**Clinical Effectiveness Report**

1. **Trustwide Clinical Audit**

**Ensuring we are improving and learning from clinical audits remains a high priority in every clinical directorate.**

This section provides an update on the following:

* Progress update against the Trust wide clinical audit plan for 2013/2014
* Changes to the Trust wide Clinical Audit plan for 2014/15
* Action plan monitoring
* Summary of the results from the clinical audits reported and rated since the last CEC report in March 2014 (Appendix 1)

**Summary of the results from the clinical audits reported and rated since the last report in March 2014 (Table 5)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Audit Name** | **Audit cycle** | **Rating by audit matrix** | **Date action plan to be developed by** | **Date action plan submitted** |
| 2013/14) | Mental Capacity Act Audit: |  |  |  |  |
|  | 1. Community Hospitals | Re-audit | Requires improvement | 25/7/14 |  |
|  | 1. Older Adult Mental Health Inpatient Wards | Baseline | Unacceptable | 25/7/14 |  |
|  | 1. Adult Mental Health Inpatient Wards | Re-audit | Good | 25/7/14 |  |
| 2013/14 | Nutritional screening on Older Adult (OA) Inpatient wards | Re-audit | Requires improvement | 23/4/14 | Action plan outtstanding |
| 2013/14 | Pressure ulcer assessment and management on Older Adult MH inpatient wards | Re-audit | Requires improvement | 1/7/2014 |  |
| 2013/14 | Community Hospitals Assessment Tool (CHAT audit) Q4 results |  | Good |  | In place |
| 2013/14) | Re-audit of the NICE guidance in the assessment of the feverish child (Urgent Care) | Re-audit | Good |  | In place |
| 2013/14 | Health Records audit in Oxon Community Services | Re-audit | Unable to rate (see page 29) |  |  |
| 2013/14 | Electronic Health Records audit across Mental Health Services | Re-audit | Good | 21/7/14 |  |
| 2013/14 | Copying Letters to Service Users and Parents/Guardians in Swindon, Wiltshire and B&NES T3 and OSCA CAMHS | Re-audit | Requires improvement | 10/7/2014 |  |
| 2013/14 | National Quality Requirement For Audit (NQR audit) - Oxfordshire Community Urgent Care Service | Re-audit | Good |  | In place |
| 2013/14) | Re-audit of Participation of Adult Mental Health & Addiction Service Practitioners at Child Protection Case Conferences | Re-audit | Not rated (see page 41) | N/A | N/A |

**Table 5**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Year** | **Audit Name** | | **Audit cycle** | **Rating by audit matrix** | **Date action plan to be developed by** | **Date action plan submitted** |
| 2013/14 | CPA audit | CAMHS | Re-audit | Requires improvement | 15/5/14 | In place |
|  |  | Adult Mental Health | Re-audit | Good | 15/5/14 | In place |
|  |  | Forensic Units | Re-audit | Good | 15/5/14 | Action planning scheduled for 12/6/14 |
| 2013/14 | Eliminating mixed sex accommodation – ward self assessment of elements of Privacy & Dignity | | Re-audit | Good | 1/5/12 | Action plans outstanding for Eating Disorders and Adult Services |
| 2013/14 | Essential Standards | | Re-audit | Good | N/A\* | N/A\* |
| 2013/14 | Infection Control Audit Update – summary for 2013/14 | | Re-audit | Good | Developed at time of audit | Action plan in place |

\*Actions are taken immediately following the audit

All audit reports are discussed at the governance meeting for each Directorate, where action plans are agreed and monitored. A summary of results for each of the audits and action plans can be obtained from the Audit Team. Detailed performance of Audits is reviewed by the Audit Committee and Integrated Governance committee and within Directorate clinical meetings.

Immediate action has taken place following the older adult inpatient audit of mental capacity

|  |  |
| --- | --- |
| White Leaf Centre | 10 informal patients.  No evidence of lacking mental capacity for 4 people  DOLS authorisation in place for 6 people |
| Fiennes Centre | One informal patient and there is no evidence the person lacks mental capacity |
| Sandford Ward | 11 informal patients.  No evidence of lacking mental capacity for 4 people.  I person where a DOLS referral has been made  6 people with a DOLS authorisation in place |
| Cherwell Ward | 10 informal patients  No evidence of lacking mental capacity for 9 patients  1 person with a DOLS authorisation in place. |

**1.1 Community services local Clinical Audit programme results Q3/Q4**

* + 1. The audit programme information below details the year end position for 2013/14. The directorate achieved all those audits detailed on the Trust wide audit schedule. With the approval of the trust executive some audits were deferred in community nursing whilst significant demand and capacity pressures existed.
    2. 49 reports have been received to date relating to 13/14 audits (84%) – Some of these reports refer to the same audit topic, eg quarterly audits will be counted 4 times. The 84% figure represents a significant improvement on the 2012/2013 as there has been greater scrutiny and attention given to the audit schedule by service clinical, operational leads and governance team members. .
    3. Of the 49 reports referred to, 11 do not require rating as they relate to nationally ascribed data collection as opposed to the comparison against standards eg Global Trigger Tool, Safety Thermometer etc. The remaining 38 have been rated as follows:

**Overall achievement**

Excellent: 4

Good: 21

Requires Improvement: 13

Unacceptable: 0

Thirteen audits overall required improvement .

**1.2** The ‘documentation audit’ results are atypical this year. Implementation of this audit was hindered by variation across teams some using paper and others IT systems were used. This resulted in many of the parameters being looked at in the audit tool did not map across easily. In conjunction with corporate governance colleagues this has been rectified for 2014/15 though a decision taken to accept the anomalies as they occur in this year’s audit. Examples of this included where services had multiple different approaches often including both IT and written records. This issue needs addressing and will be rectified in the translation to the new electronic record over the next year.

The specific audits undertaken which required improvement included;

**1.2.1 Deprivation of Liberty – Community Hospitals**

12-13 result – Requires Improvement. Whilst the audit still requires further improvement there has been considerable improvement on previous year’s audits. Of particular note this year is:

* The use of the language of the Mental Capacity Act has increased with a very significant decrease in the use of umbrella words such as ”confusion” and “muddled”.
* There was evidence in 36% (20) of the records that patients were being asked about Lasting Power of Attorney and/or Advance Decisions to Refuse Treatment. This has risen from a baseline of 0%.
* There were 62% of structured mental capacity assessments in this audit for 2013/14 where it is stated the person lacks mental capacity. While this is not compliant, it is a significant increase compared to 2012/13 when there were 13% of structured mental capacity assessments.
* There is a significant decrease in the documentation to demonstrate that the person is being restrained within the criteria of sections 5 and 6 of the Mental Capacity Act. It would appear with the transition to the use of RiO during 2013, the care plans associated with decision making and the use of restraint have become significantly less robust.
* Deprivation of liberty authorisation figures demonstrate an increasing awareness of the DOL safeguards. It also supports the conclusion that it is unlikely that there was any unauthorised deprivation of liberty on the wards at the time of the audit.

**1.2.2** An action plan is being developed in response to this audit and will be completed by the 2nd July 2014. This will be monitored through the directorates Clinical Audit and Effectiveness committee (CAEG) the board is asked to note the improvements made and trajectory of recovery in this area.

**1.2.3 Documentation N&D**

This is the first time RIO notes have been audited and so different criteria were audited this time. An average of 71% of the standards were met [range 0 -100%]. Whilst previous paper record audits gained higher totals it is felt that the transition to electronic records affected results as some staff (particularly community dietetics) were just getting used to electronic care planning. Service clinical and operational leads have addressed this through and action plan. All actions have been completed in March 2014 and the service is due for a repeat audit in Q2. The 2011 results were 83% and the 2010 results were 78%.the results were discussed with the countywide services clinical and operational management team in the directorate’s bi annual quality assurance meeting in May 2014.

**1.2.4** **Documentation/Record keeping – bladder and bowl service**

Whilst 2012/13 results were generally good the issues highlighted in the audit were the documentation of the patients consent to share records and the acceptance of having a student present in the assessment. These issues were discussed with staff in meetings in May 2014. An action plan to address the areas of concern was completed in May 2014. Plans have been developed to amend the audit tool for 2014/15 as increasing reliance upon the RiO electronic healthcare record.

**1.2.4 Documentation - CTS**

Whilst the 2013/4 results have not changed in that this audit also requires improvement there have been considerable improvements in some areas within the service. These include;

* + There is a considerable improvement on the amount of discharge letters being produced, from 20% to 80%.
  + There is improvement in recording consent to share information, from 30% to 65%.
  + There is still not enough evidence that the care plans are being developed and agreed in conjunction with the patient.
  + There is no recording of reasons why care plans had not been created with the patient.
  + It should be noted that the absence of recording of allergies may be due to the lack of allergies in the patient, not necessarily the omission of recording by the clinician.

The areas of concern being addressed by the service clinical and operational leads are;

1. Comprehensiveness of assessments undertaken including listing allergies and medications
2. Partnership working with patients to develop and review care plans
3. Adherence to processes regarding discharge planning

Service clinical and operational leads are developing an action plan in response to this and this will be monitored through the CAEG.

**1.2.5 CG139 Catheter infection control – Community Hospitals**

The 2013/14 audit was rated as poor though this year requiring improvement. The areas of concern identified were;

* Recording type of urinary continence
* Provision of leaflet to patients
* Recording of allergies sensitivity to catheter materials
* Recording the amount of water used to inflate the balloon
* A Decision over whether Instillagel has to be prescribed for the procedure as this has not previously been required in Community Hospitals.
* A decision if the catheter record sheet is required or the care plan is used to record this information.

Actions have been undertaken by unit managers in association with the ward managers. These include specific areas for particular wards to concentrate upon eg City community hospital – need to keep a continence diary. Explanation of the risks and benefits to patients and record this in the notes.

It must be noted that the sample size was small and may have inadvertently skewed the percentage calculation having a disproportionate effect upon the audit outcomes. This is being reflected in work being tested by unit managers to review the audit tool to minimise this effect.

**1.2.6 Medicine management: controlled drugs – Community Hospitals**

The audit results in 2013/14 indicated that improvement was required. This audit was undertaken twice. Administration of drugs was deemed to be good, though the concerns specifically related to;

* The storage and reconciliation of controlled drugs including frequency of stock levels.
* The ordering of drugs with maintenance of an up to date list of signatories

Actions have been identified and completed in March 201 4 and a repeat audit is scheduled for Q2 2014. The schedule and audit tool is being reviewed by pharmacy colleagues. The service is moving towards the implementation of daily checks for controlled drugs in community hospitals. This is being led by the divisional nurse in conjunction with the matrons and ward managers

* + 1. **Audit 2**

Audit 2 demonstrated that staff need greater vigilance and adherence to good practice regarding the ‘dating’ of opened CD preparations such as ‘Oral morphine solution’. In addition staff have been reminded of the necessity to detail any changes in the controlled drug register using appropriate methods as variation in practice was seen in the audit. Medicines management standards were deemed to be very good at Wantage & Didcot community hospitals.

**1.2.8 CG29 Pressure ulcer prevention – District Nurses**

The aim of this audit is to give assurance of compliance with NICE guidance on Prevention and Management of Pressure Ulcers (CG29), and identify where improvements are needed to meet this standard in the District Nursing (DN) service. This audit undertaken in Q4 was rated as requiring improvement.

Whilst the target for all areas in this audit is 100%, this was not met in regard to the vast majority of standards. However, the overall standard has improved since the previous audit a year ago, particularly in relation to pressure damage prevention indicators. In view of the current issues with DN workforce capacity, only the most significant standards in terms of potential associated harm to the patient have been selected for specific action plan development. The selection and resulting action plan was discussed and agreed with the Tissue Viability Clinical Lead.

A new role in the DN service has recently been introduced to improve standards generally around tissue viability care – the Tissue Viability Resource Nurse role. This involves registered nurses in each cluster having additional leadership and tissue viability training to enable them to take the lead with improving quality standards around all tissue viability related care in their clusters. They will also serve as an escalation point for ground level staff to escalate TV related issues to. So far 18 nurses have been trained, and are working through the relevant TV competencies. They will take a lead in delivering the action plan below and in raising standards generally around pressure damage.

The areas of notable practice identified in the audit were;

* Assessment around pressure damage prevention
  + 97% had holistic assessment
  + 86% had MUST score recorded
  + 93% had Walsall score on 1st visit
* Care planning and care delivery around pressure damage prevention
  + 96% had a pressure damage prevention careplan
  + 100% of those patients with a careplan had had that careplan discussed with them
* Care planning and care delivery around pressure ulcer management
  + 100% had a pressure ulcer management careplan
  + 96% of dressings were prescribed in line with Trust guidelines

Improvements were made from last audit particularly around:

* Pressure damage prevention care planning increased to 96% (up 24%)
* Photographing of ulcers increased to previous target of 70% (up 15%)
* Discussion of risks and benefits of pressure ulcer treatment discussed with patient increased to 83% (up 28%)
* Incident reporting of category 2 and above pressure ulcers increased to 83% (up 38%)
* Dressings prescribed in line with guidelines increased to 96% (up 21%)

**Areas requiring improvement:**

* 57% had wound assessment form in place
* 43% had wound mapped
* 25% of those with ulcers to lower legs had received lower limb assessment/Doppler assessment
* 38% of those with ulcers had had a pain assessment
* 20% of those where the pressure ulcer healing was not as expected were referred to Tissue Viability team

Actions identified in response to this audit have been reviewed as part of the Pressure Ulcer Action Group led by Tissue Viability lead nurse and attended to by the divisional senior nurse. The actions are monitored through the CAEG.

**1.2.9 Use of COPD forms – Respiratory**

12-13 result – new audit

This audit focuses on the documentation related to COPD, specifically the COPD Discharge Care Bundle which must be completed when visiting patients admitted with an exacerbation of COPD. The Health Records for this aspect of care are audited monthly for the first 4 months of implementing the new tool, then 6 monthly and reported at the end of the year. This audit is voluntary, instigated by the service to measure the application and effect of the new recording tool. Voluntary local audit to confirm effect of new COPD reporting tool not based on perceived risk. The tool has not been in place for 12 months yet so this report shows how the use has started to improve since implementation and should also continue to improve once staff get used to using it and are continued to be educated. Certain standards on the Audit which have information that is helpful for the respiratory team to see if the discharge bundle has changed our practice but do make the overall appearance of the audit outcome to look poor and therefore could be changed as suggested previously.

**2.0 Mental health wards Essential Standards – April 2014**

**2.0.1** Twenty five of our thirty five wards are mental health inpatient wards spanning all age ranges and specilaties.. Our Essential Standards audit includes 30 standards. The audit includes 12 standards of patient experience of care and 18 standards of clinical care provided by inpatient staff.

* + 1. Data for Q4 was received from 22 out of 25 wards. Data was not received from Highfield, Marlborough House Swindon and Lambourne wards this quarter. There is an expectation that all wards participate.
    2. The overall sample size is 10 patients records per ward are examined, although this varies from question to question. Some standards were not relevant to some patients because of factors like the specific nature of the mental health problem they are suffering from and in some cases because of their presentation at the time of data collection. The compliance to a standard is based on the number of patients to whom the standard applies.

**Key for scoring**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Key =** | Excellent = 100% |  | Good = 90-99% |  | | Fair 75%-89% | |  | | Poor = <74% | | |  |  |
| **Orientation** | | | | | **Aug-13** | | **Oct-13** | | **Dec-13** | | **Feb-14** | **Apr-14** | | **Progress from previous month** |
| Patient information given out on admission to the ward (n=80) | | | | | 89% | | 95% | | 98% | | 93% | 89% | |  |
| Patients state that they have been orientated to the ward and are aware of ward routine including rights and restrictions (n=78) | | | | | 91% | | 91% | | 96% | | 93% | 96% | |  |
| **Physical Health** | | | | |  | |  | |  | |  |  | |  |
| Patient has received a physical health assessment completed within 24 hours of admission (n=110) | | | | | 97% | | 100% | | 99% | | 98% | 95% | |  |
| Patients physical health needs are being considered and identified in care plan (n=94) | | | | | 97% | | 100% | | 97% | | 92% | 97% | |  |
| Patient has been screened for VTE within 24 hours of admission (n=110) | | | | | 94% | | 98% | | 89% | | 91% | 93% | |  |
| **Capacity and Consent** | | | | |  | |  | |  | |  |  | |  |
| Is it documented the patients capacity has been assessed/ reviewed either at or since the last ward round? (n=109) | | | | | 65% | | 84% | | 86% | | 85% | 90% | |  |
| Is it documented consent to treatment/medication has been discussed with the patient either at or since the last ward round (n=104) | | | | | 70% | | 90% | | 88% | | 89% | 92% | |  |
| **Care Planning** | | | | |  | |  | |  | |  |  | |  |
| Evidence of Family / Carer / Next of Kin involvement in care as appropriate (n=107) | | | | | 91% | | 88% | | 95% | | 91% | 97% | |  |
| Patient reports being involved in care planning (n=102) | | | | | 78% | | 84% | | 96% | | 81% | 74% | |  |
| Care plan is up to date and relevant to the current needs of the patient (n=110) | | | | | 81% | | 89% | | 89% | | 88% | 83% | |  |
| Does the patient have a "knowing me form" completed as part of assessment process (OA only) (n=9) | | | | | 100% | | 100% | | 83% | | 75% | 78% | |  |
| **Risk Assessment** | | | | |  | |  | |  | |  |  | |  |
| Risk assessment AND management plan are up to date and relevant to current needs of the patient (n=110) | | | | | 87% | | 88% | | 85% | | 86% | 88% | |  |
| Current level of risk highlighted through patient status at a glance/ safety board (excludes Forensics) (n=85) | | | | | 87% | | 93% | | 92% | | 97% | 93% | |  |
| **Safety** | | | | |  | |  | |  | |  |  | |  |
| Patients report they feel staff have done everything they can to make them feel safe on the ward? (n=105) | | | | | 95% | | 92% | | 96% | | 89% | 85% | |  |
| **Medication** | | | | |  | |  | |  | |  |  | |  |
| Do the patients recall ever being told why they are taking their medication? (n=102) | | | | | 97% | | 96% | | 99% | | 98% | 92% | |  |
| Do they know what the side effects are? (n=102) | | | | | 87% | | 79% | | 89% | | 83% | 85% | |  |
| **Communication** | | | | | **Aug-13** | | **Oct-13** | | **Dec-13** | | **Feb-13** | **Apr -14** | |  |
| Patients report that they are spending individual time with staff on a regular basis (n=104) | | | | | 89% | | 90% | | 97% | | 90% | 84% | |  |
| Evidence of one to one meetings with patients are clearly documented in the nursing notes (n=105) | | | | | 90% | | 93% | | 92% | | 85% | 90% | |  |
| Patients are able to state who their key nurse is (n=104) | | | | | 82% | | 82% | | 92% | | 84% | 85% | |  |
| **Dignity & Respect** | | | | |  | |  | |  | |  |  | |  |
| Patients report that staff are courteous towards them (n=110) | | | | | 87% | | 84% | | 91% | | 90% | 89% | |  |
| Staff always knock on patients bedroom doors prior to entering (n=110) | | | | | 89% | | 83% | | 90% | | 92% | 93% | |  |
| **Discharge Planning** | | | | |  | |  | |  | |  |  | |  |
| Where appropriate patients report that they are involved in their discharge planning (n=72) | | | | | 88% | | 96% | | 92% | | 89% | 89% | | **=** |
| It is documented that the ward have contacted the care coordinator for discharge planning (n=81) | | | | | 90% | | 95% | | 96% | | 97% | 96% | |  |
| **Nutrition & Hydration** | | | | |  | |  | |  | |  |  | |  |
| The patient was seen by the dietician on assessment (to develop meal plan) (Eating Disorder Units only) (n=16) | | | | | 100% | | 100% | | 100% | | 100% | 100% | | **=** |
| Nutritional needs assessment completed (exclude Eating Disorder Units) (n=100) | | | | | 43% | | 73% | | 50% | | 53% | 64% | |  |
| Patients are given a choice of food that meets their specific needs (exclude Eating Disorder Units) (n=96) | | | | | 89% | | 97% | | 95% | | 100% | 98% | |  |
| **Observation** | | | | |  | |  | |  | |  |  | |  |
| Date and level of observation clearly documented (N/A if patient not on level 2,3 or 4) (n= 40) | | | | | 95% | | 93% | | 93% | | 89% | 85% | |  |
| Where appropriate patients on close observations can explain why these are in place (n=36) | | | | | 100% | | 86% | | 93% | | 100% | 81% | |  |
| **Patient Involvement** | | | | |  | |  | |  | |  |  | |  |
| Patients report that they have been involved in therapeutic activities in the last week (n=104) | | | | | 92% | | 92% | | 98% | | 94% | 88% | |  |
| Care plan identifies appropriate therapeutic activities related to patient need (n=109) | | | | | 84% | | 92% | | 87% | | 82% | 81% | |  |

Of the 30 standards covered under the 13 domains in the Essential Standards audit, the level of performance has improved in relation to 12 standards; however there has been a slight decline in performance in 16 standards. When analysing possible factors relating to the decline in performance, it was noted that there had been a change in a number of auditors (which may have affected consistency). The new leadership teams have been recruited and are now in post. The objective of significantly improving these core standards is a high priority, so the lack of sustained improvement is disappointing. And the variation is widespread. The lack of improvement relating to patient involvement is care planning is of concern although carer involvement is better. In eight out of the 25 mental health wards there has been regular use of temporary staff in a number of ward areas due to staff vacancies. These are in the process of being recruited to. The adult and older inpatient wards are preparing for AIMS Accreditation.

**2.1 Adult Mental Health Community Teams CPA Audit**

There are four principles which form the basis of the CPA:

* Assessment
* Care planning
* Care Co–ordination
* Review



Implicit in all of them is involvement of the person using the service, and where appropriate, their carer. The Audit Tool was reviewed in Q4 so there was no data available to report. There was a full report on the previous three quarters in the last Clinical Effectiveness report in March 2014. The newly appointed Community leads are undertaking the Q1 CPA Audit In June and will continue to do this on a quarterly basis.

| **Board Metrics – Indicator 44** | **Q1 2013/14**  **N=13** | **Q2 2013/14**  **N=26** | **Q3 2013/14**  **N=40** |
| --- | --- | --- | --- |
| Current CPA care plan completed <12 months old | 100% | 89% | 88% |
| Care plan been reviewed in past 6 months | 92% | 50% | 73% |
| Current risk assessment <12 months old | 100% | 96% | 98% |
| Care coordinator identified | 100% | 100% | 100% |
| % of records with all 4 elements in place | 92% | 50% | 70% |
| **Board Metrics – Indicator 45** |  |  |  |
| Does the assessment consider physical health needs? | 92% | 100% | 80% |

**2.2 Assessment of needs**

Of the 8 standards of the assessment process 5 were rated as excellent or good. There were 3 areas rated as requiring improvement.

* Has the core assessment component in RiO been employed?
* Is there documented evidence of family and/or carer involvement in assessment process?
* Is there clear formulation/summary of assessment identifying strengths and needs?

**2.3 Care Plan**

Of the 17 standards of the care planning process 13 were rated as either excellent or good. There were 4 areas rated as requiring improvement.

* Is there a validated care plan review within last 6 months?
* Is there evidence of family and/or carer involvement in the development of the care plan?
* Is there evidence that the service user has been offered a copy of the care plan?
* Do the records demonstrate the planned interventions have/are being carried out?

**2.4 Risk assessment**

All 3 standards of the risk assessment process were rated as excellent

**2.5 Areas requiring improvement**



Action plans are being developed by each AMHT in respect to the audit findings. These actions plans will be monitored through the divisional clinical governance group and progress reported to the Clinical audit committee.

**3.0 CQC National Patient Survey Mental Health**

**3.0.1** 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), which was considered a high response rate compared nationally, although to put this into context the number of people who responded represents only 2% of service users in current treatment. The results of the 2013 survey have been previously reported.

**3.0.2** The areas where we are seeking to make improvements include the care review meeting process and ensuring that our patients’ physical health needs are met. We also recognise people’s need to gain better access to our services in a crisis situation. The actions following the survey became part of the remodelling work in the adult mental health pathway. Early results from an internal monthly random survey (responses from October 2013 to February 2014) with responses from 211 patients are below.

|  |  |  |
| --- | --- | --- |
|  | 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% |
| I am aware of who my care coordinator is? | 75% | 84% |
| I understand what is in my care plan? | 39% | 59% |

**3.0.3** The 2014 national mental health community service survey was started in April 2014 our response rate is currently 21% with the fieldwork planned to close in mid June 2014. We were involved by the Picker Institute in the review of the questions in the national survey so those now being used in the 2014 survey are a bit different to previous years and may affect the ability to directly compare performance to 2013.

**3.0.4** We are also repeating the inpatient mental health survey in 2014 using the previous national questions, however this is not statutory. We are using an external company to coordinate the survey to be able to receive a comparison to 25 other mental health trusts. The following actions were set after the 2013 survey:

* Staffing levels to be increased (6:6:4) and more active recruitment to be tried to get the right staff
* Review provision and explanation of information covering medicines, complaints, crisis number, rights and physical health
* Pharmacy staff will be re-directing their time to spend more time speaking to patients and explaining the purpose and side effects with medication
* Look at provision of activities on the ward
* Introduce senior leadership team on each ward, supported by a leadership programme
* Dedicated Consultant to be introduced for each ward

As many of the changes were part of the wider service remodelling work and have only recently been implemented it is too early to see the impact of these via local surveys.

**4.0 Use of Volunteers**

**4.0.1** Between May 2013 and December 2013 we recruited nine volunteers from a range of backgrounds and experiences, who are currently visiting 10 mental health wards and Community Hospital wards to listen to people’s views and opinions both positive and those highlighting areas for improvements to feed this immediately back to the ward team. This initiative was introduced as a 6 month pilot and following an evaluation involving the volunteers, patients on the ward and ward staff it has been seen as positive, helpful and has demonstrated making small differences to patients. All parties involved have supported the initiative being continued. See Appendix 3 for an example of some of the changes made as a result of feedback received by the volunteers.

**4.0.2** The evaluation highlighted the secondary benefits of the initiative with patients (and ward staff) reporting the value they (patients) found in having someone to talk to socially. The number of volunteers and the support offered to volunteers will be developed over the next 12 months following the feedback from the evaluation to increase the frequency of visits to wards and to offer the same opportunity to additional wards. In addition the group of volunteers have also been helping to carry out the 15 step challenge (people’s first impressions when visiting an area) on a number of wards.

**4.0.3** Following feedback from the evaluation there are many ways to develop the use of volunteers on wards across Oxford Health NHS FT for example helping to run activities (gardening, cooking etc..), facilitating patient forums, spending time sitting with patients to talk, read etc.., however there needs to be a more robust and coordinated approach to recruiting and supporting volunteers to realise the many benefits which they can offer.

**4.1 Themes and Areas for Improvement**

**4.1.1** We have received a wide range of responses, giving the opportunity to celebrate the positives and to identify and address areas for improvement. Across our services the key theme from feedback is to improve partnership working with patients and their families. This would include working to better involve patients in decisions, in developing and reviewing their plan of care, and improving how we provide and signpost information to ensure patients are informed.

**4.1.2** This is also a consistent theme coming through from complaints and local concerns about improving communication (see below) and also through clinical audit results where we often struggles to evidence in written documentation that patients have been involved in decisions and agreed to their treatment.

**4.1.3** Across our services the key theme from feedback is to improve partnership working with patients and their families. This would include working to better involve patients in decisions, in developing and reviewing their plan of care, and improving how we provide and signpost information to ensure patients are informed.

**4.1.4** The national Friends and Family Test question has been introduced to some services and this will be extended to the majority of services over the next three months, by making the question one of the four core questions incorporated within existing surveys and formal feedback mechanisms.

**4.2 Summary of CQC Mental Health Act visits**

The CQC have conducted 6 MHA assessments since the beginning of February. All CQC reports are sent to the relevant directorate and an action plan developed by the clinical services. These are reported through to and are approved by the weekly review meeting before submission to the CQC. Details of the clinical areas together with recommendation can be seen below: -

|  |  |  |  |
| --- | --- | --- | --- |
| **Ward** | **Date** |  |  |
| Amber Ward | 21 February 2014 | 1. Section 17 leave: 2. Re-presentation of rights: 3. Consultee had not made record following Second Opinion Appointed Doctor visit: | 1 Leave forms reviewed, review of practice with staff including provision of copies to patient and carers  2. Introduction of PSAG (Patient status at a glance) to ensure patients receive information.  3. Member of staff corrected omission, consent status reviewed on all patients. |
| Chaffron Ward | 14 February 2014 | 1. Participation in care planning: | 1. :The patient’s individual care plan was updated, all care plans are to be reviewed and analysed by ward manager by May 31 2014. |
| Fiennes Centre | 28 February 2014 | 1. Dating of section 20 renewal document: 2. Consent to treatment for recalled and revoked CTO patient: delay in provision of SOAD, patient rerated under section 62 (urgent treatment authorised by responsible clinician), reminders and flowcharts had been issued to responsible clinicians, MHA Office reviewed reminder systems. 3. Section 17 leave form not signed by patient: 4. Rights forms not up to date: 5. Additional treatment being provided to patient: 6. AMHP report not received: 7. Patient status incorrect in records (section 2 instead of section 3): health 8. Patient participation in care planning: 9. Risk assessments not current: | 1. Responsible clinician provided statement relating to renewal of detention for the particular patient.  MHA Office procedures reviewed and second scrutiny introduced.   1. Delay in provision of SOAD, patient rerated under section 62 (urgent treatment authorised by responsible clinician), reminders and flowcharts had been issued to responsible clinicians, MHA Office reviewed reminder systems.   3 Reminder issued by MHA Office, review by ward management team of practice and staff awareness.  4. All patients had up to date rights forms confirmed by MHA Office, ward management team introduced weekly reviews (including consent and leave forms)  5. Immediate rectification on ward, and added to weekly medicine card review.  6. AMHP report was submitted, however, MHA Office continue to review receipt with respective Local Authority AMHP administrators.  7. Records corrected, all patient records reviewed and added to weekly review by ward management team.  8. Ward staff on 3 April, patient participation, document standards, weekly review by ward management team.  9. Review of all patients, update risk assessment by April 4, added to weekly monitoring by ward management team. |
| Mandalay | 7 March 2014 | 1. Section 17 leave forms not indicating that patient had received copy: 2. Patient participation in car planning: review of current care plans by key nurses, ward manager has met with all staff, monitoring by ward manager. 3. Updating risk assessment: AWOL patient did not have absconding included in risk history, update by key nurse and monitoring by ward manager. | 1. Liaison with carers to receive copies, monitoring by ward manager, review of current forms.  2. Review of current care plans by key nurses, ward manager has met with all staff, monitoring by ward manager.  3. Updated by key nurse and monitoring by ward manager. |
| Sapphire | 14 March 2014 | 1. Patient status not updated to section 2 in records: 2. Care plan updates: 3. Evidence of patients receiving copies of care plans: 4. Consultee recording following SOAD visit: 5. Consideration by responsible clinician of CTO for longer term leave patients: | 1. Records reviewed, and Patient Status at a Glance introduced, monitoring by ward manager.  2. PSAG introduced, care plans reviewed with key nurses and patients, ward seeking AIMS accreditation.  3. Ward review of current leave and monitoring by ward manager.  4. Record made by consultee, all staff reminded.  5. RCs have reviewed all such patients, reminded to complete section 17 documentation fully, monitoring and report over 3 month period. |
| Kennett Ward | 3 March 2014 | 1. Participation in care planning: 2. Consent documentation not kept in conjunction with prescription charts: 3. Providing copies of section 17 leave forms appropriately: 4. Provision of rights information in languages other than English: | 1. All patients have a copy of their care plan and this will be documented in their electronic record.  2. Monitoring by ward managers across forensic service, check and report by 30 June.  3. Leave form allocation is checked by modern matron, report by May 31.  4. Modern matron to complete spot checks and report by June 30. |

**5.0 New Models of Care ,Care Pathways and integrated management**

**Adult Mental Health**

**5.0.1** The new within AMH services has now been rolled out and Adult Mental Health Teams, and the five Adult Mental Health teams (AMHTs) are now in place. The AMHTs are in the process of becoming familiarized with the new ways of working however remain embryonic in terms of integration and on-going training is supporting staff to provide high quality more reliable evidence based care safer care using care clusters .

**5.0.2** The clinical model for both in-patients services and community mental health services are being introduced alongside application for AIMs accreditation within acute in-patient services, PICU and rehabilitation

**Older adult mental health**

**5.0.3** The new inpatient service at the Whitleaf Centre has continued to reduce length of stay. The staff teams have found adapting to the new environment and model a large change and the leadership from the Clinical Lead Psychiatrist and Head of Nursing through this period has been important whilst staff adapt to the new model of care.

**5.0.4** In Oxfordshire the Fiennes ward which was scheduled to close at the end of July is at the point of closing as patients are discharged . Currently there are three patients in the ward. Staff will relocate to other posts within the service.

**6.0 Older Peoples Services**

**6.0.1 Community Hospital Essential standards Audit Tool (CHAT)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Audit Rating**  *(Highlight)* | Excellent | Good | Requires Improvement | Unacceptable |

**6.0.2** The CHAT audit (Community Hospital Audit tool) has been used since 2010 in all ten wards as the means of consistently measuring the quality of care as referenced in the documentation of care. There have been some concerns regarding the applicability of some of the standards which were not essential leading to some inadvertent poor reporting in some areas. Examples of this include that the Anxiety & Depression tool. A revised essential standards audit has been agreed for 2014/15 with the service clinical and operational staff, this will be reported in future. The new methodology will involve a reduction in the sample size to 10 patients per ward will make audit swifter to complete, and should result in better adherence to the schedule and therefore more time to address actions.

**6.0.3** The results shown below are those from Q4 2013/14 as the Q1 CHAT audit for 2014/15 has yet to be completed. This will be completed by the end of June 2014. (The Q1, 2 & 3 audits were rated good.) NB The audit tool was altered slightly after Q1.

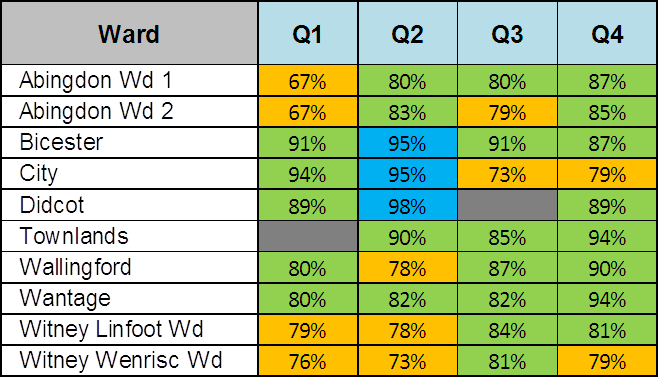
* This audit relates to the following Care Quality Commission Essential Standards Outcomes:
* Consent to care and treatment
* Care and welfare of people who use services
* Meeting nutritional needs
* Records
* Results overview

All sites were rated Good overall, except City and Witney Wenrisc which were rated Requires Improvement.

**6.0.4** The main issues included the assessment of patients with nutritional, falls and pressure damage risk with subsequent reassessment on a regular basis. The directorate has addressed this with a robust training package for staff in affected areas with oversight and support from the divisional nurse. Action plans developed to support improvement are monitored through the Directorate Clinical Governance meetings, and centrally monitored to ensure completion. Reassessment has commenced in most areas and will be complete by the end of June (city and Townlands yet to be completed though scheduled) (Q1- 2014/5). The indications are that all wards audited have improved with Witney Linfoot, Witney Wenrisc and Didcot all achieving excellent rating. City Community hospital ward is scheduled for reassessment on 18th June 2014. The directorate has also reviewed the scheduling of the audit to make completion easier for staff concerned.

**6.0.5** Overall standards are good with an improvement seen from Q3. 34 standards were rated Good or Excellent across all sites, whilst 12 were rated Requires Improvement or Unacceptable. There were 30 and 16 respectively in quarter 3.

**6.0.6** Overall rating by location 2013/4 the full audit summary by standards and ward is enclosed in Appendix 1.



**Results key findings**

**6.0.7** Q4 audits found an improved rating for 8 standards (eg Good to Excellent), and a fall in rating in 5, when compared to Q3 results.

**6.0.8** The standards which are requiring improvement have been captured in the action plans which were used to address the issues of concern are:

* Recording patient contact numbers
* MUST recording, and subsequent care plans
* Walsall (re)assessments, and subsequent care plans
* Memory screening
* Falls care planning
* Review of care plans
* Communicating discharge details to patients
* Absence of staff photo boards

**6.0.9** Teams action - selected local action plan points

* City & Wallingford to complete patient ID labels before admission, including GP identity, as this is often missed in records.
* City to complete a large set of (re)training events for staff, utilising the Clinical Development Nurse, so address such issues as MUST assessment, recording pressure relief provision, reviewing care plans, etc. This has been and continues to be supported by input from John Campbell (Directorate senior nurse). Reassessment of Q1 2014/15 is scheduled for the 18th June 2014
* Townlands will discuss standards with less good results at the RN/Ward meetings (complete)
* Wallingford to encourage staff members to introduce themselves when dealing with patients, as 40% did not know the identity of the nurse looking after them of the day of the audit. This action has been undertaken and reiterated by the Ward manager and CDN since.

The actions identified above have been completed.

**6.1 Classic Safety thermometer results Q4**

**6.1 1 Results summary:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Harm % | | | | | | | | | | | | | | | | | | | |
| Location | Harm Free | | All  PU’s | | New  PU’s | | Falls with Harm | | Catheter  /UTI | | Catheter/  new UTI | | New  VTE | | All Harm | | New  Harm | | VTE risk assess | |
| **National position** | 93.62  (93.52) | ⇧ | 4.57  (4.67) | ⇩ | 1.02 (1.01) | ⇧ | 0.74 (0.79) | ⇩ | 0.79  (0.87) | ⇩ | 0.36  (0.38) | ⇩ | 0.51  (0.41) | ⇧ | 6.38  (6.48) | ⇩ | 2.57  (2.54) | ⇧ | 61.98  (46.19) | ⇧ |
| Trust  overall  1161 | 88.11  (89.87) | ⇩ | 10.24  (7.74) | ⇧ | 2.24  (1.45) | ⇧ | 1.03  (1.79) | ⇩ | 0.86  (0.77) | ⇧ | 0.60  (0.51) | ⇧ | 0.17  (0.26) | ⇩ | 11.89  (10.13) | ⇧ | 3.96  (3.91) | ⇧ | 77.99  (94.42) | ⇩ |
| 1023 |  | 119 |  | 26 |  | 12 |  | 10 |  | 7 |  | 2 |  | 138 |  | 46 |  | 202 |  |
| Comm.  Hospitals  197 | 87.31  (89.23) | ⇩ | 11.68  (8.72) | ⇧ | 2.03  (0.51) | ⇧ | 0  (0) | ⬄ | 2.03  (1.54) | ⇧ | 2.03  (1.54) | ⇧ | 0  (0.51) | ⇩ | 12.69  (10.77) | ⇧ | 3.55  (2.56) | ⇧ | 77.66  (92.31) | ⇩ |
| 172 |  | 23 |  | 4 |  | 0 |  | 4 |  | 4 |  | 0 |  | 25 |  | 7 |  | 153 |  |
| Older Adult  In-patients  62 | 98.39  (97.30) | ⇧ | 0  (1.35) | ⇩ | 0  (0) | ⬄ | 1.61  (1.35) | ⇧ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | 1.61  (2.70) | ⇩ | 1.61  (1.35) | ⇩ | 79.03  (100) | ⇩ |
| 61 |  | 0 |  | 0 |  | 1 |  | 0 |  | 0 |  | 0 |  | 1 |  | 1 |  | 49 |  |
| Comm.  Nursing  748 | 86.63  (88.29) | ⇩ | 12.3  (9.14) | ⇧ | 2.81  (2.29) | ⇧ | 0.53  (2.29) | ⇩ | 0.53  (0.57) | ⇩ | 0.27  (0.43) | ⇩ | 0.27  (0.29) | ⇩ | 13.37  (11.71) | ⇧ | 3.88  (5.14) | ⇩ | N/A |  |
| 648 |  | 92 |  | 21 |  | 4 |  | 4 |  | 2 |  | 2 |  | 100 |  | 29 |  |  |  |
| Older Adult  CMHT  63 | 95.24  (98.95) | ⇩ | 3.17  (1.05) | ⇧ | 1.59  (0) | ⇧ | 0  (0) | ⬄ | 1.59  (0) | ⇧ | 1.59  (0) | ⇧ | 0  (0) | ⬄ | 4.76  (1.05) | ⇧ | 3.17  (0) | ⇧ | N/A |  |
| 60 |  | 2 |  | 1 |  | 0 |  | 1 |  | 1 |  | 0 |  | 3 |  | 2 |  |  |  |
| Specialist Nursing  11 | 90.91  (100) | ⇩ | 0  (0) | ⬄ | 0  (0) | ⬄ | 9.09  (0) | ⇧ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | 9.09  (0) | ⇧ | 9.09  (0) | ⇧ | N/A |  |
| 10 |  | 0 |  | 0 |  | 1 |  | 0 |  | 0 |  | 0 |  | 1 |  | 1 |  |  |  |
| Comm.  Nursing  Mixed  8 | 87.5  (83.33) | ⇧ | 12.5  (0) | ⇧ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (16.67) | ⇩ | 0  (0) | ⬄ | 0  (0) | ⬄ | 12.5  (16.67) | ⇩ | 0  (0) | ⬄ | N/A |  |
| 7 |  | 1 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 1 |  | 0 |  |  |  |
| Physio  4 | 100  (100) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | 0  (0) | ⬄ | N/A |  |
| 4 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 0 |  | 4 |  | 0 |  |  |  |
| Rehab  258 | 87.6  (86.67) | ⇧ | 9.3  (8.89) | ⇧ | 1.55  (0) | ⇧ | 2.33  (4.44) | ⇩ | 1.94  (1.11) | ⇧ | 1.55  (0) | ⇧ | 0  (0) | ⬄ | 12.11  (13.33) | ⇩ | 5.04  (4.44) | ⇧ | N/A |  |
| 226 |  | 24 |  | 4 |  | 6 |  | 5 |  | 4 |  | 0 |  | 32 |  | 13 |  |  |  |

**6.1.2** Safety thermometer results for Q4 suggest that the Trusts overall position in association with harm free care is worse than the national position (88.1% as opposed to 93.62% nationally) and has deteriorated since Q3. The areas within the directorate with greatest prevalence of harm free care are;

* + 1. **Community hospitals**
  1. These relate to the Community hospital wards in Witney and Wantage. Abingdon Ward 2 has improved since Q1 and Q2 last year.
  2. The harms in the main relate to inherited pressure damage
  3. Due to small patient numbers in Wantage hospital, prevalence of any harms have a disproportionate statistical impact.
  4. Wenrisc ward also have acquired pressure damage though have not had pressure damage occurring in the ward within the last seven months.
  5. Urinary tract infections occurring in Q3/4 in 3 patients though none outside of these times.
  6. Linfoot ward- Acquired pressure damage again is the source of the recorded harms though pressure damage occurring whilst in the ward is low occurring in Q2 2013/14.
  7. Urinary tract infections in six patients occurring in the ward in the last year accounts for the majority of harms
     1. **Community nursing**
* Pressure damage both acquired and occurring whilst in care in conjunction with patient falls accounts for the majority of all patient harms.
* In general approximately 50% of all harms are acquired.
* The city Locality has a greater prevalence of harms occurring than other localities. The harm occurrence is equitably spread across that locality.
* Wheatley, Wallingford and Watlington teams in the SE locality had higher levels of harms.
* Q3/4 harms in the Charlbury, Broadshires and Westbar teams also accounted for the harms reported.
* All community nursing teams have achieved 85% harm free care for at least one month in April/May 2014 (Q1 2014/15)
  + 1. **CMHTs**

Harms occurring in this service are equitably spread across three areas, falls, Urinary tract infections and Pressure damage. Numbers are low with on average three patients per month experiencing harm and approximately 60% attributable to the service.

* + 1. **Community rehab services.**
* Harms are generally spread across all recorded areas in the service though low in numbers.
* The west and north Community rehab teams have higher harms recorded. Harms are more likely to occur in the service than other areas. Falls constitutes the greatest harms though this is perhaps understandable in the patient population that this service manages.

**Actions being undertaken:**

1. Percentages of harm free care is recorded on the community nursing and community hospital Productive care database
2. Data regarding harm free care is made available to clinical and operational managerial staff by the clinical governance team
3. There is a direct correlation between quality of care and staffing levels in community nursing and community hospitals. In patient settings are being monitored through safer staffing initiatives with operational management scrutiny each week. This methodology is being incorporated into community nursing teams.
4. The directorate has developed an action plan to address the staffing shortfalls in the city locality (hardest hit by vacancies and sickness)

**6.1.7 Pressure ulcer incident data - Percentage of Pressure ulcer incidents that develop into SIRIs per month**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** |
| Number of pressure ulcer incidents reported | 143 | 131 | 97 | 132 | 143 | 134 | 132 | 124 | 135 | 124 | 137 | 126 |
| Number of pressure ulcer high risk incidents | 22 | 11 | 15 | 8 | 8 | 10 | 11 | 4 | 16 | 15 | 3 | 12 |
| Number of pressure ulcer SIRIs investigated | 1 | 4 | 2 | 3 | 0 | 1 | 2 | 1 | 0 | 1 | 0 | 1 |
| Percentage of pressure ulcer incidents that are deemed avoidable/ SIRIs | 0.7 | 3.1 | 2.1 | 2.3 | 0 | 0.7 | 1.5 | 0.8 | 0 | 0.8 | 0 | 0.8 |

**6.1.8** It is not possible to extract inherited and acquired pressure damage form the risk management system however as all grade 3 or 4 pressure damage is investigated and assessed for avoid ability; this is a proxy indicator.

**6.2 Safety thermometer CQUIN**

**6.2.1** The CQUIN for 2013-14 is based upon reducing the prevalence of pressure ulcers based on the year out turn 2012-13. The following provides an overview of pressure ulcers. The national trend shows a reduction, however our trust has recorded a higher prevalence of pressure ulcers in nearly every category, except new pressure ulcers and therefore the ongoing prevalence may be related to the length of time older patients remain on caseload.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Percentages | Grade 2-4 | Grade 2 | Grade 3 | Grade 4 |
| All organisations (Q4 1213) | | | | |
| All | 4.57 (5.32) | 2.93 (3.50) | 1.06 (1.17) | 0.58 (0.64) |
| Old | 3.64 (4.13) | 2.27 (2.61) | 0.85 (0.96) | 0.51 (0.56) |
| New | 1.02 (1.27) | 0.73 (0.96) | 0.22 (0.23) | 0.07 (0.08) |
| Oxford Health (Q4 1213) | | | | |
| All | 10.25 (7.01) | 7.49 (5.24) | 1.81 (0.68) | 0.95 (1.36) |
| Old | 8.61 (6.29) | 6.12 (4.51) | 1.72 (0.68) | 0.78 (0.93) |
| New | 2.24 (2.20) | 1.81 (1.61) | 0.26 (0.34) | 0.17 (0.25) |

**6.2.2** It is worth noting that these figures cover all pressure ulcers and is not indicative of the damage occurring whist the patient was in receipt of our care. Whilst the directorate is somewhat limited in the role that it can play in reducing the prevalence of acquired pressure damage work is underway through the safer care programme to reduce the potential for new harms within teams and across service interfaces.

**Specific actions being undertaken are;**

1. Development of an online Tissue Viability Site which provides educational resources and all the documentation associated with pressure damage training for staff to download.
2. Development of an E-learning package accessed via the LD portal
3. Piloting of an equipment flow diagram to assist in determining the most appropriate equipment for patients
4. The directorate is however working with tissue viability leads in the OUHT to improve care and reduce harm. This includes the joint introduction of the ‘Braden scale Risk tool’ and the introduction of a patient education and information leaflet
5. A Trust wide action group meets bi monthly to review the pressure ulcer prevention action plan which has an overall aim of reducing avoidable pressure ulcers. 5 work streams form the structure of the action plan, each with its own lead who is responsible for coordinating the work plan. These are:
   1. Integrated working with the Oxford University Hospital Trust (OUH)
   2. Education and competency frameworks
   3. Documentation and audit
   4. SSKIN bundles
   5. Working with formal and informal carers
      1. Achievements to date include:
   6. Pilot sites across OUH and Oxford Health which aim to improve patient information about pressure damage.
   7. Development of a national e learning programme which is now available for staff
   8. A competency framework which has been launched across community nursing teams
   9. Partnership working with local authority and the voluntary sector to help raise awareness of pressure ulcers
   10. Introduction of SSKIN bundle across older adult mental health wards (pilot sites)

This is monitored through the directorates Quality and Clinical Governance committee.

**7.0 Community Nursing Quality Review**

**7.0.1** Community nursing service covers District Nursing, and Tier Two, which consists of specialty community nursing services. Due to the increasing number of older people living with complex long term conditions in Oxfordshire, the need and demand for the community nursing service has grown significantly, up by 14% in the last two years alone. This has been exacerbated by changes in post-acute clinical pathways, which have also contributed to an increased caseload for community nurses (as well as GPs). As such it is one of the highest areas of concern for the division and the organisation. The service is in many respects the ‘shop window’ to the organisation within Oxfordshire as staff and patients interface on a daily basis with general Practice and hence the OCCG commissioners. The main concerns relating to the service are;

1. Matching capacity to demand as the service demand continues to exceed the contractual levels
2. Safe staffing levels as staff have left the service citing pressure of work affecting their desire to stay and other areas of work becoming more attractive
3. Holistic assessment of patients such that their risks are fully understood and appropriate care can be delivered to meet their needs.

**7.0.2** Community nursing is commissioned by the Oxfordshire Clinical Commissioning Group under a block contract (a single payment based on a fixed level of activity). Given the difficult fiscal position for the NHS as a whole, and in particular in Oxfordshire, as part of our contractual agreement for 14-15, OCCG and OHFT have agreed to work together to establish how the current activity level for Community Nursing can be reduced to the contracted activity level of 253,000 contacts per annum whilst delivering excellent care that is evidence based and meets the needs of our community.

**7.0.3** In order to stabilise the service at this level of activity the scope and volume of interventions currently delivered by Community Nursing will have to change. Some of those which will be looked at are: stand-alone phlebotomy; long term condition monitoring; non caseload flu vaccinations; postoperative wound care; patients who are mobile and in receipt of PICC lines, and catheter interventions; patients in receipt of a visit solely on the grounds of transport requirements. OCCG and OHFT will also examine the published evidence for Fragmin administration.

**7.0.4** The review will also take into account the development of integrated teams; the relationship between District Nursing and Specialist Community Nursing Services; and the potential for more radical re-design – examining best practice in the delivery of 21st Century community health services and including consideration of the options for an outcomes based contract for these services.

**7.0.5** The CCG and OHFT have committed to completing this work by October 2014: and the CCG has agreed interim funding to help address current activity pressures in the district nursing service until the review and its subsequent recommendations have been implemented.

**7.0.6** Community nursing staff have been informed about the planned reduction in workload and capacity and the forthcoming view. One of the Lead District Nurses Gabrielle Parnham is a member of the Oxford Health FT Team working directly with GP’s and Comissioners. They will be involved in the internal stakeholder group which will play a key role in developing the care packages and pathways needed for a community nursing service from 2014 onwards.

* 1. **Oxford Reablement Service (ORS)**

**7.1.1** The ORS service continues to play a major role in the whole system joint working to reduce delayed transfers of care, including:

* Streamlining the supported discharge pathway (joint working between ORS and the OUH’s supported hospital discharge team)
* Current whole system audit on readmission to acute from supported discharge pathway (ORS / SHDs, community hospitals, ICBs, restart of domiciliary care, admission to residential / nursing home bed)
* Development of a whole system bariatric pathway for supported discharge (home and bed-based)

**7.1.2** ORS is now in the second year of a 2 year contract (1 October 2012 – 30 September 2014).

The purpose of the service is work with individuals to increase functional ability after deterioration in health, trauma or a hospital admission which has resulted in a reduction in their level of independence.

The success of the service is measured by the following outcome indicators

* The percentage of people who are discharged from the service needing no ongoing domiciliary care
* The percentage of people leaving the service needing a lower level of domiciliary care than when they entered the service
* The percentage of non-completers i.e., people who do not complete their ORS episode
  + 1. **The percentage of people who are discharged from the service needing no ongoing domiciliary care**

Year 1 target – **55%**

Year 2 target – **60%**

In the first year of the contract ORS achieved on average **49.78%** per month. In year 2 to date ORS has achieved **57.18%.**

**7.1.3** In spite of struggling to consistently achieve the target month on month ORS has demonstrated continuous improvement in increasing the percentage of people leaving the service with no ongoing need through a steady upward trend since the start of the contract.

* + 1. **The percentage of people leaving the service needing a lower level of domiciliary care than when they entered the service**

ORS has performed extremely well in reducing the level of need for people leaving the service and in 13 of the 19 months to date has exceeded the target. The average achievement per month to date is 18.68% against a target of 17%.

**7.1.5** Overall since the start of the contract 71.19% of all people who completed their ORS benefited in that they left the service with no ongoing need for domiciliary support or their independence had increased and their level of need was reduced.

* + 1. **The percentage of non-completers i.e. people who do not complete their ORS episode**

The target for non-completers is 17%. People who do not complete their ORS episode include

* Hospital admissions
* Admissions to care homes
* People who die
* People who discharge themselves

The average percentage achievement per month since the start of the contract is 23.48%.

**7.1.7** This has been a particularly challenging target for ORS as hospital admissions alone since the start of the contract have averaged 17.92% per month.

**7.1.8** There has been much debate over whether a target of 17% is realistic and achievable given the level of frailty and complexity of the service users who enter ORS.

**7.1.9** Past audits have shown that the hospital admissions from ORS are unavoidable and appropriate and very often are for a health event unrelated to that which preceded the service users’ admission to ORS in the first instance.

**7.1.10** It is also known that Oxfordshire has a lower state funded admission rate to care home care than comparator authorities, the emphasis being on supporting people at home for as long as possible. The implication is that more frail older people with complex needs are being supported at home using services such as ORS. This may in part be responsible for the high percentage of ORS non- completers who are admitted to hospital.

**7.2 Quality indicators – taken from the Trusts Patient Experience Questionnaires**

**7.2.1** ORS has participated in seeking patient feedback via the Patient Experience Questionnaires since this was introduced by the Trust in 2012.

**7.2.2** The patient experience questionnaires holds a number of demographic questions plus 19 questions of which

4 are Trust wide

10 are used for services within Community Services/Older Peoples Directorate

5 are service specific (R1 to R5)

**7.2.3** The results from the two years to date (see below) show significant improvement in all areas (see results overleaf). In 2013/14 areas where patient feedback has been particularly good are

* 97% of clients stated that when they had important questions to ask the [member of staff], they got answers that they could understand
* 100% of clients reported that they received the right amount of information about their condition and treatment has been given to them?
* 96% of clients reported that the care they received was excellent or good with only 4% expressing that they felt the care was fair
* 100% of all surveys expressed they were likely to recommend this service to friends and family if they needed similar care or treatment?
* 97% of clients reported that ORS did very well or fairly well in encouraging and motivating them to become independent?

**8.0 Infection Prevention and Control Update**

**Infection Prevention and Control Report – April 2014**

***Clostridium difficile***

**8.0.1** There have been no cases of *Clostridium difficile* infection (CDI) in community hospitals or mental health services in May 2014. We remain with one CDI case so far this year against the end of year target of 8.

**8.0.2** Our Trust remains involved in a monthly CDI health economy review meeting with the OUH, Public Health England and OCCG commissioners on the 2nd Monday of each month. At this meeting all CDI cases across the health economy are presented.

**Below is a summary of the review meetings for the cases.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Month | Location | Running total of cases | Avoidable/  Unavoidable | Running total of Avoidable |
| April 2014 | Ward2, Abingdon | 1 | Unavoidable | 0 |
| Didcot CCG case | 1 | Unavoidable | 0 |
| May 2014 | No cases | 1 |  | 0 |

**8.0.3** Further collaborative work is being undertaken with the lead for infection prevention and control in the CCG and the infection control manager at the OUH to develop a county wide CDI patient information leaflet. The number of CDI cases across the health economy appears to be challenging for all Trusts.

**8.0.4** Our Trust target for 2014/15 is 8 cases again. The Department of Health have just published updated guidance for *Clostridium difficile* objectives (4.3.14), including processes for individual case review similar to the existing Oxfordshire Health economy meeting to determine if cases are avoidable, before any financial penalties are applied. The financial penalty for each case over trajectory has also been reduced to £10,000 per case from £50,000.

**8.1 MRSA bacteraemia/MSSA bacteraemia**

There have been no MRSA/MSSA bacteraemias in either community or mental health services in April or May.

**8.2 E.Coli bacteraemias**

There were no E.Coli bacteraemias in April; however there have been 2 community cases *E.Coli* bacteraemias in May identified on EMU at Abingdon hospital. There is no target for these infections but it is a mandatory reported infection. There is no target for these infections but it is a mandatory reported infection.

**8.3 Outbreaks**

There were no outbreaks in April, although ward 2 at Abingdon hospital has a confirmed outbreak of norovirus which started on 7th May.

**8.4 Community hospitals**

**8.4.1** There was a confirmed norovirus outbreaks in May (7th-13th) on Ward 2 at Abingdon hospital. It affected 13 patients and 2 staff. The ward was closed for 5 days and then partially opened to support EMU beds.

**8.4.2** There was a suspected norovirus outbreak on Linfoot ward, Witney hospital from 23rd-27th May. It affected 7 patients and 1 staff. The ward was closed for 2 days in total and then partially opened to unaffected bays.

**8.5 Mental health wards**

There were no CDI cases in April 2014. There is a suspected norovirus outbreak on Sapphire ward, Whiteleaf affecting 4 patients from 31st May – 3rd June. The ward was full at the time and no staff were affected.

**8.6 Chicken pox contact**

A member of staff working at Wantage hospital was identified as having chicken pox on 28.5.14. A full review of patients and staff for chicken pox history and immunity was undertaken. One member of staff was tested for immunity and managed by occupational health. The five patients had no known history of chicken pox, no infection developed in this population.

**9.0 CQC update and CQC compliance assurance monitoring for outcomes 2, 4, 9 & 16**

The current level of compliance for CQC outcomes 2,4, 9 and 16 (May 2014) are outlined below in table one. This shows that the Trust has self-assessed internal concerns across 2 of the 4 CQC outcomes, each of these is overseen by the Clinical Effectiveness Quality Improvement Committee.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Outcome | | Executive Director Responsible | Quality Improvement Committee | Trust wide exceptions (in addition to Division level concerns) |
|
| 2 | Consent to your care and treatment | Clive Meux | Clinical Effectiveness |  |
| 4 | Care and welfare of people who use services | Clive Meux | Clinical Effectiveness |  |
| 9 | Management of medicines | Clive Meux | Clinical Effectiveness |  |
| 16 | Assessing and monitoring the quality of service provision | All Chairs | All |  |

**Details of the areas of concern, together with agreed action can be seen in the table below:**

| Area of Concern | Actions |
| --- | --- |
| Management of controlled drugs across the Trust  (moderate) | * Following a review of the incidents reported relating to CDs (14 between Oct 2013 to March 2014) and the quarterly pharmacy audit results a number of issues were highlighted about practice (eg omitted does, errors) and record keeping. All cases have been investigated for learning. * The Drug and Therapeutic Committee rated the issues as a moderate concern on 29th April 2014. * In response to the issues daily checking of CDs was reinstated from April 2014 and the frequency of pharmacy audits has been increased to 6 weekly (next audit due at the end of May 2014). * Extra training is being provided to relevant staff. |
| Completeness of documentation around Section 17 leave across adult, older people and forensic mental health wards  (moderate) | * This has been a reoccurring issue throughout 2013 and 2014 across the wards, highlighted by the CQC during their MHA visits. * Staff have been reminded of the need to ensure all parts of the Section 17 leave form are completed and that out of date forms are removed. * Checks on Section 17 leave forms is being added to the mental health ward essential standards audit carried out by the Modern Matrons every other month. * A weekly Section 17 audit is being trialled on an older adult ward completed by weekend staff. * Safer care programme are focusing on AWOLs and Section 17 leave in adult services, similar approach to be adopted by older adult services. |

**10.0 Individual standard results by ward Q3**

Please see table below on page 36

