

Provisional List of Issues

This List of Issues has been prepared to help guide the Inquiry's investigative work.

The intention is to provide a more detailed approach to the investigation of the issues raised by the Inquiry's [Terms of Reference](#).

It may evolve as the Inquiry starts to receive evidence and undertake its investigations, with issues being added, removed or amended, as appropriate.

There may also be issues which, due to the passage of time and lack of available evidence, cannot be answered, fully or in part.

For the avoidance of doubt, this List of Issues is not intended to, nor would the Inquiry be permitted to, expand or capture issues outside the Terms of Reference.

Nothing in the drafting of this List of Issues should be taken to indicate any decision or conclusion by the Chair (or the wider Inquiry team) on the possible outcome of the Inquiry's investigations.

Written submissions from interested persons on its content are welcomed by the Inquiry and should be received by email or post before 31 July 2024. Written submissions should not exceed more than 4 pages in length.

A. Background and Landscape to NHS Funded Mental Health Inpatient Care and Treatment in Essex

1. Who provided NHS funded mental health inpatient care and treatment in Essex between 1 January 2000 and 31 December 2023?
2. How did these providers operate? How were they structured, funded and regulated?
3. How did placements with independent providers, or inpatient units out of area, work in practice? What was the nature and extent of any relationship(s) with NHS Trusts and / or commissioners in Essex?

B. The Pathway – Care and Treatment of Those Who Died

Assessment

4. Where an assessment for detention under the Mental Health Act 1983 took place, was it carried out appropriately and in accordance with legislation and the Code of Practice?
5. Where an assessment for detention under the Mental Health Act 1983 took place and a person was deemed to not meet the threshold for needing inpatient care or treatment what, if any, action was taken?
6. Where a capacity assessment took place, was it carried out appropriately and in accordance with the Mental Capacity Act 2005 and related Code of Practice?
7. Were decisions not to assess a person under the Mental Health Act 1983 or the Mental Capacity Act 2005 appropriate?
8. How frequently, what type, and in what circumstances was another form of assessment undertaken in relation to mental health admission and inpatient care and treatment? To what extent were such assessments appropriate and / or conducted in accordance with associated guidance and expected practice?
9. Where the decision was taken not to admit the patient following a mental health assessment, what if any, action was taken?

Admission

10. How were decisions as to admission made? What factors influenced where a patient was admitted, and to what extent was this justified?
11. What policies and procedures were followed when an inpatient was admitted onto a ward? Were these sufficient and appropriate in the circumstances?

Ward Environment

12. To what extent was consideration given to the ward environment from an inpatient perspective? What standards and expectations applied? How did it meet basic needs, be therapeutic and / or assist recovery?
13. How were factors relating to individual patients, such as neurodiversity, learning disabilities, dementia, co-existing physical health issues, drug and alcohol addiction,

and other social and economic factors considered and subsequently managed in this regard?

14. Were premises fit for purpose?
15. What, if any, impact did the ward environment (including, but not limited to, ward layout and / or the use of technologies on a ward) have on inpatients?
16. How, and to what extent, was an inpatient's privacy and dignity retained?

Treatment

17. How were decisions about a mental health inpatient's treatment made?
18. Was the treatment provided to mental health inpatients both appropriate and adequate?
 - a. Specifically, how was medication administered and managed?
 - b. How was risk managed and was this properly balanced with therapeutic care?
 - c. How were comorbid issues dealt with?
19. How did providers approach treating those who did not agree to taking their medication or who lacked capacity? Were second opinions appropriately sought?

Leave, Absconion and AWOL inpatients

20. How did providers deal with requests for leave (supervised and unsupervised)? What information was considered? Was this appropriate?
21. In relevant cases, how did patients manage to abscond from inpatient wards? Were safety precautions / preventative measures sufficient? If not, why not?
22. Where an inpatient absconded from a ward or was absent without leave (AWOL – for example, by failing to return following a period of leave), what processes were in place? Were these appropriate, adequate and adhered to?

Care Management

23. Was the care provided to mental health inpatients both appropriate and adequate?
24. What was the role of a care plan? How was one formulated and subsequently used?
25. How were decisions as to risk and observation levels made? What information was considered? To what extent were such decisions appropriate and adhered to?
26. What restrictive practices were employed by providers and how were they used? Were they used appropriately?
27. What consideration was given to the Deprivation of Liberty Safeguards for those who lacked capacity?
28. When any type of restraint (manual, mechanical, chemical or seclusion and long-term segregation) was used, was it used and recorded appropriately? If not, why?

29. How were records created, kept and updated during an inpatient's stay? What systems were used? Was sufficient detail recorded?
30. How, and to what extent, was inpatient information shared between staff and / or across teams? Was this sufficient and appropriate in the circumstances?
31. How, and to whom, could concerns about an inpatient's care and treatment be raised?
32. How were decisions as to when an inpatient should be transferred to another unit / setting made? What factors were taken into account? To what extent were such decisions appropriate?

C. Discharge and Continuity of Care and Treatment in the Community

33. When and how did providers start discharge planning?
34. What discharge procedures were in place and were they followed?
 - a. To what extent was statutory guidance abided by?
 - b. Were second opinions appropriately sought?
35. What was the role of a care co-ordinator and what were their associated responsibilities?
36. To what extent were decisions around discharge appropriate? Was all available and necessary information known at the time of a decision relating to discharge? If not, why not?
37. Was any community-based support, set up by providers, sufficient and appropriate in the circumstances?

D. Engagement

38. From the point of admission through to discharge, what level of information, was communicated to and / or obtained from inpatients, their families, carers and / or other members of an inpatient's support network during their time on an inpatient mental health ward?
 - a. What provisions or measures were in place to ensure that this information had been properly received and understood? Were necessary adjustments made to accommodate those who had known difficulties with communication?
 - b. How, and to what extent, was this documented?
39. How, and to what extent, were inpatients, their families, carers and / or other members of their support network involved in decisions relating to their care and treatment? Noting NHS guidance, was this sufficient and appropriate in the circumstances?
40. How, and to what extent, did providers co-operate with others to plan, commission and deliver safe discharge plans and aftercare? Was this sufficient and appropriate in the circumstances?

41. How, and to what extent, were inpatients who suffered serious harm, their families, carers and / or other members of their support network supported by providers following the incident? Was this sufficient and appropriate in the circumstances?
42. How, and to what extent, were families, carers and / or other members of an inpatient's support network:
 - a. informed of an inpatient's death; and / or
 - b. communicated with during and after any internal investigations.
 What, if any, support was offered? Was this sufficient and appropriate in the circumstances?

E. Safety

43. What steps were taken by providers to identify, assess, evaluate and mitigate safety risks to (a) inpatients (including when on leave and on discharge); and (b) staff on mental health wards? Were these sufficient and appropriate in the circumstances?
44. Specifically, what crisis management systems were in place? How did these work in practice?
45. Did inpatients feel safe when they were on mental health wards? Did families, carers and / or other members of an inpatient's support network have any concerns about their safety?
46. Did staff feel safe while at work on mental health wards?
47. What information and / or guidance was provided to inpatients, their families, carers and / or other members of their support network and staff to explain how they should raise concerns about their own, or another person's, safety?
48. Were patient and / or staff safety incidents appropriately reported? If not, why not?

F. Data Collection and Use of Technology

49. What data was captured during an inpatient's stay on a mental health ward?
50. How was it recorded and, where appropriate, analysed? What technology and / or systems were used? Were they sufficient?
51. How long was it retained for?
52. What changes, if any, were informed by the collection of data?
53. Was the correct sort and type of data collected? If not, what other information ought to have been obtained?
54. More broadly, what other technologies were utilised during the relevant period? Did these improve the provision of mental health inpatient care and treatment?
55. Was data collection, storage, processing and analysis appropriate and secure over the 24 year period?

G. Staffing Arrangements, Training and Support

56. What roles were available on inpatient mental health wards and what processes were followed for staff recruitment by providers?
 - a. What criteria were applied?
 - b. How did they seek to ensure consistency in terms of standards?
57. How was the distribution of staff split between permanent, temporary and agency staff, and staff grades? To what extent were permanent, temporary and agency staff expected to perform different roles?
58. Are there any perceivable connections or trends between the composition of staff and the level and quality of care and treatment provided on mental health inpatient wards?
59. What shift frameworks were employed by providers?
 - a. How did providers determine if wards were sufficiently staffed? Were processes sufficient?
 - b. Were caps on the numbers of temporary or agency staff permitted to work on particular shifts applied and abided by? How was this monitored?
60. How, and to what extent, did shift patterns impact on the ability of staff to properly care for and treat mental health inpatients?
61. What was the staff turnover rate on mental health inpatient wards during the relevant period?
62. Are there any trends between staff turnover and the level and quality of care and treatment provided on mental health inpatient wards?
63. What theory-based and / or practical training (on induction and during post) did staff working on inpatient mental health wards receive? Was this adequate?
64. To what extent, if any, did the training provided to permanent, temporary and agency staff differ / vary? Was this appropriate?
65. How was staff training certified and monitored by providers? What action, if any, was taken when a member of staff failed to complete mandatory or essential training?
66. Can any trends or correlation be seen between the type and / or adequacy of staff training and the level and quality of care and treatment provided?
67. What, if any, support (including emotional support) was available to permanent, temporary and agency staff? If there was a difference in terms of the level of support, how was this justified?

H. Management and Leadership (at all levels)

68. How was responsibility apportioned and what was expected of those in managerial and / or leadership positions dealing with mental health inpatient care and treatment?
 - a. What actions, practices and / or behaviours were expected of those in such positions?
 - b. What impact did these individuals have on the culture of providers?

69. What level of supervision did staff working on mental health inpatient units receive? How were reporting lines structured? Was this appropriate?
70. How did those in managerial and / or leadership positions ensure that policies and procedures in relation to the provision of safe and therapeutic mental health inpatient care and treatment were properly understood and implemented?
71. How did those in managerial and / or leadership positions ensure that incidents and investigations were appropriately recorded and / or progressed?
72. How was performance managed, and was it managed effectively?
 - a. In what areas was good practice clearly demonstrated? How was this recognised?
 - b. How were issues relating to poor practice reported and dealt with?

I. Governance

73. How did healthcare providers manage and monitor the provision of mental health inpatient care and treatment?
74. What were the functions of any boards (executive and non-executive)?
75. What factors influenced providers' decision-making and actions? What role did commercial and financial considerations play? How were decisions communicated?
76. What structures, systems, policies, procedures and processes were put in place by providers to support and encourage the delivery of safe and therapeutic mental health inpatient care and treatment?
 - a. How were these designed and monitored?
 - b. How did providers seek to mitigate risk?
 - c. What quality assurances were there?
 - d. To what extent were these structures, systems, policies, procedures and processes appropriate and effective?
 - e. What impact, if any, did resources have?
77. How robust and effective were providers' governance, information sharing and monitoring systems?
78. How did providers implement and monitor improvement processes?
79. Was learning at ward level appropriately captured? To what extent was it shared internally and built on?

J. Culture

80. Were relationships conducive to good quality inpatient care and treatment?
81. Was learning and collaborative working encouraged?
82. Did staff feel supported, professionally and emotionally? How could staff raise concerns, and to what extent did they feel comfortable doing so?
83. Were behaviours and relationships, at all levels, appropriate? To what extent were they in line with provider policies and values?

84. How were any instances of bullying, harassment and / or intimidation managed on a ward and further up the managerial chain?
85. Did those in managerial and / or leadership positions display positive role-modelling behaviour?
86. What was the general culture at each provider? How, and to what extent, did it impact on the care and treatment provided to mental health inpatients?

K. Quality of Investigations Undertaken or Commissioned by Providers

87. How and what investigations were undertaken or commissioned by providers in relation to the provision of mental health inpatient care and treatment?
88. Were investigations undertaken promptly and in accordance with any associated guidance or framework? If not, why not?
89. Who was responsible for fixing terms of reference and / or the scope of investigations?
90. If internal, who was responsible for conducting investigations? If external, how were decisions made as to who would undertake such investigations? What impact did the use of an internal investigator have, if any?
91. Was sufficient resource allocated by providers to these investigations?
92. Were investigative findings of a sufficient quality? Did they produce meaningful results, recommendations or actions for change?

L. Quality, Timeliness, Openness and Adequacy of Responses

93. How, and to what extent, did providers respond to the following in relation to the provision of mental health inpatient care and treatment:
 - a. Concerns and complaints;
 - b. Serious Incident, Root-Cause Analysis, and/or Patient Safety Incident Response investigations (or similar);
 - c. Internal and external audits, particularly when they found shortfalls in compliance and / or unmet targets;
 - d. Inspections and / or investigations by Commissioners;
 - e. Inspections and / or investigations by the Care Quality Commission;
 - f. Investigations by the Health and Safety Executive;
 - g. Police investigations;
 - h. Investigations by HM Coroners Service; and
 - i. Any other investigations or programmes undertaken or commissioned by the provider relating to the death of an inpatient or delivery of mental health inpatient care and treatment.
94. What protections were afforded to whistleblowers and were these effective? Were there any repercussions as a result of whistleblowing?
95. How did providers respond when staff were found to be underperforming, failing to comply with their duties or acting inappropriately on mental health inpatient wards?
96. How were potential issues of mistreatment and / or abuse dealt with?

97. What disciplinary procedures were in place and were these adhered to? Were appropriate referrals made in respect of any fitness to practice and / or potentially criminal matters?
98. To what extent were responses reasonable, open and in accordance with the overarching duty of candour?
99. To what extent was appropriate action taken?

M. Oversight by, and Interactions With, External Bodies

100. How did providers in Essex interact with external bodies, including (but not limited to):
- a. NHS England;
 - b. Special Health Authorities;
 - c. Other NHS Trusts;
 - d. Department of Health and Social Care;
 - e. Commissioners;
 - f. Integrated Care Boards;
 - g. Provider Collaboratives;
 - h. Local Authorities;
 - i. The Health and Safety Executive;
 - j. The Care Quality Commission;
 - k. Other professional regulators;
 - l. Complaints bodies;
 - m. The police;
 - n. National rail;
 - o. HMPPS; and
 - p. HM Coroners Service.
101. To what extent was the level of interaction appropriate and effective? If inappropriate or ineffective, what should the provider have done differently?
102. Where referrals to independent regulators were required, were these made promptly and in accordance with requisite guidelines?
103. What recommendations, including from inquests, investigations, experts and any others within the professional or regulatory sphere were made to improve mental health inpatient care and treatment? Were appropriate steps then taken by providers to act upon such recommendations?
104. To the extent that any recommendations were not implemented, what were the reasons for not implementing them? Were these appropriate in the circumstances?
105. To what extent did any failure to implement recommendations cause or contribute to a decline in the provider's quality and standard of care or treatment?
106. To what extent, if any, was Essex an outlier in terms of the provision of mental health inpatient care and treatment?

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