Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board		Date:	29 June 2016

Agenda item	Title	Executive Director lead and presenter	Report author
BD/16/75	Clinical Executive Report	Tim Williams and Andrew Dean	Linda Hutchings

This report is for:	
Decision	
Discussion	
To Note	X

History

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

Executive summary of key issues

This report contains an analysis of the key issues that the Clinical Executive wish to bring to the Committee's attention relating to quality and risk

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

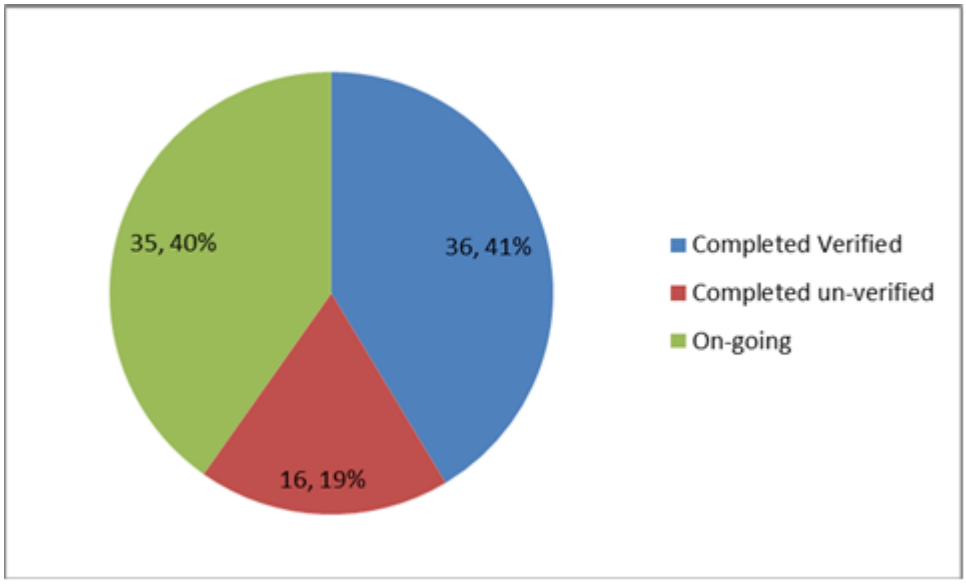
1 Care Quality Commission

During the 2 weeks of inspections between the 16th and 26th May the CQC programme team compiled daily reports from the teams that were visited. The programme team also retained both clinical and estates support teams who could provide immediate fixes for inspection concerns raised during the day. The aim of the reports were:

- Daily intelligence as to the themes from inspections, providing the next teams to be inspected with crucial information.
- Daily ability to fix simple issues.
- Daily ability to show the CQC our 'responsive' ability as an organisation.

The CQC team continue to work on the concerns highlighted by the inspection process with the compliance team, including the Nursing Director visiting sites to check that changes are evidenced and embedded.

Actions Completed dated 13th June 2016



CQC	
Concerns Raised	87
Completed Verified	36
Completed un-verified	16
On-going	35

2 Nursing

2.1 Safer Staffing

During April 2016 there were 2 wards under 95% overall for safer staffing. These were Kennet Ward and Applewood Ward.

The Safer Staffing review has changed Kennet Ward staffing numbers from 4 to 3 at night. The implementation of this was agreed to come into effect as of June 2016, however the ward have reported that they have been working to their revised Safer Staffing numbers in advance of implementation.

Applewood Ward have continued to have closed beds during April including closure of 2 beds in previously shared rooms, the ward have therefore not filled shift vacancies and worked with less staff to reflect lower occupancy rates.

18 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.

A deep dive into staffing on wards with the lowest and highest deviations from planned staffing in March was carried out and the results described below. A further deep dive will be carried out into staffing in April for Whittucks Road, (staffing 93.8% of planned staffing), and Cary Ward, (127% of planned staffing). The lowest and highest deviations from planned staffing in March 2016 were again Applewood and Wellow wards, however for both wards the narrative provided for staffing levels is supported by the previous deep dive and therefore the second lowest and highest deviations have been chosen.

No incident forms were completed regarding Safer Staffing in April 2016.

2.2 Safer Staffing Deep Dive – March 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 high deviation up and down from planned staffing. Dune Ward, (95.2% % of planned staffing filled in March), and Wellow Ward, (126.6% of planned staffing filled in March).

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.

Dune Ward:

The ward has had lower bed occupancy throughout this period. The current planned safer staffing levels for the ward are 4, 4, 3 based on 10 beds. The ward has had significantly lower bed occupancy during the period reviewed and therefore lower staffing levels would be appropriate.

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.

Wellow Ward:

Following the Safer Staffing review the ward have agreed staffing numbers of 5 staff on day shifts and 4 on night shifts. Current reporting levels are for 4 staff on day shifts and 3 on night shifts. The ward have implemented their revised staffing numbers in advance of the implementation date of June 2016.

Additional staffing above 4 at night includes the requirement for additional staffing for seclusion and continuous observations and close intermittent observations, including periods of 5 minute observations. The ward has additional allied health professionals available during the day to support the ward hence a greater level of nursing staff required at night.

3 Nursing Audits

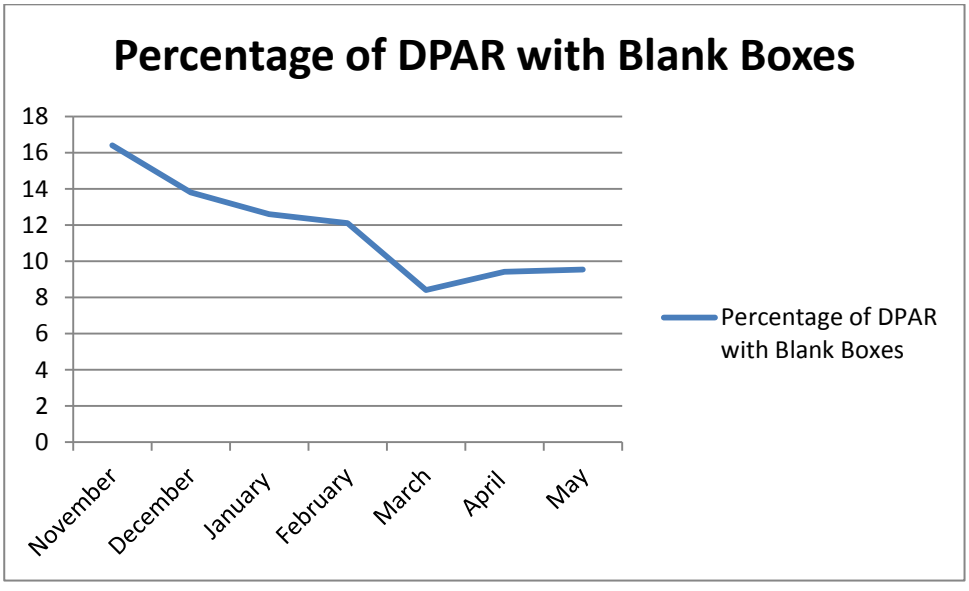
3.1 DPAR

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

Results for May audits show that 100% of wards have submitted the checklists.

- Overall compliance is 95.49% for an audit sample of 1384 records

There has been an increase in the number of "blank boxes" reported, with a slight increase from 9.42% in April 2016 to 9.54% in May 2016.



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

Whittucks Road, Dune Ward, New Horizons and St Martins Ward 4 all achieved 100% compliance in both April and May.

A review of quality improvement plans with Modern Matrons was carried out by the Executive Director of Nursing and Quality on 24th May 2016. Further actions were put in place including daily ward manager spot checks of DPARs.

A review of the results of the checklists carried out since 24th May has not shown a significant improvement in blank boxes with 8.21% of charts reviewed having 1 or more blank boxes.

The Director of Nursing and Quality is personally intervening to secure improvements in clinical practice identified from these audit results.

3.2 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 April 2016 checks:

There were 41 incidents of Rapid Tranquilisation in April 2016, however the audit process identified that Rapid Tranquillisation had been administered on other occasions but had not been reported via the incident reporting process.

Positive Behaviour Support Planning

93% 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. 2 service users did not have a care plan related to the management of violence and aggression. Of the care plans present 66% met the requirements of a Positive Behaviour Support Plan, this shows an increase of 16% compared to March 2016.

Physical Observation Monitoring

Physical observation recording pre-rapid tranquilisation significantly increased from March, (67%), to April, (71%).

Physical Observation recording post- rapid tranquilisation significantly decreased from 42% in March to 15% in April.

A review of quality improvement plans with Modern Matrons was carried out by the Executive Director of Nursing and Quality on 24th May 2016. Further actions were put in place including ward manager checks in real time of every incident of rapid tranquilisation and direct feedback and performance management for staff involved if necessary. The Associate Director of Nursing – Inpatient will also review the Trust Rapid Tranquilisation training.

The Trust procedure for Rapid Tranquilisation is currently under review to bring practice in line with NICE guidelines which limit the definition of rapid tranquilisation which should provide greater clarity to staff on when to apply the procedure. The procedure will also give guidance on the monitoring of physical observations when administering certain PRN medication which would previously have been termed rapid tranquilisation.

The risks relating to continued poor compliance with the current Trust policy have been added to the Clinical Executive Risk Register.

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 continues on target for implementation of interventions in June 2016.

5 Infection Control

Threadworm

A confirmed case of Threadworm has been reported at Vinney Green, where AWP staff work as part of a multi-provider service for CAHMS. AWP Infection Control staff have been involved with Public Health England in incident management groups and AWP staff at risk will be treated according to Public Health England guidance as a precaution.

Norovirus

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 and the initial findings from this are as follows:

- The Ward responded immediately to the outbreak following all appropriate processes and procedures. This meant that the outbreak did not spread to neighbouring wards.

- The ward training figures for practical hand hygiene training were low, although the ward had 100% compliance with infection control e-learning. The ward Infection Control Link Practitioner had left and the new Link Practitioner had not yet been inducted. This has now taken place and the Link Practitioner is undertaking Hand Hygiene training as a priority on the ward.

- During the last infection control audit it was highlighted that the staff were not always practicing bare below the elbow. This formed part of the action plan which was addressed by the ward manager and there is no evidence to suggest that this was a specific issue in this case.

- The ward had a number of scatter cushions. These could have contributed to the quick spread of infection despite a washing schedule being in place. These have now been removed.

- Staffing on the ward post outbreak was very low which may have impacted on the team ability to keep symptomatic service users isolated.

6 Strategic Workforce Group

The Strategic Workforce Group last met on 6 June. The extended Strategic Workforce Group was chaired by Tim Williams, Medical Director. The focus of the meeting was:

- Workforce Planning
- Workforce Development
- Staff engagement and culture

6.1 Workforce Planning

Workforce planning priorities include improved retention of staff (work-life balance is the primary reason for leaving) and improved productivity (use of technology, administrative burden and proportionality of training and supervision).

Current actions to improve workforce planning:

1. Implementing revised staffing model
2. Career Framework
3. Apprenticeship programme

Actions to be progressed:

1. The Strategic Workforce Group will request an update from the following:
    - Technology Programme Board – progress with respect to mobile/ agile working
    - Purposeful Recording Project – reducing administrate task related to care
    - Meridian Productivity Programme – understand roll out of productivity programme and request updates on realisation of benefits

2. The Strategic Workforce Group will focus on improving work-life balance. Recommendations will be sought from Locality Staff Engagement Groups and the Trustwide Staff Engagement Group on how to improve work life balance.

The revised Workforce Strategy will take account of the AWP clinical strategy, Sustainable Transformation Plans and apprenticeship Levy (delivery date September 2016).

6.2 Workforce Development

Statutory and mandatory training compliance is high across the organisation. As a specialist mental health provider we wish to have greater focus on essential skills training and will direct investment to ensure learning and development improves care quality, supports service development and manages organisational risk. Individual competence must be assured in relation to job role.

Analysis of investment on workforce development spend indicates considerable spend on non-mandatory training across the organisation but there is limited coordination or planning to direct this investment in accordance with organisational need and priorities.

Current actions to improve workforce development:

1. Nurse revalidation (competence assessment)
2. Certificate of Fundamental Care (competence assessment)
3. Bursary panel manages the allocation of limited funds in accordance with agreed criteria.
4. Revised appraisal form will increase visibility of the full range of learning and development opportunities.
5. Career Framework will create Trust wide standards in relation to practitioner skills, competencies and associated training.

Actions to be progressed:

1. The Strategic Workforce Group will agree a coordinated Trust wide approach for the allocation of non-mandatory training places to maximise investment impact (e.g. Quarterly Training Investment Panel to allocate training places, map investment Trust wide and measure impact).

6.3 Staff Engagement and Culture

Implementation of a 'Culture of Care Barometer' survey tool was agreed by Board as a means of measuring team, locality and organisational culture. The barometer complements the annual staff survey and will be used to identify actions to improve staff confidence and experience. A phased roll out plan commenced on 13 June 2016. Planned Staff Experience Groups will be instrumental to ensuring shared ownership for survey results, actions and delivery.

Localities have differing opinions on the value of Staff Experience Groups. The Medical Director requested that managing directors attend the Swindon Staff Experience Group to understand the benefits of a well-functioning group.

Current actions:

1. Phased implementation of the Culture of Care Barometer.

2. Staff Experience Groups have been established in the following localities: North Somerset, Secure and Swindon Localities. Terms of reference circulated.

Actions to be progressed:

1. Full implementation of Staff Experience Groups and the launch of the Trustwide Staff Experience Group by September 2016.

2. Mayur Bhatt to support Localities to understand the experience of staff from black and minority ethnic groups and identify appropriate actions.

Summary

To enable the SWG to operate effectively a single workforce dashboard is required to capture key metrics in relation to the workforce planning, development and staff experience and culture. This dashboard will focus the work of the group and ensure priorities are agreed and addressed. In addition, the revised Workforce Strategy will reflect workforce objectives and inform the work plan of the Strategic Workforce Group. Both developments will now be progressed as a priority.

7 SUI Update

An incident which occurred in April 2016 was reported to the commissioners in May 2016. As it is an April incident it is not included in the table below. This incident encompasses three different aspects: problems with the availability of transport to transfer a patient to the bed identified for him; assaults on two staff and the loss of the service user's tooth at some point either during these events or possibly during the subsequent restraint. The initial incident report did not include all the details of these events and the Trust needed to review and pull together all the information available before it could determine that the incident (in its entirety) was reportable.

Information for May 2016

The serious incidents reported to the commissioners in May 2016 are as follows:

Incident type	Number of incidents
Unexpected death of community patient	8
Serious self-harm	4*
Assault on a member of the public	1
Allegation against healthcare professional	1**
Total	**14**

*This includes one incident where the service user did not come to serious harm, but the incident was reported as potentially serious because she took an overdose on Imber ward using medication she allegedly obtained from the ward medicines trolley while unobserved by staff.

**This incident relates to an allegation that an inpatient was subjected to an inappropriate search. It also occurred on Imber ward and involved the same patient as the overdose detailed above.

Update on Aspen Ward Incident

Q&S have requested an update on the unexpected death on Aspen ward which occurred in March 2016. An inpatient was found with a ligature around his neck in his bedroom. His belt had been tied to the frame of a fold-up bed which was stored in a cupboard. CPR was undertaken and an ambulance was called. The man was transferred to an acute hospital, but subsequently died.

The Root Cause Analysis investigation is underway and the Trust has taken the following immediate actions in advance of the publication of this report:

1. The fold-up bed was removed from Aspen (it had been installed in case relatives should need to stay with a patient on the ward, but had not been used for this purpose in some time).

2. There is one room on Laurel that has a drop-down bed in a cupboard (similar to Aspen had), however this is currently not in use due to the issues with the bed and lock (not in use since the Aspen incident). A works request has been submitted to remove both the bed and cupboard completely, as it is rarely used, and the ward have other means of supporting relatives to stay for end of life care. They are able to keep this room out of use whilst awaiting this works to be completed, due to the 20-bedded ward now being commissioned for only 18 beds.

3. An immediate safety alert was issued on the subject of checking that double doors are securely locked. The alert predates the conclusion of the RCA investigation and does not specifically refer to this incident. Instead it gives more general advice about

    - The risks to patient safety and security which arise from doors that are not properly secured
    - How these risks can be avoided.

8 Imber Ward Update

A matron has been appointed to lead a turnaround programme at Imber Ward. Additionally, we have recruited a number of interim registered nursing staff to work with the substantive team to improve stability and continuity of care. A number of recruitment initiatives are underway to move to a substantive workforce as soon as possible

The matron is working alongside the Nursing and Quality directorate to improve and develop nursing practice on the ward, this involves training as well as culture and competency work.

The temporary bed closures are being reviewed and plan being put in place to incrementally re-open them.

There are regular meetings with the Wiltshire triumvirate and onward reporting to the CCG.

9 Mortality Review Process

The Critical Incident Overview Group approved a mortality review flowchart at its June meeting. This stipulates the criteria of cases for review and the review mechanism. The plan is for the reviews to be conducted by Medical Leads and this is going to the next TMAG meeting for discussion and agreement.

10 National CQUINS

The Trust has agreed the following leads for the national CQUINS and draft plans have been submitted to Commissioners via the Quality Sub Group for approval. They are:

1a – Introduction of health and wellbeing initiatives - Rachel Clark

1b – Healthy food for NHS staff, visitors and patients - Adrian Bolster and Christian Lee

1c – Improving the uptake of Flu Vaccinations in front line clinical staff - Alan Metherall

3 – Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) – Rebecca Eastley.

11 Service User and Carers Forums

In response to the individual forum requests, a workshop event to fully debate and consider the content of the new Service User and Carer Strategy has been organised for 7 July 2016 in Keynsham.

12 Clinical Audit Annual Report/Plan

Clinical audit is an integral part of the Trust's systems and processes for quality improvement. The Nursing and Quality Directorate, has taken the lead role in governing the clinical audit work plan. Local Delivery Units (LDUs) are responsible for developing their own Clinical Audit Priorities which are incorporated into the annual Trust Work Plan, supported by the Clinical Audit and Improvement Team.

The 2016-17 Work Plan has been developed in conjunction with the LDU triumvirates and professional leads. National Audits are included; otherwise the plan is based on local priorities and other Trustwide quality improvement priorities, particularly CQUINS. Work planning has been far easier this year because the Clinical Audit and Improvement Team can now also register surveys and other quality improvement projects, if they are in the interests of service users, and there is less emphasis on getting LDUs to agree their priorities at the start of the year. Following feedback from the LDU Triumvirates the work plans are more responsive to needs as they arise.

The Clinical Audit department will continue to focus on delivery and continued development of the annual plan for 2016/17 as set out in Appendix 1, but with less emphasis on locality and clinician initiated projects (focusing instead on adding these as they are needed through the year, as many get removed). The current plan (Appendix 1) remains live so only reflects the progress achieved in discussions with localities up to end May 2016 and is subject to change. Aims are similar to last year, as they are set out in our Clinical Audit Strategy 2013-16 which forms part of the AWP Quality Improvement Strategy 2013-17.

The Committee is asked to approve the Clinical Audit Plan.

13 Quality Impact Assessments

The Clinical Executive have considered 12 quality impact assessments and 6 have been approved to date, the remainder returned for further work or clarification. There are many more assessments trickling through for review

14 Risk Register

The Clinical Executive would wish to bring to the Board's attention their concern about S136 risks in view of information that has come to light that patients have been detained in excess of 72 hours without assessment. This has identified that there are no clear systems in place to monitor S136 detentions, no database for S136, no co-ordination of data regarding detentions and no escalation protocol to engage senior executives as necessary as the legal time limit starts to expire. At the time of writing, the identification of this risk is new and the Clinical Executive are responding to it and a verbal update on actions underway to manage this risk will be provided at the meeting.