Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST

REPORT SUMMARISING THE ACTIVITY FOLLOWING THE ACUTE IN-PATIENT REVIEW

1. Purpose of the Report

The purpose of the report is to describe the activity and mechanisms that the Trust has put in place since the Acute In-patient Review, and to identify the review processes that will be adopted to demonstrate successful implementation.

2. Background

As part of its Acute In-patient Review (AIR) last year, the Healthcare Commission looked at all 16 adult in-patient sites run by the Trust and recommended 10 areas for improvement (see Annex A), all of which have been addressed as a priority.

The Trust was given an informal indication of the Review's results in November 2007, which was followed by a Healthcare Commission visit to check these those results in May of this year. Having been embargoed by the Healthcare Commission, the results were formally published by the Healthcare Commission on 21 July 2008.

Since November 2007, the Trust has been focussed upon improvements across the board; a Director was appointed to lead this stream of work, alongside the appointment of an In-patient Services Manager to deal specifically with this work, and an action plan was developed and implemented. The Trust Board has received a monthly progress report on activity. The work has focussed around 4 themes:

- The care pathway
- Quality of care
- Users and carers
- Ward systems and safety

3. Activity

- The policies, procedures and key actions identified are now complete and in place.
- Ward-based scorecards have been developed that reflect the required standards and actions and also integrate standards from other sources; in all, 54 indicators have been identified. This high level view allows the Board, Executive and Operational Services to judge progress against a full range of indicators and enables a judgment to be made about risks of delivery and the performance management focus. Where performance is not at a required standard, or is at risk of failing, a delivery plan is created which articulates the gaps to be closed and sets out actions with owners for addressing it.

- The scorecards feed directly into the Trust performance framework.

- A robust system of management and assurance is in place to ensure delivery at all levels and there is ownership of performance from Board to frontline staff.

- A first audit of case notes has taken place with a small sample from each ward. During August 2008, a full review of all in-patient case notes is taking place so that our exact position is known in relation to performance against the AIR scorecard Trust-wide.

- In November 2008, the Trust will be inviting an external team to re-run the Acute In-patient Review, so that the Board and stakeholders can be assured that we are compliant with standards.

- All adult wards will be the subject of a complete notes audit in September, and therefore the Trust will be in a much stronger position to give members an accurate and detailed update at that time.

4. Conclusion

Whilst disappointed by the results, the Commission has acknowledged the evident and swift action that has taken place since the Trust became aware of its position.

The Trust is committed to providing the best quality Acute In-patient Services in a continuous cycle of improvement.

Sally Thomson
Interim Director of Integrated Governance and Nursing
28 August 2008

ACUTE INPATIENT REVIEW – AREAS FOR IMPROVEMENT

1 The Trust should ensure that its revised filing system addresses the practice of storing multiple copies of statutory documentation. The system should ensure that it helps clinical staff and administrators to easily identify current forms and documentation, thus reducing errors which may be made.

2 The Trust should consider an audit of Section 17 leave arrangements to better understand the extent of compliance and non-compliance with the requirements of the Act and Code of Practice and take necessary remedial action.

3 Where detained patients are on Section 17 leave, the Trust should satisfy itself that such patient's rights are not breached. This particularly, but not only, applies to those patients who may be on longer periods of leave from the hospital.

4 Only medication for which there is proper lawful authority should be administered. Nurses should be advised of their professional and legal responsibilities. The Trust should seek to undertake an audit of with the intention of improving compliance in this area.

5 All professionals with responsibilities under the Act who may be consulted by a SOAD should be reminded of their obligation to make their own entry of their discussion with the SOAD in the patient's file. The Trust should seek to identify good practice area and take appropriate steps to improve compliance where practice falls below the required standard.

6 RMOs should ensure that they make a record in the patient's notes of their discussion with the patient following the SOAD's visit. Where clinical judgement has been made that the disclosure of the SOAD's visit would cause serious harm to the patient then the RMO should record their reasons for not disclosing details of the SOAD's visit to the patient.

7 The Trust should take appropriate and comprehensive action to ensure that all staff with responsibilities under Part IV of the Act undertakes their duties appropriately. The Trust should review its training, audit and monitoring arrangements and from there develop plans to address systemic weaknesses noted in this and previous annual reports.

8 The MHAC would be pleased to receive further details on the Trust's programme for delivery of training in the Act.

9 A proper programme of maintenance works on all wards should be carried out irrespective of any planned closure of a ward.

10 The Trust is asked to ensure that recording of ethnicity continues to improve over the coming year and that ethnic monitoring becomes an integral part of clinical assessment and care planning.