Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board meeting (Part 1)		Date:	27 May 2015
Agenda item	**Title**	**Executive Director lead and presenter**	**Report author**
BD/15/041	**Clinical Executive Report**	**Andrew Dean, Executive Director of Nursing and Hayley Richards, Executive Medical Director**	**Andrew Dean, Executive Director of Nursing and Hayley Richards, Executive Medical Director**

This report is for:	
Decision	
Discussion	
To Note	X

History
Executive team 26 May 2015

The following impacts have been identified and assessed within this report	
Equality	
Quality	
Privacy	

Executive summary of key issues

The report alerts the board to significant, current areas of focus for the clinical executive. These relate to staffing numbers, service and pathway design and governance structures.

The annual report from the Medical Directorate is appended for information.

The Board should **note** the report.

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

1 Introduction

The Clinical Executive undertakes a programme of work throughout the year to review and improve patient safety, patient experience, and productivity. This report serves to highlight to the trust board, three areas of current focus.

2 Staffing

2.1 Safer Staffing report

The Director of Nursing is reviewing safer staffing establishment figures and the calculation methodology, as well as how we report to board and externally. The current methodology is complex and has difficulty meeting reporting requirements. The review will offer a simpler, more robust process, with daily, real-time reporting and escalation.

A full report will be presented to trust board in June 2015.

3 Service & Pathway Design

3.1 Psychiatric Intensive Care

The Director of Nursing is undertaking a review of the provision of psychiatric intensive care beds across the trust, including location, ward size, staffing and medical cover. The current care pathway is hampered by long length of stay and insufficiently responsive escalation protocols.

3.2 S136 Place of Safety

The clinical executive is focussing on Place of Safety. Currently, detainees may wait for assessment and onward moves, especially when admission is required. This causes additional stress for detainees and staff. We are also reviewing environmental design for Place of Safety, with clear standards for trust wide implementation.

3.3 Medium Secure wards

The relationship between bed numbers and nursing staffing numbers means that there is an optimal ward size at which safe patient care can be delivered with maximum efficiency. Below this ward size, staffing numbers cannot be further reduced. The Fromeside medium secure unit includes small wards of 7 and 8 beds. Consideration is being given to the optimum operating size of these wards, where there is also significant challenge in recruiting and retaining staff.

3.4 Care pathway

The clinical executive is beginning to focus on the spectrum of our care pathways, and the interventions that are offered to service users at each stage. All interventions will be designed to become congruent with NICE guidance. In addition, this work will ensure care delivery is future-proofed with regard to, for example, payment by results.

4 Governance structures

A full review of quality governance structures, including management groups, was undertaken in 2012-13. Since then, local delivery units have each developed and embedded fully functioning quality governance structures. The current trust governance structure includes central management groups, each of which requires locality representation. This is onerous and replicates work done in LDU groups. The clinical executive is working with colleagues to review current structures with the aim of reducing the number of management groups, simplifying the reporting routes and refocusing from split governance to an integrated governance structure. This will provide ward to board assurance across all governance.

A detailed report on the proposed structure will be brought to the July board meeting.

5 Annual Reporting

5.1 Medical Directorate

The annual report on the activity and performance of the Medical Directorate can be found at appendix 1.

6 Recommendation

The Board should **note** the report.

Appendix 1: Medical Directorate Annual Report 2014/15

1 Overview: Medical Directorate

The directorate is responsible for medical leadership, medical education and training, research and development, pharmacy, psychology and aspects of clinical informatics underpinning these departments. The dual focus for the year has been to improve engagement and to align activities with trust priorities in order to improve care outcomes. The directorate work-plan has been informed and driven through specific engagement activities, including:

- Medical Engagement survey 2014
- National and AWP quarterly NHS staff surveys
- GMC medical trainee survey 2014
- AWP Psychology review 2014
- Two pharmacy engagement days and pharmacy staff welfare check
- Faculty development events for:
  - Continuing Professional Development (CPD) leads
  - Undergraduate and postgraduate tutors
  - Medical leads and appraisers

2 Medical Leadership team

2.1

The **Medical Leadership team** provides clinical leadership to the trust and guidance and professional leadership to all doctors regarding medical workforce development, appraisal, revalidation, professional standards and behaviour, investigations, remediation and policy. There is increasing triangulation and communication between medical appraisal, CPD, complaints and investigations, such that, for example, any complaint or serious incident involving a doctor is communicated via a medical lead (for discussion with the doctor in supervision) and via medical education for reflection in appraisal.

Doctors in post on 31 March:

Grade	2014	2015	Change
Substantive consultant	101	99	-2
Locum consultant	13	17	+4
Specialty doctor	44	40	-4
Locum Specialty Doctor	8	8	=
Clinical Assistant (grade closed)	3	0	-3
Associate Specialist	8	7	-1
Foundation year 1	4	8	+4
Foundation year 2	11	16	+5
GP trainee	13	16	+3
Core Trainee (CT1-3)	37	39	+2
Advanced Trainee	32	31	-1
Locum Juniors (Bank only)	12	11	-1

The number of doctors in post at any time may exceed numbers of posts, since locums may be employed to cover sick leave, exclusion or maternity leave.

There were 22 new starters and 30 leavers. Leavers include retirements and moves to other trusts. Some retirees remain in post.

2.2 Medical Locums Apr 14 – Mar 15

14 medical posts required agency cover 2014-15. It is not always possible to secure continuous cover from an individual doctor, hence some cover arrangements have involved more than one agency doctor in the same episode. In total, 37 agency doctors covered 14 posts between April 14 and March 15. Indicative reasons for locum use are given below. Agency cover is a last resort. All posts are advertised for NHS locum recruitment before, and during, an agency booking.

LDU	Grade	Reason for agency cover
Wiltshire	3 Consultant	Long standing Amblescroft . Post advertised 3 times unable to appoint
		Temporary cover on PICU
		Temporary cover on IP Beechlydene
	Specialty	Amblescroft. Unable to recruit
Swindon	Specialty	Long standing vacancy Applewood. Unable to recruit
	Consultant	Backfill awaiting substantive consultant. Now substantive
Specialised	Consultant	Cover for new LD Service transferring from Southern Health
N. Somerset	Trainee	Failure to fully recruit to 2014 rotation. (2015: rotation full)
Bristol	4 Consultant	To cover secondment to North Somerset
		Cover-doctor subject to HR process
		Sickness cover
		Job description approval delayed by Royal College
	Specialty	Hard to fill post; vacancy
BANES	Specialty	Cover-doctor subject to HR process

Recruitment to Wiltshire remains challenging. AWP is working with Health Education England and Wessex Deanery on workforce planning and encouraging recruitment into psychiatry. Bristol LDU has required temporary cover during the transition period to new models of care. All medical posts are now recruiting, interviews are being held through May to July 2015.

The medical directorate cost improvement plan includes work streams to reduce spend on agency locums through use of StaffFlow, faster recruitment, and employment of trust peripatetic staff. This will result in two, substantive, consultant grade doctors to provide temporary cover where needed.

2.3 Revalidation

Revalidation was introduced in December 2013. It will take three years for every doctor to receive a recommendation. In order for a doctor to retain a licence to practice, the responsible officer (medical director) makes one of three recommendations to the GMC:

- Positive: the doctor is up to date and fit to practice
- Deferral: on grounds of insufficient evidence or subject to GMC process, or
- Notification of non-engagement: the doctor is not appropriately participating in appraisal

	AWP Recommendations to date	AWP workforce with this recommendation to date (%)	GMC position to date England, specialist register (%)
Positive	89	83	87
Deferral	17	16	13
Non-engagement	0	0	0.001
Total	107		

2.4 Appraisal

Between April 2015 and March 2015, **97%** of all AWP doctors (that is, 100% of those available) completed appraisal. 5 doctors were not available for appraisal due to maternity leave (1), excluded as a result of an HR process (2) or long term sickness (2).

Appraisals are undertaken on the electronic PReP platform. Appraisals are quality assured by the director for medical education or deputy medical director, using a validated 8 point tool.

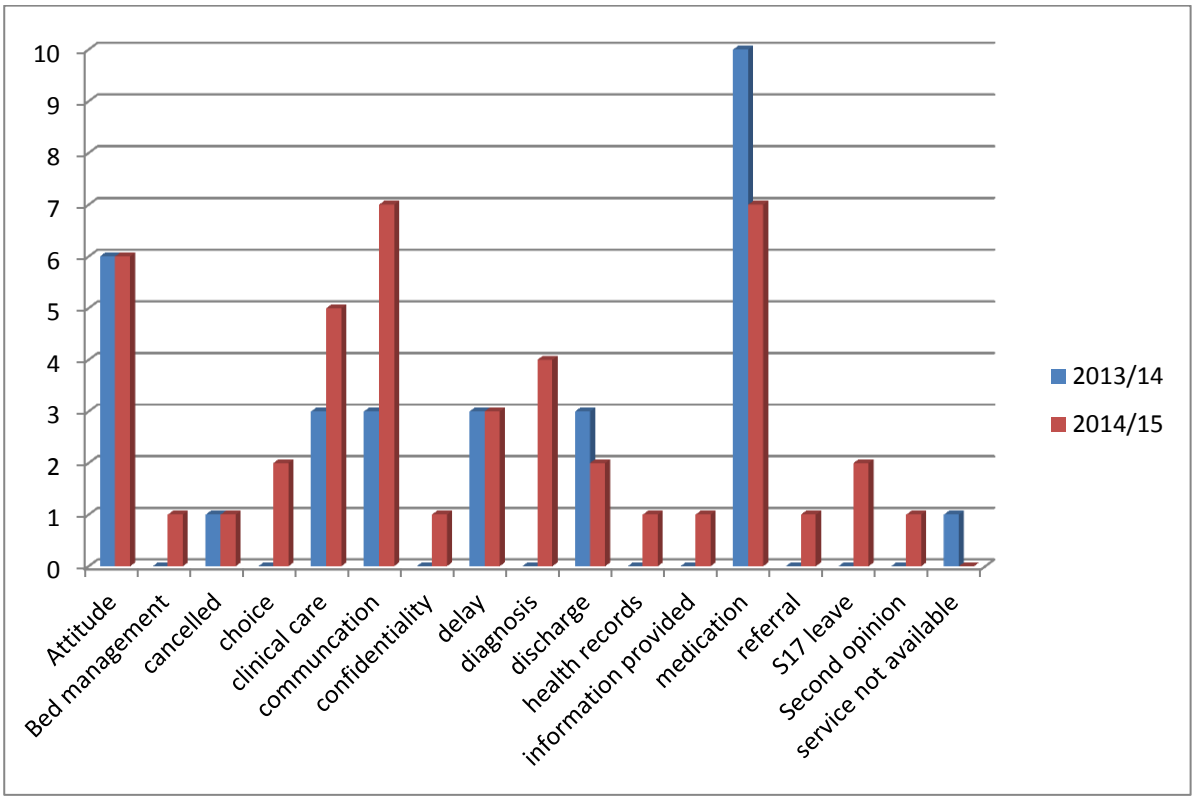
Appraisal quality is the focus for 2015-16. We will identify minimum standards for supporting information and mandatory CPD requirements, by type of role.

2.5 Investigation

The team convenes internal investigations into doctors' conduct and capability, and works with the GMC when the regulator has cause to initiate investigation. The table below summarises investigations initiated over the past three years.

Investigation	2012-13	2013-14	2014-15	Comment
GMC involved	3	4	5	3 resolved in year; 2 ongoing
Doctors with conditions		1	4	2 resolved in year; 2 ongoing
Internal AWP investigations	5	6	8	3 resolved in year; 5 ongoing
Involving exclusion	0	2	3	2 resolved in year; 1 ongoing
AWP complaints citing named doctors	46	26	23	See below

Over the last two years, the following themes have emerged from complaints relating at least in part to doctors:



In 2013-14, 50% of complaints were upheld. This approached 60% in 2014-15. Themes have been communicated through medical leads to discuss with all doctors through supervision. Individuals address the complaints issues through supervised learning plans and appraisal.

2.6 Medical management

Medical leads are responsible for medical management in each LDU. The deputy medical director has worked with medical leads to refresh the leadership model, to improve communication and oversight. Medical leads now hold monthly meetings with each consultant, reviewing the job plan, complaints, quality improvement projects against the annual objectives, sickness and offering pastoral support. This is recorded as medical lead supervision on IQ, and provides the medical director with oversight of vacancy, sickness, challenges and improvement ideas.

During 2014-5, the following policies were, or are in the process of being, approved through the BMA local negotiating group:

- Job planning policy: ensures job plans reflect trust priorities and objectives
- Continuing professional development (Study leave) policy: will align CPD with trust objectives
- ACCEA (Clinical Excellence awards) policy: rewards outstanding effort, meeting the NHS' needs

This cycle of job plans will be undertaken via the PReP electronic platform for the first time, offering greater visibility and opportunity for team job planning to meet local needs.

3 Medical Education

3.1 Delivering the Best care

In the academic year 2014-15 the Bristol University psychiatry module moved from undergraduate year 3 to year 4, meaning a year without undergraduates for mental health teaching trusts. When students return in September 2015, Swindon will take undergraduates for the first time. The Medical Education department has used the year to develop teaching infrastructure in Swindon and training and support for core trainees in Quality Improvement Projects. This has been launched jointly with the Severn Deanery to equip trainees with the skills to identify and implement care improvements.

To date, trainees are undertaking 20 projects, supervised by consultants and supported through medical education. Outputs will be reported through the Directors Team.

3.2 Continually improve what we do.

AWP successfully offered 10 examples of good practice and innovation to Health Education South West. AWP won a national prize from Health Education England for a project run by Clinical Teaching Fellow, Dr Ami Kothari, addressing Foundation doctor mentoring and support. AWP has also been awarded funding to pilot a project to promote recruitment into psychiatry in 2015-16.

In the GMC annual survey of trainees 2014, AWP was placed third for overall trainee satisfaction out of 22 trusts in Severn & Peninsula Deanery, that is, 0.1% behind second place and 0.8% behind first place.

The Foundation programme has expanded over the last year and has received the highest rating possible.

3.3 Support and develop our staff

In order to capture feedback from junior doctors we have introduced LDU trainee representatives. Trainee engagement is driven through the work of our Clinical Teaching Fellows, postgraduate trainees with special responsibility for education and engagement.

The Medical Education department has worked with the Learning and Development team to implement a coaching network for all professional groups and to revise statutory training for medical staff.

3.4 Use our resources wisely

The DME has developed two new Clinical Teaching Fellow posts starting in August 2015 through the effective application of SIFT funding.

3.5 Be future focussed.

We run an annual Summer School to promote Psychiatry as a speciality to prospective medical students. Feedback from attendees is always highly positive.

The first ever AWP Medical Education Conference was held in November 2014 and received positive feedback. We will hold our next conference in November 2015 with the theme of Educational Excellence. Professor Sir Simon Wessely, President of the Royal College of Psychiatrists, will be our keynote speaker.

4 Pharmacy

4.1

The pharmacy department has been a focus of attention following feedback from staff. There have been reviews of structure, business work-streams, staff welfare, team performance, training and skill mix. In response to findings, the following actions have been taken:

- Introduction of operational pharmacy manager
- Recruitment to all existing posts: currently one unfilled vacancy (maternity leave). All other staff are substantive except one short term agency technician and one bank pharmacist.
- Clarification of line management responsibilities
- Launch of consultation: 22 April 2015
- Pharmacy development days: November 2014 and April 2015;
- Review of training, supervision and appraisal compliance
- Review of dispensing standards

As of 15th May 2015, supervision and appraisal stand at 100% and 96% respectively. Statutory and mandatory training compliance is improving but variable. This area, plus technical training updates, will be addressed through scheduled 'protected time' for staff through May and June and will bring pharmacy to 100% compliance by end June 2015. Despite low morale and challenges, sickness is currently low at 0.65%, with no long term sickness.

4.2 Activity

4.2.1 Dispensing errors

In the 12 months to April 2015, the pharmacy hubs conducted monthly audits of dispensing errors.

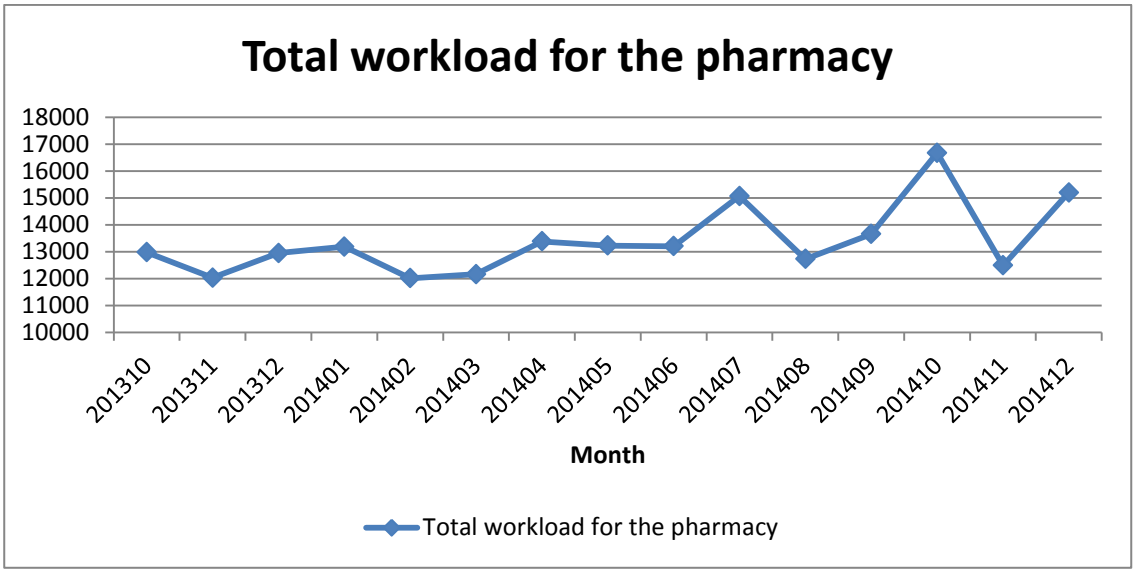
Dispensed items	Numbers of errors	Of which, serious errors	% error rate
159,454	104	7	0.065

Dispensing errors occur in about 2% of all dispensed items in hospital pharmacies, (Beso & Franklin 2005). The AWP error rate is 0.09%, or 9 errors per 10,000 items dispensed. All errors are subject to investigation.

Further reductions are predicted with increasing automation and electronic prescribing.

4.2.2 Workload

Number of items dispensed, by month.



Activity varies by month, with an upward drift from 2014. This is in line with our trust actions to bring prescribing and dispensing in house. The pharmacy model was designed to meet demand in 2012-13 and is now subject to review. Inward investment in the order of 2 band 5 WTE technicians is planned.

5 Research and Development

5.1 Activity within the department:

Launch and embedding of:

1. **Everyone Included**: Trust-wide initiative letting people know about relevant research studies. Submitted for HSJ Award. Publication in press.
2. **Medical Research Leads:** Initiative to engage medics with R&D. 8 appointed and working with the Medical Research Fellow.
3. **Specialist Registrar Research Involvement Course (SpRRIC):** 3rd year to begin in September 2015. First of its kind in the country. Article in press and other regions interested in adopting the course.
4. **Research Link Coordinators:** Initiative to engage clinical teams with R&D. Pilot completed January 2015. Programme officially started 1st March 2015 with 15 Coordinators from 13 teams.
5. **BEST in Mental Health:** Clinical question and answering service answered 142 questions in year. Funding awarded from NHS England to answer Forensic Clinical Reference Group questions. 2 articles in press.

5.2 Staffing

2014-15 saw the national transition of the Clinical Research Networks. Cuts were made to funding, of between 12-20%. AWP's continued improvement in performance resulted in the second lowest reduction in funding in the network (4.3%). Nevertheless, there has been a reduction in management staff and 40% staff turn-over in R&D.

Staff Group	WTE 13-14	WTE 14-15
Management	2.4	1.4
Administration	3.0	3.0
Senior CSOs/Research Nurses	2.4	1.9
CSOs/Research Nurses	10.6	11.6
BEST in Mental Health	2.0	1.0
Kingshill Research Centre	3.6	3.6
Study Specific Researchers	1.8	2.2
Other (Projects, finance)	1.0	2.6
Total	**26.8**	**27.3**

5.3 Finance

	2013-14			2014-15		
Cost centre	**Income**	**Expenditure**	**Variance**	**Income**	**Expenditure**	**Variance**
44402 & 03 - Research Support	£486,773	£486,773	£0	£853,410	£813,062	+£40,348*
44421 - MHRN	£444,993	£444,993	£0	£0	£0	£0
44433 - DeNDRoN	£503,583	£503,583	£0	£0	£0	£0
44436 - NIHR Suicide Prog	£436,124	£436,124	£0	£329,261	£329,261	£0
44437 - BEST in MH	£54,652	£ 54,652	£0	£89,596	£89,596	£0
44439 - RCF	£207,276	£206,614	+£662	£214,055	£205,462	+£8,593**
44440 - R&D Commercial	£68,549	£100	+£68,479*	£37,934	£37,934	£0
40717 - Kingshill	£203,360	£293,030	-£89,670	£222,346	£258,485	-£36,139

*R&D secured additional funds in month 11 to backdate medic and senior nurse clinical time throughout 2014-15, for their assistance with research related activities

**Slight underspend due to late invoicing

In 2014, Kingshill research centre came under the line management responsibility of R&D. Review of costing frameworks and efficiency has impacted positively on an annual overspend. Kingshill is predicted to breakeven in 2015-16.

5.4 National Institute for Health Research : High Level Objectives

All AWP NIHR Studies (R&D & KRC): (2013-14 n=40; 2014-15 n=45)	**2013-14**	**2014-15**
Total no. studies open or follow-up hitting FPFV target National target for studies hitting **First Patient First Visit** date = 80%	13 (33%)	26 (57%) ↑
Total no. studies open or follow-up on track to recruit to time & target National target for studies recruiting to **time & target** = 80%	27 (68%)	34 (76%) ↑
NIHR R&D Led Studies: (n=35)		
No. of studies currently open or follow-up hitting FPFV target	11 (41%)	23 (66%) ↑
No. on track to recruit to time & target	23 (85%)	30 (86%) ↑
Kingshill Research Centre Studies: (n=10)		
No. of studies open or follow-up hitting 70 day target	3 (23%)	3 (30%) ↑
Total No. on track to recruit to time & target	4 (31%)	4 (40%) ↑
% of studies - NHS Permissions within 15 days	75%	89 % ↑

The NIHR FPFV target is challenging for many trusts. AWP R&D is now achieving recruitment to 'time and target' and will achieve 'first patient first visit' from 2015-16 as a result of further change to process. Kingshill research centre is improving against 'time and target' but is unlikely to achieve FPFV targets. NIHR recognise that Kingshill is recruiting to complex studies in dementia.

Recruitment into studies

	2013-14	2014-15
NIHR AWP Recruitment	934	723
NIHR AWP Complexity Scoring (ABF)	4561	5641
NIHR AWP Commercial Recruitment (non-KRC)	70	3
NIHR AWP Commercial Recruitment - Kingshill	12	13
NIHR AWP Number of Recruiting Studies	38	35
NIHR Non-AWP Recruitment*	-	363
NIHR Non-AWP Complexity Scoring (ABF)*	-	2007
NIHR Non-AWP Commercial Recruitment*	-	17

*AWP hosts a number of Clinical Research Network staff who do not work on AWP studies but who assist in recruiting to studies in primary care and local acute Trusts.

Although the number of recruits into AWP open studies has decreased, the complexity of studies has increased; that is, we have recruited more people to 'interventional' type studies than in previous years. Our recruitment complexity score is our highest ever, at 5,641 points. We have also given patients in primary care and acute trusts, who have mental health issues and dementia, the opportunity to take part in research. This results in a significant increase in the contributions by AWP to mental health and dementia research in the West of England.

5.5 Other Achievements:

1. Highest recruiter for NALIVE nationally. In 2014, AWP R&D achieved a second national commendation from NIHR for improved recruitment activity
2. Recognition of significant contribution to the MADE trial (clinical academic trial for people with dementia)
3. The appointment of two University of Bristol-AWP, joint-funded consultant senior lecturers working in learning disability and personality disorder. AWP supported the appointment of the new, fully academic Chair and Head of Department at Bristol University, whose research background is in psychosis.

6 Psychology

6.1 Activity

Psychologists are usually embedded in teams and as such, their activity is reported as part of team performance. In order to better understand psychology contribution to clinical work and outcomes, the Head of Psychology is working with information systems to improve reporting against activity, types of intervention and treatment outcomes.

A review of psychological therapy availability across the trust has identified a range of improvements which will support the clinical strategy and the trust's objectives. These form the work plan for the psychological therapies clinical network 2015-16. The focus will be on ensuring NICE compliance for access to therapy in each setting and maximising therapeutic output from various staff groups. Priorities include:

- Identifying the interventions to be provided by other professions, plus development of training and supervision structures to embed practice and quality. This will include identifying staff who have been trained but are not currently delivering therapeutic interventions.
- Evidence based recommendations re: new models of care e.g. stepped care model, to increase access to multidisciplinary psychological therapies, sharing learning across LDUs.
- A detailed review of access to NICE recommended interventions for older people is planned.

7 Clinical Informatics

The trust continues to improve access to information on performance and activity. The Clinical Intelligence platform supports clinical decision making by identifying service users at highest risk of self-harm on any team member's caseload.

Inpatient team dashboards allow comparison of performance across out inpatient sites. These will be expanded to include community teams in 2015-16.

The Mental Health Act dashboard shows trust and LDU level performance against a number of metrics including BME detentions and those areas highlighted by CQC, namely access to S132 rights.

The Medication Incident dashboard was launched in April 2015 and shows medication incidents by type, severity and by LDU.

Future developments will include prescribing information (cost/quantity/type) to individual prescriber level (June 2015).