Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

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

Agenda item	Title	Executive Director lead and presenter	Report author
BD/15/189	**Clinical Executive Report**	**Hayley Richards and Andrew Dean**	**Ann Tweedale**

This report is for:	
Decision	
Discussion	
To Note	X

History
Some elements of this report have been received at the Q&S Committee November 17th 2015

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:

- Safer staffing update (including response to October Board Matters Arising)
- PMVA training
- Infection Control
- Caseload management tool (including response to October Board Matters Arising)
- Medicines management
- Mental Health Act Audit
- CQC Compliance
- Records Management Audit Tool Revisions
- Quality Account Improvement Priorities Quarter Two Update
- CQUIN update Quarter Two
- Matters arising updates from September Q&S Committee
- Clinical Executive Risk Register
- Acute Care Pathway Project update

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	
We will be future focussed	

1. Nursing

1.1 Safer Staffing

Detail of safer staffing numbers for October are included in the **Appendix A** with the highlights and exceptions noted below.

1.1.1 October safer staffing numbers

- No wards have reported staffing under 80% of planned for either nights or days in October.
- Two wards have reported under 80% of planned staffing for registered staff on day shifts. In both cases unregistered staff have been increased to account for this.
- 11 wards have reported staffing over 120% of planned for some shift types. Reasons for over staffing are currently being collated.

1.1.2 October Board Matters Arising

The Board requires further assurance around the fact that all 23 wards which are staffed above 120% are over-staffed due to acuity.

Response:

Assurance on this matter is supported by the introduction of the monthly Roster Review Process described below with examples of such cases where numbers have gone above 120% of plan.

1.2 Roster Review Process

The Director of Nursing and Quality has commenced a monthly review of the HealthRoster with ward managers and matrons. These started in September during which a review of the current roster periods was carried out. Rosters were reviewed against planned numbers and an analysis of reasons for areas with staff booked above these carried out. The appropriateness of increased clinical acuity as a reason was then further investigated in a number of areas, three are outlined as examples :

a) **Hazel Ward:** over 120% of planned staffing for unregistered staff on days and nights during September. The ward reported that this was due to a long standing 2:1 observation requirement for a service user with complex mental health needs who continues to await a more appropriate placement. Senior Nursing staff from Nursing and Quality reviewed the case independently and agreed the level of need was being appropriately met.

b) **Elizabeth Casson House**: over 120% of planned staffing for unregistered staff on days and nights during September. The ward reported that this was due to a service user with significant risks of harm to self inappropriately placed on the ward. The service user required 1:1 observation continually. This in addition to additional 1:1 observation requirements on the ward from different service users resulted in the need for increased staffing. This was reviewed by Senior Nursing staff from Nursing and Quality and the level of observation was agreed as appropriate.

c) **Hodson and Liddington**: over 120% of planned staffing for unregistered staff on days on Liddington and nights on Hodson. The ward reported having a number of increased observations during September including more than one 1:1 for service users with increased agitation, risk to others and risk to self. The levels of observation were reviewed by the Nursing and Quality Directorate who found all observation levels to be appropriate.

In addition the Director of Nursing has published on 13th November the **Nurse2Nurse** briefing for nursing colleagues which includes an article reminding of the arrangements for safer staffing covering the following areas:

- Safer staffing is not an absolute; the ward roster and establishment is set within given parameters which are listed
- Roster Policy explains the actions the Nurse in Charge must take if their assessment shows that staffing number need to deviate from the planned numbers (more or less staff)
- A reminder of the responsibilities of the Nurse in Charge in such circumstances

http://ourspace/Skills/Nursing/Newsletters/Forms/AllItems.aspx

1.3 Status of changes to PMVA training and L&D schedule

The Senior Nursing Team has worked with Learning and Development to plan implementation of PMVA training to be delivered to meet new annual refresher standards rather than every two years and for the inclusion of allied health professionals in this training.

Final plans are being explored to provide the training content to seek to maximise both efficiency and quality requirements within existing training budgets.

1.4 Infection Control - 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.

A dedicated water management group has been formed to manage the issue and to bring the system back to normal operating levels. Key actions that have been taken include: increased flushing, temperature controls, increased levels of chlorination and filters fitted to the high risk outlets.

AWP testing 14th August confirmed high levels on some outlets and follow up testing of all outlets on 14th September showed significantly reduced readings however some outlets still had high readings.

A follow up test on 14th October of 100% of outlets has been completed and the Trust awaits the results.

The Director of Nursing will be Chairing the group to manage the issue and making recommendation on future plans for testing on other sites.

1.5 Caseload management

The report on this work to the last Board and Quality and Standards committee set out the development and piloting of a new caseload management tool to improve intelligence around caseload management to better manage demand and capacity within community teams. Data was shared on a measure used to evaluate the pilot which reported an improvement in compliance from 16% to 36% between 1st June and 31st July.

The October Board raised a question on this measure as a matters arising as follows:

Present a trajectory for improvement, to assure the Board on the fact that the Trust is only 36% compliant in caseload management.

Response to request:

The measurement used is not of 'compliance with caseload management' but of completeness of eleven key aspects for the CPA on the RiO clinical record. These parts of the clinical record are used to support the system to weight clients, provide patient profiles and highlight areas outstanding in the clinical record.

This measure was used to evaluate the use of the tool in the pilot recovery teams across three LDU areas and not as a performance metric to monitor caseload management. The project group will be setting capacity measures as part of the project and these will be reported once finalised and data quality assured.

2. Medicines Management

2.1 Nursing Medicines Audits

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

The report of initial results is attached at **Appendix B**. 74% of wards have submitted the checklists weekly therefore this result only represents a sample of wards.

- Overall compliance is 90.44% for an audit sample of 1004 records

The requirement to complete these audits has been followed up with Ward Managers, Matron and LDU Quality Directors with the plan for all wards to be routinely completing in November.

2.2 Rapid Tranquilisation

The audit is developed and was due for completion in October, however this has had to be delayed due to Practice Development Nurse time being re-prioritised to Trust wide implementation of the Safety Thermometer in November. This audit will now be completed in November.

2.3 Storage

The weekly audit will be launched in November.

2.4 PRN Recording

This is to being developed during November for completion of a clinical audit in Q3 and Q4.

3. Mental Health Act Audit

The Director of Nursing and Quality commissioned an audit of compliance with the Mental Health Act from an administration perspective.

The audit tool was developed by the MHA Administration Manager and the Head of Patient Safety Systems. There was not an opportunity to share or pilot the tool before use and so these first audit results, whilst valid, need to be considered as a pilot initiative and discussion with clinical colleagues about the findings may lead to the tool being tweaked to maximise its effectiveness for future audits.

This is the first audit of Mental Health Act administration for some considerable time and overall the results are disappointing, with improvement required in many areas and across all sampled delivery units. The sample size is relatively small at an individual ward level but are illustrative and are collectively meaningful whilst auditors can see immediate improvements to the audit tool to be made.

Whilst there are a number of practice improvements highlighted by the audit results, undoubtedly RiO needs to be further developed to facilitate data capture of key information.

The Integrated Governance Group received the audit results in November and Phil Cooper, Director of Quality, Secure Services, will be developing an improvement plan working with Naveen Prabhakaran an inpatient consultant; this will be received to approve at the December IGG.

Summary of results

Standard	Specific requirement	% compliance
Admission Rights	Copies of Section Papers available on Wards	89%
	Rights Read Within 24 Hours	37%
	IMHA Information Given	64%
	Documented if Nearest Relative Can Be Contacted	28%
Consent to Treatment	Treatment Authority	86%
	Relevant Multiple Treatment Authorities	13%
	Responsible Clinician Record of Discussion of Treatment Plan	22%
Section 17 Leave	Family or carer informed where relevant	20%
	Responsible Clinician Record of Discussion of Treatment Plan	52%
Displayed Information	IMHA Poster/Leaflet displayed on ward	Not found on 3 wards
	Solicitors List displayed	Not found on 17 wards
	Informal Patients' Right to Leave – notice displayed	Not found on 6 wards

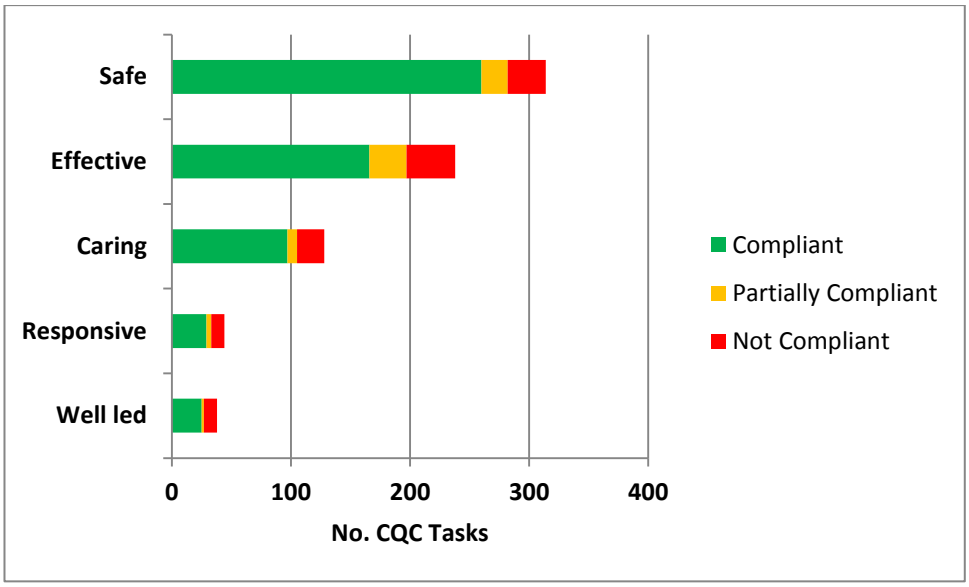
4. CQC Compliance

4.1 CQC Task List

In order to assure that CQC recommendations have been met additional assurance had 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.

Since the October CQC Task Quality Assurance report to IGG a further 34 tasks have been checked for compliance on inpatient units in the Specialist LDU: Acer; New Horizons mother and baby unit (MBU); STEPS eating disorder unit.

Task completion has been confirmed for 577 tasks (75% of tasks which have been compliance checked). A further 67 (9%) tasks have been found to be partially compliant.



Detailed reports are received at the Trust Integrated Governance Group and shared with Commissioners at their Quality Improvement Group.

The Quality & Standards Committee in November have requested a timeline for the remaining issues to be checked and compliance achieved. This will be provided to the December Committee.

4.2 Improvement work following Secure Services Week in Focus

The following provides an update on the key improvement actions against the high level themes taken by Secure Services.

Staffing

- Flexibility introduced to Safer Staffing by Nursing Executive allowing the opportunity to increase non-nursing staff into ward numbers.
- Secure Services have realised a significant reduction in agency staffing following a dedicated programme of planned reduction in August/September/October this year.
- Increase in Occupational Therapy staffing.
- New preceptorship programme introduced in September 2015 in partnership with L&D.
- Five new band 7 Senior Practitioner roles are out to advert in order to promote excellent practice and increase staff confidence and morale.

Environment

- A new dedicated environment administrator role in place. This role allows clinical ward based staff with an easy 'one-stop' process to alerting and resolving environment issues and concerns.
- A new hand held PDA programme has been established by IT, which allows staff to walk around the ward on a weekly basis to establish environmental compliance. The programme will flag repeated non-compliance on environmental standards.
- Closer working relationships have been established with our PFI provider and our own facilities team.
- Anti-Ligature work completed.

- Wellow Ward action plan and working group are due to open Wellow on 30th November 2015.

Triumvirate and Senior Management connection with services –

- A programme of senior manager allocation to wards have been completed. Each senior manager including the Quality Director supports an allocated ward. This includes the supervision of the ward a manger and attendance at the ward business meeting. Recent feedback from the CQC states that staff feel supported by their senior managers.
- A number of other initiatives have been introduced including quarterly newsletter, staff feedback
- All senior managers have been allocated a clear 'portfolio' of operations, which clarifies roles for all staff.

A 360 Review is being planned in the next few weeks with the Triumvirate. This will involve participation from the Medical Director, Nursing Director and Director of Operations. Areas to be covered are:

- Compliance with regulations
- Staffing
- Sustainability of current service provision.

4.3 Specialised Units CQC Assurance

During October 34 CQC tasks were compliance checked on inpatient units in the Specialised LDU.

Compliance was confirmed for 22 tasks (65%) and a further 7 (21%) were partially complaint.

Five tasks were judged non-compliant with required standards.

4.4 Key Issues for Inpatient Units

Theme	Key points to Highlight	Key Risks and Mitigation	Completion date
Privacy & Dignity	• The Trust is not currently compliant with single sex accommodation guidance on all wards. • Some wards can not achieve compliance due to physical limitation. • Some swing beds may have to be closed to achieve compliance.	New builds proposed for ward 4 and Juniper. Non-compliant wards to have estates review and joint plan agreed with CCGs. Discontinuation of use of swing beds may exacerbate bed shortages.	31/11/2015 for completion of estate review.
Ligature Risks	• The Trust has undertaken a major programme of estates works to reduce the availability of ligature points on the inpatient units. Units have been categorised into high, medium and low risk areas to allow prioritisation of those areas where service users are most at risk of self- harm or suicide.	Individual risk assessment & staff observation mitigates risk.	31/3/16

	• The programme for replacing all windows on inpatient units with Britplas units is scheduled for completion by March 2016. • Sanitary ware is being replaced with units which have inset taps to reduce potential ligature points. All work is scheduled for completion by end of March 2016. • Option appraisal for reducing ligature risks of doors will be available November 2015.		
Staffing	• Staff retention & recruitment is very challenging in Secure & Wiltshire services especially.	Bespoke recruitment strategies. DoN has reviewed safer staffing numbers. Secure IP units to be re-organised.	31/11/15
Medicine Management	• All storage facilities have been reviewed and refurbished as needed. • All areas have procedures for monitoring clinic room and fridge temperatures.	Application of standards not consistent. Quality Forum to focus on medicines management quality improvement.	08/01/2016
Acute Care Pathway/ Bed Mgt.	• All LDUs are actively working with partners in health and social care to improve the efficiency of the acute care pathway and reduce out of area admissions.	The Trust has commissioned a comprehensive acute care pathway review through the Project Management Office. This will be completed end of October 2015 but recommendations will have to be considered in light of the final report of the National Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults which is expected to be published January 2016.	31/10/15

4.5 Actions to be taken before next report

- Option appraisal for achieving single sex accommodation will be completed.
- Acute care pathway review will be completed.
- Option appraisal for reducing ligature risks of doors will be completed.
- Second round of CQC task compliance checking on inpatient units will be in progress.

4.6 Week in Focus

All services have now been visited to complete the Week in Focus Service review, most recently completed in South Gloucestershire and Specialised Services. These will be reported to the Quality & Standards Committee. Actions will be managed via the CQC task list with follow up compliance checks.

An external review of CQC preparedness is currently being completed and consideration of whether the Week in Focus approach continues in its current form will be part of this.

4.7 Developing Information for Quality *IQ*

As previously presented to the Quality & Standards Committee, IQ is now structured around the five CQC key questions with a system of associated risk scoring. The dashboard, able to be reviewed and drilled down to individual indicator at ward and team level, provides a system to support the Trust in monitoring quality and compliance from ward to Board with CQC standards. This offers an approach aligned to the CQC's own intelligent monitoring reporting. The new IQ was presented to the Commissioning Contract and Performance Meeting in October.

Work is ongoing to increase the number of indicators available in the system but to also ensure that quality information is presented and is easily accessible in one place to all staff. Areas currently in development are for incident data, health and safety data and medicines management audit results.

The work stream is also reviewing the approach to the records management audit and standards currently self-assessed within IQ. The proposals are being developed by the Integrated Governance Group and will be presented to Quality & Standards Committee in November.

4.8 Evidencing CQC Compliance

Work is underway to scope and develop a strategy to improve the accessibility and availability of evidence to support CQC compliance. This will improve the organisations preparedness for inspection but will also improve the organisations understanding and self-assessment of compliance.

Areas being considered include:

- Development of an **evidence library** on Ourspace to evidence the delivery of CQC improvement actions from CQC inspections and reviews linked to the Task List
- Development of an intranet document library at corporate level to evidence CQC compliance across the five key questions aligned to the CQC provider's handbook approach to inspection and associated key lines of enquiry.
- Good practice guidance for locality quality governance arrangements and records.
- Review and improvement of how corporate directorate information, policy and procedure are held in Ourspace; to improve accessibility.

4.9 Quality Forum

The Integrated Governance Group (IGG) has planned and delivered the first Quality Forum on the 15th October. The agenda of the meetings, to be held monthly, will be set by the IGG to address priority areas of compliance and to engage operational leaders in agreeing solutions,

improvement actions and how these will be implemented across all services in a consistent manner and to an agreed standard. In October the meeting focused on the area of reducing ligature risk. The agenda in November includes:

- **RiO Purposeful Recording project**
  - Point in Time Assessment
  - Risk assessment and Core assessment
- **Improving CPA Practice**
  - CPA/Non CPA
  - Local Variations
  - Standards for first 15 days of admission
  - Access to Services (Triage Tool)
  - Case Load Weighting Tool

5. Records Management Tool Revisions

A project group of SDU Quality Directors and Trust specialists have prepared the proposal with the aims, benefits and risks of the proposed changes to existing records management audit.

The current AWP audit tool comprises a set of 10 questions. We propose to change the audit tool and adopt items from the NPSA audit tool. Use of the NPSA suicide prevention toolkit will provide a higher level of assurance than the current audit tool, and will improve quality of assessment and care planning.

The implementation of the new approach will require IT development. The Executive Team are currently considering when, alongside other priorities, the necessary resources can be allocated to develop the new tool.

5.1 Current Records Management Audit

AWP conducts a monthly records management audit. Each clinical team and ward undertakes a ten item audit on five clinical records

Results are included as a Quality Indicator on IQ and reported along with team submission rate.

5.2 Aims of Proposed Records Management Audit

We now wish to improve the audit by adopting a new audit tool which will:

- Improve quality assurance,
- Help embed best practice
- Directly impact clinical practice.

5.3 Proposed Records Management Audit

We propose that the NPSA Inpatient toolkit will form the core of the record management audit for inpatient units. The AWP version will use a subset of NPSA tool standards primarily Standards 2, 5 and 6 plus additional questions more specific to the tool kit to support AWP policy compliance.

The tool is available to view at the following link:

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=65297

5.4 Key Method Points

The proposal includes:

- All AWP teams and wards will each audit five clinical records each month.
- Only service users who are currently receiving services will be included in the audit.

- The results of the audit will be reported monthly on IQ.
- The NPSA checklists will be included in the service user's electronic record.
- The NPSA toolkit generates action plans which will form part of the direct clinical response.

Future work will be undertaken to develop bespoke audits for specialised services.

5.5 Anticipated Benefits

This audit will be consistent with the standards recommended by the National Patient Safety Agency (now NHSE) and therefore provide improved quality assurance.

Although the NPSA Suicide Prevention Audit Toolkits were designed to be used following an unexpected death, they are also team development tools, designed to be used by individual teams to review their care and delivery practices. These tools highlight key aspects of care that are proven to contribute to improved service user safety.

The NPSA toolkit generates individual action plans which will enable teams to respond directly to findings. The NPSA checklists and action plans will be included in the service user's electronic record and can therefore directly benefit individual service users.

5.6 Anticipated Risks

We anticipate that performance of the Records Management Quality Indicator will deteriorate initially as the new audit is adopted. The proposed audit is more time consuming but has increased benefits for patient safety and team development which will be realised by staff. As staff become more familiar and confident in the use of the audit tool performance will improve.

The existing records management audit results are being used to measure the Trust Quality Account Improvement Priority 'to improve the clinical effectiveness of our services' therefore if the new system is implemented before year end we shall not have full year data to measure this priority.

6. Quality Account Improvement Priorities - Quarter Two 2015/16

Full detail of the Quality Account improvement priorities are set out in **Appendix C**. 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.

Improvement Priority	Summary RAG outcome measure	Summary RAG progress with actions
1. Improve service user and carer experience		
2. To improve the clinical effectiveness of our services		
3. To reduce avoidable harm		
4. To improve the physical health of our patients		
5. To provide services that are compliant with the CQC Fundamental Standards of Care		

Detail is provided below for any areas of note for which outcome measures or progress with actions are rated amber or red:

6.1 Use of the Friends and Family test to gather feedback from service users - RED

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. The improvement target is set on a trajectory and Q1 and Q2 targets, 12% and 13% respectively, have not been met in all areas. At Q2 three of the six areas are not achieving >13%: B&NES (5.9%), Bristol (4.2%) and Wiltshire (10.5%).

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.

6.2 Improved partnership working with carers – RED

The carers' indicator, which reports from the RiO electronic record that service users have been asked if they have a carer, is showing a gradual deterioration in the last 6 months across all localities. It is reported at 76% Trust wide, with an improvement trajectory set looking to meet 85% at Q2, against an end of year target of 95%.

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 RiO record data field. In addition Client Account Managers who work directly with each SDU will be ensuring locality quality and performance meetings agree local improvement actions.

The November Q&S Committee have asked for an exception report on this indicator to be provided by the Director of Operations in December.

6.3 Improving patient safety and reducing avoidable harm AMBER

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 had 4 cases reported and in Quarter Two 2015/16 1 case has been reported. Numbers of falls per quarter in the last 24 month period ranges fro 0 – 4, therefore at this stage in the year we are rating this as AMBER as this currently would not represent a reduction.

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' based on data published bi-annually by the NRLS. In March 2014 the Trust moved in to the top 25% of Trusts (14th out of 56) having maintained a continual improvement in reporting rates since March 2012. In the most recent reports for the past two six month periods, data to September 2014 and data to March 2015, the Trust has continued to improve the reporting rate however has not kept pace with other similarly improving trusts, just slipping to below the top 25% to 19th and now 20th out of 54 other mental health trusts.

To reduce the use and need for restrictive interventions and improve the use of positive and proactive approaches to care

One of the three measures is not indicating any reduction in the use of restraint. As follows:

15% reduction in all restrictive practices: Q1 367 incidents reported v's Q2 375 incidents reported. A 2.2% increase. Further context is provided in the Restrictive Practices Report in relation to improvements in the reporting culture potentially masking any reductions in actual practice.

6.4 Improving the physical health of our patients - AMBER

Two of the initiatives that support this improvement priority are national CQUINs and relate to the completion of cardio metabolic risk assessments and appropriate care planning and communication of information to GPs at discharge to include information that fully reflects lifestyle and physical health needs.

Interim audits are highlighting areas for improvement:

- Recording of cholesterol and BMI and care planning interventions for physical health conditions or improving lifestyle
- Discharge letters to include information on diagnosis and ICD codes and instructions on monitoring medications and physical health conditions

Results are shared directly with ward staff and management to take appropriate improvement actions locally.

7. CQUIN Update end of Quarter Two 2015/16

7.1 National Trust wide Schemes

As per national guidance the following national schemes are relevant to AWP services and are awarded 0.75% of CQUIN value:

Improving physical healthcare in people with severe mental illness. This is a repeat of last year's two key areas with the extension of the cardio metabolic assessments into Early Intervention services. 0.25% value.

a) Cardio Metabolic Assessments 4a

- The quarter one milestone for 4a is met with the implementation plan reported to CCGs at September CQPM, this remains to be confirmed as agreed by CCGs at CQPM 13/10/15. Quarter 2 milestones are completed but have no specific achievement criteria attached to them.
- Our latest local baseline audit of the cohort of inpatients to be included in the national audit in December show our compliance is at 60.26%, an 8% improvement compared to 52% scored nationally for 2014/15. According to the national CQUIN specification a score of 50% to 69.9% will achieve a 25% payment for 30% of the CQUIN value for inpatients and 20% for EI. 100% is achieved by scoring 90% or above. This gives a forecast 62.5% level of achievement for the CQUIN overall.
- This is the worst case scenario of forecast achievement at this stage. In 2014/15 the Trust was able to present local audit information to support CCG agreement of full achievement of the CQUIN despite the lower score received from the National Audit Team.

b) Communication with GPs 4b

- Interim audits are showing the Trust level score to be producing 59% of letters to be fully compliant with the standards.
- The final audit for the overall achievement of the scheme will be completed in Q4 therefore there is further time to improve standards in order to meet the standards for the CQUIN.
- The CQUIN has been rated as achieving 75% of potential income based on more improvements being delivered before March 2016.

c) **8b Reduction in A&E Re-attendances** 0.50% - the scheme is an agreed variation on the national UEC Menu scheme.

- Quarter one milestones are met
- Evidence is being gathered to evidence training provided for Q2 milestones.
- Data produced to measure re-attendances at A&E is currently being reviewed by operational staff to assess quality. Some issues have been identified that show incorrect recording of referral pathways to AWP from ED e.g. referrals to Intensive teams by A&E liaison have been recorded as referral from ED not an internal transfer from the A&E liaison team and therefore are incorrectly counted as a breach. Identified issues will be collated and options considered.
- The identified data quality issue also impacts on the reliability of the data used to set the baseline on which we have agreed a 25% reduction by the end of Q4.
- The scheme is rated amber as there is a risk that we shall not be able to reliably measure the reduction in A&E attendances which is one of the key measures of achievement.

Summary postion as follows:

Scheme	% Value	£ Value	Forecast payment £	Assessment of Current potential risk to delivery M7
Locally agreed and IAPT by CCG and LDU	1.75% + IAPT	2,170,411	2,170,414	Green
National Physical Health Cardio-metabolic assessments	0.20%	240,788	150,493	(62.5%) Amber
National Physical Health Communication with GPs	0.05%	60,197	45,148	(75%) Amber
National Urgent and Emergency Care Menu	0.50%	601,970	451,478	(75%) Amber
Secure & Specialised	2.50%	563,048	547,091	*(96.8%) Amber
Total	**2.50%**	**3,636,414**	**3,226,882**	**£271,791 at risk**

* Portion of Secure CQUIN that is not delivering relates to national physical health scheme 4a

7.2 Locally Agreed Schemes

All LDUs have agreed local schemes. All are reporting as having met their responsibilities at the end of M7. i.e. progress as planned and to CQUIN specification.

Wiltshire LDU MD has raised concerns that they are not able to deliver the training as planned due to all GP cluster areas due lack of GP engagement. The CCG recognise that AWP have completed their part in the CQUIN and have agreed to work with GPs to encourage involvement. There is a concern that this issue could potentially impact on the overall CCG view on the final payment of the CQUIN due to the CCG's financial pressures.

7.3 Specialised and Secure Services

No issues or risks have been raised at this time by the SDU. Reports on Q1 and Q2 milestones and for the 4a physical health scheme have been submitted and agreed by NHSE as meeting requirements. As per the Trust wide physical health CQUIN baseline results of cardio metabolic assessments and interventions are indicating target compliance levels are not being met

8. Matters Arising from September Quality and Standards Meeting

8.1 QS/15/60 Service Users in Employment Indicator

This indicator was presented to the Committee as part of the North Somerset presentation and further information was requested on the overall Trust position which is provided below:

The measure is a local authority outcome measure for mental health provision alongside the indicator for Service Users in Settled Accommodation. Each CCG service area agrees a local % target level to me monitored monthly. There is no Trust level target set as part of our contractual arrangements, however all areas have agreed a target level of 10% and this defaults to be the Trust level measure.

Service Users in employment	Aug 2015	Sep 2015	Oct 2015	Target
AWP Trust level	11.6%	11.8%	11.8%	10%
BANES	11.7%	11.1%	10.9%	10%
Bristol	8%	8.4%	8.4%	10%
North Somerset	8.9%	9.7%	9.5%	10%
South Gloucestershire	21.3%	20.4%	20%	10%
Swindon	11.1%	10.8%	11.2%	10%
Wiltshire	12%	12.2%	12.4%	10%

8.2 QS/15/072 Response rate to complaints

This issue was discussed at CIOG on 2nd November. It was agreed via the Chair, Hayley Richards, that each locality will come up with an improvement plan and that this is included in their exception report to Mathew for inclusion in his Performance & Quality report to Q&S.

8.3 QS/15/072 – Analysis of Complaints and PALs Themes

The Committee would like to understand any trends in the themes of complaints from year to year as this was not included in the paper.

Response: At the end of 2014/15 it was not possible to reliably provide this information as the classification list for complaints and concerns was revised when the Trust adopted the themes used by CQC in 2014/15. The change was made as we had been criticised that the domains previously being used were not mental health focused; therefore we have overhauled the database to allow better interrogation of complaints to allow for intelligent use of information.

In the future, reports will be looking at trends in the data and providing analysis. This will be provided in the next bi-annual report.

8.4 QS/15/070 – Quality Impact Assessments

Concerns were raised by the Committee that projects appeared to be going ahead prior to a QIA having been approved by the Clinical Executive. In response to this the Clinical Executive have ensured a clear process is in place linked to the Programme Management office project management function to ensure that all initiatives requiring a QIA have this in place and approved prior to any implementation takes place.

9. Clinical Executive Risk Register

9.1 Three highest risks to note are as follows:

1. **CE4 - Service Users may be at risk due to a number of residual ligature points across the estate. Residual risk score - Red 10**

Controls: Use of Manchester patient safety tool, staff training, programme of capital works, external review of ligature policy and rapid assessment and mitigation of risks.

The issue has been considered at the Quality Forum and several actions have been agreed to improve ward systems and process for the management of ligature risk.

2. **CE10 - The Trust will not achieve CQC compliance - Residual risk score – Red 10**

Controls: Week in focus, quality walk arounds and quality improvement group.

The Trust Quality Forum will be reviewing particular aspects of CQC compliance to develop solutions to systemic compliance issues from bottom up. Please see section 3. of this report for further information.

3. **CE11 - If we are unable to staff all areas of the Trust with sufficient staff in all our ward areas the quality of care that we deliver will decline.** - **Residual risk score – Red 12**

Despite significant activity to increase recruitment these actions are not always resulting in an increase in the overall number of staff as the turnover rate remains high.

Controls: Recruitment strategy, roster policy, bed reductions, staff benefits scheme.

10. Acute Care Pathway Project Update

10.1 Summary of recent progress

Phase 2 of the Acute Care Pathway (ACP) work commenced in August 2015 with the arrival of the project lead. Phase 2's primary aim was to evaluate the work from Phase 1 and review the proposal from the initial Project Initiation Document (PID) to ensure that the original proposal was amended if necessary to maximise impact across the whole health economy.

Phase 1 (Feb 15 – 31 Jul) was developed to tackle the pressing issue of the number of Out of Trust (OOT) beds in response to the initial ACP report with particular focus on internal bed management practice with an aim to deliver 20% reduction in out of Trust bed usage. Phase one has been a success with delivering in excess of 40% reduction in OOT usage.

Phase 2 (4 Aug – 31 Oct) was designed to evaluate the effect of phase one and design the next stage of the programme and continue to maintain the Phase 1 progress. The phase 2 work included:

- A review and verification of recommendations made in the March Review Report and subsequent draft PID
- A continuation of the Bed Team Approach to regular telephone conference calls; with an additional emphasis on the review regularity, the LOS and the DTOC status of all OOTs
- Conduct a detailed review of LOS & DTOC status and repatriation of inliers
- Review and refine escalation processes including bed state, DTOC protocol and use of flagging systems on dashboard to trigger review and escalation: approve draft processes and use as standardised protocols
- Detailed review of LOS of current in patient wards across Acute, PICU, Later Life and Rehabilitation services
- Conduct a review of 30 day readmission rates

- Utilise cluster information as an indicator for review
- Produce jointly developed PID for Phase 3
- Develop Working Groups and engage stakeholders

Phase 3 (30 Oct 15 – 31 Mar 16) is to implement a range of changes that will positively improve the acute care pathway to include all community, in patient and wider system providers. The proposal will be structured around three areas, Admission, In-patient and Discharge processes informed by PBR development.

10.2 Project Aims and Objectives Phase 3:

To implement an Acute Care Pathway Development Programme:

To take a whole system approach to the ACP: developing locally created and externally ratified LDU's ACP Development Programmes that:

- Impact positively on and provide evidence of systems of improved inpatient service performance, optimising local resources, whilst using the combined Trust wide capacity to its fullest efficiency.
- Provide evidence based, improved pathways for people with different diagnosis across community and inpatient teams optimising capacity and resources across teams.
- Implement NICE guidelines for different diagnosis groups, offering full menu of treatment options at the right time to prevent further deterioration and dependence on longer stays.
- Create ward environments that facilitates daily review and MDT Ward Rounds to improve and deliver shorter lengths of stay, with improved escalation re DTOC processes and use of fewer Out of Trust & Out of Area beds.
- Plan "Fit for Future Acute Services" with each CCG and Local Stakeholders group to match commissioning intent, population forecast and service modelling against national guidelines and best practice reviews.

10.3 Current Status

A Phase 2 outcome report with recommendations and timelines plan has been prepared for senior management.

The Head of the Quality Academy will be producing an implementation plan and leading the delivery of the project in conjunction with the Director of Operations. The next steps will be as follows:

- Project Manager to agree scope of input and support with Project Board – developing detailed plans and work programme – early November 15
- Draft PID, further development – based on final Report approval - end of November 15
- Draft Development Plan frameworks to each LDU for local input and detailed work up - end of November '15.

11. Recommendation

The Board should **note** the report