DHR-3 Action Plan

No	Recommendation	Start Date	Actions required to address recommendations	Lead agency Including Name / role of person with responsible for action	Key Milestones Achieved in enacting Recommendation	Expected End Date	Anticipated Outcomes of achieving recommendation (what will change) & measure(s) that will be used to evidence this
Middlesbrough Community Safety Partnership							
1	Middlesbrough Community Safety Partnership monitors the implementation of the Integrated Commissioning Model to assure itself that the issues identified in the way in which Kathie was dealt with have been eradicated.	April 2021	Implementation is overseen by Director of Adult Social Care and public health integration who sits on CSP and updates on progress. A system journey mapping exercise will be undertaken to understand if Integrated service model has addressed issues	Erik Scollay Director of Adult Social Care & Public Health Integration	Clear governance and lines of accountability	March 2022	Improved information sharing More effective risk management Increase engagement More coordinated response Case studies / Performance monitoring and reports
2	Middlesbrough Community Safety Partnership monitors the work of the MEAM Co-ordinator in order to establish if changes have been made	April 2021	System Change Coordinator appointed and MEAM strategic and Operational meeting developed	Jane Hill Strategic Community Safety Manager	Governance and leadership oversight over Middlesbrough MEAM work Cohort of vulnerable women identified	March 2021	Improved engagement with services Gender informed / trauma informed practice and services

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	to the system for vulnerable women.		MEAM strategic meeting reports into CSP Cases agreed to Test Innovation	Ruth Musicka Adult Social Care	Co-production work undertaken with service users with experience of systems		Review of policy and process Evidence base of what works Robust monitoring locally and nationally as part of MEAM network
Middlesbrough Recovering Together							
3.	That the risk assessment process should be improved to ensure that, when additional information becomes available the risk assessment should be revisited.		The risk assessment process has changed. Every relevant contact is recorded as a Service User Plan (SUP) update. The SUP is a combined plan to identify and manage goals and risk. All contacts with the service user, or in their absence but containing relevant information, are recorded in this way.	MRT partnership	More robust risk assessment	Completed	Implemented 2019.
4.	That clearer documentation is introduced to demonstrate the consideration of the risk posed by a potential client and the decision making process.		SUP reviews are created after each interaction with a person accessing MRT which would review any changes in risk. RAP (formerly MDT) information is added weekly to the individuals case	MRT partnership	Documentation developed which clearly identified risk and records professional judgment.	Completed	Implemented 2019/2020.

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			records and included discussions around risk and decision making.				
Foundations							
5.	That Foundations undertakes refresher training with all staff about MARAC aims and procedures.		Refresher MARAC training provided to team	Elaine Sherrick	Staff are familiar and understand MARAC process	November 2020	Staff attendance in completing training. MARAC addressed where necessary in supervision.
Recovery Connections							
6.	That a review of case recording is undertaken by Recovery Connections and training should be considered for all staff to ensure a consistent approach across the organisation.		Case note recording quality checked by line manager and through clinical audits. Detailed entries include factual contact information including telephone communication.	Regional Manager Team Leads Operational staff A review was undertaken and now Line Managers Reviews case every 4-6 weeks as part of supervision arrangements. Clinical audits are also	CQC rating of good for the Safe KLOE included case note recording as part of the assessment	Ongoing	Any dip in quality of case note recording will be identified in file audits. Case note training for new staff at induction, is in place. Line management and supervision ensure case recording is of a consistent high standard and evidence of this is recorded in supervision notes and case audit reports.

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				completed every 4-6 Weeks which dip sample cases and are checked against approved guidance. Any dips in case recording are identified and addressed by line management in 1-2-1 supervision or immediately when needed.			
7.	That Recovery Connections review the process for contact/escalation to other statutory services outside of non-working hours, particularly at weekends and cascade this to all Recovery Connections staff.		After completing internal training around systems mapping and partnership working, as well as continuing to attend the statutory external safeguarding training provided my Middlesbrough council. All staff are now aware of the procedures for	Regional Manager Team Leads Operational staff	Safeguarding level 3 training has been delivered to all staff.	Ongoing	All Incident reporting is escalated to line management and signed off by CQC registered manager. This records and provides evidence when cases have been escalated to safeguarding team and statutory services.

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			contacting the police out of normal working hours. Our on call manager rota ensures managers are always available to support.				
8.	That a review of the effectiveness of the pathway is undertaken.		A more direct route or information with NPS would be beneficial.	Regional Manager Team Leads Operational staff & partner agencies	NPS/CRC sharing all information relating to risk with recovery connections/MRT when referring someone in	Ongoing	The rehab admissions panel now has a more comprehensive understanding of peoples risk, as NPS is now sharing all historic risk when referring in someone. RC now ensures risk information has been requested and fully explored
9.	That the risk assessment process should be improved to ensure that, a comprehensive risk assessment is undertaken and is reviewed periodically particularly if additional information becomes available		Referral to the rehab is carried out by Care Coordinator (CGL) readiness and suitability is considered prior to the referral to RC based on the comprehensive assessment and risk information. Risk reviews provided by CGL form the basis for individual risk assessments; this information is taken	Regional Manager Team Leads Operational staff .	An improvement in the quality of information received from partner agencies. The process of someone entering residential rehab consists of a readiness tool that has been adapted since the incident. The tool specifically now explores or gives all agencies involved the opportunity to share any concerns they have around risk	Ongoing	A better risk review can now take place, now that NPS are willing to share risk information on people they refer in or people who self-refer but have had contact with the CJS in the past. Staff will explore risk for everyone wither they are currently involved with the CJS or have been in the past.

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			from service user's self-disclosure and information sharing between other services including probation, accommodation providers and mental health services. This is taken to the multi service meeting which discusses possible rehab residents. We have built on this by including a readiness tool completed by the prehab worker investigating current client information. All information gathered is added to the Criis system when received, this is available to be viewed 24hrs a day and reviewed weekly prior to a client entering rehab at the RAP meetings (formerly MDT) Individual information on each person discussed is added to their Criis		relating to the individual and the risk they can potentially pose to people in the rehab or who may come into the rehab whilst they are a resident		

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			records and recorded in the meeting minutes.				
10.	That clearer documentation is introduced to demonstrate the consideration of the risk posed by a potential client, including risk to themselves, others and the community and professional judgement and decision making in relation to this is documented.		SUP reviews are created after each interaction with a person accessing MRT part of this process would be updating the relevant domains which would highlight any changes in risk. RAP (formerly MDT) information is added weekly to the individuals Case records.	Regional Manager Team Leads Operational staff & partners	Documentation used is not designed by RC and forms part of the CRiiS record at partnership level.	Ongoing	Recovery connections can only assess the risk on the information they are provided. Previously not all risk was shared with RC from partners (inc NPS). This has now changed, NPS are now willing to share risk on all referral, whether they have been involved with the CJS previously or currently on licence.
Cleveland Police							
11	That weapons markers are always placed on subjects following arrest or conviction, where appropriate.		Weapons markers are now routinely added to both PNC and the Niche Intelligence system following arrest or conviction.	DI David Glass	Conducted as a result of the initial DHR submission and noted operationally during incidents since this time.	Completed	Achieved
12	That a review is undertaken of MARAC to establish if the aims of the changes have been met and the quality of MARAC and MATAC has improved.		Internal review completed by DCI Galloway as a result of the incident. This resulted in dedicated staffing and raised awareness throughout the Force area.	DCI Jayne Downes	Internal and external review to be completed. Further internal Coordinator role to be in place imminently.	Ongoing. Internal review completed following incident. External review now completed	Internal and external review to be completed. Further internal Coordinator role to be in place.

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			External review completed recently by Safer Lives in consultation with the Local Authority and DCI Downes – recommendations are to be implemented. Dedicated MARAC/MATAC internal Coordinator role funded by PCC's Office and recruitment process ongoing.				
DTV CRC							
13	That the Operational Minimum Standards (OMS) for all practitioners are monitored by each manager in supervision with each staff member every month.		Operational minimum standards introduced Standardised supervision agenda introduced Monthly supervision mandated OMS management	Kay Nicolson Head of Area Quality and Development Team Operational Managers within Offender Management	- Develop and produce standards based on high quality outcomes - Develop set supervision agenda - Introduce via team meetings and briefings - Publish on intranet - Develop MIS report with IT department to	Completed April 2019	Action completed in timescale and ongoing monitoring mechanisms in place to sustain progress

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			information developed to QA of supervision processes undertaken		monitor compliance with OMS - Introduce MIS report to operational managers - Monitor via Operational Meetings and in supervision on a monthly basis - Produce performance information - Address compliance via Quality Team initiatives or organisational processes.		
14	That current MARAC processes across DTV CRC are reviewed and that a standardised approach is introduced.		Review of all MARAC processes Development of principles and guidance based on best practice Publication and Implementation of guidance	Kay Nicolson Head of area Quality and Development Team	-Review completed identifying core processes -Principles developed and incorporated into wider domestic abuse strategy -Review of cases undertaken as part of the Quality Assurance Framework	Completed October 2019	Action completed within timescale. Quality Assurance Framework ongoing cycle of assessment and development via caseload quality assurance mechanism including domestic abuse thematic.

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			Review of practice to ensure approach embedded		-Domestic abuse thematic undertaken by Quality Team		
GP practice for both the victim and the perpetrator							
15	That the quality of primary care documentation includes any discussion with the patient relating to alcohol misuse and any subsequent actions such as referrals and risk assessment.		Awareness within practices raised around quality of documentation, there is evidence of discussions around alcohol dependency and engagement with alcohol services including detox programmes.	Practice Managers and Practice Safeguarding GPs		Completed	Clear information available and evidence of on-going monitoring and appropriate onward referral.
16	That information is included in the 'relationships' section on partners (including ex-partner, children and other family members).		Next of kin details are updated and when any safeguarding adult/child or vulnerable patient identified the practice screen for any dependants or people living with them.	Practice Managers and Practice Safeguarding GPs		Completed	Updating and linking records (where appropriate) will assist with the risk assessment process.
17	That the practice explores processes that support risk assessments of patients who are known to have alcohol (and other) dependency and the impact on relationships and parenting ability. This		All staff trained in safeguarding (adult/child) and aware of impact of relationships and parenting ability – therefore mental	Practice Managers and Practice Safeguarding GPs		Completed	Promotion of 'Think family' Improved child protection processes

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	should also provide an opportunity to assess if further support could be given to improve the management of their dependency and promote positive outcomes.		health management is offered to patient and if children involved then various formats from Early Help to Child Safeguarding are available and used by the practice				
18	That all practice staff are up to date and competent with safeguarding training		Mandatory training is completed and software in place to make sure staff always up to date	Practice Managers and Practice Safeguarding GPs		Completed	Improved knowledge base and understanding of safeguarding
19	That a Domestic Abuse Policy is developed for the GP practice and that this is audited to assess the knowledge of staff in relation to domestic abuse		Practice currently have domestic abuse training as well as safeguarding training. Policies are in place.	Practice Managers and Practice Safeguarding GPs		Complete	Improved awareness of domestic abuse
20	That consideration is given to how MARAC information can be shared with GP practices so that practices can consider if it is appropriate for primary care records to be coded and flagged to identify potential risk to others.		Awareness is present for MARAC information and when to add to notes and when to create alert and when to hide certain information based on clinical needs	Practice Managers and Practice Safeguarding GPs	MARAC information is recorded on systems	Complete	More effective risk management Practice staff aware of any potential risks posed by patient to staff
ST CCG							

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21	That consideration is given to how the learning from the DHR is disseminated to other GP practices in the area.		CCG hold primary care training sessions which includes information sharing around DHRs and lessons learnt.	CCG Named Safeguarding Doctors	Shared learning between different practices and local authority areas	Complete	Lessons learnt around DHRs are shared within primary care across Tees Valley
Adult Social Care							
22	That outcome information from the police, and other agencies, should be sought within agreed timeframes.		1. Review of operating procedure with Cleveland Police to establish agreed timescale 2.Updating of process to implement timescale 3.Implement audit process to confirm consistency	Erik Scollay Director of Adult Social Care & Public Health Integration	1.Establish task and finish group with Cleveland Police	Jan 2022	Information to inform decisions / assessment is requested in a timely way
23	That every case has a contact point – a person who provides a level of oversight of the case	Apr 2021	1.All cases allocated a contact point by as part of process of recording first contact on care management system	Erik Scollay Director of Adult Social Care & Public Health Integration	1.Review of care management processes to confirm required steps	Nov 2021 Completed	**Action complete** – all cases allocated to an individual as part of process of recording first contact on electronic care management system
24	That when information or a referral is received it should be cross referenced by a qualified social worker with previous history and consideration for any action required. This should be	Apr 2021	1.All new cases to include cross-referencing of historic information as part of process of recording first contact on care management system	Erik Scollay Director of Adult Social Care & Public Health Integration	1.Review of care management processes to confirm required steps 2.Establishment and review of audit process	Nov 2021 Completed	**Action complete** – all cases are under the oversight of a an experienced Social Worker/ Team Manager as part of the process of recording first contact on

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	discussed with a senior worker when necessary.		2.Implement audit process to confirm consistency				electronic care management system

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