Agenda Item:

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	10 March 2015
Officer	Director for Adult and Community Services
Subject of Report	**Dorset HealthCare University NHS Foundation Trust – update on progress in delivering against the Waterston action plan following Care Quality Commission (CQC) inspection of mental health services in August 2014**
Executive Summary	Following a report presented to the committee on 17th November 2014 Dorset HealthCare University NHS Foundation Trust (DHC) has been asked to submit an update report on progress on delivering the action plan following CQC inspection of mental health services at Waterston Unit (Forston Clinic) in August 2014. The Care Quality Commission carries out announced and unannounced visits to inspect providers of health care services against the Essential Standards of Quality and Safety. The inspectors make a judgement as to whether the service is meeting the outcomes inspected or not. During the visit carried out in August 2014 some improvement actions were identified and the Trust submitted an action plan to address the shortfalls on 24th October 2014. Since the last report to Dorset Health Scrutiny Committee in November 2014 DHC has received a combined compliance and Mental Health Act unannounced visit to inspect services provided at Waterston Unit, Forston Clinic in January 2015. Formal feedback and the draft report are awaited from the CQC. It is important to note that Mental Health Act visits are currently separate to CQC compliance inspections and do not directly impact on a provider's registration with CQC.

	This report provides an update on the action plan submitted to the CQC in respect of the visit in August 2014 as requested and an overview of the recent inspection in January 2015.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Dorset HealthCare University NHS Foundation Trust.
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate) Residual Risk ~~HIGH~~/~~MEDIUM~~/LOW (Delete as appropriate)
	Other Implications: None.
Recommendation	That the Dorset Health Scrutiny Committee consider and comment on the report.
Reason for Recommendation	The work of the Committee contributes to the County Council's aims to protect and enrich the health and wellbeing of Dorset's most vulnerable adults and children.
Appendices	**Appendix A – Report on actions you plan to take to meet CQC essential standards**
Background Papers	Report to Dorset Health Scrutiny Committee, 17 November 2014: http://www1.dorsetforyou.com/COUNCIL/commis2013.nsf/MIN/E43691721F9752B280257D8C00437C2A?OpenDocument
Report Originator and Contact	Name: Eugine Yafele, Director Bournemouth and Christchurch Locality, Dorset HealthCare University NHS Foundation Trust Tel: 01202 277080 Email: eugine.yafele@dhuft.nhs.uk

Dorset HealthCare
University NHS Foundation Trust

UPDATE ON PROGRESS IN DELIVERING AGAINST THE ACTION PLAN FOLLOWING THE CARE QUALITY COMMISSION (CQC) INSPECTION OF MENTAL HEALTH SERVICES IN AUGUST 2014

1.0 INTRODUCTION

1.1 The Care Quality Commission carries out announced and unannounced visits to inspect providers of health care services against the Essential Standards of Quality and Safety.

1.2 Following a report presented to the committee on 17th November 2014 Dorset HealthCare University NHS Foundation Trust (DHC) has been asked to submit an update report on progress on delivering the action plan following CQC inspection of Waterston Unit, Forston Clinic Mental Health Services on 4th & 5th August 2014.

1.3 Following the visit in August 2014 the inspectors made a judgement as to whether the service was meeting the outcomes inspected or not. Some improvement actions were identified and the Trust submitted an action plan to the CQC to address the shortfalls on 24th October 2014 (Appendix A). The action plan has been updated to show progress to date.

1.4 The Trust has been working through the actions identified in the plan.

1.5 Since the last report to Dorset Health Scrutiny Committee in November 2014 DHC has received a further combined compliance and Mental Health Act unannounced visit to inspect services provided at Waterston Unit, Forston Clinic in January 2015.

1.6 Formal feedback and the draft report are currently awaited from the CQC. Informal feedback provided following the visit has been included in this report.

1.7 This report provides an update on the action plan submitted to the CQC in October 2014 and an update on findings from the CQC Inspection visit in January 2015.

2.0 ACTION PLAN SUBMITTED TO THE CQC IN RESPONSE TO THE CQC INSPECTION IN AUGUST 2014

2.1 As reported in November 2014, improvement actions were required across 4 of the CQC's 21 domains/inspection criteria:

Outcome	CQC Finding	Potential Impact on service users
Outcome 4 – care and welfare of people who use services	Action needed	Moderate
Outcome 7 – safeguarding people who use services from abuse	Action needed	Moderate
Outcome 13 – staffing	Action needed	Moderate
Outcome 16 – assessing and monitoring the quality of service provision	Action needed	Moderate

2.2 Attached at Appendix A is a copy of the action plan submitted to the CQC to address these concerns.

2.3 To address the findings of the 4 domains/outcomes the Trust did not meet the required standards, 15 actions were identified and outlined in the action plan.

2.4 As at February 2015 the following compliance is noted in relation to the 15 actions:

- 10 fully completed
- 5 partial/in progress (2 due for completion by end of Feb, 1 end of March and 1 April 2015)

3.0 WORK BEING IMPLEMENTED TO ADDRESS COMPLIANCE AGAINST REMAINING ACTIONS

3.1 The 5 partial/in progress actions relate to the following areas:

a) We will implement core competency and risk assessment framework and associated training development within inpatient services. Standards of care planning and risk assessments will improve. Staff will be assessed against the core competencies and training delivered for those not achieving the required standards – due Feb 2015

Update: This action is on track for completion. The core competency framework and training has been developed and roll out to staff has commenced.

b) Clinical audit programme will be embedded into practice and monitored via supervision and professional accountability – due April 2015

Update: This action is on track for completion. The Mental Health Care Plan audit has been developed and rolled out, quarterly audits commenced in January 2015.

c) The ward manager post was being covered via acting up arrangements. We will appoint an interim ward manager to support the ward until permanent recruitment takes place – due March 2015

Update: This action is on track for completion. An experienced interim ward manager has been in post since August 2014. Recruitment of a permanent Ward Manager is underway. Interviews are in place for 18th February 2015.

d) We will implement ward to board quality metrics. This will provide the ward with key clinical performance information and enable them to identify patterns and trends in performance and take action where standards are not being met – due April 2015

Update: This action is on track for completion. The ward to board quality metrics have been developed and launched for consultation and finalising with clinicians on 3rd & 5th February. This was led by the Trust's Medical Director and Head of Information. The quality metrics will be live by April2015.

e) Same as action a) – due Feb 2015 see update above.

4.0 ASSURANCE ACTIONS TAKEN ARE REFLECTED IN PRACTICE - FEEDBACK FROM CQC ON VISIT TO WATERSTON UNIT, FORSTON CLINIC JANUARY 2015

4.1 On 27th January 2015 the CQC returned to Waterston Unit to carry out an unannounced compliance and Mental Health Act inspection as a follow-up from the last inspection in August 2014.

4.2 The CQC advised they were looking specifically at the areas of the last inspection. At the end of the inspection the Director of Nursing & Quality for the Trust met with the CQC inspectors to receive verbal headline feedback, alongside the interim Ward Manager and Service Manager for Inpatient and Crisis care.

4.3 The CQC advised that overall it was a very positive visit with noticeable improvements across the domains inspected. They reported that staff were professional, knowledgeable and welcoming and stated they were "very impressed" with the team and level of helpfulness that facilitated a smooth inspection.

4.4 There were no immediate compliance actions arising from the visit and the CQC noticed a much improved staff morale and remarked on the positive impact of taking the seclusion room out of commission. They also noticed good knowledge of all staff about their patients. They did however advise that they observed staff spending more time in the nursing office rather than on the ward and evidencing the activities available on the ward which is being addressed by the interim Ward Manager.

4.5 The following verbal feedback was provided on the day of the inspection in relation to the specific domains inspected (please note this is subject to change and may not be reflected in the final report):

Outcome	**CQC Finding August 2014**	**CQC Finding January 2015**
Outcome 4 – care and welfare of people who use services	Action needed Moderate	Care planning and risk assessment – good care planning, patients involved and have copies of their care plans, risk assessments improved. The CQC liked the competency framework that has been introduced for the staff and also noted improved use of the electronic patient record (RiO).
Outcome 7 – safeguarding people who use services from abuse	Action needed Moderate	Incident reporting and monitoring improved and noted good practice of the management of a serial absconder. Staff to look at completing/updating incident report more thoroughly within the Incident Reporting system (Ulysses) as in some cases appears to stop on the report then continue within the progress notes in the electronic record (RiO).
Outcome 13 – staffing	Action needed Moderate	Much better position than previously, active recruitment noted, robust contingency plans in place.

Outcome	CQC Finding August 2014	CQC Finding January 2015
		Noted sustainability as a concern because the Interim ward Manger is due to leave mid-March, CQC wanted confirmation of plan and how ward manager post will be recruited to, to ensure ongoing improvements maintained. This links to 3.1 c) ward manager interviews planned for 18th February.
Outcome 16 – assessing and monitoring the quality of service provision	Action needed Moderate	CQC noted a positive shift in ward monitoring of incidents and complaints, health & safety and audits. They noted training and supervision was good, patient meetings good and noted to be minuted. Quality assurance board and quality meeting – good

4.6 From a Mental Health Act perspective, the inspector raised issues relating to minor errors in the completion of section papers. These errors had been identified by the Trusts Mental Health Act Office during the scrutiny process and staff had been requested to amend the forms. The interim Ward Manager and Inpatient Service Manager will also review the scrutiny process on the ward in conjunction with the Mental Health Act office ensure there is standardised practice across inpatient services.

5.0 CONCLUSION

5.1 The Trust takes the findings of all CQC / MHA inspections and visits very seriously and takes all the necessary steps to implement appropriate actions to improve and maintain the high quality standards of care and welfare of patients and service users that we aspire to deliver.

5.2 The Trust assures progress of improvement through two Trust Board sub committees, the Mental Health Act Assurance Committee and the Quality Assurance Committee. Issues are escalated to the Board as appropriate.

5.3 The Trust disseminates learning so that improvements can also be made, where necessary. This benefits other services as well as those inspected.

5.4 A process of peer review within the Trust is in place. This means that staff review services which they are not responsible for against the CQC's essential standards. At a recent workshop of peer-reviewers the process has been found to be very well received and beneficial in helping to share good practice across the organisation.

5.5 In conjunction with Dorset Clinical Commissioning Group (CCG) the Trust has been engaged in an Independent Evaluation on the Mental Health Urgent Care (MHUC)

Service in West Dorset of which Waterston Unit, Forston Clinic is one of the inpatient units.

5.6 The objective of the Independent Evaluation was to assess how the MHUC service has been implemented against the specification and proposed benefits and how the new model (introduced in April 2013) has impacted on service user, carer and staff experience of accessing, receiving and delivering care. The Independent Evaluation also aims to support the assurance process which will evidence how the service model is performing and whether or not the service is:

- Responsive to needs
- Timely
- Effective
- Recovery focussed
- Delivering the agreed outcomes and aims
- Identify service user and carer views of the service

5.9 The draft report of the Independent Evaluation has been compiled and is being reviewed by Dorset CCG with a view to presenting it to the Health Scrutiny Committee in May 2015. It is anticipated a briefing paper will be sent out in March once the CCG have had a chance to consider the outcomes.

Eugine Yafele
Director Bournemouth & Christchurch Locality
February 2015

Appendix A

Report on actions you plan to take to meet CQC essential standards

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RDY
Our reference	INS1-1577508785
Location name	Forston Clinic
Provider name	Dorset Healthcare University NHS Foundation Trust

Regulated activities	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services
	How the regulation was not being met:
	The care plans and risk assessments had not been reviewed and updated and did not reflect the current needs of these patients. *Regulation 9 1 (a) (b) (i) (ii)*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1) We will carry out a snap shot audit of care plans & risk assessments of service users on the ward to ensure they are up to date and reflect the needs of the patients.

2) We will implement the Mental Health Learning and Development Pathway from October 2014. The pathway comprises two main levels of learning as follows:

   - **Level One Training**
     Foundational training which is considered to be essential core training for all mental health practitioners. To be completed by new starters commencing the Trust within 6 months of joining. Also open to existing staff requiring a fresher.
   - **Level Two Training**
     Training designed and delivered on request to a specific team or a number of teams and/or in localities to meet specific service requirements.

3) We will implement core competency and assessment framework and associated training development within inpatient services. This will consist of:

   1) Staff skills and competencies:
      - Care Plans
      - Risk Assessments
      - Safeguarding
      - Respect & Dignity of patients

- Relational Security
- De-escalation skills

2) Systems in place to ensure that post-incident support and review are available and take place:

- Staff involved in the incident
- Patients
- Carers and Family
- Other patients who witnessed the incident
- Visitors who witnessed the incident

4) We will ensure the agreed Clinical Audit schedule process is robustly embedded to be used to evidence improvement in compliance

Who is responsible for the action?	1) Ward Manager 2) Associate Director Learning & Development 3) Associate Director Inpatient Services 4) Associate Director Inpatient Services

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1) Completed. A snap shot audit was completed on Waterston on 8th October 2014.

2) MH Learning & Development Strategy agreed by the Management Group in July 2014. Delivery commencing of level one training from October 2014, designed for new starters and existing staff who require a fresher.

3) Standards of care planning and risk assessments will improve. Staff will be assessed against the Core Competencies and training delivered for those not achieving the required standards.

4) Clinical audit programme will be embedded into practice and monitored via supervision and professional accountability

Who is responsible?	1) Ward Manager 2) Associate Director Learning & Development 3) Associate Director Inpatient Services 4) Associate Director Inpatient Services

What resources (if any) are needed to implement the change(s) and are these resources available?

External trainer identified to support development of core competency framework – agreed Implementation plan to release staff to attend training developed

Date actions will be completed:	1) Completed 2) Completed 3) Partial/in progress - February 2015 4) Partial/in progress - 1st April 2015

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Completed by: (please print name(s) in full)	Eugine Yafele
Position(s):	Director, Bournemouth & Christchurch
Date:	24th October 2014

Regulated activities	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse
	How the regulation was not being met:
	The registered person did not have suitable arrangements in place to safeguard people against the risk of control or restraint being excessive. *Regulation 11(2)(b)*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

1) We will review the debriefing process on the ward to ensure the principles of the MHA CoP are adhered to by offering service users the opportunity to discuss and/or write their view of the restraint.

2) We will continue to provide debriefing sessions post restraint. An education session for staff on qualitative content of debriefs to be delivered to qualified staff.

3) We will undertake a programme of work to ensure the Seclusion room environment is fit for purpose.

Who is responsible for the action?	1) Ward Manager & Consultant Psychiatrist 2) Ward Manager 3) Head of Estates

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1) Evidence within the clinical notes and weekly review meeting

2) Education sessions for Waterston staff on qualitative content of debriefs was carried out on:
   - 1st August
   - 8th September
   - 19th September

3) Identified work plan for Seclusion Room, Waterston will be completed

Who is responsible?	1) Ward Manager & Consultant Psychiatrist 2) Ward Manager

	3) Head of Estates
What resources (if any) are needed to implement the change(s) and are these resources available?	
Funding for work programme to Seclusion	
Date actions will be completed:	1) Completed 2) Completed 3) Completed

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Completed by: (please print name(s) in full)	Eugine Yafele
Position(s):	Director, Bournemouth & Christchurch
Date:	24th October 2014

Regulated activities	**Regulation**
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
	How the regulation was not being met:
	There were insufficient nursing and support staff to ensure that people's needs could be met and that this was done safely. *Regulation 22*

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve
1) We will review Clinical Leadership on the ward to ensure robust leadership and management of staffing and resources 2) The Ward Manager post was being covered via acting up arrangements. We will appoint an interim Ward Manager to support the ward until a permanent replacement can be recruited. 3) We will implement a revised strategy using e-roster to proactively fill shift vacancies to provide more stability on the ward until permanent recruitment takes place. 4) We will continue to actively recruit to vacant posts in line with the Trusts Recruitment and retention strategy. Shortfall in staffing is monitored through proactive management of vacancies and e-roster.

Who is responsible for the action?	1) Associate Director Inpatient Services 2) Associate Director Inpatient Services

	3) Associate Director Inpatient Services 4) Ward Manager

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1) Senior Clinical Nurse Acute Care will have overarching responsibility for Forston Clinic and provides support and direction to staff across Waterston AAU. The Senior Clinical Nurse Acute Care is developing an appropriate framework to manage the units.

2) Interim Ward Manager with extensive experience of managing inpatient units in post. Recruitment for a permanent replacement is in progress for sustainability of improvement.

3) Nursing Agencies from GPS/PASSA framework have been approached and agreed to provide interim staffing on block booking/fixed term basis. These staff will be scheduled as part of the ward rota and have full access to the Patients Electronic Clinical Record.

4) Staff will commence in post in line with recruitment procedures and advertised vacancies.

Who is responsible?	1) Associate Director Inpatient Services 2) Associate Director Inpatient Services 3) Associate Director Inpatient Services 4) Ward Manager

What resources (if any) are needed to implement the change(s) and are these resources available?

Date actions will be completed:	1) Completed 2) Partial/in progress – March 2015 3) Completed 4) Completed and ongoing

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Completed by: (please print name(s) in full)	Eugine Yafele
Position(s):	Director, Bournemouth & Christchurch
Date:	24th October 2014

<table>
<tr><th>Regulated activities</th><th>Regulation</th></tr>
<tr><td rowspan="3">Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Treatment of disease, disorder or injury</td><td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010
Assessing and monitoring the quality of service provision</td></tr>
<tr><td>How the regulation was not being met:</td></tr>
<tr><td>The providers system used to identify, assess and manage risks to the health, safety and welfare of people who use the service and others did not adequately ensure that the service provided was safe and offering quality care.

Regulation 10 - (1) (a)(b)(2)(b)(iii)(iv)</td></tr>
<tr><th colspan="2">Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve</th></tr>
<tr><td colspan="2">1) We will continue to monitor and report on progress and compliance with quality and performance through clinical audit and the Trusts governance arrangements. Compliance will reviewed through ward and management group meetings.

2) Compliance with actions plans owned by the ward will be reported to the Trust's Quality Assurance Committee. This will provide assurance that the areas identified are being monitored and reviewed by the Trust Board and action taken where required.

3) We will implement ward to board quality metrics. This will provide the ward with key clinical performance information and enable them to patterns and trends in performance and take action where standards are not being met.

4) We will implement core competency and assessment framework and associated training development within inpatient services. This will consist of:

1) Staff skills and competencies:
o Care Plans
o Risk Assessments
o Safeguarding
o Respect & Dignity of patients
o Relational Security
o De-escalation skills

2) Systems in place to ensure that post-incident support and review are available and take place:

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<tr><td>Who is responsible for the action?</td><td>1) Associate Director Inpatients & Ward Manager
2) Associate Director Inpatients & Ward Manager</td></tr>
</table>

	3) Associate Director Inpatients & Ward Manager 4) Associate Director Inpatient Services

How are you going to ensure that improvements have been made and are sustainable? What measures are you going to put in place to check this?

1) Audits will be undertaken in line with the Trust's Clinical Audit schedule and reported to the Management Groups. Action will be taken to address shortfalls in compliance.

2) The Quality Directorate will continue to support the assurance systems and validate the evidence through a programme of internal inspections and report progress to the Quality Assurance Committee.

3) Quality metrics will be implemented on the ward and the data will provide key clinical performance information to staff

4) Standards of care planning and risk assessments will improve. Staff will be assessed against the Core Competencies and training delivered for those not achieving the required standards.

Who is responsible?	1) Head of Clinical Effectiveness & Ward Manager 2) Head of Compliance & Regulation 3) Medical Director & Inpatient Associate Director 4) Inpatient Associate Director

What resources (if any) are needed to implement the change(s) and are these resources available?

Date actions will be completed:	1) Completed & Ongoing 2) Completed 3) Partial/In progress - April 2015 4) Partial/In progress - February 2015

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Completed by: (please print name(s) in full)	Eugine Yafele
Position(s):	Director, Bournemouth & Christchurch
Date:	24th October 2014