Summary Table: Government's response to the recommendations of the PACAC inquiry following PHSO report on failings at North Essex Partnership University NHS Foundation Trust

Summary of PACAC recommendations	Government's response	Commentary	Legislation
The Committee notes with concern the significant body of evidence from the Care Quality Commission, the PHSO report and others that there is a need for significant improvements in the safety and quality of mental health provision. The Minister and the NHS should make this an urgent priority.	Accepted	The 2019 **National Patient Safety Strategy** covers development of a new incident reporting and learning system, a focus on improving the quality of local investigations and a new national committee – **Mental Health Safety Improvement Programme** (MHSIP). **Mental Health Patient Safety Networks** will be supported by **Patient Safety Collaboratives**. The Networks are to operate as the engine room for safety improvement and will initiate specific work on suicide prevention and self-harm. NHS England/Improvement will be supporting Mental Health Trusts to refresh and expand their **zero suicide plans** to include community settings.	Currently taking into consideration feedback on the White Paper on Independent Review of the Mental Health Act. Progressing to develop a **Bill to amend the Act**, which will be brought forward **when Parliamentary time allows**. Final guidance and implementation of the Mental Health Units (Use of Force) Act 2018 expected November 2021.

		The Department of Health and Social Care's support to the **Zero Suicide Alliance** from 2019-2021 is highlighted. The **National Quality Improvement Taskforce** seeks to make a rapid set of improvements by March 2022. **Provider collaboratives** will be working to strengthen commissioning oversight.	
In this context, the Committee welcome the steps that the NHS and the Department of Health and Social Care are taking to improve safety and the quality of mental health care provision. They agree 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.	Partially accepted	NHS England/improvement and Health Education England are **considering** whether **training** should be mandated. HEE worked with the Academy of Royal Colleges to develop the first ever national Patient Safety **syllabus** – a new approach to patient safety with an emphasis on a proactive approach to identifying risks.	
The PHSO report powerfully demonstrates the need for effective leadership within the NHS. Good leadership is not just about taking action and giving clear direction. Good leaders also empower people to speak with candour, enable difficult conversations to take place, and hear uncomfortable truths, so that concerns and problems are addressed. Furthermore, mistakes and service failures must be acknowledged early. The Committee welcome the Government's plans to specifically cover plans for leadership in the NHS within the People Plan, to be published	Accepted	Effective leaders empower people to speak with candour. The Zero Suicide Alliance developed a culture change awareness training package for NHS Trust boards to encourage understanding of the impact of a "Just and Learning Culture".	

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.			
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.	Accepted	As part of Care Quality Commission's new strategy, published in May, the CQC wants all services to have stronger safety and learning cultures. Safety is a key concern for CQC as it is consistently the poorest area of performance in their assessments.	
The Committee welcomes the minister's commitment that the families affected will be fully involved in the NHS Improvement and NHS England investigation. As they have set out earlier in their report, 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.	Accepted	The PSHO's recommendations pre date both the Health and Safety Executive investigation and the Independent Inquiry announcement. Families and others affected by the deaths were urged to give their views on issues to be considered by the Inquiry. HSIB has implemented a successful family engagement model as part of its approach to investigations which could offer learning for other investigations.	
The Committee welcomes the inclusion of the Health Services Safety Investigations Body (HSSIB) in the Health and Care Bill. In particular, they believe that the introduction of the 'safe space' principle will facilitate more open investigations and proper learning to reduce repeated incidents.	Accepted		

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.	Accepted	NHS England/Improvement has worked with HSIB while developing the new Patient Safety Incident Response Framework. HSIB will support trusts through their training and development curriculum which is currently in its pilot stage.	
The Committee reiterates their previous recommendation that there needs to be fundamental reform of the PHSO's governance, which will require legislation. They comment that it was disappointing that such legislation was not included in the Queen's Speech 2019, but the government and Parliament must ensure that the Draft Public Service Ombudsman Bill is scrutinised by a Joint Committee of both Houses of Parliament as soon as possible.	Partially accepted	The Government is considering how it can reform Ombudsman arrangements for the UK and England.	Work reforming PHSO has been paused and will require significant legislative time.