Appendix 2

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Mr D homicide action plan – JANUARY 2020

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 D before his index offence in May 2017. The quality assurance review was commissioned by NHS England in line with national policy and conducted by Mazars, 2019. Mr D was known to KMPT services from 2015 to 2017 but discharged at the time of the incident.

Improvement plan owner:	Deputy Chief Operating Officer (Community and Acute Care Groups)
Implementation monitoring:	Trust Wide Patient Safety and Mortality Review Group
Executive approval:	Executive Management Team
Executive sponsor:	Executive Director of Nursing and Quality
Reporting to:	Quality Committee

RAG KEY:	
Purple	**Embedded**
Green	**Complete**
Amber	**In progress**
Red	**Overdue**

RAG	RECOMMENDATIONS	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	1. Trust Serious Incident reports should set out the evidence and analysis used to form judgements as to whether practice was undertaken in line with Trust policy.	1. Review Root Cause Analysis (RCA) template to include: a). Within the chronology, specific policies, procedures and national guidance local practice has been compared to. b). An analysis of the how the conclusion has been reached	Head of Patient Safety	1st April 2020	Revised RCA template	Draft template was developed in September 2019 and is currently being piloted with two RCAs.

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	2. The Trust should enforce its assurance and sign off process/policy for serious incident reports.	1. Update Management and Investigation of Serious Incidents Policy to include sign off of RCA investigations relating to Level 2 incidents. 2. Revise RCA template for Level 2 SIs reflect sign off by Executive Director of Nursing and Quality, Executive Medical Director and Chief Operating Officer	Deputy Director of Quality and Safety	1. Complete 2. Complete	Updated policy	The new policy was ratified in October 2019 and available to staff on intranet on 14th November 2019. A process has been agreed whereby Level 2 serious incidents are signed off by the Care Group Serious Incident Leads, Head of Patient Safety, Executive Director of Nursing and Quality, Chief Operating Officer and Medical Director. The Serious Incident Policy will be approved by the Trust-wide Patient Safety and Mortality Review Group meeting in January 2020 and launched thereafter.
	3. The Trust should review its action plan process to strengthen action sign off, specifically: • A section in the action plan template to assign individual and/or executive team	1. Adjust action plan template to ensure that it is clear that a lead is responsible within the revised root cause analysis template. 2. Add action plan lead to Datix action plan module.	Deputy Director of Quality and Safety	1. 1st April 2020 2. Completed 3. 31st January 2020 4. 31st January 2020	1. Root cause analysis template 2. Action plan module within Datix 3. Updated	Action plan lead has already been added to the root cause analysis template. This is being piloted and launch is planned for 1st April 2020.

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	responsibility for signing off actions • Details of executive team oversight • The names and roles of individuals responsible for signing off actions.	3. Amend Serious Incident Policy to reflect to ensure that homicide cases final action plan approval is made at Trust-wide Patient Safety and Mortality Review Group and terms of reference for the group includes this. 4. New root cause analysis template to include action plan leads.			Serious Incident Policy 4. Root cause analysis template	Datix Cloud is due to be implemented in the summer of 2020 and this will allow for easier reporting.
	4. The template for 'Referral not accepted' should include a signpost to copy the General Practitioner into the letter in instances when the General Practitioner was not the original referrer.	1. Standardised template for 'referral not accepted' to be written. 2. Standardised template to be launched across all Community Mental Health Teams. 3. Audit standardised letters to ensure compliance and embedding of practise.	Deputy Chief Operating Officer (Community and Acute Care Groups)	1. Completed 2. April2020 3. 30 June 2020	1. Letter Template 2. Minutes 3. Audit results	The standardised template has been produced. It was reviewed in December 2019 and further changes made. Communication about changes are ongoing.
	5. The Trust needs to further assure itself, by way of audit, that General Practitioners (GP), patients and referring teams are being informed of a community mental health team and community mental health older adult team decision to not accept a patient.	1. In line with the CMHT operational policy, Audit letters to GPs, patients and referring agencies to ensure communication on outcome of referral.	Senior Quality Manager	30 September 2020	Audit results	Tool devised and audit scheduled to commence in March 2020. Findings will be reported to the Trust wide Patients Safety and Mortality Review Group

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	6. The Trust wide Patient Safety and Mortality Review Group should undertake an audit of the last 12 months of investigations to assure itself that the Trust adheres to Duty of Candour.	1. Review findings of Duty of Candour Audit completed in December 2018. 2. Further review and amend Duty of candour audit standards on Datix following audit. 3. Audit a random sample of Duty of Candour in relation to Serious Incidents. 4. Register and participate in Serious Incident Accreditation scheme led by the Royal College of Psychiatry (College Centre for Quality Improvement)	SI Leads Head of Patient Safety	1. Completed. 2. Completed. 3. 31 March 2020 4. 30 September 2020	Audit results Datix duty of candour section	Audit tool devised. Audit standards developed and agreed. Audit registered with Clinical Audit departments and clinical staff to conduct this being identified ready for completion end of April