Statement from Central and North West London NHS Foundation Trust (CNWL): We extend our sincere condolences to the family and friends of Ms A for their sad loss and we acknowledge the pain and distress that they have endured. In addition to the actions already taken following our internal panel of inquiry, the Trust has fulfilled all of the recommendations made in the independent investigation, so actions are implemented and embedded to improve practice. This action plan has been monitored externally by the North West London Collaboration of Clinical Commissioning Groups, who have closed the action plan following their appraisal of evidence submitted by the Trust, and context given at an action plan closure meeting with them.
Statement from the North West London Collaboration of Clinical Commissioning Groups North West London Clinical Commissioning Group (CCG) offer our sincerest condolences to all those family members and friends affected by this sad incident. NWL CCGs works with CNWL NHS Foundation Trust to seek assurance that the services they provide are safe; effective; caring and responsive. NWL CCGs has met with the Trust and is assured that the action plan has been completed. The Trust will continue to provide a range of evidence to the CCG to ensure they are providing services in line with the requirements stipulated within the contract held between the CCG and the Trust, the NHS Constitution, and Fundamental Standards of Care regulations.

Central and North West London NHS Foundation Trust (CNWL) Action plan

Rec No	Recommendation	Action to address the recommendation	Evidence of implementation
1.	The positions of individuals signing off key assurance documents should be stated.	The Trust will ensure that positions of individuals who sign off key documents are stated, and that this expectation is reflected in policy documents. Action completed	The CNWL policy on policies now explicitly states: "Responsibilities - *This section should list the key responsibilities covered or allocated by the document, and the person, group and committee(s) that is responsible for each. Functional names should always be used in preference to people's names."*

2.	**Recommendation from CNWL internal report** Investigation findings and action plan to be shared with all those involved in the care and treatment of the service user, and with other teams/services as applicable, for the purpose of learning. • Report to be reviewed at Quality Governance Group, team meetings and the quarterly feedback from SIs meeting ***Outstanding Evidence as identified by the independent investigation*** Minutes of the next quarterly feedback SI meeting	The independent investigation found that this action had been implemented but further evidence was required which the Trust has now provided. Action completed	Investigation findings are reviewed systematically though Divisional and Trust governance channels. Meeting papers submitted as evidence showed that safety and learning from serious incidents are standing agenda items. There is review of findings, action plans and learning. More recently, the Trust has also introduced Trust wide recommendations workshops at the conclusion of review of incidents of this level and type.
3.	**Recommendation from CNWL internal report** Borough and Clinical Directors to be assured that care coordinators and the operational and clinical managers in the Early Intervention Service and inpatient teams adhere to the Care Programme Approach and all policies relation to Admission/Transfers and Discharge to maintain robust communication and continuity of care • Relevant policies to be recirculated to all Hillingdon Clinical Staff to ensure borough wide awareness. • Ensure that all staff are aware of the revised model of care implemented in 2016, which addressed the issues raised prior to the completion of this report. ***Outstanding Evidence as identified by the independent investigation*** Evidence of the communication to staff to reissue the policies in the context of this action. Evidence of staff being made aware of the new model of care through communication, guidance or training.	The independent investigation required the Trust to provide further evidence that effective communication to staff of policies and the new model of care had occurred. This was in relation to transformational work that was underway across the organisation for a new model of care and service delivery. As part of the transformation, the new Operational policy was shared with staff. Action completed	The Trust ensured that new changes had been communicated to staff through meetings and emails. The Operational policy was developed and shared with staff. Latest revisions of this policy were in May 2020.

4.	**Recommendation from CNWL internal report** All Hillingdon MH services to ensure that all policies are developed and managed in keeping with the policy on the Development of Trust-wide Procedural documents August 2016, with particular attention to ensuring that they are finalised documents. The Care Quality meeting will ensure and sign off any new procedures to ensure that this is met. A tracking system will ensure any proposed procedural changes are made at this level with regard to change in clinical practice, as well as ensuring Trust wide and national guidelines are met. ***Outstanding Evidence as identified by the independent investigation*** a) Policy document "Development of Trust-wide Procedural Documents" to be provided b) Evidence of operation of tracking system for changes to policies and procedures c)Minutes of Care Quality Group meetings to assess ongoing compliance with sign-off requirements at this group d)Confirmation that Borough and Clinical Directors have oversight through the Care Quality Group The Clinical Quality Meeting in each borough to develop a tracking system, noting procedural and clinical changes and in line with the relevant local and national guidance	a) The Trust has a Policy on Policies which was shared and is available to all staff b) There is a tracker which is monitored by the Corporate Governance Team c) Meeting papers of the Care Quality Group demonstrated that there was a standing agenda item of policies. d) The Borough Medical Director chairs the Care Quality Group e) Care Quality Group Terms of Reference are structured to support Borough Director level oversight. (Also please see point (d) above) The tracker (described in (b) above) tracks author, responsibility, ratifying Committee, amendments, review dates and any other relevant information. Action completed.	Evidence of implementation is in the form of: - Amendments to the Policy on policies - Policy documents tracker - Governance arrangements - Meeting papers At a Divisional level, the Board reviews the trackers on a monthly basis and reviews any outstanding actions. There is internal challenge if there are perceived delays in closing of actions. At a local service level, any outstanding actions are picked up at the Clinical Quality Meeting, chaired by the Divisional Medical Director.

5.	**Recommendation from CNWL internal report** Borough and Clinical Directors to be assured that there are clear and explicit processes in place in EIS to facilitate caseload management between frontline practitioners. To ensure that clear transition processes are embedded within the model of care ***Outstanding Evidence as identified by the independent investigation*** Clarity on actions relating to the recommendation	Development of a Standard Operating Procedure by the Trust. Action completed	The Early Intervention Services Standard Operating Procedure was developed and implemented. The new model includes a clear transition process that staff are familiar with.
6	**Recommendation from CNWL internal report** The Zoning system should be reviewed by the EIS team for assurance that it is being followed, and that whenever changes to a lower zone are made, there is clear evidence recorded of the rationale for this. The model of care and the zoning system will assure that actions and decisions made in zoning meetings are now robustly recorded. ***Outstanding Evidence as identified by the independent investigation*** Evidence of review of the zoning system by the Early Intervention Service Evidence of assurance of adherence to the system and documentation of actions/decisions taken.	A review of the zoning system including evidencing capture of decisions and action taken. Action completed	The work undertaken to revise the Standard Operating Procedure included revision of the Zoning system • Changes were communicated to staff • The revised duty process includes Zoning guidance • A referral spreadsheet is also maintained and updated to include risk and zoning • Staff were trained in risk assessment. • Minutes of meetings evidenced that zoning decisions and actions are followed up.
7.	**Recommendation from CNWL internal report** Where team meetings are minuted, the Borough and Clinical directors to be assured there are effective governance systems in place, with particular attention to having clearly named individuals as the responsible person to progress the action, with clear expectations and contingency plans in place to support the outcome.	While the recommendation was partially met at the time of the independent investigation, further evidence was to be provided to assure that actions and decisions made in zoning meetings are now robustly recorded. Action completed	The Trust ensures that meetings are minuted and actions followed up. Decisions are recorded and actions are allocated to named individuals. Zoning decisions are recorded and evidenced. Divisional Care Quality Meeting papers show that new issue and/or revision of procedures/guidance/policies are

	The model of care and the zoning system will assure that actions and decisions made in zoning meetings are now robustly recorded. ***Outstanding Evidence as identified by the independent investigation*** Clarity on the focus of the recommendation Evidence of revised procedures to reflect the governance arrangements required in the recommendation Zoning guidance and recoding of decisions template will be reissued to all teams	Review of the zoning system (Please see recommendation 6 for review of zoning processes) Submission of evidence of relating to governance arrangement Action completed	discussed, and are a standard and standing agenda item.
8.	**Recommendation from CNWL internal report** Borough and Clinical Directors to be assured that staff adhere to the Trust Care Records Standards April 2016 with particular attention to: All clinical discussion about patients to be accurately recorded in the patients records. Where documented by administrative staff they need to be accuracy checked by a clinician. Care Records Policy to be recirculated to all staff with a memo reminding staff about documentation. Continue to participate in Trust care Records audit. ***Outstanding Evidence as identified by the independent investigation*** Confirmation that the Care Records Policy was recirculated with the accompanying email to all Staff Care Records Standards and Care Records Procedures documents dated April 2016 to be provided	The independent investigation found that this recommendation was partially met with further evidence required on evidencing the policy at the time of the review. Action completed	Care Records Standards (2018) and Care Records Policy and Strategy (2018) were sent to staff as an aide memoir. The 2016 Care records version that was requested was submitted. The Trust has a more recent Care Records 2018 version in place. The Trust carries out audits on the standard of care records every year and a report on trends and themes is discussed at Divisional meetings. At a local level, these are addressed at Care Quality Meetings. Evidence of auditing was acknowledged at the time of the independent review.

North West London Collaboration of Clinical Commissioning Groups Action Plan

Rec No	Recommendation	Action to address the recommendation	Evidence of implementation
3.	The CCG should assure itself within the next three months that it has robust systems and processes in place to monitor and test closure of SI action plans. This should include finalising a Standing Operational Procedure (SOP)outlining the internal management of Serious Incidents within the CCG.	The CCG will produce an SOP that describes the systems and processes to enable it to be assured and monitor that SI action plans have been completed within the prescribed dates set by a provider.	**Evidence of a SOP that has been signed off by Director of Quality NWL CCGs.** Completed action NWL CCGs Serious Incident Policy updated at Ratified in September 2020. This has a section on closure of action plans. The CCG is actively liaising with the Providers in terms of completion of their action plans for Homicides and Never Events. The CCG has adapted its database to be able to identify when actions should be completed by the Provider and this data is added once they have received the final report. This improvement will allow the CCG to request updates on completed action plans from the new year from

			the providers using a revised monthly provider status report. **The assurance on the robustness of this system will be provided on the completion of action 4.**
4.	The CCG should undertake a Deep Dive of Serious Incidents 12 months after the SOP has been ratified with a view to confirm action plans were closed by the provider and evidence that key themes have been tested.	The CCG will undertake a Deep Dive of SI's 12 months post the date of the SOP being approved to be assured that actions have been completed by a provider.	**Completion of the Deep Dive and a review of the recommendations from the Deep Dive**. Deep Dive to be included in the NWL CCG Serious Incidents Report for Q4 of 2021/22 which is presented to the Quality and Performance meeting across NWL CCGs.