Lancashire and South Cumbria Integrated Care Board

Integrated Care Board

Date of meeting	7 December 2022
Title of paper	Quality of Mental Health, Learning Disability and Autism Inpatient Services – Response to National Director
Presented by	Professor Sarah O'Brien, Chief Nurse
Author	Sarah O'Brien, Chief Nurse
Agenda item	12(b)
Confidential	No

Purpose of the paper

The purpose of this report is to summarise the actions requested by the National Director for Mental Health and to assure ICB Board that all five of the NHS Trusts in LSC have undertaken these actions with reports going to Trust Boards in November and December 2022.

Executive summary

On the 28th September 2022 the BBC Panorama documentary "Will the NHS Care for Me?" aired shocking footage of patients with a Learning Disability and or Mental Health condition being abused whilst in the care of a Greater Manchester NHS Trust.

Immediately following this Programme (30th September 2022), the National Director for Mental Health wrote to all NHS Trusts, ICBs and regional teams to highlight the unacceptable and inexcusable treatment of patients that was 'heartbreaking and shameful to watch'. Her letter stated that we should assume this could be happening in any organisation and she asked ALL trusts to immediately review inpatient services and assure their Boards.

The five NHS Trusts in LSC have responded to this letter and taken assurances through each Trust Board.

Recommendations

ICB Board is requested to:

1. Note the actions requested by the National Director for Mental Health in response to the BBC Panorama programme exposing poor care in an NHS Trust.
2. Be assured that the five NHS Trusts in LSC took immediate action and each board has received assurance of these actions.
3. Note the ongoing quality assurance work required by each Trust and the ICB to ensure sustainable high quality, safe care in inpatient settings.
4. Note the need to improve how we listen and engage with all patients and especially those with a learning disability and or autism.

Governance and reporting (list other forums that have discussed this paper)

Meeting	Date	Outcomes

ICB Quality Committee	16th November 2022	Discussed a similar paper and noted national letter and actions required

Conflicts of interest identified
'not applicable'

Implications				
If yes, please provide a brief risk description and reference number	**Yes**	**No**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Data Privacy impact assessment completed			x	
Financial impact assessment completed			x	
Associated risks			x	
Are associated risks detailed on the ICB Risk Register?			x	

Report authorised by:	Professor Sarah O'Brien, Chief Nurse

Integrated Care Board – 7 December 2022

Quality of Mental Health, Learning Disability and Autism Inpatient Services – Response to National Director

1. Introduction

1.1 On the 28th September 2022 the BBC Panorama documentary "Will the NHS Care for Me?" aired shocking footage of patients with a Learning Disability and or Mental Health condition being abused whilst in the care of a Greater Manchester NHS Trust.

1.2 Immediately following this programme, the National Director for Mental Health wrote to all NHS Trusts, ICBs and regional teams to highlight the unacceptable and inexcusable treatment of patients that was 'heartbreaking and shameful to watch'. Her letter stated that we should assume this could be happening in any organisation and she asked ALL trusts to immediately review inpatient services and assure their Boards.

1.3 The purpose of this report is to summarise the actions requested by the National Director and to assure ICB Board that all five of the NHS Trusts in LSC have undertaken these actions with reports going to Trust Boards in November and December 2022.

2. Actions Requested of NHS Trust Boards by National Director Mental Health

2.1 The letter stated that all trusts should be reflecting on the programme and asking what else they can do to ensure the poor and abusive actions were not present in their services. It specifically requested that trusts undertook the following actions urgently:

1) Boards to review the safeguarding of care in their 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. Care Education and Treatment Reviews (CETRs) and Independent Care, Education and Treatment Reviews (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) Boards to review how they are engaging with patients and using their experiences to influence and change processes or systems and ensure patient voices are heard if we are not meeting their care or treatment needs. She recommends trusts consider peer led support for patients as well as developing peer led mechanisms for that feedback and how it is acted on. She also suggests trusts consider independent peer led support to people being cared for in the most restrictive settings and peer-led feedback mechanisms.

3) Review use of restrictive interventions, seclusion, and segregation, and plans to support people out of these restrictions.

4) NHSE will shortly launch an Inpatient Quality Programme and she asked trusts to send in feedback to contribute to this programme of work.

3. LSC Response to the National Director letter

3.1 The Panorama programme exposed shocking care within a NHS Trust and the findings from the subsequent reviews will be vital for all trusts to reflect on and learn. The Directors of Nursing and their teams have taken immediate action in each trust in response to the letter and will take a report to each Trust Board to assure them of the safety and quality of the services.

3.2 The ICB Quality Assurance, Mental Health, Learning Disability and Autism teams will continue to work closely with all five trusts (a key component of the quality oversight function of the ICB) to ensure ongoing high standards, open cultures, effective clinical leadership and strong patient engagement across LSC.

3.2 Below is a list of the dates each of the five NHS Trust Boards are receiving a report assuring them of the actions taken in response to the Panorama programme and National Director letter. These reports are available in the public board packs for each organisation.

Blackpool Teaching Hospitals:	**Trust Board 25th October 2022**
East Lancashire Teaching Hospitals:	**Trust Board, 9th November 2022**
Lancashire & South Cumbria FT:	**Trust Board, 24th November 2022**
University Hospitals Morecambe Bay:	**Trust Board, 30th November 2022**
Lancashire Teaching Hospitals:	**Trust Board, 1st December 2022**

4 Conclusions

4.1 The BBC documentary “Will the NHS Care for me?” exposed the worst possible care and treatment for some of our most vulnerable patients. Immediate action was requested of all NHS Trusts to ensure this wasn’t happening in their organisations.

4.2 All five NHS trusts in LSC responded immediately to this request and assurances will have been received by all Trust Boards by the 1st December, however it is essential that all trusts and the ICB remain vigilant and committed to preventing similar incidences of poor care and behaviour within LSC.

4.3 This shocking incident has further highlighted the need to listen effectively and engage with all patients and in particular people with a learning disability.

5. Recommendations

5.1 ICB Board are requested to:

1. Note the actions requested by the National Director for Mental Health in response to the BBC Panorama programme exposing poor care in a NHS Trust.

2. Be assured that the five trusts took immediate action and each Trust Board has received assurance of these actions

3. Note, the ongoing quality assurance work required by each Trust and the ICB to ensure sustainable high quality, safe care in inpatient settings

4. Note the need to improve how we listen and engage with all patients and especially those with a learning disability and or autism.

Sarah O'Brien

21st November, 2022