

# PAPER

**BOD 39/2015**

(Agenda Item: 9)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**25 March 2015**

**Quality Account Priorities 2015/16**

**For: Approval**

**Summary**

The Quality Account has two main elements: a review of achievements in the previous reporting year; and an outline of objectives and priorities for the coming year. This paper describes the proposed draft priorities, objectives and measures for 2015/16.

These have been put together following discussions with each directorate, commissioners, Oxfordshire Healthwatch, Extended Executive meeting, the Governors Quality and Safety Sub Committee, a recent Governor’s Seminar, and the Quality Committee.

Key changes from last year are:

* a reduction from eight to four overall priorities
* the workforce and staff engagement priorities have been combined
* the priorities for patient outcomes, data on quality and service remodelling priorities have been combined
* the priority relating to using the new CQC regulatory framework has been removed and a regular report from directorates against the five questions will be included in each quarterly quality account report.
* the inclusion of a number of new quality improvement objectives suggested by directorates
* the inclusion of a new harm reduction priority relating to physical health management
* the expansion of the patient experience priority to include carers and the Triangle of Care

Each measure will have a baseline for 2014/15, where this is available. There is some further work required to refine the priorities and indicators relating to reducing harm from avoidable pressure ulcers and reducing harm from falls.

The increased involvement and consultation with directorates should result in a Quality Account which better reflects the quality ambitions and objectives within our clinical services. It does also, however, increase the overall number of objectives and measures.

The Board is asked to review the attached proposals and assess:

* whether the new priorities offer a good mix of physical and mental health priorities and sufficiently reflect the different patient groups for whom we provide services
* whether there is an appropriate mix of development objectives (requiring a narrative report on progress) and more quantifiable measures and indicators
* whether the four priorities capture the key issues and ambitions for the Trust relating to quality (bearing in mind the Quality Account does not aim to describe all quality activities)
* whether any objectives or indicators should be reviewed, amended or removed

**Governance Route/Approval Process**

This report has not been previously been considered in its current form. A first draft of the full Quality Account will be submitted to the Audit Committee in April and subsequently circulated to stakeholders for formal comments.

**Recommendation**

The Board of Directors is asked to approve the proposed draft Quality Account priorities

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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.*

**Quality Account 2015/16**

**Quality priorities for 2015/16**

We have set ourselves the following quality priorities for 2015/16. These are based on a review of our progress against our quality priorities for 2014/15; a consideration of patient and staff feedback; a review of incident and serious incident themes and findings; and an ongoing assessment of the relevant recommendations from the Francis, Keogh and Berwick reports. These priorities will represent the key areas we monitor and report on through the quality account. Alongside these priorities work on a wider range of quality and safety initiatives continues across all of our services.

***1. Enable our workforce to deliver services which are caring, safe and excellent***: Ensure we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams. Review actions to improve recruitment into vacant positions including implementation of the values based recruitment framework. Improve staff well-being (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***: continue the service redesign and pathway remodelling programme, specifically focusing on its benefits in terms of quality and outcomes for new pathways of care. 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. Monitor the impact of implementation of new electronic health record. Pilot the new quality dashboard at directorate level.

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

a) Prevention of suicide

b) Reduce the number of patients who are absent without leave

c) Reduce the number of avoidable grade 3 and 4 pressure ulcers

d) Reduce harm from falls

e) Reduce the need for restraint and monitor the use of seclusion

f) Improve physical health management of patients

***4. Improve how we capture and act upon patient and carer feedback*:** capture and demonstrate how we act upon patient and carer feedback and improve our care environments; implement the triangle of care to improve carer involvement in planning and delivery of care.

**Measuring progress**

For each of these priorities we have a series of indicators and measures and a set of development objectives on which we will report to the quality committee and Board of Directors over the coming year.

**The completion date for each of the development objectives detailed below is 31 March 2016 unless otherwise indicated.**

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

Ensure we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams. Review actions to improve recruitment into vacant positions including implementation of the values based recruitment framework. Improve staff well-being (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.

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

*Development objectives*

1. Review and measure the impact of the Aston team working model using interviews, impact assessment questionnaires, team stories and repeated effectiveness audits / team temperature checks; and align effective team working into the Trust organisational development strategy
2. Identify, prioritise, deliver and spread innovations for improvement using evidence-based methodologies and evaluation of these, ensuring staff involvement in designing and delivering improvement activities
3. Build effective operational and clinical leadership through trio leadership development and delivery of a collective leadership strategy; and monitor using the collective leadership scale and improvement in staff engagement score in the staff survey
4. Maintain existing levels of access to staff training and development, including clinical practice, improvement skills and professional leadership
5. Implement key actions arising from the national staff survey results to promote staff well-being and motivation, including: reduction in work related stress through improved access to psychological therapies; monitor the impact of the In- house Bank on working hours and compliance with working time directive; reduce sickness absence due to musculoskeletal injury through the MSK self-referral pilot in older people’s services (fast track physiotherapy)
6. Monitor safer staffing in inpatient services and report on remedial actions to improve staffing levels and minimise harm arising from pressures on staffing
7. Take proactive action on recruitment to vacancies and monitor the impact of the new values based recruitment framework
8. Improve floor to board engagement and create more opportunities for communication between senior managers, teams and individuals.
9. Implement processes to ensure staff can raise concerns and to monitor actions taken

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| *objective* | *Indicator or measure* | *Data source* | *Frequency* | *Purpose* | *Baseline 14/15* |
| 1 | Extent to which staff report effective team working | National staff survey | Annual | impact of Aston team working | 3.81 (benchmark 3.8) |
| 3 | Number of staff attending internal/directorate leadership training | manual | Quarterly | Access to leadership development |  |
| 3 ,8, 9 | Review of five staff stories | Qualitative and semi-structured interview | Quarterly | effectiveness of leadership and team working |  |
| 3, 8 | overall extent of staff engagement/feeling motivated and engaged | National staff survey | Annual | Measure engagement | 3.74 (3.76 benchmark) |
| 4 | Performance development  review completed in last 12 months (target 95%) | Learning and development records | Quarterly | Monitor performance review |  |
| 4 | % staff having well-structured appraisals in the last 12 months | National staff survey | Annual | Monitor performance review | 37 (38 benchmark) |
| 4 | Skills courses attendance | Learning and development records | Quarterly | Access to clinical skills  development |  |
| 5 | % staff satisfied with quality of work and patient care they are able to deliver | National staff survey | Annual | Assess staff perception of the care they provide | 69 (benchmark 71) |
| 5 | Extent to which staff report more work pressure than they can manage | National staff survey | Annual | Measure staff wellbeing | 3.11 (benchmark 3.15) |
| 5 | % of staff suffering work related stress | National staff survey | Annual | Measure staff wellbeing | 48% (47% benchmark) |
| 5 | Reduction in absence relating to MSK injury in teams participating in self-referral pilot | BARM data | Quarterly for 6 months | Reduction in MSK related staff absence |  |
| 8 | % staff reporting good communication with senior managers | National staff survey | Annual | Involvement and engagement in change | 28 (29 benchmark) |

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

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

This will enable the service to be effective and responsive

*Development objectives:*

The overall objective for remodelling pathways and services is to deliver caring, safe and excellent services to patients and their families.

1. 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
2. Evaluate the integration of physical and mental health pathways for older people and monitor impact on quality measures
3. Implement the dementia strategy with partners
4. Work in partnership with commissioners and other providers to develop outcome based commissioning across a range of services
5. Extend street triage (ST) to reduce the number of Section 136 admissions through an increase of 5% in the number contacts made via ST ; and extend A&E in-reach services to increase the number of patients seen in A&E by 5%
6. Achieve accreditation for memory services (MSNAP)
7. Introduce a new Cognitive Behaviour Therapy 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
8. Reduce the number of frequent attendances to urgent care services through identifying the top 50 frequent attenders, ensure care plans/special notes are available on 95% of the frequent attenders notes to reduce frequent attendances by 5%.
9. Review opportunities for increasing CAMHs in-reach into schools
10. Evaluate the availability and accessibility of services to Looked After Children (LAC) in partnership with local authorities across Oxfordshire, Buckinghamshire, SWB
11. Improve access to services for children and young people with a learning disability (LD)
12. Pilot the new quality dashboard at directorate level

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| *objective* | *Indicator or measure* | *Data source* | *Frequency* | *Purpose* | *Baseline 1415* | |
| 1 | % of patients with a CPA to be in employment or meaningful activity | CPA audit | Quarterly | Measure quality of life goals | |  |
| 1 | % of patients with a CPA in settled accommodation | CPA audit | Quarterly | Measure quality of life goals | |  |
| 1 | 100% of patients involved in setting and achieving goals | CPA audit | Quarterly | Assess levels of patient involvement in setting and meeting personal care plans | |  |
| 1 | Qualitative review of 10% of caseloads in AMHTs to understand whether the packages of care are being delivered in line with the cluster allocation | Audit | Annual | Ensure a focus on outcomes as well as inputs and process measures | |  |
| 2 | Number of appropriate older adult patients receiving a MEWS assessment | Audit | Quarterly | Aligning physical and mental health needs of older adult patients | | Establish baseline in Q1 |
| 5 | Number of S136 admissions | EHR | Quarterly | Reduce the need for 136 admissions | |  |
| 5 | Increase number of ST contacts by 5% | EHR | Quarterly | Reduce the need for 136 admissions | |  |
| 5 | Increase number of patients seen in A&E by 5% | EHR | Quarterly | Improve emergency care for patients | |  |
| 7 | Decrease number of dental patients requiring sedation | Audit | Quarterly | Improve care for patients | | Establish baseline in Q1 |
| 9 | % of frequent attenders of urgent care where care plan/special notes are available (target 95%) | Adastra | Quarterly | Reducing frequent attendance in urgent care | | Establish baseline in Q1 |
| 9 | Number of frequent attenders (target reduced by 5%) | Adastra | Quarterly | Reducing frequent attendance in urgent care | | Establish baseline in Q1 |
| 10 | Record parental responsibility in clinical records for LAC | Audit | Quarterly | Reduce harm to LAC | | Establish baseline in Q1 |
| 10 | % of initial health assessments offered within 20 days of notification to Looked after Children team in Oxfordshire | Audit | Quarterly | Reduce harm to LAC | | Establish baseline in Q1 |
| 11 | % of care notes which record patients with LD | Audit | Quarterly | Improve access for patients with LD | | Establish baseline in Q1 |

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

We have selected six reduction projects (detailed below). We will also continue to report on incidents and SIRIs, CDI, MRSA and MSSA, environmental infection control audits, medication incidents and the percentage of patients receiving harm free care (safety thermometer measures for physical and mental health services).

This will enable the service to be safe

***3a: Prevention of suicide***

This will enable the service to be safe.

*Development objectives:*

1. Implement learning from SIRIs across the organisation including improved continuity of care, improved risk assessment and discharge planning, and greater communication with and involvement of carers in care planning
2. Implement rapid multi-disciplinary consultant-led reviews in clinical teams following a patient (suspected) suicide
3. Continue to provide dedicated suicide awareness training for qualified and unqualified mental health and community health staff. In addition, work with relevant universities to ensure the pre-registration mental health nursing curriculum adequately covers suicide awareness, assessment, management and prevention.
4. Include the interpersonal theory of suicide in the Clinical Risk Assessment Policy and training
5. Develop a suicide prevention strategy, aligned with Bucks and Oxon public health-led suicide risk reduction strategies, to ensure both community services and mental health services are contributing to the wider community activities to reduce suicide

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline n/a* |
| Days between probable suicides in individual mental health teams (target 300 days) | Ulysses | Quarterly | Measure reduction in incidence of probable suicide | New teams |
| Days between probable suicides in individual inpatient services (target 300 days) | Ulysses | Quarterly | Measure reduction in incidence of probable suicide | Not measured by IP unit |

***3b: Reduce the number of missing patients from inpatient services***

This will enable the service to be safe.

*Development objectives:*

1. Deliver local projects to improve return from approved leave
2. Deliver local projects to reduce the number of patients who abscond

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 14/15* |
| Number of incidents (target 50% reduction) where patients do not return on time from approved leave | Ulysses | Quarterly | Measure reduction in incidence of AWOLs |  |
| Number of incidents (target 50% reduction) where patients abscond from trust premises/leave | Ulysses | Quarterly | Measure reduction in incidence of AWOLs |  |
| Number of patients absent without permission (target 25% reduction)) | Ulysses | Quarterly | Measure number of patients generating AWOL incidents |  |
| 0 patients to experience harm (rated 3, 4 or 5 in impact) as a result of being absent without permission | Ulysses | Quarterly | Measuring reduction in harm resulting from incidents of absence without permission |  |
| Reduce incidents of harm to other people (rated 3, 4, 5) arising from absence without permission | Ulysses | Quarterly | Measuring reduction in harm resulting from incidents of absence without permission |  |

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

This will enable the service to be safe.

*Development objectives:*

1. Implement learning from SIRIs including improved leadership and staffing, improved coordination of care, improved recording and implementation of care planning, implementation of the Braden assessment tool and the SKINtelligence bundle, and the introduction of level four training for nurses including pressure ulcer prevention and management training
2. Implement and evaluate the SKINtelligence programme
3. Monitor mechanisms formally to share learning from audit, incidents and complaints across relevant services to ensure long-term sustainable improvement
4. Implement and review wound care and pressure damage training for children and young people’s inpatient units

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 14/15* |
| Number of patients with avoidable pressure ulcers graded 3-4 (target 0) | Ulysses | Quarterly | Measure reduction in avoidable pressure ulcers |  |
| 100% of patients managed by the community nursing service to have a skin integrity risk assessment | RiO | Quarterly | Reduce risk of avoidable pressure damage |  |
| 100% of patients managed by the community nursing service to have a nutritional status assessment | RiO | Quarterly | Reduce risk of avoidable pressure damage |  |

***3d: Reduce the number of patients harmed by falls***

This will enable the service to be safe.

*Development objectives:*

1. Deliver local projects to reduce the incidence of falls

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 14/15* |
| Number of falls/number resulting in harm (rated as 3, 4 or 5 in impact) by 1000 bed days (target to reduce to 3.8/0.2 in mental health and 8.6/0.2 in physical health) | Ulysses | Quarterly | Measure reduction in harm from falls |  |
| 100% of patients in older adult inpatient services to have a falls risk assessment on admission | Audit | Quarterly | Reduce the risk of falls |  |
| 100% of patients in older adult inpatient services to have a further falls risk assessment after 28 days | Audit | Quarterly | Reduce the risk of falls |  |
| % of patients to have a review of care plan after a fall (target 100%) | Audit | Quarterly | Reduce the risk of falls |  |
| 100% of patients to be referred to falls service after 2 or more falls | Audit | Quarterly | Reduce the risk of harm from falls |  |

***3e: Reduce the need for restraint and monitor use of seclusion***

This will enable the service to be safe.

*Development objectives:*

1. Implement a revised training programme for prevention and management of violence and aggression (PMVA)
2. Develop and implement children’s module as part of PMVA (PEACE) training (piloted in the Highfield Unit)
3. Report on and reduce the number of avoidable prone restraints (where the person is face down), use of hyper-flexion (holding the arm to restrain)
4. Report on and monitor use of seclusion

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline 14/15* |
| Reduce number of reported incidents of violence and aggression resulting in harm (3, 4 or 5 in impact) by 25% | Ulysses | Quarterly | Measure reduction in incidence of violence and aggression |  |
| Number of prone restraints (target towards 0) | Ulysses | Quarterly | Measure reduction in incidence of prone restraints |  |
| Number of restraints involving hyper-flexion (target towards 0) | Ulysses | Quarterly | Measure reduction in incidence of hyper-flexion |  |
| Number of incidents where patients were secluded | Ulysses | Quarterly | Measure reduction in incidence of seclusion |  |

***3f: Improve the physical health management of patients***

This new priority focuses on how we manage patients’ pre-existing (long term) physical health conditions (e.g. diabetes); how we avoid harm e.g. impact of medication/treatment; how we ensure staff have physical health skills in inpatient settings, community services and sub-acute settings; how we reduce harm from poor nutrition: how we support patients to reduce risk factors for poor health e.g. smoking.

This enables the service to be effective and safe

**Development objectives**

1. Expansion of the physical health skills course and/or other ways to deliver training effectively
2. Improvement of basic physical health monitoring – BP, MEWS and standard of physical health assessment and monitoring
3. Develop a universal monitoring check list for older adult mental health patients
4. Develop a physical health policy and implementation and guidance
5. Monitor patient experience of smoking cessation and impact/perceived benefits at 6 months and 12 months for those in long term care
6. Improve diabetes management, management of delirium c.f. dementia and monitor administration of clozapine and associated monitoring
7. 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. BP and blood glucose monitors
8. 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
9. Monitor the impact of “every contact counts”
10. Map health promotion work in 2015/16 with a view to standardising activities in 2016/17

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline* |
| 100% of inpatients to be screened using MEWS and track and trigger and have physical health assessment (PHA) including VTE and MUST within 24 hours of admission | EPR/audit | Quarterly | Aligning physical and mental health needs of older adult patients |  |
| Are there any physical health needs identified in the assessment / most recent review? and if yes does the care plan address the physical health needs identified? | CPA audit | quarterly | Ensuring effective physical health management |  |
| Is the service user prescribed psychotropic medication? and if yes does the care plan detail the medication and include side effect monitoring needs relating to psychotropic medication | CPA audit | quarterly | Ensuring effective physical health management |  |
| Is there evidence that the GP has been informed of the need for ongoing monitoring of psychotropic medication issues by primary care in the community? | CPA audit | quarterly | Ensuring effective physical health management |  |
| Patient has received a physical health assessment completed within 24 hours of admission | Essential standards audit | quarterly | Ensuring effective physical health management |  |
| Patient’s physical health needs are identified at assessment are included in care plan | Essential standards audit | quarterly | Ensuring effective physical health management |  |
| Patient has been screened for VTE within 24 hours of admission | Essential standards audit | quarterly | Ensuring effective physical health management |  |
| Nutritional needs assessment completed | Essential standards audit | quarterly | Ensuring effective physical health management |  |

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

Capture and demonstrate how we act upon patient and carer feedback and improve our care environments; implement actions from the Triangle of Care to improve carer involvement in the planning and delivery of care.

This will enable the service to be caring and responsive

*Development objectives:*

1. Report on domains of patient experience
2. Implement actions from our self-assessment using the Triangle of Care and review local carers strategies
3. Monitor improvements made as a result of patient and carer feedback
4. Monitor themes from complaints and concerns and actions to improve
5. Children and Young People to establish patient experience champions and involve service users in service development and recruitment
6. Development of community hospitals patient discharge follow-up programme to better understand the patients’ experience of discharge and identify improvements
7. Review how C&YP collect patient experience and feedback, make surveys more engaging and manage communication with patients with communication difficulties to bring this into clinical practice (e.g. reported outcome measures)

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| *Indicator or measure* | *Data source* | *Frequency of reporting* | *Purpose of measure* | *Baseline* |
| Number of complaints upheld | Ulysses | Quarterly | Monitor responsiveness of service |  |
| Proportion of concerns to complaints | Ulysses | Quarterly | Patients and carers able to raise and resolve concerns locally |  |
| Number (or percentage) of actions outstanding |  |  | Ensure we learn from feedback and make changes |  |
| Review of patient stories | Qualitative and semi-structured interview | Five per care pathway per year | To assess and analyse patient experience of services they receive | n/a |
| Improving patient and carer satisfaction with services  (target improvement on 2013/14 rates) | Friends and Family test | Quarterly | Ensuring services continue to meet the needs of patients and people close to them |  |
| Number of young carers offered support | Audit | Quarterly | Ensuring services continue to meet the needs of patients and people close to them |  |