NHS England safe and wellbeing reviews: thematic review and lessons learned

NHS England has published a thematic review and lessons learned from its national review to check the safety and wellbeing of all people with a learning disability and autistic people who are being cared for in a mental health inpatient setting. The safe and wellbeing reviews (SWRs) were undertaken as part of the NHS response to the safeguarding adults review concerning the deaths of three individuals at Cawston Park Hospital between April 2018 and July 2020. If you have any questions or comments please contact NHS Providers senior policy advisor, Ella Fuller (ella.fuller@nhsproviders.org).

Key points

- The reviews indicated that for many people, their care and treatment in hospital was appropriate, and that the care they were receiving was safe and in line with expected standards.

- However, in some cases the reviews indicated that people were not receiving enough support to stay physically healthy, and that people did not have enough to do during the day, which impacted on their mental health and wellbeing. There was some evidence of high levels of restrictive practice and people's medication not always being reviewed in a timely way.

- 41% of people reviewed had needs that could be met outside of hospital, and some people did not have clear plans in place for their care or treatment, or for their journey out of their current hospital setting. The reviews also indicated that not enough was being done to support people to maintain links with friends and family, or to access support from an independent advocate.

- The report sets out a range of key considerations across the following themes: appropriate care setting; involving family members and carers; advocacy; wellbeing and positive mental health; harm reduction and safeguarding; people's physical health; workforce; and discharge.

- Aspects of the review process, including the introduction of an integrated care system (ICS) panel, will be incorporated into arrangements for quality oversight moving forward. Many local systems and regions have already developed their own action plans and responses in relation to their learning from the reviews to address issues identified and ensure all people in hospital have a clear plan for their care. NHS England will bring partners together to look at specific actions over the next 12 months that will address the challenges and themes highlighted through this thematic review.

Context

The SWRs were for children, young people and adults who: have a learning disability or are autistic; and were recorded in the Assuring Transformation dataset as being in an NHS or independent mental health, learning disability or autism inpatient setting on 31 October 2021.

Each SWR included: a review of the person's care, education and treatment review (CETR) and care programme approach (CPA) records; conversations with family and/or advocates (where permission was given and people were available); a review of people's safety, physical and mental health and quality of life; face-to-face visits with people, which included the requirement for a "sit and see" element; and oversight of the review by an ICS panel.

Findings from individual reviews were summarised in ICS reports, before being summarised further into regional reports by NHS England regional teams. In April 2022, NHS England commissioned a thematic review of the key findings based on the seven regional reports that were produced following the majority of SWRs having taken place by May 2022 (1,770 individual reviews had been carried out and reviewed by ICS panels).

Key findings

Appropriate care setting

59% of people were regarded as having care and treatment needs that could only reasonably be delivered in hospital. This varied by region, with the South West having the lowest proportion of people (47%) and London having the highest proportion of people (73%).

41% of patients had needs that could be met in the community with appropriate support. The issues impacting their ability to be discharged included:
- A lack of suitable accommodation available (this reason affected 19% of people).
- Identified or suspected delays in rehabilitation and discharge pathways with aftercare in place.
- Staff not always being trained to support people to move to community settings.
- Legal barriers – ongoing concerns for public safety and legal processes were a barrier for 14% of people in rehabilitation and secure services in one region.
- A lack of a clear formulation and/or care place (this affected 7% of people).

Other key issues around this theme related to:

- Out of area placements (OAPs): 57% of people were in OAPs. There was significant regional variation, with 34% of people in North East and Yorkshire being in OAPs compared to 73% of people in the South West.
- Forensic secure services: there were concerns relating to these services and people requiring Ministry of Justice agreement to different types of leave and a step-down to less restrictive environments, with a sense from the reviews that there were sometimes avoidable delays.
- Ward type and environment: there were examples of people being placed in psychiatric intensive care units on a long-term basis because of a lack of alternative provision, a lack of reasonable adjustments for autistic people, and children's wards not being child-friendly enough.

Key considerations identified by the review

- It is imperative that all health and social care commissioners working within an ICS identify and implement the actions required to support people to leave hospital where it has been found that their care and treatment needs no longer require hospital care.
- Where a person may require a bespoke package of care in the community, it is important that planning these services begins from the moment they are admitted, to help ensure an appropriate placement is available once the person is ready for discharge.
- For people who are not in very specialised services and who are placed outside of their ICS footprint, it may be in their best interest and/or their preference to move to an alternative setting for their hospital treatment closer to home.
- Consideration should be given as to whether the current approach to commissioner oversight of patient care has sufficient impact on improving the quality and safety of people's care and ensuring they are in the most appropriate setting for their needs.
- Staff training is essential in terms of the sensory and sensitivity needs of people, and a person-centred approach is required to understand people's unique preferences and requirements.
- Commissioners and providers may wish to analyse the data from individual reports for their ICS to further review the theme around reasonable adjustments and related subjects e.g. sensory needs.
- Further consideration should be given to the differences between regions in relation to the amount of variation in formulation planning.

Involvement of family members and carers

There were some examples of effective communication between organisations and family members, but these were outweighed by examples of poor communication. There were reports of families being excluded from planning and decisions, not being provided with basic information such as how to contact family members and visiting times, and not being listened to.

It was raised that commissioners and providers should do more to proactively engage with families by increasing their involvement in reviews and their family member's care, and proactively providing relevant information. Several regions reported that placements in hospitals far away from home, transport costs and restricted visiting hours presented challenges for family visits and communication. Some families also reported that it could be difficult to contact the ward by phone. There was some evidence that there was less engagement with family members and advocates for people who had been an inpatient for a long period of time, particularly in forensic settings.

Key considerations identified by the review

- Consideration needs to be given to exploring this theme further and identifying and implementing measurable ways of improvement.
- Individual choice must be respected with regard to family involvement.
- Where families are not involved, providers should seek to support people and families to re-engage with one another where appropriate and possible.
- Families would benefit from more support, so they can better understand their loved one's rights and what they can expect in terms of communication, care review processes and discharge.
- It is important that commissioners and providers support families to maintain involvement (in line with individual choice and consent) when time, distance and resources present challenges to this.

Advocacy

The importance of advocacy was a strong theme, and the availability and quality of advocacy for people in hospital was found to be generally inconsistent. There were some positive examples related to advocacy, such as advocates supporting people's cultural and religious needs and positively impacting treatment and discharge plans. Some providers also offered an 'opt out' advocacy service.

The role of an advocate was not always fully understood by providers or people, and information around their role and importance was either not always made available, or communicated in a clear, concise and compelling way. Several ICSs noted that some providers were resistant to creating a "culture of importance" around advocacy. For example, independent advocacy was not always offered as a reasonable adjustment or generic provision was the only offer.

Many systems reported challenges in relation to advocacy awareness and involvement, including limited attempts by providers to contact advocates and proactively involve them in processes and decisions relating to people's care. It was also noted that there was a lack of proactivity in

encouraging people to engage with an advocate. Some people who had had prolonged admissions to forensic services were less likely to engage with an advocate. Several ICSs in one region noted that the independence of advocates could be compromised if they were contracted by the provider.

Key considerations identified by the review

- Further consideration needs to be given to the challenge of both perceived and real independence of advocacy when it is commissioned by a mental health inpatient provider.
- Proactive efforts should be made to encourage people in hospital to take up advocacy. This should include clear communication with people and their families about the role of an advocate and the benefits they can provide. For people that do not initially opt for an advocate, they should be offered new opportunities to engage an advocate over time.
- Providers should proactively involve advocates in processes and decisions that affect people in inpatient units.

Harm reduction and safeguarding

Three per cent of people required a safeguarding concern to be raised to the local authority as a direct result of the SWR process. In the South East and South West, no safeguarding concerns were raised, while in the London, 6% of people had safeguarding concerns raised. None of these concerns led to either people or units being raised for escalation or support with NHS England.

There were examples of a 'risk averse culture' discouraging 'positive risk-taking', leading to increased restrictions, and driving a resistance to transferring or discharging people or allowing them to take Section 17 leave. Acknowledging that providers often face complex decisions around risk, some stakeholders raised the possibility of setting up a network of peer support to enable the sharing of best practice around positive risk-taking.

Further themes raised regarding practice and harm reduction included:
- autistic people experiencing inconsistent and/or high levels of restraint, seclusion and segregation
- people not being assessed appropriately under the Mental Capacity Act (MCA) or in a timely way
- the harms associated with weight gain during admission and long lengths of stay
- the standard and inconsistency of incident reporting
- the potential inappropriate and inconsistent use of medication.

Key considerations identified by the review

- Services must consider the various sources of information about 'what good looks like' and deliver high quality care and treatment at all times.
- ICS panels should do further work to understand the source of safeguarding concerns, variation across regions, and consistency around escalation.
- ICS panels should ensure they have oversight of and actions in place to address the use of restrictive practices.
- All inpatient providers are required to meet the Care Quality Commission requirement to ensure staff receive training on learning disability and autism. This must include training around use of the MCA and autism awareness specifically.
- Providers may benefit from a network of peer support and national guidance to enable the sharing of best practice around positive risk-taking.
- Inpatient providers and NHS-led Provider Collaboratives should be reminded of their STOMP-STAMP commitments in relation to the appropriate use of medication. Consideration should be given to the aspects of SWRs that enabled greater oversight and action to address harm and safety issues and how these can inform ongoing oversight.
- Due consideration should be given to ensuring all settings and care and treatment practices balance safety, autonomy and helping the person to recover so they receive a prompt discharge.

People's physical health

There were multiple references in regional reports to people with a high body mass index and significant weight gain following being admitted to hospital, including instances where this led to people developing diabetes. The most common reasons for this were: a lack of physical activity and access to outdoor space; an overreliance on 'treats' and a lack of means and ability for people to choose and/or prepare their own food; boredom; a lack of ongoing advice and support to promote healthier lifestyle choices; and potential side effects to medication. Reference was made to the limited access of physical activity as a result of Covid-19 restrictions. There was a general theme around activities for people appearing to focus on watching television or going shopping, with limited evidence of building life skills e.g. meal planning and preparation.

There were some positive examples around weight management, such as an initiative to remove unhealthy vending machine snacks and work proactively to pool budgets with the catering department of the organisation to ensure a range of healthy options were made available.

There were mixed comments on ensuring people had equitable access to all aspects of healthcare, including eye, dental, hearing and sexual health checks, screening and access to other services, such

as podiatry, electrocardiograms and vaccinations. There were inconsistences around access to and support following annual health checks and planning for people with a learning disability. There were also examples of overprescribing of medication.

Key considerations

- People in a mental health inpatient setting should receive the same standard of physical healthcare as any other member of society, including access to health screening.
- It is important that providers make explicit provision through staffing, resources and care planning to mitigate the impact of restricting a person's access to day-to-day physical activity or time spent out of the ward environment on their physical health.
- Health screening should be as accessible to people in hospital as it is in a community setting.
- It is important that the health approach is holistic, recognises these potential interactions and people have access to relevant specialist advice in a timely manner when needed.
- Medication management should be optimised and fully understood by staff.
- If staff are unable to engage people with heathy eating and/or exercise for any reason, this should be explicitly included and addressed in risk and care planning. It is important that providers explore a range of approaches, and consider reasonable adjustments, to support people to engage with making healthy choices.
- Commissioners should consider how their contracts with providers of mental health inpatient care can be used to make explicit providers' responsibilities relating to supporting people to stay physically healthy.

Supporting individual wellbeing and positive mental health

Significant concern was raised around the lack of meaningful activities in hospital and the 'boredom' people experienced as a result. It was reported that meaningful activities were not consistently available, and where they were, were not always age-appropriate, co-planned and person-centred. There was also a lack of activities to improve people's skills in preparation for their lives and wishes outside hospital, which included but was not limited to, effective access to education and learning.

One good practice example from a hospital unit involved therapy teams planning activities to align with a person's care plan. Activities were often hampered by a lack of staff availability to support sessions/outside activities or financial resources being available for activities outside the hospital.

People's wellbeing and quality of life were also impacted by: delayed discharges; distance from family; a lack of social connection; a ward's risk management plan and strategy; and issues/difficulties relating

to staff or other inpatients. Some concern was raised about whether eating disorders were being factored into the general understanding of the person's overall physical health.

Key considerations

- Providers and commissioners of inpatient services should consider the routine use of quality of life measures upon admission, and use quality of life audits as a core part of service quality improvement initiatives.
- Giving people the opportunity to do more meaningful activities can help provide a structure to their day and reduce stress, frustration and boredom. It can also help to increase their social interactions, relieve anxiety and improve physical and mental wellbeing.
- Meaningful activities should be co-designed with additional relevant teams (for example, therapy teams) as standard.
- People should only be in hospital if there is a clear therapeutic benefit that cannot be achieved outside of the hospital setting.
- The risk of loneliness should be considered on a person-by-person basis to explore whether someone needs and desires more social activities and support to make friends.

Workforce

Issues arising as a result of a lack of staff was a significant theme, with Covid-19 an exacerbating factor. Families and advocates raised concerns about whether wards were unsafe when there were significant staff shortages on them. Various ICSs recognised the impact that staff shortages had on people and their ability to access quality activities, which in turn had an effect on their physical and mental health. Staff 'burnout' was referenced in more than one regional report.

There were reports of a heavy reliance on agency and/or temporary staff. This had negative impacts on people being able to access regular activities and on patient-staff relationships. Poor staff culture, particularly 'institutionalisation' and risk aversion, was often raised as a key theme.

There were several reports of staff not having the appropriate training or skillset to effectively meet the needs of people. Some of the suggested training needs related to developing person-centred service specifications, trauma-informed care and therapy, understanding and using the Mental Health Act (MHA) and developing SMART (specific, measurable, achievable, realistic and time-bound) actions. In addition, there were several reports of staff not having specific learning disability and autism training, though there was evidence of organisations already acting on this.

There were several examples of best practice around multi-disciplinary teams in inpatient settings, including: speech and language therapists working in innovative and caring ways with people who may have no speech or verbal communication; dieticians working closely with core clinical teams to support holistic healthy eating plans, rather than specific dietary issues; and clinical teams providing person-centred care that addressed both the physical and mental health needs of a person. However, these examples were largely ad hoc and did not offset the overall theme of a lack of specialist professionals being available to support wider care and treatment.

Feedback was gathered about the impact of the current oversight framework, CETRs, CPAs, and commissioner oversight visits on current workforce availability. It was reported that it was challenging to form various panels and make sure those on panels had the right skills and experience. There was also a perception that review processes were removing staff from core clinical duties.

Key considerations identified by the review

- Multi-disciplinary teams that bring together a range of clinical and non-clinical skills will improve the quality of care and care planning.
- Continuity of staff should be an important element in the provision of care, especially for autistic people and those who have difficulty forming relationships and trusting new people.
- There is no easy solution to the problem of recruiting and retaining staff, but it is clear that vacancies, high turnover and use of agency staff can have an adverse impact on quality of care and patient experience.
- Staff training should be a priority, with an emphasis on working with autistic people and people with a learning disability, person-centred service specifications, trauma-informed care, therapeutic benefits and understanding and use of the MHA.
- Staff should have the maximum time available to engage in therapeutic and clinical activities.

Barriers to discharge

It was often reported that discharge planning "did not take place early enough", discharge dates were "not realistic", or planning was not being done in collaboration with the person and their family. It was found that deviations from the discharge plans were sometimes not communicated to the person and/or their families or carers. Regional reports referred to the 12-point discharge plan not being used consistently and may be a contributing factor to missing and overdue discharge dates.

Concern was raised around long stays in hospital, with some people being in a particular setting for up to 20 years. There were some suggestions of a staff culture that does not sufficiently address

discharge delays. While the processes around discharge can be time consuming, staff may perpetuate this by accepting such delays as necessary or inevitable.

A lack of timely access to effective after care services was raised as a key barrier to discharge. Some of the issues related to: the availability of appropriate providers for specific types of after care; existing services not having capacity or being reluctant to take on a person; difficulty recruiting staff and pressures on existing staff; and single-person commissioning rather than strategic commissioning.

Other general points raised concerning discharge related to:
- effective advocacy being a key element in effective discharge and discharge planning
- a lack of detail on milestones, targets and outcomes required before progressing discharge
- some services not implementing plans that could be continued into the community
- a lack of clarity in staff understanding around lifestyle changes for a person on Section 17 leave
- public safety concerns forming a barrier to discharge for a minority of people in secure settings.

Key considerations identified by the review

- Best practice around the most appropriate discharge plan for the person should be followed. This includes ensuring the 12-point discharge plan is actively used for all people.
- All discharge planning should be done in conjunction with the person and at least a key person for them, unless the person has mental capacity and has chosen not to have people involved.
- A regular process of reviewing delayed discharge should be in place in each ICS with a clear and rapid escalation route to leadership if required.
- The NHS England Better Care Fund team has expanded its programme of support to systems and this should be considered in light of the themes.
- Why any anticipated or actual deviations from a discharge plan has occurred and what mitigating actions need to be taken to ensure discharge can happen effectively as per a new plan should be communicated to the person and/or family and carers.
- Special care and attention should be given to discharge planning and life planning for anyone with a significantly long length of stay.
- Cultural change may be required to support significant positive changes to discharge.
- Consideration should be given to all available and potentially appropriate settings for a person to be discharged to, with several options available to reduce the likelihood of delay should the primary option become unavailable or unsuitable.

Effectiveness of current oversight and review processes

There were some positive comments about the effectiveness of current oversight and review processes, namely, the commissioner oversight visits, CETRs and care programme approach reviews (CPAs). However, there were many areas of concern such as: the processes being resource intensive and challenging to provide input into; inconsistent use and completion of review documents; and a lack of specifics around discharge planning.

Specifically referring to CETRs and CPAs, concerns were raised around: the reviews not always being carried out; the lack of family involvement; duplication of effort and information; variations between CETRs and CPAs due a lack of a joined-up approach; and inconsistency of CETRs being delivered in line with national guidance. Several stakeholders felt there could be an opportunity to review and potentially streamline current oversight processes.

Learnings from the safe and wellbeing process

Many stakeholders reported that the SWR process was resource-intensive and time-consuming, taking place during immense pressure from Covid-19 and alongside other review processes. There were several reports of the reporting template being restrictive and subjective, limiting the quality and consistency of the feedback. However, the process was found to be a valuable intervention designed to ensure that people with a learning disability and autistic people in hospital were safe and well, and implement change where this was not the case.

Many stakeholders reported that the ICS panels (a new approach tested through SWRs) were highly valuable, enabling: input, oversight and accountability from senior ICS officials partnership working and fresh perspectives from stakeholders with diverse expertise; and the identification of good practice for replication in other areas. The "sit and see" sessions were also identified as a positive element of the SWRs. Some stakeholders suggested that aspects from SWRs should be implemented in ongoing review processes.

Conclusion

The themes and challenges that were reported as affecting multiple systems and regions were not unexpected or new. Many local systems and regions have already developed their own action plans and responses in relation to their learning from the reviews.

However, it is critical now that NHS England, the Building the Right Support Delivery Board, ICSs and partner agencies, are focused on how they can drive the change needed to make sure that people who no longer require care and treatment in a hospital setting can be supported to move to

somewhere they can call home as soon as it is possible to do so. For those who do need to be in hospital, all partners must work together to ensure they receive the very best care and treatment.

Many of the commitments in the NHS Long Term Plan for people with a learning disability and autistic people are already addressing some of these challenges, but there are areas where there needs to be a stronger focus or a different approach.

NHS England, on a national and regional footprint, will bring partners together to look at specific actions over the next 12 months that will address the challenges and themes highlighted through this thematic review.

NHS Providers view

While this national review has found that for many people, their care and treatment in hospital was appropriate, safe and in line with expected standards, the report provides a stark reminder of some of the key challenges in consistently providing the right level and nature of support for people with a learning disability and autistic people. These challenges need to be addressed as a priority and so we welcome NHS England bringing partners together to look at specific actions over the next 12 months.

To improve the access of people with a learning disability and autistic people's to high-quality care and support as close to home as possible, national bodies, providers and their partners must work together to ensure rapid progress is made in five key areas. Firstly, tackling the stigma associated with learning disabilities and autism and raising awareness of the priority that needs to be given to improve accessibility and quality of care here nationally and locally. Secondly, improving and increasing the transparency of funding mechanisms to help drive funding for the sector to the frontline services that need it most and ensure it is invested in the establishment of high-quality services people need where these do not currently exist.

Sustainable levels of revenue and capital funding across health, social care and wider public services, including education, housing and employment support, is also crucial, as is maintaining a focus on the strategic development of the learning disability and autism workforce. Finally, we need to progress the plans set out in the NHS long term plan to support local providers to develop new models of care to provide care closer to home and invest in intensive, crisis and forensic community support.

We welcome NHS England recognising that there are times when admission to a mental health

inpatient setting is appropriate and agree partners must work together to ensure people receive the very best care and treatment while in hospital. It is crucial that discussions and decision making regarding the best approach to delivering high-quality, person-centred care in highly specialist and forensic settings is balanced and evidence-based, taking into account the nature of the care and support provided by these services and the geographic spread of their service user populations.