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# Mental health, learning disability and autism inpatient quality transformation

Agenda item: 7 (public session)
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### Content



### Organisation objective

- Governance

Working with people and communities:

What approaches have been used to ensure people and communities have informed this programme of work?

- Recruited Patient and Public Voice (PPV) Partners
- Consultation / engagement
- Partnership working with voluntary, community and social enterprise organisations
- Other (please list below)

The programme has been co-produced in partnership with people with lived experience of mental illness, learning disabilities and autism and their families. This included site visits and engagement events with hundreds of people and families, clinicians, executives, academics, system leaders and other key stakeholders. Specific Lived Experience events were held with reflective spaces and support in place. People with lived experience are directly employed within the programme team, and over 90 patient and public voice partners support our work.

### Executive summary

In October 2022, in the immediate wake of the shocking and deeply distressing care scandal which occurred at the Edenfield Centre in Greater Manchester, NHS England considered the actions required to improve the quality and safety of mental health inpatient services and best enable the care people receive to be close to home, less restrictive and focused on therapeutic benefit.

In February 2023, following extensive engagement with people, families and stakeholders a new national Quality Transformation Programme was confirmed and launched. The Quality Transformation Programme's (https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/) aim is to **support cultural change and introduce a bold, radical, reimagined model of care for the future** across all NHS-funded mental health, learning disability and autism inpatient settings.

To achieve the aim, the programme has five objectives:

1. To localise and redesign inpatient services,
2. To improve the culture within inpatient services and support people and staff to flourish,
3. To enable the least coercive care through reducing restrictive practices,
4. To support systems and providers facing immediate challenges,
5. To make oversight and support arrangement fit for the sector.

Achievements to date include:

- Every NHS Trust and provider has completed a 'Could it happen here?' review and shared their findings and actions through their public boards.
- Launched planning commitment for every ICB in England to develop a 3-year plan to localise and realign the hospital care they commission for their local population, including for people with a learning disability and autistic people.
- Developed a co-produced Inpatient Commissioning Framework that contains a shared vision of 'what good looks like' to support ICBs
- Launched a culture-change universal improvement offer for 60 providers of NHS Commissioned Mental Health Inpatient services to support
- Launched a Quality Improvement Programme for 50 providers to reduce the inequalities people subject to the Mental Health Act experience
- Developed a methodology to identify units and wards more likely to be at risk of developing a closed culture.

### Action required

The Board is asked to note this update and provide feedback on progress to date and the aims and ambitions of the programme.

### Background

1. Many mental health inpatient services across the country are delivering good care and outcomes. They show what is possible and achievable. However, while significant progress has been made, some parts of the country still rely on certain types of poor quality and outdated bed-based provision (including out of area placements)

2. Recent inquiries and rapid reviews [1][2][3] into mental health inpatient services, including those specifically for people with a learning disability and autistic people, have identified particular 'setting conditions' and/or characteristics of service models which negatively contribute to the delivery of high quality, person-centred care but also, within this carry some of the inherent risk factors for developing a 'closed culture [4]..'

3. On 28 September 2022, BBC Panorama aired 'Undercover Hospital: Patients at Risk'. The programme featured footage shot by an undercover reporter who had spent three months working at the Edenfield Centre, a secure NHS psychiatric hospital in Prestwich, Bury, operated by Greater Manchester Mental Health NHS FT. Among the many distressing incidents shown in the footage were examples of physical and verbal abuse of inpatients, including unnecessary restraint, by staff.

4. As a result of the unacceptable issues highlighted in the programme, alongside commissioning a specific review, NHS England wrote to all Mental Health providers requesting that each organisation urgently review safeguarding of care, recognising the inherent risk factors of certain bed-based provision. All providers have since published their review and subsequent actions they are taking.

5. The action plans published by each provider informed the scope of our Quality Transformation programme. In addition to collating these findings, an extensive engagement exercise was undertaken during 2022/23. Through this engagement work, colleagues across the sector, people and families identified the need to consider the current model of inpatient care and its capacity to create, or undermine, the conditions for individuals (patients and staff) to flourish.

6. As a result of this work, the programme aims to support every system to achieve a bold, reimagined model of mental health inpatient care. This model draws on the evidence base to present a vision for the future that is characterised by strong therapeutic relationships achieved through continuity of care, and underpinned by citizenship and the rights and responsibilities that this denotes.

7. The findings and recommendations from the specific review into the Edenfield Centre have also been cross-referenced with the Quality Transformation programme scope, to ensure learning is embedded in the programme deliverables.

### Localise and redesign inpatient services – objective one

8. To support local systems to redesign the current model of inpatient care to mitigate the inherent risk factors, it is critical that changes to care models focus on:

- care being delivered close to people's homes and communities;
- least restrictive models of inpatient care; and
- models which promote the therapeutic relationship through continuity of care.

9, In the NHS 2023/24 Planning Guidance, systems were asked to co-produce a strategic plan, to localise and realign mental health inpatient services over a 3-year period in line with a Commissioning Framework.

10. A Commissioning Framework for inpatient services and associated baselining tools have been produced to support ICBs with this task. The guidance provides a clear and shared understanding of 'what good looks like' and pays particular attention to models of inpatient care where people are in hospital for years at a time, such as inpatient rehabilitation.

11. Subject to agreeing the overall approach to 2024/25 with the Government, we propose ICBs will be supported with £42 million investment to aid development of local innovative services in line with the inpatient framework. Local systems will be able to align this with the existing community and crisis transformation they have been leading since 2016.

12. In addition we propose £15 million will be invested in 2024/25 and 2025/26 to learn from models of 24/7 community care which promote continuity of care and enables a more responsive acute care offer to mental health patients in crisis.

### Improve the culture within inpatient services and support people and staff to flourish and enable the least coercive care through reducing restrictive practices – objective two and three

13. The NHS England Board have previously discussed the criticality of the culture of care within mental health inpatient services. The collective ambition is for all services to foster a culture where everybody; patients and staff, can flourish.

14. Increased oversight, regulation and staffing challenges can contribute to a 'task-oriented' approach to care, despite the best efforts of staff, which detracts from the main goal of providing therapeutic support to people in their most vulnerable state. Frontline staff and providers articulated the need to 're-set' the culture of mental health inpatient services. We know that achieving a positive workplace culture has benefits for employee engagement and performance, staff retention and patient outcomes.

15. Over 100 front line staff, people and families, academics, system leaders, providers, and stakeholders have developed a set of standards which articulate the culture of care the sector wants to achieve across inpatient services now and in the future model.

16. A culture change improvement programme has been established as a Universal Support Offer for 60 providers of NHS Commissioned Mental Health, Learning Disability and Autism inpatient services. The change programme will be centred on supporting 300 teams to achieve a culture of care which is focused on Therapeutic Relationships as the greatest predictor of good clinical outcomes is equality focussed, trauma and autism informed.

17. The culture change improvement programme launched in January 2024 and over the next two years (to March 2026) will deliver six interventions to 60 providers across England. This will include delivering Quality Improvement coaching to support changes in practice to realise the Culture Standards and delivering training in relational approaches to care to up to 200 ward teams; and Supporting 60 Executive Teams and Boards to consider how the Culture Standards can be supported through Organisational culture and leadership ward-to-board, alongside 3 other interventions.

18. The intended impact of the Culture Change Improvement programme is improved patient experience (as measured by patient reported experience measures), a reduction in Restrictive Practice and improved staff experience (measured through Staff Survey Results). These expected benefits are aligned to our work to improve

the Early Warning Signs for inpatient quality, detailed in point 21 and 22.

19. Realising the workforce growth ambitions of the NHS Long Term Workforce Plan is fundamental in boosting the therapeutic offer of inpatient mental health care where it is needed, equipping community services to intervene early before crisis, and improving the overall experience of both service users and staff.

### Support systems and providers facing immediate challenges and make oversight and support arrangement fit for the sector – objective three and four

20. It is critical that whilst sustainable transformation is underway, we collectively focus on people and families who are at risk of being cared for in unsafe and poor-quality settings now.

21. In support of local Quality assurance and improvement, the Quality Transformation Programme is:

1. Supporting regions and systems to identify those units most at risk of developing a closed culture through the development of a tool aligned to inherent risk factors and drawing upon CQC ratings.
2. Making available a range of quality recovery offers to complement existing improvement offers, which systems and regions can draw upon as needed.

22. To support providers, systems and quality governance bodies to more proactively spot and reduce risks to poor quality care, the Quality Transformation Programme is developing a suite of evidence-based Early Warning Signs aligned to the inherent risk factors and agreeing roles and responsibilities for proactive action.

23. Sentinel metrics aligned to the inherent risk factors will be agreed in early 2024, with a view to update and align the NHS Oversight Framework and system-facing support tools thereafter. This will improve the ability to identify quality and safety concerns early in order for improvement to be realised sooner.

### Interdependencies and wider considerations

24. Through our inpatient quality transformation work with colleagues across the country, we are seeking to address the root causes that have created poor quality and unsafe mental health inpatient care.

25. Throughout 24/25 we will continue to support Integrated Care Systems and their provider colleagues to drive transformation across the whole health and care pathway, which is critical if we are to achieve the ambition of a bold, reimagined model of care which promotes autonomy and choice, therapeutic benefit and least restrictive care in line with the Independent Review of the Mental Health Act (https://assets.publishing.service.gov.uk/media/5c6596a7ed915d045f37798c/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf).

26. There remain two rate limiting factors which systems and providers are working creatively to overcome, but which remain significant challenges. Those are workforce growth, retention and recruitment, and addressing quality issues with the physical estate.

### Next steps

27. The Quality Transformation programme has a number of deliverables for 2024/25, set out below:

| Objective | Deliverable | Due date |
|---|---|---|
| 5 | Agree and signal Early Warning Signs of quality and safety issues in Mental Health, Learning Disability and Autism Inpatient Settings | April 2024 |
| 1 | Integrate care boards publish 3-year ans to localise and realign care | June 2024 |

| Objective | Deliverable | Due date |
|---|---|---|
| 4 | Implement approach to better co-ordinate quality support for challenged providers and systems | June 2024 |
| 1 | Test viability of 24/7 open access community services which promote continuity of care across community and inpatient | July 2024 |
| 2 | Publish co-produced sector guidance on Digital Solutions in Inpatient Services | October 2024 |
| 3 | Publish guidance on recognising, reporting and learning from coercive care | December 2024 |
| 1 | Launch Implementation of Children and Young People's Inpatient Model Review | March 2025 |

### References

[1] Rapid review into data on mental health inpatient settings: final report and recommendations – GOV.UK (www.gov.uk) (https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations)

[2] NHS England » Safe and wellbeing reviews: thematic review and lessons learned (https://www.england.nhs.uk/publication/safe-and-wellbeing-reviews-thematic-review-and-lessons-learned/)

[3] Baroness Hollins' final report: My heart breaks – solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people – GOV.UK (www.gov.uk) (https://www.gov.uk/government/publications/independent-care-education-and-treatment-reviews-final-report-2023/baroness-hollins-final-report-my-heart-breaks-solitary-confinement-in-hospital-has-no-therapeutic-benefit-for-people-with-a-learning-disability-an)

[4] 'a poor culture that can lead to harm, including human rights breaches such as abuse'

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