IAN ARTHUR Witness Statement Lampard Inquiry

Section A: Preliminaries

1. I am currently employed by the Essex Partnership University NHS Foundation Trust and have been asked to provide evidence as part of the Lampard Inquiry investigating mental health deaths in Essex.

Section B: Background and Experience

2. I am a registered mental health nurse. I have been registered with the Nursing and Midwifery Council since the completion of my training in August 2000.

3. I have worked for Essex Partnership NHS trust and its predecessor organisations since 2003. These are the team that I have worked with over the following years:

1. January 2003 – Charge Nurse Drake House, Chelmsford area (Mid locality), older people dementia assessment ward. My duties at the time would have been to offer care and risk planning as part of a named nurse/keyworker role. I would have been undertaking various day to day responsibilities including shift coordination, administration of medication, providing direct hands- on care, as needed. I would be also creating care plans along with liaising with families and loved ones to help meet the needs of the patients that I had been allocated to care for.
2. June 2004 – Community Mental Health Nurse, Maldon area (Mid locality) within the adults of working age team. When I was a community nurse from 2005 until 2008, my role included as acting as a care coordinator for a named group of patients. The case load varied with each team that I was employed for. When I was appointed to the Older Peoples Community Mental Health Team in Chelmsford (which had its office at Drake House, next to the inpatient ward) my duties included undertaking various assessments for new patients, families and loved ones. Also assisting with the initiation of anti-dementia medications along with monitoring its effectiveness were key responsibilities within the team.

- November 2007 – Community Mental Health Nurse, Harlow area (North West Locality) within the Assertive Outreach Team.
- July 2008 – Community Mental Health Nurse, Chelmsford area (Mid locality) within the older peoples community mental health team.
- January 2009 – Ward Manager, Lucas Ward, Kings Wood Centre, Colchester (North East Locality).
- January 2012 – Team Leader Dementia Service, Kings Wood Centre, Colchester (North East Locality).
- March 2015 – Advanced Nurse Practitioner, Dementia Service, Kings Wood Centre, Colchester (North East Locality).
- November 2015 – Clinical Manager, Inpatient Services Matron, Crystal Centre, Chelmsford (Mid Locality).
- December 2017 - Clinical Manager, Inpatient Services Matron, Landermere (Clacton on Sea District Hospital Site) and Kings Wood Centre Colchester (North East Locality).
- November 2022 – Service Manager, Inpatient Services (North East Locality).

- September 2023 – Clinical Manager, Inpatient Services Matron, Landermere (Clacton on Sea District Hospital Site) and Kings Wood Centre Colchester (North East Locality).
- November 2025 – Seconded to Mid and South Essex NHS Foundation Trust – Integrated Discharge Hub Mental Health Lead.

4. I have maintained uninterrupted employment with Essex Partnership University NHS Foundation Trust since 2003.

5. During my time of employment with EPUT and its predecessor organisations, I have undertaken a wide variety of roles and responsibilities. My clinical duties have included assessments, care planning, implementation of plans and then evaluation of the care provided. My roles within EPUT have also included working with adults of working age, experiencing mental distress and illness, older people with a variety of mental illnesses. Also, I have worked within inpatient and community services, again both with adults and older people who are experiencing a period of mental health crisis. My various roles over the years have allowed me to work over the majority of what was the North Essex Partnership University NHS Trust (NEP) in all three localities of North East, Mid and North West, both in community and inpatient services.

6. In 2009 I was recruited into the ward manager post at Lucas Ward, Kings Wood Centre, Colchester. The Lucas ward was a 24-hour inpatient service that offered continuing care for older people who had significant and complex care needs. This was my first leadership position within what was NEP. Since this time I have worked within various leadership roles within NEP and the current organisation of Essex Partnership NHS Trust. I lead a team of around 25 registered and unregistered colleagues to provide 24-hour care. My direct line manager was [I/S] Clinical Manager, Matron, with Service Manage[I/S] being [I/S] [I/S] line report and [I/S] being the Director at this time. I am uncertain of the management structure above [I/S] at this time.

7. The role of Lucas Ward manager included ensuring that day to day good clinical care and practice, whilst helping to meet the organisations overall strategic direction , with the visions and values being All together, better. Management of staff, budget accountability and meeting Key Performance Indicators, were intrinsically linked to this role.

8. At the end of 2011, Lucas ward was decommissioned and I was appointed to Team Leader for the newly commissioned Dementia Service in January 2012. The service was commissioned to offer community services and support to those who had or were suspected of having a clear dementia diagnosis within the North East locality of Essex. I led a team of Nurses, Occupational Therapists and Psychology colleagues to offer timely interventions to the patient cohort. The team was averaged to a size of around 30 individuals that had direct line reporting to me. Again, management of staff, budget accountability and meeting Key Performance Indicators were intrinsically linked to this role. I cannot recall what the specific Key Performance Indicators were at this time. NEPT and EPUT organisationally did and do provide reports to the organisation with the current level of achievement and actions needed to meet the overall targets. I am unsure of who set the targets

9. At the end of 2011, Lucas ward was decommissioned and I was appointed to Team Leader for the newly commissioned Dementia Service in January 2012. The service was commissioned to offer community services and support to those who had or were suspected of having a clear dementia diagnosis within the North East locality of Essex. I led a team of Nurses, Occupational Therapists and Psychology colleagues to offer timely interventions to the patient

cohort. The team was averaged to a size of around 30 individuals that had direct line reporting to me. Again, management of staff, budget accountability and meeting Key Performance Indicators were intrinsically linked to this role. Following a trust change to the community services model this was called the 'Journeys' programme. I was assigned into an Advanced Nurse Practitioner post; this was within the same team with more increased clinical focused level of work. The leadership role continued with ensuring that staff support metrics being adhered to.

10. In November 2015 I was appointed Clinical Manager/Matron for the Crystal Centre, Chelmsford (Mid Locality). The role was to take leadership of two wards. These were the Topaz and Ruby wards (Ruby ward at the Crystal Centre, part of the Broomfield hospital site in Chelmsford is a functional older adult ward).

11.and what was then Community Team for people with dementia. During this time, I had two ward managers and three senior staff who directly would report to me, within the dementia pathway. A dementia pathway is a general description of services that are offered to a particular cohort of patients. Whilst working within the North East locality, the dementia pathway as it was at the time encompassed various work streams under a unified leadership team. For example, the Memory Clinic (a service that diagnoses dementia), post diagnosis support for people impacted with the diagnosis again at the time were included in the dementia pathway. Urgent response for those with a diagnosis of dementia such as duty services, home treatment team were part of the dementia pathway. The philosophy at the time was to reduce duplication for patients and loved ones using the service, to enable a better experience that was less bureaucratic and much more responsive to needs. The inpatient wards for people with Dementia are also part of the dementia pathway

12. In November 2015 I was appointed Clinical Manager/Matron for the Crystal Centre, Chelmsford (Mid Locality). The role was to take leadership of two wards. These were the Topaz and Ruby wards, and what was then Community Team for people with dementia. During this time, I had two ward managers and three senior staff who directly would report to me, within the dementia pathway. I was responsible for around 100 staff members working within these teams. Ensuring that good quality and effective care was executed, as this is one of the key aspects of this role. I directly reported to [I/S], Service Manager, who in turn reported to [I/S] Mid Area Director. I cannot remember the management structure above [I/S] at this time. An internal restructure in around June 2016 resulted in my direct line report changing to [I/S], who in turn reported to [I/S] I cannot recall the management structure above [I/S] for this period of time.

13. In December 2017, my location changed to the North East area but I remained with the same leadership role and expectations. My areas of responsibility included Tower and Bernard wards within the Landermere Centre on the Clacton District hospital site. Both Tower and Bernard wards were both dementia care inpatient wards. The Tower ward was a female dementia care ward, and the Bernard ward being a male dementia care ward. I also had responsibility for Henneage Ward, this is an older adult functional (typical mental illness such as depression, anxiety) ward which is located on the Kings Wood Centre, Colchester General Hospital site. My direct line reports remained as [I/S] and [I/S]

14. Within a time frame in 2018, I was also asked to take on management for Peter Bruff ward, (assessment unit for North Essex) which is based on the Kings Wood Centre site. I cannot recall

the exact date. I therefore had responsibility for Tower Ward, Bernard Ward, Henneage ward and Peter Bruff wards.

15. In April 2020, the Bernard ward was mothballed as an interim action as part of the COVID 19 pandemic, with the Tower ward then becoming a stand-alone mixed sex ward within the Landermere Centre site, as there was no other Essex Partnership NHS Services located on this site.

16. In November 2022 I was appointed as Secondment Interim Service Manager for the North East Locality. This role was a leadership role for 6 wards and the Urgent Care Pathway. I was Service Manager for Ipswich Road, Ardleigh, Gosfield, Henneage Peter Bruff and Tower wards. Also this role covered overseeing the Urgent Care pathway. This pathway included the overall responsibility for Hospital Liaison for Colchester Hospital and the two-community hospital at Harwich and Clacton Hospitals. The Crisis Team and Home Treatment Teams make up the final three teams which form the North East Urgent Care Pathway.

17. After an appointment of a substantive manager of Service Manager in October 2023, I returned to Clinical Manager/Matron for Henneage, Tower and Peter Burff wards. I remained in this role until November 2025 where I remain on Secondment to Mid and South Essex Foundation NHS Trust in the Integrated discharge hub for three acute hospital sites.

18. Prior to my time of working with dementia specific services, I did not receive any specific training in regard to dementia care. In 2011, NEPT developed dementia specific professional training that was offered via Essex University. The university developed specific modules for dementia care which is still offered to this day. However, this training is offered to registered professionals only. Unregistered staff have access to mandatory training to increase understanding for those who have a diagnosis of dementia. I am not aware of any specific training for older people who have a functional type of illness.

Section C: Safe & Therapeutic Inpatient Care

19. During my time as Charge Nurse on Drake house, I cannot recall how formulation of risk and care plans were made. The nursing process would have been followed, but the exact detail for my allocated patients as keyworker I cannot recall.

Assessments

20. Upon my return to inpatient care in 2009 as Ward Manager, NEP had structure set via the Care Programme Approach (CPA). CPA is a framework utilised across all mental health services that allow care and risk planning to occur both within community and inpatient services. The structure had set assessment criteria which allowed the formulation of plans that were tailored to the individual needs. The structure would include historical issues for the patient, current risks, levels of observation, underlying physical health considerations, manual handling issues, family connections and thoughts for their loved ones in hospital. For safe and therapeutic inpatient care assessments, the organisation uses risk assessments to formulate a care risk plan. The individual risk plan is unique to each individual and will tailored accordingly. The risk assessment and plan will cover a multitude of considerations, with the current presenting risk that cannot be mitigated within the community safety being of a primary part of care planning.

21. These documents were recorded on the patient administration system at the time called Care Base. In regards to accessing the previous electronic patient record system called care base, clinical staff and administration staff had access to this system.

22. Upon my return to inpatient care in 2009 as Ward Manager, NEP had structure set via the Care Programme Approach (CPA). CPA is a framework utilised across all mental health services that allow care and risk planning to occur both within community and inpatient services. The structure had set assessment criteria which allowed the formulation of plans that were tailored to the individual needs. These documents were recorded on the patient administration system at the time called Care Base. Care plans detailed most aspects of the patients' needs were attempted to be holistic and comprehensive to address the underlying presenting illness. These care plans would include consideration of any physical health considerations, such as facility, mobility continence needs, etc. The Lucas ward would receive complex presentation patients from Henneage and Bernard wards which at the time were all located within the Kings Wood Centre, Colchester. The wider multidisciplinary team would assess, coordinate and implement the patients needs.

23. The wards population were generally cared for under detention, which is under the Mental Health Act (1983) due to their significant and compiled needs that they were presenting at the time. Mental Health Act (1983) assessments for admission occur in the community. I am unable to comment how each individual situation for a Mental Health Act assessment is requested and completed, as this will vary on the needs of the person being assessed, and will occur prior to my involvement within inpatient services. Also, the Mental Capacity Act (2005) was utilised for certain decisions that met that requirement as a lesser restrictive option where this could be safely offered. Mental Capacity Act Assessments can be undertaken within the community, wherever the patient is. The assessments undertaken were face to face, included family where possible. In regards to assessments undertaken, I am referring to initial new admission assessments, with using the family and loved ones as lived experts. These would be risk assessment and care planning for the admission.

24. If there were clinical issues that the team were not able to resolve, accessing senior leadership would be the immediate course of action. Senior leadership would include the clinical manager/matron, consultant psychiatrist, expertise from the nursing directorate, the Risk team and Allied Health Professionals and service manager to review the difficulty and work a strategy for the clinical need of the individual patient.

25. Also drawing on wider trust wide resources were called upon. An example of this may include a patient who has significant cognitive impairment, who lacks capacity, presents with agitation and aggression, but also has been assessed as having a high risk of falls and complex manual handling needs. The ward team would be able to draw on wider trust teams to address the issues and offer a wider range of interventions that would meet the needs of this patient. What was the risk team at the time included manual handling for patients, but also safe methodology for the staff caring for the person in question. What was the TASI team (Therapeutic and Safe Interventions) at the time would in reach and offer strategies to help mitigate the unpredictable aspects of the patient. The wider multidisciplinary team would review the interventions according to the overall care plan. TASI is a mandated course for staff working within inpatient services. The training is geared up to look at de-escalation and management for patients who may present as agitated and aggressive.

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27. Generally, the Lucas ward offered care for longer periods of time than in comparison to Henneage and Bernard ward. Due to this, the needs of the cohort of patients on the ward would often change, and their needs would become less complex and more predictable. With the overall aim of offering the least restrictive option, detention under the Mental Health Act would be an active consideration as part of review of care plans. If a patient's care no longer required formal detention the patients Responsible Clinician would rescind the section. The patient's ability to have informed capacity to remain on the ward would be part of this review. If it was deemed necessary, a deprivation of liberty safeguards (DoLS) process would be implemented. This would allow the team to continue to act in the persons best interests but in a lesser restrictive option rather than formal detention. The assessment of the DoLS application is undertaken by Essex County Council as the local authority.

28. Undertaking of DoLS application assessments is a component of most registered health care practitioners. Mental Capacity Act which involves Deprivation of Liberty Safeguards process was and is part of the NEPT/EPUT trusts mandatory training requirements to ensure that all legal aspects are understood and followed.

29. Lucas ward at the time, when I was ward manager, only accepted transfers in from Henneage and Bernard wards. Most patients at the point of transfer into the ward presented with significant and complex needs which warranted detention under the Mental Health Act. The wider multidisciplinary team would review the need to continue to offer care under the act, if a lesser restrictive option was possible, such as being an informal patient or a DoLS process.

30. When Lucas ward was decommissioned in 2011 I moved into community services.

Admission

31. I returned to a blended role of clinical manager/matron at the Crystal centre in 2015. As described the role of Clinical Manager/Matron included a dementia care ward (Topaz ward) and an older adult functional care ward (Ruby ward) and the Mid locality community dementia pathway.

32. At this point of time, admissions into Topaz and Ruby wards were made via the Mid area community teams including the Dementia pathway, Specialist community mental health teams

that were age inclusive and home treatment teams. Prior to the NEPT implementation of what was the community review and realignment of community care, NEPT followed a traditional Community Mental Health Team (CMHT) approach. A CMHT usually worked on a locality-based way of working which was also age dependent. For example, a 40-year-old patient who had severe depression could potentially be offered longer term support via a community team via the 'Adult CMHT'. An older person who could be over 70 years old who may have severe depression would be cared for by the Older Adult CMHT. The NEPT journeys programme (I cannot recall the specific date that the implementation occurred) moved away from an age specific approach to a more 'needs/problem' approach. Again, for example a 40-year-old and a 70 year old patient who was severely depressed would be cared for in the community by a 'Specialist' community team for depression. The community pathways were realigned along this model to make them 'age inclusive' and more focused on the 'needs' of the patients to offer parity regardless of age. NEPT undertook this approach sometime in the mid 2010's. SEPT and now the 'South EPUT' community teams continue to follow a traditional CMHT age exclusive approach.

33. At this point of time, admissions into Topaz and Ruby wards were made via the Mid area community teams including the Dementia pathway, Specialist community mental health teams that were age inclusive and home treatment teams.

34. At this time of working at the crystal centre, there was no specific bed management SITREP calls as NEPT did not operate an entire bed stock approach to community demand. Generally, localities such as Mid Essex, North West Essex and North East Essex worked independently in managing bed stock. After merger and creation of EPUT, including management structure changes, there was a much more integrated approach to utilising of bed stock. I cannot recall the exact date, but a daily morning bed management call was commenced with all EPUT wards expected to dial in via a telephone call to give an update on current bed availability and expected discharges. The call was managed with colleagues from the bed management team taking notes for the expected availability. I am not able to recall which senior staff were making clinical decisions for patient's to be admitted to what ward and for what reason.

35. Also, staffing for the wards was 'checked' on this call, with teams giving a Red, Amber or Green rating for the shift ahead. If a team was not 'green' as part of the sitrep call, mitigation for that clinical team was discussed as what can be offered to ensure safe care is maintained. Part of the mitigation would usually be reviewing the needs of the entire locality. For the 'North East' area, the six wards staffing levels would be checked to see if staff could be redeployed from one ward to another without impacting on safety. Also, the use of other non-nursing colleagues would be reviewed to see if further support could be offered. This may include the use of Occupational Therapy, physio therapists and or psychology colleagues used to help meet the needs of the ward that was not 'green' for safer care.

36. Also, staffing for the wards was 'checked' on this call, with teams giving a Red, Amber or Green rating for the shift ahead. If a team was not Green, mitigation was expected to be described for the shift ahead to meet the deficit that had been declared.

37. Decisions about where to admit patients were taken at this call for entire county who were in acute care hospitals and the wider community.

38. At the time of creation of EPUT there was an initial once a day SITREP call in the morning. As time has progressed EPUT now has three SITREP bed management specific calls. AM and PM

calls are locality based, e.g. North East, North West and Mid and South Essex. The 1230 SITREP call is a trust wide assessment and review of all the clinical demand and expected discharges from the wards. The SITREP calls have representation from inpatient services, community and also urgent care teams which will include home treatment, crisis and hospital liaison teams who continue to care for the patient whilst an appropriate bed is identified. The purpose is to review and avoid unnecessary delay in admission where needed, whilst ensuring that mitigation is provided for unresolved demand.

39. If admission for a patient was required and the most appropriate bed was identified within the EPUT bed stock they would immediately be admitted to that ward. Patients who were deemed necessary for admission but without an immediate bed available, the SITREP call usually offers mitigation that a community service will continue to support until a bed is identified and vacant.

40. Admissions to Topaz and Ruby wards were a mix of patients assessed in the community that due to their needs were unable to be safely cared for at home and required hospitalisation. The admissions were a mix of patients that had been assessed, with recommendations for detention under the Mental Health Act or those who agreed and willing to be admitted into hospital as an informal patient.

41. Factors that the community teams considered were risks including patient aggression towards themselves and others. This may include verbal threats of violence, actual reported violence towards others (this is a commonality for patients who have a severe cognitive impairment who end up in a dementia care ward). A patient's ability to make good, informed decisions or not as the case may be, also are driving factors for potential admission into hospital. This may include a deterioration in a presenting mental illness which impacts on the persons ability to make decisions including thoughts of self-harm and suicide. Family requests for where a patient is admitted is part of the admission process. However, it is not a determining factor, and there can be instances where families disagree with an outcome. For example, a patient who has dementia who lives in Clacton on Sea is needing to be detained under the Mental Health Act. The locality for this person to be admitted should be Tower Ward, Clacton Hospital. However, if there are no empty beds, the clinical need for the patient to be admitted, would result in the person being admitted to Kitwood (Epping) or Meadowview (Thurrock) wards who may have bed availability. This would impact on the loved one's ability to have ease of visits as these sites are a significant distance from the Tendring area. The overriding clinical risk would outweigh wishes of the family and loved one needing to be detained.

42. As the trust continued to proceed with the merger from the predecessor organisations into EPUT, there was a drive towards offering a more standardised approach to an EPUT bed management style. The aim was to utilise the entire EPUT bed stock to meet the community demand that existed and to offer a bed to a patient who needed it.

43. At the beginning of 2020 at the start of the pandemic, I believe I remember the evolution of this call was transferred to a telephone call to a Microsoft teams video call where it remains to this day. Over time, the SITREP call has evolved to have much more clinical oversight by the expanded patient flow team, and senior attendance to assist with decision making. The patient flow team has grown over the years. Initially when EPUT was created I was aware of a number of 'bed managers' who were administration colleagues who monitored the discharges throughout the day and assisted with the SITREP calls to suggest where patients who were needing admission should be offered a bed. Over the years the size of the team has expanded and there

are now several clinical colleagues within the team that assist with the flow aspect of the organisation. I am not certain of the exact numbers of colleagues within the team, and the overall operational responsibilities that they undertake. Currently SITREP calls are chaired by a senior manager within the locality who can help make decisions about which patient will be admitted to which ward. This is done with the assistance of the bed managers who will have an oversight of the entire organisations bed demand. Usually, the calls are chaired by a service manager or someone of a more senior grade.

44. At the beginning of 2020 at the start of the pandemic, I believe I remember the evolution of this call was transferred to a telephone call to a Microsoft teams video call where it remains to this day. Over time, the SITREP call has evolved to have much more clinical oversight by the expanded patient flow team, and senior attendance to assist with decision making.45. Decision to where to admit, is a clear part of the patient flow team, and the decision-making process for which ward to admit a patient to, and to which team, continues to be part of this call.

46. There is representation from the community teams, urgent care pathways, wards, the bed management team and a chair for the call.

47. I am aware that there is guidance of what the levels of care are needed in the interim time for when a bed is identified as needed and then accessible, but in my Clinical Manager/Matron role, I am unfamiliar on the scoring tools that the flow and capacity team use to identify the most urgent patients needing admission. I am unaware if there is any training available to help decide of the level of care needed in the interim.

48. I am unaware of barriers to decisions relating to the admission that were appropriate and adequate. I am not aware of any barriers to the decision to admit patients to wards or if there were decisions that prevented admission to wards.

49. I am unaware of barriers to decisions relating to the admission that were appropriate and adequate.

50. As my time and experience in the SITREP calls has developed, the ability to feel confident in decision making for the demand aspect for bed management has increased. The clinical colleagues in the flow and capacity team utilise the clinical dependency scoring tool that offers a more structed approach to help identify the most clinically acutely unwell patient to allow them to be admitted into hospital. This was not the case when the trust wide SITREP calls were initiated.

Ward Environment

51. When I was appointed as a Lucas ward manager 2009, the key environmental priorities were to ensure the area was kept clean, comfortable, and as safe as possible in terms of reducing the risks of falls, as falls for the patient cohort was the main clinical risk. I can not recall if at that point risk assessments that included consideration for ligature concerns was undertaken by NEP at that time in question.

52. Prior to my time at the Crystal Centre, I am aware that there was an incident on Ruby ward where a patient ligatured from an ensuite shower room door. I cannot recall if the incident was in reference to Iris Scott nor what year it occurred.

53. Prior to my time at the Crystal Centre, I am aware that there was an incident on Ruby ward where a patient ligatured from an ensuite shower room door. Therefore, there was a much more

in-depth consideration for ligature risks. I am aware that there was environmental works undertaken on site to reduce and mitigate ligature points. At the time this included redesigning shower room doors.

54. I vaguely recall that prior to the creation of EPUT that ward based risk assessments for ligature awareness were taken. Upon creation of the EPUT organisation, formal ligature risk assessments were initiated with actions required to reduce or mitigate the identified issues. This work was undertaken by the trusts Risk department with a schedule of follow up and assurance tools used to capture the desired change. I can not recall the exact date for when this work was initiated.

55. Upon my appointment to Clinical Manager/Matron a core responsibility was ensuring that the wards remained as ligature risk reduced as is possible, but balanced with making a clinical ward area as comfortable as is possible. This overall responsibility clearly sat with this role. Ward teams were expected to undertake checks as described in certain trust based schedules. The schedule of the checks was shared with the ward teams. The schedules were updated within the EPUT audit team. Outcome of the assessments were shared with the teams via email each month when the results are given to the wards. This allows all wards to know when and what audits are required and to standardise the monitoring and assurance process. These audits are logged via the 'Tendable' tool that the trust uses to log audits. Tendable is an electronic platform that EPUT uses to capture most audits.

56. Upon my appointment to Clinical Manager/Matron a core responsibility was ensuring that the wards remained as ligature risk reduced as is possible, but balanced with making a clinical ward area as comfortable as is possible. This overall responsibility clearly sat with this role. Ward teams were expected to undertake checks as described in certain trust based schedules. The schedule of the checks was shared with the ward teams. These included checks for emergency equipment, fridge temperature, ward-based security checks, and a full plethora of other assurance checks, which were then collated within the matron's assurance checklist. This assurance document was completed by the Matron and submitted to the locality to give an overview of current performance.

57. When I became a Clinical Manager/Matron for the Crystal Centre, Broomfield Hospital site, the site is one of the more recent builds for the trust being built in the 2010's. The building is of a modern design with (at the time), the most evidence-based approach to patient and staff use part of layout. Lines of sight, intuitive pathways etc being considered. However, at the time of myself being Matron, both the Ruby and Topaz wards had individual bedrooms and used traditional hospital profiling beds.

58. During my time as Crystal Centre Clinical Manager/Matron both the Ruby and Topaz wards had Assistive Technology installed in the bedroom areas to help mitigate the unwitnessed falls that had been noted in the entire trust at that time. The assistive technology that was installed was a motion sensor, that noted when a patient moved from a lying position to a sitting position. The sensor allowed the nursing team to respond to this movement to allow early intervention to identify and prevent falls from occurring. When the ward teams were using assistive technology to care for patients in their bedrooms, the system used a 'pager' based system that was integrated along with the emergency assistance system called 'aquarius'. When activated the electronic system would activate the display in the office and the wider ward to alert the team that a patient was moving from their bed and offer interventions that would reduce a risk of falls.

The alarm would alert staff via a noise and a flash on a screen, but not with the same level of urgency if an emergency was occurring on the ward.

59. The Assistive Technology was installed in all Older Adult bedrooms across what was NEPT as part of a standardisation for falls prevention. This applied to Ruby, Topaz, Roding, Kitwood, Tower, Henneage and Bernard wards. I cannot recall the final roll out or when it was completed. When the technology was being installed staff had local training in how to use the equipment. It was not mandated by the trust. However, all NEPT older adult wards had this technology installed. I cannot recall if there was a planned schedule for testing the equipment. But repairs to any damaged equipment was undertaken by inhouse estates staff.

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61. The Kings Wood and Landermere Centres were built in the late 1990s as part of the reprovision from the closing Severalls Hospital site in Colchester. As a result the layout and design of the building is typical of design at the time. The layout and floor plans are much less intuitive with lots of lack of direct sight points and bends in corridors. To mitigate this, various adaptations were undertaken such as convex mirrors to address corners.

62. The Crystal, Kings Wood and Landermere Centres had furniture that was geared towards older people which posed increased risks of ligature and self-harm. Mitigation for these risks was addressed in the Ligature Audits and individualised risk assessment. Recently there has been a drive towards reduced ligature furniture in the older adult wards which has reduced the ligature risks but decreased the ability for patients themselves to move pieces of furniture such as dining room chairs independently as it is of a heavy, low to the floor design. The ability to mitigate out ligature opportunities is a key driver for the organisation, but the balance to meet this obvious risk with the needs of the patients themselves in using basic furniture is of an ongoing challenge.

63. During my time as Clinical Manager/Matron the issue for eliminating of mixed sex wards increased over the time. At the time the Henneage ward was a mixed sex ward, but the layout allowed for cohorting of patients within certain areas aligned to a particular gender. Tower and Bernard wards were of a single sex ward by design.

64. The Peter Bruff ward, after its relocation from Clacton Hospital Site to the Kings Wood Centre (Colchester), its layout was purposely designed to offer single sex accommodation. Patients had their own swipe cards to maintain independent access to their bedroom without having permissions to other areas that were out of bounds.

65. All wards had a number of refreshes and refurbishments over the years, with ligature reduced and fixed furniture being installed in all areas. This included Dementia Care wards, where the use of this type of furniture is of a lesser initiative style such as integral push buttons for sinks and toilet flushes. Wardrobes were removed with fixed furniture installed in all wards.

66. Falls risk for older people wards was mitigated by the falls risk assessment within individualised care plans developed to reduce to concerns identified. Mitigation may have been increased observations, use of assistive technology to offer a lesser restrictive option for the individual. This may include mattress sensors, the physically installed edge of bed and floor sensors. Edge of bed sensor refers to a sensor placed at the physically edge of a bed when someone may be trying to get up, rather than just moving in the bed to get more comfortable. Floor sensors are located at the side of the bed and used for when a patient has swung their legs off the bed and put the feet on the floor triggering the 'aquarius' system. Edge of bed sensors and floor sensors were available to help mitigate this aspect of the patient's care.

67. Falls risk for older people wards was mitigated by the falls risk assessment within individualised care plans developed to reduce to concerns identified. Mitigation may have been increased observations, use of assistive technology to offer a lesser restrictive option for the individual. This may include mattress sensors, the physically installed edge of bed and floor sensors.

Treatment

68. Decisions about treatment and care plans are multidisciplinary in approach to meet the needs of the patients on the ward. Nurses, Doctors, Physiotherapists, Occupational Therapists, Psychology and pharmacy colleagues take part in the MDT. Experts in specific fields are often co-opted in to give a consultation for a specific need of a patient. This could include the nursing directorate, medical experts for second opinions etc. General Practitioners do not offer direct input to care or risk planning for the patients on the ward, but will be provided the outcome of the admission via a discharge summary.

69. Decisions about treatment and care plans are multidisciplinary in approach. Responsible Clinicians carry significant influence for certain decisions especially in relation to the Mental Health Act. Consideration for least restrictive options have significantly increased over my time with NEPT and EPUT. The thoughts and wishes of the patient as lived expert and the family or carers are much more integrated into the formulation of the care plan.

70. With increased numbers of people involved in treatment and care planning the inherent issue of disagreements of desired outcome is more often. Disagreements for next steps of a patient's journey can be raised and discussed in a variety of ways. CPA reviews, ward reviews, Multidisciplinary Team meetings, and if needed specifically arranged professionals' meetings are opportunities for the team to come together to address specific concerns and come to an agreed outcome. Patients who had an underlying cognitive impairment or an acute episode of a poor mental state used family's to advocate on their behalf. Access to formal advocacy also is a mandated requirement for patients under the Mental Health Act or the Mental Capacity Act. I am unaware of recent times where accessing to formal advocacy has been an issue.

71. The teams had access to a wide range of allied health practitioners where appropriate. I am aware of times where access to certain individuals or services was complicated. This included access to Speech and Language Therapists in a timely manner as the service agreement needed to be signed off by seniors, so spot purchasing for this service was required whilst this was being arranged.

72. Older People who present with unpredictability such as violence and aggression can be complex to offer care to on a day-to-day basis, especially people with dementia. Bernard wards and Tower wards had examples of severely aggressive behaviour that is due to person with dementia deteriorating understanding and cognitive state. Person Centred Care planning is key to offer interventions to reduce this risk. I am aware of patients who have injured other patients and staff including causing severe injury and fractures. Pharmacological interventions for older people and those with dementia are significantly decreased. Accessing more intensive care settings for cognitively impaired patients within EPUT is not currently possible. This is due to the Psychiatric Intensive Care Units following current NHS PICU guidance which specifically excludes patients with a cognitive impairment and dementia. This then results in dementia care wards having to offer care to severely unpredictable and often aggressive patients within a ward which already has frail and confused patients within the setting. Whilst I acknowledge that this particular issue for caring for this particular type of patient is infrequent, when this type of presentation does arise, it poses significant challenges to older people inpatient services.

73. Person centred care planning will look at the life of the patient that the team will be caring for. As an example, whilst caring for a patient on Lucas ward, a male patient who had severe dementia would often get agitated and aggressive when he was in his bedroom area. After consulting with his family about this, it eventually became more understandable that this patient did not like classical music. The team at the time were trying to use this music within his bedroom as a tool to help soothe and de-escalate him during times of agitation. Without the in-depth knowledge and use of the 'lived experts' such as family, the ability to offer care without triggering inadvertently was not possible. Care teams regardless of the patient's needs, must and should always endeavour to work in a person centred and a trauma informed manner which will build upon known triggers and identify other opportunities to work in a collaborative manner.

74. I have cared for this small cohort of patients on a number of occasions. For patients who are unpredictable and aggressive and have an underlying cognitive impairment there is no specific national or pathway to follow. To "self check" and ensure that the wider MDT are following best practice and the least restrictive option available to the individual patient, I would set and arrange professional's meetings of a minimum weekly basis, or more often if there was a change in the patient's presentation. The MDT would review the current care plan and ensure the basic considerations including the persons physical health was reviewed. On these occasions for the professional's meetings that I called for, wider representation was called for from other parts of the trust. This would include Senior Nursing representation from the nursing directorate, physical health expert input, physical interventions from the TASI team, pharmacy, safeguarding and any other team member who would have been helpful in consideration for providing the least restrictive option for the persons care whilst addressing the unpredictable and aggressive behaviour.

75. Caring for patients who are unpredictable and aggressive is complex, and can cause teams and individuals understandably apprehension and anxiety. Caring for patients who exhibit this type of behaviour and have an underlying cognitive impairment can pose even more challenges. The expected improvement with unpredictable behaviour due to a traditional mental illness normally occurs with conventional treatment. Patients with a cognitive impairment who are severely unpredictable and aggressive do not have a 'recovery' and the future care planning is therefore more complex with few limited options both within EPUT services and lesser restrictive options within the community.

76. I have not been matron for any services in the North West locality of Essex, including the Mental Health Unit at St Margarets Hospital in Epping, and I am unable to make reference the care and services offered there.

77. Treating patients who present or have a diagnosis of Emotionally Unstable Personality Disorder and/or a borderline personality disorder is highly complex particularly within an inpatient hospital setting.

78. The most effective treatment for people experiencing an emotionally unstable personality disorder or a borderline personality disorder is significant interpersonal psychological or psychotherapy treatment, where the patient themselves are willing and able to undertake a self-learning journey to explore much more healthy coping mechanisms. When patients who have these types of illnesses present in a state of urgency and crisis, the mental health risks escalate as impulsive with links to dangerous types of self harm behaviour. This can include overdose, self harm and strangulation.

79. Ward based psychologists are readily available to compile a formulation for a clinical presentation with recommendations made for further community based therapy when clinically indicated. Ward based psychologists offer 1:1 sessions to patients on the ward that require this level of assessment to understand and formulate possible future inventions that would support recovery in the community post discharge. For patients with a dementia diagnosis, psychologist can formulate suggestions for certain types of behaviours that a patient may be presenting with, which again allows a closer person centred, trauma informed approach to be undertaken. Also, psychology colleagues undertake family and carer support groups for each ward.

80. My experience for my time within NEPT and EPUT, there has been a shift towards wards having their own dedicated individual professionals. At appointment to my first ward manager role in 2009, there was very infrequent allied health professional input into the older adult wards. Over time, this has increased with the expectation that each ward has its own dedicated staff. I cannot recall when the increased staffing levels for Occupational Therapists and Psychology staff occurred. Psychology colleagues are being used to help staff understand the importance of trauma informed care, which has also now been made part of the mandatory training for EPUT staff.

81. Ward based psychologists are readily available to compile a formulation for a clinical presentation with recommendations made for further community based therapy when clinically indicated.

82. The ability for mental health services to make a judgement call for a person presenting with severe emotionally dysregulation but the need to offer care within the community is a day-to-day clinical decision that MDTs make each and every day. There is significant evidence that this cohort of patient group have a poor experience within an inpatient setting, develop other poor coping strategies and increase impulsive self harming behaviours. With the ongoing presenting complex risk behaviours noted on a ward, more restrictive treatment and care plans are applied to mitigate the risk of behaviours which are being presented with. This may include increased observations, considerations of legal interventions including the Mental Capacity Act or the Mental Health Act.

83. Caring for this clinically unpredictable patient group has inherited risks. With Peter Bruff and Henneage wards, there are a high number of patients with this type of illness being cared

for together. This patient cohort generally are admitted to wards due to the community teams and resources believing that they are so significant that they should remain in hospital.

84. Providing a compassionate and person-centred level of care, I believe this can make the teams feel overwhelmed and uncertain of how to devise a discharge pathway with a person who consistently states, that they are 'well' on a ward, but they voice thoughts of suicide, if they were to be discharged out of a hospital setting. This basic challenge that patients display and how to safely offer a discharge are decisions made within the wider MDT on a daily basis.

85. The Ward teams have had increased access to training, professional development and access to ward based psychological team members. This type of training has been aimed at registered colleagues, but I am aware that half of ward based nursing teams also consist of unregistered colleagues. Accessing training for these staff members is generally limited to mandatory training, but I believe that if this staff group had training to help them understand in more depth why a patient may be presenting in a particular manner, which can help develop a better therapeutic relationship. With the roll out of the new operational model and a clear drive to offer trauma informed care which will now start to embed training and education for all care staff. The new EPUT inpatient operational model is based on the NHS England 'Acute inpatient mental health care for adults and older adults' strategy that was released in 2023. The model incorporates three key stages for admission, Purposeful admissions to inpatient care, Therapeutic Inpatient care, Proactive discharge planning and effective post discharge support. This model also has four key principles, Personalised care and shared decision making, Care that advances health equality, Trauma informed Care, Joined up partnership working

86. Caring for patients who have an underlying substance abuse or addiction can again present as challenging. These challenges may include drive and motivation for the persons willingness to change unhelpful behaviour. However, teams are aware of how to access timely interventions and onward referrals is well established. I am unaware of limitations for patients to access timely assistance from substance abuse or addiction services.

Medication

87. Medication administration within the inpatient setting is an integral aspect of nursing care. Traditionally the wards until recently used a paper based 'treatment card' system. The treatment card would have been written by a medic and cross checked by a pharmacist for potential interactions between medications. This method was in place for years until the role out of the electronic prescription/administration system called EPMA, Electronic patient medication administration system. This role out has been undertaken very recently to inpatient services.

88. In regards to patients who were declining medications, thoughts about self determination and the ability to make informed decisions were part of the nursing team at point of administration of medication. If there was a suggestion that a person who may lack understanding and capacity to decide about taking medication nurses and the wider team would have a clinical conversation about this specific issue. If this was the case, then a formal Mental Capacity Assessment would be undertaken. Consideration may be made to formally assess a patient under the mental capacity act to ascertain if a best interest decision is needed to administer the prescribed medication. Family and next of kins would be consulted, to seek further options as they are the lived expert for the patient.

89. An independent mental capacity advocate would be sourced to ensure that the least restrictive options are considered before treatment is administered against the patients wishes.

90. I am unaware of any intentional culture of over medication within any of the ward based services that I have had contact with over the years.

91. I am unaware of any restrictions of medications that would be offered to the patient's on the wards that I have had contact with over the years.

92. Pharmacy colleagues undertake medication reconciliation and further checks to any changes to medication treatment plans. If needed, nurses could call (or visit the pharmacist team based at Kings Wood Centre) for further advice or clarification where needed.

93. Administration of medication within inpatient wards is very established and clearly known by most of the teams within EPUT. Protected time for medication administration is well established by the nursing team. Red 'do not disturb' tabards are available and used by the nursing team to clearly offer a visual prompt to people of the wards.

94. Prescriptions are reviewed at various times throughout the day. These actions are discussed in the Red to Green meetings, Care/ward review meetings, MDT meetings and as/when if necessary, such as a significant change to a patient's clinical presentation. Red to Green meetings are daily MDT meetings to ensure that there is a purpose for a patient being in hospital and that the team is working towards a discharge plan. Green days are where there is a purpose for a patients need to remain in hospital. A Red day is where there is no purpose for that patient to remain on the ward. After three consistent three red days, the MDT should discuss what needs to occur to either gain purpose or consider what the delay to discharge could be.

95. Prescriptions are reviewed at various times throughout the day. These actions are discussed in the Red to Green meetings, Care/ward review meetings, MDT meetings and as/when if necessary, such as a significant change to a patient's clinical presentation.

96. Historically I am aware that inpatient services including services that I have responsibility of, had noted gaps and omissions within treatment cards. Prior to the implementation of the electronic patients medication system called EPMA, the administration of medication was solely a paper based way of working, with significant opportunity for human error. Even with two people cross checking paper based cards, there remains an opportunity for human error. Prior to the shift to EPMA, the paper cards were taken into the nursing handover to get the following shift to cross check medication cards and to prevent issues such as missed doses of medication.

97. To overcome this issue various initiatives were used to drive improvements including the overlapping shifts checking cards. The handover from one shift to another included taking in the paper medication cards into the meeting. For example, a day shift would ask the night shift to cross check the medication cards to ascertain that there were no errors, missed doses of medication or omitted signature boxes. With the use of the EPMA system the ability to 'miss doses' have improved the overall compliance of this intervention. EPMA clearly triggers timeframes for the administrating nurse so that missed doses of medication do not occur.

98. Patients who have been noted to have swallowing difficulties have access to the Speech and Language Therapy inhouse team who can offer advice and care plans to these individuals who may need adaptations to meet the treatment plan needs along with the general aspect of providing appropriate diet and fluid requirements.

99. I am unaware of any barriers to appropriate and adequate prescription and administration of medication to mental health inpatients.

Transfer

100. Decisions to move a patient from one clinical ward to another could be made for a variety of reasons. An example may be, Peter Bruff Assessment Unit who have assessed and recommended that longer treatment is needed for an individual within a treatment ward. For example, a bed has become available on Ardleigh ward (the Lakes), who are able to offer care for the patient on Peter Bruff ward. On the various SITREP calls that occur throughout the day, the decision is usually made there that a transfer can occur from Peter Bruff ward to Ardleigh ward. There are also times where a patient has been admitted to a bed which is not within the locality of the area. Like if a patient was admitted to Ruby ward Chelmsford, but lives in the Colchester area. A bed becomes available on Henneage ward for this patient and a ward-to-ward decision is made to repatriate the patient back to their locality. The wards will undertake a telephone conversation to understand risks, and a handover sheet will be completed and sent to the receiving ward in preparation for the transfer.

101. Internal transfer process has significantly changed over the years that I have been working in inpatient services. I can recall decisions being made without individual wards being involved or consulted with. I cannot recall when the formalisation of the internal handover process being implemented using the trust wide approved model. The handover from one nursing shift to the following staff group is an integral part of inpatient nursing care. Throughout EPUT the process varied across all wards. At some point in the 2010's there was a push to standardise this process and allow all EPUT wards to follow the same process. I cannot recall when the exact date when this process was initiated.

102. Internal transfer process has significantly changed over the years that I have been working in inpatient services. I can recall decisions being made without individual wards being involved or consulted with. I cannot recall when the formalisation of the internal handover process being implemented using the trust wide approved model.

103. Considerations that are undertaken currently in the trust currently prior to transfer include, the overall clinical presentation of the patient needing to be transferred, the demand on the receiving ward is reviewed and the overall safety to allow the transfer is undertaken by both teams including safe and adequate staffing.

104. If a transfer was indicated but not completed this could be for a multitude of reasons. More commonly this may be due to hospital transport being unable to respond to the demand in a timely manner. Also, a change in the patient's clinical presentation may delay or stop a transfer from safely occurring. Other considerations may be the receiving ward having a change in clinical dependency of the current ward population which may not allow a safe transfer to occur as well, such as increased observations or an emergency situation on the receiving ward. The overall experience of a patient not transferring within the expected time would normally impact in a negative manner. This may include the lack of family visiting due to distance needing to travel, and overall disappointment of plans not coming to fruition.

105. I am unaware of training to help make decisions about transfer of care between wards.

106. I am unaware of barriers about decision making regarding the transfer of patients within mental health wards.

107. Over time the transfer of patients within mental health wards has become much more strengthened and robust with the approach. Clear actions and expectations are set within the guidance and allow safety risks to be reviewed and addressed prior to the transfer occurring. The handover itself will include the current risk and care plans. This handover will also include reasons for admission and observation levels. Also, with the new EPMA system, the medication treatment plan is automatically handed over with the patient.

Safeguarding

108. In regards to the safeguarding process, this has expanded and become much more integral into the day-to-day care of patients within the trust and is much more central to EPUTs organisations culture over time. Various mechanisms existed that could be used to raise and escalate various aspects of a patients care and journey that clinical teams may have been experiencing over the years. This may have included conversations between team members, 1:1 conversation with line managers, and also much more utilised the Essex Thurrock and Southend safeguarding process. EPUT have had the *Freedom to Speak* up process to raise concerns, but I am unaware if there had been any clinical concerns for patients escalated via this process.

109. Safeguarding concerns would generally be shared with the team themselves via raising a safeguard (SETSAF) if the incident happened whilst on the ward. The safeguarding team would also share with the teams any other safeguards that had been raised for a patient by a person outside of the team. This could be Police, external organisations and also internally via EPUT colleagues for issues and concerns that may have felt to be needed to be looked at in more depth.

110. I have had concerns with peers and colleagues over the years that have been in regard to observations about clinical practice. In the past I have had to undertake various investigations and acted as panel hearing managers for staff who had allegations made against them including suggestions of staff being asleep whilst on enhanced observations. The formalisation of the process is driven by patient safety, safeguarding and uses various Human Resources policies to arrive at an outcome. Outcomes for staff who have allegations made against them have included written warnings, further training and on occasion dismissal from the trust.

111. I have had concerns with peers and colleagues over the years that have been in regard to observations about clinical practice. These types of concerns are usually managed with either the line manager of the person involved or by a professional clinical lead for the profession if it was a non-nurse practitioner. I felt confident in having a difficult and open conversation with team members in regards to these observations about poor practice and potential capability issues. This would include an onward referral to the Nursing and Midwifery Council (NMC) to allow the practice to be reviewed to decide about fitness to practice. I am unaware of any other non-nurses ever being referred to any regulatory body for further investigation.

Clinical Records

112. Over the years EPUT has used a variety of clinical recording systems. Upon my initial recruitment as a nurse in 2003, care and risk planning was undertaken primarily via a paper-based system. Over time most paper-based systems were complemented by a NEP update of a system called CareBase. Whilst incredibly clunky, the system was visually clear in the use of a Red, Amber and Green to identify if and when certain KPIs were in date or needed to be reviewed. Key Performance Indicators include the expectation for when a clinical staff member

has used a paper-based document for recording, are scanned and uploaded to the various patient administration systems is within 24 hours. This work is undertaken by the administration team such as ward clerks and reception staff.

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114. Some community services have moved away from the electronic Paris system to System One' which ward based services do not have direct access to. System One is the system that most (not all) GP services use to record patient records.

115. With the creation of EPUT, the ability to access the 'Health Information Exchange' or HIE helped improve electronic patient communication between the two predecessor organisations. Mobius and Paris both feed into the HIE and give key information across the organisation. Some of the specific details in both systems are difficult to navigate and access even with full training. EPUT is moving towards a central patient administration system, called NOVA, along with the Mid and South Essex Acute hospitals. This will help improve the ability for teams to access to records in a timely fashion. The formal launch date of the new system is still being confirmed. I am uncertain if those community teams for EPUT who have moved away from Paris will be expected to return to the replacement system called NOVA or remain on the system one.

116. Certain key documents are still paper based, but clinical teams have access to admin support who have certain KPIs to ensure that these are scanned, quality checked and uploaded into each system within a specific time frame. The role of admin was to upload the paper based documents on behalf of the clinical teams. The scanning would be sent to the inhouse EPUT scanning team to check for quality assurance. I am not aware of the full remit of the scanning team or what their key performance indicators are. I can not recall when the scanning team was formed or when the trust used the team to offer assurance for the quality of the scanning process.

117. When using paper-based notes, they were contemporaneous and of a multidisciplinary type of way of recording. If I recall, different teams had certain grouping of notes recorded. With paper based notes, there were limitations of this way of working. For example, community teams recorded notes in a certain part of the records, wards again in a certain part of the physical record, day hospital teams a certain place but, the individual team's notes would include the wider MDT note recording. All of these teams would be keeping records, but these would be held within the service that was caring for the patient; inpatients holding a file, the community team holding a file, the outpatients holding a file and day services holding a file. Centralisation of the records usually occurred when a patient's care was discharged from a part of a team. For example, when a patient was discharged, the physical notes that had been

generated were sent to the community team to follow up with the patient. When accessing physical notes there is always a delay in gaining them from colleagues within other teams. Also accessing physically archived notes can be challenging to access in a timely fashion.

118. Paris and mobius clinical recording systems allow contemporaneous notes to be made and filtered in a variety of ways specifically for each user.

119. Issues or concerns relating specifically to the Paris system are escalated via the corresponding channels with changes made over time, if needed. With the use of two separate patient administration systems in use for EPUT, there are two corresponding Information Technology staff who have expertise in each system. For Paris, there is [I/S] who works with the company that provides the system to deliver the necessary changes required. [I/S] [I/S] is the expert for the Mobius system. I am uncertain who the EPUT expert is for System One that is used within some community teams.

120. Issues or concerns relating specifically to the Paris system are escalated via the corresponding channels with changes made over time, if needed. Paris has been updated significantly over the years since I have started using it within my day-to-day activity. Over time the ability to access patient recording systems has increased, with the use of laptops, overhead projectors to display clinical conversations with patients and the wider team. Use of smart boards have helped teams to have better clinical discussions.

121. Within my time in community services and my return to ward-based services, the auditing and quality assurance aspect was a crucial part of the senior lead role. This continued in all of my leadership roles. There were various audits expected to be undertaken with a focus on quality and safety for the patient group. At this time, the audits and quality assurance that clinical teams are expected to adhere to is shared with the teams, monitored and action taken if adherence is not maintained. This is via the audit schedule and captured on the system called 'Tendable' to allow easy access and review which then is shared with teams to learn and improve.

122. The audits that are required include but are not exhaustive of:

- Clear to care – safer staffing levels – Daily
- Electronic Prescribing and Medicines Administration (EMPA) – weekly
- Mattress Adult – weekly
- Oxevision – Fortnightly
- Ward Managers Audit -monthly
- Person Centred Audit – Monthly
- Health and Safety Audit -monthly
- Mental Health Act Audit -monthly
- Matrons Assurance – Record Keeping Audit - Monthly
- Infection Prevention and Control adult – three monthly
- These audits are logged on the system called 'Tendable'

123. The audit results are collated by the performance team and reported on monthly to the inpatient services group to monitor and ensure effectiveness of a clinical team.

124. With these audit outcomes, I would cross reference the overall performance to be part of the ward managers 1:1 time. For example, all staff mandatory training would be discussed in this time, with actions needed to ensure adherence for good compliance for the team. If there

were issues such as a drop in a teams 1:1 being noted in one month, the discussion between myself and the ward manager would include what actions are needed to be completed in the next month to ensure that staff are provided with 1:1 and that this particular issue can be resolved. This action would then be cross checked at the following months 1:1 for compliance and adherence. Whilst as a Clinical Manager/Matron and service manager, I always offered the direct line reports below me 1:1 monthly. The EPUT standard is a 1:1 if offered at least each 8 week period. I offer the increased level of 1:1 to ensure that staff feel valued, supported and that timely interventions are discussed and agreed to prevent complications from arising.

Care Plans

125. Care planning is a highly skilled, complex and dynamic aspect of any patients care. Nursing care plans have developed over the years within my time in EPUT. Initially at the beginning of my time within inpatient services, these were in a form of a paper based on Activities of Daily Living or "ADL" focused assessment, which progressed to a much more comprehensive multifactorial document that attempts to encompass the want, wishes and view of the patient, the family and loved ones, and the wider MDTs ability to offer care that is in a least restrictive, positive risk taking approach, but is also part of trauma informed person centred care.

126. Formulation of care plans, updating reviewing and sharing are intrinsically the cornerstone requirement of the nursing team. The care plan should be devised with the patient receiving the care to help make the interventions truly person centred, ensure that families voice is captured and the risk identified has been addressed and mitigated.

127. Care and risk plans are audited weekly as specified within the audit schedule. Due to the dynamical nature of care plans, they can be changed, reassessed, plans altered with the changed assessed need. This could be at any time of the day as would be necessary if a patients presentation changed.

128. My initial training of undertaking care planning was a key aspect of my nurse training. However, EPUT over time has offered enhanced levels of training for nurses to be able to develop these skills further with fundamentals of care role out of enhanced care planning and the forethought of trauma informed care.

Therapeutic Engagement and Supportive Observation

129. Decisions in relation to risk and observations levels are made by the wider MDT. The risk assessment and care plans identifies the clinical need and requirement for all current levels of observations. The risk assessment and care plan are very dynamic, with a view to a trauma informed person-centred approach whilst mitigating the presenting clinical need of the patient. Nurses, Doctors, Occupational Therapists, physiotherapists are key with the decision-making process for risk and observation levels required at that time.

130. The implementation of reviewing the need for enhanced observations has significantly changed over time. If a patient was on any enhanced level of observations, with several team members believing that the observations were no longer required, the decrease in observation levels used to be part of a consultant psychiatrists' overall role who was the sole decision maker. However, overtime, the MDT aspect for risk assessment and mitigation of the clinical presentation has changed the point of decision making. The ability to review, increase or decrease observations has been changed to allow the team to be more responsive to a

changing patients presentation and risk profile. The observations and engagement policy has been one of the most looked and changed EPUT polices and from predecessor organisations.

131. Observation levels are determined on a patient's presentation and risk assessment. More communally increased levels of observations are due to threats of self-harm/suicide, sexual safety concerns, aggression towards others, absconding, increased risk of falls, or gender breach to mitigate sexual safety risks. The level of observations is dynamic and can change from one moment to another.

132. The information that would be considered would be previous patterns of behaviour, the risk from self-harm being described by the patient at a moment in time. The information from the wider MDT, electronic records, family/loved one's concerns, a patient's clinical profile and presentation are all considered when changing a level of observations. I am not aware of any situations where a decision to observations were not adhered to.

133. I am not aware of any factors that impacted on observations levels external to the need of the patient that impacted on the decisions for any enhanced levels of care, such as staffing or finances.

134. The current approach to observations and the changing of levels of enhanced engagement I believe are strong and provide a good team approach to the needs of the individual within the ward environment.

135. I am unaware of any potential barriers to delivering appropriate observation and engagement for the patients on the wards.

Discharge

136. Discharge planning is a clear MDT aspect for all patients within the wards. Discharge planning should occur prior to any patient being admitted. Ward care environments are artificial and have significant restrictions which can impact negatively on a person's care, whilst they are a necessity during a period of crisis. Wards plan discharge at point of admission to ensure that the patient, carer/loved ones and other clinical teams involved in the persons care work towards an expected discharge date.

137. Discharge planning follows current EPUT guidance which incorporates the Care Programme Approach (CPA) process and policy. Over the years the trusts discharge policy and process has altered. The use of Key Performance Indicators that have followed evidence and best practice have been introduced. This includes strengthening the follow up arrangements post discharge. Clear plans in place of which team will be asked to undertake the follow up either it be the home treatment or the community teams The time frames for this work have shortened over the years due to change in evidence and best practice. Ward based telephone call follow up for discharge have been introduced following national guidance and best practice.

138. All decisions to make discharge occur with a wide variety of clinical information. This may include reassessment with a patient, family, loved one, wider MDT members including the wider community services offering post discharge follow up. Consideration of the patient's mental capacity and if appropriate the Mental Health Act would be central to the decision for all patients to be discharged. Important considerations would include appropriate community support, the availability of clinically needed Home Treatment teams, suitable accommodation if needed. I am unaware of any factors that were beyond my control that impacted on the discharge plans for patients. The daily escalation calls via SITREP continue to capture the

overall demand for inpatient beds through the organisation. This demand is shared with the wider wards, whilst asking the for teams to review the ward population daily to ascertain if any early discharge can occur safely.

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140. The discharge process is clearly defined, and most team members would be aware of which clinical information needs to be shared and with whom. Follow up arrangements would be confirmed prior to the actual discharge occurring.

141. Care plans were created at point of admission, with the Expected Date of Discharge (EDD) being shared with the wider team including community colleagues who would be supporting the patient and family post discharge. Discharge plans would note the reasons for admission, current medication treatment, and the plans for post discharge support with telephone contacts of key contacts including home treatment teams, the named community team.

142. Medical colleagues would prepare the post discharge prescription which would be sent to the EPUT pharmacy service prior to the date of discharge. This would allow the ward to have the medication prepared prior to discharge. If there was an urgent need to have the prescription made quickly, such as a same day discharge, the in-house pharmacy in Kings Wood Centre would often help meet this need to allow the person to be discharged quickly.

143. At the point of discharge, the clinical team would assess the safety of a discharge to occur. Thoughts of suicide, self-harm would be explicitly discussed if this was the initial reason for admission into hospital and documented in the clinical notes.

144. A physical copy of the discharge plan is given the patient at point of discharge, which would include the current medical treatment plan. This information would be forwarded to the relevant community team which were appropriate for the persons post discharge follow up. The GP would be also copied in for this updated information via email.

145. Day-to-day demand on hospital beds has remained significant for my time within inpatient services. There have been repeated conversations at the SITREP meetings to ensure that the ward populations are reviewed each day to ascertain if there are any opportunities for safe earlier discharge. The directive from the chairs of the meeting is a clear directive to reassess the ward population and to give updates throughout the day if there has been any progress in generating discharges earlier than the planned EDD. There is always contact pressure within the organisation to generate discharges and flow. I am unaware of inappropriate pressure to facilitate discharge that is not based on the best decision of a patients care.

146. Wards can use overnight leave to test a patient's ability to safely plan for discharge. This process occurs frequently if clinically appropriate to do so. This application for patients who may have had an extended stay in hospital can be helpful in assuring people involved in the care that discharge is a safe and appropriate decision.

147. As part of the discharge process, considerations that included appropriate community support was assessed and plans put into place to ensure a safe and effective discharge. This may include allocation of a care coordinator via a community team, home treatment team, district nurses and GP interventions for ongoing physical health interventions that may be needed.

148. On occasion there may be no further support as the patient may not be experiencing any underlying mental illness that required further intervention from statutory services. These discharge planning processes would run in tandem with the ward-based care plans to ensure that barriers to discharge are identified and mitigated through a patient's pathway.

149. The most significant barrier to discharge that I have experienced in my various roles is where there is a patient who has been admitted into hospital, possibly detained under the Mental Health Act but who then later assessed by the ward-based team as not having any underlying mental illness that requires ongoing mental health hospital admission. This cohort of patient can express clear thoughts of impulsivity and can make threats of self-harm/suicide when they would be discharged. To mitigate this issue and risk is a complex aspect for a clinical teams to ensure that discharge is appropriate. The ability to ensure that good documentation based on the risk and the understanding that the current presentation is not relating to an underlying mental illness is significantly subjective. Making a decision in this respect is inherently a positive risk-taking process but is balanced with the ability for the patient in question to make informed decisions and who may be expressing intent to cause harm to themselves.

Section D: Engagement

150. All patients within a clinical setting will be consulted and have various conversations about their care on the ward. These 1:1 session will include conversations about a wide range of subject matters including reason for hospital admission, current risks, updating of care plans and would also include levels of observations. This would apply to all patients' groups. Those with a cognitive impairment would have their 1:1 time adapted to consider suggestions from the loved ones who by default would be lived experts.

151. There are occasions where a patient declines to share information with families and loved ones. The MDT will consider aspects such as if a mental illness is impacting on the ability to make informed decisions and continue to share information with families and loved ones on best interest basis. This may include patients who are detained under the Mental Health Act, patients who may lack capacity who have been assessed under the Mental Capacity Act, and also informal patients. The need to act in the best interest of the patient is not always what a patient verbally expresses to a team. Safety of the wider contacts and community allow the team to breach patient confidentiality. This may include threats of violence towards others, threats of self-harm to themselves which can be disclosed without a patient's permission. Teams are confident in their understanding of when needing to break patient confidentiality with the forethought of best interest is the overriding deciding factor. These conversations with the relevant parties would be recorded within the patient's records.

152. Peter Bruff ward did not care for patients on the latter part of the end-of-life pathways. Tower ward would offer care occasionally where clinically deemed the best option for a patient's death would occur. This decision would be dependent if a patient had previously decided where to die, or if during a stay on Tower ward that the family and or loved ones felt that a more comfortable death would occur remaining on site. Tower ward believed that this was an excellent marker of having a good relationship with a family and the wider support network for patients approaching their end of their life. Caring for patients who are actively dying is a rewarding aspect of nursing, and having families choose to have their loved ones die on a ward, demonstrates the excellent interpersonal relationships that the team worked on with this small but very important patient cohort. Tower ward achieved 'Gold Standards Framework' accreditation as part of a nationally recognised provider of end-of-life care. At the time of accreditation, Tower ward was one of an incredibly small number of NHS mental health providers that offered this specialist intervention. Families and loved ones are the absolute expert in the patients journey in this part of their life and death and are consulted as and when needed to gather further information and offer timely updates to clinical presentations.

153. When an incident occurs that impacts upon patient care, the care team will initially note and record the incident itself. There will be considerations if further internal escalations are needed, such as safeguarding referrals, informing the families and loved ones. Incidents that impact upon patient care may include situations such as a patient who may have been found on the floor, with physical investigations being undertaken and a noted fracture of a femur being detected. Family and loved ones would be a primary source of contact. However, formalisation of a datix (a widely used NHS system for capturing incidents across various services) incident would be initiated, a safeguarding referral completed, also the likelihood of such a serious incident being noted to EPUT Patient Safety Team would be notified to allow further trust wide investigation, if required.

154. During my career with the trust, the engagement with families and loves ones has strengthened over time. At this point of time with the trust I believe that decisions regarding the care and treatment, have a much stronger family and loved one focus involvement.

Section E: Safety

155. Safety as part of my role encompassed a wide variety of subject matters. Safety could relate to the health and safety of a building, the services that use it, the safety of the ward population and safety of the staff and colleagues within all these mentioned.

156. With reference to preventative measures that have been put into place to reduce patient's from harming themselves has shifted significantly over the years. As part of the trusts planned audits and assurance measures for the physical environments, 'Hot Spot' with visual cues have been developed. 'Hot Spot' pictures show a known risk that the clinical team need to be aware. The 'Hot Spots' are generated by the trusts risk team and are visited for accuracy at the years audit and the six-month assurance visits. 'Hot Spot' examples may include but not exhaustive of ligature reduced furniture, tables, chairs, curtain rails and wall mounted grab rails.

157. By being in a restrictive setting such as a mental health inpatient ward, inadvertent harm will be occurring. Mental health wards have significant restrictions applied to patients who are needing to be cared for in a ward setting. Normal life situations are applied in a manner with restrictions applied. Some of the procedures may include the need to search patients upon returning from leave for restricted and prohibited items. Another restriction may be the need to

suspend leave due to poor mental state with risks so severe that a patient is required to remain in a place of safety until stabilisation has occurred. By being in a mental health ward, as a voluntary or detained patient, will by its nature case inadvertently cause a level of harm that is not replicated by being within the community itself. By being on observations itself poses potential psychological harm. All patients on a ward will have at least a minimum of a physical face to face check which will also include staff going into a bedroom in the middle of the night. These procedures are predominantly there to support patients to remain safe but may add to people's suspicion and possible traumatic previous life experiences.

158. If a patient ligatured, the emergency call system called 'Aquarius' would be activated in a clinical area to identify a situation that needed immediate response. Clinical teams would rush to the area identified for a response, and the team's emergency 'grab bag' would be taken as part of the response to allow immediate emergency treatment if needed. This would also apply to patients who were suspected of having a cardiac arrest. All wards have access to diagnosis systems such as sphygmomanometer, blood oxygen saturation meters and oxygen cylinder's that again assist with managing an emergency situation.

159. The EPUT Training Department undertakes yearly 'emergency response' drills on each inpatient. These drills are designed to test ward staff response to an emergency situation. Ward staff are not given notice of these drills to make it as real life as possible. The drills will include various emergency life scenarios with using resuscitation equipment, defibrillators, and demonstration of good basic life support. If there concerns and or issues, the drills can be repeated to ensure that a satisfactory response is achieved.

160. If a clinical team's response to an emergency required the need to segregate and seclude a patient due to the severe levels of unpredictability, vulnerability of the patient or the wider ward population, the team can separate a patient to offer a safer level of support the individual. This could be use of a bedroom to help de-escalate a patient's increased risk presentation. Also, the use of formal seclusion would be offered if all other means of de-escalation had been exhausted. Not all teams have access to a formal seclusion area. The Tower ward in Clacton does not have a seclusion room but can access a de-escalation part of the ward if a patient needs this intervention.

161. At times of emergency situations that occurred in the clinical environments, the offer for a de-brief to the patient's cohort was always offered. This could allow a conversation to occur that allowed patients to express thoughts, feelings and concerns that may have arisen during a team's response to an emergency. By undertaking this intervention would allow unsettling thoughts to be shared in a therapeutic way to instil a feeling of safety. If there were other actions that occurred as part of the debrief, the team would allocate these to the appropriate people to follow up on. If all the various de-escalation methods had been exhausted, then physical restraint may be required to ensure that the patient and others around them remain safe. This would be the last resort. Given the clinical presentation of the patient, administration of certain prescribed medications could be given against a patient's express wishes. Again, offers to encourage a patient to take oral medication would be exhausted prior to any other route such as intramuscular injection.

162. I have a significant level of knowledge and experience of caring for patients with a wide variety of mental health issues. I am part of a wide range of teams that have experienced significant levels of aggression and violence at work. I feel safe and confident at work with my

ability to utilise my strong interpersonal skills on a day-to-day basis. I have not had difficulties personally in accessing personal alarms myself.

163. Staff safety is instrumental as part of a ward environment. Day-to-day care of a patient would follow the interventions set by the patients care and risk plans. The balance of what a patient would express and have a desire of, versus the need to provide a safe and therapeutic environment is complex. An example could be the use mobile phone charging cable. A patient may have the need to use this to ensure that an individual's communication with families and loved ones is maintained. The balance of this in comparison to the misuse of a cable as a potential ligature is a decision that teams make throughout the stay of a patient. The cable itself may not be a risk the patient in question but could pose a risk to another patient who may use as a mechanism of harm.

164. The trusts welcome packs that were offered to patients and loves ones, include an overview of what a typical hospital admission would look like. This would include how to raise concerns about any aspect of a patient's admission. There are ligature reduced notice boards that also have this information placed throughout the wards.

165. Ward teams have access to a wide variety of support mechanisms to support in the event of adverse clinical events. Local support is provided by the team itself, which may include de-briefs etc, but also access to more structed support can be accessed by occupational health, the trust 'here for you' service and Employee Assistance Programme to access further assistance. Onward access to other agencies can be offered such as access to the Police, safeguarding processes and union assistance of needed.

166. I have not directly experienced any serious incidents of self-harm whilst in my clinical practice.

167. If there were reported incidents of serious harm that were shared with the organisation, they would be via the safeguarding process or via the police depending on the risk being reported. These concerns would be investigated via the appropriate route such a safeguarding investigation or Human Resources.

168. I have been asked to provide comments in relation to a patient called Carol Taylor who was cared for on Roding Ward, St Margarets. I have not worked at St Margaret's Hospital and do not have any recollection of this patient or the investigation that followed her death.

Sexual Safety

169. Specifically sexual safety is a clinical risk that all teams manage on a day-to-day basis. There are some wards that are of single sex. The overall issue of sexual safety is not resolved by offering single sex wards. There are potential sexual safety issues with patients of any gender, so care and risk plans need to address and reduce any noted concerns.

170. If there are known issues that may relate to sexual safety, the clinical teams will mitigate this risk where possible. This may involve the moving of a patient to a single sex ward, or if appropriate increase a patient's level of observation to offset the known risk.

171. Movement of patients from a mixed sex ward to a single sex ward, can and does occur to help meet the needs of certain vulnerable patients. However, single sex wards do not remove the overall risk of sexual vulnerability and should therefore always be a factor for caring for all patients, regardless of if they are on a mixed or single sex wards. There are times where same

sex vulnerability for sexual safety concerns are noted, and therefore the teams approach to this needs to ensure that everyone's safety, including staff working on a ward are offered risk mitigation.

172. One example of sexually disinhibited type of behaviour that I have noted has included an older adult male who has a diagnosis of dementia in a lounge area of a dementia care ward, getting his penis out and attempting to urinate in a corner of the room. The patient's cognitive impairment did not allow him to express his thoughts and wishes, and the care team then encouraged him into a toilet area to help manage his privacy and dignity needs. With this type of behaviour, a safeguard can be raised if occurring more than once. Risk and care plan for this patient would include thoughts if there was an underlying reason for this type of incident, i.e., does the patient need to have a urine sample sent to microbiology to ascertain if there is an underlying infection or is the behaviour part of the patients poor cognitive state that my need a care plan specifically to be adapted to meet the patients toileting needs.

173. I have witnessed sexual disinhibited behaviour during my career. This has included patients unable to understand the appropriateness of dressing appropriately, keeping clothing on and masturbating in a public area. These types of behaviour are usually experienced when a patient is experiencing a period of significant mental decline. This type of behaviour I have witnessed in both males and females, both adults and older people's services too. These types of incidents are noted in the clinical records and noted via Datix. If necessary, there may be a need to raise a safeguard if there a noted incidents that involve other patients in a clinical setting. If there are noted incidents that occur after a risk and care plan had been developed, a wider team discussion would occur. This discussion would review the need to ascertain if a more intensive level of care is needed, such as a Psychiatric Intensive Care Unit (PICU), a single sex ward, levels of observation or if clinically required the use of segregation and or seclusion during this acute period. These periods of sexual safety risk were reviewed frequently throughout the day. If there are noted issues of sexual safety, and restrictions were applied to a patients care such as 1:1 observations, there is a clear need to ensure that this mitigation is proportionate to the risks posed but may be necessary during a period of acute disturbance.

174. My professional experience between adult and older adult services have commonality of types of sexual safety incidents. Frequency of incidents varies greatly with the individuals on the ward, at that moment in time. There can be times where the number of sexual safety incidents are high in relation to one particular patient who may be presenting in a severely unwell and disinhibited manner. There are times too where there are no known sexual safety incidents, with a ward population that is presenting in a period of stability. This ward clinical presentation can present in this way both on Adult and Older Adult wards. A generalisation of patients who have a bipolar disorder can present in a time of elation as disinhibited with these possible increased risks of sexual disinhibition. This risk is similar for both male and females. I have cared for patients with severe thought disorder who have at times needed to be segregated from the ward population as they are unable to keep themselves dressed because of a poor mental state. With active treatment and interventions, patients who present in these kinds of behaviour, normally stabilise in their mental state and can return to the ward population quickly.

175. Multi agency working is integral to potential ongoing clinical risk of sexual safety. Use of the wider MDT and external agencies are key to assessing and mitigating of a patient's sexual safety. The use of the MDT allows a comprehensive risk profile to be developed, and clear interventions put into place to reduce and mitigate risks both whilst as an inpatient and as part of the wider community when a patient is able to be safely discharged from hospital.

176. I have had experience of both leading mixed and single sex wards. As described earlier, single sex wards can assist with aspects of sexual safety risks. However, sexual safety risks can still exist within a single sex ward. If there are obvious risks of sexual safety in regard to male and female mixed sex wards, then options to transfer a patient into a single sex ward are undertaken with expediency. If the options to mitigate a sexual safety risk, such as a dementia care ward, then the use of enhanced observations are usually undertaken as there are no single sex dementia care wards within EPUT.

177. Peter Bruff ward (assessment unit) is a mixed sex 17 bedded ward, with the ability to 'swing' three bedrooms to either a male or female physical area of the ward depending on the current EPUT demand. The individual bedrooms and the male and female areas of the ward are accessed independently by the patients themselves via a 'swipe card' system. This system does not allow patients of the either gender to access areas that have been set to the opposite sex. The Henneage ward is also a mixed sex ward, which again has the same swipe card system that allows the individual patient access to their own room without access to other bedrooms or the other genders ward area. I cannot recall the CQC intra-inspection in the summer of 2020. Sexual safety risk assessments are part of the wider individual clinical risk assessment, with actions needed to mitigate this risk captured in the plan.

178. Peter Bruff ward was part of the national collaborative centre pilot project for sexual safety. This initiative commenced in around January 2020. Prior to the role out of the Project, I was not aware of the Care Quality Commission publication – "Sexual Safety on Mental Health Wards" (September 2018) and the Collaborating Centre for Mental Health "Sexual Safety collaborative: standards and guidance to improve sexual safety on mental health and learning disabilities inpatient pathways.

179. Peter Burff ward participated in the pilot to help improve the experience of patients regarding a better approach to sexual safety. The ward manager at the time was leading the rollout of the actions from the collaborative work group. This included staff feedback, opportunities to gather real time thoughts from patients on the ward, noted incidents of sexual safety. The collaborative would then cross check and help identify potential patterns. The full roll out of the programme was significantly interrupted with the COVID 19 lockdown, with support from the collaborative going virtual for the remaining duration of the project. The change in approach to consideration for sexual safety on wards shifted considerably with the roll out of the collaborative project within Peter Bruff ward. The shared learning and experience from the project is has allowed the development of the EPUT wide "sexual safety sub committee" which has been set up following the outcome working with the collaborative to help push through a standardised approach to overall sexual safety within the organisation.

180. EPUT has sexual safety training mandated as part of the training requirements for all inpatient staff that gives knowledge and skills for caring for patients who are presenting with increased sexual safety risks. This training has developed and become more comprehensive over time.

181. All staff undertaking work allocated to them would be expected to have an understanding of the risk of the individual patient, and how to care for them referring to their care plan. I cannot recall when Sexual Safety training was first mandated as part of EPUT mandatory training. I am unaware of when the training was enhanced to the current provision.

182. There are several mixed sex wards still operational within EPUT. The wards that I can confirm that are of mixed sex are, Peter Bruff Assessment Unit, Grange waters Assessment Unit, Tower, Kitwood, Meadowview, Roding, Gloucester, Beech, Ruby and Topaz wards are of mixed sex.

183. I am unaware of any incidents where there were people under the age of 18 that had been admitted to an adult ward (over the age of 18).

Section F: Technology

184. Oxevision

I was matron for Peter Bruff ward in 2020 when the team was identified as a pilot area for Oxevision. Peter Bruff was a number of wards identified within EPUT to ascertain if there was a lesser restrictive option to care for people in a safer manner than without this technology.

185. I cannot recall the specifics of the development of the Oxevision standard operating procedure. The Standard Operating procedure was coproduced with various trusts departments with a clinical input from myself, the Peter Bruff ward manager and the other wards that had been piloting the system. I had not had any formal training on how to devise a standard operational policy at the time and I cannot recall the involvement I had in developing the latter versions of the Standard Operational Policy. I believe that the comments made about the pilot of Oxevision on Peter Bruff ward at the time captured my thoughts on the system. I believe that Oxevision has provided a good level of enhanced care to the ward population. The care teams that use Oxevision have noted patients within bedrooms that have intentionally attempted to harm themselves. Oxevision as an absolute last point of safety has helped prevent significant harm from occurring to a number of patients by alerting the team of something unusual from occurring in a patient bedroom.

186. Oxevision itself allows a further level of safety for patients within a clinical ward setting. The system allows itself to check for blood oxygenation and respirations. The system is monitoring constantly and is active when a person is in a bedroom area. Oxevision system can alert the team if there are any abnormal readings that are occurring within a bedroom area.

187. I cannot recall what 'long conversation about how to help staff use the system properly' is referring to or who was involved.

188. The priority of the roll out of the system was to enhance the overall safety of the patients on the ward. However, when Oxevision was rolled out to Peter Bruff and Ardleigh wards (both were at the time under the same senior manager structure) in spring 2020 the issue of consent was not specifically considered or referred to.

189. I did not have specific concerns raised to myself regarding consent to the use of Oxevision from patients or families or loved ones. I have not experienced concerns from families or loved ones about communication in regards to the use of the Oxevision systems that the trust has in place. Over the period that teams have been using the Oxevision System I am unaware of patients expressing concerns about the permanent presence of camera system that is in bedroom areas.

190. I am aware that when Oxevision was rolled out to Henneage ward, the 'Edge of Bed' system was activated. This part of Oxevision was intended to supplement other assistive technology to assist with potential falls risks for the ward population. Within the first few weeks of the system going live on the Henneage ward, Oxevision had activated for a response on a highly significant

number, with the specifics I cannot recall. The system would activate if a patient went to the wardrobe cupboard, getting out of bed to use the toilet or to just get a drink from a bedside cabinet. The nursing team at the time were having to manage the system rather than care for the ward population. With this 'alarm fatigue' very quickly becoming apparent, this aspect of Oxevision was disabled with the system focus on abnormal pulse and respirations that resulted in alerts being sounded.

191. With the roll out of Oxevision to other teams within EPUT, there was a much clearer drive to ensure that consent of the system was undertaken with all the ward patient populations. My experience is that teams discuss with patients and get informed consent from each patient each day to use the system to provide enhanced levels of care and have this documented in the patients notes. EPUT has also provided further mandatory training in the use of Oxevision for ward-based staff and is measured against the overall performance for each ward-based team. This approach has been applied to all wards within EPUT that use the Oxevision system.

192. At the time of the death of Adam Steel in October 2021, the ward based staff on Peter Bruff had been using the Oxevision system to check on patients in their bedroom rather than opening the bedroom door and disturbing the patients throughout the night. Various team members believed that this provided a more comfortable approach to care for patients, especially at nighttime as opening the bedroom doors for checks is noisy and will often disturb a person sleeping. I believe at the time that the ward staff were acting in a way which helped with the checks that were needed, whilst allowing patients to sleep through the night undisturbed. I was unaware that this practice had developed over the time of the Oxevision system being installed. With the approach being brought to my and the team's attention, the revisiting of the Standard Operational Policy (SOP) for the entire team was revisited.

193. I discussed with various teams about the installation of the Oxevision system specifically, that this was not going to be used to allow the technology to replace clinical staffing on the ward. Repeatedly I was assured that this was not going to be the case. Since Oxevision was installed in 2020, staffing levels have increased for all wards.

194. I agree that staff would often simply note 'observed' within the clinical records. I believe that this practice became more often used to ensure that patient safety was being noted, without the need to actively engage with the patient themselves. I became much more aware of the shift in practice with a refresh with the ward teams understanding of the need to adhere to the SOP and the rationale behind the approach. After the death of Mr Steel on Peter Bruff ward, the ward manager and I discussed the need to shift the team's recordings from observed to a culture of engaging with the patients and being more descriptive in the notes they record. This work was discussed at handovers and team meetings to push forward with the teams understanding of the requirement to provide a more rounded aspect of care for the ward population. In reference to the environmental issues that had been raised in the meeting for the vision panel issues that did not allow direct line of site of the bed from the door, I was informed that if staff were adhering to the Standard Operating Procedure, of actually going into the bedrooms, this would mitigate the risk. There has been no other work to the layout or doors since this issue was raised. Since the incident with Adam Steel, the ward staff have demonstrated the understanding and importance of ensuring that checks for patients follow the procedure, of going into each bedroom area as specified on the individual's observation levels. This may inadvertently wake up patients sleeping. The Oxevision system has continued to operate on the ward since its installation in 2020 with the environmental issues addressed as is best for a building approaching 30 years old.

Other Technology

195. Over my career I have witnessed other aspects of assistive technology to assist teams with caring for patients within mental health wards. Prior to Oxevision, my professional use of assistive technology was predominantly within older people's wards, with reference to falls detection and prevention. Over the years, what was the NEPT, the older adult wards invested in technology to allow detection for if and when patients who were deemed of a high risk of falls, could be cared for in a lesser restrictive way at nighttime. The technology was installed on all at the time 7 older adult NEPT wards in each bedroom. The technology allows it to be tailored to individual bedrooms of patients who have a high risk of falls. The technology allows detection of movement over the edge of a bed and alerts the team that there is unexpected movement in a patient's bedroom. The team can then respond in a timely manner to attend to a patient's needs and prevent a fall from occurring.

196. I cannot recall when body worn cameras were rolled out to EPUT wards. Body worn cameras are used by the team to help mitigate concerns for patients who may be escalating and becoming unpredictable in their presentation. The use of these types of devices by team members is infrequent within my old care teams. They have been used if there is apprehension for patients who may suggest allegations or make threats against staff and other patients on the ward.

197. I cannot recall when CCTV was installed in NEPT or EPUT services. Most EPUT areas have some form of CCTV in place.

198. Over time with EPUT, the use of various technology has become much more explicit. The expectation for informed consent, this daily checking for this consent, clear visual cues for use of CCTV and body worn cameras are much for prominent in material given to patients but also displayed throughout EPUT buildings.

199. The use of the various forms of technology have generally assisted in providing an improved level of safety within the ward settings. Upon my commencement in 2003, there was no assistive technology used within the ward setting.

200. The welcome and information pack which includes Oxevision has been rolled out to allow a better understanding for the patients being cared for on the wards. I cannot recall the creation of a network of Oxevision champions but am aware that there was an Oxevision link role created. The consent aspect was revisited after the Oxevision SOP was updated. More recently there has been mandated Oxevision as part of the trusts overall mandatory training. Ward based teams are expected to ensure compliance with this and all other mandatory training courses.

201. I cannot recall if there was formal training for the use of assistive technology in older adult wards. The technology is a physical key switch outside of bedroom area that is turned on for those of a higher risk of falls. Those who are not assessed as high risk of falls do not have this technology turned on in their bedrooms. This assistive technology is simple to use with the ward teams very familiar with their use.

Section G: Staffing Arrangements

202. From my career with EPUT, inpatient ward staffing levels have significantly changed over the years. The current levels of staffing on the services that I have had leadership with are significantly higher than my return to inpatient services in 2009. I recall Lucas ward had 2 -

Registered Nurses (RN), and 3 - Health Care Assistants (HCA) on what was then an AM (0700 – 1430hrs) shift, 2 – RN, 2 - HCA on a PM (1330 – 2100hrs) shift, 1 - RN supported by 2 - HCA for the Night (2030 – 0715hrs) shift. Currently Henneage wards base line for a Long Day (0700 – 1930hrs) and a Long Night (1900 – 0730hrs) is 2 – RN, and 2 - HCA per shift. If the clinical dependency is significantly higher due to patient's complexity, senior staff can request this each day with a clinical explanation for this as part of the trust wide staffing escalation daily call.

203. Various factors were considered when allocating staff specific duties per shift. These may include but is not exhaustive of the following factors: The experience of the team on shift may need last minute changes to offer safety across all the sites. The overall gender mix for the teams on individual sites, wards may swap staff at last minute to ensure that there is a safe balance of either gender if needed. The clinical dependency of the patient population at that time, an example: observations, extended escorted leave to an acute hospital for urgent physical care.

204. Duties for the ward allocations at the beginning of the shift will consider all the above, but then the shift co-ordinator would then work on ensuring the ward population are allocated a nurse for the forthcoming shift who could be a point of reference for the day ahead. Issues that would influence the allocation of specific patient on shift would consider gender, personal interpersonal professional relationship building, a patient's preferences, safety of the individual staff member themselves again are the common aspects for shift allocation. Planning for the shift will also include, who would be most appropriate to undertake specific tasks, such as medication round, ward/care review, MDT, escorted leave off the ward, security nurse, environment nurse. This would include considerations of unregistered nurses to undertake some of these duties and tasks.

205. The experience of the team on shift on a particular ward would be considered by the site co-ordinator. As mentioned earlier if there were deficiencies in one team in an area the site co-ordinator would look at the entire set of ward staff to offer a strategic view of all team, with local knowledge of newly registered nurse's verses those with more experience being shared across all wards. Again, thoughts of registered nurses against unregistered colleagues would be considered, along with if a staff member is substantive or temporary including agency workers.

206. The current staffing model has significantly increased the base line for staff. However, with the added improvements for community services, the acuity, complexity and dependency for ward population have significantly increased as well. This level of clinical dependency increase has been noted in both adult and older adult services that I have had responsibility for.

207. Peter Bruff ward staffing establishment is now 4 registered nurses with 4 health care assistants on both a Long Day and Long Night. Prior to the role out of the 'time to care' inpatient model the ward shift pattern long day was 3 registered nurses supported by 2 health care assistants, Long Night shift was 2 registered nurses supported by 2 health care assistants. Henneage ward Long Day and staffing is now 3 registered nurses supported by 3 health care assistants. Prior to the time to care model, Henneage staffing establishment was 2 registered nurses supported by 2 Health care assistants both Long day and Long Night.

208. Oversight of night shifts is led by the ward-based staff and oversite provided by a site coordinator. I am not aware of a different approach being taken to overnight and out of hours care within the teams that I have had oversight of.

209. Staff were rostered over a 24 hour 7 days a week basis. I am aware of certain individuals who have individual adjustments that support their attendance at work. This may include, not undertaking night or days shifts that impact on that individual person. The majority of the team members worked both long day and long night shifts.

210. I have no professional knowledge of the work pattern for medical staff including ward doctors or consultant psychiatrists.

211. Agency staff were utilised by EPUT as a last minute resolution to unexpected unfilled/vacant shifts. My professional experience for the times that EPUT wards used agency staff would be out of hours including weekends. The use of temporary staff who were unfamiliar with clinical areas disrupted various aspects of a wards function. The individual worker would not be familiar with the patient cohort, individual teams approach to care delivery, sometimes not able to use recording patient administration systems as initial difficulties to overcome. The remaining colleagues on shift would then have to support the staff member to achieve the necessary ward-based demands which could prove to be a distraction on top of a complex ward situation.

212. Staff who were utilised on a shift, regardless if they were a permanent or temporary worker, were expected to undertake the duties, roles and expectations for that grade. There would be a difference in the level of care provided in comparison to temporary staff in comparison to permanent staff. This would relate to a worker being either familiar or not of the ward population, unique work styles to a particular team etc. This issue would apply to both adult and older adult wards, with the local area induction being used to help mitigate the risk and enable a staff member to undertake duties for the ward safely.

213. Patients who have co-morbidities, more so but not exclusively to the older adult wards, would have the increased demand upon the nursing team's time. Patients who have co-morbidities would often have increased medication rounds, attendance to acute care for monitoring and follow up care. Also, the attention for any physical health needs relating to frailty were factors in higher nursing care workloads.

214. Throughout my time as a leader, I have always endeavoured to ensure that recruitment for all and any unfilled vacancies were actively acted in the most quickest way possible. To assist with ward managers, during formal monthly 1:1 sessions, staffing and recruitment, was part of the standing agenda. I would go through the establishment reports to ensure that posts that were vacant were in *active* recruitment and would often participate in the shortlisting and interview process.

215. I am unable to answer the question about turnover as this measure was noted by the trust performance team. I am unable to make reference to consultant vacancies as this issue was managed by the medical teams themselves.

216. The majority of the ward teams that I have led over the years have had peaks and troughs in relating to vacancies. During and immediately after the pandemic, ward based nurse's vacancies became much more significant, with unfilled shifts being expected to be filled by temporary staffing. When EPUT undertook overseas recruitment and commenced offering student nurses posts in their final years of study, the vacancy rates have continued on a downward trajectory. Prior to my secondment to Mid and South Essex Hospital Trust, Tower, Henneage and Peter Bruff wards were full to establishment for staffing. In my return to inpatient

services, I had never been in this position where all teams had no need to recruit due to all posts being filled.

217. With patients being offered more intensive care in the community, those who do require hospital care are much more likely to be more acutely unwell, and therefore this level of unpredictability with the patient cohort has increased too. During my career, the increased level of threats of violence, violence and aggressive behaviour from patients has been noticeable. The Time to care inpatient model has been the first noticeable consideration of increased staffing levels to address a much more complicated and clinically dependant ward population.

Section H: Training

218. After my appointment in 2009 as ward manager, I did not undertake any formal training for the role. My line manager at the time was instrumental in assisting in moving from a purely clinical role to one of a manager and leader. EPUT now offer a management development program for newly appointed managers, which helps understand the complexities of being a line manager and leader. I was fortunate to have the same line manager for a substantial period until her retirement. As part of my 1:1 with my line manager, I was expected to ensure that all mandatory training requirements were met with what the trust set out at the time. This included refresher training at specified timeframes as needed for a particular subject matter. Training locations tend to be centralised at trust headquarters in Wickford, which at times makes releasing staff who do not drive complicated, especially travelling from places on the periphery of the county (such as Harwich and Clacton).

219. I was also encouraged to undertake professional development to enhance my knowledge and skills base. This included local universities for a master's degree pathway.

220. Further training for areas that may require a more tailored approach such as dementia care usually takes the form of mandated training. Bespoke training for specific issues such as external feeding systems including PEG (Percutaneous Endoscopic Gastronomy) or NG (Nasal Gastric) systems have been devised to allow teams to undertake specific roles as and when needed. Falls Awareness training is mandatory for all EPUT inpatient staff both Adult and Older Adult wards.

221. Such bespoke training is arranged if and when clinically required for the entire team. Recently to get a team of nurses competent in NG feeding a group of around 20-30 nurses needed to be trained to undertake this activity. Staff who were external to the trust (colleagues from East Suffolk and North East Essex foundation Trust) were asked to undertake cascade training for the ward staff. To get all staff members trained, skilled, competent and then confident took a number of days. Bespoke training is helpful to meet the need of a particular patient at a particular time. However, if this still is not used frequently, confidence is lost, then there will be a lack of competency again.

Section I: Support

222. To undertake a complex and demanding role such as working on a mental health ward, the primary source of support will be peers and colleagues working in that environment. If a team has experienced an unusual or adverse incident, 'hot debriefs' (unusually on the shift when the incident occurred) would be undertaken by the most senior of staff members present. This could be the ward manager, site coordinator or even myself. These debriefs would allow teams to off load concerns, undertake reflection and give opportunities to learn from the incident.

223. Certain incidents may require more planned debriefs to allow the capture of the wider team. If these occurred, the wider team and psychology colleagues would usually be present to offer additional opportunities to discuss thoughts and feelings that may have arisen due to an incident. I am aware of colleagues who have accessed independently the EPUT Employee Assistance Programme (EAP), occupational health, here for you and the freedom to speak up services. I believe that these services provide helpful for staff who need extra help and support for both work and non-work-related issues.

224. With my experience in dealing with significantly traumatic events, both within work times and work issues that I have not been physically present to, there has been a lack of understanding of the trauma that colleagues and I must deal with on a day-to-day basis. The psychological impact on finding someone who has intentionally attempted to harm themselves cannot be underestimated. Finding a person who may have stopped breathing due to an incident, is both abnormal and frightening, even for the most experienced staff within a mental health setting. Being exposed to this type of behaviour repeatedly by patients who may be wanting to end their life can cause significant trauma to any care team who are attempting to continue to care for a ward population that may have a similar care need and dependency.

225. I am unaware of any staff member who had experienced a significant adverse incident who did not receive sick leave if they were unable to immediately return to work.

226. I believe that staff were supported in raising concerns with a wide range of issues. This may include poor performance of colleagues, concerns regarding bullying type of behaviour. I have a recent concern from a nurse colleague who moved within EPUT to another team. The nurse who moved then raised a formal grievance about his previous ward manager, with reference to being bullied and being unsupported. The formal process was initiated, with the outcome being confidential between the two staff members directly.

Section J: Management and Leadership

227. For a significant period of my leadership journey, I was fortunate to have the same line manager, (with the exception around a 9-month period) who instilled confidence and clarity which I rely on to this day. My line manager until she retired provided a clear structure to roles and expectations. 1:1 (previously called management supervisions) had a fixed agenda, but also the flexibility to discuss any other business. During these sessions, previous notes were reviewed for completion of actions. Then changes such as policy updates, key performance data measures, team priorities, HR issues, finance etc were discussed and noted with next steps decided together. If there were specific issues or concerns that I had, then these would be discussed at these sessions.

Supervision and Performance Management

228. Clinical (non-management) supervision for nurses has always been 'optional'. I have rarely taken up clinical supervision personally. I am currently unaware of any nurse that undertakes clinical supervision. The ability to access clinical supervision would impact on nurses' rosters as the current provision of staffing is solely focused on clinical care time and mandatory training. Opportunities to undertake clinical supervision are therefore much more limited.

229. Standards of care are monitored by a variety of mechanisms. This may include direct feedback from patient's, families, loved ones. Audit and assurance also are vital in ensuring that the team are following an agreed plan for a patients care. Shadowing, role modelling are

also instrumental in having a good knowledge of the care that is being delivered by the ward team.

230. My direct reporting line management team would lean into wards if and when significant incidents would occur to offer help for the teams. Senior managers would have involvement down to ward manager levels on a monthly basis via various meetings etc. To offer assurance and drive desired team changes to care and practice, the use of action plans would be devised to look at the actions needed to drive changes and measure if the desired outcomes had been achieved.

231. I cannot recall being an adult acute champion or the expectations that would have come from this role.

232. Since my long-term line manger retired in 2022, and a new line management team structure was put into place, I believe that my senior staff are remote and disengaged with the structure below them. 1:1's does not occur with staff at my grade and above, appraisals are not completed. I have witnessed peers within my locality behave in a rude, abrupt and hostile manner to other EPUT colleagues. Recently, I have had several line managers who are disinterested, remote, with one who wanted less than once a week contact with me as a line report. I raised this issue with senior directors, with limited actions/responses to my concerns that I had expressed.

233. Overall performance for the teams that I had overall responsibility for was managed via a variety of mechanisms. EPUT performance teams would compile various reports that would be shared with teams through the month. As part of my 1:1's with my teams, I would use this data to ensure that all the trusts performance measures were looked at, discussed and agreed if necessary, actions need to be taken. This would then be triangulated and checked as part of the standing agenda for the next month's 1:1 for completion. Since my long-term line manager retired, I have had sporadic 1:1's with my supervision tracker noting on occasions that I had had a 1:1 on days where I was actually on leave and not at work.

234. I am aware of the Pulse and staff surveys as mechanisms to provide feedback to the trust in regard to feedback about leadership.

235. Within my role I would be a conduit for teams that were raising safety concerns. If needed, I would approach a team or person directly to get a particular issue resolved. If there was a delay or a lack of response, I would then escalate these issues to my seniors to ask for assistance in getting the issue resolved.

Complaints and patient safety

236. Complaints and safety issues would be cascaded down to the teams when a specific subject was raised. More often, the clinical teams and ward managers would have been proactively addressing and offering resolution prior to any formal process being initiated by any parties outside of a team. The complaints process has a clear process with feedback and closure being part of this. If there are specific safety concerns, these would normally be raised via the EPUT 'Datix' system to allow capture of completion of necessary actions. Senior colleagues would be included in the Datix system to have oversight if actions have been completed or not. I am not aware of any barriers to reporting complaints or safety incidents.

Section K: Culture

237. During my time as leader, I believe that I have worked in a manner of promoting patient care, safety and one of inspiring excellent clinical practice. I also believe in the need to have open and honest conversations. I have not shied away from having frank and sometimes difficult conversations with peers and colleagues especially if there is any potential impact upon patient care or team dynamics as both my professional code of practice, and my personal integrity ensure that I act quickly and effectively to offer resolution and clear direction. With the teams that I have led, I strongly believe that this culture can help improve clarity of practice and offer an improved patient experience. I have worked in several wards and units where openness and integrity for the people that I care for are paramount if the overall culture of a clinical team. This style is supported with the trust visions and values that have altered over the years but still had thought and consideration for the people that we care for day by day.

238. Over the years I have fostered good working relationships with colleagues within the trust, external partners and good third sector collaboration for team and service improvement. One example of this type of working was the initiation of a 'non-statutory' independent advocacy service with the third sector undertaking this role. The advocates offered an independent voice to be heard by the wider team, that was not instructed under various legal frameworks such as an IMCA (Independent Mental Capacity Advocate) or IMHA (Independent Mental Health Advocate). This work continued throughout the pandemic and was eventually ended when the service was taken into the now statutory Rethink Advocacy service where there may have been a conflict of interest arising. Rethink Mid Essex was an charity that offered impartial 'generic' advocacy that was not under the IMCA or IMHA provision. The service is no longer operational.

239. Tower ward also undertook the Gold Standards Framework (GSF) revalidation process. GSF accreditation is a nationally recognised accreditation for teams providing excellent end of life care. Accreditation is undertaken by the GSF team who cross reference evidence provided and direct families and loved one's experience of the end-of-life experience on the ward. GSF accreditation continued throughout the pandemic and was awarded in 2021 and reaccredited in 2024. At the time of accreditation, Tower ward was one of the first NHS England Mental Health Wards to be accredited with the Gold Standards Framework.

240. Overall, I believe that staff behaviour and professionals relationship building was generally appropriate. However, over my time within the trust I have been tasked to undertake various HR issues that directly related to poor practice or inappropriate behaviour to patients or colleagues by staff members. On occasion these times have resulted in termination of staff members and recommendations for onward referrals to professional bodies for further consideration of potential action. These actions of these individuals were not aligned with the trust policies and values.

241. When incidents of bullying, harassment or intimidation are alleged, the trust HR process is initiated quickly with an initial fact-finding exercise being undertaken to identify next steps. These incidents trigger the trust grievance process with timeframes and outcomes measured in this process.

242. My experience of positive role modelling would depend on the individual. My direct line report did not display interest in the services that he had oversight of. I attempted over a course of several months to try to engage with my line report to develop a better working relationship, but the response that I received was of repeated disinterest and long arms reach contact. Seniors above him would often appear kind and compassionate during the interactions that I had with them myself.

243. I am unaware of long held practices, beliefs of assumptions that teams undertook on a day-to-day basis because they have 'always been done this way'. Over my time with various teams, there has been a willingness to change and improve clinical practice to give a better patient experience. I believe that both team and myself would feel confident in challenging peers and colleagues if this type of practice was occurring.

244. I am unaware of any teams where they were stigmatising certain issues and or behaviours.

245. With the ethos of the equality act, everyone has some protected characteristic, and if there was a need for further assistance these needs and plans would be addressed in the individualised care plan for that patient. I am unaware of any differences in the treatment that may arise from this particular aspect of a patient.

246. I am unaware of structural racism and or discrimination for the teams that I have had responsibility for. However, the development and use of the staff networks over the years have helped to identify ways in which to offer a better staff experience in those who are from a BAME background.

247. There are times where wards and teams are caring for a complex patient cohort and at these times the need to be proactive and give even more attention to the team's needs, is required. This will include the need to ensure that huddles are undertaken even when not stipulated. Making sure that team meetings are adhered to even when there are significant clinical demand and patient dependency. The use of 1:1 time is of most paramount importance during these times, to allow each team member to vent and voice issues and concerns that may be arising with severely complex patients.

248. It is difficult to separate desensitisation to risk with the various teams that I have worked with, as myself, I may be desensitised and not aware of this. However, the contact with outside parties such as compliance visits, CQC inspections, and other peer contact, I believe that the teams were aware of the issue for potential desensitisation. The teams have access to reflective practice sessions that are facilitated by psychology colleagues. Also, ongoing professional development is encouraged for team members with an overall aim of increased knowledge and improved resilience.

249. The culture that I have experienced on the wards, would be one of honesty, integrity with openness and compassion at the team's core.

Section L: Quality of Investigations

250. Since 2009 I have been tasked to undertake various internal investigations. These may have been related to HR processes or patient safety incidents. As part of my role as line manager of undertaking Root Cause Analysis (RCA) reports I would be given a term of reference in regards to a patient safety incident and tasked with undertaking the investigation. The patient safety team would determine the Terms of Reference. The investigation would include review of the patient notes (both paper and electronic), collating witness statements from those involved in the incident. This would normally include EPUT staff, families and if needed the patient themselves. The report would then determine if recommendations were needed, what action and evidence is needed to demonstrate the desired change. Once the report was completed and signed off, the patient safety team would follow up to ensure that actions requested for the teams involved had been undertaken with assurance then going back to the trust as complete.

251. I have undertaken a number of these investigations over the years. I cannot recall the exact number that I have undertaken.

252. The investigations that I have been tasked to undertake have been within timeframes specified in the terms of reference. I have asked for extensions for investigations on several occasions due to the complexity of the case.

253. As lead author I have undertaken single investigations as well as joint investigations with another registered professional. The reports that I have undertaken as joint investigations have always been medical colleagues. The investigations undertaken covered a wide variety of subject matters, with recommendations detailed in the report with clear actions to be addressed as part of patient safety improvements. Outcomes from learning from serious incidents and notifications from the coroner regarding Prevention of Future Death reports, with following up evidence as necessary is undertaken by the patient safety team. The patient safety team will request updates from the clinical teams for evidence of how a teams practice may have altered as part of the action plan from an investigation.

254. I believe that investigators should have suitable professional's qualifications, but experience was gained by undertaking the investigation itself. Training to undertake investigations is part of an individual's own learning and development plan. Training is provided for RCA/PSIRF inhouse by EPUT colleagues. I would expect staff to undertake investigation training prior to EPUT staff being commissioned to undertake these reports. If I have asked staff to undertake any RCA/PSIRF investigation, I have ensured that they have undertaken trust inhouse training prior to being commissioned for the work.

255. For Serious Incidents (SI) that involved a patient's death, the patient's family and loved ones are the most important people to be part of any investigations. I have purposely met and involved families in capturing additional questions that they would like clarity and further information to an untoward incident that may have occurred. Over time, my understanding of the importance of this cannot be understated in ensuring that a family's views are taken into the report and any recommendations that are made as part of the report outcome.

256. Investigations are part of the line manager role. However, having protected, dedicated time to undertake a comprehensive and well composed report is needed. Balancing this need, along with all the various day to day operational demands is a hugely complex work. If some of my line reports were commissioned to undertake various investigations, I would go through the workers job plan to ensure that time was dedicated for this work to progress within the set time frames. I am not aware of any cultural barriers to completing investigations by myself or my direct line reports.

257. When completing the investigation, I would have conversations with the teams about these recommendations prior to submission to ensure that the actions were achievable and sustainable, with direct improvements to patient's safety and wellbeing.

258. The implementation of the recommendations would be monitored via the investigation tool. Actions would be monitored by embedded evidence and assurance that was then returned to the trust patient safety team and sign off. Investigation feedback would be made to a team, normally via a team meeting with myself as the author, verbally discussing the report, notable practice noted. The need for further action and/or change to particular practice would also be discussed and the handover for the assurance being passed over to the team where the investigation had taken place. I believe that having early conversations about team's areas for

improvement was helpful. This allowed the team where the report was being undertaken to adopt positive early changes to practice.

259. I am unaware of any internal whistle blowing concerns that involved services that I have had oversight of.

260. Issues with poor staff performance, acting inappropriately or failing to comply with duties are addressed with the services that I had overall responsibility for, as quickly as is possible. I have had direct experience with a wide variety of the trust disciplinary procedures, including commissioning of fact-finding exercises, chair of investigation outcomes, suspension of staff and where necessary staff termination. Concerns were shared with the appropriate HR officers to allow proper advice and actions needed to adhere to trust policy. I would follow the various trust policies and procedures to determine the outcome. I am unable to comment on if a disciplinary or criminal finding outcome was appropriate or not.

Section M: Quality of Responses

261. Since the creation of EPUT, I strongly believe that the RCA and now PSIRF process is much more geared to ensuring the family and loved one's voices are integral to the internal investigation process. My reports that I have been commissioned to undertake have become much more centred about the needs of the people affected by a serious incident. This was not my experience whilst I worked for NEPT.

Section N: Examples of Good Practice

262. After the death of Michal Wood on Henneage ward in 2020, the use of traditional profile beds for those who may have a higher level of frailty but also have thoughts of self-harm and suicide are of a significant clinical risk decision. If a patient is moved to a fixed based bed to mitigate the risk of ligature, the patient who is then frail cannot the use equipment that may support independence as it usually has ligature points.

263. With the learning that occurred for the death of Mr Woods, older adult functional care wards now have explicit care plans for the use of profile beds and the mitigation needed for those who may have thoughts of suicide. Rather than a blanket rule of 'suicidal patient in a profile bed needs enhanced observations' an individual, tailored care and risk plan is used to help mitigate and manage a ligature issue. This personalised approach manages the complexity of profile beds along with the risk of ligature incidents with the equipment that is needed for the more frail patient.

264. Also, the installation of the Oxevision system was driven by the trust wanting and attempting to offer a safer patient environment. With this installation there was a true intention of providing a level of enhancement to the ward population. The lack of consent for this technology was not considered at the point of the equipment install. The Oxevision system has assisted in offering a lesser restrictive approach to patient care. To address the issue of consent, possibly could the 'camera' part of the system be disabled with the infrared monitoring part of the technology remain? This would address the privacy and dignity issues that have become much more apparent.

Section O: Examples of Poor Practice

265. I have not witnessed examples of poor practice within the teams that I have been leader for over the years.

Section P: Illustrative cases

266. I was the clinical manager/matron for Kings Wood Centre at the time of the death of Mr John (Michael) Wood on Henneage ward in 2020. Factors that would be considered for the admission of Mr Wood from an adult ward to older adult wards would include the age, the level of frailty and the overall clinical view of his needs and whether these would be best met on an adult or older adult ward.

267. I undertook the Root Cause Analysis investigation for [W8] in 2017.

268. I undertook the Root Cause Analysis investigation for Sharon Kelly in 2019.

269. I undertook the PSIRF investigation for Josua Leader in 2020.

270. Whilst undertaking investigations into the deaths of [W8] Sharon Kelly and Joshua Leader I did not encounter any barrier to complete the reports needed.

Section Q: Recommendations

271. I have heard repeatedly the 'parity of services' between mental and physical health. Currently actions taken do not support this. Mental Health care continues to be a 'Cinderella Service' with its voice not heard or understood.

272. I have worked for the trust for a significant number of years. With my experience in NEPT and EPUT, the direction of improving care has remained constant. Having such a huge organisation allows good economies of scale to be achieved with a more consistent and standard approach to patient experience. I truly believe that all employees within the NHS, including EPUT come to work regardless of the position to offer good care and experience to those using it. Past failures to specifically engage with families and loved ones, are glaringly obvious issues that I have personally learned from to make sure that I do not replicate them. If possible, I would like to make sure that the engagement with families and loved ones, especially at a point where something has gone wrong is addressed, resolved, apologised for is continued to be pressed for all NHS staff.

I believe that the facts stated in this statement are true.

Signed....[I/S]

Ian Arthur

Integrated Mental Health Discharge Hub – Mid and South Essex Trust

Previously Clinical Manager/Matron Essex Partnership NHS Trust

Dated.....04/06/2026