**Mr J homicide (Mr J - NICHE) action plan – December 2021**

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| **STEIS** | 2018/23654 |
| **Datix** | 82793 |

This action plan has been developed to address the recommendations from an independent quality assurance review of KMPT’s Root Cause Analysis investigation into the care and treatment provided to Mr J before his index offence in September 2018. The quality assurance review was commissioned by NHS England in line with national policy and conducted by NICHE, 2021. Mr J was open to KMPT services at the time of the incident.

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| **Improvement plan owner:** |  |
| **Implementation monitoring:** | Trust Wide Patient Safety and Mortality Review Group |
| **Executive approval:** | Executive Management Team |
| **Executive sponsor:** | Executive Director of Nursing, AHPs and Quality |
| **Reporting to:** | Quality Committee |

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| **Reviews and updates** |
| 01/12/2021 | Action plan developed in response to NHSE’s request to develop actions from recommendations from the final draft of the independent quality assurance review. |
| 11/01/2022 | Action detail and evidence coordinated by central patient safety team and action plan added to |
| 25/02/2022 | Evidence added |
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| **RAG KEY:** | |
| **Green** | **Complete** |
| **Amber** | **In progress** |
| **Red** | **Overdue** |

| **RAG** | **NICHE RECOMMENDATIONS** | **ACTIONS TO BE TAKEN** | **PERSON RESPONSIBLE** | **TARGET COMPLETION DATE** | **EVIDENCE TO BE PROVIDED** | **PROGRESS TO DATE** |
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|  | 1. The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHSE (London) investigation guidance issues in April 2019 on engaging with families after a mental health homicide. | * 1. Review the national guidance in relation to engaging of families after homicide and update the SI Policy and Duty of Candour Policy.   1.2 Complete an audit of the next three homicide RCAs that have been completed after the update policies are in place. If there are not three homicide RCAs in the 18 months after development of polices, to extend completion date, but meanwhile audit those that have been completed. | AO, Head of Patient Safety and CMcL, SI and Complaints investigation Lead  AO, Head of Patient Safety and CMcL, SI and Complaints investigation Lead | 30/06/2022  31/12/2023 or earlier | SI Policy  Duty of Candour Policy  Paper submitted to Trust-wide Patient Safety and Quality Committee |  |
|  | 1. The Trust must provide assurance to their commissioners that appropriate, timely and effective action is being taken to complete and embed the learning from the outstanding recommendations in their internal investigation relating to this case. | * 1. Overdue actions from the RCA to be reviewed and closed.   2. Action plan and evidence to be presented to Trust-wide Patient Safety and Mortality Review Group for approval to close.   3. Action plan and evidence to be provided to the CCG. | CC, Service Manager for Early Interventions in Psychosis Service  Care Group Patient Safety Leads  AO, Head of Patient Safety | 31/10/2020  08/03/2022  11/02/2022 (Within one month of agreed closure at Trust-wide Patient Safety and Mortality Review Group) | Evidence of each closed action on Datix.  Trust-wide Patient Safety and Mortality Review Group minutes uploaded to Datix  Email sent to CCG and uploaded to Datix. | Completed 05/11/2020  This was presented at the July 2020 meeting, but at that time there remained one outstanding action. This was taken and presented to TWPS&MRG on 11/01/2022. |
|  | 1. The trust must provide assurance to their commissioners and the Board that within the early intervention in psychosis service risk assessment and risk management plan are completed, reviewed, updated and documented in accordance with organisational policy. | 3.1 Quality of risk summaries reviewed every 2 months via CliQ Checks  3.2 Accuracy and quality of risk information and its reflection in the care plan reviewed every 2 months via CliQ Checks  3.3 CliQ action plan owners to ensure that all risk related actions are fully completed within one month  3.4 Risk summary training has been provided to all relevant EIS staff. Clinical Quality Manager to work with relevant professional leads in highlighting any staff who continue to have difficulties in completing a high-quality risk summary and reflecting this in the care plan | Clinical Quality Manager (CRSS)  Clinical Quality Manager (CRSS)  EIP Service Manager  Clinical Quality Manager (CRSS)  Head and Deputy Head of Nursing  Lead and Deputy AHP Lead | 3.1, 3.2 & 3.3 Actions are on a rolling programme  Evidence can be provided 31/03/2022  31/03/2022 | CliQ results  CliQ results  EIS governance meeting minutes  Training slides and confirmation from quality lead | Evidence 3.1 & 3.4    Training slides |
|  | 1. The trust must ensure that where appropriate, the Dual Diagnosis Policy is understood and actively implemented by clinical staff. | * 1. New Kent and Medway Joint Working Protocol for Co-occurring Mental Health and Substance Misuse Disorders to be developed.   2. New Kent and Medway Joint Working Protocol for Co-occurring Mental Health and Substance Misuse Disorders to be accessible to all KMPT staff   .   * 1. Co-occurring Conditions Training to be delivered   2. New 2022 Co-occurring Conditions Policy to be shared with all EIP staff when ratified.   3. Recruit a Substance Misuse Lead for EIP services and Substance Misuse Workers for each locality.   4. Vacant co-occurring conditions project manager post to be filled. This role will be critical in evaluating the implementation of the protocol by all agencies. This role is managed by public health and funded by the CCG. | Head of Service –Community Recovery Specialist Services  Head of Service –Community Recovery Specialist Services  Head of Service –Community Recovery Specialist Services  EIP Service Manager  EIP Service Manager  Head of Service –Community Recovery Specialist Services | 31/12/2021  30/04/2022  30/04/2022  31/01/2022  30/06/2022  30/04/2022 | Protocol  Evidence of distribution Trust wide  Attendance list  Business meeting minutes and governance meeting minutes.  Job descriptions and start date of staff.  Confirmation that post has been recruited to | Accessible to all KMPT staff  <http://i-connect.kmpt.nhs.uk/document-library/joint-working-protocol-for-co-occurring-mental-health-and-substance-misuse-disorders/284>  Discussed in detail in Community recovery care group patient safety meeting.    Co-occurring Conditions Training has been delivered to KMPT staff.  Training was delivered by Alcohol Change UK to nominated KMPT staff working in community teams between July 2021-March 2022)  L&D have provided training records for 84 members of staff who have currently completed the training (18/02/2022)  There is one more course running in March 2022 that has 22 members of staff booked.  Shared with EIP East      Shared with EIP West |
|  | 1. The Trust must provide assurance to the Board and its commissioners that formal operational procedures exist for all services and that those procedures have been reviewed within the appropriate timeframe in accordance with the Trust’s own policy on the management of policies. | 5.1 Publication of the newly approved “Development, Approval and Management of Formal Trust Documents - Policy and Procedures”  5.2 All Committees’ workplans to include reporting of policy status (frequency and timing to be agreed by Committee)  5.3 Annual report to the Trust’s Audit and Risk Committee on the adequacy and compliance with “Development, Approval and Management of Formal Trust Documents - Policy and Procedures” | TS, Trust Secretariat  Committee Chairs  Trust Secretary | End of January 2022  June 2022  Dec 2022 | Policy  Committee workplans  Annual report | Published in w/c 3rd January 2022 |