Camden and Islington NHS

NHS Foundation Trust

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26th June 2015

Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Dear Ms Hassell

Re: Regulation 28 Prevention of Future Deaths report – Tamara Holboll (date of inquest 20 April 2015)

I write in response to the Regulation 28 Prevention of Future Deaths report sent by you on 27 April 2015. You raised in your letter a concern about the lack of precision in our trust with respect to recommendations arising from Serious Incidents investigations on the need for good communication. Thank you for your very helpful comment and example of the clear format for the wording of actions to address the need for better communication. We have considered your recommendation carefully and we agree with you that we should improve the way we formulate our actions to ensure they achieve the desired result. We have an ongoing plan in place to review and improve our Serious Incidents processes; we are committed in particular to improving our ability to learn from incidents.

Before I explain what actions we have taken to improve on this, it may be helpful to set out briefly the process of preparing and reviewing action plans arising from serious incident investigations. Serious incident investigations are usually allocated to an appropriately trained senior manager (Lead Investigator) from a Division other than the one where the incident occurred (the purpose of this is to achieve a level of objectivity); they are supported by a Clinical Expert from the Division where the incident occurred; this person is a specialist

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Chair: Leisha Fullick
Chief Executive: Wendy Wallace

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C&I is an NHS Foundation Trust providing treatment and social care for mental ill-health and substance misuse in adults in partnership with Camden and Islington councils.

in the clinical area relevant for the investigation, but have not had direct involvement with the service user involved in the incident. The Lead Investigator and Clinical Expert prepare a report with recommendations following from their findings. Each serious incident investigation has an allocated Action Plan Manager, who is a senior manager in the Division where the incident occurred. The Action Plan Manager assists the investigators with preparing the action plan to ensure that the actions are in line with the workings of the service or appropriate to the Division. The Action Plan Manager also is also responsible for ensuring that the action plan is implemented. The action plan template is designed to prompt the author to allocate a responsible person for each action, a deadline for completion of each action and what evidence is required to confirm that the action has been completed (for example, if a policy needs revising the evidence will be a revised policy). Draft reports with action plan are reviewed by the Clinical Governance team, who may work further with the authors to ensure that the report and action plan comply with the Trust guidance included in the Serious Incident Investigation template. Finally, the report with action plan is approved and signed off by Executive Directors.

The trust has taken the following actions to address the issue you have raised in your letter; some of these actions were started shortly before the inquest as part of our ongoing improvement plan for learning from serious incidents:

1. We have amended the action plan template and revised our guidance to authors writing recommendations and action plans.

    a) We have added an action row in the action plan table to prompt the authors to write an action arising from each respective recommendation. We find that recommendations are usually drafted in rather general and less concrete language, the prompt to produce and action based on the recommendations helps to remind the authors that specific, concrete action is required.

Previous action plan template from former guidance:

RECOMMENDATION	LEAD	TIMESCALE	EVIDENCE REQUIRED

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