COMMITTEE TITLE:	**Nottinghamshire County Council – Health Scrutiny Committee**
DATE OF MEETING:	**23 July 2019**
TITLE:	**Briefing: Responding to the Care Quality Commission (CQC) Core and Well-Led Inspections of 22 January to 7 March 2019**
PRESENTING OFFICER:	**Dr John Brewin (CEO)**

1. PURPOSE OF THE REPORT

1.1 This briefing is for information and sets out the context of the most recent Care Quality Commission (CQC) inspection of the following core services operated by Nottinghamshire Healthcare NHS Foundation Trust:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based mental health services for adults of working age
- Child and adolescent mental health wards
- Community mental health services for people with a learning disability or autism
- Mental health crisis services and health-based places of safety
- Forensic inpatient or secure wards

1.2 The services were selected for inspection because of their previous inspection ratings or the CQC's ongoing monitoring.

1.3 This briefing covers the findings from the inspection, actions being taken and how actions and improvements will be assured. It assumes that the reader has read the inspection report, which can be found on the CQC website here: https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ0482.pdf and is supported by the Trust's Quality Improvement Plan.

2. BACKGROUND

2.1 When the CQC inspects, they assess services against five key questions. Is the service safe; is it effective; is it caring, responsive and well-led?

2.2 The CQC carried out unannounced inspections at various sites across the Trust between 22 January and 7 March 2019 to look at the quality of care delivered by the six core service types listed above. The final inspection report was published on 24 May 2019 and highlighted a number of areas for improvement.

2.3 If the CQC find that a registered provider is in breach of the regulations, they take action to make sure they improve. The action they take is proportionate to the impact that the breach has on the people who use the service and how serious it is. *(CQC Enforcement Policy - February 2015).*

2.4 The CQC's judgement following their 2019 inspection was that the breach of

regulations they found did not warrant the use of enforcement action against the Trust. They decided that the most appropriate method of addressing the improvements required was to issue requirement notices.

2.5 The CQC rate NHS Trusts at a core service level not an individual hospital or service level. For example, three forensic in-patient hospitals were inspected however only one overall rating was applied which incorporated all three hospitals.

2.6 The CQC made a total of 24 requirement notices against seven Health and Social Care Act 2008 (Regulated Activity) Regulations (2014) and the six core services inspected were rated as follows:

Table 1: Core service ratings following the 2019 CQC inspection:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate ↓ May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Inadequate ↓ May 2019	Inadequate ↓ May 2019
Forensic inpatient or secure wards	Inadequate ↓↓ May 2019	Good →← May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Child and adolescent mental health wards	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Community-based mental health services for adults of working age	Good ↑↑ May 2019	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019
Mental health crisis services and health-based places of safety	Requires improvement ↓ May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019
Community mental health services for people with a learning disability or autism	Good ↑ May 2019	Good →← May 2019	Good →← May 2019	Requires improvement ↓ May 2019	Good →← May 2019	Good →← May 2019

2.7 An aggregation of the core service ratings led to the Trusts rating going down to 'Requires Improvement' overall:

Table 2: Overall rating for the Trust: 2019:

Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

2.8 Plans have been put in place to address the inspection findings with the Trust taking a wider approach to the improvements required which is intended to progress from 'Requires Improvement' to 'Good' with the ambition of ultimately achieving an 'Outstanding' rating.

3. FINDINGS AND ACTIONS

3.1 The CQC has rated 12 of the Trusts 16 core services as good overall this include the previous ratings of services not inspected this time.

3.2 After receiving the final CQC inspection report, the Trust began to prepare its response to address the areas of non-compliance. The planned actions can be categorised into trustwide and service specific. The inspection report recognised progress made since services were last inspected as follows:

3.2.1 **Acute wards for adults of working age and psychiatric intensive care units**:

3.2.1.1 The Trust had implemented nine of the twelve actions made at the previous inspection and had made progress in two of the remaining actions outstanding.
3.2.1.2 The Trust had recruited specialist nurses to provide psychological interventions, but these nurses came into post after the CQC inspection therefore they did not see increased psychological interventions in place.
3.2.1.3 Staff carried out checks of emergency resuscitation equipment, but on two this was not consistently happening.
3.2.1.4 The Trust had also made improvements in most of the areas the CQC had flagged, however, staff failed to consistently always protect the privacy of patients which was the case at our last inspection.

3.2.2 **Community based mental health services of adults of working age:**

3.2.2.1 Clinical premises were safe and clean. The teams' caseloads were not too high and waiting lists were well managed. Staff assessed and managed risks well and followed good practice in safeguarding.
3.2.2.2 Holistic, recovery based care plans were in place supported by a range of professionals who followed the principles of the Mental Health Act 1983 and the Mental Capacity Act 2005.
3.2.2.3 Staff treated patients with compassion and kindness and involved families.
3.2.2.4 The service was well-led.

3.2.3 **Child and adolescent mental health wards:**

3.2.3.1 The service provided safe care and the clinical environment was clean and well-organised.
3.2.3.2 Holistic, recovery based care plans were in place supported by a range of professionals who followed the principles of the Mental Health Act 1983 and the Mental Capacity Act 2005.
3.2.3.3 Staff treated patients with compassion and kindness and involved families.
3.2.3.4 The service was well-led.

3.2.4 **Community mental health services for people with a learning disability or autism:**

3.2.4.1 The services provided safe care. Caseloads were not too high and waiting lists were well managed. Staff assessed and managed risks well and followed good practice in safeguarding.
3.2.4.2 Staff followed the principles of the Mental Health Act 1983 and the Mental Capacity Act 2005.

3.2.4.3 Staff treated patients with compassion and kindness and involved families.
3.2.4.4 It was easy to access the service and managers organised staff caseloads well.

3.2.5 **Forensic inpatient or secure wards:**

3.2.5.1 Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
3.2.5.2 Managers ensured that staff received training, supervision and appraisal. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
3.2.5.3 Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
3.2.5.4 Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
3.2.5.5 Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.

3.2.6 **Mental health crisis services and health based places of safety:**

3.2.6.1 Clinical premises where staff saw patients were safe and clean. The number of patients on the caseload of the mental health crisis teams and of individual members of staff was not too high. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
3.2.6.2 Staff had provided a range of treatments suitable to the needs of the patients and staff engaged in clinical audit to evaluate the quality of care they provided.
3.2.6.3 The mental health crisis teams included or had access to the full range of specialists required to meet the needs of patients. Managers' ensured staff received training. Staff worked well together as a multi-disciplinary team and with relevant services outside the organisation.
3.2.6.4 Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
3.2.6.5 Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients, families and carers in care decisions.
3.2.6.6 The mental health crisis service and the health-based places of safety were easy to access. Staff assessed people promptly. Those who required urgent care were taken onto the caseload of the crisis teams immediately. Staff and managers managed the caseloads of the mental health crisis teams well. The services did not exclude people who would have benefitted from care.

3.2.7 In their report the CQC also acknowledged the following areas of 'Outstanding' practice:

3.2.7.1 **In community mental health services for people with a learning disability or autism:** the Trust engaged with the 'Stopping Over-Medication of people with a learning disability or autism programme. Staff in the epilepsy service worked across Nottinghamshire to provide a comprehensive service for adults.

3.2.7.2 **In forensic inpatient or secure wards:** patients were supported to access a range of vocational activities, electronic devices were being used to record patient observations and the Trust had introduced a communication wall to support patients in the seclusion suite.

3.2.7.3 **Trustwide:** The clinical development unit was working to support future capacity and capability across the local healthcare system. The Trust had started to enable clinicians to access the GP repository clinical care electronic system. Peer flu vaccination schemes had increased uptake and finally, the Trust hosted a Patient Feedback Matters conference.

3.2.8 **The areas where the Trust needs to take further action are:**

3.2.8.1 **Trustwide:**

3.2.8.1.1 To review the Trusts governance structures to ensure adequate oversight of key performance areas across the organisation.

3.2.8.2 **In acute wards for adults of working age and psychiatric intensive care units:**

3.2.8.2.1 To have enough suitable staff so that patients have access to leave and 1:1 sessions.
3.2.8.2.2 To carry out physical health observations after rapid tranquilisation
3.2.8.2.3 To carry out physical health care planning and observations when required throughout admission.
3.2.8.2.4 To carry out checks of resuscitation equipment
3.2.8.2.5 To review blanket restrictions
3.2.8.2.6 To ensure the privacy of patients during observations on one of the eight wards inspected.
3.2.8.2.7 To have effective governance structures so that supervision and team meetings take place
3.2.8.2.8 To ensure risk assessments are in place

3.2.8.3 **In community-based mental health services of adults of working age:**

3.2.8.3.1 To ensure staff store medicines correctly.

3.2.8.4 **In child and adolescent mental health wards:**

3.2.8.4.1 To ensure patient information cannot be seen by visitors.

3.2.8.5 **In community mental health services for people with a learning disability or autism:**

3.2.8.5.1 To ensure all patients know how to raise concerns

3.2.8.6 **In Forensic inpatient or secure wards:**

3.2.8.6.1 To ensure there are enough suitably qualified staff to support the effective care of patients
3.2.8.6.2 To follow best practice in medicine management
3.2.8.6.3 To carry out physical health observations after rapid tranquilisation

3.2.8.6.4 To ensure ward environments are clean and well maintained
3.2.8.6.5 To ensure staff have easy access to emergency equipment
3.2.8.6.6 To ensure clinical equipment is checked
3.2.8.6.7 To have effective governance arrangements in place
3.2.8.6.8 To use tools to monitor deterioration in patients physical health.
3.2.8.6.9 To follow observation policies
3.2.8.6.10 To record when changes to the care environment are made.

3.2.8.7 **In mental health crisis services and health-based places of safety:**

3.2.8.7.1 To follow medicine management policies
3.2.8.7.2 To ensure places of safety are safe and secure
3.2.8.7.3 To have safe staffing levels

3.3 Following receipt of the final CQC inspection report the Trust submitted its Quality Improvement (QI) Plan (Appendix 1).

3.4 A standardised QI approach continues to be promoted and increasingly expected by NHS England, NHS Improvement and by the Care Quality Commission. In September 2018, the CQC published a report entitled “Quality Improvement in Hospital Trusts: Sharing learning from Trusts on a journey of QI”. This report from the CQC shares learning from acute, community and mental health Trusts in achieving their ‘Outstanding’ level of care. All contributing providers had one thing in common; a well-led, embedded, staff and patient driven QI approach.

3.5 QI is continuous and requires the whole workforce to embrace the methodology in order to make lasting improvements for patient care, safety and experience.

3.6 Quality priorities have been agreed by the Board of Directors for 2019/20 and help to address the more complex issues highlighted by CQC which will take time to resolve.

4. REPORTING AND MONITORING

4.1 The Quality Improvement Plan ensures achievement and monitoring is embedded in good governance with a robust process to internally and externally monitor our progress.

4.2 Each outcome has a designated executive lead and clinical lead who is responsible for the completion, with a clear route to monitoring implementation according to agreed timescales.

4.3 Regular updates and evidence are supplied to the Trust’s Quality Committee and to the Board of Directors with evidence of implementation.

4.4 Actions and improvements will be reported through to the CQC and onward, to other regulators and stakeholders (NHS Improvement) through an agreed strategic oversight meeting.

5. CONCLUSION AND RECOMMENDATIONS

The Trust can evidence that it is taking the findings of the inspection very seriously and is working to improve in all areas identified by the CQC, aspiring to achieve and sustain improved ratings at future inspections. The CQC has recognised that improvements are beginning to

Ongoing monitoring will continue through improved governance structures, a process of self assessment of compliance and the following quality improvement approach:

1. A review of key policies and their related training and governance (ie rapid tranquilisation, safe staffing)
2. Targeted QI programmes directed at medicines safety, resuscitation equipment and care planning that include all the involved services.
3. Increased professional leadership in relation to safe staffing and reducing restrictive practice.
4. The review of governance, continuing to move leadership and governance resource to Quality First, with an underpinning engagement approach with ward leaders.
5. Focus on Adult Mental Health (AMH) leadership and services models, which started with a review with staff on the 10th May 2019, focusing on leadership, staffing, safety and clinical sustainability.

There is the significance of the culture and values work and advised review of recruitment and retention given the underlying conditions that this is creating for staff.

The Health Scrutiny Committee should seek assurance on the actions the Trust is taking to bring about sustainable improvements following the CQC inspection.

6. REFERENCES, SUPPLEMENTARY READING & APPENDICES

CQC 2019 Inspection Report of Nottinghamshire Healthcare NHS Foundation Trust:
https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ0482.pdf

CQC Enforcement Policy:
https://www.cqc.org.uk/sites/default/files/20150209_enforcement_policy_v1-1.pdf

Appendix 1: Quality Improvement Plan submitted to the CQC in response to the inspection findings.