Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

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

Title:	**Chief Executive's Report**
Item:	**BD/14/314**

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

1.1. Since the Board last met I have attended a number of interesting and engaging events, both within the Trust and with other organisations.

1.2. On 4 March I attended the West of England AHSN Board and chaired NIHR Clinical Research Network: West of England Partnership Group.

1.3. On 6 March I attended a Ward Managers/Modern Matrons meeting at Callington Road to discuss rosters and hear from the team about the processes in place to manage these. This was a valuable meeting. I spent an afternoon in North Somerset and met staff on Cove and Dune, Juniper and Elham Way. I will continue to visit our front line staff as regularly as possible.

1.4. I attended a presentation by Will Hall on 10 March on system leadership which was delivered to representatives of Bristol organisations. I congratulate Will in his appointment as System Leader for an initial 12 month period.

1.5. On 10 March I attended the NHS Confederation dinner with Sir Mike Richards and David Prior which focused on the inspection process for aspiring Foundation Trusts.

1.6. The meeting of the South West Mental Health Chief Executives took place on 16 March, followed by the NHS Confederation Mental Health Network Dinner with Norman Lamb MP on 17 March and the NHS Confederation Mental Health Network Annual Conference & Exhibition the following day.

2. Current issues

2.1. TDA Board to Board – 5 March

We await formal feedback from TDA. The key themes covered at the meeting were:

- **COC Inspection** and the need to ensure that all matters of compliance were addressed. The Trust is fully prepared for a re-inspection within the next three months.
- **Out of area treatment** Ensure action is taken to provide local care to reduce the unacceptable number of out of area treatments and to demonstrate a sustained position.
- **Staffing and staff survey** While recognising the staffing challenges across England there is grave concern in relation to our staff survey position.

2.2 Staffing and Development

The outcome of the staff survey is a major risk for the Trust. This coupled with our recruitment challenges and turnover highlights the need for even greater focus and action to resolve. While continuing with all aspects of our OD programme, specific attention and targeted action by local delivery units to close the gap on staff engagement is required.

Clinical directors will report to board on specific areas of challenge and action. This will be overseen by operations and will be monitored by ESEC and through triumvirate reviews.

I am pleased to welcome Dr Toby Sutcliffe to his new role as Clinical Director for Wiltshire. Toby completed his general medical and psychiatric training in London and worked in St Georges in inner city and rural areas during his psychiatric specialist training. He has been employed in Wilshire as a consultant since 2005, taking up a medical post later that year. For the past two years, Toby has worked as Primary Care Liaison Consultant for Wiltshire. Toby hopes that his experience and understanding of the concerns and interests of colleagues in the area will allow him, in this new role to collaborate innovatively to improve the care we provide.

2.3 Swindon highly rated for dementia diagnoses

I am pleased to report that Swindon is in the top four trusts in England as having the highest dementia diagnosis rate. The Government tasked NHS England to increase the percentage of expected people with dementia registered with their GP. NHS England tasked the Clinical Commissioning Group (CCG) and the Swindon CCG tasked us. Our target was 66%. Four months ago we had a 42% dementia diagnosis rate. This has now increased to 70%. This rapid improvement was achieved by accessing everyone admitted to hospital diagnosed with dementia; increasing capacity in the memory clinic, working with people in care homes with an established diagnosis but not on the GP register and diagnosing people after GP referral where the home was confident the resident had dementia.

3. National issues

3.1. NHS Investigations into Jimmy Savile and the Kate Lampard Lessons Learnt Report

Last month, 16 NHS and Trust reports and the overarching Lesson Learnt Report authored by Kate Lampard were published. Themes which have emerged from the investigations' findings are:

- Security and access arrangements, including celebrity and VIP access
- The role and management of volunteers
- Safeguarding
- Raising complaints and concerns (by staff and service users)
- Fundraising and charity governance
- Observation of due process and good governance

The Secretary of State for Health has accepted in principle 13 recommendations that Kate Lampard has made. Trusts are urged to take a considered approach to DBS checks on volunteers, including the use of enhanced DBS services where volunteers may work closely with service users in the future.

We are developing an action plan to identify any areas where additional action is required against these recommendations. This will be done in the next three months and progress confirmed to the NHS Trust Development Authority by the end of May 2015 using their prescribed template.

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 5 serious untoward incidents in February 2015, all of which were grade 1 incidents requiring a 45 day report. Two of incidents were suspected suicides, one of a patient known to North Somerset Intensive team and one of a patient known to North Somerset Recovery Team. There were two incidents of slips/trips/falls given rise to fractures, one in Aspen Ward and the other on Liddington Ward. The Aspen incident involved a hoist but the preliminary investigation, including inspection by the manufacturer, shows that there was no fault with this medical device. A patient known to Wiltshire Liaison Service seriously self-harmed requiring hospital admission and surgery. Root cause analysis investigations have been commissioned for each of these incidents and immediate appropriate actions have been taken. The report recommendations will be rigorously followed up through the Patient Safety Development Plan.

5. Recommendation

The Board should **note** the report.