Appendix 1 - PHSO Findings Action Plan – Updated January 2021

	Service Failure or Maladministration	Action already taken	Further actions the Trust is taking	Timescale	Completion Date and Evidence	Measurement	Measurement Data available
1	De-escalation techniques were not considered or used before rapid tranquilisation was administered on 8 November 2012.	Therapeutic and Safe Intervention (TASI) training was introduced in 2015 and is a mandated training programme for all inpatient nursing staff. De-escalation strategies are an integral part of the programme. The training comprises of: • Initial training - 5 day programme supported by an assessed workbook • Yearly refresher - 2 days All agency workers must be TASI trained before working in the Trust.	The Trust's incident management system (Datix) is being adjusted to record debrief details.	October 2019	Completed and email provided by PS to confirm. Email from PS - PHSO Action re Debrief.msg	Monitoring of extract reports from the Datix system.	In place. Monitored at HSSC. 7.1 - Risk Management Report (
						Monitor the use of de-escalation techniques on the matron's assurance tool.	In place. Monitored through the Perfect Ward Report. Matron's Assurance - 01-Dec-2020.pdf
						Monitoring of TASI training compliance.	In place. Training Tracker. Mandatory Training Matrix.docx
		All policies were reviewed post-merger. EPUT has in place a Restrictive Practice Policy & Procedure (this is a current policy, next review date October 2020) and Clinical Guidelines for Pharmacological Management of Acutely Disturbed Behaviour in place (next review date January 2023).					In place. Monitored by the Safe Care Task and Finish Group.
		The Trust has recently approved a Restrictive Practice Framework which will be monitored by the Restrictive Practice Group.					
2	Not properly allocated a key worker, nor was his care adequately planned.	The Trust has adopted "My Care My Recovery" which is a patient led care plan given to every patient following admission. Every patient is allocated a Named Nurse/Keyworker at point of admission on a treatment ward. The details of the Named Nurse/ Keyworker are added onto the patient's "My Care My Recovery" document.		N/a	N/a	Weekly ~~care plan audits~~ weekly ward manager audits are conducted across all wards in the Trust from July 2020 the ward managers' audit will be available on Perfect Ward.	In place. Monitored through the Perfect Ward Report. Ward Manager's Audit - 01-Dec-2020.(
						Audits of the Matron Assurance Checklist.	In place on Matron's Assurance Checklist.

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3	Physical health needs were not adequately looked after, including his nutrition.	The Trust has in place Clinical Guidelines on Physical Healthcare (next review date November 2022).	Matron's assurance check of care plans to include physical health needs and dietary issues.	December 2019	Completed.	Audits of the Matron Assurance Checklist.	In place on Matron's Assurance Checklist.
			Consideration being given to procuring an app to log physical health checks on phones/ipads which then transfers data into the EPR.	January 2021	Testing completed (November 2020) rollout delayed.	TBC	
			ADs and service managers to receive a weekly position on the questions regarding physical health	September 2020	~~A flag has been incorporated on the app by the perfect ward team week commencing 24 July enabling a weekly position statement to be sent to managers~~ ADs and service managers receive details of who have completed the weekly Matron Assurance tool. Any questions not scoring 100% are forwarded to the Ward Manager and Matron to confirm an action plan is in place.	Perfect Ward report	In place. Email evidence to be embedded.
			Clinical Audit to add physical health to it.	~~October 2020~~ November 2020	Added to the audit list due for completion in October 2020. Audit commenced in October 2020 however some areas outstanding. Report will be compiled in November 2020.	Clinical audit report.	Clinical audit report.
		There has been the introduction of Physical Health Link Workers who disseminate information on physical healthcare for their area and attend enhanced training.				Audit training compliance rates.	Records held by Executive Nurse directorate for 6 months then provided to Workforce, Training and Development.
		Malnutrition Universal Screening Tool (MUST) risk assessment is completed for patients on admission to the ward. Development of care plans and any deviations from the norm are escalated to the MDT.					In place on Matrons Assurance, escalation process as part of SOP.

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		Compliance with Venous Thromboembolism (VTE) requirements are monitored and reported to the CCG as part of contract monitoring.					In place. Reported to CCGs. Evidence to be embedded.
4	Staff did not always engage adequately.	All patients are allocated to a member of staff on a shift basis and it is the responsibility of that member of staff to spend time with the patient and engage with them in accordance with their care plan. The multi-disciplinary team provide a therapeutic activities programme including nursing staff, occupational therapists and psychologists, on a one to one or group basis.		N/a	N/a	Complaints and compliments themes and analysis of feedback completed as part of the Patient Experience Sub Committee.	In place. Reports provided quarterly. 2020-21 Q1 Thematic Report.doc
5	Observations were not properly managed.	Following the merger, the Trust has worked as part of a collaborative with Leeds University to implement the Trust's reviewed Engagement & Supportive Observation Policy (next review date January 2023). In line with the policy and procedure there is an explicit need to record the rationale for decisions to change observations.	A review of the observation recording forms will be added to the Ward Manager Daily Check.	~~November 2019~~ March 2020	~~In place. Part of Daily Checks confirmed by GM.~~ Evidence received shows this review is undertaken as part of the Matron's Assurance. Querying with Ops where the correct place is for this review of observation recordings. Included in matron's assurance, following a meeting with matrons to discuss Perfect Ward and the audits it contains there was agreement to develop a weekly ward managers' audit and this will also be included in that one. Schedule for implementation is March 2020. Weekly ward managers' audit developed and this action added to do, however delayed implementation due to Covid-19. Reinstated across the Trust from	Audit of Ward Manager's Daily Checks.	In place as part of ward manager weekly audit.

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					8.6.20.		
			Pilot of Oxehealth being undertaken.	September 2020	Pilot completed and paper going to Trust Board for approval in September 2020.	Oxehealth reports	Pilot completed and paper going to Trust Board for approval in September 2020.
			ADs and service managers to receive a weekly position on the questions regarding observation charts	September 2020	~~A flag has been incorporated on the app by the perfect ward team week commencing 24 July enabling a weekly position statement to be sent to managers~~ ADs and service managers receive details of who have completed the weekly Matron Assurance tool. Any questions not scoring 100% are forwarded to the Ward Manager and Matron to confirm an action plan is in place.	Perfect Ward report	In place. Email evidence to be embedded.
			Clinical Audit of observation charts.	~~October 2020~~ ~~November 2020~~ January 2021	~~Added to the audit list due for completion in October 2020.~~ ~~Audit to be completed in November 2020, however weekly assurance on this area is given through the Ward Manager Audit and the Matron's Assurance Tool on Perfect Ward.~~ Collection ongoing due for completion by the end of January 2021.	Added to the audit list due for completion in October 2020.	Clinical audit report.
		Staff training completed on a 3-yearly basis.				Monitor staffing training compliance.	In place. Training Tracker. Mandatory Training Matrix.docx

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		Observations are recorded on an observation chart which includes a summary of presentation. The policy includes a brief on the parameters for increasing and decreasing of observation levels.	Implement a checking process during handover and at safety huddles to ensure that staff are completing contemporaneously.	Ongoing	Process In place and added to the Matron's Assurance Checklist.	Monitor details from unannounced visits.	In place. Monitored by the Executive Nurse's Directorate.
6	The assessment and management of risk, including environmental risk, was not rigorous enough.	Post-merger the Trust has a Clinical Risk Assessment and Safety Management Procedure (next review date July 2022).	The Trust is currently evaluating the use of SBAR (Situation, Background, Assessment, Recommendation) to facilitate prompt and appropriate communication.	December 2019	In place and being monitored by the Executive Nurse's Directorate.	Audits of the Matron Assurance Checklist.	In place on the Matron Assurance Checklist.
		Individualised risk assessment and management plans are developed for patients. A Key Performance Indicator (KPI) has been introduced that sets the expectation of a risk assessment that includes a risk management plan within 4 hours of admission to a treatment ward.	Implementation of support from people with experience in reviewing ligature points on our wards.	December 2019	In place. Pilot completed and further reviews being scheduled in 2020.	Monitoring of ligature audits undertaken.	Audits in place.
						Audits of the ligature wallet and ward manager weekly audit.	In place. Monitored through the Perfect Ward Report. The question asks is: does the ligature pack reflect the current ligature risks on the ward?
		Staff attend Clinical Risk training 3-yearly.	Rolling programme of ligature audits.	Ongoing	Audits in place.	Monitoring of ligature audits undertaken.	Audits in place.
						Training compliance monitoring.	In place. Training Tracker. Mandatory Training Matrix.docx
		Post-merger all processes in relation to				Compliance with safety	All relevant alerts are monitored

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		the risk assessing of environmental risks were reviewed. A new Ligature policy and procedure has been developed and implemented (next review date October 2022).				alerts.	by HSSC. Compliance and actions embedded through an audit by BDO, who will also include this longer term via the annual site audits
		Ligature awareness training is completed 3-yearly for all inpatient staff.				Monitoring of risk assessment KPI.	In place. Monitored through the Perfect Ward Report. Checklist modified to include the KPI on risk management plan being in place within 4 hours.
		Full re-audit of inpatient wards commenced in April 17 and have been completed.					
		The audit tool has been revised and strengthened.					
		Ligature audits take place bi-annually. Action taken to remove/ reduce any risks identified in the audit or to mitigate against them if removal is not possible. Identified risks are highlighted on a heat map and all of this information is held in a red coloured ligature wallet on each ward. Local ward inductions include discussion about ligature risks.					
		Line of sight audits have been completed and appropriate action taken.					
		There has been investment in environmental risks since April 2017.					
		The Risk Reduction Group sign off ligature risk assessments. The Estates Reference Group oversees solutions.					
		Support has been obtained from NHS Improvement and the CQC to implement best practice.					
7	Adequate action was not taken when rape was reported.	Post-merger the Trust's Safeguarding Adult procedure was reviewed (next review date February 2023). It is to be followed if a patient reports being raped or any allegation of sexual assault.	Sexual Safety leaflets will be added to all patients welcome packs.	November 2019	In place.	Training compliance monitoring.	In place. Training Tracker. Mandatory Training Matrix.docx

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		The Trust has 4 levels of Safeguarding training and the frequency of completion is determined by their role.					In place monitored by the duty safeguarding team.
		Key messages around serious incidents (SIs) have been implemented including sexual safety and exploitation.					
		Information relating to sexual safety for our patients has been added to each unit's Operational Policy following the CQC publication relating to this that was released in 2018. Staff were also informed and briefed about this publication and awareness has been raised.					
		Sexual safety is discussed as part of the safety huddles.					
8	Clinical record keeping was not robust enough.	There is a monthly record keeping audit that is completed by every ward. Any shortfalls are addressed through findings from this audit. Spot checks are also carried out on a more regular basis.		N/a	N/a	Monthly audits.	In place. Shortfalls built into the app and monitored by clinical audit and matrons 20019 - Audit of Record Keeping in Ad
		As noted in point 2 "My Care My Recovery" is completed on admission.				Audits of the Matron Assurance Checklist.	In place. Monitored through the Perfect Ward Report. Checklist modified to include the KPI on risk management plan being in place within 4 hours.
		As noted in response to point 6 a KPI has been introduced that sets the expectation of a risk assessment that includes a risk management plan within 4 hours of admission.					
		The Trust provides training on record keeping for staff.					
		Action was taken in relation to the falsification of records by the Trust and NMC.					

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9	Overall, NEP's investigation of the death was not adequate.	Post-merger the Trust has in place an Adverse Incident Policy including Serious Incidents (this is a current policy last reviewed February 2019).	An internal audit of SIs is being added to the Trust's audit plan.	December 2019	Completed. Audit added in December 2019 and audit completed in February 2020.	Internal audit of SIs.	In place. Records with the SI Team.
10	The conclusion of the SI panel report is at odds with its findings, and the recommendations are not sufficiently robust or comprehensive.	Staff who are allocated to complete Serious Incident (SI) Investigations have all completed Root Cause Analysis (RCA) training, which has been informed by families and carers. There is training for staff regarding the Family Liaison Officer (FLO) role, which has been established and assisted in its development with the police. FLOs are engaged at the point of an incident. They provide input into the terms of reference for the investigation and raise questions on behalf of the families and support their input into the report. Meetings with families offered following SI outcomes.					
11	The SI panel investigation failed to provide assurance that NEP had learnt from the death and improved patient safety.		New training for investigators in line with new national SI framework in place.	~~May 2020~~ October 2020	First cohort of training has taken place with positive feedback. Further dates scheduled and all places filled. On hold due to Covid-19. Seeking approval to revise the date to October 2020 Two cohorts of training taking place. Discussions taking place with provider to commence further training in September/October Currently considered that there are sufficiently staff trained to support investigations with new system but plan to further increase capacity in the autumn.	RCA training compliance monitoring.	In place. Records with the SI Team
						FLO training compliance monitoring.	In place. Records with the SI Team.
						SIs reported to the Executive Operational Sub Committee.	In place. Continually reviewed.

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			The retention of appropriate evidence in relation to SIs will be added into the policy and procedure	~~December 2019~~ ~~April 2020~~ October 2020	Not yet been added to the policy and procedure, this will be incorporated when the new framework is introduced. However, there are processes in place and evidence is sent to SI team. Proposed revised date to April 2020 Processes are currently in place and work has commenced to incorporate into policy frameworks. On hold due to Covid-19 nationally. Seeking approval to revise the date to October 2020. National Framework not being implemented until Spring 2021, decision taken to add into current policy Chair's action taken, policy now being updated.	Policy and procedure in place.	In place. CPG3 - Adverse Incident Procedure.pd
			The Trust is implementing guidelines from the national Learning from Deaths work.	Completed.	A working group is in place to cascade learning Learning from Deaths.pptx	Mortality Review Sub Committee quarterly reports to Trust Board.	In place. Reported quarterly.
		Sign off process for Serious Incident Investigations requires the oversight and sign off by the Executive Nurse, the Medical Director and the Executive Chief Operating Officer.	The Trust is implementing guidelines from the national Suicide Prevention work.	Ongoing	Work is ongoing to ensure compliance. Paper presented at Quality Committee in December 2019. An action plan is in place and a dashboard is in development. A paper regarding systems and processes to support new SI guidance and the framework will be scheduled for quality committee. The Trust has in place a one page Strategy on Suicide Prevention and	Internal audit of SIs.	In place. Records with the SI Team.
		All reports are sent to the CQC.				Monitor the implementation of national guidelines.	Suicide Prevention Sub Committee is in place and reports to the Quality Committee on a quarterly basis.

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					monitor progress against the national guidelines.  Suicide Prevention Zero Ambitions.pptx  3.1c Twenty Point Plan Zero Suicide Amt		
		The Trust has a "5 Key Learning Points" bulletin that is sent to all staff across the Trust on a monthly basis to share learning. This is available for inpatient staff to view on their Performance Stations on each ward. An annual thematic review of SIs is undertaken by the Trust. The Trust commissioned a review of SIs by Professor Appleby (who leads the National Suicide Prevention Strategy for England) in 2018 and all actions have been completed. Reported 100% compliance regarding duty of candour letters.	The Trust has been selected to be an early implementer of the new NHS SI Framework.	Implementation date of September 2019	Two cohorts have been trained and discussions taking place with provider to train further cohorts in the autumn. New framework on hold due to covid. We worked with our commissioners and agreed an interim response with 7 day reporting progressing to RCA where there were outstanding concerns. In line with the philosophy of the new framework.  20200304 PSIRF agreement - Essex Pa	Internal audit of SIs. Compliance with Duty of Candour monitoring.	In place. Records with the SI Team. In place. Training Tracker.  Mandatory Training Matrix.docx
12	NEP did not fully address all the safety problems at the Linden Centre in a timely way, despite indicating otherwise in correspondence to the complainant and MP in February 2015.	All complaints sent to EPUT are registered and follow Department of Health NHS Complaints guidelines. EPUT's complaints process is robust and includes sign off by the Chief Executive including the investigation and the lessons learned. The Trust has developed its values with stakeholders one of which is 'Open'. An apology has been given to the complainant. Post-merger the governance processes in place at former NEP were reviewed and changed to ensure the relevant committees of the Board are sighted on safety issues.		N/a	N/a	Non-Executive Directors review of complaints process in place.	In place.  EPUT NED Review Form Sept 18.docx

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		As noted in response to point 6, post-merger all processes in relation to the risk assessing of environmental risks have been reviewed. A full re-audit of inpatient wards commenced in April 2017 and has been completed. There has been investment in environmental risks since April 2017.					

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