Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Health Select Committee	Date:	9 January 2018

Agenda item	Title	Lead Presenter	Report author
	Avon and Wiltshire Mental Health Partnership Trust (AWP) CQC improvement programme - update	**Patrick McKee Clinical Lead, Wiltshire**	**Phil Cooper Associate Director of Governance**

This report is for:	
Decision	
Discussion	x
To Note	x

History

The Trust Received a comprehensive inspection in 2016 with a follow up focussed inspection in June 2017 from the Care Quality Commission (CQC).

The CQC published the Trusts 2017 Quality report on the 3 October 2017 and provided an overall rating of 'Requires Improvement', although the CQC rated 'Good' for caring, responsive and well-led.

This report will provide an update on the 'requirements' that the CQC reported in their Quality report, AWP's improvement programme and any recommendations.

This report will also go into greater depth on the main issues within the CQC report, which relate the Trusts Health Based Places of safety (HBPoS).

The CQC inspection report can be accessed here.

The following impacts have been identified and assessed within this report	
Equality	X
Quality	X
Privacy	X

Executive summary of key issues

CQC actions 2017

The CQC published the Trusts 2017 Quality report on the 3 October 2017 following 2 weeks of inspection. The overall rating was 'Requires Improvement', containing the following core area results:

- **Safe** Requires improvement
- **Effective** Requires improvement
- **Caring** Good
- **Responsive** Good
- **Well-led** Good

The CQC made 72 recommendations with 27 of these "actions the provider must take to improve". Requirements act as a precursor to enforcement and notify providers where they are failing. If providers do not improve then the CQC can move to formal enforcement action which including warning notices, special measures and prosecution.

A significant number of the 'Safe' and 'Effective' areas for improvement are related to the Trusts Health Based Places of safety (HBPoS) and to the newly acquired Children's CAMHS services in Bristol and South Gloucestershire.

This report addresses these strategic priorities:	
We will deliver the best care	x
We will support and develop our staff	
We will continually improve what we do	x
We will use our resources wisely	x
We will be future focussed	x

The specific HBPoS 'requirements'

Currently, there are 2 HBPoS in Wiltshire and 1 in Swindon. The CQC state that the Trust must make changes to the way in which individuals receive services, particularly in relation to the time that it takes to receive an assessment and the time taken to find a bed for those that require ongoing in-patient care. The CQC did acknowledge in their report that AWP Trust would not be able to resolve all issues without multi-agency solutions.

The specific 'requirements' are:

- 'There were significant problems accessing beds for people requiring admission to hospital. We saw examples of patients waiting 32 to 50 hours after being assessed in all the place of safety suites before admission to hospital'.
- The CQC stated that 'There was limited access to Section 12 Doctors (a Psychiatrist) who acts as a second opinion in the application of the (MHA) which was causing delays to Mental Health Act assessments, in order to work within the trust's Section 136 joint protocols and the Mental Health Act Code of Practice'.
- The CQC stated that 'There regularly remained significant delays in assessments commencing at the places of safety. There were significant problems with the availability of section 12 approved doctors. There were times when the AMHP services were delayed in attending due to the need to attend when the doctor was

available or due to problems with their own capacity to respond. Overall 61% of people waited more than 12 hours to be seen for assessment. This was an increase on the level of people waiting 12 hours or more than at our inspection in May 2016.

- The provider should ensure that local guidelines are followed so that the places of safety are staffed with staff trained in prevention and management of violence (PMVA).
- In 2016 the CQC stated 'that the HBPoS in Salisbury and Swindon lacked general space and both environments lacked an outdoor space that could be accessed without using the ward facilities, which created 'mixed' dynamic of ward based patients and detainees within the same area'.
- The provider must demonstrate that action is being taken to ensure that limitations on access to Section12 doctors are not responsible for delays to Mental Health act assessments in order to work within the trust's Section 136 joint protocols and the Mental Health Act Code of Practice.
- The provider must ensure that there are clear procedures and joint working arrangements in place with local authorities, to ensure assessments take place in a timely manner in the each place of safety and reduce the level of transfers between places of safety.

As from the 11th December 2017, the Police and Crime Act will amend the Mental Health Act to reduce the maximum period someone can be detained on a Section 135/6 from 72 to 24 hours. This change in the law increases the pressure to make significant changes to increase pace and flow through the system requiring oversight by staff skilled in managing and accessing 136 detention services. This change requires a dedicated HBPoS improving capability and capacity to manage these processes as efficiently and effectively as possible.

Other 'requirements'

There are other Wiltshire related 'requirements' that do not relate to the HBPoS, which are managed through the Trusts Governance, improvement and quality team and reporting to sub-committee and Trust Board

- Problems with personal alarm systems these are addressed quickly and replaced if necessary, to ensure optimum safety of patients, staff and visitors in Salisbury.
- All Staff must ensure they transfer patients' risks clearly to care plans.
- Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in each team in order to meet the demands on the service.
- Ensure that at all crisis/intensive teams there is sufficient monitoring of the medicines prescribed and held in the services.

Action update

The Trust, NHS England, Wiltshire and Swindon CCG's are currently working together to identify solutions to the issues raised by the CQC.

All 72 issues are now allocated to a work-steam and will be monitored and reported monthly to Clinical Quality overview group through subcommittee to the Trusts Board. Current position is that all actions related to RED and therefore risks are connected to the HBPoS in Wiltshire and Swindon.

The other issues highlighted in this report that do not relate to the HBPoS, such as the alarm system in Salisbury and on track and expected to be completed within the early in the new year.

The Trust has completed actions to ensure that medicines are managed more effectively in crisis/intensive teams.

All issues that are highlighted with risks are allocated on the Trusts risk registered and monitored and reported through committee to Trust Board on a monthly basis.

All issues are externally reported through the joint commissioning quality sub-group and any exceptions reported to all CCG's including Wiltshire.

Recommendations

The Trust, NHS England, Wiltshire and Swindon CCG's are currently working together to identify solutions to the issues raised by the CQC.

The Trust continues to address all of the 'requirements' from the CQC and to provide assurance to Trust Board.

The Trust continues to promote new ways to increase sufficient numbers of suitably qualified, competent, skilled and experienced staff across all of its services in Wiltshire. The Trust continues to promote retention of staff through engagement activity such as Listening into Action (LIA) and other staff benefits.