

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

# Board of Directors

**For Information**

**BOD 124/2015**

(agenda item: 9)

**30 September 2015**

**Quality Account Q1 Report**

**For Information**

The attached report summarises progress to date on the quality account priorities and provides an overview from directorates on the five CQC questions (IC5).

**Progress has been made on:**

* improving access to musculoskeletal support for staff to reduce sickness absence
* increasing opportunities for staff to engage and raise concerns with senior managers
* implementing the recovery star, recovery college and outcome based care
* provisional notification of AIMS accreditation of seven adult mental health inpatient wards and application for accreditation in memory clinics
* development of a partnership to deliver mental health services for adults in Oxfordshire
* new CBT pathway for patients in dental services
* investment in the Looked after Children service in Oxfordshire
* the new model to improve access to children’s services using the community learning disability services in Wiltshire and BaNES
* reduction in incidents of deliberate self harm in Marlborough House, Swindon
* reduction in falls and harm from falls in community hospitals
* reduction in incidence of prone restraints and restraints involving hyper-flexion
* first audit for monitoring patients prescribed psychotropic medication completed and baseline established
* good examples of gathering a range of stories to understand experience of people receiving and delivering services
* self assessments in teams using Triangle of care

**Areas for improvement include**

* CPA audit figures are not at the required target level
* Not currently on target to reduce absence without leave by 50%
* Not on target to reduce SI reportable pressure damage by 10%
* Not on target to achieve target for staff attending level 4 training
* Not on target to achieve 25% reduction in reported incidents of violence and aggression
* Have not achieved required % of patients managed by district nursing service to have had nutritional status assessment
* LAC assessments performance has dipped and is related to an increase in referrals

**Conclusion**

**Harm Reduction** -It is evident there has been improvement in rates of falls in Community Hospitals overall through improved assessment and observation of people at risk. The excellent innovative work in Marlborough Hose Swindon has been shared at the Senior Leaders Conference and the recent Linking Leaders conference and the interventions used will be considered for adoption and spread in other wards. The continued reduction in the use of prone restraint as the adapted PMVA and now new PEACE training is delivered is positive. A renewed focus on our harm reduction work in forensic services to reduce violence and aggression is being taken forward by matrons. Senior clinical and managerial leadership to support and sustain the innovation to reduce avoidable pressure damage is in place. Capacity within teams to sustain improvements is limited in some teams.

**External Accreditation for services** -The news of provisional notification of achieving AIMS in the 7 adult wards is an excellent achievement The majority of our mental health wards including all forensic wards, Eating Disorders CAMHS have achieved accreditation. PICU has one element to improve on and will re submit for accreditation in September. Our three older adult wards are commencing the AIMS accreditation process, our memory clinics are part way through an accreditation . There is no similar accreditation systems for Community Hospital wards. Peer Review have taken place instead.

An internal team to team Peer Review Programme was established from October 2014 and up to the end of quarter 1, 58 reviews were completed across the trust. The good practice identified and the themes for improvement are reported at Directorate and Trust wide level, with the trust wide themes included in the monthly Improving Care: 5 Questions taskforce (IC:5) highlight report presented to the Extended Executive Team.

The dip in performance in CPA metrics is attributed to ensuring consistent recording in Care Notes in adult and older adult mental health services. The dip in timeliness of LAC assessment is a result of an increase in referrals and timeliness of out of area assessments other providers.

**Governance Route/Approval Process**

An earlier version of this report was considered at the Trust Board of Directors in July 2015 and the Quality Committee in September 2015.

**Recommendation**

The Board is asked to note the report.

**Author and title:** Tehmeena Ajmal, Head of Quality and Risk

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

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

**Quality Account 2015/16: Quarter 1 Report**

**IC5 – CQC five questions for quality**

**Are our services safe?**

**Adult services**

* Each team continues to update their own risk register; the service manager for each service is working with their teams to ensure that these documents are up to date and reviewed regularly.
* A summary of the Q1 position on the mental health safety thermometer is provided below, highlighting the improvements and areas of improvement required.

|  |  |  |  |
| --- | --- | --- | --- |
| **Period** | **Combined** | **Inpatient** | **Community** |
| Q4 14/15 | 751 | 566 | 185 |
| Q1 15/16 | 949 | 768 | 181 |

* Overall in Q1 15/16 there has been a 26% increase in the number of submissions compared to Q4 14/15, mainly due to an increase in inpatient submissions (36% increase). Community submissions saw a small decrease (2%) compared to Q4 14/16.
* Q1 2015/16 saw a small increase in the proportion of patients that had been the victim of violence/aggression in the previous 72hours (Q1 15/16 was 0.4%, Q4 14/15 was 0.0%)
* April 15 saw the highest proportion of medication omissions at 6.6%.
* Q1 2015/16 saw a decrease in the proportion of patients that had self-harmed in the previous 72 hours (Q1 2015/16 was 2.4%, Q4 2014/15 was 4.7%)
* Q1 saw an increase in the proportion of patients feeling safe at the point of survey (Q1 15/16 was 92.9%, Q4 14/15 was 91.2%).
* June15 saw the lowest number of medication omissions at 2.5%.
* Q1 15/16 saw an increase in the proportion of patients with harm free care (Q1 15/16 was 90.8%, Q4 14/15 was 87.9%).

**Older People**

* Improvements to the efficiency and monitoring of incident management but need to ensure effective sharing of learning from incidents across the Directorate and at all levels and that all incidents are reported
* Development of Risk management process across the Directorate to ensure risks are appropriately identified, managed and escalated as appropriate

**Children and Young People**

* Training for frontline CAMHS staff from Professor Paul Stallard will be offered in November following the published review of suicide within young people via ligature (carried out within C&YP), and the subsequent learning. This will also run as a workshop to consider how practice might develop (two venues, Oxon and Swindon for frontline CAMHS Staff).
* Wider consideration has been given from senior staff to the implementation and uptake of mandatory training. Improving on line courses, supporting local group training especially for impatient staff, reducing the amount or courses where appropriate and ensuring the training is delivered at a suitable level for staff learning.

**Are our services caring?**

**Adult services**

* The baseline work for the triangle of care has now been completed; this involved the completion of questionnaires by each service area to understand how compliant they were against a set of measures.
* Two action groups have been set up: one inpatient and one community.
	+ The inpatient group is working on the identified actions for the wards which include an action for all wards around meeting and greeting protocols for carers as well as individual actions for each ward.
	+ The community group will incorporate the partners from the 3rd sector in Oxfordshire; the leads for this group have been identified and work will commence on reviewing the results of the baseline in September after which time the action plan will be compiled to work through.
* The service user forums are continuing in the AMHTs however work is underway with the Team Manager & Service Manager in Oxfordshire City AMHT to support to the implementation of the forum as there has been limited uptake by service users for this forum so far. The directorate is trying to identify alternative ways to include service users to ensure that their feedback and involvement is not lost.
* The format for collecting the data for the patient experience questionnaires has changed; these are now held within the AMHTs for sharing with patients. It is hoped that this approach will improve participation and response.
* Inpatient services have agreed to undertake a pilot to understand some of the roadblocks which are causing poor response to the questionnaires and to improve patient involvement and feedback.
* The directorate is beginning to set up our carer forums across the teams and hopes to have these in place by the end of September in at least two AMHTs.

**Older people**

* Duty of Candour workshop held for clinical leads to deepen understanding and ensure compliance
* New pain assessment tool rolled out across District Nursing service
* Further work required to ensure a greater understanding and recognition of issues relating to deteriorating patients
* Further reviews of the discharge planning process are required to improve communication with patients and information shared

**Children and Young People**

* one to one sessions are seen as valuable within the directorate and all staff are supported to access them at least 6 weekly. This further supports the ongoing approach of PDR (rather than a one off yearly meeting) and promotes successful implementation and development of action plans and staff development, aiding in job satisfaction.

**Are our services effective?**

**Adult services**

* 147 patients now have recovery stars
* Review of the physical health forms available within adult services to ensure that these not only monitor key measures for our patients but that they enable teams to report against the national standards for physical health; and to combine three forms into a single form with a prompt to inform the patient’s GP

**Older people**

* Embedding a regular and robust process to manage implementation of NICE guidance
* Care Notes successfully rolled out to inpatient mental health services
* Teams need to develop mechanisms to support teams to produce SMART action plans following
* Need to improve access to appropriate Medicines Management training for staff
* Need to increase compliance with pressure ulcer management training clinical audits

**Children and Young People**

* Clinical Supervision is now available in all service specialisms. Dentistry, Integrated therapy, Health Visiting, School Health Nursing and HFU all have specifically developed processes for local delivery. HFU has a monthly audit running for assurance. Staff are all working towards recording on the OTR system to support Trustwide assurance about the delivery of clinical and management supervision across the directorate. All teams are developing a process for reviewing clinical documentation within Management Supervision.
* Documentation audits are being done within service specialisms to review qualitative standards and learning within professions and services, and to support the consistent use and further development of CareNotes.

**Are our services responsive?**

**Adult Services**

* Work is continuingwith partnership agencies to identify the most effective way to implement a single assessment function for the partnership providing adult mental health services in Oxfordshire.
* Training is underway to assist staff across all agencies to complete the Recovery Star, the patient reported outcome measure we will be using across the partnership.

**Older people**

* District Nurse teams hub model developed which is designed to improve satisfaction of patients and staff
* Estates Group established to manage estates by identify risks and opportunities
* Launch of twitter account to share work and learning around clinical skills lab and Assistant Practitioner role in OHFT District Nursing service nationally
* A complete redesign of the musculoskeletal pathway is required
* A review of District Nursing, Out of Hours and Oxfordshire Reablement teams is required to improve efficiency by identifying areas to increase capacity

**Children and Young People**

* Patient Led Filming Project at CWH Oxon - The aim of the project was to promote patients and staff working together to produce a guide to managing supported eating in the dining room.
* The patients took the lead to produce a short film which will act as a training guide for all new staff commencing employment at CHOxford.
* Patients scripted, starred in, directed, edited and produced the film.
* Therapeutic benefits included building of teamwork and leadership skills, along with the development of planning and time management skills. Patients also learnt how to negotiate, engaging staff as actors and procuring the necessary props and accessing time to film on certain areas of the ward. An additional benefit was the significant work that could take place around body image as patients needed to be ‘on film’ and also watch themselves back through the editing process.
* The team at CH Oxford are very proud of the achievement and were extremely pleased with the feedback received from the Trust Board when a trailer for the film was presented. This is the first example of a fully patient led staff training video.

**Are our services well-Led?**

**Adult services**

* The service has been identifying the areas of improvement for the staff survey. Following discussions, the service will implement a shortened version of the annual questionnaire to see whether the changes it is making have improved the experience of staff.

**Older People**

* Established Directorate Clinical and Professional Leadership Forum to give consistency to the clinical voice at management level
* Integrated Locality away day held to further define the operational and clinical leadership roles
* Positive comments in regard to support and development from District Nursing staff during exit interviews
* Further work is required to ensure the quality agenda is also discussed at a more local level
* The directorate needs to re-start the Peer Review programme and ensure learning is shared

**Children and Young People**

* Staff have been supported in implementing and sharing the learning from the TRIO leadership course.
* PDRs are being well supported and prioritised and delivery/uptake is generally good across the directorate.

**Quality priority 1: Enable our workforce to deliver services which are caring, safe and excellent**

*There is a direct link between staff capability, capacity and motivation and quality. High performing teams with effective leadership are known to deliver higher quality care with increased patient satisfaction. This priority recognises the need to support, develop and engage all of our staff in whatever role they perform. This will enable the service to be caring, safe, effective, responsive and well-led.*

**Monitor safer staffing in inpatient services and report on remedial actions to improve staffing levels and minimise harm arising from pressures on staffing.**

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| --- | --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency*  | *Target* | *Baseline 14/15* | *Q1 1516* |
| Number of wards unable to staff 90% of shifts | Manual | Quarterly | 90% of shifts fully staffed  | New indicator | 40 shifts over 90%70 shifts under 90% *of which* 30 shifts under 75% |

**Maintain existing levels of access to staff training and development, including clinical practice, improvement skills and professional leadership.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Performance developmentreviews completed in last 12 months  | Learning and development records | Quarterly | 95% | 84% | 71% in line with new PDR launch in October and change to review date |

**Reduce sickness absence due to musculoskeletal injury through the musculo-skeletal (MSK) self-referral pilot in older people’s services (fast track physiotherapy).**

This six month pilot aims to provide very rapid access to musculoskeletal (MSK) physiotherapy to Older People’s Directorate staff with the aim of reducing sickness absence levels and agency costs relating to MSK injuries for staff working within the Directorate.

From 2 February 2015 to 30 April 2015:

• A total of 56 patients have been referred to the Fast Track Physiotherapy Service.

• There have been no non attendances (did not attend / DNA).

• 95% of staff were offered an assessment within 7 calendar days of referral

• 75% of staff were assessed within 7 calendar days; the remaining 25% who were not, was due to patient choice on location of treatment as the physiotherapist treated from a different location on each working day.

Comments from the Patient Satisfaction Questionnaires include:

‘*I have been given hope at a time when pain was restricting my movements’*

*‘I have recommended the service to other staff’*

*‘Being able to stay at work and have this treatment was excellent’*

*‘I was impressed with the speed of response to my referral’*

*The physiotherapist was sensitive to my needs and identified how I could improve my health’*

**Improve floor to board engagement and create more opportunities for communication between senior managers, teams and individuals.**

The Older People’s directorate is developing a proposal for a staff engagement forum to ensure all staff have an opportunity to share their continued feedback on the new directorate structure and future outcome-based commissioning.

Leadership events have taken place across the Trust with team leaders and middle managers called Linking Leaders and senior clinical, operational and service managers attend the regular Senior Leaders Forum.

The blog from the service director and clinical director for Children and Young People, is maintained on a monthly basis. The CQC peer reviews on those services flagged up a disconnect between senior management and frontline staff. Heads of service have committed to spend an increased amount of time actively with teams to promote accessibility, understanding of core issues for them, and acting on concerns that has been raised.

Senior leaders visit wards and teams routinely.

**Implement processes to ensure staff can raise concerns and to monitor actions taken.**

District Nursing teams were invited to complete an online survey. The feedback emphasised the strain that staff are feeling due to capacity of teams, pressures of current demand and a feeling amongst staff that managers and leaders were not addressing their concerns.

The Service Director and Director of Nursing and Senior Matron for Community Nursing have worked directly with the district nursing leaders to agree specific local actions and share action plans with teams; and to ensure better communications with staff to advise what actions are taken to address concerns. It has been agreed by LNC and the CCG to revert to a one shift way of working within the DN service as the extended hours service remains unfunded by OCCG. Out of Hours needs for DN support will be picked up by the Out of Hours teams and Hospital at Home. The strategic group involving OHFT, community leaders, GPs and OCCG has recently concluded their work to propose piloting some new ways of working to help to improve patient experience, flow and improve the management of demand and capacity.

**Quality priority 2: Improve quality through pathway remodelling and innovation**

*The primary aim of our pathway remodelling has been to improve quality through aligning and integrating care for patients, working with patients to develop and deliver outcomes and working in partnership within local health systems. This will help us to meet the changing needs of our patients – a diverse and ageing population living with complex long term conditions, which require care delivered closer to home. This will enable the service to be effective and responsive.*

**Evaluate quality improvements relating to new pathways of care, including the impact of the recovery star on outcomes, the impact of cluster packages, and the impact of redesigned team structures.**

Recovery Star

* Number of staff trained: 239 to date
* Number of stars online: 147 (patients) to date (across all services)
* Working to train 3rd sector organisations in Oxfordshire
* Working with IT to have Star in CareNotes

Cluster Packages

* The psychosis package is pending feedback from the Early Intervention Service
* The non-psychosis packages have been completed in draft form
* Work is underway to identify the ‘generic’ information to be included in each package
* Steering group due to review on 3/09/15 for agreement to share with Leads for sign-off.

**Recovery Model**

Older people’s mental health staff will work with service users to agree with the individual what recovery means for them, and to support them to achieve their stated goals. Recovery models promote self-care, the management of physical and mental health and the achievement of an individual’s optimum level of recovery and independence. The older people's mental health services are reviewing a number of tools to use with patients.

The Recovery Star, a patient generated outcome tool, has been introduced into adult mental health services and 120 stars have been completed since we first implemented this in early 2015; this is an average of 20 per month over the last two quarters.

**Older People's Mental Health Service Remodelling Evaluation**

In 2014 the Older People's directorate introduced a new service model to align the older people’s mental health services with a locality structure that mirrors the Clinical Commissioning Groups of Buckinghamshire and Oxfordshire. This placed the older people’s community mental health teams within integrated local health and social care services (mental health, physical health and adult social care), with mental health practitioners as a core part of those teams.

To ensure services are responsive and accessible, changes were made to extend the working hours of the community teams and also to enhance the staffing of the duty function to ensure patients receive an early assessment of their needs and before a crisis develops.

The older people’s acute mental health inpatient wards have streamlined assessment processes and the delivery of inpatient care, to ensure treatment and care is focused and timely. Staffing on the older people’s mental health acute inpatient wards have been improved. The expected outcome is reduced length of stay for patients. There will be continued emphasis on rehabilitation and recovery, or the achievement of optimum functioning.

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| --- | --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency*  | *Target*  | *Baseline 1415* | *Q1 1516* |
| % of patients with a CPA to be in employment or meaningful activity  | CPA audit | Quarterly | 11.8%  | n/a | 14.7% |
| % of patients with a CPA in settled accommodation  | CPA audit | Quarterly | 78.7%  | n/a | 78% |
| % of patients involved in setting and achieving goals | CPA audit | Quarterly | 100% | 88% | 84% |

**Achieve accreditation for memory services (Memory Services National Accreditation Programme).**

Memory clinics provide specialist medical assessment with supporting diagnostics to make accurate diagnosis and initiate treatment, and provide tailored information for the patient, carer and GP, with a plan for follow up and management of the condition.

In order to ensure our services are providing the highest quality of care all community mental health teams are applying for Memory Services National Accreditation Programme (MSNAP). Currently all teams are completing and submitting their self-assessments.

**Accreditation for Inpatient Mental Health Services (AIMS)**

AIMS looks at the quality of the service delivered ensuring basic standards set out by the Royal College of Psychiatry are met. Working alongside the CQC domains, the reviews consider whether the wards are well led, safe in terms of risk management plans and environmental factors, caring through feedback on the day from patients and carers and involvement with staff from a patient perspective. Also that we have effective management strategies to manage risk and improve services (e.g. compliments/complaints) and how we are responsive through the mitigation of risk and how we follow NICE guidance whilst supporting staff and patients/carers. The notification of intention to award AIMS has been issued and official confirmation is awaited. Taking our wards through an accreditation process provides assurance that we are providing a safe service to patients.

Our first ward to be awarded a rating of Excellent was Opal Ward, the rehabilitation unit in the Whiteleaf Centre, which is excellent news.

**Work in partnership with commissioners and other providers to develop outcome based commissioning across a range of services.**

The Oxfordshire Mental Health Partnership (OMHP) works together to deliver an agreed a set of outcome measures for the duration of the partnership (5 years). These outcomes include the following areas:

* % aggregated improvement in score on validated recovery evaluation tool (e.g. Star Recovery Tool) amongst service users in cluster 4-14 at most recent cluster review
* 50% of services users in paid employment, undertaking a structured education or training programme or undertaking structured voluntary activity, with at least 33% of those in paid employment
* 70% of service users living in stable accommodation
* % reduction in the prevalence of smoking amongst the service user population under the care of the contract

**Internal Peer Review Programme**

The trust established a programme of internal team to team peer reviews from October 2014 and to date 58 reviews have been completed across the trust. The good practice identified and the themes for improvement are reported at Directorate and Trust wide level, with the trust wide themes included in the monthly Improving Care: 5 Questions taskforce (IC:5) highlight report presented to the Extended Executive Team. Below is a summary of the good practice identified and the areas for improvement.

Good practice:

* Patient, parent and carer feedback has been very positive, describing staff as caring, kind and professional. Patients have said they highly value the service they receive.
* Teams have demonstrated a caring and committed attitude and compassion for their patients
* Staff show a good knowledge of the patients on their caseload
* Strong clinical leadership within services
* Good understanding and evidence of adult safeguarding
* Good management and monitoring of waiting times where they exist
* Some examples of excellent leadership were seen and staff reported feeling very ‘connected to’, valued and supported by their immediate managers
* Examples of good communication and partnership working across internal services and with external partners
* Some teams are using the 5 questions as a framework for business meetings
* Staff report feeling listened to and more supported following the peer review visits.

Areas for improvement:

These are set against the five national quality standards and the size of the circle relates to number of consistent themes raised.



**Introduce a new Cognitive Behaviour Therapy (CBT) pathway for patients with dental anxiety to reduce the need for sedation by rolling out a pilot project to train members of the dental team on CBT approaches and provide individual and group interventions.**

The dental service have now completed an overview CBT training event and individual key members of the sedation clinical teams are currently completing their final intensive CBT training sessions in conjunction with Psychological therapies.

The pathway from referral and triage and onward treatment in the service is being refined to accommodate all pain and anxiety management techniques including CBT as part of the routine pathway into the service for those patients with significant dental phobias. The first cohort of patients to take part in this innovative new pilot (which is one of the first in the UK with this particular integrated model between dental and mental health services) will commence September 15 with onward supervision built into the programme to support the dental nurses and sedation clinicians.

**Review opportunities for increasing CAMHS in-reach into schools.**

* 14 schools receiving link and in reach service from PCAMHS (increase of 5 schools as compared with quarter 4 2014-15)
* ​Increase in sessions provided to the schools from 69 to 101
* ​In September South Oxon and remaining schools in Central will also be coming on line to provide both link and in-reach.

**Implementation of Dementia Strategy**

The partnership working between Buckinghamshire health and social care to develop a Bucks Dementia Charter is progressing well.  There are four projects streams:

* A single Buckinghamshire Dementia Passport i.e. ‘Knowing Me’/‘This is Me’ for all services in Buckinghamshire
* Dementia Awareness Training delivered to all health and social care staff across Buckinghamshire
* Development of a defined pathway to respond to people with dementia and their carers approaching crisis and offer support during a period of crisis
* Development of a shared approach to the diagnosis and treatment of people with possible delirium or dementia

An inaugural Bucks Dementia Charter Project Board meeting is due to take place in July at which the project framework, leads and teams will be agreed.

**Reduce incidents of deliberate self-harm (DSH) in Marlborough House, Swindon**

Marlborough House Swindon have reduced their DSH requiring physical intervention by 85% since June 2014 and they are sustaining their improvement. This has been achieved by introducing specific improvements, including ensuring two members of staff are present in communal areas at three times during the day when young people reported they felt unsafe. They have also made improvements to feedback and patient engagement in case management. As a result, between July 2013-June 2014 the number of DSH incidents was approx. 134 and between July 2014-June 2015 there were 20 incidents of DSH.



**Evaluate the availability and accessibility of services to Looked After Children (LAC) in partnership with local authorities across Oxfordshire, Buckinghamshire, Swindon, Wiltshire and BaNES including recording parental responsibility and offering health assessments within 20 days of notification.**

A review of Looked After children service continues in partnership with Oxfordshire County Council/CCG Commissioners and this has resulted in additional funding and a new service model. This will allow for an increase in capacity and flexibility of delivery. This increase is in recognition of the increase of children and young people entering care and/or the Kingfisher service. We are planning for a team approach that includes evening and weekend working in order to best meet the needs of the child or young person.

LAC health assessment timescales are monitored as a KPI by commissioners. Oxfordshire continues to have increasing numbers of children and young people into the LAC system, challenging the capacity to deliver LAC health assessments in a timely manner. This new investment and model will address this gap. We are looking to develop a lead GP role with the CCG to enable us to triage some of the LAC health assessments to specialist GPs where it is appropriate to manage the assessments in a primary care setting.

Percentage of Children notified by LA to the LAC team as new to care to be offered a health assessment within 20 working days

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Apr-15** | **May-15** | **Jun-15** |
| % | 100% | 88% | 64% |
| Numerator  | 30 | 29 | 23 |
| Denominator | 30 | 33 | 36 |

During June the service experienced a significant and unexpected increase in new to care children in one week, which has seen our performance dip in this area. Fifteen children were taking into the care system, which is an unusual number. We are working jointly with commissioners to address capacity and to minimise the impact in this area. We are also working with our social care colleagues to agree a referral process into the LAC team to reduce the amount of staff time spent gathering social care information and consent (which is something that should occur prior to the referral).

The new service model of Buckinghamshire CAMHs is due to commence 01.10.15 and includes a co-located team with children’s’ social care. Buckinghamshire County Council have agreed to provide information about Looked After Children and this will be added to CareNotes to ensure staff are aware of the legal status of the child.

**Improve access to services for children and young people with a learning disability**

A new model for Learning Disabilities CAMHS across Wiltshire and Bath & North East Somerset was developed during 2014. We made a number of key appointments including a Clinical Lead for LD to ensure that this vulnerable group’s needs are understood across all of our services and access to specialist assessment, advice and consultation is evenly distributed across our patch. The new model is more highly skilled, proportionate across the geographical areas, and integrated with mainstream CAMHS.

LD CAMHS Oxon, Bucks & Swindon have participated in the Carer’s Triangle Assessment (part of the Carer’s Strategy) and have demonstrated as such how well they work on a very individualised basis with their families who will be long term service users, often with complex needs, affecting the patient and the family as they try and move forward with their lives.

All teams have identified via the assessment for the Carer’s Triangle that they have approaches to family work to ensure the families have the best access to health care (as carers and as patients) possible.

Oxon and Bucks LD teams are now working to take forward a new carers group commencing Q2 2015. In Swindon there is an existing group established.

Letters are sent to all patients and carers within LD services explaining the services and acknowledging referrals, and there are links to the new Trust Website. Staff have, and continue to tailor the website to meet the specific needs of their client group (specific to the service specialism) and therefore to encourage knowledge and accessibility of services within and related to Oxford Health NHS Foundation Trust.

**Extend Street Triage (ST) to reduce the number of Section 136 admissions through an increase of 5% in the number of contacts made via ST; and extend A&E in-reach services to increase the number of patients seen in A&E by 5%**

The data below shows that the number of S136 has increased by 10 in 2015 compared to the same period last year (FY14-15) however, the admission % overall has fallen indicating that only appropriate referrals and section 136 are being made.



**Quality priority 3: Increase harm-free care**

*Safety remains one of our key priorities. For our patients this means both reducing self-harming behaviour and ensuring we deliver harm-free care. A renewed national emphasis on prevention and health promotion is reflected in a new priority to improve physical health management. As well as six specific harm reduction priorities we will also continue to report on incidents and SIs, infection prevention and control, medication incidents and safety thermometer measures for physical and mental health services. This will enable the service to be safe and effective.*

**3.1 Prevention of suicide**

**Implement rapid multi-disciplinary consultant-led reviews in clinical teams following a patient (suspected) suicide.**

In older people’s services, following a suicide in Q1 the manager and consultant led a team review within one week of the incident occurring. The suicide prevention lead is working with the deputy medical director to take this forward more widely across mental health teams.

**Include the interpersonal theory of suicide in the Clinical Risk Assessment Policy and training.**

Training is now ongoing and the interpersonal theory is now in the mandatory risk training curriculum.

**3.2 Reduce the number of missing patients from inpatient services**

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| --- | --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency*  | *Target*  | *Baseline 14/15* | *Q1 1516* |
| Number of incidents where patients do not return on time from approved leave | Ulysses | Quarterly  | 50% reduction | 218 | 62 |
| Number of patients absent without permission  | Ulysses | Quarterly  | 25% reduction | 153 | 43 |
| Days between harm to patients or other people arising from absence without permission | Ulysses | Quarterly  | 300 days between | Start count from Q1 | 91 |

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

**Roll out SSKIN**[[1]](#footnote-1) **bundles to increase reliability of prevention damage prevention and management.**

Although there is evidence to support the benefits of using a SSKIN bundle to reduce pressure ulcers in the acute setting, implementing it within a community setting is more challenging. The Pressure Ulcer Action Group piloted the concept of using a bundle as part of the assessment process in targeted Community Nursing teams and at two community hospitals. This demonstrated how SSKIN bundles can be applied within the community, but also highlighted barriers to sustaining its use in practice. As a result, the implementation of SSKIN bundles has been prioritised for both the next SKINtelligence programme and the work being undertaken by the patient safety collaborative pressure ulcer work stream.

A SSKIN bundle prompt card is being developed for use by all Community Nursing teams.

**Increase staff knowledge and capability through ongoing development of level 4 pressure ulcer prevention and management training.**

An educational training ‘package’ was made available to staff attending training and to the tissue viability resource nurses to disseminate training to other staff. Compliance with training is monitored and where uptake of training is poor Clinical Development Leads are alerted and signposted to both the roll out training package and the core pressure damage training delivered by tissue viability. In order to improve access to training a Braden e-learning programme is currently being developed by Tissue Viability and L&D.

In 2014/15 320 places were available on the pressure damage prevention and management training, with 177 staff attending. Additional courses are being offered by the tissue viability service including a large event at Unipart in September and in-house training to Amber ward in Aylesbury.

AT the end of Q1 43% of appropriate staff had been trained. This figure has been steadily improving over the past 8 months. Alongside this, the directorate is reviewing the Electronic Staff Record to ensure staff who have left the Trust are not included in the data.

**Implement and evaluate the third iteration of the SKINtelligence programme to improve partnership working with care homes and use Institute of Healthcare Improvement methodology to reduce avoidable pressure damage across the health and social care system.**

A third SKINtelligence IHI programme will be run later this year and will be Oxford specific. The course will be attended by clinicians working within Oxford Health and Oxford University Hospitals NHS Trust, and the Trust will be supporting staff through the course. This work will dovetail closely with both the patient safety collaborative project and the work streams led by the Pressure Ulcer Action Group. The improvement work undertaken as part of the IHI programme will focus predominantly on the implementation of a SSKIN bundle.

**Implement and review wound care and pressure damage training for children and young people’s inpatient units**.

Joint work with the Modern Matron Highfield Unit with Tissue Viability and Urgent Care Lead has resulted in a new care pathway being developed for wound care and pressure damage for patients who self harm and eating disorder patients who are at risk of pressure damage. Staff training has been also been undertaken.

Staff attending Pressure Damage training in Q1 2015

HFU 17 staff

MH Swindon 6 staff

CWH Oxon 11 staff

CWH Marlborough 7 staff

Oxon CAMHS Medical 2 staff

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency*  | *Target* | *Baseline 14/15* | *Q1 1516* |
| Reduce avoidable grade 3- 4 pressure tissue damage  | Ulysses | Quarterly | 10% reduction | 12 | 9 |
| % of required staff attending level 4 training | L&D | Quarterly | tba | 71% of phased target[[2]](#footnote-2) | 43% |

**3.4 Reduce harm from falls**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency*  | *Target* | *Baseline 14/15* | *Q1 1516* |
| Number of falls/number resulting in harm by 1000 bed days  | Ulysses | Quarterly  | 3.5 (0.3 harm) MH 8.6 (0.3 harm) PH | 3.7 (0.3 harm) MH 12.6 (0.5 harm) PH | 8.9 (0.2 falls with harm) PH MH data not available |
| % patients in older adult inpatient services to have falls risk assessment on admission  | Audit  | Quarterly  | 100% | 95%(based on 3 data points) | 88% |
| % patients in older adult inpatient services to have a further falls risk assessment after 28 days  | Audit | Quarterly | 100% | 60% (1 quarter’s data) | 57% |
| % of patients to have a review of care plan after a fall  | Audit | Quarterly  | 100% | 69% | 89% |

The falls team have been working with Amber ward to reduce the number of falls on the ward. Key priorities are to increase first fall reporting and to ensure the skill base of ward staff in relation to assessment of postural blood pressure readings.

The process from referral to the Falls service or Community Therapy Service through to home based exercise programmes is being scoped out with a view to improving the quality of provision and equity across localities.

***of patients to be referred to falls service after 2 or more falls: 60%***

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

**Report on and monitor use of seclusion.**

All episodes of restraint are now reviewed every Monday at the weekly review meeting. The meeting is advised of the number of restraints by clinical areas, and the number of prone restraints. The meeting has noted a reduction in the number of prone restraints across in-patient areas, and has now requested data regarding the length of time/duration that patients are restrained in the prone position. Any concerns are highlighted to the relevant Head of Nursing who will request an additional review if required to ensure the restraint or seclusion was appropriate.

**Develop and implement children’s module as part of PMVA (now known as PEACE) training (piloted in the Highfield Unit) to reduce the number of incidents of violence and aggression (V&A) and harm (rated 3, 4, or 5 for impact) by 25%**

Highfield started training on 13/07/15 as a Trust pilot. The ward team is positive about completing training together and being involved in developing module content and timetable. There is a challenge to release 15 staff for 5 days training and manage the ward.

Improved recording on Ulysses incident reporting system has been promoted on C&YP for prone restraints following the detailed study of data for one month in the Autumn of 2014. Restraints data is now reviewed at the weekly governance meeting and sent to the quality/governance team as a weekly report for review and action as required.

The policy for rapid tranquilisation has been approved and updated to support staff implementing the correct physical observations following IM tranquilisation when required (July 2015).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency*  | *Target* | *Baseline 14/15* | *Q1 1516* |
| Reduce number of reported incidents of V&A resulting in harm (rated 3, 4, 5 impact) | Ulysses | Quarterly | 25% reduction | 69 | 21 |
| Number of prone restraints | Ulysses | Quarterly | Towards 0 | 374/1679 | 56/511 |
| Number of restraints involving hyper-flexion  | Ulysses | Quarterly | Towards 0 | 39 | 8 |
| Number of incidents where patients secluded | Ulysses | Quarterly | 25% reduction | 336 | 166 |

**3.6 Improve the physical health management of patients**

**Improve basic physical health monitoring – blood pressure, early warning scores and standard of physical health assessment.**

* A mapping exercise across teams has commenced to identify how teams are addressing the physical health monitoring for service users.
* For service users who are resistant to attending their GP for physical health monitoring, well-being groups are being developed across the teams.
* A training needs analysis is underway to identify training needs for different staff groups in relation to being competent in basic physical health monitoring.
* The physical health assessment forms on CareNotes are being reviewed to create assessment form(s) which will improve and standardise physical health assessments across the service.
* A physical health information leaflet is being developed for service users and carers.

**Develop a physical health policy and implementation and guidance.**

Work is underway in the older people’s directorate to review the physical health tools available with a small group of clinicians to ensure that this captures all of the necessary information required. One of the GP Commissioners will join the group so they are aware of the work underway and the data we will be capturing. This tool will be available within Care notes; the current tool will require some adaptation to accommodate the changes.

**Ensure timely information is shared with GPs and received from them and that OHFT has relevant information on the physical health and history of patients to whom we are providing care.**

* Teams have nominated clinicians linking directly into GP practices.
* Prior to CPA reviews teams are routinely writing to GP’s to request information on physical health.
* Communication with GPs is monitored each month through our 10 day letter audit and the interim discharge summary audit
* In the last audit of GP communication in the older people’s directorate, which included physical health, it was noted that improvements were necessary. We are also beginning to discuss the possibility of linking Care notes with Docman, the GP system to share information between services.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency*  | *Target* | *Baseline**1415* | *Q1 1516* |
| % of adult and older adult inpatients to have MEWS, track and trigger, physical health assessment, VTE and MUST within 24 hours of admission | EPR/audit | Quarterly | 100% | VTE 92%PHA 99% | VTE 88.7%PHA 100% |
| % of patients have their physical health needs assessed % of those care plans address the PH needs identified | CPA audit | quarterly | 95%95% | New audit 15/16 | 54%89% |
| % of patients prescribed psychotropic medication are monitored for side effects relating to that medication | CPA audit | quarterly | 95% | New audit 15/16 | 62% |
| % of patients prescribed psychotropic medication where their GP has been informed of the need for ongoing monitoring by primary care in the community  | CPA audit | quarterly | 95% | New audit 15/16 | 70% |

**Ensure baseline monitoring and improve how patients manage their physical health e.g. obesity, malnutrition and dehydration and ensure equipment is available for community staff e.g. blood pressure (BP) and blood glucose monitors.**

Physical health leads/champions are being identified in each of the inpatient ward and community settings. As part of their role they are completing an equipment audit to identify if all necessary equipment is available to carry out physical health assessments.

**100% of patients managed by the district nursing service to have a nutritional status assessment:**

Patients are referred to dietitian following their physical health assessment if indicated, or by patient request. Many patients will fit into one of two categories - those who are overweight or are gaining excess weight and those who are underweight and at high risk for malnutrition. Any patient requiring dietetic support is assessed one to one and an action plan agreed with the patient and/or ward staff; written information may be given to patient and/or staff. A review is offered as appropriate on the ward or as a community outpatient.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Indicator or measure* | *Data source* | *Frequency*  | *Target* | *Baseline**1415* | *Q1 1516* |
| Nutritional needs assessment completed | Essential standards audit | quarterly | tba | n/a | 70% |

**Quality priority 4: Improve how we capture and act upon patient and carer feedback**

*Patients and carers (relatives and friends) are experts in their own care and their involvement and feedback is critical to our understanding of when our services do well and where we need to make improvements. The lack of involvement of carers with care planning at the point of discharge from inpatient services has been raised as an issue on a number of occasions in the findings of serious incident investigations and the work to deliver the Triangle of Care recognises that carers are intrinsic to effective care planning. This enables the service to be caring and responsive.*

**Capture and act upon patient experience**

The Board has set up a programme of patient feedback and stories from directorates, and in Q1 heard the following stories:

|  |  |  |
| --- | --- | --- |
| BoD Meeting | Directorate | Patient Story |
| April 2015 | Children and Young People | 3 short patient stories; two relating to school nurses and one to CAMHS LD |
| May 2015 | Older People | 2 x stories covering Witney EMU, H@H, Falls service and CHC. |
| June 2015 | Adult | 1x AMHT stories and 1 x staff members from an adult acute mental health ward |

The table below shows different experiences of our community hospital wards, which were gathered in June 2015.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient stories** | **Relative’s story** | **HCA stories** | **Student nurse’s story** | **Social worker’s story** |
| *“The staff are absolutely excellent. I came in here because something was wrong with my leg. I have been here before, on a previous admission, and so asked to come back. The staff are friendly, they will always take a joke. I don’t really like the food. It is tasteless and repetitive. The bed is not that comfortable, and I find that I have to move a lot to get comfortable. However I do seem to sleep well at night and it is not too noisy considering. The garden doesn’t interest me."**“The food is not bad, I like the roast dinners. Some of the staff are nice, I see quite a few faces but I can’t remember every ones names. I feel a little frustrated that it is taking me so long to get home, which is where I want to be, but it is nice that I am now in a hospital that is near my home. I had a fall while since being on the ward, the staff helped me, I wasn’t in any pain.”* | *I am visiting my mother who has been at the Community hospital for approximately one month following a fall at home. Staff are generally friendly and willing to discuss my mother’s progress. My only concern would be my mother’s hygiene. On serval occasions that I have visited she did not appear to have been bath/showered. This could be due to her refusing as I am aware she can be difficult.”* | *“I work part time and find every day different. I am a HCA and sometimes feel like you aren’t taken seriously and tend to be spoken over. I think they are flexible with hours especially those with small children. Staff all help each other if we are short or if patients are more demanding, however, this can affect your one to one time with patients and families. I think the way staff care for the patients is the best I have seen, even if we are short no one goes without or less.”**"I currently work at the Community Hospital on a sessional contract, mainly at the weekends. Generally I enjoy coming to work, however sometimes it can be quite stressful due to staff shortages and patient demand, as well as the demands of some relatives. At times I do feel that certain “jobs” are pushed on to the HCAs rather than the RN doing them, for example on this ward, on a late shift the HCAs are always expected to do the observations, answer bells, try to do the tea trolley, whilst still being asked to do more.**Over all I would say that this Community Hospital is a pleasant place to work and as a team the majority of the ward is very supportive."* | *"I am a student nurse on the ward and have been working here for the last 3 weeks. I have enjoyed my experience here, everyone has been very welcoming and really helpful. Everyone works well as a team, however there is some issues with staffing which increases levels of stress and means that I am not always supernumery."* | *"I have been working in the community hospital for the past 2 years as a social worker, completing work on the wards as well as EMU. My experience of working in the hospital has mostly been a positive one. From the moment I arrived I have found staff to be both helpful and friendly. From the admin staff to the ward consultants I was always made to feel like a valuable member of the team. I always observed staff caring for patients in a respectful and gentle manner. The feedback I often got from patients was that they had never been in a nicer hospital and that the care was 'second to none' "* |

**Monitor improvements made as a result of patient and carer feedback.**

Alongside work to increase the frequency, range and diversity of patient and carer feedback we report and monitor improvements we have or plan to make as a result of feedback we have received. Examples include:

| Directorate (service) | Your Said | We Did |
| --- | --- | --- |
| Adult |
| Emergency department psychiatric service | You don’t always receive the written safety/ discharge plan | The safety/ discharge plan template has been updated to incorporate an emergency contact number with a new form for carers.  |
| Luther street general practice | Patients have made a number of suggestions about the physical environment.  | The team have de-cluttered the noticeboards, put up a multi-lingual welcome sign and staff photo board, upholstered the wooden benches in reception, a magazine rack with improved reading material content & re-painted the mental health practitioner room. |
| Children and Young People |
| Dental service | Staff could consider peoples different needs better | The service set up customer service training in April 15 for all staff. |
| CAMHS | Feedback about tone and wording of initial invite and assessment letters.  | Changes have been made to improve the tone and wording of the letters.  |
| The parents and carers attending the autism workshops said they would like to incorporate time to discuss medication  | A medic now attends at least the end of each workshop to allow time for questions. |
| CAMHS OSCA | Lack of information about service | Service leaflet refreshed and currently being printed. Crisis credit cards are being developed to include details of childline, Samaritans etc.. |
| Highfield CAMHS inpatient ward | Young people requested animal visits on the unit | A qualified PAT dog now visits the unit with fantastic feedback from young people. |
| Health visiting | Not always responding quickly to messages left | Answerphone message recorded was changed with a consistent system for allocating messages to health visitors. Improvements to consistency so clients can keep the same health visitors up to 8 weeks where requested. |
| Speech and language team | Timeliness of reviews and lack of written assessment/ goals following recent therapy sessions | New protocol so that parents can request written feedback by letter or email after each therapy session. |
| Children’s integrated therapies | Parents fed back difficulty with timing and location of appointments clashing with work | The therapists have arranged to have appointments in alternative locations and on different days. |
| As a SENCO I would like a training package for newly appointed teaching assistants. | Therapists delivered training to new teaching assistants which enabled a quicker discharge.  |
| Eating Disorder inpatient unit | Patient raised concerns over the use of bank staff that were unfamiliar with the ward procedures  | A staff film was developed by patients on what support would be helpful. |
| Patient wanted more involvement in the decision making during the clinical team meetings | A new system has been developed giving each patient a 15 minute slot to attend the clinical team meeting if they wish |
| Older People |
| Minor Injury Units | The waiting times vary and can be long with not much communication about where you are in the queue | Reviewed data for last 3 years to understand peak demand times by location. As a result the number of staff on rotas at peak times e.g. Monday morning, were increased and staffing skill mix was varied in the evening. As a result waiting times have reduced, and feedback has been positive from patients and staff. |
| Older people CMHTs | Issue regarding written information and contact details during a mental health crisis | Developed an emergency care plan template that can be hand written with client and carer on emergency and urgent assessments. This can then be photographed using the iPad and scanned into RiO. |
| Older people memory services | Carers said they would like to be more involved, to have a separate consultation and more information about how to get support for themselves | All family members are given the opportunity to be seen privately. Carers Oxfordshire brochures are now given to all carers and the dementia advisor provides information on how to obtain a Carer’s Assessment.  |
| Physical Disability Physiotherapy Service | We would like to exercise in a group environment | Six week “Exercise and Education course”  commenced for patients with neurological disability.  |
| Emergency Multidisciplinary Unit | More information on diagnosis, treatment, who is named nurse/ medic and follow up requested | New discharge information form and wipe clean forms for each bed to put up who the named nurse and medic is for each patient. |
| Respiratory service | Clearer/more detailed informationBetter liaison with Dietetics and more Physio input in Pulmonary Rehab Group | Improved visual aids in the “Understanding your Lung Condition” talk, and in process of updating other disease-specific information. The team have established a clear referral routine to the Dietetics service and increased physiotherapy presence |

**Monitor themes from complaints/concerns and implementation of actions**

The Trust has received 43 formal complaints (excluding those withdrawn) during Quarter 1 with 29 in Adult Services Directorate, ten in Older People’s Directorate and four in Children and Young People’s services. There have been 24 fewer (37%) complaints than in Quarter 1 in 2014/15, with the main decrease in Older People’s Services.

Nine (21%) complaints were responded to within the initial timescale agreed with the complainant and six (14%) complaints were responded to within an extension agreed with the complainant. At the time of writing this report, 28 (65%) complaints remain open and under investigation. By comparison, in Quarter 1 2014/15, 36 complaints were responded to within the initial time agreed with the complainant, 25 complaints were responded to within an agreed extension and six complaints were sent outside of the agreed timescale.

**Complaints by Category**

The primary categories of the complaints (upheld and not upheld) in Quarter One were:



At least 80% of complaints (either primary or secondary issues) have issues relating to communication which links closely with staff attitude/behaviour. Greater emphasis needs to be put into improving interactions with patients and those close to them. Carers continue to report that they are “not heard or listened to”. They feel that their views are not being taken into account and that staff hide behind “confidentiality”. They feel that they should be more involved with what is happening with their relative’s care.

**Implementation of actions**

Of the fifteen complaints investigated, seven actions have been identified. Of these, two actions have been completed within time and five actions are due to be completed over the next couple of months. Examples of actions include:

* Add to the procedures that when referrals are received, an assessment of the suitability of planned/current other psychological interventions.
* Develop a standard operating procedure in relation to front door assessments to ensure clinicians consider all other options re assessment venue before arranging a front door assessment and put in place a risk assessment for this.

**Implement actions from the Triangle of Care to improve carer involvement in the planning and delivery of care**

Carers frequently report that their involvement in care is not adequately recognised and their expert knowledge of the ‘well person’ is not taken into account. This leads to gaps in practice which can result in the carer being left on the outside and in failures to share information that may be vital to risk assessment, care planning, and to acting in the best interests of both service user and carer. The concept of a triangle has been proposed by many carers who wish to be thought of as active partners within the care team. All five older people’s community mental health teams and three older adult mental health inpatient wards across Oxfordshire and Buckinghamshire have been sent the self-assessment questionnaire to complete. Three of these assessments are outstanding, support is being offered to the teams who have yet to complete it. The initial assessments received have some common themes, including:

* a lack of training in the carer experience beyond a short session in the corporate induction when people first join the organisation
* teams do not routinely have an identified carers lead, or a wider forum for carers leads to come together
* the need to consistently record the service users consent for the carer to be involved.

In C&YP a self-assessment for the Carers strategy has been taken in the following teams:

* Highfield Unit
* Marlborough House Swindon
* Cotswold House Marlborough
* Cotswold House Oxon
* LD CAMHS Bucks
* LD CAMHS Oxon
* LD CAMHS SWB
* Neuro CAMHS Oxon

The next stage is to look at School Health Nursing to see how the carers assessment might fit with that, and also to see how it can relate to Young Carers.

Next steps across the Trust are to ensure that teams have embedded the self-assessment and are using it as a living document to drive improvement in the areas where they have identified that they are not fully compliant; and to engage directly with carers to provide a challenge to the teams’ self-assessment and offer suggestions as to how working with carers could be improved.

In November as part of the accreditation process a team from the Trust will undergo a peer review process in presenting to the regional group in London about the work we have undertaken as a Trust to improve how we engage with carers.

**Report on domains of patient experience**

The national community mental health survey for 2015 has started with the fieldwork running from March to 24th July 2015. The current response rate is 31%. The postal survey is sent to a random sample of 850 patients aged 18 and above who have had more than one contact with mental health services between Sept-Nov 2014. The results will be published in October 2015.

Following the previous annual survey results (September 2014) the adult and older people mental health community services decided to focus on: improving information given and available to patients and their families; physical health care; and family (as well as patient) involvement in their own care through working in partnership.

Some of the service wide actions being taken include:

* Seven service user forums have been introduced by each of the adult mental health teams across Oxfordshire and Buckinghamshire to improve patient involvement in service changes and developments. Work is ongoing to develop the membership and attendance at the forums across the two counties.
* In Oxfordshire the mental health service is developing a partnership model with five third sector organisations (Mind, Restore, Connections, Elmore and Response) to develop services. Patients have been involved in the tendering and development of the partnership model.
* Development of a recovery college approach across Oxfordshire and Buckinghamshire to support learning and confidence amongst patients, carers and professional. The college is being co-designed with third sector organisations and patients.
* Introduction of the recovery star by all adult mental health teams to support patient led approaches to the management, participation and review of outcomes from treatment.
* Involvement in the ‘every contact counts’ initiative to improve the focus on patients mental health and physical health needs. A number of the adult mental health teams have also introduced physical health clinics and well-being clinics for patients.

**Development of community hospitals (CH) patient discharge follow-up programme to better understand the patients’ experience of discharge and identify improvements.**

During Q1 a pilot is being developed for Witney Community Hospital. The project will focus on patients discharged from hospital and leaving services provided by our organisation. Three key questions have been agreed to enable staff to confirm that the patient can stay at home and their current care plan is appropriate.

1. tool that acts as a prompt to staff to undertake a risk assessment and provide management of the risk with patients [↑](#footnote-ref-1)
2. Phased targets have been removed and replaced by a target of 90% of staff in post [↑](#footnote-ref-2)