Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board meeting (Part 1)		Date:	25 May 2016

Agenda item	Title	Executive Director lead and presenter	Report author
BD/16/042	**Clinical Executive Report**	**Tim Williams, Acting Medical Director, and Andrew Dean, Director of Nursing and Quality**	**Linda Hutchings, Head of Patient Safety Systems**

This report is for:	
Decision	
Discussion	
To Note	X

History
None

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

Executive summary of key issues

In the absence of the Quality and Standards Committee being held this month, a reduced a summarised edition of the monthly Clinical Executive report is provided for Trust Board. The Board is asked to note this report.

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

1 Care Quality Commission

The Trust is pleased to welcome its Regulator to undertake a full compliance inspection of our services over a 2 week announced period. The Chief Executive has thanked staff for their preparation for the visit and encouraged them to speak proudly about the work that they do.

2 Nursing

2.1 Safer Staffing

During March 2016 there was 1 ward under 95% overall for safer staffing. This was Applewood Ward. The ward had closed 2 beds during March in order to continue carrying out anti-ligature work. The staffing levels were safe.

19 wards were over 105% of their safer staffing levels in March. Reasons for this vary and include advanced implementation of revised Safer Staffing levels and increased clinical need. The reasons for the increased clinical need seemed appropriate, and the nursing team is working with wards to undertake interim checks and challenge.

2.2 Safer Staffing Deep Dive – February 2016

A deep dive to further explore deviances from planned safer staffing numbers was carried out for the February 2016 safer staffing report. This included the wards showing the greatest deviation up and down from planned staffing - Applewood, (89.1% of planned staffing filled in February), and Elizabeth Cason House, (134.6% of planned staffing filled in February).

Information considered in the review was admission and discharge rates, occupancy rates, incident rates and a review of all service users' clinical records for the time period, including review of engagement and observation rates.

2.2.1 Applewood

The ward has had lower bed occupancy throughout this period. The current planned safer staffing levels for the ward are 7, 7, 7 based on 18 beds. The ward has only had 16 beds open therefore have staffed the ward to 6, 6, 6 on the majority of shifts, (with 7 staff on some shifts where rosters had already been agreed).

The level of staffing would be appropriate for a 16 bedded ward taking into account the unit also covers the 136 provision for Swindon.

The incident rates and levels of observation do not indicate that the ward would have needed any additional staffing during this period in order to manage any increased clinical need.

2.2.2 Elizabeth Casson House

A review of staff by shift shows that the ward has attempted to work to 6, 6, 6 throughout the time period covered. This would be consistent with achieving their revised safer staffing numbers plus 1 per shift to accommodate the 2 x1 observation (which was validated as being necessary). This would account for the 118% over planned staffing for unregistered staff on night shifts.

Additional extra staffing on day shifts of 49% over planned staffing for unregistered staff on day shifts.

3 Nursing Audits

3.1 DPAR

The DPAR checklist measures the completion of the DPAR for all inpatient wards weekly.

Results for April audits show that 94% of wards have submitted the checklists weekly. 2 wards have not submitted any results in April 2016, Fairfax Ward and Amblescroft North. This is now

the 4th month that Fairfax Ward have not submitted. Clinical Directors will be asked to account for non-returns at the Extended Executive Team meeting.

- Overall compliance is 95.07% for an audit sample of 1476 records

There has been an increase in the number of "blank boxes" reported, with an increase from 8.46% in March 2016 to 9.42% in April 2016, based on the number of submissions per ward. This equates to 139 charts with blank boxes in April 2016, compared to 141 in March 2016.

10 wards achieved 100% completion of DPAR's in April 2016 compared to 12 in March 2016.

Wards which have consistently shown high performance in this area will now reduce the frequency with which the checklist is completed to monthly. This is Whittucks Road and New Horizons.

The Associate Director of In-patient Nursing will take this forward as a priority action to include daily checking and regular scrutiny.

3.2 Medicines Storage

A weekly Nursing Medicines Storage checklist should be carried out on all wards. The checklist covers compliance with medicines storage in 3 areas; availability of appropriate storage devices, that medicines are stored in the appropriate device and that all devices are clean, tidy and all medicines are in date.

92.1% of wards have completed the checklist in February 2016. Those who have not completed are Beechlydene, Siston and Applewood Ward and this is actively being followed up.

Overall compliance is 98.88%.

Non-compliant areas remain the same, where wards do not have space for enough physical storage for individual storage devices for each type of medicine, e.g. Patients Own Drugs, To Take Away, Stock, etc. and separate areas of the same cupboard are used for different medicine types; and where illicit substances are required to be temporarily stored on the ward awaiting destruction.

It is suggested that the results of the Nursing Medicines Storage checklist will be reviewed monthly by the Nursing Directorate and reported by exception to the committee in the future as levels of compliance are high.

3.3 Rapid Tranquilisation

Monthly checks are carried out on all incidents of Rapid Tranquilisation in the Trust focusing on the areas of practice identified as of concern in the Trust wide Rapid Tranquilisation Audit carried out in October 2015. The following are the results of the March 2016 checks:

There were 42 incidents of Rapid Tranquilisation in January 2016, this is almost double the amount reported in previous months.

3.3.1 Positive Behaviour Support Planning

96% service users had a care plan in relation to the prevention / management of violence & aggression, making reference to RT and restraint which they were involved in where appropriate. Only 1 service user did not have a care plan, on this occasion the rapid tranquilisation was administered on admission and therefore no care plans had been developed at that time. Of the care plans present only 50% met the requirements of a Positive Behaviour Support Plan, this shows a decrease of 23% compared to February 2016.

3.3.2 Physical Observation Monitoring

Physical observation recording pre-rapid tranquilisation significantly increased from February, (24%), to March, (67%). All instances where observations were not recorded pre-rapid tranquilisation occurred in Bristol and South Wiltshire, this mirrors results from February and

therefore the Practice Development Nurse for Physical Health will undertake targeted work with wards in these areas.

Physical Observation recording post- rapid tranquilisation also significantly increased from February, (9%), to March, (42%).

The Trust Matrons have developed a Quality Improvement Plan targeted at improving practice in physical observations when using restrictive interventions. Matrons will be asked for updates on progress in implementing the plans, with the expectation that all appropriate improvements will be delivered by the end of quarter 2.

4 Safewards

100% of wards have now commenced implementation. A further quality objective has been developed relating the implementation of Safewards. All wards will implement all 10 Safewards Interventions. A quality tracker has been developed to track this throughout the year including trajectories. Currently the tracker show that the Trust is above target for implementation of interventions in May 2016.

5 Infection Control

An outbreak of confirmed Norovirus occurred on Laurel Ward on 28th March 2016. The outbreak affected 15 service users, all of whom showed symptoms on the 28th March 2016. An RCA is underway, the incident was responded to appropriately and improvement actions were immediately taken in respect of hand hygiene training and the removal of scatter cushions (which **may** have been contributory).

6 Strategic Workforce Group

The Strategic Workforce Group last met on 3 May. The Group reviewed the following:

- Workforce Report (including in depth discussion about training compliance amongst bank staff)
- Staff Survey Action Plan
- Building a culture of gratitude and thanks
- Workforce Race Equality Standards

6.1 Workforce Report

6.1.1 Appraisal rates (target 95%)

Appraisal rates for 2015/16 across all localities were high. Bristol, Swindon and Wiltshire did not achieve 95% completion. The target of 95% of staff receiving an appraisal remains for the coming year.

6.1.2 Supervision rates (85%)

Wiltshire was the only area not to achieve compliance with supervision target. The target of 85% of staff receiving monthly supervision remains for the coming year.

Staff Survey Action Plans 2016/17 include improving the quality of supervision and appraisal.

6.1.3 Locality statutory and mandatory compliance rates - substantive staff (April 2016)

Compliance with statutory and mandatory training is significantly improved and focus is maintained through direct alerts to individual members of staff advising them that training will soon expire. Reports on Ourspace makes training compliance visible and are updated monthly.

The areas showing poorest compliance relate to moving and handling training. Training was changed mid-year to make training more relevant to staff groups. Training compliance for

practical patient handling and safe assistance of moving patients will be achieved in the coming year.

Subject matter experts are working with the Learning and Development Team to address remaining areas of non-compliance

6.1.4 Bank staff compliance with statutory and mandatory training (April 2016)

Overall, compliance with statutory and mandatory training for bank staff remains poor. Further analysis will be conducted to understand levels of compliance amongst staff that have worked within the Trust over the last two months to provide a more accurate picture and identify potential risks.

Colleagues from the Bank Team attended the meeting to describe actions taken to improve compliance. The Bank Team have successfully recruited additional people to join the bank; recruitment initiatives have included establishing the Student Bank to allow those training to be a nurse or allied health professional to work in AWP alongside their training.

This influx of bank staff has increased induction and training requirements. Actions taken to improve training compliance include accepting equivalent training from other organisations and 'hosted' e-learning days to support bank staff to undertake training. The L&D team and Bank Team continue to work collaboratively to address training challenges and ensure appropriate provision.

6.2 Staff Survey Action Plan

The Staff Survey Action Plan was presented to the SWG. The plan includes three priority areas:

- Quality of supervision and appraisal; access to learning and development
- Dignity at Work
- Health and Wellbeing

The plan includes actions under each heading. The Director of Nursing and Quality is responsible for the Staff Survey Action Plan and each action has a responsible lead. The benefits of each action are clearly articulated and impact measures identified.

Discussion focused on the specifics of the Health and Wellbeing CQUIN. The Group recommended investment in dedicated resource to ensure delivery of the CQUIN locally. Appointment of Trust Health and Wellbeing Lead is underway.

The Culture of Care Barometer was discussed. Managing Directors recommended Quality Directors take the lead on the deployment of the questionnaire.

Establishment of a local Staff Experience Group was discussed. A Staff Experience Group has already been established in Swindon and Secure Services. Agreement will be reached on this proposed development at the next meeting of the Strategic Workforce Group (6 June 2016).

Final sign off of the Staff Survey Action Plan will be achieved on 6 June 2016.

6.3 Building a culture gratitude and thanks

The Strategic Workforce Group received a report describing the recently launched AWProud Campaign, an update on the Team of the Month programme and an update on the Staff Awards which go live on Monday 16 May.

These initiatives are embedded within the Staff Survey Action Plan.

6.4 Workforce Race Equality Standards

The WRES has been included in the NHS standard contract, and the Care Quality Commission will consider the Standard in their assessments from April 2016. A report has been produced to provide a full 2015-16 years' data against the WRES indicators and highlights any changes/

improvements since 2014-15. As a key contractual requirement, the full report will be appended to the June Clinical Executive Report for consideration by members of the Quality and Standards Committee.

6.5 Workforce Retention

Strategic Workforce Group maintains focus on retention. Strategies to retain staff were described in the HR report to Board in April 2016. Analysis of turnover data to understand underlying trends will allow focussed retention activities appropriate to the staff group to maximise impact. An update will be provided in the next Clinical Executive Report.

7 SUI Update

There were 5 serious incidents reported to the commissioners in April 2016, as follows:

Incident type	Number of incidents
Unexpected death of community patient*	2
Serious self-harm	1
Slip/trip/fall resulting in a fracture	1
Allegation against healthcare professional	1
Total	**5**

*One of these incidents occurred in March 2016, but was reported to the Trust in April 2016.This incident involves the death of a man who had a one-off assessment by AWP A&E Liaison services prior to his death, prior to referral to services in his home town outside of AWP's catchment area.

8 Quality Tracker

The Quality Tracker has been developed to support the Trust and Clinical Executive in maintaining a focus on the high priority quality improvement areas or issues for the Trust. It is designed to provide greater visibility on actual progress and ensure momentum is sustained to achieve improved outcomes within planned timescales. The Quality Tracker is owned by the Integrated Governance Group and reported quarterly to the Quality & Standards Committee.

The 2015/16 Quality Tracker has now been closed and the 2016/17 has been developed. Quarter 4's plan saw some items removed as they had been achieved and the 2016/17 plan has new items to track that either build on achievements or are new areas of focus. Key achievements relate to triangle of care, safer wards, Carer's Charter, quality of the clinical record. Key additions/migrated items include:

- As the Safer Wards initiative has now been implemented, the focus will now be on the implementation of the 10 modules that make up this initiative.

- The carer's charter is being relaunched as it has become evident from our carers that this has not had the impact that we wanted it to achieve, the relaunch is being developed by the Carer Forum. The tracker will monitor the progress of the implementation plan.
- Accessible information standard implementation plan will continued to be monitored.
- Local medicines optimisation plans
- Contract penalties relating to serious untoward incidents have been added to the plan.
- The sign up to safety plan will now track the implementation of our safety pledges.
- Priority 1 and 2 audits have been added.
- Seclusion improvement plan has been added.
- Mazars' implementation plan has been transferred.

9 Seclusion Audit

A substantial audit of seclusion practice in the Trust has been undertaken by a staff grade doctor and the results were considered at the Integrated Governance Group. Overall, the audit showed many areas of poor clinical practice in respect of seclusion and in particular highlighted data recording issues, environmental issues and issues of physical healthcare monitoring.

The group agreed immediate actions to be taken through the matron's network and that this would be the priority focus for the June Quality Forum. The output of this work, together with the action plan will be monitored through the Quality Tracker (as detailed above).

10 Service User Forum

The Service User Forum has requested a workshop event to fully debate and consider the content of the new Service User and Carer Strategy and this is being organised for June 2016.

The Forum was pleased to welcome Mark Doughty of the Centre for Patient Leadership to its last meeting and has invited Mark to submit a proposal to provide developmental support to its work.

11 Carer's Forum

The Carer's Forum is working hard on the development of an implementation plan for the new charter.

12 Quality Impact Assessments

The first quality impact assessments for the 2016/17 have been submitted to the Clinical Executive for review.

13 Risk Register

The Clinical Executive would wish to bring to the Board's attention the risk it is managing in relation to the lack of clarity about S136 provision post June 2016 when the police introduce their new protocol and is working with Commissioning colleagues in relation to this.

The Clinical Executive's priority is on improving care planning, physical observation practice and focussing particularly on the issues of restraint and seclusion.