Wiltshire Council

Health and Wellbeing Board

20 November 2014

Subject: Avon and Wiltshire Mental Health Partnership (AWP) Care Quality Commission (CQC) Inspection

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Executive Summary

The report provides a summary of the recent inspection findings and the response of AWP to these.

Proposal(s)

It is recommended that the Board notes the update from AWP.

Reason for Proposal

The update outlines the measures being undertaken to ensure a good quality service is provided.

Iain Tulley — **Chief Executive**
Dr Elizabeth Hardwick — **Interim Clinical Director for Wiltshire**
Avon and Wiltshire Mental Health Partnership

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Subject: **Avon and Wiltshire Mental Health Partnership (AWP) Care Quality Commission (CQC) Inspection**

Purpose of Report

1. To outline AWP's action plan in response to the latest CQC inspection.

Background

2. The new CQC inspection methodology across health and social care commenced in 2013. For mental health providers the pilot wave inspections took place in January 2014 to October 2014.

3. The key changes to the inspection regime included a move from focused compliance based inspections by generic inspectors to judgement based, comprehensive inspections carried out by expert inspectors working with clinical advisors and service user and carer "experts by experience". The inspection considers the core domains of safety, effectiveness, caring, responsiveness and well-led across all core services and for the provider as a whole.

4. For providers inspected within the pilot waves although a full comprehensive inspection was carried and compliance action may be taken a shadow rating only was given which is not formally published.

5. AWP volunteered to be a pilot site for the early inspections to test out the improvement process already in place and progress the trust's application to become a foundation trust.

6. The inspection was carried out through the week of the 9th June. This was a weeklong process involving a team of approximately 80 inspectors, including clinical specialist advisors and service users. The team inspected every inpatient ward within the trust and a sample of community services in addition to interviews, focus groups with staff, listening events with service users and public and unannounced night visits.

Trustwide key findings

7. The report commended the transformation journey of the trust and the clinical focus and priorities. It stated good quality of care overall and compassionate care demonstrated by staff across the trust.

8. However 4 warning notices and 10 compliance actions were imposed following the report.

The warning notices related to:

Fromeside (secure service)

- Environment and ligatures
- Staffing numbers, supervision and management

- Hillview Lodge, Bath (acute in-patient unit)
  - Environment
- Whole trust
  - Failure to take action consistently on issues raised through governance mechanisms, by staff and by service users

9. All issues identified through the warning notices have been acted upon and responded to within the set timescales. The trust is awaiting CQC reinspection of these areas to confirm whether the warning notices will be lifted.

Findings with regard to Wiltshire

10. Wiltshire services inspected were:

- Imber ward, Green Lane Hospital – adult general ward
- Beechlydene ward, Fountain Way – adult general ward
- Ashdown ward, Fountain Way – Psychiatric intensive care unit
- Amblescroft North and South, Fountain Way – older adults inpatient care
- Place of safety – Green Lane Hospital
- Place of safety – Fountain Way
- ECT service – Green Lane Hospital
- North intensive team – crisis and home treatment service
- South intensive team – crisis and home treatment service
- North recovery team – adult community mental health service
- South CIT team – older adults community mental health service

11. The report commented on good overall quality of care and staff who were compassionate and treated patients with dignity and respect.

12. The ECT team highly commended by chair in verbal feedback to trust.

13. Robust local governance processes and processes for managing performance and behaviour issues were found with no concerns re safeguarding.

14. Good multi agency local working was commented on.

15. Feedback from service users contacted was that there had been no issues with access to crisis services

Key issues relating to Wiltshire

16. Areas of concern within the report relating to Wiltshire were

- Environment
    - Places of safety- ligature point and non barricadeable door in Fountain Way and concerns in both regarding the therapeutic environment for a person in distress
    - Fountain Way – temperature in clinic rooms, seclusion and wards
- Medicines storage, stock management and waste management
- Staff numbers, supervision and training – Ashdown and Beechlydene mentioned specifically with concern to staff numbers but concerns across all
- Delays both in MHA assessments and transfers of care
- Equipment maintenance at Fountain Way
- Staff felt isolated from the trust management structures

Process followed post report

17. Pre and post summit meetings were held with the CCG and local authority to discuss the findings in the local context and agree actions. Meetings were also held with local managers and teams.

18. A trust action plan was agreed with the CQC to address all warning notices and compliance actions within the allocated timescales. This was shared with the CCG and a set of local action plans were agreed with CCG/LA, capturing the trust issues and local ones and monitored through the existing monthly performance meeting

19. The CQC confirmed on initial unannounced visit in June that many of the issues originally raised within Fountain Way had already been dealt with. We are awaiting notification of the formal CQC reinspection to determine whether the warning notices will be lifted.

20. All equipment has now been serviced and has a maintenance schedule. An updated SLA is now in place with Salisbury District Hospital.

21. Anti ligature work has been carried out and new furniture ordered for the places of safety.

22. Medication storage and waste issues have been addressed and a new governance group has been set up within the locality to monitor medicines management and compliance with standards.

23. There is a temporary closure of beds in Fountain Way on both Ashdown and Beechlydene to ensure the service is functioning at safe and therapeutic staffing levels and an Intensive staff recruitment campaign is ongoing.

24. A staff concerns log has been launched on the locality webpage.

25. Supervision arrangements have improved – 87.7% in Wiltshire in October (trust target 85%) and ongoing weekly monitoring is in place.

26. All teams and wards have training plans in place to achieve full compliance and additional local training is being arranged where necessary. This includes a focus on the Mental Capacity Act.

27. Caseload profiling work was implemented in the CMHTs in the summer and the focus is currently on embedding work.

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