City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of Bradford District Care NHS Foundation Trust (BDCFT) to the meeting of the Health and Social Care Overview & Scrutiny Committee to be held on 26 September 2019

I

Subject: CQC Inspection and BDCFT Response

Summary statement:

Following an inspection of services in 2019, the CQC published their final report on Bradford District Care Trust NHS Foundation Trust on 11 June 2019.

During the inspection period, the Care Quality Commission took enforcement action against Bradford District Care NHS Foundation Trust. The Trust received a Section 29a Warning Notice on 28 March 2019 about the quality of care we provide for the Assessment or Treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury. A significant piece of work was undertaken to address the issues identified by the CQC.

On the publication of their final report the CQC identified areas of outstanding practice and areas of improvement. The Trust has developed an action plan in response to the CQC report (Appendix A).

The Trust's status remains the same of the 2017 inspection of 'Requires Improvement'.

This report provides an overview of the CQC inspection, the work undertaken by the Trust to address the findings and the governance arrangements to ensure the actions are addressed and embedded.

Portfolio:

Healthy People and Places

Report Contact: Debra Gilderdale
Phone: (01274) 228300
E-mail: Debra.Gilderdale@bdct.nhs.uk

1. Summary

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2. Background

The CQC undertook an inspection of services between 28 February and 10 April 2019. The CQC identified the core services to be inspected based on previous inspection ratings, information relating to risk received through engagement and ongoing monitoring, and the length of time since the service was last inspected. The CQC inspected eight of the Trust's fourteen core services.

- Acute wards for adults of working age and psychiatric intensive care units
- Forensic inpatient/secure wards
- Wards for older people with mental health problems.
- Wards for people with learning disability or autism
- Mental health crisis services and health-based places of safety.
- Community-based mental health services for older people
- Community end of life care
- Community health services for children, young people and families

The inspection also included an assessment of the well-led domain and included interviews with the Executives and Non-Executives.

During the inspection period, the Care Quality Commission took enforcement action against Bradford District Care NHS Foundation Trust. The Trust received a Section 29a Warning Notice on 28 March 2019. This highlighted concerns about the quality of care for the Regulated Activities we provide for the Assessment or Treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury and required us to make significant improvements.

Following the completion of the inspections the CQC published their report on 11 June 2019. In response to this, the Trust reviewed the *must do* and *should do* recommendations to develop a high level action plan.

A high-level action plan was developed in response to the report and submitted to the CQC on 9 July 2019. Sitting behind this are detailed workstream action plans to help support the delivery of actions and enable to Trust to closely monitor progress.

3. Report issues

3.1 Section 29a Warning Notice

Following receipt of the Section 29a Warning Notice, the Trust commenced a significant and immediate executive-led response. During the week commencing 1st April 2019 around 100 clinical and corporate staff members were engaged in a 5-day Rapid Improvement Workshop (RIW). This utilised approaches from our newly introduced Quality Improvement System, The Care Trust Way. We sought support from NHSI, local trusts, social care representatives, the voluntary and community sector and local CCG colleagues, to establish and progress workstreams focussed on area of concern. A copy of the action plan can be found in Appendix B.

A joint Quality and Safety/Mental Health Legislation Committee (sub-committees of our Board of Directors) meeting took place on 16 April 2019 to review the response and action plan. The Trust submitted the plan and evidence of the improvements to the CQC. On 12 August 2019 a further joint Quality and Safety/Mental Health Legislation Committee meeting was held to review the action plan and supporting evidence.

To support the work and delivery of the actions from the RIW it was agreed that clinical audits would but undertaken to support the ongoing monitoring of improvements in the areas identified. The audit have demonstrated improvement and, where further support is required to ensure the improvements are embedded. The outcomes of the audits have been reported to the Quality and Safety Committee.

Improvements have been noted across all areas of the action plan, including use of admission assessment tools, completion of register of movement and a decrease in medication incidents. Whilst improvement has been made across all action points the Trust continues to review and monitor these areas to ensure robust monitoring and embedding of practice across in-patient services.

The Trust also developed a program of quality checks for the wards. These are undertaken every month by senior staff from across the Trust and are supported by colleagues from NHSI and the CCG. The checks have demonstrated improvements across the wards in the areas highlighted in the Section 29A warning letter.

The CQC will return to review the progress made against the issues they raised in the warning letter. The CQC returned to re-inspect the wards on Tuesday 10th September 2019. Their report is likely to be available in November 2019.

3.2 CQC Report Findings 2019

On 11 June 2019 the CQC published their report and the Trust remained as *requires improvement*. The Trust was rated as follows:

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement → ← Jun 2019	Requires improvement → ← Jun 2019	Good → ← Jun 2019	Good → ← Jun 2019	Requires improvement → ← Jun 2019	Requires improvement → ← Jun 2019

The inspection highlighted many positives, particularly around the caring and responsive domains which are detailed in full info the report. There are however areas for improvement. These areas are detailed in full in the report.

The ratings for the our Community Services improved to outstanding in the caring domain. The remaining ratings remained static.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good → ← Jun 2019	Good → ← Jun 2019	Outstanding ↑ Jun 2019	Good → ← Jun 2019	Good → ← Jun 2019	Good → ← Jun 2019
Mental health	Requires improvement → ← Jun 2019	Requires improvement → ← Jun 2019	Good → ← Jun 2019	Good → ← Jun 2019	Requires improvement → ← Jun 2019	Requires improvement → ← Jun 2019

The CQC rated the Trust as *requires improvement.*

- Of the 14 core services, one is rated as inadequate and five as requires improvement.
- Overall ratings went down for the acute inpatient mental health services for adults of working age and the psychiatric intensive care unit to inadequate, and for the community health services for children and young people to requires improvement. The forensic low secure services were rated as requires improvement. The rating stayed requires improvement for the wards for older people with a mental health problem.
- The CQC had issued the Trust a Section 29A warning letter as reported in section 3.1.
- The action taken by the Trust to address many of the areas for improvement identified from the last inspection had not been effective in all areas.
- Arrangements for governance and performance management did not always operate effectively.

The CQC did identify positive areas of practice, specifically:

- Community end of life services were rated as outstanding overall
- Three of the six mental health services were rated as good with improvements noted in the ward for people with a learning disability and mental health crisis services and health-based places of safety.
- The community mental health services for older people were rated as good
- Staff interactions were kind, respectful and compassionate
- The trust has introduced a new vision and strategy to improve services

In the report the CQC did note that significant action had been taken by the Trust in response to the 29a warning letter.

3.3 CQC Action plan

The Trust has worked closely with NHSI to help develop a template for the action plan. In addition to this a session with senior clinical and management leaders (Forward to Excellence Forum) was held on the delivery of the action plan. It was evident that there needed to be two significant changes 1) the action plan needed to be detailed with micro actions to ensure clear oversight of progress and, 2) staff wanted to be involved in developing the solutions.

A high-level action plan has been developed with a two-phase process:

> **Phase 1** delivery of the actions and this is completed no later than December 2019.
> **Phase 2** testing the actions to demonstrate that actions/improvements are embedded/effective.

There are 13 workstreams within the action plan, each of which has a lead executive with overall responsibility and a Committee into which it reports.

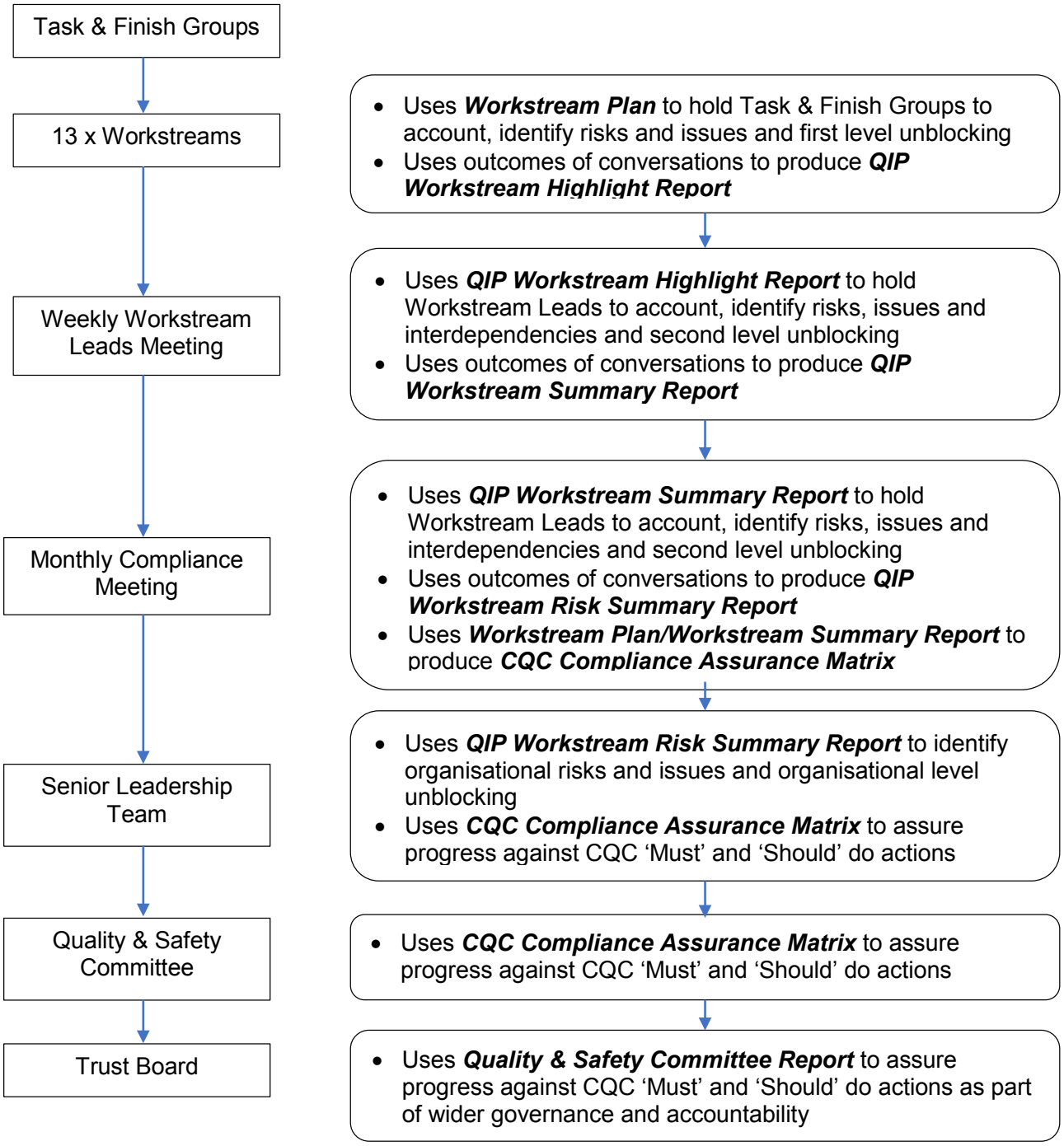
Each workstream lead has developed more detailed action plan. As the issues highlighted in the Section 29A Warning Letter were already being addressed, a number of the workstreams were already in place and action had already been taken to address the issues raised in the CQC report.

3.4 Governance Arrangements

The governance arrangements were reported to the Quality & Safety Committee 2 August 2019. Templates have been devised to support the governance processes. The flow chart below details the arrangements for the governance arrangements of the workstreams.

NHS
Bradford District Care
NHS Foundation Trust

Quality Improvement Plan Governance (QIP)



Audit will be a key feature of ongoing monitoring of the CQC action plan and quality issues.

3.6 **Improvements made since the inspection**

There has been significant progress against a number of actions following the feedback from the CQC. Key areas of progress are:

- An integrated governance framework has been produced to support good governance and escalation processes
- Governance and monitoring process have been improved including the introduction of Daily Lean Management and the development of electronic reporting systems to support managers in identifying areas of improvement
- A business case has been approved to introduce door alarms on the wards and patient call alarms.
- A number of policies have been reviewed and revised
- The Care Trust Way has been introduced (see section 3.7) and is supporting some of the workstream actions.
- A new admission tool has been introduced. This has improved the accessibility of information available to ward staff for new patients arriving on the ward.
- Audits undertaken have demonstrated improvements in risk management, care planning, medicines management, clinic checks and management of leave processes.
- The introduction of 'say so' groups where in-patients have the opportunity to share their experiences and views on how to improve the ward environment and therapeutic offers.
- A new system for recording staff supervision has been piloted.

4. Recommendations

The Committee note the action taken by BDCFT in response to the CQC's findings

7. Background documents

CQC final report 2019 CQC final report

8. Not for publication documents

None

9. Appendices

Appendix A – CQC Action Plan 2019
Appendix B – Section 29A Action Plan