

# Report to the Meeting of the Oxford Health NHS Foundation Trust

# Board of Directors

**For Information**

**BOD 101/2015**(Agenda item: 7)

101/2015

Agenda item

**29 July 2015**

**Quality and Safety Report**

**For Information**

This report outlines current progress, including areas of concern or priorities across our trust in relation to quality and patient safety for quarter 1 (2015/16).

The report includes:

1. Areas of current good practice and areas of current risk across all three domains of safety, effectiveness and patient experience
2. Patterns of reported incidents
3. Restraints
4. Serious incidents requiring investigation
5. Infection prevention and control
6. Examples of improvement work across the Trust

This report should be read in conjunction with the Quality Account Quarter 1 highlight report which provides information on progress to deliver our quality account priorities.

**Incidents and serious incidents overview**

The Board is asked to note that the overall number of incidents has increased this quarter which supports our ambition to report any and every patient safety incident. The proportion of serious incidents remains low; however there has been an increase in serious incidents in Q1 and a steady increase since the same time last year. The number of deaths has decreased since Q4 with fewer suspected suicides since Q4. The number of pressure ulcers reported in Q1 has increased reasons. The increased rates are analysed further in the report.

Smoking related incidents have increased since the introduction of the no smoking policy.

The new serious incident framework offers opportunities to improve timeliness of reporting, investigation and implementation of learning from serious incidents. We are also making improvements to ensure we meet our obligations for duty of candour and openness with patients and those close to them when something goes wrong.

The number of incidents in web-holding awaiting a managerial review has decreased significantly since Q4.

**Restraints**

There were a increased number of restraints in April and May, before a fall in June. Overall we have seen a fall this quarter in the percentage of restraints during which the patient was prone. We have changed the categories used to report types of hold used to more clearly differentiate between different types and impact on the patient. We commenced the new Trust’s programme for the reduction in the use of restrictive interventions known as PEACE.

**Infection control overview**

*Areas of compliance/good practice in infection prevention and control*

There was overall sustained good compliance with hand hygiene audits and ATP environmental cleanliness monitoring in the older people’s in patient’s areas. Results are monitored in real time by the IPC team and any issues followed up with the services. Quarterly reports are provided for the directorates to discuss in their governance meetings.

There is overall good staff engagement.

*Areas of unsatisfactory compliance/areas of risk in infection prevention and control*

* Number of staff trained is 74% and remains below the Trust target of 90%.
* There is currently non standardised documentation in teams for management of patients with urinary catheters. This was identified in a staff knowledge survey and work is in progress to standardise.. The Trust has also joined with the Academic Health Science Network (AHSN) project to reduce catheter associated urinary tract infections. Other Trusts involved in this project include OUH and we are working together to review patients care plans and procedures.
* There is currently non standardised practice with local teams/services developing documentation or processes rather than one overall process which will be addressed through the AHSN work, Our Senior Matron for Infection Control is leading this work

**Recommendation**

The Board is asked to note the report.

**Author and Title:**

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**Lead Executive Director:** Ros Alstead, Director of Nursing and Clinical Standards

1. *A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.*

**Board of Directors Quality and Safety Report Q1 2015/16**

**Summary of good practice and areas of risk for improvement**

Each month one of the three quality domains is the focus of the trust wide quality report (i.e. once a quarter) and this month **safety** is highlighted.However, it is important to ensure the Board of Directors also receives a monthly overview of current progress and areas of risk against all three quality domains **(safety, effectiveness** and **patient experience)**. Below is a summary of the current high level themes for safety, effectiveness and patient experience which are emerging from 63 peer reviews, clinical audit, incidents and serious incidents investigations and management, and feedback from patients and carers reported.

**Good practice**

* City and North East AMHT are undertaking a significant project to improve medicines management, and pharmacy technicians have increased support to community teams
* Patients and carers regularly describe staff as caring and kind and there are many examples of involvement of carers e.g. in district nursing
* Clear evidence of commitment of staff to provide high quality care
* Strong clinical leadership
* Partnership working, communication and liaison between services and with GPs
* Proactive care e.g. responsive when people are in crisis, staff flexibility to see patients quickly, following up when patients do not attend, step up care and increased frequency of outpatient reviews, effective management of emergency reviews
* Examples of good documentation
* Good relationships reported by patients and carers with care coordinators and patient involvement in decision-making if moving to a different care coordinator
* Significant work to improve policy management
* Plan to improve process for the reporting, review, investigation of and learning from incidents and serious incidents,
* Improvements in action planning and implementation and proactive risk management
* Safer care and wider improvement work in many teams
* MEWS rated highly, and good compliance with S17 leave form requirements
* Improvement in essential standards and community hospital audits
* Reduction in the number of prone restraints
* PEACE training has commenced

**Risks and areas for improvement**

* Working in a way that is meaningful for patients so that they feel involved in their care and care planning
* Involvement of families in care planning, decision making about transitions of care, carer assessments. More complaints are being made by families now. Team self assessments against Triangle of Care highlight lack of carer awareness training for staff and insufficient information for carers
* Medication management including handling medication, prescribing around insulin, under reporting of incidents, resourcing in community pharmacy, omissions (signing for drugs to ensure record of when and whether have received medication), ability to e-prescribe, safe management of polypharmacy, regular review of prescriptions and prescribing behaviour
* Record keeping in all areas, e.g. in mental health services there are examples of poor recording of risk assessment and care plans (not updated, not completed) and contingency planning; in district nursing there are examples of incomplete recording of care planning, review of care plan, update of risk assessments, comprehensive and comprehensible notes to enable continuity and consistency of care
* Staffing and resourcing including capacity and workload, limited time to attend PPST training or to maintain good records, an overreliance on telephone contact, examples of inadequate safeguarding and DoLS assessment of capacity.

Controls and improvement actions are implemented through directorate structures, with assurance managed through the quality sub committees, Quality Committee and directorate business performance review meetings which include executive and non executive directors.

A number of issues are addressed through the Quality Account priorities for 2015/16, namely

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

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

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

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

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

***2. Improve quality through service* *remodelling***

*This will enable the service to be effective and responsive.*

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

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

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

***3. Increase harm-free care***

*This will enable the service to be safe and effective*.

3.1 Prevention of suicide

3.2 Reduce the number of patients who are absent without leave

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

3.4 Reduce harm from falls

3.5 Reduce the need for restraint and monitor the use of seclusion

3.6 Improve physical health management of patients

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

*This will enable the service to be caring and responsive*.

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

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

1. **Reported Incidents**
   1. **Total number of incidents by quarter**

The level of incident reporting has increased over the last four quarters and is now at the highest level than at any time over the last two years. This is encouraging and suggestive of a positive safety culture.

**Total number of incidents per quarter[[1]](#footnote-1)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Q2 2013/14 | Q3 2013/14 | Q4 2013-14 | Q1 2014-15 | Q2 2014-15 | Q3 2014-15 | Q4 2014-15 | Q1 2015-16 |
| 3005 | 2958 | 2753 | 3032 | 2848 | 2963 | 3165 | 3184 |

**Number of incidents by Quarter**

**Incidents by actual impact**

The numbers of reported green and yellow incidents (low/minor injury or property damage) continues to represent the highest proportion of total reported incidents. There have been 48 deaths reported this quarter compared with fifty nine in Q4 2014-15.

The following chart shows the number of incidents reported by quarter with major injury/severe property damage or death.

**Reported deaths**

In Q1 48 deaths were reported, thirteen of which were expected deaths. These are reported when the patient is expected to die from a known illness. Expected deaths are reported as incidents in the mental health areas of the Trust and reviewed internally. Mental health related deaths are all reviewed internally and reviewed externally by the coroner to establish cause of death.

The Older Peoples directorate manages incidents relating to deaths in two ways. All unexpected deaths in the community are reviewed using the incident reporting and management process and investigated as an orange or serious incident. There are a small number of incidents annually involving urgent care whereby the service is contacted by a member of the public who has found a relative dead at home. As above these are reviewed through the incident reporting and management processes. Where these cases have had no prior involvement with any of our services, we generally do not need to manage as an SI as our involvement is not related to the event.

In community hospitals the same process applies though in addition to this all deaths are reviewed in conjunction with the OUH gerontology teams using the Mortality and Morbidity Review Process. These may also be subject to a SI investigation if circumstances warrant this, for example, where a patient death is expected but issues associated with the patients care warrants further investigation. This may be an issue related to symptom control or communication with professionals and with family. This would be followed through the current incident management process.

Thirty five were unexpected deaths with twenty five of these occurring in the community and ten in an acute hospital or in an Oxford Health inpatient unit. Eleven were SI reportable at the time of writing this report. The rest are managed as an orange incident within the relevant directorate and outcomes of investigations reported at the weekly review meeting as well as being reviewed within directorate meetings and reported through business performance meetings.

Children and Families reported five non SI unexpected deaths. Of the remaining, one was a cot death, one was death by accidental drowning and three were unexpected deaths of which two were hangings. All of these were subject to rapid response meetings and were subsequently not reported as SIs. All child deaths are reviewed externally through the Child Death Overview Process.

Adult services reported seven non SI unexpected deaths, which include deaths by natural causes (including liver and renal failure) or other causes. In all cases detailed case note reviews will be undertaken to produce an initial investigation report to determine the level of further investigation required. There was one reported death by hanging but this person had not been under the care of the Trust for over a year.

Older people’s services reported seven non SI unexpected death. These were reports of death by natural causes or physical causes that were not related to any failings in care by Oxford Health FT. These deaths are reviewed through the incident management process and Mortality and Morbidity review. One incident of death by clostridium difficile at the OUH was investigated and the care that we delivered prior to the patient moving to the GP was found to be of a good standard.

|  |  |
| --- | --- |
| **Type of death** | **Total** |
| D01 Expected Death In Community | 9 |
| D02 Expected Death In Oxford Health Hospital | 2 |
| D03 Expected Death In Acute Hospital E.g. JR | 2 |
| D05 Unexpected Death In Acute Hospital E.g. JR | 10 |
| D06 Unexpected Death In Community | 25 |
| **Grand Total** | **48** |

**1.3 Incidents in web holding**

Teams or units who are high reporters (which is positive) will necessarily have more incidents requiring a management review. The Quality and Risk Team is working with a user group to explore ways of making it easier for incidents to be reported and reviewed. At the time that this report was run there were 1327 in web-holding in Q1 compared to 2159 incidents in Q4 14-15 which is a significant improvement. 640 of these related to incidents reported in Q1 2015/16.

The majority of delays are those that have been in web-holding for more than sixteen days. The Quality and Risk team run regular reports for teams and escalate issues to heads of service, heads of nursing and clinical directors. The team also reviews the most longstanding incidents in web-holding on an incident by incident basis and take action with the team manager accordingly.

This issue is also monitored at the directorate business performance review meetings, the Quality Committee and Quality Sub Committee: Safety**.**

**Incidents in web-holding by quarter and by time**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | **Quarter** | Number of incidents | | **2014/15 [2]** | 879 | | **2014/15 [3]** | 908 | | **2014/15 [4]** | 1628 | | **2015/16 [1]** | 640 | | |  |  | | --- | --- | | **Days in w/h** | **Number of incidents** | | 0 to 5 | 129 | | 6 to 10 | 72 | | 11 to 15 | 58 | | 16+ | 1068 | |

**Incidents in web-holding by team**

A specific piece of work is being commenced with the teams with the highest number of incidents in web-holding.

**1.4 Incidents by Division/Directorate**

At the beginning of Quarter 4 the project to align Ulysses incident reporting system with the new Directorates and teams went live. This meant that any incident put on the system after this date was attributable to either:

* Adult Directorate
* Older People’s Directorate
* Children and Young People’s Directorate
* Corporate Directorate.

The chart below gives the number of incidents reported in Q4 14-15 and Q1 15-16 by the new Directorates. The picture remains broadly similar with the older people directorate reporting significantly more incidents than the adult directorate and both of these reporting much more than the two remaining directorates. It would be expected that corporate services would report the smallest number of patient safety incidents.

**Incidents by directorate**

**1.5 Top seven cause groups by quarter**

The following chart shows the top seven main categories of reported incidents over the last 12 months.

**Health**

Health was the most commonly reported incident in Q1. This cause group is used primarily for reporting pressure ulcers (avoidable and unavoidable)[[2]](#footnote-2). There were 681 health related incidents, of which 500 were pressure ulcers. This is a slight overall reduction from Q4 14-15 but still higher than in previous quarters.

Amongst these figures are a large number of inherited pressure ulcers. That is to say, pressure damage that occurred prior to OHFT becoming involved in a patient’s care. This damage may have arisen in people’s own homes, care homes or acute hospitals. Where this is the case we raise this formally with the appropriate provider for investigation and management. and/or safeguarding alert is appropriate.

Any incident that relates to a patient being discharged without support mechanisms for previously existing pressure damage is recorded on a spread sheet and feedback is requested from the trust involved. One of the main issues identified in poor discharge relates to patients not being referred to community nursing services on discharge. This is escalated to and managed through the system wide discharge group.

**Violence and aggression**

Violence and aggression is the second highest incident reported in Q1. The cause groups within this include verbal aggression, violence no injury, violence with injury.

The number of violence and aggression incidents have reduced slightly in Q1 15-16 compared with Q4 14-15 but it still remains high compared with previous quarters.

The majority of incidents did not result in major harm or death. The three incidents that were serious are reported within the SI section of the report.

**Self Harm**

Self-harm was the third highest type of incident reported in Q1 overtaking medication management. There were 407 incidents reported in Q1 15-16 compared with 327 incidents reported in Q4 representing a further increase from Q4. The variation in number is linked to specific patients and solutions relate to individualised care planning as well as broader improvement initiatives.

The most common type of self-harm is “other” which consists of a number of different types of self-harm including predominantly head banging and ingestion of items such as paper or batteries. Ligatures, cutting and overdosing are the next three most common ways of self harming.

The CAMHS unit at Marlborough House Swindon (Tier 4 children service) has been working to reduce the incidents of self-harm. The specific aim of the project was to reduce incidents of deliberate self-harm (DSH) requiring nursing intervention by 50% by the end of June 2015; they have in fact reduced the incidents by 85% in the year June 2014 – June 2015 when compared with the number in the previous year.

The OSCA team have developed a project with Safer care to support seriously unwell patients with the aim of providing clearer cover to those at high risk of serious self-harm, and a smoother transition from Tier 3 to OSCA or T4 to avoid crisis referrals. The project is working towards the 'watchlist'[[3]](#footnote-3) ceasing to exist from the 1st June 2015 and there is a project plan and steering group to ensure that the correct actions have happened to safely support this transition. As part of this work the response time to referrers has been reduced. The response to referrers has consistently been within 2 hours in 100% of the times since January 2015.

Five Adult Mental Health Teams are working on adapting and adopting the ‘Always Events’ previously carried out the Crisis Teams. At this stage this work aims to ensure that there are reliable processes in place when people are referred into the Assessment Functions of the AMHTs.

**Medication incidents**

Medication related incidents were the fourth highest type of reported incident in Q1. The types of medication error cover a wide range of types of incidents with 27 possible cause options. It covers the medication process from prescribing through to administration.

Overall the most common types of incidents were omissions, wrong dose given and prescribing errors.

Four of the Forensic Wards are working on reducing the number of medicines omissions. As part of safer care work, Watling ward has focussed on medication omissions and succeeded in reducing omissions to zero.

**Fall Related**

Fall related incidentswere the fifth most commonly reported type of incident in Q1. The numbers of reported falls have fallen again slightly from Q4 14-15 and remain at the lowest number for the last two years.

Falls in this cause group range from slips and trips; falls from bed/commode/wheelchair; being found on the floor and falling from a height. Most commonly falls are reported which had not been witnessed. There are no obvious themes or trends or individuals that accounted for the majority of falls.

Amber ward, which reported an increased number of falls, has been working with the falls team to reduce the number of falls on the ward through a steering group which includes a doctor, physiotherapist and OT, nurses and HCAs). The group identified that more falls were happening at night and early morning and staff now monitor and check individual patients at an agreed frequency (e.g. every 15 minutes or every 2 hours) depending on their level of risk of falling.

Small change processes are being introduced and include:

* random sampling of notes to ensure falls assessments have been completed within 24 hours and that care plans are in place
* checks that MEWS are completed daily and fluid intake is closely monitored
* multifactorial falls care plans in place for patients at high risk of falling which are completed with family involvement
* patients feet are assessed on a regular basis with a referral to podiatry if required
* patients have an OT and Physio assessment within 72 hours of admission to identify risk and care planning in place; if support is needed for mobility patients will be measured for walking frame
* medication is reviewed in every ward round
* trialling a sensor mat to assess how often patients leave or try to leave their bed at night and alarm call bells to alert staff
* introduction of a falls communication sheet to capture, manage and escalate a risk of falling as appropriate

**Communication/Confidentiality**

Communication/confidentiality incidentswere the sixth most commonly reported type of incident in Q1. A total of 230 incidents have been reported. The top reporters have reported relatively small numbers overall.

These types of incidents relate to a range of issues including poor communication, IT failure/overload/outage, breach of confidentiality, record keeping, and admission and discharge problems.

**Security**

Security related incidentswere the seventh most commonly reported type of incident in Q1. A total of 214 incidents were reported, of which 102 related to incidents involving AWOLs or patients failing to return/going missing. This is an increase from Q4 where a total of 71 AWOL/missing incidents were reported. This may be as a result of the safer care programme in adult mental health wards highlighting AWOLs and increasing incident reporting

|  |  |
| --- | --- |
| **AWOL Type** | **Number** |
| S015 AWOL Detained Escorted | 24 |
| S016 AWOL Detained Unescorted | 32 |
| S017 AWOL Detained No Leave | 7 |
| S018 Missing Patient - Informal | 9 |
| S019 Attempted AWOL | 30 |
| **Total** | **102** |

The Safer Care work relating to patients who fail to return on time from leave and time away from the ward which was tested on Phoenix Ward project now includes all adult acute and rehabilitation wards in the Trust. The focus of the work is to ensure that a philosophy of care and safety underpins the leave and time away process, rather than a security focused process.

The aim of the work is to reduce the number of times patients fail to return on time to the ward by 50% by 1st April 2015. Four wards have achieved this aim, Phoenix, Allen, Vaughn Thomas and Ruby. Opal, Sapphire and Wintle Wards have each made significant reductions.

**Example Vaughan Thomas Ward**

03/06/2014

10/06/2014

17/06/2014

24/06/2014

01/07/2014

09/07/2014

16/07/2014

24/07/2014

01/08/2014

09/08/2014

17/08/2014

24/08/2014

01/09/2014

09/09/2014

17/09/2014

24/09/2014

01/10/2014

09/10/2014

23/10/2014

01/11/2014

08/11/2014

16/11/2014

24/11/2014

01/12/2014

09/12/2014

17/12/2014

25/12/2014

01/01/2015

09/01/2015

19/01/2015

26/01/2015

01/02/2015

09/02/2015

16/02/2015

23/02/2015

01/03/2015

08/03/2015

15/03/2015

22/03/2015

29/03/2015

Weekly audit dates

10

30

50

70

90

110

130

150

170

190

% of returns to ward

Vaughan Thomas AWOLs - Percentage of Returns on time

Baseline 1.20.010

1

**Other incidents of note**

In Q 4 and Q1 there has been an increase in the number of reported fires/near miss. The table below gives the breakdown of reports in Q1 highlighting the majority of incidents reported are related to smoking and most likely to the recent introduction of the Trust as smoke free. None of the incidents resulted in significant harm. A detailed report will be reviewed by the Health and Safety Committee on 23 July, 2015. Phoenix and Watling wards are the highest reporters.

|  |  |
| --- | --- |
| **Fire related incidents** | **Count of Cause Group** |
| Fire – Arson | 2 |
| Fire - False Alarm | 7 |
| Fire - Faulty Equipment | 7 |
| Fire - Smoking Related | 102 |
| Fire - Cooking Related | 7 |
| **Grand Total** | **125** |

1. **Restraints**
   1. **Overview of restraints in Q1**

There were 511 reported incidents of physical restraint in quarter one. Totals for the previous eight quarters ranged from were 312 to 477. The mean number per month for the last twenty four months is 135. The graph below shows a fairly steady rate of incidents with occasional peaks and troughs around the mean rate until this March. We then had three months with a high number of incidents, before a fall to a level nearer the mean in June. This has led to the highest number of restraints in one quarter since we have been completing these reports and individual patients account for a large proportion of these.

The pattern by quarter now shows a gradual rise over the last seven quarters. There have been over 400 incidents for the last four quarters.

The **gender** of restrained patients has been a consistent finding with around 65% involving female patients. This figure had risen during 2014 to 75%, partly due to the repeated restraint of a number of female patients. It has however fallen back to 67% in quarter 1 from 62% in the last quarter (4).

The number of patients restrained five times or more is 23 this quarter (a high figure compared to previous quarters; there were 19, 19 and 18 such patients in the last three quarters).

Those with the most restraints have all featured in previous reports but the figure of 93 restraints is higher than any previous figure for one patient in a quarter (the previous highest being recorded last quarter when a Highfield patient was restrained 66 times.).

As an example, a patient restrained 32 times on the Highfield unit is a young person who was transferred to the Unit’s High Dependency Unit in January of this year from Vaughan Thomas Ward as an emergency admission, where he has remained while a package of care to meet his medium and long term needs is agreed.

**2.2 Restraints by Ward**

All mental health wards, including older adult, adolescent and eating disorder services reported some restraints over the quarter except for Glyme, Chaffron, Lambourn, Opal and Cotswold House, Wiltshire. The number of restraints ranged from 0 to 146.

The five wards with the highest number of restraints are Ashurst, Highfield, Kestrel, Kingfisher and Sandford. This is the same as last quarter. The high reporters, as would be expected, are related to the presence of individual patients who required multiple restraints.

**2.3 Reasons and Causes**

The incident form requires a ‘cause group’ to be selected for each incident. Many different types of cause group were selected but violence and aggression (50% of all incidents) followed by self harm (35%) remain the main reasons for restraint. The other causes relate to restraints for administering medication and to prevent absconding. The pattern does not vary from previous quarters.

|  |  |
| --- | --- |
| Type of incident | Percentage of incidents |
| Violence/Aggression | 50.3% |
| Self Harm | 35.0% |
| Security | 5.3% |
| Medication Incidents | 3.1% |
| Sexual | 1.2% |
| Other | 5.1% |

**2.4 Types and rating of incidents**

The manager of the area reporting the incident rates the risk level of the incident. 91% of the incidents were graded as yellow or green (moderate or low risk) or were not yet graded. Forty oneforms were graded orange (high risk) this quarter. There were no incidents that resulted in serious harm.

Examples of orange incidents were attempting to or actually punching or biting staff, sexualised behaviour, tying a noose in a sheet and standing on a chair, or very disruptive behaviour such as throwing furniture. Eight orange incidents involved the Highfield young man and fifteen a Kingfisher patient restrained 93 times wtihs a result of repeated self-harming behaviours. Many of the other incidents rated orange do not differ markedly from incidents rated as yellow.

The restraint tab requests the names of the staff involved and their role in the restraint, the typoe of hold, the position the patient was restrained in (seated, standing, prone or supine) and the duration of the restraint are all requested.

The report for this quarter is complicated because the categories for type of hold were changed during the quarter. Previously there were three ‘levels’ of hold, that is, low, medium and high. This has been changed to five to reflect the range of techniques taught and used in the Trust.

The new 5 types of hold are:

1. Non touch
2. Low level simple escort
3. Medium level double handed
4. Medium level figure of four
5. Thumb- wrist hold

The previously defined medium level of thumb and wrist hold, which can cause pain, is now regraded to the highest level, to be used only in high risk or life threatening situations. These changes will allow more detailed and informative reporting on types of hold from now on.

The number of forms recording the use of ‘pain compliance’ remained very low at 1.4% in the old system of catgeorisation. The new high level of thumb wrist hold was even lower at 0.2%. This indicates that the fall in the use of high level holds and use of pain is real and has been maintained (one caveat being that 6.5% of forms did not state the level of hold).

Types of hold in Quarter 1 - Old classification in *italics*, new classification in **bold**.

|  |  |  |
| --- | --- | --- |
| **Type Of Hold** | **Number of incidents** | **Percentage of Incidents** |
| **1. Low - Non Touch** *or simple escort* | 45 | 8.8 |
| **2. Low Level - Simple Escort** | 3 | 0.6 |
| *2. Medium- Double Handed/figure 4* | 412 | 80.6 |
| *3. High - Thumb Wrist Hold* | 7 | 1.4 |
| **3. Medium Level - Double Handed** | 3 | 0.6 |
| **4. Medium Level - Figure 4 Hold** | 7 | 1.4 |
| **5. High Level - Thumb-Wrist Hold** | 1 | 0.2 |
| Not stated | 33 | 6.5 |

The percentage of restraints recorded as prone has fallen to 11%, having been steady at 20% to 30% until quarter 4 last year. It appears that the reduction across the Trust of its use has been maintained, as our work on minimising restrictive interventions continues. Patients on Kingfisher accounted for 16 (29%) and Ruby Ward 11 (20%) of the 56 prone incidents. In total, prone restraint occured a mean of 4 times a week in the last six months across the Trust, compared to nine times a week in the previous six months. The wards reporting prone restraint are shown below.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Position of patient during restraint** | **No of incs Q2 2014-15** | **% of incs Q2 2014-15** | **No of incs Q3 2014-15** | **% of incs Q3 2014-15** | **No of incs Q4 2014-15** | **% of incs Q4 2014-15** | **No of incs Q1 2015-16** | **% of incs Q4 2015-16** |
| Chair | 73 | 18% | 60 | 14% | 79 | 17% | 106 | 21% |
| Prone | 116 | 30% | 109 | 26% | 56 | 12% | 56 | 11% |
| Supine | 73 | 19% | 73 | 18% | 116 | 24% | 117 | 23% |
| Standing | 119 | 31% | 129 | 31% | 176 | 37% | 183 | 36% |
| Kneeling | 10 | 3% | 7 | 2% | 11 | 2% | 14 | 3% |
| Not Stated | 0 | 0% | 39 | 9% | 39 | 8% | 35 | 7% |

1. **All Serious Incidents (SI)**
   1. **Serious incidents framework (2015)**

The new framework provides opportunities in addition to challenges. Key changes include:

* Reporting of SIs within 48 hours and initial investigations to be complete and reported within 72 hours. This means that services need to be much smarter in completing reviews and more incidents will now be reported on STEIS immediately. Open discussions will need to be had immediately with the commissioners about whether to report on STEIS or not. Practice will be to report if not sure and incidents can be downgraded at any time. In practice this will lead to many more SIs being reported and a larger number of them being downgraded. The quarterly report is likely to reflect this by appearing to show a large number of SIs at the end of the quarter with number refreshed in the following quarter as incidents are downgraded.
* Timescale: 60 working days is now the timeframe for completion of all investigation reports. Previously grade 1 incidents had to be completed within 45 working days.
* Language used refers to “Serious Incidents” (SI) rather than “Serious Incidents Requiring Investigation” (SIRI).
* Scale and scope should be proportionate to the incident. Root Causes Analysis (RCAs) may be therefore managed by an individual (with support as required) while others will require a team. RCA is the standard systems based approach. There are two templates for constructing reports which are expected to be used: A concise template for less complex incidents which can be managed by an individual or small groups at local level and a comprehensive template: for more complex issues
* Types of SIs are likely to change e.g. a suspected suicide may not automatically be an SI and we may manage as an SI incidents such as high risk near miss incidents.

There have been a number of issues highlighted in recent months including the delays in getting completed IIRs submitted, difficulties finding investigators for SI reviews, scheduling of SI panels and requests for extensions from the commissioners. The new framework has provided an opportunity to fundamentally review the way we manage these processes and an action plan has been developed (Appendix 1) which has been agreed with the directorates and shared with commissioners. They have always seen the Trusts investigative approach to SIs as being very robust and thorough however they have been concerned about the delays that have become part of the system. The action plan is designed to address this.

* 1. **Serious incidents (SIs)**

Figure 7 shows the total number of red SIs per quarter after all figures have been refreshed. The total number of SIs in Q1 is thirty five which is a further increase from Q4 and the highest it has been over the last two years. The Quality and Risk team reviewed quarter 4 incidents with each of our main CCGs once investigations had been completed and determined that there was no systemic or underlying issue, and that they covered a number of different teams and cause groups. We will need to complete the same process once the investigations have been completed for Q1 SIs. Key quality issues and concerns are discussed in detail once a quarter with CCGs with any concerns in the meantime reviewed at the monthly contract meetings.

**SIs by Quarter**

**SIs by type**

The national reporting system (STEIS) has made some changes to its categorisation of incidents. This means that the old categorisations such as suspected suicide no longer exist. Suspected suicides are now recorded within the category of “Apparent/actual/suspected self-inflicted harm meeting SI criteria”. In quarter 1 there have been:

* One alleged homicide. The alleged perpetrator was under the care of the early intervention service in Oxford. An internal RCA investigation is underway.
* Nine apparent/actual/suspected self-inflicted harm meeting SI criteria and one suspected suicide (a total of five of these are thought to be suspected suicides).
* Four were unexpected deaths.
* Two were ligatures
* One was a man hit by a train but survived
* One was the death of a fifteen year old by hanging
* One patient was hit and killed by a car.
* Six pressure ulcers meeting the SI criteria. A further three pressure ulcers were reported in Q1, one that occurred in Q3 14-15 and two that occurred in Q4 14-15
* Four falls meeting SI criteria:
* Two hip fractures. In one case the patient died later in acute hospital and so was recorded as an unexpected death.
* One head injury and possible fracture
* One fall
* Four unexpected deaths categorised as diagnostic:
* One was the death of a patient sometime after falling off a horse.
* Three were unexpected deaths where the patients had been deteriorating
* Three incidents categorised as disruptive/violent or aggressive behaviour:
* One allegation of arson
* One allegation of Kidnap
* One allegation of a sex attack
* Two medical equipment incidents both occurring on the same ward and both related to the use of oxygen cylinders.
* One medication incident where a patient who had been exposed to HIV was prescribed PED prophylaxis but this was not given for four days.
* One accident where a CAMHS patient attempted to go AWOL over a fence and fell fracturing her ankle.
* One historical allegation of sexual abuse by a patient against a staff member.
* One assault with a weapon by a community patient under the care of the early intervention service in Oxford.
* One incident of a female patient engaging in non-penetrative sexual acts with a male patient on Ashurst PICU.

**Homicide investigations**

Two historical external homicide reviews are now complete. The first has been published on NHS England website on 21/07/2015 and we are still waiting confirmation about publication for the second.

The first was the multi-agency investigation into a homicide of a man in receipt of mental health services. He was been sentenced to 24 years for the murder of his estranged wife in August 2011. There is no evidence that his mental health played a part in his actions. Oxford Health FT had some brief involvement with the patient via crisis and later following referral by a GP to the CMHT. He was not seen face to face by our service. He was under the care of South Essex Partnership Trust at the time of the offence.

Oxford Health NHS Foundation Trust completed their internal RCA investigation which went through the internal SIRI panel assurance review process and was incorporated into the multiagency report. NHS England commissioned an external body to undertake an investigation.

The second homicide occurred in January 2013 where a patient who was being treated by the Assertive Outreach Team1 (AOT) based in Aylesbury assaulted a man who later died of his injuries. The patient was detained under Section 3 of the Mental Health Act 1983 (MHA) and was on leave under Section 17 of the MHA from a general adult ward at the time of the assault. He was convicted of manslaughter on 24 February 2014. An internal investigation was conducted by the Trust and NHS England South subsequently commissioned an external investigation. The main recommendation from this was “… *that the trust review the effectiveness of the new service model in 12 to 18 months. The trust should reflect on the recommendations of the trust internal investigation to ensure that progress of their implementation”*. The outcome of this review will be published in the next few months.

**Pressure Ulcers**

In Q1 a total of nine pressure ulcer SIs were reported. Previous reports have detailed actions which are being taken to try to reduce the number of these SIs.

There have been a number of issues in recent months involving delays in reporting incidents which were awaiting an avoidability assessment and with identifying investigators. These are actively being managed by the older people’s directorate, and the changes proposed by the new SIF provide opportunities to expedite all stages of the identification, review, reporting and investigation process.

* 1. **Suspected and confirmed suicides by quarter**

The number of suspected suicides in Q1 has reduced to five in Q1 from eleven in Q4. The trend continues downwards. All of these reported deaths occurred in the community.

**Suicides by Quarter**

* 1. **In-Patient Suicides by year**

The days between deaths that meet the criteria for inpatient deaths at the end of Q1 is 530 days. All of the previous deaths reported in the table below were of patients who were not on the ward at the time they died. One of the deaths was of a detained patient who died in a prison abroad. This is in keeping with the confidential inquiry on inpatient suicides.

**Inpatient suicides by year**

|  |  |
| --- | --- |
| **Year** | **Inpatient** |
| **2009/10** | **1** |
| **2010/11** | **1** |
| **2011/12** | **0** |
| **2012/13** | **1** |
| **2013/14** | **2** |
| **2014/15** | **0** |
| **2015/16** | **0** |

**3.5 Location of SIs by Directorate**

Quarter one 2015-16 has seen a reduction in the number of SIs reported by the Older People Directorate and a slight increase in the adult directorate. Children and Young People reported two SIs and there were none reported by Corporate Services.

* 1. **Completed Root Cause Analysis (RCA) actions**

There were a total of sixty three out of date actions from SIs at the end of Q1. This is a reduction from Q4 and the Risk team are developing a scheduled report to go out on a monthly basis to the new directorates to provide a regular update on actions outstanding. This report is currently out for consultation but will be sent monthly from August 2015

* 1. **Learning Events**

A Trust wide learning event focusing on medication management was held on Friday 19th June 2015 at Unipart. There were close to sixty attendees including service users who shared their experiences in two of the presentations. There was good representation from medical, nursing, pharmacy and OT staff across the Directorates. Mr Lyn Williams, one of our non-executive directors in the Trust, chaired the day.

The presentations covered a wide range of topics and covered some of the learning in addition to highlighting a number of excellent practices that are happening around the Trust.

Key issues from the day for staff included:

* The need for relevant, pragmatic Medication Management practice guidance (current guidance felt to be too in-patient centric)
* The need for greater pharmacy input into community teams to assist with medicines and clinical management (both mental health and community teams, again current pharmacy service felt to be too in-patient centric)
* The need for good, well-embedded medicines reconciliation processes with results clearly documented (no more trawling through three years of letters to find a list of medications)
* The need to raise awareness of medication incident reporting with medics, increase reporting and medic  involvement in reducing prescribing errors
* The need to share good practice examples more widely e.g. work on non-purposeful omissions.
* The need for holistic advice on the treatment and management of insulin-dependent diabetics (current specialist service confined to community outpatients only) and the training needs for staff working with insulin dependent patients
* The appetite for electronic prescribing and administration system as a patient safety innovation.
* Transitions between teams and wards. Transitions are well known to be points where risks are higher and patient safety incidents are more likely to happen.
* Issues relating to poor communication including the ongoing theme of the number of different electronic patient records and remote prescribing. Some improvements were noted for community based staff who reported that they now had access to the GP EMIS recording system which all of the GPs in the West of Oxford had signed up to. The challenges for staff trying to access information about prescribing also leads to significant time being taken to carry out medicine reconciliation on admission.
* Numerous ordering systems for medications e.g. polarspeed, eprescribing etc. This needs some standardisation.
* Access to out of hours advice and information for patients. Patients will contact the out of hours service asking for information, not having TTOs or lack of clarity about their treatment or doses.
* Commissioning arrangements with primary care.
* Inefficiencies in clozapine administration and monitoring in particular. Monthly blood testing is a requirement for patients on clozapine and there was a strong feeling that this activity should be carried out by GP services rather that in “clozapine clinics”.
* Differing practices and views with different GPs services. An example of a drug prescribed by the psychiatrist which had been “blacklisted” (due to cost) by GP and therefore not prescribed.
* ADHD shared care. Not specific for adults but many GPs unhappy to take patients back.
  1. **Training**

In quarter one three RCA training days were run cross the Trust training approximately sixty members of staff. Additional work has been undertaken to highlight what the duty of candour is and why it is important through team briefings and video podcasts. Presentations have been given to the extended executive and Board.

**3.9 Risk Notes**

There have been no Risk notes issued in Q1

**3.10 Being Open Duty of candour**

In Q1 2015-16 there were seventeen SI panels and four record review panels.

Duty of Candour is not just confined to serious incidents and staff are now required to record the actions taken on the Ulysses incident reporting system for orange rated incidents. The most recent report run from Ulysses indicates that *recording* of duty of candour is not routinely happening. It does not indicate whether in practice it *is* taking place. Out of 318 incidents that should trigger duty of candour and a decision whether it applies or not, only seven had been completed. In six cases the relevant person had been contacted and in one case it is recorded that they had not. Of the six relevant people contacted one had refused the written explanation and one had refused a copy of the investigation report. The Quality and Risk team has developed guidance and a template letter and is briefing teams on the requirements.

**3.11 Themes from SIs**

Of the SIs completed in Q1 it is clear that there is an increasing number that are beginning to raise the issues of lack of staffing, reduced management and leadership support, staff turnover, capacity and volume of work and citing these as contributing factors to some of the issues raised below. This is more noticeable in community services in the Older People Directorate.

There are a number of SIs in Q1 that found no issues of concern or which, following the RCA process, we are expecting to be downgraded from an SI. This would be done in discussion with the commissioners and reflects the fact that in many cases, although there is learning, it is clear that the incident did not occur as a result of anything our services did or did not do.

**Documentation:** This is a familiar theme occurring in many SIs and often related to lack of recording of key information in relation to risk assessments and care plans.

**Team and service boundary issues:** This is a theme that has been noted in the past and it is well known that transitions between teams and services present unique risks. In Q1 this was raised particularly in relation to interface between organisations and it is of note that communication breakdowns occur both ways.

**Overreliance on telephone contact:** Although this was mentioned in one incident this has been highlighted in the past where staff have found face to face contact challenging because of access to the patient and relied on their self-report to make an assessment of risk.

**Carer’s issues:** Family/carer involvement and support is a regular theme and has been raised on several occasions again this quarter.

**Communication:** Communication is central to most of the care and service delivery issues raised and is a regular theme. In Q1 some specific examples of communication problems are given below. As noted previously with boundary issues, communication is two way and concerns relate to communication problems into as well as out of the Trust

**Safeguarding and capacity:** Safeguarding and capacity are themes that are raised from time to time and usually noted as additional issues not directly related to the incident itself.

**Lack of physical healthcare monitoring:** Issues with the management and monitoring of physical healthcare is an ongoing theme that is a focus not just in incidents but in Clinical Audit. It is becoming more of an issue with the numbers of patients presenting with complex co-morbidities and in particular the management of long term conditions such as diabetes. The recognition of the deteriorating patient has raised issues about the need for training for staff. One finding that was noted in an SI in Q1 was the need for staff to be adequately trained in the use of new equipment (in this case diabetic pens).

**Lack of holistic approach:** This has been a longstanding theme in community nursing services and continues for be raised from time to time and includes involvement of specialist advice.

**Good Practice** There were many examples of good practice or practice that one would expect to be present in most of the SIs. These include:

**Proactive care** e.g. follow-up, flexible working, prompt triage and assessment, increasing frequency of outpatient reviews and offering step up care when risks escalated.

**Communication and liaison between services**

**Good documentation**

**Patient/Family/Carer involvement** e.g. positive carer feedback on care and good relationships with care coordinators.

**4. Infection Prevention and Control**

**4.1 Surveillance**

*Clostridium difficile infection (CDI)*

There has been 1 confirmed case of *Clostridium difficile* in Q1 in Older Peoples’ services.

The threshold this year is to still be agreed but likely to be 8 cases.

**April 2015 -** 1 case for a patient on Wenrisc ward, Witney hospital

**May 2015 -** no cases

**June 2015 -** no cases

Robust RCAs have been completed and any learning identified communicated back to clinical teams and discussed in training for staff.

Each RCA is reviewed by the monthly health economy CDI meeting, with representation from the OUH, Public Health England and commissioners.

All CDI cases have been reviewed and assessed as unavoidable with no lapses in care.

In June there was a patient identified with CDI within 72 hours of admission to the OUH following transfer from Bicester community hospital. This patient unfortunately passed away and CDI was cited on part 1a of the death certificate. A case review meeting is being held between the Trust and OUH to review and an RCA completed.

There were no cases of CDI in mental health.

*MRSA and MSSA bacteraemia*

There were no cases of MRSA or MSSA bacteraemia attributable to the Trust. There was a community patient seen in EMU, Abingdon hospital who was identified with a MRSA bacteraemia. The CCG undertook the investigation.

*E.Coli bacteraemias*

**April 2015**– No cases

**May 2015** – No cases

**June 2015 –** There were 3 cases. One was pre 48 hours and therefore a community case and two were attributable to the Trust (Abingdon and Witney). RCAs were completed and no lapses in care identified.

*Outbreaks*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Location** | **Dates** | **Management** | **Cause** | **No. of cases** |
| Bicester hospital | 05.05.15- 08.05.15 | IPCT management with full terminal clean before the ward resumed normal operations.  Ward not closed. | Possible norovirus outbreak | 4 patients and 1 staff |
| Ashurst ward, Littlemore hospital | 07.05.15-09.05.15 | IPCT management with full terminal clean before the ward resumed normal operations.  Ward not closed. | Possible norovirus outbreak | 2 patients and 2 staff |

**4.2 Audit programme**

*Environmental Audits*

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

*Hand hygiene*

Hand hygiene audits scores average in the community hospitals for Q1, continue to demonstrate excellent compliance. Community Hospital Hand Hygiene Audit average compliance was 99% and bare below the elbow was 100%.

Hand hygiene in mental health wards is continuing bi monthly as well. The overall compliance score for the hand washing technique for Q1 was 94 %. Bare below the elbows was 95%.

These results are collated and presented as posters to directorates for discussion though local governance.

**4.3 Training**

Training numbers continue to be a challenge. The Trust has set the target of 90% of all eligible staff to complete infection prevention control training. The current figure is 74% of staff are in date with training requirements. Training is also available via the E learning programme and work book for staff to access and the IPCT continue to review and update presentations.

**4.4 Policies and procedures**

As per the rolling programme of review several procedures have been reviewed in Q1.

**Areas of compliance/good practice**

There was overall sustained good compliance with hand hygiene audits and ATP environmental cleanliness monitoring in the older people’s in patient’s areas. Results are monitored in real time by the IPC team and any issues followed up with the services. Quarterly reports are provided for the directorates to discuss in their governance meetings.

There is overall good staff engagement.'

**4.5 Areas of unsatisfactory compliance/areas of risk**

* Number of staff trained is 74% and remains below the Trust target of 90%.
* There is currently non standardised documentation in the Trust for management of patients with urinary catheters. This was identified in a staff knowledge survey and work is in progress to address this. The Trust has also joined with the Academic Health Science Network (AHSN) project to reduce catheter associated urinary tract infections. Other Trusts involved in this project include OUH and we are working together to review patients care plans and procedures.
* There is currently non standardised practice with local teams/services developing documentation or processes rather than one overall process.

**4.6 Future Issues or concerns**

IPCT involvement needs to be maintained with other services in the Trust including consultation with estates on building projects.

**4.7 CQC compliance/national directives**

Outcome 12 Cleanliness and Infection Control is monitored quarterly via the IPCT and governance team. Overall, areas are demonstrating good compliance with this outcome, except the numbers of staff trained in infection prevention and control remain below the target of 90%. There are also some concerns regarding audit results and decontamination record keeping. The IPCT have been working with community district nursing teams to review current practice.

**4.8 Environmental cleanliness**

Monitoring and audit reports are submitted to the facilities teams. ATP environmental cleanliness monitoring continues monthly in community hospitals and older adult mental health wards.

**Decontamination**

Decontamination compliance remains generally high with appropriate processes in place including external contracts. One area of non-compliance remains poor documentation of cleaning records. This is being addressed locally with teams as well as raised with directorates.

**Patient involvement**

All wards have patient information leaflets and infection control notice boards. The HCAI data for the Trust continues to be updated weekly onto the Trust infection control internet page for public access.

**5. Improvement and innovation to improve patient safety**

The table below describes a range of activities, outcomes and achievements in quarter 1 across all three directorates.

|  |  |
| --- | --- |
| **Teams and activities** | **Outcomes/achievements** |
| Specialised Services Oxon. & Bucks  ASD diagnostic pathway stage 2 commenced  Highfield supported activity follow training for Safer Staffing  Oxfordshire Therapeutic services for sexual Abuse: supported  modelling of pathway flow chart | initiation of clear diagnostic pathway for 0-18 years, with a single point of access  increased direct care time  Visual representation  to support clear pathway |
| **Public Health Services**  Banbury Health Visitors Input with demand and capacity work completed support with reporting | increased direct care time, safety and productivity |
| **Complex Care**  CCN CNS Team development session  Children's Integrated Therapies  OT service development  stage 1 complete  Bucks SLT Facilitation of whole service development session on managing difficult conversations  Bucks SLT EYCN team support for feedback on progress with pathway redesign and development of outcome measures | review of core work and role to increase productivity  OT service pathways reviewed  core messages for service delivery embedding with staff  Bucks SLT EYCN Pathways redesigned – improved capacity and positive service user feedback |
| **Services in SWB&NES**  Cotswold House Marlborough support with productivity project  Swindon CAMHS Team development day focussing on  staff wellbeing and patient assessment process | Improved productivity  improved staff wellbeing  and productivity |
| **Adult Services**  *“Activity Follow”* training offered to adult mental health wards  Forensic and Offender Health Productive Care Workshop (April)   * + *Activity follow* training completed   + Reviewed Smoke Free transition   + Implement security lead nurse role -Thames House   + Implement new medication administration process  - Woodlands   + *Activity follow* completed Huntercombe   + medication process reviewed ; Prisoner access to healthcare streamlined and improved within prison   + Bullingdon – Reviewing non-patient facing activities – measurement completed   Sapphire ward – handover review moving to implementing new way of working  Medication competency workbook completed with working group – format shared for use with teams to review in 4 months  Central AMHT (Oxon) – completed mapping medication administration process including storage and dispensing risks | increased direct care time  8% Increase in Direct Care Time  Successful transition to Smoke Free environments  Improved safety  Improved consistent communication within staff team – increased safety and quality of care  Releasing time to care for improved therapeutic interventions  Improved assurance  and identification of staff development needs  promoting parity of physical health within mental health settings  Increased Safety and quality of care  Reduction in variation across teams and firming up SOP of processes  Clarity about team members roles and responsibilities around medication administration and management |
| **Older People’s community teams**  Venous Leg Ulcer Pathway – 45 Teams reporting using PSAG  Productivity Project with North East and West  teams   * + Aiming to reduce waste in non-patient facing time   + Staff development days (SE Band 6, Kidlington DN Team; ILT Senior Managers; North CMHT * Bladder & Bowel – introducing automated text messaging services, supported transition to use of electronic health records, mapped triaging pathways * Single Point of Access – review of clinical and administrative processes * Re-ablement Training – Support dashboard development | improved healing rates or decrease in number of weeks patients reported on pathway - 26% of patients reported on pathway  have healed and the average length of time taken to heal on the pathway is currently 7.9 weeks .  Increased team capacity  Staff engaged in measuring process and capturing current state perspective  Embedding Team Based Working strategies  Improved understanding of individual and cluster performance – focus on quality and linking to 5 Improving Care Questions  Increased team cohesion  Identified priorities  including, locality plan, quality account and CQC contributions  Increased admin capacity - Reduce non-value added admin tasks  Increased team capacity – reduce non-value added tasks  Support team prioritising and reporting |
| **Older People’s mental health wards**  *Activity follow*  training  **Community Hospitals** | embed improvement cycle and LEAN processes into ward culture  improving staff and patient involvement by displaying visible results and action plans related to patient safety, share best practice  increased productivity  opportunities for reduction in stock spend |

1. All data is sourced from Ulysses incident reporting and management system [↑](#footnote-ref-1)
2. The OPD undertakes a rigorous process to assess causation and avoidability of every grade 3 and 4 pressure ulcer, based on the regional avoidability assessment tool [↑](#footnote-ref-2)
3. The watch list was seen as the high risk, contains names of potentially around 50 patients who may be deemed to be at high risk and so need 'watching'. [↑](#footnote-ref-3)