Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board meeting (Part 1)			Date:	30 September 2015
Agenda item	**Title**	**Executive Director lead and presenter**		**Report author(s)**
BD/15/135	**Chief Executive's Report**	**Iain Tulley, Chief Executive**		**Company Secretary, Trust Paralegal**
This report is for:				
Decision				
Discussion				
To Note				X
History				
None.				
The following impacts have been identified and assessed within this report				
Equality	None identified			
Quality	None identified			
Privacy	None identified			
Executive summary of key issues				
This report advises the Board on some of the key management and development issues facing our Trust, considering internal and external influences. The Board is asked to **note** the 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 National issues

1.1 Learning not Blaming – What Trusts Need to Know

This month saw the publication of the Government's response to three reports on patient safety contains several new requirements, structures and arrangements for NHS boards to be aware of and act on.

The report details the Department of Health's response to the Freedom to Speak Up Review consultation, the Public Administration Select Committee's report Investigating clinical incidents in the NHS and Dr Bill Kirkup's report on failings in care at Morecambe Bay. It also provides an update on progress against report recommendations and next steps.

For us, the key actions or changes to be aware of are:

- All trusts in England are to appoint a Freedom to Speak Up Guardian to encourage and enable staff to raise concerns over patient safety in a confidential setting.
- The guardian should be appointed by the chief executive and will act as a "genuinely independent figure". The guardian will raise concerns with the chief executive or board. If the guardian has lost confidence in how the organisation is handling concerns, they are also able to raise concerns with a national guardian. I will be appointing our guardian in due course, following the national guidance.
- The national guardian position will be based at the Care Quality Commission (CQC) and will be appointed by December 2015.
- An Independent Patient Safety Investigation Service (IPSIS) will be created to conduct independent expert-led investigations into patient safety incidents. IPSIS will be brought under the single leadership of Monitor and the NHS Trust Development Authority.
- The Parliamentary and Health Service Ombudsman (PHSO) will be reformed to simplify and modernise its existing structures.
- Late summer 2015 will see the publication of the first round of hospital complaints data collected quarterly, rather than annually.

1.2 Mental Capacity and Deprivation of Liberty Consultation Paper.

On 7 July 2015 the Law Commission published its Consultation Paper on Mental Capacity and Deprivation of Liberty. We will be considering this consultation carefully with our service users and stakeholders, and will be responding by the deadline of 2 November 2015.

1.3 The five year forward view mental health taskforce: public engagement findings.

This report carried out by MIND and Rethink Mental Illness summarises the views of more than 20,000 people on the top priorities for reshaping mental health services, as part of a drive to develop a five year national NHS strategy for people of all ages.

The top five calls for change by 2020 were:

- Better access to high quality services
- Wider choice of treatments
- More focus on prevention
- More funding
- Less stigma

In our forthcoming Member event in Swindon, we will be discussing with members, what your views are on the future strategy looks like, amongst other issues.

2 Local issues and Trust news

2.1 National Standards for Psychiatric Intensive Care Units (PICUs)

The Acting Director of Operations Mathew Page has presented the New National Minimum Standards for PICUs for Young People at the National Association of PICU annual conference at the University of Warwick this month. Mathew was the lead author of the standards which have taken four years to develop. A team of clinicians,

managers, commissioners and young people contributed to the document which is endorsed by the RCN and RCPsych.

The project involved working with a wide range of stakeholders from the NHS, the private and third sectors and across many professional disciplines to develop these specialist clinical standards. The new standards offer more detailed advice in areas considered vital to the care of young people in PICUs.

2.2 Team of the Month

This month we celebrate two amazing teams - Bristol Quality Improvement Team and the Swindon Intensive Team and Applewood Ward (acute care pathway).

2.2.1 Bristol Quality Improvement Team

This team have set up some impressive systems and processes to help teams improve quality in the locality. As a result of their work, CPA has increased from 50% to 90% and waiting times have been significantly reduced, making a real impact on service users. These outcomes are excellent and I commend this work to the Board.

2.2.2 Swindon Intensive Team and Applewood Ward (acute care pathway)

The integrated work between the intensive team and the acute ward (Applewood) in Swindon has achieved some excellent results, due to the dedication and motivation displayed within the teams and across the acute care pathway collectively. Historically Swindon has had to use beds outside of the Trust. However over the last 6 months by working together supported by the introduction of a new bed manager post, there are now no Swindon service users in beds outside of the AWP boundary. This is a tremendous achievement.

3 Serious Untoward Incidents (SUIs)

There were 2 externally reportable incidents involving 3 patients this month, a substantial reduction in serious incident numbers over previous months. One matter involved the death of one patient and the arrest of another in relation to an incident involving an illicit substance. Both patients were or had been known to community and the Drugs and Alcohol Provider in Wiltshire. An externally led root cause analysis investigation is being commissioned. The third matter reported related to the discovery of legionella in the water system on the Southmead hospital site. Advice from Public Health has been provided and business continuity arrangements put in place, however no harm has been reported to either patients or staff.

4 Staff Survey 2014 – Areas of Greatest Focus

4.1 Bullying and Harassment

At Board Seminar this month, the Board received and discussed three key reports:

- Independent 'deep dive' into staff on staff bullying, harassment and physical assault.
- Leadership Impact report describing the 'climate' of the organisation i.e. how it feels to work here. This research was also conducted by an independent partner.
- A review of the AWP organisational development programme of work conducted and presented by Donal Laverty, Partner at Baker Tilley.

Board and Directors' Team have identified a series of actions in the light of feedback that will further inform out approach to staff engagement.

4.2 Appraisal Training

Appraisal and supervision training has commenced and work begun on commissioning an electronic appraisal platform that will support planning of workforce development, inform the implementation of organisational development approaches, enable talent management and support nurse revalidation.

4.3 Staff Engagement

4.3.1 Leadership Development

The fourth cohort of managers will today commence the ILM 5 Leadership and Management Programme. This programme was informed by a training needs analysis undertaken with current band 7 and 8 managers and is therefore tailored to meet the specific requirements of this group of staff.

The first cohort of managers completed this programme at the start of September and reported positively on the content, teaching delivery, opportunity to network with other managers and problem solve as a group. Development opportunities for this group will continue as they complete a 360 feedback tool to assess their leadership impact. Individuals from this group are also accessing development through our coaching network and action learning sets.

4.3.2 Staff Awards

We look forward to our Staff Awards celebration on Friday 9 October. The event provides an opportunity to celebrate the extraordinary work of our staff. We are delighted to have Johnny Benjamin; a mental health campaigner whose moving story was the subject of a documentary 'The Stranger on the Bridge'.

4.3.2 4.3.3 Staff Friends and Family Test Results

In accordance with our phased approach to surveying staff using the nationally mandated Staff Friends and Family Test, we have surveyed staff in the following areas: Corporate Services, Specialised Services, South Gloucestershire, North Somerset, Swindon and BANES.

Survey feedback shows signs of improvement across all localities and evidences the increased focus on staff engagement Trustwide.

Localities have shared this data with their teams locally and Executive Directors have considered feedback from staff in corporate services. Staff engagement plans will be informed by feedback.

Survey feedback is incorporated into Locality Workforce Development Dashboards and the Board Assurance Dashboard. Survey results are discussed with Locality Leadership Teams as part of regular performance reviews with the Executive Team. Full data will be reported to Quality and Standards and then to Board.

5 Recommendation

The Trust Board is asked to **note** the report.