Trust Board	Date:	29 March 2017

Agenda item	Title	Executive Director lead and presenter	Report author
BD/16/268	**Clinical Executive Report**	**Andrew Dean, Deputy CEO & Director of Nursing & Quality**	**Phil Cooper, Associate Director of Governance, Improvement and Quality**

This report is for:	
Decision	
Discussion	
To Note	X

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

Executive summary of key issues

Summary of CQC current position

The Committee considered the current CQC position and a detailed report to Quality and Standards Committee will be provided in April 2017 meeting.

Safer Staffing Analysis:

The Committee noted an improvement in Safer Staffing numbers and considered the overall improvement in the number of wards managing within 5% tolerance.

Drug Prescription and Administration Record (DPAR) Analysis:

A further reduction in compliance which has been identified as inaccurate and inconsistent data reporting. A new audit tool is in development, which will address the deterioration.

NEWS Physical Observation Monitoring Pre and Post RT Analysis

The Committee considered the overall improvement in recording for pre and post RT physical health monitoring.

Clinical Executive Report

The Committee considered the format of the Clinical Executive Report and agreed to move to a new model of reporting in April 2017 meeting.

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 Nursing

1.1 Safer Staffing

Update for previous month actions:

Rehab service safer staffing review completed and with the required adjustment has now shown all services within parameters of safer staffing which is a significant improvement.

There are a total of 41 in-patient wards which were reviewed for variances with their safer staffing figures for January 2017. There were 26 wards that were within the parameters of 5% above or below safer staffing numbers which accounts for 63.4% of all wards. This is an improvement upon last month and the reduction has been demonstrated in wards showing a variance between 5-10% above or below.

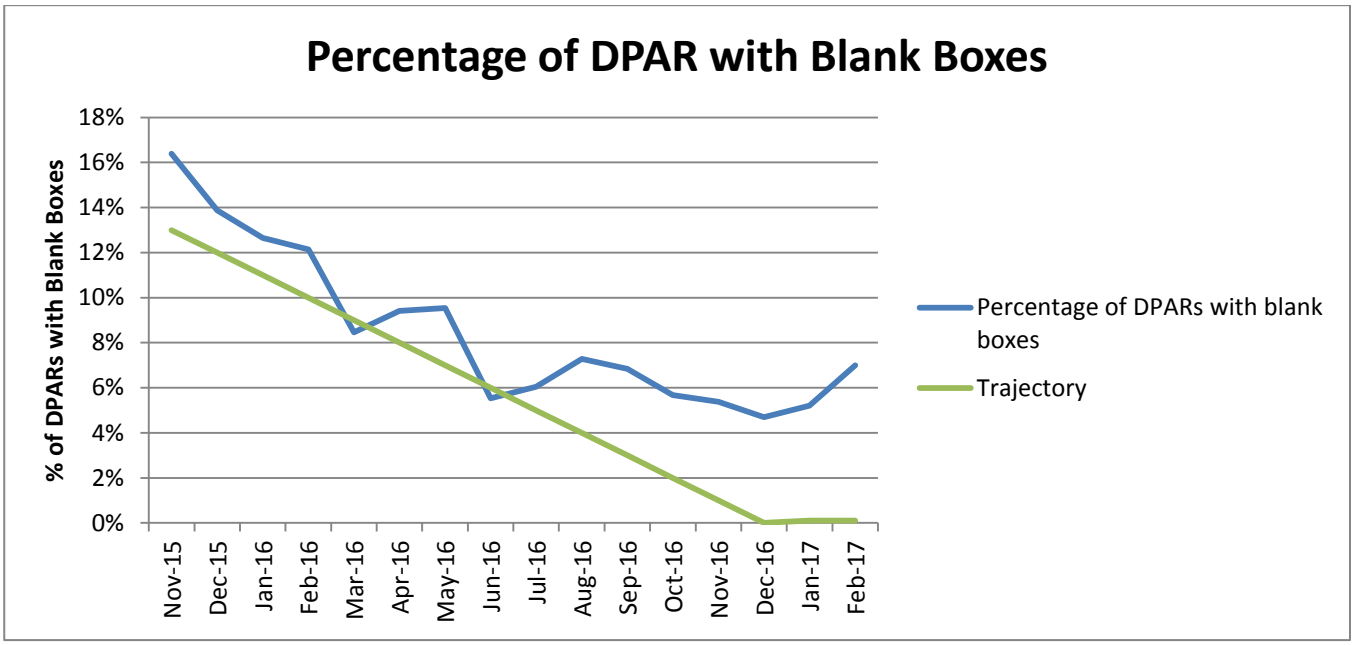
The new recording of observations within RiO commenced last month therefore has been too early to pull data to corroborate ward responses to the differentials however will be used to support responses for the next report.

Plans for the coming month:

- Review of CAMHS safer staffing requirements in line with service changes
- Specialised services safer staffing review to be concluded
- Discuss Secure service variances with Managing Director as although total variances not extreme the variances between Registered and Unregistered staff remains high
- Review recorded levels of observations from RiO report
- Review Amblescroft South use of enhanced observations

Drug Prescription and Administration Record (DPAR).

This month there continues to be an increase in reported blank boxes on the DPAR (December = 95.30%, January = 94.79% and February 93.01%) which is not in line with the predicted trajectory. It is anticipated, that once the audit standards are re-set, the audit tool revised, and there is clear guidance for line managers re: the management of blank boxes in place the number of DPARs with "blank-boxes" will decline in the future.



NB; four wards did not submit any audit results for February 2017

Analysis:

There was a broad spread of non-compliance, with only 10 areas out of 35 (29%) achieving 100% of no blank boxes on the DPAR chart during February. These 10 areas were distributed across all 7 LDUs.

At the beginning of 2017 there was a review of the audit process for blank boxes. This highlighted that the audit tool currently in use required refinement to ensure the data captured is both accurate and meaningful in the future. The tool will be revised this month along with clear standards for wards as to how the audit should be undertaken. Once we are assured the data being collated is accurate and consistent across all wards, this should better inform both trust wide and local actions to significantly reduce the number of blank boxes reported each month in the future.

Actions:

- A review of the audit schedule for wards is to be completed to minimise duplication of information and increase completion rates and engagement by clinical staff (90% engagement over the past quarter) this month
- Ensure trust procedures are clear to ensure both preventative and responsive measures around blank boxes are clear and consistent. This will be supported by the development of a process flow chart to guide managers in the management of blank boxes this month
- An escalation process to be developed to ensure that accountability is held with the individual and ward team
- Matrons/Ward Managers to undertake capability assessments where there is identified poor practice by staff members

- Through the South of England Collaborative Mental Health Quality and Patient Safety Improvement Group we have reviewed both the audit tools and interventions other mental health trusts have successfully implemented to reduce blank boxes. This will help inform our own learning in the future

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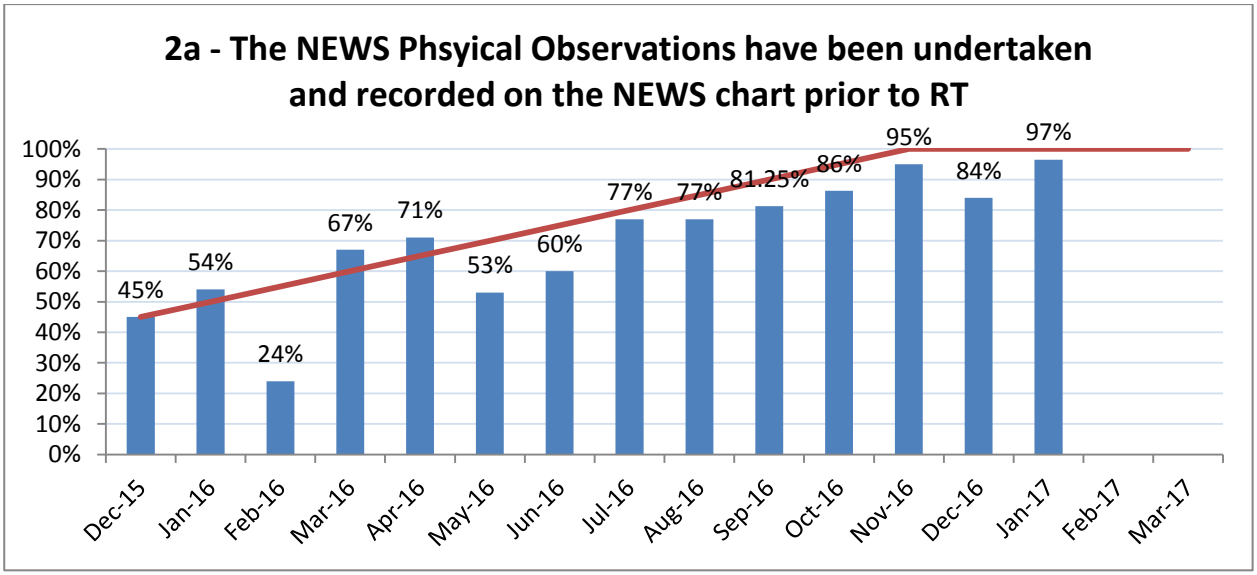
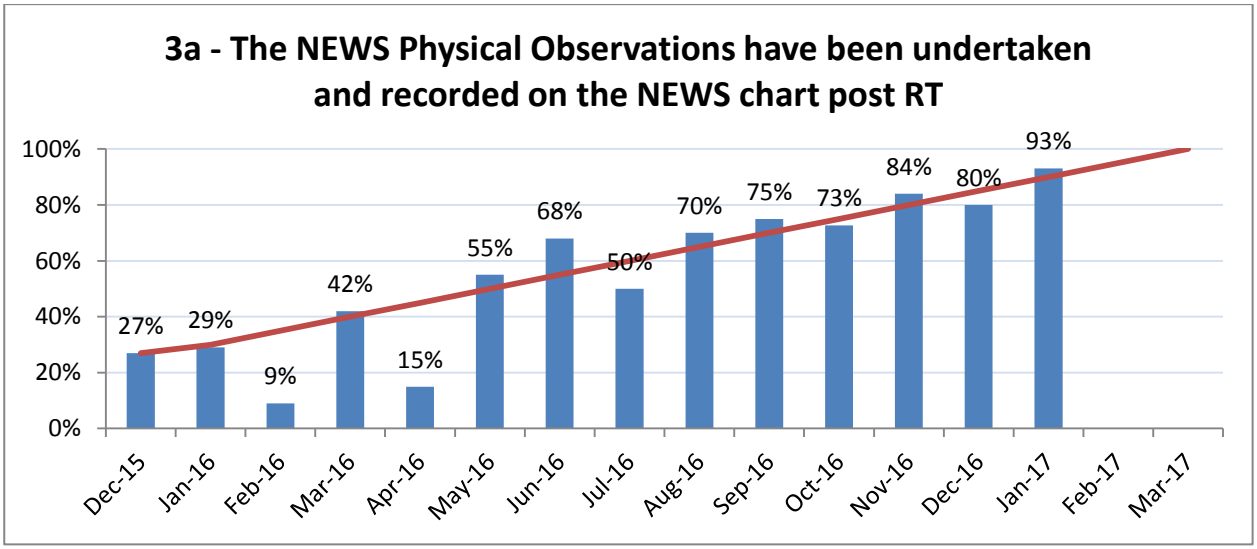
Rapid Tranquilisation (RT)

There were a total of 28 reported incidents of RT during January 2017 which accounted for a total of 22 patients; this is a slight increase to last month but with a significant increase in recording physical observations evident. The highest increase has been within Later Life wards and a decrease within PICU for this month. Where a record was not made there is clear evidence of engagement with the patient pre and post RT and a record has been made to reflect refusal by the patient although Non-contact observation was not articulated.
The 1 episode that was not recorded pre RT was due to the incident occurring at the point of admission to an acute admission ward and staff unable to undertake a physical examination however post observations were recorded clearly.
The 2 episodes that were not recorded post RT – 1 acute admission and 1 later life which were recorded as refused so physical observation was considered but no record of non-contact observation being made.





There were no reports for Ashdown or Hazel male PICU and only 2 episodes of RT for ECH which is a significant reduction from December where there were 8 episodes across the 3 wards. This accounts for 7.1% of all episodes of RT for January.

Actions

- Discuss data review with Managers and Matrons during monthly quality reviews with Associate Director and Head of Nursing for Inpatients
- Review RT against incident and seclusion data especially for Later life given the increase of RT episodes

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Mixed Sex Accommodation

During January there were 4 reported incidents for mixed sex accommodation. All 4 incidents occurred within acute admission wards (2 Applewood, 1 Imber and 1 Beechlydene) whereby a patient required admission or returned from leave and the bed available was of the opposite sex. In 1 incident it was rectified immediately by another patient going on leave freeing up a bed. In the other 3 incidents the Mixed Sex accommodation policy was implemented and mitigating factors were put in place. The environment was placed on enhanced observations and patients on increased 1:1 observation. There were no reported incidents contravening the Trust policy therefore no incidents were reported as breaches for January.

2 Human Resources and Organisational Development

2.1 update

HR and OD Section

The section of the report covers HR and OD and a number of areas which members of the Strategic Workforce Group (SWG) meeting, held on 7 March 2017, agreed the Committee should be made aware of.

Strategic Workforce Group

The SWG meets on a monthly basis with a focus on the development of workforce related strategies, policies and programmes of work, ensuring alignment and coordination of activity to maximise impact.

Regular agenda items include Sustainability and Transformation Plans; Workforce Planning; Recruitment and Retention Activities; Health and Wellbeing; Culture of Care Barometer; National Staff Survey; Leadership and Team Development Training; Statutory and Mandatory Training; Apprenticeship Levy and Career Framework and any other workforce related topical issues.

As advised at the last meeting the terms of reference of the Strategic Workforce Group have been discussed and reviewed and initial discussions held at the March meeting suggesting the Strategic Workforce Group becomes an Oversight Group for the work carried out by the following groups:-

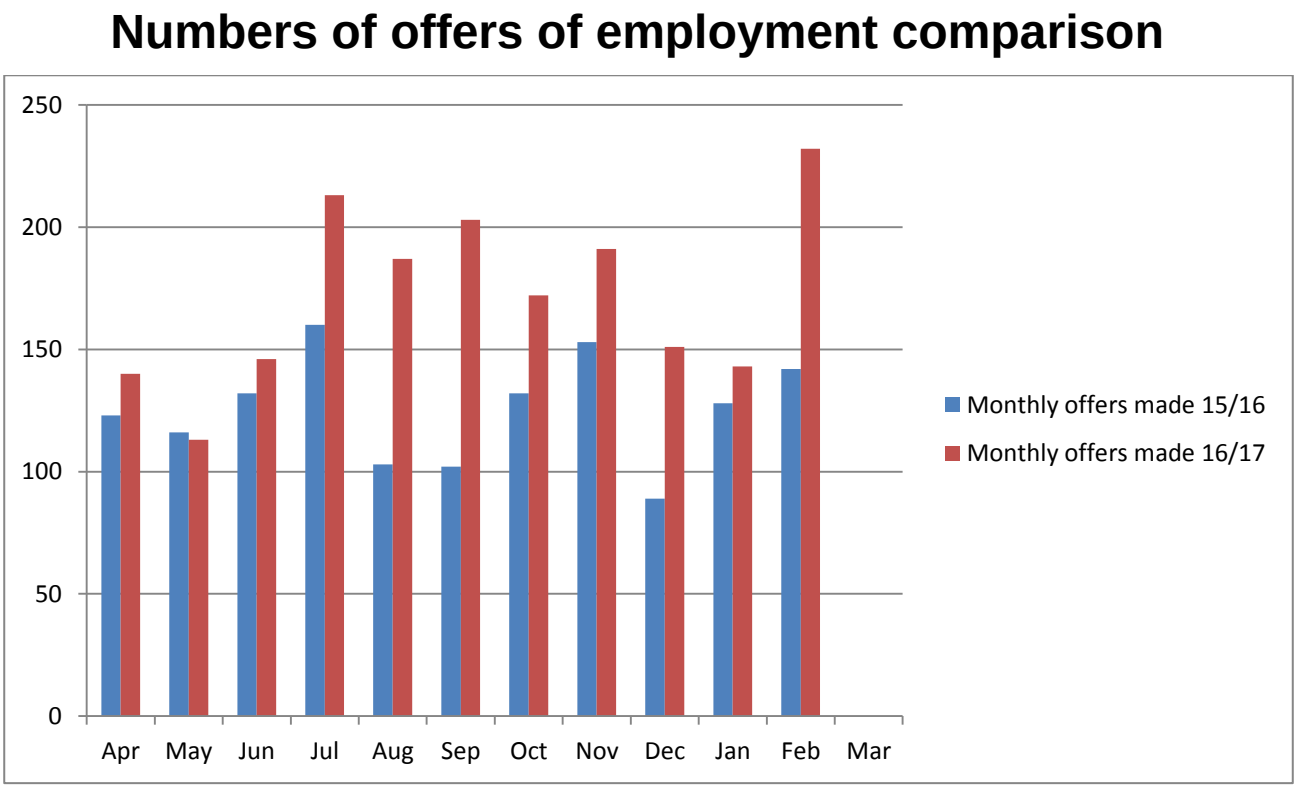
- Workforce planning group

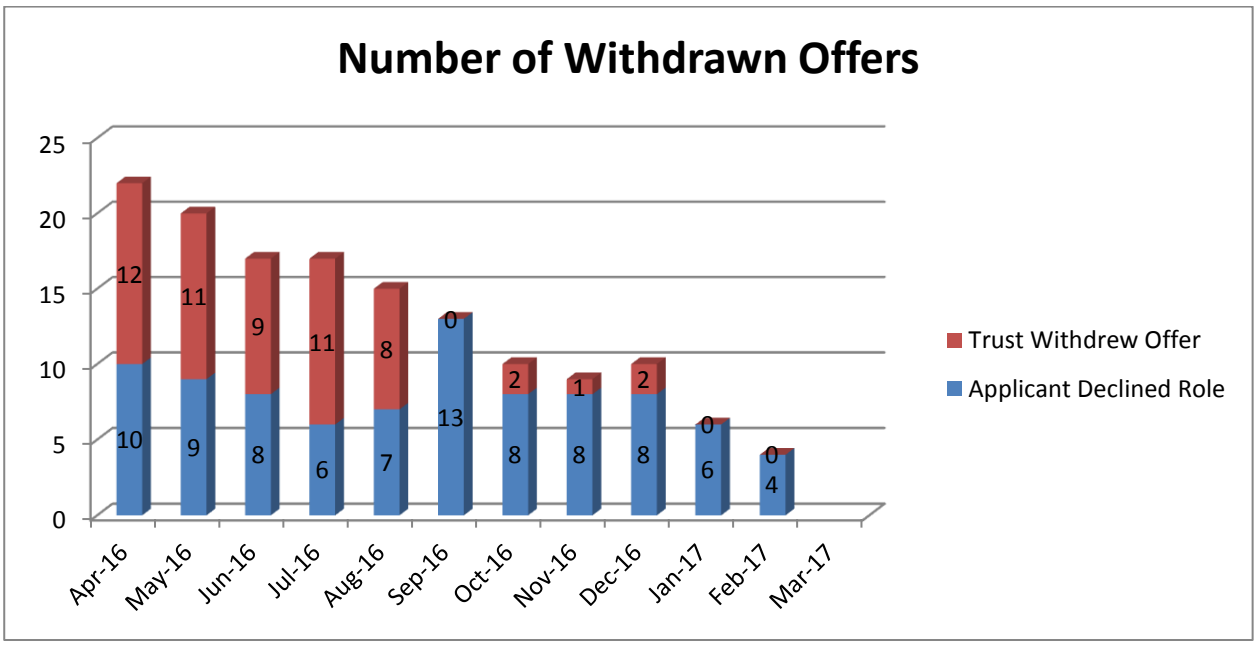
- Recruitment and retention improvement groups
- Other workforce related groups i.e. apprenticeship group

A final proposal with terms of reference will be presented to the April meeting.

Recruitment

The Trust's Employment Lead advised the Group that since the beginning of the financial year until the end of December the Trust had made 1891 offers of employment, compared with the same time last year 1380.





She continued to state that 143 of those offers had either been withdrawn by the Trust as a result of unsatisfactory clearances or failure to respond to clearances, or as a result of the applicant having declined the role for either personal reasons or because they had another role. Compared with the figure of 237 over the same period last year, this is a

reduction in offers being withdrawn or applicants declining the role which is a positive position.

The SWG further heard that 1904 job adverts had been placed compared to 1455 during the same period last year.

The Group were informed that the Trust wide KPI for time to hire from vacancy authorisation to start date as at 2 March 2017 is 78.7 days. The Recruitment Lead confirmed that work is ongoing with TRAC to share comparative data from other Trusts and this will be shared as soon as it is available.

The Group heard detailed feedback from the Trust wide Recruitment and Retention Improvement Group which assured it that it was taking forward a range of actions and the action plan was shared with Q&S last month.

3 Incidents

3.1 Steis Reported Incidents October 2016

For Clinical Executive Report: Information for February 2016

Serious incidents reported to the commissioners on STEIS

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

Incident type	**No. of incidents**
Unexpected death of community patient	4
Serious self-harm	2*
Alleged homicide	1
Patient on patient assault (resulting in serious harm)	1
Total	**8**

*Further details of these two serious self-harm incidents are as follows:

1. A service user was on leave from an AWP acute inpatient ward and was receiving support from Somerset Partnership services at the time of the incident. AWP has reported the incident and is the lead agency in the investigation, but Somerset Partnership are collaborating with this process.

2. A service user was admitted to ITU for treatment and it was initially reported that he had taken an overdose of medication. It subsequently transpired that this was not the case and he was actually being treated for pneumonia. Closure of this incident has been requested and a response from the commissioners is awaited.

A Root Cause Analysis investigation is routinely commissioned for all serious incidents with the exception of:

- Any incidents where the commissioners have agreed that an RCA is not required

- Any incidents of alleged abuse which are being followed up via a safeguarding process.

Additional information on incident reporting and investigation

- An AWP Mental Health Liaison Team assessed a patient on two occasions. He was referred on to Somerset Partnership services and was subsequently admitted to one of their inpatient units. He absconded from this unit and stabbed his mother, who then required hospital treatment for her injuries. Somerset Partnership has reported the incident and is the lead agency in the investigation, but AWP are collaborating with this process.

- Two patients died on an older adult inpatient unit at the end of January. Their deaths are believed to be the result of physical health problems (suicide is not suspected). Resuscitation was attempted in both cases. The usual investigation in such circumstances would be a mortality review. In these cases, however, the ambulance service subsequently raised some concerns about the management of the resuscitation attempts by AWP and acute hospital staff. Consequently an RCA investigation has been commissioned in both cases and input to this process is being sought from the acute trust.

- The CIOG meeting in February noted the National Reporting and Learning Service's (NRLS) comparative report of incident reporting by mental health trusts. This shows that AWP is performing well against its peers. The trust has improved its ranking and continues to report high levels of incidents where no harm came to the service user (a marker of a strong incident reporting culture). The NRLS summary report is submitted with this paper for information.

- The Clinical Executive report in January noted that there had been a small increase in the number of management reports and RCA reports that had submitted late to the commissioners (i.e. beyond the 60 day limit set nationally). In itself this increase was not believed to be significant. In tandem, however, it was noted that the Trust was increasingly requesting 'extensions' on RCA reports This meant that that, in addition to the increasing number of reports which were being submitted 'late', there was also an increase in reports being submitted 'on time', but to a new, and longer, deadline.

  The table below includes updated information on the position reported in January:

Month	Number of RCA reports submitted late	Number of RCA extensions requested	Total submitted beyond the 60 day deadline
Jul 16	0	1	1
Aug 16	1	0	1
Sept 16	0	2	2
Oct 16	1	3	4
Nov 16	0	1	1
Dec 16	1	3	4
Jan 17	2	7	9
Feb 17	0	3	3

Although the table appears to show a decrease in the number of reports submitted late and the number of reports for which an extension has been sought, the situation has actually worsened.

In December and January the reports that were running late were late by a few days and were, therefore, submitted within the same month that they were due. At the end of February, however, five reports were outstanding; four were due to be submitted in February and one was due for submission in January. Consequently reports are now running late by weeks rather than days.

4 Infection Prevention and Control

4.1 Report of data August to October 2016

Infection Prevention and Control and Medical Devices Report February 2017Infections /Outbreaks

New Horison Mother and Baby Unit Southmead Hospital. - 4 bedded unit.
On 22/02/2017 The IC team was informed that two babies had positive results to Norovirus. Infection control precautions instigated including isolation of those affected and enhanced cleaning. As this is the third similar incident since October 2016 and the index cases seem to be siblings or family members of babies, The IC team have advised precautions regarding visiting and home leave. New horizon on this occasion has not been officially closed as isolation was possible. One baby is currently still experiencing loose nappies so precautions remain in place until they are having normal stools or an alternative cause is established.

Legionella at Southmead site

The situation continues to be managed proactively. There have been no cases of legionnaires disease .A capital programme has been developed which involves changes to the water system and is scheduled to start at the end of March. This includes replacement of softening and dosing systems to reduce build up in pipe and biofilm long term.
Replacement of boilers and water heaters which will give greater control of the hot water system. Also some basins will be replaced with automated controls and automated flushing systems.

5 CQC

5.1 Key Areas of risk

The CQC have confirmed the 26 June 2016 as the date for inspection and re-inspection of AWP services.

The CQC are planning which core services they will review, but this will include as a minimum –

- **Wards for older adults**

To complete work to improve our ward dementia friendly environments having benchmarked against National standards and to ensure that there are no variations across the Trust estate.

The Trusts Consultant Nurse for Dementia has developed a draft Dementia strategy and is currently implementing a plan based on the benchmarking data. This plan will deliver changes to the environment ensuring consistent dementia friendly environments across the older adult estate

Low risk and achievable

- **Crisis services and health based place of safety (PoS)**

To have completed environmental work across Trust estate and to have put in place a rigorous and embedded governance process to ensure that there are no breaches to 72 hour rule.

The programme of work across the Trust has been completed with changes made to the PoS estate. Work continues with the wider health community with the risk issues that AWP cannot solve alone. These include:

- Local Authority response to detained person (timescales)
- The number of people detained by the Police
- The number of section 12 Doctors available

The rules around the amount of time a person is detained change April 2017 from 72 hours to 24, which will cause significant pressure on the system. Bed pressures in AWP, although managed well are still significant.

Medium risk and partly achievable

- **CAMHS**

The Trust has completed a 'Week in Focus' and has an update on current performance including a clear understanding of risks to quality of the service position overall. The Trust is also clarifying this position with commissioners outlining a future goals for the service in line with their expectations.

CAMHS continues to be of concern to the Trust and presents a number of risks:

- Issues with Records Quality during period of transfer to the IAPTUS System
- Variable lone working practices across the CAMHS services
- Low morale and a significant disconnect from AWP
- Mandatory training compliance is low overall and the team reported that it is very adult focussed and work is required between L&D and CAMHS to ensure adequate training provision for staff and focus from the managers to ensure completion.
- Estates issues remain unresolved in the Riverside inpatient unit

Medium to High risk and partly achievable

- **Wards for people with a learning disability (the daisy unit)**

The Trust is working to ensure that the unit has a clear position of the service that it is clear in the operational position against our registration as a hospital environment so that

the service can clearly evidence the compliance standards that are used to provide the service.

Low Risk and achievable

- **Well Led and Governance**

The Trust has addressed this, in part, in our response to the section 29A Warning Notice in that the Trust did not satisfy the Regulator that it could understand and identify breaches to the 72 hour rule. The Trust has now developed and implemented systems through RiO to address this.

However, there are wider issues around Governance that have required attention to ensure that our Regulator is confident that the Trust has sight on issues and risks within service provision. These are:

- Full Governance review
- A full review of how risks are managed
- A process for managing quality improvement
- A process for ensuring learning from incidents

Medium Risk and achievable

Theme/Service	Lead	No. of Actions		Completed		On track		Risks Overdue		Overdue/ Concern	
		Must	Should	Must	Should	Must	Should	Must	Should	Must	Should
Governance	Phil Cooper	2	11		4	2	6		1		
Place of Safety	Phil Cooper	7		4		3					
Older Adult Review	Anita Hutson	1	2			1	2				
Seclusion Review	Liz Bessant	3	2			3	2				
Workforce	Mathew Page	2	8		1	3	7				
Leadership	Phil Cooper		3			0	3				
Ligature Reduction Programme	Liz Bessant	2	1		1	2	0				
Estates	Adrian Bolster	1	5		1	0	4				
Medicines Management	Val McElhinney	1	2			1	2				
CPA Compliance	Nicola Hazle	2	16			2	16				
NICE Compliance	Nicola Hazle	1				1	0				
Privacy & Dignity	Liz Bessant	3	2			3	2				

Total		25	52	4	7	21	44		1		

The project team will provide weekly updates to the Executive team through the project

6 Section 136 Place of Safety

6.1 Weighted data

Covering time frame September 2016 – February 2017

		Weighted Population (16-64 only)		Registered Population (16-64 only)	
CCG	Count of detentions in PoS	Population (16-64 only)	Rate per 10,000 head of population	Population (16-64 only)	Rate per 10,000 head of population
B&NES	43	118,317	3.6	132,562	3.2
Bristol	216	355,191	6.1	336,357	6.4
North Somerset	80	113,111	7.1	128,735	6.2
S Glos	59	75,867	7.8	166,385	3.5
Swindon	44	114,498	3.8	150,392	2.9
Wiltshire	58	212,011	2.7	297,306	2.0

Analysis:

Bristol marginally increases with DoH weighting scales, but stays around 6 per 10,000

South Glos increases disproportionally with weighting. This may be, in part, due to borders with Bristol

North Somerset is high with population, but increases with weighting. North Somerset is consistently high and an outlier.

Wiltshire stays low in both weighted and non-weighted

BaNES statistically as expected and similar with weighting

Next Steps

To add mix of where the detainee was initially detained

To understand this against North Somerset and Bristol

For further understand implications for future resourcing decisions