Leicestershire Partnership NHS
NHS Trust

REPORT FROM LEICESTERSHIRE PARTNERSHIP NHS TRUST

BRADGATE MENTAL HEALTH UNIT

Purpose of the Report

1. The purpose of this report is to:

   - Provide an honest, open and transparent report about the current issues and challenges affecting Leicestershire Partnership Trust.
   - Outline the specific findings, implications and immediate actions taken following the Care Quality Commission (CQC) visit at the Bradgate Mental Health Unit in July.
   - Explain the approach the Leicestershire Partnership Trust is taking in the medium term to assure high quality sustainable care for local mental health service users, and all our other services users.
   - Demonstrate public accountability and set out how the Trust is working to restore confidence in its services.

Overview of CQC Visit July 2013

2. The Bradgate Adult Mental Health Unit was inspected by the CQC on 4 and 17 July 2013.

3. The CQC found two areas of major concern and three moderate areas of concern and on 30 July, Leicestershire Partnership Trust was issued with two warning notices with respect to the two major areas of concern, which related to care planning and discharge planning.
http://www.leicspart.nhs.uk/Library/PRCQCresponse30July.pdf

Warning Notices	
Outcome 4	Care and welfare
Outcome 6	Cooperating with other providers
Moderate areas of concern	
Outcome 7	Safeguarding people who use services from abuse
Outcome 14	Supporting
Outcome 16	Assessing and monitoring the quality of service provision.

4. In line with usual practice, the CQC report arising from this visit was initially issued in draft form to the Trust for checking for factual accuracy.

5. The Trust's response to the draft report and our response on receipt of the warning notices were made within the CQC's required timescales.

6. The report was published on the CQC website on 28 August. Direct link to the CQC report:
http://www.cqc.org.uk/sites/default/files/media/reports/RT5KF_The_Bradgate_Mental_Health_Unit_INS1-711321412_Scheduled_22-08-2013.pdf

For further information about the inspection regime please see the CQC website home page www.cqc.org.uk)

7. The Trust is required to submit a further response to the CQC by 4 September which will address the three areas of moderate, such as seclusion facilities and access to interpreters.

8. The Trust is required to show sufficient progress to address the issues raised in the warning notices within a 30 day period.

9. A follow up inspection will be undertaken by the CQC which we anticipate will be in the early part of September; however this will be an unannounced event.

10. Should the Trust fail to demonstrate sufficient improvement in the two areas that relate to the warning notices, further sanctions may follow in line with the CQC regulatory framework. These can include applying a significant fine and could ultimately affect the ability of the Trust to provide certain services.

The Response of the Trust

11. The Trust has taken this report extremely seriously and acknowledges that the provision of high quality care planning and discharge planning is a fundamental part of providing safe, effective and person-centred care to all patients in all our services.

12. The feedback from the July CQC visit has shown considerable inconsistency in the application of good practice in care planning and discharge planning, in particular with respect to recording the associated documentation in clear and systematic ways.

13. While some wards demonstrate good practice in both the planning of care and discharge arrangements and documenting this, others have not demonstrated good practice in one or both aspects, or have been unable to demonstrate this consistently.

14. A Trust Board meeting was held on 31 July to investigate the position and an extraordinary Trust Board meeting was held in public on August 29 where the Trust formally received the CQC report, reported on progress in addressing the warning notices, and responded to a number of questions from members of the public.
Board papers can be viewed at http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2013-August2013.aspx.

15. We also issued this statement:
http://www.leicspart.nhs.uk/Library/AMH_025_13CQCreport.pdf

Extract from the statement:

Sue Noyes, LPT Acting Chief Executive, and David Chiddick, LPT Chair, said: "We are very disappointed by the report and are very sorry for the failings identified by the CQC. We fully accept the CQC findings, recognise the severity of this situation and are being transparent in all aspects of its response. This latest CQC visits reinforces that, while several wards have maintained good performance, this performance has not been consistently maintained across all wards at the unit."

Issues, Concerns and Progress in Adult Mental Health Services 2012 / 13

a) Issues and Concerns

16. There have been a number of related issues that have affected the Bradgate Unit's overall performance and quality assurance over the past two to three years. Cumulatively this has led to escalating public concern along with more intensive commissioner and media scrutiny. The issues and concerns have broadly included:

- The independent Professor Louis Appleby review into patient suicides between 2010 and 2012 - the report considered thematic findings from a number of patient related Serious Incident investigations in the inpatient services.
- Associated coroner cases / rulings.
- Findings from previous CQC and Mental Health Act inspections.
- Monitor's decision to defer the Trust's FT application in December 2012 due to insufficient assurance on the Trust's quality governance framework (materially affected by the Bradgate Unit's trend in serious incidents at that time).
- A recent File on Four radio documentary examined serious incidents in mental health inpatient settings (using LPT as an example) and considered if independent investigations should be the policy in the future.

b) Progress in 2012

17. In August 2012 as part of the development of the Trust's overall five year business plan, the Trust Board approved a comprehensive service development initiative for adult mental health services which aimed to drive up the quality of care across the pathway from inpatients to community settings (Appendix A).

18. These developments include the continuing capital programme to relocate inpatient wards from the Towers hospitals into new modern accommodation at the Bradgate Unit.

19. In November 2012 the Board received the findings of Professor Louis Appleby's independent review. This review considered a number of inpatient suicides in the adult mental service between 2012 and 2012. As a result of this review the Trust put in place a quality improvement plan to address the thematic findings of this review.

20. Professor Appleby's report and the individual incident investigations highlighted themes such as the quality of communication, record keeping, handover and risk assessments by staff at the Bradgate Unit which were contributing factors in some of the serious incidents (SIs) within the Unit.

21. The weblink below takes you to the Professor Louis Appleby report. There is also a link at this page to the latest progress report given at our Quality Assurance Committee in August 2013.
http://www.leicspart.nhs.uk/_CommitmentstoCare-LouisApplebyreportandLPTsresponse.aspx

22. Along with the planned service developments and the actions to address the Louis Appleby report findings the Trust has increased staffing resource on the wards as follows;

- 2012/13 investment of £650k to increase the staffing levels ratio to 5:5:3
- 2013/14 additional investment of £810k to fund the skill mix change to a 60:40 split of qualified/unqualified staff; with the full year effect of an increase of £1.3m (£300k for the therapeutic liaison workers to improve the type and availability of therapeutic activities for inpatient service users)

c) Progress in 2013

23. To understand the effectiveness of the actions taken in response to the Professor Louis Appleby report, and compliance with CQC standards and outcomes, a series of internal quality assurance visits were made to all adult mental health wards in January and February by members of the Trust Board and the Trust's quality team.

24. The Trust Board was able to see personally the good progress that was being made at this time. A CQC inspection in February also noted the improvements seen as a result of this work.

25. The leadership team at LPT acknowledges that the assurance taken at this time both internally and externally may have led to the view that these changes were progressing sufficiently, and would now be sustained.

d) Current Position July-August 2013

26. Given the outcome of the latest CQC report, LPT has recognised that the improvements initially made have either not been sustained, or not been consistently applied, across all our adult mental health wards during the first half of 2013, which is extremely disappointing, and for which the Board stands accountable.

27. The Board also acknowledges that our own assurance processes and early warning systems should have identified and tackled any slippage, rather than this becoming apparent via an external assessment.

Overview of the Immediate 30 Day Action Plan

28. The 30 day action plan has focused on an in-depth review of all care plans across the adult mental health wards at the Bradgate Unit, examining the quality of the care planning process and documentation using an audit tool with four core sections.

29. A team of staff have been released from other work to lead on this audit including two lead nurses and two lead consultants.

30. Each record has been audited and the respective named nurses, ward matrons and medical staff have been given specific feedback and actions to take to improve the quality of the care planning activities and documentation for each service user including discharge planning, physical health needs and risk assessment.

31. In addition other clinical divisions in the Trust have completed a thematic review of the findings of the CQC report. Care plans in other parts of the Trust are being scrutinised to examine where further improvements can be made, utilising the same tools and techniques as the adult mental health unit.

32. The new Medical Director and new Chief Nurse have been leading this work personally and holding clinical meetings on site at the Bradgate Unit every 48 hours to ensure staff and clinical leaders are fully supported in this work.

33. In doing so they are jointly building a picture of the cultural changes that are needed to improve clinical and professional leadership across the adult mental health division and the Trust as a whole.

34. They are working with the Chief Operating Officer, clinical and divisional directors to identify where improvements can be made to leadership, culture, policies, procedures, documentation, IT and environmental issues.

35. In particular they have been examining the root causes that prevent staff from delivering consistently high quality care. Initially this has been with respect to care planning / discharge planning / risk assessment / documentation / ward rounds, in that this has been the focus of the first 30 days and the CQC

warning notices. This is now broadening out to consider a wider range of organisational development issues which the Board will be discussing in September.

36. The 30 day action plan is attached at Appendix B and shows the detail of individual actions and their status.

37. This includes a range of measures to support staff from an HR and OD perspective including targeted stress management support and improving recruitment timescales, particularly for areas of clinical priority.

38. Improvements are also being made to environmental matters such as seclusion facilities based on the CQC report findings.

39. The action plan also shows the extent of the communications and engagement including internal and external briefings, and the Trust's on-going engagement with service users, voluntary sector, commissioners, the Trust Development Authority (TDA), Local Healthwatch, Overview and Scrutiny Committees, Chairs of Health and Wellbeing Boards, and the media.

40. A weekly report has been made during August to the Trust Board on the progress towards the completion of these actions, recognising that some areas have started within the 30 day plan but will continue to develop in the medium term.

Escalation of Concerns and the Impact on the Trust's Foundation Trust Application

41. On 13 August the Executive Team met with the Trust Development Authority to discuss the warning notices and the Trust's response.

42. This was a constructive meeting which included wider themes such the refresh of the Trust's Quality Strategy and the further work needed on the Trust's Quality Governance Framework to ensure sustainable high quality services.

43. The Executive Team also discussed with the TDA the impact of the CQC warning notices on the Trust's position in the FT pipeline and fed back the views of the Trust.

44. Board's assessment from their meeting on 31 July to withdraw from the Monitor application at this stage. The TDA agreed with the Trust's view, and a formal Board decision was subsequently recorded at the meeting in public on 29 August to withdraw our application. Board papers can be viewed at http://www.leicspart.nhs.uk/_Aboutus-Trustboardmeetings2013-August2013.aspx.

45. On 15 August the Trust also met with representatives from all 3 local clinical commissioning groups to discuss the CQC report, the warning notices, the Trust's response and the wider cultural and organisational issues that were

being uncovered in examining the root causes of the variability of care quality and record keeping across the Bradgate Unit.

46. Due to the escalation of concerns by a range of external agencies, the Trust Development Authority, NHS England, Local Clinical Commissioning Groups, the CQC and Local Healthwatch invited the Trust to attend a Risk Summit on 29 August. A statement about the summit can be found at Appendix C.

47. Members of the Trust Executive Team are also visiting all three council's scrutiny committees in September and we welcome the opportunity to discuss these matters with the respective committees.

48. We are approaching this in an open and transparent way and welcome all feedback, challenge and support, and will be pleased to follow up with any additional information and activities as needed following discussion with the respective committees.

Sustaining Improvement and Delivering High Quality Care in the Medium and Longer Term

49. As a Trust, and with the support and challenge of the external agencies as described above, we have had to address some very difficult issues over the past month and confront head on a number of failings from Board to ward.

50. This is seen as a watershed for the Trust and everyone understands that this is not just about an immediate action plan for the 30 days, nor is it just about the services within the Bradgate Unit or our mental health division. Our priority is that high quality clinical care is sustained and that everyone can be more assured and confident of the care provided by the Trust.

51. An outcome of the Risk Summit is that we will now be working closely with a core external group representing local CCGs, Local Authorities, Local Healthwatch and the TDA, who will be holding the Trust Board to account for the medium term improvements that are required.

52. Now that we have moved beyond the initial 30 day actions, our next steps will primarily be focused on cultural change and bringing patient centred values into the forefront of the organisation, building on the positive work we have already begun through the Listening into Action programme with our staff and our "Changing your Experience for the Better" programme for service users.

53. The Board and wider leadership team will continue to understand all the underlying issues that could prevent our staff from delivering consistently high standards of care and discussions with clinical staff in recent weeks are already starting to produce a different conversation than has been historically the case.

54. In particular our new Medical Director, Chief Nurse and new Chief Executive will be working across the Trust focusing on changes to clinical and professional leadership, assessing the processes and policies that impact

both positively and negatively on operational and clinical delivery from staff and service user perspectives, improving our internal quality assurance arrangements, embedding a fundamental cultural change throughout all our clinical divisions from the front line to the Board.

55. With all our stakeholders including patients and commissioners, we will be reviewing the adult mental health care pathway, and sense checking our existing plans to ensure we are making the best possible changes for the future. We will also be improving data flows and analysis about how we measure and assure care quality from ward to Board.

56. We have also made a commitment to bringing more independent scrutiny into patient care related serious incidents and we will be working with a range of stakeholders over the coming months to see how this can best be achieved

57. We have already appointed Professor Hilary McCallion, lately Chief Nurse of South London and Maudesley NHS Foundation Trust to lead two inquiries into recent suicides in the community; and undertake a thematic review of suicides in the community over the past two years.

58. We are also seeking additional external advice, support, research and scrutiny from a range of perspectives in order to uncover, understand and address concerns from all angles to gain valuable insight and bring best practice from elsewhere into Leicester, Leicestershire and Rutland.

59. Our Board stands accountable for the impact the current position of the Trust has had on public confidence and we are being completely open and transparent in our communication and engagement on these matters.

List of Appendices

Appendix A: August 2012 Trust Board Paper – Improving Acute Adult Mental Health In-Patient Care

Appendix B: Immediate CQC 30 Day Action Plan

Appendix C Outcome of the Risk Summit