Oxford Health NHS
NHS Foundation Trust




Quality Account 2015/16 and Quality Report 2014/15

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Part 1: Statement on quality from the chief executive

Chief executive's statement

I am delighted to introduce the Quality Account and Quality Report for Oxford Health NHS Foundation Trust (OHFT) which provides us with the opportunity to reflect on our quality achievements and successes over the past twelve months as well as to identify areas for further improvement, including our quality priorities for the coming year. To the best of my knowledge the information contained in this report is accurate.

In 2014, the Commonwealth Fund identified the NHS as the best healthcare system among eleven other developed nations[1]. This is a testament to the hard work, commitment and compassion of staff across the NHS and I would particularly like to thank everyone here at OHFT for continuing to provide such excellent care.

The challenges we face are not just financial. People are living longer than they used to and often with more complex health needs. Mental health services also continue to influence national policy and funding to ensure parity of esteem. In the long run it is unlikely that we have the right workforce available to meet the changing demands across health and social care systems. This is why we need to find new ways of working. We are developing partnerships with our colleagues working in social care, hospitals and the voluntary sector to come up with system-wide solutions. High quality care that is caring, safe and excellent, that focuses on early intervention and involves patients and those close to them, will achieve the best outcomes and is the best value care.

Last year we set ourselves an ambitious set of quality priorities which have resulted in some quantifiable successes. We have seen an increase in the number of patients who return on time from leave and a reduction in the number of serious incidents resulting in severe harm. Staff have delivered a range of innovations and improvements which are detailed in this report. Community nursing teams are improving assessments and care for patients at risk of pressure damage. We will shortly be implementing our new Electronic Patient Care Support (CareNotes) System which was commissioned with our staff. We have also rolled out the Friends and Family test to all our services and ensured that all teams have ways of collecting and responding to patient and carer feedback. The whole trust became smoke-free on 2 March 2015, including our new community hospital in Bicester.

Over the last twelve months we have implemented our comprehensive service and pathway remodelling programme in adult and older adult services. The aim was to ensure our services are patient-centred, that we emphasise family and carer involvement in developing outcome measures and that interventions are evidence-based. This is reflected in the recent move towards outcomes based contracts, delivery of services in partnership with other providers, and integration of care locally.

[1] Commonwealth Fund report: comparison of 11 countries

In the coming year we have consolidated our quality priorities into four key aspects of quality: a safe and effective workforce supported by effective leadership, working well in teams and focused on continuous improvement; improving quality through service remodelling; striving for a positive patient and carer experience (and acting when this is not the case); and increasing harm-free care.

Stuart Bell CBE
Chief Executive

May 2015

Who we are

OHFT is a community-focused organisation that provides physical and mental health services integrated with social care with the aim of improving the health and wellbeing of all our patients and their families.

Our trust provides community health, mental health and specialised health services. We operate across Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Wiltshire, and Bath and north east Somerset (BaNES).

We employ 6172 staff with a contracted WTE of 4743.61[2]. This number includes

- 306 medical staff
- 686 therapists
- 1837 qualified nurses
- 1026 health care workers
- 354 other support staff including ancillaries and, care workers
- 707 other professional including psychology, dental staff and social workers

In Oxfordshire we are the main provider of the majority of non-GP based community health services for the population of Oxfordshire and deliver these in a range of community and inpatient settings, including eight community hospital sites (ten wards). Our mental health teams provide a range of specialist healthcare in the community and from inpatient settings across the geographic areas of Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire and BaNES. We also provide forensic mental health and eating disorder services across a wider geographic area including support for patients in Berkshire, the wider Thames Valley and Wales.

We currently operate our services out of 32 freeholds, 45 leased/licenced and 100 informal properties (mainly general medical service and other general practice premises) across around 155 sites in five counties. We have a capacity of 400 inpatient mental health beds, and are also commissioned for 191 community hospital beds.

Our aim is to improve the health and wellbeing of all our patients and families and we work in partnership with a range of other organisations in the areas in which we provide services. These include:

- the University of Oxford to promote innovation in healthcare, support research and to advance doctors and psychologists

[2] numbers correct as of April 2015

- Oxford Brookes University, Bucks New University, the University of West London, the University of Bedfordshire, University of Reading, University of Coventry and Thames Valley Local Education and Training Board to educate nurses and allied health professionals
- local partner NHS organisations for example, Oxford University Hospitals NHST
- local authorities and voluntary organisations
- GPs across all the locations we serve in order to provide joined-up care

You can find out more about the many different services we provide and our locations on our website: www.oxfordhealth.nhs.uk.

Executive Summary

All NHS Trusts are required to produce annual Quality Accounts to describe past and future activities to improve the quality of the services they provide. In this report (from page 8) we describe our main quality priorities for 2015/16. We are required to include specific data from 2014/15 which we have provided to national bodies such as the Care Quality Commission and the Health and Social Care Information Centre (from page 32). In section 3 (from page 36) we describe all of our achievements against the eight quality priorities we set ourselves for 2014/15. We have explained acronyms and terms in the main text or in footnotes; there is also a full glossary at the end of the report.

Key achievements last year

We set ourselves eight quality priorities in 2014/15 covering workforce, data quality, service remodelling, staff engagement, patient experience and outcomes, and assessing our services using the new five CQC questions (are our services safe, effective, caring, responsive and well led?). Staff across our Trust have spent time reviewing their services against the five CQC questions with the aim of making this business as usual.

We have achieved or exceeded many of our targets and objectives for last 2014/15 and the detailed review of progress can be found in Section 3 (page 36) of this report.

We achieved most of our objectives for our workforce priority. Almost 225 managers have received team effectiveness training and report an improvement. Despite staffing pressures we have maintained levels of access to training. We did not achieve our appraisal target due to significant changes in management structures over the year. Staffing levels are monitored every week and no ward dropped below 92.7% of shifts being fully staffed.

In our 2014 staff survey we had above average scorers for percentage of staff able to contribute towards improvements at work; staff recommendation of the trust as a place to work; and percentage of staff agreeing feedback from patients/service users is used to make informed decisions in their directorate. We were in the worst for seven (work pressure and harassment). We were shortlisted for the Nursing Times and Award for excellence in supporting staff and wellbeing.

We achieved the objectives we set for quality of data and quality on data. Our quality dashboard will help us to assess where we are doing well and potential areas of vulnerability in terms of quality. We have also approved a standard data quality matrix for use across the

Trust to monitor and track data completeness and accuracy. Our data quality audits identify further room for improvement.

We achieved most of our objectives for service remodelling. The planned service changes in adults and older people's services have successfully been implemented, including extended hours, leadership teams, cluster packages, outcome-based measures, integrated locality teams and the relocation of the City Community Hospital to the Fulbrook Centre. We need to improve some of our Care Programme Approach (CPA) metrics – our new care record system will ensure better documentation of actions.

We achieved our physical health assessment targets but not our venous thromboembolism (VTE) assessment target (however we have not had any VTE events) and we also need to continue work to measure multi-disciplinary assessments for older adults with complex needs. A number of services have a range of locality and ward based patient forums. We achieved our objectives to review early intervention and complex needs services and a system-wide dementia care strategy has been agreed.

All schools in Oxfordshire now have a health plan. We exceeded our health visitor staffing targets and have delivered a range of activities to improve infant feeding and breastfeeding-friendly access. We describe three pathways where we have worked with patients and those close to them to develop outcomes and then measure progress against these.

We achieved most of our objectives to improve staff engagement. We have substantially reorganised our quality governance structures at a trust and directorate level. Peer reviews to assess service quality have taken place across all care pathways. Whist some opportunities were available to bring together staff and Board members, this requires further work to make it more consistent and frequent.

We have developed a framework for values-based recruitment but now need to implement and measure the impact of this. We have developed a new risk management process for the Trust which is working well in some areas; however not all teams have transitioned to the new system.

Staff have delivered a substantial number of improvement activities which have resulted in some quantifiable benefits in terms of increased time to care and reduction in harm.

We achieved some of our objectives for reducing harm. Incident reporting (which demonstrates a strong reporting culture) has increased again this year, with no overall increase in serious incidents. We have improved on last year's number of Clostridium Difficile (CDI) cases and did not exceed the threshold set by our commissioners. Reported medication incidents have increased since last year reflecting work to improve reporting. The pharmacy team are leading a number of actions to reduce harm from medication incidents.

There have been fewer suspected suicides this year. The overall number of absences without permission (AWOLs) has reduced but we have not achieved our target of a 50% reduction. There was no harm reported as a result of any AWOL this year.

We have not achieved the reduction in avoidable pressure damage we were aiming for this year. Skin integrity assessment was maintained the same level as last year figures but there has been a drop-in nutritional assessments. Our 2015/16 priorities describe the actions we will take as a result.

We have achieved our target for reducing the number of and level of harm from falls in mental health wards. We have not achieved our target for reducing falls on community hospital wards. We plan to improve falls related assessments in the coming year. The number of incidents relating to violence and aggression has increased. However the number of prone and hyper flexion restraints has reduced (the latter by nearly 75%).

We achieved most of our objectives for implementing our patient experience strategy. This year has seen a change in the range and scope of patient experience feedback. We worked with local organisations including Healthwatch Oxfordshire to improve how we share and respond to feedback and detail a number of actions we have taken as a result. We are still working on the development of a webpage to share feedback.

We achieved our objectives for developing outcome measures with patients. We are reviewing outcome measure tools including the outcome star for school health nurses, developing a system for health visitors and using goal-based outcomes with speech and language therapy services in Buckinghamshire.

We achieved our objectives for using the new CQC framework including peer reviews across all of our services using the new CQC standards. Staff now routinely discuss and review their practice against the CQC's five questions.

Examples of good practice include:

- We carried out 35 clinical audits and participated in 100% of the national clinical audits and national confidential inquiries we were eligible to participate in.
- We recruited over 2000 people to participate in approved research.
- Safer staffing is reported and monitored weekly and improved recruitment.
- Safer Care projects are in place in child and adolescent mental health services (CAMHs), school health nursing, inpatient units and community teams.

- OHFT has achieved or is working towards 24 external accreditations and peer reviews.
- Opal Ward (mental health rehabilitation) at the Whiteleaf Centre, Aylesbury, has been accredited as "excellent" by the Royal College of Psychiatrists' Combined Committee for Accreditation and achieved accreditation in mental health inpatient services.
- Two eating disorder wards also achieved an "excellent" rating using national standards.
- Oxfordshire dental services have been awarded the quality in dentistry award by the British Dental Association.
- In Witney, of 33 GPs, 100% were likely or extremely likely to refer a patient within the next month to the Emergency Multi-disciplinary Unit.
- Advanced Assessment Skills training was rolled out to staff working in the assessment function of the adult mental health teams (AMHTs).
- On one of our adult mental health wards we have set up a physical health clinic which patients can attend to receive advice and support.
- Over the last six months the out of hours service has seen a 2.5% increase in home visits to help patients remain in the community.
- Patient satisfaction scores remain high despite pressures on all services.
- We have received the Dignity Plus award for dementia care.
- We have actively involved patients and carers in service remodelling.
- There is 24/7 day working in community mental health and urgent care services and enhanced staffing levels on mental health wards.
- Our Patient Advice and Liaison Service (PALS) visits wards and runs open surgeries for patients to raise concerns at the point at which they are receiving care.
- There are "Have your say" forums to deal with problems as they arise.
- There are 18-25 services for Looked after Children in Wiltshire and BaNES.
- We have implemented transitions clinics with adult mental health services in Wiltshire and BaNES to plan ongoing care post-18 years.
- There is a co-ordinated response to winter pressures to support patients at home.
- We have replaced the East Kent Outcome Scores (EKOS) with the Functional Independence Measurement (FIM) tool in Community Hospitals.
- The Chiltern Memory Team, South Buckinghamshire, was identified as an excellent example of best practice in memory services across England, seeing people within 40 days from assessment with a 90% response rate.
- There are daily ward rounds to improve discharge, reducing the average length of stay.

Areas for improvement (which are all reflected in our priorities for 2015/16) include:

- Improve how we share learning from incidents and complaints.
- A range of building works to ensure premises are safe and suitable.
- Improve clinical leadership and reduce vacancies in community nursing.
- Some aspects of medicines management for example, management of controlled drugs, medicines reconciliation and learning from medicine incidents.
- Improve nutrition and hydration care in all care settings.
- Improve the number of goals patients achieve through the Recovery Star.
- Improve documentation in patient records supported by the new care record system.
- Improve how patient and family feedback is presented and shared with staff.

- Improve the level of carer satisfaction through the Triangle of Care, carer awareness training for staff and improving our involvement in local carer reference groups.
- Improve how we ask for feedback for example, increase the attendance at local involvement forums, survey along care pathways and develop clinician level feedback.
- Continue to work with patients and their families so they feel they are involved in decisions about their care as much as they would like to be.
- A review of staff musculoskeletal injuries and stress.
- Joint working between our trust and acute services to share skills and reduce harm.
- Increase our response rate to the national staff survey by 5% and improve our scores.

Quality in 2015/16

Our four quality priorities for the coming year reflect where we need to make further improvement as well as some new areas for inclusion.

1. Enable our workforce to deliver services which are caring, safe and excellent:
Competent staff with regular access to training, working well in teams, and supported by effective leaders deliver safer, more effective care. We want to maintain access to training despite pressure on capacity, to increase the quality of performance development reviews, continue our work to embed effective team working and deliver a comprehensive leadership strategy. We also intend to improve staff wellbeing and ensure good communication between senior managers and staff working directly with patients and those close to them.

2. Improve quality through service remodelling:
We want to ensure service changes have a positive impact on quality and patient experience. We will deliver new projects to improve access and integrate care. We will also deliver a new patient care record to support our work on improving documentation and data quality.

3. Increase harm-free care:
We have made progress on reducing harm; however, we recognise there is an ongoing need to manage and reduce harm from suicide, falls, pressure damage, absence without leave and restraint. Older adults and patients with mental health needs have an increased risk of ill-health and we have added a new priority to improve health promotion and the physical health management of our patients.

***4. Improve how we capture and act upon patient and carer feedback*:**
In the previous year we have made a qualitative and quantitative improvement in capturing and acting upon patient feedback. We recognise, however, that this remains an area for improvement and we have added activities to improve carer involvement in planning and deliver of care.

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Priorities for improvement 2015/16

OHFT will focus on four priorities in 2015/16 covering staffing, improving quality through service change, harm reduction and patient and carer experience to enable our services to be caring, safe and excellent. Specific objectives and measures for each priority are detailed from page 12.

1. Enable our workforce to deliver services which are caring, safe and excellent

This will enable the service to be caring, safe, effective, responsive and well led. This builds on last year's workforce priority (page 45) and the staff engagement priority (page 57).

1.1 Ensure we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams.

1.2 Review actions to improve recruitment into vacant positions including implementation of the values-based recruitment framework.

1.3 Improve staff wellbeing (including reduction of harm to staff related to musculoskeletal injury and work-related stress), motivation, engagement between patient facing staff and more senior management and involvement in improvement activities.

2. Improve quality through service remodelling

This will enable the service to be effective and responsive. This builds on last year's service remodelling priority (page 51).

2.1 Continue the service redesign and pathway remodelling programme, specifically focusing on its benefits in terms of quality and outcomes for new pathways of care.

2.2 Monitor specific projects to improve outcomes, for example the extension of the Street Triage project; the work to extend A&E in-reach services; a partnership approach to managing patients frequently accessing services; implementation of the integrated locality teams; improve access for Looked After Children (LAC).

2.3 Monitor the impact of implementation of new electronic health record. Pilot the new quality dashboard at directorate level.

3. Increase harm-free care

This will enable the service to be safe and effective. This builds on last year's harm reduction priority (page 64).

3.1 Prevention of suicide (page 17)

3.2 Reduce the number of patients who are absent without leave (page 18)

3.3 Reduce the number of avoidable grade 3 and 4 pressure ulcers (page 18)

3.4 Reduce harm from falls (page 19)

3.5 Reduce the need for restraint and monitor the use of seclusion (page 20)

3.6 Improve physical health management of patients (page 22)

4. Improve how we capture and act upon patient and carer feedback

This will enable the service to be caring and responsive. This builds on last year's patient experience priority (page 78).

4.1 Capture and demonstrate how we act upon patient and carer feedback and improve our care environments.

4.2 Implement the Triangle of Care to improve carer involvement in planning and delivery of care.

Our quality priorities for 2015/16 were developed in discussion with our clinical directorates, our Governors, commissioners, and Healthwatch. They reflect feedback from patients, carers and staff, a review of themes from incidents, serious incidents requiring investigation (SIRIs), complaints, clinical audit and peer reviews of services, and consideration of local and national changes to service commissioning and provision.

We have retained those priorities from 2014/15 which remain key for us because of the nature of the service we provide (for example, prevention of suicide and reduction in the need to use restraint); which had an end date beyond the end of the financial year (for example, pathway remodelling); or where we consider we have further improvement to make (for example, patient and carer experience and involvement; ensuring staff wellbeing and reducing the number of avoidable pressure ulcers at grade 3 and 4).

They also include some new development objectives across a range of services. These priorities will represent the key areas we monitor and report on through the quality account. This list is not exhaustive and work on a wider range of quality and safety initiatives continues across all of our services.

These quality priorities and objectives are being delivered in the context of significant financial, staffing and activity pressures. OHFT considers quality improvement to be a key factor in delivering value, improving effectiveness and efficiency and ensuring better outcomes for patients and those close to them.

Key changes from last year:

- We have reduced from eight priorities last year to four in the coming year.
- We have combined workforce and staff engagement.
- We have combined service remodelling with data quality and improving outcomes.
- We have removed the priority relating to using the new CQC regulatory framework as this has become business as usual.
- We have included a number of new development objectives to show some of the quality improvement plans across the diverse set of services we provide.
- We have expanded the patient experience priority to include carers and the implementation of the Triangle of Care.
- We have created a better balance of physical and mental health priorities to reflect the different patient groups for whom we provide services.

Each measure will have a baseline for 2014/15, where this is available. The completion date for each of the development objectives is 31 March 2016 unless otherwise indicated.

Quality priority 1: Enable our workforce to deliver services which are caring, safe and excellent

There is a direct link between staff capability, capacity and motivation and quality. High performing teams with effective leadership are known to deliver higher quality care with increased patient satisfaction[3]. This priority recognises the need to support, develop and engage all of our staff in whatever role they perform. *This will enable the service to be caring, safe, effective, responsive and well led.*

1.1 Ensure we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams

a. Review and measure the impact of the Aston team working model using interviews, impact assessment questionnaires, team stories and repeated effectiveness audits / team temperature checks; and align effective team working into the Trust organisational development strategy.
b. Build effective operational and clinical leadership through trio leadership development[4] and delivery of a collective leadership strategy; monitor using the collective leadership scale and improvement in staff engagement score (staff survey).
c. Maintain existing levels of access to staff training and development, including clinical practice, improvement skills and professional leadership.
d. Monitor safer staffing in inpatient services and report on remedial actions to improve staffing levels and minimise harm arising from pressures on staffing.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
1.1a	Extent to which staff report effective team working	National staff survey	Annual	3.85	3.80 (national benchmark 3.84)
1.1a, 1.1b	Review of five staff stories	Qualitative and semi-structured interview	Quarterly	Stories from all services	n/a
1.1b	Evaluate trio leadership development and assess impact on leadership capability	Feedback from attendees	Six-monthly	Improved capability	n/a
1.1b	Performance development reviews completed in last 12 months	Learning and development records	Quarterly	95%	84%

[3] http://www.dh.gov.uk/health/2011/08/nhs-staff-management/

[4] Trio leadership development brings together the ward manager, consultant and matron; or team manager, community lead and consultant(s). The programme is aiming to support the trios in providing clear leadership for their respective teams working together to understand the different needs of the services and how these are delivered both operationally and clinically.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
1.1b	staff report having well-structured appraisals in the last 12 months	National staff survey	Annual	75%	38% (41% national benchmark)
1.1c	Skills courses attendance to maintain existing levels	Learning and development records	Quarterly	Maintain 14/15 levels	8671
1.1d	Number of wards unable to staff 90% of shifts	Manual	Quarterly	90% of shifts fully staffed	New indicator

1.2 Review actions to improve recruitment into vacant positions including implementation of the values-based recruitment framework

a. Take proactive action on recruitment to vacancies and monitor the impact of the new values-based recruitment framework.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target and lead*	*Baseline 14/15*
1.2a	Reduce vacancies as % of establishment	ESR	Quarterly	Target tba	*5.66%*

1.3 Improve staff motivation and wellbeing (including reduction of harm to staff related to musculoskeletal injury and work-related stress)

a. Implement key actions arising from the national staff survey results to promote staff wellbeing and motivation.
b. Reduce work-related stress through improved access to psychological therapies.
c. Monitor compliance with the working time directive for all Trust staff.
d. Reduce sickness absence due to musculoskeletal injury through the musculoskeletal (MSK) self-referral pilot in older people's services (fast track physiotherapy).

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
1.3a	% staff satisfied with quality of work and patient care they are able to deliver	National staff survey	Annual	75%	71% (national benchmark 76%)
1.3b	% of staff suffering work-related stress	National staff survey	Annual	No more than 42%	47% (42% national benchmark)
1.3c	% of staff working extra hours	National staff survey	Annual	No more than 70%	79% (national benchmark 71%)
1.3d	Reduction in absence relating to MSK injury in participating teams	BARM data	Quarterly for 6 months	Target tba	Baseline set Q1

1.4 Increase engagement between patient facing staff and more senior management and involvement in improvement activities

a. Ensure staff involvement in designing and delivering improvement activities.
b. Improve floor to board engagement and create more opportunities for communication between senior managers, teams and individuals.
c. Implement processes to ensure staff can raise concerns and to monitor actions taken.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
1.4a	% of staff able to contribute towards improvements at work	National staff survey	Annual	75%	73% (national benchmark 72)
1.4b	Overall extent of staff engagement/feeling motivated and engaged[5]	National staff survey	Annual	3.76	3.75 (3.72 national benchmark)

Quality priority 2: Improve quality through pathway remodelling and innovation

The primary aim of our pathway remodelling has been to improve quality through aligning and integrating care for patients, working with patients to develop and deliver outcomes and working in partnership within local health systems. This will help us to meet the changing needs of our patients – a diverse and ageing population living with complex long-term conditions, which require care delivered closer to home. *This will enable the service to be effective and responsive.*

2.1 Continue the service redesign and pathway remodelling programme, specifically focusing on its benefits in terms of quality and outcomes for new pathways of care

a. Evaluate quality improvements relating to new pathways of care, including the impact of the Recovery Star on outcomes, the impact of cluster packages, and the impact of redesigned team structures.
b. Evaluate the integration of physical and mental health pathways for older people and monitor impact on agreed quality measures.
c. Achieve accreditation for memory services (Memory Services National Accreditation Programme).

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 1415*
2.1a	% of patients with a CPA to be in employment or meaningful activity	CPA audit	Quarterly	11.8%	n/a
2.1a	% of patients with a CPA in settled accommodation	CPA audit	Quarterly	78.7%	n/a
2.1a	% of patients involved in setting and achieving goals	CPA audit	Quarterly	100%	88%

[5] Combines "Ability to contribute to improvements at work"; "Willingness to recommend the organisation as a place to work or receive treatment"; and "Feeling motivated and engaged with their work".

2.1a	Qualitative review of 10% of caseloads in AMHTs to	Audit	Annual	100% of audited caseloads in line with cluster allocation	New indicator

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
2.1b	Number of appropriate older adult patients given early warning score assessment (MEWS)	Audit	Quarterly	tba	Establish baseline Q1
2.1c	Accreditation achieved	manual	Annual	Accreditation achieved	n/a

2.2 Deliver specific projects to improve outcomes

a. Evaluate the goals based outcomes toolkit and impact of personalised outcomes and circles of support on patients' achievements in speech and language therapy services in Bucks.
b. Work in partnership with commissioners and other providers to develop outcome-based commissioning across a range of services.
c. Introduce a new cognitive behaviour therapy (CBT) pathway for patients with dental anxiety to reduce the need for sedation by rolling out a pilot project to train members of the dental team on CBT approaches and provide individual and group interventions.
d. Reduce the number of frequent attendances[6] to urgent care services and ensure care plans/special notes are available frequent attenders' notes.
e. Reduce incidents of deliberate self-harm in Marlborough House, Swindon.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 1415*
2.2a	Improved achievement of goals	Manual	Annual	tba	n/a
2.2b	Outcome-based commissioning extended	manual	Annual	Increase in OBC	n/a
2.2c	Decrease number of dental patients requiring sedation	Audit	Quarterly	tba	Establish baseline in Q1
2.2d	% of frequent attenders of urgent care where care plan/special notes are available	Adastra	Quarterly	95%	Establish baseline Q1
2.2d	Number of frequent attenders	Adastra	Quarterly	5% reduction	Establish baseline Q1
2.2e	Reduce incidents of deliberate self-harm	Ulysses	Quarterly	Reduce by 50%	Establish baseline Q1

[6] A frequent attender is a patient who contacts the service regularly and consistently presenting with a clinical picture similar to past attendances, more than three times per month over a period of three months. This is different from a repeat caller where the patient may have deteriorated and be calling for a further consultation; these are defined as 2 or more calls within 24 hours.

2.3 Improve access to services

a. Review opportunities for increasing CAMHS in-reach into schools.
b. Evaluate the availability and accessibility of services to Looked After Children (LAC) in partnership with local authorities across Oxfordshire, Buckinghamshire, Swindon, Wiltshire and BaNES including recording parental responsibility and offering health assessments within 20 days of notification.
c. Improve access to services for children and young people with a learning disability implement the dementia strategy with partners.
d. Extend Street Triage (ST) to reduce the number of Section 136 admissions through an increase of 5% in the number of contacts made via ST; and extend A&E in-reach services to increase the number of patients seen in A&E by 5%.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 1415*
2.3a	Opportunities for CAMHs in-reach identified	Manual	Annual	tba	n/a
2.3b	Record parental responsibility in clinical records for LAC	Audit	Quarterly	tba	Establish baseline Q1
2.3b	% of initial health assessments offered within 20 days of notification to LAC team (Oxon)	Audit	Quarterly	tba	Establish baseline Q1
2.3c	% of care notes which record patients with LD	Audit	Quarterly	tba	Establish baseline Q1
2.3d	Increase number of Street Triage contacts	EHR	Quarterly	5% increase	Establish baseline Q1
2.3d	Increase number of patients assessed out of hours within one hour of referral	EHR	Quarterly	tba	Establish baseline Q1

2.4 Improve information on patient care and quality

a. Monitor the impact of the new electronic health record against planned benefits. This is expected to make significant differences to staff in their ability to deliver accessible and comprehensive recording.
b. Pilot the new quality dashboard at directorate level.

Quality priority 3: Increase harm-free care

Safety remains one of our key priorities. For our patients this means both reducing self-harming behaviour and ensuring we deliver harm-free care. A renewed national emphasis on prevention and health promotion is reflected in a new priority to improve physical health management[7]. As well as six specific harm reduction priorities we will also continue to report on incidents and SIRIs, infection prevention and control,

[7] This also reflects our findings from clinical audit, incidents and SIRIs, and complaints and concerns which suggest that more needs to be done on the assessment and monitoring of physical health both for inpatients and for patients cared for in the community.

medication incidents and safety thermometer measures for physical and mental health services. *This will enable the service to be safe and effective.*

3.1 Prevention of suicide

a. Implement learning from SIRIs including improved continuity of care, risk assessment and discharge planning, and communicate with and involve carers in care planning.
b. Implement rapid multi-disciplinary consultant-led reviews in clinical teams following a patient (suspected) suicide.
c. Include the interpersonal theory of suicide in the Clinical Risk Assessment Policy and training. In addition, work with relevant universities to ensure the pre-registration mental health nursing curriculum adequately covers suicide awareness, assessment, management and prevention.
d. Develop a suicide prevention strategy, aligned with Bucks and Oxon public health-led suicide risk reduction strategies, to ensure both community services and mental health services are contributing to the wider community activities to reduce suicide.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.1a	Days between probable suicides in individual mental health teams	Ulysses	Quarterly	300 days between in 8 teams	Achieved in 3 teams
3.1a	Days between probable suicides in inpatient services	Ulysses	Quarterly	300 days between	achieved
3.1b	Rapid review occurred within 10 days of incident	Initial Investigation Report	Quarterly	100% of incidents	n/a
3.1c	Curriculums developed	Manual	Annual	n/a	n/a
3.1d	Strategy developed	Manual	Annual	n/a	n/a

3.2 Reduce the number of missing patients from inpatient services

a. Reduce the number of incidents of patients who fail to return from leave on time, or who abscond from leave or premises by 50%.
b. Due to the low level of harm we will start to measure days between of harm (rated 3, 4 or 5 for impact) to patients or others a result of absence without permission.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.2a	Number of incidents where patients do not return on time from approved leave	Ulysses	Quarterly	50% reduction	218

3.2a	Number of patients absent without permission	Ulysses	Quarterly	25% reduction	153
3.2b	Days between harm to patients or other people arising from absence without permission	Ulysses	Quarterly	300 days between	300

3.3 Reduce the number of avoidable grade 3 and 4 pressure ulcers

a. Improved coordination of care through the introduction of risk stratification of patients and use of safety rounds for patients on district nursing caseloads.
b. Introduce the SOAPIE[8] model for care planning and the Braden Pressure Ulcer Risk Assessment Tool across all services.
c. Roll-out SSKIN[9] bundles to increase reliability of prevention damage prevention and management.
d. Increase staff knowledge and capability through ongoing development of level 4 pressure ulcer prevention and management training.
e. Implement and evaluate the third iteration of the Skintelligence programme to improve partnership working with care homes and use Institute of Healthcare Improvement methodology to reduce avoidable pressure damage across the health and social care system.
f. Implement and review wound care and pressure damage training for children and young people's inpatient units.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.3a-e	Days between avoidable pressure damage grade 3 and 4 in community teams and hospitals	Ulysses	Quarterly	300 days between	New indicator
3.3a-e	Reduce avoidable grade 3- 4 pressure tissue damage	Ulysses	Quarterly	10% reduction	12
3.3b/c	SOAPIE, Braden and SSKIN bundles in place	audit	Quarterly	n/a	n/a
3.3d	% of required staff attending level 4 training	L&D	Quarterly	tba	71% of phased target
Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.3e	Evaluate Skintelligence programme	Manual	Annual	n/a	n/a

[8] Subjective (patient), Objective (clinician), Assessment, Plan, Intervention, Evaluation.
[9] tool that acts as a prompt to staff to undertake a risk assessment and provide management of the risk with patients

3.3f	Number of staff attending training in C&YP units	L&D	Quarterly	tba	Baseline set Q1

3.4 Reduce the number of patients harmed by falls

a. Reduce the number of falls by 1000 bed days to 8.6 in physical health and maintain at under 3.8 in mental health.
b. Reduce the level of harm from falls by 1000 bed days (rated 3, 4 or 5 for impact) to 0.2 in physical health and maintain at under 0.2 in mental health.
c. Ensure patients have appropriate risk assessments on admission, after 28 days and after a fall.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.4 a/b	Number of falls/number resulting in harm by 1000 bed days	Ulysses	Quarterly	3.5 (0.3 harm) MH 8.6 (0.3 harm) PH	3.7 (0.3 harm) MH 12.6 (0.5 harm) PH
3.4c	% patients in older adult inpatient services to have falls risk assessment on admission	Audit	Quarterly	100%	95% (based on 3 data points)
3.4c	% patients in older adult inpatient services to have a further falls risk assessment after 28 days	Audit	Quarterly	100%	60% (1 quarter's data)
3.4c	% of patients to have a review of care plan after a fall	Audit	Quarterly	100%	69%
3.4c	% patients to be referred to falls service after 2 or more falls	Audit	Quarterly	80% MH 80% CH	37% MH 67% CH

3.5 Reduce the need for restraint and monitor use of seclusion

a. Implement a revised training programme for Prevention and Management of Violence and Aggression (PMVA).[10]
b. Develop and implement children's module as part of PMVA (now known as PEACE) training (piloted in the Highfield Unit) to reduce the number of incidents of violence and aggression (V&A) and harm (rated 3, 4, or 5 for impact) by 25%.

[10] This is in line with the DOH publication *Positive and Proactive Care: reducing the need for restrictive interventions* (April 2014). This is part of the government led initiative called *Positive and Safe* which is a two-year project to change the approach to managing challenging behaviours in health and social care settings

c. Report on and reduce the number of prone restraints (where the person is face down) and use of hyperflexion (holding the arm to restrain).
d. Report on and monitor use of seclusion.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.5 a/b	Reduce number of reported incidents of V&A resulting in harm (rated 3, 4, 5 impact)	Ulysses	Quarterly	25% reduction	69
3.5c	Number of prone restraints	Ulysses	Quarterly	Towards 0	374/1679
3.5c	Number of restraints involving hyperflexion	Ulysses	Quarterly	Towards 0	39
3.5d	Number of incidents where patients secluded	Ulysses	Quarterly	25% reduction	336

3.6 Improve the physical health management of patients

3.6.1 Improve the management of patients' pre-existing (long-term) physical health conditions (for example, diabetes) and monitor the impact of medication and treatment

a. Improve basic physical health monitoring – blood pressure, early warning scores and standard of physical health assessment.
b. Develop a universal monitoring checklist for older adult mental health patients.
c. Develop a physical health policy and implementation and guidance.
d. Improve management of diabetes, and of delirium rather than dementia and monitor administration of clozapine.
e. Ensure timely information is shared with GPs and received from them and that OHFT has relevant information on the physical health and history of patients to whom we are providing care.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.6.1a	% of adult and older adult inpatients to have MEWS, track and trigger, physical health assessment, VTE and MUST within 24 hours of admission	EPR/audit	Quarterly	100%	VTE 92% PHA 99%
Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.6.1a	% of patients have their physical health	CPA audit	quarterly	95%	New audit 15/16

	needs assessed % of those care plans address the PH needs identified			95%	
3.6.1b	Universal monitoring checklist approved	Manual	Annual	n/a	n/a
3.6.1c	Physical health Policy approved	Manual	Annual	n/a	n/a
3.6.1d	% of patients prescribed psychotropic medication are monitored for side effects relating to that medication	CPA audit	quarterly	95%	New audit 15/16
3.6.1e	% of patients prescribed psychotropic medication where their GP has been informed of the need for ongoing monitoring by primary care in the community	CPA audit	quarterly	95%	New audit 15/16

3.6.2 Ensure staff have physical health skills in inpatient settings, community services and sub-acute settings

a. Expansion of the physical health skills course and/or other ways to deliver training effectively for staff in mental health and community/sub-acute settings.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.6.2a	Number of staff attending physical health skills training	L&D	*Quarterly*	tba	n/a

3.6.3 Support patients to reduce risk factors for poor health for example, nutrition and smoking

a. Monitor patient experience of smoking cessation and impact/perceived benefits at six months and twelve months for those in long-term care.
b. Ensure baseline monitoring and improve how patients manage their physical health for example, obesity, malnutrition and dehydration and ensure equipment is available for community staff for example, blood pressure (BP) and blood glucose monitors.
c. Monitor the impact of "Making Every Contact Count" (MECC).
d. Map health promotion work in 2015/16 and standardise activities in 2016/17.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.6.3a	Patient stories	Manual	Six-monthly	5 stories	n/a
3.6.3b	Nutritional needs assessment	Essential standards	quarterly	tba	n/a

	completed	audit			
3.6.3c	Evaluation of MECC	Manual	Annual	n/a	n/a
3.6.3d	Health promotion activities mapped	Manual	Annual	n/a	n/a

Quality priority 4: Improve how we capture and act upon patient and carer feedback

Patients and carers (relatives and friends) are experts in their own care and their involvement and feedback is critical to our understanding of when our services do well and where we need to make improvements. The lack of involvement of carers with care planning at the point of discharge from inpatient services has been raised as an issue on a number of occasions in the findings of SIRI investigations and the work to deliver the Triangle of Care recognises that carers are intrinsic to effective care planning. *This enables the service to be caring and responsive.*

4.1 Capture and act upon patient experience

a. Report on domains of patient experience (PE).
b. Monitor improvements made as a result of patient and carer feedback.
c. Monitor themes from complaints/concerns and implementation of actions.
d. Children and Young People (C&YP) to establish patient experience champions and involve service users in service development and recruitment.
e. Development of community hospitals (CH) patient discharge follow-up programme to better understand the patients' experience of discharge and identify improvements.
f. Review how C&YP collect patient experience and feedback, make surveys more engaging and manage communication with patients with communication difficulties to bring this into clinical practice (for example, reported outcome measures).

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
4.1a	Review of patient stories	Survey and interviews	Quarterly	5 per quarter	n/a
4.1a&1b	Improve patient satisfaction with services	Friends and Family test	Quarterly	tba	88%
4.1b	Examples of improvement actions	Manual	Quarterly	5 per directorate	n/a
4.1c	Number (%) of complaints actions outstanding			0 (0%)	
Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
4.1d	Number of PE champions	Manual	Annual	tba	n/a
4.1e	Number of CH patients contacted	Manual	Quarterly	tba	n/a
4.1f	New mechanisms to capture patient	Manual	Quarterly	n/a	n/a

	experience

4.2 Implement actions from the Triangle of Care to improve carer involvement in the planning and delivery of care

a. Implement actions from our self-assessment using the Triangle of Care and review local carers' strategies to improve communication with and involvement of carers in care planning, and ensure carer queries are responded to while appropriately maintaining confidentiality.

b. Evaluate impact of communication protocol toolkit in the Oxon Integrated Therapy Service on creating joint outcomes for children and improving communication with carers and carer involvement in care planning.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
4.2a	Improve patient and carer satisfaction with services	Friends and Family test	Quarterly	tba	CH +59.6 MIU + 72.5[11]
4.2b	Number of young carers offered support	Audit	Quarterly	tba	n/a

[11] 1. Don't know responses are excluded from the denominator for the net promoter calculation
2. Responses saying likely are excluded from the net promoter calculation (based on old national guidance)
3. The way of displaying the results in this way as a 'net promoter' is no longer supported nationally, figures should be presented as a % to each available answer option

Part 2.2 Statements of assurance from the board of directors

The trust has brought together all the mandatory statements required in the Quality Account into the following sections.

Review of services

During 2014/15 OHFT provided and/or subcontracted 58 NHS services. These services are based on the organisation of services within directorates in OHFT during 2014/15.

Children and Young People

Buckinghamshire, Oxfordshire and Swindon, Wiltshire and BaNES Child and Adolescent Mental Health and Specialist Services
Eating Disorders (community and inpatient)
Children's community services e.g. health visiting, school nursing, children's nursing
Oxfordshire Integrated children's therapy service
Public Health Services
Community Dental services
Buckinghamshire speech and language children's therapy service

Adult Service

Buckinghamshire and Oxfordshire adult mental health services (community and inpatient)
Forensic Services (community and inpatient)
Prison Health services
Luther Street Homeless GP practice
Psychological Therapies

Older People's Services

Buckinghamshire and Oxfordshire older adult mental health services (community/inpatient)
Eight community hospital sites providing inpatient care in ten wards in Oxfordshire
District nursing and specialist nursing therapies
Urgent care services
Dietetics
Podiatry
Musculoskeletal and physical disability physiotherapy
Re-ablement Service
Specialist Diabetic Service

Each of these divisions reviews service provision through quarterly quality and performance meetings, monthly clinical governance meetings, and patient feedback. The data reviewed covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience. The amount of data available for review has not impeded this objective to effectively review the quality of performance.

OHFT has reviewed all the data available to it on the quality of care in all 58 of these services. The income generated by the relevant health services reviewed in 2014/15 represent 100% of the total income generated from the provision of relevant health services by OHFT for 2014/15.

Activity in 2014/15

The following tables outline the activity delivered by OHFT in 2014/15.

Number of admissions

Admissions	Q1	Q2	Q3	Q4	2014/15 Total
Community hospitals	587	545	532	549	2213
Mental health	400	353	380	331	1464
Trust total	**987**	**898**	**912**	**880**	**3677**

Number of occupied bed days

Occupied bed days	Q1	Q2	Q3	Q4	2014/15 Total
Community hospitals	17019	20911	21108	17356	76394
Mental health	34293	34801	30113	33784	132,991
Trust total	**51312**	**55712**	**51221**	**51140**	**209385**

Face to face contacts

Face to face contacts	Q1	Q2	Q3	Q4	2014/15 Total
Community	266349	260631	265838	263594	1056412
Mental health	71051	68940	70335	67669	277995
Trust total	**337400**	**329571**	**336173**	**331263**	**1334407**

Service quality and accreditations

OHFT has achieved or is working towards 24 external accreditations and external peer reviews as of the end of 2014/15. These can be found in appendix 1.

Participation in national audit and confidential inquiries

Clinical audit priorities are selected on the basis of national requirements, commissioning requirements and local evidence, including where analysis of incidents and complaints have established specific areas for improvement. The Trust prioritises high risk, high cost or high volume activity. In addition any clinical audit rated as requiring improvement or unacceptable will automatically be returned to the plan for the next year. We operate a three year rolling audit programme. The Trust wide clinical audit plan for 2014/15 contained a total of 35 audit requirements across the directorates.

The table below provides the rationale for topic selection for the 2014/15 Trust wide Clinical Audit Plan. Five (22%) of the high priority internal audits were included on the plan as they were previously rated as either requiring improvement or unacceptable.

Rationale for topic selection 2014/15 audit plan	Number of audits	%
Mandatory audit requirements		
National audits	8	23%
Commissioning for Quality and Innovation (CQUIN) Audits	2	6%
Local Commissioning Audit Requirements	2	6%
Trust Priority		
High Priority Internal audits	23	65%
Total	**35**	

Of the 35 Trust-wide audits 12 (34%) were baseline audits and 20 (57%) were re-audits.

Type of audit	Number of audits	%
Baseline	12	34%
Re-audit	20	57%
Annual data submission	1	3%
Point prevalence audit - monthly data collection	2	6%
Total	**35**	

National audits

During 2014/15, eight national clinical audits and one national confidential inquiry covered relevant health services that Oxford Health NHS Foundation Trust provides. During 2014/15 Oxford Health NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the national confidential inquiries which it was eligible to participate in, as detailed below.

	Audit or inquiry	Participation (Yes or No)	Number of cases required by teams	Number of cases submitted	Percentage
1.	Prescribing Observatory for Mental Health (POMH-UK) Topic 14a: Prescribing for Substance Misuse (Alcohol Detoxification)	Yes	n/a	N=42	n/a
2.	POMH-UK Topic 12b: Prescribing for people with	Yes	n/a	N=76	n/a

	Personality Disorder				
3.	POMH-Topic 9 Antipsychotic prescribing in people with a Learning Disability	Yes	n/a	N=62	n/a
4.	Urgent Care telephone triage NQR4	Yes	n/a	N=269	n/a
5.	National audit of Intermediate Care	Yes	n/a	N=70	n/a
6.	Safety Thermometer Classic - reduction in harms (monthly point prevalence audit)	Yes	n/a	n/a	n/a
7.	Safety Thermometer Pilot for Adult Mental Health - reduction in harms (monthly point prevalence audit)	Yes	n/a	n/a	n/a
8.	Stroke Care (SSNAP)	Yes	100%	62	100%
9.	Mental Health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes	34	33	97%

A total of four national audits were reported and reviewed during 2014/15 following data collection in 2013/14. One of the key national audits for the Trust which reported in 2014/15 was the National Audit of Schizophrenia.

The results for Oxford Health did show an improvement from the baseline audit but a major finding both nationally and for Oxford Health was:

- poor monitoring of, and intervention for, risk factors for diabetes and cardiovascular disease.
- significant gaps in the availability of cognitive behavioural therapy and family interventions.

Key actions following National Audit of Schizophrenia

It is anticipated that the actions taken in relation to this audit will also address gaps identified in other national audits such as POMH Lithium and POMH attention deficit hyperactivity disorder (ADHD) monitoring which also included aspects of physical health monitoring.

- CP review to be used as the platform to review and monitor physical health by ensuring that GPs are contacted prior to every CPA review for the results of patients' annual health check and any relevant blood tests.
- Increase clinician access to local general hospitals laboratory results to support physical health monitoring.

- Ensure that clinics in the community are equipped with suitable equipment for physical measurements and include up-to-date information (for example, The Lester Tool).

Examples of some of the actions taken to improve patient care during 2014/15

Audit Title	Key actions taken to improve patient care
Audit of care standards for service users not on CPA	Template letter implemented across the Adult and Older Adult mental health teams which will standardise the information provided on all GP letters which includes the following: • Clear indication that the letter is the care plan • State risks or no risks and advise how they should be managed • Address arrangements for management of physical health issues • Include next review date • Include the trust 24 hour contact number
POMH Topic 7d Monitoring of patients prescribed Lithium	Forensic service has implemented a Lithium initiation form and a Lithium monitoring form which will prompt clinicians to undertake relevant physical health monitoring.
Audit of Conditions Relating to Community Treatment Orders (CTOs)	Process reviewed and strengthened by all new CTO1 forms and paper work received by the Mental Health Act office to be checked and active follow up with teams when documents are missing.
POMH-UK Topic 4b – Prescribing anti dementia drugs	Blood Pressure and Blood Pressure Monitoring machines supplied to all memory clinics to enable nurses to undertake physical health monitoring as part of their assessment
Audit of the prevention and management of pressure ulcers in the District Nursing service	A new role in the District Nursing service was introduced to improve standards generally around tissue viability care – the Tissue Viability Resource Nurse role. This involves registered nurses in each cluster having additional leadership and tissue viability training to enable them to take the lead with improving quality standards around all tissue viability related care in their clusters. They will also serve as an escalation point for ground level staff to escalate Tissue Viability related issues to.

Clinical research

The table below shows the number of studies currently recruiting participants within the trust. Fields containing a * are no longer being monitored.

As of 10 April At 1600	Total Number of studies	of Total OHFT sponsored	of Total Students	of Total, Clinical Psychology Trainees	of Total Funded	of Total PICs	of Total CTIMPs	of Total CCG/OHFT new	of Total NIHR UKCRN Portfolio	of Portfolio via CSP	of Portfolio via CSP OHFT Lead
Open	89	9	*	*	87	18	38		57	52	
Awaiting approval	19	1	*	*	15	2	6		8	1	

CTIMP Clinical trial of an investigational medicinal product(s) – drug trial
Open Currently recruiting or in analysis within study start and end dates
Awaiting approval Yet to be granted NHS Permission
PICs OHFT has agreed to act as a Participant Identification Centre
NIHR National Institute for Health Research
UKCRN United Kingdom Clinical Research Network
CSP Co-ordinated System for gaining NHS Permission – this is nationwide
OHFT Lead OHFT responsible for global (study-wide) governance checks

The number of patients receiving relevant health services provided or sub-contracted by OHFT in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee is 1901 for NIHR portfolio studies, and 369 for non-NIHR p-portfolio studies.

Commissioning for quality and innovation (CQUIN) payment framework

A proportion of OHFT's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between OHFT and any person or body that they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework.

The income conditional on achieving CQUINs for 2014/15 was £4,900,968 and for 2013/14 was £4,617,249.

Income from CQUINs 2014/15

Commissioner	Service	Amount	% of contract
Oxfordshire CCG	Adult and Older Adult Mental Health	£1,130,976	2.5
Oxfordshire CCG	Community Services	£1,599,848	2.5
Buckinghamshire CCGs	Adult and Older Adult Mental Health	£801,856	2.5
Wessex Area Team	Forensic, Eating Disorders & CAMHS	£834,675	2.5
Buckinghamshire County Council	CAMHS	£62,405	1.15
Wiltshire & BaNES CCG	CAMHS T3	£134,789	2.5
Swindon CCG/BC	CAMHS	£49,530	2.5
Wiltshire CCG	Eating Disorders	£5,844	2.5
Thames Valley AT	Public Health and Health & Justice	£255,150	2.5
Oxfordshire County Council	Harm Minimisation	£23,798	2.0
Swindon CCG	Community Services	£2,097	2.5

Income from CQUINs 2013/14

Commissioner	Service	Amount	% of contract
Oxfordshire CCG	Adult and Older Adult Mental Health	£1,123,694	1.2
Oxfordshire CCG	Community Services	£1,614,510	2.1
Buckinghamshire CCGs	Adult and Older Adult Mental Health	£800,305	2.5
Buckinghamshire CCGs	Speech and Language Therapy	£17,222	2.5
Wiltshire & BaNES CCG	CAMHS T3	£134,789	2.5
Swindon CCG	CAMHS	£51,102	2.5
Wiltshire CCG	Eating Disorders	£5,952	2.5
Wessex Area Team	Forensic	£599,537	2.5
Wessex Area Team	Eating Disorders & CAMHS Inpatients	£207,733	2.5
Buckinghamshire County Council	CAMHS	£62,405	0.4

Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care services in England. They make sure that the care provided by hospitals meets government standards to provide people with safe, effective, compassionate and high quality care. The CQC monitors these standards of care through inspections, patient feedback and other external sources of information gathered. They publish which trusts are compliant with all the essential standards of care and which organisations have conditions requiring improvements.

OHFT is required to register with the CQC and its current registration status is "registered without conditions". The CQC has not taken enforcement action against OHFT in 2014/15.

OHFT has not participated in any special review or investigations during 2014/15. We were involved in one themed review on mental health crisis care covering Oxfordshire Local Authority which included an announced visit in January 2015. Oxfordshire was one of fifteen local authorities selected. The review took a care pathway approach to assess how services and agencies work in partnership to provide help, care and support to people during a crisis. The three main pathways reviewed were how people accessed services via the emergency department, the police and through secondary mental health services. Providers will not be rated following the review. The main findings were as follows;

Areas of good practice

- Strong multi-agency working and a commitment to looking at joint work to encourage positive outcomes for people in mental health crises.
- Consideration of diverse needs of different groups in the local area. For example, students and homeless people.
- No groups are excluded from either health based place of safety.
- The Street Triage service was widely seen as a valuable service. Since being commissioned fewer people had been admitted to a health based place of safety.

Areas for development

- Improved communication between the two liaison services provided at the John Radcliffe Hospital and development of joint protocols for record keeping and risk assessment.

- Ensuring that monitoring of use of the Mental Health Act Code of Practice is embedded in internal processes so that where there are lapses these are identified and action taken.
- Review availability of AMHP and section 12 doctor resource, particularly out of hours, to ensure timely assessments are undertaken.
- Effective engagement with people who use services and carers in the development of services.

The Trust has had seven mental health act (MHA) visits in 2014/15 to our mental health wards; Cotswold House Marlborough, Ruby, Kingfisher, Ashurst, Wenric and Phoenix. From these visits there were a number of positive findings, including:

- caring and helpful nature of staff
- patients reported feeling safe
- availability of food and drinks 24/7
- a programme of environmental improvements completed and in progress
- cleanliness of ward environment
- patients are given the opportunity to raise any issues at weekly ward meetings
- patients can access fresh air within secure outdoor areas when they wish
- patients are having their rights explained and protected
- information about the Independent Mental Health Advocacy (IMHA) services was available on the ward and the advocacy service visited each ward weekly
- risk assessments updated regularly
- de-escalation is used by staff to minimise use of restrictive interventions
- completeness of medication charts

The areas for improvement included:

- Section 17 leave forms: expired copies still in central folder, opportunity to sign.
- Variable quality of care plans with many not fully showing patient and carer involvement.
- When a Second Opinion Appointed Doctor (SOAD) is used, those staff consulted with need to record their discussion in the notes, as well as the decision of the SOAD.
- Need to better document that patients' rights to an IMHA have been explained.
- Staffing levels were not always to expected levels, however staffing was always safe and there was evidence actions had and were being taken.
- Completeness of seclusion and S136 records specific to one ward.
- Ensure patients have their rights re-presented (there is initial explanation of rights).

Quality Risk Profile (QRP)

The QRP no longer exists and the CQC has instead introduced a new intelligence monitoring tool, with the first report published in November 2014. The report shows the CQC's risk assessment for each provider which helps guide them to decide when, where and what areas to inspect. The key sources used for the intelligence include; the NHS staff survey, mental health and learning disabilities dataset (MHMDS), MHA visits, Patient-Led Assessments of the Care Environment (PLACE) visits, electronic staff record (ESR), the national community mental health survey and concerns raised by trust staff. Based on the report the CQC has placed each mental health provider into a priority band from one (high perceived concern) to four (lowest perceived concern). In Oxford Health's first report (November 2014) 57 indicators are

reported of which 1 indicator was identified as a risk namely high delayed transfers of care based on data between April-June 2014. No elevated risks were identified. Based on the information the trust has been placed in priority band four (lowest perceived concern).
OHFT was issued with two Regulation 28 reports/Preventing Future Deaths reports in 2014/15. In the first the Coroner's concern was that the Trust's electronic records system did not make it apparent if we had consent to contact, for example,, a family member and who we should contact (for example, family) in the event of a service user entering a period of crisis or heightened risk. In the second the Coroner's concern was that there is no specific Trust protocol or guidance on the use of Clopixol Acuphase; a further concern was the absence of a documented follow-up in terms of physical observations after a Clopixol injection to include consideration of VTE given that the patient was immobile in bed from 20 February 2014.

During 2014/15 the Health and Safety Executive (HSE) investigated an incident that occurred in the Fiennes Centre in 2013, concerning a patient having fallen from a first floor bathroom window. The HSE investigated the window design and maintenance, and the Trust's procedures relating to the Central Alerting System (CAS) alert. The Trust cooperated fully with the investigation and implemented a detailed action plan to ensure that the risk of a similar incident occurring at any site was minimised.

Data quality

OHFT submitted records during 2014/15 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

which included the patient's valid NHS number was:	which included the patient's valid General Practice Code was:
100% for admitted patient care	97.8% for admitted patient care
100% for outpatient care	99.6% for outpatient care
93.0% for accident and emergency care	97.0% for accident and emergency care

OHFT's Information Governance Assessment Report overall score for 2014/15 was 77% and was graded green (satisfactory).

OHFT was not subject to a payment by results clinical coding audit during 2014/15 by the Audit Commission.

As a result of two data protection breaches the Information Commissioner's Office (ICO) has provided a form of undertaking for the Trust with respect to certain data protection matters. In the last 12 months the Trust has had two incidents reported to the ICO.

OHFT will be taking the following actions to improve data quality:

- A data quality work stream is in place to review data quality processes, promote benchmarking and embed the trust's data quality strategy.
- Data quality indicators for Monitor are reviewed by the board including data completeness and data outcome indicators. Our process will be reviewed to address recommendations from the Auditors on the Quality Report indicators.

- Training for the new care record has focused on data accuracy and staff ownership of data input to be monitored in 2015/16 as part of the Quality Account priority 2.
- We have developed a data quality dashboard, using business intelligence, which highlights errors or mistakes to target data correction.
- Data quality work stream meets bi-monthly to review data quality, to develop data quality reports and processes for managing data correction with each directorate taking ownership for their data quality via data improvement plans.
- We will pilot a quality dashboard at directorate level in 2015/16.

Part 2.3 Reporting against core indicators (Department of Health mandatory indicators)

This section includes data on nationally specified indicators for the current and previous reporting periods as part of the statutory requirements.

100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital

OHFT considers that this data is as described for the following reasons

- there is a documentary audit trail for the compilation of these figures
- internal audit review the quality of the compilation process

OHFT has taken the following actions to improve this percentage, and so the quality of its services

- all breaches are reviewed and the reason why the patient was not followed up within seven days is reported to learn any lessons
- the community services were remodelled from February 2014 so that services are now available seven days a week providing extended hours from 7am-8pm every day
- the community mental health teams, community crisis teams and assertive outreach teams have been brought together so there is a single point of access, a patient's route through services is better defined and co-ordinated

When assessing this criterion, we apply one exclusion in addition to the national guidance for patients who are discharged from inpatient care who are discharged directly to the care of another mental health provider trust (whether inpatient or community services). Where we have verified that discharge documentation includes clearly set out arrangements for the handover of responsibility for care to the other provider, we have assumed the requirements under the indicator have been met.

The table below shows the results of individual reports provided by the Department of Health and the NHS Commissioning Board from data supplied quarterly by the trust throughout the year.

Reporting Period	Trust Value	National Min	National Max	National Average
Apr-Jun 2014	96.3%	93.0%	100%	97.0%
Jul-Sep 2014	96.6%	91.5%	100%	97.3%
Oct-Dec 2014	96.5%	90.0%	100%	97.3%
Jan-Mar 2015	Data not yet available			
Apr-Jun 2013	96.4%	94.1%	100%	97.4%
Jul-Sep 2013	97.9%	90.7%	100%	97.5%
Oct-Dec 2013	96.6%	77.2%	100%	96.7%
Jan-Mar 2014	96.4%	86.4%	100%	97.4%

Admissions to acute wards had access to crisis resolution home treatment acting as gatekeeper

OHFT has taken the following actions to improve this percentage, and so the quality of its services.

- The community services were remodelled from February 2014 so that services are now available seven days a week providing extended hours from 7am-8pm every day.
- The community mental health teams, community crisis teams and assertive outreach teams have been brought together so there is a single point of access, a patient's route through services is better defined and co-ordinated.
- Since February 2014 one dedicated consultant psychiatrist and modern matron has been identified for each adult acute ward and this will be embedded over the next few months.

When assessing this criterion, we apply four exclusions in addition to the national guidance:

- Crisis services in Oxfordshire will include activity of the crisis team as well as those responsible for crisis work within the community mental health teams in line with agreed service specifications signed off by the strategic health authority (SHA) and national institute for mental health in England (NIMHE) under the Fidelity and Flexibilities Framework in 2006.
- Admissions via the liaison psychiatry service in Oxfordshire will be deemed to have been considered for home treatment on the basis that all admissions are arranged through the crisis team or those responsible for crisis work within the community mental health teams in line with agreed service specifications signed off by SHA and NIMHE under the Fidelity and Flexibilities Framework in 2006.
- Patients who have had contact with the Crisis Team within three days prior to admission will be deemed to have been considered for home treatment as for the preceding exclusion above.
- Patients of specialist services (forensic, eating disorders and CAMHS) will be excluded.

The table below shows the results of individual reports provided by the Department of Health and the NHS Commissioning Board from data supplied quarterly by the Trust throughout the year.

Reporting Period	Trust Value	National Min	National Max	National Average
Apr-Jun 2014	99.1%	33.3%	100%	98.0%
Jul-Sep 2014	99.5%	93.0%	100%	99.5%
Oct-Dec 2014	99.0%	73.0%	100%	97.8%
Jan-Mar 2015	Data not yet available			
Apr-Jun 2013	97.8%	74.5%	100%	97.7%
Jul-Sep 2013	97.6%	89.8%	100%	98.7%
Oct-Dec 2013	98.4%	85.5%	100%	98.6%
Jan-Mar 2014	97.9%	0.0%	100%	98.2%

Patients re-admitted within 28 days of being discharged

This information is not available as the NHS Information Centre website has not published these statistics since 2011/12. The Department of Health Quality Account team have informed us that the data is for emergency readmissions only and is not relevant to this Trust.

Patient experience of community health mental health services with regard to contact with a health or social care worker (weighted average across four survey questions)

OHFT considers that this data is as described for the following reasons:

- The patient experience survey is a national statutory requirement and co-ordinated for this Trust by an external CQC approved survey contractor.

Between 2011 and 2014 the trust has seen an improvement following focused actions which have included:

- the development and use of service user information folders
- each service user being given an information credit card with the care coordinator/lead clinician's name and contact numbers and what to do in a mental health crisis
- family engagement training delivered to community mental health staff
- clear expectations for staff about six-monthly care review meetings with service users which has included asking service users for their feedback after every review meeting
- all service users receiving treatment have been put on the CPA
- the service has been re-modelled to improve access and coordination across services and to deliver a service seven days a week

Further work continues on:

- evaluating and embedding the new service model
- working closely in partnership with voluntary organisations to increase the provision of services available and to improve the care pathway between statutory and voluntary services
- continuing to implement the use of the Recovery Star with service users
- improving the information on the Trust's website for service users and their families/ carers
- working towards the Carers Trust accreditation so that service users, carers and practitioners are working jointly together

Reporting Period	Trust Value	National Average
2014 survey	79.0 out of 100[12]	79.0 out of 100
2013 survey	84.9 out of 100	85.8 out of 100

[12] The 2014 score is a composite of 3 questions, whereas the 2013 score was based on 5 questions. There is only 1 question which is the same from 2013 to 2014.

Patient safety incidents resulting in severe harm or death

OHFT considers that this data is as described because there is a documentary audit trail for the compilation of these figures.

OHFT has taken the following actions to improve this percentage, and so the quality of its services:

- We continue to review and report every incident quarterly and in addition all serious incidents (including those resulting in severe harm and death) are reviewed weekly and senior clinicians are involved in deciding what level of investigation to commission.
- This trust has continued to set quality priorities each year to reduce suspected suicides and has a target of 300 days between suspected suicides in AMHTs.

The table below shows the results of individual reports provided by the NHS from data supplied by the trust throughout the year. The data is provided via the national reporting and learning system (NRLS) in six month periods.

Reporting Period	Number of Patient Safety Incidents Reported	Number/ % of incidents resulting in severe harm	Number/ % of incidents resulting in death
April 2014-Sept 2014	2693	9/0.3%	19/0.7%

Minimising delayed transfers of care (DTOC)

The following table shows the bed days lost to DTOC in mental health inpatient services as a percentage of occupied bed days.

	Q1	Q2	Q3	Q4	FY 14/15
Delayed transfers of care	1.4%	2.3%	1.9%	1.8%	1.9%

Part 3: Achievement against the quality priorities for 2014/15

Introduction

The annual Quality Account details our approach to delivering high quality services which are safe, effective, outcome focused and in which the experience meets expectations. It describes specific quality activities supported by a number of specific objectives and a range of metrics to measure and evaluate progress over the year. Our eight priorities and summary of actions and progress are detailed below.

We also started using the five questions devised by the CQC to assess the quality of our services: Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led?

Our eight quality priorities for 2014/15 were:

1. **Workforce**
2. **Data on quality and quality of data**
3. **Service remodelling**
4. **Staff engagement**
5. **Reduction in harm from falls, pressure damage, absence without permission, violence and aggression and attempted suicide**
6. **Implementation of our patient experience strategy**
7. **Development of outcome measures**
8. **Using the new CQC regulatory framework**

1. Summary of progress

The CQC has devised five key questions for NHS services. Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led? We have been using these questions to assess the quality of our services over the past twelve months and use them to organise the summary of our progress against our eight quality priorities.

Is the service safe?

Do we monitor incidents, learn when things go wrong and improve safety standards if they do? Do we have reliable systems for medicine management, patient records, infection prevention and control, use of equipment, safety of built environment, safeguarding children and vulnerable adults? Do we plan for potential risks to our services?

We measure safety in a number of ways, through the essential standards audit, the community hospitals assurance tool, the safety thermometer, local safety assessments, clinical audit, reporting and responding to safety incidents and reporting on national and local standards. In 2014/15 our safety thermometer results demonstrate a reduction in harm

on those measures. We are making progress on our harm reduction priorities within the quality account (*priority 5*), with a reduction in reported absences without leave, fewer probable suicides, a reduction in harm from falls in older adult mental health and a decrease in the use of prone restraints, despite three wards managing some particularly complex patients during this time presenting with very challenging behaviour.

As a Trust we have a strong reporting culture for safety incidents and an effective process for identifying, investigating and learning from serious incidents (*priority 5*). All staff are aware of the online incident reporting system which flags all incidents with our clinical leads via emails to ensure they are aware of incidents; staff are also encouraged to contact the leads directly when a serious incident occurs so that support can be given to the team affected. However, there are a number of teams and professions which report few or no safety incidents and this is an area where we need to do further work.

We share learning in a number of ways, including newsletters, visits to teams, attendance at governance meetings and running learning events. However, we need to strengthen feedback to staff and trend reporting and analysis to teams. We also need to assist them in making sense of a plethora of data and ensuring we are confident our data is consistent and accurate *(priority 2)*. We are now working with services to integrate and prioritise action planning to focus on those actions which will make the biggest difference (*priority 8*).

Each directorate reviews safety information at a senior management, service and team level. This is open to scrutiny during the regular directorate performance reviews with executive and non-executive directors. The Quality Committee and four quality sub-committees provide assurance to the Trust that we have effective processes in place to deliver a safe service and monitor progress against our safety and quality priorities (*priorities 4 & 8*). This is also reported to the Board of Directors at their monthly meetings (which are held in public). The Trust also has a Governors-led quality and safety sub-committee which acts on behalf of the governing body to scrutinise and monitor service quality and safety in detail.

The Trust has a range of policies and procedures which are designed to ensure safe practice. As part of a review of our governance arrangements we are improving our policy review and approval process to ensure policies are kept up-to-date and readily accessible to staff.

We have carried out a complete overhaul of our risk management processes (*priority 4*) and teams have engaged very positively with a simpler reporting format and a strengthened escalation process linking local risk registers with directorate and corporate risk registers.

In each team (ward and community) a safety board or Patient Status at a Glance (PSAG) boards are in place allowing the teams to monitor the safety of all patients on the team's caseload. These are RAG rated for risks so the team can easily identify any patients for whom safety is a concern. All patients have a risk assessment carried out by the team whether they are in an acute setting or the community. This is regularly reviewed and updated to ensure that patient safety is monitored (*priority 3*). In the forensic wards, the specialised forensic risk assessment is completed for all patients within 72 hours of admission. All teams follow the safeguarding systems in place to record any suspected or actual cases of abuse regarding patients and their families, supported by the Trust's safeguarding leads.

We monitor staffing levels in relation to nursing staffing on a weekly basis to ensure safe staffing levels are available on every shift (*priority 1*) and risk rate wards which are experiencing challenges with, for example, filling vacancies or managing sickness absence. We have a strategic recruitment campaign which has introduced a variety of ways to improve how we attract and retain staff (*priorities 1 & 4*). We are monitoring vacancy levels to ensure that teams can support the number of patients on their caseloads safely and services can be responsive to service demands.
Following feedback from Oxfordshire Clinical Commissioning Group we have added the following:

Challenges exist in relation to recruiting and retaining staff in district nursing teams in South Oxfordshire. Elements of this relate to the fact that there is a recruitment premium in neighbouring counties and the impact of increased activity and complexity of patients within the community. We are actively working with partners to match capacity and demand and to model future workforce requirements.

Examples of good practice

- Skintelligence programme continues to improve pressure damage care across the older adult directorate (*priority 5c*).
- Introduction of senior clinical leads across disciplines (*priority 5*).
- Improving the medication management process to reduce errors (*priority 5*).
- More robust management of complaints - themes and learning are shared and triangulated against the five key questions developed by the CQC (*priority 7*).
- Safeguarding, serious incidents requiring investigation and orange incidents are reviewed, initial investigation reports completed, learning and action plans monitored by services (*priority 5*).
- Safer staffing is reported and monitored, which led to the development of a strategic recruitment campaign (*priorities 1&4*).
- Safer Care projects in place in CAMHs, school health nursing, inpatient units and community teams (*priorities 4&5*).

Areas for improvement

- Reduce incidents of pressure damage (all categories) (*priority 5c*).
- Reduce medication omissions (*priority 5*).
- Improve sharing of learning from incidents (*priority 5*).
- Full rollout of the new risk management strategy to ensure risk registers at all levels and escalation processes in place *(priority 4)*.
- A range of building works to ensure premises are safe and suitable including a programme to minimise ligature points across mental health wards.
- Improve clinical leadership and fill vacancies in community nursing *(priorities 3&5)*.
- Some aspects of medicines management for example, management of controlled drugs, medicines reconciliation, replacement of drugs cupboards and learning from medicine incidents *(priority 5)*.
- Continue reporting and monitoring of staffing levels across community services.
- Improve workload and capacity in District Nursing.

Is the service effective?

Do we properly assess patient needs and deliver appropriate care and treatment? Do we deliver good patient outcomes? Do staff have the skills, knowledge and experience to deliver effective care? How well do staff, teams and services work together? Do staff have access to the patient information they need? Is people's consent to treatment always sought? Do we protect the rights of our patients detained under the mental health act?

We are reviewing our clinical audit process to monitor and report on audits where improvements are required, to ensure actions are implemented so that re-audits show an improvement in practice (*priorities 4&6*). We have a process for reviewing our services against NICE guidance and Central Alert system (CAS) alerts. The research and development committee oversees innovations and the use of evidence-based practice. Staff are involved in a range of improvement activities (*priority 4*).

The medical devices group is ensuring we have an up-to-date register of all medical devices equipment, that faults or failures are rapidly rectified and that staff are competent to use medical equipment. There are relatively few incidents relating to medical devices.
Staff are required to attend mandatory training, monitored by the Board of Directors (*priority 1*). We also monitor the percentage of staff who have received a performance development review and had the opportunity to access skills and knowledge training (*priority 1*).

Multi-disciplinary working is promoted through service remodelling (*priority 3*) which is developing locality-based teams for older adult services and bringing together physical and mental health practitioners to improve outcomes *(priority 7)*. We work in partnerships to deliver care to patients, and to manage or solve system-wide issues or problems (for example delayed discharges of care or management of pressure ulcers (*priority 5*)). In 2015 we will deliver a new partnership agreement with the third sector in Oxfordshire (*priority 7*).

Non-executive directors participate in mental health act hearings and we are subject to a range of monitoring to ensure we are compliant with the mental health act and mental capacity act (*priority 6*). This is reviewed in detail by the effectiveness quality sub-committee. Staff receive training in their responsibilities and in the rights of patients and families in relation to legislation. Areas for improvement relate to the quality of documentation.

We have training placements for various disciplines at undergraduate and postgraduate levels. We work closely with Health Education Thames Valley to ensure trainees get appropriate development and assessment opportunities. With Oxford Brookes University School of Life Sciences we have also developed a successful programme of physical health care training in mental health settings.

Adult services have assessments in place in all settings which are carried out upon the patient's referral to the teams and updates at points of reviews where appropriate. These are monitored through a monthly CPA audit (*priority 3*) involving a quantitative analysis (have requirements been met?) and qualitative (have they been done well?). We use the national benchmarking tool to assess how our Trust compares to others around the country.

Adult mental health services introduced the Recovery Star in 2015 to help patients set goals and assess their progress (*priority 7*). Services are also assessing and managing both physical and mental health needs (*priorities 3&5*).

The way in which services are commissioned is also changing, with a focus on outcomes which are measurable and meaningful in an individual's recovery (*priority 7*).

Following feedback from Oxfordshire Clinical Commissioning Group we have added the following:
OHFT will continue to support Multi agency Safeguarding Hub developments and continue to work in partnership with other agencies in relation to the identification, support and risk management of Children who are at risk or have experienced Child Sexual Exploitation. These and other areas of work are outlined in the Trust Safeguarding Children action plan which is monitored via the Safe Sub-committee and reported to Trust Board.

Examples of good practice

- Re-ablement is performing at above national average for patients discharged from the service with no on-going care needs (*priority 6*).
- In Witney, of 33 GPs surveyed 100% were likely or extremely likely to refer a patient within the next month to the emergency multi-disciplinary unit (EMU) (*priority 3*).
- Advanced Assessment Skills training was rolled out to those staff working in the assessment function of the AMHTs (*priority 1*).
- District nurses are receiving diabetes and insulin training (*priority 1&5)*.
- On one of the adult wards, they have set up a physical health clinic which patients can attend to receive advice and support *(priorities 3&5*).
- Personalisation training programme is being delivered across older people's services
- Over last 6 months the out of hours (OOH) service has seen a 2.5% increase in home visits to help patients remain in the community *(priority 3*).
- Good patient outcomes resulting from improved joint working in integrated locality teams (ILTs) *(priority 3*).
- Retendering is providing opportunities for service redesign work including Bucks CAMHs and school health nursing services *(priority 3*).
- Reported outcome measures will be completed for CAMHs new referrals *(priority 7*).
- We are reviewing other outcome measure tools for other services; introducing outcome star for school health nurses (SHNs), developing a system for health

visitors and using goal-based outcomes with speech and language therapy (SLT) Bucks Services (*priority 7*).

Areas for Improvement

- Improve nutrition and hydration care in all care settings *(priorities 3&5)*.
- Continue to establish holistic physical and mental health care *(priorities 3&5)*.
- Training for urgent care staff and GPs in urinary tract infections.
- Information sharing/implementation of Oxfordshire Care Summary (*priority 2*).
- Review of pathway between SPA and ILT to further reduce duplication (*priority 3*).
- Training being developed following audit of catheter care (*priority 5*).
- Increase the number of goals patients achieve through the Recovery Star (*priority 7*).
- Improve the end of life pathway (*priority 3*).
- Reduce delayed transfers of care in Oxfordshire (community hospitals) *(priority 6)*.
- Increase supervision of staff (*priority 1*).
- Update the resuscitation policy (*priority 5*).
- Strengthen processes for reviewing NICE guidance and CAS alerts.
- Improve documentation supported by the new care record system.

Is the service caring?

Are our patients treated with kindness, dignity, respect, compassion and empathy? Do we involve patients and their carers as partners in their care?

The Trust uses a variety of methods to assess whether patients experience our services and staff as being caring, respectful and compassionate. The national Friends and Family test is a regular way of capturing a snapshot of patient feedback. We have introduced this test as part of the existing mechanisms we have to gather feedback so we can review quantitative and qualitative information together (*priority 6*). We have also introduced a staff Friends and Family Test including the question "*How likely are you to recommend OHFT to friends and family if they needed care and treatment?*", but response rates are still very low (*priority 1*). One issue staff raise is that pressures on staffing, heavy workload, and

increased activity and patient acuity are limiting the ability of staff to spend the time they would like with patients to provide support and reassurance (*priority 6*).

We need to develop more structured ways of developing outcomes measures with patients and those close to them *(priority 7)*. The new care clusters for mental health patients provide some opportunity for this, but we are seeking creative ways of focusing on outcomes, rather than simply processes or inputs across all of our services and care pathways (*priority 3)*. All of our wards ensure that the dignity and respect of patients are adhered to through single sex wards. Patients are also given access to cordless phones so they can contact their family and friends within the privacy of their rooms or specific areas on the wards.

Patient and family involvement from the point of referral to discharge is crucial (*priorities 6&7*). Where agreed, families are involved in a patient's care planning and their assessments. This provides support to the patient but also offers an opportunity for families to be supported by the teams. The Trust offers 'carers' assessments to ensure that the person, whether they are a family member, relative or friend, are supported and their needs identified. In Oxfordshire, we have strong links to Rethink and the Carers Reference Group to understand and gain feedback from families about their experiences of services. During the remodelling of adult services in 2013/14, families were invited to participate in the local forums to help shape the future services. These meetings provided the directorate with an opportunity to understand how service changes impact on families as well as patients.

Work to achieve the Triangle of Care accreditation will help to ensure that carers and family members are involved in planning and treatment of patients who access services (*priority 6*). We have been working with the local authorities to meet the amendments to the Care Act.

Examples of good practice

- Patient satisfaction scores remain high despite pressures on all services (*priority 6*).
- Feedback from patients and families and observations during peer reviews demonstrate the caring approach and compassionate attitude of staff (*priorities 3/6)*.
- Award for dementia care.
- Following dementia training "Knowing Me" documentation passport has been launched across acute, social care and community settings in Oxfordshire *(priority 3)*.
- There has been an increase in the number of circle of support workers plus further funding awarded to continue the training for three further months (*priority 6*).
- Patient experience of pain project completed to improve care (*priority 6*).
- Patient experience survey and national audit of intermediate care survey show service users perceive our staff as caring and respectful of dignity (*priority 6*).
-

Areas for Improvement

- Documentation project pilot by three district nursing teams to support holistic assessment of patients *(priority 5c)*.
- Wider use of "Knowing Me" documentation passport (*priority 3*).
- Improved learning from complaints (*priority 6*).
- Provide opportunity for service users to give immediate feedback to practitioners at the point of discharge (*priority 6*).
- Improve how patient and family feedback is shared with staff (*priority 6*).

- Improve the level of carer satisfaction through the Triangle of Care, carer awareness training for staff and our involvement in local carer reference groups (*priority 6*).
- Improve how we ask for feedback for example, improving the attendance at local involvement forums, surveying along care pathways and clinician level feedback (*priority 6*).
- Integrate human rights and improve accessibility for diverse groups (*priority 6*).

Is the service responsive?

Do we plan and deliver our services to meet the needs of different patients? Do we routinely seek out and learn from patient and carer feedback?

Our services are subject to national and local indicators for responsiveness, which include referral to treatment times, waiting times and accessibility. Our teams have clear targets for responding to referrals whether they are emergency, urgent or routine. We report to commissioners, national reporting bodies and Monitor on a range of such measures, accounting for any failures to meet targets and assurance that remedial actions are in place (*priorities 3 & 6*). We have substantially increased the availability and accessibility (through self-referral) to community, urgent care and in-reach services out of hours as part of our service remodelling programme (*priority 3)*.

We have extended our psychiatric liaison into emergency departments in each county. We have also worked alongside other organisations for example, the police, ambulance service, emergency departments and county council to support the implementation of the Crisis Concordat, which is a joint statement about how public services should work together to support individuals with a mental health need in crisis (*priorities 5&6*).

Feedback assists us to understand how our services are received by patients and those close to them, and whether they are consistent with our quality aims. We ask for people's views

about their experience of care in a number of ways including paper questionnaires handed out or posted directly to someone's home, using handheld electronic devices, stand-alone kiosks and online surveys to get near real time feedback, social media (for example, Twitter, Facebook, Patient Opinion), face to face forums, focus groups, drop-in surgeries, and one-to-one interviews *(priorities 3&6)*.

This year we gathered patient and staff stories through interviews (sometimes filming or recording these) and conversations during peer reviews (*priority 6*). A sample of these stories are regularly heard at quality meetings and the Trust Board. Analysis shows that patients in general rate the services they receive more highly than the staff who deliver them.

Each directorate works hard to involve patients, parents and their families in their own care as well as asking people their views of how services should develop and change.

We have reviewed the number of patients who have a learning disability as well as a mental health illness to understand any gaps in service delivery. Within Oxfordshire, we have the GP practice at Luther Street providing support to vulnerable or disadvantaged patients who are not otherwise in contact with primary care services. We also work alongside two third sector organisations, Elmore Community Services and Connection Floating Support to meet the needs of patients who may need support in the community.

Our equality and diversity strategy aims to reduce the barriers experienced by some patients and families to accessing services (*priority 6*) and ensure they are culturally appropriate.

Following feedback from Chiltern and Aylesbury Vale Clinical Commissioning Group we have added the following:
The Trust's Equality & Diversity Officer is gathering data for the Race Equality Audit and also developing a plan for WRES.

Examples of good practice

- Involvement of patients and carers in service remodelling (*priority 3*).
- 24/7 day working in community mental health and urgent care services (*priority 3*).
- Patient experience strategy (*priority 6*).
- Our governing body includes patient and carer representatives (*priority 6*).
- Governor-led quality and safety sub-committee (*priority 6*).
- Proactive Patient Advice and Liaison Service which visits wards and runs open surgeries for patients to raise concerns at the point they are receiving care (*priority 6*).

- "Have your say" forums receive real time feedback and work with patients to deal with problems or issues they may have (*priority 6*).
- Carers' strategy work is being taken forward to reflect young carers (*priority 6*).
- Implementation of 18-25 services for vulnerable young people. In BaNES and Wiltshire we have done this for Looked after children (*priorities 5&6*).
- Implementation of transitions clinics with adult mental health services in Wiltshire and BaNES to plan ongoing care post-18 years (*priorities 5&6*).
- New person friendly webpage is in place for Buckinghamshire CAMHs (*priority 6*)
- Enhanced staff levels in older adult inpatient units (*priorities 3&6*).
- A co-ordinated response to winter pressures enabling more patients to be supported at home (*priority 3*).
- We have replaced the EKOS with the FIM tool in community hospitals (*priority 7*).
- The Chiltern Memory Team, South Buckinghamshire, was identified as an excellent example of best practice in memory services across England seeing people within 40 days from assessment with a 90% response rate (*priority 3*).
- Urgent Care service access issues have been resolved with no delays (*priority 3*).
- Community mental health teams are providing step up care to assist with admission avoidance (*priority 3*).
- Inpatient wards and CMHTs have implemented a daily ward round to improve discharge, reducing the average length of stay (*priority 6*).
- Flexible working across urgent care services to meet patient needs (*priority 6*).

Areas for improvement

- Continue to work with patients and their families so that they feel they are involved in decisions about their care as much as they would like to be (*priority 3*).
- Support more people to be able to die at home who choose to do so (*priority 6*).
- Implement the Green Light[13] and audit service accessibility (*priority 6*).
- Ensure emergency medical unit services are well used, accessed into the evening (until 8pm) and better support people with sub-acute needs to remain at home in the evenings (*priority 6&7*).
- Continued work on improving adult speech and language therapy response times.
- Improve patient flows to urgent care including via 111 (*priorities 5 and 6*).
- Deliver single assessment process for adult services in Oxon (*priority 6*).
- Improve waiting times in specific services (*priority 6*).

Is the service well led?

Do we have a clear vision and strategy for quality of care? Does our leadership and culture support this vision? Do we have effective governance systems? Are we open and honest? Do we strive for continuous improvement?

The Trust has agreed a strategy which includes the strategic objective "Driving Quality Improvement". Specific quality priorities are defined in the annual quality account. We have invested in skills and capacity to deliver quality and safety improvement and innovation

[13] A toolkit to evaluate and improve accessibility of services for people with a learning disability.

through our innovation team, our productive team and our safer care team (*priority 4*). They work across the Trust to implement and embed safety projects (*quality priority 5*).

Board meetings are now held in public. We maintain our duty of candour in reporting progress and achievements, and also areas requiring improvement. Directorates reflect on their quality performance with Board members on a regular basis and use this opportunity to identify future risks to service quality as well as to promote innovations and progress (*priority 4*). We have also implemented a patient experience strategy to improve how we act on feedback gathered from patients, parents and their families to improve care (*priority 6*).

The Chief Executive, executive directors and service directors routinely visit teams and offer drop-in surgeries to enable staff to share concerns and to raise awareness of good practice in their teams or services (*priority 4)*. We have a number of initiatives to support staff motivation and improve staff wellbeing (*priorities 1&4*).

The Trust has recently reorganised its overall governance structure to reflect the five key questions developed by the CQC and service directorates are similarly reorganising their quality and governance meeting structures (*priority 8*). Directorate leadership teams have been restructured to deliver integrated, clinically-led care (*priority 3*). Each non-executive director has an identified lead area to bring independent scrutiny to performance and quality, as part of which they undertake visits and sit on quality committees and groups. We have also established a well-functioning system for peer reviews across our services (*priority 8*). Our new risk management strategy offers a more structured approach to identifying and managing risks at all levels in the organisation (*quality priority 4*).

Attendance at leadership development events has increased since the same period last year and we provide a range of opportunities for formal and informal leadership development. We hold quarterly senior leadership conferences to bring together our senior management teams. We have recently approved our organisational development strategy and we regularly review organisational development and leadership development at the Board of Directors.

We have also rolled out the Aston teamwork model to improve team functioning and effectiveness (*priority 1*). Mental health wards have strengthened their leadership teams and older adults have aligned physical and mental health services under a single leader to promote multi-disciplinary working and more seamless care for our patients (*priority 3*).

The Trust has significantly increased its academic profile over the past two years. We are members of the Academic Health Sciences Network (AHSN) and Centre (AHSC). We host the CLARHC (Collaborative Leadership in Applied Health Research) which offers £9 million funding plus £9 million matched funding over five years. We also host the Diagnostic Evidence Collaborative which is our first significant physical health academic development. These partnerships and collaborations help us translate research into clinical practice.

Examples of good practice

- Peer reviews across a range of services (*priority 8*).
- Combined training for nursing, medical and operational leaders (*priority* 1).
- Internal clinical and professional networks (*priority 1*) and external benchmarking.
- Funding identified for a six month staff MSK self-referral pilot to start early next year.
- 'Leading the Way' and 'Planning for the Future' programmes (*priority 1*).

- Consultation with staff and patients on service remodelling (*priorities 3&4*).
- Quality leads identified at each management level and in all professions (*priority 4*).
- Staff discuss and review their practice against the CQC's 5 questions (*priority 8*).
-

Areas for improvement

- A review of staff musculoskeletal injuries and stress (*priorities 1&4*).
- Develop a vision for community nursing and review how community nursing works with primary care for the benefit of the patient (*priority 7*).
- More skills training and clinical supervision for staff (*priority 1*).
- Joint working between OHFT and acute services to enable skill sharing and harm reduction across both settings (*priority 5*).
- Provide a five day leadership development programme for clinical leaders (*priority 1*).
- Increase our response rate to the staff survey by 5% (*priorities 1&4*).
- Improve our staff survey scores and implement actions from feedback (*priority 4).*
- Improve management of policy review and approval process (*priority 5*).
- Ensure staff are able to articulate and meet the requirements of the duty of candour.

Quality priority 1: workforce

Almost 225 managers have received team effectiveness training and report an improvement. Despite staffing pressure we have maintained levels of access to training. We did not achieve our appraisal target due to significant changes in management structures over the year. Staffing levels are monitored every week and no ward dropped below 92.7% of shifts being fully staffed. Our staffing indicators for the quality dashboard have been agreed.

In our 2014 staff survey we had above average scores for percentage of staff able to contribute towards improvements at work; staff recommendation of the trust as a place to work; and percentage of staff agreeing feedback from patients/service users is used to make informed decisions in their directorate. We were in the worst for seven (work pressure and harassment). We were shortlisted for the Nursing Times award for excellence in supporting staff and wellbeing.

Agreement of quality-focused workforce indicators as part of a wider quality dashboard by 30 September 2014

The quality dashboard is trialling a number of workforce related measures which include:

- sickness absence (%)
- vacancies as a proportion of establishment
- number of wards unable to fill 80% of their shifts
- agency staff bill as a percentage of budget for clinical staff
- percentage of staff who have completed patients and personal safety training (PPST) in the last twelve months
- percentage of staff who have been appraised within the last twelve months

Roll-out of the Aston Teamwork model[14] across the organisation to nominated managers

A total of 223 managers have commenced or completed their effective team based working learning and practice, an increase of 11% in comparison to last year. In addition to the team

based working orientation sessions, 81 teams have received direct support including advice and coaching for the team leader/manager and facilitating team development sessions/days. Improvements to team effectiveness include:

- *Improved understanding of the challenges and issues and increased trust.*
- *Better communication, both within the leadership team and outside it.*
- *"The team have become very skilled at problem solving together. They own the issues and then own the solutions which is great to see."*
- *"There have been thorny issues to resolve … and we are now able to have those difficult discussions without damaging team relationships."*

indicator	Data source	purpose	FY 13/14	Q1	Q2	Q3	Q4	FY 1415
a) no. of team leaders trained in Aston teamwork principles – target 250	Improvement and innovation team attendance records	Monitor spread of skills development	178	50	57	98	18	223
b) 100% attendees reporting they are equipped to lead team working effectiveness		Effectiveness of model	86%	90%	86%	89%	98%	91%

Maintain existing levels of access to staff training and development, including clinical practice, improvement skills and professional leadership

The level of performance development review (PDR) has increased over the year but is lower than at the same point last year. This is attributed to the cumulative effect of a year in which significant restructuring created long periods when teams were without settled managers and the continued concern that compressing the PDR into Q1 made it more difficult to meet with all staff in time. Next year we are moving to an incremental date PDR timing. This transition period will reduce the reported level of completed PDRs in year, and may take until end 2016/17 to be fully stabilised. Longer term, however, this will improve the PDR process.

indicator	source	purpose	FY 13/14	Q1	Q2	Q3	Q4	FY 1415
Performance development review completed in last 12 months (target 100%)	Learning and development records	Support staff development, performance review	90%	56%	79%	83%	84%	84%
Skills courses attendance	Learning and development records	Ensure staff develop and update clinical leadership skills	8900	2318	2055	2301	1997	8671

Deliver expected nursing staffing levels on inpatient wards

Staffing levels by ward are reviewed shift by shift by ward staff and immediate managers, daily by Matrons and Heads of Nursing, and weekly by the Director of Nursing and Chief Operating Officer to ensure there is appropriate escalation and that staffing levels match the acuity and needs of patients to provide safe and effective care. There is also a monthly review by the Board of Directors.

The table below shows the percentage of shifts which were fully staffed since May 2014. Using the existing range of quality, safety and workforce measures in our matrix, we have not identified a link between actual staffing levels achieved and adverse outcomes for patients.

	Day time shifts (Early, late and twilight shifts)		**Night time shift**	
	Registered nurses	**Unregistered staff**	**Registered nurses**	**Unregistered staff**
May 2014	96.20%	94.50%	99.50%	99.80%
June 2014	96.9%	97.3%	95.6%	97.7%
July 2014	98.7%	96.3%	92.5%	98.6%
August 2014	95.1%	93.4%	94.9%	97.5%
September 2014	95.6%	93.9%	95.5%	96.4%
October 2014	96.1%	95.1%	96%	96.3%
November 2014	95.5%	94%	94.8%	98.1%
December 2014	95.1%	94.1%	95.1%	97.3%
January 2015	95.2%	94.7%	96%	97.8%
February 2015	94.7%	93.2%	95.2%	97.9%
March 2015	94.7%	92.9%	95.2%	98.7%

Nursing vacancies are the main reason for under-staffing on the shifts for many wards, related to recruitment difficulties in some geographical areas and some specialties (reflected nationally). The increase in staffing establishment (and therefore expected staffing levels) on a number of wards which is taking time to recruit into. Vacancies are being monitored and managed on a weekly and monthly basis with the Executive Team.

A number of actions were taken specific to each ward to manage capacity, for example:

- managing capacity through a temporary reduction in bed numbers on wards
- considering individual patient level of need when deciding where to admit patients
- staff who are normally supernumerary to the nurse staffing numbers (for example, matrons) have worked as part of the nursing shift numbers
- staff were borrowed from other wards to increase the staff to patient ratio
- staff worked flexibly, for example, working an extra hour at the beginning or end of a shift
- 'long lines of work' were established with agency staff to improve continuity of care and reliability of temporary staff

Our recruitment action plan outlines attraction and retention activities and career development opportunities. This includes:

- Improvement of external webpages.
- Improvement to advertisements and attachments on NHS jobs.
- Incorporation of values into all recruitment material.
- Promotion of staff accommodation and key worker housing.
- Financial incentives.
- Improving links with Universities.

Friends and Family staff survey "how likely are you to recommend this organisation to friends and family as a place to work/if they needed care or treatment?"

The Staff Friends and Family test was introduced on 1st April 2014 and asked two questions:

1. *How likely are you to recommend OHFT to friends and family if they needed care and treatment?*
2. *How likely are you to recommend OHFT to friends and family as a place to work?*

Quarter 1 had a 6% response rate. For Q2 the surveys were emailed to staff who received a unique password to complete the survey. The response rate increased to 12% (compared to a national average of 16%). The Q3 result is taken from the national staff survey.

	Recommend to receive care		Recommend as place to work	
	Result	Response rate	Result	Response rate
Q1	Extremely likely 24% Likely 49% Combined 73%	316, 6%	Extremely likely 18% Likely 41% Combined 59%	313/6%
Q2	Extremely likely 21% Likely 48% Combined 69%	723, 12%	Extremely likely 18% Likely 40% Combined 58%	702/12%
Q3	Extremely likely and Likely combined 61%	1646, 32%	Extremely likely and Likely combined 55%	1646/32%
Q4	Extremely likely 23% Likely 50% Combined 73%	987, 18%	Extremely likely 17% Likely 40% Combined 57%	963/18%

National staff survey 2014

The national staff survey is carried out across all NHS trusts in England. It allows staff to comment confidentially on how their trust supports, trains and involves them in delivering high quality and safe services. NHS trusts delivering similar services are able to compare or benchmark themselves against each other on the basis of whether they are in the top 20%, above average, average, below average or in the bottom 20% of similar trusts. In 2014 for the first time the Trust had the opportunity to survey all 5,168 members of staff. Previous surveys have been carried out on a random sample of 850 staff.

The response rate was 31.84% which was in the lowest 20% of trusts (the average was 44%) although the actual number of staff responding was higher. OHFT is compared with mental health and learning disability trusts.

The overall staff engagement score for OHFT is 3.75 which is above average compared with other mental health/learning disability trusts (see graph below). This combines:

- staff ability to contribute towards improvement at work; the Trust score was 73% which is above the average of 72%;
- staff recommendation of the Trust as a place to work or receive treatment; the Trust score was 3.63 which places it above the average of 3.57;
- staff motivation at work; the Trust score was 3.85 placing it above the average of 3.84.

We had above average scores for percentage of staff able to contribute towards improvements at work; fewer staff feeling pressure to attend work when feeling unwell; fewer staff experiencing physical violence from patients, relatives, the public and staff; staff recommendation of the Trust as a place to work; percentage of staff agreeing feedback from patients/service users is used to make informed decisions in their directorate; and equality of opportunity for career progression.

Our lowest ranking scores were for percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; percentage of staff working extra hours; work pressure felt by staff; percentage of staff appraised in the last twelve months; percentage of staff reporting errors, near misses or incidents witnessed in the last month; and percentage of staff experiencing harassment, bullying or abuse from staff in the last twelve months.

Implementation of the key actions arising from the national staff survey results to promote staff wellbeing

Action plans for improving areas where we did not score well are now part of the annual requirements for each directorate and are monitored through quarterly performance reviews. They incorporate the specific areas from the staff survey results, which are localised to the directorate and have included:

- tools to enable people to recognise and manage workplace stress
- initiatives to support staff to take breaks and reduce working of excessive hours
- support after bereavement
- improve opportunities for engagement between staff and senior managers

Quality priority 2: data on quality (and quality of data)

We have agreed a set of quality indicators which, taken together, will allow us to assess where we are doing well and potential areas of vulnerability in terms of quality. This is supported by our standard data quality matrix for use across the Trust to monitor and track data completeness and accuracy. The new Electronic Health Record is being implemented and will improve documentation and access to data.

This will enable the service to be safe, effective and well led.

Agreement of a quality dashboard

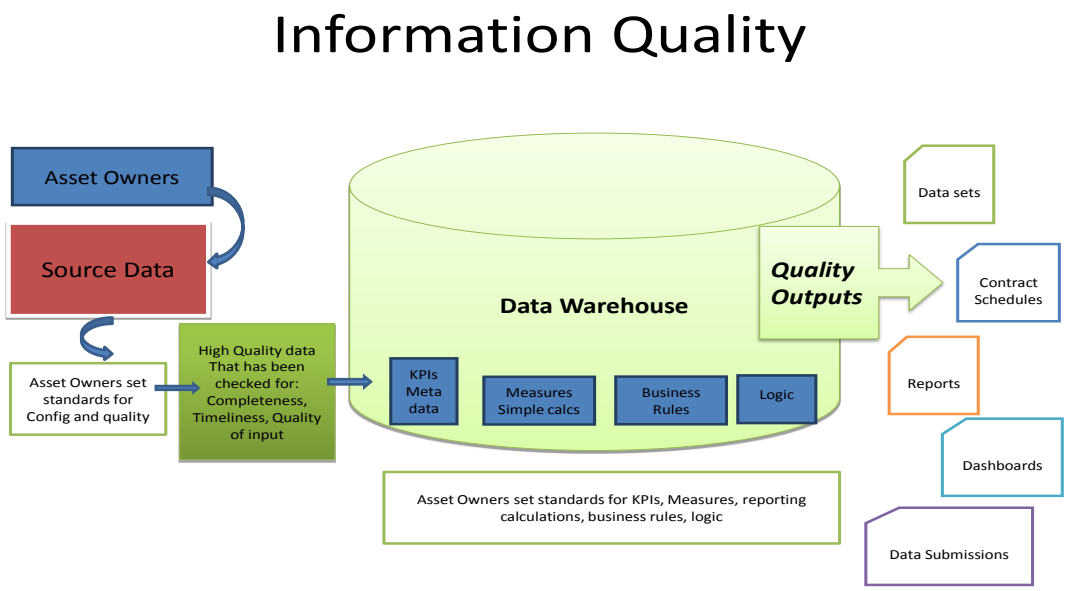
We have agreed a set of indicators (Appendix 2) which include access and waiting times; safety metrics and staffing measures. The project to develop the quality dashboard will continue in 2015/16 as we set up ways to populate the dashboard at a Trust wide,

directorate and service level and begin to use it as part of our quality reporting. We will also align this with the CQC intelligent monitoring dashboard which is still in development.

Development of standard operating procedures for data quality including written controls for quality indicators and a standard process for sourcing, verifying and checking reported data with assigned data leads

The Data Quality Review Group meets every two months to review and monitor the quality of data recorded and reported at the Trust. The group is responsible for implementing standard operating procedures to manage data quality in the Trust. Each directorate has provided details of the reports and process that they follow to review and improve the quality of data. The group has approved a standard data quality matrix for use across the Trust to monitor and track data completeness and accuracy. In addition, an individual health care professional version of this matrix has been completed (My_HCP Dashboard) to provide access to data have entered that is incomplete or inconsistent with Trust standards.

As part of the implementation of the new patient care record, standard operating procedures ensure users of the new system will adhere to consistent data capture methods. Asset owners, who will be allocated at a directorate level, will be required to review, monitor and control the quality of data recorded and reported at the Trust.



Quality Priority 3: service remodelling

We have successfully implemented the planned service changes in adults and older adult services, including extended hours, leadership teams, cluster packages, outcome-based measures, integrated locality teams and the relocation of the City Community Hospital to the Fulbrook Centre. We achieved our physical health assessment targets. We have a range of locality and ward based patient forums, although attendance varies. Early intervention and complex needs reviews are complete. We have a system-wide dementia care strategy.

All schools have a health plan. We have exceeded our health visitor staffing targets and have improved infant feeding and breastfeeding-friendly access. We need to improve some of our CPA metrics in the coming year – the new care record system will ensure better documentation of actions. We did not achieve our target for VTE assessments. We also need to measure multi-disciplinary assessments for older adults with complex needs

This will enable the service to be caring, safe, effective, responsive and well led.

Fully implement a new model of care based on cluster packages[14], care programme approach[15], and the recovery star[16]; ensuring patients and their families are clear about who is providing their care, what the care is and what to expect throughout their time in the service; supporting the patient (and/or family) to set their own goals

The new model of care for the AMHTs was implemented in April 2014 across Oxfordshire and Buckinghamshire, working alongside the carers reference group and service user forums.

We implemented the Recovery Star within our service in early 2015. This tool enables us to work with patients to develop their own goals and recovery plans. The Star contains a number of domains in which each patient can determine where they are now and where they would like to be; staff can then work with them to reach these goals. The Star is being used in conjunction with our care plans. Once the Star is available on iPads in the community teams we will be able to link to the new care record system.

Care clustering is now well embedded within the adult teams. All patients are now clustered upon entry to the service.

We are working on improving carers support through the implementation of the 'Triangle of Care'; this is being led clinically by professional leads in conjunction with Oxfordshire County Council. The purpose of the Triangle of Care is to ensure carer involvement.

Through the partnership with third sector in Oxfordshire, we are developing a Recovery College which will ensure co-design and co-production with service users and carers.

The new model of care for older people's mental health services has been implemented in each county. Benefits include an increased capacity in Oxfordshire memory clinics following service changes. We are now working towards memory clinic accreditation.

Inpatient wards and CMHTs have implemented a daily ward round to proactively confirm which patients are ready for discharge and to prepare for patients returning home. Since Christmas, CMHT and inpatient staff plan together the prioritisation of pending admissions to ensure timely or early discharge; there has been a positive reduction in average length of stay for inpatient services.

Outcomes based clustering is being applied to older adults mental health and the next steps are to embed evidence-based treatment packages in line with clusters.

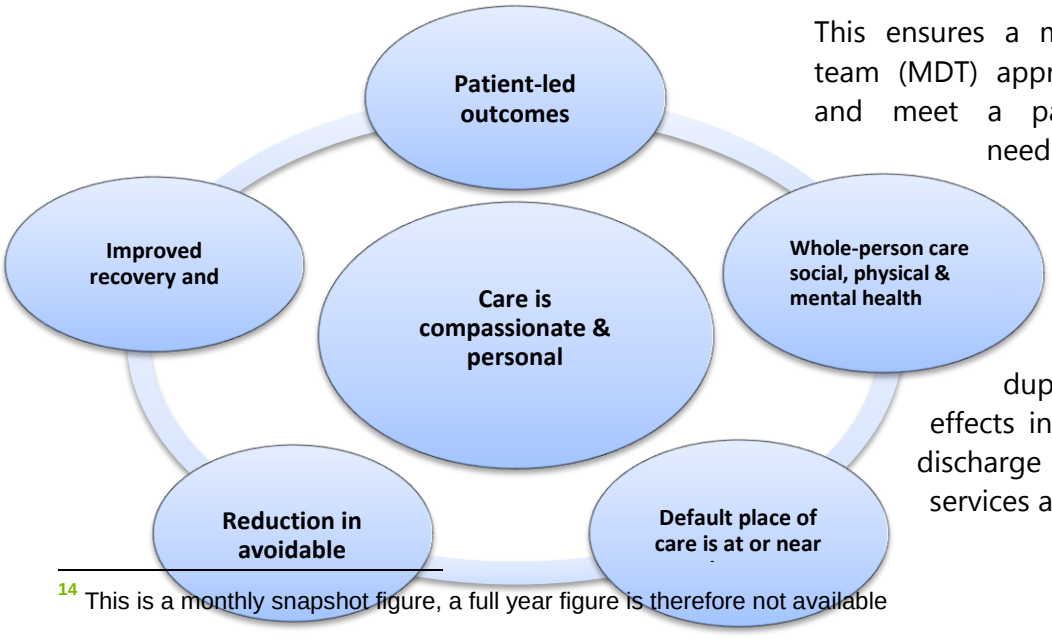
Involvement in care planning has gradually increased over the year to a high of 93% in Q4. The percentage of patients in employment or settled accommodation has dropped in Q4. This is due to changes in the way data has been collected.

Indicator or measure	*Data source*	*Purpose of measure*	*FY 1314*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
% of patients with a CPA to be in employment or meaningful activity	CPA audit	Measure quality of life goals in care planning	n/a[5]	11.7%	11.6%	11.4%	10.9%	n/a[14]
% of patients with a CPA in settled accommodation	CPA audit	Measure quality of life goals in care planning	n/a[5]	78.6%	77.8%	78.6%	75%	n/a
100% of patients involved in setting and achieving goals	CPA audit	Assess patient involvement in setting and meeting care plans	92%	85%	87%	87%	93%	88%

Fully implement the integrated physical and mental health pathways for older people

The Older People's Directorate implemented ILTs in Oxfordshire on 1 December 2014. This is part of a whole system programme that will develop over two years. There are six integrated locality teams: North, North East, Central, West, South East and South West Oxfordshire.

ILTs are the collective name for community services/professionals working in a locality. This does not mean a change to the way that staff will work within their *specialist* area of expertise but that when required (i.e. in response to complex, escalating or uncertain referrals for patients requiring multi-disciplinary input), they will work in an integrated or 'joined up' way with colleagues from other specialties also working in that locality.



This ensures a multi-disciplinary team (MDT) approach to assess and meet a patient's holistic needs and eliminates duplication. Positive effects include enhanced discharge from acute services and discharge

[14] This is a monthly snapshot figure, a full year figure is therefore not available

planning from mental health (MH) wards, plus improved recognition of MH distress in care home residents.

VTE assessment has reduced over the year, but there has been an increase in other physical health (PH) assessments. There have been no VTE events. As part of the work to improve physical health management of patients (priority 5f in 2015/16) the quality and frequency of physical health assessments will be improved.

Indicator or measure	*Data source*	*Purpose of measure*	FY 1314	Q1	Q2	Q3	Q4	FY 1415
100% of patients on older adult mental health wards to have MEWS[15] and PH assessment including VTE	audit	Align physical and mental health needs of older adult patients	VTE 96% PHA n/a	VTE 96% PHA 95.75%	VTE 96% PHA 100%	VTE 87% PHA 100%	VTE 87% PHA 100%	VTE 92% PHA 99%

Transfer of the Oxford City Community Hospital to the Fulbrook Centre to support the integrated model of care

The City Community Hospital ward and the Fulbrook Centre are now co-located providing an integrated model of care for patients and an opportunity to share nursing skills and knowledge. The directorate is working up a joint model of care for people with high physical care needs and bed based mental health care needs. Due to the co-location there is informal joint working including informal coaching or mentoring for each of the units. The directorate will review the longer term benefits once the ward is established. Delivery of integrated physical and mental health care will be continued in Community Hospitals.

Implement locality and ward based patient and carer forums

Most localities now have a patient and carer forum which is attended either by the modern matrons or community leads/team members. There is also representation from the wards (modern matrons) attending the AMHT sessions to provide a link between the services and ensure any concerns / issues raised in this forum are fed back appropriately.

The ward forums take the shape of 'Have your say' meetings and meet each week on the wards. Patients are encouraged to participate and raise any concerns they have. Each forum is taking its own approach to the agenda and use of the time; in Aylesbury patients in attendance have been identifying which professionals they would like to meet with and have been thinking about social events to hold. In Chiltern, they have developed a newsletter which feeds back the updates following the forums. The forums have been advertised on the wards and in the AMHTs as well as information being sent to GP practices. The patient forums have on average three to four attendees in Chiltern and Aylesbury saw ten patients

[15] Compliance with MEWS (early warning system measures) will be audited in 2015

attend the last meeting in March 2015. In Oxfordshire, both the north and south have had three to four attendees each time. The groups are looking to see how they can further promote the forums and attract new attendees.

The Early Intervention service now has a carer forum in place. In Oxfordshire this is in partnership with Rethink, which also provides a carer's forum for the wards in conjunction with modern matrons and ward managers.

Implement patient and carer outcome measures

A patient satisfaction questionnaire is undertaken at the point of the patient review to assess satisfaction with setting and achievement of outcomes and care planning. These are anonymous questionnaires which are supported by an external company (Patient Perspective) which collates results and feeds back to the teams. Further work is required to establish a carers' feedback mechanism. Carers' outcome measures are under development. The Triangle of Care will improve the engagement of carers in patient treatment.

Review and develop early intervention in psychosis services (EIS)

The review has been completed and the new model is now in place. The service is remaining in the Adult Directorate under the direct management of the Buckinghamshire service manager to provide continuity between the services; an enhanced research function has also been included, supported by the Oxford Academic Health Science Network.

The service have the following research posts: five posts for the AHSN Clinical Network, two for the CLAHRC, two in Oxford Health research and development and one for the local clinical research network.

Review and develop the complex needs services with CCG leads

A review of the services commenced with Oxfordshire and Buckinghamshire CCG leads undertaking patient feedback sessions. There are two options awaiting decision: for each county to have the same service model or for each county to have a different service model.

Develop, implement and evaluate new staffing models including seven-day working and extended hours

The new staffing model and seven-day working commenced in April 2014 for adult services. Extended hours began in Buckinghamshire for older adult mental health services at weekends from 1 September 2014 and on weekday evenings from 1 October 2014. In Oxfordshire teams implemented extended hours on the 1 October 2014.

The CMHTs are providing step up care to assist with admission avoidance. This is provided through an intensive co-ordinated response from the CMHT to hold people through a period of acute mental illness, therefore avoiding admission to hospital.

The duty system has been introduced into the Oxfordshire ILTs and Buckinghamshire multi-agency groups (MAGs) and multi-disciplinary assessment unit. This enables us to support patients in the community and streamline inpatient processes with partner providers.

The urgent care workforce in Oxfordshire now works flexibly, for example, if the Witney minor injury unit (MIU) service faces high demand, EMU will cross cover to ensure patients' needs are managed promptly. The out of hours service manages patients with more assertive (intensive) treatment plans and responds to very unwell patients more quickly. Our staff can provide clinical expertise from illness and minor injury to acute cardiac arrest management.

Implement leadership teams in adult mental health wards

All of the adult inpatient wards now have a leadership team in place comprising the ward-based consultant, modern matron and ward manager. The trio are attending the Planning for the Future (PFTF) programme to help build a strong leadership team for the ward. These sessions have been taking place over the last ten months with experts in the field of leadership.

Agree a health plan for every secondary school in Oxfordshire

Health improvement plan templates are in place and have been completed by school health nurses who have been gathering information on their schools, working together with school staff, referencing School Development Plans. These have now been completed and agreed with the individual schools. They have been submitted to the commissioners, and with some minor modifications they have now been agreed and are in use in schools. The service has already received some feedback about the positive impact of this.

Increase the number of health visitors in line with the national call for action

Our target is 123.6 WTE and we currently have in post 130.4 WTE, so are above our trajectory, however this factors in succession planning in light of forthcoming retirements. This is in line with the National Call to Action and we are staffed to the required numbers.

Support the breastfeeding initiative to promote breastfeeding-friendly areas

All the health visiting teams are receiving training in breastfeeding, with the requirement to provide evidence of competence in supporting women to breastfeed. We now have eight trainers. A two day 'Breastfeeding and relationship building' training was run in November and February. A framework for breastfeeding awareness induction for non-clinical staff has also been developed; this will be rolled out now the updated policy is in place. Breastfeeding information is now included in the health visiting section of the trust website.

Women are able to breastfeed in the drop-in baby clinics, and in most of the sites there is a private space for them if they do not wish to remain in the public room. An audit is under way for the UNICEF breastfeeding friendly status and will inform the Trust of how many sites are breastfeeding friendly. It includes all sites used to provide services to include health centres, children's centres, and village halls.

Our infant feeding policy has been reviewed in line with updated Breastfeeding Institute standards, and is now approved for use within the directorate and the health visiting teams, and the application for a certificate of commitment has been submitted. The Nutritional Guidelines for under 5s have also been reviewed to ensure compliance with the updated standards and have been approved and published for staff on the intranet. A question regarding infant feeding is now included in the monthly patient survey.

Agree and implement model to offer multi-disciplinary (MDT) assessment to older adults with physical and mental health needs

A variety of community therapists, district nurses, re-ablement staff and mental health staff have taken part in shared skills training to facilitate multi-disciplinary working. Topics covered to date have been varied and have included:

- pressure area care and simple wound care;
- nutritional assessment (MUST tool) and support with nutrition;
- supporting patients with eating challenges who have dementia;
- awareness of urinary symptoms and collection of urine specimens;
- assessment for toileting equipment and simple mobility aids;
- positioning for patients with respiratory problems and post stroke;
- supporting patients who have anxiety.

Sessions have also supported skills that staff may need to enable them to work more confidently in other areas than their own locality and this also supports the goal of seven-day working.

As part of this objective we set ourselves a measure of success as the number of appropriate older adults with co-morbidities receiving a multi-disciplinary assessment. It has not been possible to gather meaningful data on this measure in 2014/15.

Further development and agreement of the dementia care strategy with partners

Dementia leaders across various mental and physical health services have attended regular training courses and continue to work with Age UK and Circles of Support to provide extended personalised support for patients and families.

We are part of the Dementia-friendly Communities Project in Buckinghamshire giving advice on how to develop dementia-friendly communities. Stokenchurch was launched as the first dementia-friendly community in February 2015. The local community has come together to be trained to ensure that local resources (for example, garages, banks, shops) have awareness of people with dementia and can respond by providing a safe place for people to live.

The "Knowing Me" documentation passport has been rolled out across Oxfordshire and Buckinghamshire. The passport has been well received by patients and carers. Further feedback about the "Knowing Me" passport is being sought from patients and carers with a view to extending its use outside inpatient services and ideally to be provided at the point of diagnosis in memory clinics across Oxon and Bucks.

We have begun discussions with Buckinghamshire agencies to establish a single dementia passport document. This links to the Dementia Care project in Buckinghamshire which is part of the Integrated Care Programme. We are also part of the Dementia Partnership Board in Buckinghamshire which is delivering the Buckinghamshire Dementia strategy.

The CMHTs in Buckinghamshire are members of the multi-agency group meetings at more than 40 GP surgeries. This ensures all parties share clinical information on frail elderly or frequent attenders to anticipate and prepare for the next episode or contact.

All community hospitals have been adapted to create a "dementia-friendly" environment. Initial feedback from patients suggests this has made a difference as patients can use the wards more independently. A formal evaluation is being undertaken through the "Dignity First" project.

Improve patient and carer satisfaction with services

Indicator or measure	*Data source*	*Purpose of measure*	*FY 1314*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Improving patient and carer satisfaction with services	Friends and Family test	Ensuring services meet the needs of patients/people close to them	n/a	+33.3 CH +52.2 MIU	+37.5 CH + 80.0 MIU	+ 66.1 CH + 69.1 MIU	+70.7 CH +71.0 MIU	+59.6 CH + 72.5 MIU

Quality Priority 4: staff engagement with the quality agenda

We have substantially reorganised our quality governance structures at a Trust and directorate level. Peer reviews to assess service quality have taken place across all care pathways. Opportunities have been created to bring together staff and Board members, however this requires further work to make it more consistent and frequent.

Our framework for values-based recruitment is now agreed, but we now need to implement and measure the impact of this. We have developed a new risk management process for the Trust, which is working well in some areas; however not all teams have transitioned to the new system.

Staff have delivered a substantial number of improvement activities which have delivered quantifiable benefits in terms of increased time to care and reduction in harm.

This will enable the service to be caring, safe, effective, responsive and well led.

Review and align governance processes to further develop a safety culture where staff notice, respond to and anticipate quality failures by 30 September 2014

Each operational directorate has reviewed their quality and governance structures to allow a greater degree of assurance and to ensure oversight of quality innovations as well as quality failures. The Older People's and the Children and Young People's directorates have organised their meetings to reflect the new CQC questions. The Quality and Risk team is working with individual teams and managers to review the information they receive on safety incidents to support a renewed focus on the management of incidents and the use of information to anticipate areas of risk. The intention is to ensure teams and individuals receive feedback as a result of reporting an incident and understand what actions have been identified as a result. The Quality and Risk team is also monitoring those teams where no incidents have been reported.

The peer reviews[16], which are being organised to enable teams to assess themselves against the five CQC questions, bring together a range of data to allow a 360° view of each service.

Implement values-based recruitment

Values-based Recruitment (VBR) is when employers seek to recruit staff/students with personal values and behaviours that fit with their organisation. Recent national reports and enquiries have highlighted a gap between the values of the NHS and the quality of care that people receive. This approach aims to ensure that the NHS has the right workforce, with the right skills, and the right values (aligned to the NHS constitution), to support effective team working to deliver excellent patient care and experience.

Value-based Interviewing (VBI) is a structured way to explore examples of work behaviours, focusing on how and why the individual has made certain choices in their work and the attitudes and reasons underpinning their behaviour. By incorporating this information alongside an applicant's experience, skills and competencies, the recruiting manager can gain a wider and more comprehensive view of them. This will enable the Trust to recruit high-performing, effective staff more closely aligned with our values. Organisations have seen improved morale and job satisfaction and a reduction in turnover and agency costs.

[16] A peer review brings together a range of information about a specific service, supported by a visit or visits to the team and clinical area where services are delivered, to make an assessment against a number of specific standards and questions. It is led by staff working in a similar type of service elsewhere.

The VBI method builds on good recruitment and safeguarding practice. It is not a substitute for good pre-employment checks and sound general recruitment. We conducted a survey with a cross sample of staff to develop a Behavioural Framework. This will form the basis of the values-based interviewing as well as the PDR process. Interview questions have been developed and training will commence in 2015/16.

Identify and deliver opportunities for staff and board members to meet and discuss quality issues and concerns

A number of surgeries are being organised with executive directors to enable staff to speak directly to them and raise concerns. Staff are also invited to speak with Board members on specific topics, and Board members undertake quality visits to clinical areas.

Review and redesign the risk management process across the Trust to develop and embed a risk based approach to quality and safety

The risk management strategy and policy was substantially rewritten and approved in November 2014. Training and briefing has taken place across all directorates and services to support them with using the new process. The response has been extremely positive and teams are developing a range of ways to ensure it remains a live and active document for them. As an example, ward managers in the Whiteleaf Centre (adult mental health) are planning to use the Patient Status at a Glance board to enable a daily review of risks and concerns shift by shift, which will formally be reviewed on a weekly basis by the ward leadership team with a view to transferring to the ward risk register as required. The ward risk registers will be discussed each week with the service manager and any risks escalated to the head of service as necessary.

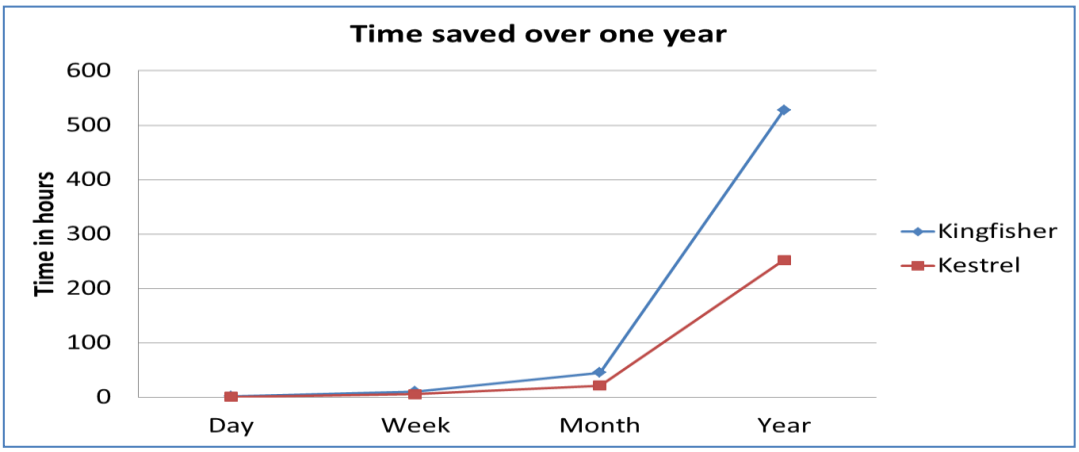
The new process has been the subject of an internal audit process during its initial phase and has been given reasonable assurance. Recommendations have been implemented to further improve how we identify, manage and control risk.

Provide opportunities for staff to engage in improvement activities and projects

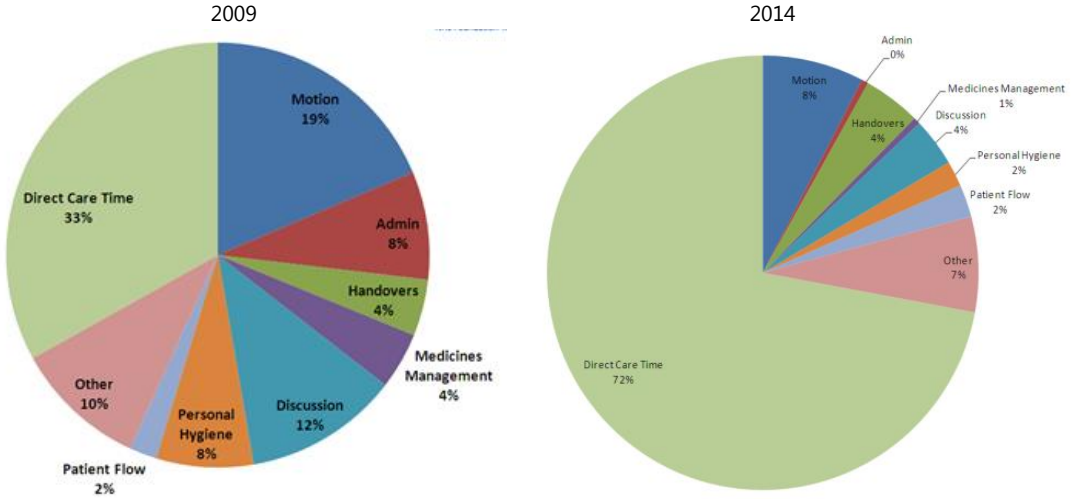
Staff have been involved in designing and delivering a vast range of improvement and change projects or schemes some of which are very local and small scale, and some cover a number of areas or teams. Examples include:

Releasing time to care

Thames House (forensic services) has completed work on improving the efficiency of covering nursing shifts at short notice. The graph below demonstrates the release of time for staff to engage in therapeutic activists with their patients.



Didcot Community Hospital has achieved the following increase in time to care between 2009 and 2014.



By reviewing all the activities of health care assistants and registered nurses, and finding ways to reduce the time spent on tasks which don't add value, staff on Abingdon community hospital ward 2 managed to increase direct time health care assistants (HCAs) spent with patients by 24% and registered nurses by 5%.

Improving the venous leg ulcer pathway

The community nursing service has adopted PSAG across seven teams in Oxfordshire. At the start of the project venous leg ulcer patients took on average nearly two years to heal from the start of the nursing intervention. The project has achieved:

- 67% of patients are healing by 24 weeks with the aim of reaching and maintaining a healing rate of 70% within 24 weeks
- an improvement in the standard of wound care for all venous leg ulcer patients, quicker, more accurate diagnosis and treatment
- a release of clinical time as fewer district nursing visits are necessary

Improving referral processes

The Continuing Care service has been supported to review all of their processes, enabling a greater clarity of role and a more timely response to referrals and inquiries. This has reduced the average turnaround time for referrals from six working days to two working days.

The District Nurse 'referral into service' form has been reviewed to reduce the number of incomplete referrals and the time spent managing incomplete and inappropriate referrals. Incomplete referrals have been reduced by 68%

Accreditation of services
Cotswold House, Oxford is working on the Quality Eating Disorders accreditation project. Actions relate to information and communication at all stages of the patient journey.

As part of their work towards AIMS, adult wards are devising a medication competency framework for all registered mental nurses (RMNs). The competency framework is in pilot stage with two wards, with a view to roll-out across all adult wards. The aim of this work is to improve the safety of medication administration and regularly assess the skills of nurses.

Improving the environment and return from leave
Woodlands and Lambourn House have improved the experience of patients returning from leave and the environment for carers and visitors. Lambourn House have introduced an electronic document to record accurately patients returning from leave and have achieved 98% completion. Woodlands secured funds to improve their 'airlock' space and now have -a photo board of staff and updated information leaflets for clients and visitors.

Catheter care review
An audit of catheter care was undertaken to identify current practice and levels of knowledge. It was found that there are variations in both areas. As a result the standard operating procedures are being reviewed and a standardised care plan is being developed to support the delivery of care and to ensure best practice guidance is implemented.

Community hospitals medication omissions
A project in community hospitals to investigate medications omissions using root cause analysis techniques has been successful and learning is being shared. Any medication omissions will continue to be monitored.

Urgent care education evenings
The urgent care service is running a programme of education evenings designed to bring services together to discuss best practice and share learning. A recent event focused on urinary tract infection was well attended. The evening was open to all practitioners and providers across Oxfordshire included five presentations from a range of services (including acute, EMU, and GP) considering best practice and management.

Smoking cessation at Cotswold House, Marlborough
Since October 2014, Cotswold House Marlborough Eating Disorders Unit has been completely non-smoking. Previously our patients had the use of a designated smoking shelter in the hospital grounds which presented a number of problems:

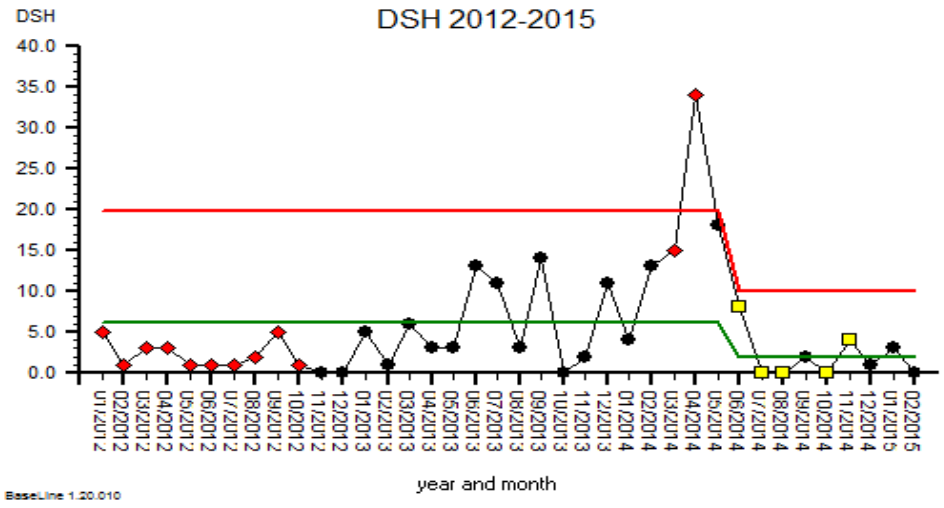
- impact on patient health including link to suppressing appetite
- staff time required to accompany patients wishing to smoke
- issues arising from some patients being unable to smoke
- interruptions to care letting patients in and out of the unit

Five members of our team across disciplines trained in smoking cessation and we are able to prescribe appropriate nicotine replacement products. Not all of our patients choose to give up smoking, and they may continue to smoke when on leave, but we provide a high level of support if they do want to quit. Staff time is being used more effectively with a considerable reduction in interruptions. It is easier to manage the amount of time patients have off the ward based on their BMI and physical health, without also needing to consider whether or not they smoke and patients know our guidelines apply equally to all patients.

We extended smoking cessation to all Trust sites on March 2, 2015.

Reducing deliberate self-harm in Marlborough House, Swindon (Tier 4 service)
After reviewing the factors which increased the likelihood of deliberate self-harm, the project tested the impact of having two members of staff in communal areas. This was in response to staff and young people feeling unsafe at times in these areas of the ward. A nurse was rostered 9-5 to attend the case management meetings and to systematically provide feedback to the young person, the family and the ward team within agreed time frames.

Key working and a family nurse role have been introduced and also therapeutic groups for young people who self-harm. The run chart shows a significant reduction in the mean number of self-harm incidents requiring physical intervention since the team commenced their safer care work. Narrative collected from young people during the project has revealed enhanced feelings of safety and that formal observations are now less common on the ward. Staff also report a greater sense of psychological safety.



Implement processes to ensure staff can raise concerns and to monitor actions taken

A revised whistleblowing policy and process has been operating in the Trust since November 2014 and four have been investigated using the new process. All employee relations cases are discussed every week alongside serious incidents, complaints, coroner's reports and other harm reduction information. Outcomes of investigations and any actions are monitored through our governance structure. A review of the whistleblowing policy against the recommendations in Sir Robert Frances' Freedom to Speak Up review will be undertaken through the Well Led Quality Sub-Committee.

Implement actions to improve staff wellbeing and motivation at work

The work of the wellbeing group was been shortlisted in the category "**Excellence in Supporting Staff Health and Wellbeing**" as part of the Nursing Times Awards 2014. Some of their activities include:

- **Stress Awareness -** during December including a designated intranet page signposted staff to useful resources, tips on how to reduce stress and who to contact for further support. Mindfulness sessions and wellbeing days have were held at three sites.

- **Oxfordshire Sports Awards -** the trust has been named as the most active workplace in Oxfordshire, after becoming a winner at the Oxfordshire Sports Awards, supported by BBC Oxford and Oxford Mail. The award was in recognition of innovation to increase physical activity.

- **Oxon Bikes -** we entered three bids to Oxfordshire County Council for their Local Sustainable Transport Fund from the Department for Transport in December 2014. We were awarded funding for our main three sites in Oxford Littlemore, Chancellor Court and Warneford with a total of 22 bikes being installed. The next steps are to expand the scheme to other sites and look into the addition of electric bikes.

- **Health checks** for 25 members of staff at the Whiteleaf Centre in December with more planned for April. All 25 staff said that they were now more interested in their own wellbeing as a result of their check.

- **Increased access to exercise** over the past twelve months has included health walks which encourage staff to take a break, table tennis tables over the summer, the couch to 5k running programme and the pedometer challenge.

- **The September pedometer challenge** involved over 450 members and over 50 million steps. Staff feedback shows that they felt it was a great way to have fun with their teams and also made them more aware of increasing the amount of exercise that they do. The next challenge is set for May 2015 (national walking month).

- **Monthly public health campaigns** have included smoking cessation team, oral health and health protection for Stoptober, Mouth Cancer Awareness, stress, and Dry January. Staff have used the campaigns to provide information to patients.

- **H2Go** in January encoured staff to drink more water and support Dry January (to give up alcohol). The H2Go button signposted staff to useful resources on how much water they should be drinking and tips on how to increase their fluid intake.

Supporting staff through bereavement

Following outcomes of staff surveys and serious incident investigations a working group was established to develop a proposal for supporting staff after critical incidents such as the following:

- acts of actual or threatened violence against staff

- any incident which is particularly poignant or emotionally charged for example, the sudden death of a patient or colleague in adverse circumstances such as suspected suicide.
- injury or death to a staff member whilst on duty
- any incident in which the circumstances are so unusual or the sights or sounds so distressing as to produce a high level of immediate or delayed emotional reactions that overwhelm normal coping mechanisms
- any incident which attracts unusual and intensive media attention

A staff psychological debriefing service, comprising suitably trained staff from all directorates in the Trust was formally launched on 2 March 2015. This service offers facilitated group or individual debriefs between one and two weeks after critical incidents, with an offer of follow up sessions if required.

Both of the indicators below have dropped since last year and improving engagement and involvement will continue as priorities in the coming year.

indicator	source	frequency	purpose	1314	1415
- ability to contribute to improvements at work	National staff survey	Annual, comparative with previous year's results	Assess staff engagement and motivation	77%	73%
- staff notivation at work				3.90	3.85

Improving access and equality

Using the Equality Delivery System, the following objectives were achieved for 2014/15:

- 'Islam and Wellbeing' Conference with Mind, TalkingSpace and the local Muslim community.
- A 'Bariatric Care' Action Group has been set up to address the diverse range of problems experienced by patients with obesity issues.
- Ensure the patient care record captures data on the nine protected characteristics.
- Raise awareness of psychological therapies available to the community.
- Translation of patient leaflets into twelve community languages.
- A survey of our estate to establish how well it supports accessibility.
- 'Two Ticks' award for a commitment to be positive about disability.
- A new Corporate Accessible Communications Guide.
- A Transgender Equality Guide.

Patient and staff stories

We asked our three directorates to gather a range of patient and staff stories to help us understand what patients value about the care we deliver and what they would like to change. We also wanted to understand how staff feel about what they do, and what helps or makes it more difficult to provide the quality of care they would like to give. This feedback was gathered in a variety of ways: filming patients as they spoke, letters of feedback, surveys

and conversations during peer reviews. It is considered alongside all of our other mechanisms for gathering feedback, including audit, FFT, surveys, complaints, concerns and compliments.

Appendix 3 offers a sample of those stories. What is clear is that there are many incidences of kindness, care and compassion from all of our staff which have a significant impact on our patients and those close to them. These include time to listen to patients and their relatives, recognising when they need support, and patients working with the same clinician or therapist during their therapeutic journey. They also comment that staff seem busy and there are not always enough activities on wards.

Staff feel there is good access to training and development and management and leadership support is improving. However, they reflect that the increase in the number and acuity of patients, and pressures on staffing mean that staff don't always have the time they would like to spend with patients and their families.

Quality Priority 5: reduction in harm

Incident reporting has increased again this year, with no overall increase in serious incidents. We did not exceed the commissioner threshold for Clostridium Difficile (CDI) cases. Reported medication incidents have increased since last year reflecting work to improve reporting. The pharmacy team are leading a number of actions to reduce harm from medication incidents.

Suspected and confirmed suicides have reduced by approximately 25% since last year and by 45% since 2011/12. The overall number of AWOLs has reduced but we have not achieved our target of a 50% reduction. There was no harm reported as a result of an AWOL this year. There has been no slight reduction in avoidable pressure damage this year. Skin integrity assessment has maintained last year's figures but there has been a drop in nutritional assessments. There are a range of factors and remedial actions which are detailed below.

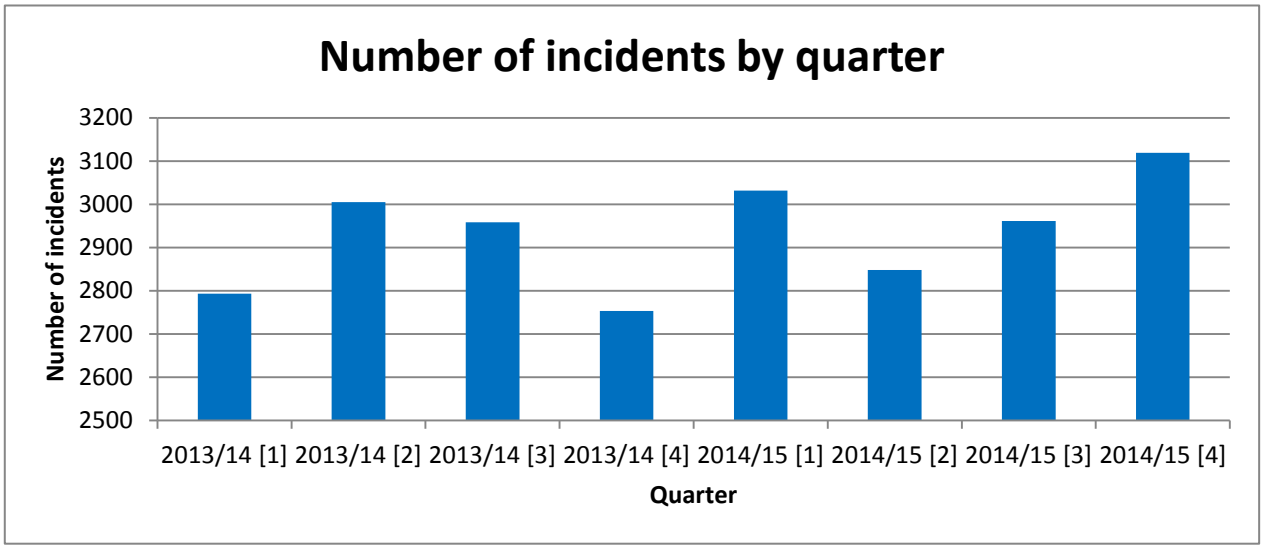
We have achieved our target for reducing the number of and harm from falls in mental health wards. We have not achieved our target for community hospital wards. We plan to improve falls related assessments in the coming year. The number of incidents relating to violence and aggression have increased. However the number of prone and hyper flexion restraints have reduced (the latter by nearly 75%).

This will enable the service to be safe.

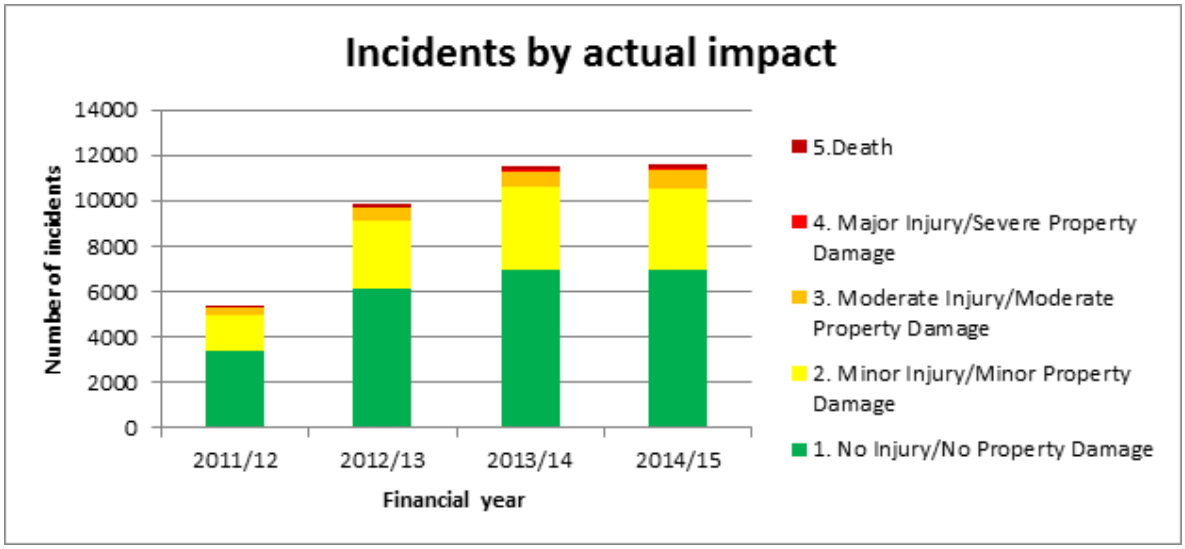
Incident reporting

Over the last four years there has been a steady increase in incident reports. High levels of incident reporting is a key indicator of a positive and open safety culture. Incident reporting has increased from roughly 600 per month in 2011/12 to just over 1000 in 2014/15. The most recent NLRS[17] figures put us in the mid-range for reporting for mental health providers.

[17] National Learning and Reporting System which captures all reported patient safety incidents and provides benchmark data for NHS Trusts



The quarterly reporting figures have ranged from 2717 in quarter 2 to 3119 in quarter 4. The two highest reported incident types were violence and aggression and health (primarily pressure ulcers). Other types of incidents include fall related, self-harm, security (mainly in relation to patients going AWOL or failure to return to hospital), communication, confidentiality and medication. The numbers of reported green and yellow incidents (low/minor injury or property damage) continues to represent by far the highest proportion of total reported incidents.

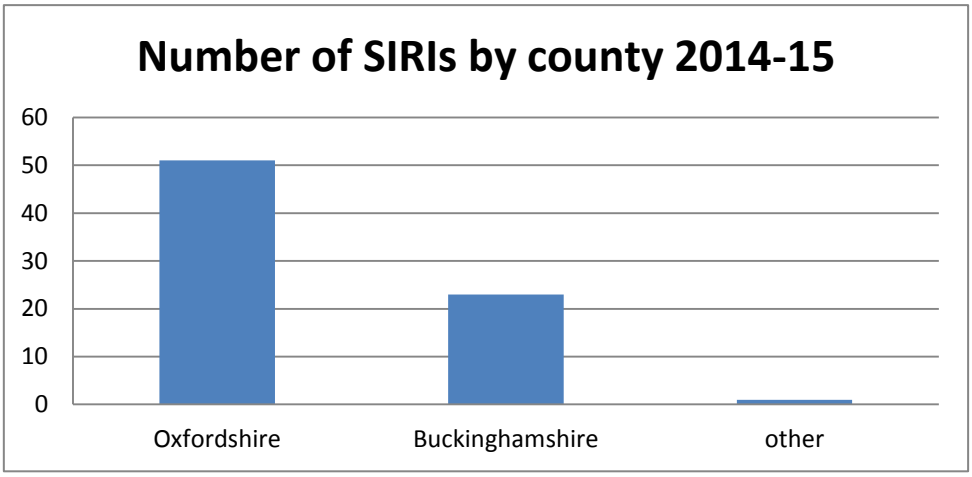


The number of SIRIs we are reporting has remained broadly stable over the last two years sustaining the significant reduction from 2012/13. In 2014/15 there were a total of 75 SIRIs reported with the highest number over the last two years occurring in Q4 2014/15. Both Adult and Older People Directorates saw a spike in these incidents in this quarter. The adult directorate saw the third consecutive quarterly increase and the older people's directorate saw a sharp rise after the previous three consecutive decreases in SIRIs.

There have been no never events or inpatient deaths by suicide.

Oxfordshire services were the highest reporters of SIRIs in 2014/15. This is largely to be expected as all of our community physical health services are located in Oxfordshire and the

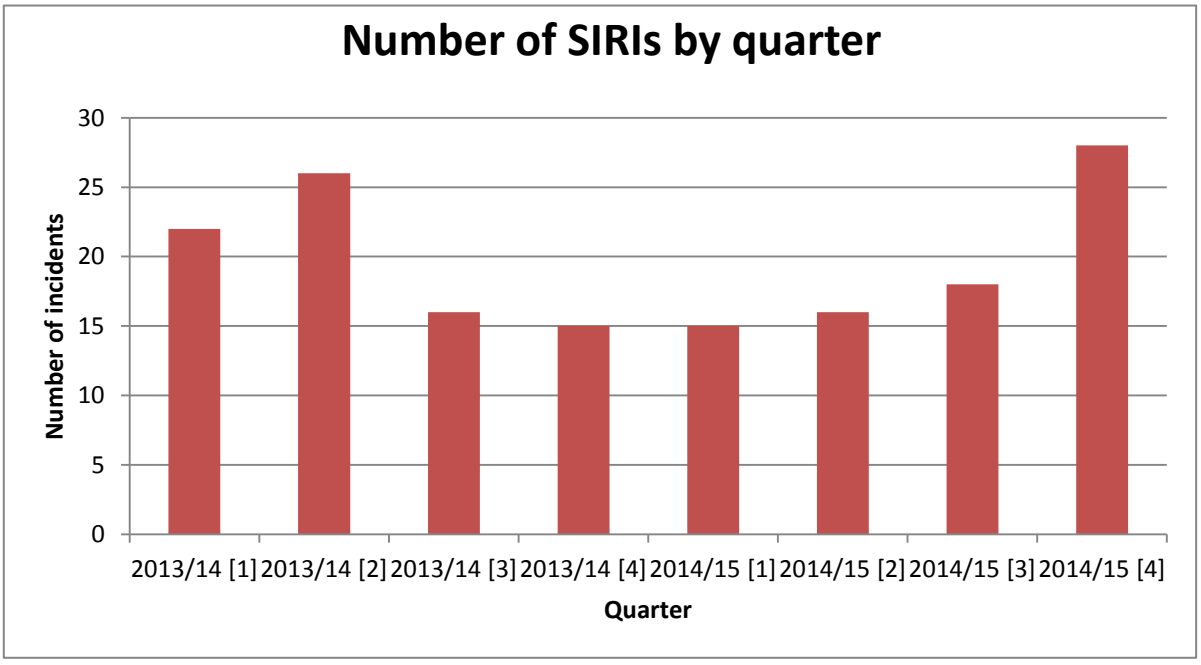
number of patients using our Oxfordshire based services is considerably higher. Overall the numbers of SIRIs reported in Oxfordshire were lower and in Buckinghamshire higher than in 2013/14.



Learning from SIRIs

We use a number of approaches to learning from SIRIs including team briefing, local and trust-wide learning events, and through relevant committees, groups and team meetings. Key themes from 2014/15 which have resulted in improvement actions have included:

- Involvement of carers with care planning at discharge from inpatient services.
- Discharge planning in general and in relation to communication between different parts of the service; also issues with communication and transfers of care.
- Assessment, recording and care planning of risk including crisis and contingency planning.



- Documentation.
- Lack of co-ordinated care, forward planning and communication issues, named nursing, care planning and documentation, training and staffing issues, management of capability, lack of supervision and leadership in community nursing.

- Lack of comprehensive recording of physical observations on the early warning score and noting of patients' refusal to have their observations taken.

We also found many examples of good practice during investigations, including:

- good liaison within and between teams and external agencies and clear evidence of effective multi-disciplinary team involvement in care and multiagency working.
- timely responses and assessment by AMHTs to referrals from GPs including same day response to GP referrals and thorough assessments.
- collaborative, flexible and responsive working between teams and with patients. This included good practice in relation to timely and consistent step up care, contact with care coordinators and effective management of transitions along pathways.
- assertive follow up following non-attendance for appointments.
- evidence of swift, appropriate and supportive interventions at times of crisis.
- ongoing high levels of community support after discharge.
- good review and management of physical health concerns.
- evidence of good communication with carers with a couple of notable individual interventions by staff.
- strong leadership.
- timely provision of pressure ulcer relieving equipment, involvement of tissue viability and in one case a notable example of whole team engagement in post incident learning with a culture of staff able to escalate concerns in community nursing services.

Improvement actions have included:

- remodelling of mental health services leading to a reduction in transitions from team to team and agreed model of care for in-patients and community services
- development of Standard Operating Procedures
- revised discharge policy
- improved staff debriefing after serious incidents
- protocol on managing patients found smoking on wards reviewed (forensic)
- standards of documentation
- identifying what other services the patient is accessing and their key contacts
- identifying parental responsibility and that patient consent sought and explained
- ensuring clear information is given to carers regarding patient's medication and risks
- updating leaflets and website information

Infection prevention and control

Indicator or measure	*Data source*	*Frequency of reporting*	*Purpose of measure*	*Baseline 13/14*	*Q1 2014/15*	*Q2 14/15*	*Q3*	*Q4*	*FY 1415*
No more than 8 cases of CDI	Ulysses	Quarterly	Measure preventable infection		1	2	1	3	7
0 MRSA/MSSA	Manual	Quarterly	Measure preventable infection		0	0	0	0	0
E. Coli	Manual	Quarterly	Measure		4	7	2	1	14

Indicator or measure	*Data source*	*Frequency of reporting*	*Purpose of measure*	*Baseline 13/14*	*Q1 2014/15*	*Q2 14/15*	*Q3*	*Q4*	*FY 1415*
bacteraemia			preventable infection						
Bare below the elbow	audit	Quarterly	Prevent infection		96%	97%	97%	97%	97%
Hand hygiene	audit		Prevent infection		97%	96%	96%	97%	97%

The 2014/15 threshold for *Clostridium difficile* cases in community hospitals has been set at eight. This target contributes to the overall health economy target. Six were in community hospitals in Oxfordshire and one was in an older adult mental health ward in Buckinghamshire; all seven cases have been peer reviewed and assessed as unavoidable.

All E.Coli cases, the vast majority of which are pre-48 hours and community acquired, have had a thorough root cause analysis completed and any learning points identified and discussed within the service. These infections require mandatory reporting but do not have a target.

Cleanliness and infection control is monitored quarterly via the infection prevention and control (IPCT) and governance team. Overall, areas are demonstrating good compliance with this outcome, except the numbers of staff trained in infection prevention and control remain below the target of 90% at 82%. Training is also available via the e-learning programme and work book for staff to access. There are also some concerns regarding audit results and decontamination record keeping.

Environmental audits continue to demonstrate good compliance with infection prevention control standards.

Improving medicines management

NHS England and the MHRA have mandated that organisations must have a nominated individual with responsibility to support medicines incident reporting and learning. This role, the Medication Safety Officer (MSO), is held by the lead pharmacist. The MSO has established the Medicines Safety and Governance Group to focus on implementing and monitoring Patient Safety Alerts, reporting and learning from medicines incidents, education and training needs around medicines safety, medicines policy and practice, and overview of the safe and secure handling medicines audit programme.

The Medication Safety Officer has oversight of all medication incidents in the Trust, and inputs at individual level as well as monitoring trends and patterns which may identify more systematic and underlying factors. Directorate lead pharmacists work with their respective governance teams to improve medicines safety.

The Trust has introduced a medicines management e-learning programme, which is part of staff PPST. This will help ensure safer practice around medicines. Pharmacy is involved in regular audits, for example the controlled drugs audit, medicines management audit and antimicrobial audit. Audits of specific high risk drugs such as anticoagulants and insulin are also underway.

Pharmacy have recently been successful in securing a small amount of funding from the Patient Safety Federation to develop safe medication pathways between care settings, plus funding from Higher Education Thames Valley (HETV) to evaluate medicines management in urgent care. Initiatives around medicines safety continue within the Safer Care Programme, particularly around reducing delayed and omitted doses and medicines reconciliation.

We are working hard to increase the level of reporting of medication incidents whilst reducing the overall level of harm. We have increased reporting over the year but the proportion of harm has increased by 0.65%.

Indicator or measure	*Data source*	*Frequency*	*Purpose of measure*	*Baseline 13/14*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Number of medication incidents and rating of harm	Ulysses	Quarterly	Measure reporting and reduction in harm	1009 (15 rated 3 and 1 rated 4)	272	303	247	299	1121 (24 rated 3 for impact)

5a: prevention of suicide

Agree suicide awareness and prevention strategies in teams across the trust and review the impact on practice, benchmarking against other providers for common indicators

Suicide awareness training has been delivered to staff across mental health and community health services, using a bespoke model. In addition, training has been provided for mental health nursing students and some health and social care partners. The training covers epidemiology, clinical and social risk factors, lived experience and staff experiences of working with suicide risk. The Interpersonal Theory of Suicide (Joiner 2005)[18] has been introduced in all training to offer a framework to help guide staff thinking, assessment and intervention and to help evolve a shared understanding of suicide across the

[18] The Interpersonal Theory of Suicide (Joiner 2005 looks at recognising the point or trigger(s) where desire becomes intent and capability in order to help staff differentiate between patients who think about suicide (ideation) and those who are likely to attempt suicide.

organisation. Follow up reflective practice sessions explore practice and complex cases, with which some teams are continuing to engage.

In October Dr Thomas Joiner, the originator of the Interpersonal Theory of Suicide, visited our Trust and delivered lectures to a number of our staff.

Around 400 staff have received training to date (exceeding the target to train ten teams over the year) and it has been agreed that dedicated suicide awareness training should continue to be offered to mental health and community staff. The interpersonal theory of suicide has been incorporated into the clinical risk assessment and advanced assessment skills training.

Evaluation has relied on a self-reported effect of training on knowledge, understanding and confidence in relation to working with suicide and has been positive.

Implement recommendations and share learning with safeguarding children's boards from OHFT internal report into children's and young people's suicide

A review was undertaken to examine unexpected deaths by possible suicide of young people under the age of 18 years during the period 1st April 2010 until 31st December 2013 across the geographical area served by OHFT.

During quarters 2 and 3 learning has been shared with all five Local Safeguarding Children Boards with which the Trust works, within the Trust and with our partners in order to increase awareness of risk factors associated with suicide, improve identification of at risk young people and to explore how practice can be improved to increase their safety.

Reduction in probable suicides in community and inpatient services

This year there has been a further reduction in the total number of suspected and confirmed suicides reported. This is the fourth reduction in as many years. The first three quarters were below the median for the last three years, however quarter four has seen an increase in the rate reported. The majority of these deaths are reported in the adult mental health teams, which is to be expected. During this period both Chiltern and Aylesbury AMHTs in Bucks have been reviewed and a number of operational pressures have been identified. Plans are in place within the directorate to help address these concerns.

The table overleaf shows the days between suspected suicides in individual adult mental health (community-based) teams where a suspected suicide occurred in 2014/15. There have been no inpatient suicides in 2014/15.

Teams which have achieved 300+ days between suspected suicide	Incident date	Days between incidents
North and West Bucks AMHT	12/05/2014	322
North West AMHT	21/09/2014	439
OA North CMHT	21/02/2015	536
Bucks IAPT (Healthy Minds)	09/03/2015	551
TalkingSpace	24/11/2014	635
South Oxon PCAMHS	21/08/2014	Over 1238[19]
OA Wycombe CMHT	12/03/2015	Over 1238
Teams which have not achieved 300+ days between suspected suicide	**Incident date**	**Days between incidents**
Community Drug and Alcohol Team	24/03/2015	5
Aylesbury AMHT	20/01/2015	12
Chiltern AMHT	27/03/2015	38
City and NE AMHT	18/01/2015	83
South Oxon AMHT	07/12/2014	125
Prison In-reach Team (HMP Bullingdon)	24/06/2014	162

5b: reduction in the number of missing patients from inpatient services

Review and evaluate absence without leave (AWOL) projects in three wards

Patients detained under the Mental Health Act who absent themselves from hospital without the written authorisation of the responsible clinician, or who fail to return from authorised leave of absence at the required time (including failure to return within ten minutes following planned leave), or absent themselves from a place where the responsible clinician requires them to reside are deemed to be AWOL.

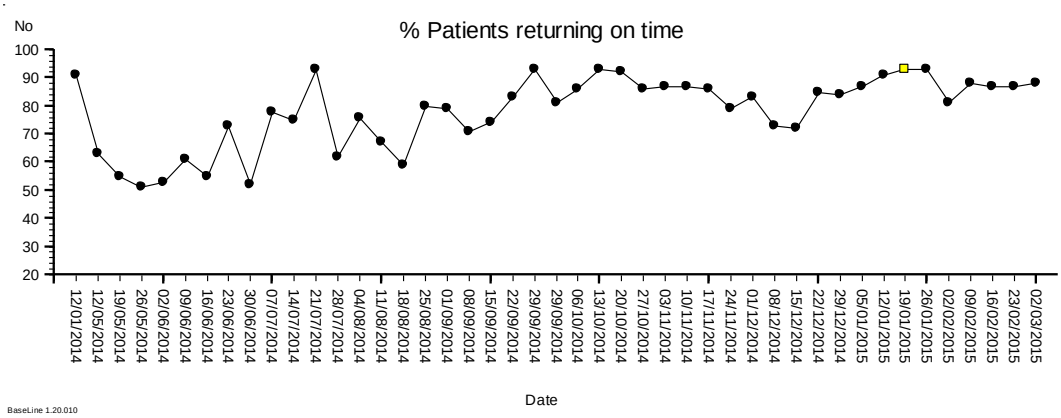
Patients who fail to return on time from leave and time away project: adult wards

This project continues and has now extended to include all adult acute and rehabilitation wards in the Trust. The focus of the work is to ensure that a philosophy of care and safety underpins the leave and time away process, rather than a security focused process.

Each PDSA[20] cycle has been discussed with patients in ward community meetings. The PDSAs include planning for leave during ward reviews, the provision of patient information for both detained and informal patients developed in collaboration with the CQC, a change to policy guidance, the offer to patients of a ward card with leave details and ward contact numbers, and a range of information posters. A signing in and out book affords nurses and patients the opportunity to discuss their leave or time away agreements and to discuss how leave went upon return. Intentional rounding has been implemented to check the leave status of all patients every hour on the ward. The data chart overleaf shows progress on Allen Ward (adult acute).

[19] The teams with over 1238 days between incidents have not reported an incident since the beginning of FY 11/12.

[20] Plan, Do, Study, Act (PDSA) is a structured approach to testing out small scale changes and improvements

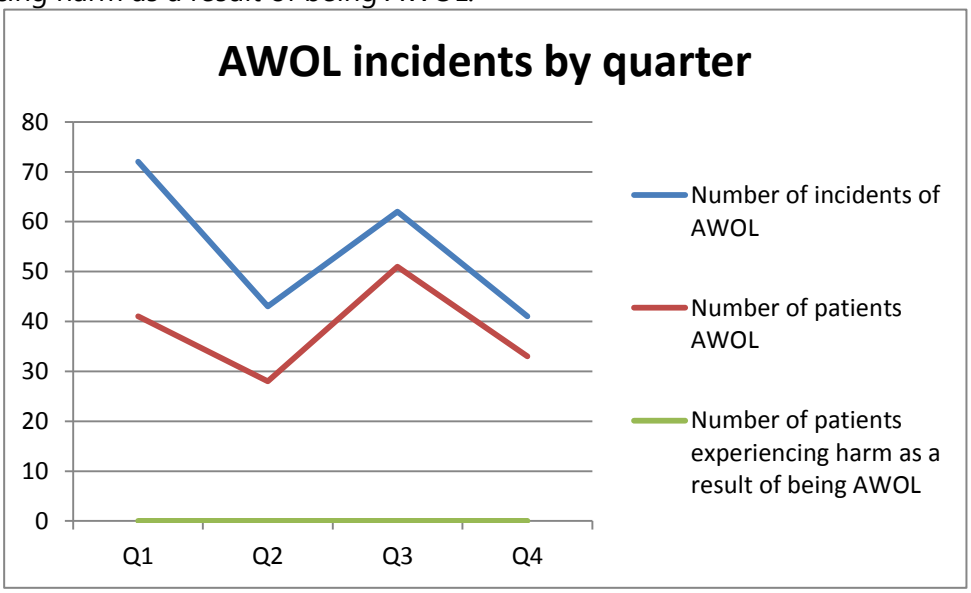


Allen Ward

Chaffron Ward is continuing to monitor the days between AWOLs for the safer care project and this stands at 483 from the start of the project. Opal Ward has improved the percentage of patients returning on time to 93%.

All adult wards are engaged in the project to test interventions to ensure that patients return from time off the ward at the agreed time, and safe and well. Phoenix Ward provided the first test site and introduced systematic tests of change using Institute for Health Improvement methodology including the use of a signing in and out book, multi-disciplinary discussion with the service user on the therapeutic aims of leave and the time required to achieve these, cards with ward contact details and agreed time of return, and intentional rounding to check safe return. The ward initially improved the rates of return on time from 30% to 74%. With further consolidation, the ward is now sustaining 93% of service users returning to the ward on time.

Overall the number of AWOLs has decreased in 2014/15, both number of incidents and number of patients. While we have achieved a 50% reduction in some areas, we have not achieved our overall target reduction of 50%. There have been no incidents of patients experiencing harm as a result of being AWOL.



Indicator or measure	*Data source*	*Purpose of measure*	*FY 1314*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Number of incidents of AWOL	Ulysses	Measure reduction in AWOLs	229	72	43	62	41	218
Number of patients absent without permission	Ulysses	Measure number of patients generating incidents	174	41	28	51	33	153
0 patients[21] to experience harm (rated 3, 4 or 5 in impact) as a result of AWOL	Ulysses	Measuring reduction in harm from incidents of absence without permission	2	0	0	0	0	0

5c: reduction in the number of avoidable pressure ulcers

There has been no change in the number of avoidable pressure ulcers reported in 2014/15 compared to the previous year which means we have not achieved the required reduction in avoidable grade 3 and 4 pressure ulcers this year. Prevalence of all pressure damage has reduced recently, as indicated by safety thermometer data. However, the prevalence of new pressure damage remains high in comparison to the national figures for all NHS trusts.

Every category 3 and 4 pressure ulcer is assessed using a regional avoidability tool, which includes a full review of the patient notes and of compliance with procedures and policies. The main themes that have been identified following investigations include:

- missed opportunities to complete in-depth risk assessments and to support risk assessments with comprehensive care plans
- regular and routine review of risk assessments and care plans

Staffing levels and capacity of teams have also been highlighted as contributory factors in avoidable incidents. Improvement actions have included:

- improved 1: 1 supervision and group clinical supervision for teams
- support for new starters with additional assistance from clinical practice educators
- PSAG boards to alert teams to high risk patients
- documentation audits to encourage ownership of records by teams
- weekly meeting to discuss issues in the caseloads for all clinical staff
- introduction of pressure damage prevention core competencies for registered nurses and assistant practitioners at Level 4

Review skin integrity assessment tool and agree options for replacing the Walsall assessment tool

The skin integrity assessment tool was reviewed and the Braden tool[22] which is recommended by NICE and is the most validated and reliable risk assessment tool available

[21] Three incidents rated as 3 for impact (Q1, 3 and 4) but this was damage to property

[22] The primary aim of this tool is to identify patients who are at risk of developing a pressure ulcer and to determine the degree of risk. The Braden Scale is made up of six subscales, which measure elements of risk that

was identified as the replacement for the Walsall assessment. The Braden assessment is part of the standard documentation for community nursing and this is being supported by a Braden and equipment e-learning package due in May 2015. The Older People Directorate has also developed a tissue viability resource (expert) nurse role within the district nursing service.

The Braden tool was implemented in partnership with Oxford University Hospitals to ensure uniformity in risk assessment and management of care. Prior to discharge a bundle of 'always actions' will be carried out which includes a discussion with the patient and their carers about the pressure ulcer risk and any self-management strategies; sharing a patient information leaflet; ordering equipment and explaining the equipment to the patient.

Skintelligence

The Skintelligence programme commenced in October 2014 utilising methodology from the Institute of Healthcare Improvement service to undertake local interventions that reduce the harm caused to patients' skin as a consequence of pressure. A total of 34 participants, representing twenty teams from a range of older adult services have engaged in activities in partnership with local nursing and residential homes.

Agree and pilot a set of appropriate and reportable indicators to support pressure damage harm reduction projects

During 2014/15 the indicators measured to support the reduction of pressure damage focused on compliance with the completion of appropriate risk assessments. The risk assessments are the skin integrity risk assessment and the nutritional status assessment which when completed indicate appropriate interventions for each patient to prevent pressure damage.

The Fulbrook Ward staff have started collecting data and are using a safety cross to record any skin damage. The random testing of five sets of notes to check all have a risk assessment in place started in October and this will happen weekly to establish a baseline and next steps.

Work has commenced using an initial *Ask five staff* if they know what to do if they see any pressure damage and how they implement further interventions. Each ward has already identified one patient who is at high risk and are testing out different ways to encourage staff to use the SSKINS model. They are adapting the notes template and a member of staff has created a poster on avoiding skin damage as a prompt for staff. Next year we start to measure days between pressure damage in individual teams.

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contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. These are: sensory perception, moisture, activity, mobility, friction, and shear. Each item is scored between 1 and 4, with each score accompanied by a descriptor. The lower the score, the greater the risk. It is being adopted because it is considered to offer better inter-rater reliability and to enable OHFT risk assessments to be consistent with Oxford University Hospitals NHS Trust which currently uses the Braden tool.

We have not achieved 100% of patients receiving skin integrity assessments, although in the last two quarters the figure has increased to 97%. We have also not achieved 100% of patients having a nutritional status assessment and this is generally lower than last year.

Indicator or measure	*Data source*	*Purpose of measure*	*Baseline 13/14*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Number of patients with avoidable pressure ulcers graded 3-4 (target 0)	Ulysses	Measure reduction in avoidable pressure ulcers	13[23]	3[24]	2	4	4	13
100% of patients managed by district nursing service to have skin integrity risk assessment on 1st visit	audit	Reduce risk of avoidable pressure damage	96%	93%	93%	97%	97%	95%
100% of patients managed by district nursing service to have nutritional status assessment on first visit	audit	Reduce risk of avoidable pressure damage	93%	86%	86%	80%	87%	85%

Case study: embedding the use of patient status at a glance (PSAG) to improve venous leg ulcer (VLU) healing rates in district nursing services

A recent pilot of the VLU pathway showed greatly improved healing rates for patients with use of the pathway which in turn reduces their pain and improves their quality of life. As a result of this project five patients were added to the VLU pathway and PSAG:

- One healed within eight weeks
- Two undiagnosed diabetics identified
- Principles of the VLUP followed for eleven mixed aetiology or non-concordant patients leading to:
  - two patients achieving a 40% reduction in six weeks
  - three patients healed
  - one patient agreeing to full compression

5d: reduction in the number of patients harmed by falls

Implement and evaluate a falls harm reduction project in Sandford Ward

Falls risk assessments are completed across the mental health wards on admission, after a fall and after 28 days. We have also introduced:

[23] This figure has changed from last year reflecting the refreshing of data to take account of potential SIRIs which were downgraded by the CCG.
[24] This figure has changed as one SIRI was appropriately reallocated to Q4 1314 when the incident occurred.

- two-part falls assessment and agree documentation to be included in falls booklet
- falls awareness training is now available via an e-learning package
- lunchtime falls awareness training delivered across older adult mental health services

When we monitor patient falls significant contributory factors include cognitive behaviour and decline, the absence of documented effective and in depth care planning and non-application of appropriate controls following completion of risk assessment.
Local actions taken to address these themes include:

- compliance with falls awareness training within the agreed timeframe
- support to carry out an audit of care planning on the ward
- training in the correct assessment and understanding of the interventions recommended in NICE Guideline for urinary symptoms in females
- all grades of staff have access to the learning around delirium that is planned for ward doctors and nurses

Patients have access to interventions such as Tai Chi classes and physiotherapy support to improve balance. The falls team have promoted the referral process with all teams to raise awareness and ensure consistent referrals are made. Currently an older adult mental health patient is referred to the falls service after one fall, rather than two as is the procedure in community hospitals. This change was implemented to help address the falls rate in older adult mental health wards which has decreased substantially. In addition, all patients are receiving physiotherapy assessment irrespective of mobility issues, which has increased effective screening.

Agree a set of appropriate and reportable indicators to support falls harm reduction projects

The safer care collaborative measure is to reduce harm from falls by 50%. There has been a consistent reduction in harm from falls in the past two quarters, with a 30% reduction in harm since last year in mental health services (Q4 compared with 1314 full year figure). However, the number of falls and level of harm has increased in community hospitals.

Our falls audit collates data on patients in older adult inpatient services to have a falls risk assessment on admission, patients having a falls risk assessment after 28 days and completion of a review of patients' care plans after a fall. This was introduced during Q4. The audit will be carried out quarterly during 2105/16.

Indicator or measure	Data source	Purpose	Baseline 13/14	Q1	Q2	*Q3*	*Q4*	*FY 1415*
Number of falls (with harm rated as 3, 4 or 5 by 1000 mental health bed days (target 3.8/0.2)	Ulysses	Measure reduction in harm from falls	4.8 MH (harm 0.3)	4.4 (0.2 harm)	5.1 (0.6 harm)	4.1 (harm 0.2)	1.2 (harm 0.1)	3.7 (0.3 harm)
Number of falls (with harm rated as 3, 4 or 5) by 1000	Ulysses		10.6 (harm 0.3)	11.9 (harm 0.5)	10.5 (0.7 harm)	15 (0.4 harm)	12.9 (0.4 harm)	12.6 (0.5 harm)

Indicator or measure	Data source	Purpose	Baseline 13/14	Q1	Q2	*Q3*	*Q4*	*FY 1415*
physical health bed days target 8.6/0.2								
100% of patients in older adult inpatient services to have falls risk assessment on admission	audit	Reduce the risk of falls	87.75%	99% CH	n/a	95% CH	91%	95% (based on 3 data points)
100% of patients in older adult inpatient services to have a falls risk assessment after 28 days	audit	Reduce the risk of falls	Baseline set Q1	Data from Q4	Data from Q4	Data from Q4	60%	60% based on 1 quarter's data
100% of patients to have a care plan review after a fall	audit	Reduce the risk of falls	Baseline set Q1	74% CH	n/a	68% CH	65% CH+ OAMH	69%
100% of patients to be referred to falls service after 2 or more falls	RiO	Reduce the risk of harm from falls	Baseline set Q1	n/a	MH 30% CH 70%	n/a	MH 43% CH 63%	MH 37% CH 67%

5e: reduction in violence and aggression

Implement a revised training programme for prevention and management of violence and aggression (PMVA)

The project to review the Trust's PMVA (prevention and management of violence and aggression) training has recently been completed. This is in line with the DoH publication *Positive and Proactive Care: reducing the need for restrictive interventions* (April 2014). This is part of the government-led initiative called *Positive and Safe* which is a two-year project to change the approach to managing challenging behaviours in health and social care settings.

The outcome of this project was to develop a new training programme which has been named positive engagement and calm environments (PEACE). We will start training teams in the summer of 2015. A new group has also been set up to oversee the programme to reduce restrictive interventions, to monitor the use of restraint, seclusion and rapid tranquilisation and initiatives to improve the mental health wards as therapeutic environments.

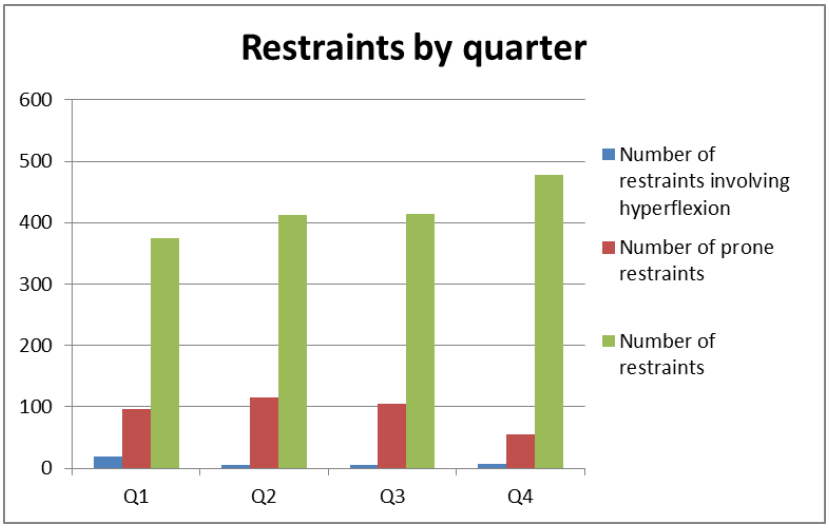
The Highfield Unit has implemented a project co-ordinated by the safer care team to reduce the incidents of serious violence/aggression leading to prone restraints. Their initial target in March 2014 was achieved, and the second target was to reduce incidents of violence and aggression by a further 25% by March 2015. To support this they implemented a sensory assessment & care plan focused on how patients manage when feeling overwhelmed and distressed. The occupational therapist has been involved in assessing new admissions and the case team have been reviewing the assessment, formulating a care plan together and

liaising with parents. Patients have welcomed the use of a sensory ladder which communicates to the team how patients are feeling and what may help in that moment. The overall level of prone restraints has steadily decreased.

Sandford ward is currently completing an audit to measure the number of restraints occurring on the ward, to compare with the numbers reported on incident forms. There has been a successful reduction in incidents of violence and aggression on Watling Ward (medium secure forensic service) as part of safer care work.

Report on and reduce the number of avoidable prone restraints (where the person is face down) and use of hyperflexion (holding the arm to restrain)

The graph shows the number of restraints per quarter, including the number of restraints involving hyperflexion and prone restraints. Although the overall level of restraints has increased over the four quarters, the proportion of both prone restraint and restraints involving hyperflexion has decreased.



Indicator or measure	*Data source*	*Purpose of measure*	*FY 1314*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Reduce by 25% number of reported incidents of violence and aggression with harm (3, impact 3/4/5)	Ulysses	Measure reduction in incidence of violence and aggression	28 (incidents in our inpatient units only)	20 (all incidents)	22	14	13	69
Number of prone restraints/all restraints (target towards 0)	Ulysses	Measure reduction in incidence of prone restraints	392/1464	97/375	116/ 412	105/ 415	56/ 477	374/ 1679
Number of restraints involving hyperflexion (target 0)	Ulysses	Measure reduction in incidence of hyperflexion	146	20	5	6	8	39

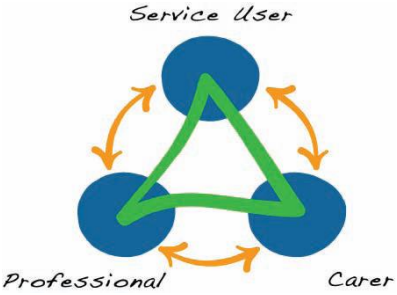
Quality Priority 6: implement the patient experience strategy

We achieved the majority of our objectives, with the exception of developing a webpage to share feedback. We are working with local organisations including Healthwatch Oxfordshire to improve how we share and respond to feedback and some of the actions we have taken as a result of feedback can be found in the section below.

This will enable the service to be caring and responsive.

"Seeking and acting on patient feedback is key to improving the quality of healthcare services and putting patients at the centre of everything we do."

Our patient experience strategy is co-ordinated through a Trust wide group. The purpose of the strategy is to deliver a range of quantitative and qualitative approaches to collect and ask for feedback, to collect and share patient stories, and to describe actions taken at a team and clinician level to address patient concerns.



We have also established an organisation wide carer's strategy forum chaired by the Chief Operating Officer to oversee the achievement of the Carers Trust 'Triangle of Care' external accreditation. The forum is made up of representatives from carers, staff from each directorate, voluntary organisations, and the county councils.

Develop a webpage to share feedback and how this has been learned from and acted upon

We have not achieved this objective this year; however we have used a variety of mechanisms to share learning and actions internally. We are also participating in a new quarterly whole system meeting facilitated by Oxfordshire HealthWatch to discuss and share quality issues being raised by patients and the actions each organisation is taking as a result.

90% of teams to be collecting feedback on patient experience feedback and 50% of teams to demonstrate they are listening to and acting on feedback

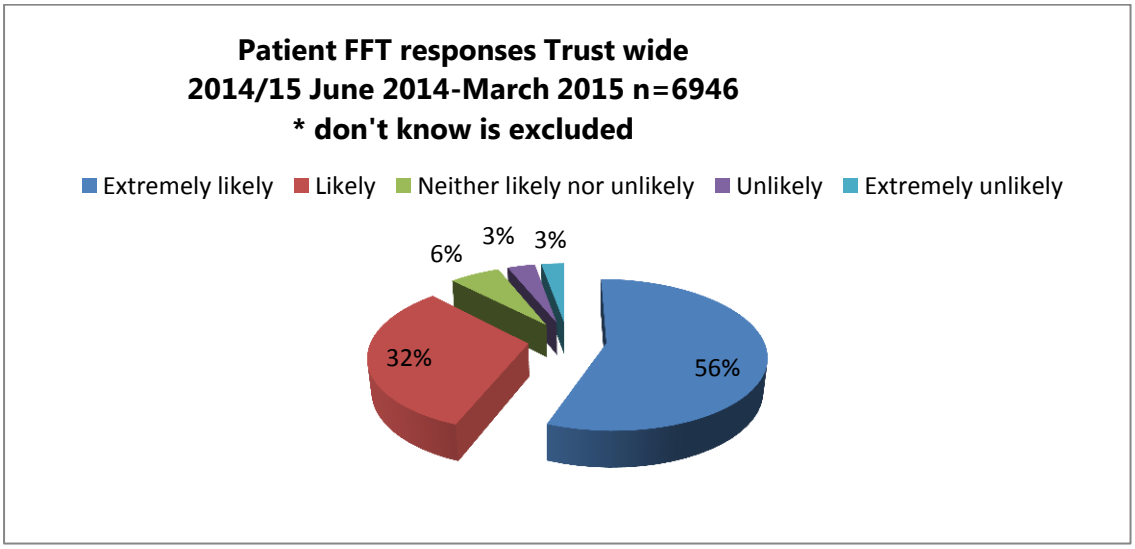
Every service is now collecting feedback and it is possible to evidence the mechanism of this and the action taken as a result. Patient experience leads are reporting on themes and improvement actions through the patient experience group and in reports to the quality committee and Board.

In the recent national staff survey (1646 responses, 32% response rate):

- 74% of staff said yes patient experience feedback is collected within their team (national average 79%)
- 55% said they receive regular updates on patient feedback (national average 56%)
- 57% said they feel feedback from patients is used to make informed decisions within their team (national average 53%)

Roll-out of the Friends and Family test across all services

This year we expanded our Friends and Family Test to include our mental health services. The following chart shows the response to the question *how likely are you to recommend our service to friends and family if they needed similar care or treatment*.



Introduce a system for capturing patient and staff stories

Each of three directorates has spent time speaking to patients and staff to capture their views and experiences of receiving and delivering care. We have filmed patients and staff talking; we have gathered views during care planning and reviews; we have sent anonymous surveys; we have spoken to patients and staff during peer reviews; we have invited patients and carers to training and learning events and we have invited staff to attend Trust Board and committee meetings. Patient stories are now heard at the start of our Board meetings. Some of these stories can be found under Priority 4.

On line feedback forums (iwantgreatcare, Patient Opinion and NHS Choices)

Since the Trust has changed its approach to managing and responding to online feedback forums we have received an increase in the number of postings between July 2014-Feb 2015. The forum most often used has been NHS Choices. From April 2014 to February 2015 (n=34), eighteen postings have been positive, thirteen postings have been negative and three mixed with both positive and negative feedback; no themes have been identified. The majority of postings are about the minor injury units and all postings have been responded to within a week to open a dialogue with people.

Acting on patient feedback

Gathering patient feedback is only the start of the journey. What is important is how we respond to that feedback and what actions we take as a result.

Team	
Adult Acute Wards	**You said** there were a lack of activities across a series of wards. **We have** reviewed and changed the type of activities available and staff are being asked to promote the weekly timetable.
Adult Mental Health Teams	**You said** we want to know about how we can be involved in services. **We have** set up service user forums aligned to each AMHT. The more successful forums have promoted and gained a large representative of service users. Through these forums there has been positive feedback about the recent changes.
Forensic Wards	**You said** it is taking a long time to recruit staff, it is difficult to contact family and friends if mobile phones are not allowed, families live far away and can't visit, curfew time should be extended and you can't order items over the internet as you are unable to use debit cards. **We have** involved patients in recruitment, developed with patients, for patients to have basic mobile phones (no camera or internet access). The pilot is running for six months from Jan 2015 before rolling out to other areas if successful and problem free. Service users can use Skype as a means of contacting loved ones. Curfew time has been extended to 8pm and is regularly reviewed. Payment cards are now available for people that wish to have them.
Psychological Therapy Service	**You said** you were unhappy with waiting times and services accessibility for assessment and treatment and with the choice and availability of these and there were technical problems with appointments by telephone and using electronic education packages. **We have** started monitoring weekly waiting times and monthly DNA rates, informing patients in writing about the expected wait to treatment, offering courses after 6pm, working with the telephone provider to improve call quality and discussing treatment choices with the patient to identify the most appropriate treatment.
Children and Young People's mental health services	**You said** information about services and how to access can be difficult to find and we don't understand some of the terms used by the teams for example, consent and confidentiality. **We have** developed a new website and more user-friendly information in consultation with young people and parents as well as professionals and each service will have a nominated champion who will be responsible for keeping their service information up-to-date on the website. We have also installed TV screens at a number of team bases to improve information for patients waiting for appointments.
Children's therapy services	**You said** as parents you would like to be more in involved in service developments. **We have** developed a new stakeholder's engagement plan and held a parents' information event. We are also implementing a new approach to collect non-verbal feedback from very young people by interviewing a parent/carer as well as watching and recording positive or negative behaviours from the young person whilst therapy is being delivered.
Eating Disorder Service	**You said** there is inconsistency between staff at meal times. **We have** involved patients in making a film for all staff to watch around how to support and encourage people during mealtimes 'induction to meals'. Information resources are being developed for professionals, especially those new to working with patients struggling with an eating disorder.
Community Hospital wards	**You said** there is not enough information, soft meals can be hard to swallow or unpalatable, there are not enough daily activities, wards are not dementia-friendly and there should be more home visits before discharge. **We have** set up a daily "walk round" and a regular "clinic" to answer patients' questions and clarify issues, put up posters promoting planned activities, given information on home visits and made changes to the environment to make them more dementia-friendly.

Team	
District Nurses (DN)	**You said** you would like times for DN visits to be more specific. **We have** updated the initial assessment sheet to identify if the patient would prefer morning, afternoon or no preference to time of visits.
Physiotherapy services	**You Said** waiting times for appointments are too long. **We have** amended the referral letter to include accurate waiting time predictions, ensure GPs are aware of how to arrange urgent appointments, started to send text reminders to reduce DNAs and increased capacity.
Dietetics Service	**You said** you did not always feel they get sufficient support and information. **We have** set up a Nutritional Action Group created for patients who are malnourished or overweight, supporting carers and families to maintain better nutritional health.
Diabetes service	**You said** you would like to be supported to have increased self-management and independence. **We have** procured MapMyDiabetes online platform procured, allowing patients to upload data, and download information, and allowing Type 2 patients to self-manage.

Case study: using client feedback to improve Health Visitor clinic services
The health visiting team in Witney spoke to staff and clients to improve their weekly clinics. As a result of feedback they changed the days and times of the clinics, offered time slots to see a health visitor, started a six-weekly health promotion cycle, and changed to a more appropriate room which offered better access, hand washing facilities and more privacy when talking to a Health Care Professional.

Case study: responding to patient experiences of pain
Three patients were filmed talking about their experiences whilst receiving care from district nursing. This was very positive and we have identified where some improvements can be made. Work is underway to improve pain assessment and management. A number of pain assessment tools are being reviewed to be implemented in 2015/16.

Case study: district nursing services the teams have recently completed making a film which has targeted engaging service users who are difficult to reach. The film is to be used to facilitate changes to practice and care where needed and therefore improve the experience for patients

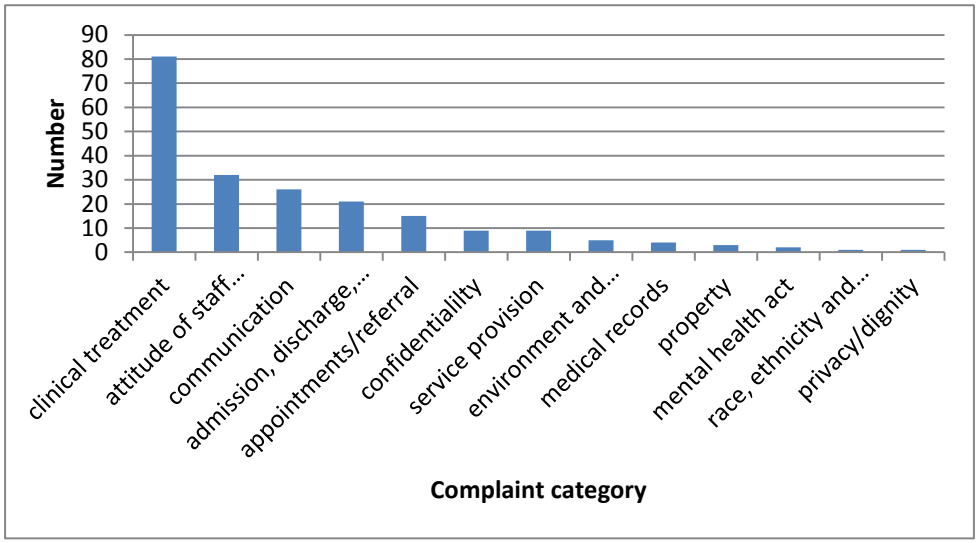
Case study: improving the experience of patients in forensic services
Groups of service users have been involved in making a film about their experiences being in hospital and their recovery journey. This has been used to form part of the forensic induction for all new staff. Glyme Ward patients and staff produce a joint newsletter on a monthly basis, this has proven very popular and a positive way to celebrate patient success and keep parties informed of developments. A number of service users have been involved in planning an event across the Littlemore site and a football tournament will take place in August.

Themes from complaints
The Trust received 209 complaints (excluding withdrawn complaints) in 2014/15. This is an 8% reduction when compared to the 226 complaints received in the previous year. This can be attributed to an increase in PALS dealing with concerns at a local level to resolve problems quickly. During this period of time, 26 complaints were withdrawn by complainants and were resolved informally through PALS.

In 2014/15, 103 (49%) of the 209 complaints received were responded to within the initial timescale agreed with the complainant. 65 (31%) complaints were responded to within an extension agreed with the complainant. 17 (8%) complaints were responded to outside of the agreed timescale. At the time of writing this report, 24 (12%) complaints remain open and under investigation.

Complaints by Category

The primary categories of the complaints (upheld and not upheld) received across the Trust in 2014/15 were:



Following investigations, 292 actions have been identified of which 226 (77%) have been completed within time, 38 (13%) actions are overdue and 18 (10%) actions are due to be completed over the next couple of months. Examples of actions include:

- Spot checks by modern matrons for the Buckinghamshire adult mental health wards on the quality of leave planning, leave forms and contact with family around leave. Checklist for monthly spot checking to be created.
- Reviewed handover system on a ward using productive ward tools to ensure that key information is not missed and that essential clinical information is handed over from one shift to another.
- Senior team to develop and agree standards for physical health monitoring, including monitoring for diabetes when prescribing neuroleptic medication.

Healthwatch "independent voice for patients'

We have been sharing feedback and themes received from patients with our local Healthwatch organisations and have supported each other to recruit patients and their family members to be involved in reviewing and improving services for example, PLACE assessments in March 2015. A number of applicable impact studies have been commissioned by Healthwatch in Oxfordshire and Buckinghamshire, based on themes identified locally and nationally by patients. These include access to and experience of health services by a range of groups, personal budgets, young people's mental health, experience of being discharged from hospital, carer experience and dignity in care. The Trust provided an update in January 2015 to the findings and suggested recommendations from the impact studies.

The Older People Directorate is contributing to the Healthwatch Oxfordshire Discharge Quality Review. The project will seek to engage with patients through patient experience questionnaires and visits to services to build a picture of the care provided from the patients' perspective and to test discharge processes to see if they are working as expected.

Healthwatch Oxfordshire and Age UK Oxfordshire are teaming up to try and find out how well national standards on dignity in care are being met in Oxfordshire. Patients, clients and carers will be interviewed about whether the care they are getting matches up to the required standards of dignity in all care settings.

Agree core domains of patient experience to measure and report on

Across our services the key and consistent areas for improvement fed back from service users, patients and carers are:

- Patients want to feel informed, be given options and take part in decisions
- Patients want good information that is tailored to them and is timely
- Patients want staff to communicate clearly with them
- Families and carers want to be involved, listened to and respected

The NQB NHS National Quality Board developed the NHS patient experience framework (2012) which provides an evidence-based list of the elements that patients reported are critical to have a positive experience. We have adopted this as our framework for the domains of patient experience.

Critical elements to a positive experience	Aspect of care
1. **Respect of patient-centred values, preferences and expressed needs** including cultural issues, dignity, privacy and independence and shared decision making	Relational
2. **Coordination and integration of care** across and within services	Functional
3. **Information, communication and education** on diagnosis, treatment, progress and processes of care to facilitate autonomy, self-care and health promotion	Relational
4. **Physical comfort** including help with daily living, pain management, and the cleanliness, comfort and safety of the physical environment	Functional
5. **Emotional support** and alleviation of fear and anxiety about diagnosis, treatment, and the impact of illness on their lives	Relational
6. **Welcoming the involvement of family and friends** in decision making and awareness of their needs as care givers.	Relational
7. **Transition and continuity** including coordination, planning and support to ease transitions, as well as information that will help patients care for themselves away from a clinical setting	Relational
8. **Access to care** including ease of access and waiting times at each stage through their treatment	Functional

Quality Priority 7: development of outcome measures

The three pathways we profile have all seen improvements in patients setting and achieving goals and outcomes.

This will enable the service to be effective.

Select two new areas (pathways or services) for development of outcome measures and report on progress during the year

In 2013/2014, Bucks speech and language therapy (SLT) introduced goal-based outcomes (GBO) for young people in Buckinghamshire. It was designed to measure outcomes following an initial speech language therapy session at start of their school term.

The adult mental health service has been implementing the Recovery Star within the AMHTs and acute inpatient wards over the past twelve months.

Demonstrate that the development process maximises opportunities for involving patients and those close to them in developing and reporting on outcome measures

Bucks SLT

As part of the implementation of outcome measures in SLT, the service developed a standardised tool for assessing outcomes. The tool is used to capture an outcome measure together with the patient at start of school term and to evaluate the patient outcomes against measures at mid and end term. The tool (a questionnaire) is used to make a plan of care that matches the patient's health needs with their therapist which is in turn used to track impact of the care plan on patient's outcomes.

As the tool points out the areas where intervention could improve care and measure progress towards this outcome it influences the relationship between process of care and the outcome. It is hoped that by targeting together (patient and therapist) areas where improvement would yield best results and by working with the tool we are maximising opportunities for involving patients and those close to them in developing and reporting on meaningful outcome measures.

In the 2013/2014 year all the young people seen by Bucks SLT reported an improvement from the first contact to the last contact on their self-selected outcomes and on average reported a perceived 25% improvement against their self-selected outcomes.

In 2014/15 we will start rolling out self-selected goal setting/therapy targets to younger age groups; having successfully piloted GBO with secondary aged pupils . The use of goal-based outcomes will now apply to all children from Y1 to Y13 and we have revised the toolkit to ensure it's appropriate to developmental needs of the younger cohort.

Recovery Star and clustering in adult mental health services

This is a patient reported outcome measure which allows the individual firstly to identify where they feel they are and where they would like to be across a number of domains (managing mental health, physical health and self-care, living skills, social networks, work,

relationships, addictive behaviour, responsibilities, identity and self-esteem and trust and hope). To date, we have 64 stars completed across the directorate.

Care clustering has also been underway within mental health services for the last year, which aims to provide treatment and support to patients based upon their needs rather than their diagnosis. We have also implemented clustering in our increasing access to psychological therapies (IAPT) services; we have worked with the local CCGs to develop the appropriate packages of care for these patients. For both the Recovery Star and clusters, we are developing reporting mechanisms to understand how these measures are working and the pathways which patients are taking and whether these are as expected.

Deliver outcome-based care clusters in older adult mental health services

Staff are delivering cluster packages of care for older people within two pathways:
Pathway 1: functional mental health conditions pathway
Pathway 2: dementia conditions or organic mental health pathway

Treatment is provided within these pathways following a specified cluster care package.

- The treatment for people with functional mental health conditions will follow the care packages for clusters 4 to 8 and 10 to 17
- For people with early memory problems where memory assessment and diagnosis is required the care packages for clusters 18 and 19 will followed
- Treatment for people with deteriorating organic mental health conditions will follow clusters 19 to 21 depending upon the stage of the disease and the corresponding care needs

Clustering of patients is being maintained at a good rate within OPMH Services with 90% of all patients clustered.

Systematically monitor, report and share learning from outcomes continuously to improve the quality of care for patients

Cluster outcomes have been set by CCGs for each cluster. Work is ongoing to identify the most effective ways of evidencing these.

Work in partnership with commissioners and other providers to develop outcome-based care across a range of services

The Trust recognises that we cannot meet all the needs of our patients as a single organisation and this year has seen the development and formalisation of partnerships between the Trust and key partners with which we have worked with more informally for many years.

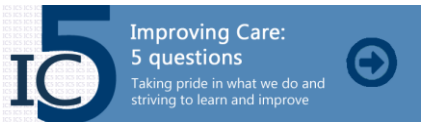
- The Oxfordshire Mental Health Partnership (OHFT, Response, Oxfordshire Mind, Restore, Connection and Elmore) was formed to be able to provide health, housing, care at home and employment support for people for severe mental illness.

- We have developed an alliance with Oxford University Hospitals NHS Trust to deliver joined-up urgent care for older people.
- We have developed mental health urgent care services as part of delivery of the Crisis Concordats in both Oxfordshire and Buckinghamshire with police, ambulance services, acute hospitals and other partners to ensure that people of all ages with a mental health crisis receive the best care as quickly as possible.
- We have developed high support step down accommodation on the Whiteleaf site in Aylesbury in partnership with Comfort Care and Buckinghamshire County Council.

Quality Priority 8: using the new CQC framework

Staff across our Trust have spent time reviewing their services against the five CQC questions with the aim of making this business as usual.

Ensure staff across the organisation are familiar with the changes to the regulatory framework



The project " Improving Care: 5 (IC:5) questions" was launched in June 2014 to develop a sustainable approach for embedding and monitoring the new quality standards being introduced by the CQC. Staff have responded very positively to the new framework and have found the detailed questions helpful and relevant.

Key achievements since project started include:

- a new central trust wide clinical service directory for staff
- visits to each clinical service and corporate support team to discuss what the standards mean to each team and how they can ensure these are being met
- information for clinical teams to encourage staff to talk about the standards
- we were a pilot trust consulted on the new mental health intelligence monitoring tool compiled by the CQC and continue to be involved in the development

Adapt the Trust's approach to quality in recognition of changes in regulation

questions. This means that our new Quality Committee (led by the Chairman) and the groups which are accountable to it (led by executive directors) receive information on all aspects of the five questions to identify compliance and good practice, and areas of risk requiring improvement. Local and trust wide quality reporting and quality improvement plans are monitored by the weekly clinical governance/senior operational management meeting.

Set up peer reviews across and between different services

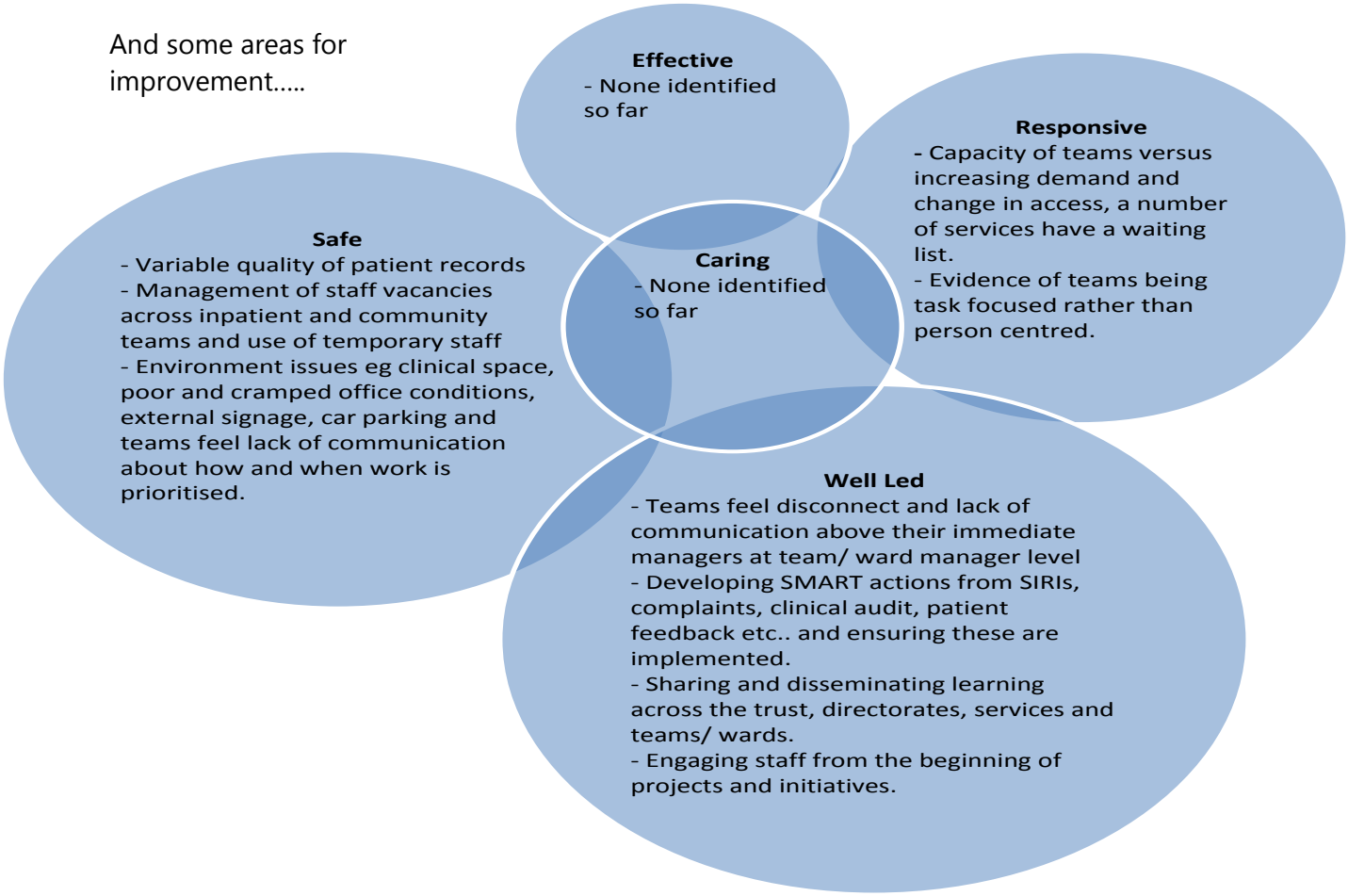
We have set up an internal peer review programme which involves teams of staff visiting other services (for example, wards, community teams and clinics) to review them against the five CQC questions. The detailed key lines of enquiry and prompts provide a robust set of questions with which to assess our services. Prior to the visit the team reviews a range of information including audits, performance reports, patient feedback, complaints and compliments, incidents and service reviews. During the visit the team assesses the

environment, documentation, equipment, safety and quality processes, and speaks to staff and patients about their view of the care provided. We have completed 46 peer reviews to date.

We identified some very good practice during our reviews:

- Overall patients have reported being happy with the care they are receiving.
- Teams demonstrated a caring attitude and compassion for their patients.
- Staff show a good knowledge of the patients on their caseload.
- Good understanding and evidence of adult safeguarding.
- Good management and monitoring of waiting times where they exist.
- Some examples of great visible leadership where staff feel valued and supported.
- Development of pathways with OUH and other partners.
- Some teams are using the five questions as a framework for business meetings.
- Examples of good communication and partnership working across services.

And some areas for improvement.....



Annex 1
Statements from our partners on the quality report and account

Oxford Health NHS Foundation Trust Governors

The Quality and Safety Sub-committee has met four times in 2014/15 in a variety of locations to review the quality and safety of services provided by OHFT on behalf of the Council of Governors. Its membership includes governors, a non-executive director, the director of nursing and clinical standards, the trust secretary and the head of quality and risk. In these meetings the sub-committee has reviewed a number of areas of quality including: patient experience feedback; the service remodelling programme in adult and older adult services; the quality account indicators to ensure they reflect the appropriate priorities; the process for investigating and learning from serious incidents; the new requirements from the Care Quality Commission (CQC); an update on the CQC themed review into crisis services in Oxfordshire; and the peer review process of clinical services and units using the five CQC questions.

The sub-committee, along with other Governor representatives, has reviewed the quality report for 2014/15 and the quality account for 2015/16. The Quality Account is a good and comprehensive report which reflects the different services provided by OHFT across different counties. The Governors would like to celebrate the achievements made by staff to improve quality and encourage staff to keep working on the areas we did not fully achieve last year.

The Governors are pleased that there are just four main priorities for 2015/16 but note that there are a large number of different objectives. These include objectives carried on from last year as well as some new objectives set by different services in the Trust. OHFT should consider focusing on fewer objectives in future years although we recognise that the quality priorities and objectives reflect suggestions made by our staff and our external stakeholders, which is important.

We are pleased to see that supporting and developing staff will continue to be a key priority. Carer representatives were also pleased to note that more work is planned to improve communication with and involvement of carers, through the Triangle of Care.

However, as Governors we want to ensure that the context for the quality priorities is fully understood. We are asking staff to improve quality and safety at a time when all NHS organisations are having to make cost improvement savings, while demand is increasing. We believe that good quality care is also cost effective care but we must ensure the cost improvement programme does not prevent us from maintaining the quality improvements we have already achieved.

It is a long document with many facts and figures, and Governor suggestions to help signpost readers and explain terms have been accepted and changes made to the report. The glossary is helpful, however it may also be worth explaining some terms in the text.

The Committee has found the Trust to be diligent in its presentation of information and willing to be open where improvement is required or objectives have not been achieved. We are pleased, therefore, to endorse the quality account and quality report and to continue to work with the Trust to improve services for local people across its range of services.

Healthwatch Oxfordshire

Thank you for inviting us to comment on the Trust's Quality Account for 2015/16. The issues raised about OHFT with Healthwatch Oxfordshire this year have primarily related to:

- Access to community-based mental health services and psychological therapies for people of all ages.
- Delayed discharges from hospital.
- Communication issues.
- Concerns relating to the district nursing service.
- The impact of recruitment and retention problems on effective service delivery.

In addition, through the Trust's active involvement in our multi agency Quality and Patient Experience leads meeting, we have jointly identified with you and other partners a set of 8 quality improvement priorities for the whole Oxfordshire health and social care system, based on our collective analysis of service user feedback. These shared priorities, which will be enshrined in the refreshed Health and Wellbeing strategy for 2015/16, are to improve:

- How well care is joined up, when it is being delivered by a range of health and/or social care providers.
- Communication between different organisations within the system about individual patients.
- Communication by all parts of the system with patients and carers, both in terms of staff attitudes, involvement of people in decision making about their care and delivery of dignity standards.
- Carer involvement in care planning and care delivery.
- Treatment of patients with physical and mental health needs.
- How well the psychological component of all healthcare is recognised and met.
- How able staff, carers and patients feel to raise concerns or complaints without fear of retribution.
- Public education about how to use the NHS wisely and how to look after oneself when that is the most appropriate thing to do.

Whilst this shared agenda was not explicitly referenced in the 2015/16 Quality Account, Healthwatch Oxfordshire welcomes the commitments you have made to:

- Address workforce issues
- Improve floor to board communication
- Improve processes to ensure staff can raise concerns and monitor action taken
- Evaluate integration of physical and mental health pathways
- Improve the management of patients long-term physical health conditions
- Extend the CAMHS in-reach service in schools
- Improve information sharing with GPs
- Implement and evaluate the Traingle of Care, in order to improve patient and carer involvement in care planning and communication between the Trust, its patients and their carers.

We were also pleased to see in the review of 2014/15 that the Trust was:

- Developing partnership based approaches to improving outcomes for MH patients and older adults with local 3rd sector organisations and OUHT
- Adopting a framework for assessing and improving patient experience
- Implementing integrated physical and mental health pathways for older people.

Whilst we understand that some of the 2014/15 priorities will be rolled forward, we were disappointed not to see a greater emphasis on improving integrated working with OUHT and social services in the 2015/16 priorities in order to reduce delayed discharges and issues associated with transfer of care between organisations.

We would also have welcomed a significantly enhanced focus on improving access to community-based mental health services and psychological therapies.

Finally we would like to have seen the focus on supporting staff to raise concerns to have been extended to include patients and carers and a much more explicit commitment to reporting on the action taken as a result of implementation of the new framework for assessing and improving patient experience.

We have established a good relationship with the Trust in 2014/15 and you have been open to working with us on patients' behalf. We were glad to see this relationship recognised in the Quality Account, and to see your ongoing commitment to working with us. We look forward to continuing to both support and challenge you in the year ahead, in the interest of helping you improve services for local people.

Chiltern and Aylesbury Vale Clinical Commissioning Groups

Chiltern and Aylesbury Vale Clinical Commissioning Groups have reviewed the Oxford Health Foundation Trust Quality Account against the quality priorities for 2014/2015. There is evidence that the Trust has relied on both internal and external assurance mechanisms an example of such being the Care Quality Commission reports, and the Mental Health Act visits. The commissioners are satisfied as to the accuracy of the data contained in the Account.

The report provides a balanced overview of the Trust and clearly identifies their achievements to date, but also areas within their service delivery where improvements could be made. The Clinical Commissioning Group welcome the openness and transparency of this approach and are committed to supporting the Trust in achieving improvement in the areas identified within the Quality Account through existing contract mechanisms and collaborative working.

One of the purposes of the Quality Account is to support the Trust Board in assessing quality across the totality of the services they offer. This is successfully achieved. We have focussed on the Mental Health services as it is those which are commissioned by the Buckinghamshire CCGs.

Quality Priority 1: Workforce

We the commissioners acknowledge there has been a drive for managers to receive team effectiveness training. We note that the Trust has been shortlisted for Nursing Times excellence award in supporting staff and wellbeing which reflects the range of activities to improve the staff wellbeing. Workforce is a priority; however there is nothing on the equality and diversity agenda which we know significantly impacts on quality when representation from top to bottom of organisation is addressed. We also note that the appraisal target has not been met due to changes in the management structure over the year.

We would welcome actions the Trust has identified to address how the appraisal target will be met. We would like to know what the Trust will do to implement the new E&D measure in 2015/2016.

We agree and welcome the key actions identified, such as tools to enable people to recognise and manage workplace stress, following the national survey results to promote staff wellbeing.

Quality Priority 2: Data on Quality

It is positive to know that a set of quality indicators have now been agreed that will enable of the trust to assess areas that are working well and any potential areas of vulnerability in terms of quality. The new Electronic Health Record will ensure consistent data capture methods. The Data Quality Review Group that meets regularly implements the standard operating procedures for managing data. As commissioners, we would welcome some details in the data section about how the trust are delivering care closer to home, i.e. to report achievement at locality level.

Quality Priority 3: Service remodelling

The trust highlight a number of successful service changes which have improved the engagement of patients and staff, such as the Recovery Star tool that focuses on patients taking the lead with their own goals and recovery plans. As commissioners we acknowledge the work that has gone into this and that the 'new model of care' for older people's mental health services has been implemented in each county, with the benefit of an increased capacity in Oxfordshire memory clinics following service changes. We support any memory clinic accreditation.

Quality Priority 4: Staff engagement

It is demonstrated that there has been a concerted effort over the last year to address staff engagement. The staff have raised the issue of pressures on their workload, due to increased activity and increase in patients level of acuity, which has impacted on the amount of time that can be spent with patients providing support and reassurance. Staff have been involved in designing and delivering a number of projects that address their engagement activities. It is welcomed that the Trust have set up a number of surgeries with executive directors where staff are able to raise concerns and speak with the Board members on specific topics. We would be interested in knowing the uptake of this by the staff in the future. The achievement made at Didcot Community Hospital, of demonstrating an increase in nursing time to time to care, with more input into therapeutic activities is commendable, and we are interested in knowing if this has been replicated in other sites.

Quality Priority 5: Reduction in harm

There has been an increase in incident reporting this year and this demonstrates a positive and open safe culture. The trust has a robust mechanism for reviewing SIRI's which encompasses a number of approaches demonstrating inclusivity. We acknowledge that there are also examples of good practice found during the investigations which is also cascaded to other areas in the trust. The trust have been transparent and detailed in the areas of improvement that need to be made such as; a regular review of any physical health concerns; revised Standard Operating Procedures; and an overall improvement in the standards of documentation. This with details on medicines management, suicide prevention strategies,

and the sharing of learning from safeguarding issues will improve the reduction of harm still further.

Quality Priority 6: Patient experience

Oxford Health clearly demonstrates that it values feedback about the patients' experience and uses this to help shape improvements for the future. There has been work to expanded the Family and friends test to include the question on whether the patient would recommend this service, though the response rate at the moment remains low. In addition they have introduced a system to capture patient stories and these are heard at the start of the Board meetings. Every service is now collecting feedback on patient experience. Patient experience leads are reporting on themes and improvement actions through the patient experience group and in reports to the quality committee.

The Trust are seeking new ways to develop more structured outcome measures with patients which, where agreed, includes family and friends, such as with the new care clusters. The trust offers 'carers' assessments, and has strong links to Rethink and the Carers Reference Group, and is working to achieve the Triangle of Care accreditation which will help to ensure that carers and family members are involved in the planning and treatment of patients who access these services. In addition with the Care Act they are working with local authorities to meet the changes These initiatives can only improve the patients' overall experience of the service.

The Future

The 2014/15 priorities contained in the Quality Account are consistent with priorities agreed with both commissioners. We welcome the Trust's reference to increasing partnership with third sector in Oxfordshire and its benefits. It would be useful to know when this will be extended to Buckinghamshire.

We are particularly pleased with the development of the outcome measures as the Recovery Star and clustering in adult mental health services and developing the self-selected goal setting/therapy targets to the younger age groups.

Conclusion

This Quality Account provides a comprehensive overview of the quality of care within the Trust and commissioners look forward to continuing to work alongside the Trust in meeting the quality aspirations of local users, carers, partners and staff. It is clear that the trust is positively embracing an integrated style of working across the health and social care sectors and welcomes the benefits this will bring to service users and their families/carers.

Oxfordshire Clinical Commissioning Group

OCCG has reviewed the Oxford Health Quality Account and believes that the information it provides is accurate. Oxford Health is a large NHS organisation that covers many services across a large geographical area. As a consequence, OCCG recognises that this document will never be able to provide the public with full assurance about the quality of all the NHS services the Trust provides.

OCCG is committed to commissioning high quality care for the population of Oxfordshire. OCCG would therefore like to see a greater acknowledgement within Quality Account

priorities of how the Trust interacts with partner organisations. It is encouraging to see that one of the priorities set by the Trust focuses on staff. OCCG feels that one of the biggest quality challenges facing Oxford Health is around the staffing of the district nursing service. One of the staff stories in Appendix 2 eloquently states the problems faced by the district nursing service. The priorities selected have some very clear quantitative measures which is encouraging. However, the volume of indicators may be overwhelming. Fewer targets may help the Trust to be more focused.

The Quality Account could make it clearer for readers in stating the location of the services that are being spoken about and whether there is a variation between the same service in different locations. The Quality Account does highlight many of the challenges faced by the Trust whilst highlighting areas of quality improvement work which have been undertaken. It is essential to identify areas for quality improvement. It is also important to note successful quality improvement within the Trust. This document highlights some successful areas. In partnership with OCC, OCCG has invested in services to support the initiation and maintenance of breastfeeding. We are pleased that OHFT mentions its commitment to UNICEF breastfeeding initiation accreditation. This is an important step towards delivering high quality evidence based support to improve maternal and infant outcomes.

The section on patient feedback shows that Oxford Health is seeking to deliver patient-centred services. OCCG would encourage OHFT to maintain this approach and feedback to patients when improvements have been made.

While acknowledging the size of the document and the challenge of including all issues, OCCG felt that the Account could contain more information about safeguarding issues. In particular, Oxford Health's response to the recent high profile child sexual exploitation (CSE) case and the Trust's involvement in establishing the multi-agency safeguarding hub (MASH).

The Oxford Health Quality Account explains its topics clearly. Overall, it could be improved by better sign posting to allow readers to navigate the document more easily. OCCG look forward to continue to work together with Oxford Health to deliver high quality care for the patients of Oxfordshire. Overall, OCCG believe that this Quality Account should give readers confidence that the Trust is being open and honest about the quality of services being provided across the organisation and is committed to driving continuous quality improvement.

Annex 2
Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2014 to June 2015
    - Papers relating to quality reported to the board of directors over the period April 2014 – June 2015
    - Feedback from the commissioners dated May 2015
    - Feedback from the governors dated May 2015
    - Feedback from local Healthwatch organisations dated May 2015
    - The trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, submitted May 2015
    - The latest national patient survey 2014
    - The latest national staff survey issued March 2015
    - The head of internal audit's annual opinion over the trust's control environment dated April 2015
- the Quality Report presents a balanced picture of the NHS foundation trusts performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. This is because:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in the internal audit programme of work each year.

- Data is collected by a large number of teams across the trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its Board of Directors continually strive to improve data quality and validation processes to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

May 2015 Chairman May 2015 Chief Executive

Annex 3
Auditor's statement of assurance

Independent auditor's report to the council of governors of Oxford Health NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Oxford Health NHS Foundation Trust to perform an independent assurance engagement in respect of Oxford Health NHS Foundation Trust's quality report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Oxford Health NHS Foundation Trust as a body, to assist the council of governors in reporting Oxford Health NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Oxford Health NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- admissions to inpatient services had access to crisis resolution home treatment teams; and
- minimising delayed transfers of care (mental health).

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the Monitor *2014/15 Detailed guidance for external assurance on quality reports*; and

- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the '*NHS foundation trust annual reporting manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with

- board minutes for the period April 2014 to 28 May 2015;
- papers relating to quality reported to the board over the period April 2014 to 28 May 2015;
- feedback from the Commissioners dated May 2015;
- feedback from the governors dated May 2015;
- feedback from local Healthwatch organisations, dated May 2015;
- feedback from Overview and Scrutiny Committee, dated XX/05/2015;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13/05/2015;
- the national patient survey dated 2014;
- the national staff survey dated 2014;
- Care Quality Commission Intelligent Monitoring Report dated 20/11/2014;
- Care Quality Commission reports; and
- the Head of Internal Audit's annual opinion over the trust's control environment dated April 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;

- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in 2.1 of the Monitor *2014/15 Detailed guidance for external assurance on quality reports*; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

Appendix 1 Accreditation

Accreditation	Body	Service	Comments
Memory Services National Accreditation programme (MSNAP)	The Royal College of Psychiatrists	North Oxfordshire Memory Clinic	Affiliate member only (self assessment and peer visit not completed). See below re. Thames Valley initiative led by AHSM to achieve accreditation.
Electro convulsive therapy (ECT)	The Royal College of Psychiatrists	Whiteleaf Centre, Aylesbury	Accredited to April 2017 (review decision 3.4.15)
ECT	The Royal College of Psychiatrists	Warneford Hospital, Oxford	Accredited to Jan 2017 (review decision 15.1.15)
Quality Network for Inpatient CAMHS	The Royal College of Psychiatrists	Marlborough House, Swindon	Membership is current, checked on 11.11.14.
Quality Network for Inpatient CAMHS	The Royal College of Psychiatrists	Highfield, Oxford	Membership is current, checked on 11.11.14.
Community of Communities	The Royal College of Psychiatrists	Oxfordshire Complex Needs Service	Renewed accreditation from 3.4.15-3.4.17
Community of Communities	The Royal College of Psychiatrists	Buckinghamshire Complex Needs Service	Assessed and accredited in 2009 and 2012. Accreditation completed every 3 years. Re-accreditation due to be completed end of Jan 2015.
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	Marlborough House, MK	Annual peer review (last review Feb 2014)
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	Woodlands, Aylesbury	Annual peer review (last review Feb 2014)
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	The Oxford Clinic, Wenric and Thames House	Annual peer review (last review Feb 2014)
UKMi (UK Medicines Information)	UK Medicines Information	Trusts Medicines Information Department	Awarded following audit in 2009
Quality Network for Eating Disorders (QED)	Royal College of Psychiatrists Centre for Quality Improvement	Cotswold House, Marlborough	Awarded excellent (accredited till Jan 2017)
Triangle of Care member (carers)	Carers Trust	All services	The Trust became a member in June 2014 and is working to achieve 1 star in the next 12 months and 2 stars over 2 years.
Quality in Dental Service Award	British Dental Association (BDA)	Salaried dentist service	Application submitted to BDA in March 2014. Site visit

			completed in Nov 2014 and informed in Dec 2014 achieved accreditation.
Safe Effective Quality Occupational Health Service (SEQOHS)	SEQOHS	Occupational health team at Oxford Health NHS FT	Achieved March 2015
Quality Network for Eating Disorders (QED)	Royal College of Psychiatrists Centre for Quality Improvement	Cotswold House, Oxford	Formal review in Dec 2014.
Quality Network for community CAMHS	The Royal College of Psychiatrists	Oxford City CAMHS	Accredited to Jan 2014. Accreditation possibly has lapsed. Team will go for re-accreditation in next cycle in 2015/16.
Quality Network for community CAMHS	The Royal College of Psychiatrists	Buckinghamshire OSCA	Self-assessment being completed, plan to go for accreditation in next cycle 2015/16.
Quality Network for community CAMHS	The Royal College of Psychiatrists	Buckinghamshire learning disability team	Status to be confirmed.
UNICEF baby friendly breastfeeding status	UNICEF	Health visitors service	In progress.
Psychiatric liaison accreditation network (PLAN)	The Royal College of Psychiatrists	Emergency Department Psychiatric Service Oxfordshire	Application submitted to PLAN. Self-assessment completed in Dec 2014 and visit in Feb 2015. Currently in review stage.
Memory Services National Accreditation programme (MSNAP)	The Royal College of Psychiatrists	Memory service clinics Oxon and Bucks	A Thames Valley initiative led by AHSM has started to support memory service clinics to complete the self-assessment and peer review visit to achieve accreditation.
Accreditation for inpatient mental health services	The Royal College of Psychiatrists	Adult mental health wards	Project established to complete self-assessment and submit application for peer review to achieve accreditation. Initial visits completed in November 2014, final visits planned between Feb-April 15. Waiting to hear outcome.
Imaging Services Accreditation Scheme	UKAS selected to deliver and manage Imaging Services Accreditation Scheme	x-ray services hosted at Abingdon, Bicester, Witney and Henley Community Hospital sites	OUH manage staff and equipment through SLA from April 2014. OUH will apply for external accreditation in June 2016.

Quality indicators		
Source	**Domain**	**Indicator**
Manual	Safe	Number of MRSA incidents
Manual	Safe	Number of CDIs
Audit	Caring	CPA % patients involved in setting and achieving goals
F&F test/manual	Responsive	% extremely likely or likely to recommend the service
Audit	Safe	Urinary Tract Infections – new
Ulysses	Responsive	% of upheld complaints
Ulysses	Responsive	% complaints responded to within timeframes
Ulysses	Responsive	% complaints actions awaiting completion
Ulysses	Caring	Number of accolades received
Ulysses	Safe	Number of AWOLs
Ulysses/manual	Safe	Number of falls with harm (1000 bed days)
Ulysses	Safe	Number of medication incidents with harm
Ulysses	Safe	Number of pressure ulcer incidents
Ulysses	Safe	Number of prone restraints
Ulysses	Safe	Number of self-harm incidents
Ulysses	Safe	Number of Orange Incidents
Ulysses	Safe	Number of SIRIs
Ulysses	Safe	Number of suspected suicides
Ulysses	Safe	Number of avoidable grade 3 and 4 pressure ulcers
Ulysses	Responsive	Compliance with Duty of Candour
Ulysses	Safe	Number of Incidents awaiting management review (>15 days)
Ulysses	Safe	Compliance with venous thromboembolism risk assessment
Audit	Safe	No. of venous thromboembolism events
Audit	Effective	Compliance with nutritional risk assessment (%)
Ulysses	Safe	Compliance with Central Alert System alerts (%)
Safety thermometer	Effective	Patients receiving Harm free care (%)
Ulysses	Effective	(%) Scheduled Trustwide clinical audits completed
Ulysses	Effective	(%) Trustwide clinical audits rated good or excellent
Manual	Effective	Gap analyses complete for directly relevant NICE guidance (%)
Manual	Effective	Gap analyses that identify no gaps (%)

Performance indicators		
Source	**Domain**	**Indicator**
Manual	Responsive	% admitted service users RTT within 18 week
Manual	Responsive	% non-admitted Service Users RTT 18 weeks of referral
Ulysses	Responsive	Sleeping Accommodation Breach
Audit	Responsive	CPA % service users followed up within 7 days of discharge
Audit	Responsive	CPA % with a documented risk assessment
Audit	Responsive	CPA % with a documented crisis contingency plan

Manual	Responsive	Emergency readmissions within 28 days of discharge (Adult)
Manual	Responsive	Emergency readmissions within 28 days of discharge
Manual	Responsive	Delayed Transfers of Care MH % of bed days lost
Manual	Responsive	Delayed Transfers of Care MH- Number of patients delayed
Carenote	Responsive	% Clinic letters sent back to GPs within 10 working days
Carenote	Responsive	% Cancellations by services
Carenote	Responsive	% GPs receive discharge letter within 48 hrs of discharge

Workforce indicators		
Source	**Domain**	**Indicator**
Manual	Safe	Number of wards which were unable to fill 80% of their shifts
ESR	Well led	Vacancies (as a % of establishment)
ESR	Well led	Sickness absence (as a % of establishment)
Manual	Effective	Agency staff bill as a % of budget - clinical staff
L&D/ESR	Effective	Compliance with PPST (%)
L&D/ESR	Effective	% PDRs completed within 12 months
L&D/ESR	Effective	Safeguarding training Level 1

Appendix 3
Patient and staff stories

Service/team	Patient story and feedback	*Staff story and feedback*
District nursing service	"it was the district nurses that made me go to the podiatry - it was the nurses who noticed they [my toes] were going on an uncertain path - they [the nurses] all have their own special qualities." " … She [the nurse] knows all my little worries - you build up a relationship after time" "What they mean to me - reassuring , they have made it possible for life to go on as normal" "... She's so good, so kind... She tells me what she's doing ... She's so kind ..." "If it wasn't for the nurses I wouldn't be able to have this done ... They have worked wonders on my leg ..." "They are all so busy ... They don't have time to sit and talk to you ... They talk to you when they are doing the dressing ... Sometimes it's nice to have someone to talk to."	*"Working in older adult community services for OHFT is challenging and ever evolving. I have been fortunate over the past seven months to have been seconded full-time into the district nursing specialist practitioner course where I have been supported to develop my knowledge and skills surrounding district nursing locally and nationally. Without the support and commitment of OHFT financially to be supernumerary throughout the entire twelve months of the course, the course would be an impossible undertaking.* *Pressure on staff in older adult community services at present is unprecedented and relentless in nature with increased demand for services not being met by the levels of staffing required to meet this demand due to retention challenges. I believe the pressure to deliver care above and beyond on staff new in post exacerbates the retention difficulties being seen in district nursing at present as they feel unsupported to deliver the quality of care they deem appropriate in the time they have available. There is no easy answer to meeting this challenge as the needs of the patient will always be prioritised by district and community staff nurses."* ***District Nurse Specialist Practitioner Student*** *"We must understand that we must respect that we are guests in people's homes and are invited in to support their care. Unlike in a hospital, where they feel that they may have limited choices, we must respect this*

		and work to support them, even though these may not be our choices." *"This is often the first time where clients are able to be heard and listened to – we often find that patients are not sleeping because of pain or that there may be a psychological impact. We refer many patients to talking health."*
Older adult inpatient ward	"… when I was so poorly and could not even eat for myself, and felt that I could not be of any help for my children, even if they are grown up, the staff on the ward worked with me, my family, and my care co-ordinator and help me to get back on my feet again, they help me to get my confidence back again. I don't know how the staff does it, but they give so much of themselves … it is a good place to be when you are not well'.	
H@H, CCT and Heart Failure Nurses	"I just want to thank everyone who was involved in caring for my aunt … She had severe heart failure, pulmonary hypertension, and her kidneys were failing … [my aunt] came to Oxford and received wonderful care from many people. Hospital at Home is an extraordinary innovation, which enabled [my aunt] to have a Furosemide drip at home, they stopped [her] taking carvedilol and suggested oxygen therapy; all of these transformed her health. Heart failure nurses - thank you to the team who continually fine-tuned her diuretics and she no longer had fluid retention and the Continuing Care team who were so efficient and kind."	
EMU, Community Hospital, CHSS	"Mum was sent by the GP to EMU in November. The GP highly recommended the service for a thorough assessment and had high praise for their patience and understanding of carers coping with older family members (in this case my Dad). Mum was looked after extremely	*"I find working for Oxford Health NHS FT very rewarding. I see the patients receiving excellent care on a daily basis despite some of the challenges faced by our organisation. I see the patients' wellbeing and best interest as the focus of the care being given and alongside these*

	well on the unit, a holistic assessment took place with several clinicians asking many questions over a period of around eight or so hours. They took time to listen to mum waffle on about her past … even though they were clearly very busy and stressed … and they managed to get her to eat, which she hadn't really been doing for weeks. She was admitted to a bed at Witney Linfoot that day and the relief I felt was enormous, reducing me to tears. The EMU lead … quietly removed me from the bay to talk whilst mum and dad chatted on regardless. This is something that really touched me and will remain with me for a long time. Mum's stay in Witney was much longer than anticipated … She liked to sit in the day room, calling it the "flower room" when we went to see her, finding it easily identifiable by the mural on the wall. She recognised the toilet by the colours on the door and signposting. She would spend nights pacing and the nurses would allow her to roam constantly reassuring her and trying to keep her calm. We were always updated on how she was after MDTs, quiet spaces were found when we became upset over her deterioration. The ward let me know if dad was looking tired and encouraged him to take a break as much as possible. Mum rang us all often when confused. The nurse in charge would always explain what was happening before putting her on the phone and then take the phone back to make sure we were ok once Mum had had a rant. We all felt very looked after by the ward team a caring bunch of people from the matron to the ladies handing out tea whenever they saw us. The whole team always found time to talk to mum and listen to her stories … and to listen to my dad whilst he reminisced when mum was asleep. I could see how very busy the ward was and I wonder how they manage it!	*patients' families being listened to and included in decision making. I feel supported as a member of staff and have opportunities for further development at various levels. I am kept up-to-date with what is happening in the Trust which in turn leads to a more effective team."* ***Community Hospital Nurse*** *"I am very proud to be working for Oxford health NHS Trust. As a nurse working within a community hospital I feel the care that we provide is excellent. The team that I work in is friendly and hardworking ranging from the nurses, medics, therapists, cleaners and admin staff. The ward shows to be ever dynamic in the way we work to become more efficient in the ever changing world of the NHS and the management team are approachable. I enjoy going to work and supporting my local community as a nurse, however I do feel the pressures of larger workloads, increasing in responsibilities/duties and caring for the complex patients within the community can at times affect the quality of care I and my team are able to provide at times. Together with caring for individuals who have cognitive impairment and challenging behaviour ever being more frequent in the community hospital setting, I do feel that training needs and support of extra staff are not always met fully, mainly due to time restraints.* ***Community Hospital Nurse***

CMHT	"I would like to thank everyone in the mental health team for the care and support they gave my mum and to the rest of the family. Knowing that there would be somebody visiting regularly and also that there was always somebody we could ring at any time was invaluable. The help given made a very difficult situation much easier to deal with."	
Urgent care		*"I am proud to be part of a team within Oxford Health NHS FT who puts the patient at the heart of their decision making. We are all facing many challenges with staffing and capacity and are often required to discover innovative ways of working at short notice to meet an immediate patient need. The Trust is moving towards locality working which will support colleagues in providing quality care across many services. It is recognised this is a culture change and will be challenging for some; a supportive structure will enable such change. I believe the Trust to be forward thinking and this momentum needs to continue."* ***Clinical Lead, Urgent Care***
CAMHS (Bucks)	Patient A found that the use of a consistent therapist was really important to her. She was worried about trusting people and getting to know people to begin with. A didn't mind having a different person at the assessment, and she didn't mind someone join for the guidance re food, but having the consistent therapist thereafter was crucially important to her. Patient A explained that she has found the service she has received to be excellent, she could not fault it. She is so positive about her experience, the trusting relationship she has with her therapist, and how that has helped her to get better as she believes and trusts what the therapist suggests for treatment, even if it is a bit daunting to her	

	at times. Patient A feels she can tell her therapist anything, she is very grateful for this and it makes a big difference to her quality of life at home and school. In relation to things we could improve on, she said nothing for the service or the quality of work from the CAMHS staff. She did say she was extremely anxious when she first came. She found the waiting area very daunting as there were a lot of children there, some younger and it was very noisy which she found very hard to cope with. She was asked if separate areas or zones might work (specifically a quiet area with more privacy) and she said yes, certainly for people who are very anxious.	
Community CAMHS Swindon	Patient B explained the venue was a good one and she did like going there as she recalled it from an appointment when she was younger for her brother. It was good for her to go to a familiar place and she appreciated seeing a toy dolls house when she first attended, that helped her feel relaxed. She liked the waiting room as there was a section she could sit in that was more private. She really liked always having the same therapist and building a trusting relationship was very important to her recovery. She trusted her therapist completely and felt very safe. She felt without CAMHS she might have made an attempt on her life as she feels she was very ill and was desperate for help. Patient B was sad that she now had to leave the service as she is approaching 18yrs. She	*This was general feedback from a staff wellbeing meeting:* *Staff love their jobs and the work they do. Most have been in post for several years and also within this team for a long time as they love working within the team.* *Staff feel very supported by their local managers and feel they could approach them easily if they had problems or concerns.* *If all staff, led by the most senior, started to change the culture regarding emails that would be very helpful; therefore work over a six month period to ensure that emails are only sent within working hours (pertinent to your working environment as some do work shift patterns).*

	has not left education, she is partially better but not fully, and she worries she will relapse (she is currently not serious enough for adult services). She wishes services in CAMHS went up to 21yrs.	
School Health Nursing (SHN) service	Patient C was seen at her secondary school in the North of Oxfordshire. She was well engaged with her SHN who is now based within the secondary school and Patient C found that very helpful. She feels very able to attend regularly for appointments and has done so for some time. She also feels able to ask for help if things suddenly become tricky. Her presentation is now one of a more confident and calmer person with better skills to look after herself, improved self-confidence and an improving relationship with her father. She does feel she can fully trust her SHN although she does know that if the SHN feels she is at risk she might break the confidence (having told Patient C) to keep her safe. She is very pleased she has a confidential relationship with the SHN as she cannot get this with school staff. This helps her find space and time to think about how to change things and keep safe and well in the long run. Patient D was very clear she would never have attended the GP with her worsening anxiety and problems, however after the SHN did an assembly in school (after they became based at school), she realised that the symptoms she had could be helped and that she could talk to the SHN. Patient D texted her and made and appointment to see her, and a referral was immediately made to PCAMHS. Patient D subsequently received treatment for quite serious symptoms at CAMHS and is now	*The SHN felt this was a good development in the end although many had reservations and anxieties initially. Being within the school for her has been a real benefit. She has a supportive school and works well with them and them with her.* *She also explained her concern about lone working as she is based within the school and misses her colleagues who she was sharing an office with and got support from for peer development and shared working. Additionally she explained about difficulties about attending Trust-based training and meetings as she needs to be present in school.* *She explained the managers have been very supportive and communication is hard but they try their best and the monthly newsletter from the operational manager is very well received and helpful.* *She loves her work, feels the change is good and will embed more successfully in due course, but would benefit from more peer support, easier access to meetings and training.*

	fully recovered. Patient D explained that had she not seen the talk from the SHN and been able to access her in school she knows she never would have had the ability to go to the GP with her symptoms, despite being very unwell. She now maintains contact with the SHN to ensure that all remains well especially during exam pressures but she remains on track for high level results and a successful future ahead.	
Health visiting service	Mother explained that she found the Health Visiting Service extremely helpful since she had her baby sixteen weeks ago. She explained it was very helpful to her to have the Child Health clinic at the same venue that her antenatal group had been as this made it easy for her to attend and know where she was going once she had her baby; she felt that was important and things may have been harder if it had been a new venue. The mother of Baby C explained that she found the Health Visitor incredibly helpful, she was there if needed but if all was well she was not inhibiting mum with unnecessary appointments. She had been very helpful with problems with breastfeeding.	*She loves her job and is deeply passionate about health visiting and the opportunity to impact positively upon the life and development of babies and young families. In particularly she is very enthused about the ability to promote attachment in mothers and their young babies, and is acutely aware of the physiological impact upon brain development of this is not achieved.* *She feels they work well with families and work well with the children's centre staff and GP practices.* *She is eagerly awaiting the new EHR as RIO is a terrible system and has made their lives incredibly difficult as practitioners.* *She reports that staff have really valued the iPads they now use.*
Community Children's Nursing		*The staff member explained staff are working way over their hours and this is not sustainable indefinitely. The explained they are very passionate about their work and really enjoy the level of work they can give to patients.* *Staff sometimes feel over managed and there was a suggestion that this pressure could be better 'shared' by allowing more lime management*

		and delegation of responsibility in line with banding and capability, throughout the structure.
LD CAMHS Buckinghamshire		*Staff feel well led, especially by the team manager in post who provides a quick response and clear actions.* *The client group are well known to them often as they are often with the service for a long time. It can be difficult at times but they do generally love their work, although the increase in workload at the same time as the staff provision has been so vulnerable has made work very challenging.* *The building is not the best, it is accessible but it is 'tired' and space for seeing clients is often difficult. However sharing with colleagues is very good and some staff do have their own offices which is very helpful given some telephone calls are highly sensitive and require privacy.*
Adult inpatient mental health	**C is an inpatient in Aylesbury. She experiences psychosis.** I have been in mental health services since I was nineteen. I found it really hard to explain my symptoms and experiences and the Psychiatrist just assumed that I was well. I had to work really hard to convince the doctor that I was not. I shouldn't have had to do this. In my experience with doctors they generalise too much and they need to consider everything before they diagnose. They ask a checklist of questions such as "are you hearing voices?" "Are you low in mood?" yet they need to ask more around those questions and explore more. They shouldn't rule things out.	***Staff Nurse, Adult Services*** *As a student nurse, Oxford Health NHS FT as a Trust were incredible, the dedication into the training for student nurses was beyond what was expected. Its partnership with university worked well, we had placements three times a year and I personally always felt supported.* *I have only worked within the Trust [as a qualified nurse] for around four months now and no one can prepare you for what you're going to experience. I was given an induction week of training and a week of Prevention in Management of Violence and Aggression training. As a newly qualified nurse however OHFT does not offer any other support or training. We are encouraged to use supervision at work but are not given*

	I find it difficult on the ward as we are told to leave our rooms at a specific time and our doors are locked for most of the day. They do this so that we take part in activities but mostly there is nothing to do. They do not use the art room enough and this is only open a couple of times a week. For me distraction is key and we need more to do. Staff are too busy and they spend a lot of time writing notes but they do not talk to us to inform the notes. I think they should prioritise time with patients and organise times more productively. My Psychologist is great, she goes out of her way to help and she really listens. The new occupational therapist is also really good. **M is an Oxfordshire patient receiving care on Opal Ward in Aylesbury. M has a dual diagnosis of schizophrenia and Aspergers.** I have been in mental health services for three and a half years. I was admitted to Phoenix Ward at first and this was a very scary time for me. It was demanding on the ward and I lacked confidence which is not good when you are in hospital. I then was moved to Vaughan Thomas ward and then to Mandalay in Aylesbury. I have been on Mandalay and Opal for one and a half years now. I haven't got anywhere to live but the hospital helps me to look for somewhere. I will visit a supported accommodation in Bicester soon. Being in hospital is a helpful process as it gives me time to reflect and I can get involved in activities. I do this because I thrive on activities and I really look forward to them. I don't like it when I have lots of time to think.	*enough time or enough staff to be able to utilise it.* *During placements on the ward and in the community basis you learn extreme amounts from staff, who can offer you support when you need it; who can offer you guidance; who will push you to learn and be at your best. These are the people that shaped me into the nurse that I am today. As a nurse so much time is spent on paperwork; sitting in an office at a computer making sure that care plans and risk assessments are updated. To me that is not nursing, nursing is about being on the ward, speaking to patients and understanding how they feel. I don't believe that as a Trust they are able to understand what a nurse's job should be about and how much stress people are under to meet the demands and deadlines of the paperwork that has to be completed.* *Though there are staff shortages and deadlines for teams to meet, the Trust have praised people for all of their hard work and appreciate what we do. Teams work together and from my experience as a nurse, Oxford Health NHS FT work as a team.* ***Preceptee, Adult Services*** *I feel that the provision of training for CPD is great and have been consistently supported in getting on these courses, with management being keen to develop me via training and through formal and informal discussions and supervision.* *Through the preceptorship project I felt that this was a great opportunity for those newly qualified to develop and continue their learning whilst being able to showcase new staff to various people from the Trust: it was*

	I am on money management which is brilliant as I have saved about £10,000. Any areas for improvement? It would be good if there was more money for day trips. **A is an inpatient in Aylesbury. A has a diagnosis of schizoaffective disorder** I have been in mental health services since I was twelve. I was seen in Oxford when I was younger at a unit called the Park. I was not diagnosed until I was fourteen-sixteen . At this time we moved to Buckinghamshire. They diagnosed me first as being Bipolar. I have been on many wards including adolescent and adult acute wards. In August 2013 I started hearing voices and was admitted into the Tindal centre. I have been in hospital since then. I am now prescribed Clozapine and a mood stabiliser as well as other drugs. Positive things that I have experienced in this Trust are: • I used to attend groups for service users in Haleacre, these were really good and helped me a lot. Sadly these do not happen anymore. They were stopped. • I once had eight sessions of aromatherapy with massage that was very helpful. • I find my Psychologist really good and this really helps me. I get this on Opal Ward. Things that need improving are: We do not get that much time from staff on the ward as they are	*good to instil from the start the prospect of service improvement. This time was safeguarded and was helpful in my development. The project was great to have done and a nice way to end - however the preceptorship course was not helpful and did not appear well organised.* *Whilst on the ward, staffing was a consistent issue for around a year yet the team remained supportive and was a great learning environment as well as being a safe and caring environment for patients. I felt that I have been supported to develop well throughout this time by a caring team. A more collaborative approach from management appears to have emerged from over the previous year which has yielded a more supportive and supported team.* *The major difficulties experienced by myself and I believe other clinicians are those of being moved around the wards as it interrupts patient care. I was lucky enough to have been supported in getting a promotion recently and was again supported by the team in preparing for the interview and the role and have found consistent support from the team in terms of development and training.* *Many issues faced on the wards when I started appear to have dissipated with having one consultant on the ward and having a matron on a ward.*

	always busy with people in seclusion or doing their notes. They can be firm sometimes which I do not think is fair. Leave is stopped sometimes because there is not enough staff to take us out. We are not able to smoke on Opal Ward and this is unfair as the patients on the other two acute wards are allowed smoking breaks. Why is that allowed? We should have more information on medication so that we can understand it better.	

Glossary of terms

A&E Accident and Emergency
ADHD attention deficit hyperactivity disorder
AHSN Academic health sciences network
AHSC Academic health sciences centre
AIMS Accreditation for inpatient mental health services
AMHT Adult Mental Health Teams
Aston teamwork model approach to developing effective team working and team leadership developed by Aston University
AWOL absent without leave, referring to patients who have been allowed out on escorted (with a member of staff) or unescorted (without supervision) leave and who have not returned to their ward within 10 minutes of the agreed time of return
BaNES Bath and north east Somerset
Baseline starting point (to measure improvement)
Bed days measure of a period of time (24 hours)
Benchmark data to compare with another organisation(s)
BHT Bucks Healthcare NHS trust
C&YP Children and Young People
CAS Central alert system
CAMHS Child and Adolescent Mental Health Services
CBT Cognitive Behaviour Therapy
CCG Clinical commissioning group
CDI clostridium difficile infection is a bacterium that is the most serious cause of diarrhoea often associated with taking antibiotics, making people in hospitals particularly susceptible
CH Community Hospital
CIPs cost improvement programme
CLARHC Collaborative leadership in applied health research
CMHT Community Mental Health Teams
CPA Care Programme Approach, a national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery
CQC Care Quality Commission: the government body that regulates the quality of services from all providers of NHS care
CQUIN Commissioning for quality and innovation
CTO Community treatment order
CUBE Information management system for the trust
DEC Diagnostic evidence collaborative
DoH Department of Health
DTOC delayed transfer of care occurs when a patient or service user is delayed in being discharged from hospital into the community
EKOS East Kent Outcome Scores
EIS early intervention service
EMU Emergency medical unit
ESR Electronic staff record
Essential standards audit tool for mental health inpatient services which measures quality and safety indicators
FFT the Friends and Family Test which was introduced to assess the satisfaction of patients with NHS care and to assess whether they would recommend their local NHS services to friends and family
FIM Functional Independence Measurement
GBO Goal-based outcomes
GP General practitioner
HETV Higher education Thames Valley
HR Human Resources
IAPT Increasing access to psychological therapies
ICO Information Commissioner's Office
ILT Integrated locality team
IPCT Infection prevention and control
IMHA Independent Mental Health Advocacy
MAG Multi-agency groups
MDT multi-disciplinary team
LAC Looked After Children
MECC Make Every Contact Count

MH Mental health
MHA Mental health act
MHMDS Mental Health and Learning Disabilities Dataset
MIU Minor injury unit
MRSA/MSSA Two varieties of bacteria which lead to illness and are characterised by being particularly resistant to treatment -its presence in hospitals has therefore led to a concerted campaign to eliminate it from such locations
MSO Medication safety officer
MSK Musculoskeletal
NAIC National audit of intermediate care
NHS National health service
NICE national institute of clinical effectiveness
NIMHE National institute for mental health in England#
NQB National Quality Board
NRLS National reporting and learning system
NSPCC National society for the prevention of cruelty to children
OHFT Oxford Health Foundation Trust
OOH Out of hours
OUH Oxford University hospitals NHS trust
PCAMHS primary children and adults mental health services
PDR performance development review
PDSA Plan, Do, Study, Act
PE patient experience
PEACE Positive engagement and calm environments
PFTF Planning for the future
PH Physical health
PLACE Patient-Led Assessments of the Care Environment
PMVA prevention and management of violence and aggression
POMH Prescribing observatory for mental health
PPST Patients and personal safety training
Productive care an improvement programme based on the institute for innovation productive series
PSAG patient status at a glance board
QED Quality eating disorders
QRP Quality Risk Profile
RCA root cause analysis
Recovery Star highlights areas to work with individual patients to identify and address their difficulties with core areas of life. These areas are managing health, self-care, trust and hope, living skills, identity and self-esteem, special networks, responsibilities, work, addictive behaviour and relationships.
RiO electronic patient record
RMN Registered mental nurse
Safety Thermometer is a national tool for measuring, monitoring and analysing patient harms and harm-free care using point prevalence (count of the number of incidents at a fixed point time)
SHA Strategic health authority
SHN School health nurse
SIRI serious incident requiring investigation
Skintelligence programme a skin integrity work stream to improve the management of pressure damage
SLT Speech and language therapy
SMT senior management team
SOAD Second Opinion Appointed Doctor
SOAPIE Subject (patient), Object (clinician), Assessment Plan, Intervention, Evaluation
SSKIN bundles a tool that acts as a prompt to staff to undertake a risk assessment and provide management of the risk with patients
ST Street Triage
UNICEF United Nations children's fund
V&A Violence and aggression
VBI Value-based interviewing
VBR Values-based recruitment
VLU Venous leg ulcer
VTE venous thromboembolism
WTE Whole time equivalent