Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board meeting (Part 1)	Date:	27 January 2016

Agenda item	Title	Executive Director lead and presenter	Report author
BD/15/218	**Clinical Executive Report**	**Tim Williams, Acting Medical Director and Andrew Dean, Director of Nursing and Quality**	**Linda Hutchings**

This report is for:	
Decision	
Discussion	
To Note	X

History
Some elements of this report have been received at the Integrated Governance Group

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 Quality and the Medical Directorate covering the following areas:

- Safer staffing update
- Infection Control
- Nursing Medicines Management Audits
- CQC Compliance
- CQUIN update
- Clinical Audit Update
- U18/U16 Usage of 136 Place of Safety
- Safe Wards Update
- Quality Tracker
- Acute Care Pathway Project update
- Serious Untoward Incidents
- SUI Workshop
- Quality Impact Assessments
- PICU Review
- 2015 In-patient Survey Results

The Trust Board is asked to make a **decision** regarding the Trust Annual Objectives, as detailed in 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 November were presented to the December meeting. The full December data for all wards is not yet available. Currently it is known that during December there was 1 ward under 95% overall for safer staffing. This was Applewood Ward and it reflects reduced staffing due to reduced use of 136 suite at night. 20 wards were over 105% of their safer staffing levels in December. A detailed analysis of the December data is currently underway and will be reported in the February 2016.

Additional detail has been provided on November data:

Safer Staffing Narrative – Wards below 80% planned staffing for shift types

During November there were no wards below 80% planned staffing. Three Secure Services Wards were under 80% for some shift types during November. Secure Services staffing is undergoing transition to re-open Wellow Ward and to implement revised Safer Staffing.

Safer Staffing Narrative – Wards above 120% planned staffing for shift types

Ward	Staffing % Above Planned	Narrative
Alder Ward	On day shifts 39% over planned staffing for registered staff and 48% over planned staffing for unregistered staff	Current ward staffing exceeds establishment for Safer Staffing figures due to closure of Blaise View and Larch Ward. The management team feel that staffing levels are set too low for Alder unit and it is planned to review this as part of the implementation of the new Safer Staffing levels.
Aspen Ward	On night shifts 39% over planned staffing for unregistered staff.	The ward have reported increased clinical need during November, this has resulted in increased levels of observation requiring additional staffing.
Cove Ward	On night shifts 94% over planned staffing for unregistered staff.	The increased staffing reflects agreed increase in staffing on Cove Ward as a result of Roster Review process.
Elizabeth Casson House	22% over planned staffing for unregistered staff on day shifts and 97% over planned staffing for unregistered staff on night shifts.	The Ward has experienced high levels of clinical acuity including service users with high risk of self-harm requiring increased observation levels up to 2:1 whilst awaiting specialist placement.

1.2 Infection Control – Southmead Water Management Issues

Unfortunately, the current test results show an increase test on test in the number of outlets showing as positive for legionella spores. This means really that we have a 2-fold problem. Our current work is not working because the results are continuing to get worse, identifying more of a systematic problem than a local problem, requiring an immediate fix and longer term solutions.

As a result a full decontamination of the system will be undertaken and filters fitted to every outlet. Whilst this still gives a quick fix and some breathing space, this does not give us a final solution. The team is meeting on the weekly basis to discuss and agree options. Options under consideration are:

- Completely replace the whole system
- Re-engineer the current system

The Quality and Standards Committee will be kept informed of developments.

1.3 Nursing Medicines Management Audits

1.3.1 DPAR

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

85% of wards have submitted the checklists weekly therefore this result only represents a sample of wards.

- Overall compliance is 92.78% for an audit sample of 1333 records

A summary of the issues including wards that are not yet completing the checklist has been circulated to the Directors of Quality. There has been little change in the number of "blank boxes" reported, with a slight decrease to 13.8% from 16.4%. This equates to 185 blank boxes in December. Localities have been asked to develop ward based action plans to address this issue. Further review of these will be facilitated at Modern Matrons Forum on 29th January 2016. The action plan will also be agreed at the Forum and presented at the next Quality and Standards Committee meeting.

1.3.2 Storage

In order to monitor and report on good Medicine Storage practice the Head of Nursing was asked to implement a weekly check. The weekly check was slightly delayed from the planned November launch and has been launched in January 2016.

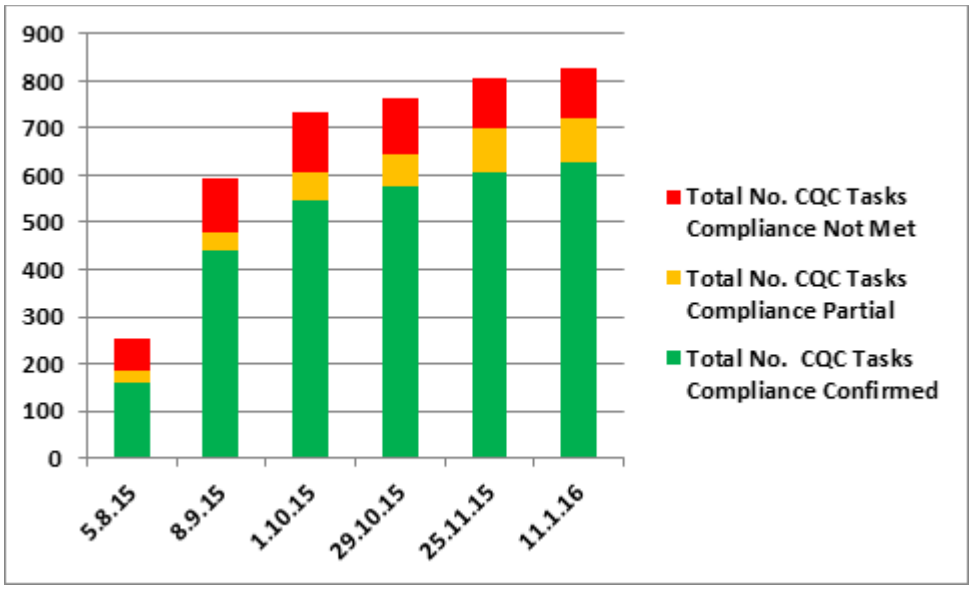
1.3.3 PRN Recording/Rapid Tranquilisation

The data collection for the full audit is now complete and the report will be presented to the Trust Violence Reduction Group. The audit has identified particular areas of practice that require further ongoing review, including the monitoring of physical observations. A monthly review of all rapid tranquilisation incidents has been implemented and the results of a review of the December incidents will be available in February. This review will continue monthly.

2 CQC Compliance

2.1 CQC Compliance Checking

This executive summary provides an update on the compliance checking programme for CQC task completion as of 11.01.2016. The Quality & Assurance team have now checked **825** items relating to inpatient units and community services at least once. The tasks from the unannounced Bristol inspection are not yet included in the task list for the purpose of this report. 626 (76%) tasks have been checked and confirmed as completed, and a further 94 tasks partially completed.



2.2 CQC Bristol Inspection

Appendix 1 summarises the results of the unannounced Care Quality Commission inspection of the Bristol Crisis service, and the three Assessment and Recovery Teams, conducted 7 and 8 December 2015, and progress on achieving the required improvements.

The CQC found evidence that healthcare provision required significant improvement because:

1. Care and treatment was not always provided in a timely way.

2. There was a lack of safe care and treatment.

3. There was a lack of governance systems in place to manage the quality and effectiveness of the service.

4. Staff providing care to patients did not always have the competence or experience to provide care safely.

5. Staff did not always take steps to safeguard patients from abuse.

6. The premises and equipment were not suitable at Brookland Hall and the Greenway Centre

A Section 29A Warning Notice requiring significant improvement to be made in the above areas was served 31 December 2015.

A support team for Bristol has been appointed to work with the Bristol management team to address the immediate concerns. The substantive triumvirate will develop plans to address longer term issues of culture, engagement and sustainability.

2.3 CQC Programme Board

The CQC Programme Board is now established and will run fortnightly until mid-May 2016. Please see Terms of Reference (Appendix 2) and Flow Chart (Appendix 3).

The Board will oversee compliance and:

- Check current compliance with a programme of audit.
- Identify 'hotspots' within LDU's and provide an immediate response
- Agree standards and roll out changes to LDU's agreed in the Integrated Governance Group and the Quality Forum
- Hold a roll out list
- Fully engage and hold to account Quality Directors in CQC compliance

- Provide rapid solutions to challenges through the 'everyone in the room' concept
- Manage the CQC task list
- Inform the Executive Team of any hotspots that require a higher level of intervention

2.4 Response to Bristol Report

There is a current audit taking place in order to understand the position of all LDU's against report from Bristol CQC visit. The audit will run with the same numbers used in Bristol proportional to each LDU.

Teams audited are:

Service	Standing caseload (assessed + taken on)	Total records to audit (5% for CHMT, 25% for Crisis)
BANES CIT	288	14
BANES Intensive	39	10
BANES Recovery	493	25
N.Som CIT	308	15
N.Som Intensive	36	9
N.Som Recovery	606	30
S.Glos CIT	233	12
S.Glos Intensive	66	17
S.Glos Recovery North	222	11
S.Glos Recovery South	276	14
Swindon CIT	233	12
Swindon Intensive	38	10
Swindon Recovery	579	29
Wiltshire Intensive North	61	15
Wiltshire Intensive South	49	12
Wiltshire NEW CMHT	530	27
Wiltshire Sarum CMHT	515	26
Wiltshire WWYKD CMHT	593	30

The audit will focus on:

- Care planning compliance. (is there a care plan? Is it the up to date and relevant?)
- Care plan quality. (is there evidence of Service User participation? Is the care plan specific and comprehensive?)

- Care plan validity (Is this the right care plan for the service user?)
- Crisis and contingency planning in place?
- Risk assessment (up to date and relevant?)
- Risk assessment (connected to a change in the Care Plan following a change or / and incident?)
- Safeguarding – the audit will take a qualitative analysis into the same number of records for information on safeguarding practice.

3 CQUIN Delivery 2015/16

3.1 CQUIN Meeting

At the meeting of CQPM on 12 January 2016, the Chair of the meeting announced on behalf of Commissioners (bar BaNES who were not present and whose views were not known) that they did not believe they had been provided with the necessary information in order for them to agree that the quarter 2 milestones for CQUINs had been achieved and therefore payment would not be made. Commissioners expressed frustration that the information they required had been requested on 3 occasions. Prior to this news, the Trust had assessed its CQUIN performance as follows:

Scorecard updates	M1	M2	M3	M4	M5	M6	M7	M8	M9
Cardio Metabolic Assessments		AMBER	AMBER	GREEN	AMBER	AMBER	AMBER	AMBER	AMBER
Care Plans shared with GPs		AMBER	AMBER	GREEN	GREEN	AMBER	AMBER	AMBER	AMBER
Reduction of reattendance at A&E			AMBER	GREEN	GREEN	GREEN	AMBER	AMBER	AMBER
Local Scheme - Overall						GREEN	GREEN		
Local Scheme - BANES		GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER	AMBER
Local Scheme - Bristol				GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
Local Scheme - N.Somerset		GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
Local Scheme - Secure Services				GREEN	GREEN	GREEN	GREEN		GREEN
Local Scheme - S.Gloucestershire		GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
Local Scheme - Specialised Services			GREEN			GREEN	GREEN	GREEN	No return
Local Scheme - Swindon		GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	AMBER
Local Scheme - Wiltshire				GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
CQC - Non compliance with essential standards: Enforcement action		GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	RED

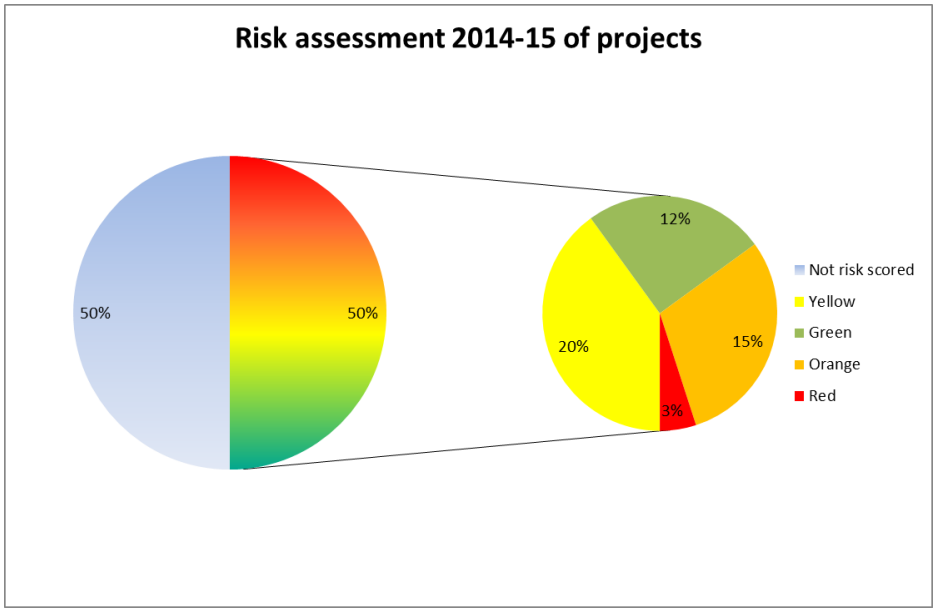
The red status on CQC compliance reflects the warning notice regarding Bristol. BANES continue to report amber as the commission led meetings have not yet been scheduled and Swindon reported amber as the CCG only agreed to pay 80% for Q2 for the Length of Stay CQUIN as they did not feel that the Experienced Based Design aspect had been described or actioned completely and it is not possible to recover that position.

4 Clinical Audit Update January 2016

4.1 2014-15 Workplan

The 2014-15 Workplan is nearing completion. 59 projects are on this plan, 32 (54%) have completed reports with closed action plans. 7 (12%) have completed reports and pending actions. 19 (33%) have competed data analysis and are being written up. One more is collecting a second set of data before being written up. This means that this work plan is close to completion of all projects and remaining actions will be followed up by the Clinical Audit and Improvement Manager.

There was a significant increase in risk assessment of audits on this plan with 20 having been risk assessed so far, 20 not applicable and the remaining awaiting a risk score. Of these 5 were assessed as green, 8 yellow, 6 orange and 1 red.



Of the orange ranked projects 5 have completed actions, 1 has just been written up and has an action plan and one is in the final stages of report writing.

The red ranked audit (Mental Health Act Admission and Assessment Delays) has completed actions.

Topics include Prescribing, Medicines, Physical Health, Restrictive Practices, Risk Documentation, Mental Health Legislation, NICE Guidance, Management Supervision, Suicide, Transitions between CAMHS and Adult Services and Safeguarding.

4.2 2015-16 Workplan

The 2015/16 Workplan is progressing as expected. Three Projects have completed reports with agreed action plans; 14 have completed data collection and analysis and are being written up; 2 have completed data collection and are being analysed; and 18 are collecting data. This year's work plan has 95 topics listed, but 58 of these have not yet commenced, so we anticipate a similar number of completed projects as the previous 2 years (50-60), after topics are removed or rolled over to 2016-17.

We expect all of the 2015-16 plans to be risk scored. So far 5 have a risk score – 4 yellow and 1 orange (Discharge Processes at New Horizons).

5 Under 18 usage of 136 Place of Safety

5.1 Bristol Update

The request to commissioners in the Avon area to determine short-term contingency arrangements for under-16 detainees when Mason is full has not yet been actioned.

In addition there are further emerging issues in relation to s136 provision arising from the Avon area, namely:

- The CQC thematic inspection of safeguarding children in the South Gloucestershire area reviewed the provision for children in the Mason s136 suite. Initial feedback and the draft report from the CQC comments on problems with the access to staff with appropriate skills to assess and care for younger children and the suitability of the unit environment for children. A draft joint action plan in relation to these recommendations has been agreed with South Gloucestershire CCG
- There have been problems where people detained in the Avon area have been taken by police to s136 suites in the Wiltshire area, with subsequent issues in relation to timely assessments and disposal in such cases

- Avon & Somerset Police have written to AWP (through the Chief Executive) stating their intention, in advance of the passing and implementation of the Policing and Criminal Justice Bill to implement the "exceptional circumstances" criteria for the use of Police Cells for s136 detention for adults as of the 1st June 2016, suggesting a task and finish group to agree the arrangements to meet their target, based on their understanding that national funding for improvement in place of safety provision will be available locally

It is intended that an internal working group, commissioned by the Director of Nursing and Quality will urgently consider the current issues and risks, including the emerging issues in relation to s136 provision in the Trust, and develop a Trust strategy in relation its delivery of commissioned s136 provision for adults and children within the wider multi-agency s136 pathways.

6 Safewards Update December 2015

95%, (36/38), wards have now commenced implementation. The two wards that have not commenced the implementation yet are Beechlydene and Dune. A full report on the impact of Safewards and other restrictive practice reduction initiatives was reported to the Quality and Standards Committee in November 2015.

7 Quality Tracker

The quality tracker is being revised for the end of quarter 3 and will be presented to the Quality and Standards Committee next time. Work is in hand to strengthen the indicators (and the measures being used) as well as testing of the quality of the underpinning evidence. Three new indicators have been added to the plan this quarter to date:

- Trust response to the Mazars' report
- Action plan to respond to Contract Penalty Notice
- Clinical Audit action plan.

8 Acute Care Pathway Project Update

The Acute Care pathway programme board met on 3rd December 2015 and agreed the main priorities for the next year in three phases:
1) consolidation of active bed management actions
2) improvement and development of internal care processes
3) improvement of inpatient & crisis model of care including designing future provision of services.
The terms of reference have been reviewed and the project structure, which includes a project group, has been established. Representatives from LDUs and Commissioners are included within this project structure.
Short term actions agreed at the meeting were:

- Improve financial information to LDUs regarding Out of Area placements
- Develop a plan to reduce contracted beds
- Introduce planned date of discharge consistently across all beds
- Carry out a "balance of care" audit to assess whether patients' current place of care is appropriate
- Implement 72 hour and 15 day standards
- Establish project working groups for Adult acute, Later Life and link to PICU review group
- Establish benchmark measures for overall project.

Alongside the ACP project, in response to the winter pressures experienced over the last few weeks in terms of out of area placements, the Operations team have agreed some escalation

measures on 6th January 2016. These include daily calls with very senior manager attendance, out of hours' procedures to ensure consistent medical to requests for placement and enhanced clinical scrutiny of placements and wider patient flow. The team will also be holding a rapid improvement event within the next two to three weeks to revise the escalation policy, review principles of local bed management action and to assure that they are reflecting national best practice.
External advice regarding best practice in patient flow/bed management has also been sourced and will inform the development of the project. The next meeting of the Programme Board is on 8th February 2016 where the Project Initiation Document will be agreed.

9 Serious Untoward Incidents

9.1 Alleged Homicide

The Trust has alerted the commissioners to an alleged homicide, although this has not been reported formally on the STEIS system. An ex AWP service user is alleged to have killed a woman in Hertfordshire at the end of December 2015. The last contact from adult community services in AWP was in March 2015, when he made threats to commit murder. The team contacted the police and he was arrested, charged and remanded in custody. At this point he was discharged by adult services. He had some input from AWP CARS and prison mental health services following this and was released from custody in April 2015. At this point he moved to his parent's address in Hertfordshire. He was subsequently admitted to hospital and had mental health input from Hertfordshire services. The Trust is required to report alleged homicides which occur within 6 months of discharge from our services. There is no requirement to formally report Incidents on STEIS when they occur more than six months after discharge and the appropriateness of doing so is determined in discussion with the commissioners on a case by case basis. As this man's care was provided more recently by another Trust and as it was more than 6 months since his discharge from AWP, the commissioners have not requested that we formally report this incident on STEIS. The Trust is, of course, fully co-operating with the police inquiry and will contribute to any subsequent investigation into his care if and when this is commissioned.

9.2 SUI Workshop

The Trust hosted a serious incident workshop with commissioners on 12th January 2016. This was attended by representatives from each commissioner and the Commissioning Support Unit. The group work focussed on the Duty of Candour; recurring themes in investigations and demonstrating learning. A summary of the key issues is being presented to CIOG on 18th January and the output of the workshop will inform changes to the Trust process for serious incident investigation and implementing learning from incidents.

10 Quality Impact Assessments

The policy for Quality Impact Assessments requires review. This review will be led jointly by the Head of Patient Safety Systems and the newly appointed Head of Transformation. Its aim is to strengthen processes:

- To reduce duplication
- To facilitate compliance with national best practice
- To strengthen exception reporting
- To introduce a post implementation evaluation

An update on progress, including timescales, will be included in the next Clinical Executive Report.

11 PICU Review

The Director of Nursing and Quality is meeting with the service user who presented his concerns about his PICU experience to the Board to share the PICU review plan that was shared with the Quality and Standards Committee last month. The PICU plan will be revised in terms of any feedback as it is really important the core areas of concern that initially triggered this work are fully addressed.

12 2105 Inpatient Survey Results

The initial results of the 2015 mental health inpatient survey are an improvement on last years' inpatient survey results in many areas. The survey was sent to people who had inpatient care in the second half of 2014. 112 service users took part and the response rate was 22% (the average for the 17 trusts participating was 21%). This was a more ethnically diverse group of respondents than in previous years. Although the sample is relatively small, it is statistically valid.

Some of the most improved scores are for: service users always feeling safe on the ward, getting help with organising the home situation, nurses listening carefully and service users having trust and confidence in nurses, service users finding talking therapy helpful, care for physical problems, Mental Health Act rights being explained clearly, awareness of how to make a complaint and for overall care. These improvements on 2014 scores varied between 7 and 15 percentage points. However, for one question, 'Did you receive the help you needed from hospital staff with organising your home situation?' 55% said that they received all the help they needed this year compared to 29% last year, an improvement of 24 percentage points

There are eleven questions where our score fell slightly. These include access to talking therapies; more people wanted them than said that they received them on the ward. Many people told us that there are still not enough activities on the wards, particularly at evening and weekends.

A fuller report will be prepared for the Quality and Standards Committee once the detailed results are received.

13 Recommendation

The Trust Board should **note** the report.