Safeguarding Adults Review

Shared Learning Brief

Independent Secure Hospital

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Foreword

The author would like to formally thank all those who contributed to the review for their honesty, openness and transparency throughout this review.

1 Introduction and Background

1.1 The purpose of this briefing paper is to outline the multi-agency lessons learned arising from the death of a patient and subsequent multi-agency safeguarding concerns at an independent secure hospital for patients with serious mental illness centrally located in Doncaster. The hospital is an independently owned hospital with most beds (97) commissioned by NHS England.

1.2 In response to this an independent consultant was commissioned by the Doncaster Adult Safeguarding Board; the author was previously a Chief Executive Officer of an independent sector mental health provider of a similar size and remit to the Doncaster independent hospital and was deemed to have the appropriate knowledge, skills and experience to carry out the review.

1.3 The aim was to identify any lessons that could be learnt by the hospital and those agencies that support it, that could further improve patient safety. The SAR was not intended to replace the formal processes in relation to the serious incidents themselves but to take a broader view of the hospital and the systems surrounding it embracing a 'Just culture' approach.

2 The Approach

2.1 A combination of interviews, documentation review and site visits were used to inform the review. The following agencies were involved in the review;

- Independent Secure Hospital
- Care Quality Commission
- NHS England
- Doncaster Adult Safeguarding Team
- Doncaster Advocacy Service
- Police
- Northumberland, Newcastle and North Tyneside NHS Trust
- Families

2.2 In keeping with the 'just culture' ethos of the review, individual feedback was treated anonymously, and this report will identify agencies and roles but not named individuals.

2.3 An important aspect to the review was to provide ongoing feedback throughout the process so that improvements did not need to wait until a report was issued. Agencies were found to be receptive to this and quickly instigated changes where this was indicated.

3 Key Findings

3.1 **Commitment to Patient Safety** - Across all agencies, there was a noticeable willingness and motivation to ensuring patients safety was prioritised and that the hospital and the agencies did their best to provide the best possible care to patients. Without exception, professionals responsible for putting systems around the patient to ensure patient safety were working hard to do so

3.2 **Formal levers were not always utilised fully -** the formal contract monitoring process in place, which ensures a quarterly exchange between commissioner and provider on the full range of patient issues had not taken place twice in a 12-month period. In addition, there is an NHS England Regional Safeguarding team which could have provided additional support to commissioners.

Also the Doncaster Safeguarding Adults Board 'procedure for the coordination of overarching safeguarding investigations' was not widely understood and/or represented by key agencies in a consistent way.

3.3 **Good processes need to be consistently applied** - The hospital was put into special measures in August 2017 as a result, regulatory activity and scrutiny by agencies increased exponentially, which created a huge demand and additional pressure upon the hospital. These findings were unexpected by the hospital despite being previously rated as 'requires improvement'.

Regulators and the hospital provider should consider reviewing their own systems to reassure themselves that they are effective in picking up issues on patient quality on a day to day basis.

3.4 **Hospital Corporate Governance** – There is need for the hospital to bring the business and quality agenda of the hospital closer together so that decisions about business development are considered alongside those about patient care.

The hospital should put in place a formally documented bi-monthly Board meeting to provide a clear audit trail of decisions made underpinned by a dashboard of information i.e. incidents, occupancy, staff sickness, training levels, supervision levels, overspends, quarterly clinical governance report, monthly accounts etc.

3.5 **Hospital Management Arrangements -** There had been significant change in relation to managerial roles and responsibilities for patient care in the previous 18 months with managers moving on and a new CEO taking over operational management. This continued to evolve at the time of the review. This was having an impact on the organisation as there was a noticeable difference in perception of the way in which the board and senior team functioned.

Multiple examples were found where this lack of clarity within the organisation had led to inefficient though not unsafe practices, such as the way in which CQC notifiable incidents and safeguarding events were reported which had significantly improved but still failed to provide a single point of reference within the hospital for analysis and to examine trends on a regular basis.

Additionally it was noted that the registered manager for the hospital was not operationally accountable for the wards for which they were registered. Whilst this is not unusual and not raised as a concern about the CQC appointment process, this can create difficulties and confusion on the frontline.

The Board should look towards quickly clarifying the management arrangements for the hospital to create stability and to improve and streamline its decision-making processes allowing the CEO to focus on managing the performance of the senior team as whole and further develop stakeholder engagement.

3.6 **Clinical Governance -** The hospital had made significant improvement in this area with newly established systems and processes. Clearly documented clinical governance meetings had taken place with full participation of key staff and a thorough review of the clinical activity in the hospital. The morning meeting provided a day to day avenue for the coordination of patient activity.

During the review hospital appointed its first external chair of the hospital's Clinical Governance Group in December 2018.

The hospital should consider two areas for further development; strengthening the reporting arrangements internally for the reporting of incidents and events so that there is a single point of contact for the analysis of this data and the identification of themes and, the bringing together of all its key data into a single dashboard. The latter could then be utilised by the whole organisation from the Board to the wards. Implemented correctly, the dashboard can drive the performance of the whole hospital, provide reassurance on key patient safety issues and give clarity to staff on day to day priorities as well as highlight areas for action at a very early stage.

3.7 **Supervision, Education and Working practices -** A common theme across all agencies was the lack of consistent supervision for those working in and in relation to mental health leading to unsupported and unnecessarily anxious staff. Within the hospital, key lead clinicians and managers had not received either management supervision, clinical supervision from someone with their own professional background and/ or appraisal for 6 months. Outside, the hospital, the adult safeguarding team had assigned the workload of the hospital to staff without any mental health background and at the time of the review, without supervision from someone with mental health experience. The reviewer also observed understandably effected staff at times suggesting further debriefing opportunities alongside formal supervision might be usefully considered.

Forensic mental health is a specialist area within the mental health field and supervision is a crucial way in which the quality of patient care can be reassured as well as supporting the performance and emotional wellbeing of conscientious staff. All agencies should reassure themselves that their own policies are being followed and are effective, and following serious incidents staff are given additional opportunities for debrief.

3.8 **Least Restrictive Practice and Patients' Rights -** A theme of the CQC inspection visit in 2017, leading to an overall rating of inadequate, was that the hospital fell significantly short of expected standards of care in relation to a patients' rights and freedoms within the hospital. The hospital has clearly worked hard to become more progressive since then, with family and friend visits on the wards, searching processes only undertaken for patients where the risk assessment indicates this necessary, access to mobile phones and the extent of patient property in the bedrooms.

However, despite previous work on this area between NHS England, the provider and the CQC, most hospital staff interviewed felt that the right balance had not yet been struck and the above changes had created difficult to manage incidents on the wards. Good care records which

document in an objective way a justifiable reason for taking any of these rights away would support this.

3.9 **Involvement of Family and Friends and Advocacy -** A well-attended family and friend's forum takes place at the hospital. This could be further strengthened with more frequent meetings and a clearer feedback loop which is publicised on the wards along the lines of 'they said, we did', an approach found to be successful in the NHS. The advocacy service provides a useful service which is widely accessed by patients, however, the current contract was stretched by patients accessing the patient helpline. Advocacy also chaired the forum; however this was recently changed to a member of the senior hospital team. The hospital may wish to reconsider an independent chair going forward.

The involvement of patients in their care plans is an important area for development. We came across differing views on the importance of this and the difficulty of achieving this in a meaningful way in a busy ward environment is not underestimated. However, time getting this right and supporting staff to understand its potential positive impact on the patient's recovery and the management of the patient's conditions on the wards is recommended.

3.10 **Multi-disciplinary working in the hospital and therapeutic models -** There was considerable confusion around the therapeutic models utilised in the hospital with reference to the Positive Behaviour Support model more recently implemented. Staff found the patients PBS plan too complicated to practically apply on the ward and that there was an inconsistent implementation depending on the experience and knowledge of the ward staff. This is a model which quickly breaks down if all staff do not consistently apply the agreements made in the PBS plan and this was demonstrated in an incident which required police involvement earlier in the year. The incident escalated quickly with the patient gaining access across the hospital with staff appearing unclear on what to do. Clear clinical leadership, a simplified model and training for all ward staff as a priority should be considered alongside a review of the approaches taken across the hospital.

The turbulence of the previous 18 months was found to have taken its toll on the individual disciplinary teams with the professionals feeling they could do more to support and lead the clinical models but unsure if they could do so. The clarification on management arrangements referred to earlier would address this; it was clear that the hospital had attracted some extremely talented and committed clinicians, all of whom were keen to do more to support the hospital on its improvement journey once given the freedom to do so.

4 The Recommendations

The recommendations are illustrated in Appendix 1

Appendix 1 – SHARED LEARNING SUMMARY RECOMMENDATIONS

Contract monitoring meetings

- NHS England to ensure there are regular fully documented contract monitoring meetings with the hospital, with priority given to learning the lessons from recent incidents and a review of performance with attention to incident and supervision levels.
- NHS England to consider using these meetings to more formally feedback case manager site visits.
- Hospital to identify specific contact point for all commissioning issues and ensure consistent attendance.

Commissioners

- NHS England commissioners to make links with the NHS England Regional Safeguarding team and update the team on the hospital's recent serious incidents with a view to securing potential support now and for the future.
- NHS England or external facilitator to coordinate a Doncaster based seminar on forensic mental health seeking contributions from RDASH and the hospital.

All Agencies

- To encourage a culture of learning and self-assessment which adopts a 'just blame' culture.
- To reassure themselves that clinical supervision and management support arrangements for all staff working in the mental health field are effective and where there have been serious incidents to ensure adequate debriefing has taken place.

Safeguarding Adult Service

- The adult safeguarding team to review the support and systems around staff assigned with the mental health portfolio. Where safeguarding officers do not have a mental health background, line managers should arrange open access to a mental health professional for the discussion of cases, formal supervision arrangements from someone with mental health experience and make explicit when cases should be referred onto agencies with a mental health background.
- The adult safeguarding team to ensure that all past and ongoing safeguarding cases are investigated and resolved against timescales and where this is not possible for them to be referred onto the appropriate agency. Consider producing a thematic report on the findings from these cases for sharing with agencies.

Independent Hospital

- The hospital to identify one senior manager responsible for receiving and reviewing all incident reports and whose responsibility it is for ensuring they are reported to the CQC and safeguarding team. Establish formal incident review group linked to clinical governance meeting. Hospital to review the reporting pathway and ensure staff understand this and where to go with issues. Update policy accordingly.
- Hospital to clarify the roles and responsibilities of the senior management team including lead clinicians with attention paid to who is accountable for the core service, namely, the wards with a clear link to the registered manager. Communicate new lines of accountability and consider external leadership development for all managers and lead clinicians.
- Hospital to strengthen the corporate governance of the hospital, bringing together the business and quality agenda into documented Board meetings.
- Hospital to implement a comprehensive KPI dashboard which pulls together a weekly snapshot of progress against the full range of related issues to include occupancy, staffing levels, incidents, supervision and training levels. Weekly management team meeting to review this data and identify areas for action.
- Hospital to review the understanding of front-line staff of the therapeutic models in the hospital and the current application for the PBS model. Hospital to prepare a learning and development plan utilising key members of the MDT to upskill ward teams on the delivery of these programmes.
- Hospital to consider reinstating independent chair to family and friends forum and to review the level of resource available for advocacy, particularly for case work. Hospital to identify a senior manager to act as the clear link point for the feedback of advocacy issues.

Regulators

- CQC to continue ongoing rigorous but practicable arrangements for progress monitoring with the hospital in recognition of the repeated areas of concern raised across CQC inspections since 2015.
- CQC to work with the hospital on how to more effectively balance least restrictive practice with keeping the patient safe, utilising the policies of those areas where this is a challenge as a basis for discussion, for example, patient property.

Advocacy Services

- Advocacy services to ensure in instances where there have been serious incidents that officers involved with these cases are given additional time over and above supervision arrangements, for de-briefing by someone with a mental health background as policy.

Doncaster Safeguarding Adult Board

- Doncaster Adult Safeguarding Board (DASB) have an important role in terms of being the conduit for information across agencies and they should maximise this opportunity to trigger multi agency investigations at as early a stage as possible where concerns of any nature have been raised.
- DASB should re-share and check the understanding of the procedure for the coordination of overarching safeguarding investigations amongst agencies.
- DASB should formalise its intention to utilise this more frequently going forward to pre-empt more embedded problems developing in struggling organisations.
- The DASB to consider requesting key reports relating to the hospital to be shared at board meeting or sub-group of the board.
- Doncaster Safeguarding Board to commission a 12-month review of actions taken following the formal receipt and presentation of this report.