

**Report to the Meeting of the**

**BOD 75/2015**

(Agenda item: 9)

**Oxford Health NHS Foundation Trust**

**Board of Directors**

**27th May 2015**

**Quality and Safety Report**

**Quarterly Clinical Effectiveness Report**

**For: Information**

**Executive Summary**

This report provides a summary of the Trusts’ position, primarily in Quarter 4 (January – March 2015), in relation to a range of clinical standards and risks considered by the Trust’s Quality Sub-Committee - Effectiveness (QSCE) and reported as appropriate to the May 2015 Trust’s Quality Committee.

The work of the Trust’s new QSCE is evolving. Following the last Quarterly Clinical Effectiveness Report to the Board, in February 2015, the committee, at its second meeting, established two new sub-groups to deal with physical healthcare issues and also with public health, areas which the QSCE felt it was not receiving sufficient assurance upon. Formal reporting on these areas will now be provided to future QSCE meetings. Further consideration of the organisation and governance surrounding the QSCE has occurred.

The QSCE has considered a range of reports relating to its various key lines of enquiry. A finalised workplan will be agreed at the next sub-committee meeting to manage, in particular, the additional areas for which the QSCE is now responsible. The groups which report into the QSCE are reviewing their terms of reference and workplans for the year.

The following issues are highlighted to the Board:

**Areas of compliance/good practice**

*Clinical audit*

The attached report includes a number of positive aspects in relation to clinical audit. It is notable that action plan monitoring has reduced outstanding actions from 36 to 13.

*Mental health code of practice*

The Mental Health Act office team has developed a very useful document describing the changes to the Mental health Code of Practice which is available to all relevant staff and will be processed through clinical and operational governance meetings. Further work will be done to check adherence to the revised guidance.

*Research and Development*

OHFT was the top recruiting NHS Trust in the UK. We now have five research assistants in clinical teams which has been well received. Ethics application for CRIS (research and audit purposes) has been submitted.

**Areas of unsatisfactory compliance/risk/concern**

*Clinical Audit*

There are a total of two clinical audits that had not yet started (safe and supportive observations and DNACPR). The latter is a risk area for the Trust. Internal audit identified inconsistences with recording on DNACPR which has generated some actions to ensure completed more effectively (GPs complete these). A group is working to improve this area.

Although the documentation audit was overall good, some improvement is needed in care plans being revised, and care plans being in place, following identified risk. Clinical teams are addressing this.

CPA audit – improvement is needed regarding the sharing of care plans with service users and GPs. Clinical teams are addressing this.

Essential standards – outdated section 17 paper forms in notes needs rectifying. The Directorates are addressing this.

*Review of practice against**NICE guidance*

A template has been devised using the quality standards; a gap analysis will be undertaken of guidelines and then technology appraisals. It is being sent to directorates and clinical leads for completion.

*Clinical Policies*

A number of clinical policies are beyond their review date. This is being actively pursued by the Trust, including via a sub-group of QSCE.

Mental Health Act Issues

CQC MHA visits continue to show some areas for improvement which have been highlighted to apprpraite staff across the directorates.

**Possible future Issues/concerns**

*Care Certificate*

The new Care Certificate will have a cost associated with providing training and development.

*Recruitment*

Challenges with recruitment are being compounded by various factors including the quality and standard of local nursing accommodation and the expense of private accommodation.

In order to provide the Board with more detail on areas deemed to be of particular relevance, the attached report provides specific information in relation to:

* Clinical audit
* The safety thermometers
* External accreditations & peer reviews
* Certain practice & innovation issues
* Mental health legislation issues

The report also provides an update on infection prevention and control.

**Recommendation**

This report is for information.

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**Lead Executive Director: Dr. Clive Meux, Medical Director.**

*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.*

*This paper (including all appendices) has been assessed against the Freedom of Information Act and the following applies:*

*THIS PAPER MAY BE PUBLISHED UNDER FOI*

1. **Introduction**

The Quality Sub-Committee Effectiveness (QSCE) is responsible for ensuring that patients’ needs are assessed and that care and treatment is delivered in line with current legislation, standards and evidence-based guidance. The Key lines of enquiry (KLOE) for the committee are aimed at ensuring that relevant and current evidence-based guidance, standards, best practice and legislation are identified and used to develop how services, care and treatment are delivered).

The work of the focus of the QSCE is to seek assurance that the organisation is complaint with the KLOE which have been identified for the sub-committee. These are as follows:

* Are people’s needs assessed and care and treatment delivered, in line with current legislation, standards and evidence-based guidance?
* How are people’s care and treatment outcomes monitored and how do they compare with other similar services?
* Do staff have the skills, knowledge and experience to deliver effective care and treatment?
* How well do staff and services work together to deliver effective care and treatment?
* Do staff have all the information they need to deliver effective care and treatment to people who use services?
* Is people’s consent to care and treatment always sought in line with legislation and guidance?
* How are people supported to live healthier lives?
* Are people subject to the Mental Health Act 1983 (MHA) assessed, cared for and treated in line with the MHA and Code of Practice?

1. **Trust wide Clinical Audit**

The following clinical audit update provides a summary of the full clinical audit report which was considered by the Clinical Audit Group (CAG) and reported to QSCE and the Quality Committee. It reviews progress against the trust wide audit plan for last year and the current year; identifies which audits have yet to be initiated and any risks associated with this; and provides an update on actions which are closed and for which no update has been given.

**Progress update against the Trust wide clinical audit plan for 2014/15**

In January 2015 there were a total of 16 (41%) out of 39 clinical audits that had not yet started. January CAG approved four audits to be carried forward to the 2015/16 audit plan, which left a total of 35 audits on the 2014/15 Trust wide clinical audit plan.

The status of all the projects on the 2014/15 audit plan was reviewed again at CAG in March. The number of audits still to commence has reduced from sixteen to two. Both these audits are past their planned time scale to commence:

* Audit of the Safe & Supportive observations of patients at risk (policy CP03)
* Do Not Attempt CPR (DNACPR)

It was agreed at CAG that both audits that had not yet started and the four that were carried over should be prioritised and scheduled to commence as early as possible in 2015/16 with the exception of DNACPR audit for the reasons given in table 1 below.

The reasons for the delay in undertaking the six audits detailed in table 1 are in relation to capacity issues within the corporate clinical audit team. This has been previously reported. Recruitment has been successful and we are awaiting the start of a full-time quality & audit specialist.

Table 1 below provides a list of the audits to be carried forward to the 2015/16 plan with the rationale for that decision.

|  |  |
| --- | --- |
| **Name of audit** | **Rationale** |
| Audit of the Safe & Supportive observations of patients at risk | This audit was last carried out in 2012/13 and rated as requiring improvement. The bi-monthly Essential Standards audit provides some assurance on the following:   * General observation - Date and level of observation clearly documented * Patients on close observations can explain why these are in place * Evidence that the observation records are fully completed for the previous 24 hours (levels 1-4 as appropriate)   Results for February are rated as excellent |
| Do Not Attempt CPR (DNACPR) | This was to be a baseline audit. It is a high risk area for the Trust. Considerable work is underway currently in relation to End of Life Care. There are some assurances in relation to this audit.   * An internal audit has been carried out by TIAA and there are specific actions around DNACPR   There is the ‘One Chance to Get it Right’ project underway which includes a work stream for developing effective governance systems, specifically including the role out of the Thames Valley Competency package and training across the Trust. It is recommended that this audit should be scheduled for Quarter 3 2015/16 as indicated in the work stream action plan to allow for training to be completed. |
| Care standards for Non CPA cases | This audit was rated as requires improvement in 2013/14. The action plan from the baseline audit was to implement a standard template letter. This template has only recently been implemented across Older People and Adult Services therefore the audit can be carried forward to 2015/16 plan. |
| Health Records Audit | NHSLA require Trusts to undertake a health record audit at least every two years. As a health record audit was undertaken in 2013/14 this audit can be carried forward |
| Non-medical prescribing | If Urgent Care has already started this audit, it could continue, but all other areas to be informed that this will be carried forward to next year’s plan as does not require highest priority. |
| Use of Time Out follows policy and procedure | Remove from audit plan completely as ‘Time Out’ is not an intervention used within Oxford Health |

**Table 1 Audits to be carried forward to 2015/16**

A summary of the status of the projects on the Trust wide Clinical Audit Plan at March is provided in Table 2 below.

|  |  |
| --- | --- |
| **Status** | **Number of projects** |
| Quarterly reporting | 8 |
| Completed | 4 |
| In progress | 17 |
| **Not yet started** | **2** |
| Data submission only | 1 |
| Report writing stage | 3 |
| **Total** | **35** |

**Table 2 – project status update**

Eight of the 35 projects report quarterly of which five are up-to-date and have reported for Quarter 3 and three are behind schedule and are still to report. An up-date was provided to CAG in March and it is anticipated that the remaining three will report for Quarter 3 within the next four weeks. These are:

1. Quarterly audit of Controlled Drugs
2. Quarterly audit of safe & secure handling of medicines
3. Classic Safety Thermometer

**Reported audits with no action plan in place**

The number of audits with no action plan in place within the 6 week time frame was reviewed at CAG in March. There are a total of 18 improvement memos that have been sent out to Directorates for action planning since January. The 18 improvement memos currently out for action planning relate to the following six audits:

* Safe and secure handling and storage of medicines (quarterly reporting)
* Controlled drugs audit (quarterly reporting)
* CPA audit (quarterly reporting)
* Drug allergy recording audit
* Section 17 audit
* POMH Alcohol detoxification

Actions taken to mitigate for outstanding improvement memos include; escalation to the Medical Director and a request at CAG for Directorates to address this as a matter of urgency. It is of note that the Forensic service has all of the outstanding improvement memos in the Adult Directorate.

There is an unusually high number of improvement memos sent out since January due to high audit activity. This then has an impact on Directorates workload and demands. Table 3 below provides the number of improvement memos outstanding by Directorate

|  |  |  |  |
| --- | --- | --- | --- |
| **Directorate** | **Total number of improvement memos sent out for action planning** | **Number of improvement memos outstanding but still within 6 week time frame** | **Number of improvement memos**  **past 6 week time frame** |
| Older People | 7 | 2 | 5 |
| Adult Services | 9 | 4 | 5 |
| Children & Young People | 2 | 2 | 0 |
| **Total** | **18** | **8** | **10** |

**Table 3**

**Action Plan Monitoring**

Monthly scheduled reports are now produced for the directorates to review their outstanding audit actions at their governance meetings. A report on the number of actions outstanding was run on 9th March 2015 for review at Clinical Audit Group on 19th March 2015. Overall there has been a decrease in the number of out-of-date actions from 36 in January to 13 in March. Older People have 11 out of the 13 actions. This may be due in part to problems accessing Ulysses to update actions by the audit lead in the directorate. The Directorate has been asked to address this as a matter of priority.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Division** | **Total number**  **of completed actions** | **Total number of actions outstanding** | **Number of actions in date** | **Number of actions out of date** |
| Trust wide actions relating to all directorates | 43 | 6 | 6 | 0 |
| Adult Services | 156 | 7 | 5 | 2 |
| Older People’s Directorate | 115 | 12 | 1 | 11 |
| Children & Young People | 80 | 10 | 10 | 0 |
| **TOTAL** | **394** | **35** | **22** | **13** |

**Table 4 – Number of actions out of date**

**Summary of the results from the clinical audits reported and rated since the last Clinical Audit Group meeting**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Audit Name** | **Directorate** | **Baseline / Re-audit** | **Audit rating** | **Date action plan to be developed by** | **Date action plan received** |
| Audit of the quality of Section 2 assessments | All (Mental Health) | Baseline | Good | 7/11/14 | In place |
| MEWS Older Adult Mental Health Wards | Older People | Baseline | Good | 10/2/15 | In place |
| Safety Thermometer Adult Directorate (Oct-Jan 15) | Adult Services | Monthly | N/A | N/A | N/A |
| Community Hospitals Documentation Audit Q3 | Older People | Re-audit | Good | 10/2/15 | Outstanding |
| CPA Q3 (Mental Health) | All (Mental Health) | Re-audit | Good | 23/3/15 | Still in date |
| Track & Trigger Q3 | Community Hospitals | Quarterly | Good |  | In place |

**Table 5 - Summary of the results from the clinical audits reported and rated since the last Clinical Audit Group meeting in January 2015**

The audit results were scrutinised by CAG and overall there has been an improvement in audit results. However, although the audits were rated overall as good there were a number of issues raised relating to three of the audits which require actions:-

**Community Hospitals Documentation Audit Q3**

From the summary of results reported there were a number of areas identified overall as requiring improvement. These included care plans not being reviewed weekly and care plans not being in place following an identified risk. As there was no breakdown by individual community hospitals included in the summary to CAG it was not possible to determine if this was an issue for all community hospitals or an individual site. The Older People’s Directorate was asked to review this and ensure relevant actions were put in place to address these issues.

**CPA Q3 (Mental Health)**

The majority of the standards measured in the CPA audit were rated as either good or excellent. However, there continues to be an area rated as either unacceptable or requiring improvement across the services around the sharing of care plans with the service user and GP. Directorates were asked to review their action plans to ensure areas still requiring improvement were being addressed and specific focus is being placed on this within clinical areas.

**Essential Standards**

The majority of standards continue to be rated as good or excellent. Concerns were raised that there was still an issue around Section 17 paper forms being removed when out of date and uploaded to the electronic record. This issue continues to be raised during CQC Mental Health Act inspections. An improvement memo has therefore been sent to Directorates for specific action planning and a follow up audit is planned in adult services.

**Other Clinical Audit Issues**

A clinical audit policy and a clinical audit strategy have both been developed and discussed in various fora. Both are nearing completion.

1. **Delivering Effective Outcomes**

**The Patient Safety Thermometer**

The Patient Safety Thermometer Classic is a point prevalence audit completed by many services in the Older Person’s Directorate, as defined nationally, reported a month in arrears. Although comparison with national trends is possible, many of the audit participants are not analogous with Oxford Health (acute Trusts, private care homes, etc.), so it is of limited value.

Although the Trust’s Harm Free total is below the national figure, it is believed that this is down to a more rigorous reporting of grade 2 pressure ulcers by Oxfordshire District Nurses. An investigation to understand the impact of this will be completed during quarter 2 of 2015/16.

Pressure Ulcers account for over three quarters of harms reported by Oxford health in the Safety Thermometer Classic audit. It should be noted that this data shows all pressure ulcers, including inherited pressure damage. As the incidence of avoidable pressure damage within Oxford Health remains low this may reflect whole systems issues.

The Safety Thermometer classic audit continues to show that OHFT is a long way above the national trend regarding VTE risk assessment completion.

**Mental Health Safety Thermometer**

The Mental Health Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with mental health services. It’s a point of care survey that is carried out on one day per month which supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines.

Its aim is to enable teams to measure harm and the proportion of patients that are 'harm free' from self-harm, psychological safety, violence and aggression, omissions of medication and restraint (inpatients only). This is a point of care survey that will be carried out on 100% of appropriate patients on one day each month.

To date the data available through the national Safety Thermometer website is limited. In relation to community mental health services, we are showing:

* a figure of 7 (compared with a national figure of 5) for the proportion of patients who have self-harmed in the last 72hours
* When compared with the national average patients in Oxford Health feel safer
* There is a slight increase in the number of patients who have been the victim of violence in the previous 24 hours
* There is a slight reduction in the number of medication omissions in the previous 24 hours when compared with the national average.

**Inpatients**

In relation to in-patient Oxford Health is showing:

* A slight increase 5.5 compared with 4.5) of patients who have self-harmed in the previous 24 hours.
* A slight reduction in the % of patients who have felt safe in the previous 24 hours (79 compared with 82)
* A slight increase in the number of medication omissions (6 compared with 8).
* A higher number patients who have been restrained in the last 72 hours (7 compared with 3).

The figures provided via the Mental Health Safety Thermometer is based on a census of all patients seen on the day of the monthly census in both community and in-patients services. The workload associated with collating and recording this data is high, and to date the information being produced is limited.

**External Accreditations and External Peer Reviews (Updated January 2015).**

The information in table 6 provides an update of the external accreditation and external peer reviews currently achieved or being worked towards (highlight in grey) is reported at least six monthly to the QSCE. All processes for accreditation and peer reviews will be reported through to the QSCE. Currently Adult in-patient services are going through the process for AIMs accreditation. At the time of reporting we have received confirmation that Opal ward has received accreditation and that the general adult wards have been deferred whilst identified actions are undertaken. It is planned that the acute wards will be reassessed on 3rd June 2015.

| Accreditation | Body | Service | Comments |
| --- | --- | --- | --- |
| Memory Services National Accreditation programme (MSNAP) | The Royal College of Psychiatrists | North Oxfordshire Memory Clinic | Affiliate member only (self assessment and peer visit not completed). See below detail about Thames Valley initiative led by AHSN to achieve accreditation. |
| ECT | The Royal College of Psychiatrists | Whiteleaf Centre, Aylesbury | Accredited to April 2017 (review decision 3rd April 2014) |
| ECT | The Royal College of Psychiatrists | Warneford Hospital, Oxford | Accredited to Jan 2017 (review decision 15th Jan 2014) |
| Quality Network for Inpatient CAMHS | The Royal College of Psychiatrists | Marlborough House, Swindon | Membership is current, checked on 11th Nov 2014. |
| Quality Network for Inpatient CAMHS | The Royal College of Psychiatrists | Highfield, Oxford | Membership is current, checked on 11th Nov 2014. |
| Community of Communities | The Royal College of Psychiatrists | Oxfordshire Complex Needs Service | Renewed accreditation in April 2014 from 3rd April 2014 to 3rd April 2017. |
| Community of Communities | The Royal College of Psychiatrists | Buckinghamshire Complex Needs Service | Assessed and accredited in 2009 and 2012. Accreditation completed every 3 years. Re-accreditation process started due to be completed end of Jan 2015. |
| Quality Network for Forensic Mental Health Services | The Royal College of Psychiatrists | Marlborough House, MK | Annual peer review (last review Feb 2014) |
| Quality Network for Forensic Mental Health Services | The Royal College of Psychiatrists | Woodlands, Aylesbury | Annual peer review (last review Feb 2014) |
| Quality Network for Forensic Mental Health Services | The Royal College of Psychiatrists | The Oxford Clinic, Wenric and Thames House | Annual peer review (last review Feb 2014) |
| UKMi (UK Medicines Information) | UK Medicines Information | Trusts Medicines Information Department | Awarded following audit in 2009 |
| Quality Network for Eating Disorders (QED) | Royal College of Psychiatrists Centre for Quality Improvement | Cotswold House, Marlborough | Awarded excellent (accredited till Jan 2017) |
| Triangle of Care member (carers) | Carers Trust | All services | The Trust became a member in June 2014 and is working to achieve 1 star in the next 12 months and 2 stars over 2 years. |
| BDA Good Practice Scheme | British Dental Association | Salaried dentist service | Application submitted to BDA in March 2014. Site visit completed in Nov 2014 and informed in Jan 2015 achieved accreditation. |
| Quality Network for community CAMHS | The Royal College of Psychiatrists | Oxford City CAMHS | Accredited to Jan 2014. Accreditation possibly has lapsed. Team will go for re-accreditation in next cycle in 2015/16. |
| Quality Network for community CAMHS | The Royal College of Psychiatrists | Buckinghamshire OSCA | Self assessment being completed, plan to go for accreditation in next cycle 2015/16. |
| Quality Network for community CAMHS | The Royal College of Psychiatrists | Buckinghamshire learning disability team | Status to be confirmed. |
| Quality Network for Eating Disorders (QED) | Royal College of Psychiatrists Centre for Quality Improvement | Cotswold House, Oxford | Formal review in Dec 2014, awaiting outcome (Feb 15). |
| UNICEF baby friendly breastfeeding status | UNICEF | Health visitors service | In progress. |
| Psychiatric liaison accreditation network (PLAN) | The Royal College of Psychiatrists | Emergency Department Psychiatric Service Oxfordshire | Application submitted to PLAN. Self assessment completed in Dec 2014, waiting for date of visit. |
| Memory Services National Accreditation programme (MSNAP) | The Royal College of Psychiatrists | Memory service clinics Oxon and Bucks | A Thames Valley initiative led by AHSM has started to support memory service clinics to complete the self assessment and peer review visit to achieve accreditation. |
| Accreditation for inpatient mental health services | The Royal College of Psychiatrists | Adult mental health wards | Project established to complete self assessment and submit application for peer review to achieve accreditation. Initial visits completed in November 2014, final visits planned between Feb-April 15. |
| Imaging Services Accreditation Scheme | UKAS selected to deliver and manage Imaging Services Accreditation Scheme | x-ray services hosted at Abingdon, Bicester, Witney and Henley Community Hospital sites | OUH manage staff and equipment through SLA from April 2014.  OUH carrying out a two year programme (including the community hospitals) to prepare through self assessment and then apply for external accreditation in June 2016. |

**Table 6 - External Accreditations and External Peer Reviews**

1. **Practice and Innovation**

**NICE**

To date 62 NICE Quality Standards have been identified as being either of Direct or Indirect relevance to clinical services with Oxford Health NHS Foundation Trust. At the present time staff in all three directorates are undertaking a GAP analysis in order to identify if services are fully, partially or non-compliant with each of these quality standards. The outcome of this analysis is to be submitted to the CCG by Friday 29th May followed by regular three monthly updates.

**Meeting Nutritional Needs**

There is a quarterly audit on District Nursing patients to confirm that they have a MUST assessment completed on first visit. The result from 14/15 Q4 was 87% compliance.

The completion of a MUST assessment within one 72 hours of admission is included in the Community Hospitals Documentation audit. The result from 14/15 Q4 was 98% compliance.

In adult services nutritional assessments are included within the essential standards audit which overall is showing an upward trend since December 2013.

Policies

At present there are currently a number of policies which are due for renewal. Plans are in place for the review of all policies which are to be reviewed and there is a target for all policies to be reviewed by the end of July 2015. A Trust wide group met in May 2015 in order to agree a work plan for clinical, MHA, infection control, HR and corporate policies. Progress against this work plan will be monitored by the deputy Director of Nursing.

**Procedural Documents**

The Older people’s directorate have taken ownership of a number of divisional procedures and guidelines (mainly procedures that have historically been produced by the previous organisation of Community Health Oxfordshire (CHO) as policies which have since been identified as a procedure or guideline. There are approximately 65 policies on the OP division database, 28 of which are identified as past their view date. This risk has been escalated to the Senior Management Team.

A meeting with the Clinical Director and Nursing Leads will take place in May to determine how this work is best taken forward.

1. **Mental health and mental capacity acts**

**CQC Visits – Mental Health Act**

The information below outlines the three CQC MHA visits which have taken place since the last report. Details of the issues raised by the CQC following these visits together with our responses are detailed below

|  |  |  |
| --- | --- | --- |
| **Ward** | **Issues identified** | **Actioned** |
| Wenric Ward | Section 17 Leave – old forms not crossed through and removed from folder.  Participation in care planning.  SOAD consultation not recorded:  Patient issues:  manner in which staff spoke to patient  leave not always facilitated due to lack of escorts | Action: expired forms immediately removed, trust procedure enforced, increased monitoring from ward manager and modern matron.  Action – specific issue in relation to Occupational Therapy, patients are involved but OTs reminded to ensure recording of care plan reflects involvement, monitoring via supervision and review of OT entries in records.  *Action: P*atient records were reviewed and appropriate record had been made by consultee, however, all potential consultees reminded of the requirement to make a record of the consultation. In addition the issue was tabled on the agenda item for the Forensic Clinical Governance meeting.  complaint had been addressed  explanation to be provided to patients where unplanned staff absence impairs leave with escort. |
| **Phoenix Ward, 10 February 2015** | Section leave forms had expired.  Participation in care planning.  Section 132 rights  Patient issues – provision of waste paper bin to patient, and re-prescription of analgesic gel to another. | Action - new form authorising leave had been completed but not uploaded to electronic patient record. Consultant has been reminded of responsibility and existing procedures, monitoring by modern matron.  Action – teaching sessions undertaken with ward staff, monitoring by modern matron vis the Essential Standards Audit.  Action: appropriately presented and recorded but IMHA not sufficiently covered. A reminder was issued to staff, at the business meeting item, and a review by Mental Health Legislation Group.  Both of these issues have been completed. |
| **Wintle Ward, 17 February 2015** | Section 17 leave forms expired and conditions not clear.  Consent to treatment.  Participation in care planning.  Patient issues – delayed discharge? | Action – expired forms have been removed, forms will be signed by patient prior to uploading to electronic record, daily checks in place.  Action – statutory consultees not making record of consultation with SOAD, entry in record now present.  Action - teaching sessions have taken place with ward staff, monitoring by modern matron via the Essential Standards Audit.  Action: Patient placed on trial leave and the CTO application completed. |

**Mental Capacity Act and Documenting of Capacity Assessments**

A range of requirements/standards in relation to the Mental capacity act were identified and agreed at the MHA quality group and have been disseminated to clinical services:

1. Capacity assessments should be made and recorded at the time of admission and each time a decision regarding the patient’s treatment is required, irrespective of whether patients are detained under the Mental Health Act or informal. The record of each assessment should be in the patient record at the point when the decision is being made.
2. Staff recording in patient health records should adjust the language being used – for example instead of stating that patient lacks insight or is confused, they should explain that due to mental health problem(s) patient is unable to understand/process the information, and evidence this. All junior doctors attend the Trust MHA/MCA Induction session where these issues are addressed in detail.
3. With regard to patients detained under the Mental Health Act, capacity to consent to treatment assessments are recorded for ‘first administration of treatment’ following admission and at the 3 month point when patients detained under the Act must either consent to treatment or have a second opinion in order for medication to be administered.
4. It was agreed that the Eating Disorder Unit inpatient service should be included in the MCA audit of capacity assessments.

CAMHS – The MCA applies to those aged 16 and over. Under 16s are covered by the Children Act. The CAMHS service is looking into how capacity assessments are to be recorded for this care group.

The Older People’s Directorate is developing a process of assurance to ensure that consent to care and treatment is always sought in line with legislation and guidance. Currently all patients are asked to provide consent for care and treatment. The Directorate wishes to confirm this is consistently managed through a question to be added during 2015 to the planned patient story interviews, and through clinical audit.

An audit of consent was to treatment and examination was completed in the Minor Injuries Units during April 2015. The results revealed 100% compliance with the standard.

Assurances that our services comply with the Mental Capacity Act are sought through an audit completed by the Trust’s Adults Safeguarding Manager. The 13/14 audit was rated Not Compliant. The main areas of concern were enquiring whether patients have an advanced decision to refuse treatment or if they have a Lasting Power of Attorney, and documentation of a mental capacity assessment. Each Community Hospital has developed an action plan in response to the results. Actions taken included:

* Addition to the standard Community Hospital admission pack has been to include a flag to document Advanced Decisions and Lasting Power of Attorney
* Introduction a checklist, agreed with ward medics, for MDT and ward rounds that includes mental capacity assessments

Further work to check compliance will be undertaken.

**Deprivation of Liberty (DOLS)**

Following the Cheshire West ruling earlier in the year, there has been an increase in the requests for DOLS assessments nationally and this has been reflected in Oxfordshire and Buckinghamshire Local Authorities, supervisory bodies. The Trust’s MHA office is now monitoring urgent authorisations and expiries of standard authorisations very closely in order to ensure that all authorisations are in date and correct. The results of this will be reported through to the QSCE for analysis and required actions discussed and agreed.

Discussions are to take place with the Eating Disorder Inpatient Service to ensure that all staff are familiar with DOLS

Some areas of concern have been identified with the current DoLS process within the older adult directorate. The changes in legislation have led to an increase in DoLS applications. The impact of this has been delays in the assessment and subsequent outcomes of applications. This is being monitored by the older adults quality group and reported through to QSCE.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Department | Feb | March | April | Total |
| Oxon | 2 | 1 | 6 | 3 |
| Bucks | 1 | 0 | 4 | 1 |
| Total | **3** | **1** | **10** | **4** |
| Granted | **2** | **0** | **5** | **2** |
| Awaiting Outcome | 2 | 1 | 5 | 3 |

**Table 7: Number of DoLS raised within OPD:**

**Revised Mental Health Act Code of Practice**

The Mental Health Act Office has developed a summary of key changes in the revised Mental Health Act Code of Practice which has been cascaded through directorate governance structures and circulated to staff. Further work will be done to check adherence to the revised guidance.

1. **Infection Prevention and Control Update**

**Community health services**

***Clostridium difficile***

There was one case of *Clostridium difficile* infection (CDI) in March (an inpatient on City ward, Fulbrook centre).

There were 7 CDI cases against the end of year target of 8.

RCA’s have been completed and reviewed at the monthly CDI health economy review meetings and all cases classified unavoidable.

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**MRSA bacteraemia/MSSA bacteraemia**

There have been no MRSA or MSSA bacteraemias.

**E.Coli bacteraemias**

There was a pre-48 hour patient admitted via EMU to Ward 2 Abingdon (31.3.15); not Trust attributable.

**Outbreaks**

There was a possible norovirus outbreak on Opal ward, Whiteleaf centre, affecting 8 patients and 2 staff. The ward was affected between 12.3-20.3.15 after which a full terminal clean was completed before the ward resumed normal operations.