Essex Partnership University NHS Trust – Position Statement, 27 March 2025

Introduction

1. Essex Partnership University NHS Foundation Trust has been invited by the Lampard Inquiry to file a Position Statement, addressing matters relating to the Inquiry's "Relevant Period", i.e. 1 January 2000 – 31 December 2023. The Inquiry asked for the Statement be signed by a Senior Officer of the Trust (or "EPUT").

2. As the Chief Executive Officer of EPUT since 2020, I am responding to that invitation. I would like to give some context and background to many of the issues that Baroness Lampard and her team are considering. I will also cover some of the steps taken to improve care since the formation of the Trust in 2017, as well as future plans and areas where more progress is required. I hope the Statement will support Baroness Lampard and her team in their important work.

3. I would like to begin by expressing my deepest condolences to all those who have lost loved ones while under the care of Essex Mental Health Services over the past 24 years. Since joining EPUT in 2020, I have had the opportunity to hear from some of these families, either through direct meetings or by listening to their testimonies. Their accounts have profoundly affected me, the Board and everyone in the Trust and I hope this Inquiry provides them with the answers they seek and reassures them that services are evolving for the better as a result of their willingness to share their experiences.

4. I think it is also important to acknowledge the wider issues facing mental health across the sector and some of the issues I touch on will resonate with many other providers of mental health care. Lord Darzi's Independent investigation of the NHS in England - GOV.UK published in 2024 highlights many areas of concern relating to mental health. He specifically cites the significant deterioration in the population's mental health over the last decade and the rise in demand for services, especially among children, young people and within perinatal services.

EPUT – Formation and Responsibilities

5. I have set out observations on behalf of EPUT on the detailed matters that the Inquiry has asked about below, but I need to address the topic of EPUT's formation, functions and responsibilities first.

6. EPUT was formed on 1 April 2017 and has been in existence for just under 7 years of the Inquiry's Relevant Period, which covers 24 years. EPUT was formed by the merger between South Essex Partnership University Foundation Trust ("SEPT") and the North Essex Partnership University Foundation Trust ("NEP"). As the successor in title of these previous Trusts, we hold document repositories relating to these earlier periods. EPUT also inherited their liabilities – including criminal liabilities such as the responsibility of responding to the Health and Safety Executive (HSE) prosecution which took place over 2020- 2021. But, as Baroness Lampard will be aware, the EPUT Board's legal duty is in respect of the leadership and performance of the current Trust.

7. I joined EPUT as CEO six months into the Covid 19 pandemic, in September 2020. The direct impact of the pandemic on how services were delivered fluctuated during this period. The various waves of the virus had different impacts, varying from restrictions on ward visits, the accelerated discharge of patients, Personal Protective Equipment (PPE) needing to be worn in all clinical areas, areas for quarantine being established, high levels of sickness and staff absence resulting in difficulties staffing wards. This was a very disruptive period. We had difficult decisions to make about whether we were able to keep all our wards open for those who needed them. There were also long-lasting impacts of staff tiredness, disruption to established operational and clinical processes and changing behaviours of patients. The health service, and EPUT, are still recovering from the impact of the pandemic.

8. During the pandemic we were also asked to deliver Covid 19 Mass Vaccination services across the majority of Essex and the whole of Suffolk – delivering over 1.6 million vaccines. This was a major, and critical, operation. We needed to recruit and train thousands of people, acquire new properties and develop new clinical protocols. Whilst we are proud of what we achieved there was undoubtedly a diversion of resources, from our core business to running the vaccination programme. This particularly impacted on our leadership, HR processes and clinical safety teams.

9. I think it is relevant to give some sense of the scale and size of EPUT today. The Trust provides community health, mental health and learning disability services to support people living across Luton and Bedfordshire, Essex and Suffolk. We are a large employer in the East of England with more than 7,200 staff working across more than 200 sites. We also provide services in people's home and community settings.

10. Since the Inquiry was set up, we have received a significant number of formal requests from the Inquiry for written statements on various topics, each of them covering the Relevant Period. The process of responding to witness statements is ongoing. We have tried to assist the Inquiry, families and other core participants as well as the public in Essex to the best of our ability, by providing relevant information and copies of documents which we hold. Some of these documents date back to the period before EPUT's formation, and relate to events when NEP and SEPT were still in existence.

11. I and other Board members and staff will do our best to provide the Inquiry with the relevant information held by us about events and periods before EPUT's formation. But in responding to the Inquiry's request for a Position Statement, I can only speak for the current Trust, EPUT. I have made a few comments on what was known at the point of merger, particularly as a result of the 'due diligence' exercise, but I do not have the authority or the knowledge to make assessments about what happened in previous years. Furthermore, it would be potentially unfair to patients and families, and to those staff members of previous Trusts who may be asked to contribute to the Inquiry's work, to set out judgements on the performance of the previous Trusts, at least in this early stage of the Inquiry as information is still being gathered and disclosed.

12. I will keep this position under review as the Inquiry's important work continues. If we believe that we can contribute by commenting knowledgeably on events in previous years, before EPUT was formed, we will seek to do so. And we will of course continue to support the Inquiry by supplying the written material that is in our possession to it, and further factual material if possible.

Mental healthcare and its complexities: context

13. As I explained above, EPUT was formed in 2017 from the merger of SEPT and NEP. Whilst both of these Trusts faced challenges, NEP in particular had been rated as "requiring improvement" by the CQC in 2015, whereas the overall rating for SEPT services was "good". The aim behind the merger was to improve standards of care and outcomes for patients, above all in the former NEP services, and to drive organisational cultural change to underpin such improvements. In addition, NEP had faced serious financial pressures, and it was considered that a merger was the only realistic way of securing the financial support necessary for NEP – even though SEPT would be challenged to do this from its own financial resources, which would be 'diluted' as a result. It was also thought that a larger Trust would be better able to recruit and retain a scarce workforce, as there would be better opportunities for career development.

14. Since its creation in 2017 EPUT has focussed on efforts to improve care for patients. Much has been achieved, but I also recognise that much remains to be done to improve Mental Health services, and the work to create a single Trust, from NEP and SEPT, providing safe and effective care across all its services has been challenging. As the Inquiry gathers evidence and hears testimony, it will learn of tragic incidents, errors in care giving, and the ongoing challenges of treating individuals with serious mental illnesses. I am determined to continue to seek improvement and develop services to ensure better outcomes and experiences for the people we care for.

15. In carrying out its work, I hope that the Inquiry will consider the complexity of all healthcare. In particular:

    - We have not yet found a way to eliminate all risks when providing care and support, making clinical judgments, or creating systems and processes. This is true across all developed healthcare systems, both in England and internationally, as well as across all healthcare sectors, including Mental Health.

    - In relation to risk, Mental Health care presents unique challenges. It requires difficult decisions regarding treatment, balancing restrictions on individual freedoms, and ensuring the safety of both the individual and the wider community. These decisions often involve a balance of risk and autonomy and remain the subject of ongoing debate nationwide and we are seeing this reflected in a number of national reviews/inquiries in this area.

    - There is a continued need for research into the causes of serious mental illness, the effectiveness of various treatments, and why some interventions work for certain individuals but not for others.

16. The scope of NHS Mental Health services extends from primary to tertiary care, supporting individuals with conditions ranging from anxiety and depression to those who have committed serious crimes while suffering from mental illness. These services cater to all age groups, from children and young people to older adults. The Mental Health system is highly complex, involving multiple agencies, including NHS Trusts, charities, and social care providers, with links to education, housing and the police. There is a critical level of interdependency that is essential for the success of the whole system. Deficiencies in one area have a significant impact on other parts of the system. For example, a shortage of local authority places leads

to blockages for people ready to be discharged. This results in increased numbers of people being placed outside Essex or kept in A&E or other places of safety for longer periods than necessary or supported by community teams when hospital admission is needed.

17. The commissioning of Mental Health services is also complex, with multiple commissioners, funding constraints and competitive tenders being part of the landscape. This impacts on service provision as it increases the number of providers and the interfaces where different IT systems, practices and cultures need to be managed. There are opportunities for simplification of the commissioning and funding of mental health care which could have significant patient benefits in quality, consistency and availability of care. All involved in the system would probably recognise the potential gains from simplification, but solutions are not readily to hand.

18. Like all public services, we operate within financial constraints. The extent of these constraints varies over time, often depending on national policy decisions, and affecting the availability and depth of services.

19. Another factor impacting service delivery is the availability and expertise of clinical professionals. Recruitment has been and remains difficult in Mental Health services both in Essex and nationally.

20. Demand for Mental Health services has increased and evolved over the years, often driven by social and economic factors. For instance, mental illness is more prevalent among the homeless and shifts in the provision of supported housing can influence demand in specific locations. The COVID-19 pandemic had a profound impact on the delivery of care across all sectors – physical and mental. Changes had to be made to the way in which we organised and delivered care and we saw an enormous impact on the nation's mental health. This has left a legacy which we still do not fully understand today. Significantly we saw a change in how people with neurodiversity presented (and continue to) with their mental health conditions, which is an ongoing area of improving understanding. In this statement, I have briefly noted how the impact of the pandemic forms part of the context in which EPUT has functioned, since 2020.

21. In Essex, capacity and demand have impacted quality of care for our patients. Over the last year or so we have been managing a complex situation with the flow and capacity across our inpatient services. The resulting impact has been higher than planned out of area placements and bed occupancy between 80-100% (varying by service but with acute wards most impacted). This is driven by a number of reasons: increasing complexity of illnesses (e.g. Emotionally Unstable Personality Disorder (EUPD), neurodiversity etc.), the impact of the pandemic, a risk-averse culture in some areas leading to a delay in discharge, insufficient community support and social care, and an increased demand for mental health services generally.

22. More generally, a growing understanding of the relationship between neurodiversity and Mental Health highlights the need for further progress in ensuring neurodiverse individuals receive appropriate support in education, employment and healthcare settings. We also continue to see challenges in meeting the needs of those with EUPD, where admission to an acute mental health ward does not always meet their care needs.

23. I have described in this document the areas that needed improvement and our responses. This is not intended to be defensive or complacent. Describing where we have attempted to make improvement is intended to show the deficits that existed and that we have tried to learn from the past. It is also important to note that these improvements have not been without challenges and their own learning. For example, the introduction of the Patient Safety Incident Response Framework (PSIRF), caused concern that the guidelines for local teams were too ambiguous - we have since strengthened and clarified the guidance for teams. Another example of the need to refine and improve is around the implementation of Oxevision remote monitoring systems, where post implementation we have changed our policies to reflect concerns around the issue of consent in line with feedback from staff, patients and national bodies. We are currently reviewing the latest guidelines from NHS England (published February 2025) relating to the use of digital technologies in mental health and are also seeking feedback through patient focus groups on how we can improve the experience of Oxevision.

24. Finally, the process of cultural change is a lengthy and ongoing process. In contrast to changes to the physical environment (refurbishing wards, removing ligature points), changing day to day behaviour and working practices does not involve one-off, measurable actions. Behaviours and mind-sets are complicated and, in a Trust that serves around 100,000 patients at any one time, there are literally thousands of patient interactions every day. I would like every contact to be excellent, but the potential for errors impacting on care from even a small number of instances is significant. So the challenge that we face is to embed change, at every level and in every encounter between staff and patients, their families and carers. I acknowledge that a lot of what I have described below is relatively new, and will take time to make a real and practical difference.

EPUT's focus: Personal Reflections

25. When I joined EPUT as CEO in September 2020, I immediately focused on the work that the Trust was doing to be more open and responsive and to modernise services in co-production with patients, their families and carers. The Trust already had and continues to have a clear focus on safety. For example, capital investment had already been committed to improving the fabric of wards – with a particular aim of eliminating the risk of fixed ligatures.

26. In 2021 I attended Court on behalf of the Trust when the Health and Safety Executive (HSE) brought a prosecution relating to the safety of inpatient wards in the former NEP. This related to events from October 2004 to March 2015, focusing on eleven inpatients deaths and one 'near miss' event, all using fixed ligature points within the ward environment. This experience had a profound impact on all involved, including me, and the resulting recommendations led me to intensify the Trust's plans to improve patient care and safety. It also caused us to drive forward plans to increase the patient, family and carer voice across services and led to a reaffirmation that while some progress had been made, we clearly had, and have, much more to do. The Trust launched the 'Safety First, Safety Always' strategy in response to issues identified by the HSE and I will touch on this later in this statement.

27. Another event that had a profound impact on me was in October 2022, when Channel 4's Dispatches aired hidden camera footage in EPUT wards. This was closely followed in May 2023 by a report by the Care Quality Commission which downgraded the rating of EPUT adult mental health wards and psychiatric intensive care units to "inadequate". This period

also highlighted for me the complexity of the nature and oversight of regulation facing NHS Trusts given the interest from multiple parties within the wider health and social care sector.

28. While many of the issues identified by CQC and featured in the under-cover filming were areas that we had already identified as needing focus – for example a move away from restrictive practices to more therapeutic observations - I and my colleagues on EPUT's Board found both the coverage and CQC report deeply concerning. We subsequently launched the 'Quality of Care' Strategy in 2024. This strategy built on the foundations of the 'Safety First, Safety Always' Strategy with a recognition that while progress had been made (especially in relation to the removal of fixed ligature risks) there was a need to do more to improve the quality and experience of care, alongside reducing physical risk.

29. I recognise the profound impact that some of the events I have outlined will have on patients, families and carers, along with our staff. The impact statements presented during the first oral hearings of this Inquiry were a moving and powerful reminder of the importance of Mental Health services, and the enduring impact on families when things go wrong.

30. Since joining EPUT, my work has focused on acknowledging past failures and reducing the risks associated with delivering healthcare. As I have outlined, Mental Health care is a complex, multifaceted service with diverse perspectives on effective treatment and a multi-layered regulatory framework. Achieving consensus on necessary changes and implementing them is challenging. I have sought to prioritise changes that have broad agreement and fall within EPUT's control. These include improvements in patient environments, staffing levels, the culture of inpatient services, the integration of technology to support care and the greater involvement of patients and families in healthcare design and delivery. Furthermore, I have aimed to ensure that changes are sustainable and long-lasting, even though this often means longer timescales to ensure that changes are properly implemented and embedded.

31. We have seen improved outcomes as a result of the changes we have made. But I know there is more to do. One area of focus in the coming years is to implement a unified Electronic Patient Record across all our mental health services, our community services and with our acute partners in Mid and South Essex NHS Foundation Trust. As well as ensuring relevant information is readily available to clinicians, I anticipate that this will improve compliance with the Trust's policies and procedures.

32. We continue to roll out our "Time to Care" clinical and operational workforce model across all of our wards. This was designed with painstaking work with both staff and patient representatives. It provides for a more diverse workforce with paid roles for people with lived experience, as well as therapists and higher numbers of nurses. We expect that the benefits in relation to safety, staffing levels, expertise and flow will be felt by patients, leading to better therapeutic inputs and faster return to their normal lives. We expect it will be an attractive model for staff, aiding our recruitment and retention. I will describe the new model in more detail later in this statement.

33. We will also continue to encourage the growing influence of those with lived experience and their families on the delivery and design of our services – I believe this is the key driver for cultural change.

34. Our community mental health services are under growing pressure especially since the COVID pandemic and need to be changed to respond to the needs and what has been and will be learned, as a result of the tragedies of the past. We are working to reset, improve consistency and improve the matching of resources to demand through this work, including the launch of a new improvement programme called Community First.

35. The changes that we have made since the formation of EPUT cannot be made without an impact on financial resources. Improved staffing levels, the use of IT, the improvement of our wards' environments, the improvement in governance of change, the infrastructure to support patient and family involvement have all led to an increase in costs of delivering the service. There are choices to be made in the future for Mental Health services about the amount of financial resources available, a better understanding of both productivity and the impact of improvements on patient outcomes.

36. We can point to tangible improvements, learning from those willing to share their stories, the maintenance of services through a pandemic, and continuing to run a complex organisation under operational and clinical pressure, as well as the scrutiny of the Inquiry. We are committed to learning from the Inquiry and ready to implement recommendations arising from the Inquiry which are in our control.

Response to the Inquiry's Request for Information on EPUT's Position

37. I will now take in turn each of the areas that Baroness Lampard has asked me to address. The Inquiry's questions are wide, covering the whole of EPUT's activities. I have tried to focus on the key areas of challenge, change and improvement. But the account below cannot be comprehensive and we look forward to working with the Inquiry and its core participants to explore these areas in more detail in the months ahead.

(1) The Role and Responsibilities of EPUT in relation to mental healthcare:

In relation to the Trust's role and responsibilities in providing mental health inpatient care during the Relevant Period, and in particular the key policies, processes, and regulatory frameworks that applied, reflect on what the Trust knew, what actions were taken (or not taken), and what should have happened.

38. In the course of its work, the Inquiry will no doubt identify and examine the relevant legal duties and responsibilities, including national healthcare policies, the CQC Regulations and the Health and Safety at Work Act, and I have not tried to set out a summary of the regulatory framework in this statement. I have understood this question as referring to the broad strategies for safe and effective care required from the Trust Board. Under question 2, I have focused on specific patient safety initiatives; here, I have set out in general terms some of the key policy work that has been led by the Trust Board to address the issues identified in 2017 and subsequently.

39. Much of the context I have already outlined in this statement relates to safety issues in inpatient wards. In particular, at the point of the merger in 2017, EPUT knew that it faced

the challenges outlined in (for example) the CQC inspections of 2015 and 2016. These reports are publicly available, but the routine CQC inspection of NEP in August 2015 stated:

- Overall, the services provided "requires improvement";
- The safety of services was "inadequate";
- The domains of effective, responsive and well-led care required improvement, although the "caring" domain was rated as "good";
- With regards to the safety of services, the CQC highlighted the high number of incidents related to a ligature tied to a fixed point;
- It also noted that segregated accommodation for men and women was not always provided; that some care records and risk assessments were inadequate and that restrictive practices were seen on wards. There were concerns that previous actions required had not been actioned with sufficient urgency.

40. The serious concerns about ligature risks were underlined by the HSE prosecution that followed, the finding of liability and the fine imposed.

41. The CQC undertook focused inspections across a range of inpatient services in mental health and learning disabilities in November 2017. Six reports were based on the core services inspected. These inspections identified areas of good practice but also reinforced the need for action. The areas for further work and improvement included the following:

- The quality of the environment in specific locations inherited by the new organisation including:
    - Improving some seclusion facilities
    - Ensuring environmental changes to improve safety and observation
- Staffing levels and use of temporary staff on some wards
- Consistency on policy availability and use
- Consistency on record keeping
- Greater focus on physical health care for people on mental health wards.

42. As a new Trust EPUT had already identified a number of these issues in 'due diligence' work prior to merger and was taking action. However, the depth and scale of the work required was not identified in full until post-merger. The merger itself proceeded without a Chair and EPUT inherited a number of issues relating to cultural differences and the need to align two very different organisations. The challenges were increased by difficult financial circumstances and the need to make savings, leading to a lack of resources for change in certain key issues including the poor state of ward environments, outdated data systems and the need to improve ward safety especially in relation to ligature risk.

43. A further issue was the sheer number and breadth of recommendations and actions from a wide range of sources and over a large period of time. This led to numerous action plans, but these were delivered in isolation without a consistent understanding of how impactful and sustained changes were. EPUT, or its predecessors, have not been alone in facing challenges in managing and prioritising recommendations for action and improvement: see the HSSIB report of 16 September 2024, "*Recommendations but no action: improving the*

effectiveness of quality and safety recommendations in healthcare".[1] But we have aimed to 'learn better' – see para 46 below.

44. Both the challenges faced by EPUT in improving service delivery and implementing change, and progress made, can be seen in the further CQC reports which have followed the merger and which are publicly available. The CQC Inspections of November 2022 – January 2023 culminated in a CQC Report published on 12 July 2023 which gave EPUT an overall rating of 'requires improvement', noting many issues of concern especially in acute wards of adults of working age and psychiatric intensive care units where the service was rated as 'inadequate' within the safe and well led domains.

45. CQC scrutiny is critical to making sure that issues are raised and that improvements can be made and sustained. Action plans have been developed in response to each CQC report, but I acknowledge that, at times, progress to implement those plans has not been as rapid or as consistent (across the whole Trust) as we would have wished. So, for example, the CQC report of July 2023 found that some plans or strategies were new and not yet embedded, and that not all the changes required in the CQC warning notice issued in October 2022 had been achieved consistently across all the wards.

46. As a Trust we have faced a large number of recommendations and actions from a wide range of sources over a significant period of time. This led to numerous action plans, but they were delivered in isolation with an impact on the way in which change was sustained. We changed our approach to incorporate cultural change and strengthened governance to ensure actions are Trust wide and embedded to enhance learning across the organisation. We also ensured that our strategies responded to recommendations that had been made and reflected the fact that we had much to learn about the process of sustained learning.

47. In 2023 we put in place a new system of working across our services and with colleagues to strengthen the production and implementation of clear and robust action plans to respond to issues raised by CQC. We know that all too often action plans do not lead to meaningful and sustained change, so this new approach is designed to be driven by the people at the frontline of delivering patient care with scrutiny and governance to make sure that change is supported, actioned and embedded. EPUT has provided, in a draft statement for the Inquiry, copies of the master plans from June 2024 related to CQC actions and for responses to Prevention of Future Deaths Reports from Coroners, for which the same process has now been adopted.

Board Strategy and Leadership

48. Our strategic decision making as a Board has focused on improvement and patient safety. Our investment profile and the initiatives such as international recruitment, and the Board programmes of 'Safety First, Safety Always' and the 'Time to Care' programme show this. However, we know that we have more to do at ward level and with our community teams to deliver the services Essex residents require.

[1] https://www.hssib.org.uk/patient-safety-investigations/recommendations-but-no-action-improving-the-effectiveness-of-quality-and-safety-recommendations-in-healthcare/report/

'Safety First, Safety Always'

49. 'Safety First, Safety Always' was a Board level strategy launched in January 2021, designed to lead directly to an increased focus on safety in our inpatient wards. It was a three-year approach which centred on five key areas:

- Patients and families feel safe in our care
- Stakeholders have confidence we are safe
- No preventable deaths
- A reduction in self-harm
- A reduction in patient safety incidents

50. While there remains more to do, there have been some quantifiable improvements in the key areas of patient trust and safety outlined in the Safety First, Safety Always Strategy. 'Input' data, from metrics such as levels of staffing, new technology investment, anti-ligature measures and environmental improvements spending, can be tracked to show the commitments that we have made. By contrast it is harder to find 'outcome' measures that are agreed to be reliable or have been reported consistently.

    In term of outcome measures, we can note examples of changes, such as the number of patients and families who say they feel safe in our care having increased, rising from 94.1% in December 2022 to 98.2% in December 2023. From internal reporting via Power BI and Datix incidents, we are seeing a higher number of no harm/low harm incidents than those categorised as moderate or above, which is in keeping with expected national patient safety outcomes. The overall use of prone restraint is on a downward trajectory and, I consider, reflects the impact of our work on therapeutic engagement and observations as well as other actions designed to enhance the quality and experience of care.

51. However, national and local comparisons for all such indicators are difficult as there is limited benchmark data or consistent data standards. We are therefore largely restricted to assessing improvements based on historic information and direct feedback from external sources, including patients and their families, staff and regulators.

52. I think it is important here to note the tension that sometimes exists between attempts to eliminate or reduce risk and the need to provide an enriching and therapeutic environment. The Mental Health Act itself addresses these issues and the need to balance risk against the rights of the individual. This is something colleagues across the Trust have to balance on a daily basis.

Quality of Care Framework

53. Over time we have moved towards a wider perspective of the importance of balancing the effectiveness, safety and experience of care for our patients. This led to the development of a 'Quality of Care' Strategy, agreed by our Board in 2024. It builds on the safety priorities that were embedded as part of 'Safety First, Safety Always', but with a move to focussing on the quality and experience of care Key to this is the patient voice and the involvement of carers and families at all stages. This strategy was developed in partnership with current and former patients, and those with lived experience of services.

Time to Care

54. In many respects 'Safety First, Safety Always' established the environment and put in place the processes to support safe care – and we undoubtedly saw improvements, as I have outlined above. However, a radical transformation of mental health care – moving from a medical and clinical led focus on observations to a more holistic approach - takes a cultural shift and we have not yet fully achieved that.

55. In May 2022 EPUT's Board approved the 'Time to Care' programme. A draft statement has already been provided to the Inquiry setting out the details of the programme. It is a programme of practical and cultural change across EPUT, largely centred on our inpatient wards and designed in co-production with patients and their families. The plan is to release more clinical time to spend on direct patient care. It is a five-year programme at the early stages of implementation. The initial discovery phase started in July 2022 and comprised a detailed analysis of the existing situation. In the Spring of 2023, the second phase focused on developing and implementing a new staffing model, moving away from a clinical and medical focus to a more multi-disciplinary approach of therapeutic engagement. The premise that underlines this is a clear purpose for each admission, a care plan that is agreed with the patient and their family and a route to discharge and support in the community. The third phase of the programme will start in April 2025 with a focus on embedding transformation and beginning to realise the benefits of the programme. The expected benefits will include more therapeutic staff on wards, new roles, staff with enhanced skills and training, changes to how data and technology are used, better communication between staff, patients and their families and reductions in the use of agency staff and out of area placements contributing to a safer and high quality service for all. The programme will continue to be reviewed and developed further as required.

(2) Patient Care and Safety:

In relation to the Trust's approach to delivering safe and therapeutic inpatient treatment and care, including ward conditions, physical safety measures, and continuity of care post-discharge, acknowledge any gaps, challenges, or areas for improvement in ensuring patient safety during this time.

Ligature Risk on Wards and the Ward Environment.

56. I have already outlined the development of the 'Safety First, Safety Always' Strategy. As part of this we invested £20m in our inpatient wards, aiming to make them safer via the removal of fixed ligature risks as well as digital investment in remote monitoring and CCTV. This was in response to the limitations of the estate which was old and poorly designed. Details of the work done to address fixed ligature risks were set out in the material provided to the Court in June 2021, as part of the HSE prosecution. They included an estates project to address environmental risks, supported by inspections and audit; training for staff; individual patient clinical risk assessment, and ligature wallets and pouches to support rapid reactions to an incident.

57. We recognise the continued challenge in ensuring that a safe environment is not only created but maintained. Anti-ligature systems have to be checked and updated, and there have still

been tragedies despite the work done. Despite this, overall we have seen considerable improvement in the physical environment and safety of our wards.

58. However, physical risk reduction of this nature must sit alongside the creation of more therapeutic ward environments – not just from a visual perspective but also considering the need for an environment which supports safe care and recovery. While there have been significant improvements in some of our wards, there are others that have fallen short and the facilities do not meet the standard we would want for our patients. This is due to constraints on capital available.

59. In addition, I am under no illusion that this is only part of the wider picture and a move to supporting more people in the community can lead to more instances of self-harm outside of hospital. I think it is important that we reflect and acknowledge the complexity of mental health and the challenges that we face in working with our patients over many years, whether in hospital, or supported in the community.

Wider challenges to safe patient care.

60. Ligature risks are only one of a number of wider challenges to providing safe patient care. Risks can be identified through a number of routes, including (i) inquests and 'prevention of future death reports'; (ii) internal and external audits or inspections, such as those from the CQC; (iii) incident reports and investigations, including the application of NHS England's Patient Safety Incident Framework (PSIRF); (iv) staff, patient and family feedback. This is not an exhaustive list.

61. From sources such as this, and specifically EPUT's 2023 – 2025 Patient Safety Incident Plan (PSIRP), the Trust has 10 Safety Improvement Plans (SIPs) to monitor the effectiveness of safety actions in the following areas:

- Ligature Risk Reduction
- Falls Risk Reduction
- Transition from CHYPS to adult services
- MDT communication gap
- Record keeping
- Clinical Handovers
- Policies and SOPs
- Patient disengagement
- Medication Incident risk reduction
- Discharges and transfers

62. In addition, the Prevention of Future Death Reports (PFDs) from inquests into patient deaths which occurred since the date of merger have been analysed thematically to identify systemic issues. The systemic themes identified included:

- Communication, including failures in joint working and information sharing, and in the involvement of family members or carers
- Training and supervision, including criticisms of Oxevision training and failure to convey its limitations / use of the tool as a substitute for in-person observations and care

- Record keeping
- Discharge planning including the inadequate assessment of patients
- Care planning
- Failures to assess risk and manage risk adequately.

63. All PFDs must lead to an Action Plan whose implementation is overseen by the Safety of Care Group, with assurance by Board Level review.

64. EPUT has rolled out the use of Oxevision from April 2020 onwards, an assistive tool to support patient care. I understand it to be used by around half of Mental Health providers. We have aimed to ensure that its rollout is evidence-based and commissioned a study in association with Anglia Ruskin University about its use. It is designed to support patient observations and safety, but it should not be a substitute for therapeutic engagement and care. We recognise that there are challenges in ensuring that staff are properly trained in its use, and that at times, there have been failings in this regard. However, Datix records from April 2020 to July 2024 suggest that its roll out has been associated with reductions in incidents of ligation, self-harm, and falls.

65. I recognise that there are concerns that greater patient safety comes at the expense of reduced privacy. In 2021 we developed a Standard Operating Procedure for the use of Oxevision and this is reviewed regularly. These reviews have included our approach to the consent process. We know that this is a matter that will be explored by the Inquiry in depth, and look forward to this.

66. Specific activities we have taken to ensure that learning is systemised and embedded across the Trust include the following:

- In 2021 we appointed a Director of Patient Safety and created a Lessons team. The team has focused on enhanced knowledge sharing to reduce recurring incidents by systematically capturing, analysing, and communicating lessons learned from clinical and operational experiences. By integrating reflective practices and promoting a learning mind-set, the team supports EPUT's mission to deliver safer, more effective care.

- The Patient Safety team has also employed 11 Patient Safety Partners – colleagues with lived experience who bring their personal experience and insight to driving improvements in safety on our wards, acting as the voice of patients and undertaking quality walkabouts at ward level.

- A ‘Ward to Board’ focus on safety was established with the Chair of the Trust Board also chairing the Board Safety Oversight Committee, to oversee sustained and imbedded improvements in the ‘Safety First Safety Always’ strategy.

- We have recruited registered General Nurses to enhance the physical healthcare of patients on wards, and enhanced guidance and training on the care of deteriorating patients or emergency responses to crises (e.g. those requiring resuscitation).

- Care Planning: in 2018, the Trust introduced the 'My Care, my Leave Plan' to improve the planning of leave.

(3) Patient and Family Engagement:

In relation to how the Trust engaged with patients in decisions about their care and how it involved families and support networks, address any difficulties, shortcomings, or areas where engagement could have been improved.

67. I have consistently heard from families that mental health services did not listen to their views on the treatment of their loved ones and by improving how we listen and act services would improve. As a result one of my key areas of focus has been improving the way in which we work with patients and families across The Trust. A key part of the new model is to ensure the patient's voice is at the centre of care planning and service provision.

68. There is more to do in this cultural shift but there has been progress, and I would like to use this opportunity to thank all those who have and continue to work with the Trust to make sure the voice of lived experience continues to grow. This is led from Executive team level, and myself and other colleagues regularly meeting families with concerns or who want to share their experiences with us. I know that this will be a small number in the context of the 100,000 people who use our services at any one time, but for me it is an important reality check on the present and future plans.

69. In 2021 we restructured the Patient Experience portfolio, under the leadership of an experienced senior manager, to amplify the voice of lived experience across our services. This has led to a number of positive outcomes, including the following:

- Around 300 people with direct or family experience of using EPUT services now support strategy developments, change programmes, service improvements and funding bids.
- We have trained around 100 Peer Support Workers in the last 3 years (a number that continues to grow) who may have personal experience of mental health challenges, and have received treatment on a mental health inpatient ward. They provide one-to-one and group support to patients, drawing on their own experiences to offer hope through recovery.
- We have also taken steps to make the voice of lived experience stronger in our decision-making and governance across the Trust, to aid this a Working in Partnership with People and Communities Strategy was agreed by Board in November 2023, and we have made lived experience a core component of the trusts quality strategy with lived experience leads being members in each priority group.
- We have established a recurring EPUT Forum which is aligned to The NHS Constitution and sits alongside the Trust's Your Voice meetings and for the last two years we have held an annual Co-Production conference which has been well received across EPUT and with partners across the wider system.
- The Trust's Lived Experience Advisory Panel for research was set up in July 2024 with the aim of strengthening lived experience in the design and delivery of mental health research.

- As part of the delivery of the quality of care strategy, we set up the 'Experience of Care group', chaired by an executive director, which meets monthly and oversees the ongoing improvement and change activity in the experience of care domain.
- In November 2024 we established Lived Experience Leadership Group which is formed of lived experience leaders, working across the Trust and play a key role in influencing and developing the strategic ambitions for Lived Experience Practice trust-wide. Each member is actively leading and contributing to several key streams of work across the organisation and system.

70. The CQC inspection report of July 2023 recognised that much work had been carried out to improve patient feedback and involvement. For example, *"The 'your voice' community provided challenge and feedback to the board and the trust launched 'I want great care' in January 2022. The patient experience annual review from November 2022 demonstrated positive results for involvement …"*

71. The question posed by the Inquiry includes asking about areas where engagement "*could have been improved*". I hope that what I have described shows the concerted attempts that have been made in recent years to build and support effective patient and family involvement, and that much progress has been made on that journey. I acknowledge that there have also been times when patients and their families have not been listened to as they should have been. EPUT (and wider mental health services) are still in the process of building a mental health service that puts patient experience and autonomy at its heart.

(4) Staff Management and Conduct:

In relation to staffing levels, training, and support structures in place during the Relevant Period, reflect on any concerns regarding staff conduct, performance, and the overall ability of the staff to deliver effective care.

Staffing, Recruitment and Retention

72. When I joined the Trust we were in the midst of the Covid-19 pandemic and not only seeing an increase in demand for services, but also facing unprecedented challenges in attracting and retaining staff, resulting in significant bank and agency use. We had issues with staff who were unfamiliar with our wards and found ourselves in competition with other providers who were offering golden hellos, or salaries that included London weighting.

73. Across the health service we know that a stable permanent staffing base is a key basis for safe and compassionate care. Over the last four years we have focused on recruitment. This has included an international recruitment campaign which has led to 240 registered nurses, 20 Allied Health Professionals and 33 doctors joining us from around the world. They contribute to the diversity of skills and experience across EPUT. Many of these colleagues also have a background in physical health and are able to bring a new perspective to our wards – recognising the interlinking nature of physical and mental health. We have also increased domestic recruitment with a particular emphasis on working with local communities. We are seeing sustained levels of engagement and retention across the Trust with staff turnover rates at 8%, the lowest in 3 years while absence rates have continued to

reduce to 5%. We have also partnered with Department of Work and Pensions to fill vacancies in hard to recruit areas.

74. All of this activity is having tangible benefits in new colleagues joining us and more in the pipeline:

- 151 new healthcare assistants (HCAs) have joined us since July 2024 – the HCA vacancy rate is now down to 10 per cent;
- 132 newly qualified nurses joined EPUT in 2024 – the overall vacancy rate is 17 per cent.

Staff support

75. It is critical that all staff are supported and understand the part they have to play in the wider organisational culture. As a result, The EPUT Behaviours Framework and Leadership Behaviour Toolkit was launched in 2023 and is a key part of addressing feedback from our staff survey, concerns of poor behaviours and enabling leaders at all levels of the organisation to develop high performing and compassionate team cultures. We continue to develop this further, with plans to extend detail around unprofessional behaviour and working with the Nursing and Midwifery Council and General Medical Council on 3 modules on sexual safety, incivility and behaviours which will form the basis of future monitoring and measurement of progress.

76. We have strengthened our culture of openness with many opportunities for two-way communications, appointed a new Principal Freedom to Speak Up Guardian, nationally recognised for her work in championing whistleblowing. We have signed up to the NHS Sexual Safety Charter.

77. These areas touch on the fundamental culture of the Trust. I acknowledge this as an area which needs further development – we know that issues with racial abuse and sexual safety are experienced by some of our staff. I acknowledge that staff have sometimes reported that they do not feel confident in speaking up, not least as wards can be small communities where 'everyone knows everybody'. In relation to the investigation of staff complaints and concerns, there have been times when Trust policies or procedures have not been applied consistently or sufficiently rigorously, and the training of those conducting disciplinary investigations has not been sufficient.

78. There is more to do to address these issues and to make sure that everyone feels safe and supported in the workplace – only by doing this can we ensure that colleagues are able to provide the best therapeutic care for others.

Staff conduct

79. While it is vital that we look after the wellbeing of our staff – offering support when they speak up, providing open and honest communications and creating an atmosphere of psychological safety - we also need to ensure that standards of behaviour and performance are upheld.

80. So, while we have increased support for staff, we have also strengthened our conduct procedures as it is critical that any staff falling short are held to account. As an example, as soon we were contacted by Harbar 8 Production Company around their footage (part of the C4 Dispatches programme in October 2022) we took immediate action to safeguard our patients. Despite limited information at that stage (Harbar 8 and C4 declined to disclose the undercover footage to us) we set up an internal task force to review the issues raised,

including the footage within the programme when it aired. This resulted in five workers going through an HR investigation and ultimately a number of colleagues sanctioned and reported to the NMC, in cases where the worker was a registered nurse.

Ability of Staff to Deliver Effective Care.

81. I have been asked about the overall ability of staff to deliver effective care. Overall mandatory and essential training compliance is running 92% for our substantive workforce. We continued delivery throughout the pandemic under strict regulations and with limited venue availability but this had a significant impact on overall compliance for all clinical staff. We fully recovered mandatory training compliance, post pandemic, in line with our targets in 2024.

82. In its inspection report of July 2023, despite noting a number of issues, the CQC rated the "caring" domain as "good", noting positive feedback from inpatients about feeling safe, valued and respected (p7). I am confident that the work we have carried out investing in a new staffing model for our wards, implementing the Behaviours and Leadership Framework, alongside our efforts to create an open and two-way culture combines to create an environment where staff are better supported to deliver safe and effective care. But there is more to do and we will continue to focus on future improvements.

(5) Leadership, Governance and Culture:

In relation to the Trust's leadership and governance structures and their impact on patient care and staff experience, reflect on whether organisational culture supported effective care and identify any areas where improvements could have been made.

83. I have already touched upon some of the challenges, including cultural alignment ones, that faced EPUT upon its creation. This undoubtedly left a legacy. When I joined EPUT, there was a recognition of the need to shift the culture at EPUT from one of centralised control to a devolved model where local clinical decision making was enabled, and was better able to respond to the needs of diverse local communities. A new target operating model and organisational structure was introduced in late 2021, with the creation of six operational care units designed to enable place-based care and devolve decision making.

84. The creation of care units with a multi-disciplinary leadership – operational, nursing and medical - has been an important step in allowing us to meet the needs of local people. There is undoubtedly more to do; currently we are seeing challenges around flow and bed occupancy, causing us to reassess the way in which we undertake flow and capacity management at a Trust level. We are also looking to move bed management to a more local devolved model.

85. The new organisational structure has been underpinned by the adoption of an accountability framework, providing corporate support and data to the operational leadership while holding them to account for their local decisions and actions in the following key areas:

- Quality and safety
- Operational performance

- Workforce and culture
- Finance
- External relations

(6) Incident Investigations and Responses:

In relation to the Trust's approach to incident investigations and responses to concerns, reflect on any shortcomings in incident handling or areas for improvement.

Patient Safety Incident Response Framework

86. I have already outlined some of the work we have done with the creation of a Lessons team to create a culture of learning across the Trust. A key part of this was the early adoption of NHS England's Patient Safety Incident Response Framework (PSIRF), the new way that the NHS looks at patient safety incidents. It replaced the 2015 Serious Incident Framework and represents a significant shift to more compassionate engagement and involvement for those affected by patient safety incidents. EPUT was one of the first 'early adopter' NHS Trusts to introduce PSIRF. The implementation plan led to the recruitment of Director of Patient Safety in 2021 and Learning Lessons Team in 2022.

87. The Trust previously operated a centralised investigation team who did the majority of investigations into patient safety incidents under the Serious Incident Framework; this continued under the PSIRF. This approach has at times disempowered local clinical teams from taking ownership of patient safety incidents and embedding timely learning at a local level. It has also meant that processes for investigating and learning have at times been complicated and taken far too long to complete, with shortcomings in patient and family involvement. The quality of some investigations fell short of what patients, their families and staff were entitled to expect.

88. Therefore, the Trust in 2024 strengthened the investigative capacity locally, supported by permanent trained patient safety leads across all care units, to serve as a resource of skills and expertise to support local staff to conduct good quality patient safety incident investigations working alongside patients and families. Additional Freedom to Speak Up Guardians have also been employed to promote a just and open culture across the Trust. This has emphasised the importance of accountability for the effective investigation of incidents and for subsequently making improvements to systems and learning. Care Units hold weekly senior care unit leadership 'huddles', feeding into monthly local quality and safety meetings and monthly accountability meetings. There is Executive oversight of patient safety incidents and learning, reporting to the Quality Committee.

89. In recognition of the shortcomings in patient and family involvement, the Trust, as part of its quality priority setting for 2025/26 has further plans to develop further compassionate engagement of patients, families and carers who have been involved in a high level patient safety learning response.

Structural changes

I have already touched on the structural changes we have made and the creation of a target operating model to facilitate clinically led local decision making and this is still embedding across the Trust.

90. In March 2023 we created Deputy Director of Quality and Safety roles for each of our operational, local care units to ensure that the quality and safety of care was central to the place-based and devolved decision making which is at the core of the operating model. Initially these roles reported into our Directorate of Nursing; additionally, our Patient Safety Incident Management (PSIM) team (which plays a key role in coordinating investigations and response to patient safety incidents) also sat in the Nursing Directorate. While both teams were closely aligned to the operational Care Unit Leadership it was clear to me, based on observations and feedback from the CQC and Coroners that we needed to do more to foster better communication and collaboration, especially in relation to the investigation of patient safety incidents. As such in the last couple of months we have moved the DDQSs and PSIM teams to the operational managerial line under the Directors of our local care units. We are already seeing the early benefits of collaboration, speed of identifying issues and shared learning.

(7) Data Management and Record-Keeping Practices:

a. *Explain how patient records and data were maintained during the Relevant Period, identifying any systemic challenges and issues that affected the accuracy, accessibility, and reliability of information.*

b. *Describe the steps taken to improve data management practices over the Relevant Period, while also acknowledging any ongoing gaps.*

91. Over the last 24 years there have been many changes to the way in which patient information has been recorded. Requests for statements from the Inquiry have highlighted the challenges of interrogating numerous systems – digital and manual – held by many different Trusts and providers over the last 24 years. As the CQC noted in its July 2023 report (p23), since its formation EPUT has used 7 different systems across its services, dating back to that merger. The use of multiple and legacy patient record systems results in complexity and system specific limitations for both our clinicians and managers.

92. EPUT is making significant investments in new digital technology. This includes improving how we record and manage information on care through our electronic patient record and medicines management systems and using smart technology to provide access to the right information when needed. EPUT has accredited our electronic records management controls though an independent British standard certification (BS10008) that provides assurance that our practices and policies are robust and appropriate.

93. Longer term, we are working with our neighbouring acute Trust in Mid and South Essex in a 'first of type' Electronic Patient Record (EPR) across acute, mental health and community services. Implementation will be in 2026/27 and has the potential to make fundamental improvements by allowing frontline clinical staff to access a complete medical record across all services. Creating a true, current and single source of information for our patients across all services to support the right care at the right time and place. A unified EPR system will provide critical support to the Trust's operations, providing timely access to a single view of patient information and ensuring that processes are efficient. As a result of legacy systems, the Trust currently has seven separate patient record systems. We have put in place

mitigations to make it easier for clinicians to access the data they need across these multiple systems, but this is far from perfect and staff will be served much better by a single electronic patient record system that manages and reports data related to the care of our patients.

94. Work has also been going on across Mid and South Essex to roll out the shared care record which connects primary care records across the area.

Policies and Procedures

95. Access to and adherence to Trust policies remains an area of concern across EPUT, along with many other NHS Trusts. Lack of adherence to Trust policies is a frequent concern raised by feedback from Coroners and the CQC.

96. We have invested in a new digital solution and easy to use platform to facilitate the digitisation of standard operating procedures, guidelines and policies across EPUT so that they can be viewed easily and are clear to follow, supporting busy frontline clinical staff to have easy access to this information. We are currently training all our staff with a view to being fully operational with all policies, guidance and procedures as soon as possible.

Conclusion

97. In concluding I once again apologise to all who have lost loved ones while in the care of Essex Mental Health services and reiterate that I will do all I can to support this Inquiry to deliver clear recommendations to improve care and services for all.

98. I am also clear that there is more to do. Our priorities for the coming years are to embed Time to Care, implement a new Electronic Patient Record and to take a similar approach to Time to Care with our Community Mental Health teams with a programme called "Community First".

99. I have also set out that the Mental Health system is complex and one part cannot operate in isolation. Alongside this, the fragmentation of commissioning and the balance of available funding and the needs of our communities should also be considered.

100. Finally, I want to reiterate that we have really attempted to learn from the past and listen to the voices of those affected by past failures. I am determined that we will do all we can to continue to improve Mental Health service in Essex.

Statement of Truth

The content of this statement is true to the best of my knowledge and belief

Signed: [I/S]

Dated: 27 March 2025