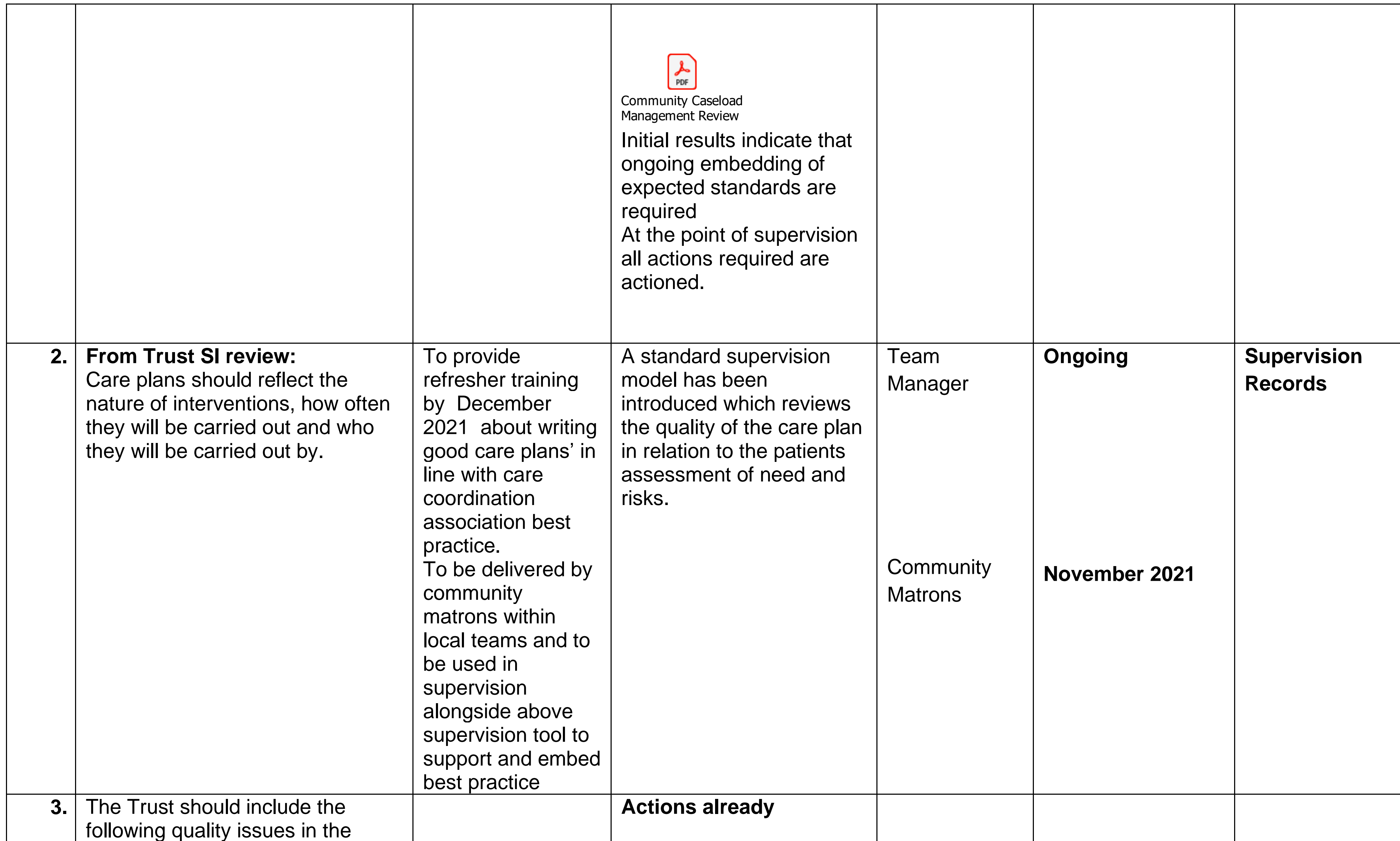
ACTION PLAN FOLLOWING INDEPENDENT HOMICIDE INVESTIGATION BY NICHE

No.	Recommendation	Actions	Actions already taken	Action plan owner	Date Target for completion)	Evidence (to be retained by action owner)
1.	**From Trust SI review:** The rational for clinical decisions and outcomes should be recorded within the patient's clinical record. Staff must also record if a patient does not attend an appointment.		The Team Manager has raised this issue within the team governance meetings and also in their regular team nurses forums. A standard supervision model has been introduced to monitor a range of record keeping standards within each clinicians supervision session A good practice audit has been developed and utilised to support safe risk management and subsequent care planning. PDF Community Caseload Management Review-	Team Manager Team manager Community Matrons	**Completed** **Ongoing** **Ongoing**	 **Supervision records** **Audit documentation**

			 Community Caseload Management Review Initial results indicate that ongoing embedding of expected standards are required At the point of supervision all actions required are actioned.			
2.	**From Trust SI review:** Care plans should reflect the nature of interventions, how often they will be carried out and who they will be carried out by.	To provide refresher training by December 2021 about writing good care plans' in line with care coordination association best practice. To be delivered by community matrons within local teams and to be used in supervision alongside above supervision tool to support and embed best practice	A standard supervision model has been introduced which reviews the quality of the care plan in relation to the patients assessment of need and risks.	Team Manager Community Matrons	**Ongoing** **November 2021**	**Supervision Records**
3.	The Trust should include the following quality issues in the		**Actions already**			

	revision of policy and practice with reference to the serious incident investigation and review process: • Definitions of level of investigation used in the Serious Incident Reporting and Serious Incident Review Policy should be changed to the definitions used in national guidance • Terms of reference should include family involvement as standard • Reports should be assessed against internal quality standards including whether actions identified reflect an adequate analysis of the findings and are sufficient to address learning Review the operation of 'RCA meetings' as set out in the relevant policy , with a view to	The Serious Incident Policy is under review and will pick up any disparities to reflect national guidance Terms of reference will be adopted to reflect this recommendation The Trust's report template and assurance process for homicides will be reviewed to reflect this recommendation. The Trusts RCA guidance will be reviewed to reflect	**undertaken** A Quality improvement event was held on 06/07/2021 as part of improving the experience of patients and families during serious incident reviews. Part of this work will involve reviewing the Serious Incident Review policy and re-visiting the content of the terms of reference. A draft recommendation from the Learning event is to develop a set of key lines of enquiry to provide the assurance panels with a methodology for: • Assuring that the review has involved the right people and asked the right questions to address the scope identified within the terms of reference, and that	Director of Quality Governance	**Nov 2021**	

	making the process more robust, with the inclusion of external clinical input	this recommendation	families have been adequately involved, their views are clearly represented, and they have agreed the report content and findings • Assuring that the review has identified the care delivery issues and drawn robust conclusions about the scale and impact of these on the incident, the care quality and experience of the patient and their family • Assuring that action plans have been developed to address all systemic factors			

			affecting care delivery issues, and that these actions are being taken at the appropriate levels to ensure they are addressed across the range of affected services Bespoke training has been provided for all reviewers (delivered by Maria Dineen) in how to achieve a proportionate approach to investigating, scoping and using case assessment to enable more reliable and better quality in-depth investigations. This is in preparation for the revised standards and Patient Safety Incident Framework. The report advocates the use of a structured case note review which facilitates a structured analysis of care			

			which is then quality assurance checked by a peer professional not involved in the care and management of the patient – using a specialist subject matter advisor where appropriate			
4.	The Trust must revise internal policies and procedures relating to the functioning of Clozapine clinics' in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described/documented and supported.	Local Operating Protocols will be reviewed to provide clarity on the purpose and function of the Clozapine Clinic services the Trust operates in line with this recommendation		Dr Sally Bell Senior Clinical Director Adult Mental Health and Substance Misuse.		**Dec 2021**