UHCW response to mental health related inspections by the Care Quality Commission: Report for Coventry City Council Health and Social Care Scrutiny Committee

National Context

There has been a renewed government emphasis on creating policy with the objective of improving outcomes for people with mental health issues.

In November 2013 the Department of Health's *NHS Mandate 2014/15* outlined the broad development priorities for NHS England. These included a range of measures with the objective of putting:

> mental health on a par with physical health, and [to] close the health gap between people with mental health problems and the population as a whole (p15).

This commitment to 'parity of esteem' was reinforced in *Closing the Gap*: *priorities for essential change in mental health*, a DH policy document that targets twenty-five priority actions grouped into four broad themes:

- Increasing access to mental health services
- Integrating physical and mental health care
- Starting early to promote mental wellbeing and prevent mental health problems
- Improving the quality of life of people with mental health problems

For acute hospital trusts particular emphasis is placed on the need to respond effectively to people who present with self-harm by facilitating ease of access to psychosocial services. But there is also an expectation that physical health outcomes for people with mental health issues should reflect those for the general population.

In February the Department published the *Mental Health Crisis Concordat*, a multi-agency commitment to improve and standardise urgent and emergency care for people experiencing a mental health crisis. There is an expectation that

> people in mental health crisis should expect Emergency Departments to provide a place for their immediate care and adequate liaison psychiatry services to ensure that they obtain the necessary and on-going support required in a timely way.

And that

> Clear responsibilities and protocols should be in place between Emergency Departments and other agencies and parts of the acute and mental health and substance misuse service to ensure that people receive treatment on a par with standards for physical health. (p29)

The Care Quality Commission and mental health

As the Regulator for Health and Social Care providers, CQC undertakes inspections to evaluate the safety and quality of services.

CQC also have a responsibility to monitor the implementation of the Mental Health Act and the Mental Capacity Act, including its provisions relating to the assessment of capacity and the Deprivation of Liberty Safeguards.

CQC uses its programme of 'thematic reviews' to consider and report on issues relating to implementation of the legislation and the quality of clinical pathways including the degree of constructive collaboration between providers. These inspections include visits to a sample of acute hospital trusts. UHCW has received such visits twice:

- A Mental Health Act monitoring visit (11 February 2013), and
- Dementia Care thematic review inspection (15 January 2014)

On both occasions the Trust was judged to be fully compliant with the Essential Standards whilst also receiving helpful comment on how services or practice might be improved.

These comments are considered by relevant front-line staff and an action plan agreed, monitored and reviewed by the Quality Governance Committee, a sub-committee of the Trust Board. Where appropriate the QGC can escalate issues to the Board.

Mental Health Act Inspection Visit: 11 February 2013

This inspection had the purpose of judging the Trust's compliance with mental health legislation. Inspectors explored how staff complied with legislative requirements, assessed and responded to clinical need and also sought the views of patients and carers as to their experience of services. Although compliant with all Regulations, the Inspector's report made several suggestions for improving the service. As a result the Trust has

- Reviewed training to ensure that it is appropriate and available to all staff
- Negotiated continuing training arrangements with AMHAT until March 2014
- Ensured that there are auditable training records
- Ensured that health records demonstrate how patients are informed of their rights
- Audited documentation to ensure records are completed appropriately
- Instigated trust-wide briefings on mental health issues, with more to follow through 2014
- Begun a trial of a new safeguarding and notification pathway for the MHA and DoLS with daily site-safety briefings and a new safeguarding dashboard.
- Made Improvements across ED to remove potential ligature points

- created three dedicated assessment and treatment spaces (one in ED and two in the Observation Suite) for people with mental health issues (to be completed by March 2014), fully compliant with RCPysch and CEM standards. There have also been improvements to triage rooms to enhance safety for MH triage
- Reviewed all Trust policies to ensure they reflect best practice guidance
- Liaised with the ambulance service and other providers to minimise delays to discharge or transfer.
- Provided training to security staff in de-escalation and management of challenging behaviour techniques and mental health awareness training.
- Planned a DoLS documentation audit (for completion in March/April 2014) with a repeat audit six months after later.

In addition, AMHAT have been providing liaison psychiatry since early 2013 with much improved access to MH teams, particularly during the week.

The outstanding issue relates to shared access to mental health records. UHCW and CWPT have yet to resolve how to create a system for information sharing for patients seen and/or admitted through the Emergency Department.

Dementia Care Thematic Review: 15 January 2014

This is the third such national review by CQC (or its predecessor), but the first time that UHCW has been involved.

Inspectors visited A&E and several wards where they felt patients with dementia were likely to be a significant presence. Only the draft report is to hand and it is broadly complimentary in its findings. Whilst the Trust is judged to be compliant with the relevant standards, inspectors have again offered helpful comments on potential areas for improvement. These relate to:

- Better use of electronic systems to track patients with dementia through the Trust
- Access to mental health records (including prescribing and medication decisions)
- Improving the reliability of information sharing with Care Homes
- Extending dementia awareness training to all staff (including non-clinical staff)
- Reviewing discharge arrangements for patients with dementia (by extending the pharmacy outreach service to weekends for instance)
- Reviewing the provision of specialist dementia care nurses
- How senior managers might arrange to spend more time alongside frontline staff

Staff were noted to have a positive approach to people with dementia and to be making good use of the dementia care 'bundle'.

The Trust is already making progress with these improvements whilst awaiting the final report. This will be published on the CQC website; the national report on the Thematic review is scheduled for publication in May 2014.

Next Steps

Both reports commented favourably on the consistent compassion and care shown to people with mental health issues and dementia. They also noted the robust protocols and policies that help staff to comply with legal requirements of the MHA and MCA. The Trust will continue to provide the support and training to staff to ensure that these high standards are maintained.

The Trust will also continue to learn from all relevant local and national reports. It undertakes gap analysis and takes necessary steps where improvement or change is indicated. The Trust will also continue to implement improvements identified through the inspection process.

Over the coming months we further expect

- NHS England to continue their review of urgent and emergency care, including specific reference to models of care that work for people in mental health crisis, with a report by October 2014.

- NHS England and CCGs to review the adequacy of liaison psychiatry arrangements

- An audit and review of Emergency Department access to specialist mental health services by RCPysch and CEM, reporting by September 2014

- A CEM audit of mental health assessment rooms in Emergency Departments leading to PLAN accreditation.

- A RCPysch/CEM model for effective joint agency arrangements to address safeguarding and the needs of vulnerable people, including personality disorders, addictions or dependencies, and who turn to emergency services for help at times of crisis and are at risk of exclusion from mental health services (by September 2014)

- A DH Review and update of local Mental Health Act protocols on mental disorder and intoxication from alcohol or drugs to include guidance for emergency services, so that people who appear to be mentally disordered and so intoxicated as to represent an immediate physical health risk to themselves will be medically assessed in an Emergency Department

- CCGs to agree appropriate protocols with hospital providers that ensure Emergency Departments, police and ambulance services understand the security responsibilities of the hospital and the safe operation of restraint procedures on NHS premises

- DH to support agencies to ensure the sharing of key information about a person, in line with current guidance: *Information Sharing and Mental Health*

Summary:

The trust has made solid process in responding to a challenging Mental Health agenda. This progress is reflected in the Inspection reports, a year apart, that help demonstrate the improvements made by the Trust. Both inspection reports comment on the need to improve

access to clinical and prescribing information from mental health patient records and the Trust would want an early resolution of this issue.

Peter Short
Compliance Manager

19 February 2014

Glossary

CQC Inspections:

- Comprehensive: large-scale intensive inspection involving clinicians and 'experts by experience'. A core of eight clinical areas is always subject to unannounced visits with other wards or departments visited as inspectors deem appropriate

- Responsive: unannounced inspections, usually to specific clinical areas, to investigate concerns about safety and quality of services.

- Thematic: national reviews into areas of concern or interest; commonly they look at clinical pathways and the relationships between providers (such as for child safeguarding)

Abbreviations

CEM: College of Emergency Medicine
CQC: Care Quality Commission
CWPT: Coventry and Warwickshire Partnership NHS Trust
DH: Department of Health
DoLS: Deprivation of Liberty Safeguards
MCA: Mental Capacity Act
MHA: Mental Health Act
NHSE: NHS England
NICE: National Institute for Health and Care Excellence
PLAN: Psychiatric Liaison Accreditation Network
RCPysch: Royal College of Psychiatrists

References

Closing the Gap: priorities for essential change in mental health (DH January 2014)

Information Sharing and Mental Health: Guidance to Support Information Sharing by Mental Health Services (DH 2009)

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (DH: February 2014)

Monitoring the Mental Health Act in 2012/13 (CQC: January 2014)

Monitoring the Use of the Mental Capacity Act Deprivation of Liberty Safeguards 2012/13 (CQC: January 2014)

NHS Mandate 2014/15 (DH November 2013)

The Sixth Year of the Independent Mental Capacity Advocacy (IMCA) Service 2012/13 (DH February 2014)