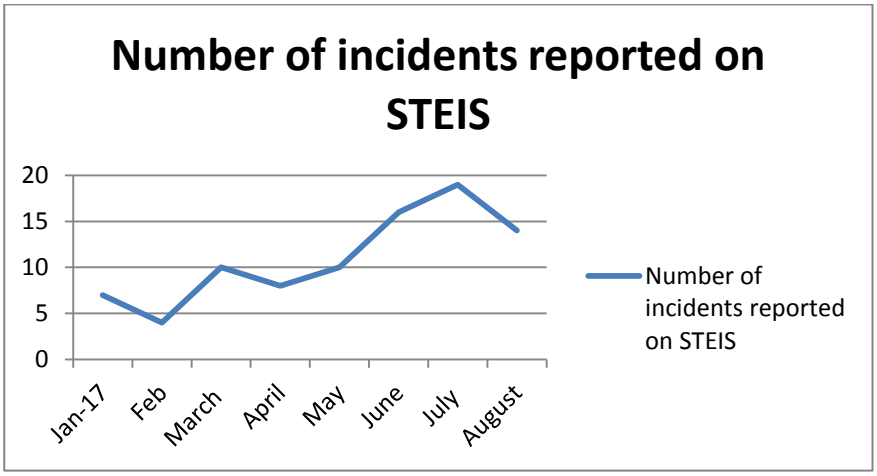
Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board meeting			Date:	27 September 2017
Clinical Executive Report				
Agenda item	**Title**	**Executive Director lead and presenter**		**Report author**
BD/17/139	**Clinical Executive Report**	**Director of Nursing/Medical Director**		**Head of Quality and Improvement**
This report is for:				
Decision				
Discussion				X
To Note				
History				
Discussed at Quality & Standards Committee on 19 September 2017				
The following impacts have been identified and assessed within this report				
Equality	X			
Quality	X			
Privacy	X			
Executive summary of key issues				
Patient safety – The data displayed this month displays continued pressure to comply with completion of 72 hour reports and RCA timelines. Actions are underway to address these issues and a trajectory for improvement is included Plans for changes to the records management audit to support and monitor the Trust pledge to 'Zero Tolerance' to incomplete or poor quality risk assessment in line with Trust Sign up to Safety pledge **Clinical Effectiveness** – Plans to launch the Trust Smoke Free Policy on the 1st October, this will support the work of the physical health group in reducing/preventing risky behaviours.				
This report addresses these strategic priorities:				
We will support our service users and carers:		X		
We will engage our staff:		X		
We will be sustainable		X		

1 Patient safety

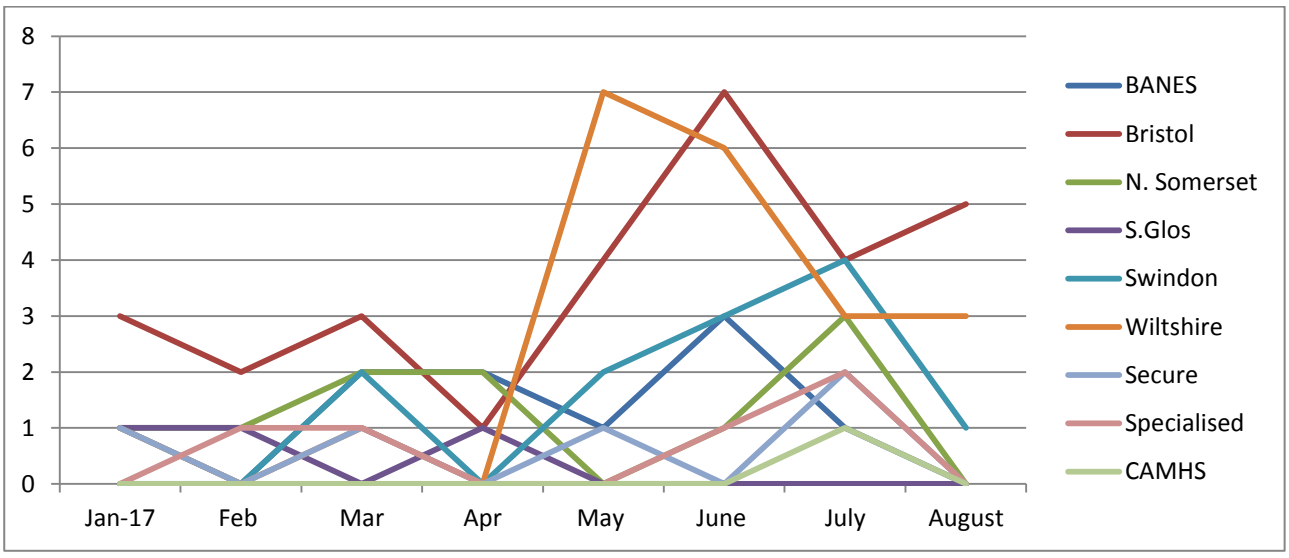
1.1 Serious Untoward Incidents

The Trust has reported nineteen incidents in July and fourteen in August on STEIS, a sustained trend since June 2017. This is an expected finding and a result of improved governance processes that have been implemented regarding identification and review of potential serious incidents.

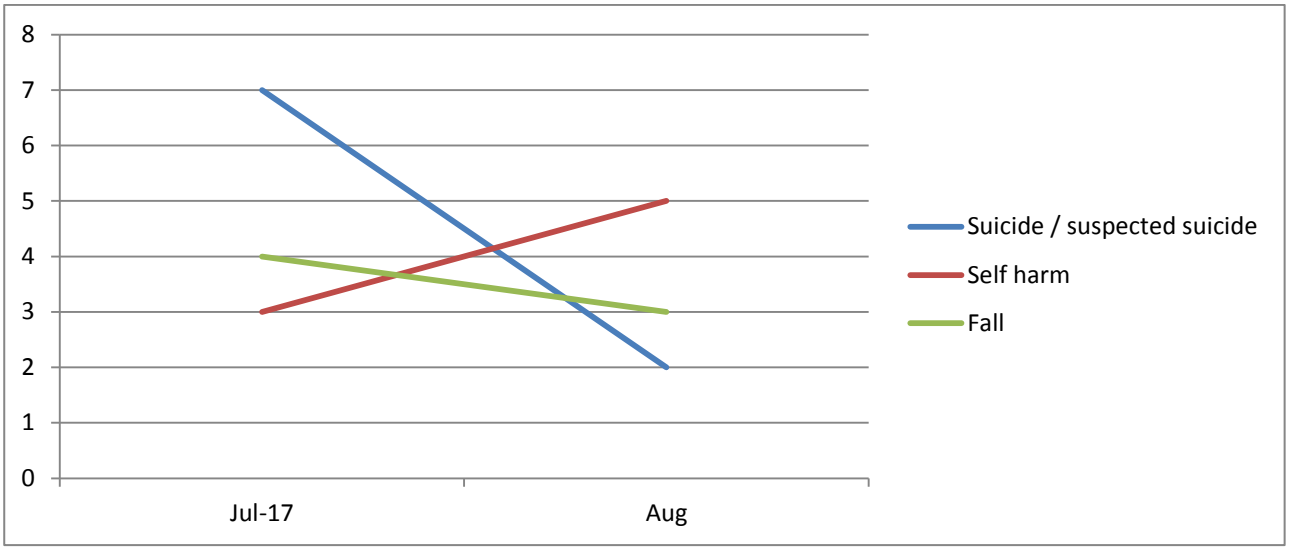


This information is further broken down by locality in the graph below. The data will continue be monitored for trends, and where trends are identified, further review will be undertaken to understand the information and identify any relevant learning. The chart reflects a decrease in incidents reported from Bristol and Wiltshire in July with a slight increase for Bristol in August and a plateau for Wiltshire. Swindon, N. Somerset, Specialised and CAMHS saw an increase saw in increase in serious incidents in July followed by a decrease August. This reflects expected fluctuations in line with improved internal governance processes and no upward trends have been identified.

Incidents by locality



The most commonly reported category of serious incidents are suicide / suspected suicide, self-harm and falls. The chart below reflects data from July and August, however over time this will provide trend analysis.



There was a decrease in suicides/suspected suicides from July to August. Of the 7 reported incidents, 2 occurred in Wiltshire and 2 in Bristol, while the remaining deaths were single deaths reported across localities. It is an expected finding that more incidents will be reported from Wiltshire and Bristol because these are the largest geographical areas covering the largest volume of population. The Suicide Prevention and Sign Up to Safety Lead continue to analyse reporting and lessons learned in relation to the Trust wide improvement work.

Self-harm incidents increased from July to August. A trend in incidents in relation to locality has not been identified other than the highest proportion occurring in the localities that service the highest population.

Falls incidents decreased from July to August. It is expected that there will be an increase in the reporting of the number of falls-related serious incidents in future reports. This is as a result of the Trust reviewing and amending the type of injury resulting from a fall that will be reported as a serious incident; any fall resulting in a fracture will be reported as a serious incident, historically only falls resulting in a fractured neck or femur have been escalated as a serious incident.

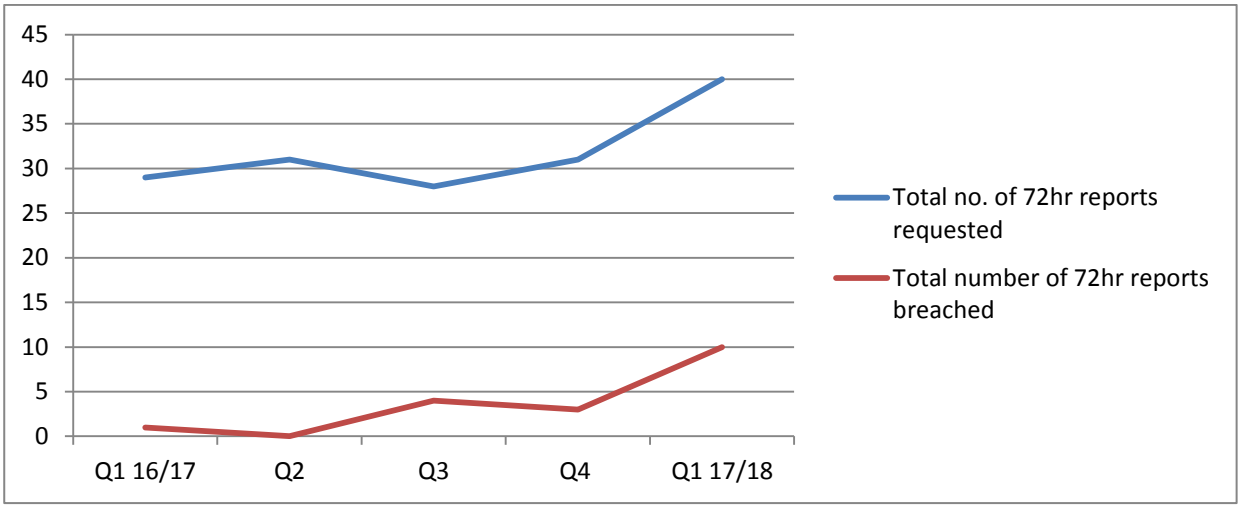
STEIS Performance

The chart below demonstrates that the Trust continues to have challenges with regard to complying with the national requirement to provide initial incident review findings within the 72 hour timeframe. Three of the delays were due to a process issue in the patient safety team, which has now been reviewed and a solution implemented. The remaining breaches resulted from delay in the report being submitted to the patient safety team. This has been escalated to the operations team and the locality quality director.

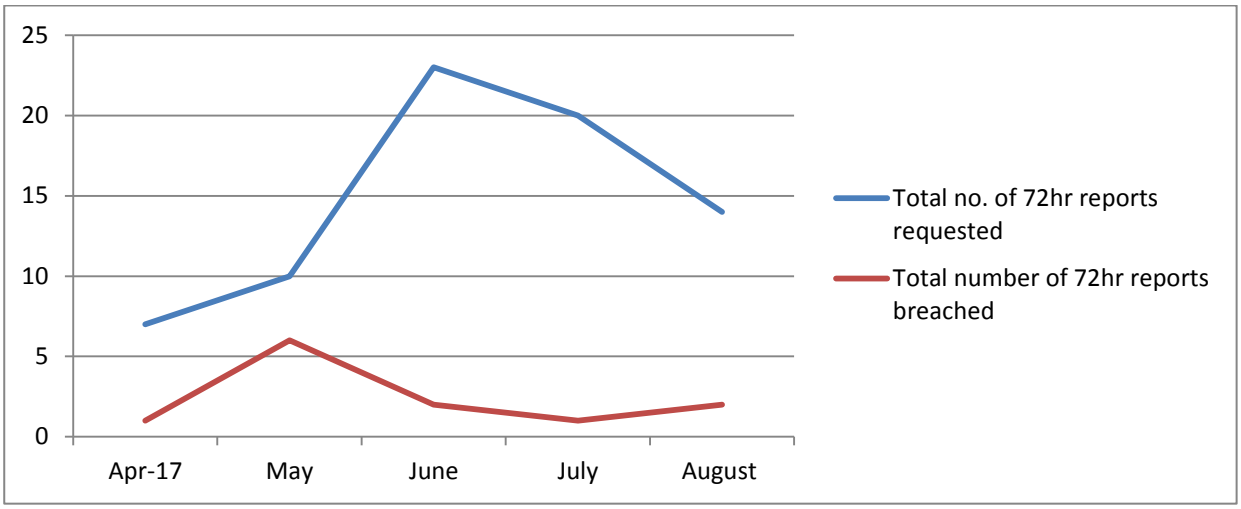
The Trust has implemented the agreed alternative process to review all potential serious incidents, the findings of which will be utilised to inform STEIS. This does not remove the function of the red management report, which will continue to be requested to provide detailed information regarding potential serious incidents to inform and support decision making.

Future reporting of breaches will be by month to provide more timely information.

Number of breached 72 hour reports

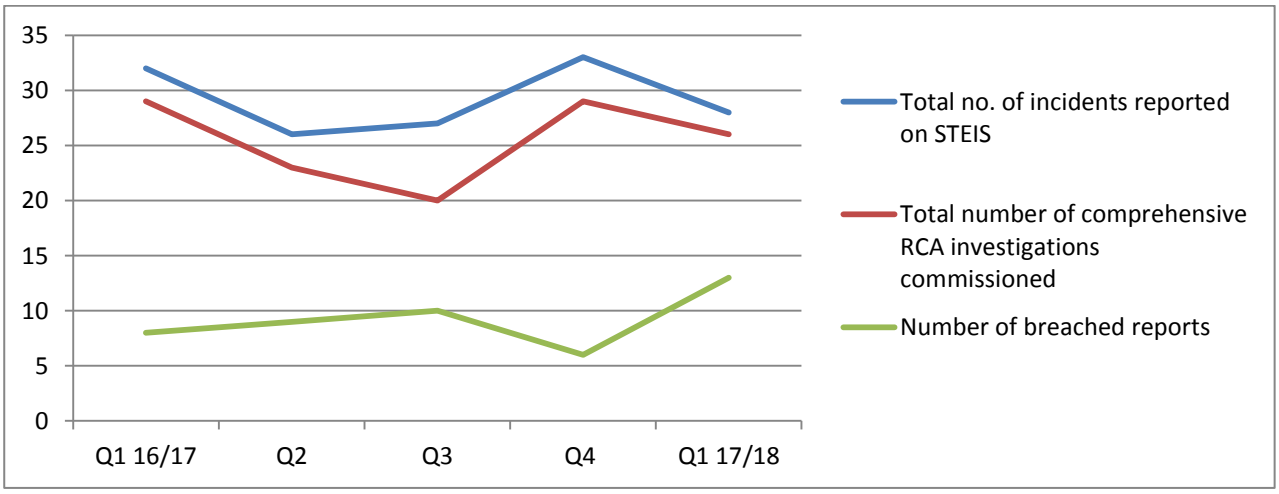


*Data updated since previous report to reflect updated

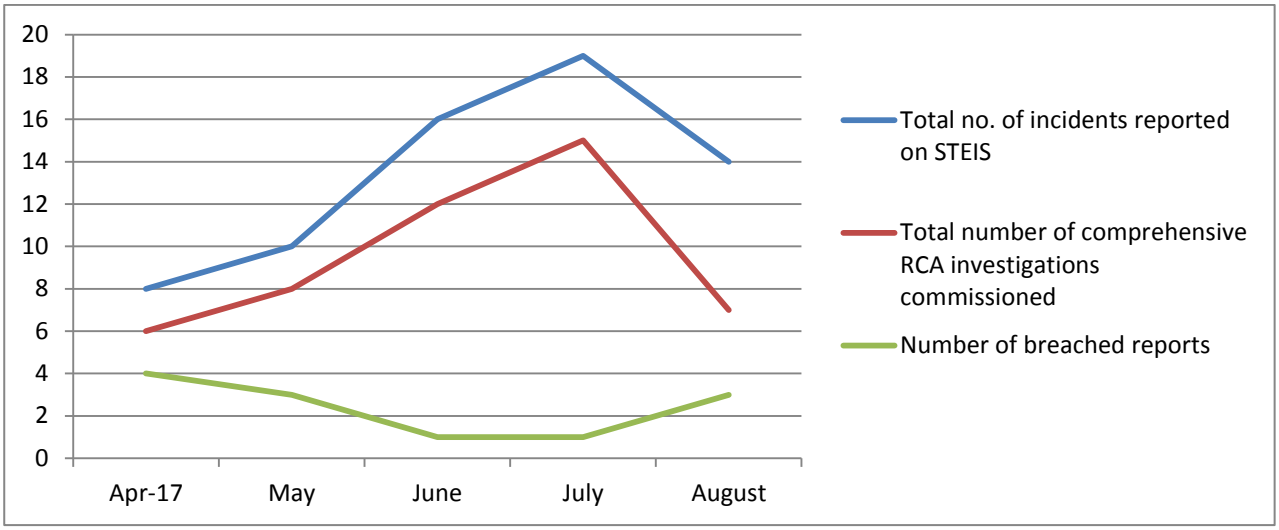


As demonstrated in the charts below, performance regarding completion and submission of serious incident investigation reports within the required 60 day timeframe continues to be challenging for the Trust.

Number of breached incident reports



** Number of breached incident reports relates to the quarter the investigation report was due.



The breaches have resulted from either rejection of reports at the ratification stage or delay in submission of the final report from the locality. Of the 4 breaches in July and August, extensions from the CCG were requested for 2 of the incidents.One extension was granted, however the extension was breached and the other declined.

The Patient Safety System Team has implemented a robust weekly review process to monitor progress of RCA reports. This will enable the team to communicate more effectively with commissioners regarding potential delays and where appropriate negotiate deadlines.

The volume of investigations undertaken by the patient safety review team is increasing with new appointments to the team. The Trust is considering a proposal to support a patient safety review team that will manage all serious incident investigation, thus standardising the quality of reports and removing the pressure from locality Chairs.

Currently, where the patient safety review team do not have capacity to undertake an investigation, the Lead Patient Safety Reviewer aims to have oversight of the progress of the investigation and provides support to the Chair to improve likelihood of completion within 60 days. However, as reflected in the chart above, this has been challenging to achieve. The most significant issue has been in the ability to identify suitable chairs within the localities to manage the increased number of investigations. Further in-house root cause analysis training is planned for November to provide a wider cohort of staff who are able to undertake investigations. This will not, however, address the issues related to staff being required to complete investigations whilst performing in substantive posts.

Improved governance was developed in July and a ratification committee implemented in August to review all final draft investigation reports and ratify the report prior to sharing with key stakeholders. The committee will be accountable for monitoring compliance of meeting the 60 day submission timeframe as well as scrutiny of the quality of the reports.

Trajectories and improvement plans are currently under development and will be reported next month.

Learning from incidents

All ratified incident reports are reviewed at the Critical Incident Overview Group (CIOG) meeting where learning is discussed and agreed. Monitoring and testing of completion of actions is managed via the Trusts Quality Improvement Plan and (QIP) by both the locality and Trust Quality Improvement Teams. Accountability for incomplete actions is monitored by the Clinical Quality Governance Group (CQGG).

Learning from Deaths

AWP is committed to learning from deaths. The internal implementation plan to develop a robust systematic approach to mortality review dovetails with the national requirements outlined by the National Quality Board 2017. The process will support organisational learning from deaths and lessons learned.

Any suicide, suspected suicide or homicide related death is investigation as a serious incident. Deaths from other cause are also investigated as serious incidents if they meet the national threshold. Historically only a small number of deaths that have not met the criteria for investigation as a serious incident have been reviewed using a recognised mortality review. A robust system of mortality review has been agreed in principal by the Trust and a mortality review policy is being developed (planned completion of draft policy end of September 2017 and implementation by the end of October 2017).

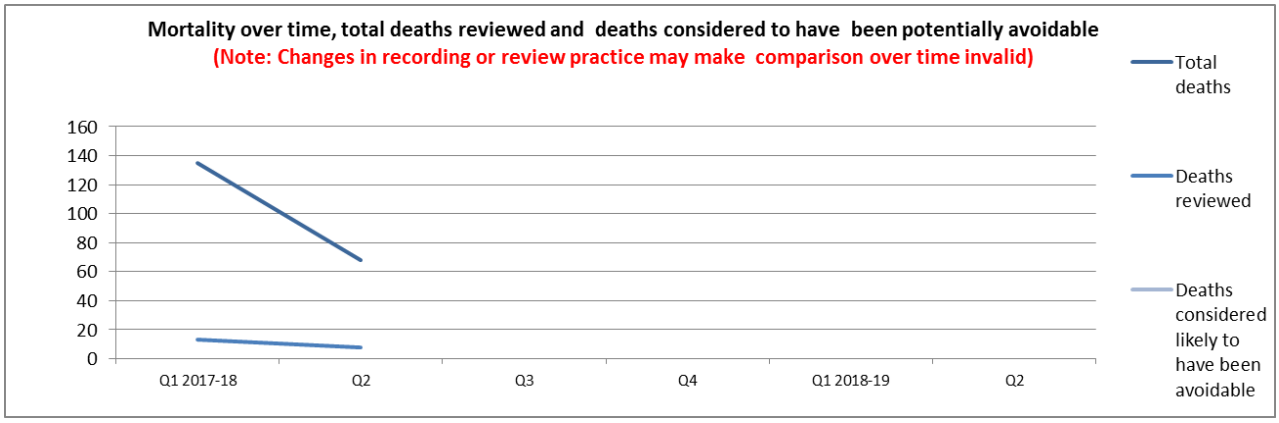
Following ratification of the policy the Trust will continue to identify and investigate serious incidents in line with the national serious incident framework. Remaining deaths will be subject to potential mortality review using a nationally recognised structured judgement (SJR) tool, adapted for mental healthcare services. The reviews will be undertaken by locality clinical teams, who are not directly involved with the patient care. A cohort of all deaths meeting specified criteria will undergo SJR. A proportion of the remaining reported deaths will be randomly selected to undergo SJR. The SJR process concludes by the reviewing team making an avoidability judgement score based on structured analysis of key aspects of care; if a score identifies an avoidable or probably avoidable death this will be escalated for review by the professional review meeting panel and managed and investigated in line with the serious incident framework.

The policy incorporates a clear process for learning from deaths at both an organisational and locality level. Future learning and improvement will be incorporated into this report.

Since July 2017 all deaths reported via the Trust incident management system are reviewed at a multidisciplinary professional review meeting. Whilst a systematic SJR has not yet been implemented each death is reviewed and where a potentially serious incident is identified a full root cause analysis investigation commissioned.

The data chart below provides the Trust Board with mortality data represented in line with national requirements. The chart shows the total number of deaths reported in Q1, the number of deaths that have undergone a mortality review utilising the Trusts current process and those considered likely to have been avoidable; there were no reported deaths of patients with learning disability in Q1 or in the first 2 months of Q2.

This data does not include deaths that are reviewed within the serious incident framework and reflects the current position of AWP in relation to structured mortality review. Reassuringly, of those deaths reviewed using the current process, all were deemed not avoidable. It is expected that from Q3 the data will reflect the implementation of the Trusts mortality review policy.



*Deaths reviewed do not include those reviewed through a serious incident process.

** Q2 data incomplete, July and August data included.

Safety Alerts / Red Top Alerts Published

1 alert was issued in July and 1 in August. The alert in July related to breaches in the Trusts seclusion procedures and the alert in August to avoiding information governance breaches in relation to using incorrect patient NHS numbers and addresses.

Alerts are issued in response to key learning that has been identified at Trust wide or national level. Alerts share information and identify actions that specific staff are required to undertake in order to minimise future risk. The alerts are circulated to the locality managers with the required actions and uploaded to the Trust intranet (Our space) to enable all staff to have access to the alert. Governance of compliance with the required actions is managed and monitored by the Risk Facilitator System Manager.

Another approach the Trust has taken is the development of a safety bulletin. The format is a 2 page newsletter style document with key safety messages regarding a specific clinical issue. The first report was circulated in June and was well received; the Trust is going to continue to use this approach to share organisational safety messages.

1.2 IQ Records Management Audit

It has been identified that the IQ records management audit requires intervention in order to improve effectiveness. Whilst results presented in the IPR show largely 'green' results across the Trust, as previously highlighted to the committee, Clinical Audit and RCA outcomes suggest this is not representative of the quality of clinical records.

A review of the system and consequent changes has resulted in the following system.

The purpose of the IQ records management will be:

- To provide assurance regarding performance on records components of audits and quality metrics
- To provide insight into areas of quality improvement needed within AWP clinical records
- To encourage a culture of enquiry into the nature of quality regarding clinical records via peer review completion, Clinical Lead review, and supervision.

Focus of Audit questions:

- The majority of the questions will be objective and focused directly on quality targets. In the first instance this will be the National Patient Safety Agency (NPSA) standards listed within our Trust 17/18 Quality Accounts.
- Questions will be changed periodically depending on identified needs for quality improvement.

- A small number of questions will be subjective quality based judgements covering general areas of clinical recording.

Process:

- Team managers will each audit five random records from their team every two months. Localities will be encouraged to peer audit on alternate audits. Results will be shared via IQ.
- Clinical leads will re-audit five random records from the pool of records audited for the teams in their localities. Results will be shared via IQ.
- Each member of clinical staff will audit one record in each management/caseload supervision session with their supervisor. Records will be kept with supervision records.
- A full physical audit of clinical records facilitated by the clinical audit team will be undertaken once each year. This will contain all, but not be limited to, all objective metric based questions in the IQ records audit.

As a result of these changes it is expected that we will be able to provide effective assurance around the quality of clinical records with governance via triangulation. Where we identify opportunities for the improvement in the quality of records we will be able to flex the tool in order to adjust focus. By placing audit at the level of supervision, team management and at clinical lead level, we will encourage conversations about the nature of quality in the clinical record and therefore drive an improvement in standards.

The design of the audit has been completed and most technical changes have been achieved. We intend to offer consultation with the Operations Directorate alongside the design of the transformation plan. We would expect this to go live in eight weeks.

2 Clinical Effectiveness

Launch of the Tobacco Free Smoke Free Environment Policy

On 1st October we will be launching the Trust Tobacco Free Smoke Free Environment Policy with the expectation of the Trust being completely smoke and tobacco free by the end of November. To meet current legislation and support a smoke free NHS, this means that all staff, service users, visitors and contractors to any AWP site will not be able to smoke or use tobacco products. Arrangements for managing this across clinical services will be set out in supporting procedures and guidance which includes supporting the use of e-cigarettes by service users. All staff are required to complete e-learning training relevant to their role, with additional training available for Nicotine Replacement Therapy to be provided under a Patient Group Directive (PDG). Training for staff to become Stop Smoking Practitioners is also available with the aim of having at least 1-2 per ward or community team.

The policy is written in accordance with NICE Guidance *Smoking Cessation – Acute, Maternity and Mental Health Services (PH48*) where we are participating in the NHSE and PHE *Leading Change, Adding Value Smoking and Mental Health Programme* to share learning from other providers and NHSE and PHE colleagues. In addition the work links with our completion of CQUIN 9: Preventing ill health by risky behaviours – alcohol and tobacco which is a new two-year CQUIN from 2017/18. We are also participating in

other smoking cessation working groups in both STPs. The Smoke Free Group continues to meet monthly to oversee progress of the launch and the communication strategy and will continue to do so for at least the next 6 months as implementation of the policy is fully embedded.

The launch will coincide with the national Stoptober campaign, which is run by Public Health England and encourages participants to pledge themselves not to smoke during the 28 day period, with a mind to giving up altogether.

Flu Campaign

Following the success of last year's campaign (66% achievement against the CQUIN) the Flu Planning meetings have continued to meet monthly throughout the year to take and build on the learning for another success campaign this year (CQUIN target = 70% for 2017/18). Training for peer vaccinators (registered nurses across all services) has been underway during July – September. The vaccine is expected to arrive with pharmacy in the third week of September with clinics starting from 25 September 2017.

Resilience, Pharmacy and Facilities have made some improvements to the logistics of the clinics this year with 7 main sites identified across the Trust from which smaller satellite clinics will operate from. A similar communication strategy to last year will be implemented with the Flu Planning Group holding weekly teleconferences from the first week of clinics to monitor implementation and resolve any issues.

In line with DH guidance staff will be reminded of the expectation under their professional codes to minimise risk of harm to patients and the public. Similar to last year significant communications in relation to myth busting will be circulated.

Additional guidance has been drafted for inpatient teams to support the provision of the flu vaccine to identified inpatients in high risk clinical groups to avoid the impact that an outbreak can have on our inpatient bed capacity (where Amblescroft South were closed for 14 days in January 2017).

3 Service User and Carer Engagement/Experience

The 2017 community survey is available but embargoed for sharing until the autumn. The findings will be shared within this report as soon as is possible. There was a delay in the development of the 2016 action plan resulting in a short period of time between ratification of the action plan and the results of the 2017 survey being available to the Trust, wider work addressing the issues highlighted within has taken place. The 2016 action plan will be incorporated into the 2017 action plan to ensure the areas for improvement plans seamless continue.

The co-produced engagement strategy is an enabling strategy of the organisational strategy. Further work is being undertaken to ensure that the engagement and organisational strategy dovetail in relation to timelines and work steams. The Director of Strategy and the Head of Patient Experience are planning to hold a workshop in Q3 for interested involves to attend. This workshop will discuss and develop a work plan. From the workshop a group of involvees will be identified to continue to be involved in the implementation and monitoring of the strategy.

4 Quality Improvement Plan

Issues rated as red:

1. **Review of how medicine order forms are accessed to comply with controlled stationery standards**

The Acting Chief Pharmacist is leading on services further utilising the emailing of medicine orders/prescriptions to Pharmacy, from generic ward/clinic email boxes, to improve security. The issue remains red as it will only be sufficiently resolved by the purchase and implementation of a full Electronic Prescribing and Medicines Administration System.

Issues rated as Amber*:*

1. **Use of medication and provision of physical health care in Place of Safety Suites**.

The Acting Chief Pharmacist has produced a procedure for the use of medication in Place of Safety Suites. This is being taken to the Medical Advisory Group in September for feedback. The issue was discussed a Clinical Quality Governance Group this month and it was agreed that further actions are required outside of the remit of the Lead Pharmacist. The Associate Medical Director agreed to carry forward this work as part of the Clinical Effectiveness workstream.

2. **An action for pharmacy to review all blood results before dispensing**

The Acting Chief Pharmacist has investigated the feasibility of ensuring this occurs. It has been identified that there are ongoing challenges for pharmacy staff to fully implement this and these are being worked through. Examples of this include the fact that pharmacy staff don't know when bloods have been taken and that they can't access all laboratory systems to view results. The Acting Chief Pharmacist has highlighted the importance of the prescriber, requesting the supply, taking responsibility for reviewing blood results and taking necessary action. The issue was discussed at this month's CQGG who concurred that while an additional check of blood results by pharmacy is always preferable, the responsibility for checking blood results before prescribing lies with the prescriber. The Associate Medical Director agreed to lead on prescriber responsibilities under the Clinical Effectiveness workstream.

3. **The Trust should ensure shared protocols are in place to implement the Police Attendance at Mental Health Units Memorandum of Understanding**

Overseen by the Human Rights and Mental Health Legislation Workstream, shared protocols are being developed with the police.

Issues added in August:

- The Trust should ensure shared protocols are in place to implement the Police Attendance at Mental Health Units Memorandum of Understanding
- The health and safety workstream report to CQGG highlighted ongoing concerns regarding access control and supervision of garden spaces. It was agreed at CQGG that this issue should be allocated to the Clinical Environment to follow up. This will include: A review of Beechlydene, Sycamore, Poppy, Juniper and Steps EDU garden spaces AND a review of trust environmental standards for garden spaces.

5 Recommendation

The Board is asked to note the report.