

Mental Health, Learning
Disability and Autism
provider CEOs

National Mental Health Director
Mental Health Team

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By e-mail

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30 September 2022

Dear Colleagues,

Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services

Like me, you will have been appalled at the BBC Panorama programme which showed patients being abused while in the care of an NHS Trust. It is both heart-breaking and shameful and I know that patient groups, professionals and partners will want to leave no stone unturned to ensure that we collectively do all in our power to identify, eradicate and prevent this kind of abuse from happening.

In the immediate aftermath of the programme we need to proceed on the basis that this could be happening elsewhere. We are urgently considering what more we can do nationally, with regulators, with our inpatient quality programme about to be launched and with issues such as workforce supply. However, abuse is grown and prevented locally by registered staff taking accountability for theirs and other's actions, by teams who regularly review the quality of care they provide, by local leaders who support, challenge and role model, by senior clinicians and managers, who train colleagues and have an open door and by boards who have line of sight to data, complaints, other intelligence, who walk the patch and who create a safe environment for people to speak up about poor care.

Most fundamentally organisations who place the voice of people and families at the heart of their governance, service design and delivery and who have the mindset of "this could happen here" are those most likely to identify and prevent toxic and closed cultures. I know you and your teams will all be reflecting on what you saw and asking yourselves what more you can do to ensure these behaviours and actions are not present in your own services. With this in mind, I am asking you and your teams to urgently undertake the following:

1. Your boards to review the safeguarding of care in your organisation and identify any immediate issues requiring action now; including but not limited to:
 - a. freedom to speak up arrangements,
 - b. advocacy provision,

- c. complaints,
- d. CETRs and ICETRs,
- e. other feedback on services.

We all have a responsibility to our patients and their families to ensure they receive the best possible care, treated with dignity and compassion in safe surroundings. It is vital boards ask:

- could this happen here?
 - how would we know?
 - how robust is the assessment of services and the culture of services?
 - are we visible enough and do we hear enough from patients, their families and all staff on a ward e.g. the porter, cleaner, HCAs?
2. In the programme, patients told those around them of the unsafe and abusive care they were subjected to. In your own organisations you must ask how you are not only hearing the patient voice, but how you are acting on it? When people and families tell us things are not right as leaders, we must take action. You should therefore consider independent peer-led support to people being cared for in your most restrictive settings and peer-led feedback mechanisms.
 3. We also saw the role inappropriate use of restrictive interventions played in the unsafe treatment of patients, including Long Term Segregation and Seclusion. You will want to double down on the efforts in your organisation to tackle and reduce the use of restrictive interventions. You should review why people in your services are in Seclusion and Long Term Segregation, how long for, what is the plan to support them out of these restrictive settings?
 4. We want to ensure that the inpatient quality programme we are about to launch tackles the root causes of unsafe poor-quality care, looking at the best evidence for preventing and uncovering abuse. The work will capture your views about what support, education and information, will best help you prevent and fight abusive and poor care. To this end we are fast tracking the roll-out of the programme and will want to shape it with you, your clinical experts, people with lived experience and partners. Therefore, your feedback to the national team through Liz Durrant (L.Durrant1@nhs.net) our recently appointed head of programme, will be appreciated.

Clearly, there is positive work already in train across many parts of the country, but we must act now to ramp up that action to prevent the formation or perpetuation of toxic and closed cultures, and tackle unacceptable practices; the mindset that 'it could happen here' must be front and centre of each organisation's response to what we collectively witnessed. We must prioritise listening to the people we serve and their families and taking effective action when they tell us something isn't right. The NHS has repeatedly made clear that it expects providers to deliver a safe and high standard of care, and where this is not happening, we will work with partners to take the strongest action possible.

Yours sincerely,

Claire Murdoch
National Director, Mental Health

CC Regional Directors
 Regional Chief Nurses
 Regional Chief Medical Officers
 ICB CEOs

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