Report to Health Scrutiny Sub-Committee

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Report of:	Sheffield Health & Social Care NHS Foundation NHS Trust
Report to:	Health Scrutiny Sub-Committee
Date:	8th March 2023
Subject:	Lesson Learned from the Inadequate CQC Rating of the Assessment and Treatment Service (ATS) at Firshill Rise.

Purpose of Report:

- To inform Health Scrutiny Sub Committee of the concerns raised with regard the Assessment and Treatment Service (ATS) at Firshill, the lessons learned and actions taken to address the concerns.
- To consider the implications of other national high profile deficiencies in service provision for residential and in-patient care for services in Sheffield and actions taken.
- To understand the key areas of learning and actions related to accountability, leadership, governance arrangements, engagement with service users and carers and the health and social care strategy.
- To consider how this work has informed the learning disability transformation project.
- To give the Committee an opportunity to comment on this work.

Recommendations:

That the Committee:

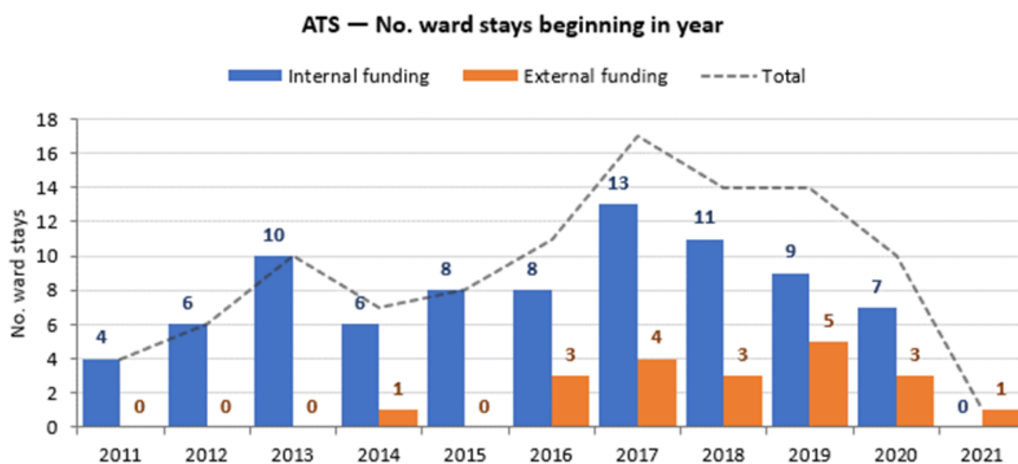
I. Notes the issues raised in the paper and considers in line with the work to

rebalance and modernise the provision and model of community services to support people with learning disabilities and their families in Sheffield.

Lesson Learned from the Inadequate CQC Rating of the Assessment and Treatment Service (ATS) at Firshill Rise

1. Background

The Assessment and Treatment Service (ATS) at Firshill Rise was commissioned as a 7 bed unit for people with learning disabilities with additional complex needs arising out of mental health and behavioural issues. The service provided hospital care to people from Sheffield and the wider region. The unit was staffed by a multi-disciplinary team including nurses, support workers, psychiatrists, psychology, occupational therapy, speech and language therapists and physiotherapy.
The demand for in-patient care for people with learning disabilities has been decreasing since the development of the transforming care agenda that has supported people to return from inappropriate hospital placements, many of which were out of area. In 2020, there were only seven people who needed hospital care. This dropped to zero in 2021.



Since the temporary closure of the ATS in 2021 we have not identified any service users who required specialist hospital care in an ATS. There have been two admissions to mainstream adult mental health beds which were appropriately managed on an adult acute ward with in-reach from the community learning disability service. This is in line with best practice outlined in the Greenlight Tool Kit, a tool to audit and improve mental health services for people with a learning disability. This supports people with a learning disability to access needs-led care and treatment in mainstream services.

In 2020 a new leadership structure was introduced to the learning disability service and concerns surfaced about the care and treatment at the ATS. This led to immediate actions and an external review. The Care Quality Commission (CQC) were alerted to the concerns about the ATS immediately. A subsequent CQC Inspection Report found that the service was inadequate. Sheffield Health and Social Care Foundation NHS Trust takes full responsibility for the inadequacy of the service provided and has undertaken a full review of service provision and learnt lessons across the whole organisation. Sheffield Health and Social Care NHS Foundation Trust issued a statement accepting full responsibility for service failings and outlining a programme of improvement in June 2021. Sheffield Clinical Commissioning Group (CCG) and Sheffield City Council have worked collaboratively with Sheffield Health and Social Care to deliver a service improvement programme for learning disability services.

2. Investigation into Service User Care

Sheffield Health and Social Care NHS Trust Foundation Trust commissioned an external investigation into the care and treatment of a service user who was an inpatient for 2 years at the Assessment and Treatment Service after concerns were initially raised in early 2021. The report was commissioned in March 2021.

The local authority commissioned a section 42 report, this report has not yet been shared with Sheffield Health and Social Care Foundation NHS Trust.

The paper outlines the areas for investigation and the concerns that were identified. The investigation considered whether:

- **Care was delivered in line with expected local and national quality standards.**

  The report found concerns in the following areas:

  1. Diagnosis
  2. Care Planning
  3. Explanation of medications
  4. Activities
  5. Seclusion
  6. Effective multi-disciplinary team working

- **The service followed policies and procedures following incidents and allegations.**

  The report found concerns in the following areas:

1. Under reporting of seclusion
2. Timeliness of reviews of incidents
3. Quality of incident reports and immediate actions
4. Ineffective responses into incidents

- **Safeguarding procedures were followed.**

  The report found concerns in the following areas:

  1. Ineffective systems between the local authority and Sheffield Health and Social Care NHS Foundation Trust for reporting safeguarding concerns
  2. Lack of feedback from the local authority safeguarding team

- **Issues were appropriately escalated.**

  The report found concerns in the following areas:

  1. Not all incidents were escalated.
  2. Concerns that the suitability of the placement was not escalated.
  3. Failure to escalate the lack of advocacy for service users.

Staffing

The investigation reviewed staffing issues and found that there were instances when the staffing levels fell beneath the required standard. The rate of supervision compliance for the ATS was 30-40% against the Sheffield Health and Social Care Foundation NHS Trust standard of 80% of staff receiving at least 8 supervisions per year. The process of offering staff debriefs after incidents was inconsistent.

Appropriateness of the placement

The unit aimed to provide hospital care for of up to 6 months. One service user received care for more than 24 months, which was longer than needed. There were regular Care and Treatment Reviews in line with NHS England Policy. Five Care and Treatment Reviews took place in line with the expected frequency. There were regular commissioner oversight visits but the conclusion of the report was that these did not include contact with advocates, family and only one visit out of five mentioned a discussion with the service user.

Access to Advocacy

There was access to an advocate on a regular basis which were every 2-3 weeks. The advocate discussed a range of issues from future accommodation needs to activities the service user liked to do.

Summary

The summary of the external investigation was that there was poor leadership, management and a lack of guidance at the Assessment and Treatment Service. There was not sufficient oversight, support and challenge to provide a good quality of care. There were concerns about the effectiveness of safeguarding. There were missed opportunities to have provided effective care and treatment.

3. Care Quality Commission Inspection

A CQC inspection took place at ATS between 28th April 2021 – 10th May 2021. The subsequent report published on 15th July 2021 rated the service as inadequate.

The key findings of the report were:

- The service could not evidence it followed the principles of the Right Support. Right Care, Right Culture.
- The service was not safe with concerns about staffing skills and training, medications management and safeguarding.
- The service was not effective. Care was not person centred. The multi-disciplinary team was not effective. Patients did not receive outcome focussed care in line with best practice. Communication was poor impacting on consistent care and treatment.
- The service was not caring with evidence of staff ignoring people's requests for basic needs. Relatives were not involved in the care of their relatives.
- The service was not responsive. Discharge planning was poor with long lengths of stay. Staff did not meet the needs of people who's first language was not English. People were not supported to access meaningful activities and develop skills in preparation for discharge.
- The service was not well led. Governance processes were not adequate. There was no ward manager, the matron and general manager were new into post. Actions were not progressed to effect change. Staff did not feel supported and were not provided with appropriate training and guidance.

- The nature of the concerns meant that restrictions were put in place to prevent the service from accepting admissions. The service was required to submit regular updates to the CQC.

4. **Learning from National Quality Concerns with Hospital and Residential Placements for people with learning disability and mental health problems.**

There have been a number of national high profile institutional failures regarding in-patient and residential services including Whorlton Hall and Winterbourne. The response to these serious issues has informed the Sheffield Health and Social Care Foundation NHS Trust's response to the failures at the ATS.

In addition on Wednesday 28 September 2022 Panorama aired an undercover documentary into Edenfield, a secure unit run by Greater Manchester Mental Health Trust. The programme highlighted a culture that had grown and pervaded across teams and wards. The behaviours of staff towards some of the most vulnerable people in society, admitted for care and treatment was unacceptable. It highlighted a toxic culture and deficits in the system. Later in October 2022 Channel 4 dispatches aired "Hospital Undercover: Are our Mental Health Wards Safe" which shared concerns about the safety of wards, use of bank and agency staff, observation of vulnerable service users, prevalence of ligatures and responses to removal, overuse of restraint and attitudinal issues within both NHS and independent provision.

Sheffield Health and Social Care Foundation NHS Trust leadership issued a statement to highlight that the values and behaviours of staff at Manchester's Edensfield Unit were unacceptable, we also recognised the role of leaders to prevent these cultures developing and to ensure we maintain good standards of care. Leaders subsequently gathered to reflect and consider how we could be assured on our cultures and further actions we could take to support healthy workplaces for staff and service users.

It would be remiss to not mention the poor-quality care delivered in ATS during 2020/21 which led to the subsequent pausing of admissions whilst an independent investigation into the care of service users took place, and a broader Section 42 safeguarding enquiry was completed by the Local Authority. Sheffield Health and Social Care Foundation NHS Trust has reflected and acted on the issues raised within the learning to prevent poor cultures developing.

5. **Lessons Learned and Actions**

i. Accountability

Sheffield Health and Social Care HNS Foundation Trust issued the following statement following the publication of the CQC Report.

> ‘We are very sorry that we have not delivered good care consistently in our unit at Firshill Rise and we will improve the care provided there.
>
> ‘We have now temporarily closed the unit to admission to give us time to make the required changes including training staff and thinking carefully about how we provide services in the future. The service users who are still in the unit have more activities and extra support to help them have a better experience of our care.’

The external review and the CQC review resulted in consideration and actions related to accountability. An approach of organisational learning was adopted to seek to learn lessons and take appropriate action. This was combined with consideration of any appropriate human resource procedures and actions for individuals with specific responsibility for the failings in the service. This identified personal and organisational learning alongside consideration of disciplinary action where appropriate.

ii. Leadership

A review of the leadership for the learning disability service including both the ATS and community teams took place once concerns were raised. A new leadership structure was implemented that strengthened multi-disciplinary leadership. This included recruitment to a new matron role, a clinical director who is an experienced learning disability consultant psychiatrist and a general manager. This team are full time and provide dedicated leadership for learning disability services in Sheffield.
Sheffield Health and Social Care Foundation NHS Trust implemented a new directorate leadership structure that has enhanced clinical leadership. This directorate leadership structure provides clinical and operational leadership to oversee all clinical services in the Trust. The new structure now includes dedicated leadership time with the following roles; Clinical Director, Head of Nursing, Head of Service, Lead Psychologist and Lead Allied Health Professional. A Head of Social Work works across both clinical directorates has also been appointed. Recruitment into new posts has included attracting people with expertise in learning disability from throughout England.

iii. Governance

Sheffield Health and Social Care Foundation NHS Trust has reviewed and enhanced governance arrangements since the Trust received an inadequate CQC rating in June 2020, the ATS inadequate rating and the report into the Edensfield service.
This has included:

- Improved visit schedule for Board members to meet service users and staff on all sites.
- Improved information reporting from team to board with detailed monthly performance reviews at team and board levels that are reviewed at team, service, directorate and board level.
- Review of training at mandated and developmental offer to improve skills and competency of clinical staff.
- Leadership investment in matrons and ward managers including specific clinical and leadership training.
- Systems to ensure compliance with supervision to ensure staff are receiving effective supervision for practice development, support and reflective practice.
- Freedom To Speak Up (FTSU) model developing with champion roles to enable better coverage across the Trust.
- Engagement – non professional leads working into inpatient units to hear patient voice
- Safeguarding mechanisms improved with stronger links to the local authority and clarity about responsibilities.
- Incident huddles – Every incident is reviewed independently with mechanisms to deep dive and to ensure good incident reporting and learn lessons.
- Lived Experience work opportunities to be developed across service lines.
- Every restrictive practice to be reviewed and scrutinized including additional scrutiny commenced for Seclusion above 72 hours.
- Long Term Segregation became a Board level event and with notification of any instances.
- Culture and Quality Visits – standard plan for all services. These visits have focussed on ensuring that issues of closed cultures are explored.
- Incidents/complaints and CQC enquiries are triangulated.
- Operational policies reviewed for all services.
- External accreditation – all services are supported to apply for external accreditation where there is a process to follow. This learning is applied in services and lessons learned are supported across services.

iv. Engagement with service users and carers

The learning disability service has engaged with service users and carers to support service transformation. This has included working with Sheffield Voices to organise a series of events that have involved a range of service users in developing current practice and designing new models of care.

Carers have been involved in forums to consider practice and develop new models.

A transformation board was established which was jointly chaired with a service user and had representation from carers and experts by experience.

Reports and lessons learned have been shared with carers and service users of the ATS to support accountability and candour.

v. Clinical & Social Care Strategy

A clinical and social care strategy has been developed. This is being implemented across all services.
The strategy is supporting development of care that is:

- Person Centred
- Strength Based
- Evidence Based
- Trauma Informed

The clinical and social care strategy has workstreams that working on each of these priorities across Sheffield Health and Social Care NHS Foundation Trust. All services are developing plans in line the strategy. The transformation programme for learning disability services has been developed.

6. Learning Disability Transformation

A project to oversee the strategic direction of learning disability services in Sheffield was established in 2021. This group is jointly chaired by a service user and the new clinical director for learning disability services.#

The membership of the group includes experts by experience, carers, clinical experts, representatives from Sheffield City Council, Sheffield Place, South Yorkshire ICB and representatives from the voluntary sector.

The project group has considered best practice from other services nationally. This has included visits to other services to consider different approaches. Evidence from national guidance has informed the development of the future direction. The work has been informed by experts by experience.