Safe and Wellbeing Reviews

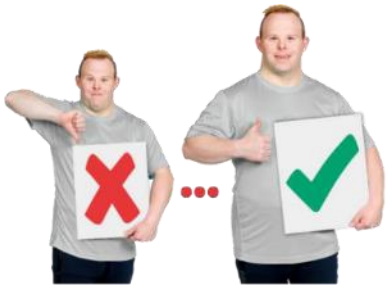
1. Introduction

Safe and Wellbeing Reviews check if people in mental health hospitals are safe and well.

They were set up by NHS England after the deaths of Joanna, Jon and Ben.

They were adults with a learning disability. Joanna and Jon were also autistic.

They died in Cawston Park hospital after long stays.



The reviews looked at what was and was not working well and what could be done better.

They were for children, young people and adults who have a learning disability or are autistic

and were in hospital on 31 October 2021.

The reviews included:

- looking at records from other reviews of each person's care and treatment

- talking to each person's family and advocates

- looking at each person's
  - safety

  - physical health

  - mental health and how good a life they have

- face-to-face visits with people.

- Groups of people on **Integrated Care System** panels, including experts by experience, checking the reviews had been done properly by people.

An Integrated Care System or ICS is where local health and care organisations work together.

By May 2022, 1,770 reviews had been done and reviewed by panels.

The reviews happened at a time when coronavirus was still affecting services.

This report tells you about important information from the reviews carried out in the 7 NHS regions of England.

It looks at:

- what we have learned from all the reviews.

- what regional leads, family members, advocates, commissioners, panel members, clinicians and hospitals have told us.

This report does not look at the quality of individual reviews.

2. Important information

2040 people needed a Safe and Wellbeing Review on 31 October 2021.

1,770 people had a review.

By July 2022 all the reviews had been done.

The 2 main reasons for people not having a review were:

- leaving hospital before a review could happen
- being on a break from hospital at the time of the review.

Just over half of people were in a hospital outside of their home area.

In some regions this number was bigger or smaller.

For example, about 3 out of 4 people from the south-west were in hospitals outside of their home area.

Where possible we want people to be able to get mental health hospital care closer to home.

a. Getting the right care

6 out of 10 people had care and treatment needs that could only be met in hospital.

So, 4 out of 10 people could have had care somewhere else.

Some of the reasons for this were:

- not enough suitable places to live in the community

- delays in leaving hospital

- staff not trained to support people to move into the community

- legal barriers

- no care plan

- Ministry of Justice not agreeing to less restrictive support

- people being placed in hospital because there was nowhere else to go.

It was also found that reasonable adjustments are sometimes not being made to meet the sensory needs of autistic people.

Being out of your home area makes it harder to keep links with family, local services, communities, clinicians and social workers.

What needs to happen

- Commissioners must support people to leave hospital when they no longer need hospital care.

- Where a person will need specialist care in the community, planning should start from when they first go into hospital.

- People in out of area hospitals that are not very specialised services should move closer to home where possible.

- Think about what more commissioners and hospitals can do to improve the quality and safety of people's care.

- Training for staff on sensory and sensitivity needs and person-centred thinking.

- Commissioners and hospitals should look at how they can make better reasonable adjustments for people.

- Take action around the differences between regions.

b. Involving family members and carers

Some organisations communicated well with family members, but many did not.

Families said they were sometimes:

- excluded from planning and decisions

- not given basic information such as how to contact people and visiting times

- not being listened to.

- finding it hard to visit family members in out of area hospitals because of:

  - transport costs

  - set visiting hours

They thought commissioners and hospitals should do more to include them.

There was less contact with family members and advocates for people who had been in hospital a long time.

Families thought they might benefit from:

- peer support networks

- social events on wards

- practical support such as a website.

What needs to happen

- There needs to be a way to measure improvements in family involvement.

- People’s choices must be respected.

- Hospitals should support people and families to connect where possible.

- Families should get more support around peoples’ rights and what to expect from communication, reviews, and discharge.

- Commissioners and hospitals should support families to stay involved,

especially when people are in out of area hospitals.

c. Advocacy

Advocacy is not always available for people in hospital.

It was thought that people were safer when advocacy is provided.

There were concerns about how long it takes to get an advocate and how good they are.

Sometimes family members have to speak up for people but don’t get any training.

The role of an advocate is not always understood by hospitals or people.

Some hospitals did not always offer independent advocacy as a reasonable adjustment.

People were sometimes not encouraged to get an advocate.

What needs to happen

- Need to check if advocates who work for hospitals are really independent.

- Need to get better at encouraging people in hospital to take up advocacy.

- People who choose not to have an advocate at the start should be given the chance to get one later.

- Hospitals should involve advocates in decisions that affect the person.

d. Safeguarding

A safeguarding concern was raised in 50 of the 1,770 reviews.

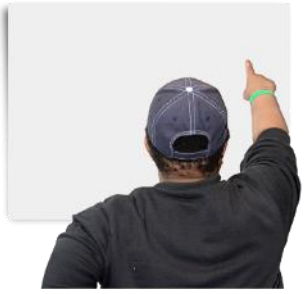
Sometimes safety worries meant people:

- had their activities taken away

- were not allowed hot drinks

Some suggested that staff should talk more about how people can safely do things that others think are risky.

Autistic people were sometimes restrained or kept away from other people.



Checks to see if people can make their own decisions were often not done well or in line with the law.

Some people put on a lot of weight when in hospital for a long time.

People did not always feel safe because

of how other people on the ward and staff treated them, and

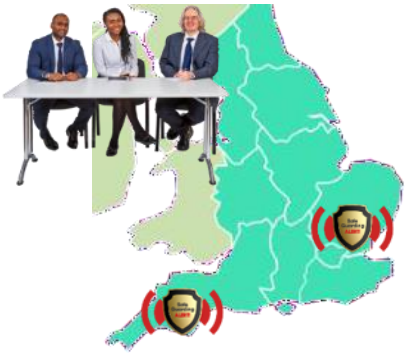
there were not enough staff around.

Safeguarding issues were not always reported in the right way.

People were more likely to be given medicine for mental health problems to control their behaviour, even if they did not have a mental health condition.

What needs to happen:

- Hospitals must think about what good care looks like and improve quality.



- Panels should work to understand why there are more safeguarding issues in some regions of England.

- Panels should make sure:

- rules are being followed about people being restrained safely

- and only when there is no other choice.

- Hospitals need to make sure staff get training.

- Hospitals should be reminded about the STOMP-STAMP campaign to stop giving people too much medication.

Hospitals need to balance:

- safety

- independence

- and helping the person to recover so they can leave hospital.

e. Physical health

There were lots of people who were overweight.

The main reasons for this were:

- lack of physical activity made worse by coronavirus.

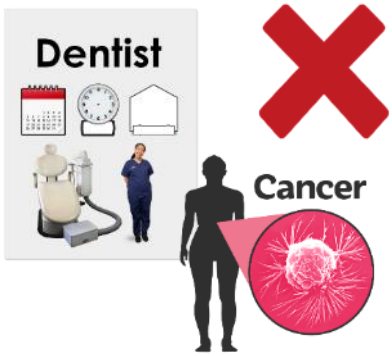
- not enough access to going outside

- unhealthy food being used as a reward

- being bored

- a lack of advice and support on healthy choices

- side effects of medication.



People did not have equal access to healthcare services like the dentist and cancer screening.

What needs to happen:

- People in hospital should get the same quality of physical healthcare as everyone else.

- When it's difficult for people to be active outside of the hospital, the ward should put on other opportunities for exercise.

- People in hospital should get health screening.

- Services should look after the whole of a person's health.

- The use of mental health medicines should be improved.

- Hospitals should use different ways to help people make healthy choices.

- Contracts with hospitals should make sure they support people to stay physically healthy.

f. Supporting wellbeing and positive mental health

There was lots of concern about a lack of meaningful activities and people being bored.

There was also a lack of activities to prepare people for leaving hospital.

Lack of staff and money were often blamed.

People’s wellbeing and quality of life were also affected by:

- delays leaving hospital

- being far away from family

- a lack of social connection

- lack of positive risk-taking

- people not feeling safe and spending more time alone in their rooms.

What needs to happen

- Hospitals and commissioners to understand people's quality of life better.

- Hospitals should make sure people have plenty of activities they enjoy, to help with being in hospital.

- These activities should be co-designed with other teams like therapists.

- People should only be in hospital if there is a good reason for being there.

- Hospitals should look at ways of reducing loneliness for each person.

g. Staff

Lots of people talked about lack of staff which has got worse since coronavirus.

Families and advocates were concerned this makes wards unsafe.

The reviews talk about the effect that having less staff has on a person's wellbeing.

There were concerns that meetings such as Care (Education) and Treatment Reviews took staff away from their day-to-day work.

Some staff do not have the right skills and need training on:

- person-centred service plans

- caring for people who have had very difficult experiences. This is called trauma informed care.

- understanding and using the Mental Health Act

- make sure that efforts to make things better for people are achievable and work for people in hospital.

Some staff do not have specific learning disability and autism training.

Some staff limit what people can do because they do not like to take risks.

What needs to happen

- We need teams of people with different skills to support the needs of people with a learning disability and autistic people.

- Having the same staff over time should be an important part of people's care. It is not easy, but hospitals need to work to keep the same staff.

Staff training should be a priority, covering:

- working with autistic people and people with a learning disability

- person-centredplanning

- trauma-informed care

- therapeutic benefits

- understanding and using the Mental Health Act.

- Staff should have time for activities which help people get better.

h. Barriers to leaving hospital

There was a lot of feedback that plans for leaving hospital are often not made early enough.

Also, that plans do not involve people and families enough.

People and their families are sometimes not told when the plan is not followed.

Some areas are not using a plan that helps people leave hospital when they are ready.

Not using this plan means that some people are being delayed in leaving hospital.

Some areas call this the 12-point discharge plan.

There are difficulties discharging people who have been in hospital for many years, or who are ready to leave but are still in hospital.

They need a very person-centred approach.

Getting the right care in place

for when people leave hospital can cause delays.

Good advocacy was thought to be important for people leaving hospital.

There was not enough information about all the things that should be happening for people to leave hospital.

Some services did not put a health action plan and other care plans in place that people could take with them into the community.

What needs to happen

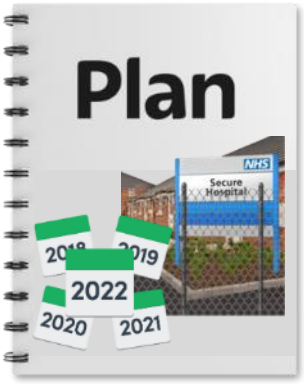
- Best practice around plans for leaving hospital should be followed. This includes using the 12-point discharge plan.

- All planning should be done with the person and a family member or advocate.

- There should be checks to make sure people with delayed discharges are getting the help needed to leave.

- The NHS England Better Care Fund may be able to help.

- Tell the person and their family when the plan is not followed.



- Take special care with planning for anyone with a long stay.

- Change the culture to be more positive around people leaving.

- Plans should include a few places that people could go to when they leave hospital, to cut down the risk of delays.

3. Do reviews work?

There were some positive comments about current reviews like Care (Education) and Treatment Reviews.

There were also some concerns:

- They take up staff time and money

- It can be hard for people and their families to have an input.

- They are not always done in the same way.

- They sometimes do not have much detail around planning to leave hospital.

- People felt the reviews could be joined up to work better.

4. Learning from the reviews

Many people found the Safe and Wellbeing Reviews took up a lot of time.

They were good at making sure people in hospital were safe and well and making changes where this was not happening.

The Integrated Care System panels were thought to be really good because they:

- have senior leaders on them

- have lots of different people working together.

- identify good practice which can be copied in other areas.

Some suggested that parts of the Safe and Wellbeing Reviews should become part of regular reviews, like C(E)TRs.

5. Conclusion

Lots of people worked hard to make sure that Safe and Wellbeing Reviews happened. This report identifies the main learning from the reviews.

The most important thing was hospitals and commissioners taking action to make sure people are safe and well.

Many local regions have developed their own action plans in response to what they have learnt.

A lot of the problems identified in this report are not new.

It is important that NHS England and others make sure change happens so that people who no longer need care and treatment in a hospital can be supported in the community.

For people whose care and treatment does need to be in hospital, all partners must work together to make sure they receive the very best.

NHS England's long-term plan for people with a learning disability and autistic people already addresses some of these problems.

But some areas need a stronger focus or different approach.

Many areas across the country have put in plans to change things because of what the Safe and Wellbeing Reviews found.