Hampshire Partnership NHS
NHS Trust

# Directorate Report for Clinical Governance and Risk Committee (Report format – ONE)

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| Report Completed By: | K Page |
| Date: | May 2008 |

## Positive Aspects and Developments since Last Report

C5b & C5c Supervision & Leadership

The directorate participated in the trust wide clinical supervision audit with the results of this audit considered at the directorate clinical governance group. An action plan has been developed in response to the audit and this will be implemented through a nominated directorate working group which will include representatives from each locality.

In Southampton and the New Forest Localities where there was no leadership from a head Occupational Therapist, and hence a high degree of peer supervision, the situation has now been rectified and there is now leadership and clear supervision structures in both of these areas. All members of Occupational Therapy staff receive clinical supervision from a higher grade Occupational Therapist, and the higher grades receive management supervision from their line manager, which in many cases is a team leader (non Occupational Therapist)

The annual review "RITA" of trainee medical posts such as SpRs now requires trainees to complete a form reflecting on the quality of their education and supervision in their current post.

The availability of Occupational Therapy specific training has recently increased with emphasis on evidence based practice, using outcome measures.

C5d – Clinical audit

A draft clinical audit programme for 2008/09 has been developed. This is awaiting consideration for trust priorities and is still to be agreed at Trust CG&R Committee.

Once agreed (May 2008 anticipated) this will be presented at the Directorate Clinical Governance Committee for consideration of other directorate priorities (July 2008 tbc).

A Directorate Clinical Audit Leads Group has been established.

A number of significant audits have been undertaken including records, clinical supervision, falls and suicide prevention.

C6 Cooperative working

Service manager and senior practitioner posts with a joint management and professional responsibility for both health and adult services staff have been recruited to in the Southampton locality.

Essence of Care Pressure Ulcers

An OPMH Directorate Locality Leads Group has been established to address pressure ulcer prevention & management.

Pressure ulcer grading is now recorded in OPMH using the European Pressure Ulcer Advisory Panel Classification System. All pressure ulcers graded 2 and above now documented as a local incident.

Staff are being educated on the importance of incident reporting of pressure ulcers in OPMH.

Patients receive an initial and ongoing risk assessment in the first episode of care for pressure ulcer care.

A mattress audit has been undertaken in OPMH and as a result a number of high specification foam mattresses have been purchased for all clinical areas.

All those who are vulnerable to pressure ulcers are placed on a high specification foam mattress.

## Aspects of Concern which the Committee Requires to Consider

C5d – clinical audit

Ensuring robust action plans following directorate involvement in clinical audit has proven challenging although it is clear that progress has been made in a number of areas e.g. Falls

This is an important area and will be further considered by the directorate clinical governance committee to identify ways in which improved compliance in this area can be achieved. Ensuring and being able to evidence action following audit will be an important part of the locality audit leads role.

Essence of Care Pressure Ulcers

The optimum wound healing environment should be created by using modern dressings, needs to be a working group established across the Directorate with medical and pharmacy input. (For example, hydrocolloids, hydrogels, hydrofibres, foams, films, alginates)

Compliance with the Nice guidance needs to be ascertained across the Trust and guidance implemented in all areas. Need to establish communication pathway within Trust.

## Future Development Plans

C5b & C5c – Leadership & supervision

To continuously review supervision structures to ensure that they are robust. To ensure that all

staff that are responsible for supervising others have received the appropriate training and keep up to date with this training.

To implement the action plan developed as a result of the audit

Clinical skills
In occupational therapy to ensure that all members of staff attend at least 2 professional development per year. Skills and professional development will continue to be reviewed in supervision and yearly appraisals

C5d – Clinical audit

The whole process of continuing to review how clinical audits are both chosen and undertaken within the directorate (and the trust) is an important area of work and is a key tool in assuring best practice and improving patient care.

The development of the audit leads group will allow a greater focus to be applied to clinical audit in 2008/09.

Essence of Care Pressure Ulcers

Scoping exercise to be carried out around the Trust, this is to include equipment audits and to find out the tools and forms being used for pressure area prevention and management.

The development of inpatient paperwork in OPMH which will have consistent standards of assessment for pressure ulcer care is underway.

To develop a Trust Policy and Procedure for pressure ulcer management and prevention once international guidance has been disseminated.

The Patient Safety Federation (PSF) has identified pressure ulcer prevention & management as one of 8 key themes to address in the year 2008 – 2009. A working group has been established which will be known as the No Needless Skin Breakdown Work Stream (The Committee). See attached appendix 1 for terms of reference.

Physical Health & Wellbeing

The directorate has agreed to establish a working group to implement the requirements within the Physical Health Assessment Policy. This will meet for the first time in June and the group will include representation from each locality and a range of professional groups.

NPSA

This report has been considered by both the Risk Heath & Safety and Directorate Clinical Governance Groups.
Key areas of the identified for action within OPMH were: -

- A number of recent improvements in ward areas have taken place to enable improved 'zoning' and segregation of bathroom facilities e.g. Zoning in OPMH wards at Western Hospital. This is being captured within our directorate privacy and dignity work plan.
- Review of risk assessment documentation to ensure that risk assessment is an integral part of the initial care plan and full assessment documentation.

- Privacy & Dignity work plan to be submitted to DMT in July
- A time limited working group has been established to look at developing a standard for the environmental safety and patient security within inpatient units. This work is still underway.

John Barrett Action Plan

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| 5. MAPPA must be applied to all service users who meet the MAPPA criteria. | (Multi-agency public protection arrangements) have been circulated to clinical governance group members for consideration | Locality managers have been asked to review operational policies to reflect the need for MAPPA compliance | Letter to LM's requesting same sent Feb 2008 |
| 7. Strong systems in place for staff to receive clinical supervision and caseload management | All ward and department managers have been reminded of the requirement to ensure their staff have access to clinical supervision appropriate to each staff members individual needs.<br><br>There are several models in place.<br><br>The Directorate is checking robustness of existing systems through participation in clinical supervision audit in September 2007 (results awaited)<br><br>A workshop to ensure effective caseload management arrangements are in place took place in September 2007. Its aim was to share good practice across OPMH and to establish a standard for caseload management that sets a benchmark for good practice and enables the service to monitor its effectiveness. | Results considered at January meeting. Action plan now developed.<br><br>Caseload management standard agreed – implementation from April 2008 Plan to audit implementation after 6/12 | Working Group to meet to implement plan<br><br>Team leaders, managers |
| 8. Procedures for contacting out of hours managerial and clinical staff (including on-call medical staff) are | A new system for contacting the duty OPMH manager has been introduced with effect from the beginning of October. This new process simplifies the previous system and | New system in place and confirmed as satisfactory | |

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| clear in all areas of the Trust | requires contact via a single pager number.<br><br>On call contact details for medical staff in S/NF & MH are faxed to units on a daily basis from switchboard at MGN.<br><br>Basingstoke and St James switchboards hold rotas for their areas | OPMH will review arrangements for medical on call and identify options which could simplify current system<br><br>Draft report completed and currently being considered. | DMT |
| 9. Effective handovers | A standard for nursing handover documentation and its use has been developed and is currently being used in a number of OPMH areas. Evaluation will be undertaken via the Optimum Admission Project Group | | OAP Group |

| DOMAIN 2 – CLINICAL AND COST EFFECTIVENESS<br>Criteria – from the Healthcare Commission's Inspection Guide for C5b (Supervision and Leadership) | Met Y/N | Evidence which demonstrates compliance against this criteria |
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| 1. Staff groups, students and trainees who require clinical supervision are identified and there are appropriate supervisors with sufficient seniority and training | Y | Results from clinical supervision audit.<br>Trainee SHOs and SpRs receive weekly supervision from their educational supervisors.<br>In OT there are now clear supervision structures throughout the directorate. All OT staff that provide supervision have received appropriate training.<br>Ward managers have been asked to display their supervision arrangements on staff notice boards. |
| 2. Staff have protected time to participate in clinical supervision | Y | Demonstrated through supervision records |
| 3. The directorate should ensure that all relevant staff receive supervision taking into account guidance from professional bodies | Y | In OT supervision records are kept by supervisor and supervisee. Logs of when supervision takes places is available |
| 4. Supervision is monitored and reviewed, including reviewing feedback from staff on their experiences | Y | Review of clinical supervision audit and development of action plan to further embed into practice |
| 5. Students and trainees receive supervision in accordance with their educational and/or professional body | Y | Students receive weekly supervision whilst on placement in the directorate in line with university guidelines |
| 6. Senior clinical staff are aware of their leadership responsibilities eg by including them in their job description | Y | All staff from band 5 above have supervisor roles in their job description |
| 7. Clinical leaders from all disciplines are involved in strategic and operational decision making (e.g. membership of relevant committees) | Y | DSB and clinical governance committees include representation from key disciplines |
| 8. Clinical staff are provided with opportunities to develop leadership skills (e.g. training, mentoring) | Y | Trust has leadership training course available. Clinical staff also take on leadership roles in their teams on specific projects |
| **Criteria – from the Healthcare Commission's Inspection Guide for C5c (Clinical Skills)** | | |
| 9. The Trust should have systems in place to identify the relevant and necessary skills for clinicians to undertake their clinical work including the identification of required updates of existing skills, and clinicians acquiring new skills and techniques required for their clinical work. This may be undertaken through a number of ways, including service | Y | Annual appraisal and personal development plan system informs the education plan and purchased academic and taught modules from university or more bespoke educational pathways.<br>Clinical supervision is one process by which ongoing skills needs may be highlighted. |

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| reviews, or in the planning for implementation of new clinical guidance | | The directorate nursing strategy has a specific workstream looking at competencies for 'core' person centred skill areas |
| 10. Support is provided to clinicians to support them to update their skills (eg financial support, protected time for learning, bursaries and study leave etc) | Y | Study leave is available to all staff. Internal and external courses can be applied for. Examples – OT tech has received a bursary to complete the part time Occupational Therapy BSC course<br>For consultants there are 10 taught days per year to attend external courses and seminars<br>Each locality has a specific education and training resource to support more individually identified training needs |
| **Criteria – from the Healthcare Commission's Inspection Guide for C5d (Clinical Audit)** | | |
| 11. Clinicians should be involved in undertaking and discussing reviews, for example through regular forums within the organisation, such as departmental meetings, clinical governance groups, and/or effectiveness groups | Y | Lead clinicians part of directorate clinical governance group.<br>Locality clinical audit leads identified for each locality.<br>It is planned that these leads will meet quarterly with audit priorities to be agreed at meeting in May<br>In Southampton East there is a specific clinical audit group<br>A number of clinicians have led and been involved in clinical audits in their area<br>Results of clinical audits are considered at clinical directorate clinical governance and other groups as appropriate e.g. falls group |
| **Criteria – from the Healthcare Commission's Inspection Guide for C6 (Co-Operative Working)** | | |
| 12. The Directorate should have worked with its partners to manage where service users care crosses health and social care organisational boundaries, for example they may have developed protocols for admission, transfer, discharge and follow up | Y | In all areas there are Social Workers linked to the Health Teams. Protocols exist for the transfer of patients from Adult Mental Health to Older People's Mental Health workers.<br>There are GP link workers attached to every surgery. There is a discharge protocol for patients from our service going back into the community, and this involves informing the GP and any other professionals involved with that patient after discharge.<br>Letters are sent to all referrals following assessments and then the 6 month follow-ups are also done. The Psychiatric Liaison Service is in place in most parts of the county.<br>There is an Integrated Working Group and there is local cooperation.<br>Community teams are currently looking to develop a more |

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| | | consistent referral process across the directorate |
| 13. The Directorate should communicate clearly with staff about its joint working policy, procedures and practices | Y | Staff from both agencies attend joint team meetings and there are protocols in place to ensure staff work cooperatively.<br>In Hampshire as part of the Towards Integrated Working project, Locality Managers have established and progressed links with District Service Managers colleagues in Adult Services. This has included Joint Team Meetings and Workshops designed to allow staff to work more co-operatively and assisted by the introduction of the OPMH Pathway which identifies the key procedural stages that require joint working and the OPMH Standards which detail criteria to provide improved outcomes for Users & Carers. |
| 14. The Directorate should have monitored and reviewed the effectiveness of its work with partners to ensure individual service user needs are met | Y | The GP survey monitors how we are working with GPs and recent feedback has been positive for OPMH. The User & Carer Reference Group seeks feedback on how we are working together. There have been workshops held across Hampshire. There are regular meetings between Ruth Dickson from Hampshire County Council and Martin Robertson of Hampshire Partnership Trust. |
| 15. Where there is integrated service provision under Section 31 of the Health and Social Care Act, the Directorate enables different professionals to work within a single management structure | | N/A |
| 16. The Directorate requires operational managers to ensure that staff work to the standards and objectives that have been set with partners for jointly managed or jointly commissioned services | | N/A |
| **Essence of Care Benchmarks on Safety** | | |
| 17. All service users are fully orientated to the health environment in order to help them feel safe | Y | Orientation to the ward is an established part of the admission process within inpatient areas |
| 18. Service users have a comprehensive, ongoing assessment of risk to self with full involvement of the service user to reduce potential harm | Y | |

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| 19. Service users have a comprehensive, ongoing assessment of risk to others with full involvement of the service user to reduce potential harm | Y | |
| 20. Service users are cared for in an environment which balances safe observation and privacy | Y | The directorate has developed an action plan around privacy and dignity that seeks to further improve the quality of environment and ability to supervise patients effectively. |
| 21. Service users are regularly and actively involved in identifying care that meets their safety needs | Y | Through care plans and review of risk assessments |
| 22. There is a no blame culture which allows investigation of complaints, adverse incidents and near misses and ensures that lessons are learned and acted upon | Y | The DSB, Clinical Governance and Risk Health & Safety Groups receive reports on adverse incidents and issues of concern in summary form (and in detail) and identify learning points for sharing across the directorate e.g. recent medication report to DSB and Clinical Governance |
| **Essence of Care Benchmarks on Pressure Ulcers** | | |
| 23. All service users identified as being at risk of pressure ulcers in the screening process progress to further assessment by assessors who have required specific knowledge and skills which they update on an ongoing basis | Y | Patients receive an initial and ongoing risk assessment in the first episode of care (within 6 hours) by a qualified nurse.<br><br>Staff still require specialist training in pressure ulcer prevention and management. Safety Federation working group looking to establish consistent training. |
| 24. Service users and/or carers have ongoing access to information concerning the prevention and treatment of pressure ulcers and have the opportunity to discuss this and its relevance to their needs, with a registered practitioner | Y | NICE guidance leaflets available for all patients & carers. All patients who require pressure ulcer prevention and management receive a copy of their care plan. |
| 25. Individualised documented plans for the prevention and treatment of pressure ulcers are agreed between multidisciplinary teams, service users and/or their carers with evidence of ongoing reassessment. The individualised plans are fully implemented and evaluated by the multidisciplinary team, service users and/or carers | Y | The multidisciplinary team take responsibility for documented plans for the prevention & treatment of pressure ulcers, which are reviewed regularly. |
| 26. The service user's need for repositioning has been assessed, documented, met and evaluated with evidence of ongoing reassessment | Y | Staff are aware of the need for repositioning; all patients are assessed and repositioned accordingly.<br><br>30 degree tilt not used, moving & handling do not include this in her training. |

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| 27. Service users at risk of developing pressure ulcers are cared for on pressure redistributing support surfaces that meet their needs | Y | All clinical areas have high specification foam mattresses and have access to alternating pressure overlays, or sophisticated continuous low pressure systems as required. |
| 28. Resources and equipment are available for service users who require them to prevent and treat pressure ulcers | Y | All clinical areas have high specification foam mattresses and have access to alternating pressure overlays, or sophisticated continuous low pressure systems as required. |
| **Essence of Care Benchmarks on Continence** | | |
| 29. Service users and/or carers have access to evidence based information about bowel and bladder care which has been adapted to meet their needs | Y | As required and accessed via specialist service |
| 30. Service users have access to professionals who can meet their continence needs | Y | Basic assessment undertaken by OPMH staff as required. If expert continence advise is required this is accessed via local continence advisory service |
| 31. Service users are offered continence assessments where it is identified that they have bladder or bowel problems and this is completed where the service user accepts | Y | As above |
| 32. Service users are assessed and care is planned by professionals with continence care training and the care plans are continuously evaluated and updated with needs either being met or the care plan being modified. | In part | As a directorate although basic assessments are undertaken a broader training needs analysis has not yet been undertaken within the directorate |
| 33. Opportunities are taken to promote continence and a healthy bladder and bowels among service users and the community | Y | Undertaken through community team assessment. |
| 34. Service users have access to appropriate continence supplies to manage their incontinence and their carers have had appropriate continence care training including ongoing updates | Y | |
| 35. Continence care is provided in an environment that is conducive to the service user's needs | Y | |
| 36. Service users and/or carers have the opportunity to access other service users who can offer support with continence care | Y | |
| 37. Service users are involved in planning and evaluating services and their input is acted on | Y | ? via PCT |

| Self-Assessment of compliance status:- | Met | Partially Met | Not Met | Action Plans Attached |
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| At date of report | Y | | | |
| Projected / Anticipated score at 31/03/09 | Y | | | |

| Additional Comments: |
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| Please return to Debbie Sloan, Clinical Governance & Audit Facilitator, Maples, Tatchbury Mount, Telephone 07920 701195 or e-mail: Debbie.sloan@hantspt-sw.nhs.uk |