

**Oxford Health NHS Foundation Trust**

**Quality Account 2012/13**

Report for the 3rd Quarter 2012

January 2013

### INTRODUCTION

Every year the Trust publishes its Quality Account and Report in which it looks back over the previous year at its achievements compared with what it said it would do in the last Quality Account, and sets new targets and initiatives for the following year.

This is the third report of the year showing the progress we have made towards achieving our goals and targets, and where more attention needs to be focused.

The targets and initiatives have a RAG rating stripe on their right hand side for ease of scrutiny as follows:

RED: targets are being significantly missed, or there are severe difficulties in achieving the initiatives and actions

GREEN: targets are being met. Initiatives have been completed

AMBER: measures are on track to achieve the target within the timescales or satisfactory progress is being made towards carrying out the specified actions

BLACK: No information is available at the time of compilation.

The entries for initiatives are additive, in order to see an increasing history of progress on specific initiatives over the year.

We will be pleased to share this document with our partners and receive their comments and questions on its content and its format, with a view to making it more informative and useful.

### SUMMARY

The following are the major headlines for the third quarter:

#### Significant Highlights this Quarter

* Supporting care closer to home to avoid hospital referral has been significantly improved through initiatives such as the “Hospital at Home” initiative (H@H) which has seen a marked rise in the number of patients being assessed and treated in community settings, from 105 last year to currently 513.
* The number of non-severe patient/service user-related incidents has continued to rise as expected; meanwhile the number of serious incidents reported has after an apparent anomalous rise in quarter 2.
* The overall number of **patient/service** user falls showed a decline in the last quarter, but when the rate of falls per occupied bed days is taken into consideration, Community Services shows a slight increase.
* The new Child Protection Service Model Actions have been implemented
* The exercise to pilot wearing of uniforms in Marlborough House Swindon and Sandford Ward has been successful with positive feedback from patients, staff, carers and visitors
* The Crisis Services in Oxfordshire have been successfully remodelled, including 1 additional training and improved out of hours service and a marked reduction in incidents causing harm.
* The actions identified to promote an open culture of reporting safety incidents were completed.
* The regular audit of CPA procedures showed a 100% compliance in quarter 3 across all the four indicators.
* Rehabilitation care has been improved within Community Services for patients with dementia
* A lot of attention continues to be paid to reducing the number of drug errors (actual and potential).
* Emergency readmissions of adult mental health service users continues to fall significantly (from 9.8% in Q1 to 7.4% in Q3) and although the percentage for older adult readmissions rose in Q3 (3.1%), it is still below the target of 5.3%
* The level of Delayed Transfers of Care (DTOC) is still higher than planned, being markedly above the target (estimated 110 instances against a target of 72)
* The number of mental health service users reported as having Advanced Statements in place has risen significantly from 30 last year to 284 at the end of Q3.
* The local survey of community mental health patients is showing improvement in some of the area where the performance was poor in the national survey for community mental health.
* There is good progress in achieving CQUINs across the Trust, apart from a few elements in Community Services and in Wiltshire & BaNEs CAMHS & Eating Disorders.
* The CQC assessments of us in their monthly Quality & Risk Profiles continue to show important improvements over Q1
* Targets set by the Department of Health for Health Visiting continue to be exceeded

#### Significant Highlights from Previous Quarters

* Our Community Services local patient survey shows considerable improvement over last year
* The performance dashboard for Community Hospitals is being developed further, but is proving very useful in monitoring key indicators to performance. Currently, these indicators show almost all positive trends
* The Single Point of Contact and 111 services are fully implemented
* Although the number of complaints rose significantly in the first two months of Q3, December figures fell back to the average
* The number of inpatient suicides has remained at zero for at least the last 2 years however it is too early to tell whether the downward trend with the number of community suicides will be maintained
* New medicines management procedures in Bullingdon and Huntercombe prisons have been implemented
* Actions intended to reduce the number of potential impacts of serious drug errors in Community Services have been implemented
* The use of the “Liverpool care pathway” for people supported in dying at home has been improved

#### Areas for Further Improvement

* The annual Community Mental Health survey was published in the second quarter. The results are disappointing showing little or no improvement. A comprehensive action Plan has been approved by the Board of Directors.
* The level of DTOC is still a cause for concern and there is now a singular DTOC project to address this issue.
* Our audits have shown a decline in the number of service users who report not being given an opportunity to engage in the development of their care plan. The levels of training in certain aspects of the Prevention & Management of Violence & Aggression (PMVA)m continues to be below target
* The rate of number of falls in Community Hospitals per occupied bed days continued to rise between the 1st & 3rd quarters, though this was principally due to multiple incidents relating to two specific patients

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| User Experience |

### Domain 5: Ensuring people have a positive experience of care

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| **Patients’ Experiences of Inpatient/Outpatient services will improve** | |
| **Measures:** | |
| 1. **Admitted and non-admitted Referral to Treatment time (e.g. 18 weeks)** | |
| * The measure for this is currently under development by the Department of Health |  |
| 1. **Position in the annual patients’ survey relative to other Trusts** | |
| * The Community Mental Health survey was published in Q2. We were “about the same” as other Trusts on seven sections of the survey, each section being a cluster of questions, and worse on two sections; care co-ordinator and care review. Last year we were the same in eight sections and worse in one. * The Trust did not score better compared to other Trusts on any questions in the survey and scored worse compared to other Trusts on four questions;   + for knowing who their care co-ordinator (or lead professional) is   + for having a chance to talk to their care co-ordinator or lead professional before the CPA meeting about what would happen (those that had a care review)   + For being asked within the last 12 months about any physical health needs they may have   + for receiving good overall care from NHS mental health services in the last 12 months * A detailed action plan has been produced to address these shortcomings. This is in the process of being implemented. |  |

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| 1. **Productive Dashboard**   Note: The following is for year-to-date results from Community Hospitals only. | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Measure** | **Target** | **2010/11** | **2011/12** | **2012/13** | | Number of falls | <88 per month | 43 | 48 | 44 | | MRSA Screening Compliance | 95% | 98% | 94% | 99% | | MRSA | Info only | 76 | 25 | 15 | | Clostridium difficile *(Cdiff)* | <34 per annum | 15 | 10 | 4 | | Hand Hygiene | >/=90% | 100% | 99% | 99% | | Cleaning scores via ATP swabbing | 90% | 96% | 96% | 97% | | Urinary Tract Infections (UTIs) |  | 181 | 206 | 130 | | Pressure Ulcers Grade 2 and above |  | 32 | 65 | 15 | | Average length of stay (ALOS) | <28 days | 38 | 37 | 31 | | Average length of stay (ALOS) (excluding DTOC) | <24 days | 25 | 26 | 22 | | AHP assessment completed within 2 working days | 65% | 87% | 79% | 94% | | MUST | 85% | 84% | 94% | 98% | | Protected Meal Time Audit | 85% | 86% | 77% | 91%[[1]](#footnote-1) | | Track and Trigger 10 note audit compliance | 100% | 93% | 78% | 93% | | Patient Satisfaction | Above 80% | 79% | 82% | 89% | | Staff Satisfaction | Above 73% | 75% | 67% | 77% | | Short term sickness | <3.5% | 4% | 3% | 3% | | Direct Care Time RGN | 60% | 56% | 48% | 59% | | Direct Care Time HCA | 65% | 67% | 59% | 69% | |  |  |  |  |  | | | |
| 1. **Results from local surveys** | | | |
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| **Targets:** | | | |
| 1. **Improve the % of mental health patients who positively respond in the monthly service users’ survey** | | | |
| * The number of patients responding positively to the question has risen from 78% at the year end to 89% in Q3 | |  | |
| 1. **Community Services aim to improve the percentage of patients who rate their care good, very good or excellent. In the monthly patient users’ survey to the** **question by reporting it is good or excellent (service user priority).** | | | |
| * Risk assessment reflects the challenge of the CQUIN 3 indicators, in particular indicator 1. * See table below under “Community Services Patient Survey” | |  | |
| 1. **Within two years achieve a “good” or “excellent” score in the annual patients’ survey to the question “Overall how do you rate the care you are receiving from Mental Health Services?” which is equal to or above the average of other Trusts, and within five years within the top 20% of integrated health trusts.** | | | |
| * The Trust was judged at 6.1 out of 10 for the overall care provided in the 2011 Annual Community Mental Health Services Survey which was below the average for other Trusts | |  | |
| 1. **Year on year improvement of measures on the Productive Dashboard** | | | |
| * See table above. All measures are still showing improvement on last year | |  | |
| 1. **Achieve at least 90% uptake of “Ages and Stages” checks for 2-2.5 year olds** | | | |
| * Proactive Work is underway to be able to use RiO data to improve quality targets to increase delivery from 80% - 90% by Q4 * Performance is measured monthly using new electronic data reports and is currently at 94%. | |  | |
| 1. **Achieve at least 90% in measuring height and weight of children in reception year and year 6** | | | |
| * School health Nurses met the 90% target in Q1 to weigh and measure children in year’s reception and year 6 for the fifth year running, with a figure of 93.9% for Reception, 90.8% for Year 6, making a total of 92.5%. This is an annual exercise between January and July with the results being available in September. | |  | |

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| **Initiatives:** | | |
| Implementation of Patient Experience Clinical Guidelines as produced by the National Institute for Clinical Excellence (NICE) Clinical Guideline 138 “Patient Experience in Adult NHS Services” (Feb 2012) | * This has been managed with under the normal NICE procedure. * A gap analysis between the guidance and our practices has been carried out * Each discrepancy identified has been checked to ensure that it is part of a suitable action plan |  |
| Complete the refurbishment of the Highfield inpatient ward for young people and adolescents | * The new 18-bed Highfield build is completed with final fitting and furnishing in progress. The patients and staff will move in from week beginning 25th February 2013. |  |
| Build new mental health services in Buckinghamshire on the former Manor House site | * The investment in the new hospital (on the old Manor house site) is in construction phase at the moment – due to be completed October 2013. * In preparation we are adopting new practices in advance of the new hospital being opened which complements our commitment to the improvement of quality of the care we provide. These practices include improvements in delivery of clinical care models, mobility of community staff, enhancement of support services (facilities enhancement) and trialling new IT solutions. |  |
| Uniforms to be piloted in CAMHS mental health inpatient services in Swindon | * “Wash and Wear” tests have led to uniforms by Meltemi being selected * The team officially commenced wearing uniforms on Monday 3rd Sept * Feedback has been received from parents, carer meetings and visiting professionals, community meetings (staff and patient) and patient and parents’ questionnaires. All have been extremely positive. * Children, Young People, and visitors can now clearly identify the nurse in charge, which has improved patient safety and the quality of information being shared as well as giving staff both a professional and corporate look while at work. * The wearing of a uniform adheres to Trust Infection control policy, (bare below the elbows) hence an improvement in the unit’s Infection Control audit. * Staff report feeling a sense of belonging to a wider Trust now (as Swindon so isolated) staff also report taking more of a pride in their appearance at work since the uniform project began which also assists them to feel more confident and competent to carry out their duties effectively including the adherence to personal and professional boundaries. A second pilot in Sandford ward in Oxford has commenced. |  |
| Improve waiting times for prison health services | * Although we do not always have direct control over waiting times for healthcare services or provision, we are committed to improving waiting times in those elements we provide in the 5 prisons and 1 Young Offenders Institute across Oxfordshire and Buckinghamshire by actively supporting a “shared care” approach: closely working alongside other combined health care services, including locality providers. * Waiting lists are subject to prioritisation depending on need.  All emergency care needs are supported by Healthcare staff and any prisoner requesting to see at GP, is firstly triaged by a nurse, and if felt necessary the patients will be seen by a GP within 48 hours or sooner according to urgency. If a prisoner presents with a serious life threatening condition, a GP accompanied by health care staff will immediately review and 999 will be called. |  |
| * Improve waiting times for access to physiotherapy services | * The average waiting time has risen since last year from 10 weeks to 14 weeks at the end of Q3, however the waiting times reflect the 13% increase in referrals year to date (20% in November). The service is online to fulfil the contract on numbers seen, * The referral level into the service has continued to rise – this service has been part of a national benchmark that demonstrates that the service is seeing more people to whole time equivalents of staff than the national average. |  |
| * Develop and roll out use of alternative user satisfaction measure as part of health visiting Call for Action programme delivery | * An audit of parental understanding of service is in progress before the launch of a new service leaflet which is in development. Over 300 users contributed to survey report which completed in October 2012. * A new leaflet has had user / stakeholder involvement and was ready for publication November 2012 * A reaudit will occur post-leaflet launch, especially to demonstrate user awareness of the Health Child programme * Patient satisfaction questions for 2012 patient survey have been reviewed and agreed |  |
| * Implement Productive Programme releasing Time to Care to all teams, increasing the number of teams that have successfully implemented Productive Teams | * The Productive Care Programme is live in all 4 clinical divisions in the Trust, including all inpatient areas and a growing number of community based teams and services.  A number of areas have completed the formal module based programme and are now working to sustain Productive Care and make the ways of working ‘business as usual’. * There is a detailed implementation plan in place and agreement about which remaining services will be introducing the programme in 2012-13 and 2013-14. We are currently on track to deliver according to this plan. The implementation of the programme has received SHA and national recognition. * A Steering board is in place which meets regularly and receives detailed progress reports. This is chaired by the Director of Nursing and Clinical Standards. * Additional developments arising from the implementation of this programme have also been introduced including a pilot of the 15 steps challenge which is a way of assessing quality of care through the perspective of service users and carers and the development of CQC standards prompt cards which show staff how Productive Care can support evidence for CQC. |  |
| * Roll out and implement “Ages and Stages” quality initiative | * The project plan is on track. Monthly RiO reports monitor coverage targets with current performance 86-88% (Target: 90% March 2013). Current coverage has increased to 94% Dec 2012 * Ages and stages is an evidenced based tool incorporating a social and emotional assessment of all children aged 2years old. This has mainstreamed in to clinical practice January 2013 * Train the trainer programme has been delivered, with pilot locality has been well received. * 100% of staff have been trained in the new tool of assessment (over 200 staff) * This initiative has raised staff morale, improved user experience and involvement * Additional benefits include a new paediatric pathway, and integrated working with our OCC early year’s partners. * New staff competency framework and health assessment framework have been initiated * Oxford Health have shared our project learning with other trusts and will present this work in February 2013 at a National event through a poster presentation submitted to the DH |  |

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| **Responsiveness to Patient/Service User’s Needs will improve** | |
| **Measures:** | |
| 1. **Patients/Service users & carers report a positive experience in patient surveys** | |
| * The Annual Community Mental Health Services Survey results have been published at <http://www.cqc.org.uk/survey/mentalhealth/RNU> | |
| **Targets:** | |
| 1. **Improve patient satisfaction scores in mental health services by 10%** | |
| Comparing the results of the survey above with that from last year gives the following table:   |  |  |  |  | | --- | --- | --- | --- | |  | **2011** | **2012** |  | | Health & Social Care Workers | 8.2 | 8.2 |  | | Medications | 7.1 | 7.1 |  | | Talking Therapies | 7.1 | 6.4 |  | | Care Coordinator | 7.7 | 7.9 |  | | Care Plan | 7.1 | 6.6 |  | | Care Review | 7.2 | 6.9 |  | | Crisis Care | 6.4 | 5.9 |  | | Day to Day Living | 5.5 | 5.4 |  | | **Overall** | **6.3** | **6.3** |  |   Although the overall rating is unchanged from last year, it is disappointing that most of the items have dropped. |  |
| 1. **Improve the patient satisfaction scores in community health services according to the individual targets set** | |
| * See section below on Community Services Patient Survey |  |
| 1. **Children’s Therapies to achieve “You’re Welcome” accreditation** | |
| * Submission for accreditation is now likely to be about September 2013 when it is expected that the number of criteria achieved will have risen from 31 to the necessary 35 out of 36 (see below) |  |
| 1. **Increase the number of people supported to die at home according to the CQUIN requirements** | |
| * 99% of patients on the EOL Community Matron Caseload have a care plan, special notes and purple forms in place. |  |

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| **Initiatives:** | | |
| Enhance the support for people wanting to die at home | * Subject to CQUIN – see above * Work is underway to determine the number of palliative patients on the District Nurse caseloads and ensure that over 90% have their care plan in place at their usual place of residence as well as purple forms and special notes if appropriate.  Reports are also currently being run from RiO which will be cross reference with SystemOne to determine the number of palliative patients requiring urgent care intervention that have special notes in place. * ‘High rate’ GP practices (i.e. those with a higher proportion of palliative patients who die in an acute setting) are being visited by the EOL Community Matrons to ensure engagement and awareness of palliative community services and the support available to avoid acute admission. * District Nurses who attend GP practice GSF meetings are able to identify and facilitate referral to Community Matron Service to support improved access. * Current position; Oxford Health is awaiting data from the PCT with regards to the current position (% of palliative patients who have died in an acute setting).  Early indications suggest that the Trust is performing well against this performance requirement. |  |
| Continue roll out of patient wellbeing checks with patients in community hospitals | * Now implemented in stroke pathway, EMU patients and Fracture neck & Femur patients |  |
| * Scoping exercise being undertaken with regards to impact of roll out to general rehabilitation pathway patients * Currently we only expect to use this with existing pathways as there are so many other pieces of work being undertaken with patient experience and surveys including new request for Department of Health with the “Friends and Family” Test |  |
| Agreed actions carried out in Children’s Therapies to achieve “You’re Welcome” accreditation | * Audit of “You’re Welcome” completed by Integrated Therapy Service * Achieved 31 of 36 criteria, as “good”, with one non applicable, and rest (4) “satisfactory” * Action plan timelines for service developments go into 2013 * Review of action plan and re-evaluation on “You’re Welcome” audit tool to be September 2013 before submission for accreditation |  |
| Actions to reduce the number of complaints within the Prison Service | * Complaints have fallen over the year. * Tender for primary health care in Bullingdon Prison awarded to Virgin so service will pass to them by April 2013. |  |
| Carry out bespoke patient experience survey in the Addictions Harm Minimisation Service | * Survey questions have been agreed. * Survey completed. Awaiting report. |  |
| Implement session by session outcome measures for Children & Young People in CAMHS IAPT services | * The joint project with OUH regarding the urgent care pathway for children and young people has led to the expansion of the CCN team to provide support out of hours and to support children in the community preventing admission and speeding up discharge. * The OUH paediatric CDU is now open 24/7 and there are plans in place to extend CCN working hours to 8 to 8 to support this from Dec 2012. * The health visiting service has remodelled its Clinical Practice Teacher working and is training a higher number of health visitors in order to support our drive to increase the numbers of health visitors working in Oxfordshire. * CYP IAPT, the CBT and parenting trainees have almost completed their training and are utilising routine outcome measures, which are starting to evidence effective interventions. Year two trainees have been recruited and started training. * The service is in the process of implementing the transformation projects from the Leadership training including self referral and implementation of routine outcome measures across the whole service which is on track to complete by March 2013. |  |

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| **Patient’s Access to Community-based services will improve** | |
| **Measures:** | |
| 1. **Number of patients assessed and treated in community settings** | |
| * Part of Hospital at Home initiative * The number of patients assessed in Q4 last year was 105 * In Q1, number of patients was 476, compared with a target of 320 * In Q2, the number of patients accepted in to H@H was 412 (to 11th September) * In Q3, the number of patients accepted in to H@H was 513. * Service is at current capacity | |
| 1. **National CQC Community Mental Health Service User Survey results** | |
| * The Annual Community Mental Health Services Survey results have been published at <http://www.cqc.org.uk/survey/mentalhealth/RNU> | |
| **Targets:** | |
| 1. **The Trust aims to score better than the average of other organisations in the National Survey (Community) in the following areas:**     * **Service users knowing who their care coordinator was**    * **Service users being offered a copy of the care plan**    * **Service users have had a care plan review meeting in the past 12 months**    * **Having a contact number out of hours** | |
| * In the Annual Survey, the responses to the questions showed that we were “about the same” for all of these, except for the first question, which was worse than the average. |  |
| 1. **Reduce the number of incidences of Delayed Transfer of Care attributable to OCS** | |
| * See below |  |

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| **Initiatives:** |  |  |
| Develop skills in community nursing to extend scope and volume of sub-acute nursing care (Hospital at Home – H@H) | * H@H team skill development has been undertaken to ensure staff have both sub acute and community nursing skills to enable care at home and prevention of hospital admissions where possible. * A clear recruitment and training strategy and programme is in place * PDRs up to date and training monitored through this and competency framework. * Extended training sessions attended. * Rotation of shifts between H@H and MIU/OOH commenced to increase skill base. * Training sessions continuing. * New H@H overnight service commenced which will expose H@H and OOH staff to varied patient acuity and skills to be able to manage sub acute patients on a 24hr basis. |  |
| Introduce recommendations of the Delayed Transfer of Care (DTOC) action plan | * Progressing as per plan. |  |
| Introduce Single Point of Contact (SPOC) and 111 service to improve access to community based services for referrers | * Now in place |  |
| Pilot Routine Outcome Measures (ROM) and Self Referral within CAMHS as part of the Young People IAPT project | * A joint project team has been set up working across OUH and Oxford Health engaging Primary Care colleagues in developing integrated pathways for delivery for acutely ill children in the community and in hospital. Early progress is that the OUH paediatric CDU is now open 24/7 and we have extended CCN working hours to 8 to 8 to support this from Dec 2012. * The health visiting service has remodelled its Clinical Practice Teacher working and is training a higher number of health visitors in order to support our drive to increase the numbers of health visitors working in Oxfordshire. * CYP IAPT, the CBT and parenting trainees have completed their training and are developing routine outcome measures, which are starting to evidence effective interventions. Year two trainees have started their training.. * The service is in the process of implementing the transformation projects from the Leadership training including self referral and implementation of routine outcome measures across the whole service which should be complete by the March 2013. |  |
| Increase number of home-based community treatments in line with the care clustering packages | * Care clustering is underway and we are piloting the care packages in two Oxford Community Mental Health Trusts, Early Intervention Team, Assertive Outreach and one inpatient ward. * The full roll out will happen between January and April 2013 by which time all new patients will be having their community treatments in line with clustering, thus teams should be ready to fully participate in April 2013 |  |

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| Complaints |

Between April to December 2012 196 complaints and MP forwarded concerns have been received (excluding those withdrawn), this breaks down as 42 in Q1, 68 in Q2 and 86 in Q3. The graph below shows the number received by month, the average number received from April 2011 to Dec 2012 is 19 per month. Out of the 196 cases received, 32 were received via an MP. There was an upward trend in the number of complaints received from September to November 2012, however in December 2012 and a perspective look at January 2013 the numbers have reduced significantly to be nearer to the average. This trend is also reflected in the number of calls made to the Complaints and PALS Service free phone number to discuss and log either a formal complaint or informal concern.

There are some differences in the figures reported between Q2 and Q3 for 2012/13 as between Nov 2012-Jan 2013 a programme of data quality work has been completed to test and ensure the accuracy of the complaints data held on the Safeguard System between 1st April and 31st Dec 2012. This work has included ensuring formal complaints and MP concerns are recorded correctly, identifying and completing any blank key fields, ensuring withdrawn complaints are recorded correctly and therefore excluded from reporting and adding MP patient concerns to the report specification. A monthly data quality exercise has now been introduced and all figures reported on a monthly and quarterly basis are refreshed back to 1st April 2012 each time.

The majority of complaints which have been received are from or about the care and treatment of different patients/ service users; out of the 196 complaints received 187 were from different patients (three patients have made two complaints and one patient has made three complaints).

Between April to December 2012, 16 concerns initially raised as a formal complaint have since been withdrawn by the complainant and resolution has been reached informally.

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| Community Services Patient Survey |

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| **2011** | | | **2012** | | |
| **Have you been given or offered a care plan?** | | | **Did someone discuss with you a plan for your care and treatment?** | | |
| Yes | 27 | 28% | Yes | 17 | 55% |
| No | 56 | 57% | No | 5 | 20% |
| Don’t know/Not sure | 15 | 15% | Don’t know/Not sure | 9 | 25% |
| This question was changed to make it clearer, as some patients may not understand the term "care plan". This may have had an effect on the results, which show that 55% of patients are confident that their plan for care and treatment has been discussed with them in October 2012, compared to 28% of patients who were aware that they had a care plan in 2011. The community hospitals patient survey is on a rolling programme so results for this question in the new format can be tracked for improvements until December. | | | | | |
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| **Do you understand what was in your care plan?** | | | **Did you understand what the plan for your care and treatment was?** | | |
| Yes, definitely | 23 | 46% | Yes, definitely | 16 | 57% |
| Yes, to some extent | 11 | 22% | Yes, to some extent | 5 | 32% |
| No, I did not understand it | 5 | 10% | No, I did not understand it | 1 | 5% |
| Not sure | 11 | 22% | Not sure | 4 | 6% |
| Question changed to make it clearer as some patients may not understand the term "care plan". Of patients who responded to this question, 73% now say that they "definitely" understand it, compared to 46% in 2011. | | | | | |
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| **Do you think your views were taken into account when deciding what was in your care plan?** | | | **Do you think your views were taken into account when deciding a plan for your care and treatment?** | | |
| Yes, definitely | 18 | 39% | Yes, definitely | 15 | 41% |
| Yes, to some extent | 19 | 41% | Yes, to some extent | 6 | 40% |
| No | 9 | 20% | No | 1 | 19% |
| This is the key question for the quality account priority and there is a clear improvement in patients who think their views were taken into account when deciding on their care plan: from 39% in 2011 to 68% in 2012. | | | | | |

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| Patient Safety |

### Domain 1: Preventing People from Dying Prematurely

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| **People will not die prematurely** | | |
| **Measures** | | |
| **1. PYLL (Potential years of life lost) from causes considered amenable to healthcare** | | |
| * This is a Department of Health measure and has not been fully developed by them yet | |  |
| **Targets** | | |
| 1. **To reduce towards zero the number of community suicides by 2014 (24 known suicides in 2011/12, with a further 19 deaths where the Coroner’s verdict is pending)** | | |
| * The number of apparent community suicides is approximately 28 in the first three quarters, which is a rise on the equivalent period last year (24). Note that these are “apparent” suicides, which means that the Coroner has yet to give a judgement, which means that the actual figures may be lower than appear at present. This slight increase is in line with national trends. * However, for those deaths where the Coroner has given a verdict, the overall trend appears to be downward as shown in the accompanying chart. |  | |
| 1. **To maintain at zero the number of inpatient deaths from suicide** | | |
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| * There have been no suicides by in patients or patients on leave in the Trust last year or this year to date. |  | |
| 1. **To be fully compliant with Access to Healthcare for people with Learning Disabilities** | | |
| * Self assessment and action plan updated and reported to the Trust Board on October 12. The Trust Board declared us to be compliant with a score of 21/24. * Key actions be progressed in Q4 are:   + Carers strategy   + Communication & Involvement strategy |  | |

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| **Initiatives** | **Present Situation** | |
| Roll out the Leading Improvement in Patient Safety (LIPS) programme across the Mental Health Divisions to increase safety and reduce avoidable harm from health and social care interventions | * LIPS Initiative is now known as the “Oxford Health Safer Care Programme” * The programme incorporates the Safety Thermometer workstream * All Divisions have their Head of Nursing as the Safer Care Lead   **Mental Health Division**   * Has a well-established Crisis Services Workstream with an organisational aim of reducing death by suicide by 50% by March 2013. Always events have been employed to develop 100% reliability against risk management planning. Bucks teams have established 100% sustainability and Oxford Team has achieved 85% against this target to date. PCT Commissioners have set a CQUIN of £207K against the work and we are on target to achieve this * Both Oxfordshire and Buckinghamshire Teams have achieved 100% reliability on Always Events for handling referrals and risk planning. * .Has commenced a workstream to review the use of HDAs in PICU over the next six months. * Has commenced a workstream to review the duty systems and standardise care delivery in the CMHTs * Third Always event commenced in Jan 2013 and targets the improvement on carer’s services from the team (including young carers). The work includes written information, the team engagement and work with carers, and a carer survey conducted independently of the team. * 100% of all staff will have attended Advanced Assessment Skills training by Jan 2013. * High Dependency Areas (PICU) work is underway and diagnostic phase has completed. Work is to incorporate visits to other male / female PICUs for comparison.   **Specialised Services**   * Has a workstream focused on implementing a nutritional assessment and care plan for 100% of patients. They have set a target of encouraging the women to lose 5% of their body weight in one year. Baseline measures agreed and monitoring in place. Innovation fund supporting health education materials. Applications for exercise equipment underway. * Safer Restraint project started. Data completeness work to commence using prospective data analysis to enable accurate representation across a range of data points   Work on Kingfisher Ward currently under review. Initial objectives achieved (to introduce a screening tool for under nutrition and over eating.  **Children’s and Families’**   * Safer Restraint project commenced on the Highfield Unit. Always Events are being developed to create 100% reliability against clear documentation of triggers for escalations and calming interventions from the perspective of both family and young person. Highfield is currently preparing to move to new building so the pace of work has been adjusted accordingly. * Marlborough House continues the work on WRAP plans for all young people transferred to community services. Marlborough House is to undertake work on role clarity in respect of work planning and standard work on the unit. Meanwhile, SBARD work continues * BANES outreach team Keynsham are continuing project to pilot the use of Face Time with young people as an adjunct to face to face contact, enhancing safety and reducing waste. The Head of Nursing has requested a measurement of progress from the team. * Melksham PCAMHS have undertaken a process map of referral process and identified potential harms. The team is to review and gain consensus and interventions to be agreed on 3rd Jan 2013   **Community Services**   * Developing new guidelines on VTE assessment post stroke * Safety Thermometer work continues and GTT use to identify harms across the division. |  |
| Deliver Deliberate Self Harm (DSH) training for partner agencies, establishing a multiagency group to facilitate and update workshops in each of the target counties | * Multi-agency guidelines are embedded in Banes and Wiltshire.  Wiltshire schools have commissioned additional training from CAMHS to support their local guidelines and practice. * Swindon multi-agency guidelines have been agreed and will be formally launched on the 21st March 2013 * CAMHS continues to offer multi-agency DSH training as part of an agreed programme of mental health training in Wiltshire & Banes * We continue to work with our 3 acute hospitals around their DSH protocols to ensure young people receive care in line with NICE guidance.  Further development is required at Salisbury hospital which CAMHS is supporting. |  |
| Undertake ward refurbishment programmes as part of our annual Capital Programme | * As part of the mid-year review, carried out in October 2012, the FY13/FY15 Capital Plan has been re-prioritised to address issues raised by recent CQC inspections, Specialised Commissioning Group visits and Manchester Tool Assessments. Alongside Security, Risk and Infection Control, the Manchester Tool Assessments these are the 4 criteria used for Capital allocations. * As Part of this new process and capital reallocation the following projects are progressing as full schemes within FY13:-   + Vaughan Thomas – Environmental Works   + Phoenix – Environmental & Safety Works   + Wintle Ward   + Wenric   + Marlborough House – Milton Keynes * Completed schemes in FY13 include the upgrade of the Hard-Room on Oxford Clinic, phase 2 of the Clinical Trials Unit, Cotswold House refurbishment, Thames House extension, Wallingford CMHT relocation, Rectory Rd refurbishment, infrastructure upgrades at Warneford and Car Parking safety works. * The New Highfield unit at the Warneford is complete and patients will be moving in February 2013. * A programme of work has been prepared for all the approved refurbishment works. The works are all due to commence in March 2013. |  |
| Enhance rapid access to treatment for cardio-vascular events by monitoring the patient contacts using the new Single Point of Contact service | * Access to rapid access is through the new 111 service and not Single Point of Contact which is not an emergency treatment service. 111 is in operation but as a hybrid model at present with partner organisation and previous service model at weekends through urgent care OH * A search between the commencement of full 111 to the end of December indicated no emergency cardio-vascular events occurring in the OOH service. This indicates that the 111/SPOC is ensuring rapid access to alternative service for these. |  |
| Investigate potential to improve access to services for people with a learning disability to support addressing nationally identified excess mortality for this patient group | * There is an ongoing action plan in relation to this that is monitored by the learning disabilities steering group. * A protocol for making reasonable adjustments for people with learning disabilities has been developed. * An audit has been completed for mental health services; Community services are to complete audit in Q4. |  |
| Actions in respect of Health Visiting strategy | * A Multiagency Programme board is in place and meets quarterly with the last on 25th October 2012. The Implementation Programme is monitored internally through a programme  board and 7 SHA cluster meetings * Oxford Health is an Early Implementer site, supported by the Department of Health. * Workforce growth is a key target with trajectories agreed between commissioners and the strategic Health authority to achieve 123.6WTE by 2015. These are monitored monthly by the department of Health and Oxford Health remains on track to deliver our March 2013 target. Increasing the number of students into training is a key challenge of the programme along with increased practice teachers to support them. We have achieved all milestones with 14 new students recruited in September 2012. We have Reached 2013 target for number of Practice teachers to support the students CPT’s and we have commenced our recruitment for students starting 2013. Oxford Health NHS FT are confident that we can deliver the  expected workforce  growth by March 2015 * A Transformational programme of service change is in progress to deliver a new service offer to children and families in Oxfordshire along with a strengthened Health Child Programme. This year we are particularly focusing on developing an improved Maternity /Health Visiting pathway, improving delivery of the Healthy child programme at 2 years old and strengthening Early Intervention and attachment theories into clinical practice. |  |

### Domain 2: Treating and caring for people in a safe environment and protecting them from avoidable harm

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| **Patients will be protected from harm** | |
| **Measures:** | |
| 1. **Number of patient incidents involving severe harm or death** | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Cause** | **Q3 11/12** | **Q4 11/12** | **Q1 12/13** | **Q2 12/13** | **Q3 12/13** | | Unexpected Death | 6 | 5 | 3 | 4 | 2 | | Pressure Ulcer | 3 | 5 | 4 | 7 | 4 | | Possible Suicide | 8 | 9 | 6 | 14 | 8 | | Self Harm | 0 | 0 | 1 | 1 | 0 | | Injury | 1 | 0 | 1 | 1 | 0 | | Allegations Against Staff | 0 | 0 | 1 | 2 | 0 | | Security | 0 | 0 | 2 | 1 | 1 | | Fall Related | 1 | 1 | 3 | 3 | 1 | | Patient Murder/Manslaughter | 1 | 0 | 0 | 1 | 0 | | Safeguarding | 1 | 1 | 0 | 1 | 0 | | Medication | 0 | 1 | 0 | 0 | 0 | | Under 18 admitted to adult ward | 0 | 0 | 0 | 2 | 1 | | Sexual | 0 | 0 | 0 | 1 | 0 | | Violence and Aggression | 1 | 0 | 0 | 0 | 1 | | **Totals** | **22** | **22** | **21** | **38** | **18** |  * The table above shows the total number of severe SIRIs by quarter. The sharp rise experienced in quarter 2 appears to have been an anomaly with Q3 figures returning to below previous levels. * As usual, apparent suicides, unexpected deaths and pressure ulcers are the three main areas of SIRIs. These fell in number in Q3 compared with Q2 * It should be noted that these are “possible” suicides. Further investigation or a judgement in the Coroner’s Court is needed to confirm this assessment or otherwise. |  |
| 1. **Levels of training in Prevention and Management of Violence and Aggression (PMVA) to reach 85% in Mental Health Divisions (71% at the end of 2011-12)** | |
| * 71% at the end of Q3 |  |
| **Targets:** | |
| **1. Increase the number of staff who have completed the Trust’s clinical safe and supportive observations competency training from 65% to at least 85% of mental health staff and 100% of new starters on mental health wards** | |
| * The figure of 65% was for new starters only. Now that it is mandatory training for all new Mental Health staff, it is being phased in over the year. |  |

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| 1. **Improve the level of PMVA training to beyond 85%** | |
| |  |  |  |  | | --- | --- | --- | --- | |  | **Q1** | **Q2** | **Q3** | | PMVA Breakaway | 60% | 65% | 61% | | PMVA Breakaway - In-Patient Nursing Staff - MH | 72% | 74% | 59% | | PMVA Conflict Resolution Training (Enhanced) | 51% | 68% | 57% | | PMVA Full Course - Recertification Annual | 67% | 60% | 70% | | PMVA Full Course - Teamwork | 84% | 85% | 88% | | PMVA Personal Safety (New Non Clinical Staff) | 84% | 62% | 44% | | PMVA Rapid Tranquillisation | 85% | 89% | 92% | | PMVA Short Course - Recertification | 78% | 70% | 75% | | PMVA Short Course - Teamwork | 81% | 85% | 85% | | **TOTAL** | 66% | 71% | 67% | |  |
| 1. **Reduce the avoidable serious drug errors in the Community Hospitals to fewer than 24 (2011/12 experience)** | |
| * There have been 20 drug errors in the three quarters of the year that were subject to initial investigation reports, all of which were deemed to be near-misses as none caused any harm to patients. * Each incident is investigated and learning lessons shared via ward and Unit manager’s meetings. Trends are reported and monitored via medicines management and the Quality and Clinical Governance committees, where a breakdown of the errors is advised. Also the division monitors individual staff to ensure the same staff are not making repeat errors. * To date there has been no actual harm but the errors are rated serious as the type of error usually relates to a near miss never event category e.g. insulin related error * The following is being undertaken to reduce the number of such errors:   + Monthly medicine management training sessions are held for new starters and for those needing refresher training   + Competency frameworks for insulin, warfarin and controlled drugs is being rolled out in community services   + A mandatory e-learning medicines management package is under development   + Diabetes and insulin training is being arranged for community services nurses with a view to expanding to other divisions   + We are continuing to request action plan and learning needs from investigations for all serious medication incidents   + Annual medicines management audit took place late November * Note: we have re-evaluated how a serious drug error is defined. The revised target for 2011/12 is now 24 (this being the audited CQUIN figure) |  |
| 1. **Reduce the overall number of falls by patients/service users in the Trust to below 1,396 (5%) in 2012/13 from about 1,470 in 2011/12 (precise measurement was difficult due to different systems being used for the first 6 months of 2011/12** | |
| * The graph above gives the number of falls on an annual basis. The number of falls dropped between the 2nd quarter and 3rd in mental health wards, whilst staying about the same in Community Hospitals * The increase in falls in Community Hospitals is principally due to multiple incidents related to two specific patients |  |
| 1. **Achieve less than 8.6 falls per 1000 occupied bed days by 2014 (current position is 10.1). Target for 2012/13 is 9.4 per 1000 bed days.** | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  |  | **2012 Q1** | **2012 Q2** | **2012 Q3** |  | | Fall rate Mental Health | | 3.4% | 3.0% | 2.1% |  | | Fall rate Community Hospitals | | 9.7% | 10.2% | 10.3% |  | | **Combined** | | **5.4%** | **5.3%** | **5.0%** |  |      * The position in the Community Hospitals has been reviewed and the rise in falls is due to specific patients who have cognitive needs at two locations, resulting in a temporary spike. Those areas have been in liaison with Fullbrook, where the patients had been transferred from, with regards to their management. All appropriate care and actions for falls management were in place. |  |
| 1. **Increase the percentage of service users admitted to psychiatric wards that have a physical health examination, including for venous** **thromboembolism (VTE) within 24 hours of admission from 93% to at least 98%, including those that refuse an examination.** | |
| * An audit in Q2 showed that 96% of patients had a completed physical health assessment (92% in Q1). Results for VTE screening documented are not yet available from the new Essential Standards audit. |  |
| 1. **Increase the percentage of community health patients who are physically assessed for dementia and VTE within 48 hours of admission or referral, to Community Hospitals to at least 85%** | |
| * There has been a clear improvement since the implementation of safety thermometer and greater awareness – see graph below. * Action taken to improve compliance includes:   + compliance to be raised at the medical staffing contract meeting   + increased awareness raising especially targeting those units with less than 85% compliance * Dementia screening results are given later under Dimension 3 |  |
| 1. **At least 85% of patients will be assessed for pressure ulcer risk on their first visit or within 6 hours of admission for Community Nursing and 24 hours for Older Adult Mental Health wards, and will have actions indentified on the key risk factors and any preventative measures implemented within 2 days** | |
| * 100% for Community Nursing (83% in Q2) |  |
| * An audit will be carried out within Mental Health in Q4, though it should be noted that Older Adult Mental Health wards represent about 5% of the Trust’s pressure ulcers |  |
| 1. **At least 85% of community hospital patients and Older Adult Mental Health service users will have a Malnutrition Universal Screening Tool (MUST) nutrition assessment within 3 days of admission** | |
| * MUST tool compliance from CHAT audit was 92% in Q3 (89% in Q2) for community hospitals * MUST tool compliance from CHAT audit for Older Adult Mental Health service will be reported in Q4 |  |
| 1. **Reduce the number of mental health patients who go Absent Without Leave (AWOL) from 237 to fewer than 213 (10%)** | |
| * Total this year to date: 198 of which 155 were detained patients |  |

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| 1. **Implement the Safety Thermometer according to the nationally-defined Commissioning for Quality and Innovation standard (CQUIN) in Community Hospitals, District Nursing and Older Adult Mental Health teams** | |
| * We are currently in phase 1 of the implementation as agreed in a CQUIN. * Community Services has an established dashboard for inpatient services and this is being developed for other services in line with the “productives” programme implementation as part of a phased approach. All services identified in phased plan to commence the Safety Thermometer audit submission in Q3 has been achieved. * All Older adult MH wards and 4 CMHT’s are now taking part in the monthly safety thermometer audit, as per schedule |  |

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| **Initiatives:** | | |
| Implement the new Child Protection Service Model Actions in respect of Health Visiting strategy | * Trust Lead Nurse Safeguarding Children and Divisional and Named Nurses are in post. Trust Lead Doctor is in post. * Additional Named Doctors are in post for Bucks and Swindon, Wilts and B&NES. * Trust membership of Local Safeguarding Children Boards are in place * New Trust safeguarding training programme is in place. Trust-wide Targets achieved for Q3. * Safeguarding supervision arrangements have been reviewed and continue to be delivered. * Divisional Named Nurses are working with Divisions to increase assurance regarding CQC Outcome 7. |  |
| Implement the Buckinghamshire Children and Adolescent Mental Health Services (CAMHS) model, to be fully operational by the end of the year | * Buckinghamshire CAMHs service model is now embedded * Further work on the LD service and Neuro psychiatry service is taking place and is on course for full delivery by the end of Q4 |  |
| Remodel Crisis Services in Oxfordshire | * The LIPS programme – now known as ‘Safer Care’- will be used within the crisis service to improve patient safety. This will be done through the use of Always Events, which clearly states clinical processes and outcomes that must 'always' be achieved. * Always Events have been established (with supporting evidence) and the 3rd Always Event about to roll out involving carers. * 100% of staff will have completed the advanced assessment skills training. * Bucks - now at 87.5% - only three more staff members need training, all booked on. Oxon – 73.6% - five remaining staff to be trained. * All calls into the Crisis Team are now call handled by the Out of Hours Coordination Centre, both counties – (used to be a phone line with answer machine sitting in the Oxford CAS office) – this team are also able to take referrals for the team – thus creating capacity for the staff in Crisis. * All vacancies have been successfully recruited into across both counties. |  |
| Implement care clusters. This is a system of classifying mental health service users by their condition in order to provide appropriate care packages | * The care clusters work is focused in the mental health division.  In Specialised Services, this is in its early stages and we are piloting care clusters and five forensic pathways in line with this year’s CQUIN. * Service specifications and care packages are all in draft form and pilots commenced on 15th October in the city east, city central, early intervention and assertive outreach teams. Allen ward will also take part in the initial pilot, to be reviewed in February ready for implementation in April 2013. * Older Adults have now been added to the pilot sites |  |
| Implement new management of medicines procedures in prison environments | * Bullingdon and Huntercombe procedures are in place and implemented. Usual Medication Management audits are timetabled. * Numbers of complaints and incidents related to medicines have reduced |  |
| Implement new Addictions Harm Minimisation service in conjunction with partners to provide a recovery led service | * The new Harm Minimisation (Harm Min) service is one of the new 6 national pilots for addiction services and the department has undergone a significant transformation both in terms of staffing, location and bringing a non-statutory organisation and NHS health care together. This model is likely to be replicated in other parts of the country in a push to move patients to recovery. * The new service opened 2 April 2012 having completed a significant refurbishment at Rectory Road. The new model of care has been challenging for all providers as the patient systems are each reliant on all the other providers playing their part and Oxford health being only one part of the jigsaw. * Harm Minimisation service has been implemented and is in place. * Assessment stage of new model has been moved from Aquarius and is now managed by probation. * We are continuing to work in the new model and to date have achieved all the performance related pay criteria. * Management of the organisations are continuing to work on joint working and communication. * The success of the model will be evaluated by the RAND Europe public-policy research institute at the end of the first year. |  |
| Implement the action plans to reduce the number of serious drug errors in Community Health Services and roll out staff competency framework on prescribing and/or administering medicines | * Medicines management completed its role in 2011. * The action plan was completed as part of 2011 CQUIN * Competency framework for controlled Drugs, insulin and warfarin was rolled out as part of the CQUIN. * Clinical development leads for each service are now responsible for ensuring staff undergo competency assessment. * Two audits have been carried out by Clinical Governance to monitor progress of implementation. |  |
| Enhance ward-based falls reduction programmes | * As part of the Falls project ward staff are receiving training updates on use of the falls risk screening tool (which was part of the Prevention of harm from Falls Policy). This ward based training has been completed on the Mental Health older adult wards by ward based sessions. The staff involved will cascade the training and updates on use of the assessments will be offered in 2 months time by the Physiotherapy team and /or the falls service. * New appointments of physiotherapy technical instructor for the Bucks OA wards has allowed falls reduction/balance/ strengthening exercise groups to commence. * In the Oxfordshire Older Adult wards group and individual programmes (including OTAGO. and tai chi) continue to be provided by physiotherapists and Technical Instructors. * Negotiations with the Buckinghamshire Falls service are on-going in order to support the Older Adult metal health wards in Aylesbury. * Buckinghamshire County Council and Health providers have included a Physiotherapist from the Mental Health division, Oxford Health in their County wide project on Falls prevention. This will enhance the co-related work in Bucks Older adult wards and community falls service |  |
| Monitor and analyse acquired infections in more detail by location and service, implementing any preventative actions that may be identified as a consequence | * This forms part of the infection control work programme and issues identified in RCA action plans are monitored locally through the weekly Clinical Governance Committee and Infection Control Committee. * The work has now been completed and vancomycin is now in all community hospitals to respond quickly if CDiff infection is detected. |  |
| Introduce the Mortality Global Trigger Tool in Community Hospitals | * Global Trigger Tool is now embedded and regular reporting to divisional QCGC has commenced |  |
| Investigate the number and nature of physical restraints and use of seclusion within the Mental Health wards with a view to analysing such incidents to ensure compliance with best practice and guidance and also to review current policy and practice | * LIPS project started * Base line data gathering period completed on 31/12/12. * Stages of analysis of data, additional analysis of patient characteristics and review of ICA areas to be completed by April 2013. |  |
| Deliver the health visiting call to action using locally developed non-QIPP (Quality, Innovation, Productivity and Prevention) CQUIN | * All pathway and service development considered an integrated QIPP approach. * A CQUIN is in place in respect of 2 year review and excellent progress is being made * An innovative approach to maternal mental health pathway in place; lessons will be shared as a case study to DH. * Significant progress has been made in improving data quality reporting to evidence, drive and support clinical quality |  |
| Implement a programme of quality and safety walkabouts in Oxford Health Community Services Division (OCS) | * Work has started in January 2013 to explore further evidence based programmes to underpin and further improve the Health Child programme * Growth trajectories are agreed with commissioners, understood and on track and reported monthly to SHA * Contract variation via commissioners to reflect investment required is completed * Increased numbers of students have started training in Sept 2012 (14). Vacancies have reduced. Trajectories on track with use of a flexible workforce * New preceptorship programme to support newly qualified staff is in place |  |
| Improve the level of safeguarding referrals by developing thresholds for safeguarding jointly with the relevant local authority and commissioners. | * Thresholds are in the process of being agreed. * Work continues with partners and CQC on safeguard thresholds, the safeguarding leads meeting for the South central is also working on this with Trusts within the region |  |
| Improve Child Health & early detection & intervention to improve health of young children through increasing the number of Health Visitors in Oxfordshire | * The Health Visiting service has remodelled its Clinical Practice Teacher working and is training a higher number of health visitors in order to support our drive to increase the numbers of health visitors working in Oxfordshire. * Our Health Visiting implementation plan has vision to grow the Clinical Practice Teaching capacity to 9 by September 2012. This has been achieved with 10 CPT staff in position. This is crucial in enabling our growth of students to the workforce. Our student and growth plans are monitored monthly and we are on track to deliver our student and workforce trajectories. * Work will start in January 2013 to explore further evidence based programmes to underpin and further improve the Health Child programme * Growth trajectories have been agreed with commissioners, which are understood, on track and reported monthly to SHA * Contract variation via commissioners to reflect investment required has been completed * Increased numbers of students have started training in Sept 2012 (14). Vacancies have reduced. Trajectories are on track with use of a flexible workforce * A new preceptorship programme to support newly qualified staff is in place |  |

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| **Patients will be treated and cared for in safe environments** | |
| **Measures:** | |
| 1. **Number of healthcare associated infections** | |
| * There have been 3 cases of CDiff in Q3. We have had a total of 8 cases to date against the target of 10. * There were no occurrences of bacteraemia in Q3 | |
| **Targets:** | |
| 1. **Increase the overall number of non-severe incidents reported from 6,686 in 2011/12 to 8,500 (27%) in 2012/13** | |
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| 1. **Reduce the incidence of avoidable infections of C. diff (clostridium difficile) from 15 in 2011/12 to 10 or fewer in 2012/13** | |
| * For figures, see measure above * A Board report has been provided and a Cdiff masterclass given to the Board, Executive Team and non-executive’s directors in September by Professor Derrick Crook, Consultant Microbiologist at OUH. |  |
| 1. **Maintain a zero incidence of bacteraemia (MRSA and MSSA)** | |
| * There have been no occurrence of bacteraemia in Q3 |  |
| 1. **Achieve the Quality in Dental Services Award in 2012/13** | |
| * Assessment will be in spring 2013. |  |

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| **Initiatives:** | | |
| Actively promote reflective review of safety incidents, including the establishment of patient safety workshops in order to promote an open culture of reporting safety incidents | * The 7th Learning from Incidents newsletter was published in Q3 giving the top 6 categories of incidents, patterns of SIRIs, number of restraints, updates from each division, Themes from clinical audits and a focus on the new national suicide prevention strategy published in September 2012. * 2 Trust-wide Learning from Incidents events took place in October 2012 which focussed on some of the key areas of learning over the last few months including injuries sustained during restraint, falls prevention and learning from Serious case reviews.. * 5 further risk notes were issued in Q3 as a result of incidents. * A patient safety intranet button is due to be launched in the new year which will include a significant section on learning. * A year thematic review (July 2011-June 212) is in the process of being finalised and action planned. It was submitted to the clinical advisory board in December 2012 and is awaiting signoff. * A 1 day externally facilitated RCA training programme was delivered to 18 senior staff on the 10th December 2012. |  |
| Assess the impact of changing the testing for C. diff | * The C. Diff action plan is in place and 90% of actions have been completed, the remaining actions to be concluded by the end of January 2013 * Review of antimicrobial guidelines * Improved transportation of specimens * Improved staff access to case notes |  |
| Continue implementing the current programme for acquired infections within community hospitals | * RCA action plans continue to be monitored. * Work is on-going to increase capacity of domestic services in community hospitals |  |
| Work towards achieving the Quality in Dental Services Award in 2012/13 | * A coordinating team has been established and the senior team have now decided to submit to the British Dental Association in spring 2013. * Mock assessor visits were carried out in all the clinics in October/November 2012. These assessments went well and are due to continue on a rolling programme over the next 3 months. * Oxfordshire Salaried Primary Care Dental Service has now collated over 90% of the evidence required for achievement of the Quality in Dental Services award and is currently gathering the remaining evidence. * Nine of the ten domains have been sent to the clinics/sites and have been implemented. The remaining domain (Dental Public Health) will be sent out for implementation in the clinics/sites December 2012. * QIDS is a standing item on all SMT, peer reviews and clinic meetings so that information can be both cascaded and feedback. * All dental staff are engaged to achieve this award. * Service newsletters continue to be produced by the clinics on a rota basis and are sent out every 6 weeks with the next edition due in time for Christmas. |  |

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| PEAT Assessment Results 2011/12 |

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|  | **Target** | **Q1** | **Q2** | **Q3** |  |
| Children & Families Mental Health Specialised | 95% | 97% | 98% | 98% |  |
| Community Services | 95% | 97% | 97% | 96% |  |

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| Effectiveness |

### Domain 3: Enhancing quality of life for people with long-term conditions

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| **The Quality of Life for People with Long-Term Conditions will improve** |
| **Measures:** |
| 1. **% of service users engaged in meaningful activity** |
| * The required metric is currently being developed to monitor this. We are looking at the possibility of using the care plans as a way of being able to show that service users have a plan around meaningful activity as the first phase |
| 1. **% of service users in settled accommodation** |
| * 74.7% in the 3rd quarter, 75.8% in the 2nd quarter and 65.2% in 1st quarter |
| 1. **% of service users in employment** |
| * 13.3% in the 3rd quarter, up from 12.7% in the 2nd quarter and 10.5% in 1st quarter |
| 1. **Number of people with long-term conditions (LTC) receiving IAPT** |
| |  |  |  |  | | --- | --- | --- | --- | |  | **Q1 2012** | **Q2 2012** | **Q3 2012** | | Oxfordshire | 30 | 50 | 188 | | Buckinghamshire | 76 | 104 | 317 |  * Q3 a further substantial increase in the numbers of people with LTC accessing both IAPT services in Oxfordshire and Buckinghamshire:   + Oxfordshire Talking Space had 1059 people entering treatment in Q3, giving a percentage of 17.8% for those with LTC   + Buckinghamshire Healthy Minds had 1199 people entering treatment in Q3, giving a percentage of 26.4% for those with LTC |

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| **Targets:** | |
| 1. **100% of mental health patients on the Care Programme Approach (CPA) should have a current care plan, had care reviewed in the last 6 months; a care coordinator and a risk assessment which has been reviewed in the last 12 months** | |
| Note that these figures are for Adults, Older Adults and Forensics only and obtained from a sample-based audit.  All figures are now at 100%. |  |
| 1. **100% of mental health patients have a copy of their care plan and were offered an opportunity to be engaged in its development** | |
| The results shown above are an amalgamation of the audit questions:   * Is there evidence that the service user has agreed care plan? * Is there reason for no agreement?   Unfortunately, it has not been possible to produce figures for Q3 due a change in the questions asked. |  |
| 1. **At least 85% general rehabilitation patients admitted to Community Hospitals have been screened for dementia and depression based on the screening and assessment protocol.** | |
| * Further investigation has shown that this metric appears to be impractical to measure. * The service has started reviewing the tools used in the screening flowchart in conjunction with colleagues at OUH and older adult services. * Current results show 56% compliance with AMTS for community hospitals, which is the required initial screening tool. * New admission packs have been now implemented in all community hospitals and includes AMTS screening tool; staff have been advised that this must be completed by a member of the MDT for all patients on admission. Results are expected to improve significantly in Q4. * In addition a depression tool has also been added in the admission pack and compliance will also be monitored from Q4 * The follow on second level of screening as indicated through the AMTS initial screening has been revised and now the service is using MOCHA tool and not MMSE tool. |  |
| 1. **Patients with long term conditions will have a named professional coordinating their care** | |
| * This is linked to the single point of access and has been agreed that it will be for those who require input from more than two people / teams – i.e. those at highest risk * This work continues to be part of the single point of access and the developing locality teams |  |
| 1. **Redesign of Community Children’s Nursing Services to reduce unplanned admissions and support early discharges** | |
| * Investigations into developing the metric to achieve this continue to be explored in Q3 |  |
| 1. **Patient Survey results show an improvement in involvement in care planning compared to 2011/12 as a result of the “East Kent” rehabilitation assessment & Outcome setting tool for rehabilitation in OCS in-patients and community** | |
| * See previous results in Domain 5 |  |

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| **Initiatives:** | | |
| Improve access to IAPT | * The IAPT services in Oxfordshire and Buckinghamshire continue to undertake a wide range of strategies to increase access including:   + use of web sites, marketing materials – posters, new leaflets, coverage  in local press radio and TV etc,   + improved triage and assessment processes,   + fast access to low intensity treatments such as Stress control,   + alternative methods for delivery of psychological therapy – psychology on line trial etc. * Both services are undertaking work to improve access for older patients and for patients with long term physical health problems  (see below) |  |
| Ensure the integration and cross-working of physical and mental health skills to support people with Long Term Conditions (LTC). This will lead to improved access to IAPT for those with a LTC | * The IAPT services in Buckinghamshire and Oxfordshire are both DH pilot sites for LTC work. These pilots reported the half year progress reports to the DH on 31st October and will by year end include an evaluation of impact on local health economies. * The Pilots are working with patients who have Cardiac (Oxon) and COPD (Bucks) physical health issues. This includes working with specialist community cardiac and respiratory nursing staff and primary care colleagues teaching them to recognise mental health issues and also in providing a psychological approach to care * Recruitment and training for staff is in progress. Oxon and Bucks now have staff to work with people who have both physical health and common mental health problems. * Both services are working closely with commissioners and acute hospital providers to clarify the pathway for people who have strokes, and their carers * SHA funded Training for staff from both services to work with older people took place in December and January. The evaluation indicated the training was successful and it will now be provided for all staff in spring 2013. The training resource pack developed for the pilot will be made available to all IAPT services across England. * The Executive Team have agreed an approach to integrating LTC and psychological care across the Trust. Meetings are in progress with OUH and Clinical Commissioners to take this forward in Oxford. * Both services are working with their CCGs on the development of psychiatric liaison services. |  |
| Implement Patient Reported Outcome Measures (PROMs) in specific areas | * See “Implement  session by session outcome measures for Children & Young People in CAMHS IAPT services” above |  |
| Implement a self-monitoring system (Oxtext 7) that allows patients with a variety of conditions to take more control over their illness and also allows their care interventions to be tailored to the individual. | * This is a research-based project being led by Oxford University. They have now approach the first two teams and are discussing the first use of Oxtext 7 with any patient known to the team who would want to participate. The remaining teams act as the controls. * The project will be rolled out at 3 monthly intervals with a further two teams at each phase taking part until all teams are using the system * The roll out will commence in January across all Community Mental Health Teams |  |
| As part of PROMs, launch Outcomes Project within Forensics service in 2012 | * The project is launched and meetings continue. * A workshop led by the Clinical Director was held on 04/12/12. Principles of how to develop outcome measures and list of measures was agreed. * Work is underway to develop each outcome measure in more detail. |  |
| Improving rehabilitation care for patients with dementia in OCS | * All patients complete Mini Mental State Examination (MMSE) on admission * Monthly audit using CHAT audits in place across community hospitals * We are applying to join “Butterfly” scheme and pilot this in Bicester, Didcot and Townlands hospital. * Also for the new builds at Townlands and Bicester staff have attended the Kings Fund dementia friendly environment conference and we are working with Estates and PCT to ensure that the environment in relation to such as soft furnishings, wall colours, lightening etc are following the guidelines around supporting cognitive improvement for patients with dementia * Dementia bundle training is being rolled out. * A joint application is being placed for Department of Health funding for dementia friendly environments with OUH and OCC |  |
| Improve use of the “Integrated Care pathway” for people supported in dying at home | * In fact we are using the “Integrated Care Pathway” (ICP) which is an adapted Liverpool Care Pathway * All District Nursing teams have received training in the use of the ICP. As of April 2012 there was approximately a 65% uptake. Room for improvement has been identified within some teams whilst confidence in its use is developed. Support is available from both the EOL community matrons and the EOL facilitators. * The ICP cannot be added to RiO as it is a multidisciplinary document however work is in progress to develop a system whereby this may happen in the future. * The existence of the ICP, “purple form” (DNACPR) and / or the ACP (advanced care plan) is noted on RiO (and progress notes) as either freetext or as an alert as appropriate. Currently this is undertaken by the EOL community matrons however work is underway to extend this out to the DN teams. * Dialogue has taken place with all Oxfordshire GP practices about how we can better work together to support people to die at home (if that is their preference) and improve use and access to “special notes” detailing people’s personal palliative care plan (as agreed with the patient). * ICP “surgeries” have been held by facilitators in conjunction with Locality Clinical Leads for DN localities to maintain confidence following national ICP adverse media coverage |  |
| Consistent implementation of primary nursing across district nursing | * Standard Operating Procedures have been developed and shared with the CDLs. * Currently working on process to enable roll out and dissemination of SOPs * A named nurse is in place in all localities and the locality clinical leads have developed an audit to measure how many team have adopted named nurse and this will be carried out towards in March |  |
| Roll out of “East Kent Outcomes tool” to help assess rehabilitation for stroke patients | * “East Kent Outcomes Tool” is being put on to RIO: community therapy will go on in November and community hospitals fully uploaded in December, so that clinical assessments and outcomes in “East Kent” will follow the patient through * Early supported discharge for stroke has started in the Henley area and this uses “East Kent” as their outcome tool * The feedback from patients has been positive, in the patient centred approach that it fosters |  |
| Implement the 4 key principles for the development of services that support the management of patients with long term conditions and frail elderly patients in OCS | * These are known as the Philips Principles and we have started a project on ‘Discharge to assess’ which is now fully implemented as from November 2012. * Central to this is a discharge policy which has been agreed across OUH and OCC. * The Interface medicine project has been progressed to develop a draft specification for community hospital and EMYU medical cover. This will start in April 2013 * Interface medicine revised specification now at contract implementation stage for contract revision with OUH and PML contracts. * Discussions with commissioners being held to develop outcome based approach for frail elderly patients across the entire patient pathway and not just OH FT. |  |
| Develop our services to support care closer to home through acute hospital avoidance for OCS patients | * System 111 and Single Point of Access for referrals now in place * SPA has developed to merge with OCC both in location and in development of new discharge pathways. Strong links have been built between OUH/OCC/OH to support care closer to home with discharge to assess in particular.  Referrals through SPA:   May   117  June  113  July   112  August  168  September 166  October 248  November 206  December 217  Avoided admission in Dec – 46   * Concerns for success depend on a revision of staffing model to meet demand. * H@H service continues to support patients within their own home. Referrals remain constant. For Q3:   October  170  November 171  December 172 |  |
| For service users with non-psychotic and psychotic high need, define clear and comprehensive early intervention packages of care | * Care packages are in draft form and have clearly defined NICE guidance, core interventions and outcomes expected for the patient * These are now being used within the pilot teams and refined as needed |  |
| Promote the wellbeing of people with mental health conditions through initiatives such as smoking cessation | * Kick the Habit manual developed from successful work undertaken at Wenric House.  This is a manual of resources and guidance to encourage wards and teams to carry out smoking cessation groups, including evaluation tools to enable us to understand the most effective approaches. * Smoking cessation Training and clinical support if provided by the Smoking Advice Service who promote kick the habit in their training programmes. * L&D and currently Marlborough House are working together to provide training to staff to equip them to talk to patients about their lifestyle behaviours with the aim of working towards behavioural change.  This is in line with making Every Contact Count.  The eventual aim is to have tailored training for all clinical areas. * A public health strategy has been written and submitted to the executive team for approval.  The strategy is based on national guidance that the NHS role in public health is predominantly health improvement and it aims to embed Making Every Contact Count into organisational culture and practice.  Alongside the strategy a proposal for increase public health co-ordinator has been devised in order to achieve the strategic aim of MEEC.  The Trust have linked with public health who are supporting pilot areas in the Oxford Deanery to implement MEEC. |  |

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| **People with Long-Term Conditions will spend less Time in Hospital** | |
| **Measures:** | |
| 1. **Number of unplanned hospital admissions for long-term conditions** | |
| * This is no longer a CQUIN and does not need to be reported on | |
| **Targets:** | |
| 1. **At least 85% of general rehabilitation patients admitted to Community Hospitals have been screened for dementia and depression based on the screening and assessment protocol** | |
| * MMSE now in place and monthly CHAT audit should give these figures in future. * See above for measurement of dementia screening |  |
| 1. **100% of mental health patients on CPA:**  * **have a current care plan** * **had care reviewed in the last 6 months** * **have a care coordinator** * **have a risk assessment which has been reviewed in the last 12 months** | |
| * + See previous chart |  |
| 1. **Reduce the incidence of emergency readmission in mental health services within 28 days of discharge by careful discharge planning and assertive follow up**  * **Under 10.3%**[[2]](#footnote-2) **of 28 day readmissions for adults (10.2% in 2011/12)** * **Under 5.3% of 28 day readmissions for older adults (1.4% in 2011/12)** | |
| * 7.4% for adult emergency readmissions at the end of Q3, down from 7.9% in Q2 and 9.8% in Q1 * 2.5% for older adult emergency readmissions at the end of Q3, 2.1% in Q2 and 3.1% in Q1 |  |
| 1. **CQUIN Delayed Transfer of Care (DTOC) target (presently being finalised)** | |
| * Across the whole system the result was 110 delays against a target of 72, although mental health figures have been estimated due to non - submission.  This figure will be updated upon receipt. * Whilst the CQUIN scheme targets have not been achieved, the number of DTOCs continues to decrease |  |

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| **Initiatives:** | | |
| Set up Single Point of Access action plan to support long term care and support in the community to avoid unnecessary admissions | * Now set up for referrals * Referrals are increasing and are being extended to taking referrals for OUH. * See above for figures |  |
| Support diabetic patients to feel confident in managing their condition | * All target levels in the contract are being achieved * Training has been put in place for Practice Nurses in helping them manage their patients with Diabetes and this is continuing through Q4 |  |
| Redesign of Children’s Community Nursing Service in line with specification and project plan to reduce admissions to children’s acute hospital | * Redesigned current service in line with integrated community children’s nursing specification. 2011-14 * Developing urgent care pathway with the acute to prevent admission and promote early discharge. * Increased senior leadership in the team and staff appointed and in post * We have reviewed the on call system to support extended hours and ensure safe delivery and now have robust on call system in place * Increased our capacity for training and up-skilling staff.  Student Community practice teacher started training September 2012 * Appointed project lead in July 2012for urgent care, jointly funded with OUH to facilitate the urgent care pathway. * Recruited qualified nursing staff and administration to support the urgent care pathway. * Developed excellent partnership working with acute colleagues in OUH and formed a project board that meets monthly to monitor progress. * We plan to extend our CCN provision from 8-6 pm to 8 to 8pm by February 2013. We plan to offer increased provision at weekends by December 2012 according to need and capacity. Clinical decision Unit at OUH now open 24 hours * Processes put in place to gather relevant data to measure outcomes. |  |
| Develop pathways of care to integrate physical and mental health care for older people | * A skills and competences group is running and we are developing Competency Stencils for older adult ward staff. * A course for physical health care skills has been developed with the local university and after the success of the first run we have secured funding for another 3 courses |  |
| Review the provision of care for people with complex enduring mental illness to provide a planned pathway of care for those patients who need a different provision from those currently available in acute and forensic low secure accommodation. | * Preparatory work for new ward completed and project board continues to meet. * Awaiting agreement on a site for the ward for project to progress. * Principle of service agreed with commissioners. * Clinical Model has been developed and written up. |  |
| Reduce delayed transfers of care (DTOC) in Oxford Health Services and work in partnership to improve pathways and minimise delays across health and social care | * There is an organisational programme working in partnership between Health and Social care and involving the OUH and Oxford Health to attend to issues of DTOC. There is now also a singular DTOC project within the division. * There are eight individual workstreams associated with this plan and OH has developed an internal project team with programme manager to ensure that those actions pertaining to OH are met. * A tri organisational discharge policy has been agreed to drive improved fore-planning of patients’ needs and optimal flow across all organisations. * The Chief Operating Officer manages progress and performance via monthly meetings. * Discharge policy now implemented and audit tool agreed. * Single Point of Access (SPA) remit changes have been implemented to provide additional support to meet timely transfers of care * DTOC figures are given above |  |

### Domain 4: Helping people to recover from episodes of ill-health or following injury

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| **Patients will be supported to manage their own condition** | |
| **Measures:** | |
| 1. **Proportion of people report feeling supported to manage their condition** | |
| * Note: Q1 2012 was an unrepresentative sample (see results in Domain 5 previously) |  |
| 1. **Number of people with a personal physical health budget (PHB)** | |
| * 34 people have had a direct payment for the Neuro LTC pilot * 49 so far from CHC have had a PHB – 40 direct payments (this includes 12 clients who have died and 1 who has fallen out of funding) and 9 notional budgets * 1 direct payment has been set up for a children’s complex care client | |
| **Targets:** | |
| 1. **Increase by 20% the number of mental health patients who have Advanced Statements in place** | |
| Q4 2011: 30 instances on RiO  Q1 2012: 75 instances on RiO  Q2 2012: 222 instances on RiO  Q3 2012: 284 instances on RiO |  |

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| **Initiatives:** | | |
| Roll out and take up of personal health budgets (PHB) within OCS | * Personal Health Budgets (PHB) are now normal operational practice in Continuing Healthcare, so all new referrals are taken through PHB and offered the option of a direct payment * The PHB is being transferred from Oxfordshire PCT to Oxford Health NHS FT, now that we have been confirmed as a further, faster site, and a peer learning hub. The new project started on November 1, 2012 * PHB are being developed in the following areas over the next 12 months – a project plan has been agreed covering * Continence products * CHC children in transition * End of Life * Elements of Mental health * In elements of Long term conditions management * Acquired Brain injury * Shared care to develop joint health and social care personal budgets * Oxfordshire has also established a Peer network and is a learning hub for South Central SHA |  |
| Review in Oxfordshire of self care of OCS patients with long-term conditions | * Self care programme has been reviewed by commissioners and this will now form part of the long term conditions work in 2013 |  |
| Develop and roll out use of alternative user satisfaction measure as a part of Health Visiting Call for Action | * An audit of parental understanding of service is in progress before the launch of a new service leaflet which is in development. Over300 users contributed to survey report which was completed in October 2012. * The new leaflet has had user and stakeholder involvement and was ready for publication in November 2012 * A re-audit will occur following the leaflet launch, in particular to demonstrate user awareness of the Health Child programme * Patient satisfaction questions for 2012 patient survey have been reviewed and agreed |  |
| Deliver Hospital at Home services for the population of Oxfordshire | * In place |  |
| Provide alternative services to support patients to prevent their attendance at acute A&E service using the new 111 service | * Full 111 service is now operational. * Patients are being directed to OOH; however there are concerns that MIU not being used as effectively and could possibly take more from ED. * Analysis of ED attendances from 111 in progress. |  |
| Implement clinical recommendations from the OCS District Nursing review | * On track:, supervision in place for 7 and 6s now being rolled out for the other bands * Training on being a supervisor is taking place * Reference groups are operational * New service delivery hours of 8am to 6.30 in place with exception of south when this will be in place in the new year |  |
| Extend provision on the Trust website of medication details and information on specific conditions to include community health services | * In progress |  |
| Access & Enablement Service and Hospital at Home service reducing length of stay and avoiding admission | * No change for H@H service; service delivery numbers at capacity * The reablement contract started on October 1, 2012 – since then the numbers seen weekly in reablement has increased, and at the end of the quarter there were just 3 people waiting in community hospitals and none in the acute hospitals across the county for reablement. |  |

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| Participation in Clinical Audits and National Confidential Enquiries |

| Audit or Inquiry | Participation (Yes or No) | Number of Cases Required by Terms | Number of Cases Submitted |
| --- | --- | --- | --- |
| Access to Healthcare for People with a Learning Disability | YES | n/a | n/a |
| National Audit of Psychological Therapies | YES | n/a | n/a |
| POMH-UK Topic 2: Screening for metabolic side effects of antipsychotic drugs | YES | n/a | 81 |
| POMH-UK Topic 12: Personality Disorder | YES | n/a | 49 |
| POMH-UK Topic 11: Prescribing antipsychotics for people with Dementia | YES | n/a | 197 |
| POMH-UK Topic 4: Prescribing Anti-Dementia Drugs | NO[[3]](#footnote-3) |  |  |
| National audit on fever in children (urgent care) | NO[[4]](#footnote-4) | 50 |  |

| Title of National Audit | Agreed actions to improve the quality of healthcare |
| --- | --- |
| Eliminating Mixed Sex Accommodation | * The results were 100% for the 2 standards assessed so no further actions apart from update Trust wide declaration which was taken as paper through Trust Board. |
| Back pain management by Occupational Health Services | * Since the audit took place, the OH department has moved to a paperless, software system which has the ability to build in safety mechanisms for documentation i.e. tick box for “red” and “yellow” flags considered, the clinician cannot proceed without ticking these. * Literature on musculoskeletal conditions is now handed out as well as advice on prevention and management of symptoms. |
| Record keeping by Occupational Health Services | * Since the audit took place, the OH department has moved to a paperless, software system. Enables regular spot checks of data quality and completeness of records. |
| POMH-UK Topic 1 | * Results received end of June 2012, currently being disseminated for action planning. |
| POMH-UK Topic 10 | * Results disseminated to C&F Division and awaiting finalised action plan. |
| POMH-UK Topic 12 | * Data collection fell in 2012-2013 and waiting for national report. |
| National Audit of Schizophrenia | * Results received end of June 2012, currently being disseminated for action planning. |
| POMH-UK Monitoring of patients prescribed lithium (mental health) | * Medics/ Care Coordinators to follow up results of 3-monthly GP monitoring (by reviewing on-line biochemistry results) and record review of results and side effect monitoring with patient as part of 6 monthly care plan review. * Consultants to ensure all junior doctors know as part of local induction how to access on-line biochemistry results completed by GPs. * The Trusts Drug and Therapeutic Committee have identified this as an area for work, with an initial action to write Trust guidance on where and how to label information entered on RiO around medical reviews/ side effect monitoring. |
| National Audit of Psychological Therapies for Anxiety and Depression (mental health) | * IAPT and Psychology Services: to continue to monitor waiting lists within teams (both 13 weeks referral to assessment and 18 weeks referral to treatment) * Oxfordshire IAPT: increase evening clinics and increase group session sizes for step 2 to improve referral to treatment times * Psychology Services: implement information groups for patients to enhance treatment engagement * IAPT and Psychology Services: to hold a training event for staff on the benefits and how to develop a therapeutic alliance * Psychology Services: increase CORE-OM return rates by piloting extension of last therapy session by 15 minutes to complete forms |

| Trust Wide Clinical Audits | Agreed actions to improve the quality of healthcare |
| --- | --- |
| Oxfordshire Community Hospital use of DOLs | * The Community Hospital Managers will monitor random patient records for evidence that the two stage capacity test is being applied and the umbrella terms such as “confused” and will discuss the issue with the relevant member of staff. * Community Hospital staff to be reminded to ensure they ask all patients whether they have a Lasting Power of Attorney or Advance Decision to Refuse Treatment in place as part of the admission process as appropriate |
| Older Adult Mental Health Wards use of DOLs (mental health) | * DOLs checklist to be introduced by modern matrons for older adult mental health wards (supported by adult safeguarding leads) * Teaching and learning sessions to be set up with older adult mental health ward staff on DOLs process by adult safeguarding lead(s). * Develop/ re-issue guidance on how and where to record Capacity and Consent for formal and informal patients on RiO (older adult mental health wards) * Review and consult on making DOLs mandatory training |
| CQUIN Oxon self harm service against NICE guidelines (mental health) | * Ensure all staff complete mandatory adult and child safeguard training in next 3 months * Raise staff awareness about child protection issues through teaching session with Child Protection Team * On-line self harm training package for staff to be developed and rolled out * Produce assessment checklist and display in clinic room as aid for all staff |
| CQUIN Older Adult Mental Health Wards looking at considering the preferences for patients with dementia (mental health) | * Modern Matrons to continue to monitor implementation of “knowing me form” on wards for dementia patients. Re-audit to ensure form being used in 3 months. * Modern Matrons to hold regular drop-in sessions/ surgeries on the wards with PALS for patients, carers and families * Carer engagement/ information sessions to continue to be held for example in Buckinghamshire the Older Adult Family and Friend Evening in March 2012 and the “Navigating the Maze” session to be ran by the carers team in March 2012. |
| Trust wide CPA Q4 results (mental health) | * Further local team-based training on the use of the care planning and risk assessing component in RiO * A standard operating procedure for RiO to be developed to register and record carers. * A standard operating procedure for RiO and a patient information leaflet (including a pro forma) on advanced statements to be developed. * Division CPA leads to raise awareness and continue to work locally to embed the CPA standards. * Risk note to be developed and circulated to ensure clinician/ medics are recording risk management plans are recorded in the care plan * CPA Leads meeting to be re-established with representation from each Division. CPA Leads meeting will review Division level action plans. |
| Health records audit (mental health) | * Standards for electronic recording to be developed and circulated to every team and ward manager as well as posted on intranet (to include clarity on who’s responsibility it is to synchronise records to the national database spine) * Implement the “Record keeping – competence standards” in order to the improve the validation process * Awareness program for the use of abbreviations in clinical notes (to be included within overall list of electronic recording standards) |
| Quality of telephone triage in urgent care services | * Clinical Leads to ensure routine monthly system to provide feedback from audit to clinicians * Telephone triage training to be included on agenda of educational evenings. * The 3 standards with poor compliance to be feedback within the next clinical governance letter with case examples |

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| Department of Health and Monitor Targets |

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| **Indicator** | | **Target** | **2011/12 position** | **2012/13 position** | **RAG Status** |
| CPA Patients receiving follow-up contact within seven days of discharge | | 95% | 97.7% | 96.8% | **●** |
| CPA Patients having formal review within 12 months | | 95% | 97.7% | 96.1% | **●** |
| Minimising mental health delayed transfers of care | | <=7.5% | 4.6% | 2.0% | **●** |
| Admissions to inpatients services had access to crisis resolution home treatment teams | | 95% | 98.7% | 99.3% | **●** |
| New psychosis cases seen by early intervention teams | Oxon:  Bucks: | 127/month  50/year | 111%[[5]](#footnote-5) | 133  52 | **●**  **●** |
| Data completeness: identifier information for patients | | 97% | 99.5% | 99.5% | **●** |
| Data completeness: outcomes for patients | | 50% | 83.1% | 80.0% | **●** |
| Access to healthcare for people with a learning disability | | 6 standards:  Rated 1-4  Max score: 24 | 18 | 21 | n/a |

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| Quality Risk Profiles |

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| **Outcome** | **Q2 2012** | **Q3 2012** |
| **Section 1 - Involvement & Information** |  |  |
| 1. Respecting and involving people who use services | Low Neutral | High Neutral |
| 2. Consent to care and treatment | No Data | Low Neutral |
| **Section 2 - Personalised Care** |  |  |
| 4. Care and welfare of people who use services | Low Neutral | High Green |
| 5. Meeting nutritional needs | Low Neutral | High Green |
| 6. Cooperating with other providers | Low Amber | High Neutral |
| **Section 3 - Safeguarding and Safety** |  |  |
| 7. Safeguarding people who use services from abuse | Low Amber | High Neutral |
| 8. Cleanliness and infection Control | Low Neutral | Low Neutral |
| 9. Management of medicines | High Neutral | High Neutral |
| 10. Safety and suitability of premises | Low Neutral | Low Neutral |
| 11. Safety, availability and suitability of equipment | High Green | Low Neutral |
| **Section 4 - Suitability of Staffing** |  |  |
| 12. Requirements relating to Workers | Low Neutral | Low Neutral |
| 13. Staffing | Low Amber | High Neutral |
| 14. Supporting staff | Low Neutral | Low Neutral |
| **Section 5 - Quality & Management** |  |  |
| 16. Assessing and monitoring the quality of service provision | Low Neutral | Low Neutral |
| 17. Complaints | High Neutral | Low Neutral |
| 21. Records | Low Green | Low Green |

Note: figures correct as per the latest QRP data in their report dated 30/01/13

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| CQUINs |

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| **Oxfordshire and Buckinghamshire Adult and Older Adult Mental Health** | | | |
|  | **Milestones to Date** | **Progress** | |
| Patient experience | Indicator & milestone not agreed |  |  |
| Results of 2012 NHS Staff Survey | Milestones not agreed |  |  |
| NHS Safety Thermometer | 3 months of survey data for 100% of relevant patients across inpatient settings  3 months of survey data for two localities of relevant patients across OA CMHTs | Met |  |
| Assistive Technologies | Set up plan & achieve Q3 targets | Met |  |
| Digital by default | Set up plan & achieve Q3 targets | Met |  |
| Improve & enhance Crisis Service | 70% of appropriate staff to have taken advanced assessment skills training  Develop & meet Always Events | Met |  |
| Mental Health Clustering/ Outcomes | Pilot draft care packages for each cluster | Met |  |
| Reduce the use of Physical Restraints | Gather baseline for number of restraints that occur | Met |  |

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| **Oxfordshire and Buckinghamshire Community Services** | | | |
|  | **Milestones to Date** | **Progress** | |
| Improve responsiveness to personal needs of patients | >/=85% of services to improve or maintain the scores achieved in 11/12 for the 3 agreed survey questions | Not met |  |
| Develop action plans in response to survey | Met |  |
| Provide a report evidencing actual changes that have been made as a result of patient feedback made through the patient surveys, complaints and PALS. | Met |  |
| NHS Safety Thermometer | Three months of survey data for 100% of relevant patients using the safety thermometer tool across community hospitals | Partially Met |  |
| Three months of survey data for 66% (four localities) of relevant patients using the safety thermometer tool across District nurses | Partially Met |  |
| Adopt the use of assistive technologies | Establish how assistive technology will b implemented and the technical requirements that need to be in place | Met |  |
| Implement digital by default within defined remit | Status unknown |  |
| Reducing unnecessary face to face contact through the use of electronic media | Determine which services would benefit from digital by default tools | Met |  |
| Implement digital by default within defined remit | Status unknown |  |
| Reduce the number of patients that die in an acute hospital setting | Implementation of proactive measures to increase the proportion of patients who die at their usual place of residence | Partially met |  |
| Achieve a 10% shift (TBC) in the ratio against the 11/12 baseline ratio in the number of patients who die in a non-acute setting | Partially met |  |
| Action planning | On going |  |
| Reduce the number of admissions of patients with cellulitis to an acute hospital setting | Agree access to pathway and identify protocol for management of Cellulitis in the community (provision of antibiotics in the community) – from Q1 | Not met in Q1 |  |
| Commence implementation of plan | On going |  |
| Roll out and implement the “ages and stages” assessment tool | Achievement of >= 90% uptake of Ages and Stages to 2-2.5 year checks | Met |  |
| Improve uptake of breastfeeding in Oxfordshire | >=63% of infants who are breastfed at 6/8 weeks for 2012/13 | Not met |  |
| Reduce the number of Delayed Transfers of Care in Oxfordshire | Existing pathway mapped and new pathway developed, signed off and implemented by providers. Sign off to be agreed with partners | Not met |  |
| 30% reduction in the number of delays from an agreed baseline in Q1, further reduction of 30% in Q2, further 30% reduction in Q3 | Not met |  |

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| **Forensic Specialist Commissioning Group** | | | |
|  | **Milestones to Date** | **Progress** | |
| Reduction in average length of stay by 30 days | Provide a report that details, how efficiencies might be made in admitting and discharging patients. | Met |  |
| Submit action plan detailing implementation of efficiencies from above report | Met |  |
| Service User defined CPA | Provider to submit report benchmarking current process against standards and how they will implement gaps over the next three quarters | Met |  |
| Provider to submit report detailing, training/awareness they have targeted to care staff to increase understanding of standards | Met |  |
| Provider to submit report detailing how they have implemented at least 10 of the standards and plan on developing service user feedback questionnaires by Q4 | Met |  |
| Payment by Results (PbR) | Put in place process to ensure all applicable staff has receive training that is available both within the tool kit and the two national events being organised by the national PBR Working group | Met |  |
| Service to have developed a benchmarking structure for implementation of the toolkit benchmarking requirements | Met |  |
| Reporting structures identified within the toolkit confirmed as fit for purpose for clustering all new admissions | Met |  |
| Clustering data to be reportable in line with the requirements set out in Toolkit | Met |  |
| Number of admissions in Q1 confirmed and set against 5 pathways and MH Clustering tool | Met |  |
| Benchmarking data set against all cases admitted from April 2012 as required in Toolkit | Met |  |
| Feasibility reporting tool implemented | Met |  |
| Evaluate progress using feasibility project toolkit and written report to be available setting out progress | Met |  |
| Shared Pathway – Recovery and Outcomes | Establish joint service user/staff recovery and outcomes implementation group | Met |  |
| Provide joint implementation plan, including training needs | Met |  |
| Reports detailing how all staff/service users have been given training on the shared pathway. | Met |  |
| 50% of service users have completed the shared understanding element of shared pathway and completed baseline with outcomes framework | Met |  |
| Shared understanding an outcomes framework to have been completed with 50% of service users demonstrating the use of recovery tools | Met |  |
| Access to Services | Written report detailing current gate keeping process, make up of assessment team. Timescales for response. | Met |  |
| Written report detailing, changes made to process in negotiation with commissioners. | Met |  |
| Report on numbers of assessments leading to admission and those declined for admission. High level summary of reasons for both. | Met |  |
| Report on numbers of assessments leading to admission and those declined for admission | Met |  |
| Implementing Clinical Dashboards for Specialised Services | Identify & provide contact details on overall dashboards lead and leads in each clinical area | Met |  |
| Provide summary of plans for implementation of dashboards | Met |  |
| Demonstrate implementation of routine reporting against quality dashboard requirements for all relevant services | Met |  |
| Provide a brief update for each clinical area detailing any specific comments or issues | Met  Met |  |

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| **CAMHS** | | | |
|  | **Milestones to Date** | **Progress** | |
| Alignment of performance reporting to new CAMHS structure | Capture referral information from SPA to door services.  Develop waiting list functionality | Met |  |
| Completeness of performance reporting for CAMHS service | Complete coverage of service for patient feedback.  Develop patient/carer questionnaire | Met |  |

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| **Buckinghamshire SLT Contract** | | | |
|  | **Milestones to Date** | **Progress** | |
| Access to SALT (Speech and Language Therapy) assessment and interventions | Produce action plan and agree with commissioners  Evidence of the delivery of milestones in action | Met |  |

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| **Wiltshire & BaNEs CAMHS & Eating Disorders** | | | |
|  | **Milestones to Date** | **Progress** | |
| Patients completing patient experience 50% of caseload | Patient experience report showing 50% or more response rate against the average active annual caseload | Not met |  |
| Maintain Reduced Length of Stay (LOS) in inpatient setting | LOS < 50 days – 100% achievement | Not met |  |
| LOS 51-55 days – 90% achievement | Not met |  |
| LOS 56-60 days – 75% achievement | Not met |  |
| LOS 61-65 days – 50% achievement | Met |  |
| Pilot use of Routine Outcome Measures (ROM) | CYP IAPT Trainees collecting ROM | Met |  |
| 3rd submission of ROMs. Development of small pilot projects | Met |  |
| Small projects to commence | Met |  |
| Medication review for children | Link with clinical audit team and pharmacy to gain provisional report on progress | Met |  |

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| |  | | --- | | Glossary of Terms | |

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| **Abbreviation** | **Term** |
| A&E | Accident and Emergency |
| Advanced Statements | These are statements by a patient/service user in advance describing what level and nature of care they would like the event that they might subsequently lose the capacity to make or express such decisions |
| Ages and Stages | A nationally accredited evidence-based quality assessment tool for children |
| AHP | Allied Health Professionals, such as dentists and podiatrists |
| ALOS | Average Length of Stay of a patient/service user in hospital |
| ATP | Adenosine Triphosphate, used as a test for the level of hygiene for a particular location |
| AWOL | Absent without Leave – in this context, a patient or service user that has gone missing without the knowledge or consent of the staff |
| C. diff | Clostridium difficile is a bacterium that is the most serious cause of diarrhoea often associated with taking antibiotics, making it particularly susceptible to people in hospitals |
| CAMHS | Children and Adolescent Mental Health Services |
| Care Cluster | A Care Cluster is a classification of a mental health service user based on their individual characteristics, condition and behaviours. There are 21 such Care Clusters. |
| Care Package | The sum total of services provided to a patient/service user as part of their care, be it social, clinical or otherwise. |
| CAS | Clinical Assessment Service |
| CBT | Cognitive Based Therapy, a specific approach to help people with mental difficulties and disorders |
| CCN | Children’s Community Nursing Service |
| CDU | Clinical Decision Unit – a short-stay unit to initially assess and diagnose patients |
| CHAT | The Comprehensive Health Assessment Tool (CHAT) is a set of forms developed to provide for the consistent and comprehensive identification and assessment of the health and health-related needs of children and young people in contact with any part of the youth justice system (YJS). |
| Children’s Therapies | (Children’s therapies refers to an integrated therapy service in Oxon for children aged 0 to 18, commissioned as one service comprising therapies of Speech and Language Therapy, Physiotherapy and Occupational Therapy, which were previously commissioned separately |
| CHO | Community Health Oxford: the body that looked after community care in Oxfordshire prior to its merger with Oxfordshire and Buckinghamshire NHS Mental Health Trust in 2011 to form Oxford Health NHS Foundation Trust |
| CMHT | Community Mental Health Team |
| COPD | Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have trouble breathing in and out. |
| CPA | Care Programme Approach: a system of delivering community services to those with mental illness |
| 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: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets |
| CYP | Children and Young People |
| DH | Department of Health: the Government department responsible for health care in England and Wales |
| DSH | Deliberate self-harm |
| DTOC | Delayed Transfer of Care occurs when a patient or service user is delayed in being discharged from hospital into the community |
| EOL | End of Life |
| FT | Foundation Trust – an NHS Trust that has a degree of independence from the Department of Health and has a level of managerial and financial freedom |
| GP | General Practitioner – the doctor in the local practice with whom the patient/service user is registered |
| GTT | Glucose Tolerance Test – used to diagnose diabetes |
| Harm Min | Short for Harm Minimisation Service |
| HCA | Health Care Assistants |
| HDA | The Health Development Agency - a special health authority established to provide evidence to improve health and reduce health inequalities |
| Hospital at Home (or H@H) | Hospital at Home is a service designed to give patients extra support so that they are not admitted to hospital or so that their admission is as short as possible. |
| IAPT | Improving Access to Psychological Therapies |
| L&D | Learning and Development Department |
| LINk | Local Involvement Networks (LINks) are groups made up of individuals and community groups, such as faith groups and residents’ associations, working together to improve health and social care services |
| LIPS | The Leading Improvements in Patient Safety programme (LIPS) is concerned with building capacity and capability within hospital teams to improve patient safety |
| Integrated Care Pathway adopted from the Liverpool | A care pathway designed around care and dignity for those nearing the end of their life |
| LTC | Long Term Conditions may include dementia, diabetes, medically unexplained symptoms, respiratory & cardiac problems and strokes |
| MMSE | The mini–mental state examination (MMSE) is a brief questionnaire test used to screen for cognitive impairment |
| MRSA | Methicillin-resistant *Staphylococcus aureus* is a bacterium that leads to several forms of illness and is characterised by being particularly resistant to treatment. Because of this, its presence in hospitals has resulted in a concerted campaign to eliminate it from such locations |
| MSSA | A Methicillin-Sensitive Staphylococcus Aureus (MSSA) infection is an infection caused by the staph bacteria which is able to be treated with most penicillin based antibiotics and has yet become resistant to the more common antibiotics. |
| MUST | The Malnutrition Universal Screening Tool is a tool to identify adults, who are malnourished, at risk of malnutrition or obese. |
| NHS | National Health Service is the name of the publically-funded healthcare service in the UK (excluding Northern Ireland) |
| NICE | The National Institute for Clinical Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health |
| OA | Older Adults |
| OCC | Oxfordshire County Council |
| OCS | Oxford Health Community Services Division – the division of the Trust that provides the community health services mainly provided by CHO |
| OH | Occupational Health |
| OOH | Oxfordshire Occupational Health |
| OUH | Oxford University Hospitals NHS FT comprising four hospitals: the John Radcliffe Hospital, Churchill Hospital, the Nuffield Orthopaedic Centre and the Horton General Hospital. |
| Oxtext 7 | Oxtext 7 is a self monitoring system that allows patients with a variety of conditions to take more control over their illness and also allows their care interventions to be tailored to the individual. |
| PALS | Patient Advice and Liaison Service provides information to the public on NHS matters and helps resolve any concerns and problems that people may have with the NHS |
| PbR | Payment by Results (PbR) aims to provide a transparent, rules-based system for paying trusts, rewarding efficiency, supporting patient choice and diversity and encouraging activity for sustainable waiting time reductions. |
| PCT | The Primary Care Trusts (PCTs) oversee the operations of providers of NHS care in a particular geographic location. The PCT responsible for Oxford Health NHS Foundation Trust is principally NHS Buckinghamshire and Oxford Cluster |
| PEAT assessments | Patient Environmental Action Team assessments are evaluations carried out by the NPSA into the quality of the environment, nutrition, privacy and dignity in every inpatient location |
| PHB | Personal Health Budgets are a means for patients to have some control over where money allocated for their care is spent |
| PICU | Psychiatric Intensive Care Unit |
| PMVA | Prevention and Management of Violence and Aggression is a series of methods of dealing with violent and aggressive patients and service users |
| Productive Care Programmes | A series of programmes to support NHS teams to redesign and streamline the way they manage and work. |
| Productive Dashboard | A series of measures brought together to track key indicators in the quality of our services on a regular basis |
| PROMs | Patient Reported Outcome Measures are measures of a patient/service user's health status or health-related quality of life. They are typically short, self-completed questionnaires, which measure the person’s health status or health related quality of life at a single point in time. |
| PYLL | Potential years of life lost |
| QIPP | The Quality, Innovation, Productivity and Prevention (QIPP or sometimes QUIPP or QUIP) is a collection of methods, techniques and best practice provided by the NHS intended to be a resource for everyone in the NHS, public health and social care for making decisions about patient care or the use of resources. |
| QRP | The Quality Risk Profile is a monthly compilation by the CQC of all the evidence about a trust they have in order to judge the level of risk that the trust carries in order to fulfil its obligations of care. It is not a publically available document |
| RCA | Root Cause Analysis (RCA) is a structured and disciplined method of investigating issues |
| RGN | Registered General Nurse |
| RiO | This is the name of the electronic system for recording service user care notes and related information within Oxford Health NHS Foundation Trust. It is being implemented across all of the Trust’s areas of operation. |
| ROM | Routine Outcome Measures |
| Safety Thermometer | The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care |
| SALT | Speech and Language Therapy |
| SHA | Strategic Health Authorities are bodies set up by the Department of Health to manage the NHS locally. There are 10 such SHAs, and Oxford Health NHS Foundation Trust reports into the South Central SHA. |
| SIRI | Serious Incidents that Require Investigating is the classification of the more serious incidents that may occur |
| SPOC | Single Point of Contact is the new Department of Health initiative to offer the public a phone-based health line by dialling 111 |
| Talking Therapies | A set of methods in which therapists use dialogue, conversations and other techniques to help patients and service users with a range of mental problems and issues |
| Track & Trigger | An early warning system designed to identify early signs of deterioration in patients, with thresholds that “trigger” appropriate clinical intervention |
| VTE | Venous Thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis |
| You’re Welcome | You’re Welcome is an accreditation for those organisations that offer a defined level of young-people friendly health services |

1. Returns from 3 out of 10 wards only [↑](#footnote-ref-1)
2. Note: targets have been revised from 9.3% & 4.3% respectively [↑](#footnote-ref-2)
3. This audit has been withdrawn by POMH UK and will take place during 2013/14 (Planned for October 2013) [↑](#footnote-ref-3)
4. Following submission of 50 cases the Trust was informed that this national audit should be identified as ‘not applicable’ [↑](#footnote-ref-4)
5. Expressed as a percentage of annual target [↑](#footnote-ref-5)