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Safe and wellbeing reviews

Thematic review and lessons learned

Version 1, 21 February 2023

Contents

1. Context

The safe and wellbeing reviews (SWRs) were set up by NHS England as part of the response to a safeguarding adults review (SAR) and subsequent report concerning the deaths of Joanna, Jon and Ben at Cawston Park, published on 9 September 2021.

Joanna, Jon and Ben were all adults with a learning disability; Joanna and Jon were also autistic. They died in Cawston Park hospital after long inpatient stays.

The primary purpose of the SWRs was to check whether people with a learning disability and autistic people who were being cared for in a mental health inpatient setting were safe and well. Reflecting on the learning from Cawston Park, and other reports and reviews, the SWRs also focused on physical health, meaningful activities for patients, and putting actions in place where there were concerns in these areas. In addition, they sought to understand what was and was not working well for people in hospital and to identify opportunities to improve care.

1.1 Carrying out the safe and wellbeing reviews

The SWRs were for children, young people and adults who:

- have a learning disability or are autistic; and
- were recorded in the Assuring Transformation (AT) dataset[1] as being in an NHS or independent mental health, learning disability or autism inpatient setting[2] on 31 October 2021. Please see pages nine and 10 for further details on data relating to the number of people eligible for a review, and the number of people who received a review.

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[1] There may be people with a learning disability and autistic people who are admitted to specialist mental health inpatient hospitals for a very short period of time and therefore are not entered onto the assuring transformation (AT) database. These people and their care were not included in the scope of the SWB reviews, which included anyone who was on the AT database on the 31 October 2021.

Each SWRs included:

- a review of the person’s care, education and treatment review (C(E)TR) and care programme approach (CPA) records.
- conversations with the person’s family and/or advocates (where permission was given and people were available).
- a review of people’s safety, physical health, mental health and quality of life.
- face-to-face visits with people, which included the requirement for a “sit and see” element not previously specified in review processes.
- oversight of the review by an integrated care system (ICS) panel.

Having completed the SWR for a person, their commissioner was responsible for agreeing and monitoring the completion of any immediate reparative actions required to address issues that were identified as necessary to improve the safety or wellbeing of the person.

Each review was scrutinised by an ICS panel, which included the senior responsible officer for learning disability and autism, people with lived experience (experts by experience), provider collaborative representatives and a senior clinical representative. Many panels also included a local authority representative. The role of the panel was to check that the review was of sufficient quality and that reparative actions were effective and appropriate. The panel could request further information and/or direct additional actions.

Findings from individual reviews were summarised in ICS reports, before being summarised further into regional reports by NHS England regional teams. When regional reports were completed in May 2022, 1,770 individual reviews had been carried out and reviewed by ICS panels.

1.2 Impact of the COVID-19 pandemic

The SWRs took place at a time of considerable impact from COVID-19 on the country and the emergence of the Omicron variant. It was a challenging time for all involved in health and care, including providers, commissioners, people and their families.

Whilst the overall level of COVID-19 restrictions had reduced by the time the reviews took place, there were still significant limitations on visiting and people being able to take Section 17 leave[3] from mental health and learning disability inpatient hospitals. There was also a considerable impact on staffing availability due to the direct and indirect effects of illness and people needing to isolate, and the direct and indirect effects on people's health, both physically and mentally.

COVID-19 also impacted on the availability of staff to carry out the SWRs and to convene the oversight panels in the context of other demands and the restrictions at that time.

1.3 This review

In April 2022, NHS England commissioned the NHS Transformation Unit to carry out a thematic review of the key findings based on the seven regional reports that were produced following the majority of SWRs having taken place as at May 2022.

It was agreed that the review would be carried out in two parallel stages:

1. **Desktop review of thematic findings:** Extracting key themes, learnings and examples of best practice from the seven regional reports provided, as well as 11 ICS reports and 31 supporting documents (including presentations and summary reports).

2. **Engagement with key stakeholders through a series of thematic review sessions:** Facilitating and collating findings from targeted engagement sessions with NHS England regional leads, family members and advocates, commissioners, ICS Oversight Panel members, clinicians, and those involved in provider operations/management.

The key findings are discussed in section 2. This report and associated findings are also available in easy-read format.

There were a number of limitations in relation to the review and this report:

- It was not within the scope to undertake qualitative or quantitative analysis of individual SWR reports. It is right that ICSs, commissioners, and those providing day-to-day care for people make the immediate changes that are

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[3] Section 17 leave enables people who are detained under the Mental Health Act to have a leave of absence from the hospital in which they are detained; this may be for a very short period, or for several weeks. This leave will be part of an agreed care plan for people and is designed to support transition out of hospital and into the community.

required as a result of the SWRs, rather than rely on a thematic report such as this.

- This report is based on the statements and findings contained in the seven NHS England regional reports (in addition to the insights gained from the engagement process and thematic review sessions). The seven regional reports were based on individual ICS reports, which summarised the themes from the ICS Panel findings in the SWRs themselves. Inevitably there has been a distilling of the information and a loss of some granularity and context.

- The scope of the SWRs included a diverse range of people, in different types of units, for different lengths of time. Without segmenting these variables, it is not possible to provide detailed findings or considerations by certain characteristics such as diagnosis or setting. For example, any findings about weight management and nutrition cannot be attributed to one particular group of people, or any specific setting, without access to data from all of the reviews. Whilst this puts a limitation on the findings and considerations within this report, all 42 ICS areas have access to the data in their area and can conduct their own local analysis. This report can therefore provide a foundation upon which ICSs can apply a more detailed, local understanding and enact positive change.

- All of the metrics and quantitative data used within this report are based on questions which have elements of subjectivity and interpretation.

2. Key findings

Individual reviews of 1,770 children, young people and adults were carried out between October 2021 and May 2022. 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 well-being. There was some evidence of high levels of restrictive practice and people's medication not always being reviewed in a timely way. Nearly half of the 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 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.

A very small number of people (3% of people reviewed) required a safeguarding referral to be made to address significant concerns identified during the review.

The SWRs provided the opportunity for a comprehensive review of people's care.The review findings are being used by commissioners and local systems to ensure that any issues identified can be addressed, and that all people in hospital have a clear plan for their care. Aspects of the review process, including the introduction of an ICS panel, will be incorporated into arrangements for quality oversight moving forward.

2.1 Headline figures

The regional reports included several headline figures related to people who were eligible for and received a SWR.

As outlined in table 1, 2040 people were eligible[4] for a SWR as they were in a mental health learning disability or autism inpatient setting on the 31 of October 2021. At the time that regional reports were submitted (May 2022), 87% of these people had received a SWR and had their review signed off by an ICS panel.

Apart from a small minority who were still to complete their review and/or have it signed off by the relevant ICS panel by the time the thematic review was carried out (these were all complete by July 2022), the two main reasons for people not receiving a SWR related to:

- People being discharged in the time period between the person being identified and the review taking place (this was the main reason).
- People being on extended Section 17 leave (see definition on page 5) from the hospital.

Table 1

Headline figures from regional reports related to the number of eligible people versus the number of people who received a SWR (and had their review signed off by an ICS panel) at the time of submission (May 2022).

Region	Number of people eligible for a SWR	Number of people with a completed SWR (as at May 2022)	% of eligible people who had a completed SWR (as at May 2022)
East of England	180	160	89%
London	295	250	85%
Midlands	425	385	91%
North East and Yorkshire	330	300	91%
North West	310	260	84%
South East	305	255	84%
South West	195	160	82%
Total	**2,040**	**1,770**	**87%**

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[4] Those who were eligible for a SWR included people with a learning disability and autistic people who were recorded as being in an NHS or independent mental health, learning disability or autism inpatient setting on 31 October 2021.

Table 2

Table 2 outlines headline figures relating to people whose reviews had been completed, in respect of those who required a safeguarding issue to be raised, and their care setting. Some points to note relating to this data are:

- out of area figures relate to all people who were in scope on 31 October 2021
- some people were discharged in the time period between being identified as eligible for review, and the review taking place (this was the main reason).

Region	Are in an out-of-area placement (of those who were in scope on 31 October 2021)	Have care and treatment needs that can only reasonably be delivered in hospital	Required a safeguarding concern to be raised
East of England	55%	57%	5%
London	62%	73%	6%
Midlands	68%	53%	1%
North East and Yorkshire	34%	59%	2%
North West	52%	57%	5%
South East	59%	66%	0%
South West	73%	47%	0%
England	**57%**	**59%**	**3%**

Out-of-area placements

Across England, 57% of people were in out-of-area placements. There was significant regional variation, with 34% of people in North East and Yorkshire being in out-of-area placements, compared to 73% of people in South West.

For the purposes of this review, 'out-of-area' was defined as where the hospital site was outside the geographical boundary of the patient's originating ICS or transforming care partnership (TCP) (i.e. the ICS or TCP of their GP or usual residence)[5].

Theme 1 in section 4 provides further discussion about out-of-area placements.

Appropriate care setting

Across England, 59% of people were regarded as having care and treatment needs that could only reasonably be delivered in hospital. This varied by region, with South West having the lowest proportion of people (47%) and London having the highest proportion of people (73%) who were regarded as having care that could only reasonably be delivered in hospital. Notwithstanding the data limitations as highlighted below, the key conclusion from these figures is that, at the point of the SWR, 41% of patients had needs that could be met in the community with appropriate support. Theme 1 in section 4 discusses this in more detail, alongside the reasons for people not being discharged when their care and treatment needs no longer require hospital treatment.

Safeguarding

Across England, 3% of people (50 out of 1,770) required a safeguarding concern to be raised to the local authority as a direct result of the SWR process. In South East and South West, no safeguarding concerns were raised, while in the London, 6% of people had safeguarding concerns raised.

2.2 People themes

Theme 1: Appropriate care setting

As outlined in the previous section, **59% of people were regarded as "having care and treatment needs that can only reasonably be delivered in hospital".** This means that 41% of people potentially had needs that did not require continued admission to a hospital setting. It should be noted that many of these indivdiuals

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[5] There are more specialised services, primarily secure services, which are only offered on a regional, super-regional or even national footprint (for example, high secure). It could therefore be considered that some placements may be identified as out-of-area, but this may be appropriately so, either because the individual is in a very specialised service that is not provided locally, or because they have chosen to be in a unit that is closer to their family or network. Since the inception of integrated care systems (ICS) in July 2022, 'out of area' is now defined as where the treating hospital site is outside the geographical boundary of the patient's originating ICS.

will have been on a discharge pathway, but there were issues impacting on their ability to be discharged from hospital in a timely way, including:

- a lack of suitable accommodation available; 19% of people were deemed as having care and treatment needs that could be delivered in a community setting, but a suitable option was not available.
- identified or suspected delays in the rehabilitation and discharge pathway to prepare people to go into the community with appropriate aftercare in place.
- staff not always being trained to support people to move to community settings.
- legal barriers; one region reported that ongoing concerns for public safety and legal processes were barriers to discharge for 14% of people in rehabilitation and secure services.
- some people not having a clear formulation and/or care plan[6]; the regional reports stated that overall, 7% of people did “not have a clear formulation and care plan linked to the formulation”.

Other key issues around appropriate care setting related to:

- **Out-of-area placements:** 57% of people were recorded as being out-of-area. While there are instances where this may be in the best interests of a person, out-of-area placements can make it harder for the person to maintain links with family, local services, communities and clinical/social work professionals (who can help monitor the quality of care and progress discharge).
- **Forensic secure services:** There was a specific concern relating to forensic secure services and people requiring Ministry of Justice agreement to less restrictive steps including different types of leave and a step-down to less restrictive environments. The reviews conveyed a sense that there were, at least sometimes, avoidable delays in these processes.

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[6] Formulation can be described as a collaborative process that promotes shared understanding of an individual’s situation, background and narrative to ensure mental health professionals work with individuals effectively to plan and implement meaningful care.

- **Ward type and environment:** There were examples of people being placed in psychiatric intensive care units[7] on a long-term basis, because of a lack of alternative provision. There were also examples of reasonable adjustments not being made to meet the sensory and sensitivity needs of autistic people, and children's wards not being child-friendly enough.

Summary and key considerations

- 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. This could help ensure an appropriate placement is available once the person is ready for discharge.
- For people who are not in very specialised services[8] 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 (which includes a variety of different commissioner reviews) has sufficient impact on improving the quality and safety of people's care, and ensures that 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 (both points linked to theme 2: workforce and theme 8: mental health and quality of life).

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[7] Psychiatric intensive care is offered to service users who are compulsorily detained and require treatment in low secure conditions during an acutely disturbed phase of serious mental disorder.

[8] For the purposes of this review, very specialised inpatient services are those that are commissioned by NHS England or NHS-led provider collaboratives and provided on a national or regional footprint, for example, high secure setting or adult eating disorder service.

- Commissioners and providers may wish to analyse the data from individual reports for their ICS area to further review the theme around reasonable adjustments and related subjects including sensory needs.
- Further consideration should be given to the differences between regions in relation to the amount of variation in formulation planning.

Theme 2: Involvement of family members and carers

There were some examples of effective communication between organisations and family members, but these were far outweighed by examples of poor communication.

There were reports of families:

- being excluded from planning and decisions about their loved ones (for example, discharge planning and being involved in care, education and treatment reviews (CETRs) or care programme approach meetings).
- not being provided with basic information such as how to contact family members and visiting times.
- not being listened to in relation to the care and treatment of their family member, or decisions about their care and wellbeing.

Addtionally, 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 (for example, the outcome of reviews).

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.

One ICS stated that in 39% of their safe and wellbeing reviews, family representatives either could not be contacted for the purposes of the review, they did not want to be contacted, or the person did not want them to be contacted. While some family members may not wish to be involved, or people may not opt to involve their families, it was raised during thematic review sessions that providers could do more to support family involvement. This could involve communicating the value of family involvement and providing opportunities for families to get back in touch over time.

During thematic review sessions, several people raised the need to better support families. They noted that the hospital system can seem complex and daunting – they may not be aware of their loved one’s rights and what they can expect in terms of communication and care review and discharge processes. It was raised that families may benefit from peer support networks, social events on wards, or through more practical support such as a dedicated website.

Summary and key considerations

- Given the high number of families not involved in the process, and reports that involvement of families is often challenging and/or limited, consideration needs to be given to exploring this theme further and identifying and implementing measurable ways of improvement. This includes enhancing family involvement through existing quality oversight mechanisms such as CETRs and commissioner oversight visits. Families will often provide the best insight and knowledge about a person.

- Individual choice must be respected with regard to family involvement.

- Where families are not involved (either due to family or individual choice), 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.

Theme 3: Advocacy

The importance of advocacy was a strong theme in all regional reports and in the thematic review sessions. One of the main points was that the availability and quality of advocacy for people in hospital is generally inconsistent.

There were some positive examples related to advocacy. It was noted within one regional report that people were “safer when advocacy is provided” and there were examples of advocates supporting people’s cultural and religious needs and positively impacting treatment and discharge plans. Some providers also offered an ‘opt out’ service rather than ‘opt in’ which assumes people will want an advocate unless they explicitly say they do not.

Concerns were raised about timely access to advocacy and the quality of advocacy services. It often fell to family members to be advocates in place of professional advocacy, though they are generally not trained to do so, may not know all the options available, and cannot be fully independent. As a result, this can cause tension and put family members in difficult positions. It was also apparent that carer assessments were not always considered for all family members.

There was a theme around the role of an advocate not being fully understood by providers or people, and that the information around their role and their importance was either not made available, or not communicated in a clear, concise and compelling way. One region noted that there was a lack of understanding from staff as to the role of an advocate, particularly the importance for people whose family are not involved in their care.

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 (without evidence of assessing the person’s need for this support).

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 (such as multi-disciplinary meetings). It was also noted that there was a lack of proactivity in encouraging people to engage with an advocate (including in cases where they may have declined to in the past). It was reported within the regional reports that 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.

Summary and Key Considerations

- 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.

Theme 4: Harm reduction and safeguarding

Three percent of safe and wellbeing reviews (SWRs) led to a safeguarding concern being raised.

None of the safeguarding issues led to either people or units being raised for escalation or support with the NHS England National Learning Disability and Autism Improving Quality team.

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. Some specific examples of overly risk aversive practices provided during thematic review sessions include:

- hot drinks banned on a ward following an incident where a staff member was scalded
- ward staff refusing to replace a person’s old pair of shoes (which had holes in) with a new pair of shoes for fear of being accused of theft.

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.

Regarding practice and harm reduction, specific themes were raised in relation to:

- autistic people experiencing inconsistent and/or high levels of restraint, seclusion and segregation.
- people not being assessed appropriately under the Mental Capacity Act or assessments not being completed in a timely way. Several ICSs within one region reported variable quality in assessments, with one example of blanket assumptions being made rather than decision-specific assessments.
- the harms associated with weight gain during admission (increasing the likelihood of health problems and premature mortality) and long lengths of stay
- issues associated with people being placed in inappropriate settings (for example, mixed-gender wards), the absence of CCTV in inpatient settings, issues with staff attitudes and relationships
- “patient relationship challenges” and concerns that low staffing levels sometimes meant people didn’t feel safe around other inpatients
- the standard and inconsistency of incident reporting.

There was also a theme related to the potential inappropriate and inconsistent use of medication. One regional report found that some reviews identified concerns around the appropriate use of antipsychotic medications and benzodiazepines within best practice guidelines, as well as the use of PRN (‘pro re nata’, meaning ‘as needed or as circumstances require’) medication. Another regional report stated that people receiving care in secure settings were more likely to be prescribed antipsychotic medication for impulse/behavioural control than those receiving care in non-secure funded services, and that there was no clear rationale for this.

Summary and key considerations

- 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 (for example, seclusion and restraint).
- 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 Mental Capacity Act 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.

Theme 5: People’s physical health

Weight gain for people not being adequately addressed was a key issue raised in the Cawston Park safeguarding adults review. There were multiple references in regional reports to people with a high body mass index[9] and significant weight gain

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[9] The body mass index (BMI) is one way to calculate whether someone’s weight is healthy. As it is based on a simple calculation of height and weight, there will be instances where someone can have

following being admitted to hospital, including instances where this led to people developing diabetes. The most common reasons for this were:

- a lack of general/incidental[10], planned and targeted physical activity, including access to the gym, often due to a lack of staff who can supervise the activity.
- lack of access to fresh air and outdoor space for some people.
- an over-reliance on ‘treats’ including snacks from vending machines, takeaways and a lack of means and ability for a person to choose and/or prepare their own food.
- a theme of ‘boredom’, particularly among children and young people.
- a lack of ongoing advice and support to promote healthier lifestyle choices.
- potential side effects to medication (particularly psychotropic medication).

As discussed in the previous theme, significant weight gain increases the likelihood of health problems and premature mortality. It can also negatively impact people’s confidence and mental health.

There were some positive examples around weight management. One clinician noted an initiative of removing unhealthy vending machine snacks and working proactively to pool budgets with the catering department of the organisation to ensure a range of healthy, low-sugar and low glycaemic index options were made available.

There were mixed comments on ensuring that people had equitable access to all aspects of healthcare, including eye, dental, hearing and sexual health checks, screening (for example, for cancer, diabetes and other long-term conditions) and access to other services, such as podiatry, electrocardiograms and vaccinations. There were inconsistences around access to and support following annual health checks and annual health planning for people with a learning disability.

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a high BMI and not be overweight (i.e. muscular people) or a normal BMI and still be at risk of some weight-related health conditions.

[10] Physical activity related to normal daily activities, such as household cleaning or walking to the shop.

As raised in theme 4: harm reduction and safeguarding, there were examples of overprescribing of medication (in dosage and duration). This can be caused by a range of factors, not least diagnostic overshadowing (where the person’s needs are ascribed to a learning disability or to autism), poor diagnostic practice, poor psychiatric or mental health formulations and a lack of consideration of psychosocial interventions before medication or alongside medication.

Other general themes raised around physical health are listed below:

- Reference was made to the limited access of physical activity as a result of COVID-19 restrictions. One regional report noted that COVID-19 undoubtably played a part in this, but the overall sedentary nature of inpatient care was referenced as a primary driver of lack of physical activity for people where they are able to be physically active.

- One regional report referred to other physical health needs that required triangulation with specialist services, and how it was not always the case that the issues were followed up and a care plan evidenced. They provided information around two people who had a less well understood syndrome: there was no available care plan demonstrating how people’s needs related to the syndrome were understood or managed.

- One regional report described a correlation between the level of security in a hospital setting and poorer physical health monitoring, with the higher security levels potentially resulting in poorer physical health.

- There were some instances of people in hospital not having access to specialist diets, such as gluten free.

- There was a general theme around activities for people appearing to focus on watching television, leaving the hospital to go shopping, and other activities with limited evidence of building life skills, such as meal planning and preparation.

Summary and key considerations

- As standard, 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.

- Where an inpatient setting results in people having restricted access to day-to-day physical activity or time spent out of the ward environment, it is important that providers make explicit provision through staffing, resources and care planning to mitigate the impact of this on people’s physical health.
- Health screening should be as accessible to people in hospital as it is to people 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, given that this is a relatively small, known population accommodated in inpatient environments, often for a significant duration of time.
- If staff are unable to engage people with heathy eating and/or exercise for any reason, this is a significant risk to the person’s health that should be explicitly included and addressed in risk and care planning. Clearly, there may be significant complexities in managing this with some people, but it is important that providers explore a range of approaches to support people to engage with making healthy choices. The clinical team should consider what additional steps or reasonable adjustments are required to support people to engage.
- 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.

Theme 6: 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, especially for children and young people.

It was reported that 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.

One good practice example from a hospital unit involved therapy teams planning activities to align with a persons care plan.

People's wellbeing and quality of life were also impacted by:

- delayed discharges
- being placed far away from family; this can also have a negative impact on family members' wellbeing.
- a lack of social connection; some people reported having few or no friends.
- the risk management plan and strategy being followed on the ward.
- issues/difficulties relating to staff or other inpatients, for example, there were reports of people feeling unsafe around specific individuals and spending a lot of time alone in their rooms.

There was some concern raised about whether eating disorders were being factored into the general understanding of the person's overall physical health.

Summary and 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. This will ensure quality of life outcomes for anyone are at the heart of person-centred care.
- 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.

2.3 Service themes

Theme 7: Workforce

A significant number of discussions in the thematic review sessions focused on the issues around a lack of staff, which was exacerbated by COVID-19. Families and advocates raised concerns about whether wards were unsafe when there were significant staff shortages on them.

In the SWRs, 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.

Feedback was received about the impact of the current oversight framework,care education and treatment reviews (CETRs), care programme approach reviews (CPAs), commissioner oversight visits etc. on current workforce availability. Whilst it remains a core part of clinical duties to participate in review processes (including CPAs/CETRs), 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.

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. It was suggested that temporary and agency staff could, on occasion, feel less approachable than substantive staff. One regional report also highlighted the effect of increased temporary and agency staff on autistic people in particular, who found changes in staff distressing.

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 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
- clinical teams providing person-centred care that addressed both the physical and mental health needs of a person (additional roles included activity co-ordinators and physiotherapists).

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.

Finally, poor staff culture, particularly ‘institutionalisation’ and risk aversion (as discussed in theme 4), was often raised as a key theme. One ICS noted that health and/or social care teams can sometimes “project a historical risk as a current risk and this can influence providers”.

Summary and key considerations

- Multi-disciplinary teams that bring together a range of clinical and non-clinical skills, to support the diversity of needs presented by people with a learning disability and autistic people, 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 staff 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 Mental Health Act.
- Staff should have the maximum time available to engage in essential therapeutic and clinical activities.

Theme 8: Barriers to discharge

It was often reported that discharge planning “did not take place early enough” or was not being done in collaboration with the person and their family. There were concerns that discharge dates were “not realistic” and/or families were not involved in the decisions about this. It was found that deviations from the discharge plans were sometimes not communicated to the person and/or their families or carers.

There is reference in the regional reports that the 12-point discharge plan recommended by NHS England is not being used consistently, and this may be a contributing factor to the 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. This raises complex issues around the needs of people with significantly long stays (and the huge adjustment associated with a transfer to a new care setting) and those who are ready and wish to be discharged who still find themselves with unnecessarily long stays. A person-centred approach should apply in both of these instances.

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[11] 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 personl, difficulty recruiting staff, pressures on existing staff and single-person commissioning rather than strategic commissioning.

Other general points raised in relation to discharge related to:

- effective advocacy being a key element in effective discharge and discharge planning
- a lack of detail on milestones, targets and outcomes that would be required before discharge could be progressed
- some services not implementing a health action plan/other care plans that could be continued into the community
- a lack of clarity in staff understanding around the lifestyle changes for a person who is on Section 17 leave.

Two regional reports stated that for those in secure settings, an ongoing concern for public safety formed a barrier to discharge for a minority of people.

Summary and key considerations

- Best practice around the most appropriate discharge plan for the person should be followed. This includes ensuring the [12-point discharge plan](https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/learning-disability-and-autism/) is actively used for all people to ensure discharges are timely and effective.[12]
- All discharge planning should be done in conjunction with the person and with at least a key person for them (who may be the Mental Health Act nearest relative, a family member, or a nominated person), unless the person has mental capacity and has chosen not to have people involved.

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[11] People who have been detained under treatment sections of the Mental Health Act are entitled to S117 after care under the Mental Health Act, which will need to be in place to meet needs that are associated with the individual's mental health problem in the community and reduce the likelihood of readmission.

[12] https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/learning-disability-and-autism/

- A regular process of reviewing delayed discharge should be in place in each integrated care system, 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 in response to the new national discharge policy requirements and this should be considered in light of the themes.[13]
- Any anticipated or actual deviations from the discharge plan, why the deviation 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.

2.4 Effectiveness of current oversight and review processes

While there were some positive comments about the effectiveness of current oversight and review processes, namely, the commissioner oversight visits, care education and treatment reviews (CETRs) and care programme approach reviews (CPAs), there were many areas of concern. Notably, there were several reports of:

- the processes being resource intensive and challenging for people and families to provide input into.

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[13] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/better-care-fund/better-care-fund-support-offer/

- inconsistent use and completion of review documents.
- 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 across CETRs and CPAs.
- variations between CETRs and CPAs due a lack of a joined-up approach.
- the 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.

2.5 Learning from the safe and wellbeing review 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, despite concerns regarding time pressures, the SWR 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
- 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.

3. Conclusion

NHS England is grateful for the effort and engagement of people in hospital, their family and carers, commissioners, providers, panel experts and ICBs to ensure that safe and wellbeing reviews took place in line with the agreed guidance.

Whilst this report is helpful in identifying key thematic learning, the most important outcomes of the reviews were the ability for commissioners to take immediate action when any issues or concerns about people were identified, for ICBs to understand and know all of the people they are commissioning services for, whether that is close to home or not, and to enable any necessary local and immediate actions to be taken to ensure people were safe and well.

Many local systems and regions have already developed their own action plans and responses in relation to their learning from the reviews.

The themes and challenges that were reported as affecting multiple systems and regions were not unexpected or new. 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 whose care and treatment does need to be in hospital, all partners must work together to ensure that 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.

To follow the publication of this report, NHS England, on a national and regional footprint, working with people with lived experience, family carers, integrated care boards, providers and commissioners, 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.