Action Plan to Address Learning Identified in Homicide Review
Created January 2023

Plan Owner:	Phil Brice, Director of Corporate Services	**Date last updated: (and version no)**	06.03.23 Version 0.9
	Jane Yeandle, Service Director – Mental Health & LD Alison Van Laar, Associate Director of Patient Care (MH&LD) Laura Walker, Head of Patient Safety & Learning	**Next review due by - Group / Committee: Date:**	Homicide Sub-Group 22.03.23

	Action What specific actions will be taken to address the issue(s)	**Lead by:**	**Achieve by:**	**Progress update / notes**	**Status**	**Assurance Mechanism**
1.	**PRE-INCIDENT RECOMMENDATIONS**					
1.1	**Family engagement:** Families supporting an individual must be involved in HTT mental health assessments. In instances where a family member is not involved, the assessing staff should document the rationale.	LH/TY	30/04/23	**16.01.23** L Hopkins is working to update the HTT recording proforma to include family involvement, and will be working with teams to brief and engage staff around this. To involve Inpatient & Urgent Care CD to support medical colleagues with documentation.	B	Agreed to liaise with Kay Southway to undertake an audit in late April 2023.
1.2	**Crisis plans:** Service user crisis plans should include planning for the service user's safety and the safety of others in the event of the service user's mental health deteriorating.	CM/TY	30/04/23	**16.01.23** D Wint has developed a safety plan proforma for including in Dialog+. The forensic team are also working with the police on specific management plans where there is a risk of harm to others including alerts on RiO. C Munt, L Hopkins, T Young, D Wint and C Stepney to meet and review the existing proforma to check this is sufficient. This will then be issued to all teams by the end of February 2023. **27.02.23** Safeguarding team to be involved to ensure safeguarding has been fully considered in any revisions of the crisis plan template (via Heather Sparks). Group has met to review the proforma and agreed for this to be tabled at the next directorate governance meeting for further discussion and agreement.	B	Agreed to liaise with Kay Southway to undertake an audit of safety plans in late April 2023.
1.3	**Capacity assessments:** Capacity assessments for each separate decision must be documented by clinicians in line with the Trust's Using the Mental Capacity Act Policy and the legal requirements of the Mental Capacity Act (MCA).	DMT/ EL	Completed Completed Completed	**Actions taken since the incident occurred**. - Mental Capacity Act Training across the Trust has been revamped with a focus on practical application of the law and principles. - Training emphasises the decision specific nature of the MCA - Training discusses legal requirements regarding MCA assessments and recording expectations.	B	Trust training package/slides Trust training package/slides Trust training package/slides

Status tracking		
Complete	**Green**	G
On plan	**Blue**	B
Risks slippage	**Amber**	A
Barriers – not achieved	**Red**	R

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			Completed	- Trust MCA service has completed a extensive piece of work visiting all inpatient setting including MH units to discuss mental capacity issues specific to that area of work. **Further actions to be taken in response to this report:**		‘MCA Roadshow’ completes across Aug/Sept 2022
		EL/TP	30/3/2023	- A learning briefing to be produced and circulated to all staff who may complete capacity assessments for informal admission of a person to mental health inpatient unit.		Briefing document
		EL/TP	30/4/2023	- MCA/MHA Lead to meet with Home Treatment Team and Community Psychiatrists for follow up Q&A/discussion session after briefing has been circulated.		Record of meeting
		EL	30/10/2023	- Audit of capacity assessments for patients admitted to mental health wards to be completed 6 months following that.		Audit
2.	**POST-INCIDENT RECOMMENDATIONS**					
2.1	**Protocol for emergency access to a medium secure mental health bed:** The Trust, in collaboration with provider collaborative forensic services, must ensure that the protocol for emergency access to a medium secure mental health bed is adhered to by clinicians, specifically in relation to: a) its purpose and when it should be triggered; b) escalation pathways if a secure bed is not immediately available; c) the efficient direction to a secure bed when service users are unknown to services and/or are considered to be high risk; and d) the criminal justice system not being used as an alternative route to access a secure bed. This should be addressed within six months of receipt of this report	CS	30/04/23	**16.01.23** To request that the wording of this action is amended from ‘in collaboration with forensic services’ to ‘in collaboration with provider collaborative forensic services’. C Stepney to work with forensic consultant to confirm that all escalation protocols are in place and that our on call managers are aware of these. **16.02.23** Request to amend wording has been agreed. Response received from provider collaborative outlining that their approach is ‘prison consideration first’ and divert to hospital later (if appropriate), however this contradicts the recommendation made in the NICHE report. FW_ Admission protocols.msg	G	To embed escalation processes.
2.2	**Records management:** Records and medical recommendations created by Trust staff, even if not used, must form part of the service user’s enduring medical record.	TP/AP	31/03/23	**16.01.23** A Papadopoulos and T Phillips to work with AMHP colleague (R Owen) to agree a clear	A	Where a recommendation has been made to audit whether this forms part of the medical record (April 2023); to also

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Complete	Green	G
On plan	Blue	B
Risks slippage	Amber	A
Barriers – not achieved	Red	R

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				protocol. To then sense check with DPT to check our processes are broadly aligned. **27.02.23** P Brice to speak to T Phillips and request an update.		sense check with DPT to check our processes are broadly aligned for further assurance.
2.3	**SI QUALITY ASSURANCE: SI investigation report authors must be involved in the SI investigation quality assurance process**					
2.3.1	The first draft of all SI reports is presented to SIRG by one or both authors to allow informed discussion with the opportunity to seek any clarification or request more detail as needed.	SA/LW	Complete	**Standard practice since Oct 22**	G	Review SIRG minutes
2.3.2	If revisions are recommended by either SIRG or ICB, the author(s) are asked to make these before submitting further draft report for review by SIRG so any changes are made by the author(s).	SA/LW	Complete	**Standard practice since Oct 22**	G	Author survey
2.3.3	Agreed process following ratification: 1. Confirm with author(s) that draft report has been ratified at SIRG with relevant report attached to e mail for transparency 2. At SIRG agree who will share report with patient/family 3. Update front sheet so that date of ratification, date of sharing are completed	SA/LW	Complete	**Standard practice since Oct 22**	G	Audit SIRG minutes/author survey/SIRG records
2.3.4	Action plans subject to SIRG scrutiny 1. Written and presented by appropriate team to SIRG 2. Once ratified, agreed process to review progress with date for review in SIRG action log 3. After actions completed, assurance eg. Audit, survey undertaken and presented to SIRG before archiving to demonstrate actions effective and embedded.	SA/LW	Complete	**Standard practice since Oct 22**	G	Audit SIRG minutes and papers
2.3.5	Update SIR SOP to reflect change in practice	SA/LW	March 2023	**27.02.23** To ask L Walker for an update at the March Homicide Sub-Group meeting.	B	SOP updated

Measures of success - How will we know the issue(s) have been addressed?	
What issues / action in the plan does this cover?	**Monitoring method** (e.g. audit, spot check, document produced):
Recommendation 1.1	• To undertake an audit in late April 2023.
Recommendation 1.2	• To undertake an audit of safety plans in late April 2023.

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Barriers – not achieved	**Red**	R

Recommendation 1.3	• Audit of capacity assessments for patients admitted to mental health wards to be completed 6 months following that.
Recommendation 2.1	• To embed escalation processes.
Recommendation 2.2	• Where a recommendation has been made to audit whether this forms part of the medical record (April 2023); to also sense check with DPT to check our processes are broadly aligned for further assurance.
Recommendation 2.3	• Review SIRG minutes • Author survey • Audit SIRG minutes/author survey/SIRG records • Audit SIRG minutes and papers • SOP updated

ACTION LEADS		
Laura Hopkins	Home Treatment Team, Operational Service Manager	LH
Tim Young	Head of Inpatient & Urgent Care	TY
Emma Lawton	Mental Capacity Act, DoLS and Liberty Protection Safeguards Lead	EL
Tracey Phillips	Mental Health Act Lead and Head of Mental Health Act Administration	TP
Chloe Stepney	Forensic Service Manager	CS
Andreas Papadopoulos	Associate Medical Director, Mental Health & Learning Disability Care	AP
Sarah Allford	Medical Governance Lead	SA
Laura Walker	Head of Patient Safety and Learning	LW
Directorate Management Team	N/A	DMT

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Barriers – not achieved	**Red**	R