NHS England and NHS Improvement

Chief Executives – Mental health trusts

Medical Directors – Mental health trusts

Directors of Nursing – Mental health trusts

Dear colleagues, Parliamentary and Health Service Ombudsman report – Missed Opportunities:

What lessons can be learned from failings at the North Essex Partnership University NHS Foundation Trust

We wanted to draw your attention to the Parliamentary and Health Services Ombudsman (PHSO) report entitled Missed Opportunities, published in June of this year.

The report sets out a series of significant failings in the care and treatment of two vulnerable young men who died soon after being admitted to a mental health trust in 2008 and 2012 respectively and describes how the lack of a learning environment and culture meant that key lessons were not learnt from the first death and indeed not implemented until a number of years after the second death.

We want to commend the PHSO on their report and urge leaders of mental health trusts to consider the learning from this report and the implications for their own cultures and organisations processes and training, in relation to patient safety and quality improvement. We are sure, you will do as we have done and read this report not just as professionals but as parents and understand the gravity of the lessons being learned.

The PHSO report recommended that NHS England and NHS Improvement undertake a review of how the trust leadership and culture contributed to these failings in patient safety and what lessons can be learnt for the wider NHS as it strives to strength the quality of care for people with mental health needs. This review will begin as soon as the Health and Safety Executive have concluded their work and will be led by the regional team in line with the Ombudsman’s recommendations. Once this review is undertaken we will update you again and share any learning points, recommendations and actions with you.

Both cases involved a failure to adequately undertake a full assessment and management of the clinical risk and to develop appropriate plans to ensure the patients’ safety. Therefore we want to remind colleagues that Trusts should ensure their policies reflect NICE Guidance1 on the use of risk assessment and incorporate latest evidence and best practice in the assessment and management of clinical risk.

1 These guidelines are being reviewed and updated, with publication likely in 2021.

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Risk assessment tools should not be used on their own, but as part of a comprehensive assessment at points of key decision making.

Trusts should also seek to improve assessment of ligature points and environmental risks. It is essential that trusts access the Estates and Facilities Alert – Assessment of ligature points, and subsequent alerts from the NHS England and NHS Improvement Estates and Facilities Team via the Central Alerting System log on.

In July, NHS England and NHS Improvement published the NHS Patient Safety Strategy. The strategy sets out the actions we will take on safety to support NHS organisations by embracing the principle of continuous safety improvement, underpinned by a safety culture and effective safety systems.

Lastly, the recent publication of the NHS Mental Health Implementation Plan 2019/20 – 2023/24 outlines investment in acute mental health care to ensure that this offers an increasingly therapeutic experience and drives improved outcomes for individuals, which colleagues across the country will be planning to deliver as part of the STP/ICS strategic plans.

Thank you for your continued work to improve the quality of care and patient safety in our mental health services.

Yours sincerely,

Prof Tim Kendall

National Clinical Director for Mental Health

Dr Aidan Fowler

National Director of Patient Safety