



House of Commons  
Public Administration  
and Constitutional Affairs  
Committee (PACAC)

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**Follow up on PHSO report:  
Missed opportunities:  
What lessons can be  
learned from failings at the  
North Essex Partnership  
University NHS Foundation  
Trust**

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**Second Report of Session 2019**

*Report, together with formal minutes  
relating to the report*

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## Public Administration and Constitutional Affairs Committee

The Public Administration and Constitutional Affairs Committee is appointed by the House of Commons to examine the reports of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England, which are laid before this House, and matters in connection therewith; to consider matters relating to the quality and standards of administration provided by civil service departments, and other matters relating to the civil service; and to consider constitutional affairs.

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# Contents

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<b>Summary</b>	<b>3</b>
<b>1 Introduction</b>	<b>4</b>
The Parliamentary and Health Service Ombudsman	4
Missed Opportunities, the PHSO's report	4
The Committee's inquiry	4
<b>2 The PHSO investigation</b>	<b>6</b>
The PHSO's recommendations	6
The formation of EPUT	7
<b>3 The safety of acute mental health care provision</b>	<b>8</b>
The need for better safety in acute mental health care provision	8
Enabling good practice and improving safety and mental health care provision	9
<b>4 Leadership</b>	<b>11</b>
The importance of leadership	11
Improving leadership in the NHS	11
<b>5 Developing a culture of learning</b>	<b>14</b>
The value of a healthy learning culture	14
Embedding a healthy learning culture in the NHS	15
Involvement of families and carers in the forthcoming review	16
Calls for a public inquiry	16
Improving health service investigations	17
Health Service Safety Investigations Bill	17
The need for a Public Service Ombudsman Bill	18
<b>Conclusions and recommendations</b>	<b>19</b>
<b>Formal minutes</b>	<b>21</b>
<b>Witnesses</b>	<b>22</b>
<b>Published written evidence</b>	<b>23</b>
<b>List of Reports from the Committee during the current Parliament</b>	<b>24</b>



## Summary

In June 2019, the Parliamentary and Health Service Ombudsman (PHSO) presented to Parliament a report entitled *Missed Opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust*, which was published following the PHSO investigation into the cases of two deaths at the North Essex Partnership University NHS Foundation Trust (NEP). The report is not an easy read; it details serious and significant failings in the care of two young men. It is also clear that complaints about the Trust were not restricted to those two patients and the report also identified wider systemic issues at the Trust including a failure to develop a culture of learning and a lack of leadership at the highest level. The PHSO recommended that NHS Improvement should conduct a review of what went wrong at the NEP focusing on patient safety, culture and leadership. Any learnings found from the review should be disseminated across the wider NHS.

The Committee's inquiry highlights the issues identified in the PHSO report and investigates what actions have been undertaken since the report has been released in the areas of: safety of acute mental health care provision; leadership; and developing a culture of learning within the NHS.

The Committee found that significant improvement in the safety and quality of mental health provision is needed throughout the NHS and it recommends that the Minister and NHS England ensures that this is a top priority. The Committee agrees with the recommendation of the Care Quality Commission that NHS England and NHS Improvement should ensure that patient safety forms part of ongoing mandatory training as part of continuing professional development.

On the topic of leadership, the Committee concludes that the PHSO report powerfully demonstrates the need for effective leadership within the NHS. We welcome the Government's proposal 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.

On developing a culture of learning in the NHS, the Committee welcomes the Government's commitment to ensuring the families affected will be involved in the upcoming NHS Improvement and NHS England review. We also welcome the inclusion of Health Service Safety Investigations Bill (HSSIB) in the recent Queen's Speech, a piece of legislation that the Committee has strongly supported for many years. In particular, we believe that the introduction of the 'safe space' principle will facilitate more open investigations and proper learning to reduce repeated incidents and recommend that it be included in the Queen's Speech after the upcoming General Election.

# 1 Introduction

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## The Parliamentary and Health Service Ombudsman

1. The Parliamentary and Health Service Ombudsman (PHSO, or ‘the Ombudsman’) is independent of the Government, the NHS and Parliament. It reports to Parliament and is accountable to the Public Administration and Constitutional Affairs Committee (PACAC), which scrutinises its reports, and the overall performance of the PHSO and its use of resources. PACAC usually holds an annual evidence session based on the PHSO annual report and accounts. The Ombudsman can lay reports before Parliament, often to highlight cases that he feels raise issues of wider concern. *‘Missed Opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust’* was one such report.<sup>1</sup>
2. The Ombudsman combines the two statutory roles of the Parliamentary Commissioner for Administration (Parliamentary Ombudsman) and the Health Service Commissioner for England (Health Service Ombudsman), whose powers are set out in the Parliamentary Commissioner Act 1967 (the PCA) and the Health Service Commissioners Act 1993 (HSCA) respectively.

## Missed Opportunities, the PHSO’s report

3. In June 2019, the Parliamentary and Health Service Ombudsman presented to Parliament a report entitled *‘Missed Opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust’*.<sup>2</sup> The report, which makes very difficult reading, describes significant failings in the care and treatment of two young men (Mr R and Mr Matthew Leahy) who died shortly after being admitted to the North Essex Partnership University NHS Foundation Trust (NEP).

## The Committee’s inquiry

4. At the time of writing this report, the Health and Safety Executive (HSE) was conducting an investigation into how the NEP managed its mental health wards in relation to reducing and removing potential ligature points and there remains a possibility of criminal charges being brought against the Trust once that investigation is concluded.<sup>3</sup>
5. We launched this inquiry to highlight the areas of focus identified in the PHSO Report and to investigate what actions have been undertaken since the report has been released. At this time, due to the ongoing HSE investigation and in keeping with the principle that PACAC does not investigate individual cases, we have taken a wider approach, looking at:
  - the safety of acute mental health care provision (Chapter 3);
  - leadership (Chapter 4); and
  - developing a culture of learning within the NHS more generally (Chapter 5).

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1 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019

2 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019

3 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019, pp 7 & 12

Our inquiry has not investigated the individual cases mentioned in the report nor have we sought to reach conclusions on the facts of those cases.

6. For this inquiry we received seven pieces of written evidence. We also held an evidence session, hearing from:

- Nadine Dorries MP, Minister for Mental Health, Suicide Prevention and Patient Safety;
- William Vineall, Director of Acute Care and Quality Policy, Department of Health and Social Care; and
- Professor Tim Kendall, National Clinical Director for Mental Health, NHS England and Improvement.

We are thankful to all those who have contributed to this inquiry.

## 2 The PHSO investigation

7. The PHSO investigation into the cases of Mr R and Mr Leahy, which occurred in 2008 and 2012 respectively, found that the risk to patients' safety had not been managed properly. The main problems identified by the PHSO report were:

- For one patient, Mr Matthew Leahy, although a full risk assessment had been undertaken, the furniture in the room was subsequently altered and a new risk assessment was not carried out meaning new safety issues were not identified e.g. ligature points.
- Mr R's medical dosage was increased and on that day he was granted ward leave. This placed the patient in danger as his response to the increase in medication was not monitored and therefore unknown to staff.
- Neither patients' care plans had been updated or adequately planned, this was alongside insufficient assessment and management of risks.

8. The PHSO's investigation found repeated failings at the NEP, demonstrating wider systemic issues at the Trust. In particular, the PHSO found that there was a failure to develop the learning culture required to prevent similar mistakes from being repeated and a lack of leadership at the highest level. These failures were evidenced by the Care Quality Commission (CQC) inspection reports which reference the NEP's lack of learning from these incidents and question whether it was acting to prevent reoccurrence.<sup>4</sup>

### The PHSO's recommendations

9. The report argued that the cases should have prompted immediate action from the senior leadership of the Trust who were accountable for delivering and evidencing improvement.<sup>5</sup> The PHSO concluded that there were questions to answer about why learning had not taken place at the NEP for so many years and change had only started once the leadership of the newly merged Essex Partnership University NHS Foundation Trust (EPUT) started to drive improvement.<sup>6</sup>

10. The PHSO therefore recommended that NHS Improvement<sup>7</sup> should conduct a review of what went wrong at the North Essex Partnership University NHS Foundation Trust, focusing on patient safety, culture and leadership in order to establish both what should have happened instead and the learning that should be taken from this. The PHSO stated that the lessons learned from this review should be disseminated across the wider NHS.<sup>8</sup>

11. It recommended that the review should not take place, however, until the HSE investigation, and a possible commissioner-led review, which is planned to be undertaken by the local Clinical Commissioning Group (North East Essex), has been completed to avoid duplication. The PHSO suggested the proposed review's terms of reference should

4 [North Essex Partnership University NHS Foundation Trust Quality report](#), Care Quality Commission, January 2016

5 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019

6 [ibid](#), p 8

7 NHS Improvement has recently merged with NHS England to operate as a single organisation

8 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019

consider the views of the PHSO, CQC, the Trust and the families and carers affected, as well as HSE and Essex Police.<sup>9</sup> The PHSO indicated it expected this review to consider the key aspects that led to the “apparent improvements” mentioned in the most recent CQC report since the merger and that any good practice that can be identified from the merger should be widely disseminated. Additionally, the review should include an assessment of whether there is explicit learning that could contribute to existing initiatives on mental health safety improvement.<sup>10</sup>

12. The Government in its written evidence to this inquiry indicated that a regionally-led review would be undertaken by NHS England and Improvement, with an independent Chair and would not be undertaken until after the HSE’s investigation was concluded (expected early 2020).<sup>11</sup>

### The formation of EPUT

13. In April 2017, the NEP merged with the South Essex Partnership University NHS Foundation Trust (SEP) to form the Essex Partnership University NHS Foundation Trust (EPUT). The PHSO have accepted that since this merger, improvements appeared to have been made. For example, EPUT received an overall ‘good’ rating from the Care Quality Commission (CQC) in an inspection report in 2018 (but the safety of services was rated as ‘requiring improvement’).<sup>12</sup>

14. In addition to the recommended review, the PHSO also suggested that EPUT should formulate an action plan to address any outstanding issues regarding the death of Mr Matthew Leahy. The PHSO plans to publish this action plan once it has received it and plans to share it with the CQC and NHS Improvement so progress can be considered by the review and as part of future regulatory inspections.<sup>13</sup>

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9 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019, p 14

10 [Ibid](#)

11 Department of Health and Social Care, [NEP0004](#)

12 [Essex Partnership University NHS Foundation Trust](#), Care Quality Commission, July 2018,

13 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019, p 15

## 3 The safety of acute mental health care provision

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### The need for better safety in acute mental health care provision

15. The PHSO's *Missed Opportunities* report details serious and significant failings in the care of two young patients but it is also clear that complaints about the Trust were not restricted to those two patients, as shown by the evidence we received from anonymous service users<sup>14</sup> and Mr Robert Wade,<sup>15</sup> who detailed their experiences with the Trust. The Minister, in oral evidence, told us that the Government's response to the PHSO's report had been one of "huge concern" and described herself and officials as being "personally distressed at the cases that we have heard"; she said that she would ensure that any recommendations made by the investigations and review would be "not only honoured in spirit but, where possible, incorporated and enacted going forward".<sup>16</sup> Dr Kendall acknowledged that the families involved "must have gone through hell" and was clear that "we have to take this as an opportunity to learn about how we should do these things better".<sup>17</sup>

16. The PHSO published a report last year, *Maintaining Momentum*, which looked at problems in acute adult mental health care and treatment across the NHS. The report highlighted the failure by local NHS organisations to investigate complaints effectively. The PHSO report stated that:

In 2016–17 there were 14,106 complaints made to NHS mental health trusts, with around 65% being upheld or partly upheld by the local organisations. In 2016–17, we completed a further 352 investigations into NHS mental health trusts and found failings in 130 (37%) of these cases. We also saw failings in a further 37 complaints which were either already accepted by the organisation, or where we were able to resolve the complaint without completing a full investigation.<sup>18</sup>

17. The CQC's report, *The state of care in mental health services 2014 to 2017*, based on evidence from its inspections, highlighted key challenges that the NHS faces.<sup>19</sup> The CQC found that 39 per cent of NHS trusts were rated as requires improvement and one trust was rated as inadequate. In particular, the CQC's report stated "our biggest concern is about safety", the most "cross-cutting themes" were:

- the poor physical environment of many mental health wards;
- some services struggled to ensure that mental health wards are staffed safely at all times; and

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14 Supporters and Anonymous Service Users, [NEP0006](#)

15 Mr Robert Wade, [NEP0002](#)

16 [Q4](#)

17 [Q6](#)

18 [Maintaining momentum: driving improvements in mental health care](#), Parliamentary and Health Service Ombudsman, March 2018

19 [The state of care in mental health services 2014 to 2017: Findings from CQC's programme of comprehensive inspections of specialist mental health services](#), Care Quality Commission

- staff in both inpatient and community services did not always manage medicines safely.<sup>20</sup>

## Enabling good practice and improving safety and mental health care provision

18. In written evidence to our inquiry, the CQC set out a number of aspects that can “either aid or inhibit a provider’s ability to secure high patient safety standards”. These include:

- a) values and behaviours that encourage engagement with families and carers and support for staff;
- b) clear and consistent leadership and governance by a specific person who is at a reasonably high level in a trust’s hierarchy;
- c) a positive, open and learning culture that encourages staff to speak up about safety issues and has a focus on improving the care of patients;
- d) staff with the resources, training and support to carry out reviews and investigations; and
- e) positive working relationships with other organisations also providing care for the person who has died, to enable the sharing of information and learning from any investigation.<sup>21</sup>

19. In oral evidence, the Minister assured us that safety was a key focus of the Department:

The [PHSO] report focused mainly on safety, and that is very current—in both my portfolio and the Department there is a focus at the moment on patient safety.<sup>22</sup>

The Minister also expressed optimism in terms of embedding a culture of safety and learning, saying:

I think we are on the edge of something: a whole new culture change, going from blame and retribution to safety and learning.<sup>23</sup>

20. In 2017, the Government published *Our approach to patient safety*.<sup>24</sup> The report stated that patient safety was viewed as a core component of quality in healthcare, alongside clinical effectiveness and patient experience. The report set out an ambition for the NHS to be “the safest healthcare system in the world”. In practice this would look like:

- An NHS that openly and transparently identifies and acts on risks to patients.
- An NHS that demonstrates a just culture, where the whole system works to reduce the chance patient safety incidents occur, individuals are not inappropriately blamed and there is candour with patients and families when things go wrong.

20 [Ibid](#), p 29–30

21 Care Quality Commission, [NEP0001](#)

22 [Q4](#)

23 [Q18](#)

24 [Our approach to patient safety: NHS Improvement’s focus in 2017/18](#), NHS Improvement, October 2017

- An NHS where staff, patients and families are empowered to identify where change is needed and are supported to act, and which also recognises where co-ordinated and systemic action is needed.<sup>25</sup>

21. William Vineall, Director of Acute Care and Quality Policy, Department of Health and Social Care, explained to us in oral evidence some of the steps that were being taken specifically in relation to mental health provision:

On wider patient safety and mental health patient safety, when we published the patient safety strategy in the summer, there was a specific component on mental health safety improvement. NHS England and NHS Improvement are working with all 54 mental health trusts to look at reducing the use of restraint, sexual safety and suicide prevention. There are bespoke activities for service improvement in safety across the piece.<sup>26</sup>

22. Mr Vineall also emphasised that trusts did not need to wait for investigative reports before implementing improvements, saying that the message was very much “There is plenty you can do now based on the resources and advice you have to improve services. You do not need to wait for a further report to make improvement happen.”<sup>27</sup>

23. In written evidence to the inquiry, the Care Quality Commission provided the following recommendations to improve patient safety, calling for:

NHS Improvement to work in partnership with Health Education England and others to make sure that the entire clinical and non-clinical NHS workforce has a common understanding of patient safety. Patient safety should form part of ongoing mandatory training and be included as part of continuing professional development (CPD) requirements and ongoing development. Leaders should release their staff from their substantive duties to carry out this development, not as an optional extra, but as a vital part of every employee’s role.”<sup>28</sup>

**24. 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.**

**25. 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.**

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25 [ibid](#)

26 [Q18](#)

27 [Q31](#)

28 Care Quality Commission, [NEP0001](#)

## 4 Leadership

### The importance of leadership

26. The NHS Long Term Plan highlighted that “evidence shows that the quality of care and organisational performance are directly affected by the quality of leadership and the improvement cultures leaders create” and that only some parts of the NHS have created and sustained the leadership cultures necessary for outstanding performance.<sup>29</sup> The Minister told us that there was “no excuse for poor leadership”.<sup>30</sup>

27. The PHSO’s report found that there was a lack of leadership from the top of the Trust in response to the two cases and stated that action should have been taken by the Trust’s leadership to tackle the problems repeatedly highlighted to it. In particular, the leadership should have been “driving a culture of learning and improvement to address the serious problems that had been repeatedly highlighted to it” and “putting in place clear oversight of the changes that were needed to achieve this”.<sup>31</sup>

28. An example of the PHSO’s concerns about leadership were highlighted by the response from the NEP to a Freedom of Information request dating back to September 2016. The request asked for the number of attempted suicides since 2006 at the Linden Centre. The PHSO expressed surprise that the Trust stated that this information was not readily available, expecting that the senior leadership team would have already requested such information, given the problems raised at the Linden Centre and across the Trust more widely. Having such information would have given the senior leadership better understanding of what was happening to prevent future incidents.<sup>32</sup> In its written evidence, the Government accepted these concerns saying “We agree with the PHSO that the cases it highlights also raise serious concerns about the effectiveness of leadership within the Trust to engage seriously with patient safety improvement.”<sup>33</sup>

### Improving leadership in the NHS

29. The issue of leadership is by no means unique to the NEP. The NHS Long Term Plan stated “Great quality care needs great leadership at all levels” but highlighted that a survey in 2018 by the King’s Fund and NHS Providers found 8 per cent of Executive Director roles were filled by an interim or vacant, while 37 per cent of trusts had at least one vacant Executive Director post.<sup>34</sup> The Long Term Plan set out steps to improve leadership within the NHS by “doing more to nurture the next generation of leaders by more systematically identifying, developing and supporting those with the capability and ambition to reach the most senior levels of the service.”<sup>35</sup>

30. In *The state of care in NHS acute hospitals*, the CQC concluded that effective leadership, which is values-driven and has a strong culture of learning, delivers high-

29 [The NHS Long Term Plan](#), NHS, January 2018, p89

30 [Q32](#)

31 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019, p.13

32 [Ibid](#), p 8

33 Department of Health and Social Care, [NEP0004](#)

34 [The NHS Long Term Plan](#), NHS, January 2018, p89

35 [Ibid](#)

quality care. In hospitals which were rated good or outstanding, the trust boards had enabled a culture where staff felt valued and empowered to suggest improvements and question poor practice.<sup>36</sup>

31. In written evidence the CQC reiterated the need to develop strong leadership across trusts in order to “prevent fatalities and in driving the highest standards of care and patient safety in health and social care”.<sup>37</sup> It further stated it was important that trust leaders, as is evident from their inspection catalogue, embed “change through the creation of an environment, where potentially fatal practices are fully explored, and learning encouraged via sufficient resources and staff training”.<sup>38</sup>

32. In its written evidence to this inquiry, the CQC highlighted good practice when it comes to leadership in the NHS:

This includes having a specific lead, at a senior level in the trust, to drive forward work on post-death learning and action. It requires senior management and board support, ensuring serious incidents are considered a priority and that this is filtered across the organisation. In line with this, trust leaders need to take a long-term view by investing and building the necessary capabilities and capacity to robustly investigate adverse circumstances, such as deaths, and to foster staff members’ understanding of how to improve patient care.<sup>39</sup>

33. The Government explained in written evidence that a “People Plan” will be published “later this year” (an *Interim People Plan* was published in June<sup>40</sup>), which will “set out their proposals on NHS leadership, with a focus on Board level engagement with safety and learning from incidents”. The Department of Health and Social Care suggested this would help prevent recurrence of failures to engage with safety, learn from incidents and take effective and timely action.<sup>41</sup>

34. Mr Vineall further commented on the future steps that the Department plans to take:

I mentioned the [interim] people plan before, which came out in the summer. One of the chapters is about leadership—and another document is enthused about leadership—and there are some things that we have committed to do now, during 2019–20, which include: first, as the Minister said, establishing effectively what we mean by leadership, as fully understood across the NHS; secondly, ensuring that the CQC reviews its “well-led” framework to ensure a greater emphasis on leadership, which in a sense is a theme of this report and others; and also having more talent boards across the NHS, as well as some very straightforward things—or seemingly straightforward—such as having a central database of directors, so that we know where the leadership comes from.<sup>42</sup>

36 [The state of care in NHS acute hospitals: 2014 to 2016 Findings from the end of CQC’s programme of NHS acute comprehensive inspections](#), Care Quality Commission, p 8

37 Care Quality Commission, [NEP0001](#)

38 [Ibid](#)

39 Care Quality Commission, [NEP0001](#)

40 [Interim NHS People Plan](#), published 3 June 2019, NHS Improvement

41 Department of Health and Social Care, [NEP0004](#)

42 [Q32](#)

35. 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.*

## 5 Developing a culture of learning

### The value of a healthy learning culture

36. The King's fund, an independent charity with the aim of improving health and care in England, has argued that healthy cultures in NHS organisations are crucial to ensuring the delivery of high-quality patient care. Below is a list of characteristics they have stated are fundamental to a healthy culture:

- Inspiring vision and values;
- Goals and performance;
- Support and compassion;
- Learning and innovation;
- Effective teamwork; and
- Collective leadership.<sup>43</sup>

37. 37. When the word 'culture' is used, it must be clear that this refers to the attitudes and behaviour which people in the organisation tend to adopt. It further emphasised the importance of sustaining a culture of high-quality care which involves all staff focusing on continual learning and improvement of patient care. It wrote that all staff should encourage, welcome and explore feedback and treat complaints and errors as opportunities for learning across the system rather than as a prompt for blame. This encourages collective openness to and learning from errors, near misses and incidents. A focus on improvement should ensure that:

- Teams at all levels collectively take time to review and improve their performance.
- Quality and patient safety practices are an ongoing priority for all.
- There are high levels of dialogue, debate and discussion across the organisation to achieve shared understanding about quality problems and solutions.<sup>44</sup>

38. The PHSO identified a failure of the NEP to develop the learning culture necessary to prevent similar mistakes from being repeated. The evidence outlined in the report demonstrated serious deficiencies in the culture of learning and improvement across the NEP, the PHSO suggested:

There could be valuable learning taken from a more fundamental review of the approach to leadership, learning and improvement at NEP and why the pace of change only seemed to improve following the merger to create EPUT. It is important that the opportunity to do this is not lost.<sup>45</sup>

43 <https://www.kingsfund.org.uk/projects/culture>

44 <https://www.kingsfund.org.uk/projects/culture>

45 [Missed opportunities: What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust](#), Parliamentary and Health Service Ombudsman, 11 June 2019, p9

39. They further stated the Trust's leadership should have been driving a culture of learning and improvement to address the serious problems that had been repeatedly highlighted to it. The PHSO recommended that the review should also include:

An assessment of whether there is specific learning that could contribute to existing initiatives on mental health safety improvement, as identified in NHS Improvement's own consultation on the NHS safety strategy, including the ambition to prevent all inpatient suicides<sup>46</sup>

40. In January 2016, almost seven years after Mr R's death, the CQC released an inspection report which highlighted concerns about whether the NEP was learning from incidents and if it is being active in preventing them from reoccurring.<sup>47</sup>

41. The Royal College of Psychiatrists, in written evidence to the inquiry, emphasised the importance of learning from every death, whether or not it meets the criteria for a Serious Incident Investigation.<sup>48</sup>

### Embedding a healthy learning culture in the NHS

42. In evidence to this inquiry, the Government stated it introduced the Learning from Deaths Programme in 2017 aiming to improve the review, investigation, reporting and transparency about hospital deaths. The Learning from Deaths programme also provided guidance to the NHS on improving investigations and learning from incidents with a focus on mental health.<sup>49</sup> Further guidance was issued focusing on bereaved families with specific references to working with families bereaved by suicide.<sup>50</sup>

43. The Care Quality Commission, in evidence to this inquiry, outlined various aspects which can either aid or inhibit a provider's ability to secure high patient safety standards. These include:

- values and behaviours that encourage engagement with families and carers and support for staff;
- clear and consistent leadership and governance by a specific person who is at a reasonably high level in a trust's hierarchy;
- a positive, open and learning culture that encourages staff to speak up about safety issues and has a focus on improving the care of patients;
- staff with the resources, training and support to carry out reviews and investigations; and
- positive working relationships with other organisations also providing care for the person who has died, to enable the sharing of information and learning from any investigation.<sup>51</sup>

46 [https://www.ombudsman.org.uk/sites/default/files/page/Missed\\_opportunities\\_What\\_lessons\\_can\\_be\\_learned\\_from\\_failings\\_at\\_the\\_North\\_Essex\\_Partnership\\_University\\_NHS\\_Foundation\\_1.pdf](https://www.ombudsman.org.uk/sites/default/files/page/Missed_opportunities_What_lessons_can_be_learned_from_failings_at_the_North_Essex_Partnership_University_NHS_Foundation_1.pdf) p.14

47 [https://www.cqc.org.uk/sites/default/files/new\\_reports/AAAE1332.pdf](https://www.cqc.org.uk/sites/default/files/new_reports/AAAE1332.pdf)

48 Royal College of Psychiatrists, [NEP0003](#)

49 [National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care](#), National Quality Board, March 2017

50 [Ibid](#)

51 Care Quality Commission, [NEP0001](#)

**44. 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.**

### Involvement of families and carers in the forthcoming review

45. Mrs Leahy, the mother of one of the deceased, described in written evidence to the Committee a lack of involvement in the potential upcoming NHS England and Improvement review:

We have not received any contact from them to indicate where, when, how and to what ends this review will take place. Engaging in review and review, is exasperating and confusing, it feels like we are moved from one agency to another, each defining their remit to exclude some of the elements of Matthew's care we believe need to be highlighted.<sup>52</sup>

46. In oral evidence the Minister assured us that:

When the NHS England and NHS Improvement regional body moves in to undertake its investigation, we will ask that it discusses all elements of the investigation with family members as a priority, so that their voices will be heard through the process. It will not be us discussing them and being unable to discuss individual cases; they will have input into the review. Their stories will be heard. Their questions will be put and, hopefully, answered. They will have a considerable input into the investigation, when NHS England and NHS Improvement take over.<sup>53</sup>

**47. 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.***

### *Calls for a public inquiry*

48. In evidence to this inquiry, Mrs Leahy stated there had been a call for a Public Inquiry.<sup>54</sup> Supporters of the call for a public inquiry include Anonymous Service Users, Members of Parliament and Charity supporters. There had also been a petition to the UK Government calling for a public inquiry to take place which received over 49,000 signatures.<sup>55</sup>

49. In oral evidence, the Minister explained the Department's position on calls for a public inquiry:

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52 Melanie Leahy, [NEP0005](#)

53 [Q10](#)

54 Melanie Leahy, [NEP0005](#)

55 <https://petition.parliament.uk/petitions/255823>, accessed 24 October 2019

public inquiries do not happen for individual cases; they tend to happen when there is a systemic problem or there are multiple cases. In this case, a public inquiry is not an appropriate response because we are talking about two cases. That is the answer I have been given.<sup>56</sup>

## Improving health service investigations

50. It is vital that, when serious incidents occur in the NHS, families can have confidence that effective investigations will take place which facilitate learning to avoid such incidents being repeated. The written evidence we received to our inquiry has indicated a lack of such confidence. Melanie Leahy described her lack of trust in investigative processes.<sup>57</sup> Mr Robert Wade also expressed a lack of confidence in the NEP's investigations.<sup>58</sup>

### *Health Service Safety Investigations Bill*

51. In the Queen's Speech 2019, the Government announced plans to introduce a Health Service Safety Investigations Bill.<sup>59</sup> This would establish the Health Service Safety Investigations Body (HSSIB). This was an approach that originated from our predecessor Committee.<sup>60</sup> We have since repeated calls for the Healthcare Safety Investigation Branch to be given a proper statutory basis, most recently in our report on eating disorders.<sup>61</sup>

52. In the oral evidence session, the Minister explained her intention for the upcoming Bill to act as a catalyst towards creating a culture of learning in the wider NHS system:

It's about learning. It's about the NHS becoming an organisation of learning and improvement rather than fear of blame or liability. That is the change that will happen, and the safe space is what brings all this about.<sup>62</sup>

53. Mr Vineall further explained how the 'safe space' principle of HSSIB investigations will help investigations:

The safe space principle that HSSIB will operate basically resolves that and allows for things to be heard in privacy and to then go forward and contribute to the investigation. We are doing that, first, because we think it is effective and, secondly, because we have learned that, as the Minister was saying and as you started your remarks with, the culture that exists in the NHS at the moment—in places, not everywhere—for better or for worse, is not always as open as it should be.<sup>63</sup>

**54. We welcome the inclusion of Health Service Safety Investigations Bill (HSSIB) in the Queen's Speech, a piece of legislation that the Committee has strongly supported for many years. In particular we believe that the introduction of the 'safe space'**

56 [Q55](#)

57 [Melanie Leahy, NEP0005](#)

58 [Mr Robert Wade, NEP0002](#)

59 [Queen's Speech 2019](#)

60 Sixth Report from the Public Administration Select Committee of Session 2014–15, [Investigating clinical incidents in the NHS](#), HC 886, March 2015

61 Seventeenth Report from the Public Administration and Constitutional Affairs Committee of Session 2017–19, [Ignoring the Alarms follow-up: Too many avoidable deaths from eating disorders](#), HC 855, June 2019

62 [Q12](#)

63 [Q12](#)

principle will facilitate more open investigations and proper learning to reduce repeated incidents. We recommend that the Bill be included in the Queen's Speech following the upcoming General Election.

55. 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.*

### **The need for a Public Service Ombudsman Bill**

56. In our report, *PHSO Annual Scrutiny 2017/18: Towards a Modern and Effective Ombudsman Service*, we called for legislation to reform the governance of the PHSO to be to be scrutinised by a joint committee of both Houses of Parliament as soon as possible.<sup>64</sup>

57. *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.*

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64 [PHSO Annual Scrutiny 2017/18: Towards a Modern and Effective Ombudsman Service](#), Sixteenth Report of the Public Administration and Constitutional Affairs Committee of Session 2017–19, 19 March 2019, HC 1855

# Conclusions and recommendations

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## 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)
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)

## 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)

## 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)
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)
6. We welcome the inclusion of Health Service Safety Investigations Bill (HSSIB) in the Queen's Speech, a piece of legislation that the Committee has strongly supported

for many years. In particular we believe that the introduction of the ‘safe space’ principle will facilitate more open investigations and proper learning to reduce repeated incidents. We recommend that the Bill be included in the Queen’s Speech following the upcoming General Election. (Paragraph 54)

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)
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)

# Formal minutes

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**Thursday 31 October 2019**

Members Present

Sir Bernard Jenkin, in the Chair

Kelvin Hopkins      Mr David Jones

David Morris

Draft Report (*Follow up on PHSO report: missed opportunities: what lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 57 read and agreed to.

Summary agreed to.

*Resolved*, That the Report be the Second Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

[Adjourned till Tuesday 5 November 2019 at 09.30am

## Witnesses

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The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

### Tuesday 15 October 2019

**Nadine Dorries MP**, Parliamentary Under Secretary of State for Mental Health, Suicide Prevention and Patient Safety, Department of Health and Social Care, **William Vineall**, Director of Acute Care and Quality Policy, Department of Health and Social Care, and **Professor Tim Kendall**, National Clinical Director for Mental Health, NHS England and NHS Improvement

[Q1–59](#)

## Published written evidence

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The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

NEP numbers are generated by the evidence processing system and so may not be complete.

- 1 Care Quality Commission ([NEP0001](#))
- 2 Department of Health and Social Care ([NEP0004](#))
- 3 Leahy, Melanie ([NEP0005](#))
- 4 NHS England and Improvement East ([NEP0007](#))
- 5 Royal College of Psychiatrists ([NEP0003](#))
- 6 Supporters and Anonymous Service Users ([NEP0006](#))
- 7 Wade, Mr Robert ([NEP0002](#))

## List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

### Session 2017–19

First Report	Devolution and Exiting the EU and Clause 11 of the European Union (Withdrawal) Bill: Issues for Consideration	HC 484
Second Report	Parliamentary Boundary Reviews: What Next?	HC 559 (HC 1072)
Third Report	PHSO Annual Scrutiny 2016–17	HC 492 (HC 1479)
Fourth Report	Ensuring Proper Process for Key Government Decisions: Lessons Still to be Learned from the Chilcot Report	HC 854 (HC 1555)
Fifth Report	The Minister and the Official: The Fulcrum of Whitehall Effectiveness	HC 497 (HC 1977)
Sixth Report	Accounting for Democracy Revisited: The Government Response and Proposed Review	HC 1197
Seventh Report	After Carillion: Public sector outsourcing and contracting	HC 748 (HC 1685)
Eighth Report	Devolution and Exiting the EU: reconciling differences and building strong relationships	HC 1485 (HC 1574)
Ninth Report	Appointment of Lord Bew as Chair of the House of Lords Appointments Commission	HC 1142
Tenth Report	Pre-Appointment Hearings: Promoting Best Practice	HC 909 (HC 1773)
Eleventh Report	Appointment of Mr Harry Rich as Registrar of Consultant Lobbyists	HC 1249
Twelfth Report	Appointment of Lord Evans of Weardale as Chair of the Committee on Standards in Public Life	HC 930 (HC 1773)
Thirteenth Report	A smaller House of Lords: The report of the Lord Speaker's committee on the size of the House	HC 662 (HC 2005)
Fourteenth Report	The Role of Parliament in the UK Constitution Interim Report The Status and Effect of Confidence Motions and the Fixed-term Parliaments Act 2011	HC 1813 (HC 2065)
Fifteenth Report	Status of Resolutions of the House of Commons	HC 1587 (HC 2066)
Sixteenth Report	PHSO Annual Scrutiny 2017/18: Towards a Modern and Effective Ombudsman Service	HC 1855 (HC 2640)
Seventeenth Report	Ignoring the Alarms follow-up: Too many avoidable deaths from eating disorders	HC 855 (CP 105)

Eighteenth Report	Governance of official statistics: redefining the dual role of the UK Statistics Authority; and re-evaluating the Statistics and Registration Service Act 2007	HC 1820 (HC 2656)
Nineteenth Report	Strategic Leadership in the Civil Service: Sustaining Self Governance and Future Capability while Supporting the Government of the Day	HC 1536 (HC 2687)
Twentieth Report	The Role of Parliament in the UK Constitution: Authorising the Use of Military Force	HC 1891 (HC 251)
Twenty-First Report	Work of the Committee since the 2017 General Election	HC 2658
First Special Report	Will the NHS never learn? Follow-up to PHSO report 'Learning from Mistakes' on the NHS in England: Government Response to the Committee's Seventh Report of Session 2016–17	HC 441
Second Special Report	The Future of the Union, part two: Inter-institutional relations in the UK: Government Response to the Sixth Report from the Committee, Session 2016–17	HC 442
Third Special Report	Lessons still to be learned from the Chilcot inquiry: Government Response to the Committee's Tenth Report of Session 2016–17	HC 708
Fourth Special Report	Government Response to the Committee's Thirteenth Report of Session 2016–7: Managing Ministers' and officials' conflicts of interest: time for clearer values, principles and action	HC 731
Fifth Special Report	Parliamentary Boundary Reviews: What Next?: Government Response to the Committee's Second Report	HC 1072
Sixth Special Report	PHSO Annual Scrutiny 2016–17: Government and PHSO Response to the Committee's Third Report	HC 1479
Seventh Special Report	Ensuring Proper Process for Key Government Decisions: Lessons Still to be Learned from the Chilcot Report: Government Response to the Committee's Fourth Report	HC 1555
Eighth Special Report	Government Response to the Committee's Eighth Report: Devolution and Exiting the EU: reconciling differences and building strong relationships	HC 1574
Ninth Special Report	Government Response to the Committee's Seventh Report: After Carillion: Public sector outsourcing and contracting	HC 1685
Tenth Special Report	Government Response to the Committee's Tenth Report: Pre-Appointment Hearings: Promoting Best Practice, and to the Committee's Twelfth Report: Appointment of Lord Evans of Weardale as Chair of the Committee on Standards in Public Life	HC 1773
Eleventh Special Report	Government Response to the Committee's Fifth Report: The Minister and the Official: The Fulcrum of Whitehall Effectiveness	HC 1977
Twelfth Special Report	Government Response to the Committee's Thirteenth report: A smaller House of Lords: The report of the Lord Speaker's committee on the size of the House	HC 2005

Thirteenth Special Report	Government Response to the Committee's Fourteenth Report: The Role of Parliament in the UK Constitution Interim Report The Status and Effect of Confidence Motions and the Fixed-term Parliaments Act 2011	HC 2065
Fourteenth Special Report	Government Response to the Committee's Fifteenth Report: Status of Resolutions of the House of Commons	HC 2066
Fifteenth Special Report	PHSO Annual Scrutiny 2017–18: Towards a Modern and Effective Ombudsman Service: Government and PHSO Response to the Committee's Sixteenth Report	HC 2640
Sixteenth Special Report	Governance of official statistics: redefining the dual role UK Statistics Authority; and re-evaluating the Statistics and Registration Service Act 2007: The UK Statistics Authority response to the Committee's Eighteenth Report	HC 2656
Seventeenth Special Report	Government response to the Committee's 19th Report: Strategic Leadership in the Civil Service: Sustaining Self-Governance and Future Capability while Supporting the Government of the Day	HC 2687

### Session 2019

First Report	Electoral Law	HC 244
First Special Report	Government Response to the Committee's 20th Report of Session 2017–19: The Role of Parliament in the UK Constitution: Authorising the Use of Military Force	HC 251