East London NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
22 FEBRUARY 2018

Title	CQC Inspection November 2107- Luton and Bedfordshire Mental Health Inpatient Services
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Purpose of the Report:

The Care Quality Commission carried out a focussed inspection of the acute wards for adults of working age and psychiatric intensive care units in Bedfordshire and Luton on 8th and 9th November 2017. This inspection was prompted by four unexpected deaths and one near miss incident that occurred in the service between December 2016 and June 2017. The inspection report was published on 07.02.18 and received some media interest in response.

The purpose of this paper is to summarise the findings of the CQC inspection and to review this against the action plans that the Trust put in place following the investigations into the incidents.

Any further actions that still require to be carried out with the services will be highlighted.

Summary of Key Issues:

Following incidents that occurred in Luton and Bedfordshire mental health services in 2016/17 the Trust carried out extensive investigations into these incidents and developed action plans to address the issues that were raised.

The CQC carried out a focussed inspection of these services in November 2017. This confirmed the work the trust had carried out to improve the safety of the inpatient services. It also identified some further areas for the Trust to improve services further.

The Trust has responded to these finding robustly.

Strategic priorities this paper supports (Please check box including brief statement)

Improving service user satisfaction	☒	
Improving staff satisfaction	☒	
Maintaining financial viability	☒	

Committees/Meetings where this item has been considered:

22.02.18	Part 2 Trust Board

Implications:

Equality Analysis	This report has no direct impact on equalities
Risk and Assurance	This report gives an update on the progress with actions following CQC inspection and incident within services.
Service	Paper relates to Luton and Bedfordshire mental health services.

User/Carer/Staff	
Financial	There are no financial implication in this report.
Quality	This report details the actions that are being put in place to improve patient safety and improve the quality of service we provide.

Supporting Documents and Research material

a.
b.

Glossary

Abbreviation	In full
CQC	Care Quality Commission
MDT	Multi-Disciplinary Team

1.0 Introduction

1.1 Between December 2016 and July 2017 there were four unexpected deaths of and one near missed incident within the Bedfordshire and Luton mental health inpatient services.

1.2 In response to these incidents the Trust had carried out detailed Serious Incident Investigations. Action plans to address issues raised from these were developed.

1.3 The Care Quality Commission carried out a focussed inspection of the acute wards for adults of working age and psychiatric intensive care units in Bedfordshire and Luton on 8th and 9th November 2017. The inspection report was published on 07.02.18 and received some media interest in response.

1.4 The purpose of this paper is to review the actions of the Trust following the incidents and summarise the findings of the CQC inspection.

1.5 Any further actions that still require to be carried out with the services will be highlighted.

2.0 Incident in Bedfordshire and Luton Mental health Services December 2016 to June 2017

2.1 Between December 2016 and June 2017 there were four unexpected deaths of and one near missed incident within the Bedfordshire and Luton mental health inpatient services.

2.2 There were limited connection of incidents, however a common theme was the challenges of a stand-alone unit, inconsistent leadership across all disciplines, and inconsistent practices.

2.3 The workstream focused on these main areas: service user numbers on the ward and managing the environmental challenges, multi-disciplinary team leadership and development of working practices, stability in nursing and medical leadership team, and development of staff skills, knowledge and practice.

2.4 There was an external review chaired by Dr Dudley Manns, Clinical Director for Newham that supported and also raised issues in relation to MDT working, unit isolation and leadership. However it noted significant improvements from the point of incident to time of review.

2.5 The Care Quality Commission carried out a focussed inspection of the acute wards for adults of working age and psychiatric intensive care units in Bedfordshire and Luton on 8th and 9th November 2017.

2.6 A summary of their findings are given below:

- Ash ward had reduced from 27 beds to 19 beds which allowed staff better oversight of patients. Many of the wards within the service continue to have bed

numbers in excess to those recommended in the Royal College of Psychiatrists Guidance (16 beds).

- Improvement were noted in ward security and safety with processes put in place to address the access to contraband items.
- Partnership working with the local Police was evident to reduce access to illegal substance on wards
- Staff had received training on suicide prevention
- Management of physical health on the ward had improved with the introduction of a physical health care nurse within the service.
- Improvement were noted in risk assessment and updating of risk assessments following incidents.
- Although recruitment and retention of nursing staff continued to be an issue, it was noted that the staff reported morale as good and that the service was improving.
- Although overall medicine management was good it was noted that in several clinical rooms it was still too hot.

2.7 In particular the CQC noted the following areas that required further improvement:

- Physical health monitoring following rapid tranquilisation was not consistently carried out.
- Incidents were not consistently reported which lost the opportunity to learn from incidents.
- Inadequate records of cleaning and maintaining equipment.
- Basic life support and immediate life support training was below 75%.

2.8 In response to the CQC investigation report the service has developed an action plan which includes the following:

- Basic life support and immediate life support to have 95% staff compliance (March 2018)
- Address and monitor temperature in treatment room (February 2018)
- Improvement of care planning and pathways for diabetes (April 2018).
- Improvement of recording of physical health observations (April 2018)
- Improvement in physical observation following rapid tranquilisation (February 2018)
- Improvement in observation policy compliance (January 2018)
- Improve consistency of incident reporting on Datix (January 2018)

  All actions are being actively pursued and are on time to be completed. This is being reviewed regularly by the Directorate Management team.

3.0 Conclusions

3.1 A considerable work has been carried out within Luton and Bedfordshire Mental Health inpatient services since the incidents in 2016/17.

3.2 The recent inspection by the CQC on these services confirmed the extent of this work and that a great deal of improvement had been made in the provision of safe services for patients.

3.3 The CQC inspection also pointed out some areas for further improvement which the services have provided a robust response to.

4.0 Action being requested

4.1 The Board is asked to **RECEIVE** and **NOTE** the report for information