Devon Partnership NHS Trust

Devon County Council Health and Adult Care Scrutiny Committee

12 November 2020

Devon Partnership Trust CQC Inspection – Improvement Plan

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1. Background

1.1 During 2019 the Care Quality Commission (CQC) undertook a planned, routine inspection of four of the Trust's 'core services' alongside the annual Well-Led inspection.

1.2 In June 2020, in response to three inpatient deaths reported within a 12 month period, the CQC undertook a focused, unannounced inspection of Delderfield Ward (Exeter) and Moorland View Ward (North Devon).

1.3 In August 2020, following a death at the Langdon Hospital Forensic Mental Health site, the CQC undertook a focused, unannounced inspection of Holcombe and Ashcombe Wards.

2. CQC 2019 Core Service and Well Led Inspection 2019 – Key Themes and Trust responsive Improvement Action Plan

2.1 The CQC's published report in relation to the 2019 core service with well-led inspection, highlighted the following key themes for improvement:

- Trust clear oversight and safe monitoring and management of people who are on waiting lists for adult community mental health services, to include robust and routine review of any change to people's level of risk while waiting
- Improvements to staffing levels on inpatient wards and in adult community teams, ensuring holistic, person-centred, collaborative care and treatment
- Robust risk assessments of ward environments to ensure mitigating risks and plans are shared with and understood by all staff
- Provision of mental health beds for the population of Devon to avoid people having to travel out of Devon to receive inpatient mental health services
- Improvement to the physical health monitoring in compliance with NICE guidelines
- Continued partnership working with local commissioners to ensure resources are secured to meet the needs of people waiting for the Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder service.

2.2 Devon Partnership NHS Trust Improvement Action Plan in response to CQC's 2019 inspection is split into five sections, aligned to the structure of the CQC core services that were inspected.

- Provider level action plan
- Adult Community Services action plan
- Adult Inpatient Services action plan
- Older Person's Inpatient Services action plan
- Community services for people with a learning disability or autism action plan

2.3 Positive progress has been made against the plan from the 2019 inspection, which is routinely reported through to the Trust Board of Directors.

Specifically, the following progress has been made:

- The Centralised Waiting List Management Team established following the findings of the inspection, remains in place, overseeing the waiting lists for all 17 adult community mental health teams; to maintain accurate records, manage correspondence with clients and plan regular clinician calls according to each individual's priority status. This centralised team carries out welfare calls, assesses the current situation for each client and any change to priority status or risk rating which is reflected on their clinical record and on the waiting list. They liaise with the appropriate community team where there are queries or concerns. Any identified risks or changes to risk are recorded in the progress notes and updated on the risk assessment within the client's clinical record and escalated to the team manager for allocation where required.

- Recruitment has been undertaken in both the inpatient wards and the adult community teams to increase the numbers of qualified, substantive staff to improve team capacity and stability and reduce the need for bank and agency cover. However, staffing remains one of the Trust's biggest challenges as is the case nationally and we continue to focus on recruitment, retention and staff wellbeing as one of our key priorities.

- Across the three localities, all ward environmental risk assessments are in place and all staff have easy access to these. To ensure staff are up to date, the content is raised through supervisions, team meetings and high risk areas are raised at routine handover. Ward environmental risk assessments are complete and in date. Daily ligature checks take place and identify works that need to be undertaken, which are reported to Estates and commence as soon as practicably possible.

  Environmental risk assessment is a topic on business meeting agendas, and also covered in supervision. Each supervision has a prompt in relation to ligature and management. Routine handovers include high risk areas. The Health and Safety Team and Estates Team do routine health and safety assessments on the wards in partnership with the ward management teams.

- The Trust continues to work in partnership with the local Clinical Commissioning Group and Local Authority colleagues and with NHS England to develop the bed stock for Devon as well as to improve flow through the inpatient mental health services, preventing the need for people to be placed out of Devon for acute adult or older adult inpatient mental health care. Building works have commenced for a new 16 bed ward in Torbay. In addition to this, as part of our plans to cope with the potential surge in demand for mental health services as a result of COVID-19, we have identified some additional inpatient capacity through leasing a brand new facility called Pinhoe View, in Exeter. The unit is owned by Elysium Healthcare, has been registered with the CQC and comprises two 16-bed wards and eight flats on one site. Our Russell Clinic rehabilitation service has recently moved into the Pinhoe View facility.

- All community bases have physical health monitoring equipment in place required to fulfil monitoring requirements of the Lester Tool; a national tool implemented by NHS England to '*support frontline staff in making assessments of cardiac and metabolic health, helping to cut mortality for people with mental illnesses.'* Staff

training in physical health monitoring has been refreshed and rolled out to support staff in delivering monitoring requirements and recording the interventions. COVID-19 restrictions to face to face contact have limited the ability to deliver this monitoring, but it remains a key Trust priority to progress as part of the wider Community Mental Health Framework implementation.

- We continue our partnership working with local commissioning groups and Local Authority partners in relation to the Autistic Spectrum Conditions and Attention Deficit Hyperactivity Disorder service pathways and this work, while delayed due to COVID-19, is now progressing again.

3. CQC June 2020 Unannounced Inspection to Delderfield and Moorland View Wards - Key Themes and Trust responsive Improvement Action Plan

3.1 Immediately following inspection, inspectors identified some serious concerns about patient safety on Delderfield Ward that needed immediate action. The CQC wrote to our organisation shortly after the visits were completed, requesting that we take urgent action to address the concerns that were raised. The CQC was assured by the action that we took, and are continuing to take, to ensure patients are safe.

3.2 The published June 2020 focused, unannounced inspection report that followed highlighted the reported key themes for improvement, which were:

- Robust, routine environmental risk assessments to be updated, including following every serious incident, to ensure robust mitigation is in place. This is to include environmental risks being reduced in a timely manner.
- Robust, comprehensive patient observations and intentional rounding to take place, completed in line with Trust policy.
- Staff must be appropriately trained, competent and confident in intentional rounding, observation and the assessment and management of patient risk.
- All staff, including temporary staff must have a thorough induction to the ward to ensure they are familiar with the ward and the tasks required.
- Quality and oversight of the ward to be ensured to ensure staff are completing their duties to a high standard.
- Learning from audits and serious incidents must be responded to and learned from in a robust and timely manner, ensuring that learning is shared with staff without delay.

3.3 Significant progress has been made against the plan from the 2020 Delderfield and Moorland View inspection, with the action plan nearing completion.

Progress made has been:

- The Trust has completed the Serious Untoward Incident Investigations into all three deaths that occurred on Delderfield and Moorland View Wards. The Trust has engaged with families during these investigations. In addition, the Trust has undertaken a thematic review of all three inpatient deaths, involving our Safer from Suicide team. This review will be completed by the end of this year.
- Significant strengthening of engagement and observation practices, to include a review and enhancement of the Trust's Engagement and Observation policy, particularly in relation to Level 2 observations and direct supervisory support to staff to enhance practice in relation to this.
- Robust auditing in place of engagement and observation processes, to highlight daily where staff require support to improve practice. This has had a positive impact on consistency and confidence across the staff team.

- Suicide prevention and ligature management programme led by the Safer from Suicide Team, which has resulted in the implementation of virtual simulation training; the training includes scenarios that staff have contributed to.
- Approval and progression of the Trust anti-ligature door sensor programme, which is currently in the procurement phase.
- Completion of ligature works in the bathrooms and toilets on Delderfield Ward following suspension of works during COVID-19 first lockdown.
- All incidents are reviewed daily on the ward for immediate action and weekly for themes and shared learning discussed by the Ward Managers and Senior Nurse Managers, to ensure shared action across all adult inpatient wards. Safety briefings are also shared to cascade learning from incidents organisation wide.
- The wards currently operate local induction programmes for new staff. However, in response to the inspection findings, all agency staff receive a local induction at the start of every shift, to ensure that all staff are aware of the most current protocols, policies, procedures and practices.
- Appointment of a substantive Consultant Psychiatrist to Delderfield Ward who commenced in post in September 2020.
- A new Ward Manager has been appointed, and has strengthened the ward management, governance and staff support arrangements, to include robust supervision and team meetings which have safety, quality and learning as the highest priorities.

4. Unannounced Inspection to Secure Services – August 2020 - Key Themes and Trust responsive Improvement Action Plan

4.1 On 18 and 19 August, CQC undertook an unannounced inspection to Langdon Hospital, in response to a death that occurred on 31 July 2020.

4.2 The published August 2020 focused, unannounced inspection report that followed highlighted the reported key themes for improvement, which were:

- Sufficient numbers of suitably qualified, skilled experienced staff to meet the patients care and treatment needs are required on Holcombe and Ashcombe Wards
- Learning from serious incidents and mitigating risks must be shared across all the trust's relevant ward and services and that the learning is used to inform practice.
- There must be safe observation practice on all wards and that staff always account for items that pose a risk
- Themes from conversations with the well-being leads must be escalated so these can be used to inform methods to support staff

4.3 The Secure Services Directorate has developed a responsive action plan to address these issues, which has been included as part of the wider Secure Services Quality Improvement Plan. The Directorate also enacted several interventions to mitigate the identified risks immediately following the serious incident that triggered the CQC's inspection.

Specific progress already made:

- To improve the potential for recruitment of staff, the Secure Services Directorate has invested in a Service specific recruitment team who are proactively seeking staff to recruit and improve the recruitment process. Additionally, the Service has invested in expansion of the Practice Education team who support staff progressing through the career pathway through to Senior Qualified Clinical posts. Further work is progressing in relation to inpatient staffing levels as part of the Trust's annual Safer Staffing review.

- There are forums in place within the directorate to routinely review learning from incidents and from experience and to disseminate this across the wards within the service.
- The Service has employed a Health and Wellbeing (HWB) Lead to develop systems and processes to ensure all staff are supported. As this is a new role they are developing a work plan to ensure their focus on a quality improvement approach to issues and themes identified.
- The lead will ensure a robust post incident management system, a Wellbeing group made up of staff from all professions and grades and to ensure staff views are heard at all levels of the directorate via monthly meetings with the Service Directorate Manager to ensure key themes are shared and issues at all levels are addressed. In addition staff have a confidential escalation route to the Trust Guardian who provides 'Speak Up' Supervision to the HWB Lead.

5. On 28 August 2020, a Quality Surveillance Group was convened led by NHS England / NHS Improvement, at the request of the NHS Devon Clinical Commissioning Group, attended by Care Quality Commission, NHS England Specialist Commissioning and Devon Partnership NHS Trust. The purpose of the QSG was to consider whether the Trust had robust systems and process in place to manage quality and safety of care.

The Trust presented the improvement action already undertaken and the progress that has been made in respond to these concerns. The Quality Surveillance Group resolved that robust assurance had been received and that no further formal action was required of the Trust. Enhanced partnership working was agreed as an outcome of the meeting, to ensure that the Trust is supported and enabled to enact some of the changes required that are not fully in its control to deliver.

6. Conclusion

The safety of the people we look after and the quality of services we deliver to them remain of paramount importance to the organisation. No death of a person in our care is acceptable. We extend our deepest sympathies to the families of the four patients who have died. We have already addressed many of these concerns and we will be working closely with the CQC and our Clinical Commissioners to continue to monitor progress and provide overall assurance that our services are safe.

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