NHS Enfield Clinical Commissioning Group

NHS North and East London Commissioning Support Unit

DRAFT- Summary of the quality issues regarding Barnet, Enfield and Haringey Mental Health Trust, 24th February 2014

CQC inspections and service user experience

A CCG-led Task and Finish Group was established to address concerns at The Oaks (inpatient service for dementia and serious mental illness). The concerns were identified in reports from a number of agencies: CQC (March 2013); London Borough of Enfield's Provider Concerns Strategy Group (June 2013); the Trust's Quality Summary (presented at the July 2013 CQRG).

Commissioner and clinicians led 'walk the pathway' visits to speak to staff and patient, assess records and verify how multi-disciplinary care was planned and coordinated. Specific action plans were developed to address deficiencies and positive feedback was given where good examples of patient care were identified.

A CCG Task and Finish Group was set up in response to the findings of the initial CQC inspection at The Oaks.

- Enfield CCG appointed a Quality Assurance Manager to work with the Trust to ensure The Oaks Improvement Plan is delivered, and to undertake a number of detailed reviews.
- The further findings from the subsequent CQC inspections are followed up through this group to ensure that learning from previous failings as well as learning from improvements in one area is embedded across the organisation.
- The Task and Finish Group will be reporting to January CQRG.

Previous feedback from the Task and Finish Group to the CQRG indicated:

- Improved patient experience at The Oaks.
- Improved care-plans and models of care at The Oaks.
- Building refurbishment is underway at The Oaks and Silver Birches units; this will continue into 2014/15.

The CQC inspection in September 2013 showed that there were significant improvements in the care provided to patients on The Oaks, but there was concern about the limited sharing across the organisation of lessons learnt.

- The CQC visited a number of older people's inpatients services at the Trust in September 2013. This included a second visit to The Oaks as well as a number of other services including, Silver Birches, Cornwall Villas and Bay Tree House. The purpose of the inspection was to assess progress made since the previous inspection on the older adults mental health ward based at Chase Farm Hospital.
- Where the previous inspection found that the Trust failed to meet regulations, the CQC found that overall

significant improvements had been made to the care provided to patients at The Oaks. However, there remained some areas of non-compliance on other older adult's wards. The CQC concluded that this demonstrated that lessons learnt from previous failings had not been shared effectively across the organisation.

- The CQC report was published 23 November 2013 and the Trust was found to be non-compliant in three out of five standards.

The report (published 17 December 2013) from the November 2013 CQC inspection of Magnolia Ward showed evidence of good patient experience. Magnolia Ward is part of Enfield Community Services (provided by the Trust) offering a unique inpatient service focused on preventing avoidable admissions to acute hospitals.

Seclusion rooms used overnight as temporary bedrooms

The Trust had used seclusion rooms as bedrooms for overnight emergency admissions, following risk assessment and with Medical Director approval. The alternative had been to place people out of area a long way from home.

This exceptional practice was notified to the CCG as a strategic concern about bed use, bed capacity and inpatient care models for discussion at the Transformation Board.

The November 2013 Clinical Quality Review Group was notified of the exceptional practice, and offered assurance that the clinical needs of all service users on the ward was taken into account before the Medical Director gave approval, and that each occasion was reviewed subsequently.

- In December 2013, the CQC issued an Enforcement Action to stop this practice.
- The CCG supported the Enforcement Action through a teleconference discussion with the Trust to agree arrangements for emergency admissions.
- The Trust complied. In January 2014, the Trust reported that there were no further breaches.

An action plan has been developed and is being agreed by the Trust (due in the week beginning 13 January 2014).

- The Trust will share this action plan with commissioners once it has been updated and will be an agenda item for the March CQRG
- The Trust report that they are on track to deliver the action plan by end of February 2014.

Delayed transfers of care

There have been an increasing number of delayed transfers of care reported. This impacts on occupancy rates and was identified as a contributing factor to the inappropriate use of seclusion rooms. The Commissioners are establishing a separate group to ensure a whole system management approach to improve current performance on DTOCs.

Coroner's Inquest regarding the quality of service from the Haringey Home Treatment Team (before reconfiguration)

The Trust's Haringey Home Treatment Team had been involved in a coroner's inquest regarding a suicide (approximately 18 months ago). There is another Inquest scheduled for September 2014 involving Haringey Home Treatment Team.

The Trust investigation at the time of the incident had led to the dismissal of two staff and the restructuring of the service. The action plan has been reported to and monitored by the Clinical Quality Review Group.

- At the November 2013 Clinical Quality Review Group, the Trust commented that the two staff who had been dismissed had given evidence to the coroner that was inconsistent with the evidence gathered by the Trust.

The Coroner's Inquest took place in January 2014:

- The Coroner did not reach a verdict of neglect, nor did they issues a 'Report to Prevent Future Fatalities' (previously known as Rule 43);
- The Coroner did deliver a narrative verdict that acknowledged concerns about the service provided.
- The verdict and action plan already in place will be discussed at the January 2014 CQRG.
  The Coroner's Inquest scheduled for September 2014 had a planning meeting (PIR) on the 6th of January. The Coroner has requested an additional 6 statements from staff and the trust advise that it is likely the Coroner will be requesting an Expert Independent Report as well. The trust has met with the family and has offered to meet again if requested. Regular updates will be taken at the monthly CQRG.

Community CAMHS access to inpatient beds disrupted

Recent suspension of the Beacon Centre (inpatient Child and Adolescent Mental Health Service, CAMHS), necessitates collaboration with NHS England on pathway management

The Trust reported to the October 2013 Clinical Quality Review Group (CQRG) that community CAMHS services (commissioned by CCGs) had been affected by the suspension of admissions to their inpatient CAMHS unit (commissioned by NHS England Specialised Services).

- The Trust was not clear on the alternative arrangements for admission, nor the process for reviewing and re-opening the inpatient service. The issue has been reported to and monitored by the Clinical Quality Review Group.
- Enfield CCG raised this issue with NHS England
- At the February CQRG Commissioners have requested data analysis on community CAHMS in order to assure that the community pathways are working effectively and that the current reduced capacity in tier 4 services is not affecting local residents in access to local services when they are required.

User experience

Carer involvement audit

The Trust reported to the January 2014 Clinical Quality review group the results of the monthly carers involvement

Audit. The target for compliance is set at 90%. The Trust achieved this once in year in September 2013 achieving 92% .This

slipped back to 87% in October 2013. The overall trajectory is upward.

The Carers' Strategy has been widely promoted and consulted with input from local authority, carers groups and service user groups as well as clinical input across all service lines. Actions for improving carers' involvement and support are identified in the strategy. From October 2013 the following actions have been completed:

- Identification of carer champions on inpatient ward teams
- Development of carer information leaflets
- Development of staff carer training
- Audits of triangle of care standards at inpatient ward level

The Trust undertook a thematic analysis of the Quality assurance standards which was presented at the February 2014 CQRG meeting. This identified that the area with lowest performance was supporting and involving carers. The Trust have implemented actions to address these findings including refreshing their carers strategy, identifying carer champions on inpatient wards, development of carer information leaflets, staff carer training programmes and audits of triangle of care standards at inpatient ward level.

Some initiatives proposed in the strategy require support at executive level. These include:

- Defined posts responsible for carer initiatives
- Carer awareness to be included in mandatory training.

Complaints

The Trust received 173 formal complaints between 1st April and 31st October 2013. The target is for 90% (noted at CQRG that this is an ambitious target) of complaints to be responded to within 25 working days. The numbers of complaints received to 31st October 2013 and compliance figures for each service line are as follows:

Enfield Community Services (AOP) – 7 complaints– 75% compliance

Enfield Community Services (CYP) – 4 complaints – 75% compliance

Crisis and Emergency – 50 complaints – 65% compliance

Common Mental Health – 12 complaints – 62% compliance

*Corporate Services – 3 complaints – 67% compliance

Dementia and Cognitive Impairment – 9 complaints – 67% compliance

Forensic – 24 complaints – 75% compliance

Psychosis – 29 complaints – 59% compliance

Severe and Complex Non-Psychotic – 35 complaints – 76% compliance.

Staff experience

Quality Dashboard

Peer review CQC Outcomes 13 (Staffing) and Outcome 14 (Supporting workers)

Clinical Quality & Safety

The Trust presented the quality dashboard at the January 2014 CQRG meeting. CQC compliance is undertaken via trust service peer review a trust wide system of assessment which also includes compliance against statutory standards and best practice standards. The dashboard identified that CQC Outcomes related to staffing and supporting workers were non-compliant at peer review in October with 65% and 83% compliance respectively. Low scores are related to availability of training matrix at local team level rather than significant staffing issues.

The Clinical Quality and Safety report presented to the January CQRG identified a shortfall of 12 District Nurses and staff to manage the Safeguarding Children's processes. The Trust has plans entrain for recruitment of the District Nurses. Staff to manage the Safeguarding children's processes have now been recruited.

A ward manager's development programme has taken place which was well received by staff and a second is planned for February 2014. This will be rolled out to community managers in the coming year.

An HCA/Carers conference is planned for June 2014.

Serious incidents

The trust currently have a review underway (Wyncham Associates) on SIs in order to strengthen how they can implement the lessons learnt from SIs.

The Trust has 12 overdue SI reports at the end of January 2014 the highest volume this year to date. Three of the cases are overdue by 3-6 months, and 8 cases are overdue by 0-3 months.. The Trusts also have 31 cases where further information is required from them before closure. These will be discussed with the Trust in a meeting scheduled on the 4th of March as the trend of overdue SI reports has been increasing since July 2013.

Access and responsiveness-

Concerns had been raised around the ease of access to crisis services within the trust in 2012/13 and the beginning of 2013/14. BEHMHT undertook a significant piece of work transforming access into trust services meaning that service users would only be assessed once by triage and then sent to the correct team. Prior to this piece of work there were multiple routes of access into the trust and patients were being assessed multiple times by different teams.

GPs were to determine whether or not a referral was to be treated as urgent or not in line with GP requests. Access targets to crisis services were set for the service user to be seen within 4 hours.

A GP advice line was also put in place in each of the boroughs which allowed GPs access to trust staff to discuss any concerns or issues they had with regards MH patients. Usage of this service has dropped, but GP attendance at primary care academies remains good.

As part of the 14/15 contract round a quality KPI is being developed to strengthen early warning systems.

Discharge letters

The Trust did not meets its CQUIN Target of 98% of discharge, assessment and review letters sent within 24 hours in Q3 scoring 58%. The percentage of discharge letters containing mandatory content was 87% in Q3 against a target of 98%. The Trust advised at the February CQRG that this was improving in Q 4. This remains a priority area for the trust and commissioners and will form part of 14/15 local CQUINs.

Clinical leadership and governance

The Trust has had a period of interim cover for their Medical Director and Director of Nursing and Governance.

The Trust has recently appointed a substantive Medical Director.
The Director of Nursing and Governance is in the process of recruiting to additional senior posts to support quality and governance and additional safeguarding posts are in post from January.

Both are be regular members of the CQRG. Cover arrangements and escalation procedures were agreed and in place during any absences.