Government response to the recommendations of the Public Administration and Constitutional Affairs Committee's inquiry on ‘Follow up on PHSO report: Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust’

Second Report of Session 2019

September 2021

CP 515

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Second Report of Session 2019

Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

September 2021

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Introduction

On 4 November 2019, the House of Commons Public Administration and Constitutional Affairs Committee (PACAC) published its report on *Follow up on the PHSO report: Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust*.

The Committee launched its inquiry to highlight the findings of the Parliamentary and Health Service Ombudsman's (PHSO) investigation and subsequent report into the cases of two deaths at the North Essex Partnership University NHS Foundation Trust and to investigate what actions have been taken since. The Committee's report sets out conclusions and recommendations across three areas – safety of acute mental health care provision, leadership, and developing a culture of learning within the NHS.

The Government welcomes the scrutiny of the Committee in this important area and its subsequent report.

As we set out in the written evidence to the Committee, the cases highlighted in the PHSO's report are appalling and unacceptable. We acknowledge that there are lessons to be learnt from the report and these lessons need to be shared more widely, to improve patient care. We remain committed to creating an NHS that learns from incidents and puts that learning into practice. We will consider the wider lessons from both the Health and Safety Executive (HSE) investigation and the recently announced Essex Mental Health Independent Inquiry (EMHII).

Mental health and learning disability and autism services care for some of the most vulnerable people with complex needs. These patients have a right to expect the highest quality and safe care which will have a positive impact on their lives and help support their recovery. This Government is clear that patient safety must remain a top priority for the NHS in England.

Although our response has been delayed due to COVID-19, that does not mean we've stopped focusing on this issue. This strong focus will continue through the delivery of substantial programmes that are planned or underway within the NHS Patient Safety Strategy, published by NHS England and NHS Improvement in July 2019 and updated in February 2021[1]. The Strategy includes a dedicated Mental Health Safety Improvement Programme (MHSIP). Building on the work undertaken during 2019/20 to support mental health trusts to develop bespoke recommendations for improvement, the MHSIP will aim to improve the safety and outcomes of mental healthcare by reducing unwarranted variation so that services provide a high quality healthcare experience for people across the system.

High quality investigations are central to our vision for a learning NHS. The Government's focus on improving local investigations is reflected in the new Patient Safety Incident Response Framework[2] described in the NHS Patient Safety Strategy. The Framework includes clear standards for investigation and supports a more proactive and proportionate approach to incident investigations in the NHS. It has been trialled in a small number of early adopter systems during 2020.

[1] The NHS Patient Safety Strategy; published February 2021; https://www.england.nhs.uk/publication/nhs-patient-safety-strategy-2021-update/

[2] Patient Safety Incident Response Framework; published March 2020: https://www.england.nhs.uk/patient-safety/incident-response-framework/

Nationally, the Healthcare Safety Investigation Branch (HSIB) is leading the way in carrying out independent and high-quality investigations. Leaders in the NHS must have the skills and expertise to deliver the improvements we have set out in the NHS Long Term Plan. That is why our vision for the NHS workforce focuses on improving leadership and supporting NHS leaders.

Together with the measures we have put in place for whole system improvement on patient safety, through the NHS Patient Safety Strategy, we believe the focus on leadership in the NHS People Plan[3] will help prevent the unacceptable failures identified in the PHSO report where safety incidents did not result in the required learning and improvement.

We acknowledge that safety goes much wider than this and we are delivering on a number of areas through the NHS Long Term Plan[4] to make the system work better for patients such as expanding the mental health workforce, eliminating acute out of area placements, increasing access to mental health services, improving the inpatient offer by investing in an increasingly therapeutic offer, improving crisis care and improving community mental health care to avoid admissions to hospital.

We will work closely with our arm's length bodies and stakeholders, to implement the PHSO's recommendations.

This document sets out the Government's response to the Committee's conclusions and recommendations.

[3] We are the NHS: People Plan for 2020/21: published July 2021: https://www.england.nhs.uk/ournhspeople/
[4] NHS Long Term Plan: published Jan 2019 – updated Aug 2019: https://www.longtermplan.nhs.uk/

The safety of acute mental health care provision

1. The Committee notes with concern the significant body of evidence from the Care Quality Commission, the PHSO report and others that there is a need for significant improvements in the safety and quality of mental health provision. The Minister and the NHS should make this an urgent priority. (Paragraph 24)

We accept this recommendation.

All patients have the right to receive effective, safe and supportive care. The 2019/20 Care Quality Commission (CQC) state of care report, published on 15 October 2020, shows that 71% of NHS mental health core services were rated as good and 11% as outstanding.

However, the same report shows significant gaps in access to good quality mental health care, with particular difficulties in accessing child and adolescent mental health services and NHS services rated as inadequate remaining at 3% in comparison to the previous year.[5]

Ensuring all providers are providing safe, high-quality care is a top priority for this Government and for the NHS. We believe that short and purposeful stays, close to home linked with quality community services can deliver improved patient care.

NHS England and NHS Improvement has set out an ambitious transformation programme in the NHS Long Term Plan and implementation frameworks and places a strong emphasis on improving inpatient settings. This includes a commitment to improve the therapeutic offer to improve patient outcomes and experience of inpatient care, alongside significant investment in community provision. There is also an expectation that unnecessarily long hospital stays will be reduced, resulting in the average length of stay in all adult acute inpatient mental health settings being brought in line with the current average of 32 days (or fewer) by 2023/24.

To support these improvements in inpatient care, new funding has been secured to increase the level and mix of staff on acute inpatient wards. By increasing access to multi-disciplinary staff groups such as peer support workers, psychologists, occupational therapists and other allied healthcare professionals throughout an inpatient admission, it is expected that both the effectiveness and experience of care will be improved. This will not only help to minimise unnecessary time spent in hospital, but also improve outcomes for those who require an admission. The proposals are supported by a funding commitment of £46 million by 2023/24.

NHS Patient Safety Strategy

In addition, the 2019 NHS Patient Safety Strategy, which was updated in February 2021 is designing and supporting programmes that deliver effective and sustainable change in the most important areas. The Strategy covers development of a new incident reporting and learning system, a focus on improving the

[5] Because CQC suspended routine activity in March 2020 as a result of the coronavirus pandemic, the ratings found in this report are as at 31 March 2020 and all comparisons with the previous year are with ratings as at 31 July 2019.

quality of local investigations, a new national committee to communicate the key risks to the NHS and a dedicated Mental Health Safety Improvement Programme (MHSIP).

The MHSIP will support the continuation of the safety improvement work beyond the original commissioned programme. It will refocus its improvement priorities in response to national insights, recommendations and scoping work that are amenable to a quality improvement approach, and in relation to the three workstreams highlighted above.

Specifically, the MHSIP will operate as four workstreams:

1. Reduce suicide and self-harm in inpatient mental health services, the healthcare workforce and non-mental health acute settings:

    - Identify the interventions that reduce absence without leave (AWOL) and scope interventions to reduce suicide and self-harm whilst on agreed leave ahead of testing and scale up;

    - Scope the incidence and understanding of suicide in non-mental health acute settings, identify interventions and commence testing;

    - Support organisations to assess ligature anchor points and other environmental self-harm risks.

2. Reduce the incidence of restrictive practice in inpatient mental health and learning disability services.

3. Improve the sexual safety of patients and staff in inpatient mental health units and within learning disability services.

4. Setup and co-ordinate Mental Health Patient Safety Networks.

The programme will also have a revised delivery mode; it will build a patient safety improvement architecture through Mental Health Patient Safety Networks supported by the Patient Safety Collaboratives. The networks will provide co-ordination and bespoke support to systems and operate as the ‘engine room’ for safety improvement, ensuring alignment to the wider mental health transformation agenda. They will establish what has worked well, test implementation and pathway redesign, and support national scale up of evidence-based interventions. The Patient Safety Networks will initiate the specific work highlighted on suicide prevention and self-harm and progress the work on restrictive practice and sexual safety with a greater number of organisations to test, prior to national scale-up.

Zero Suicide Ambition for mental health inpatients

To address the specific issue of suicide in inpatient settings, the Department of Health and Social Care launched a zero suicide ambition for mental health inpatients. NHS England and NHS Improvement supported mental health trusts to develop zero suicide plans in 2019/20. Both the MHSIP and regional suicide prevention leads will continue to share learning on effective approaches to suicide prevention for people in contact with services and support ongoing implementation of the zero suicide plans. In light of COVID-19, NHS England and NHS Improvement will also be supporting mental health trusts to refresh and expand their zero suicide plans to also include community settings during 2021 to 2022.

Furthermore, timely follow-up following discharge from inpatient care has been consistently highlighted as a priority by patient groups and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). The latest annual NCISH report covering 2008-2018 showed that post-discharge suicides were most frequent in the first week after leaving hospital when 273 (15%) deaths occurred. NHS England and NHS Improvement has therefore included 72hr follow-up in the standard NHS contract for 2021/22, and regularly monitors the performance of providers against it.

By completing follow-ups within 72 hours, trusts are ensuring patients have a well-planned discharge and a safety plan in place, which is expected to have a direct impact on patient experience as well as outcomes. This aim is supported specifically by an additional £87m in 21/22 to put in place services to support hospital discharge, seeking to bridge the gap between inpatient and community services. Improving flow through inpatient wards by reducing delayed discharges will also ensure that beds are available for timely admission of acutely unwell patients who may be at risk of suicide/harm.

This national standard has been reported for the first time in the mental health annual report for 2019/20[6]

NHS England and NHS Improvement continues to roll-out 24/7 liaison mental health teams in every acute hospital to ensure that people who present at hospital with mental health needs get the appropriate care and treatment they need. To improve the quality of care for people who self-harm and attend A&E, NHS England and NHS Improvement plans to introduce a new Commissioning for Quality and Innovation (CQUIN) framework later in 2021/22. This is expected to require psychiatric liaison teams to ensure that 80% of self-harm referrals receive a biopsychosocial assessment in line with National Institute for Health and Care Excellence (NICE) guidelines. NCISH has also been commissioned to support 12 areas to improve self-harm care in the community.

The NHS Long Term Plan notes that reducing suicides will remain an NHS priority over the 10 years of the Plan. With the support of other partners in addressing this complex system-wide challenge, NHS England and NHS Improvement will provide full coverage across the country with the existing suicide prevention programme to support local suicide prevention strategies and projects, alongside new, wider initiatives to prevent suicides such as improving self-harm care and spreading coverage of suicide bereavement support services. Every local health system in the country will receive funding for suicide prevention and bereavement services by 2023/24, from the total pot of money of £57 million allocated through the NHS Long Term Plan. A further £1 million was also announced in March 2021 to bolster NHS England and NHS Improvement's work on suicide prevention.

There is a bespoke national suicide reduction support package provided by NCISH and the National Collaborating Centre for Mental Health (NCCMH) to support local health systems in their quality improvement plans as part of the national suicide prevention programme. A key component of this programme involves supporting services with safety planning, using resources such as the NCISH Safer services: A toolkit for specialist mental health services and primary care[7].

Every local authority area in the country has a multi-agency suicide prevention plan in place too, so that all local services which come into contact with someone at risk of suicide are implementing tailored approaches to reducing suicide in their communities. The Department of Health and Social Care has worked with local government to assure the effectiveness of those plans, providing almost £600,000 in 2019/20 to the Local Government Association for a support programme to help local authorities strengthen their plans and will be providing further funding in 2021/22.

[6] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2019-20-annual-report
[7] NCISH: Safer services: A toolkit for specialist mental heath services and primary care, published March 2021: https://documents.manchester.ac.uk/display.aspx?DocID=40697

From 2019 to 2021, the Department also provided the Zero Suicide Alliance (ZSA) with £2 million of funding for a suite of work to improve suicide prevention. This work included developing and embedding suicide prevention awareness training, which has now been delivered to over 1.7m people.

In 2021/22, the Department has committed to providing £5 million of funding specifically for the suicide prevention Voluntary Community and Social Enterprise sector. This funding will help to support the sector in terms of financial sustainability, helping to ensure that support is there for those who need it.

National Quality Improvement Taskforce for children and young people's mental health inpatient services

In autumn 2019, a National Quality Improvement Taskforce was established to improve current specialist children and young people's inpatient mental health, autism and learning disability services in England. The work of the Taskforce is underway and it seeks to make a rapid set of improvements in care over the 18 months to end March 2022.

The Taskforce's Independent Oversight Board is chaired by Anne Longfield OBE, the former Children's Commissioner for England. It provides independent, expert advice and scrutiny of the Taskforce. The Taskforce's Delivery Group implements the Taskforce objectives and is made up of NHS leaders and other key partners.

The establishment of the Taskforce and Independent Oversight Board forms part of a package of measures in the NHS Long Term Plan to ensure that all NHS services operate at safe and effective levels, as well as immediately injecting a boost in care quality. A broad range of programmes supported by the Taskforce will ultimately foster positive change in culture within services. Headline programmes include the recruitment of family ambassadors into services across each provider collaborative; human rights training and the introduction of a framework for the explicit assessment of human rights of children and young people; specialist autism training and a competency framework for all staff which includes a mandatory certification arrangement for healthcare assistant staff.

The NHS Long Term Plan also set out how new provider collaboratives will be working across the NHS to strengthen commissioning oversight of mental health services and move responsibility for commissioning specialised services to lead providers in local areas, giving clinicians and Experts by Experience greater involvement locally in assuring the quality of commissioned services as well as investing in community alternatives which prevent avoidable admissions.

Mental Health Act

The Care Quality Commission is delivering a programme of improvement to its regulation of inpatient and community mental health services, with a focus on human rights principles. It is working with people with lived experience and stakeholders, including the Department of health and Social Care, to improve their monitoring of people subject to the Act. It has also produced methodology to support regulatory inspection staff to assess the quality of services - for example, improved tools to assess providers with dormitory accommodation and shared programmes that investigate the safety of inpatient environments to respond to the learning from the sexual safety programme.

The CQC has also carried out targeted and thematic work focussed on people with a mental health condition, autistic people and people with a learning disability who are restrained, placed in seclusion or subject to long term segregation. The final report on restrictive practices called 'Out of Sight – Who

Cares?'[8] was published in Autumn 2020 and found that mental health hospitals are not always therapeutic environments and people got better care in the community than in hospital. The report says people with a learning disability and/or autistic people who may also have a mental health condition should be supported to live in their communities, and in the meantime, people who are being cared for in hospital must receive high-quality, person-centred, specialised care in small units. The report made recommendations and the CQC is going to update on the progress of these soon.

Our work to modernise and improve the Mental Health Act will ensure that people will receive better care both in terms of quality and safety. Changes to the Act should ensure that people have a much greater say in the care they receive, both before, during and after their experience of care under the Act.

We are reforming the Act to give people's preferences and wishes much more legal weight. In particular, we will introduce statutory advance choice documents, so people can make statements about their care whilst they are well, for example for medication preferences and patients will also be able to choose a nominated person rather than being restricted to the nearest relative, based on a prescriptive list within the Act. In addition to the legislative reforms, NHS England and NHS Improvement will lead the implementation of a national quality improvement programme specifically focused on improving the experience of care under detention.

We also want to address the question of the care for people from ethnic minority backgrounds and address the disparity in outcomes and exposure to mental health law for people from black and other ethnic minority backgrounds. We are introducing a race equality framework which will support NHS mental healthcare providers to work with their local communities to improve the ways in which patients access and experience treatment. Where compulsion is used, we will also make it more targeted, better explained and better recorded. We published our White Paper in January 2021, setting out our response to the Independent Review of the Mental Health Act and our ambition for legislative reform. We have now consulted on the White Paper and published a response in July 2021, setting out a summary of the feedback received through the consultation process. We will take this into consideration as we progress to the development of a Bill to amend the Act, which will be brought forward when parliamentary time allows. We expect the changes to the Act will improve the quality and safety of the care people receive whilst detained under the Mental Health Act.

Finally, the Mental Health Units (Use of Force) Act[9], will increase the oversight and management of the use of force (restraint) in mental health units so that force is only ever used as a last resort, when all attempts to de-escalate a situation have been employed. In May 2021 we published the Mental Health Units (Use of Force) Act draft statutory guidance[10] for public consultation. This consultation closed in August 2021, and we expect to publish the final guidance and commence implementation of the Act from November 2021.

[8] Out of Sight – Who Cares?: CQC, published March 2020: https://www.cqc.org.uk/sites/default/files/20201218_rssreview_report.pdf
[9] Mental Health Units (Use of Force Act) 2018: https://www.legislation.gov.uk/ukpga/2018/27/enacted
[10] Mental Health Units (Use of Force) Act 2018 statutory guidance - GOV.UK (www.gov.uk)

2. In this context, we welcome the steps that the NHS and the Department of Health and Social Care are taking to improve safety and the quality of mental health care provision. We agree with the recommendation of the Care Quality Commission that NHS England and NHS Improvement should ensure that the entire NHS workforce has a common understanding of patient safety and that patient safety should form part of ongoing mandatory training and be included as part of continuing professional development. (Paragraph 25)

We partially accept this recommendation. NHS England and NHS Improvement and Health Education England are considering whether this training should be mandated.

Expanding the mental health workforce is a key priority for this Government and the NHS is committed to widening access to rewarding career options in mental health. We recently announced a non-repayable financial support package for eligible pre-registration nursing students on courses at English universities from September 2020 of at least £5,000 a year with up to £3,000 additional funding to help with childcare costs or for some students who choose to study in regions or specialisms struggling to recruit, including mental health.

Improving the safety of inpatient services, preventing suicides and improving continuity of care all depend on having enough properly trained and caring staff.

Health Education England is working with the national patient safety team at NHS England and NHS Improvement, the Academy of Medical Royal Colleges, and system partners to develop patient safety capacity and capability throughout the workforce. To achieve this, NHS England and NHS Improvement has committed within the NHS Patient Safety Strategy to: "ensure every member of the NHS has access to patient safety training; from ward to board and from commissioner to provider".[11] This will include undergraduate and postgraduate training, continuing professional development, and training within NHS organisations.

Health Education England has commissioned the Academy of Medical Royal Colleges to develop the first ever national Patient Safety Syllabus on behalf of the NHS. The syllabus was published on 13 May and represents a new approach to patient safety with an emphasis on a proactive approach to identifying risks to safe care and the impact of the care system on safety. This approach is common in other safety-critical industries that have demonstrably improved their safety record.

The multi professional syllabus is appropriate for all staff in all roles across the NHS and provides content to support all patient safety activities including: incident investigation, creating a safety culture, using human factors, proactive risk management and managing human error. Work is now taking place to develop levels 1 and 2 of the new training and education programme that sits under the syllabus. These will be universally available to existing NHS staff and provide essential knowledge and understanding of patient safety principles. Work is also underway to create associated curricula for use in training clinical undergraduates.

Health Education England is also working to improve access to suicide and self-harm prevention training across the NHS workforce. In October 2018, it published the Self-harm and Suicide Prevention Competency Frameworks[12], which set out the competencies required for effective interventions by both clinicians and non-health professionals working with both children and young people, and adults, across generalist to specialist settings. Following publication of the frameworks, it also commissioned a review

[11] The NHS Patient Safety Strategy; published February 2021; https://www.england.nhs.uk/publication/nhs-patient-safety-strategy-2021-update/

[12] Self-harm and Suicide Prevention Competency Frameworks: https://www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention

of existing suicide prevention training, to identify gaps in such provision, using the frameworks to map against quality of training. This has led to the development of an online compendium of training which will be launched shortly, providing access to training for health professionals to enable them to provide the best possible support to patients who are self-harming or at risk of suicide.

Leadership

3. The PHSO report powerfully demonstrates the need for effective leadership within the NHS. Good leadership is not just about taking action and giving clear direction. Good leaders also empower people to speak with candour, enable difficult conversations to take place, and hear uncomfortable truths, so that concerns and problems are addressed. Furthermore, mistakes and service failures must be acknowledged early. We welcome the Government's plans to specifically cover plans for leadership in the NHS within the People Plan, to be published later this year. The Government should make clear however that ensuring effective leadership within an organisation is not simply a one-off event but rather is an iterative process of continuous improvement. (Paragraph 35)

We accept this recommendation.

We are the NHS: People Plan 2020/21 – action for us all, was published in July 2020[13]. It describes what the people of the NHS can expect from their leaders and from each other. It builds on the principles of the interim People Plan and sets out how we must all continue to look after each other, foster a culture of inclusion and belonging, grow the workforce, train our people and work together differently in order to deliver the NHS Long Term Plan.

We agree that effective leaders empower people to speak with candour, enable difficult conversations to take place, and hear uncomfortable truths, so that concerns and problems are addressed. The actions we set out in the NHS People Plan 2020/21 will help to ensure that all NHS leaders have the support and development they need in order to lead in a way that promotes a culture of continuous improvement.

We are committed to ensuring that NHS leaders are equipped with the skills and qualities needed to deliver on the requirements of the NHS Long Term Plan. This includes the ability to respond effectively when patient safety incidents occur and to implement effective learning cycles and actions around safety improvement.

Together with our approach to patient safety, we believe the focus on leadership in the NHS People Plan will help prevent the unacceptable failures identified in the PHSO's report where safety incidents did not result in the required learning and improvement.

Zero Suicide Alliance

Between 2019/20 and 2020/21, we provided £2 million of funding for the Zero Suicide Alliance, which is working across the NHS and wider communities to increase awareness of suicide prevention, and developing a better culture of learning from deaths when suicides do sadly occur across the NHS. As part of this work, the Zero Suicide Alliance developed a culture change awareness training package for NHS trust boards to encourage understanding of the impact of a 'Just and Learning Culture' (culture of trust, learning and accountability) on suicide prevention, to support a fair and open culture in the NHS, and allowing lessons to be learnt to prevent errors from being repeated. This aligns with the NHS Patient Safety Strategy, reinforcing how a just culture can be embedded as part of trusts' patient safety work.

Learning from Deaths

In addition, the Government's Learning from Deaths national policy framework is supporting all trusts to learn from deaths thought to be due to problems in care and make changes to reduce risks to future patients and avoid tragedies happening in the first place.

The first ever National Guidance on Learning from Deaths was published in 2017[14] and is helping to standardise and improve the way acute, mental health, community and ambulance trusts identify, report, review, investigate and learn from deaths of people in their care. Further national guidance published in 2018 is clear that trusts should engage openly, meaningfully and compassionately with bereaved families and carers.

In 2017, the Government also introduced regulations to require trusts to publish locally the number of their deaths thought to be due to problems in care on a quarterly basis and evidence of learning and actions to prevent such deaths on an annual basis in their quality accounts. This level of transparency is fundamental to a culture of learning and ensuring the safety of NHS services.

By 2019, a review by the CQC showed signs of progress on learning from deaths across the health service but that a more open learning culture is needed to drive further improvement.

[14] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

Developing a culture of learning

4. Mental Health Trusts must be clear about their values and mission, and they need to reflect this in their culture. They must be clear that the term culture refers to the attitudes and behaviours which people in the organisation tend to adopt. Leadership must lead by example with the right attitudes and behaviour. There has to be open discussion when attitudes and behaviour is not consistent with the values of the Trust. (Paragraph 44)

We accept this recommendation.

We know that learning flourishes in environments where there is openness to challenge. Where learning is actively encouraged, people at all levels of an organisation are encouraged to raise concerns and ask questions, and there is an effective learning and improvement cycle that turns observations into actions and tests their effectiveness.

The NHS Patient Safety Strategy is built on these foundations because a safe culture must also be an open, learning and just culture. Compassion, kindness, civility and psychological support for staff are also necessary for patient safety. The Strategy will have a significant role to play in embedding these values in every NHS trust and ensuring that they continue to be effective at learning over the long term. Creating a patient safety culture requires strong leadership. Leaders in the NHS must have the skills and expertise to deliver the improvements we have set out in the NHS Long Term Plan. That is why our vision for the NHS workforce focuses on improving leadership and supporting NHS leaders.

We believe the Strategy, together with the focus on leadership in the NHS People Plan, will help to bring about the culture needed to ensure safer care.

As part of the CQC's new Strategy, published in May 2021, the CQC wants all services to have stronger safety and learning cultures. This involves regulating for stronger safety cultures across health and care, prioritising learning and improvement and collaborating to value everyone's perspectives. Health and care staff work hard every day to make sure people's care is safe. Despite this, safety is still a key concern for CQC as it's consistently the poorest area of performance in their assessments. Learning and improvement must be the primary response to all safety concerns in all types of service and local systems. Where CQC has concerns, it will direct services and systems to respond and show CQC – and people who use the services – what action they'll take to learn and improve. CQC will share this information with the public as part of its up-to-date view of quality.

5. We welcome the Minister's commitment that the families affected will be fully involved in the NHS Improvement and NHS England investigation. As we have set out earlier in our report, the two tragic cases raised in the PHSO's report were not the only complaints that have been made about the Trust. NHS England and NHS Improvement's review should make sure that all families that have been affected by similar incidents to the ones detailed in the PHSO's report are also fully involved in the investigation, if they would like to be. (Paragraph 47)

We accept this recommendation.

PHSO recommended that the NHS England and NHS Improvement East of England Region should lead a process for commissioning a review of what happened at the then North Essex Partnership Trust between December 2008 to the end of March 2017.

The PHSO's recommendation pre-dates both the Health and Safety Executive (HSE) investigation and the recent announcement of the Essex Mental Health Independent Inquiry (EMHII), and related activities.

As such, given the scope of both the investigation and inquiry, NHS England and NHS Improvement East of England has not pursued an additional review to avoid duplication.

The EMHII commenced a six-week consultation on its Terms of Reference in May 2021[15]. Families and others affected by the deaths were urged to give their views on the issues to be considered by the Inquiry. The Healthcare Safety Investigations Branch has implemented a successful family engagement model as part of its approach to investigations and this work could offer learning for other investigations.

[15] Essex Mental Heath Inquiry: https://emhii.org.uk/consultation-on-terms-of-reference/

6. We welcome the inclusion of the Health Services Safety Investigations Body (HSSIB) in the Health and Care Bill. In particular we believe that the introduction of the 'safe space' principle will facilitate more open investigations and proper learning to reduce repeated incidents. (Paragraph 54)

We accept this recommendation.

We want patients to receive world-class NHS healthcare. But sometimes things do go wrong, which is why we are looking to transform the way in which patient safety incidents in the NHS and the independent sector are investigated. The provisions in the Health and Care Bill will establish an independent Health Services Safety Investigations Body (HSSIB) to investigate patient safety concerns and share recommendations to prevent similar events happening again. The body's remit will cover healthcare provided by the independent sector as well as by the NHS, which will enable more thorough investigations.

The legislation will create a 'safe space' where staff can speak openly about what happened without fear of blame or liability.

7. It is vital that families can have confidence in clinical investigations. The lack of confidence expressed by witnesses to our inquiry is a cause of serious concern. While we have confidence that HSSIB's investigations, once it is properly established will be effective in improving learning from incidents, NHS Trusts must also be capable of performing effective local investigations when incidents arise. The NHS should take steps to use HSSIB investigations to improve their own local investigations. For example, by learning from examples of best practice in clinical investigations. (Paragraph 55)

We accept this recommendation.

High quality investigations are central to our vision for a learning NHS. Drawing on the approaches used in other safety-critical sectors, the HSSIB investigations will be independent and professionally led. They will be done for the purpose of system-wide learning and will not attribute blame or find fault.

NHS England and NHS Improvement has worked with HSIB while developing the new Patient Safety Incident Response Framework which will replace the current Serious Incident Framework to ensure it is aligned with HSIB's approach to investigation. We will continue to ensure the expectations on NHS trusts in relation to investigation reflect HSIB's and the HSSIB's views and expertise.

To ensure that trusts are capable of performing effective local investigations, HSSIB will support trusts through their training and development curriculum which is currently in its pilot stage.

8. We reiterate our previous recommendation that there needs to be fundamental reform of the PHSO's governance, which will require legislation. It was disappointing that such legislation was not included in the Queen's Speech 2019, but the Government and Parliament must ensure that the Draft Public Service Ombudsman Bill is scrutinised by a Joint Committee of both Houses of Parliament as soon as possible. (Paragraph 57)

We partially accept the recommendation.

The work reforming PHSO has been paused and will require significant legislative time. The Government is considering how it can reform Ombudsman arrangements for the United Kingdom (government departments and agencies) and England (health).

Conclusion

Following historic underinvestment, record levels are being invested to bring our mental health services up to the standards patients, families and carers expect to see. The NHS Long Term Plan will see a further £2.3 billion of ring-fenced investment in mental health services a year by 2023/24, which will ensure that the NHS provides high quality, evidence-based mental health services to an additional 2 million people. We have also announced that in 2021/22 the NHS will receive around an additional £500 million, which will support people with a variety of mental health conditions.

The cases highlighted in the PHSO report are unacceptable and we are committed to making improvements in the safety and quality of mental health provision a key priority for this government. Establishing the Essex Mental Health Independent Inquiry (EMHII) is a demonstration of our commitment in this regard.

We want to ensure the highest quality and safe care for mental health patients, and we will work closely with national bodies including NHS England and NHS Improvement and the CQC to ensure this happens. The NHS Long Term Plan set out mental health transformation and investment for improving the quality of community-based and hospital treatment for mental health. In addition, there is a strong focus on safety through the delivery of the NHS Patient Safety Strategy and the Mental Health Safety Improvement Programme.

We also expect the Mental Health Act Code of Practice[16] to be adhered to. It sets out guiding principles for ensuring mental health patients, carers and their families receive the best possible care and are treated with dignity and respect.

In addition, we have set out our ambitious plans to reform the Mental Health Act in our White Paper, to give people greater control over their treatment and receive the dignity and respect they deserve. We will bring forward a Bill to amend the Act when parliamentary time allows.

It is important that all organisations involved in the delivery of care work together, including providers, commissioners and national bodies, to improve patient safety. We are working with NHS England and NHS Improvement and the CQC to look at the quality assurance frameworks that are in place and the commissioning levers available to ensure the most robust oversight of quality and safety.

We have accepted or are considering all of the recommendations in this report because we believe that they will support the measures being taken by the Government and NHS England and NHS Improvement to ensure that consistent good quality safe care is provided to all NHS patients.

[16] Mental Health Act 1983: Code of Practice: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

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