

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>10.11.22</b>	<b>Agenda item</b>	<b>Bo.11.22.23</b>

## QUALITY AND SAFETY OF MENTAL HEALTH, LEARNING DISABILITY AND AUTISM INPATIENT SERVICES

Presented by	Professor Karen Dawber, Chief Nurse		
Author	Sarah Turner, Assistant Chief Nurse Vulnerable Adults		
Lead Director	Professor Karen Dawber, Chief Nurse		
Purpose of the paper	To provide an update to the Board of Directors		
Key control			
Action required	To note		
Previously discussed at/ informed by			
Previously approved at:	Committee/Group	Date	
Key Options, Issues and Risks			
<p>In 2022 there have been a number of high profile cases reported in the media of patients within health and social care settings experiencing abuse, neglect and ill treatment. Highlighting that 11 years later despite increased regulation, monitoring and the introduction of statutory Safeguarding Boards lessons do not appear to have been embedded.</p> <p>- Could this happen here?</p> <p>- How would we know?</p> <p>- How robust is the assessment of services and the culture of services?</p> <p>- Are we visible enough and do we hear enough from patients, their families and all staff on a ward eg the porter, cleaner, Healthcare Assistants (HCA)?</p>			
Analysis			
<p>The Covid pandemic in some respects may have contributed to the ability of organisations to be less open and transparent, as face to face contact was significantly reduced. Within the Trust visiting was reduced which meant the ability of others to spot and raise concerns was limited. The engagement of service users in feedback was also limited as again due to support needs of patients with a mental health diagnosis or a learning disability they were often unable to access technology to participate in teams meetings. During this time however, existing specialist teams ensured increase flexibility in working arrangements to ensure patients within the Trust were supported and their voices heard.</p> <p>The employment of specialist roles specifically Mental Health Specialist practitioner and Learning Disabilities lead Nurse has ensured that specific oversight of these patients is able to be undertaken with more effective links with external specialist provision such as Bradford District Care Foundation Trust (BDCFT) and Waddiloves.</p>			
Recommendation			
<p>Further work is planned to provide resources for patients to reduce stimulation and identify any additional needs to staff so reasonable adjustments can be made.</p> <p>Ongoing development of the Core 24 service. Extension of the psychiatric liaison service provided by the Care Trust to Core 24 was established in early 2022. the team has expanded and the scope of their</p>			

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involvement has also. The recruitment of a consultant psychiatrist is currently underway.

Involvement in the Learning Disability and Autism baseline workforce audit exercise with NHS England.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients		g				
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers			g			
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	<div>Low</div> <div>Moderate</div> <div>High</div> <div>Significant</div>					
<b>Explanation of variance from Board of Directors Agreed General risk appetite (G)</b>	<b>Risk (*)</b>					

Risk Implications (see section 4 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments		
Quality implications	x	
Resource implications	x	
Legal/regulatory implications	x	
Diversity and Inclusion implications	x	

Regulation, Legislation and Compliance relevance
<b>NHS Improvement:</b> (Risk assessment framework, quality governance framework, code of governance , annual reporting manual)
<b>Care Quality Commission Domain:</b> <i>Safe, Effective, Responsive</i>
<b>Care Quality Commission Fundamental Standard:</b> responsive
<b>Other (please state):</b>

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## QUALITY AND SAFETY OF MENTAL HEALTH, LEARNING DISABILITY AND AUTISM INPATIENT SERVICES

### 1 PURPOSE/ AIM

The purpose of this paper is to offer assurance in relation to the quality and safety of services for people attending the Trust who have a Learning Disability, Mental Health diagnosis and Autism

### 2 BACKGROUND/CONTEXT

On 31 May 2011, an undercover investigation by the BBC's Panorama programme revealed criminal abuse by staff of patients at Winterbourne View Hospital near Bristol. After its broadcast: A government review was commissioned which found the following:-

- **Patients stayed at Winterbourne View for too long and were too far from home**
- **There was an extremely high rate of 'physical intervention'**
- **Multiple agencies failed to pick up on key warning signs** – nearly 150 separate incidents – including Accident and Emergency (A&E) visits by patients, police attendance at the hospital, and safeguarding concerns reported to the local council
- **There was clear management failure at the hospital**
- **A 'closed and punitive' culture had developed** – families and other visitors were not allowed access to the top floor wards and patient bedrooms, offering little chance for outsiders to see daily routines at the hospital.

In 2022 there have been a number of high profile cases reported in the media of patients within health and social care settings experiencing abuse, neglect and ill treatment. Highlighting that 11 years later despite increased regulation, monitoring and the introduction of statutory Safeguarding Boards lessons do not appear to have been embedded.

In the aftermath of these cases all Health and social care providers were contacted and asked to review their arrangements for ensuring safety of their services and to ask themselves the question "could this happen here?"

Although the majority of the programmes were in specific relation to specialist care facilities, we should acknowledge that some of the themes and risks are present within our Trust. We were asked to review the following points:-

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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. CETR and ICETR,
  - 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.

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### 3 Next steps

There has been work undertaken with Calderdale and Huddersfield Foundation Trust in relation to care plans for patients with a learning disability being available within EPR. Regional involvement in the design and implementation of a training package for staff available on ESR whilst the Oliver McGowan training is finalised and implemented.

Further work is planned to provide resources for patients to reduce stimulation and identify any additional needs to staff so reasonable adjustments can be made.

Ongoing development of the Core 24 service. Extension of the psychiatric liaison service provided by the Care Trust to Core 24 was established in early 2022, the team has expanded and the scope of their involvement has also. The recruitment of a consultant psychiatrist is currently underway.

Involvement in the Learning Disability and Autism baseline workforce audit exercise with NHS England

### 4 RISK ASSESSMENT

In answering the question posed “Could this happen here?” The answer should always be “Yes”. If we start from a position of it could happen within our Trust then we hopefully would ensure that we are constantly asking the right questions and learning from recurrent themes when concerns are raised.

#### **Freedom to Speak up**

We have within the Trust Freedom to Speak up guardians; this has been promoted recently with the Freedom to Speak up week. Information is visible in all clinical and non-clinical areas and available on the intranet. Being able to raise concerns anonymously is important for staff who feel unable to raise things for fear of repercussion.

#### **Advocacy**

In essence all staff should advocate for patients by listening to their concerns and resolving issues and allaying fears, however there are certain circumstances where more formal arrangements are needed. Independent Mental Capacity Advocates (IMCA's) and Independent Mental Health Advocates (IMHA's) must be available and instructed on a patients behalf if that person is unable to voice their views and wishes i.e. where they may lack capacity or are detained under a section of the Mental Health Act.. The safeguarding team facilitate this process, via referral to the commissioned services within the District.

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## Complaints

The complaints process sits within the patient experience team and specific concerns relating to Mental health, Learning disabilities and safeguarding are discussed with the safeguarding team to ensure oversight. This allows for observation of recurrent themes and trends and involvement of external partners as required.

## CETRS and ICETRS

These are Care and Treatment reviews specifically relating to patients with a mental health diagnosis or a learning disability and are specifically related to specialist services.

## Other feedback

Feedback on services is received in a number of other ways. Service user involvement, through community groups such as Healthy lives for patients with a Learning Disability or the Mencap Treat me Well group.

Care Quality Commission (CQC) raise concerns as do the local authority safeguarding team. These concerns require formal responses and escalation. Failure to respond with appropriate assurance would result in more formal action.

1. The Covid pandemic in some respects may have contributed to the ability of organisations to be less open and transparent, as face to face contact was significantly reduced. Within the Trust visiting was reduced which meant the ability of others to spot and raise concerns was limited. The engagement of service users in feedback was also limited as again due to support needs of patients with a mental health diagnosis or a learning disability they were often unable to access technology to participate in teams meetings. During this time however, existing specialist teams ensured increase flexibility in working arrangements to ensure patients within the Trust were supported and their voices heard.

The employment of specialist roles specifically Mental Health Specialist practitioner and Learning Disabilities lead Nurse has ensured that specific oversight of these patients is able to be undertaken with more effective links with external specialist provision such as BDCFT and Waddiloves.

2. The Trust does not have segregation/seclusion facilities. We can however potentially create seclusion by the removal of objects from a person's room and the prevention of them leaving a specific area. Occasionally when a patient displays behaviour of challenge which poses a risk to themselves or others there may be a need to deprive them of their liberty and remove objects which may harm them or could be used to harm someone else. Staff should be vigilant to this and ensure they are following the legal frameworks open to them to ensure this is done in the least restrictive way. Deprivation of Liberty Safeguards (DoLS) and the Mental Health Act (MHA) can and should be used if the person fits the criteria. The safeguarding team regularly deliver training to staff regarding these and are available for support and guidance of staff

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are unclear or unsure. They also undertake ward walks with security to gain visible assurance regarding environments. There is currently estate work underway in AED and AMU in relation to providing some low stimulation rooms for patients with a Mental health or learning disability diagnosis. These areas have been designed to provide low stimulation i.e. soft lighting, less cluttered etc. As we know busy, noisy, chaotic acute wards are often overwhelming for patients with additional needs.

3. Part of the identified work moving forward nationally is in relation to the training of staff in relation to supporting patients with additional needs. The Oliver McGowan training for Learning disabilities was identified as a requirement by CQC in July this year. This training has been delayed nationally but the Trust Learning Disability Nurse is involved in the regional implementation work regarding this. A training package has been devised in the interim which is available on ESR. This package was designed by the lead nurses for Learning Disabilities from BDCFT, BTHFT, LFT and CHFT.

<b>5</b>	<b>Appendices</b>
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Appendix 1 - Letter to Providers dated 30 September 2022.