

Classification: Official



To: Norfolk Safeguarding Adult Board

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

08.09.2021

Embargoed until 11.15 on 09.09.21

Dear Ms Maughan and Ms Roach

RESPONSE TO NORFOLK SAFEGUARDING ADULT BOARD SAFEGUARDING ADULTS REVIEW – JOANNA, “JON” AND BEN

Thank you for sharing the findings of your investigation into the appalling incidents at Cawston Park, Norfolk.

First and foremost, our thoughts are with the families and friends of Joanna, “Jon”, and Ben who have been through such devastating experiences. Our deepest sympathies remain with them.

The standards of care experienced by Joanna, Jon and Ben fell well below those expected in any service either run by the NHS or being delivered on behalf of the NHS.

We can confirm to you that Jeesal Cawston Park is now closed and Jeesal is not operating any other mental health hospitals.

NHS England and NHS Improvement’s regional and national teams were closely involved in the closure of the hospital, working with the host commissioner, Clinical Commissioning Groups and the Care Quality Commission.

All of the people who were inpatient at Cawston Park have moved either to a supported community setting or to alternative inpatient settings.

We urge Jeesal to take responsibility for their role in failing our patients. We also wish to assure you that where the NHS can improve we are determined to do so.

The NHS is already taking action to safeguard the safety of our patients in inpatient care; however, we recognise that more must be done. We welcome the

recommendations in the Safeguarding Adults Review and outline below how NHS England and NHS Improvement intend to respond.

We have included a comprehensive response to each recommendation in the annex to this letter, which include:

- In light of the Safeguarding Adult Review findings, we will be undertaking a review, working with commissioners, of every single inpatient with a learning disability, autism or both in a mental health inpatient care setting to ensure that each person has a clear care and treatment plan and discharge date in place. If these are not in place, the review will explore why not.
- We will give guidance on 'due diligence' for commissioners when they are making a decision about the most suitable inpatient provision for an individual. We will incorporate the learning from the Safeguarding Adult Review report in this new guidance.
- We will review the Commissioner Oversight Guidance in the light of these recommendations to ensure that there is sufficient emphasis upon the need for commissioners to check the daily activities, physical healthcare, sleep and medication of people in mental health inpatient care.
- NHS England and NHS Improvement will develop specific guidance about the use of CPAP equipment for people with a learning disability and autistic people with clear guidelines about how to support individuals who may find the equipment uncomfortable or distressing to wear. This will include information about who should be informed as soon as there is a variation from the prescribed use.

These actions complement the measures the NHS is taking to improve safety for our patients with a learning disability, autism or both, which include:

- Commissioners are required to visit individuals in a mental health inpatient unit for whom they have commissioned the care. The visits should take place at least every eight weeks for adults and at least every six weeks for children and young people. The visits are intended to offer an additional, regular quality oversight of the care that each person is receiving in hospital; to provide an opportunity for the person to speak directly to their commissioner of care to raise any concerns or issues. The date of the last commissioner visit is now included in our Assuring Transformation dataset so that we have confirmation that these visits have taken place.
- The Care (Education) and Treatment Review Policy refresh will ensure it strengthens the focus on the physical healthcare of people with a learning disability and autistic people in mental health hospitals.

Our aim is to provide more care and treatment for people with a learning disability and autistic people in the community, closer to home. Importantly, this is what people and their families tell us they want. Working with providers, councils and most importantly individuals and their families, progressing this work is a major priority for

NHS England and NHS Improvement, the new integrated care systems which are being set up across England and provider collaboratives that have or are being established across England.

We are making progress in reducing reliance on inpatient care for people with a learning disability and autistic people. Since the start of the Transforming Care programme in 2015, significant numbers of people have left hospital for successful lives in the community and there has been a 29% reduction in the overall number of people with a learning disability, autism or both in a mental health inpatient setting since March 2015.

In order to better support patients and families and to prevent people from being admitted to hospital in the first place, in 2021/22, we are investing £45 million in strengthening intensive community support and admission avoidance work. But we recognise that we need to go further and faster working closely with social care and voluntary and community sector partners to ensure that people can access care, support and treatment in their local communities, at home or close to home. Our newly appointed national Director for Learning Disability and Autism will make this work his top priority once he is in post in September 2021.

Joanna, Jon and Ben should have never experienced such pain, suffering and neglect at Cawston Park and we are determined to continue to improve the quality of care in any setting that provides mental health inpatient care in England.

We trust our response demonstrates our commitment to making that happen, for the memory of Joanna, "Jon" and Ben and for the safety of all our patients.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Claire Murdoch'.

Claire Murdoch C.B.E.
National Director of Mental Health, Learning Disability & Autism
NHS England and NHS Improvement

NHS England and NHS Improvement – Safeguarding Adults Review Action

Recommendation	Actions already in place	Future actions
<p>Recommendation d) NHS England should ensure that (i) all placing CCGs are proactive in ensuring that they have up to date knowledge about the services they commission and how these are experienced.</p>	<p>NHS England and NHS Improvement gives national and regional guidance and support to Clinical Commissioning Groups in relation to commissioning of mental health inpatient care for people with a learning disability and autistic people.</p> <p>This year, we have published guidance about Host Commissioner arrangements Host Commissioners and Commissioner Oversight Visits Commissioner Oversight Visits.</p> <p>Host Commissioner guidance</p> <p>This sets out arrangements whereby a particular Clinical Commissioning Group will have additional oversight for the quality of care in an independent hospital setting in its local area. The Host Commissioner will take responsibility for co-ordinating the involvement and response of all placing commissioners if there are significant quality concerns about the hospital that require a joined up response. A national Host Commissioners Forum has been established which is available to all host commissioners. It allows the opportunity for commissioners to share ‘soft intelligence’ about</p>	<p>This year we will be producing additional guidance clarifying Roles and Responsibilities for Quality Assurance for commissioners. We will give guidance about how to ensure that information from people and families about the quality of care is used alongside other sources of information. We will give guidance on ‘due diligence’ for commissioners when they are making a decision about the most suitable inpatient provision for an individual. We will incorporate the learning from the Safeguarding Adult Review report in this new guidance.</p> <p>The NHS is working with partners to put in place support for commissioners including a learning disability and autism commissioning qualification. This has been successfully piloted in the South West and will be rolled out across the country.</p>

particular inpatient units, to highlight and to share commissioner approaches for addressing quality issues.

Commissioner Oversight Guidance

This sets out arrangements for commissioners to visit those people in a mental health inpatient unit for whom they have commissioned the care. The visits should take place at least every eight weeks for adults and at least every six weeks for children and young people. The visits are intended to offer an additional, regular quality oversight of the care that each person is receiving in hospital; to provide an opportunity for the person to speak directly to their commissioner of care to raise any concerns or issues

In 2021 we included metrics in our Assuring Transformation dataset to include confirmation that these visits have taken place and are reviewing the quality of this reported information. The guidance for the visits is based on the principles of the existing NHS England and Improvement initiative, Ask, Listen, Do www.england.nhs.uk/learning-disabilities/about/ask-listen-do/. This is about changing how things are done so that people with a learning disability, autistic people and their families have their voices heard and encounter a better experience of care.

<p>(ii) that when transfers take place between in-patient settings, these cease to be recorded as “continuous inpatient stay ...treatment for the purposes of the one year CTR.”.</p>	<p>We count continuous length of stay for each patient within the Assuring Transformation dataset as this better reflects how long the person has been in hospital rather than just the most recent episode of care, and continue to believe it is important that we understand the totality of a person’s length of stay in hospital.</p> <p>Our Care, (Education) and Treatment policies set out that a child in inpatient care should have a review at least every three months; adults in non-secure inpatient settings should have one at least every six months and adults in secure inpatient settings should have one at least every twelve months. The date of the first review will be calculated either from the date the person is admitted or from the date they are diagnosed with a learning disability or autism (if the diagnosis takes place after admission).</p> <p>Currently if a person is transferred from one inpatient unit to another, it does not automatically trigger another C(E)TR. However, we do encourage commissioners to schedule a review in these circumstances.</p>	<p>We will include as a requirement in the forthcoming refresh of the national Care (Education) and Treatment Review policy that a C(E)TR is undertaken when a person moves from one hospital to another regardless of the date of the last C(E)TR.</p>
<p>Recommendation g): NSAB should share this review with NHS England since it was responsible for Jon’s placement. Both NHS England and</p>	<p>NHS England and NHS Improvement are very clear that, when a person is receiving care and treatment in an inpatient setting, all of their health needs (physical as well as mental) should be met with effective care and treatment including any physical health conditions that they might have. Opportunities to participate in</p>	<p>We will review the Commissioner Oversight Guidance in the light of this recommendation to ensure that there is sufficient emphasis upon the need for commissioners to check daily activities, physical healthcare, sleep and</p>

<p>the CCGs responsible for placing people at Cawston Park Hospital should visit services, host reviews and ask questions</p> <p>CLARIFICATION FROM NHSEI</p> <p>NHS England and NHS Improvement was not responsible for the commissioning of care for “Jon” nor the other two individuals whose care was the subject of this Safeguarding Adults Review. The commissioner of care for “Jon” was Merton Clinical Commissioning Group (London).</p>	<p>meaningful activities and healthy and active daily routines should be an integral part of the care and treatment that people receive.</p> <p>Below, we have outlined some of the key aspects of national NHS England and NHS Improvement work that relate to the quality of inpatient care for people with a learning disability and autistic people and to commissioner oversight and scrutiny of the care for people they are responsible for:</p> <p>Care (Education) and Treatment Reviews</p> <p>In 2021’s LeDeR Action from Learning report, we have made a commitment to reviewing the physical healthcare questions in Care Education and Treatment Reviews to ensure that people admitted to inpatient units and people at risk of admission receive high quality physical healthcare plans in place that are regularly reviewed.</p> <p>Annual health checks and health action plans</p> <p>Those with a learning disability should always be offered an annual health check if they are in hospital and the amends to the C(E)TR guidance will strengthen the mechanisms to check in relation to this.</p>	<p>medication. We know how important this is.</p> <p>We will be publishing an updated Care (Education) and Treatment policy by the end of 2021. We will include the LeDeR commitment in the new policy and a new quality of life question will support greater questioning and challenge around people being able to participate in activities and exercise and keep busy whilst in hospital; how people are supported to maintain a healthy weight; medication and nutrition.</p>
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	<p>This year's LeDeR Action from Learning report makes a commitment to ensuring that people subject to mental health (or criminal justice restrictions) are risk stratified and prioritised for an annual health check and health action plan.</p> <p>Questions to be asked during commissioner visits Our Commissioner Oversight Guidance emphasises the importance of commissioners making effort to properly understand people's experiences day to day during their hospital stay and gives examples of questions that could be asked during the commissioner's visit about what activities the person is doing, what their days are like. The template family feedback form in the guidance asks questions about physical health and medication.</p>	
<p>Recommendation h) NHS England should be invited to provide evidence to NSAB that these questions have been circulated and incorporated into its own processes.</p>		<p>We will share the Safeguarding Adult Review report with our regional teams and ask them to disseminate to Clinical Commissioning Groups.</p> <p>We will hold learning webinar sessions for commissioners to support their understanding of the learning from the SAR and re-enforce the current guidance for commissioner oversight and quality assurance.</p>

<p>Recommendation i) NHS England is invited to bring forward evidence of strengthened mechanisms for; discharge dates; the stability of accommodation within a service; close attention to an inpatient’s physical health needs and experiences; their mental health needs and experiences and the service’s track record in addressing these.</p>	<p>We have set out below information about relevant work:</p> <p>Supporting timely discharge from inpatient care</p> <p>As well as case management and oversight by local commissioners and care teams, NHS regional learning disability and autism teams use a 12 point discharge plan and care room approaches (regular reviews of care plans at an individual level) to ensure that a person’s care and treatment in an inpatient unit remains appropriate and that actions are happening to support the person’s to be discharged as quickly as possible. We have recently revised the Assuring Transformation (AT) dataset¹ to include a greater level of detail about discharge planning, reported by commissioners at an individual level. The relevant questions within AT are:</p> <ul style="list-style-type: none"> • Is there a planned date for transfer/discharge? • What is the timescale for the planned transfer/ discharge? • What type of setting is the person being transferred/ discharged to? • Who has agreed the transfer/ discharge? • Is the person’s discharge delayed? • Reasons for a delayed discharge 	<p>In light of the SAR report we will be undertaking a review of every single inpatient with a learning disability, autism or both in a mental health inpatient care setting with their commissioner to ensure there is a clear formulation, care plan and discharge date in place and if not to explore why not.</p>
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¹ Assuring Transformation data collection by NHS Digital who publish monthly data on the care of people with a learning disability, autism or both in a mental health inpatient setting:

<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/assuring-transformation/reports-from-assuring-transformation-collection>

	<p>Supporting physical healthcare in inpatient care It is already an expectation that Care (Education) and Treatment Reviews should look at people’s activities, check that the hospital is meeting their physical health needs; to look at whether any medication is appropriate. We will be publishing a revised Care (Education) and Treatment policy by the end of the year. These are some of the issues/questions we want to cover in the new quality of life question in C(E)TRs: not a lot to do; lack of opportunities; becoming overweight due to a combination of lack of any or little exercise, medication and poor nutrition. We expect any mental health inpatient care provision to be able to adequately and effectively meet the health care needs of an individual they are caring for.</p> <p>Use of CPAP machines for sleep apnoea It was a very worrying finding by the review that people were not being supported properly to make use of CPAP machines and that there were insufficient checks to make sure that broken equipment was fixed.</p> <p>Support for commissioners Commissioners have responsibility for oversight of the appropriateness and quality of care for the people that they commission services for. This year we have undertaken work to look at how we support the effective commissioning of health services for people with a</p>	<p>In light of these findings and learning from other reviews, NHS England and NHS Improvement will be developing and issuing specific guidance about the use of CPAP for individuals with a learning disability and autistic people with clear guidelines about how to support individuals who may find the equipment uncomfortable or distressing to wear. This will include information about who</p>
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	<p>learning disability and autistic people. We have worked with Skills for Care and Health Education England on the development and delivery of a Commissioning Qualification which is now live.</p> <p>Funding in 2020/21 to support quality of inpatient care</p> <p>Mental health recovery money for 2021/22 for the NHS learning disability and autism programme includes £11million for initiatives to support quality of care and timely discharge: a review of advocacy; care facilitation and life planning for people in long term segregation/ with long lengths of stay; autism training for staff; sensory informed environments.</p> <p>Finally, we have an absolute determination to ensuring that the dynamic, proactive and person-centred community support exists that can avoid people having to go into an inpatient setting to have their mental health needs met. Our work with the Small Supports programme, delivery of our housing programme and our admission avoidance work for children and young people all show that people can be supported successfully in their own homes.</p> <p>Models of commissioning for inpatient care</p> <p>We recognise the criticisms of the current models of commissioning for inpatient mental health care, especially when individuals are being moved away from their families and local communities. Our commitment</p>	<p>should be informed as soon as there is a variation from the prescribed use.</p>
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	<p>to Provider Collaboratives moves us closer to local commissioning for secure, specialist learning disability and autism and children's mental health care. However, we accept there remains a large number of adults whose places are commissioned through their CCGs on an individual basis</p>	<p>Whilst we have introduced measures – including the host commissioner oversight arrangements – we are exploring what additional measures we can take to address the challenges and risks that this model of commissioning entails.</p>
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