In the Matter of the Lampard Public Inquiry

Opening Statement on behalf of Essex Partnership University NHS Foundation Trust

1. Introduction.

1. This is the Opening Statement of the Essex Partnership University NHS Foundation Trust, which will be referred to as EPUT or "the Trust" throughout these submissions. If the Statement uses the term "we", it is referring to EPUT, its Board and its staff.

2. In these remarks, we offer an apology for failing patients and their families, when care and services have not been safe. We have acknowledged some of the main areas in which this has occurred. We have set out how the Trust and its Board is responding now, by referring to some of the key areas of ongoing change that we hope will be explored further in the Inquiry. The Trust Board is committed to engage candidly with the Inquiry. Finally, we have set some of the challenges faced by the Trust in their national context, in the hope that the Inquiry might explore this context further and it can be confident that learning from Essex will help to improve patient services across the UK.

A. Apology

3. This Opening Statement is written at an early stage in the Inquiry, as part of a journey which we hope and anticipate will enable much learning and further change.

4. But the Trust would like to start by apologising, on behalf of both EPUT and its predecessor organisations, to everyone who has been failed – patients, family members and carers - by NHS mental health services in Essex. Patients, families and carers have a right to expect safe services and these were not always provided. EPUT's Board and its staff are committed to doing all they can to support Baroness Lampard and the Inquiry team to give patients, families and carers the answers they have been waiting for.

5. In a statement provided as part of the Health and Safety Executive's prosecution of the Trust, the Trust's Chief Executive Paul Scott expressed profound apologies on behalf of the Trust to the families and friends of those who tragically lost their lives and for the pain and distress they continue to experience. He went on to give a personal assurance to learning from the patient deaths which formed the focus of the prosecution, with a commitment to improve the environment, culture and care for all patients served by the Trust.

6. The Trust would like to repeat this apology and those assurances now, to all the families and friends who have lost loved ones so that services locally are improved, and the lessons learnt can be shared widely. We also offer condolences to anyone who has lost a loved one as a result of failings in care within Essex Mental Health services. Each loss is a tragedy. EPUT understands the importance of learning lessons from failings and from the Inquiry and to giving the fullest and most careful consideration to the Inquiry's findings and recommendations, to reduce the risk of further losses. EPUT is striving to improve care for those with mental health needs both within Essex and the wider NHS, as the Inquiry proceeds and in the light of any findings and recommendations that it ultimately makes.

7. EPUT fully appreciates that the information that will be shared and discussed during the Inquiry will cause much distress for the bereaved and many current and former patients. The Trust, working with others in the wider NHS and alongside the voluntary sector, will do all it can to support people affected during this time and beyond.

2. Background

8. Before the Trust addresses some of the issues and failings that the Inquiry will cover further, it may be helpful to give some context and background about the formation of the Trust. We have then turned to failings, what has been done to improve care by the Trust, and to the national picture.

A. Overview of EPUT

9. The current Essex Partnership NHS Foundation Trust was formed by the merger between North Essex Partnership and South Essex Partnership University NHS Foundation Trusts ("NEPT") and ("SEPT") on 1 April 2017. In the context of this Inquiry, looking back as it will over some 24 years, we, EPUT, are the corporate body which has taken over the responsibilities of the preceding trusts NEPT and SEPT [1]. We refer to EPUT, NEPT and SEPT together as "the Trusts". The creation of EPUT in 2017, and the appointment of Paul Scott as CEO in 2020, were all part of a process of widespread change to ensure the delivery of safe and therapeutic care to patients.

[1] The North Essex Partnerships University NHS Trust was previously known, at various times, as the North Essex NHS Foundation Trust, the North Essex Mental Health Partnership NHS Trust, and the North Essex Mental Health Foundation Trust. South Essex Partnership University NHS Foundation Trust (SEPT) has also been known as the South Essex Mental Health and Community NHS FT. The names reflect changing configurations, over the years.

10. This is not the time to outline further the complexities of the past organisational history. But during the 24 years covered by the Inquiry's Terms of Reference, there have been widespread changes to national Mental Health policy and resourcing, to the regulatory landscape and in the commissioners to which the Trusts have been accountable, to the physical sites from which services were provided, and across the teams that delivered care. There have been significant changes to hospital site configurations, services, IT systems, personnel and organisational changes.

11. EPUT now provides community health, mental health and learning disability services to support more than 3.2 million people living across Essex, Luton and Bedfordshire and Suffolk. This is a wider footprint than the framework set by the Inquiry's terms of reference, which commit it to looking at events within Essex. EPUT works across more than 200 sites with more than 6,500 staff. There are around 100,000 patients in its care at any one time. EPUT provides a variety of mental and physical health services – from acute mental health inpatient care to diabetes and end of life community-based care.

12. Many of the steps taken by the Trust have taken place against the backdrop of the pandemic in 2020 – 2023, which created particular stresses for both the patients, their families and loved ones as well as staff. EPUT was the lead provider for the COVID-19 vaccination programme, delivering approximately 1.6 million vaccinations to people in Essex, Suffolk and Norfolk. Generally, over the course of the 24 years covered by this Inquiry, there has been rising demand for services, including considerable pressures on beds and large numbers of out of area placements.

13. In 2021, EPUT launched its vision to be the "leading health and wellbeing service in the provision of mental health and community care" and since then we have continued the programme of wholesale change with safety and engagement as key drivers in the delivery of this vision. Prior to this and immediately following the merger of NEPT and SEPT a programme of surveying and the removal of ligatures commenced as part of the work to bring the two organisations together. A focus of investment in inpatient environment was also undertaken as well as the review and trial of new technologies including body worn cameras and other technical aids such as Oxevision. Whilst the Trust is clear about the scale of the challenges and is making significant progress, we know that there is more to do, and much to learn from this Inquiry and from those who will share their experiences.

B. EPUT's Engagement with the Inquiry

14. The Trust is committed to working with the Inquiry and is currently in the process of responding to its requests for statements. To date, we have been asked to respond to [5]

requests for witness statement (or "Rule 9 Requests") and have filed [5] draft statements as a result, which the Inquiry will disclose to Core Participants and the wider public in due course. The Trust expects to receive many further requests and will respond as fully as we can. The Inquiry has produced a detailed draft List of Issues and the Trust knows that the causes of deaths of patients in its care, as well as other serious safety incidents and possible failings in care, will be explored in detail during the Inquiry.

15. EPUT has established a Lampard Oversight Committee which reports directly to the Board and is jointly chaired by the Trust's Audit Committee Chair and Senior Independent Director. In addition, EPUT has a dedicated Inquiry Project Team which includes a Registered Mental Health Nurse. An organogram detailing the team is attached to the Trust's first R9 response, and these arrangements will ensure that the Trust considers any emerging learning from the Inquiry, as it continues.

3. Care Failings

16. EPUT is making determined efforts to improve services. However, the Trust approaches this Inquiry, and the evidence that it will hear, very conscious of the fact that despite significant improvements over recent years and a transformative plan to improve patient care and services, EPUT still has many improvements to make.

17. The Terms of Reference, together with the Inquiry's Explanatory Note and its draft List of Issues, set out a comprehensive list of areas for investigation. EPUT acknowledges, from the outset of this Inquiry, that there have been significant failures to deliver safe and therapeutic patient treatment and care. We will seek to assist the Inquiry in investigating all these issues. At this early stage, it has highlighted a number of the areas in which there have been significant failings. But the relatively brief summary which follows below is not intended to be either an exhaustive list of failings or an analysis of their causes.

18. Ligature Points and other environmental risks to patients. Many people will know that the Health and Safety Executive brought a prosecution against the Trust. In November 2020, the Trust pleaded guilty to a charge that, during the period from October 2004 to the end of March 2015, we failed to manage the environmental risk from fixed ligature points within our inpatient mental health wards, exposing vulnerable patients in our care to the risk of harm. During this period, some 11 inpatients hanged themselves using ligature points and in addition, others were also harmed due to the failure of the Trust to eliminate ligature points on our wards. In the prosecution, the Trust accepted that lessons learned did not

always result in all the required or effective remedial action; and we also know that further deaths involving fixed ligature points occurred after 2015.

19. Shortcomings in staffing numbers, staff culture and conduct, and internal reporting mechanisms. We know that there have been serious issues raised about staff conduct, including the neglect and abuse of patients, staff falling asleep on duty and inadequate patient observations. Low staffing levels, including levels below those authorised by the Trust, were reported in various wards. Although it registered some areas of improvement in culture and staff morale, the 2023 Care Quality Commission ("CQC") report also highlighted areas where the Trust needed to act to support staff. This included staff and managers' failure to report or escalate incidents of abuse of staff, including in cases of racial abuse of staff by patients, which the CQC was told was seen "regularly". The overall rating given by the CQC was "requires improvement".

20. Sexual and Physical Abuse. The Trust acknowledges that there have been serious allegations of sexual assault of patients by staff and also of staff by other staff members. There is a history of criticisms in relation to a lack of segregation on wards, which leads to sexual safety risks. The Trust also acknowledges that there have been a significant number of incidents involving violence, abuse and excessive use of restraint. The Channel 4 Dispatches Documentary in October 2022 highlighted issues within the scope of this Inquiry, including the abuse and mockery of patients by staff and the excessive use of restraint, and was followed by CQC inspections in November 2022.

21. Absconding. Patients sectioned under the Mental Health Act have left the grounds of Trust facilities and failed to return. Sometimes they have left without authorisation and sometimes after being granted day release or other forms of leave, but they have failed to return as agreed. The seriousness of the risk is illustrated by the fact that a number of absent patients have taken their own lives.

22. Discharge and assessment of patients. Patients have taken their lives shortly after being discharged from the Trust's care, after delays in receiving prescriptions, medication or urgent mental health support, or following assessments of their mental health needs that were later found to be inadequate (due to inaccurate or out of date care plans, insufficient monitoring or errors and oversights in patient records and information-sharing). The co-ordination of services, including communication with partner organisations and services, has been a repeated issue.

23. Involvement of family and friends. Failings in care have been exacerbated by failures on the part of the Trust to listen properly, or to act upon, the concerns of patients, family and

friends. Whilst there is a lot of work happening now (mentioned below) aiming to capture the feedback of service users, families and carers and to make sure that it is listened to, the Trust acknowledges that its failure to listen has led to inadequacies in care planning and the management of patients' care.

24. Issues with EPUT facilities. Safety, hygiene and quality issues have been identified at a number of EPUT facilities. Last year's CQC report of July 2023 downgraded the status of the Trust adult mental health wards and psychiatric intensive care units to 'inadequate'. Some wards showers and bathrooms were said to be "visibly dirty" and the overall environment "worn and gloomy".

25. Staff Engagement with investigations. We know that concerns were raised by the Essex Mental Health Inquiry's former chair, Dr Geraldine Strathdee, about the lack of staff response and engagement with her Independent Inquiry and its work.

26. As a result, we welcome the statutory powers of the Lampard Inquiry which gives legal clarity to the position of witnesses and to the work of the Inquiry in general. The Trust is doing all that it reasonably can to ensure that staff members – past and present – engage fully with the Inquiry and give full and frank evidence. We have provided regular updates to all staff via a variety of methods including direct email from both our CEO and Executive Director lead and have held dedicated all-staff sessions to answer questions. We have also conducted a series of site visits to ensure that all staff are aware of this Inquiry and the important role they have to play in it.

27. Professionals in the NHS owe obligations of candour. But in addition, the Trust has put in place arrangements by which staff members can seek legal advice and support in giving evidence. The Trust is open to considering any further suggestions to protect the interests of those who wish to speak up and which would further the public interest in the Inquiry hearing candid evidence from the widest possible group of staff members.

4. The Current Leadership and Remedial Programme.

A. Change Programme

28. Even as this Inquiry progresses, EPUT continues to treat patients on a daily basis. As set out above, at any one time there are some 100,000 patients in EPUT's care. Despite the serious failings that have been acknowledged and the ongoing challenges, there have also been improvements and change, initiated by the new Board after EPUT was formed in April 2017. Progress has not always been smooth or uninterrupted, and we know that there have been further tragedies as well as external shocks like the COVID-19 pandemic.

But there has also been significant development of services and our links with partner agencies and Universities. The work is led by the EPUT Board, which has focussed time and resources on understanding the issues and in taking action to address them. The Board appointed the first Director of People and Culture in August 2019 and then the 'Freedom to Speak Up' Guardian, both key posts in promoting cultural change amongst staff.

29. We have outlined some of the main steps that have been taken since 2017 to ensure that services are safe and meet patients' needs. Again, this is not a complete account – full details will be set out in statements and other evidence to the Inquiry, and explored by it.

30. On the topic of ligature points and other environmental risks, there is now a Ligature Risk Reduction Group that meets every month and is chaired by the Executive Chief Operating Officer. After its formation in 2017, EPUT undertook a full fixed ligature review across all Trust inpatient wards and spent over £6.3m on the removal of fixed ligature points. Further gaps have been tackled by the £20 million spent, since 2020, on inpatient services addressing environments and safety, including further work to reduce fixed ligature risks across the estate. All Mental Health and Learning Disability wards had a Ligature Environmental Risk Assessment carried out in the last year, and received a 6 month follow up review which focused on clinical risk management and staff coaching.

31. The need for training reflects the many complexities of this area of risk. There has been a pattern of the risk shifting from secured ligature points (such as door handles) to unsecured ligature points (e.g. clothing and bedding). Thus, managing ligature risks in the physical environment must be considered in the wider context of care provision, including training, staffing, security, patient risk assessment, patient engagement, observation and care planning. In relation to bedroom doors, the Trust is mitigating risk by using assistive technology such as Door Top Alarms, and these were in place for some 96% of inpatient incidents during 2023/24.

32. Patient Safety. In 2021, EPUT launched its patient safety strategy, 'Safety First, Safety Always' with the ambition to provide the safest possible care. It has introduced new technologies to support safer care, including the remote monitoring tool Oxevision (which allows staff to continuously track the vital signs of patients, monitor their activity and conduct observations) alongside CCTV and body worn cameras, all of which may provide data if there are safeguarding concerns. EPUT recognises that such technology must not be a substitute for in-person observations and that staff must be properly trained, confident in its use and aware that this does not replace their role and duties to check on patients if

the alarm is activated. Further information about Oxevision will be supplied in the Trust's Rule 9 statements to the Inquiry.

33. EPUT was an early adopter of NHS England's Patient Safety Incident Response Framework, rolled out to all NHS Trusts in 2023. The Framework governs how EPUT investigates and learns from patient safety incidents. EPUT has now assisted other Trusts in introducing this Framework.

34. Staff Numbers and Culture. We know that the mental health workforce nationwide has been under significant stress, with workforce shortages affecting staff workload, wellbeing, morale and the ability of staff to provide high quality care.[2] Against that background, EPUT has undertaken a major recruitment drive. The Trust welcomed over 1,700 new colleagues in 2023, including over 220 from overseas. EPUT is now accredited with the NHS Pastoral Care Quality Award for support offered to nurses and AHPs recruited internationally. Vacancy rates in the inpatient units have fallen to 10 per cent from an all-time high of 40 per cent in 2020 and EPUT is on track to have no inpatient unit vacancies by the end of 2024. While the vacancy rate will be much lower, we know that we will still be recruiting to Time to Care, see below, vacancies in December 2024, although we remain on track to further reduce our vacancy rate.

35. Through a major transformational programme, 'Time to Care' we have created new roles, including new site managers (senior nurses) at Rochford Hospital and Linden Centre to support staff and to address conduct such as the staff sleeping on duty reported by the CQC in its July 2023 report. The Trust has introduced a new Behaviour Framework to ensure every member of the organisation understands their responsibilities and their duty of care, including the need to report incidents of abuse.

36. The sexual and physical safety of both patients and staff continues to be an area of focus and concern for EPUT, which will give the fullest co-operation to any police investigation of criminal allegations. EPUT has signed up to the NHS sexual safety charter launched in September 2023, which provides the framework for a zero-tolerance approach to unwanted, harmful or inappropriate sexual behaviour for both patients and staff and has refreshed patients' leaflets and posters. All this is linked to the cultural change that we have already referred to, including the importance that EPUT attaches to the Freedom to Speak Up initiatives and the staff Behaviour Framework.

[2] BMA Report, Mental Health Workforce Report, 28 June 2024 < https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/mental-health-workforce-report >

37. Quality of Care and Family Engagement. As detailed in 35 above, the Trust has recently developed 'Time to Care', which is a five-year programme of change, co-created with service users and their families. The Trust plans to recruit more than 300 full-time equivalent posts, adding new therapeutic staff roles to teams on wards (e.g., occupational therapists, physiotherapists, and activity co-ordinators). We have also funded the appointment of peer support workers as part of our commitment to involve people with lived experience within our services and to help shape changes going forward. Recruitment to these roles is now underway. Time to Care will invest £14.4m in 2024/25, with further investment annually over the 5 years of the Time to Care Programme. The investment allows for planned reductions in the numbers and use of temporary staff and a reduction in out of area placements. This enables greater continuity and quality of care, an increase in care hours per patient, lower sickness levels, improved staff retention and improved length of stay on our wards, all of which support the delivery of a better patient experience. Time to Care also aims to ensure that support and technology are in place to enable Trust staff to spend more time in direct patient care. Further details of the 'Time to Care' programme are contained in a draft witness statement provided in response to a request from the Inquiry. In addition to the above and as mentioned earlier, the Trust has also completed recruitment of international nurses with an investment of £6.7m in 2023/4.

38. We know that families have not been involved or listened to properly in many instances where there were tragic harms to patients. EPUT is committed to developing a "*family first"* approach to our services and to working with service users, families and carers to support people to manage their own care and support their loved ones. We are determined to progressively build and further strengthen patient and public participation as a golden thread woven throughout our strategic priorities and plans. There has been a renewed focus on listening to patients, families and carers:

    a) In 2021 EPUT introduced our Reward and Recognition Policy for People with Lived Experience so that people with lived experience are paid (or can choose to receive other non-monetary recognition) when working on co-design/improvement work. In 2023, this facilitated the introduction of peer support workers on our wards.

    b) The Trust has introduced the patient, carer and family collaborative – a key decision-making body made up of patients, carers and staff at every level of its organisation that meets on a quarterly basis. We have also appointed a service user as our co-production lead.

    c) These feedback routes are supplemented by the EPUT Forum and 'iWantGreatCare', its feedback service for carers, service users and families.

d) The number of Lived Experience Ambassadors employed by the Trust has tripled over the last two years with more than 200 current and former patients now working alongside EPUT to shape improvement.

B. Embedding Change

39. Some of this work was recognised in the most recent CQC inspection (Dec 2022, published in July 2023). The Trust is not seeking to gloss over the many failings identified and the CQC ratings on "requiring improvement". But it is also fair to note that the CQC did rate the "caring" dimension of the Trust's services as "good", recognising that patients and carers gave "largely positive feedback" on the way staff treated them and the support they offered. The CQC also recognised a number of areas where there had been improvements, including:

a) "There was a full recognition by the trust of the need to continually improve the culture of the organisation. The freedom to speak up guardian, although in an interim post, had worked hard to increase their visibility and share the importance of speaking up … The trust board displayed positive role modelling behaviours which they demonstrated through the well led review …."

b) "The trust was actively involved [in] work across the systems relevant to Essex…. A priority for the board was to ensure that the trust faced outwards and developed a reputation of transparency and openness."

40. The Trust Board recognises the need to embed change throughout the organisation, to ensure that strategies are effectively implemented at every level and influence every patient interaction

5. The National Context

A. Investigations and National Information Sources

41. EPUT operates as a statutory body within the wider NHS, operating at a local level alongside bodies such as Integrated Care Boards, other provider NHS Trusts, independent sector providers of mental health and social care, primary care providers and local authorities. Overall, the NHS is regulated and inspected by the Department of Health and Social Care and by national bodies such as the Care Quality Commission, the Health and Safety Executive, and NHS England. The delivery of services to individual patients by different providers clearly overlaps and whilst integration is a key NHS objective, including

with social care, this is a complex system set within a statutory framework and subject to national guidance and regulation.

42. Sadly, the Lampard Inquiry is not unique in the focus of some of its work. At present there are a number of public inquiries considering issues touching on the performance of the NHS. These include the UK Covid-19 Inquiry and the Thirlwall Inquiry, and there has recently been a commitment that there will be a judge led inquiry to learn lessons from the tragic killings in Nottingham by a former patient, treated for paranoid schizophrenia.

43. There have also been a range of investigations into issues in Mental Health services across the UK, including in relation to subjects that are the forefront of this Inquiry, including the Wessely Independent Review of the Mental Health Act, as well as various CQC and other reports. For example, Dr Strathdee was commissioned by the Department of Health and Social Care to carry out a "Rapid Review into data on Mental Health Inpatient Settings".[3] She found that there are significant difficulties in obtaining and interpreting mental health data at present. Her report identified "*significant challenges in providing an overview of how many people die while in contact with inpatient services and the cause of their deaths. There is no published national overview of the deaths of people in inpatient mental health settings nor of the total number of deaths of people in contact with mental health services at provider level."* She made a range of recommendations to improve data collection.

44. In looking at the national context, it is apparent from reports such as:

    - The National Confidential Inquiry into Suicide and Safety in Mental Health[4]
    - The CQC reports on deaths of patients detained under the Mental Health Act.[5]
    - The Zero Suicide Alliance – Prevention Resource Map[6]

    that, sadly, there has and continues to be a high risk of self-inflicted death for those with mental illnesses. There are – at least now - a number of data sources regarding patient safety and death, but it is clear that concerns have been raised in numerous reports about the quality of data which is available to enable qualitative analysis of mental health services and their safety across England.

[3] DHSC Independent Report, Rapid review into data on mental health inpatient settings: final report and recommendations, 21 March 2024 < https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations >
[4] National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2023
[5] CQC Monitoring the Mental Health Act in 2021 to 2022
[6] ZSA Suicide Prevention Resource Map and Feedback — NHS Benchmarking Network

45. Currently, the Healthcare Services Safety Investigations Body (HISSIB) is carrying out an investigation into the safety of mental health services, due to conclude by the end of 2024. HISSIB will develop "Learning from inpatient MH deaths, and near misses, to improve patient safety" by examining the mechanisms that capture data on deaths (and near misses) across the Mental Health (MH) provider landscape, including up to 30 days post discharge.[7]

46. HISSIB will further examine topics such as local, regional, and national oversight and accountability frameworks for deaths in MH inpatient services, as well as creating the conditions for staff to deliver safe and therapeutic care – workforce, relationships, and environments.

47. Many further issues raised by the Inquiry's Terms of Reference have long been concerns in relation to Mental Health services nationwide. For example, the Wessely Review identified extensive problems with the Mental Health inpatient estate describing the environment as being "anything but therapeutic", explaining that "Facilities are substandard and worn out. This makes delivery of good care difficult." The review called for capital investment by the government and NHS to "modernise the NHS estate" and improve physical environments. The CQC report on the state of care in Mental Health services 2014 to 2017 also raised concerns that services across the country were using sub-standard buildings.

48. Ligature risk was identified by the CQC in its 2014-17 report as being an issue, as many wards contain "fixtures and fittings that people who are at risk of suicide could use as ligature anchor points." Self-harm by ligature is one of the most common methods of suicide within inpatient mental healthcare settings. The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Reports investigate data on UK suicides and the 2022 Report found that between 2009-2019 found that 49% of deaths by hanging or strangulation on wards used a door as a ligature point. Best practice guidance, such as that contained within the Department of Health's Environmental Design Guide, can help to reduce risk, but it is challenging to eliminate all risks, with deaths by strangulation taking place in circumstances where there is no ligature point.

49. Sexual safety on mental health wards is also an ongoing issue. A 2018 CQC review of the issue found that sexual incidents are "*commonplace"* on mental health wards. It noted that incidents go unreported or were not investigated, that gender separation was neither

[7] https://www.hssib.org.uk/patient-safety-investigations/mental-health-inpatient-settings/terms-of-reference/

achieved nor well managed, that staff had not received adequate training and that risks assessments and care plans were not always in place in relation to sexual safety. The CQC also found issues with joint-agency working, and little knowledge among clinical leaders about promoting sexual safety.[8] The overarching report relating to Jimmy Savile authored by the Chair was also clear in recommending the need for clear safeguarding processes to be implemented by NHS hospital trusts.[9]

50. Staffing is a further area of common difficulty. Services have struggled to ensure adequate staffing. There is a national shortage of mental health nurses. In areas of high staff turnover this can create a negative effect on morale which is difficult to address. Filling in the 'gaps' with agency staff can cause issues with patients' experience and continuity of care; and in the worst cases the CQC found that it could affect safety.

51. Other systemic issues that are relevant to this Inquiry include poor clinical information systems, issues with the physical health care of people with mental health conditions, long waiting lists and limited access to services, and extensive use of restraint to de-escalate challenging behaviour. Many of these issues have been commented on in the King's Fund Mental Health 360 – Review of Mental Health Care[10], only published in February 2024, one conclusion from which was:

"*There is a great deal of data on mental illness and mental health services. However, issues with coverage and quality of data limit its value for being able to plan services and understand what is going on. This directly impacts on the quality and safety of care, and efforts to improve care.*"

B. Observations on the National Context

52. The Terms of Reference of the Inquiry anticipate that the Inquiry may make recommendations intended to apply nationally. Against this background, we would invite the Lampard Inquiry to build upon the work of previous reviews and ongoing inquiries. It may wish to take into account the recommendations made elsewhere by other public bodies and assess the data available to enable analysis of the national context. Indeed the previous reviews, and any barriers to implementation of their recommendations, may offer insight into the challenges surrounding the provision of quality mental health services

[8] CQC, Sexual safety on mental health wards, 11 September 2018
[9] Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile, February 2015
[10] Mental Health 360 | Review Of Mental Health Care | The King's Fund (kingsfund.org.uk)

across the 24 year period and give a flavour of the complex system within which mental health service providers operate.

53. EPUT also takes the view that identifying effective levers to address such challenges, whether they consist of guidance, capital investment, or staffing transformation, is critical for its services and others across the country. We hope to learn from any examples of good practice that might be identified. To that end we would be keen to see evidence commissioned by the Inquiry on 'what works' – and to identify durable solutions to problems that are stubborn, deep-seated and widespread.

54. In relation to national benchmarking data, it is our submission that the Inquiry should seek both to understand what is available and what is not, both to place issues and outcomes within EPUT in a national context and to inform its recommendations. Although data quality and completeness issues make the task difficult, we highlight the importance, for the Inquiry, of seeking to put deaths and care at EPUT into a national context, including examining the extent to which EPUT and its predecessors have been outliers. If the Inquiry is to make recommendations that can have a national application, they would be informed by information about whether what is being examined is a national or a local issue.

55. It is important that collectively the wider NHS and health sector should understand and take action as a result of the learning that Baroness Lampard and her team will undoubtedly deliver. The Trust sees this Inquiry as a space for openness and transparency, as well as willingness to be accountable and to take action which exceeds the reputations or cultures of individual organisations. We commit to approaching the Inquiry in an open, collaborative and supportive way to achieve this.

6. Conclusion

56. In closing the Trust would like to reiterate to all those who have suffered the loss of a loved one that we are sorry; and to acknowledge that even when there may be a firm hope and belief that Inquiry will deliver the answers they have been seeking, nothing can bring back a loved one. The Trust will hold that truth with it as it moves forward with its commitment to deliver safe and therapeutic care to patients.