

Appendix 4 - PACAC Assurance Assessment

<u>Points Discussed</u>	<u>Action to be Taken by EPUT</u>	<u>Lead</u>
The Committee welcomed the Minister's commitment that the families affected will be fully involved in the NHS Improvement and NHS England investigation. The two tragic cases raised in the PHSO's report were not the only complaints that have been made about the Trust. NHS England and NHS Improvement's review should make sure that all families that have been affected by similar incidents to the ones detailed in the PHSO's report are also fully involved in the investigation, if they would like to be.	N/a. Awaiting details on NHSE/I's review.	N/a
It is vital that families can have confidence in clinical investigations. The lack of confidence expressed by witnesses to our inquiry is a cause of serious concern. While we have confidence that HSSIB's investigations, once it is properly established will be effective in improving learning from incidents, NHS Trusts must also be capable of performing effective local investigations when incidents arise. The NHS should take steps to use HSSIB investigations to improve their own local investigations. For example, by learning from examples of best practice in clinical investigations.	<p>New SI Framework being implemented expected to be in place by spring 2020 due to delays nationally. A comprehensive action plan in place. Learning from incidents and performance in relation to incidents has been introduced.</p> <p>The new arrangements will be presented to the Executive Operational Sub Committee (EOSC) for approval and then on to the Quality Committee.</p>	<ul style="list-style-type: none"> • EOSC • Quality Committee

<p>The Committee agreed with the recommendation of the Care Quality Commission that NHS England and NHS Improvement should ensure that the entire NHS workforce has a common understanding of patient safety and that patient safety should form part of ongoing mandatory training and be included as part of continuing professional development.</p>	<p>N/a. NHS E/I action.</p> <p>EPUT is currently developing a Patient Safety Strategy.</p>	<p>N/a</p> <ul style="list-style-type: none"> • Quality Committee • Trust Board
<p>The Committee welcomed the Government's plans to specifically cover plans for leadership in the NHS within the People Plan, to be published later this year. The Government should make clear however that ensuring effective leadership within an organisation is not simply a one-off event but rather is an iterative process of continuous improvement.</p> <p>Mental Health Trusts must be clear about their values and mission, and they need to reflect this in their culture. They must be clear that the term culture refers to the attitudes and behaviours which people in the organisation tend to adopt. Leadership must lead by example with the right attitudes and behaviour. There has to be open discussion when attitudes and behaviour is not consistent with the values of the Trust.</p>	<p>N/a. NHS E/I action.</p>	<p>N/a</p>
<p>Professor Tim Kendall's letter to all NHS Trusts:</p> <ul style="list-style-type: none"> • Both cases involved a failure to 	<p>Work being undertaken which will be presented and</p>	<ul style="list-style-type: none"> • Clinical Governance Sub Committee

<p>by embracing the principle of continuous safety improvement, underpinned by a safety culture and effective safety systems.</p> <ul style="list-style-type: none"> The recent publication of the NHS Mental Health Implementation Plan 2019/20 – 2023/24 outlines investment in acute mental health care to ensure that this offers an increasingly therapeutic experience and drives improved outcomes for individuals, which colleagues across the country will be planning to deliver as part of the STP/ICS strategic plans. 	<p>This work has now been built into QI Framework, led by the Executive Nurse through the QI sub-committee to the Quality Committee and then Trust Board. This work is also closely linked to the reset and recovery group post Covid-19.</p>	
<p>Patient safety strategy published in the summer – working with Trusts includes restraint, segregation, sexual safety and seclusion. All part of Quality Improvement. (Verbal statement at PACAC)</p>	<p>As above the Trust is currently developing a Patient Safety Strategy which will be monitored by the Quality Committee and Trust Board. EPUT is involved in a current collaborative using QI approach running for restraint, segregation and seclusion. EPUT is also part of a national collaborative for sexual safety.</p>	<ul style="list-style-type: none"> Clinical Governance Sub Committee Quality Committee
<p>EPUT see this as a major priority to be fixed. Inpatient unit will move to be an outstanding unit. (Verbal statement at PACAC)</p>	<p>CQC action plan is monitored by the EOSC and the Executive CQC Group. A report is received at every Quality Committee Meeting and Trust Board.</p>	<ul style="list-style-type: none"> EOSC Toward Outstanding Group Executive CQC Group Quality Committee Trust Board
<p>EPUT's action plan for PHSO, waiting to hear when it will be published. (Verbal statement at PACAC)</p>	<p>N/a sent to the PHSO for them to publish not an action for the Trust.</p>	<p>N/a</p>

Review being undertaken looking at staffing levels. (Verbal statement at PACAC)	EPUT's establishment reviews are provided to the EOSC, Quality Committee and Trust Board of Directors. A review is completed annually, and Safecare is being introduced to inform future establishment reviews	<ul style="list-style-type: none"> • EOSC • Quality Committee • Trust Board
Possible prosecutions in this case or others. (Verbal statement at PACAC)	<p>Police investigation concluded in January 2019.</p> <p>Court date of 12 November 2020 regarding the HSE prosecution.</p>	<ul style="list-style-type: none"> • Trust Board
National suicide reduction and prevention programme. Zero suicide alliance. (Verbal statement at PACAC)	EPUT has a Suicide Prevention Strategy and working Group who report into the Mortality Sub Committee and then the Quality Committee.	<ul style="list-style-type: none"> • Mortality Sub Committee • Quality Committee
<p>CQC report on care in mental health 2014-2017.</p> <p>Staffing level and medicines management were noted as a weakness. (Verbal statement at PACAC)</p>	<p>EPUT has a Medicines Management Sub Committee which reports to quality committee.</p> <p>Staffing levels are discussed at operational service SMT meetings and reported to Finance and Performance and Trust Board.</p> <p>Safer staffing reports are now included in the Trust's performance report and therefore no longer go to the Clinical Governance Sub Committee. Establishment reviews go to the EOSC and Trust Board.</p>	<ul style="list-style-type: none"> • Medicines Management • Operational SMTs • Finance and Performance • EOSC • Trust Board
Restrictive interventions / reduction programme – users and professionals to work to reduce restrictions. (Verbal statement at PACAC)	<p>EPUT has a Restrictive Practice Framework and working Group who report into Clinical Governance and then the Quality Committee.</p> <p>The Executive Nurse and members of the Quality Team have weekly discussion with operational directors, EPUT is part of a collaborative and a QI Facilitator is leading on restrictive practices in the</p>	<ul style="list-style-type: none"> • Restrictive Practice Working Group • Clinical Governance • Quality Committee

	Trust.	
Upgrading existing estate is a priority, must have good environments and be fit for purpose. (Verbal statement at PACAC)	EPUT has an Estates Strategy which is monitored by the Capital Planning Group and then the EOSC	<ul style="list-style-type: none"> • Capital Planning • EOSC • Estates Expert Reference Group