

## Board of Directors Item 5.6

**Subject:** Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services  
**Date of Meeting:** 28<sup>th</sup> November 2022  
**Presented by** Sue Pemberton Director of Nursing, Safety and Quality

BAF Ref	Impact on BAF
BAF 1	For assurance that opportunities for learning have been identified to further strengthen the quality and safety of care in LHCHH

### 1. Executive Summary

During September 2022 an undercover reporter working for the BBC Panorama programme filmed patients at a high secure mental health hospital Edenfield Centre Mental Health NHS FT. The programme was aired on national television at the beginning of October 2022, with the focus for the programme detailing extremely worrying aspects of clinical care being given to inpatients within the trust. The programme showed patient's being inappropriately restrained, examples of false recording of documentation, verbal abuse, and physical assault by hospital staff. After the programme was shown, Claire Murdoch National Director Mental Health, requested that all Trusts undertake a review of their own Trust safeguarding services. The questions posed to all Board of Directors were:

- Could this happen here? (insight)
- How would we know? (oversight)
- How robust is the assessment of services and the culture of services?
- Are senior staff visible within wards and departments, to observe standards of care and can listen to patients and their families which also includes listening to staff e.g., the porter, cleaner, health care assistants.

### 2. Background

A review of Trust safeguarding processes and those listed below was undertaken in a response to the request from Claire Murdoch, National Director Mental Health. The review explored how unacceptable clinical care would be identified and escalated within LHCH. There are various methods as to how poor care could be identified within the Trust, these include:

- Safeguarding, Deprivation of Liberty Safeguards (DoLS), including the use of restrictive interventions process
- Incident reporting
- The use of HALT
- Psychology service provision

- Mental health Liaison service provision
- Advocacy arrangements
- Freedom to speak up
- Complaints and concern processes
- Hospital at night provision
- Excellent compassionate and safe quality assessments
- Matrons' audits and walk rounds
- Patient surveys

### 3. Findings

**3.1 Safeguarding** – The Trust has several key safeguarding policies and procedures that direct all staff in how to alert any safeguarding concerns within the Trust. There is a named safeguarding doctor and lead nurse within the Trust. Following a review of concerns raised, no reports of clinical care, as reported by the panorama programme, have been witnessed or reported over the previous five years. Safeguarding mandatory training is monitored internally and externally by Liverpool Place. Overall, the Trust performance is exceptional 94%-100% for all levels of adult and children training. One area under review is level 4 safeguarding children training performance is 67%. This in the main is due to one staff member out of date for their training.

**3.2 Deprivation of Liberty Safeguards (DoLS)**- The Trust has robust processes and policies to ensure all patients are assessed who lack mental capacity and therefore have requirements for safety restrictions be put into place, which may deprive them of their liberty, whilst an inpatient at LHCH. This may include patients, for example who have hypoxic brain injury, learning disabilities and or autism, delirium, and dementia. All referrals are reviewed with management plans in place for patients.

Best interest meetings regularly occur for our patients who lack mental capacity. This is routine practice to ensure the voice of the person is heard and their wishes and beliefs are respected. Where appropriate and applicable, family members participate in best interest meetings alongside the patient.

**3.3 Incidents** - The incident management reporting system DATIX clearly guides staff into how to identify an incident, what is a serious incident, how to report an incident and grade an incident in terms of severity and harm. Upon review, no incidents like those reported by the BBC programme have been identified or raised. The same can be said of the complaint handling process.

**3.4 Psychology** - Since 2020 the psychology service portfolio has increased, across 8 specialities. The team are bound by the mental capacity act and the same principles for safeguarding across the Trust. There have been no reported incidents raised to the safeguarding team, from escalation of concerns, from the Psychology teams for LHCH patients.

**3.5 The Mental Health liaison services** - Provides mental health care to people being treated for physical health conditions in hospital. Within LHCH there is an effective liaison psychiatry service, which has robust processes and policies. At LHCH, the link between Safeguarding and Mental Health is well established and clear with all agencies working closely together, sharing information and speaking up and ensuring the voice of the person and their wishes and beliefs are respected. There have been no issues raised in relation to the clinical care given to inpatients as those reported by the Panorama programme.

**3.6 Advocacy** –At LHCH advocacy services are utilised from a wide range of local authorities. Not all are sufficiently resourced to meet the needs of the area they serve, especially in terms of funding, visits to wards and engagement with patients, without specific instruction especially when there is a distance i.e., Welsh patients. The advocacy services have not reported concerns from patients regarding LHCH patients. Healthwatch are resuming their inpatient experience forums in November/December 2022.

**3.7 Restrictive interventions** - At LHCH the use of restrictive interventions is not advocated. These may include but are not limited to, chemical restraints, most commonly oral medications, rapid tranquilising injections, mechanical restraints such as hand control mittens, seclusion, segregation and there are also eight different types of physical restraint. Any intervention used to keep patients safe from harm are reported to the appropriate service, with detailed documentation for the intervention agreed. These decisions are made following multi-professional discussions regarding the safest modality to keep patients safe from self-harm or the potential to harm others. A restraint policy is in place in critical care and is underway for the wards.

**3.8 Freedom to speak up**- The Trust has an active Freedom to Speak up Guardian and a network of champions. Staff can approach any of the guardians if they are concerned regarding patient/staff or visitor safety. There have been no issues raised in relation to any of the elements of care as highlighted by the BBC programme through the FTSU process.

**3.9 HALT** - The Trust engages and thoroughly supports staff who need to communicate a HALT, regardless of position held within the Trust or area of work. The Executive Team continue to make this pledge to all staff. Staff can raise anonymous concerns also – staff do use this process to make a HALT in situations whereby the possibility of harm could occur.

**3.10 Complaints and Concerns** - LHCH has a robust raising of concerns/complaints for patients and their families. All formal and informal concerns raised are shared with the Chief Executive and the Director of Nursing/Medical Director, this demonstrates an openness and transparent approach to all concerns raised. A thorough review of all concerns raised occurs within the Trust. Oversight of all closed complaints are reviewed by a Non-Executive panel where scrutiny of all complaints take place inclusive of Trusts responses and actions.

**3.11 Hospital at Night** - The hospital has a Critical Care Outreach service running twenty-four hours every day. Patients are reviewed if clinical deterioration occurs, and the team also supports other patients across the hospital at night. We also have a ward manager at weekends to support complex patients and they are all trained to level 3 safeguarding.

**3.12 Learning disabilities and autism** – The Trust has a matron that is also the lead nurse for patients with learning disabilities and/or autism. The matron's role is to speak with the patients and/or their families/carers prior to admission, to understand if any enhanced care is required when they become an inpatient and if so to ensure the care required is planned appropriately, for them to meet their needs on admission and throughout their stay. The matron will follow up the patients following admission and ensure their needs are met within the area they are cared for.

## **4. Summary**

The review of the services provided and the robust processes in place within LHCH provides assurance for the Board of Directors that the events observed within the Edenfield high secure unit would not occur within LHCH. In addition, the Board of Directors are also involved in ward and clinical department visits, whereby they speak to staff and observe care and standards. Any areas of concern regarding poor clinical practice would be identified through the many

observations by Senior nurses Trust wide, audits, walkrounds and the quality and safety standards assessments (the EECS). This can be triangulated with the external assurance the Trust receives inclusive of but not limited to, national inpatient survey results, friends and family survey results and follow up calls.

The Board receives regular assurance reports across the mechanisms described in section 3 above, including but not limited to FTSU, Integrated Incidents Complaints and Claims report, EECS, DoLS and Safeguarding.

## **5. Recommendations**

The Board of Directors is asked to note the assurance that the Quality and Safety of Mental Health, Learning Disability and Autism Inpatient services have been reviewed and the mechanisms in place would identify and provide escalation of poor clinical care.