

# PAPER

BOD 07/2014

(Agenda Item: 9)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**January 2014**

**Quality Account Quarter 2 Report**

**Executive Summary**

This report outlines the Quarter 2 performance against the measures outlined in the Quality Account for 2013/14. This report has been reviewed by the Integrated Governance Committee on 13th November 2013.

The purpose of the report is to note the areas where the Trust is making good progress in avoiding harm and delivering quality in service provision; and to identify any areas of concern requiring action or improvement. Once approved this report will be circulated to external stakeholders including FT Governors, CCGs, Scrutiny Committees and Health Watch in Buckinghamshire and Oxfordshire.

**Recommendation**

The committee is asked to note the report and approve for circulation

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**Lead Executive Director:** Ros Alstead

1. *A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.*
2. *This paper provides assurance and evidence against the Care Quality Commission Outcome: [Input Outcome number – 4,7,8,9,10,13*



**Oxford Health NHS Foundation Trust**

**Quality Account 2013/14**

Report for the 2nd Quarter 2013

November 2013

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| 1. Oxford Health NHS Foundation Trust |

1.1 Oxford Health NHS Foundation Trust is a community-orientated organisation that provides physical and mental health services and social care with the aim of improving the health and wellbeing of all our patients and their families.

1.2 Our Trust provides community health, mental health and specialised health and Social care services. We operate across Oxfordshire, Buckinghamshire, Berkshire, Swindon, Wiltshire, Bath and North East Somerset. In Oxfordshire we are the main provider of community health services and deliver these in a range of community and inpatient settings, including eight community hospitals. Our integrated mental health teams provide a range of specialist healthcare in the community and from inpatient settings across the geographic areas of Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire and Bath and North East Somerset (BaNES). We also provide a range of specialised health services that include forensic mental health and eating disorder services across a wider geographic area including support for patients in Berkshire, the wider Thames Valley and from Wales.

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| 2. Quality Account 2013/14 – what we said we would do |

2.1 The annual Quality Account details our approach to delivering safe services, avoiding harm and ensuring clinical effectiveness and quality. It describes specific quality activities and objectives, linked to the organisation’s strategic framework. Each set of activities is supported by a number of specific objectives and a range of metrics to measure and evaluate progress over the year.

2.2 The quality account is organised around the following four quality goals:

2.3 **For 2013/14 the Trust set itself the following 12 key quality activities and 12 associated quality objectives:**

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| **Quality Goal** | **Quality Activity** | **Quality objective** |
| **Improving Patient Safety** | 1. Specific improvements in patient safety 2. Prevention of suicides 3. Infection Control improvements 4. Environmental Improvements | * People will not die prematurely. * Patients will be protected from harm. * Patients will be treated and cared for in a safe environment. |
| **Improving Clinical Outcomes** | 1. Develop & implement integrated care pathways for children and young people 2. Develop & implement integrated care pathways for adults 3. Develop & implement integrated care pathways for older adults | * The quality of life for people with long-term conditions will improve. * Patients/service users will feel supported to manage their own conditions. * People with long-term conditions will spend less time in hospital |
| **Improving Patient and Carer Experience** | 1. Trust-wide improvement of culture of care 2. Improve patient & public engagement 3. Measuring and Improving Patient, Carer and Commissioner Feedback | * Patients’ experiences of inpatient/outpatient services will improve. * Responsiveness to patients' needs will improve. * Patients’ access to community-based services will improve |
| **Delivering Efficient & Effective Services** | 1. Productive Care 2. Use of technology to support care | * Utilisation of resources will be maximised. * Time spent on patient care will be maximised. * Patients/service users will progress through the care system in a timely way |

2.4 To monitor progress against these activities and objectives, quality and safety metrics and measures are reported each quarter, some of which are nationally proscribed and some of which have been developed locally. Specific safety and quality improvement initiatives or projects underway within the Trust are reported every six months. Audits are reported on a six monthly cycle (at six and twelve months). Those measures with a specific target have been rated as red, amber or green (RAG) reflecting the Trust’s performance in achieving these. Measures without a target are not RAG rated.

2.5 Running alongside the Quality Account the Trust has been developing a safety and quality dashboard linked to our corporate objectives. These dashboards will describe the key indicators associated with quality and safety, and a range of measures to help us understand not only how effectively we are avoiding harm to patients but also how we are maintaining quality and improving outcomes.

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| **3. Quarter 2 progress report: key highlights from Quarter 2** |

Detailed progress against the 12 quality activities and 12 quality objectives can be found in sections 4-7 of the report. The following are key highlights against each of the four quality goals.

**3.1 Improving Patient Safety**

3.1.1 The number of avoidable pressure ulcers (reported as Serious Incidents Requiring Investigation) has reduced by 50% in the second quarter of this year as a result of a range of actions being implemented within the community services division, including work to manage pre-existing pressure damage when patients come in to our services.

3.1.2. The Trust has exceeded its target of 85% for nutritional assessments in community hospitals and its target of 95% for Venous Thromboembolism (VTE) assessment across the Trust.

3.1.3 The Trust set itself a target of reducing the number of patients who go absent without leave (AWOL) to no more than 96 for the year. However, to provide us with a secure baseline to measure improvement, we have recently introduced tighter criteria for when to report an AWOL, to include any patient who returns 10 minutes or more after than their agreed return time. This change is reflected in an increased number of reported incidents this year. Leave is a critical part of the treatment and rehabilitation for patients and staff are working with patients to support them to return on time.

3.1.4 Harm from falls has slightly increased in mental health services and slightly decreased in Community hospitals. The Falls Team has included specific actions within its work programme to work towards the Trust target of a 50% reduction in harm from falls.

3.1.5 The Trust continues to report no deaths by suicide in inpatient services this year. We are working proactively to reduce the number of deaths by suicide in the community through local projects, including work with the Crisis Intervention Service. This includes a new project to develop “always events” in relation to discharge and following up appointments using texting.

3.1.6 The Trust has had no reported episodes of bacteraemia infection, and 4 reported episodes of Clostridium Difficile in quarter 2. Hand hygiene audits remain stable and 75% of the environmental infection control audits were satisfactory, with the remaining areas being re-audited in the coming quarter.

**3.2 Improving patient and carer experience**

3.2.1 The Trust has approved a patient experience strategy which describes a comprehensive approach to seeking out and co-ordinating feedback from patients and people close to them.

3.2.2 There has been an increase in the number of responses to the Friends and Family test, and an increase in satisfaction across the four core questions.

**3.3 Improving clinical outcomes**

3.3.1 We continue to see a large percentage of patients who have a long term condition (LTC) referred to the psychological therapies service and entering treatment. The actual number and percentage of people with LTC referred to the service has increased in the second quarter. This can in part be attributed to the launch of our new Live Well pilot (providing integrated physical and psychological care for people with LTCs in the Aylesbury Vale Southern Locality).

3.3.2 There has been a slight increase in the number of patients/service users with Personal Health Budgets (PHB) from 95 to 98.

3.3.3 There has been an increase in both the percentage of patients on a Care Programme Approach (CPA) in settled accommodation (79.1%) , and in the percentage of patients on a CPA in employment (13.6%). There is no target associated with these indicators.

**3.4 Delivering effective services**

3.4.1 The Trust is undertaking a substantial improvement programme to develop and integrate services for children and families, adults of working age and older adults. The purpose of this remodelling programme is to improve service quality, improve patient experience of our services and enhance patient understanding of how our services work. The first phase of the consultation has now been completed.

3.4.2 The productives and safer care programmes have worked with a number of clinical and service areas over the past quarter, to deliver specific safety and quality improvement objectives, including reducing harm and releasing time to care.

3.4.2 The Trust has commenced the procurement of its Next Generation Electronic Health Record.  A key element of this procurement will be support for mobile working, enabling better access to information at the patient’s side and improved recording of information. 

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| 4. Improving Patient Safety: Quarter 2 progress report |

### 4.1 Objectives for 2013/14

* People will not die prematurely.
* Patients will be protected from harm.
* Patients will be treated and cared for in a safe environment.

4.2 The Trust has a very clear and explicit focus on improving patient safety and avoiding harm. There are a number of ways in which we measure and monitor this, including the encouragement of incident reporting for any and every safety incident; a daily review of reported incidents; robust investigation of serious incidents; and specific audits and reviews, such as hand hygiene on wards and the safety thermometer. The Trust ensures lessons are learned from incident reviews and improvements in practice are systematically introduced, supported by an extensive training and professional development programme.

4.3 Oxford Health is also hosting a project to identify best practice in suicide prevention across mental health services in the region. This includes reviewing the variation in how different Trusts currently report suicides to the Strategic Executive Information System (STEIS), and participating in a pilot to improve and make more consistent the reporting of serious incidents, including apparent suicides. The project is also working with staff, service users and people close to them to identify ways in which to further reduce the number of deaths by suicide in the community.

4.4 Actions include training and development for mental health and community based staff (e.g. school nurses and psychological therapies services) to raise suicide awareness and develop strategies for reducing and preventing suicides. The project also includes work to improve support to families and friends who have been bereaved by suicide, including the development of a bereavement-by-suicide intervention service.

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| Measures and Targets | April-June | July-September | RAG rating |
| Unexpected deaths and serious harm (rated as SIRIs) in inpatients (mental health services) reduced to 0, or greater than 300 days between deaths over 2 years | 0 | 0 |  |
| Absence from wards without permission reduced by 50% from 192 detained patients in 2012/13 to 96 in 2013/14 | 66 | 67 |  |
| *The Trust has recently introduced a project to reduce the number of patients who are absent without leave. As part of this project, we have substantially tightened our reporting criteria to include any patient who is more than 10 minutes later than their agreed time of return. This has led to an increase in reported incidents. Staff are proactively working with patients to support them to return on time, including working out journey times and plans in advance.* | | | |
| Reduction in number of medication near miss events which results in harm (defined as 3, 4 or 5 in severity) | 6 (28 in 12/13) | 12 |  |
| Harm from falls (defined as 3, 4 or 5 in severity of outcome) reduced by 50% from 5.1 per 1,000 bed days in Mental Health Hospitals and 10.1 per 1,000 bed days in Community Hospitals in 2012/13 to 2.5% and 8.6% respectively in 2013/14 | Mental health 5.1%  Community services 10.1% | Mental health 6.9%  Community services 9.9% |  |
| Avoidable pressure ulcers (grade 3-4) reduced to 0 | 7 (19 in 2012/13) | 3 |  |
| 100% of patients treated by the district nursing services to be assessed for pressure ulcers on first visit (Walsall assessment) | N/A | 100% |  |
| % of patients with (MUST) nutritional assessment (Target 85%) | N/A | 100% |  |
| % of patients admitted to psychiatric wards with a complete physical health assessment (target 98%) | N/A | Essential Standards audit results for July 13 show 97% compliance across mental health wards and units |  |
| 95% compliance with VTE (venous thromboembolism) risk assessment and appropriate prophylaxis in all Trust services | 97.51% trust wide  Community hospitals 93%  OA inpatients 87.5% | 96.68 trust wide  Community hospitals  Older adult inpatients 98.63% |  |
| 95% compliance with triggering of physical deterioration intervention in all community services | 95% | 94.1% |  |
| Number of new catheter associated urinary tract infections (UTIs) infections across all Trust services | 6 | 7 |  |
| No inpatients to commit suicide | 0 | 0 |  |
| Reduction in the number of (apparent) community suicides towards 0 or greater than 300 days between deaths | 8 | 11 |  |
| *The Trust is working as part of a collaborative across the region to promote and implement a range of suicide prevention activities. These include patient centred training for staff; a review of systems and processes to help identify service users at risk of suicide; improved support for staff and families; and making best use of learning from incidents and investigations.* | | | |
| Level of hand hygiene scores maintained at greater than 95% in inpatient settings | Overall compliance in mental health was 93% and 100% in community hospitals (conducted in May 2013) | Average for July and September 2013 within Mental Health wards = 92%  Average for July and September 2013 for Community Hospitals = 100% |  |
| Bare below the elbows audit | n/a | Average for July and September 2013 within Mental Health wards = 92%  Average for July and September 2013 for Community Hospitals = 99% |  |
| Number of unsatisfactory environmental infection control audits and number of re-audits | N/A | 40 completed,  11 were unsatisfactory and will require re-auditing |  |
| Environmental audits | n/a | 86% |  |
| Number of bacteraemia infections developed 48 hours post-admission should not exceed 2 | 0 | 0 |  |
| Reduce overall number of Clostridium Difficile infections (CDI) developed 72 hours post admission (should not exceed 8) | 2 | 4 |  |
| Number of incidents reported (with a view to improving incident reporting and therefore increasing the number of incidents reported) | 2763 | 2979 |  |
| Number of serious incidents requiring investigation | 21 | 25 |  |

4.5 Overall the level of incident reporting has increased quarter on quarter which reflects the work undertaken in the Trust to encourage reporting of any and every safety incident. A higher level of reporting demonstrates an improved safety culture where staff see the value and importance of reporting and where improvements are implemented as a result. All incidents are reviewed on a daily basis both by managers and the risk team, and improvement plans put in place. All serious incidents requiring a full investigation are subject to a root cause analysis (RCA) which is reviewed by a panel involving a non-executive director and the Director of Nursing and Clinical Standards and Medical Director, or their deputies. All investigations are subsequently reviewed by the local Clinical Commissioning Group for closure.

4.6. The Trust reports as a serious incident (major injury/severe damage to property or death) any suspected suicide where the person involved has had any contact, however minor, with Oxford Health services in the past twelve months. The Trust is committed to carrying out a full investigation in those circumstances, whether or not the care provided contributed to or affected the event or outcome.

4.7 The number of SIRIs was higher in quarter 2 than in quarter 1, but is significantly lower than in the same quarter for the previous year.

4.8 The number of avoidable pressure ulcers is 50% lower in quarter 2 than quarter 1. The community division has been implementing a series of actions to reduce the number of grade 3 and 4 avoidable pressure ulcers, including

* improved risk assessment (with Walsall scores being undertaken for 100% of patients to assess the patient’s risk of developing tissue damage);
* improvements in documentation;
* enhanced support from the tissue viability service;
* partnership working with other care providers to ensure a consistent approach to reporting (including ensuring pressure damage is reported by the organisation where it occurred) and managing tissue/pressure damage as patients transition from one service to another
* mandatory update training every 2 years on tissue management

**4.9 Safety Thermometer**

4.9.1 The Trust continues with monthly Safety Thermometer audits. Teams are able to access their results and how these progress over time and how they compare to other teams across the trust.

4.9.2 The following table shows the incidence of harm for users of Oxford Health services. There is a slight decrease in the percentage of patients where there was no harm and a corresponding increase in the number of patients where one harm occurred.

*4.9.3 Areas of improvement*

* Older Adult In-Patients VTE risk assessment compliance rose from 87.50% to 98.63%
* Physiotherapy continue to achieve 100% harm free care
* Specialist Nursing achieved 100% harm free care
* No service dropped below 85% of patients receiving harm free care
* Community nursing mixed saw a drop from 7.41% to 0 for new harms

*4.9.4 Areas for review*

* Overall the Trust experienced a slight reduction in harm free care from 88.3% to 87.84%, this reflects a reduction of harm free care in community hospitals from 94.09% to 85.12%.
* New harms were notably increased for rehabilitation services, from 2.41% to 6.76%
* Falls with harm prevalence increased for older adult in-patients (12.50%) and community nursing mixed (7.14%) – the Falls Team has included specific actions to reduce harm from falls in its work programme
* VTE risk assessment compliance reduced overall from 98.70 to 96.68 but remains higher than the national average
* All services that reported new pressure ulcers saw an increase in prevalence. However this does not indicate that the pressure damage occurred during our care but may have been present when the patient was admitted
* The rate of conversion for pressure ulcers has reduced from a peak of 3.1% in May to 0.7% in September. However, there was an increase in the prevalence of reported pressure ulcers in Community Hospitals from 5.38% to 13.10%; these figures include pressure damage which was already present at the point of admission to our care

4.9.5 This contrasts with the national picture which shows a slight increase in patients who received harm free care.

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| 5. Improving Clinical Outcomes: Quarter 2 progress report |

### 5.1 Objectives for 2013/14

* The quality of life for people with long-term conditions will improve.
* Patients/service users will feel supported to manage their own conditions.
* People with long-term conditions will spend less time in hospital.

5.2 Quality and a sound evidence base are at the heart of our clinical services, with a focus on clinical effectiveness and good clinical outcomes. The way in which we work with, and support patients to manage their long term conditions is a critical part of achieving this.

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| Measures and Targets | Quarter 1 | Quarter 2 |
| % of adult service users on CPA in settled accommodation | 77.8% | 79.1% |
| % of adult service users on CPA in employment | 13.1% | 13.6% |
| Number and % of patients receiving follow-up contact within seven days of discharge from mental health wards | 96.4% | 98% |
| Number of patients with long term conditions (LTC) receiving psychological therapies (IAPT) | *Bucks Healthy Minds*  *Referrals with LTC*  357 = 19.48%  Entered Treatment with LTC 383 = 26%  *Talking Space*  *Referrals with LTC*  433 = 24.55%  Entered Treatment with LTC 322 = 26.70% | *Bucks Healthy Minds*  *Referrals with LTC*            422 = 21.44%  Entered Treatment with LTC 364 = 26.73%  *Taking Space*  *Referrals with LTC*  482 = 28.55%  Entered Treatment with LTC 360 = 26.85% |
| Number and % of patients readmitted within 28 days of discharge (mental health services) | *Adults* - 7.6% (21 patients readmitted out of 277 discharges)  *Older adults* - 3.4% (3 patients readmitted out of 88 discharges) | *Adults* - 8% (22 patients readmitted out of 273 discharges)  *Older adults* - 3% (3 patients readmitted out of 98 discharges) |
| Number of patients admitted to acute wards who had access to crisis resolution home treatment teams acting as gatekeeper | 99.1% - 223 admissions of which 221 had access to crisis resolution prior to admission | 98% - 252 admissions on which 246 had access to crisis resolution prior to admission |
| Number of patients/service users with Personal Health Budgets (PHB) – figures current rather than cumulative | Total = 95 | Total = 98 |

5.3 The indicators in this section relate to the management of patients with long term mental health conditions in non-acute settings, an example of which is the increase in referrals for patients with long term conditions to psychological therapies. The majority of patients continue to have access to crisis resolution home treatment teams prior to admission. For all of these measures, except for readmissions, we are seeking an *increase* in the number or percentage. We are seeking to *reduce* the number of patients readmitted within 28 days of discharge through effective discharge planning and access to robust support and treatment in the community where required.

**5.4 Develop & Implement integrated care pathways**

5.4.1 The Trust is improving the quality of care and efficiency by providing a better integrated service for patients using children and families, adult and older adult services rather than having separate discrete services. The programme to develop integrated care pathways has been continuing at a pace during quarter 2. The consultation on plans for mental health services for adults has now been concluded and plans for children and families and older adults are currently under consultation. The new Whiteleaf Centre in Aylesbury is due for completion during this financial year and will provide a purpose built environment for acute adult mental health services in the north of the county.

5.4.2 As part of the service remodelling work taking place in divisions an evidence log of engagement and involvement activity is being regularly updated. This includes communications and engagement with staff, patients, carers, public and partners. More broadly, involvement across the divisions is being reviewed as part of the cross cutting workstream to ensure a consistent approach.

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| Integration of Children’s' Physical and Mental Health Services | Re-structured key management locality meetings.  Access for key staff to both RIO systems. Development of directorate newsletter |
| ASD Pathway Neuro-psychiatry into adulthood | Core milestones for project agreed. Project group in place. Pathway re-designed in Wiltshire/BaNES – information and re-design work to be shared. Criteria for assessment reviewed.  Training Needs Analysis scoped in CAMHS via questionnaire.  Data review of ASD/ADD and ASD with LD cases in CAMHS to be completed |
| Children and young people with complex physical health needs - transitions to adult services | Transitions group have agreed core milestones for the project.  Current state process map completed and reviewed.  Future state mapping event planned to be completed. |
| Early Intervention in Psychosis Service review (children/young people/adults) | Moving to implementation |

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| 6. Improving Patient and Carer Experience: Quarter 2 progress report |

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

### 6.1 Objectives for 2013/14

* Patients’ experiences of inpatient/outpatient services will improve.
* Responsiveness to patients' needs will improve.
* Patients’ access to community-based services will improve.

6.2 The Trust’s vision is that every patient receives good care in the way they expect, and therefore they have a positive experience. To effectively put patients at the centre of everything we do, the Trust is committed to ensure support and resources are available to help each service to work through the following cycle on a continuous basis:

1. Regularly ask patients for feedback
2. Analyse this feedback
3. Share good feedback and identify any improvements with clinical teams
4. Work with clinical teams to implement the improvements
5. Share feedback and actions being taken with patients and the general public

6.3 We capture this feedback in a number of ways; self-initiated feedback in the form of compliments, concerns and complaints, both formal and informal, and through specific surveys such as the Friends and Families test. The way in which patients and carers are involved in planning their care is also critical and a number of the measures below capture this.

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| Measures and Targets | Quarter 1 | Quarter 2 |
| Number of complaints | 48 excluding MP queries and local concerns. | 57 excluding MP queries and local concerns |
| Number of complaints responded to within an agreed timescale | N/A | 31 (22 remain open) |
| Number of PALS cases | N/A | 234 |
| Delayed Transfers of Care (DTOC) Community hospitals snapshot | April 35,  May 44,  June 26 | July 32  August 35  September 33 |
| Friends and Family measures | 315 responded in total, giving a response rate of **3.6%** (with the top response rate as % of activity from Didcot Community Hospital)  F&F Test net promoter score = +**73.8 in June out of a range from -100 to +100**  **National score for inpatients was 72**  **National score for A&E was 53** | **880** responded between April and September, giving a Year to Date response rate of **4.9%** (with the top response rate as % of activity from Didcot Community Hospital)  F&F Test net promoter score = **+60.23 YTD out of a range from -100 to +100**  **Community hospitals net promoter score was 72 and MIUs was 58**  *National scores not yet available* |
| 100% of mental health service users to have opportunity to be engaged in development of care plan | N/A | 48/51 (94%) |
| 100% of MH service users on CPA to have:   1. Current care plan 2. Care reviewed in last 6 months 3. Care co-ordinator 4. Risk assessment reviewed in last 12 months | N/A  N/A  N/A  N/A | 5089/5790 (88%)  4116/5790 (71%)  5790/5790 (100%)  5144/5790 (89%) |

6.4 Community Hospital Delays for the last week in quarter 2 increased by 5 from the previous week, however there were 14 planned discharges in the week.  The current trend since the beginning of April is 36.  Choice delays are currently averaging at 4 for this quarter and result in the longer length of stay, impacting on DTOC.  Work around these delays continues, supporting families to find homes, arrange case conferences in complex cases and issue Transfer of Care letters where appropriate.

6.5 Out of area delays are currently averaging at five per week, representing 20% of the overall delays this quarter.  Social Work delays represent 40% of the overall DTOC this quarter.  Work is currently taking place in monitoring the expected date of discharge and length of stay to ensure timely discharge planning, and ensure the patient is discharged to the right place at the right time.

6.6 To calculate the Net Promoter score for the Friends and Families test, all “likely” responses are excluded. The number of responses for “neither likely nor unlikely” and “unlikely or extremely unlikely” are then subtracted from the “extremely likely” to recommend responses, to get the final score. The Trust has seen an increase in the number of “likely” responses but these are excluded from the net promoter figures and this has impacted on the net promoter score for the second quarter. The main criticism this quarter related to the length of wait in minor injuries units (MIUs) and the lack of communication about waiting times. The Trust has introduced a series of actions to keep patients informed in MIUs. Positive comments related to the caring and friendly attitude of staff, their professionalism and the high standard of care received.

6.7 The percentage of CPA users with a care plan, care review, care co-ordinator and risk assessment are in part related to the level of recording on the electronic patient record system. Divisions delivering mental health services have reviewed the areas where the level of recording is lower and agreed new guidance for clinical recording, which has already seen an improvement in results.

6.8 The table below summarises responses to the 4 Trust wide core questions both from postal surveys and electronic surveys. The information is refreshed back to April 2013 each month to allow for any time lag in receiving postal responses or uploading results from electronic devices. The start of the postal survey programme has contributed 644 responses in June. There has been a slight increase for all responses in September, and an overall increase for all core questions since April. The average number of responses between July and September was 410.

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**6.9 Community Services patient survey**

6.9.1 Patient feedback is essential for monitoring whether patients feel involved in their care. Patient feedback for Oxfordshire Community Services between April 2013 and September is summarised below.

6.9.2 The Trust has sent out 5,152 surveys to date in 2013-14, from which there has been a 29% response rate. This is an encouraging figure.

1. When patients were asked if they were as involved in decisions about their care as they wanted to be, 72.2% reported being as involved as they wanted to be, 21.9% reported being involved to some extent and 5.9% reported that they were not as involved as they wanted to be.
2. 84.3% reported having received the right amount of information about their condition and treatment, 15.3% reported not having received enough and 0.4% reported having received too much.
3. 81.6% of patients reported that they definitely had trust and confidence in their caregiver/member of staff, 15.5% had trust and confidence to some extent and 2.9% reported that they did not.
4. With regard to overall satisfaction, 61.3% of patients rated their care as excellent, 30.2% rated it as good, 6.1% rated it as fair, 1.5% rated it as poor and 0.9% rated their care as very poor. These figures are remarkably similar to those from the end of 2012-2013.

6.9.3 All services who have received survey results June-August 2013 are scheduled to complete an action plan, if issues arise, which will be based on results of individual questions and comments made by respondents.

Activity continues against action plans created following the 2012-2013 surveys as illustrated below.

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| **Service** | **Issue Raised** | **Remedial action** |
| City Hosp | Patients felt purposes and side effects of medications not suitably explained | Staff encouraged to discuss medications with patients, through meetings and newsletters. |
| MSK Physio | Some patients waited a long time for their first appointment. | Choose & Book system introduced in Podiatry, with a 70% take-up, and Physio (60%). System to be extended to SALT and Dietetics by the end of the year. |
| Home IV | Information on antibiotics reported to be difficult to understand | The 10 most common sets of instructions reviewed for increased clarity, e.g. number each step, split instructions into stages, include visual aids. |

**6.10 Patient-Led Assessments of the Care Environment (PLACE)**

6.10.1 Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. PLACE assessments were introduced into the NHS in April 2013 to provide a clear message, directly from patients, about how the environment or services might be enhanced. Local people visit hospitals as part of teams to assess how the environment supports patient’s privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not include clinical care provision or staff working practices.

6.10.2 **Results** (by inpatient unit)

**Cleanliness**

The cleanliness audits ranged from 88-100% against a national range of 24.46-100%. The average score was 96% against a national average of 95.75%.

In those areas where the cleanliness fell below 100% (relating to dusty fittings and areas requiring further cleaning) a series of deep cleans have been organised.

**Food and hydration**

These audits ranged between 75-98% against a national range of 26.67-100%. The average score was 90% against a national average of 88.78%.

Lower scores were given where food taste, texture or temperature was not rated as acceptable. In those areas the catering manager is working with staff to improve standards and these are being monitored with the ward manager.

**Privacy, dignity and wellbeing**

The results ranged between 76-98% against a national range of 52.26-100%. The average score was 87.91% against a national average of 88.9%.

Issues related to availability of private rooms, location of consultation rooms in relation to the general waiting area and signposting for single sex toilets. Issues concerning the constraints of the physical environment are being reviewed by the Trust to identify posible solutions.

**Condition, appearance and maintenance**

The results ranged between 85-98% against a national range of 36.25-100%. The average score was 93% against a national average of 88.78%.

Issues related to broken or stained ceiling and floor tiles, which are being replaced.

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| 7 Delivering Efficient & Effective Services: Quarter 2 progress report |

### 7.1 Objectives for 2013/14

* Utilisation of resources will be maximised.
* Time spent on patient care will be maximised.
* Patients/service users will progress through the care system in a timely way.

7.2 Continuous improvement of service design and delivery is robustly supported in The Trust through a substantial redesign programme which aims to develop and integrate care pathways across all age and care groups. In addition the Trust supports innovation and improvement through a range of quality and safety improvement projects and programmes including productive wards, safer care and development of team working. A programme of audit enables services to understand areas of good practice and to identify areas requiring improvement.

### 7.3 Productive Care

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| **Reasons for inclusion**  To release increasing amounts of time to care, thus improving quality and patient/service user experience. | |
| **Aims** | **Current Position** |
| Roll out improvement programme to clinical services within the remaining parts of Community Services Division | Launch completed in all remaining services. Sustainability model in development for community nursing services. Working to support rollout of leg ulcer pathways |
| Implement the Productive Care foundation module in Universal , Children and Families Division | Launch completed to Universal Services. First cycle of Improvement workshops in November |
| Implement the Productive Care sustainability model in Mental Health | Sustainability model embedded in Bucks wards, Oxon wards supported with specific issues around safe administration of medications and improving handovers |
| Inpatient settings, Community Mental Health Teams (CMHT), Community Nursing Service and community hospitals | In use in inpatient settings and community nursing teams, CHAT( Community Hospital Assurance Tool ) reviewed and to be used to assess the quality of care for all patients on a rolling basis |
| Support Specialised Services Division: Forensic Wards and Mental Health services in prisons | Quality Performance dashboard in development with association with the Cube (information resource), Harm Minimisation Service has launched. |

### 7.4 Use of Technology to Support Care

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| **Aims** | **Current Position** |
| **Reasons for inclusion**  To ensure the Trust makes best use of IT/communication opportunities to maximise time available for direct patient care, to improve communication and to enhance self-managed care | |
| Improve mobile technology to reduce duplication and cut down travel | Deployed estate:   * Circa 2500 laptops. * More than 1400 Smartphones. * 150 iPads (soon to be 500). * Resilient VPN connectivity to allow secure online access to the Trust’s network domain, systems and applications from a Trust provided laptop that is connected to the Internet. * Outlook Web Access to allow secure access to Trust email from any computer connected to the Internet.   The Trust has commenced the procurement of its Next Generation Electronic Health record.  A key element of this procurement will be support for mobile working.  Once the preferred supplier has been selected the necessary enabling mobile infrastructure and devices can be procured. |
| Develop remote patient monitoring and recording | A formal pilot project to determine whether expansion of the laptop estate for front line clinical staff use has just been completed.  This concluded that the device format is only a partial solution as the form factor and the mobile data network proved to be unacceptable and unreliable.  Therefore, further roll-out will not occur. |

**7.5 Participation in Audits**

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| **Audit or Inquiry** | **Participation (Yes or No)** | **Number of cases required by Teams** | **Number of cases submitted** |
| POMH-UK Topic 7d: Lithium monitoring | Yes | n/a | N=94 |

**Glossary of terms**

| **Term** | **Meaning** |
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| 111 Service | The new telephone service initiated by the Department of Health for people to enquire about health issues that are not critical instead of dialling 999. |
| AIMS | Accreditation for Acute Inpatient Mental Health Services: an independent accreditation that identifies and acknowledges wards that have high standards of organisation and patient care. |
| AWOL | Absent Without Leave, referring to patients who have been allowed out on escorted (with a member of staff) or unescorted (without supervision) leave and who have not returned to their ward within 10 minutes of the agreed time of return |
| Bed day | Measure of a period of time (24 hours) |
| CDI | Clostridium difficile infection is a bacterium that is the most serious cause of diarrhoea often associated with taking antibiotics, making people in hospitals particularly susceptible |
| 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 any other service. |
| CCG | Care Commissioning Group: the bodies that replaced the PCTs in having oversight of the Trust from 1st April 2013. |
| CCN | Children’s Community Nursing Service. |
| Choose & Book | A Department of Health initiative to allow patients a degree of choice over where and when they can receive clinical care. |
| CMHT | Community Mental Health Team. |
| 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. |
| Dashboard | A dashboard is a set of measures which together indicate how well a team, service or the organisation is achieving its targets for performance and quality |
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| DH | Department of Health: the Government department responsible for health care in England and Wales. |
| DTOC | Delayed Transfer of Care occurs when a patient or service user is delayed in being discharged from hospital into the community. |
| E-Rostering | E-Rostering is an electronic way of efficiently managing the rostering or planning of when staff are required to work. |
| F&F | Friends and Family test which was introduced to assess the satisfaction of patients with NHS care and to assess whether they would recommend their local NHS services to friends and family |
| 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. |
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| GP | General Practitioner: the doctor in the local surgery with whom the patient/service user is registered providing primary care medical services |
| Healthwatch | Healthwatch is the new consumer champion for both health and social care in local communities. It replaces the HOSCs as from 1st April 2013. |
| HOSC | Health Overview & Scrutiny Committees were bodies run by the County Councils to look at health issues and health services affecting their residents. HOSC were replaced on 1st April 2013 by Healthwatch. |
| IAPT | Improving Access to Psychological Therapies. |
| KPI | Key Performance Indicators. |
| LTC | Long Term Conditions, which may include dementia, diabetes, medically unexplained symptoms, respiratory & cardiac problems and strokes. |
| Mortality Global Trigger Tool | A mechanism for monitoring the number of deaths to help ensure there are no avoidable deaths in our services. |
| MRSA/MSSA | Two varieties of bacteria that lead to illness and are characterised by being particularly resistant to treatment. Its presence in hospitals has therefore led to a concerted campaign to eliminate it from such locations. |
| MUST | The Malnutrition Universal Screening Tool is a tool to identify adults, who are malnourished, at risk of malnutrition or obese. |
| Near Miss | An event which was prevented from occurring which would have caused severe or catastrophic harm |
| NHS | The National Health Service is the name of the publicly-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. |
| OCS | Oxford Health Community Services Division: the division of the Trust that provides the community health services mainly provided by CHO. |
| OUH | Oxford University Hospitals NHS Trust covering the John Radcliffe, Churchill, Horton General and the Nuffield Orthopaedic Centre Hospitals. |
| PALS | Patient and Access Liaison Service: a local service designed to help patients, carers and other users with problems, difficulties and complaints related to our services. |
| PHB | Personal Health Budgets: an NHS strategy to allot patients an amount of money to support their identified health and wellbeing needs as agreed between the patient and NHS provider. |
| PICU | Psychiatric Intensive Care Unit. |
| PLACE | Patient-led Assessments of the Care Environment audits are evaluations carried out by individual Trusts into the quality of the environment, nutrition, privacy and dignity in all of their inpatient locations. They replace the PEAT audits as from 2nd April 2013. |
| PMVA | Prevention and Management of Violence and Aggression is a set of methods for dealing with violent and aggressive patients and service users. |
| Productive Dashboard | A means of displaying important care parameters in an easy to understand and intuitive way. |
| 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. |
| 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 publicly available document. |
| RAG | RAG rated refers to the colour coding of red, amber or green in terms of achieving targets or objectives, where Green is fully achieving, Amber is achieving in part and Red is not achieving |
| RCA | Root Cause Analysis – a formal methodology of determining the “root cause” or “causes” of incidents and problems. |
| 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. |
| SIRI | Serious Incident Requiring Investigation |
| SPA | Single Point of Access is the new Department of Health initiative to offer the public a phone-based health line by dialling 111 |
| SPOC | Single Point of Contact – otherwise known as “Single Point of Access” (see SPA above). |
| STEIS | Strategic Executive Information System for reporting and recording all serious incidents resulting in severe or catastrophic patient harm |
| 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. |
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