 1	Overseen by Birmingham CrossCity CCG	Elaine Kirwan Deputy Director of Nursing, Forward Thinking Birmingham	Completed June 2017	• Opened access to services through self-referral and 24-hour crisis support. Parents and carers can also receive support or make a referral to FTB through the Access Centre • Commissioned services from voluntary and community organisations which provide culturally relevant support to children, young people and young adults. This includes psychotherapy and counselling services with expertise in engaging BME young men, as well as mental health support for BME prison leavers • Pause Computer Club launched – 1 ½ hr workshop each week for migrants aged 12-18 to reduce isolation, build confidence and develop valuable skills	B	BSoL CCG – the CCG is working with partners to secure ongoing improvement to the mental health system at all tiers of care. This work is overseen by the Mental Health Programme Delivery Board BSoL CCG will ensure the learning is embedded into the monthly contract and quality review monitoring process, learning from SI and action plan tracking will be a standing agenda item Forward Thinking Birmingham – The service constantly evolves to fulfil the needs of its users. This is evidenced by the regular attendance of a senior member of the FTB team at the monthly commissioning meetings, where services and specifications are regularly issued, in order to ensure the service evolves and develops as needed.	Ongoing and Complete
24	**All local and national organisations involved in this case and the implications of the recommendations (BCPFT, Care UK/ HMP Hewell (Healthcare), BSMHFT (PICU and HMP Birmingham (Healthcare)), Forward Thinking Birmingham, West Midlands Police, NHS Birmingham South Central CCG, NHS Birmingham CrossCity CCG, NHS Sandwell and West Birmingham CCG Sandwell Social Services, Birmingham Safeguarding Adults Board, NHS England and HMPs Hewell and Birmingham**							
	There should be a local 'lessons learned' day, as soon as practicable, for each organisation to share with others an update on the progress made on the implementation of their action plans, seek	Local Overseen by NHS England Midlands and East	Jacqueline Barnes Director of Nursing and Quality, NHS England West Midland	In progress, to be completed by end September 2017	The planning for this lessons learnt event is underway and the date is likely to be post September 2017 dependent on the chairs availability. It will be chaired by Norman Lamb MP.	C	The learning lessons day was held on 6 September 2017 with the Rt. Honourable Norman Lamb MP as a keynote speaker. A Mental health Homicide Oversight group has been established. The inaugural meeting was held 8	Complete Complete

	clarification and share experiences. We also recommend that the outcome of the 'lessons learned day' is a shared understanding and agreement of how oversight of the recommendations made in this independent investigation will be taken forward, and which body is best placed with the appropriate authority to do this. Priority 1						November 2018. The terms of reference have been approved which include ensuring oversight of the delivery of recommendations and actions. This group will meet bi-monthly chaired by NHS ENGLAND	
25	**NHS England**							
	Should provide clear guidance for the 'ownership', commissioning and oversight of future very serious incident investigations that cross organisational and agency boundaries, so that local responsibilities are very clear. Priority 1	Overseen by NHS England Midlands and East Regional Investigations Team	Jacqueline Barnes Director of Nursing and Quality, NHS England West Midlands Mette Vognsen, Head of Independent Investigations, NHS England Midlands and East	Completed – March 2015	The Serious Incident Framework (revised and published by NHS England in March 2015) describes the process and procedure to help ensure Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. This framework includes clear guidance for the ownership, commissioning and oversight of all serious incident investigations and is readily available on the NHS England website https://www.england.nhs.uk/publications/reviews-and-reports/invest-reports/	D	Local ownership is established. The 2015 Serious Incident Framework is in the process of being review, the public consultation closed in June 2018 and NHS Improvement, owner of the guidance, is due to issue the updated version in the spring of 2019. The current guidance includes some guidance on the "ownership" of complex incident, but this could be more comprehensive. NHS Improvement to be alerted to this recommendation, and asked to incorporate clear guidance as part of the updated version. NHS Improvement to be alerted via the National Independent Investigations Governance Committee oversight of national recommendations from investigation reports.	13 December 2018