BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

TRUST BOARD TO BE HELD ON WEDNESDAY 25 MARCH 2015

TRUST BOARD QUALITY REPORT

Strategic or Regulatory Requirement to which the paper reports –
Quality requirements, compliance with Quality account and Trust Quality goals.

ACTION:
The Trust Board is asked to note the contents of the Quality report and receive assurance on the issues identified.

Executive Summary
Key issues are highlighted as follows:

Safety
Physical assaults on staff and patients have decreased this month along with the number of restraints. There has been a decrease in the total number of vacant clinical posts in service areas, however there was a higher number of unfilled temporary staffing shifts reported this may be in part due to staff taking leave which tends to be higher this month.

Clinical Effectiveness
Performance continues to improve in relation to ICR completeness and the lowest number of teams below 80% compliance is reported.

Compliance
There has been a high number of CQC visits undertaken over the past month. A number of reports from these visits are still awaited. As previously highlighted, the report in relation to Sage ward was received and a detailed action plan has been submitted to the CQC. Actions arising from the issues identified particularly in relation to the Mental Capacity act are also being reviewed across all wards.

BOARD DIRECTOR SPONSOR: Sue Hartley, Executive Director of Nursing

REPORT AUTHOR: Peter Hughes, Associate Director of Governance
Angharad Newbold Clinical Governance Manager

APPENDIX:
Appendix 1. Quality report February 2015

PREVIOUSLY DISCUSSED: Quality account indicators approved by Trust Board in April 2014

QUALITY REPORT FEBRUARY 2015

1. Safety

1.1. Quality Account Objective 1: To reduce the level of recurring incidents of assaults through the further development of a structured escalation response to demonstrate the reduction of recurring issues

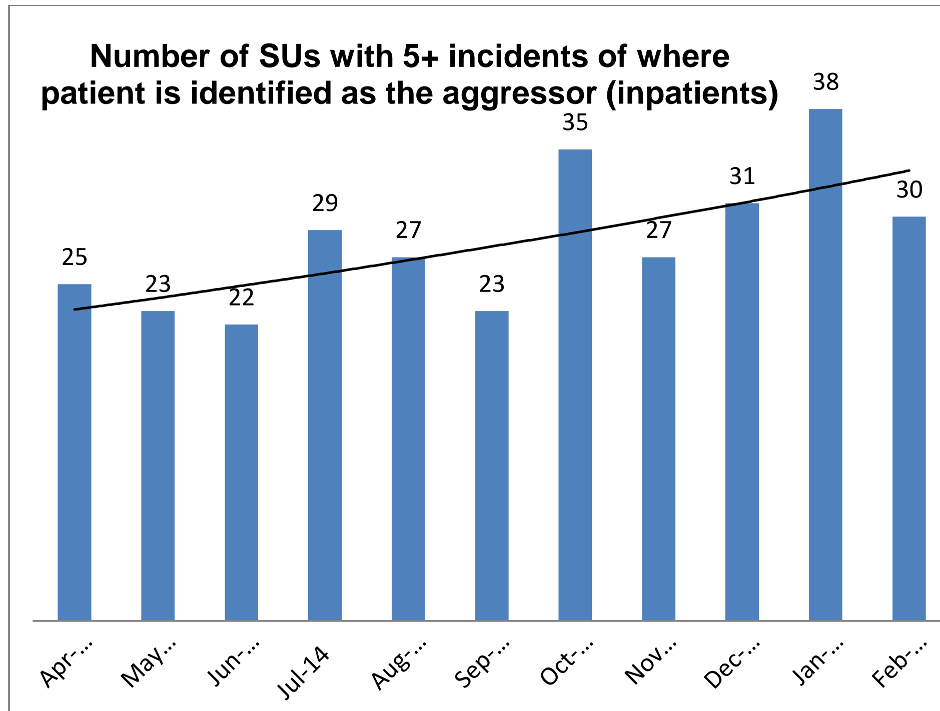
How is this being delivered?

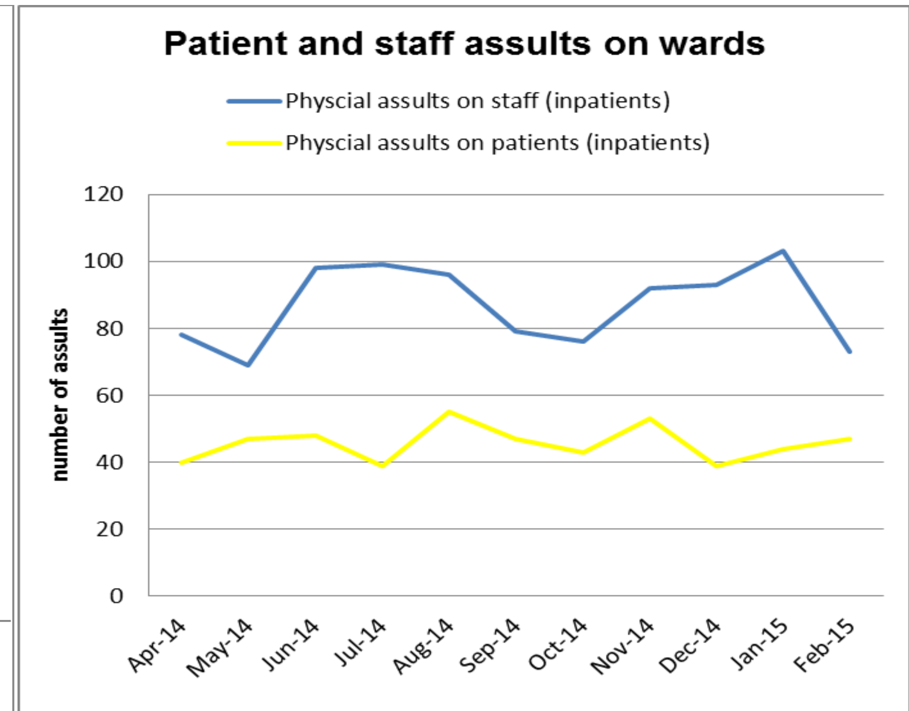
A violence and aggression group has been established and is chaired by the Executive Director of Operations. The group has agreed a programme of actions which incorporate the outcomes of the Listening into Action event which was also held in November last year.

Progress

This month there has been a reported decrease of assaults on staff along with a decrease in recurring incidents. There has also been a decrease in the number of restraints reported. A follow-up check list on assault incidents has been reinforced to all wards which is required to be completed on Eclipse (incident reporting system). Further actions identified in last months report are being put into place and a training event is being held in April for all inpatient ward managers.

Indicator	Source	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Do you feel safe on this inpatient unit?	Inpatient Nursing metrics	96.2%	96.7%	85.1%	92.90%	90.50%	93%	90%	92%	99%	88%	95%	
Does the ward feel like a safe place to be?	real time feedback – inpat. survey	62.5% (n=80)	62.2% (n=45)	54.4% (n=68)	59.6% (n=57)	62.8% (n=78)	57.6 (n=59)	suspended					
Number of SUs with 5+ incidents where patient is identified as the aggressor	Eclipse	25	23	22	29	27	23	35	27	31	38	30	
Physical assaults on staff (inpatients)	Eclipse	78	69	98	99	96	79	76	92	93	103	73	
Physical assaults on patients (inpatients)	Eclipse	40	47	48	39	55	47	43	53	39	44	47	





Safety Summary Dashboard

Indicator	Source	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Never events:	Eclipse	0	0	0	0	0	0	0	0	0	0	0	
Riddor reportable incidents	H&S team	4	9	8	10	7	3	2	12	2	13	3	
Total patient restraints	Eclipse						214	290	282	283	374	257	
Patient restraints including a position of prone	Eclipse						96	132	137	138	167	127	

1.2. Quality Account objective 2: Improve the safety of inpatient wards through reduced reliance on temporary staffing and improved compliance with defined staffing levels for inpatient wards.

How is this being delivered?

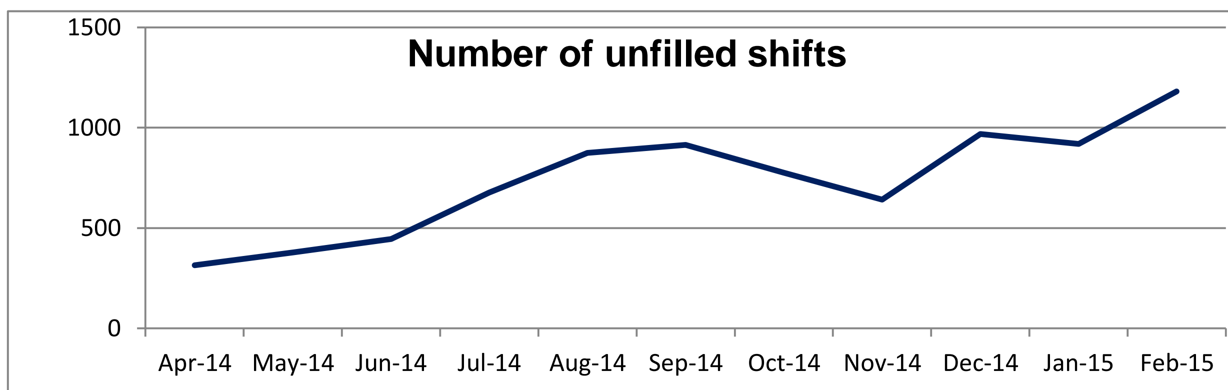
This is being monitored through the Trust workforce committee.

Progress: There has been a decrease in the total number of vacant clinical posts in service areas, however there was a higher number of unfilled temporary staffing shifts reported. A factor in this relates to a higher level of annual leave at this time of the year.

Indicator	Source	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Number of Bank filled shifts	Allocate	5951	6441	6181	6637	7199	6563	6841	6910	6258	6976	**6545**	
Number of Agency filled shifts	Allocate	2525	2561	2624	2643	2739	2885	2758	2335	2501	2982	**2663**	
Number of unfilled temporary staffing shifts across all operational services	Allocate	314	378	445	677	874	915	776	642	969	919	**1181**	
Number of vacant clinical posts in service areas	ESR	90.78	80.55	91.8	70.47	124.83	118.48	105.56	112.73	159.02	99.13	**76.98**	
Number of vacant non-clinical posts in service areas	ESR	50.38	48.02	50.21	57.65	75.3	71.52	61.05	68.4	43.9	32.4	**22.72**	

Purpose of Bank and Agency cover in February 2015

	All Shifts	Vacancy Cover Only
Bank	6,545	2,164
Agency	2,663	914
Total	**9,208**	**3,078**



2. Clinical Effectiveness

2.1. Quality Account objective 3: To continue to improve quality at each stage of the CPA process

How is this being delivered?
Via the CPA quality steering group

Progress
Performance has continued to improve with 23 teams who are still reporting under 80% CPA compliance, a reduction of nearly a half since the beginning of the year. The CPA group continues to focus on the poorest performers with the aim to ensure all teams are achieving 80%.

Objective	Data source:	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
ICR completion across the Trust	ICR report insight	79.8%	81.5%	83.3%	83.4%	83.1%	83.6%	82.1%	82.4%	80.3%	83.3%	**83.5%**	
Number of teams that did not achieve 80% in the CPA completion figure	ICR report insight	45	43	33	33	30	32	30	31	44	26	**23**	
% of service users who confirm they have been offered a copy of care plan	Real time feedback	33.3% (n=18)	32% (n=25)	25.3% (n=95)	16.7% (n=60)	32.3% (n=31)	14.2% (n=28)	Suspended					
% of service users who have a CPA review every 6 months	KPI report insight	84.1%	83.2%	84.0%	84.0%	81.7%	82.7%	80.2%	78.8%	77.8%	79.4%	**80.4%**	

There may be slight variation to the KPI report as CPA may be entered retrospectively.

3. Experience

3.1. Quality Account objective 4: Improve compliance with the triangle of care assessment tool to deliver improvements in the level of engagement with family and carers.

How is this being delivered?
This project is being led by the Associate Director of PPI through the Carers team.

Progress
The Carers lead has completed all of the self-assessments and the results have been passed to the Matrons for each division to take the action plans back to the units.

Triangle of Care	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total self-assessments sent out to inpatient units	28	0	7	0	1	0	1	0	**0**				**37**
Total self- assessments completed	10	9	1	3	4	0	2	5	**3**				**37**
First audit completed/action plan prepared and carer audit paperwork prepared	0	9	9	0	0	6	7	0	**6**				**37**
Second audit completed by carer volunteers	0	0	0	6	0	0	3	0	**0**				**9**
Signed off by Carers Voice	0	0	0	0	0	0	0	0	**37**				**37**

4. Compliance

4.1 CQC Regulation Visit

February saw the following visits, for which we are still awaiting reports:

02/02/15 – Kennett, Reaside
16/02/15 – Caffra, Oleaster
17/02/15 – Coral, Ardenleigh
23/02/15 – Lavender, Zinnia
27/02/15 – Swift, Reaside

From previous visits in January and December we are still awaiting reports for the following visits:

11/12/14 – Dan Mooney House (chased 4 times with CQC)
25/01/15 – Acacia, Tamarind
31/01/15 – Eden PICU

From previous visits, the following reports were received and the following key points raised for actioning:

16/01/15 – Sycamore, Tamarind

- What steps will be taken to ensure that care plans consistently show consideration of the patient's views and involvement in care planning and patients' comments are captured?
- What action will be taken to improve the provision of activities for patients to alleviate boredom, in particular ward based activities and provision for evenings and weekends?
- Clarification as to whether and what training is provided to healthcare assistants concerning mental health legislation and the Code of Practice
- What action will be taken to ensure that capacity assessments and consent to treatment records are completed as per the guidance in the Code of the Practice?
- Clarification regarding where capacity assessments and consent to treatment records will be captured on RIO?
- What action will be taken to ensure that clinicians fully document the reasons for urgent treatment to demonstrate how the strict criteria are made out?
- What steps are taken by the trust to monitor the use of urgent treatment as per the Code of the Practice?
- What action will be taken to ensure compliance with Chapter 17 of the Code of the Practice regarding advance decisions?
- What action will be taken to ensure compliance with 16.2 of the Code of the Practice and respect for patients' right to privacy (under Article 8) during family visits?
- What action will be taken to provide smoking shelters in courtyard areas used for smoking?

22/01/15 – Sage, Juniper

- The ward was subject to a range of blanket restrictions and as a result of this were the patients (not detained under MHA) on the ward deprived of their liberty, and if so

what steps have been taken to ensure that there is a procedure in place prescribed by law (in compliance with Article 5 of the Human Rights Act).

- Compliance with the least restrictive principle
- Plans to ensure that staff are aware of how the Deprivation of Liberty Safeguards apply to this patient group and work in practice
- Confirmation of the legal authority in place to treat the identified informal patients (those who lack capacity to consent or dissent to their care).
- Confirmation of what steps will be taken to ensure that appropriate capacity assessments will be carried out, and best interests decisions for those who lack capacity
- A patient was detained under s2 and regraded to a s3, then discharged from detention when consent to treatment provisions were due. The outcome of the investigation of this incident.
- Clarification as to why a referral for a SOAD was not made in good time.
- Confirmation that steps will be taken to ensure that MDT notes are accurately recorded.
- The AMHP report for the one detained patient was not on file
- Care plans did not show consideration of the following guiding principles the least restriction, respect and participation principles.
- There was no record that one patient had been given a copy of his s17 leave form
- Discharge from the ward remains problematic. On the day of the visit there were five patients who were awaiting discharge. Improvements need to be reported on this area

4.2 Commissioner visits

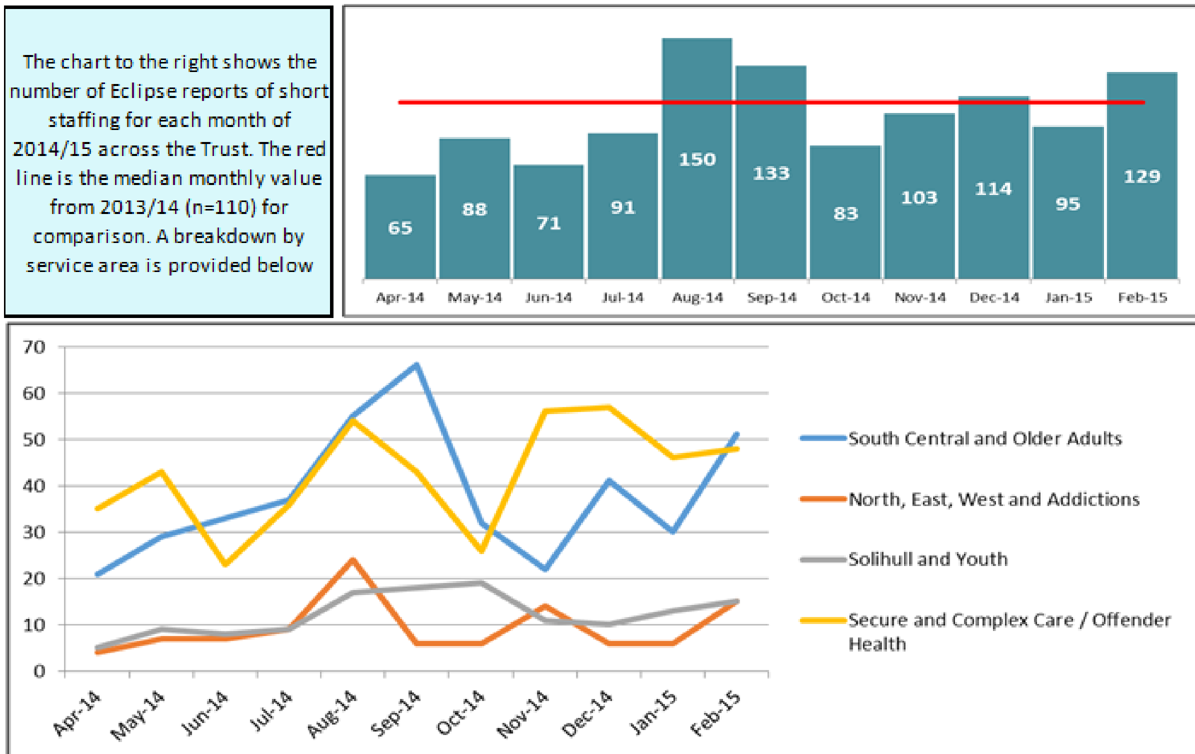
February saw the following visits, for which we are still awaiting Reports

03/02/15 Bergamot, Juniper

5. Staffing

Short Staffing Reports

Data sources Eclipse and HR



Reaside Wards- Shift RAG Rating January 2015

The overall fill rate for Reaside's inpatient services for February 2015 was 105%

The table below shows the percentage of the 84 shifts during February that were rated as red, amber or green for each ward at Reaside. The number of Eclipse reports of short staffing and each ward's reported fill rates are provided for comparison.

Ward	Shifts rated green	Shifts rated amber	Shifts rated red	No of staffing incidents reported (Eclipse)	Fill rate	Fill Rate RN	Fill Rate HCA
Hillis Lodge	100%	0%	0%	0	97%	100%	93%
Swift	87%	12%	1%	3	104%	100%	109%
Trent	86%	2%	12%	0	102%	99%	107%
Kennett	82%	18%	0%	1	104%	91%	123%
Blythe	81%	7%	12%	2	123%	117%	129%
Severn	75%	5%	20%	2	112%	116%	108%
Dove	74%	20%	6%	2	105%	109%	102%
Avon	66%	20%	14%	0	89%	89%	89%