Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

| Trust Board Meeting (Part 1) | Date: | 30th September 2015 |
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| Agenda item | Title | Executive Director lead and presenter | Report author |
|---|---|---|---|
| BD/15/137 | Clinical Executive Report | Hayley Richards and Andrew Dean | Ann Tweedale |

| This report is for: | |
|---|---|
| Decision | |
| Discussion | |
| To Note | X |

**History**

*Received at Quality and Standards Committee 15th September*

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

**Executive summary of key issues**

The Clinical Executive Report contains a summary of key areas of work from the Nursing and Medical Directorate covering the following areas:

- A commentary on the North Somerset data pack
- Safer staffing update
- Water management issues
- PMVA training
- Medicines management
- Patient safety
- Annual survey actions
- CQC Compliance
- Annual Objectives
- Quality Account progress update

| 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 | |
| We will be future focussed | |

# 1. North Somerset Data Pack - Clinical Executive Commentary

On review of this data pack the following areas are highlighted for the committee to note:

Please note that this data pack was prepared for the Week in Focus review with data from corporate departments provided to the end of July. The IQ section has been updated with August data for use for the Q&S Presentation in September. Some areas have shown considerable improvement and are noted below:

The new **IQ dashboard** arranged across the five CQC domains is highlighting a high risk score for the Effective domain. Underlying this are 6 amber indicators with the national indicator Gatekeeping of admissions by intensive team at amber. This is showing an improving picture and local information reports that the indicator will reach the target rate by the end of September. In addition in the Well-led domain sickness absence rates have deteriorated since March reaching 7%, now one of the highest rates of all SDUs.

We are pleased to see a recent increase in the **Friends and Family Test** response rates in the community services moving from 9% in June to 13% at the end of August. It is our objective for all SDU areas to achieve a rate of at least 15% in their community FFT this year and North Somerset have made good progress with this. Also to be commended is the ward response rate, one of the highest in the Trust.

The independent audits of the local IQ **record management** audit has scored lower than the locally assessed scores; highlighting issues around formulation and up to date crisis and contingency plans.

**Incident reporting** numbers are relatively high compared to other areas indicating a good safety culture. At the end of June 90 incident reports are awaiting manager review, this has now improved to 56 at the end August. We would also expect greater compliance with the use of the NPSA toolkit with investigations of unexpected deaths.

The **Health & Safety statutory risk assessment** information included highlights some issues however more recent data is showing considerable improvement with 100% compliance for the last three months. It is recommended that the locality health and safety meeting maintain these increased levels of scrutiny to sustain the improvements.

**Annual Health & Safety self-assessments**: Overall scoring well at 95% above the Trust average however the standard relating to 'safety representatives and safety committees' is indicating that the safety hub meetings are not operating. Recent enquiries of the LDU have provided evidence and assurances that the local health and safety meetings are functioning and that H&S is managed and consulted upon.

# 2. Nursing

## 2.1 Safer Staffing

The outcome of the third Safer Staffing review was approved at Board in August 2015.

The outcomes of the safer staffing numbers are:

- 8 wards have increased Establishment
- 8 wards have reduced Establishment
- 22 wards have remained the same
- Qualified nursing ratio have increased
- Band 3 Health care assistant numbers have increased

- Band 2 Health care assistant numbers have decreased

Overall the changes will be cost neutral against current budget.

For the July reporting period:

- No ward was 20% under planned staffing overall
- 11 wards reported staffing levels under 20% planned staffing for registered staff, this reflects the current difficulties in registered nurse recruitment
- 15 wards reported staffing levels over 120% planned staffing; this was predominantly in unregistered staffing

This report contains fuller detail in the following appendices:

**Appendix A** – Safer Staffing Narrative: ward based information for wards which are 20% over or under planned staffing for either Registered or Unregistered staff. We have also found that the Health Roster templates for wards to complete their rosters are not in line with the Safer Staffing numbers. The implementation of the revised Safer Staffing numbers approved in August will rectify this.

**Appendix B** – Board Summary of safer staffing numbers for actual shifts

### 2.2 Southmead Water Management Issues

The Trust was informed by North Bristol Trust on the 6th August 2015 that during routine water testing on the Rosa Burden Unit they had found above expected levels of Legionella in the hot water system. NBT lease this building from AWP and the building is on the same water system as STEPS Eating Disorder Unit, the Mason 136 Suit and Oakwood Adult Acute Ward. The site also houses the Mother and Baby Unit. Appropriate mitigation was put in place to manage the potential risk to service users. Follow up testing has shown increased Legionella rates in some outlets although full test results are not yet returned. Public Health England have been informed and involved in water management meetings to respond to the issues.

The Trust will be implementing regular testing for all ward sites on a 6 monthly basis and no cases of legionella have been reported.

### 2.3 Status of changes to PMVA training and L&D schedule

The Senior Nursing Team has met with Learning and Development to plan implementation of PMVA training to be delivered annually rather than every two years and for the inclusion of allied health professionals in this training.

Learning and Development are formulating costs to present to the Executive Team in September to identify necessary funds to deliver this.

# 3 Medicines Management

The Head of Nursing has implemented weekly audits for Drug Prescription and Administration Records (DPAR) from the 1st September for all wards.

The plan is to also roll out weekly audits of Medicines Storage and this is being reviewed to consider the results the annual audit of AWP Medicines Policy – P060 and AWP Standards for storage of medicines in wards and community teams – Med 11 are now available

From the results of the re-audit it is evident that much work has been done to improve the safe handling and storage of medication. There have been improvements with compliance in all but one of the 35 areas, ranging from increases of 3% to 90%. 30 out of 35 areas are 90% or above compliant, and no areas are less than 60% compliant.

**In previous audits there were issues noted with the following:**

- Awareness of the storage requirements for intravenous fluids, sterile topical fluids and flammable liquids, this has now improved to be 100% compliant.
- There was urgent action required from the last audit with regards to monitoring ambient temperature of the clinic rooms, this is now nearly fully compliant at 98%.
- The security of keys providing access to medicine cupboards in the possession of an authorised person or securely stored has improved to nearly fully compliant at 98%.

**Areas for improvement**

There are still some areas where the level of compliance could be improved:

- Process being in place for the review and validation of authorised signatories for those staff that can order medicines.
- The PIN codes, used as part of the access control system, being changed on a regular basis is an area which requires further attention and discussion with the team managers.
- It was felt that in the past the requirement to monitoring fridge temperatures storing vaccines twice a day hasn't always been followed, in some areas only being checked once a day. The requirement will be reiterated when any new vaccine stock is received on the ward.
- There were some issues noted with the storage of patient's own CDs, whilst all were stored securely, they weren't always separate to the ward CD stock. Some areas reported that the CD cupboard is too small, so therefore all the items are kept together, however, patients own are separated using pharmacy clear bags and have a patient label on them to make them easily identifiable.

# 4 Patient Safety

## 4.1 Suspected Homicide

The Trust externally reported a suspected homicide in August. Two STEIS reports were made and 72 hour management reports completed.

A root cause analysis investigation has been commissioned and the Trust will source an external Chair.

## 4.2 Matters Arising from Bristol data pack 13.07.15

The data pack included the following statement in relation to Mental Health Act tribunals in Bristol. "73 tribunals instigated for Q4 2014/15 in Bristol, of which 29 were actually held." Additional information confirms that the remaining 44 hearings were withdrawn, adjourned or discharged prior to the hearing.

## 4.3 Matters arising Thematic Suicide review 18.06.15

The thematic review has now been widely published, including on the Trust website. The report was formally shared with Commissioners at the Clinical Quality Performance Meeting and was praised for its quality. The action plan arising forms part of the work plan of the Suicide Prevention Group, and is subject to regular monitoring. Broader developments will be picked up as part of the Trust's application for the Sign Up to Safety campaign.

## 4.4 Annual Incident Report

Committee required further information to explore:

- Why the Trust reports more incidents of disruptive, aggressive behaviour than other mental health trusts;

- Why the Trust's level of near miss reporting is low compared to other mental health trusts; and whether further Trust action is required in relation to either of these issues.

This is addressed in a supplementary report at **Appendix C**.

### 4.5 Caseload management

Work has been ongoing to develop a web-based caseload management tool for community services. The tool is being piloted in BANES, Swindon and in North Wiltshire, and is also being used by Bristol community services. Key aspects of the tool include:

- The ability to view caseload in one place
- A weighting algorithm which demonstrates complexity
- A system to promote timely and accurate record keeping
- Recording of contracted hours and available face-to-face time for each practitioner

Metrics are being developed to enable benchmarking across the Trust which will show relative weight of caseloads for teams and individuals, alongside developing a clearer understanding of demand and capacity within services.

A further update report will be brought to the committee in a month's time.

# 5 Annual Survey 2014 – Trust level improvements

In response to the request from the Q&S Committee three improvement areas have been identified in response to the service user feedback from the annual Community Mental Health and Inpatients surveys 2014. These proposals were agreed at the Trust Integrated Governance Group in August and the following provides assurance to the committee of actions in train to address these areas:

### 5.1 Crisis Care

#### 5.1.2 Agreed actions

Ensure that service users are consistently given crisis contact details and that we provide clarity about what people can and cannot expect of crisis teams. Work to improve the effectiveness of the acute care pathway includes the provision of crisis care across the Trust.

#### 5.1.2 2014 locality survey action plans:

- Bristol – Review of the Crisis phone line staffing levels to meet peak times, the use of the Crisis Line and the need to have professionals available, to ensure that calls have the most appropriate outcome for people in distress or experiencing a crisis. South Glos - Use of supervision and training to ensure out of hours contact details are included in care plans. Objective to increase the number of service users who know who to contact out of office hours if they have a crisis by 10%.
- Progress will be reported to IGG following publication of Community Mental Health Survey results in mid Sept 2015.

### 5.2 Information about medication

#### 5.2.1 Agreed Action

Introduce an individual medicines booklet for service users. To date, a medicines booklet for service users has been developed by the Chief Pharmacist and piloted in Bath. It will now be introduced across the Trust.

### 5.3 Interaction with Nurses

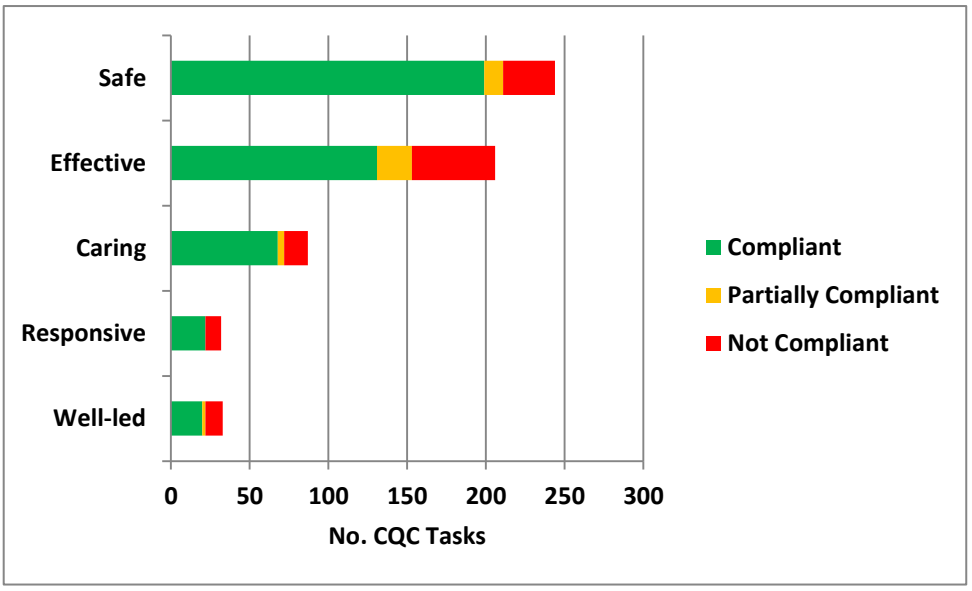
#### 5.3.1 Agreed Action

The ongoing Trust wide introduction of the 'Safe Wards Model' supports interaction with patients in inpatient units and ensures that adequate staffing levels are in place.

# 6 CQC Compliance

In order to assure that CQC recommendations have been met additional assurance has been sought through the two weekly check and challenge process and Week in Focus Service Reviews led by the Operations Directorate. Since July 2015 the Nursing and Quality Directorate has led the next stage of the programme of compliance checking via the **CQC Task List.** This is compiled from all CQC reviews of AWP since January 2013. This remains a live list and will be updated following future CQC visits. Where appropriate compliance for task completion is also tested in services other than where the initial task was identified.

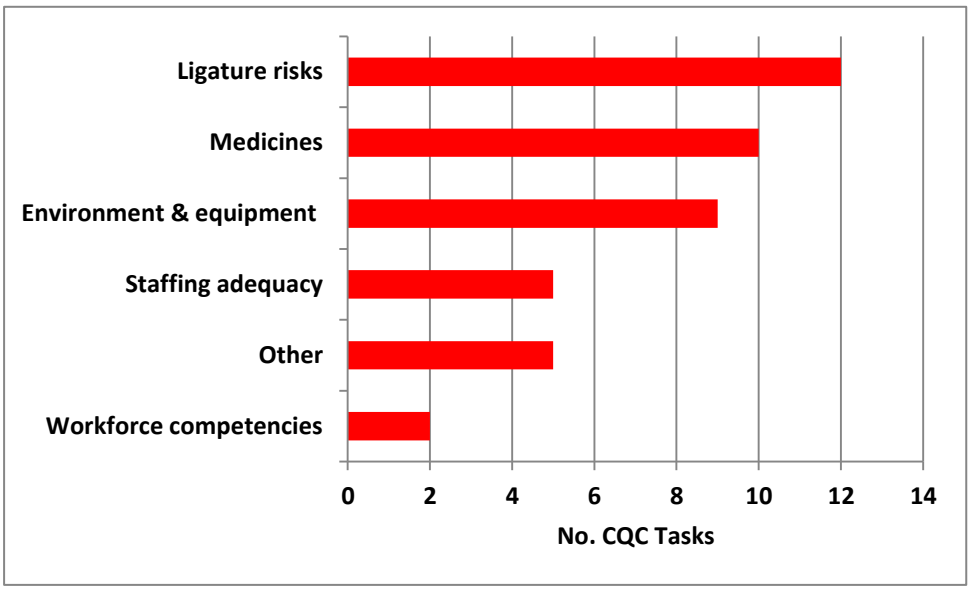
The compliance checking has commenced on inpatient units and Places of Safety and the Quality and Assurance team have to date checked over 600 tasks in Banes, Bristol, North Somerset, Secure services, Swindon and Wiltshire LDUs. As at 1st September the Quality & Assurance team have checked 602 items relating to inpatient units and compliance has been confirmed for 440 tasks (73%).




A paper has been presented to the Trust Integrated Governance Group to share findings with the Directors of Quality which gives detailed findings by LDU and theme and outstanding issues within the safety domain have been highlighted separately. The Quality & Assurance team are assisting LDUs to formulate action plans to ensure task completion. Compliance re-checking of identified non-completed tasks will commence 28 September 2015.

The assurance programme has found good progress in all areas for CQC task completion but a number of challenges remain. Feedback is given promptly locally as the compliance checking has been undertaken, and the Quality & Assurance team is working with the delivery units to assist with action plans to achieve compliance.

## 4.1 Unresolved CQC tasks by theme within the safety domain – Key issues




### 6.1.1 Anti-Ligature Work

- The Director of Nursing and Quality is revising the strategy for reducing the risk posed by ligature points in trust buildings. This has led to some work being temporarily held pending re-prioritisation.

### 6.1.2 Medicines storage and management

- Most of these unresolved tasks related to recording of medicine fridge temperatures. All units reviewed so far are recording temperatures daily but have been recorded as non-compliant due to the occasional missed recording.
- The dates of opening of bottles of liquid medication should be recorded but this is not yet embedded routinely.

### 6.1.3 Environmental and equipment safety

This is a broad theme which encompasses nine different items:

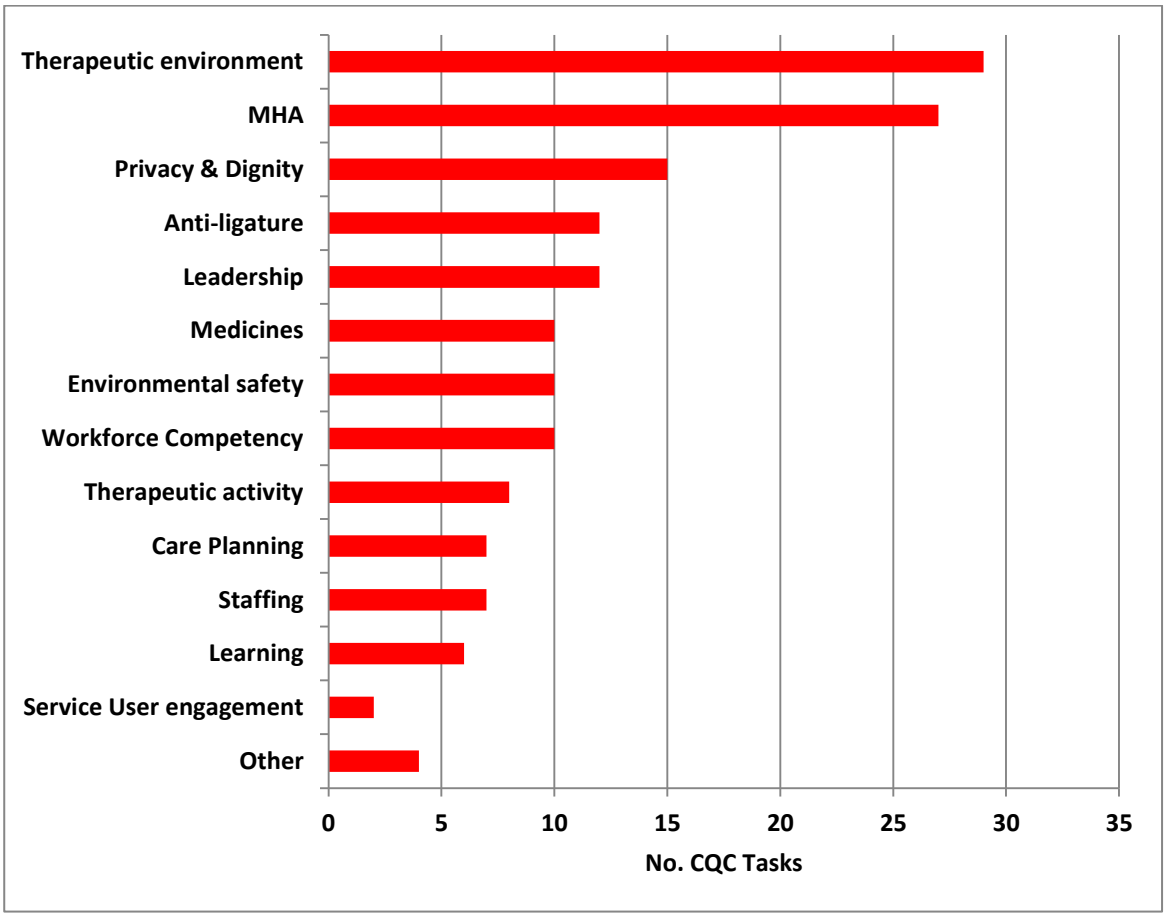
- Line of sight at Juniper needing improvement. There will be some improvement following completion of estates work by end December 2015 but there are building limitations.
- Life- saving equipment must be fit for purpose – PERT bag in POS Swindon log not updated.
- Lack of AWP fire site manager at Southmead.
- Fire drill not regular at Applewood.
- Temperature of seclusion room at Ashdown is monitored but continues to be in high range.
- Handrails on Fairfax could be absconding risk although mitigated by staff observation
- Use of drawing pins on inpatient notice boards in Bristol will be discontinued. AWP design authority group to consider trust-wide standard for notice boards.
- Garden bins at Juniper were overfilled and could pose a fire risk. Bins will be checked by staff.

### 6.1.4 Staffing

- Staffing adequacy is an issue across the trust and is consistent with the acknowledged national shortage of RMNs. However Secure services are facing significant challenges even with the temporary closure of Wellow ward.

Despite a bespoke Secure service staffing strategy which has included financial recruitment incentives, the net staffing position has not improved. Absolute staffing numbers are closely monitored and managed, but there is a high use of bank and agency staff. The lack of experienced, substantive staff remains problematic.

## 6.2 Unresolved CQC tasks for inpatient units by main themes (numerical)




### 6.2.1 Therapeutic environment

- These tasks mainly relate to the physical environment including level of cleanliness, decoration and "lack of institutionalisation". The main areas for concern are some of the secure wards, Juniper in North Somerset and Ward 4 Banes.
- The lack of weather shelters in gardens continue to be raised in CQC visits. The provision of all-weather garden shelters will be included in the trust design authority work schedule.
- Other tasks in this category include the provision of information to service users such as welcome booklets.

### 6.2.2 Mental Health Act

- A numbers of items come up repeatedly in CQC visits. MHA indicators will be included in a Quality dashboard and further work is being undertaken to implement quality improvements in this area.

### 6.2.3 Workforce competencies

- All areas monitor staff supervision and appraisal, and stat / man training. Rates have dropped below required standards at the time of compliance checking possibly due to factors such as time of year. It is not anticipated that this would be a sustained problem.

### 6.2.4 Privacy & Dignity

- A number of wards across the Trust do not meet the recent interpretations of MHA code of practice guidance on provision of single sex accommodation. A revised policy will be considered at the Integrated Governance Group. All wards will be compliance checked against the updated trust policy. LDUs will consider options with their commissioners to achieve compliance.

When all inpatient unit tasks have been checked the next phase for quality assurance will commence in community services.

# 7 Annual Objectives

The Trust Board received an update against the Trust's Annual Objectives via the Quarterly Assurance Framework Report in August. The Clinical Executive will be completing an exercise to reconcile and align the measures used to monitor the progress against initiatives that sit in both the Board's Annual Objectives and in the Quality Account Improvement Priorities for the following areas:

- To improve service user and carer experience
- To improve the clinical effectiveness of our services
- To reduce avoidable harm
- To improve the physical health of our patients
- To provide services that are compliant with the Care Quality Commission's (CQC) Fundamental Standards of care

This exercise is to ensure that the measures, actions and terminology remain current and live. For example CQC terminology requires updating to meet the revised regulatory standards and the use of intelligent monitoring rather than the previous Quality & Risk Profile (QRP). In particular this will address the measures used to report against a 'reduction in harm' described in the Quality Account versus 'avoidable harm' described in the Annual Objectives. The Trust is not currently able to reliably determine the difference between these two definitions and it is recommended that the measure uses incident data relating to those incidents causing serious harm e.g. falls causing a fracture.

Amendments will then be notified to Board in the Quarter Two Assurance Framework report to Board.

# 8 Quality Account Improvement Priorities - Q1 progress update

Full detail of the Quality Account improvement priorities are set out in Appendix D. This shows each priority alongside a description of the outcome measures and an update on the progress with the key actions to deliver the areas of improvement.

Areas to note that are rated amber or red against individual outcome measures or progress with actions to deliver are detailed below:

### 6.3 Use of the Friends and Family test to gather feedback from service users - AMBER

Work to improve the engagement in community services with the use of the Friends and Family Test is being measured via the response rate at Service Delivery Unit level with an end of year target of 15% to be met consistently in all areas. Our Q1 target of 12% has not been met in three of the six areas all remaining under 10%: B&NES 9.7%, Bristol 2.2% and North Somerset 9%.

### 6.3.1 Remedial Actions

Locality Directors of Quality are leading local improvement initiatives supported by the Trust Patient Experience Manager. New kiosks are in the process of installation in community team reception areas to help increase accessibility to the survey.

## 6.4 Improved partnership working with carers – AMBER

The indicator that reports from information recorded in the RiO electronic record that service users have been asked if they have a carer has seen a gradual deterioration in the last 6 months across all localities. Reported at 76% Trust wide with an improvement trajectory looking to meet 80% at Q1, against an end of year target of 95%.

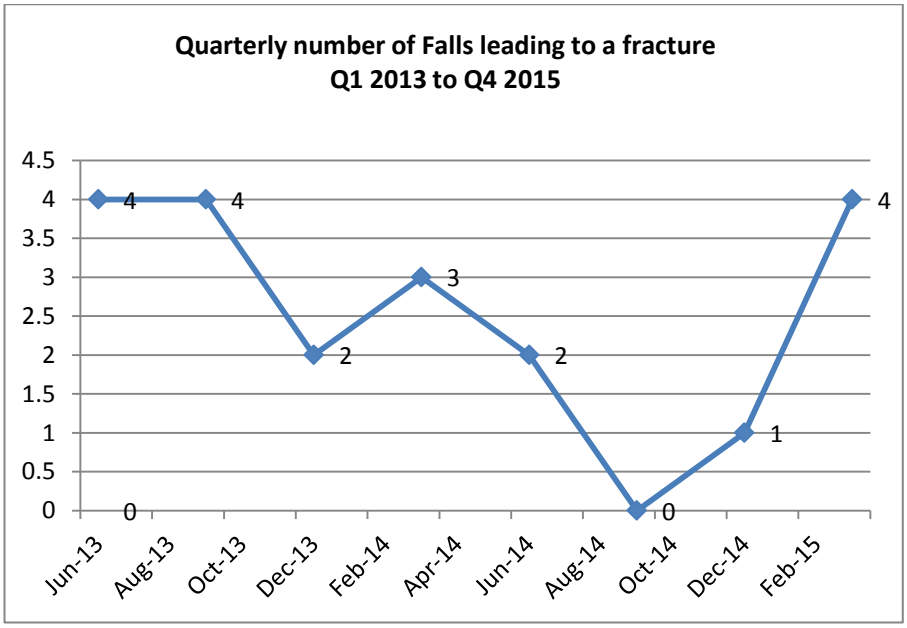
### 6.4.1 Remedial Actions

The fall in performance has been raised at the Trust wide carers' leads meeting which has cascaded the importance of ensuring that service users are asked the question and that this is recorded in the required field. In addition Client Account Managers who work directly with each SDU will be ensuring locality quality and performance meetings agree local improvement actions.

## 6.5 Improving patient safety and reducing avoidable harm AMBER

### 6.5.1 To achieve an 8% reduction in falls leading to a fracture - AMBER.

In the last two years the Trust has had on average 10 patient falls leading to a fracture per annum.




In Quarter One 2015/16 we have had 4 cases reported. As shown in the graph above numbers per quarter have fluctuated across a range of 0 – 4, therefore at this stage in the year we are rating this as AMBER as this would be at the higher range of expected numbers.

### 6.5.2 Top 25% of trusts for rate of reporting (NRLS data) - AMBER

To maintain our position in the top 25% of trusts for the rate of incidents reported. Data is published bi-annually by the NRLS. In March 2014 the Trust moved in to the top 25% of Trusts (14$^{th}$ out of 56) having maintained a continual improvement in reporting rates since March 2012. In the most recent report for data to September 2014 the Trust has continued to improve the reporting rate however has not kept pace with other similarly improving trusts just slipping in to below the top 25% to 19$^{th}$ out of 54 other mental health trusts.

## 6.6 Change of Action and Measure for Supporting CQC Compliance

The committee are asked to note that one action published in the Quality Account for the delivery of CQC compliance is no longer current. This relates to the use of self-assessments of CQC compliance at ward and team level as per the IQ tool reported during 2014/15. This

approach has been superseded by the refresh of IQ to provide an improved dashboard with additional elements of quality information at ward and team level designed to facilitate local monitoring and triangulation of information to highlight areas for improvement. Alongside this is the new approach to systematically check CQC improvement actions are completed via the CQC task list and compliance check visits. Therefore the measure for 95% of wards and teams taking part in the self-assessment will not be reported during 2015/16.

The measure has been replaced with progress against closure of actions via compliance checks of the CQC task list as per section 6 of this report. The trajectory for the planned % improvement is to be confirmed with reporting from Q2.

# 9 Quality Tracker – Mock up

The Quality Tracker is being developed to support the Clinical Executive in maintaining a focus on the high priority quality improvement areas for the Trust. Designed to provide greater visibility on actual progress and ensure momentum is sustained to achieve improved outcomes within planned timescales. Attached at **Appendix E** the first draft tool is shared as a mock-up of the planned approach; please note RAG scores are not based on fact and are for illustrative purposes only.

The Quality Tracker will log areas identified by the Clinical Executive and will be updated monthly to track the progress with improvement plans that have been put in place across the organisation. The Quality Tracker will be owned by the Integrated Governance Group and support reporting and assurances to the Quality & Standards Committee via the Clinical Executives Report on a monthly basis.