Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

Trust Board Meeting (Part 1)	Date: 25 February 2015

Title:	**Chief Executive's Report**
Item:	**BD/14/284**

Executive Director lead and presenter	**Iain Tulley, Chief Executive**
Report author(s)	**Deputy Company Secretary, External Communications Manager**

History:	*N/A*

This report is for:	
Decision	
Discussion	
To Note	X

The following impacts have been identified and assessed in relation to this report:	
Equality	None identified.
Quality	None identified.
Privacy	None identified.

Executive Summary of key issues
The report signposts some of the key management and development issues facing our Trust and draws members' attention to recent NHS and regulatory activity. The Board should **note** this report.

This report addresses these Strategic Priorities:	
We will deliver the best care	x
We will support and develop our staff	x
We will continually improve what we do	x
We will use our resources wisely	x
We will be future focussed	x

1. Introduction

Since the last Board, I have attended the Workshop for Horizons in Swindon. I also chaired the BaNES Inpatient Reprovision Project Board.

I opened a conference on personal health budgets, and attended an event on governance and 'Well Led' reviews with Paul Street from Monitor.

I have visited Imber Ward and the Intensive Team at the Trust's Green Lane Hospital.

On 23 February, I will be part of the interviewing panel for two Consultant posts in Wiltshire – a Consultant in General Adult Psychiatry with CMHT North Wiltshire, and a Consultant in Old Age Psychiatry at Amblescroft North.

On 24 February I will take part in Bristol City Council Peer Review and also speak at South Gloucestershire Strategy Day.

2. Current issues

2.1. Staff Survey

The results of the latest staff survey published earlier this week are, in some areas, disappointing for our Trust. To see in black and white that we still have staff experiencing harassment, bullying or abuse from fellow staff, is an unacceptable state of affairs.

The fact that so many of our colleagues would still not recommend AWP as a place to work or receive treatment is equally unacceptable.

Because we were aware that the survey results were likely to be disappointing, we have, over the past six to twelve months, worked on a radical staff development program designed to deliver improvements. These include:

- A new team-based working approach for all of our staff, to enable them to work smarter and support each other better
- The introduction of a new ILM 5 course for our managers, to give them practical skills and a greater understanding of their responsibilities
- The launch of our new robust Bullying and Harassment policy. This is particularly timely, not only because of what we read in the survey, but in light of the recent publication of the Freedom to Speak Up report into whistleblowing and the need for an honest and open reporting culture. Sir Robert Francis, the author of the report, says that bullying is the reason why many staff do not report concerns about safety or safeguarding. It's clear then that improving the culture and environment for our staff doesn't just protect them, but our service users too.
- As well as the initiatives outlined above, we will put a particular emphasis on, in the first instance, one locality and seek to address in depth and completely the consistent messages given by our staff on:
  - Staffing levels
  - Time to Care
  - Management visibility and support.

  We will communicate with 'Wiltshire in Focus' and seek to make early and significant improvements in key staff metrics.

2.2. Ministerial visit by Norman Lamb

We were delighted to welcome the Minister of State for Care and Support, Norman Lamb MP, recently. The minister, along with Duncan Hames MP (Lib Dem, Chippenham) were here to meet with us and introduce a new campaign by FIXERS, a group of young people in Wiltshire who are helping to banish the stigma around mental illness.

During the visit, the Minster was given a tour of our Quality Huddle, and understand some of the issues around out of area beds. He was also keen to hear about the success of our 136 Suite in Bristol, which has seen over 1,000 people pass through its doors in just 12 months.

I was also able to brief both MPs on some of the ways we are working to bring back nearer to their own homes those people affected by the appalling treatment they received at Winterbourne View (a subject that the Minister is heavily involved in). One of the projects, known as the Daisy, will be delivered in partnership with The Priory Group and will enable us to provide a safe, caring and supportive environment for those with Learning Disabilities.

2.3. Recruitment and retention of staff

Recruitment continues to be a challenge to all of us but especially within certain parts of our localities. Secure Services and the Wiltshire locality have introduced a Golden Hello of £3000 as an incentive to new nursing staff. Additionally, we have introduced a Trustwide 'Refer-a-Friend' scheme which offers current staff a £200 payment if they bring a friend into AWP employment.

We have a range of events and activities underway which support our recruitment push although we are aware that the scarcity of nurses nationally is making things difficult.

By introducing some of the mechanisms around staff development that I mentioned earlier, we hope that we can improve our figures on retaining those excellent staff we already have.

2.4 Out of area beds

We know that there is pressure on our beds and so I am delighted to say that we have introduced a new initiative to ensure that, as much as possible, people are cared for in or close to their home locality. Over the last few months, the numbers of adults of working age requiring treatment by our Trust but in an out of home locality has been extremely low compared to previous months. However we are still seeing considerable movement of older people within the Trust.

I remain very concerned at the overall number of people who need to go out of area for treatment. As a Trust, we need to be much clearer about the way we operate our beds, making sure discharges are monitored and managed properly to make room for other people who would otherwise have to go outside of their locality. I look to our clinicians – and have already discussed with Clinical Directors – the need ensure we support those service users who need to go out of area in exactly the same way they would if that person was in one of our local beds.

3. National issues

3.1. Mental Health Act annual report 2013/14

The Care Quality Commission has recently published the Mental Health Act annual report, in line with its duty to monitor how services in England exercise their powers and

discharge their duties in relation to patients who are detained in hospital or subject to community treatment orders or guardianship.

The primary purpose is to provide a safeguard for individual patients whose rights are restricted, and to review how legal powers of compulsion are being used.

Some of our key findings in the report include:

- During 2013/14, the Mental Health Act was used over 53,000 times, to detain people for longer than 72 hours, affecting around 4,200 people across England.
- Eighty-four per cent of the 3,342 records that we examined on our visits recorded that staff had given patients information about their legal rights and in 82 per cent of cases had discussed this with the patient (an increase from 71 per cent last year).
- While some aspects of practice have improved in the last five years, processes around consent to treatment are a persistent problem. In over a quarter of the records that we checked in 2013/14 during our monitoring visits there was no evidence of a patient's consent to treatment on admission.
- Our findings suggest that many carers and families do not understand their legal position; even weeks and months after their loved ones have been detained.

The Mental Health Act is complex and a number of the complaints or concerns that are raised with our own Trust stem from misunderstandings or a lack of knowledge over the use of sectioning or the responsibilities of our staff in interpreting and discussing it with carers and families. The Act is the foundation of mental health services and it is for us to help people understand why it protects the rights of the individual under our care.

3.2. The NHS Tariff

Since the 2015/16 national tariff payment system consultation was launched last year, there have been four important developments:

- 37% of provider organisations, representing more than the threshold of 51% of supply, objected to the method for calculating national prices proposed in the consultation;
- On 3rd December the Chancellor's Autumn Statement increased frontline NHS funding for 2015/16;
- On 17th December the Board of NHS England made the resulting formal NHS allocations to CCGs, specialised services, primary care and other priorities for the coming year;
- 23rd December saw the publication of 'The Forward View into Action: Planning for 2015/16' setting out NHS-wide priorities for next year.

The effect of the objection threshold being reached is that Monitor has now to decide whether to refer the matter to the Competition and Markets Authority or whether to develop further proposals on which to re-consult with the sector. This means that a new tariff will not be in place by 1 April 2015. In the interim, the 2014/15 national tariff, including the 2014/15 national prices, continues to have effect.

4. Serious Untoward Incidents

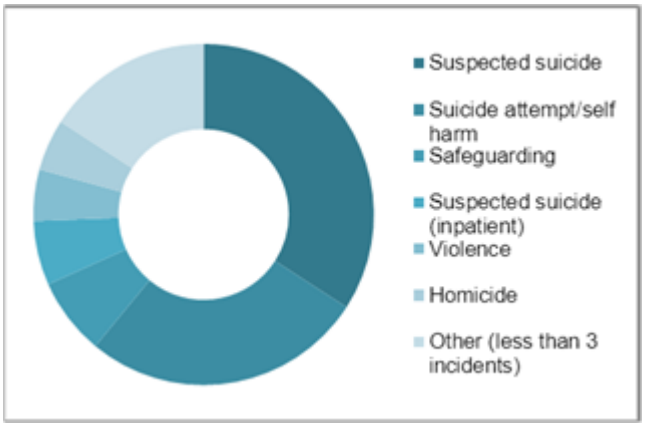
A Serious Untoward Incident (SUI) is any event or circumstance arising that led to serious unintended or unexpected harm, loss or damage. All SUIs are reported to CCGs, Local Area Teams and NHS England.

There were 7 SUIs reported via STEIS, the external reporting tool used by the Trust, in January 2015, as follows:

- A service user known to SDAS services in BANES was arrested for an alleged homicide which triggered a grade 2 RCA investigation.
- There were two unexpected deaths of patients known to South Gloucestershire Recovery Team and Banes PCLS.
- There were two attempted suicide attempts of patients known to North Somerset and Bristol recovery teams.
- An incident of arson occurred on Silver Birch ward which caused significant environmental damage, although thankfully no one was seriously hurt and staff dealt with the incident admirably. The final incident reported related to a significant business continuity issue.
- The Trust was unable to access electronic heath care records as the National Spine was experiencing authentication issues which coincided with a failure of the Trust's back up system. This left the Trust without access to the live clinical record and staff only had access to clinical information which was 5 days out of date. Appropriate mitigation actions and alerts were put in place and to the best of our knowledge no incident has occurred because of this temporary failure.

Each incident has been subject to a 72 hour management investigation and a record of immediate learning is captured at day 10, which is subsequently reflected in the root cause analysis investigation report. The Clinical Director signs off these reports to confirm that all necessary immediate actions have been taken.

The Trust's Quality and Standards Committee receives detailed review of incidents in the quarterly Learning from Experience report. Within this, trends and learning from incidents is discussed. Below is a graphic representation of the type of SUIs reported by the Trust for the first three quarters of 2014/15 taken from data presented to Q&SC in February 2015.



SUIs by type, Apr–Dec 2014