**Part 1**

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Quality Account 2014/15 and

Quality Report 2013/14

**Statement on quality from the chief executive**

**Chief executive’s statement**

I am delighted to introduce the Quality Account and Quality Report for Oxford Health NHS Foundation Trust (OHFT) which provides us with the opportunity to reflect on our quality achievements and successes over the past twelve months as well as to identify areas for further improvement, including our quality priorities for the coming year.

As we move into a new year within the NHS from 1 April 2014, OHFT is completing the final stages of our comprehensive review of the delivery and organisation of services to redesign over thirty different service lines into thirteen care pathways. The remodelling of care pathways has been driven by the desire to improve patients’ treatment and experiences of services and their understanding of how our services work. This is underpinned by ensuring our services are patient-centred with a high emphasis on family and carer involvement and that interventions are evidence based.

We will continue to maximise opportunities to translate research, training and clinical expertise to meet the healthcare challenges of the 21st Century. This will primarily be achieved through involvement and leadership in the Oxford Academic Health Science Network (AHSN), Academic Health Science Centre (AHSC) and Collaborations and Leadership in Applied Health Research and Care (CLAHRC). These partnerships focus on areas of real need, including care of the frail elderly, those with chronic conditions and dementia. We are also designing an internal research and development strategy with structures to support these external working partnerships. This will help us to implement research in practice and to rapidly adopt innovative treatments. We will continue to develop as a leading teaching centre.

This builds on a wider ambition to deliver value (outcomes delivered per £ of investment), developing our organisational culture around measurement of outcomes and experiences that matter to patients and ensuring that we learn and improve continuously. Team-based working will be the bedrock for excellent care and it will have clinical leadership and decision-making at its heart. For patients, we understand it is important they receive the right care, at the right time, in the right location by the right person. In this sense we should not be constrained by organisational boundaries or geography which can adversely impact on patient experience if care is not managed successfully across different provider or commissioner responsibilities.

Despite the extremely challenging national and local financial position, OHFT is focused on maintaining and enhancing existing levels and quality of patient care. Cost improvements are rigorously assessed against their impact on service quality and patient safety to ensure they are not compromised, through finding a more effective and efficient way of working. Our view is that cost effectiveness will result from good quality services which have a focus on achieving the right outcomes and which add value to patients and their carers. We have invested time and resources, working with our staff to select a new electronic health record provider – an effective patient record system allows us to provide timely and accurate information to staff and to improve the quality of care we provide.

We set ourselves a challenging and ambitious set of quality priorities for 2013/14 which were focused on improving patient safety and experience, and delivering good clinical outcomes and effective services.

Throughout the year we have seen an increase in the number of reported incidents, but with a reduction in the number of serious incidents, which is an encouraging indication that staff are routinely noticing and reporting patient safety incidents. We focused on reducing the number of specific types of harm related incidents including probable suicide, harm from falls, absence from a hospital ward without authorised leave and avoidable pressure ulcers. For each of these we have used a range of improvement approaches which have allowed us to establish a baseline from which to measure improvement and to establish a set of actions which we consider will make a difference. While we have made some progress in each of these areas, we will continue to prioritise them throughout 2014/15.

We have seen a steady increase in the number of referrals for patients with long term conditions to psychological therapies. We are also seeing an increase in patients with access to personal health budgets and the increased independence and flexibility which this gives them.

OHFT approved a new patient experience strategy towards the end of last year and will be implementing this throughout 2014/15. What is vital is not simply gathering feedback but acting upon what we are told. As an example of this, the friends and families test has been implemented across our community physical health services. Quarter on quarter we have seen an increase in the number of responses and we have proactively used this feedback to make improvements. You will see examples of actions taken as a result of feedback throughout this Quality Account. All staff will be using the friends and family test in the forthcoming year.

Finally, I am delighted that we have seen the opening of a new purpose built mental health and wellbeing campus in Aylesbury Buckinghamshire used for adult and older adult inpatients for the whole population of Buckinghamshire and community mental health services including day hospital provision for Aylesbury Vale. The Whiteleaf Centre is a light and spacious facility for adults and older adults, designed in collaboration with staff and services users. We have also made improvements to ward environments across all counties including acute wards at the Warneford Hospital and Littlemore, forensic wards in Oxford Clinic, Littlemore and Marlborough House, Milton Keynes and in community hospital wards at Witney and Wallingford.

In the coming year we have set ourselves an equally ambitious set of quality priorities which encompass staffing, leadership and team working, developing reliable data on service quality, specific harm reduction projects, and engaging staff in a range of improvement and quality approaches. Importantly we are also focusing on how we act upon patient and carer feedback (and share what we are doing), and co-creating relevant outcome measures against which we can start monitoring and reporting on the effectiveness and quality of our services.

I should add that to the best of my personal knowledge, the information contained in this document is accurate.

Signature

**Executive summary**

For 2013/14 the Quality Account was organised around four quality goals: improving patient safety; improving patient and carer experience; improving clinical outcomes and delivering efficient and effective services. We gave ourselves some challenging targets. We achieved some, but not all of these, and where this is the case we have set this as a priority for 2014/15.

We have delivered the planned objectives for our service remodelling programme and work continues into the coming year. This will affect the organisation of teams and services with better integration and coherence, models of care, staffing numbers, and will offer an increased focus on shared outcomes and goal setting with patients and families.

We made significant progress in soliciting patient feedback and acting on this. Staff have been involved extensively in improvement projects and they responded positively in the national staff survey to this question. Staff have also been involved in selecting the new electronic health record provider which forms part of our strategy for using technology to support clinical practice.

In 2013/14 we had 3793 admissions; 217,642 occupied bed days and 1,117,940 face to face contacts. We reported 11,469 patient safety incidents but saw a 30% overall reduction in serious incidents. We made some progress on our harm reduction priorities but need to do further work on prevention of probable suicides, reduction in harm from falls and reduction in absence without leave from inpatient mental health units. These have all been included in our priorities for the coming year.

**Key achievements last year included**

* delivery of the planned programme for service remodelling in adult mental health and older adult services, with close involvement with patients and carers
* increased staffing and extended hours of working in community teams
* a reduction in the use of restraint on the Highfield unit in Oxfordshire
* development of outcome measures for speech and language therapy services in Buckinghamshire
* a falls research project on older adult mental health wards to identify the most effective actions to reduce harm from falls – this remains a harm reduction priority
* partnership working across the system to reduce pressure damage and to reduce delayed transfers of care
* an increase in the number of patients with personal health budgets
* *Reach4Health* healthy child weight management project
* closer working with the Police to reduce the number of people detained by Police under Section 136
* developing outcome measures in partnership with users of adult mental health services
* developing the “*first ten days*” for young people in Marlborough House, Swindon to develop a shared view of the purpose of the admission, the planned length of stay, and shared goals or outcomes
* increased staffing on inpatient mental health wards
* improved clinical leadership in mental health inpatient services
* improved access for patients with long term conditions to psychological therapy services – this service was a finalist for the Health Service Journal awards
* improved technological support for patients and involving staff in selecting the new electronic health record provider

**Areas for further improvement include**

* further reduction in avoidable pressure ulcers and further improvement in the management of all pressure damage
* a further reduction in harm from falls
* a further reduction in absence without leave from inpatient mental health units
* a further reduction in probable suicides (community)
* better involvement for patients on the care programme approach (CPA) in care planning, and an increase in patients with a documented risk assessment/care plan
* a decrease in delayed transfers of care
* a decrease in medication errors resulting in harm
* sustaining and embedding change and improvements

**Quality in 2014/15**

Our priorities for the coming year have taken into account our achievements against our priorities for 2013/14 (and where we need to make more progress); issues arising from serious incident investigations and complaints; our commitment to delivering value in healthcare which focuses on good outcomes created in collaboration with our patients; and learning from the Keogh report into high mortality rates in a number of acute trusts and the Francis report following events at Mid Staffordshire. In particular we have responded to their recommendations which include

* stronger leadership and accountability (both managerial and clinical) at all levels of those organisations
* more reliable information on quality, and better use of available data
* listening and responding to staff, patient and carer concerns
* improved staffing levels and development and supervision for staff

We have taken seriously the failure to be open which was identified in Mid Staffordshire (duty of candour) and in this report we will detail areas where we have not made the progress we wanted to, as well as our successes and achievements

In the coming year we will ask ourselves whether our services are safe, effective, caring, responsive and well led. We will test this through work on developing our workforce, improving data quality, implementing our service remodelling programmes, continuing work on outcome based care and improving staff engagement. We will focus on five harm reduction priorities, implementation of our patient experience strategy and using the five CQC questions to assess our service quality and opportunities for improvement.

**Who we are**

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

Our trust provides community health, mental health and specialised health services. We operate across Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Wiltshire, and Bath and North East Somerset (BaNES). The combined population of Oxfordshire and Buckinghamshire is 1,152,296.

We employ 6275 staff with a contracted WTE of 4770.23. This number includes

* 293 medical staff
* 686 therapists
* 1880 qualified nurses
* 1094 unregistered nurses
* 409 other support staff including ancillaries and, care workers
* 645 other professional including psychology, dental staff and social workers

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

OHFT currently operates our services out of 25 freeholds, 59 leased/licensed and 75 informal properties (mainly general medical service and other general practice premises). We have a total capacity of 416 inpatient beds for mental health, forensic and eating disorder services and in addition we are commissioned for 203 community hospital beds.

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

* the University of Oxford to promote innovation in healthcare, support research and to train doctors and psychologists
* Oxford Brookes University, Bucks New University, the University of West London, the University of Bedfordshire and Thames Valley Local Education and Training Board to train nurses and allied health professionals
* local partner NHS organisations e.g. OUH
* local authorities and voluntary organisations
* GPs across all the locations we serve in order to provide joined-up care

You can find out more about the many different services we provide and our locations on our website: [www.oxfordhealth.nhs.uk](http://www.oxfordhealth.nhs.uk).

**Part 2**

**Priorities for improvement and statements of assurance from the board**

**2.1 Priorities for improvement 2014/15**

**Introduction and summary**

The NHS in England continues to be informed and influenced by the two reports written by Robert Francis into the events at Mid Staffordshire Hospital. Some of his key findings and recommendations have been further accentuated by the more recent investigations carried out by Sir Bruce Keogh into high mortality rates at a number of acute hospital trusts.

Common themes across both sets of investigations included

* a lack of leadership and accountability (both managerial and clinical) at all levels of those organisations
* a lack of reliable information on quality, and poor use of available data
* a failure to listen to staff, patient and carer concerns
* a failure to be open (duty of candour)
* workforce issues (staffing levels, fitness to practice and supervision)
* poor governance and inadequate safety and quality systems and processes
* a de-sensitisation to poor care
* cost savings and change became a distraction from quality
* a system-wide failure to recognise and act upon quality failures

The subsequent report by Professor Don Berwick offers practical approaches to improve the quality of our services provide and to ensure the safety of our patients. In particular he reinforces our view at OHFT that our staff want to offer safe and effective care to all of our patients and those close to them. We are committed to placing quality and safety at the heart of what we do. We will pay attention when our staff, patients or their carers raise concerns or offer suggestions for improvement. We are committed to developing our workforce and to continually engage them in opportunities to improve what we do and how we do it.

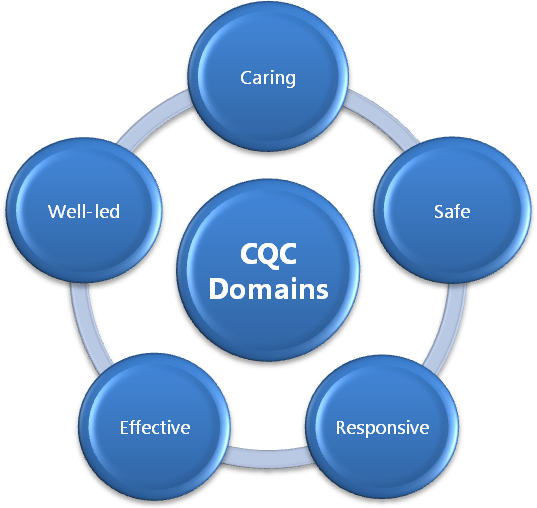
As we improve the quality of our care and ensure our processes deliver safe and effective services, we are also maintaining a focus on outcomes and value-based healthcare (as defined by Porter, M.E. & Lee T.H. HBR). This shift towards outcome-based care is reflected in the work in Oxfordshire to develop outcome-based commissioning and within the trust over the past eighteen months to create outcome measures with our patients to enable the assessment and effectiveness of our service models and care pathways. Outcomes are a core component of the way we assess the value of our healthcare against the investment we have made in it. This requires us to identify our core patient groups; to consider the care they receive along their whole care pathway (irrespective of who delivers it) and the overall cost of this; to work towards a more integrated approach to how that care is delivered; and to co-create relevant outcome measures with our patients against which we monitor and report.

OHFT has considered all of these reports and findings, held discussions with our patients, carers, staff, governors, stakeholders and the public. Our priorities reflect the areas we most need to improve or develop, the substantial remodelling work we embarked upon last year to deliver coherent care pathways and moving from a divisional to a directorate structure.

Last year we delivered the planned objectives for our service remodelling programme and work continues into the coming year. We will also focus on developing outcome measures with patients and further integration of services. We made significant progress in soliciting patient feedback and acting on this and have maintained this as a priority.

Last year we reported 11,469 patient safety incidents but saw a 30% overall reduction in serious incidents. While we made some progress on our harm reduction priorities we need to do further work on prevention of probable suicides, reduction in harm from falls and reduction in absence without leave from inpatient mental health units. These have all been included in our priorities, with associated indicators, for the coming year. Our priorities also reflect the need for improved clinical and managerial leadership, effective team working with skilled and engaged staff and access to reliable data. Some priorities from last year have become business as usual this year and do not feature specifically in the quality account 2014/15; these include

* reporting on the safety thermometer (as we have included specific indicators for pressure ulcers, VTE assessment, falls and catheter-related urinary tract infections)
* hand hygiene and bare below the elbows (as these indicators are reported as part of the infection prevention and control report to the quality committee and board of directors and for both we have had compliance during 2013/14
* number of patients with personal health budgets (as the number has continued to increase during 2013/14 and we have reported comprehensively since 2012)
* productive care programme (as this will become business as usual during 2014/15)
* number of patients being referred for and receiving psychological therapy services for long term conditions (as this is reported directly to commissioner via our quality report against nationally set standards, and the service is now established)

**Quality Account 2014/15**

For our quality account in the coming year we have taken the opportunity to consider the five questions posed by the Care Quality Commission (CQC) which will form the basis of their future reviews and inspections of NHS services, namely

*Is the service safe?*

*Is the service effective?*

*Is the service caring?*

*Is the service responsive?*

*Is the service well led?*

The detail around each of these core questions is in the process of being developed by the CQC and will be available from the autumn of 2014. For the purposes of this account, and to enable us to report from April 1st 2014, we have adopted the following working definition for each question.

**Is the service safe?**

This question looks at whether people are protected from avoidable physical, psychological or emotional harm, abuse or coercion. It will consider how many people die that are not expected to, how often events occur that should never happen, how many people catch infections in hospital, safe management of medicines and safe and suitable premises.

**Is the service effective?**

This question looks at whether people’s needs are met and whether the care they receive results in the best quality of life for them. It will consider whether care is evidence based and patient-centred; whether people achieve the outcomes they expect; what happens if patients receive poor care and whether patients develop other problems as a result of the care they receive.

**Is the service caring?**

This question looks at whether people are treated with compassion, respect and dignity and whether care is tailored to their needs. It will consider what patients and carers say about the care they receive, their confidence in staff, the information they are given, whether they feel involved and listened to and if they feel treated with compassion, respect and dignity. We are also improving our complaints process to ensure it is responsive and resolution focused.

**Is the service responsive?**

This question looks at whether people get the treatment and care they need at the right time, without excessive or unreasonable delay, and whether they are listened to in a way that responds to their needs and concerns. It will consider whether services change to meet people’s needs, how long people wait to be seen for treatment, and how quickly people leave hospital when they are well.

**Is the service well led?**

This looks at whether there is effective leadership for quality at all levels of the organisation supported by robust data on quality which is assessed and monitored. It will also consider whether there is an open, fair, transparent, supporting and challenging culture underpinned by effective governance processes and systems. It will consider what staff working in the service think, how often staff take sick days, what any whistleblowers have said, and information from other external bodies for example Monitor, HealthWatch and Ofsted.

**Priorities and indicators**

**Quality priorities for 2014/15**

We have set ourselves the following quality priorities for 2014/15. These are based on a review of our progress against our quality objectives for 2013/14; a consideration of patient and staff feedback, and an ongoing assessment of the relevant recommendations from the Francis, Keogh and Berwick reports. These priorities will represent the key areas we monitor and report on through the quality account. Alongside these priorities work on a wider range of quality and safety initiatives continues across all of our services.

1. ***Workforce*** - ensuring we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams. Support will include staff development, professional leadership and training opportunities and the creation of new disciplines such as interface medicine
2. ***Data on quality and quality of data*** - ensuring we have reliable, accurate and relevant data on the quality and safety of services provided by the trust
3. ***Service* *remodelling*** - continuing the service redesign and pathway remodelling programme, specifically focusing on its benefits in terms of quality and outcomes; and reflecting enhanced clinical leadership and team-working at the point of service delivery
4. ***Staff engagement*** - ensuring a focus on quality from the front-line to the Board, improving quality management processes, and strengthening links between the Board and staff who are directly delivering patient care
5. ***Reduction in harm*** (focusing on five specific areas: prevention of suicide; missing patients; avoidable pressure ulcers; harm from falls; aggression and violence)
6. ***Implementation of our patient experience strategy*** – capturing and demonstrating how we act upon patient and carer feedback and improve our care environments
7. ***Development of outcome measures*** – integrating services where possible according to patient needs and systematically monitoring, reporting and learning from outcomes continuously to improve the quality of care for patients
8. ***Using the new CQC regulatory framework*** to assess and, where necessary, to make quality improvements to our services to ensure they are safe, effective, caring, responsive and well-led.

**Measuring progress**

For each of these priorities we have a series of indicators and a set of development objectives and milestones on which we will report every quarter to the quality committee and Board of Directors over the coming year. **The completion date for each of the development objectives detailed below is 31 March 2015 unless otherwise indicated.**

***Quality priority 1: workforce***

Ensuring we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams. This will support our aspiration to be an excellent employer, caring for staff, supporting staff development, supporting teams and individuals to be able to work more effectively, developing our professional leadership and supporting new interventions. This work will be co-ordinated through our organisational development strategy. This will enable the service to be caring, safe, effective, responsive and well-led.

*Development objectives:*

1. Agreement of quality-focused workforce indicators as part of a wider quality dashboard by 30 September 2014
2. Roll-out of the Aston Teamwork model across the organisation to nominated managers
3. Maintain existing levels of access to staff training and development, including clinical practice, improvement skills and professional leadership
4. Implementation of the key actions arising from the national staff survey results to promote staff well-being

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 13/14* |
| Deliver expected staffing levels on inpatient wards | Manual reporting | Weekly | Establish safe staffing levels | Reporting started 4/14 |
| Number of shifts which fell below expected levels on inpatient wards | E rostering | Weekly | Assess frequency where safe staffing levels at risk | Reporting started 4/14 |
| Commentary on risk levels and remedial actions | Ward managers via Deputy Director of Nursing | Weekly | Assess and manage risk associated with staffing pressures | n/a |
| Friends and Family staff survey “how likely are you to recommend this organisation to friends and family as a place to work/if they needed care or treatment?” | Friends and Family staff survey | Quarterly | Assess staff perception of the work environment | 3.64 |
| National staff survey:  - Effective team working  - % satisfied with quality of work and patient care they are able to deliver  - % of staff who would recommend the trust as a place to work or receive treatment  (target improvement on 2013/14) | National staff survey | Annual, comparative with previous year’s results | Assess staff perception of the care they provide | 3.88  74%  3.64 |
| a) additional team leaders trained in Aston teamwork principles – target 250 leaders in 2014/15  b) 100% attendees reporting they are equipped to lead team working effectiveness improvements | Improvement and innovation team attendance records | Quarterly | Monitor spread of skills development | 178  86% |
| Performance development  review completed in last 12 months (target 95%) | Learning and development records | Quarterly | Support staff development, performance review | 90% |
| Skills courses attendance | Learning and development records | Quarterly | Ensure staff develop and update clinical and leadership skills | 16169 |

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

Ensuring we have reliable, accurate and relevant data on the quality and safety of our services. This will enable the service to be safe, effective and well-led.

*Development objectives:*

1. Agreement of a quality dashboard by 30 September 2014
2. Development of standard operating procedure for data quality by 30 September 2014, including written controls for quality indicators and a standard process for sourcing, verifying and checking reported data with assigned data leads

***Quality priority 3: service remodelling***

To continue the service redesign and pathway remodelling programme, specifically focusing on its benefits in terms of quality and safety. This will enable the service to be caring, safe, effective, responsive and well-led.

*Development objectives:*

The overall objective for remodelling pathways and services is to develop high quality health services delivering caring, safe and excellent services to patients and their families. The objectives for 2014/15 are:

1. Fully implement a new model of care based on cluster packages, care programme approach and the recovery star; ensuring patients and their families are clear about who is providing their care, what the care is and what to expect throughout their time in the service; supporting the patient (and/or family) to set their own goals
2. Fully implement the integrated physical and mental health pathways for older people
3. Transfer of the Oxford City community hospital to the Fulbrook Centre to support the integrated model of care
4. Implement locality and ward based patient and carer forums
5. Implement patient and carer outcome measures
6. Review and develop early intervention in psychosis services
7. Review and develop the complex needs services with CCG leads
8. Develop, implement and evaluate new staffing models including seven day working and extended hours
9. Implement leadership teams in adult mental health wards
10. Agree a health plan for every secondary school in Oxfordshire
11. Increase the number of health visitors in line with the national call for action
12. Support the breast feeding initiative to promote breast feeding-friendly areas
13. Agree and implement model to offer multi-disciplinary (MDT) assessment to older adults with physical and mental health needs
14. Further development and agreement of the dementia care strategy with partners

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 13/14* |
| % of patients with a CPA to be in employment or meaningful activity | CPA audit | Quarterly | Measure quality of life goals as part of care planning | snapshot |
| % of patients with a CPA in settled accommodation | CPA audit | Quarterly | Measure quality of life goals as part of care planning | snapshot |
| 100% of patients involved in setting and achieving goals | CPA audit | Quarterly | Assess levels of patient involvement in setting and meeting their personal care plans | New indicator |
| Improving patient and carer satisfaction with services  (target improvement on 2013/14 rates) | Friends and Family test | Quarterly | Ensuring services continue to meet the needs of patients and people close to them | +72.6 CH  +62 MIU |
| Outcome data (cluster outcome measures) | RiO | Quarterly | Ensure a focus on outcomes as well as inputs and process measures | Baseline in Q1 |
| 100% of patients on older adult mental health wards to be screened using the early warning scores and have physical health assessment (PHA) including VTE | RiO | Quarterly | Aligning physical and mental health needs of older adult patients | VTE 96%  PHA 95.75% |
| Number of appropriate older adult patients with co-morbidities receiving an MDT assessment | RiO | Quarterly | Aligning physical and mental health needs of older adult patients | n/a |
| Increase in number of health visitors in Oxfordshire (target to meet national rates) | ESR | annual | Support delivery of child and family strategies | Target met |
| Number of breastfeeding friendly areas in services | Manual reporting | 6 monthly |  | n/a |

***Quality priority 4: staff engagement with the quality agenda***

Ensuring a focus on quality from the front-line to the Board, improving quality management processes, and strengthening links between the Board and staff directly delivering patient care. This will enable the service to be caring, safe, effective, responsive and well-led.

*Development objectives:*

1. Review and align governance processes to further develop a safety culture where staff notice, respond to and anticipate quality failures by 30 September 2014
2. Implement values based recruitment by 31 July 2014
3. Identify and deliver opportunities for staff and board members to meet and discuss quality issues and concerns by 30 September 2014
4. Review and redesign the risk management process across the trust to develop and embed a risk based approach to quality and safety by 30 September 2014
5. Provide opportunities for staff to engage in improvement activities and projects
6. Implement processes to ensure staff can raise concerns and to monitor actions taken
7. Implement actions to improve staff wellbeing and motivation at work

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 13/14* |
| Review of five patient stories | Qualitative and semi-structured interview | Five per care pathway per year | To assess and analyse patient experience of services they receive | n/a |
| Review of five staff stories | Qualitative and semi-structured interview | Five per care pathway per year | To assess and analyse staff experience of services they deliver | n/a |
| National staff survey:  - ability to contribute to improvements at work  - feeling motivated and engaged with their work  (target improvement on 2013/14 rates) | National staff survey | Annual, comparative with previous year’s results | Assess staff engagement and motivation | 77%  3.90 |

***Quality priority 5: reduction in harm***

We have selected five reduction projects (detailed below). We will also continue to report on CDI, MRSA and MSSA, environmental infection control audits and medication incidents.

***5a: prevention of suicide***

This will enable the service to be safe.

*Development objectives:*

1. Agree suicide awareness and prevention strategies in teams across the trust and review the impact on practice, benchmarking against other providers for common indicators
2. Implement recommendations and share learning with safeguarding children’s boards from OHFT internal report into children’s and young people’s suicides

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline n/a* |
| Days between probable suicides in individual adult mental health teams (target 300 days) | Safeguard | Quarterly | Measure reduction in incidence of probable suicide | New teams |
| Days between probable suicides in individual inpatient services (target 300 days) | Safeguard | Quarterly | Measure reduction in incidence of probable suicide | Not measured by IP unit |
| Ten teams to receive suicide awareness/prevention training in interpersonal theory of suicide | Suicide prevention lead | Quarterly | Measure spread of training | New indicator |

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

This will enable the service to be safe.

*Development objectives:*

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

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 13/14* |
| Number of incidents of absence without permission (target 50% reduction) | Safeguard | Quarterly | Measure reduction in incidence of AWOLs | 230 |
| Number of patients absent without permission (target 25% reduction)) | Safeguard | Quarterly | Measure number of patients generating AWOL incidents | 174 |
| 0 patients to experience harm (rated 3, 4 or 5 in impact) as a result of being absent without permission | Safeguard | Quarterly | Measuring reduction in harm resulting from incidents of absence without permission | 2 |

***5c: reduction in the number of avoidable pressure ulcers***

This will enable the service to be safe.

*Development objectives:*

1. Review skin integrity assessment tool and agree options for replacing the Walsall assessment tool by 31 July 2014
2. Agree and pilot a set of appropriate and reportable indicators to support pressure damage harm reduction projects by 30 September 2014

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 13/14* |
| Number of patients with avoidable pressure ulcers graded 2-4 (target 0) | Safeguard | Quarterly | Measure reduction in avoidable pressure ulcers | 15 |
| 100% of patients managed by the district nursing service to have a skin integrity risk assessment | RiO | Quarterly | Reduce risk of avoidable pressure damage | 96% (Walsall) |
| 100% of patients managed by the district nursing service to have a nutritional status assessment | RiO | Quarterly | Reduce risk of avoidable pressure damage | 93% |

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

This will enable the service to be safe.

*Development objectives:*

1. Implement and evaluate a falls harm reduction project in Sandford Ward by 31 December 2014
2. Agree a set of appropriate and reportable indicators to support falls harm reduction projects by 30 September 2014

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| --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 13/14* |
| Number of falls/number resulting in harm (rated as 3, 4 or 5 in impact) by 1000 bed days (target to reduce to 3.8/0.2 in mental health and 8.6/0.2 in physical health) | Safeguard | Quarterly | Measure reduction in harm from falls | Number of falls 4.8 MH (harm 0.3) and 10.6 PH (harm 0.3) by 1000 bed days |
| 100% of patients in inpatient services to have a falls risk assessment on admission | RiO | Quarterly | Reduce the risk of falls | 87.75% |
| 100% of patients to have a further falls risk assessment after 28 days | RiO | Quarterly | Reduce the risk of falls | Baseline set Q1 |
| % of patients to have a review of care plan after a fall (target 100%) | RiO | Quarterly | Reduce the risk of falls | Baseline set Q1 |
| 100% of patients to be referred to falls service after 2 or more falls | RiO | Quarterly | Reduce the risk of harm from falls | Baseline set Q1 |

***5e: reduction in violence and aggression***

This will enable the service to be safe.

*Development objectives:*

1. Implement a revised training programme for prevention and management of violence and aggression (PMVA)
2. Report on and reduce the number of avoidable prone restraints (where the person is face down) and use of hyper-flexion (holding the arm to restrain)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline* |
| Reduce number of reported incidents of violence and aggression resulting in harm (3, 4 or 5 in impact) by 25% | Safeguard | Quarterly | Measure reduction in incidence of violence and aggression | 28 |
| Number of (avoidable) prone restraints (target towards 0) | Safeguard | Quarterly | Measure reduction in incidence of prone restraints | 392 (all prone restraints) |
| Number of restraints involving hyper-flexion (target towards 0) | Safeguard | Quarterly | Measure reduction in incidence of hyper-flexion | 1187 |

***Quality priority 6: implement patient experience strategy***

Ensuring a focus on delivering a positive experience, which meets the needs of patients and those close to them. This will enable the service to be caring.

*Development objectives:*

1. Develop a webpage to share feedback and how this has been learned from and acted upon by 31 July 2014
2. 90% of teams to be collecting feedback on patient experience feedback by 30 September 2014
3. 50% of teams/ wards able to demonstrate listening and acting on feedback by 31 March 2015
4. Roll-out of the Friends and Family test across all services by 31 December 2014
5. Introduce a system for capturing patient and staff stories by 31 March 2015
6. Agree core domains of patient experience to measure and report on by 30 November 2014

***Quality priority 7: development of outcome measures***

Ensuring a focus on how services support patients to manage their condition and/or recover. This will enable the service to be effective.

*Development objectives:*

1. Select two new areas (pathways or services) for development of outcomes measures and report on progress during the year by 31 July 2014
2. Demonstrate that development process maximises opportunities for involving patients and those close to them in developing and reporting on outcome measures
3. Systematically monitor, report and share learning from outcomes continuously to improve the quality of care for patients
4. Deliver outcome based care clusters in older adult mental health services

***Quality priority 8: using the new CQC regulatory framework***

Ensuring we assess and, where necessary, make quality improvements to our services to ensure they are safe, effective, caring, responsive and well-led.

*Development objectives:*

1. Ensure staff across the organisation are familiar with the changes to the regulatory framework by 31 July 2014
2. Adapt the Trust’s approach to quality in recognition of changes in regulation by 31 July 2014
3. Set up peer reviews across and between different services by 30 September 2014

**Part 2.2 Statements of assurance from the board of directors**

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

**Review of services**

During 2013/14 OHFT provided and/or sub-contracted 26 NHS services.

OHFT has reviewed all the data available to it on the quality of care in all of these relevant health services.

These services are based on the organisation of services within divisions in OHFT during 2013/14. During this period the management of some of these has changed as part of the service remodelling process.

**Mental Health Division**

Oxfordshire Adult and Older Adult Services (community and inpatient)

Buckinghamshire Adult and Older Adult Services (community and inpatient)

**Children and Families Division**

Child and Adolescent Mental Health and Specialist Services

Eating Disorders (community and inpatient)

Psychological Therapies

Children’s Services e.g. Health Visiting, School Nursing, children’s therapies, children’s nursing

Public Health Services

Contraception and Sexual Health Services

**Specialised Services Division**

Forensic Services (community and inpatient)

Drug and Alcohol services

Prison Health services

Community Dental services

Homeless GP practice

**Oxford Community Health Service**

8 Community hospital sites providing inpatient care in 10 wards

District Nursing and Specialist Nursing Therapies

Urgent Care Services

Dietetics

Speech and Language Therapy

Podiatry

Musculoskeletal and physical disability physiotherapy

Reablement Service

Specialist Diabetic Service

End of Life Care

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

OHFT has reviewed all the data available to it on the quality of care in all 26 of these services

The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant health services by OHFT for 2013/14.

**Activity in 2013/14**

The following tables outline the activity delivered by OHFT in 2013/14

Number of admissions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Admissions** | **Q1** | **Q2** | **Q3** | **Q4** | **2013/14 Total** |
| Community hospitals | 485 | 503 | 533 | 545 | 2066 |
| Mental health | 428 | 459 | 443 | 397 | 1727 |
| **Trust total** | **913** | **962** | **976** | **942** | **3793** |

Number of occupied bed days

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Occupied bed days** | **Q1** | **Q2** | **Q3** | **Q4** | **2013/14 Total** |
| Community  hospitals | 17310 | 17217 | 17878 | 17674 | 70079 |
| Mental health | 37178 | 37451 | 36900 | 36034 | 147563 |
| **Trust total** | **54488** | **54668** | **54778** | **53708** | **217642** |

Face to face contacts

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Face to face contacts** | **Q1** | **Q2** | **Q3** | **Q4** | **2013/14 Total** |
| Community hospitals | 209501 | 205505 | 206766 | 203276 | 825048 |
| Mental health | 74358 | 72699 | 75094 | 70741 | 292892 |
| **Trust total** | **283859** | **278204** | **281860** | **274017** | **1117940** |

**Service Quality and Accreditations**

OHFT has achieved the following accreditations as of the end of 2013/14.

[Community of Communities](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/therapeuticcommunities/communityofcommunities.aspx)

Achieved for the Oxfordshire and Buckinghamshire complex needs services.

[Electroconvulsive Therapy Accreditation Service](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/ectclinics/ectas.aspx)

Achieved for two sites across the trust in Oxford and Aylesbury, both renewed recently in Jan 2014.

[Quality Network for Community CAMHS Logo](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/childandadolescent/communitycamhsqncc.aspx)

Achieved for the children and adolescent mental health community team in Oxford City.

[QNIC](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/childandadolescent/inpatientcamhsqnic.aspx)

Achieved for both the trust’s children and adolescent mental health inpatient wards in Oxford and Swindon.

[Quality Network for Forensic Mental Health Services](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/forensicmentalhealth.aspx)

Achieved for all nine forensic inpatient wards across Oxfordshire, Buckinghamshire and Milton Keynes.



Achieved for the eating disorders ward in Marlborough and accreditation being worked towards in Oxford.



Achieved for the North Oxfordshire memory clinic.

uk Medicines Information

The UK Medicines Information awarded the trust’s medicines information department a quality award.

**Participation in national audit and confidential inquiries**

During 2013/14, six national clinical audits and one national confidential inquiry (National Confidential Inquiry into Suicide and Homicide for people with Mental Illness) covered relevant health services that OHFT provides.

During 2013/14 OHFT participated in 100% of the national clinical audits and 100% of the national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The six national clinical audits and one national confidential inquiry that OHFT participated in, and for which data collection was completed during 2013/14 are listed below, with the number of cases submitted to each audit or inquiry expressed as a percentage of the number of registered cases required by the terms of that audit or inquiry.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Audit or inquiry** | **Participation (Yes or No)** | **Number of cases required by teams** | **Number of cases submitted** | **Percentage** |
| 1. POMH-UK Topic 13: Prescribing for ADHD | Yes | n/a | N=186 | n/a |
| 1. POMH-UK Topic 7d: Lithium monitoring | Yes | n/a | N = 94 | n/a |
| 1. POMH-UK Topic 4b: Prescribing of anti-dementia drugs | Yes | n/a | N = 183 | n/a |
| 1. National Audit of Schizophrenia | Yes | 80 | N = 96 | n/a |
| 1. POMH-UK Topic 10: Antipsychotics in CAMHS | Yes | n/a | N = 66 | n/a |
| 1. Stroke Care (SSNAP) | Yes | 20 per quarter | 103 | 100% |
| 1. Suicide and homicide for people with mental illness | Yes | 42 | 41 | 99.53 |

The reports of five out of six national clinical audits were reviewed by the provider in 2013/14 and OHFT intends to take the following actions to improve the quality of healthcare provided.

**POMH-UK Topic 2f: Monitoring metabolic side effects of patients on antipsychotics in assertive outreach and forensic units**

* CPA coordinators have been instructed to ensure that for each CPA review they request a history sheet from the patient’s GP to inform the team regarding the outcome of physical health checks and to provide assurance that these checks have been done
* all community mental health teams will have trained champions in place in relation to smoking cessation

**National audit of schizophrenia**

* CPA coordinators have been instructed to ensure that for each CPA review they request a history sheet from the patient’s GP to inform the team regarding the outcome of physical health checks and to provide assurance that these checks have been done
* all community mental health teams will have trained champions in place in relation to smoking cessation
* personalised information packs for patients including details of their care co-ordinator and a copy of their care plan to be given to all new patients
* patient feedback mechanisms to be rolled out across in-patient areas and community teams to inform locally developed action plans

**Prescribing observatory for mental health** (**POMH) Topic 13 prescribing for ADHD 2013-14**

* all prescribers will ensure that a full physical health check (including heart rate, blood pressure (BP), height, weight, assessment of cardiovascular and substance misuse risk is undertaken prior to the commencement of treatment, and recorded in the progress notes
* all prescribers will ensure that the patient's heart rate and BP is recorded three months after commencement of treatment and recorded in the progress notes
* all prescribers will ensure that treatment is reviewed annually using the standardised rating scale and recorded in the progress notes
* all prescribers will ensure that the patient's weight is recorded every six months and recorded in the progress notes

**POMH Topic 7 monitoring of patient prescribed Lithium**

To assist clinicians and ensure that the relevant physical health checks are undertaken for inpatients on Lithium we will implement a Lithium initiation form and Lithium monitoring form.

We are planning a pilot project in North Oxfordshire which will involve collaboration with GPs and community pharmacists to agree responsibilities for Lithium monitoring at initiation and ongoing monitoring. Following agreement this initiative can be rolled out across Oxfordshire and Buckinghamshire.

**Local (trust wide) clinical audits**

The reports of 27 local clinical audits were reviewed by the provider in 2013/14 and OHFT intends to take the following actions to improve the quality of healthcare provided.

**Audit of care for services users not on CPA**

To ensure consistent and timely information is provided to GPs a template will be included in all correspondence to GPs

* clear indication that the letter is the care plan
* state risks or no risks and advise how they should be managed
* address arrangements for management of physical health issues
* include next review date
* include the 24 hour contact number in the heading of the letter

**Self assessment of how ‘family friendly’ inpatients wards are**

* awareness training to be provided for ward staff in the delivery of family interventions and ensure that these are offered as an integral part of the patients care plan
* training to be provided for staff to develop skills in talking to children/young people
* raise staff awareness of resources available to sign post children/young people to

**Think Family – review of clinical records**

* Think Family champions have implemented a standard operating procedure (SOP) to provide clear guidance on the recording and documentation of information relating to children and young people
* care plans and risk assessments will be reviewed for evidence of risks to children being considered and effective management plans put in place
* ensure children's individual needs are addressed within care plans and effective interventions put in place to be monitored through supervision by Band 7 Leads and progress on improvements will be reviewed within our governance structure
* snapshot audit will be undertaken during 2014/15 to provide assurance that clinical practice is improving in the documentation on RiO of key information regarding children

**Proactively following up patients who do not attend their appointment (DNA)**

* when a patient who is considered to be at risk of self harm, harming others, self neglect or relapse fails to attend an appointment, strenuous attempts will be made to resume contact with evidence of the strenuous attempts made recorded in the progress notes and monitored by the relevant clinical leads during supervision
* the care co-ordinator will actively seek contact with the patient and/or the patient's family by phone
* all patients will be reminded of the date and time of their next appointment either by text or telephone and the number of DNAs will be monitored by team managers and reported via a run chart

**Clinical research**

The table below shows the number of studies currently recruiting participants within the trust.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **As of 26 March 2014 at 16:26** | **Total Number of studies** | **of Total OHFT sponsored** | **of Total Students** | **of  Total, Clinical Psychology Trainees** | **of Total Funded** | **of Total PICs** | **of Total CTIMPs** | **of Total CCG/OHFT new** | **of Total NIHR UKCRN Portfolio** | **of Portfolio via CSP** | **of Portfolio via CSP OHFT Lead** |
| **Open** | 106 | 21 | 24 | 12 | 75 | 14 | 13 | 3 | 68 | 62 | 24 |
| **Awaiting approval** | 9 | 4 | 5 | 0 | 3 | 0 | 1 | 0 | 2 | 2 | 0 |

The figures for participant recruitment into research studies from April 2013 until the end of January 2014 is 2319 for NIHR portfolio studies, and 732 for non-NIHR Portfolio studies.  We are expecting this to increase slightly when the figures become available over the next few weeks

**Key**

***CTIMP*** Clinical trial of an investigational medicinal product(s) – drug trial

***Open*** Currently recruiting or in analysis within study start and end dates

***Awaiting approval*** Yet to be granted NHS Permission

***PICs***OHFT has agreed to act as a Participant Identification Centre

***NIHR*** National Institute for Health Research

***UKCRN*** United Kingdom Clinical Research Network

***CSP*** Coordinated System for gaining NHS Permission – this is nationwide

***OHFT Lead*** OHFT responsible for global (study-wide) governance checks

**Commissioning for quality and innovation (CQUIN) payment framework**

A proportion of OHFT’s income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between OHFT and any person or body that they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework.

The income conditional on achieving CQUINs for 2013/14 was £4,617,249 and for 2012/13 was £4,784,168

Further details of the agreed goals for 2013/14 and for the following twelve month period are available electronically at

[*http://www.monitor-hsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/\_openTKFile.php?id=3275*](http://www.monitor-hsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

***Income from CQUINs 2013/14***

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

**Income from CQUINs 2012-2013**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Commissioner** | **Mental Health Amount** | **% of Contract Value** | **Community Services**  **CQUIN Amount** | **% of Contract Value** |
| NHS Oxfordshire | £1,055,322 | 2.5% | £2,017,000 | 2.5% |
| NHS Buckinghamshire | £804,642 | 2.5% | £1,826 | 1.5% |
| Wiltshire & BaNES PCT | £159,146 | 2.5% | n/a | n/a |
| Northants | £14,159 | 2.5% | £7,163 | 1.5% |
| Swindon PCT | £59,777 | 1.5% | £3,228 | 1.5% |
| East of England SCG | £8,442 | 1.5% | n/a | n/a |
| Warwickshire PCT | £228 | 2.5% | £1,085 | 1.5% |
| South Central SCG | £652,150 | 2.5% | n/a | n/a |

We met all of our CQUINs except for NHS Safety Thermometer and review of eating disorder pathway/focus on early intervention

**Care Quality Commission**

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

OHFT is required to register with the CQC and its current registration status is “registered without conditions”. To find out more details click on the following link <http://www.cqc.org.uk/directory/RNU#providertabs-0>. The CQC has not taken enforcement action against OHFT during 2013/14.

OHFT has not participated in any special reviews or investigations during 2013/14.

Four thematic announced inspections have been undertaken in 2013/14 which covered

* the use of community treatment orders (CTOs) for patients detained under the Mental Health Act to support people to live in the community (in July 2013) and for which we are taking actions to improve documentation, develop staff awareness and understanding and develop information leaflets
* how people living in Buckinghamshire are cared for during their assessment and possible admission under the Mental Health Act (in October 2013) – the report has not yet been received
* review of looked after children and safeguarding arrangements for children in Wiltshire (in October 2013) and for which we are taking actions to ensure comprehensive case recording, improve sensitivity to issues of diversity, follow up failure to attend appointments, and to review the use of assessment tools
* review of looked after children and safeguarding arrangements for children in Swindon (in February 2014) – the report has not been received yet

The trust has undergone one unannounced inspection visit which focused on reviewing the mental health care for forensic inpatients at our Littlemore Mental Healthcare Centre in April 2013. The inspection identified the following two areas for improvement, judged by the CQC to have a minor impact on people using the services

* an unlocked refuse area on the hospital site (not on a ward)
* a need to ensure information held about a patient’s care is recorded consistently in only one section within the electronic patient record system

OHFT took action to address the conclusions or requirements reported by the CQC and the CQC confirmed they were satisfied that appropriate actions had been completed in October 2013.

The CQC has carried out sixteen unannounced visits in relation to compliance with the Mental Health Act across our children, adult, older adult and forensic inpatient areas in 2013/14. Following these visits action plans are developed where required. In 2013/14 the key themes for improvement are

* ensuring regular re-presentation of rights to patients who are detained under the Mental Health Act
* improving practice and documentation of how patients are involved in decisions about their care
* promoting information to advocacy
* improving the documentation of discussions with patients about consent to treatment

**Quality Risk Profile**

The CQC produces a quality risk profile (QRP) for all organisations that are registered with the CQC. It is seen as an essential tool for gathering key information about us and assists the CQC to monitor how we are complying with the essential standards by identifying any risks from data that CQC receive from many different sources. An assessment of the overall level of the risk for each of the sixteen CQC quality outcomes for the organisation is then made.

The scale used is: green, yellow, amber and red which indicate increasing risk. Each colour is then subdivided into low (better) and high (worse).



The QRP assists us as an organisation to identify where our performance may be lower than average and may need improvement. This enables us to take relevant actions in these key areas.

The table below shows the CQC’s current risk profile for OHFT as of March 2014. One standard is rated as amber (moderate risk of non-compliance) which is *co-operating with other providers*. This risk has been assessed by the CQC based on the number of days a patient has been delayed on a ward waiting for discharge, also known as a delayed transfer of care. We regularly monitor our position on delayed transfers of care and work actively with our partners across the whole health and social care system (local acute hospital trusts and social care organisations) to minimise the number of delays. We have carried out the following extensive service remodelling work, to be further embedded in 2014/15, which should reduce people being unnecessarily delayed on wards

* adult mental health teams extending their operating hours from 7am until 8pm, seven days a week to improve the availability and access to community services
* each adult mental health ward having increased senior leadership through a dedicated team to include a consultant, modern matron and ward manager
* integrated physical, mental health and social care teams for older people working seven days a week
* development of additional emergency multi-disciplinary units in community hospitals
* improved pathways to increase availability and access to psychiatric liaison in acute hospital trusts

|  |  |  |
| --- | --- | --- |
| **Governance Standard** | **March 2013** | **March 2014** |
| **Section 1 - Involvement & Information** |  |  |
| 1. Respecting and involving people who use services | High Yellow | High Yellow |
| 2. Consent to care and treatment | Low Yellow | Low Yellow |
| **Section 2 - Personalised Care** |  |  |
| 4. Care and welfare of people who use services | Low Green | Low Yellow |
| 5. Meeting nutritional needs | High Green | Low Yellow |
| 6. Cooperating with other providers | High Yellow | Low Amber |
| **Section 3 - Safeguarding and Safety** |  |  |
| 7. Safeguarding people who use services from abuse | High Yellow | High Yellow |
| 8. Cleanliness and infection Control | High Green | Low Green |
| 9. Management of medicines | High Yellow | High Yellow |
| 10. Safety and suitability of premises | Low Yellow | Low Yellow |
| 11. Safety, availability and suitability of equipment | Low Yellow | Low Yellow |
| **Section 4 - Suitability of Staffing** |  |  |
| 12. Requirements relating to Workers | Low Yellow | Low Yellow |
| 13. Staffing | High Yellow | High Yellow |
| 14. Supporting staff | Low Yellow | Low Yellow |
| **Section 5 - Quality & Management** |  |  |
| 16. Assessing and monitoring the quality of service provision | Low Yellow | Low Yellow |
| 17. Complaints | Low Yellow | Low Yellow |
| 21. Records | Low Green | Low Green |

**Data quality**

OHFT submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data (April 2013 to Jan 2014, published SUS data including Month 10)

- which included the patient’s valid NHS number was:

99.7% for admitted patient care;

100% for outpatient care; and

97.7% for accident and emergency care

- which included the patient’s valid General Medical Practice Code was:

97.4% for admitted patient care;

99.3% for outpatient care; and

97.6% for accident and emergency care

OHFT’s Information Governance Assessment Report overall score for 2013/14 was 90% and was graded green (satisfactory).

OHFT was not subject to a payment by results clinical coding audit during 2013/14 by the Audit Commission

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

* a data quality work stream is in place to review data quality processes, promote benchmarking and embed the trust’s data quality strategy
* data quality indicators for Monitor are reviewed by the board including data completeness and data outcome indicators
* training for the new electronic health record will focus on data accuracy and staff ownership of their data input
* we have developed a data quality dashboard, using business intelligence, which empowers staff to understand and view the data they have entered - the dashboard highlights errors or mistakes to target data correction
* data quality work stream meets bi-monthly to review data quality, to develop data quality reports and processes for managing data correction with each directorate taking ownership for their data quality via data improvement plans
* data quality is a priority in the quality account 2014/15

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

This section includes data on nationally specified indicators for the current and previous reporting periods as part of the statutory requirements for the quality account. Full details of the definitions of the indicators and the targets may be found in Appendix B of the Monitor Document *Compliance Framework 2013/14* at:

[http://www.monitor‑hsft.gov.uk/sites/default/files/Compliance%20Framework%2030%20March%202012%20FINALv1.3.pdf](http://www.monitorhsft.gov.uk/sites/default/files/Compliance%20Framework%2030%20March%202012%20FINALv1.3.pdf)

### CPA Patients receiving follow-up contact within seven days of discharge

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

* there is a documentary audit trail for the compilation of these figures
* Internal audit review the quality of the compilation process

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

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

When assessing this criterion, we apply one exclusion in addition to the national guidance

* for patients who are discharged from inpatient care who are discharged directly to the care of another mental health provider trust (whether inpatient or community services), where we have verified that discharge documentation includes clearly set out arrangements for the handover of responsibility for care to the other provider, we have assumed the requirements under the indicator have been met.

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reporting Period** | **Trust**  **Value** | **National Min** | **National Max** | **National Average** |
| **Apr-Jun 2013** | 96.4% | 94.1% | 100% | 97.4% |
| **Jul-Sep 2013** | 97.9% | 90.7% | 100% | 97.5% |
| **Oct-Dec 2013** | 96.6% | 77.2% | 100% | 96.7% |
| **Jan-Mar 2014** | Information not published as of 30th April 2014 | | | |
| **Apr-Jun 2012** | 96.7% | 94.9% | 100% | 97.5% |
| **Jul-Sep 2012** | 96.0% | 89.8% | 100% | 97.3% |
| **Oct-Dec 2012** | 96.5% | 92.5% | 100% | 96.2% |
| **Jan-Mar 2013** | 96.8% | 93.6% | 100% | 97.3% |

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

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

* there is a documentary audit trail for the compilation of these figures

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

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

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reporting Period** | **Trust**  **Value** | **National Min** | **National Max** | **National Average** |
| **Apr-Jun 2013** | 97.8%[[1]](#footnote-1) | 74.5% | 100% | 97.7% |
| **Jul-Sep 2013** | 97.6% | 89.8% | 100% | 98.7% |
| **Oct-Dec 2013** | 98.4% | 85.5% | 100% | 98.6% |
| **Jan-Mar 2014** | 97.4%[[2]](#footnote-2) | | | |
| **Apr-Jun 2012** | 100% | 83.0% | 100% | 97.8% |
| **Jul-Sep 2012** | 99.6% | 84.4% | 100% | 96.6% |
| **Oct-Dec 2012** | 98.1% | 90.7% | 100% | 98.3% |
| **Jan-Mar 2013** | 98.9% | 84.9% | 100% | 98.6% |

**Patients readmitted within 28 days of being discharged**

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

* there is a documentary audit trail for the compilation of these figures

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

* improved leadership on the wards, thus ensuring timely and appropriate discharge arrangements
* the community services were remodelled from February 2014 so that services are now available seven days a week providing extended hours from 7am-8pm every day
* the community mental health teams, community crisis teams and assertive outreach teams have been brought together to improve robust follow up of patients on discharge

The information for the table below is not available as the NHS Information Centre web site has not published these statistics since 2011/12. Also the Department of Health Quality Account Team have informed us that the data is for emergency readmissions only and is not relevant to this trust.

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator** | **2011/12 position** | **2012/13 position** | **2013/14**  **position** |
| Patients readmitted within 28 days of being discharged   1. 0-14 years 2. 15 or over | N/A  N/A | N/A  N/A | N/A  N/A |

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

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

* the patient experience survey is a national statutory requirement and coordinated for this Trust by an external CQC approved survey contractor

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

* the development of service user information folders that include information leaflets, care plans and risk assessments (following 2012 survey)
* staff visiting other trusts looking at service user involvement (following 2012 survey)
* each patient to be given an information card with the care coordinator/lead clinician’s name and contact numbers and the numbers to contact in a crisis (following 2012 survey)
* family engagement training delivered to community mental health staff (following 2012 survey)
* establish a system so that every patient can give their team feedback after each care review meeting (following 2013 survey)

and intends to take the following actions

* clear written expectations for staff around 6 monthly care review meetings with patients (following 2013 survey)
* all CMHT patients receiving treatment to be put on CPA (following 2013 survey)
* review and improve the information given to patients and carers (following 2013 survey)

|  |  |  |
| --- | --- | --- |
| **Reporting Period** | **Trust**  **Value** | **National Average** |
| **2013 survey** | 84.9 out of 100 | 85.8 out of 100 |
| **2012 survey** | 83.2 out of 100 | 86.5 out of 100 |

### Patient safety incidents resulting in severe harm or death

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

* there is a documentary audit trail for the compilation of these figures

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

* we continue to review and report every incident quarterly and in addition all serious incidents (including those resulting in severe harm and death) are reviewed weekly and senior clinicians are involved in deciding what level of investigation to commission
* this trust has continued to set quality priorities each year around the prevention of suicides, the priorities for 2013/14 were to reduce unexpected deaths in inpatient mental health services to zero and to have no inpatient deaths from suicide and for 2014/15 the priority is to prevent suicide

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Reporting Period** | **Number of Patient Safety Incidents Reported** | **Number/ % of incidents resulting in severe harm** | **Number/ % of incidents resulting in death** |
| **April 2013-Sept 2013** | 3922 | 19 (0.5%)  (Nationally 0.4%) | 17 (0.4%)  (Nationally 0.9%) |
| **Apr 2012-Sep 2012** | 3034 | 14 (0.5%)  (Nationally 0.8%) | 50 (1.6%)\*  (Nationally 0.8%) |

**Note 2012 data\*:**

The NRLS have produced data handling notes to be read alongside all data and note the “quality of data in the NRLS does vary” for the following reasons and that these should be considered when looking at the data which can explain the differences between organisations

* the NRLS system does not use a nationally established and regulated approach to reporting and categorising patient safety incidents; different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents
* differences in reporting cultures including different ways of reporting (this trust is above the average for reporting incidents because in 2012 we were choosing to report all deaths (expected and unexpected deaths, actual or apparent suicides) to NRLS
* type of services provided and patients cared for (this trust provides drug and alcohol addiction services, complex needs service, prison in-reach services, self harm services at A&E department, forensic mental health services and eating disorder inpatient and community physical health services which is not standardised across all mental health organisations)
* where community physical health care services have been transferred to be provided by an existing mental health organisation, these organisations will continue to be reported and compared to organisations which only provide mental health services
* not all deaths will be a patient safety incident e.g. deaths from natural causes (note this Trust in 2012 was reporting all deaths to the NRLS)

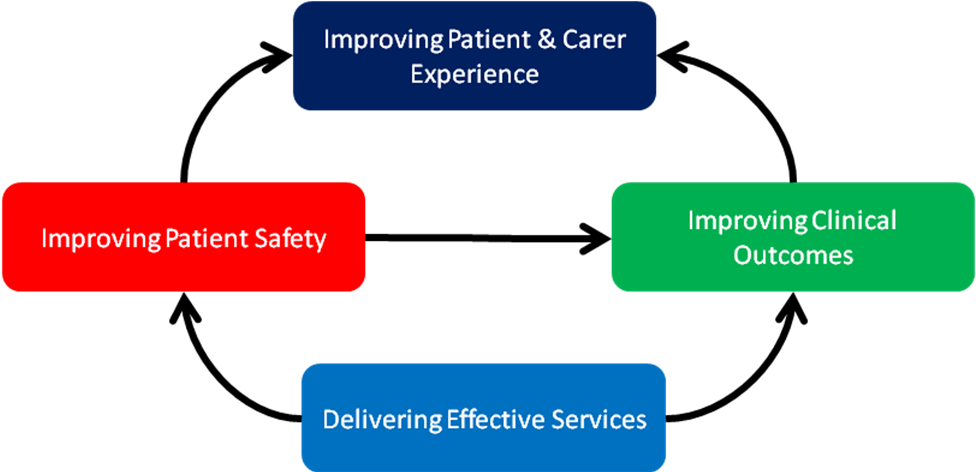
**Part 3**

**Achievement against the quality priorities for 2013/14**

**Introduction and summary**

The annual Quality Account details our approach to delivering high quality services which are safe, effective, outcome focused and the experience meets expectations. 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.

For 2013/14 the Quality Account was organised around four quality goals: improving patient carer and experience; improving clinical outcomes; delivering effective services; and improving patient safety. These reflected the NHS outcomes framework and national priorities; local stakeholder feedback; feedback from staff, patients and those close to them; and a review internally of issues and concerns arising from incidents, complaints, service changes and audits.



**Improving patient safety**

This goal focused on: ensuring that people would not die prematurely; that our patients would be protected from harm; and that our patients would be treated and cared for in a safe environment.

**Improving clinical outcomes**

This goal focused on: improving the quality of life for people with long-term conditions; supporting patients/service users to manage their own conditions; and developing service models that would enable patients with long-term conditions to spend less time in hospital

**Improving patient and carer experience**

This goal focused on: ensuring an improvement in the experience of patients using our inpatient and outpatient services; being more responsive to the needs of our patients; and giving patients better access to community-based services.

**Delivering efficient and effective services**

This goal focused on: maximising our use of our resources; ensuring our time was focused on patient care; and making sure that patients/service users progressed through the care system in a timely way.

**Against each of these four quality goals we set twelve key quality activities or priorities and twelve associated quality objectives:**

|  |  |  |
| --- | --- | --- |
| **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 |

To monitor progress against these activities and objectives, we defined a set of quality and safety metrics and measures, some of which were nationally prescribed and some of which were developed locally. Progress was reported each quarter to the integrated governance committee and the board of directors of OHFT. Progress on specific safety and quality improvement initiatives or with projects underway within the trust was reported every six months. In addition, the governors’ quality and safety sub-committee was involved in reviewing and assessing progress, in selecting indicators for external audit and in selecting quality priorities.

**Improving patient safety - summary of progress**

Our objectives centred on protecting patients from harm, reducing premature deaths and creating a safe care environment. The number of reported incidents increased last year which was a key objective for us; at the same time the number of serious incidents reduced by a third. We have sustained our performance on carrying out key risk and physical health assessments for much of the year – where we identified an issue with VTE assessments we responded quickly and have improved.

While there were two reported inpatient deaths, neither of these took place on trust properties as the patients were absent without leave at the time. However we did have a serious incident relating to faulty window restrictors which did result in serious harm; the patient is fully recovered however we were subject to an HSE improvement notice and have taken a series of actions to replace all window restrictors across the trust. Prevention of suicide continues to be a priority, supported by a 12 month project for suicide awareness and prevention training for staff.

We did not achieve our AWOL reduction target; however we have tightened reporting criteria considerably and will use this as our benchmark for work on this priority for next year. The incidence of pressure ulcers peaked earlier in the year and we responded by taking action in partnership with rest of the system which has resulted in a considerable reduction in harm. However, we failed the safety theromometer for grade 2 pressure ulcers (which does not differentiate between those that were already present on admission and those that developed after admission) so this remains a key harm reduction priority. We did not achieve our reduction in harm from falls target, despite a number of initiatives. This remains a harm reduction priority for next year.

We have carried out a significant number of improvement activities which we now need to sustain and embed so they become business as usual.

**Improving clinical outcomes - summary of progress**

Working with patients and those close to them to develop shared outcomes and goals for their care is part of our vision for quality services. We have initiated some excellent projects, and this account features case studies from speech and language therapies, co-development of outcome measures in adult mental health services, healthy children’s initiatives, and developments in mental health services for children and young people. Each quarter has seen an increase in the number of patients with personal health budgets; and we continue to increase the number of patients with long term conditions accessing talking therapies.

A significant programme of work has involved the remodelling of adult mental health and older adult services (mental and physical health) which commenced in 2013/14 and will run through the coming year. This has delivered new models of care, increased levels of staffing, and integrated teams. Strengthening our community teams and developing an outcomes focus to our care has helped us work alongside patients to help them manage their own conditions and support them to manage outside hospital.

**Improving patient and carer experience - summary of progress**

Patient experience comprises a number of factors including the care environment, the quality of care received, the opportunity to be involved in care planning and decisions about care, the quality of communication and information, and the opportunity to give feedback which results in action. We received three times as many compliments as complaints in 2013/14 and have made our PALS service more available and accessible to patients and families.

We have focused a considerable amount of effort on soliciting feedback from patients, families and staff. We have involved patients and carers in developing our new models of care; worked proactively with our governing body (including a specific focus on quality and safety); and set up local forums with patients and carers. In the coming year we will be implementing our patient experience strategy which will help us move beyond listening to acting upon feedback we receive. This is complemented by work on professional strategies (starting with nursing) which define what we expect of our staff.

The service remodelling has reflected patient feedback in relation to availability and accessibility of crisis and urgent support and we have extended hours of availability with increased staffing in community teams.

We have opened the new Whiteleaf centre in Aylesbury and made a significant number of improvements to other inpatient areas. We have also increased access to staff in community teams and health visiting services. We still need to improve the percentage of patients on CPA who were involved in their care plan, but all patients on CPA have a care co-ordinator and we have seen a slight increase in the percentage of patients with a documented risk assessment and care plan. This remains a priority for 2014/15.

In the national staff survey the overall staff engagement score for OHFT is 3.79 which places it in the top 20% compared with other mental health/learning disability trusts.

**Delivering efficient and effective services - summary of progress**

We have invested in our staff and our infrastructure to maximise the time spent on patient care and to make best use of our resources. We have bought 2,500 laptops and 700 iPADs to facilitate remote working for staff, and enable community staff to access and record information at the patient’s side. Six services went live on choose and book and more will be included in the coming year

We have developed further skills training for our staff in older adult services which will assist in the integration of physical and mental health care pathways. We have also invested time and resources in a range of improvement activities co-ordinated through our productive ward and safer care programmes, and initiated within teams and directorates, with training and support in improvement techniques.

**Improving patient safety**

|  |  |  |
| --- | --- | --- |
| **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. |

OHFT 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. We ensure lessons are learned from incident reviews and improvements in practice are systematically introduced, supported by an extensive training and professional development programme. This section details progress against specific indicators and outlines a number of different patient safety/improvement projects undertaken during the year, including suicide prevention, safer medicines management, and work to reduce the use of restraint, reduce avoidable pressure ulcers, reduce absence without leave, minimise harm from falls and increase incident reporting whilst reducing the number of serious incidents resulting in harm.

**Specific improvements in patient safety**

**Safer medicines management**

We aimed to reduce the number of reported medication incidents resulting in harm; however these increased from 28 in 2012/13 to 40 in 2013/14[[3]](#footnote-3). None of these incidents resulted in severe harm. These events took place primarily in community physical health services which had 825,048 face to face contacts and 70,079 occupied bed days in 2013/14. We have also improved our reporting and review of medication incidents in the past twelve months.

We have undertaken a number of activities over the past twelve months to improve medicines management and reduce harm from medication errors.

There are four safer care projects underway in Abingdon community hospital, Kimmeridge ward (now Sapphire) in Aylesbury, Cotswold House, Oxford and the Fiennes Unit in Banbury. The projects are focusing on reducing omitted or delayed doses and improving medicines reconciliation to support correct prescribing.

**Case study**

The medicines management technician on Vaughan Thomas adult mental health ward in Oxford has introduced weekly mini audits of the accuracy of drug charts, including a review of missed doses, with the ward team. She has also provided training and support to ward staff on medicines management. This has shown a significant reduction in the frequency of missed doses.

The pharmacy team has set up a process to record their contribution to identifying and preventing harm, for example prescribing errors, and ensuring all errors are reported. All medication related incidents are reviewed and discussed at the drugs and therapeutic committee and at local governance meetings to look at trends, issues and concerns. We aim to increase incident reporting whilst reducing the proportion of those which cause actual harm. Of particular importance is reporting and learning from medication near misses. OHFT now has an e-learning package for all staff prescribers to increase awareness of the potential for medication errors and to support consistent and accurate reporting of incidents.

**Case study: Reduction of medication errors in Cotswold House, Oxford**

This is part of safer care work on the unit. Staff were reporting a number of medication errors or omissions. This is now monitored on a monthly by the modern matron. All medication charts are reviewed weekly to ensure that they are correct and the pharmacist is also involved in working with staff to reduce errors.

We are also participating in a region-wide collaborative which enables us to measure and benchmark our medicines management against other trusts in the region and participate in new initiatives. For example the “green bag system” encourages patients to bring in their medication on admission to facilitate medicines reconciliation and continuity of treatment. This is stored in a green bag which can then go with them on discharge or transfer to another service. It also allows clinical staff to ensure we are correctly prescribing and managing patient medication. Monthly snapshot audits of allergy recording on drug charts and Warfarin treatment monitoring are also undertaken and bench-marked as part of this collaborative.

**Reducing absence without leave (AWOLs)**

Detained patients on our inpatient mental health wards have the opportunity to be granted planned leave (Section 17 leave) as part of their therapeutic journey towards discharge.

Section 17 leave is an important part of the patient’s therapeutic care plan. This enables them to be gradually and safely reintegrated back into community living. Each patient is fully risk assessed to determine the likelihood of absconsion and/or of harm; however, there are occasions when patients either fail to return at the specified time, or abscond. We set ourselves a target to reduce the number of absences without leave by 50% from 192 last year to 96 in 2013/14. The figures below[[4]](#footnote-4) show that there was a slight increase in number of absences without leave in the past twelve months, although the number started to reduce in the second half of the year. These numbers are in the context of 147,563 occupied bed days across our mental health and forensic wards in 2013/14.

As part of this initiative we reviewed our criteria for reporting absences, and tightened it to include any patient who failed to return within ten minutes of their specified time to return. This has resulted in an increase in reporting but has given us a secure baseline from which to measure improvement. Reducing absence without leave will continue to be a harm reduction priority for 2014/15.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 | FY | 2012/13 |
| Absence from wards without permission (target to reduce by 50% from 192 detained patients in 2012/13) | 66 | 67 | 55 | 42 | 230 | 192 |

**Case study**

The safer care programme has four wards working on AWOLs with a specific focus on failure to return from Section 17 leave as the largest category of patients reported AWOL. Chaffron ward in Milton Keynes is counting *days since*... the last incident and has achieved 330 days since the last reported AWOL. Patient information leaflets for all patients have been ‘approved’ by the CQC and provide information about taking leave from the ward, and of the expectations of the ward with respect to informal patients. Phoenix ward in Oxfordshire is testing a signing in and out book and contact cards. They have achieved a 30% reduction in failure to return, and a maximum of eleven days between AWOLs in December. Kimmeridge ward in Buckinghamshire is using a questionnaire with patients when they return from leave and they have achieved a maximum of 47 days with no AWOL between 21st Nov 2013 and 8th Jan 2014. Allen ward in Oxfordshire is testing planned therapeutic leave in their ward review and has achieved a maximum of six days between AWOLs.

**Prevention and management of violence and aggression (PMVA)**

We are committed to reviewing the way in which staff prevent and respond to incidents of violence and aggression, which may be patient to patient or patient to staff. We established a project which aimed to

* enable clinical teams to provide the highest standard of evidence based care in relation to the prevention and management of violence and aggression
* enable a reduction in the use of physical restraint and ensure that the techniques of prevention, de-escalation and physical restraint taught to and used by staff protect patients and staff from harm
* ensure that OHFT uses the most effective form of training in the prevention and management of violence and aggression

The project team includes representatives from clinical areas, disciplines and patients. It reports to a steering board chaired by the director of nursing and clinical standards and including a non executive director.

At the end of March 2014, the project had

* reviewed the literature on the use of restraint
* identified key areas of best practice
* reviewed trust incident data, and relevant complaints data, findings from investigations into serious incidents and audit reports.
* visited or been visited by the main providers of PMVA training packages
* hosted a visit by the safe wards team ( Institute of Psychiatry)
* visited other trusts to see their safer care work on reducing violence and aggression
* developed a means to gather patient and staff experience of the use of restraint using the King’s Fund’s evidence based co-design model (EBCD).
* initiated a weekly analysis of restraint incidents centrally

In the coming year the project will

* evaluate the alternative training programmes to determine the future content of our PMVA training
* begin the process of re-training our trainers and staff as required.
* complete the EBCD work and integrate the findings into our training package
* review ward environments against best practice environmental standards, including the provision of de-escalation, intensive care and chill out areas.

**Case study: reducing the use of restraint on the Highfield Unit**

The Highfield Unit is currently working on improving assessment information and care planning. Run charts show a reduction in the weekly median (all types of restraint) from 4.9 in the twelve months between 01/2012-01/2013 to 1.78 in the twelve months between 01/2013-01/2014 since moving to a purpose built unit. Debriefs now occur after any incident of a restraint to see if it could have been avoided and these are discussed regularly at team meetings.

**Falls**

The National Patient Safety Agency (NPSA) reports that falls are the main adverse event experienced by patients, with over 36,000 events recorded annually across England. We set ourselves a target to reduce the number of falls resulting in harm by 50% from the previous year (by 1000 bed days). There has been a reduction in the incidence of harm from falls[[5]](#footnote-5) over the first three quarters, with a slight increase in Q4 for community hospitals; and a continued decrease since Q2 in mental health inpatient wards. We have not yet made the progress we would like in reducing the overall number of falls and harm from falls. Reduction in harm from falls will therefore continue to be a quality priority for 2014/15.

**Case study: falls prevention on Cherwell ward**

Staff on Cherwell ward in Oxford worked with our productives team to reduce the number of patient falls on their ward. They recognised that their client group is at a high risk of falling, but through timely assessment and reduction of risk they have started to see a reduction in falls. Some of their actions have included reviewing medication, clinical intervention, and care planning involving the family. They monitor their progress on their Falls Board which is presented on the ward for patients and their families to view.

**Understanding causes and prevention of falls in older adult mental health services**

Our older adult mental health services ran a three year falls research project (funded by the National Institute for Health Research) in five older adult mental health inpatient wards across OHFT. Research involved interviews with staff, patients and relatives and an analyisis of serious incident investigations.

People fall for a variety of reasons including physical conditions; mental health conditions; side effects of medication; environmental hazards and co-morbidities (complex physical and mental health needs). Patients can sometimes put themselves on the floor due to their mental health condition - when this behaviour is not observed it is always recorded as a fall.

The majority of falls occur in bedrooms or in corridors. The Fulbrook centre is planning to improve lighting in its corridors. We are considering specialist ‘day lighting’ in a dedicated room in Sandford ward for people who are very agitated and experience ‘sun-downing’ to reduce night time disturbance and associated falls. The majority of patients who fall in their bedrooms (at night) appear to do so in either attempting to get up to use the toilet or slip having been incontinent. We are therefore implementing improvements to continence management.

In the coming year we are focusing on falls risk assessments on admission, after a fall, at regular intervals during an inpatient stay (patients fall, on average, on the 50th day of their admission) and after any change in a patient’s condition following baseline assessments.All incident forms that report falls are now expected to show that physical (and, where necessary, neurological) obervations have been carried out and a doctor informed.

A physical health care course for mental health nurses has been designed with Oxford Brookes University, and 75% of older adult nurses have attended and passed. We also monitor basic physical health on a daily basis. Medication Reviews are taking place on a weekly basis on all the wards. The physiotherapist for the Fulbrook unit is working with the Fulbrook unit pharmacist to review medication in relation to falls.

We are also developing care plans with the patient and their family to consider individual concerns. For example, in the falls research, female patients suggested that mobility aids made them look old so they did not use them. Hearing and responding to the voice of the patient in this way helps us to create more effective interventions for falls prevention.

**Case study: community falls team**

The community falls team set itself a target to reduce the number of falls in community hospitals by 10% by March 2014; ensure that at least 85% of all patients over 75 years of age are assessed for falls and nutrition risks in community hospitals and older adult mental health wards; and to reduce by 50% serious harm or death from falls.

Actions achieved include

1. the implementation of the falls e-learning training and 402 members (87%) of staff have undergone the training
2. the number and rate of reported falls (per 1000 bed days) have reduced compared to the previous 2 financial years, with only the months of May and June 2013 reporting higher numbers of falls compared to the same months in previous years.

**Pressure Ulcers**

Whenever a patient develops a grade 3 or 4 pressure ulcer, we undertake an assessment to determine whether or not it was avoidable i.e. did we fail to do something or was there some element of the care we provided which contributed to the pressure damage occurring. For every avoidable grade 3 or 4 pressure ulcer we carry out a thorough root cause analysis to determine why it occurred, and work closely with the staff and team involved to implement any recommendations.

In the first quarter of 2013/14 seven patients developed avoidable pressure damage, (3% of all reported pressure ulcer incidents). During the year this number has dropped considerably (to 0.7% of all reported pressure ulcer incidents)[[6]](#footnote-6). We did not achieve our target of zero avoidable pressure ulcers, and with a sustained rise in the number of patients we are caring for in the community, reducing the incidence of avoidable pressure damage remains a key priority for us.

We set ourselves a target for 100% of patients treated by the district nursing services to have a Walsall assessment (pressure ulcer). We measured this in quarter 2 when it was 100% and again in quarter 4 when it was 93%.[[7]](#footnote-7) This compares with 100% in the previous year. This will remain a safety priority for the coming year.

In order to reduce the number of avoidable grade 3 and 4 pressure ulcers, the older adult directorate reviewed and analysed the key learning from investigations into why there had been an increase in avoidable pressure damages. Key contributory factors have included a failure to carry out risk assessments, poor care planning/failure to follow the care plan, issues with patients transferring between services or teams, and failure to involve carers sufficiently in supporting care and treatment plans. In response to these issues, we set up a pressure ulcer action group to co-ordinate remedial actions in five main areas:

*1) Integrated working with OUH*

*Aim*: To minimise the risk of developing pressure damage as a consequence of poor communication between providers and services. It has identified the key risk points for patients who transfer between services/service providers, including communication with patients about their risk of pressure damage and information on how to minimise the likelihood of pressure damage occurring. The group also co-ordinates learning from poor discharges where this may have contributed to the development of pressure damage.

*2) Documentation and audit tools*

*Aim:* To ensure that documentation used in relation to pressure damage prevention and management is fit for purpose and used consistently across the trust. This includes introducing a new pressure ulcer risk assessment tool to be consistent with other services.

*3) Education, Training and Competency*

*Aim:* To improve the attendance and delivery of pressure ulcer prevention and management training and measure learning by implementing the pressure ulcer competency framework within the trust.

*4)* *Implementation of SKIN Bundles* *[[8]](#footnote-8)*

*Aim*: Explore SKIN care bundles as an effective care management tool aimed at pressure ulcer prevention trust-wide

*5) Working with Carers*

*Aim*: Work in partnership with both local authority and the voluntary sector to improve the knowledge and skills of formal and informal carers in relation to pressure ulcer prevention

In the past twelve months the incidence of avoidable grade 3 and 4 pressure ulcers has decreased markedly. Further work is now required to decrease the prevalence of avoidable grade 2 pressure ulcers and this has been included as a quality priority for 2014/15.

**Physical assessment**

There are a number of key physical health assessments which should routinely be carried out across both our physical and mental health inpatient services. We are developing a more integrated approach to the way in which we provide care to our older adult patients which takes account of both their physical and mental health needs, irrespective of how they entered our service. This will continue to be a priority for us in the coming year.

The malnutrition universal screening tool (MUST) is a short assessment that is used to identify when patients may have a particular need for a full assessment of their nutritional status. Some patients may not be screened using the MUST tool if it is apparent from their presenting history that they require a full assessment. In 2012/13 94% of district nursing patients had a MUST assessment. We measured 100% in quarter 2 of this year and 86% in quarter 4[[9]](#footnote-9). We are working with our district nursing to improve this score, supported by generic skills training for community staff (which is described in more detail in the section on efficient and effective services).

In quarter 4 we met our target that 98% of patients admitted to mental health ward will have a complete physical health assessment[[10]](#footnote-10). This has been supported by an education programme that aims to improve the skills of staff working in mental health areas in recognising when patients are deteriorating physically and responding quickly and effectively in such circumstances.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 | FY |
| % of patients admitted to psychiatric wards with a complete physical health assessment (target 98%) | 91% | 97% | 97% | 98% | 95,75% |
| % compliance with triggering of physical deterioration intervention in all community services (target 95%)[[11]](#footnote-11) | 95% | 94.1% | 97% | 94% | 95% |

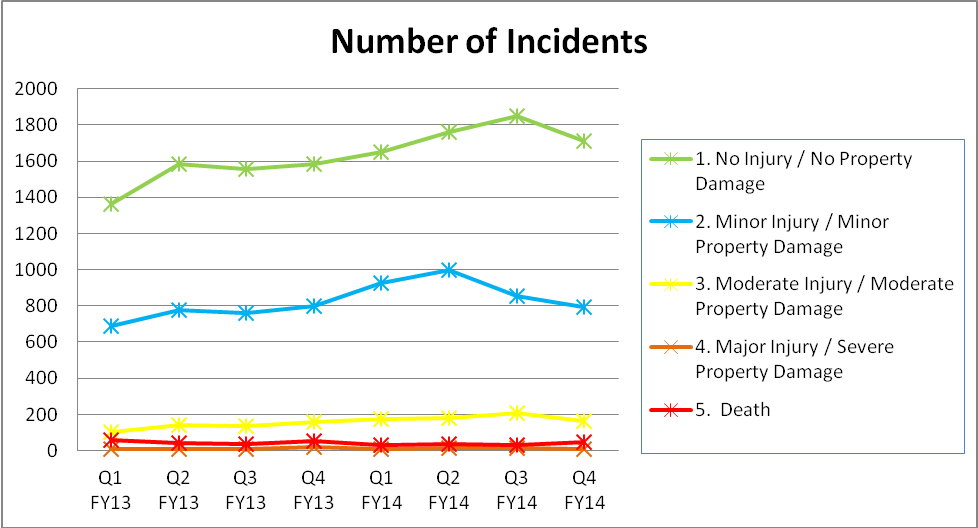
Where patients have reduced mobility a number of them may be at risk of developing blood clots known as venous thromboembolism (VTE). These can sometimes lead to serious cardio-respiratory problems if the risks are not effectively managed and treated. Our target is that 95% of all patients admitted to a community hospital or older adult mental health ward will have any risks of developing a VTE assessed on admission to a ward (last year we achieved 96% in mental health services and 85.2% in community health services). We have not met our target in quarter 4[[12]](#footnote-12) and are working to improve communication about the importance of undertaking this assessment with medical staff that have recently rotated across all our in- patient services.

**Incidents and serious incidents requiring investigation (SIRIs)**

One of the ways to improve patient and staff safety is to develop a good reporting culture where staff are encouraged to report any and every safety incident and where effective mechanisms are used by staff and managers to review and learn from them.

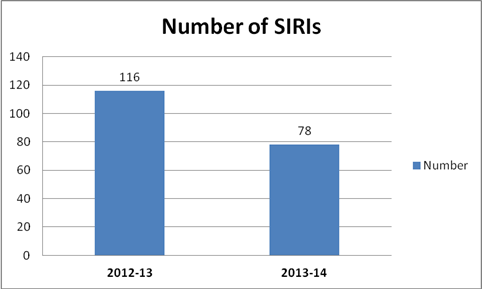
We can learn as much from incidents which cause little or no harm as we can from those where more serious harm occurred. We have therefore sought to increase the overall number of reported incidents whilst reducing the number which resulted in harm to patients and/or which were graded as a SIRI.

The quarterly reporting figures have ranged from 2717 in quarter 4 to 3001 in quarter 2[[13]](#footnote-13). Types of incident include communication, medical devices or equipment, security and medication errors. The two highest reported incident types were falls and violence and aggression. The number of serious incidents has remained approximately the same against a higher number of overall reported incidents.

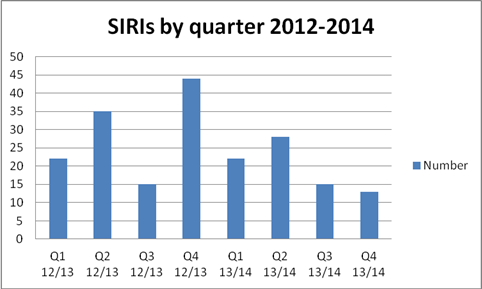


**Serious incidents requiring investigation (SIRIs)**

Over the last two years the overall number of reported SIRIs has reduced by a third[[14]](#footnote-14).



In the final quarter of this year we have seen a further decrease in the number of SIRIs. The reduction in suspected suicides and avoidable pressure ulcers have accounted most significantly for this reduction which we attribute to the work across the trust to reduce harm from these causes. There have been no never events.



Oxfordshire services were the highest reporters of SIRIs in 2013/14. This is largely to be expected as all of our community physical health services are located in Oxfordshire and the number of patients using our Oxfordshire based services is considerably higher.

There have been no rulings from the Coroner but we have received an improvement notice from the Health and Safety Executive relating to a patient fall from a window resulting in harm. This was as a result of a faulty window restrictor and we are currently implementing the required improvement actions, which included an assessment and replacement programme for all window restrictors in all inpatient units across the trust.

**Learning from SIRIs**

We use a number of approaches to learning from SIRIs including team briefing, local and trust-wide learning events, and through relevant committees, groups and team meetings. Key themes from 2013/14 which have resulted in improvement actions have included

* the coordination of care (CPA process) including the recording of CPA care on RiO and updating care plans and risk assessments
* communication problems including lack of regular team meetings and structured handovers, named nursing not in place, training issues, staff shortages and skill mix, supervision (many of these relate to avoidable grade 3 or 4 pressure ulcers)
* assessment not being completed in a timely way or not being adequately recorded
* transitions between services
* issues in relation to use of agency and locum out of hours doctors in the psychiatric liaison service, both in relation to availability, and handover/induction including ensuring access to RiO
* compliance with safe and supportive observations

**Case study**: **preventing avoidable pressure damage**

In response to a SIRI relating to avoidable pressure damage the team on ward 2, Abingdon community hospital implemented an improvement project. The aims were to prevent patients developing new pressure ulcers whilst on the ward and to prevent deterioration of pre-existing (inherited) sores.

Actions have included ensuring skin integrity checks for all patients within 6 hours of admission and photographing all existing wounds on admission; Walsall and MUST scores recorded weekly with documentation available at the patients side; online reporting of all grade , 3 or 4 pressure ulcers; using the wound formulary and tissue viability team for advice; improving communication at handover and at ward meetings; and using the safety cross system and safety dashboard to monitor effectiveness

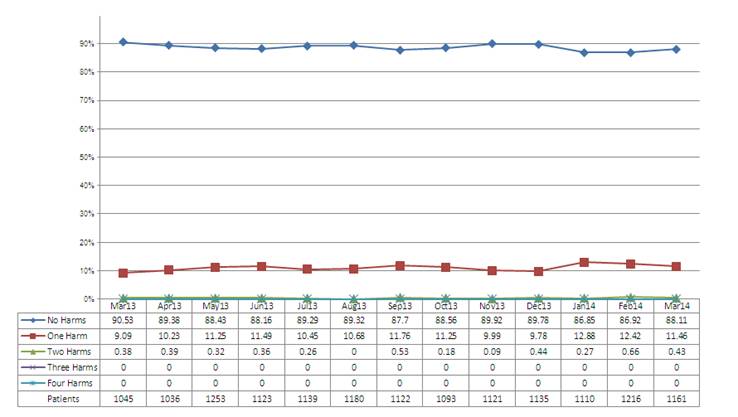
There have been no avoidable pressure ulcers on the ward since the project was implemented and the team won an improvement award from the trust’s productive programme.

**Safety thermometer**

The safety thermometer[[15]](#footnote-15) is a national initiative and measures the level of “harm free care” delivered in our physical health community services in Oxfordshire. It is a “*point prevalence*” measure which means looking at what is happening at a specific or fixed point in time, rather than looking at information from across a number of days or weeks. The safety thermometer therefore presents a snapshot of the level of harm at a particular time rather an indication of trends or increased incidence. It serves to highlight areas that may require more in depth examination.

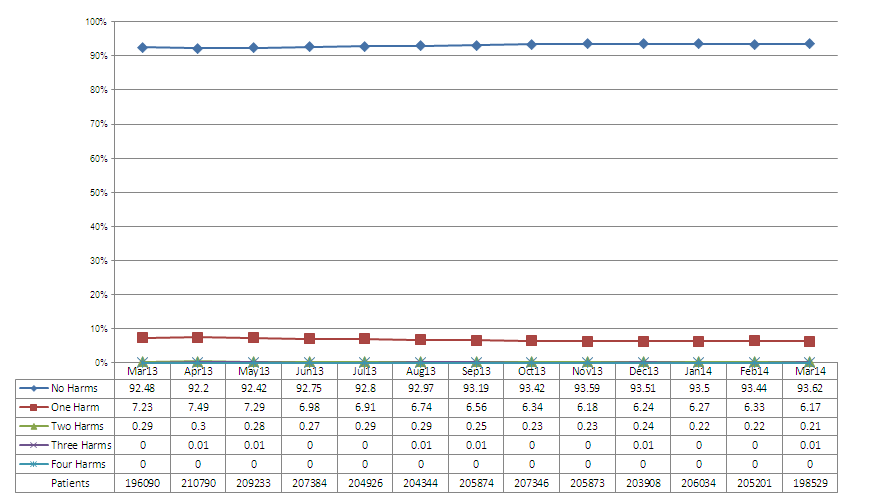
We measure harm related to venous thromboembolism; pressure ulcers (irrespective of whether they were avoidable or not); catheter-related urinary tract infections and falls. We also measure how many patients have experienced no harm, or 1-4 of these harms. The objective is to increase harm free care (the upper lines in the graphs below) and to decrease the number of actual harms experienced by patients (the lower lines in the graphs below).

Over the past twelve months the percentage of harm free care has ranged between 86.92 and 90.53% of the 1000-1200 patients assessed each month. This compares with national figures (all participating trusts in England) ranging between 92.2 and 93.62% of the 196,000-210,000 patients assessed each month.

Throughout 2013-14 when the prevalence of harm was measured within OHFT there was a small variation around the monthly average. However, there was a slight increase in the prevalence of harm in January and February which related to urinary tract infections associated with catheters, and grade 2 pressure ulcers. We have developed some focused actions to improve catheter care for patients in older adult mental health wards; and a comprehensive action plan to decrease the incidence of avoidable skin damage. As a consequence, in March 2014 we saw an increase in harm-free care.

**OHFT data**

**National data**



**Prevention of suicides**

Probable suicide is one of largest causes of serious incidents requiring investigation (SIRI) and prevention of suicide was therefore a key priority in 2013/14. Suicide prevention was the focus of a twelve month project and a number of safer care initiatives. We selected three indicators to monitor our progress to ensure people do not die prematurely and these are described below.

**Indicators:**

1. *unexpected deaths in inpatients (mental health services) reduced to 0, or greater than 300 days between*[[16]](#footnote-16) *deaths over two years*
2. *no inpatients to commit suicide*

Between 1/4/2012 and 31/3/2014 there were three deaths[[17]](#footnote-17) that would meet the criteria for an inpatient death. None of these deaths occurred in any of our inpatient areas although all were patients who had been inpatients. Two had left the ward (one was absent without leave and one was an informal patient not returning from leave). The former died in a prison abroad and the latter in the community. The third death was of a man who was an inpatient at Oxford University Hospitals NHS Trust (OUH) at the time of his death. All three died by suspected suicide. The death in OUH has been reported by that trust and has not been included in our figures below.

The days between deaths are 192, 153 and 75.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| year |  |  |  |  | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 |
| Number of unexpected inpatient deaths |  |  |  |  | 1 | 1 | 0 | 1 | 2 |

**Indicator:**

*reduction in the number of (apparent) community suicides towards 0 or greater than 300 days between deaths*

Numbers of suspected suicides reported over the last three years[[18]](#footnote-18) relate to those which were thought to be likely suicides at the time of reporting. They also include all those which will subsequently have been confirmed as suicides by the coroner. Numbers remain high but there has been a small year on year decrease. The final figures for 2013/14 may change as reported incidents are often reported in the following quarter. An analysis by quarter indicates that there is no increasing or decreasing trend.

The national picture over the last few years is that suicides rates in the general populaton have started to increase. This rise in not reflected in the figures for OHFT.

**Case study**: **community acute services (CAS)**

The community acute services achieved 483 days between deaths by probable suicide after commencing a specific safer care project. This stands in comparison to a mean of 62 days between deaths prior to the safer care project in May 2012. A plan is now agreed with the mental health safer care lead to develop the work in the new assessment teams for emergency referrals.

**Suicide prevention benchmarking project**

In 2013/14 OHFT supported a twelve month Suicide Prevention Benchmarking Project which involved reviewing how apparent/suspected suicides were being reported across the NHS South region to establish a baseline, facilitate learning across the region, and trial a new reporting template to create more consistency in reporting between different organisations. We continue to work in partnership with local and regional organisations to develop training, identify people most at risk of suicide and improve support for people bereaved by suicide.

To create a more consistent awareness of suicide amongst trust staff, OHFT has adopted The Interpersonal Theory of Suicide (Joiner 2005). In essence this theory focuses on how feelings of burdensomeness and lack of belonging can create a sense of hopelessness and suicidal desire. This model looks at recognising the point or trigger(s) where desire becomes intent and capability in order to help staff differentiate between patients who think about suicide (ideation) and those who are likely to attempt suicide.

The Joiner framework is intended to underpin and support existing suicide awareness models, tools and clinical judgement and has been shared through learning events. It is part of the clinical risk assessment and management training programme and is being rolled out through specific suicide awareness and education sessions, supported by two reflective practice sessions for all teams in the mental health division. Awareness training has also been provided for community mental health teams, out of hours urgent care services, physiotherapy staff and student nurses at Brookes University.

Pilot training in understanding and working with bereavement by suicide has also been delivered to a number of OHFT staff and this has been well evaluated. Alongside this work OHFT is developing localised information leaflets to give to relatives following the suicide of a service user and associated guidance for staff.

A working group has been established to develop a protocol for supporting staff working in teams where a patient has died by suicide. This was developed following a suicide awareness survey carried out as part of the suicide prevention benchmarking project which recommended the need for improved support for staff.

All suspected suicides must be reported to the local clinical commissioning group and nationally via STEIS (Strategic Executive Information System). The proposed new template or proforma for reporting apparent/suspected suicides was piloted in OHFT and has now been endorsed by the South of England patient safety group. All trusts are being advised to use it to aid consistent and thorough STEIS reporting of suspected suicides.

**Infection prevention and control improvements**

Infection prevention and control remains a priority for us in improving patient safety and has been adopted as one of our main strategic goals. For this reason we included a number of indicators in our quality account.

The infection prevention and control team have extended the environmental infection control audit programme in 2013/14 to Mental health day hospitals, ECT and podiatry services. We did not audit in quarter one. In quarter 2 we completed 40 of which 11 were unsatisfactory. In quarter 3 we completed 26 of which 8 were unsatisfactory. In quarter 4 we completed 14 of which 4 were unsatisfactory. All areas audited have now been revisited and passed the required standards. Some areas have significant challenges regarding the physical clinical environment, which have been identified as requiring financial investment and resources via estates services.

There has been one case of MRSA in 2013/14[[19]](#footnote-19). A comprehensive post-infection review was completed in collaboration with OUH. The blood culture was deemed a contaminant and not a true infection and therefore an internal review meeting was held. There have been no MSSA[[20]](#footnote-20) bacteraemias in 2013/14. Our target was the number of bacteraemia infections developed 48 hours post-admission should not exceed two.

The overall number of *Clostridium Difficile* infections (CDI) developed 72 hours post admission should not exceed 8. There were fourteen cases in 2013/14: two in quarter 1, four in quarter 2, six in quarter 3 and two in quarter 4[[21]](#footnote-21). This compares with 10 cases in 2012/13.

A monthly CDI health economy meeting with the OUH, Public Health England and commissioners reviews all CDI cases across the health economy to determine whether or not they were avoidable.

All fourteen cases have been reviewed with the following findings:

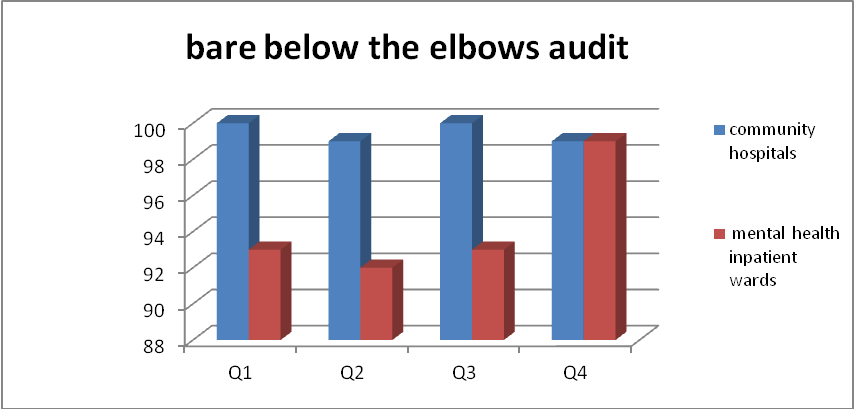
* twelve were deemed unavoidable
* one was deemed avoidable as this patient was already identified as positive for CDI in August 2013 but was re-tested in September 2013. The first episode in August was deemed unavoidable, however, this patient was retested within 28 days of the first specimen and therefore it is recounted as a new case
* one case was not classified as there was insufficient information available, however the patient management was within our guidelines

For a case to be deemed unavoidable all care has to be delivered in line with best practice and our local guidance. In all fourteen cases patients were managed safely and appropriately. The main influencing risk factor for development of CDI is the use of antibiotics and in all fourteen cases it was agreed that the antibiotics prescribed were appropriate according to the clinical need of the patients.

**Hand hygiene**

The level of hand hygiene scores has remained consistent; by quarter 4 we were meeting our target of 95% in mental health inpatient wards and met this target each quarter in community hospitals[[22]](#footnote-22).

We have excellent bare below the elbows compliance in both services[[23]](#footnote-23).



The remaining indicators related to new catheter-related urinary tract infections which we monitor through the safety thermometer (the figures below are an average across three month’s point prevalence[[24]](#footnote-24) data) and environmental infection control audits[[25]](#footnote-25).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 |
| Number of new catheter associated urinary tract infections (UTIs) across all trust services | 4 | 9 | 7 | 9 |
| Environmental infection control audits | n/a | 86% | 86% | 85% |

**Environmental improvements**

The new Whiteleaf Health and Wellbeing Centre opened in Buckinghamshire in February 2014. It comprises four inpatient wards, day services and community teams. Sapphire (previously Kimmeridge), and Ruby (previously Portland) are acute adult mental health wards and Amber (previously Mandalay) and Opal (previously the John Hampden Unit) are for older adults. The Whiteleaf centre provides a high-quality, up to date, state of the art environment for patients and carers and aids their recovery by having space, light and activity whilst offering containment and structure to the patients’ day. All staff are working to a new clinical model focused on supporting and encouraging patients in their recovery and working to the cluster pathways which provide evidence based interventions based on patient need.

The new wards are ligature-free, light and spacious areas with several spaces/lounges for patients to participate in a full activity programme. Each of these wards has had an increase in staffing taking them from a shift number of five staff in the mornings to six, five staff in the afternoon to six and four staff at night. All staff have had inductions to a new clinical model which is recovery focused and are now working to this model. The new building also has gardens, a coffee lounge and activity and resource rooms.

**Refurbishment programme**

The trust has invested approximately £10 million in 2013/14 to improve the built environment, with the majority of funds being used to refurbish inpatient areas. The work we have undertaken includes

* reduction of ligature risks across seven mental health wards
* extension of beds and bathing pool at Wallingford maternity unit
* development of a new emergency medical unit at Witney community hospital
* dementia ‘friendly’ work across all community hospital wards e.g. to improve lighting, review use of colours, textures
* internal and external work across the forensic mental health wards to meet national best practice standards
* a programme of maintenance work to address issues identified through infection control audits, window safety and to improve resilience as part of contingency planning e.g. provision of generators
* improving the provision of car parking and pedestrian walk ways across a number of the larger hospital sites e.g. Warneford, Littlemore, Abingdon and Witney hospitals

**Patient-led assessments of the care environment (PLACE)**

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. Patients, service users and carers were part of teams which completed an unannounced annual visit to each of our 36 inpatient wards. They assessed how the environment supports patient 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. A summary of the results for 2013 are below.

***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.

***Quality and availability of food and drink***

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.

***Condition, appearance and maintenance of premises***

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.

***Privacy and dignity***

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.

**Improving clinical outcomes**

|  |  |  |
| --- | --- | --- |
| **Quality Goal** | **Quality Activity** | **Quality Objective** |
| **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 |

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.

**Develop & implement integrated care pathways for children and young people**

The children and families directorate has reorganised the management of its services over the past twelve months to create a more locality based focus to the care it provides. This has enabled teams to work in partnership with local commissioners, service providers, schools, voluntary organisations and patients and their families. We have achieved our milestones for integrating care pathways for children and young people.

**Case study: Buckinghamshire children’s speech and language therapy service**

The Buckinghamshire children’s speech and language therapy service is developing a new approach to working with young people attending secondary schools. The intention is to enable children, young people and their families to be involved in setting their own outcome goals and measures, and to shape the intervention that will help them achieve these outcomes. The goals for the period of therapy will be set in negotiation with the young person, so they influence priorities and set goals that align with their views on what is important. The young person will rate themselves at the beginning of an intervention, mid way through the period of therapy and at the end of several sessions of work with the speech and language therapist.

It is envisaged that having trialled this practice, there are opportunities for roll out of its use across other client groups accessing the speech and language therapy service.

**Marlborough House, Swindon**

Marlborough House accepts referrals for young people aged between 11 and 18 who require assessment and treatment for acute psychiatric illnesses and who cannot be managed in the community because they require more intensive therapeutic input or because they present a risk to themselves or others.

Young people suffering from a severe eating disorder can also access assessment and/or treatment, including admission for inpatient care. Traditionally the aim of in3patient units has been to resolve all of the presenting problems before deciding that a young person is ready for discharge; however there are disadvantages to inpatient care including the possible loss of support from the child’s local environment, the potential for self-harm whilst the young person is acutely unwell, and the effects of admission on family life. Marlborough House has therefore developed a structured approach to the “*first ten days*” of admission to address the difficulties and risks while ensuring children spend the least possible time in inpatient care.



**Safer care**

**Day 1**

**admission**

**Day 2-5 introduction & goal**

**setting**

**Day 5**

**review & planning**

**Day 6-9**

**engagement & observation**

**Day 10**

**CPA**

The “*first ten days*” seeks to involve young people and their families, along with the multi-disciplinary team (MDT) and community staff in a “therapeutic alliance”. The aim of this alliance is to develop a shared view of the purpose of the admission, the planned length of stay, and shared goals or outcomes.

*Day 1 admission*

Core documentation is completed including risk assessment, care plan and the allocation of link workers.

*Days 2-5 introduction and goal setting*

The young person meets the team involved in their care, the goals for admission are identified and CPA (care programme approach) is commenced

*Day 5 review and planning*

The MDT, nursing, unit school and care co-ordinator review the purpose of admission, the current mental state of the young person and levels of risk, their identified goals and plans to achieve these, the current and future treatment plan and the plans for discharge. This is then discussed with the young person and their family.

*Days 6-9 engagement and observation*

During this period the young person has individual time with their nursing team, ward doctor and consultant supported by engagement with a therapeutic timetable and regular progress reviews.

*Day 10 care programme approach (CPA)*

A CPA meeting is held with the MDT, young person and their family to review the purpose of admission, the initial assessment, the tasks and goals for treatment, an assessment of what has worked well and what has not worked well, and the plans for discharge.

As a result of this new approach the ward has reported clearer goals for admission that are agreed between patients, their families and staff; goals and planned outcome based on individual patient needs and aspirations; and shorter lengths of stay.

**Case study: reducing section 136 detentions**

We are involved in two initiatives trialling approaches to work more closely with the Police to reduce the inappropriate use of Section 136 of the Mental Health Act and to facilitate the options of alternative Police interventions. Section 136 is used by the police to detain a person so that they can take them to a safe place where a mental health assessment can be undertaken. One initiative is through a shared triage car with Thames Valley Police to facilitate joint assessments by a community psychiatric nurse (CPN) and a police constable (PC) in Oxfordshire. The second initiative is working with Wiltshire Police in Wiltshire and Swindon through introducing a joint working protocol for young people in significant mental health distress or crisis (under the age of 18). When a PC responds to a young person in significant mental health distress or crisis they contact the local CAMHS service from the scene by phone (24 hours a day/365 days a year) to discuss risk, consider alternative options, or to arrange an emergency mental health assessment. Early indications suggest that both initiatives are reducing the number of people detained by Police under Section 136.

Reach4Health

**Rethink eating and activity for child health**



**Case study: *Reach4Health* healthy child weight management project**

This project was established in January 2012 and funded to run until March 2014. The National Childhood Measuring Programme (NCMP), now in its seventh year, shows in Oxfordshire that 12% of children in reception classes (4-5yrs) and 15% of children in year 6 (10-11 years) are overweight or clinically obese. The aim of the *Reach4Health* project is to provide a healthy lifestyle and weight management service for 4 to 16-year-olds in Oxfordshire. This has involved training school nurses in weight management strategies; setting up play and exercise programmes; educating children and families in healthy eating and marketing of the programme.

**Develop & implement integrated care pathways for adults**

**Service remodelling: adult mental health services**

Throughout 2013 and the start of 2014 the adult mental health division has been coordinating the pathway remodelling for adult services. The key changes include

* a new clinical service model for in-patient and for community services
* enhanced skill mix, leadership and staffing for inpatient wards
* an increase to seven day working for community mental health services in main localities within Oxfordshire and Buckinghamshire
* implementation of care clustering to be delivered within new assessment and treatment mental health teams

The remodelling of care pathways has been driven by the desire to improve patient treatment and experiences of services and their understanding of how our services work. Building on feedback from service users and carers, complaints and SIRI investigations the remodelling has worked to ensure that the service is patient centred, maintains a high emphasis on family and carer involvement and uses evidence-based interventions.

The key priorities for the service remodelling in adult mental health services have been to

* improve inpatient care and inpatient environments
* develop a new way of working and a clinical model that reflects recovery for patients and provides support to both patients and their carers
* improve standards of leadership
* develop mechanisms for collecting patient and carer feedback and use this to develop services for the future
* develop clustering, cluster packages and transparent outcomes for patients and their carers
* develop good quality data

Buckinghamshire now has two adult mental health teams (AMHTs - previously known as community mental health teams, community acute services and assertive outreach) both of which work to the same localities as the two CCGs; the Aylesbury Vale AMHT with a main base at the Whiteleaf centre and the Chiltern AMHT with its main base in High Wycombe and a satellite base in Amersham. Oxfordshire now has three AMHTs which work to the same localities as the clustered GP localities, with main bases at the Horton hospital in Banbury, the Warneford hospital in Oxford City, and Wallingford community hospital.

**“*Thank you for your support over the past few months since the arrival of our little boy. We are looking forward to the future as a family”***

adult community mental health team in Oxfordshire

The AMHTs are now providing extended hours until 9pm every evening, seven days a week with night assessment teams based at the Warneford hospital in Oxford City and Whiteleaf centre in Aylesbury. In each of the AMHTs there is a leadership team made up of a community team manager, a number of consultants and a community lead who is focused on the quality of care and best practice interventions.

The wards have increased the number of nursing staff available on each shift. Each ward now has a dedicated modern matron focused on quality of care and ensuring all interventions are up to date and based on best evidence. There is a consultant psychiatrist and a medical team for each ward delivering high quality care on admission and discharge, and providing the opportunity for patients to work with a consultant during their stay in hospital.

It is recognised that people with mental ill-health do recover and can lead full and satisfying lives. To reflect this, the focus of the new model of care is on recovery, drawing on the “recovery star” and outcomes based on best evidence. A considerable amount of work has gone into developing appropriate outcomes for the clusters, which will be monitored and reviewed over time.

The “Recovery Star” highlights areas to work with individual patients in identifying and addressing difficulties that they have with these core areas of life. These areas are also the basis for care planning through care clustering and will form the basis for care delivery in the new teams.



Over 150 patients and carers were involved in developing this model through dialogue and focus groups. The new teams will build on this to develop reference groups for their own localities which are made up of patients and carers who can support and help further to develop the new models.

**Harm minimisation service**

In response to the 2010 drug strategy *reducing demand, restricting supply, building recovery: supporting people to live a drug-free life* there has been a whole systems change within Oxfordshire drug treatment services resulting in service remodelling and recommissioning.

In April 2012 the harm minimisation service entered into a partnership agreement with the Oasis Partnership, a third sector provider, to deliver a wider remit of psychosocial interventions. The service provides

* substitute prescribing for opiate dependence which is focused on maintenance regimes (945 patients at present)
* brief interventions
* needle exchange
* group work
* drop ins

Following issues with its provision on the 1st of February 2014 we took over the Local Area Single Assessment and Referral service (LASARs) front door service to provide independent assessment whilst acting as a single point of contact for those wishing to refer in to, or access the Oxfordshire treatment services. The service has adopted a new approach that incorporates the LASAR function for those requiring a comprehensive assessment by the harm minimisation Service.

The LASAR front door service is delivered as a first point of contact for professionals, patients, individuals, parents and carers across Oxfordshire. Its main aim is to provide information on all the available commissioned treatment provisions. The service operates as a standalone service, however its incorporation within the existing harm minimisation service aims to reduce fragmentation and provide a clearer introduction and signposting to services than was previously achieved.

*“****Great Staff, very motivational, realistic and helpful with my issues. Thank you, you have helped me on my path to a better life”***

drug and alcohol Service

We have also taken over the assessment function for residential rehabilitation. The assessments for residential placements are offered across the county from our six open access and drug treatment centre sites. The service also now provides the link to prisons and we ensure there is provision for picking up any unplanned prison releases throughout the week and an additional resource through a Friday afternoon clinic.

**Improving access to psychological therapies (IAPT)**

*Bucks Healthy Minds*offers evidence-based talking therapies for people with depression and anxiety disorders in Buckinghamshire. Over 43,000 people in Buckinghamshire will experience significant depression or anxiety disorders each year. Healthy Minds has received more than 6000 referrals and over 4000 people have started treatment this year (in quarter 4 last year they treated 371 patients).

Improving access to psychological therapies for people with long term conditions (LTC) continues to be a key priority for the Healthy Minds service. In 2013/4 the service was successful in receiving Department of Health funding for the Breathe Well project (year two) to continue the roll-out of services for people with COPD. Funding was also received from Aylesbury Vale CCG to develop an innovative pilot primary care based service for people with LTC in five GP practices – the Live Well project.

*Oxfordshire TalkingSpace*offers a similar service in Oxfordshire. Last year TalkingSpace received a total of 1034 referrals with LTC compared with 1734 this year, and last year a total of 906 people with LTC entered treatment compared with 1414 this year.

These positive trends reflect the additional investment from the CCG for LTC work and the pilot project for the Department of Health IAPT pathfinder site Heart2Heart for people in cardiac rehabilitation (shortlisted in Secondary Care Innovation and Redesign HSJ Awards November 2013).   We also undertook local development work to stream-line pathways for patients with diabetes, stroke and chronic fatigue.  Next year we aim to increase our offer to those with COPD as Healthy Minds has done.

The table below shows the number of patients with LTC being referred for and receiving IAPT services[[26]](#footnote-26); they are also shown as a percentage of the total number of referrals and total number of patients receiving treatment.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 |
| **Bucks Healthy Minds** | referrals with LTC   357= 19.48%  entered treatment with LTC 383 = 26% | referrals with LTC  422 = 21.44%  entered treatment with LTC 364 = 26.73% | referrals with LTC   543 = 26.67%  entered treatment with LTC        443 = 30.49% | referrals with LTC 567 = 24.21%  entered treatment with LTC 492 = 32.16% |
| **Talking Space** | referrals with LTC  433 = 24.55%  entered treatment with LTC 322 = 26.70% | referrals with LTC  482 = 28.55%  entered treatment with LTC 360 =26.85% | referrals with LTC     441 = 23.48%  entered treatment with LTC        381 = 26.02% | referrals with LTC    378 = 17.66%  entered treatment with LTC        351 = 22.36% |

**Case study: Breathe Well project**

COPD is a common respiratory condition that causes breathlessness and can have a debilitating effect on someone’s life. In addition to the physical symptoms caused by the disease, the incidence of panic disorder is ten times higher amongst people with COPD. This can have a very negative effect on their quality of life and ability to self-manage their condition. In February 2012, Healthy Minds became a pathfinder site to explore the best way to provide integrated psychological and physical care to people with COPD. This pioneering work was undertaken jointly with the Chiltern CCG, NHS Buckinghamshire and Buckinghamshire Healthcare Trust. Staff from Healthy Minds began working with nurses based at 9 GP surgeries in High Wycombe to deliver clinics teaching self-help techniques to tackle breathlessness. All patients who have received therapy reported significant improvements in their mood, to the extent that they were no longer diagnosable with a mental health condition. The project was a finalist for the *Health Service Journal* Care Integration Awards 2013

***Wendy’s story***

Wendy is an 86-year-old lady who has had COPD for five years. She has had no previous mental health problems or therapy and reports being very anxious and tearful at times. Following a referral from her GP practice nurse, Healthy Minds became involved with Wendy and offered an assessment. During the assessment, Wendy reported symptoms indicating moderate depression and anxiety. Wendy reported anxiety about what the future may hold for her in terms of her COPD and concerns about what might happen if one day she cannot catch her breath.

Wendy participated in a five week intervention, after which she reported feeling more in control of her condition and more able to manage her symptoms effectively. She has decreased anxiety and depression, and has been able to learn about and better understand her condition with her husband. She is able to complete more tasks around the house and has started gardening again.

**Develop & implement integrated care pathways for older adults**

*Service remodelling: older people’s services*

The overall aims of the older people’s transformation programme is to develop an integrated model of care for older people and to provide personalised, integrated community, mental health and social care services organised in localities (or areas) which offer one quick and simple route to care.

This will

## enable patients to stay independent at home/their usual place of residence as much as possible avoiding admission to hospital and supporting timely discharge from hospital wherever possible

* allow patients to experience community health and social care delivered by one service providing outcomes that matter to them, irrespective of whether they enter our services through a mental health or physical health pathway

## support patients to manage their own condition

## safely support patients though periods of illness regardless of how many different community based health and social care specialists are involved in providing that care

* ensure GPs and acute service providers will have one quick and simple referral route to well joined up, locality-based care
* provide each patient and/or their GP with appropriate levels of support and liaison to resolve their immediate issues
* enable supportive relationships between health and social care professionals and GPs in the six Oxfordshire clinical commissioning localities to facilitate the best treatment to be provided to patients.
* contribute to the reduction of the number of avoidable acute hospital admissions in Oxfordshire
* contribute to the reduction in the number of delayed transfers of care (DTOCs) in the health and social care system in Oxfordshire through timely and effective discharge of patients

Progress this year has included

* development of an integrated, countywide, cross organisational approach to rehabilitation
* development of a leg ulcer pathway to improve healing times
* development of clinical leadership in district nursing teams
* joint work with OUH on a supported discharge policy
* generic skills training for community staff
* development of an emergency medical unit (EMU) in Witney
* provision of same day multi-disciplinary assessment and treatment for urgent care needs (physical health, mental health and social care)

***“I am writing to thank you, your hospital-at-home team, and all the staff at Abingdon Hospital for your exemplary care of my mother during her hospital admission with urosepsis last month. She received immaculate care from the first point of contact until she returned home”****.* Patient assessed at Abingdon EMU, admitted to community hospital ward and then discharged with support from hospital at home.

*Older people’s mental health services*

The service change in Oxfordshire and Buckinghamshire for older people’s mental health services will deliver a number of key benefits

* older people’s mental health teams, working as part of integrated locality multi-disciplinary teams in Oxfordshire and Buckinghamshire (mental health, physical health and adult social care), with mental health practitioners as a core part of those teams, able to provide older people’s mental health services into the Oxfordshire and Buckinghamshire CCG localities
* older people’s mental health teams that are able to provide mental health crisis response and home treatment and contribute to the delivery of an integrated urgent care pathway, in order to reduce avoidable admissions to acute physical or mental health inpatient care, through an enhanced mental health team duty function with extended hours and new ways of working
* increased capacity in older people’s mental health teams in the community to deliver early dementia diagnosis for an anticipated increased prevalence of dementia of 30% over the next 3 years, and also to provide an 8 week referral to first appointment response, through re-investment of part of the current day hospital provision into the older people’s mental health teams, streamlining of dementia pathway and the introduction of choose and book
* streamlined inpatient care in the Fulbrook Centre and the newly designed Whiteleaf Centre, through a new model for mental health inpatient care, increased staffing levels and improved skill mix

***“I was always so grateful that you listened to me and helped me to find a way through.  You were instrumental in helping me to cope and ultimately being able to keep mum at home with me until the end”***

older adult community mental health team in Buckinghamshire

* increased inpatient capacity and reduction in the ‘wasted’ days during inpatient care (including a reduced average length of stay), through improved admission, treatment and discharge procedures and access to rehabilitation 7 days a week
* a reduction in the number of admissions of older adults with mental health problems to older adult acute mental health inpatient units, through enhanced and extended older adult mental health community teams within integrated older people’s services
* increased opportunities for patients to access a range of community support services which promote mental health and social inclusion, through service change, designed and delivered in partnership with local health and social care agencies and with local non statutory providers and organisations, e.g. Alzheimer’s Society, Age UK

**Personal Health Budgets (PHB)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 |
| Number of patients/service users with PHBs – current**[[27]](#footnote-27)** | 95 | 98 | 107 | 109 |

Payments under the PHB system have been made to people with a range of needs, including continuing healthcare, acquired brain injury and neurological long term conditions who are in receipt of continuing healthcare (CHC) funding. A small number of PHBs have also been delivered to children eligible for CHC funding.

We follow some key principles including involvement with patients and carers; a “whole life” approach to care planning; regular reviews; equality of access; flexibility in how to use payments, supporting appropriate risk taking (with mitigation), and good communication. Our focus for 2014/15 will be to develop the PHB offer for children; develop systems for people with a learning disability; work with social care to deliver an integrated system; and consider how to make PHBs more available to patients in receipt of mental health services.

***Peter’s story***

Following a car accident 7 years ago Peter received a spinal injury which has resulted in partial tetraplegia. Prior to his accident, Peter was extremely fit and active. He has received continuing healthcare funding since 2007 with a personal health budget and direct payment since 2013. Peter’s assessed need is for 24 hour care – for personal care and all activities of daily living. He purchases live-in care from an agency that provides support 7 days a week. Normally the live-in carer has a 3 hour break every day so his budget also includes funds to purchase additional care for these hours. Peter has chosen to employ personal assistants to provide this element of his care.

Through the course of developing his support plan, Peter identified some important wishes and preferences for ongoing treatment and support

1. to improve his physical fitness which impacts his quality of life, physical and emotional wellbeing and although physio exercises and stretches were completed by his carers daily he reported spasm and muscle tightness, which greatly impacted on his mood and sense of wellbeing
2. to be able to spend some time alone – not to be surrounded by carers all the time

It was agreed that Peter could take a chosen risk to spend time alone without covering the live in carers absence. This enables Peter to save some money in his budget with which he can purchase additional private physiotherapy and gym membership. The gym he attends has specialist equipment suitable for people with spinal injury and his physiotherapist works with the gym staff to ensure that he is setting realistic goals in relation to his condition.

Peter’s health and care needs are fully met, and through his PHB he is able to use the funds allocated to his care flexibly to achieve additional health and wellbeing outcomes – which would not be possible through traditional service delivery.

**Improving patient and carer experience**

|  |  |  |
| --- | --- | --- |
| **Quality Goal** | **Quality Activity** | **Quality Objective** |
| **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 |

**“Seeking and acting on patient feedback is key to improving the quality of**

**healthcare service and putting patients at the centre of everything we do”**

The trust’s vision is that every patient receives good care in the way they expect, and they have a positive experience. To effectively put patients at the centre of everything we do, we are 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 staff
4. work with staff to implement the improvements
5. share feedback and actions being taken with patients and the general public

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 as a number of the measures below capture.

**Trust-wide improvement of culture of care**

We have developed a new professional strategy for nursing in collaboration with staff and Governors and in the coming year we will develop similar strategies for all of our professional groups, We are piloting values based recruitment and using learning to finalise the process. The trust has re-focused its staff and wellbeing group and this is now the Staff Health and Wellbeing Group which co-ordinates the improvement plan from the staff survey results.

**The health visitor implementation plan 2011-2015** - **increasing access to health visiting services**

OHFT provides health visiting services for children aged 0-5 and their families throughout Oxfordshire. Health visitors lead the[*Healthy Child Programme*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf%20) to ensure a healthy start for every family. Health visitors are qualified nurses or midwives with specialist training in public health, child development and protecting children. Our health visiting teams (also including community staff nurses, nurses and healthcare support workers) provide advice and support the health and wellbeing of babies, children and their families.

The government’s health visitor implementation plan was launched in early 2011, setting out a vision which recognised that the start of life is a crucial time for children and parents, and that good, well-resourced health visiting services can help ensure that families have a positive start. The plan specifically set out a ‘call to action’, with the challenging commitment to provide an extra 4,200 health visitors before the next general election in 2015, reversing years of decline. The plan also sets out a newly transformed service which would be made possible by these additional health visitors, covering four ‘offers’: community, universal, universal plus (specific expert help) and universal partnership plus (multi-agency response to complex issues over time), as well as safeguarding children.

**Progress in Oxfordshire**

The workforce growth target translated to an increase from 96.2 to 122.6 whole time equivalents by March 2015, a rise of 26.4 (22%) for Oxfordshire. Building on this success, new health visitors are now graduating and boosting our workforce, allowing us to deliver on our plan to put in place the new service offer.

Highlights have included:

* *Early Implementer*: the Department of Health awarded Oxfordshire ‘early implementer’ status, along with 22 areas in its second wave of implementation which allowed us to share good practice such as our approach to 2 year reviews and our monthly e-newsletter, and learn from other high-performing trusts
* *Baby-Friendly Initiative*: Oxfordshire was awarded £24,000 from the Department of Health in February 2014, to implement stage 1 ('Building a firm foundation') of the UNICEF ‘Baby Friendly Initiative’ across health visiting in Oxfordshire, which will support breastfeeding and parent-infant relationships

*“The point of the review is so much clearer as a result of completing the questionnaire .. it has helped me understand Tom’s development”* (mother of three)

* *Ages & Stages:* a significant development has been the successful introduction of the evidence-based Ages & Stages questionnaire at the 2 year review to ensure school readiness which has trained 100% of staff benefiting 94% of families with children under five; 85% of parents report an increased understanding of their child’s development when using the tool

*“The use of this tool has given me renewed confidence in the quality of my assessments” (health visitor)*

**Generic skills training**

In the summer of 2013, the West locality leads in Oxfordshire community services developed a ‘one stop shop approach’ to patient care at home. Community nursing teams and community therapy teams, including physiotherapists, occupational therapists and intermediate care mental health practitioners in the West of Oxfordshire took part.

During the first training session, nursing staff updated the therapists on how to recognise and prevent pressure damage, use of the Walsall assessment score and how to prescribe simple pieces of pressure relieving equipment such as cushions. The therapists updated the nurses on mobility aids including promoting safe use of aids and the prescription of the simpler types of aids such as sticks and mobilators.

Later topics have included basic wound care, detecting urine infections and positioning for patients with stroke and respiratory problems. Another session focused on nutritional assessment and included the mental health practitioners giving a session on eating challenges for patients with dementia.

Staff fed back that the training gave them more understanding of people’s roles leading to an increase in clinical dialogue, appropriate referrals to teams and joint working. The training has resulted in less delay in basic interventions, for example therapists are now more likely to issue basic pressure equipment to prevent deterioration themselves whereas previously they would have made a referral to another service. The training has led to more efficient use of resources by reducing team to team referrals and the resultant risks of such ‘hand-offs’. Now one professional can visit a patient and address a range of nursing, therapy and psychological wellbeing needs.

**Case study: skills lab**

The skills lab provides an environment for staff to receive training in theory and practical skills prior to assessment. It runs three courses: minor illness; minor injury; student negotiated award to develop skills outside formal training. The first course has been accredited with the University of West London at masters level and the other two are currently being reviewed for accreditation.

A recent course on recognising the deteriorating patient resulted in more confidence in making appropriate referrals. a community hospital nurse was able to recognise a potential pulmonary embolism and make an appropriate referral to the Emergency Medical Unit

*I gained more knowledge and am now more confident to manage the deteriorating patient*

**Delayed transfers of care**

A delayed transfer of care (DTOC) occurs when a patient is ready to depart from inpatient care but is awaiting admission home or back to residential care or to another care provider.

The number of DTOCs applied to OHFT has remained broadly the same over the past twelve months[[28]](#footnote-28).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 |
| community hospitals snapshot (number) | April 35  May 44  June 26 | July 32  August 35  September 33 | |  | | --- | | Oct 33  Nov 31  Dec 33 | | January 30  February 34  March 32 |
|  | Q1 | Q2 | Q3 | Q4 |
| community hospitals average (number) | 37 | 36 | 32 | 30 |
| mental health (%) | 1.5% | 1.4% | 1.6% | 1.2% |

Oxfordshire has a history of issues with respect to DTOC and nationally has performed in the bottom quartile. The main commissioners of health and social care and the main providers of health and social care in Oxfordshire (OHFT, OUH and Oxfordshire County Council Adult Social Services) agreed to deliver a joint approach to resolve persistent issues affecting care delivery in the county. DTOC was identified as a critical issue. The impact of DTOCs are felt by patients, care providers and the wider system.

All Oxfordshire providers have an agreed supported discharge pathway operating policy (SDPOP) which is applied by all three providers. There are weekly meetings for each provider and for all three providers together to review DTOCs and then, as a whole system, implement the standard operating procedures in the SDPOP to act on identified DTOCs quickly and with clear escalation processes. This is regularly audited.

Further actions are led and managed by the cross provider discharge pathway steering group. A key issue to manage is patient choice for onward care taking precedence over the choice to remain in an acute or community hospital bed. Further work to support patients and staff in making these decisions is being undertaken.

**Dental services**

***“You made our smile better….”***

dental services in Oxfordshire

Our dental service in Oxfordshire is in the process of achieving the British Dental Association (BDA) quality in dental services scheme award (QIDS) which is a quality assurance tool to help salaried dental services comply with current accepted standards of good practice.

In order to achieve this award we have to show compliance against ten domains which are: work systems; treatment decisions; good business practice; health and safety; infection control; dental public health; staff development; human resources; patient and public involvement; and public protection. The evidence required for the ten QIDS domains is the same as that required for CQC and the dental service has now completed the required final portfolio of evidence for QIDS.

Some of our specific quality activities include

* infection control improvements – as a result of feedback from a patient survey the cleaning of dental sites has been addressed =and improvements are being monitored
* all fabric chairs within the clinical environment have been replaced with vinyl chairs to meet current infection control guidelines
* following QIDS inspections improvements have been made to clinics to improve signage, patient information boards, cleaning, de-cluttering of surgeries and waiting areas
* the service regularly asks for patient feedback and concerns and runs repeat surveys to monitor improvement in patient satisfaction
* the service has been working hard to improve communication and customer service and all staff have now attended training days with further sessions planned during 2014/15

**Case study: Care Home Support Service (CHSS)**

CHSS was set up to ensure that residents in care homes receive the right care and services to ensure their health needs are managed and treated appropriately. Benefits include improving the overall quality and standards of care received by care home residents, reducing the occurrence of inappropriate hospital admissions, and reducing the burden of medications.

At each regular visit to the care home the CHSS team

* sees all new residents and those recently discharged from hospital to review their medications, identify if they have documented end of life care/advanced care planning and to assess their falls/fracture risk and address any immediate concerns/issues
* sees any other residents whom the care home have concerns about
* reduces the need for other health care provider visits
* monitors the standard in care homes in partnership with the contracts team at Oxfordshire County Council

**National staff survey**

The national staff survey is carried out across all NHS trusts in England. It allows staff confidentially to comment on how their trust supports, trains and involves them in delivering high quality and safe services. NHS trusts delivering similar services are able to compare or benchmark themselves against each other on the basis of whether they are in the top 20%, above average, average, below average or in the bottom 20% of similar trusts. The results for the 2013 staff survey are detailed below. The response rate remained at just over 50% in line with other trusts.

The overall staff engagement score for OHFT is 3.79 which places it in the top 20% compared with other mental health/learning disability trusts.

There are 3 sub-dimensions to employee engagement

* staff ability to contribute towards improvement at work; the trust score was 30% placing it in the top 20%
* staff recommendation of the trust as a place to work or receive treatment; the trust score was 3.64 which places it above average
* staff motivation at work; the trust score was 3.90 placing it in the top 20%

The 2013 staff survey results show continuing improvements for the trust.  We now have 21 key findings that are in the best 20%, better than average or average and only one area in the worst 20%.  There are, however, a number of areas where improvements still need be made.

Areas which have improved (statistically significant) in the 2013 survey are

* percentage of staff having equality and diversity training in the last 12 months (75%)
* percentage of staff believing the trust provides equal opportunities for career progression or promotion (93%)
* we had top ranking scores for support from immediate managers; fewer staff suffering work related stress; percentage of staff able to contribute towards improvements at work; staff motivation at work; and equality of opportunity for career progression.
* our lowest ranking scores were for percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; percentage of staff working extra hours; percentage of staff reporting errors, near misses or incidents witnessed in the last month; percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months; and percentage of staff reporting good communication between senior management and staff

Divisional action plans for improving areas where we did not score well are now part of the annual requirements for each operational division and are monitored through the Staff Health and Wellbeing Group and quarterly performance reviews.  They incorporate the specific areas from the staff survey results, which are localised to the division.

There is one area in which the trust has deteriorated (statistically significantly) since 2012, which is *percentage experiencing harassment, bullying or abuse from patients, relatives or the public in the last twelve months (36%).* Further analysis is required to identify if staff are experiencing harassment, bullying or abuse from patients, relatives or the public in all areas or in specific areas.

To ensure continuing progress and improvements, the Staff Health and Wellbeing Group (previously Wellbeing and Culture Group) has launched a Wellbeing Guide and Plan which is updated annually and has its own dedicated section on the staff intranet.  We now have over 100 Wellbeing Champions who are geographically spread throughout the trust.  The initiatives be taken forward this year are

* four staff health and wellbeing days a year
* implementation of mindfulness programmes
* development and trial of health walks schemes at main trust sites
* increased access to yoga/ fitness classes at trust locations
* develop a proposal for a “bike to work’’ scheme
* bi-annual pedometer challenges
* wellbeing notice boards
* support an annual programme of public health campaigns, sharing health advice and information with staff
* review management and leadership development activities to incorporate messages about staff health, wellbeing and support
* review the appraisal process and incorporate wellbeing

**Equality and Diversity**

OHFT is committed to advancing equality of opportunity for all, eliminating unlawful discrimination, harassment and victimisation and fostering good relations between people of all protected characteristics. We recognise and value the difference diversity makes to the communities we serve and to our workforce.

We have been using the NHS Equality Delivery System to progress our equalities work. This framework has helped us to ensure that service users, carers and staff are treated fairly. Using the Equality Delivery System, the following Equality Objectives were identified for 2013/14

* to improve equalities data collection
* to improve the use of equalities information to inform policy, service redesign and business decision making
* to improve service quality and health outcomes for patients and service users

To this end, we have achieved the following against these objectives:

1. In our drive to improve the collection of equalities information, a number of services have successfully closed the gaps in information, for instance: MH RiO (Children and Families) are achieving on average 85% of complete and valid entry on electronic patient records for *Ethnicity* across all teams in the Division; MH RiO (Adults and Older Adults, and Specialised Services) are achieving on average 80% of complete and valid entry for *Ethnicity* on electronic patient records; ‘Talking Space’ are achieving on average 75% of complete and valid entry for *Disability* and *Physical Restriction* fields on electronic patient records; and ‘Healthy Minds’ are achieving on average 83% of complete and valid entry for *Disability* and *Physical Restriction* field on electronic patient records. We intend to build on the success of this data collection by possibly extending coverage to other protected characteristics.
2. Service remodelling projects have been impact assessed to ensure that they comply with the Public Sector Equality Duty and to demonstrate that ‘due regard’ has been taken into consideration in service redesign.
3. We are investing in the new ‘next generation electronic health record’ (EHR) system to improve the information collection and recording system to allow clinicians and managers to capture, access, and report on information across all nine protected characteristics and use the equalities information to inform policy development to improve health outcomes for patients and carers.
4. An objective has been set in our patient experience strategy to conduct an equality analysis each year to identify any particular groups or sections of the communities who are not being reached effectively by the current approaches to collect patient feedback. The annual analysis and resulting actions will ensure that our methods are accessible and inclusive.
5. A total of nine ‘Deaf Awareness’ Training sessions have been delivered across the trust to key teams to help promote a better understanding of the issues and barriers faced by deaf people when accessing health services.

**Improve patient & public engagement**

We have involved patients and carers in a number of our development and redesign programmes, most notably the service remodelling for adult mental health and older adult services. There are numerous examples across our services of how we involve and engage our patients and those close to them, as well as local partners. However we see involvement and engagement as critical to the delivery of high quality services and will be developing further work over the coming year.

**Case study: stakeholder group for Oxfordshire children’s integrated therapy service**

We believe that a successful therapy service requires a wide network of partnerships and we set up a stakeholder group which includes parents, community paediatricians, social care, special school head teachers and mainstream schools. There is a pool of five parent/carers that have an induction from the service manager to support them in understanding the specification and being empowered to contribute: typically two or three parents are at each meeting.

The group quality checks service delivery and development and having an independent chairperson helps ensure a collaborative problem solving approach to developing the service in line with the service specification. Representatives value the forum as they have a place to raise items of concern and interest, and they can influence developments. Commissioners appreciate the impact of the group. With the contract ending March 2015 commissioners will consult with the group on the new specification and its development.

**Care programme approach**

The care programme approach is a system of delivering community mental health services to individuals diagnosed with a mental illness and who have complex needs that mean that one or more clinicians are involved in their care. The approach requires that health and social services assess need, develop a written care plan with the patient and their family, allocate a care coordinator, and then regularly review the plan with the patient, their family and relevant professionals.

The CPA care coordinator should:

* Be appointed to co-ordinate the assessment and planning process. The co-ordinator is usually a nurse, social worker or occupational therapist. It is recommended that the person who needs CPA support is involved in the assessment of their own needs and in the development of the plan to meet those needs. The person should be informed about the different choices for care and support available to them, and they should be treated with dignity and respect.
* Develop a formal written care plan with the patient that outlines any risks and includes details of what should happen in an emergency or crisis.
* Make sure that the care plan is reviewed regularly. A formal review is made at least six monthly. The review will consider whether CPA support is still needed.

We use a number of indicators related to CPA which don’t have a specific target attached, but for which we aim to see an increase over time. These are:

1. *The % of adult service users on CPA in settled accommodation[[29]](#footnote-29) -* this is the % of people who we have noted are in owner occupier, rented, residential accommodation; therefore this does not include those homeless or in temporary accommodation. This percentage has increased since last year.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 | 2012/13 |
| % of adult service users on CPA in settled accommodation  *(snapshot)* | 77.8% | 79.1% | 79% | 77.3% | 77.7% |

2. *The % of adult service users on CPA in employment[[30]](#footnote-30) -* people in paid employment but does not include voluntary work. This percentage has remained stable since last year.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 | 2012/13 |
| % of adult service users on CPA in employment  *(snapshot)* | 13.1% | 13.6% | 13.3% | 11.9% | 12.78% |

3. *Is there evidence that the service user has been involved in the development of their care plan?[[31]](#footnote-31)* That is, evidence that the care coordinator had spoken to the service user and developed their care plan with them. This has increased significantly since the previous year but remains an improvement priority for 2014/15.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 | 2012/13 |
| 100% of mental health service users to have opportunity to be engaged in development of care plan | N/A | 48/51 (94%) | 34/40 (88%). | N/A | 78% |

### 4. *The number and % of patients receiving follow-up contact within seven days of discharge****[[32]](#footnote-32)*** *from mental health wards* - all patients should have a follow up by a clinician within 7 days of discharge from the ward. Usual reasons for not meeting this target are patient moves out of area, goes on holiday, or has not left contact details.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Q1 | Q2 | Q3 | Q4 | 2012/13 |
| % of patients receiving follow-up contact within seven days of discharge from mental health wards | 96.4% | 98% | 96.6% | 96.4% | 97.7% |

In addition we audited the following four CPA indicators in quarter 2 and quarter 4[[33]](#footnote-33). These will continue to be improvement priorities for 2014/15.

|  |  |  |
| --- | --- | --- |
|  | Q2 | Q4 |
| Current care plan  Care reviewed in last 6 months  Care co-ordinator  Risk assessment reviewed in last 12 months | 5089/5790 (88%)  4116/5790 (71%)  5790/5790 (100%)  5144/5790 (89%) | 5364/5999 (89%)  4231/5999 (71%)  5999/5999 100%)  5445/5999 (91%) |

**Case study: developing outcome measures for users of adult mental health services**

During 2013 a series of workshops was carried out with users of adult mental health services and their carers in Oxfordshire. The intention was to co-create a set of agreed and common outcome measures with patients and carers which can be used to assess both the therapeutic journey of the individual patient and to monitor and evaluate the effectiveness of the service and care models. Seven core outcomes were agreed

1. people will live longer
2. people will improve their level of functioning
3. people will receive timely access to assessment and support
4. carers feel supported in their caring role
5. people will maintain a role that is meaningful to them
6. people will continue to live in stable accommodation
7. people will have fewer physical health problems related to their mental health

**Measuring and improving patient, carer and commissioner feedback**

*Complaints and PALS Information*

We welcome and seek out feedback, including complaints, as an opportunity to learn from people’s experiences to improve the quality of care. For this reason we are keen that patients and carers tell us when they are unhappy with the care they have received, either as a formal complaint or informally via the patient advice and liaison service (PALS). We are also keen to hear when things go well to enable us to build on our strengths.

*PALS concerns and requests for advice and information*

During 2013/14, the PALS team has responded to 1172 local concerns[[34]](#footnote-34), requests for advice and information and comments - a significant increase on the previous year which reflects our efforts to make this service available and accessible. The PALS team cover all of our services and provide additional support to the 36 inpatient wards by visiting patients on the wards on at least a monthly basis. Concerns include lost property, replacing damaged furniture and equipment, understanding Mental Health Act processes, delays to equipment arriving, and waiting times for treatment.

We also received over 3,500 written compliments in 2013/14.

***“Very good here, it is excellent in every possible way. Members of staff are really kind, they are also very good at getting you to exercise”***

*c*ommunity hospital in Oxfordshire

***“Staff have been absolutely fantastic with the care and support they had provided our daughter so far.  You had kept her safe, and been so understanding towards her.  We are really impressed with you all”***

adult acute mental health ward in Buckinghamshire

**“*Therefore I would just like to say a last massive thank you to the NHS for providing me a safe place in possibly the darkest time of my life.  Although I have missed a summer of my life here I’ve also gained the rest of the summers left in my life and I don’t know where I would be if I hadn’t come here, so thank you very much”***

children and adolescent mental health ward in Swindon

***“Quite literally you did all save my life and for that I will be eternally grateful*”**

GP homeless practice in Oxfordshire

***“Feels that the NHS and ...... ward in particular, have been excellent and nothing but supportive to our son over the years”***

forensic inpatient ward in Oxfordshire

*Complaints received*

In 2013/14, we received a total of 226 complaints[[35]](#footnote-35), of which 88% were responded to within the agreed timeframes (this excludes complaints still open and in time). This represents a small reduction of 3% when compared to 232 complaints received in the previous year, which we feel is a reflection of the recent changes to increase the capacity of the PALS to resolve problems quickly. In addition in 2013/14 we received 48 concerns raised by an MP on a patient or family member’s behalf which are responded to using a similar process to complaints, this compares to 46 received last year.

The main themes have been

* insufficient care in the community (feeling unsupported)
* poor or inappropriate communication or sharing of information
* attitude of members of staff
* difficulties with admission, transfer or discharge from a ward

*Learning from complaints*

We have taken many actions as a result of patient feedback, including

* ensuring each adult acute mental health ward uses a property log book and makes patients aware of their responsibility to keep their belongings safe
* improving communication pathways between health visitors and midwifery, including regular meetings between the services
* keeping copies of discharge letters in the patient’s health records in community hospitals
* training on the management of suspected stress fractures for urgent care staff
* a new autism strategy in CAMHS
* a review of the x-ray referral pathway for urgent care to ensure this is effective and efficient.
* fixing faulty equipment e.g. the door bell on one of the adult acute mental health wards
* a new clinical nursing model for the adult acute wards
* training, supervision and mentoring of staff to improve communication
* physical health care training and support for mental health ward staff

*Friends and family test*

We introduced the friends and family test to patients across our 8 community hospital sites (10 wards) and three minor injury units from January 2013, across a number of community physical health services from April 2013 and plan to extend this to the majority of our services by December 2014. The test has been introduced nationally for acute hospital trusts and we have asked the same single question: whether you would recommend the ward or unit to friends and family if they needed similar care – this is then used to calculate the *net promoter score*.

In 2013/14 our friends and family test score for community hospitals was +72.6 based on 252 responses which equals 13% of patients discharged (national average for acute inpatient wards +72 score). Minor injuries unit (MIU) was +62 based on 2147 responses which equals 7% of patients treated (national average for A&E department +55 score).[[36]](#footnote-36)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | Extremely likely | | Likely | | Neither likely nor unlikely | | Unlikely | Extremely unlikely |
|  |  | |  | |  | |  | |  |  |
| Community Hospitals | | Number | | 194 | | 47 | | 7 | 2 | 2 |
| Percentage | | 77% | | 19% | | 3% | 1% | 1% |
| Minor Injury Units | | Number | | 1507 | | 465 | | 72 | 45 | 58 |
| Percentage | | 70% | | 22% | | 3% | 2% | 3% |
|  |  | |  | |  | |  | |  |  |

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. We have seen an increase in the number of “*likely*” responses but these are excluded from the net promoter figures.

*Core Questions*

We introduced four core questions identified as important to patients across the majority of internal paper and electronic patient surveys. For all four questions the number of positive responses has increased from April 2013 to March 2014, and this is reflected across both inpatient and community based services. The question where most improvement is still required is around patients being given the right amount of information.



*Food Survey*

Patient surveys are carried out about the food provided across all 36 inpatient wards on a quarterly basis by our main food supplier. We received feedback from 128 patients and 75% of patients rated the overall quality of the food as excellent or good.

*Acting on What Patients Tell Us*

In 2013/14 OHFT received over 32,000 responses from patients about their experiences of care through formal feedback mechanisms e.g. surveys, formal complaints and compliments, face to face and telephone interviews with patients, informal feedback received by our staff, local suggestion boxes, and feedback from patient groups and councils.

As a result of patient and carer feedback we have initiated a number of changes and improvement, just a sample of which are listed below.

* reviewed and increased staffing levels of nurses on each ward by one person a shift
* a map of the hospital site was put up on a particular ward so that patients know where to go for things e.g. the canteen, patient finance, patient advice and liaison service, main reception
* the milk order for a particular ward was increased and a jug was purchased to try and avoid patients drinking from the milk cartons
* improved the process for 6 monthly care review meetings for all patients (at regular points to give and discuss information, review your care plan in partnership)
* review and standardise the information given out by each team to patients and carers and create a range of additional leaflets and information
* improving the control of temperature on wards
* a care plan template has been developed and introduced by all staff to improve joint working with patients, and to help them to manage their condition across a number of services
* new patient slots for podiatry services were increased from 40 minutes to 45 minutes
* quiet close bins have been purchased and ‘noisy’ doors on wards were reported to the facilities team for maintenance
* a revised cleaning audit was introduced on the particular ward with concerns, followed by a meeting with the contractor which led to a fixed cleaner being allocated to the ward for a set number of days a week
* waiting time boards were put up in each minor injury unit and reception staff have been asked to keep these updated and staff on reception have been asked to inform each patient of current predicted waiting times on arrival
* two food suppliers, in addition to our main supplier, have been identified and are now being used across our services to increase the range of choices
* The equipment in the music room in a forensic unit has been replaced/ updated and is now ready for use and an art group has been started on a forensic ward
* the dental service increased the number of domiciliary dental teams from 2 to 3 to see patients in residential and private homes who are unable to access clinics
* Luther Street will monitor the demand for male and female GPs to make a choice available
* better information is sent out to new CAMHS patients and it now includes some pictures of where people will be coming to for their appointment and a list of frequently asked questions developed with patients and parents

**Case study: Oxfordshire integrated children’s therapy service**

**Constraint induced movement therapy (CIMT)**

This evidence based intervention is given by physiotherapists and occupational therapists to children with upper limb hemiplegia to help children and young people develop the use of their weak limb. As a result of feedback from parents about their preferred way of their children accessing this, support groups were set up in the school holidays for CIMT (rather than individual programmes set up in schools during term-time). Children with hemiplegia are often ‘isolated’ being the only child in a school with this condition and an additional positive outcome of the group-based school-holiday structure was the social contact between children and families.

**Therapy narrative group**

Primary school aged children in Oxfordshire were offered group based support in the school summer holiday to develop their expressive language skills. This focus outside of a busy school curriculum gave the necessary boost to their development. A requirement of the activities was for the children to do some work at home; however, they did not like the idea of doing “homework” during the school holidays so in response to their feedback it was renamed as “home based activities.

*The National Patient Survey*

In 2013 a survey was sent to 827 people receiving care from community adult and older adult mental health teams. We received a 33% response rate (275 completed questionnaires returned), This was higher than the average response and represents a sample of 2% of patients in current treatment.

The table below identifies how OHFT scored against each section of the survey out of a maximum of 10 and gives a comparison of performance against other trusts. The survey highlights that we have achieved similar results compared to other trusts for the majority of questions.

Our services are rated highly in response to questions relating to the care and compassion from staff; with a score of 9.2 (out of 10) for patients feeling they were treated with respect and dignity and a score of 8.6 (out of 10) for patients feeling listened to by staff.

Areas where we will be seeking to make improvements include the care review meeting process and ensuring that our patients’ physical health needs are met. We have also reflected people’s need to gain better access to our services in a crisis situation in our extension of community services operating hours. One significant area of improvement was the question ‘*does the service user know who their care coordinator is’* which, following targeted work, is now scored by patients at 7.6 out of 10 (as opposed to a score of 5.3 out of 10 in 2012).

Early results from an internal survey (responses between October 2013 to February 2014) with responses from 211 people show continued improvement in two areas: *knowing who the care coordinator* is (averaging 84%) and people saying they *understand what is in their care plan* (averaging 59%).

|  |  |  |
| --- | --- | --- |
|  | 2013 National Survey  N=275 | Local Survey Oct 2013-Feb 2014  N=211 |
| In the last 12 months have you had a care review meeting to discuss your care? | 54% | 66% |
| Did you find the last review meeting helpful? | 64% | 61% |
| Do you have the number of someone from the mental health services that you can phone out of office hours? | 48% | 54% |

**Case study: Marlborough House, Milton Keynes**

During February 2014 Marlborough House completed its third round in the annual peer review process. All medium secure units in the country currently participate with a shared aim of learning and information sharing. The programme is run by the Royal College of Psychiatrists and is funded from the central service budget. During the course of the review which lasts a working day – all aspects of functioning relating to the unit are examined. In addition the review team will meet with ward staff, patients and the management team to gain verbal feedback. Following the latest cycle the unit scored 76%.

**Delivering efficient and effective services**

|  |  |  |
| --- | --- | --- |
| **Quality Goal** | **Quality Activity** | **Quality Objective** |
| **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 |

Continuous improvement of service design and delivery is robustly supported in OHFT 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.

**Productive care**

**Improvement programmes**

We give a high priority to service improvement and support two main improvement programmes in OHFT: productive care and safer care.

*Productive ward programme: releasing time to care*

Productive care has developed over the last eight years from the national productive ward and productive community services programmes. The underlying principles are to find ways to increase the time available to deliver direct care and to reduce waste and duplication. OHFT was one of the first community based trusts to adopt the productive series in 2009 and now over 80% of all clinical teams across the organisation have been offered training and been supported in improvement tools and techniques by the productive care team. Teams measure improvement over time and one of the key principles is openness – so a productive ward will usually display a range of graphs and posters on their progress for patients and carers to see.

**Case study: Peppard Ward**

Peppard ward in Townlands hospital, Henley, cares for older patients with a wide variety of conditions and needs. The ward staff have used the productive ward framework to systematically work through a range of topics including meals, medications, accurate observations and handovers at the change of shift times.

The clear goal was to release time to give personalised care and to improve the quality of the patient experience. The ward staff use time within their regular staff meetings to work on specific areas for improvement, led by the productive ward facilitator and the ward manager.

The ward has seen a consistent improvement in scores for both patient and staff satisfaction. These results and other areas of improvement work are displayed on the *Knowing How We are Doing* board. The ward team also uses the productive ward performance dashboard as a means to review their current position and to create regularly reviewed action plans in any areas requiring improvement, for example meals provision, reducing harm from falls and reducing the incidence of hospital acquired infections .

**Case study: adult mental health wards**

Buckinghamshire adult mental health wards have been using productive care principles in order to work together on improvement ideas through a regular forum. The group decided to focus on improving the quality of patient progress notes and agreed an audit against a set of standards on all five wards. In December 2012 the group devised and introduced a standardised template for note writing along with guidance notes for clinical staff which was piloted on two of the wards. After using the template for three months the team undertook another audit. The results demonstrated improvement in several areas including patient one to one time, determination of risk and discharge planning. At a visit from the CQC in March 2013 to one of the participating wards the standard of progress notes was commended. After a further audit, further amendments were made and adopted by the pilot wards in November 2013.

The improvement in direct contact time with patients was maintained as was the accuracy of discharge planning. There remain other areas of documentation which will provide the focus for improvement in the future for the Bucks productive ward safari group. There are plans to involve the wider professional team members in improving the knowledge and skills of staff in communication and assessment of patients with complex mental health needs.

*Safer care programme*

Safer care methodology is a highly systematic approach to identifying and reducing harm to patients. Using a project approach, measures are developed for each harm reduction project to determine accurately the existing level of harm and assess the impact of improvements on the outcome and process of care.  The plan, do, study, act (PDSA) cycle offers an approach to testing improvements in a controlled manner to find out what works or makes a difference. Measurement of improvement involves run charts and statistical process control (SPC) charts to analyse the impact of change over time.

In OHFT we have a dedicated safer care programme which is supported by a group of thirteen NHS trusts in the region (South of England mental health and integrated services safety collaborative). The collaborative aims to

* reduce death from self harm and from unexpected causes
* reduce unplanned absences and incidences of violence and aggression
* reduce medication errors and improve good practice in medicines management
* reduce the number of falls and catheter associated urinary infections
* improve VTE risk assessment and management
* improve patient and carer experience
* assess staff perceptions of patient safety

As part of the safer care programme staff are trained in a suite of tools which assist with identifying and prioritising the most harmful stages of care processes and designing ways to standardise and test the reliability of care. The work is guided by safety leaders drawing upon the expertise of clinical teams. Harm reduction projects are selected in response to quality monitoring where concerns or issues have been identified.

Over the past twelve months safer care projects have included reduction in unplanned absences; reduction in medication omissions and improved medicines reconciliation; reduction in self-harm and a reduction in restraint.

### Use of technology to support care

A key priority has been to invest in technology to support our peripatetic and mobile staff. This means that staff do not always have to return to an office base to access information or input information related to patient care, which also enables staff to complete records in a timely manner. As a result of significant investment staff now have

* more than 2500 laptops, in excess of 1400 Smartphones and approximately 700 iPads in use by staff across all services
* resilient VPN (remote access) connectivity to allow secure access to the trust’s network domain, systems and applications from a trust-provided laptop connected to the internet
* Outlook web access provided to all staff allowing secure access to trust email from any computer or smartphone connected to the internet

A formal pilot project was completed to determine whether laptop use should be expanded for additional frontline clinical staff.  The pilot project concluded that this could only be a partial solution, as the form-factor and the mobile data network proved to be unacceptable and unreliable.

In contrast patients and staff have been benefiting from the expansion of iPad devices for staff. For example: access from anywhere to a department specific clinical record in psychological therapy services; writing offline assessments and clinical notes at the point of care delivery ready for uploading to the core EHR; video conferencing between clinicians and patients (using FaceTime) which negates the need for time consuming journeys; the use of various Apps to collect patient outcome scores, and provide patients with real-time interactive teaching/guidance thereby improving the clinical encounter.

We made a successful bid to the Nurse Technology Fund and were awarded almost £1million of funding to equip clinical staff with iPad devices. Plans are now progressing to start deploying the iPads across clinical services over the coming year.

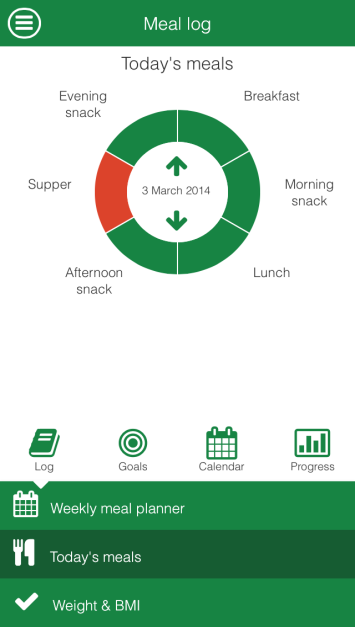
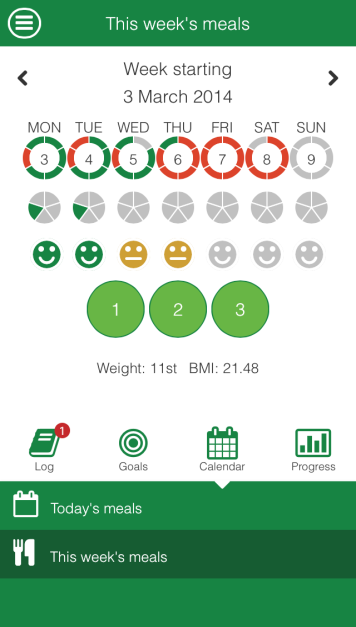
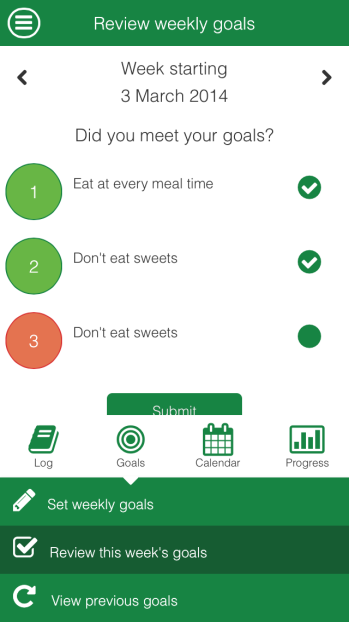
During the past year we commenced the procurement of its EHR in collaboration with clinical staff across all of our services.

*Replacing Face-to-Face Contacts (where appropriate)*

We have reviewed a number of video-conferencing options (including FaceTime) in Melksham children and adolescent mental health service (CAMHS). In addition, we have recently approved a ‘standard operating procedure’ that outlines how staff can use Skype (or similar) hosted video conferencing for online patient consultations. This is in addition to our community hospitals using Skype to communicate between the emergency medical unit in Abingdon and gerontology colleagues at OUH.

**Case study: App for patients with an eating disorder**

We have also developed a ‘proof of concept’ *App* for those suffering from an eating disorder. The App has been designed by staff and patients for use in treatment and for self-help. It offers users the ability to monitor progress, as well as the ability to link goals, thoughts and feelings (see screen shots below). This will enable patients to record their food intake, feelings and weight with meal logs and goals/progress trackers which can be monitored from a distance by clinicians. It also has web site links and resources for patients. We will be trialling this with patients in Wiltshire initially.



**Case study: FaceTime project**

We are piloting the use of FaceTime with young people in Wiltshire. This will enable young people to be “seen” via face time without staff necessarily having to drive to appointments. It also allows parents to talk to staff. The idea is to reduce travelling time but still have face to face interactions with young people and their families, creating more capacity within the team and more time spent directly delivering care.

*Remote patient monitoring, recording and self-help*

We have recently rolled out the True Colours mood monitoring system across mental health services which will enable patients to self-report their symptoms using mood rating scales. In addition, a two year randomised controlled trial commenced using a tablet device to assist patients in the self-monitoring and management of moderate to severe COPD.

We are also working with colleagues in Oxford University to develop an App which enables us to record routine outcome measures for children and young people. The idea is that this will be available on tablets, laptops and iPhones to enable young people to give real time feedback to the service.

In keeping with other areas / domains, it is predicted that an Apps-based approach to care, self-help and wellbeing will become an increasingly important part of the care delivery over the coming years.

**Choose and book**

A directly bookable appointment means the patient is able to leave the surgery with an appointment location, date and time or have the information to book their own appointment at a later time.

The following services are currently live on choose and book:

* podiatry - go live 01/12/2012
* MSK physiotherapy - go live 21/01/2013
* community dietetics - go live 09/09/2013
* enhanced care diabetes service - go live 09/09/2013
* memory clinics Oxfordshire - go live 23/09/2013
* memory clinics Buckinghamshire - go live 06/01/2014

The following services are currently being explored as potentially suitable for choose and book:

* older adult mental health teams - planned for 2014/15
* adult mental health teams - planned for 2014/15

**Annexes**

Annex 1

Statements from our partners on the quality report and account

Annex 2

Statement of directors’ responsibilities in respect of the quality report

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

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

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

* the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
* the content of the Quality Report is not inconsistent with internal and external sources of information including:
* Board minutes and papers for the period April 2013 to June 2014
* Papers relating to quality reported to the board of directors over the period April 2013 – June 2014
* Feedback from the commissioners dated May 2014
* Feedback from the governors dated May 2014
* Feedback from local Healthwatch organisations dated May 2014
* The trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, submitted 14 May 2014
* The latest national patient survey 2013
* The latest national staff survey issued March 2014
* The head of internal audit’s annual opinion over the trust’s control environment dated 8 April 2014
* the Quality Report presents a balanced picture of the NHS foundation trusts performance over the period covered
* the performance information reported in the Quality Report is reliable and accurate
* there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
* the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
* the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

Annex 3

Auditor’s statement of assurance

Annex 4

Glossary of terms

**ADHD** attention deficit hyperactivity disorder

**AHSN** Academic Health Sciences Network

**AMHT**adult mental health teams

**Aston teamwork model** approach to developing effective team working and team leadership developed by Aston University

**Awaiting Approval** is yet to be granted NHS Permission

**AWOL** absent without leave, referring to patients who have been allowed out on escorted (with a member of staff) or unescorted (without supervision) leave and who have not returned to their ward within 10 minutes of the agreed time of return

**BaNES** Bath and North East Somerset

**Berwick Report** response by Don Berwick following publication of the Keogh report (see below)

**Bed days** measure of a period of time (24 hours)

**CAMHS** Child and Adolescent Mental Health Services

**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 classification of a mental health service user based on their individual characteristics, condition and behaviours

**CAS** Community Acute Services

**CCG** care commissioning group, the bodies that replaced the PCTs in having oversight of the trust from 1st April 2013

**CEO** chief executive officer

**CHAT** Community Hospital Assessment Tool

**CHC** continuing healthcare funding

**Choose & Book** 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

**CLAHRC** Collaborative Leadership in Applied Health Research and Care

**COPD** chronic obstructive pulmonary disease

**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

**CSP** Coordinated System for gaining NHS Permission – this is nationwide

**CTIMP** Clinical trial of an investigational medicinal product(s) – drug trial

**CTO** community treatment order

**Dashboard** a set of measures which together indicate how well a team, service or the organisation is achieving its targets for performance and quality

**DNA** did not attend (appointments)

**DTOC** delayed transfer of care occurs when a patient or service user is delayed in being discharged from hospital into the community

**EHR** electronic health record

**EMU e**mergency medical unit

**E-Rostering** 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

**Francis Report** findings and recommendations following an investigation by Robert Francis into high mortality rates at Mid Staffordshire NHS Trust

**GP** General Practitioner, the doctor in the local surgery with whom the patient/service user is registered providing primary care medical services

**Healthwatch** is the new consumer champion for both health and social care in local communities and it replaces the HOSCs as from 1st April 2013

**HSJ** Health Service Journal

**IAPT** improving access to psychological therapies

**IPMS** integrated pain management service

**Keogh Report** findings and recommendations following an investigation led by Sir Brice Keogh into high mortality rates at 14 acute trusts in England

**Ligature risk** presence of structures to which ligatures can be attached and therefore cause harm

**LTC** tong term conditions, which may include dementia, diabetes, medically unexplained symptoms, respiratory & cardiac problems and strokes

**MDT** multi disciplinary teams

**MIU** minor injuries unit

**MRSA/MSSA** Two varieties of bacteria which lead to illness and are characterised by being particularly resistant to treatment -its presence in hospitals has therefore led to a concerted campaign to eliminate it from such locations

**MSK** musculo-skeletal

**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 may 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)

**NIHR** National Institute for Health Research

**NQR** National Quality Requirement

**NRLS** National Reporting and Learning System

**OA** older adult

**OHFT** Oxford Health Foundation Trust

**Open** Currently recruiting or in analysis within study start and end dates

**OSCA** outreach service for children and adolescents

**OUH** Oxford University Hospitals

**PALS** patient advice and liaison service is a local service designed to help patients, carers and other users with problems, difficulties and complaints related to our services

**PDSA** Plan, Do, Study, Act, is a cycle that offers an approach to testing improvements in a controlled manner to find out what works or makes a difference

**PHB** personal health budgets is 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 units

**PICs** Oxford Health NHS FT has agreed to act as a Participant Identification Centre

**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 replaced the PEAT audits as from 2nd April 2013

**PMVA** prevention of management and aggression

**POMH-UK** Prescribing Observatory for Mental Health UK

**PREM Patient** reported experience measures

**PROM** Patient reported outcome measures

**Productive Dashboard** is a means of displaying important care parameters in an easy to understand and intuitive way

**Recovery Star** tool to help patients in identifying and addressing areas of difficulty to support recovery

**RiO** electronic patient record

**Safer Care** improvement tools toidentify and reduce harm to patients.

**Safety Thermometer** is a national tool for measuring, monitoring and analysing patient harms and harm-free care using point prevalence (count of the number of incidents at a fixed point time)

**SKIN bundles** tool that acts as a prompt to staff to undertake a risk assessment and provide management of the risk with patients

**SIRI** serious incident requiring investigation

**SOP** standard operating procedure

**UKCRN** United Kingdom Clinical Research Network

**UTI’s** urinary tract infections

**VTE** venous thromboembolism

**Walsall assessment tool** for assessing risk of developing pressure ulcers

Annex 5

How to contact us

**About this report**

If you have any questions or comments concerning the contents of this report, would like to provide feedback on the report, or have any other questions about the trust and how it operates, please write to:

Chief Executive Officer

Oxford Health NHS Foundation Trust

Trust Headquarters

Warneford Hospital

Warneford Lane

Oxford OX3 7JX

Or email him at: [Stuart.Bell@oxfordhealth.nhs.uk](mailto:Stuart.Bell@oxfordhealth.nhs.uk)

Alternatively, you may telephone on 01865 741717 or fax on 01865 782198.

**Other Comments, Concerns, Complaints and Compliments**

Your views and suggestions are important us. They help us to improve the services we provide.

You can give us feedback about our services by:

* Speaking to a member of staff directly.
* Completing our [Comment, Concern, Complaint and Compliment Leaflet](http://www.partnershiptrust.org.uk/pdf/leaflets/complaints0210.pdf), available from any of our locations or from our web site <http://www.oxfordhealth.nhs.uk/> .
* Contacting GUiDE & PALS (Patient Advice and Liaison Service) on 01865 738567.
* Writing to the appropriate service manager or the trust’s Chief Executive.

**Alternative Formats**

If you would like a copy of this report in large print, Braille, audio cassette tape or another language, please telephone us on 01865 782195.

1. As a result of data refreshing this value has now changed from the figure previously submitted to HSCIC [↑](#footnote-ref-1)
2. Trust value submitted to HSCIC - information not published as of 30th April 2014 [↑](#footnote-ref-2)
3. Data source Safeguard – number of reported incidents where harm was reported as 3, 4 or 5 for impact [↑](#footnote-ref-3)
4. Data source Safeguard – number of reported incidents [↑](#footnote-ref-4)
5. Data source Safeguard – number of reported falls by 1000 bed days and number of falls where harm was reported as 3, 4 or 5 for impact by 1000 bed days [↑](#footnote-ref-5)
6. Data source – STEIS and internal SIRI database [↑](#footnote-ref-6)
7. Quarterly audit of 30 patients throughout county [↑](#footnote-ref-7)
8. SKIN bundles are a tool that acts as a prompt to staff to undertake a risk assessment and provide management of the risk with patients [↑](#footnote-ref-8)
9. Quarterly audit of 30 patients throughout county [↑](#footnote-ref-9)
10. Bi-monthly Essential Standards audit.  All mental health inpatient wards sample 5 patients per ward - overall sample 130 [↑](#footnote-ref-10)
11. Track and trigger audit [↑](#footnote-ref-11)
12. Safety thermometer – manual point prevalence data on single day per month [↑](#footnote-ref-12)
13. Safeguard – number of reported incidents [↑](#footnote-ref-13)
14. OHFT SIRI records which are more up to date than the reporting system STEIS (downgraded incidents must be removed by the CCG and there can be a delay from the request being made, the evidence being reviewed and the action being taken). [↑](#footnote-ref-14)
15. Monthly audit – point prevalence data (manual compilation) [↑](#footnote-ref-15)
16. The measurement of *days between* or *days since* is designed for measuring harm that occurs at very infrequent intervals. It can be employed once the rate of harm is very low, for example less than one harm per week. This then makes *days between* a meaningful way of measuring for improvement. It also works most effectively for individual services rather than across an entire service. For future projects we will therefore set a *days between* aim for each individual assessment and treatment team. [↑](#footnote-ref-16)
17. SIRI database [↑](#footnote-ref-17)
18. SIRI database [↑](#footnote-ref-18)
19. Any positive lab results for a mandatory organism- this includes MRSA/MSSA bacteraemias and CDI’s recorded and verified by the lab processing the specimen-this will be in the acute Trust and for us usually the OUH. The data is managed by the lab and uploaded onto a national reporting database. As a Trust we have no control on the data. Once a positive result is obtained it will automatically be reported. The data is entered manually by the lab and verified by a lab senior clinician/manager- it is then reported electronically. [↑](#footnote-ref-19)
20. As above [↑](#footnote-ref-20)
21. As above [↑](#footnote-ref-21)
22. audit data collected manually via audit tool and entered onto a database for electronic report collation. Data is verified by the person completing the audit [↑](#footnote-ref-22)
23. As above [↑](#footnote-ref-23)
24. measuring what is happening at a specific or fixed point in time, rather than looking at information from across a number of days or weeks. [↑](#footnote-ref-24)
25. audit tool based on national standards- audits conducted by infection prevention and control nurses with manuals data entry to audit tool and entered onto a database for electronic report collation [↑](#footnote-ref-25)
26. PCMIS system (compliant follows the national IAPT data standard) data checked by data leads and clinical leads [↑](#footnote-ref-26)
27. Spreadsheet – manual [↑](#footnote-ref-27)
28. Community hospital data: manual review of all patients against DH criteria; mental health data is manual review of patients calculated as percentage of lost bed days against occupied bed days [↑](#footnote-ref-28)
29. Electronic data via RiO/Omnivo report calculation as percentage of all adults on CPA [↑](#footnote-ref-29)
30. As above [↑](#footnote-ref-30)
31. CPA quarterly audit [↑](#footnote-ref-31)
32. Electronic data via RiO/Omnivo report calculation as percentage of all adult discharges [↑](#footnote-ref-32)
33. Quarterly CPA audit [↑](#footnote-ref-33)
34. Safeguard [↑](#footnote-ref-34)
35. Safeguard [↑](#footnote-ref-35)
36. this is based on the proportion of patients who were extremely likely to recommend minus those who are indifferent, unlikely or extremely unlikely to recommend. The patients who said they are likely to recommend the service are excluded as per national calculations. [↑](#footnote-ref-36)