Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

NHS 70 YEARS OF THE NHS 1948 - 2018

# Meeting of BNSSG Governing Body

**Date: Tuesday 2nd October 2018**
**Time: 1.30pm**
**Location: The Vassall Centre, Gill Avenue, Downend, BS16 2QQ**

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## Agenda number: 7.3

## Report title: Avon & Wiltshire Mental Health NHS Partnership Quality Report

**Report Author:** Kate Chisholm-Mitchell, Lead Quality Manager & Bridget James, Associate Director of Quality
**Report Sponsor:** Anne Morris, Director of Nursing & Quality

### 1. Purpose

The purpose of this paper is to describe current quality concerns within Avon & Wiltshire Mental Health Partnership NHS Trust (AWP), focusing on both the most recent Care Quality Commission (CQC) inspection outcomes and local quality issues identified through quality contract monitoring. The paper will present the background, current position and mitigations for each of the areas identified.

### 2. Recommendations

The Governing Body is asked to note the contents of this report.

### 3. Executive Summary

Information has been provided regarding the issues which were identified within the 2017 Care Quality Commission (CQC) investigation report and actions which have been taken since. These include, health based place of safety and CAMHS services. It is noted that the CQC are due to revisit the Trust during September and October.

The report presents local issues, including; suicide prevention, Serious Incident management, perinatal mental health services, delayed transfers of care and physical healthcare monitoring.

The CCG will continue to closely support and monitor the Trust in its endeavours to improve quality via the monthly Quality Sub Group, Performance and Contracting LCQPM, with

recognised mechanisms for escalation to the Executive Contract, Quality and Performance meeting.

Within the last year there have been improvements at AWP in several areas, including health-based place of safety, suicide reduction, DToC and perinatal mental health. However the Trust acknowledges that there are still areas which require further advancement which the CCG is working with AWP to improve including; further suicide reductions, the physical health of services users, medicines optimisation and the health and wellbeing of staff.

## 4. Financial resource implications

There are no specific financial resource implications in this paper.

## 5. Legal implications

There are no specific legal implications in this paper.

## 6. Risk implications

The risks associate with this paper have been identified and addressed under each section.

## 7. Implications for health inequalities

It is noted that people with serious mental illness face stark health inequalities and are less likely to have their physical health needs met, both in terms of identification of physical health concerns and delivery of the appropriate, timely screening and treatment. Mitigations to address this are highlighted within the paper.

## 8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

There are no specific implications for equalities in this paper.

## 9. Implications for Public Involvement

This paper is an overview of current quality issues and has not required consultation or communication with the public.

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## 1. Background

Mental Health is currently an STP key priority and significant effort is being channelled into this area to improve outcomes for patients across BNSSG. The CCG is currently in the final stages of developing a Mental Health Strategy which will be widely shared across all partners.

In 2016, AWP received an announced comprehensive CQC inspection and were given an overall rating of 'Requiring Improvement' and issued with a Warning Notice (section 29) relating to the Trust's Place of Safety suites. The Warning Notice was issued due to concerns regarding length of time service users spent in the suites and ligature risks that had not been appropriately assessed or mitigated. This was the second Warning Notice the Trust had been issued within a year, the first being issued in December 2015 relating to significant concerns about the Bristol crisis, assessment and recovery services delivered to adults of working age following an unannounced inspection of the Bristol Community services. This was lifted following the 2016 inspection.

In 2017 the Trust received a focused CQC inspection to follow up on the areas identified for improvement in the 2016 inspection. Following this inspection, the overall rating of 'Requiring Improvement' remained unchanged. Whilst acknowledging the improvements that had been made were sufficient to remove the warning notice for the Place of Safety suites, this service was given a rating of Inadequate. The actions have been implemented to support improvement of this service.

Across all of the CQC domains, AWP rated as follows:

- Are Services Safe? *Requires Improvement*
- Are Services Effective? *Requires Improvement*
- Are Services Caring? *Good*
- Are Services Well-led? *Good*
- Are Services Responsive? *Good*

Of those services inspected, Children and Young Peoples' services, (both inpatient and community provision) were rated separately as Requiring Improvement. Mental Health Crisis services and health based Place of Safety were rated as Inadequate.

The CQC are due to revisit the Trust during September and October.

## 2. Quality Concerns

### a. CQC Identified issues:

#### i. Health Based Place of Safety: Inadequate

The Trust received this rating because of the length of time people were being detained in the Place of Safety suites before a bed was located. In 2017 some patients waited 32 to 50 hours after being assessed in the Place of Safety before admission to hospital. This put pressure on capacity and may have been a factor in levels of restrictive interventions. This in turn put pressure on the crisis teams who had to deal with a high level of acuity of risk in the community. This was compounded by limited access to Section 12 qualified Doctors 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.

Between April-June 2018 there have been a total of 10 breaches of s136 detentions (over 24 hours) across the whole AWP area. Five of the seven breaches were due to delays in being able to identify an appropriate psychiatric intensive care unit (PICU) bed for admission.

Mitigations*:*

Since the 2017 inspection the maximum length of stay at the Place of Safety reduced to a maximum of 24 hours (Police and Crime Act, 2017). This was implemented in December 2017. The Trust implemented a suite of interventions including a daily bed management call, improved discharge planning processes and better joint working with Local Authorities to support timely admissions and flow of patients. In addition, the Trust is undertaking a programme of work to reduce usage of seclusion and restrictive practice with the increase in usage of Safewards interventions.

AWP has not reported any inappropriate use of Police Custody or the use of an Emergency Department (ED) as a capacity overflow for health-based Place of Safety. However more recently there has been an increase in the number of long waits within EDs of patients waiting for mental health beds. There is ongoing work to review the main causes for these delays.

The Trust is working closely with NHS England specialised commissioners for CAMHS tier 4 beds to improve timely identification and access to this resource.

A project board and action plan has been put in place to support the reduction in restrictive practice. A pilot has taken place on two wards to increase patient engagement with a view of not using seclusion. Learning from this pilot and training will be developed and delivered across the whole Trust.

#### ii. CAMHS Inpatient and Community: Requires Improvement

There was insufficient staffing or skill mix to safely meet all the requirements of the children and young people using the services and there were staffing issues at each of the teams visited by CQC.

Mandatory training (including safeguarding children and medicines management) was also noted to be below what was required. The CAMHS inpatient unit (Riverside Unit and Blackberry Hill Hospital) had multiple safety concerns throughout the ward.

CAMHS community mental health services showed some variance in the quality and completeness of care records across the different teams. Care records were not holistic or recovery focused. They contained limited evidence of treatment goals or patients' strengths. There were significant concerns about the storage and timely access to CAMHS clinical records, in order for safe care delivery and record keeping.

Mitigations:

The Trust has made significant efforts to recruit replacement and additional staff in CAMHS, and this remains an on-going programme. In addition, the services have implemented regular supervision, annual appraisals and regular team meetings.

In addition to the issues raised by the CQC regarding CAMHS services, management of risks in the community service continues to be an area of concern for both AWP and the CCG, and is reviewed continually in the Quality Sub Group. Recognising that it is frontline practitioners undertaking the majority of risk assessments, training is being targeted to support and upskill staff.

## b. Local Issues:

### i. Reducing the number of adult suicides in secondary mental health services.

Despite austerity and subsequent reduced funding to Local Authorities with respect to debt advice, housing and residential support, it is notable that AWP's suicide rate (per 10,000 population) decreased from 11.4 in 2016 to 8.6 in 2017. Whilst this remains above the national average, it continues to decrease year on year.

In addition to support the Bristol Multi-Agency Suicide Prevention Strategy, AWP Suicide Prevention Strategy was launched in December 2017 to meet the aim of reducing suicides across BNSSG by 10% by 2020 with an associated action plan, which is reviewed regularly at the Quality Sub Group. There is alignment across these plans and with the public health led council plans.

Risk assessment was a key theme identified in the Suicide Prevention Strategy and remedial actions are included within the overall Trust wide action plan. AWP are also seeking to improve the electronic patient record system (RIO) to improve recording of risk and management plans.

The CCGs (including Bath & North East Somerset, Swindon & Wiltshire (BSW) CCGs) agreed at the August Quality Improvement Group to co-produce a quality-focussed Suicide Prevention Summit with AWP, involving key partners such as the six Local Authorities, Public Health England and the Academic Health Science Network, to further develop evidence-based interventions. The aim of having all relevant partners present is to acknowledge that suicide prevention is broader than just a secondary care mental health issue.

Every unexpected death and serious attempt of self-harm reported as a serious incident is investigated thoroughly by AWP, and Root Cause Analysis (RCA) investigations and associated action plans are reviewed for assurance by the CCG to ensure learning is identified and embedded across the Trust.

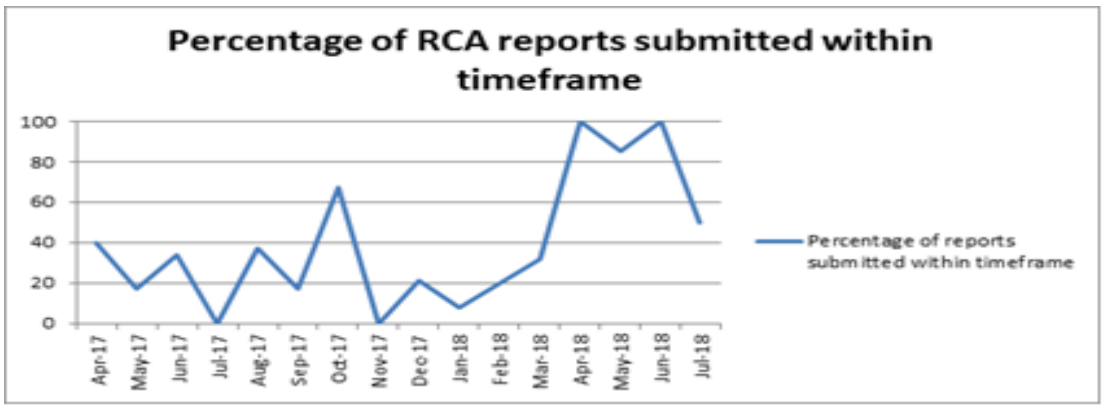
Mitigations:

There are numerous initiatives to support suicide prevention underway across AWP and BNSSG CCG. These include the following:

- The process of information-sharing between AWP systems and Connecting Care is being developed, with identified care plans and patient-level information being shared across the systems over the next six months. Scoping of multi-agency, multi-professional risk assessments and care planning is underway.
- AWP has set a new target to review all patients within 3 days of discharge from inpatient units; their previous target was 7days.
- BNSSG CCG has received £365K Suicide Transformation funding. This will be used to support an expansion of the successful Hope Project across BNSSG (the service delivers psychosocial interventions for those who are experiencing debt and financial difficulties).
- There will be a short term extension of the voluntary sector liaison worker in Bristol University: £100k of the Mental Health Investment Standard funding will be targeted for the Student Health service and AWP to provide additional individual support via extension of the primary care pilot.
- There will be an awareness campaign later in the year jointly with Public Health around Sport (Bristol Rugby and Bristol City & Rovers involved) – including match day activities and linked media work, specifically targeting men.
- BNSSG CCG along with the Royal College of Psychiatrists is organising an event in September to provide local data on suicides and to help assess and support local interventions.
- The CCG and AWP are working towards wider system involvement in RCAs, particularly in relation to student health to ensure learning is captured, shared and embedded across organisations.

## ii. Serious Incident Management – Contract Performance Notice

In December 2017 the CCG issued a contract performance notice to AWP for a sustained period of poor performance in the management of Serious Incidents, particularly for the submission of root cause analysis reports within the 60 day timeframe. The Trust developed a remedial action plan with the focus on implementing a skilled corporate team to support the investigation of all serious incidents.




It is noted that AWP has made progress in this area (please see above), but had a significant decrease in performance in July. This was anticipated by the Trust, due to the high volume of reports due in July. It has been discussed that once improvements have been maintained for a consecutive 3-month period, then consideration will be given to lift the Contract Performance Notice. This will be monitored via Quality Sub Group.

Mitigations:

Timeliness in investigating and acting on the findings is crucial to support learning and improvements. The CCG is also now focused on supporting AWP in improving the quality of the RCA investigations. To do this, one of the CCG's quality team is now a member of the Trusts new serious incident ratification meeting and provides critical challenge and support in the review of RCA reports prior to submission to the CCG for approval.

The Trust has also established a new Serious Incident and Safeguarding overview committee for safeguarding and serious case reviews which started in July 2018. This will support the integration of safeguarding processes across the organisation providing assurance and opportunities to embed learning from all investigations.

The Trust is exploring alternative ways to investigate and effectively learn from Serious Incidents. This will include human factors training, incorporating the SWARM model and develop a specific improvement plan for working with families.

## iii. Perinatal Mental Health Services

The official launch of the Perinatal Mental Health service occurred in November 2017, following an identified need in the system for commissioned services for the provision of assessment and intervention for women experiencing high risk mental health conditions within pregnancy and in the post-natal period up to one year.

The team delivers services across the following work streams:

- Advice and Guidance line (health professionals)
- Adjunctive service to adult mental health service for perinatal period
- Case holding new onset high risk mental health presentation, those with history of serious mental illness who may be well but managed within primary care and family history of severe post-natal depression/post-partum psychosis.

AWP continues to provide inpatient perinatal mental healthcare at the New Horizons Mother and Baby Unit in Bristol. The unit currently has 4 beds and AWP is working with NHS England on plans to increase beds to 8. This is considered a national resource with referrals for admissions received locally, across the South West and nationally.

The Perinatal Mental Health team report bi-annually to the Quality Sub Group. Their last report was in May 2018. At that time, the team had continued to make progress since the last reporting period. A recent peer review report from College Centre for Quality Improvement (CCQI) examining compliance with perinatal community standards in December 2017 gave positive feedback from the review team, particularly around skill mix and progress to date. It is noted that in Quarter 4 (2017/18), the service saw a slightly reduced number - 71 women.

| **Period** | 16/17 Q4 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 | 17/18 Q4 |
|---|---|---|---|---|---|
| **Trajectory** | | 50 | 50 | 75 | 100 |
| **Number seen** | **38** | **59** | **65** | **74** | **71** |
| **Cumulative total (per year)** | **38** | **59** | **114** | **188** | **259** |

The service continues to add to their staffing establishment with the addition of a Social Worker and Parent Infant Therapist and a further Band 6 clinical professional.

- The service missed its Quarter 4 trajectory of seeing 100 women in that quarter. The service is small and therefore is vulnerable to reduced resilience caused by, for example, sickness or training within the team.
- There is inconsistency within the BNSSG footprint regarding crisis care pathways (for example, South Gloucestershire Crisis Team does not accept self-referrals)
- There is no dedicated prescribing budget within the service, leading to potential delays in accessing clinical interventions from Primary Care
- The consultant psychiatrist has undertaken training, forcing an absence from the service
- There can be difficulties in the sharing of information two-way across the perinatal specialist team and maternity services/primary care.

Mitigations:

- The service is strengthening its senior management representation, in order to facilitate a greater strategic oversight, and improved mechanisms for escalation.
- Each Crisis Team in Bristol has a perinatal champion, ensuring better links between Crisis Services and the Perinatal Team.
- BNSSG CCG will continue to monitor via the Quality Sub Group. The STP structure will support this process. The Consultant has recently returned to the service, and will continue to support the already established shared care arrangements across the BNSSG footprint.

- Ongoing IT meetings are established and Connecting Care is identified as the system for sharing of pertinent documents relating to maternal mental health plans (at 32 weeks' gestation). AWP and the acute Trusts are exploring sharing of information at a senior level.
- The Wave 2 bid for a BSW area Community Perinatal Service was successfully approved with Wiltshire CCG leading this. AWP has a perinatal mental health pathway in place across BSW to support women with perinatal mental health problems within core primary and secondary mental health services.

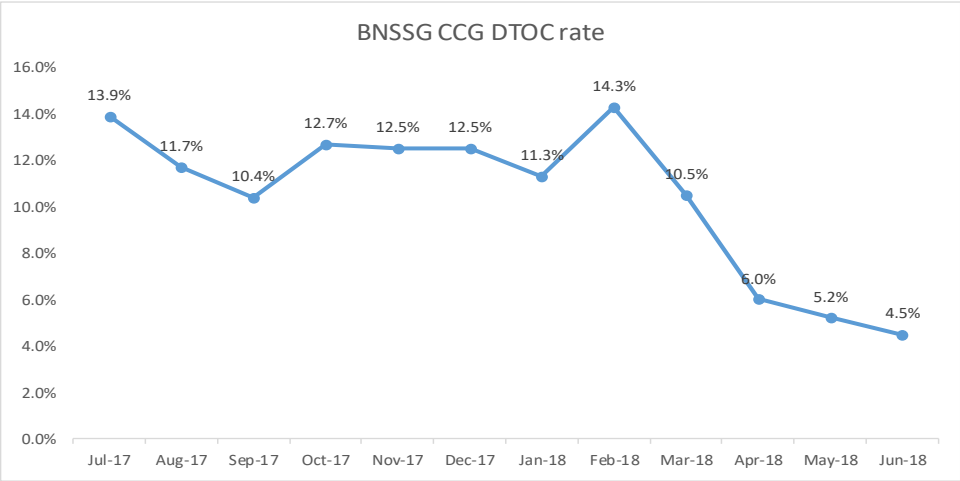
## iv. Delayed Transfer of Care and Out of Area Placements

Delays Transfers of Care (DToC) are an indicator of patient flow and as such there has been much good work in this area, with DToCs at a record low in BNSSG. As of June 2018, 4.6% of BNSSG wide commissioned beds were classed as DToC which is exceptional and exceeds target, (graph below shows the trajectory up until end of June 2018).

The Mental Health Enabling Discharge Group for the last 9-12 months has been focused on improving discharge and the reduced DToC rate is one success from that work.

**Delay Transfer of Care (DTOC), percentage for BNSSG CCG service users**

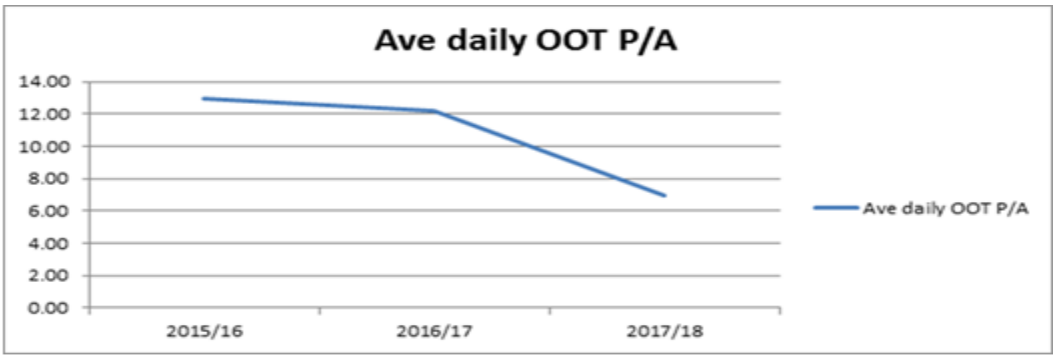
| | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BNSSG CCG DTOC rate | 13.9% | 11.7% | 10.4% | 12.7% | 12.5% | 12.5% | 11.3% | 14.3% | 10.5% | 6.0% | 5.2% | 4.5% |




Bristol now has a mental health Integrated Discharge Team (IDS) focussing on discharges from Callington Road Hospital, benefits of which are to be optimised and shared across the system. The process of discharge countdown within AWP is changing and a method of assessing positive time versus down time for patients is underway.

There has been a recent successful introduction of Urgent Transfer beds to assist flow and reduce risk with long waits for onward care and there is increasing use of Crisis Houses as step down from inpatient facilities or when an alternative to hospital admission is appropriate.

Out of Area Placement numbers are also on an overall downward trajectory (see below).




AWP has carried out much work as part of their transformation work to improve the allocation of beds by area, which has seen a marked reduction in Out of Area Placements. This includes introduction of the Acute Community Unit for step down and facilitated discharges, daily bed meetings, inclusion in system bed calls, improved clinical handovers, improved template for information sharing with Out of Area Providers and centralised bed management.

The Mental Health Enabling Discharge group focuses on flow, DToCs and out of area placements and will be directly contributing to work to reduce OOA placements to minimum levels by 2020 (in accordance with Five Year Forward View for Mental Health, 2016). Supporting effective discharge, performance relating to seven day follow up after discharge has predominantly remained above target across BNSSG with the majority of patients receiving follow up in a timely manner. AWP discuss all breaches of seven day follow up internally.

Supporting this work, the CCG has a dedicated Clinical Reviewer for mental health and learning disability to review placements and care plans and seek to improve bed availability and management in the context of quality and appropriate patient care.

Mitigations:

- Two wards are being reviewed with respect to making better use of the current capacity.
- BNSSG CCG is to develop an Out of Area Strategy with AWP and other partners. Discharge from Out of Area placements into In Area community support will be incorporated into the Out of Area Strategy and operational action plan supporting that.
- Bristol City Council is leading on a market management review and improved pathway system for mental health patients. Two posts are being jointly recruited to (Health & Social Care) to deliver this.

## v. Physical Healthcare monitoring

People with serious mental illness (SMI) face stark health inequalities and are less likely to have their physical health needs met, both in terms of identification of physical health concerns and delivery of the appropriate, timely screening and treatment.

Compared to the general population, individuals with SMI (such as schizophrenia or bipolar disorder):

- Face a shorter life expectancy by an average of 15–20 years
- Are three times more likely to smoke
- Are at double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream)

These issues are compounded by:

- Lack of clarity around responsibilities in healthcare provision in primary and secondary care
- Gaps in training among primary care clinicians
- Lack of confidence across the mental healthcare workforce to deliver physical health checks among people with SMI
- Lack of integration between primary, physical health and mental health services.

AWP is currently engaged in various Commissioning for Quality and Innovation (CQUIN) schemes, one of which is physical healthcare monitoring in those with serious mental illness (CQUIN 3a). The CQUIN focuses on; ensuring staff are appropriately trained; that there are clear pathways for interventions and signposting for cardio-metabolic risk factors; and the trust completes an internal audit to provide assurance that physical health assessment and interventions data are being recorded appropriately on the electronic care record. The CQUIN demands these milestones are achieved, over the four quarters.

AWP are now reporting physical issues as incidents e.g. pressure injuries, demonstrating an increased understanding of connection between physical and mental health.

AWP has published its Physical Health Delivery Plan (2017-2020), with resulting actions to be delivered (please see mitigations).

Evidence in the 2017 CQC inspection showed that there were improved signs of involving patients in their care planning across most services. At the learning disability inpatient unit in Wiltshire, the 2017 CQC visit identified hospital passports had been completed for all individuals, which were kept in the residents' records. Individuals' likes and dislikes were noted, including how they preferred to communicate. The passports also had relevant details on physical health histories and strategies to support resident's behaviours. These were ready in case any resident required admission to an acute hospital. All residents had a health action plan in place, identifying physical health needs and current treatment plans.

Mitigations:

- Monthly reports are being sent to each Locality for planning and actions to be taken to ensure full compliance with physical health monitoring and treatment, in accordance with the CQUIN requirements.
- Individual work with Localities will continue with the CQUIN and AWP's Physical Health Leads where there are specific areas of lower performance in relation to training compliance.

- There will be continued focus on the staff completion of training against the training plan targets with further communications to be sent out in relation to this to ensure optimal compliance with training targets.
- Monthly reporting of compliance with physical health assessments is planned in line with the launch of the updated public health pages on the electronic patient records system. This will quickly give an accurate picture of any new admissions into inpatient services and an implementation plan has been devised for community and early intervention patients over the next 3 months.
- CCG/AWP joint work towards agreed protocols for physical health monitoring aligned to national guidance and standards.
- The National Early Warning Score (NEWS) system is being embedded within the inpatient units to enable the early recognition of deterioration and appropriate action to be taken in a timely way.
- Implementation of the 'Think Sepsis' agenda if a service user triggers a NEWS score of 5 or 3 in one parameter, looks ill and or has signs of infection to ensure prompt screening and early intervention.
- The SBAR (Situation, Background, Assessment and Recommendation) process is to be used as a communication system for handover and medical emergencies.
- Patient clinical record systems will have dedicated physical health pages to support the accurate recording of comprehensive physical health assessments.

To support the improvements in physical health care monitoring, the Trust has appointed a new Head of Health Care, and has signed up to the NHS Improvement – Closing the Gap Collaborative. This project is about using Quality Improvement methodology to improve physical health checks in Early Intervention.

## 3. Summary

AWP published its Quality Account for 2017/18, which has identified areas of success, and areas that require on-going work for 2018/19. BNSSG CCG will continue to closely support and monitor the Trust in its endeavours via the monthly Quality Sub Group, Performance and Contracting LCQPM, with recognised mechanisms for escalation to the Executive Contract and Quality and Performance meeting, where necessary.

The Trust's recently appointed Director of Nursing has reviewed the Nursing and Quality Directorate structure and is currently reviewing all governance processes and corporate oversight of safeguarding arrangements within the Trust. Included within this review is the development of a quality dashboard which once finalised will be monitored at the monthly Quality Sub Group.

Over the coming months, the Quality Directorate is planning a programme of quality assurance visits, including Safeguarding, Medication Management and Infection Control.

The CQC are currently visiting AWP to undertake a 'well led' inspection and also review those services that required improvements from the previous inspection. The Quality Sub Group has seen evidence of good progress against all of the recommendations from the last inspection.

Within the last year there have been improvements at AWP in several areas, including health-based place of safety, suicide reduction, DToC and perinatal mental health. However the Trust acknowledges that there are still areas which require further advancement which the CCG is working with AWP to improve including; further suicide reductions, the physical health of services users, medicines optimisation and the health and wellbeing of staff.

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## 9. Consultation and Communication including Public Involvement

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## 10. Recommendations

The Governing Body is asked to note the contents of this report.

**Report Author:** Kate Chisholm-Mitchell, Lead Quality Manager & Bridget James, Associate Director of Quality
**Report Sponsor:** Anne Morris, Director of Nursing & Quality