

**CG 03/2016**

(Agenda item: 8)

# Report to the Meeting of the Council of Governors

**09 March 2016**

 **Chief Executive’s Report**

**For Approval**

***External regulation/inspection/accreditation/learning***

**1. Care Quality Commission Inspection**

The CQC published the report of the inspection it undertook commencing 28th September 2015 on 15th January 2016 and Governors were circulated a summary of the ratings prior to publication. In brief, the Trust was inspected across 15 core services (two core services, Community Dentistry and GP Out of Hours were not inspected on this occasion) against five domains of quality – caring, responsive, well-led, effective and safe. Of those 75 specific assessments, 49 were rated ‘good’, 6 ‘outstanding’ and 20 as ‘requires improvement’. None were found to be ‘inadequate’ and there were no enforcement notices issued.

We were over-all rated ‘good’ in three out of five quality domains – caring, responsive and well-led and ‘requiring improvement’ in the remaining two, effective and safe. Based on weighted scoring across all services inspected the Trust therefore received an over-all rating of ‘requires improvement’.

Within this composite picture the majority (10 out of 15) of the Trust’s core services were over-all rated ‘good’ (10) and one, our children and young people’s community service, which includes school health nurses, health visitors and children’s community nurses, was rated as ‘outstanding’. Four core services, Community Health Inpatient Services, the Rehabilitation Mental Health Ward, Community Based Mental Health Services for Adults, and Acute Wards for Adults of Working Age, were overall rated as ‘requires improvement’.

The CQC found that the Trust was well-led with: accessible visible management at all levels and good working governance systems. It was responsive to people’s needs across services especially in a crisis, including reducing the need for police involvement in mental health crises, and in providing emotional support and counselling, especially for end of life care and bereavement. Patients and staff knew how to raise concerns and there was good learning from incidents and complaints. Perhaps most importantly, staff were found to be caring.

The report notes: “In most services, we found that staff were committed, dedicated and passionate about the work they did. Patients and their carers spoke positively about the care received and felt they were treated with dignity and respect.” In some services caring was rated ‘outstanding’… “Luther Street medical practice, CAMHS community services and community children’s services … showed passion, enthusiasm and received overwhelmingly positive feedback.”

Improvements are required in safety to ensure that across all Trust services the same high standards are observed. Inspectors noted “On the whole services were safe, but the trust received a rating of requires improvement because we found pockets of poor practice.” They also noted that some of our older estate, especially inpatient mental health settings at the Warneford Hospital, was outdated for the delivery of modern mental health care. Other areas of further work include:

* Improving how we record and demonstrate patients’ involvement in their own care planning
* Ensuring consistent high quality records of care plans and assessments
* Continuing our work to implement a new end of life care pathway and monitoring the impact of this work
* Continuing to monitor and respond to increasing demands on staff specifically in community services
* Reviewing ‘blanket’ restrictions on some wards for example allowing all patients free access to garden areas
* Tightening monitoring arrangements around equipment including resuscitation equipment and trust labelling for ‘To Take Out’ medicines
* Continuing to work with staff to ensure all mandatory training specifically resuscitation is completed.

Inspectors noted that: “Across all services trust staff were good at recognising safeguarding and reporting incidents. Teams learnt from incidents and there was shared learning across services, through regular ‘briefing notes’ and “staff had good access to mandatory training and good induction programmes, as well as opportunities for continuous professional development.”

On partnership working inspectors noted, “the Trust is clearly committed to services that are multi-agency and multi-disciplinary and this was evident from the board discussions we observed and how staff at the frontline described the care.”

Effectiveness was rated as requiring improvement. The main area is involving patients in planning and reviewing their care and noting it on their records. A major piece of work on developing a new Patient Involvement and Engagement Strategy, in collaboration with patients and people who care for them is underway and due for completion by Spring 2016. The second area for improvement is around embedding more consistent patient assessments to evaluate pain (although timely administration of pain relief was reported positively by patients) and swallowing difficulties; and the third area is continuing to implement and assess the impact of our new end of life care pathway. Work has been completed or is underway to address all of these matters. Overall inspectors found that National Institute for Health and Care Excellence (NICE) guidelines were followed.

The CQC has indicated that is considers the action arising from the inspection is of such a nature that it would be able to return for a focused inspection in around six months’ time, with a view to assessing whether, by that point an overall rating of ‘good’ had been obtained. In the meanwhile the follow up action to the individual recommendations will drive the Trust’s improvement activity. Following a successful Quality Summit involving key stakeholders, Monitor and the CQC, an action plan with the support of our Commissioners has been finalised and will be submitted to the CQC and to Monitor. The CQC will oversee our progress through established quarterly meetings; the Board’s oversight will primarily be through its Quality Committee and we will continue to appraise the Governors of such progress, most probably under the aegis of the Council’s Quality and Safety Committee.

**2**. **Monitor Investigation**

Although Governors were sent a copy of the letter and outcome towards the end of November, for completeness, Monitor has concluded its investigation into the Trust’s finances, and has decided to take no formal regulatory action. The Trust’s governance rating has since returned to green. Nevertheless, given the very challenging financial environment faced by all NHS organisations we can continue to expect close monitoring as we develop our plans for next year and as we implement those for the remainder of this year. It is encouraging to see the recognition that the Trust is already very efficient in its provision of services against a number of benchmarking indicators, in addition to the Reference Costs Index figure, which continues to mark us out amongst the most efficient of NHS organisations, all of which serves however, to make significant cost reduction relatively more challenging for the Trust.

**3. Baby Friendly Initiative**

The Baby Friendly initiative (BFI) is a worldwide programme developed by the World Health Organisation (WHO) and UNICEF that aims to improve standards of care for breastfeeding within healthcare settings. In the UK, BFI works with public services to protect, promote and support breastfeeding and strengthen mother – baby and family relationships. Inherent in the programme is a recognition that support for these relationships is important for all babies, not only those who are breastfed.

There are a set of standards that underpin BFI and the initiative is implemented through a staged approach. Stage 1 accreditation depends on building a firm foundation via, inter alia, written policies to support the standards, development of an education programme and the development of processes to implement, audit and evaluate the standards.

At stage 2, there is an assessment to ensure that staff can implement the standards according to their role and the services provided. The Trust’s Health Visiting service has recently had a stage 2 accreditation visit. Two assessors interviewed 30 members of the Health Visiting teams, along with the project lead, a locality team leader, operations manager and senior nurse to ensure that training was implemented as stated, and that staff have the knowledge and skills to effectively provide support to families in line with the standards.

Feedback from the assessors was outstanding and they noted the warmth and sensitivity shown by staff. The lead assessor commented on everyone's enthusiasm and desire to support Mums, saying that, until Oxford Health FT, she had never done an assessment where all staff demonstrated communication in a mother centered way.

We are already preparing for the stage 3 assessments, and hope to complete this during Spring/Summer 2017.

**4. Trust’s response to Mazars report into Mental Health and Learning Disabilities deaths in Southern Health NHS Foundation Trust**

The Trust has a system so that all serious incidents and unexpected deaths are clinically reviewed by a group on a weekly basis, and further investigations are commissioned as appropriate. All investigations follow the serious incident process which involves at least two people investigating and preparing a report which is then presented to a panel for approval, before being scrutinised by our commissioners. We also ensure the duty of candour requirements are followed as part of the serious incident process.

All NHS providers were asked by the Director of Patient Safety and Medical Director at NHS England to compile and submit figures by 31st Jan 2016 setting out the number of deaths in the previous year, along with information on how many were locally reviewed, and how many were potentially preventable. Following communication with three other similar NHS Trusts, it became apparent that as a result of limited instructions for the submission of data, each Trust was counting and reporting the data differently. The Trust has raised a concern with NHS England about the information being published, as it seems that the data collection tool needs further development to ensure the data is accurate and can be compared.

In addition to the above submission, the Trust is carrying out a self-assessment against the recommendations made by Mazars into the deaths at Southern Health NHS alongside other national recommendations e.g. Monitor’s mortality governance guide, to test our current processes and systems pertaining to how we review, learn and analyse data around deaths. This work is being led by Ros Alstead and Clive Meux, with regular reporting to the Trust Board. We hope to complete the self-assessment and identify any actions by the end of April 2016.

***Local system-wide initiatives/matters***

**5.** **Delayed Transfers of Care (DToC) – Oxfordshire**

Whilst good progress is being made with the plan to use nursing home beds enhanced to provide intermediate care for a cohort of patients who were ready for discharge from acute and community hospitals, there remain considerable pressures on the system in Oxfordshire to effect discharge of patients admitted since then. In particular, the improvements which have been made to the system are highlighting the importance of, and the difficulty in obtaining, additional domiciliary social care. We are working closely with acute and social care colleagues and have agreed to implement a common ‘command and control’ system to deploy resources as effectively as possible across acute and community hospital beds, and across Supported Hospital Discharge (SHDS), Reablement and domiciliary social care services. We are also seeking to augment the capacity in SHDS/Reablement by encouraging staff who wish to volunteer to work additional shifts. This will be funded from the resources provided for the DToC plan by the Clinical Commissioning Group (CCG).

**6.** **Oxfordshire Devolution**

As I mentioned at the Council’s last general meeting, following the interest in proposals for devolution in Greater Manchester and elsewhere, which have embraced health and social care, the Department of Communities and Local Government invited, at relatively short notice, outline proposals for devolution. Oxfordshire local authorities put forward such a proposal, and following consultation with health colleagues it was developed to include health.

The Oxfordshire devolution proposal was submitted to central government at the end of November. Follow up discussions are taking place mainly through the CCG and County Council, but are closely related to the need to develop a five year ‘place based’ plan outlined in the most recent planning guidance. In the last few days a separate proposal for the development of unitary authorities has been made public by District Councils in Oxfordshire, which also entails some integration and devolution of health and social care. The Trust has not so far been involved in the development of that proposal, but it adds to the range of options now under consideration. Further updates will be provided as the situation develops.

**7. Oxfordshire County Council (OCC) – ‘One Public Estate’**

Over the last year OCC have held a number of discussions with the Trust and other public sector colleagues about the financial challenges we all face and the potential solutions. Property has often been part of that discussion and clearly has the potential to be delivered in a different way between us all and this is also reflected in the Oxfordshire devolution proposals that OCC are currently developing with partners.

The ‘One Public Estate’ programme is an initiative funded by the Cabinet Office Government Property Unit. The programme is designed to facilitate and enable local authorities to work successfully with each other, with central government and with other local agencies on public property and land issues through sharing and collaboration. It has four main objectives:

1. Create economic growth

2. Generate capital receipts

3. Reduce running costs

4. Deliver more integrated and customer focused services.

 The programme has already had a number of tranches and it seems a further tranche is due to be launched in March. OCC are keen to take this opportunity to engage in the programme and have suggested that an initial meeting of those who are interested is held as early as possible. Our Director of Estates will attend this meeting to bring back to the Trust details of how it might support the programme

**8. Henley Townlands**

The Trust continues to work in partnership with Oxfordshire CCG, the Royal Berkshire NHS Foundation Trust and locality partners to plan the implementation of the Rapid Access Care Unit (RACU) model of care in preparation for the completion of the new hospital building.

The transition/implementation plan comprises of three key areas:

• Implementing the new model of care for the RACU in conjunction with partners, including staff consultation processes.

• Interim/transition arrangements, including the move undertaken late last year to move the inpatient capacity from the old Peppard ward to Wallingford Hospital pending implementation of the RACU and the “step-up/step-down beds” (the latter to be co-located at Henley Townlands hospital site).

• Move arrangements for existing services that will transfer from the current accommodation into the new hospital building once it is completed, for example the minor injuries unit, GP Out of Hours (OOH) and outpatient services such as podiatry.

Once the contractors have completed the new build and it has achieved formal completion status, the Trust will re-locate existing services into the new building within an anticipated 28 day timeframe. This will also enable the final stages of the RACU implementation to be completed. A key aspect of this transition is to ensure any potential disruption to service delivery during the actual move from the old to the new accommodation.

***Trust – internal initiatives/matters***

**9. Junior Doctors**

The dispute over the Junior Doctors’ contract has reached the point where Sir David Dalton, who was leading negotiations on behalf of the Department of Health, wrote to the Secretary of State to say that he believed that a fair and reasonable final offer had been made to the BMA, but had been rejected. The Secretary of State has indicated that he intends therefore to impose the contract. Further strikes have since been announced and the prospect of judicial review. We are assessing the impact of the new contract, both in terms of the means by which it might offer opportunities to improve safety and quality and also its likely cost, as the impact on Trusts will vary depending on the extent to which they already deploy junior doctors across the seven day week, and the extent to which existing rotas are onerous. Arrangements to fund any additional costs of the contract are not yet clear at a national level.

**10. Buckinghamshire Recovery College Open Afternoons**

The Whiteleaf Centre in Aylesbury and Haleacre in Amersham recently hosted successful open afternoons when patients, carers and staff came together to learn more about this new initiative. The Recovery College is aiming to start offering taster courses from April in a number of different locations across the county, and the project board are working hard on the recruitment campaign for this whilst ensuring the college follows its principles of “Hope, Control and Opportunity”.

These two afternoons generated lots of ideas and suggestions about the types of courses the College could offer such as peer support, social inclusion, and understanding medication as well as yoga, mindfulness, and managing stress.

**11. Improving staff well-being and continuity of patient care: Physio pilot for staff**

I am grateful to the Trust’s Charity Committee for proposing that members of the Musculoskeletal **(MSK)** Physiotherapy team attend the March Council of Governors’ meeting to present the successful outcomes of a recent pilot. This work has reported significant positive impact on reducing staff sickness and improving staff morale and has led to very positive feedback from staff. These outcomes are progressive, although a longer period of provision of this intervention is required to fully quantify the benefits of increased continuity of care achieved through reduced staff sickness absence. There will be further consideration given in due course to how this intervention might be offered on a sustainable basis to all staff, incorporating both primary prevention (advice and education to staff to reduce the risk of MSK injuries) and physiotherapy treatment where required.

**12. Board appointments**

I am pleased to report that Dr Mark Hancock has been appointed as Medical Director to succeed Dr Clive Meux upon his retirement at the end of March. Dr Hancock is currently Deputy Medical Director, and so arrangements are now in process to fill that position too. The post of Chief Operating Officer and Deputy Chief Executive was accepted by Mr Dominic Hardisty; formerly Deputy Chief Executive of Northamptonshire Healthcare NHS Foundation Trust and Dominic commenced working for the Trust on 22nd February 2016. I am grateful to those Governors that were able to participate in the recruitment process through involvement in the focus groups.

I wish to place on record my appreciation to Dr Clive Meux, for his tireless commitment to the role of Medical Director and I am delighted that our service users and the Trust will continue to benefit from Clive’s professionalism and experience through his continuing clinical work in the Trust. I wish also to formally record my thanks to Pauline Scully for acting as COO since the beginning of January, who following a short period of support for handover will return to her role as Service Director.

**13. Recommendation**

The Council of Governors is invited to note the report and to seek any assurances pertaining to matters arising from it where necessary.

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