Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board meeting		Date:	31 May 2017
Agenda item	**Title**	**Executive Director lead and presenter**	**Report author**
BD/17/043	Clinical Executive Report	Director of Nursing/Medical Director	Head of Quality and Improvement

This report is for:	
Decision	
Discussion	X
To Note	

History

We have updated the format and information provided in the Clinical Executive based on discussions with the Chair and intentions of the Clinical executive to provide relevant analysis of data that is flexible, meaningful and triangulated with other sources of intelligence where possible. This is a first draft of the updated version and will evolve over the next few months based on comments and discussion.

Additional quality indicators are included in the integrated performance report, these will include:

- Safer Staffing
- Safety Thermometer
- Records Quality Audit
- Place of safety

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

Executive summary of key issues
Patient Safety **Incident investigation** - Inability for the organisation to complete investigations in the required timeframe poses a risk to the quality of the service. The clinical executive proposes a resolution in the paper **Risk – The full summary of risks allocated to the clinical executive are included in the integrated performance report.** 3 risks allocated to Q&S are rated red – Place of safety governance, Inadequate investment in IT and external scrutiny of our governance structure, update and mitigation included in the integrated performance report. **External Visits** - Issues with non-compliance with key stat/man training and activity provision on inpatient wards **QIP –** 2 exceptions reported this month, staffing and recruitment and publication and implementation of updated Search policy. 4 items added to the QIP this month – progress towards 24 hour legislation for PoS, Water issues in Swindon and Bristol, Activity provision across the Trust and Internet provision for service users **The Board is asked to discuss and note the 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 Patient safety

1.1 Serious Untoward Incidents

The Trust has report 8 incidents to STEIS in April 2017.

Number of incidents by LDU is as follows

- BANES -3 – all serious self-harm
- Bristol -2 – both suspected suicide
- North Somerset -1 – fall
- South Glos – 1- alleged abuse
- Wiltshire – 1 – serious self-harm

A narrative summary of the incidents reported in April is as follows:

- A patient of the Wiltshire South Intensive team took an overdose with antifreeze and was admitted to ITU. He was assessed by the Liaison Service following the incident and plans for his care following discharge from the acute hospital were made with the Intensive Team.

- A patient on Dune Ward slipped and fell resulting in a fracture of the right neck of femur. Transfer to an acute hospital for treatment was delayed by a 7½ hour wait for an ambulance. Concern about this has been escalated to the ambulance service for further investigation.

- An ex-patient of the South Glos Psychotherapy Service made a number of allegations about a member of their staff.

- A patient of the North Bristol Assessment and Recovery Team was found dead at home during welfare check by the police. At the time there was no indication that suicide was suspected and natural cause was assumed. The initial post mortem was unable to identify a cause of death, however, and histology and toxicology tests have been requested. The incident was reported as suicide is now considered a possibility following initial findings. His family have concerns about whether his prescribed medication could have contributed to his death. They have been invited to contribute to the investigation and pharmacy advice is being sought.

- A patient of the Bristol Early Intervention team was found dead, having been seen jumping from the suspension bridge. He was estranged from his family for some years, but contact with his mother has been established via the Coroner and she is being offered support.

- It came to light during a complaint investigation that a patient of the BaNES Recovery Team had been admitted to ITU following a self-harm attempt. She was assessed by the Liaison Service following the incident and was subsequently transferred to an AWP inpatient unit. The issue of delayed reporting of this serious incident has been flagged with the local delivery unit

- A patient of the BaNES Early Intervention Team was found with lacerations to their neck and both wrists. Emergency surgery was carried out and the patient was expected to be in ICU for a minimum of 24 hours. The team have since reflected on the fact that she had attended her last appointment prior to the overdose accompanied by a friend. With

hindsight they believe that it may have been helpful to see her alone to facilitate a more in depth mental state examination and risk assessment. This will be explored further in the root cause analysis investigation.

- A patient of the BaNES CIT Team took a significant overdose and was being treated in ITU. She was assessed by the Liaison Service following the incident and plans for her care following discharge from the acute hospital were made with the Intensive Team. It is clear that excess medication was removed from her home prior to the incident, but it is not yet clear whether her GP was asked to limit further supplies of medication to her (or whether the medication used came from another source), this will be reviewed in the RCA.

STEIS Performance

Undertaking 72 hour management reports and RCA's within given timeframes gives the organisation an ability to effectively learn from incidents and provide assurance to the relevant internal and external parties and provides clarity for services users and their carers and families involved in serious incidents. A summary of performance in relation to timeliness of the submission of initial management reports is shown in the table below.

	Pre Jan 16	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Apr 17
72 hour reports breached	61	0	1	0	4	3	2

Performance regarding the submission of the full investigation report (the RCA) is more complex:

- Of the 28 reports which are outstanding (i.e. the investigation is still in progress or the report is not yet approved) 43% (12) have already breached the 60 day deadline or a revised deadline agreed with the commissioners.
- This means that, the Trust has already breached or will inevitably breach the deadline for a quarter (24) of the RCA investigations commissioned in 2016-17. This figure will increase further if the remaining 16 reports, which are not yet due to be submitted, are submitted late.

The reasons for this are often due to the capacity of team managers to complete the investigation and report, and the persistence of the clinical executive to ensure that the quality of RCA's and subsequent recommendations provide the assurance that this will resolve the root cause.

Proposals to increase the capacity of the patient safety review team are underway to centralise writing of the RCA's. This will resolve the 2 main issues identified above.

Safety Alerts / Red Top Alerts Published Last Month

The Trust issued two safety alerts in April to highlight the following issues:

- An increase of actualised and attempted suicide in the over 65 patient population.
- The findings of the themed review of medication incidents involving consent to treatment issues

Each alert identified a number of actions that staff needed to take in order to minimise future risk.

1.2 External visits

CQC MHA visits in March 2017

STEPS – Regional eating disorders unit – 22nd March 2017

The CQC highlighted positive comments from service users and actions that had been resolved since there previous visit. The highlighted further issues in the following areas

- Difference in care highlighted by services users when bank and agency staff were on shift
- Lack of meaningful activates on the ward during evenings and weekends
- Quality of food
- Compliance with PERT training was only 62%

Ladden Brook – Regional medium secure unit – 28th March 2017

The CQC highlighted that service users spoke positively about their experience on the ward.

Further issues requiring improvement were

- No internet access available for service users
- Insufficient opportunity to engage in meaningful activities
- Quality of the food
- Compliance with PERT training was insufficient and a large number were out of date

The clinical executive have added the issue of activity provision to the Trust QIP as this appears to be an issue in a number of wards

Statutory/Mandatory PERT training sits on the Trust QIP following the CQC inspection last year. Below are the Current figures for PERT training 30th April 2017:

Trust Overall	BANES	Bristol	CAMHS	N.Somerset	S.Glos	Secure	Specialised	Swindon	Wiltshire
73%	92%	80%	56%	70%	71%	60%	62%	87%	74%

To address this following actions have taken place;

1. **Review of training provision to ensure adequate placed by head of L&D**

Below shows the analysis of the review conducted

Based on the Oct 2015 TNA, covering 01/11/2015 - 31/10/2016	PERT
Places required	551
Numbers of programmes/places in the last year organised	630
Number of places taken up	413

DNA for these two subjects (latest data, 01.04.2016 - 31.03.2017)	64 places lost (equates to 11 courses)
Current gap (as at 31.03.2017)	see below
Number of places organised already in the future (courses currently available up to 31.10.2017)	240
Number of places currently booked	162

This demonstrates that capacity for places does not seem to be the main causative factor for the low compliance as 120% of the places required were provided last year.

2. **Head of L&D to attend Operations call 2 weekly to discuss issues and barriers to achieving training compliance**

This commenced last week and means operations are provided with a regular position of Stat/Man training compliance. Discussions take place about barriers to achieving compliance

3. **Changes to booking arrangements**

This enable staff to book places on training courses throughout the organisation rather than in their own locality- this provides greater opportunity for staff to attend and increase compliance

4. **Submission of a business case to support increased numbers of 'trainers'**

This would increase the capacity for delivery of formal training of PERT and also enable delivery of in situ simulation in ward environments. The clinical executive may also look at taking on the approach of allocating training places to staff that require training to ensure compliance.

In analysing the potential issues and barriers to achieving compliance it is apparent that the number of courses provided cover the requirements of the service. In order to cover the shortfall in staffing, members of staff are being pulled from training to cover clinical shifts, and the turnover of staff is high which is effecting compliance.

To mitigate the risk the Clinical executive plan to ensure at least 1 member of staff on the shift is in date with training to ensure patient safety is not compromised.

The board should note that the CQC instruction to be compliant with this training will not be achieved prior to the visit in June – however improved communications and additional mitigation are in place to ensure patient safety is not compromised.

2 Clinical Effectiveness

2.1 CQUIN

This month a separate report is provided to give an overview of all CQUINs for 2017-19. Next month we will provide an update against milestones.

2.2 Physical Health

The draft of the Physical Health Care (PHC) Strategy was presented to the PHC Meeting at the end of April and is out for comment at present. Associate Director of Nursing (Community) and the Practice Development nurse are currently reviewing the PHC policy which is due to be republished in August 2017. Training has been publicised to relevant staff to support the requirements of the PH CQUIN focussing on smoking cessation and alcohol brief intervention. The training matrix for Physical health should be completed in May 2017 and will outline requirements for the various disciplines of teams; discussions will then be required with L&D to ensure the training provision to support the plan is achievable. There are MLE training packages to include smoking cessation and alcohol screening although getting these advertised to staff is taking some time.

Urgent revision of the RiO pages for physical health recording is required to be able to support the achievement of the CQUIN, there has been slow progress with moving this forward over the last 3 months and will be escalated at the Technology Programme Board this month.

2.3 Medicines Optimisation

The CQC do not issue a single checklist for medicines optimisation, although they do outline some 'key lines of enquiry'. They also draw heavily on guidance issued by other bodies such as NICE, NHS Improvement and NHS Protect, and the Royal Pharmaceutical Society (and other professional bodies).

The Trust is now moving towards a culture of continuous improvement rather than a 'check list' approach to assessing the quality and safety of its services. With this in mind, this suite of documents is the successor to the old Medicines Optimisation Frameworks (issued by the NHS Trust Development Authority, now part of NHS Improvement).

The intention is that a team or locality can use the Medicines Optimisation Assurance Tool (MOAT) to generate a gap analysis showing areas where the management of medicines could be improved. This gap analysis should then be reviewed, prioritised and used to populate a realistic work plan for the coming six months. The documentation should also include identified gaps which cannot currently be addressed, for example due to lack of resource, workload pressures or wider Trust issues. Where key vulnerabilities are identified, which have no straightforward solution, work plans should explain why this is the case, and how any associated risks have been mitigated (reference may be made to the relevant risk register). After a six month period the workplan can be reviewed, completed actions added to the MOAT and the process repeated. In April 2017 a version of the assessment tool for wards was sent out to support the self-assessment work on inpatient wards and community teams.

Team level workplans will be overseen by the locality governance group or its medicines subgroup. The locality level workplans will be overseen by the Trust Medicines Optimisation Group and Clinical Quality Governance group. Trust level plans will be developed for pharmacy services and executive level governance. All workplans will be monitored through the QIP, so themes and repeating issues will be easily identified.

2.4 Infection Prevention and Control update

There have been no outbreaks during April.

Service Line Agreement for Infection Prevention and Control;

From 1st April 2017, Royal United Hospital Bath (RUH) became our sole service level agreement provider for advice and support for infection prevention and control for inpatient units during office hours Monday to Friday. They are a team of one band 8, one band 7 and three band 6 infection prevention and control nurses. They will continue to work closely with and support our own infection prevention and control team of two. Decisions regarding management of suspected or confirmed outbreaks will be made collaboratively. For suspected or confirmed outbreaks during out of hours, the existing arrangements to contact the acute Trusts microbiology departments remain in place.

Legionella at Southmead site

The situation continues to be managed proactively as previously reported, supported by estates.

2.5 Clinical Effectiveness Group

Since the revision of the clinical executive structure localities have been monitoring publication of NICE guidelines, however the Clinical executive are aware that this is sporadic and that there is no central oversight of publication, benchmarking or implementation of NICE guidelines and Quality Standards which requires improvement.

As part of the review and revision of the governance structure and assurance framework of the organisation a Trust wide Clinical Effectiveness group is planned. Within the Terms of Reference for the group central oversight of all aspects of benchmarking and implementation of NICE guidelines will sit. This group will be chaired by the Associate Medical Director and will meet quarterly and the membership of the group is currently under construction. This should be implemented and functioning by Q2.

We currently have no items on the risk register relating to non-compliance with NICE guidelines

We have an annual audit plan shared at the last meeting which details the audits relating to NICE guidelines some of which are;

- Sepsis
- Anxiety and Depression
- Physical Health
- Rapid Tranquilisation
- Various Prescribing audits

2.6 Example of Clinical Audit and Quality Improvement

Audit report for April 2017: SPC-006-16 Re-audit of Bristol SDAS care plan reviews for opiate users

Aspect of care being audited and location:

This audit looked at the quality of care plan reviews for service users under the care of Bristol Specialist Drug and Alcohol Service (BSDAS), Stokes Croft Clinic. It was a re-audit of one completed in 15-16 (SPC-003-16). Optimising Opioid Substitution Treatment:

PHE Turning Evidence into Practice Briefing (January 2014) stated “Although Opioid Substitution Treatment (OST) is the most effective treatment for heroin users, the medication itself, and accompanying psychosocial/recovery interventions need to be ‘optimised’ to give the service user the best chance of recovery. This is achieved via regular and on-going reviews with service users, with interventions being ‘phased and layered’ accordingly”. This re-audit aimed to assess the quality of such reviews.

Standards being audited:

Medications in recovery: best practice in review of treatment PHE (2014) www.gov.uk/phe

Areas of good practice:

All service users had undergone a review of their care.

Areas for improvement:

Need for comprehensive Strategic Care Plans Reviews to be embedded in the service.

Summary:

A re-audit was planned in order to see if there are were any positive changes in the quality of patient reviews since the initial audit and to complete the audit cycle making it a full quality improvement project. Patients were identified who were currently open to and being prescribed opioid substitution treatment from BSDAS.

Based on the finding of the initial audit results, the auditor leads discussed and educated the members of the team directly involved with the care of the patients as to what particular information is expected to be obtained and recorded as part of a Strategic Care Plan review.

The initial audit result and findings were shared with rest of the team at BSDAS. The recommendations to edit the audit tool and action plans were introduced to improve compliance with the implementation and recording of Strategic Care Plan Reviews.

The results from this re-audit show a marked improvement in the quantity and quality of strategic care plan reviews within Bristol Specialist Drug & Alcohol Service. The increase in numbers of patients receiving SCPR’s increased from 4% to 44% in the 2 audits. This was largely achieved by establishing SCPR’s as a gold standard of practice within the drug and alcohol service. The two key components for doing this were firstly through training members of staff in the team and secondly through using the audit tool as a prompt / guide during the SCPR’s.

3 Service User and Carer Engagement/Experience

KPI’s and themes are underway and will be included in next month’s report these will include:

- Themes on a monthly basis from FFT
- Update of previous actions identified from CMH survey and inpatient survey

4 QIP

The data in the integrated performance report demonstrates the scale and progress of Trust wide actions on the QIP

Exceptions (Red) this month;

1. increased staffing levels of registered posts to further consolidate progress made and to ensure further improvements to service delivery
   Update:
   - Health roster system in place Trustwide
   - Safer staffing numbers agreed
   - Agency controls in place
   - Ongoing programme of recruitment - All above internal actions complete, however continued pressure with recruitment in particular areas such as Wiltshire

2. Development and implementation of updated Search policy
   Update:
   - New search policy written
   - Identified further amendments required to ensure fit for purpose – Is this resolved
   - Delays in Quality Forum to enable effective implementation – When is this planned

Added to the QIP in April 2017

- Water provision on Applewood ward- Due to issues with the water pressure on Applewood ward there is often no water available at the male end of the ward.
- Water provision on Oakwood and Mason Unit – Due to situation of these wards which fall at the end of the water line, the low pressure means that there are intermittent periods where water is unavailable.
- An examination of the place of safety stays which exceeded 24 hours in January this year highlighted issues to address;
    - Where a service user is admitted to an out of area Place of Safety (within the Trust, for example a Bristol person admitted to the Swindon POS), assessments are delayed until the person can be returned to their home area. Notes suggest this is a decision made by the AMHP teams. This practice will be difficult to maintain and accord with the new legal framework
    - In 11 of the 22 identified cases, the identification of a bed following assessment was the main reason for the delay.
    - Where the first attempt at an assessment is curtailed due to circumstances such as suspected intoxication, the arrangement of the replacement assessment will need to be prompt.
    - Some delays were introduced by the team waiting for a person to arrive at the POS before the AMHP team are informed. Where this is a transfer in from an external POS this becomes more urgent as a significant amount of time may already have elapsed.
  - Service users are unable to access the internet on all wards within the trust except from secure services wards (if they do not have their own devices with 3/4G). This can be a barrier to access courses, employment and housing.

- Activity provision across inpatient wards – This has been mainly due to the issues with recruitment of volunteers to deliver activities. Further work will be led by the Associate Director of Inpatient Nursing to review.

5 Summary from Clinical Executive

This month we have continued to work hard on fully embedding the QIP process and support the process as it evolves, we have also been developing the new clinical governance structure. Preparations continue for the CQC visit, detail of which is included in the CQC report. The Guardian of safeworking report was made available and is included as Appendix 2 for your review.