

**BOD 34/2016**

(Agenda item: 8)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**23rd March 2016**

**Quarter 3 2015/16 Quality Report -Safety**

**Executive Summary**

The Quality Report for February provides a summary on progress made during the month completing the CQC improvement plans and initiating our internal process to ensure we are completing the agreed actions on time with oversight from OCCG.

In our regular meeting with the CQC we discussed the scope and timing for the re-inspection of the four core services which 'Require Improvement'. The timing is likely to be slightly earlier and take place late May or early June. The inspection will focus three mental health core services as the CQC community services team lack capacity to re inspect within this timescale. We have established weekly 'gold command' meetings to ensure we support the necessary improvements and developments.

Sign up to Safety Campaign – Following the Safer Care Conference in September, we are ready to pledge to sign up to Safety as an organisation. Our objectives will be aligned to the harm free objectives set out in our Quality Account.

MONITOR and TDA – A joint publication of an 'annual learning from mistakes' league table has been published drawing in data from the National Staff Survey 2015 and NRLS patient safety data, ahead of the Global Patient safety summit in March . We were amongst the 120 organisations rated as outstanding or good and rated 52 out of 120. 78 organisations had significant concerns and 32 poor reporting cultures.

In the forthcoming year there will be an expectation on FT's to publish a charter for openness and transparency so staff have clear expectations of how they will be treated if they witness clinical errors.

The quarterly safety report summarises the significant types and trends of incidents and serious incidents, including what we are doing to address and reduce harm through our Safer Care work.

**Governance Route/Approval Process**

This report was considered by the Safety Quality sub-committee at its meeting on 27th January 2016 and the Quality Committee on 18th February 2016.

**Recommendation**

The Board is asked to note the report.

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

**Quarter 3 2015/16 Quality Report -Safety**

**1. CQC Inspection and Improvement Plans**

Following previous updates, the improvement plans to address the findings from the CQC inspection in September/ October 2015 have been consulted on, finalised and shared with the CQC, Monitor, our commissioners, our council of governors and external partners which were involved in the quality summit on 29th January 2016. The full detail of the plans will be shared with all staff through a briefing from the IC:5 campaign in March/ April 2016. A key priority across the plans is around improving how we work in partnership with patients to ensure care is coordinated, enabling and personalised to meet the needs of each person.

The Oxfordshire CCG is the lead commissioner to sign off the completion of actions across all three improvement plans through the existing quality review meetings, on a quarterly basis. The CQC will monitor progress with actions through the existing routine relationship meetings held quarterly. Internally the improvement plans will be fed into the Trusts ongoing quality improvement work to align priorities and ensure sustainability. Internally progress with the plans will be monitored through an action plan review group which will include testing the completion of actions through post inspection reviews. The action plan review group will report monthly to the Extended Executive Team Meeting starting in March 2016.

The CQC has offered the Trust the opportunity for some of the core services rated as ‘Requiring Improvement’ and Luther Street GP Practice to be re-inspected and re-rated within the next few months (May/ June 2016) if the areas for improvement have been addressed. The re-inspection of the services rated as ‘Requiring Improvement’ will involve a visit to the ward/ team for about a day reviewing the quality of care against all of the five quality standards and not just the areas identified for improvements. Further details of the timescale for a likely re-inspection have been requested from the CQC.

**2. National initiative- Sign up to safety**

Sign up to Safety is a national initiative developed by NHS England to help NHS organisations and staff to develop a patient safety improvement approach and a positive and strong safety culture through sharing and celebrating progress and providing practical support. For more information go to <https://www.england.nhs.uk/signuptosafety/>

Following the safety conference in September 2015 and further work to develop our 2016/17 quality objectives the trust will be applying to the Sign up to Safety national campaign. The pledges and actions we identify will be aligned to the objectives under the quality priority of increasing harm free care (one of our trusts Quality Account priorities for 2015/16 and 2016/17).

**3. Global Patient Safety Summit March 2016**

Ahead of the global patient safety summit on 9th March 2016 Monitor and the NHS TDA published the first annual ‘learning from mistakes’ league table drawing on data from the 2015 national staff survey and the incident information submitted to the national reporting and learning system (NRLS), to identify the level of openness and transparency by NHS organisation. This year the league shows 120 organisations were rated as outstanding or good, 78 had significant concerns and 32 had a poor reporting culture. We were rated good, with a rank of 52 out of 230 organisations. In 2016/17 NHS Improvement (Monitor and NHS TDA) will be asking all trusts to publish a charter for openness and transparency so staff have clear expectations of how they will be treated it they witness clinical errors.

**4. Incidents**

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

The level of incident reporting has increased in Q3. It is now at the highest level in the last three years. Organisations reporting higher levels of incidents are generally considered within the NHS to be organisations with stronger safety cultures. Incident analysis by type and team is reported in detail to teams. This report identifies areas of strategic importance or exception.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 2014/15 [Q1] | 2014/15 [Q2] | 2014/15 [Q3] | 2014/15 [Q4] | 2015/16 [Q1] | 2015/16 [Q2] | 2015/16 [Q3] |
| 3032 | 2848 | 2963 | 3165 | 3207 | 3118 | 3338 |

*Table 1.*

* 1. **Incidents by actual impact**

The numbers of reported green and yellow incidents (low/minor injury or property damage) continues to represent the highest proportion of total reported incidents and have increased compared with Q1 and Q2 15/16.

Death and major injury/property damage have seen a marginal increase in numbers reported to Q2 but less than Q1 and less than the last two quarters in 2014/15.

There have been 37 deaths reported this quarter compared with 31 in Q2 and 49 in Q1.

* 1. **Incidents by type**

Top three groups by quarter

* Health (of which 79% of incidents relate to pressure ulcers)
* Violence and aggression (mostly with no jury or damage, and by patients on staff. The highest reporters were Sandford ward, Cherwell ward and Kestrel ward)
* Self-harm (there has been an increase in Q3 this relates to an increase in incidents on two wards; Highfield ward and Ruby ward)

Further detail by type/ cause group is below.

**4.3.1 Health related**

Health was the most commonly reported incident in Q3.  This cause group is used primarily for reporting pressure ulcers. There were 601 health related incidents, of which 475 concerned pressure ulcers.  This is slightly lower than the previous three quarters.

**Pressure ulcers**

In Q2 79% of health related incident were attributable to pressure ulcers compared with 61% in Q3. In February 2016 Oxfordshire CCG supported the trust to develop an action plan to identify how to systematically reduce pressure ulcers in the community, the plan has been finalised and is proposing to use improvement methodology within an agreed number teams across the District Nurse Services. The speed of working within all the 43 District nursing teams is limited by the improvement capacity to support this work at team level.

*Reduction in pressure ulcers safer care* Project with Henley District Nurses aims to reduce the number of acquired pressure ulcers, work underway with aim, driver diagram and meetings in place.

**VTE**

There were no reported incidents of a VTE/DVT reported in Q3.

**Sudden deterioration**

On one of the wards at Witney a safer care project is underway to ensure the recognition of and rescue of the deteriorating patient. A test of change is being set up with the MEWS Track and Trigger Tool. This particular issue has been raised as part of findings from more than one serious incident (SI).

Opal Ward are in the very early stages of beginning an additional piece of work which concerns improving the physical health of their patients.

**Other Safer care work in teams to reduce harm related to poor health and self harm**

*Reliable and safe referrals*

The *Day Hospital* has begun a project which aims to ensure the safe referral of patients into their service. Current focus is on a reliable process for referrals to be made to the team with a particular focus on the role of the shift- co-ordinator.

*Holistic assessments*

Oxfordshire Emeregcy Department Pshciatric Service (EDPS) work focusses on ensuring that 100% of all patients, where appropriate, have a full drug and alcohol assessment undertaken at first assessment and an appropriate plan for treatment in place.

**4.3.2 Violence and aggression**

Violence and aggression remains the second highest incident reported in Q3. The number of violence and aggression incidents however has reduced slightly for the third quarter with 557 incidents reported.

There were two serious violence and aggression incidents resulting in death and the details are below;

* The first incident was an alleged homicide. This was following the death of a member of the public in South Oxfordshire. The man arrested was a patient under the care an AMHT in Oxfordshire. A full internal RCA investigation is being currently undertaken and we would anticipate that this will be subject to an independent mental homicide review by NHS England.
* A second serious safeguarding incident was reported by the Witney Minor Injury unit. This is also being investigated.

Sandford ward remains the highest reporter of violence and aggression for the third quarter although numbers have fallen from 96 in Q2 to 66 in Q3. It is of note that both Cherwell and Sandford wards are both older adult wards and are reporting two out of three of the highest number of incidents of violence and aggression in the Trust. As is commonly found many of the incidents involve single patients and risk of harm is managed through multidisciplinary care planning.

Having sustained the improvement Phoenix Ward are commencing work on reducing incidents of violence and aggression. This work is currently in the diagnostic stage and they are forming a working group. They will continue to collect AWOL data at a reduced frequency thereby being assured that the improvement continues to be sustained.

**4.3.3 Self-Harm**

Self-harm was the third highest type of incident reported in Q3 and has seen a sharp rise in numbers reported compared with Q2. There were 516 incidents reported compared with 319 in Q2 and 407 in Q1. A significant number of increases in incidents were reported by two wards which will in part account for this overall increase in Q3.

The most common type of self-injurious behaviour was “cutting” followed by “Other” and “ligature”. “Other” consists primarily of activity such as head banging/deliberate injury to self, hair pulling, inserting sharp objects and trying to swallow objects.

There were no incidents reported in Q3 that resulted in major injury:

Highfield was the highest reporter in Q3. Learning form the work in Marlborough Hose Swindon, Highfield are undertaking a safer care initiate using the PDSA cycle to reduce self-harm incidents between 8.30 and midnight which is when incidents tend to peak.

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

*Always events in the assessment function of the AMHTs*

Each of the five AMHTs has begun work to adapt the ‘Always Events’ work undertaken in the former Crisis Teams. Current work focuses on the reliable management of Emergency and Urgent referrals and communication with the GP/referrer. Baseline process measures have been collected.

The data collection from all teams indicates that the first two measures, the entry of the referral in the electronic health record and the recording of the triage decision in electronnic health record are completed reliably. The data indicate that the communication of the triage decision to the GP/referrer in Urgent referrals should be made more reliable. Tests of change will therefore focus upon this area.

*Safe management of referrals*

Work in progress to put reliable systems in place for the safe management of referrals in the new single point of access for the Buckinghamshire CAMHS service.

*Support for patients at risk of serious self-harm*

The Oxfordshire OSCA developed a project with safer care to support seriously unwell patients with the aim of providing clearer cover to those at high risk of serious self-harm, and a smoother transition from Tier 3 to OSCA or T4 to avoid crisis referrals. The work has been completed and the new policy and procedures reflect the changes made to the service.

**4.3.4 Communication/Confidentiality**

Communication/confidentiality incidentshave remained the fourth most commonly reported types of incidents in Q3. There continues to be a gradual rise in incidents reported over the last six quarters.

A total of 299 incidents were reported in Q3 compared with 279 in Q2. Incidents reported were broadly spread out across services. These types of incidents relate to a range of issues including poor communication, IT failure/overload/outage, breach of confidentiality, record keeping, and admission and discharge problems.

There are consistent themes relating to usability and functionality of care notes. These themes are being feedback for resolution to the Care notes Project Board. The pace of improvement is slower than anticipated.

**4.3.5 Medication incidents**

Medication related incidents were the fifth highest type of reported incident again in Q3. There are no obvious trends to reporting noted. The types of medication error cover a wide range of types of incidents with 27 possible cause options. It covers the medication process from prescribing through to administration.

There were 264 incidents reported in Q3. Two of these are considered as near miss incidents which could have had more serious outcomes so are being managed as SIs. These are reported in the SI section below. Fortunately in both cases the error did not result in significant harm.

As previously reported there is work underway to improve the process for reporting medication incidents on Ulysses.

**4.3.6 Fall Related**

Fall related incidentswere the sixth most commonly reported type of incident in Q2 with 292 incidents reported. The numbers of reported falls have risen slightly from Q2 14-15 (Chart 8).

Falls in this cause group range from slips and trips; falls from bed/commode/wheelchair; being found on the floor and falling from a height. Most commonly, falls are reported which were unwitnessed.

The top reporters of falls in Q3 were Amber, Cherwell and Sandford Ward reporting 34, 32 and 18 respectively. There was one incident where a patient slipped and fractured their hip on Cherwell ward. This is being managed as an SI.

**4.3.7 Security**

Security related incidentswere the seventh most commonly reported type of incident again in Q3. Reported incidents have risen slightly since Q2 15-16. A total of 231 incidents were reported, of which 102 related to incidents involving AWOLs or patients failing to return/going missing. This is a further reduction in percentage terms compared with Q2. There were no serious security related incidents that occurred in Q3 that require management through the SI process.

*Patients missing from mental health inpatient wards – failure to return from leave*

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

The aim of the work is to reduce the number of times patients fail to return on time to the ward by 50% by 1st April 2015. Six wards have achieved this aim, Allen Ward patients return on time median 90% of the time, Phoenix Ward 90%, Vaughn Thomas 91%, Opal 96%, Wintle 87%. Sapphire (75%) and Ruby (68%) have made significant reductions and are continuing to work towards the 50% reduction.

**4.4 Incidents by Directorate**

Chart 6 gives the number of incidents reported over the last four quarters by the Directorates. The picture remains broadly similar with the older people’s directorate reporting significantly more incidents than the adult directorate and both of these reporting much more than the two remaining directorates. It would be expected that corporate services would report the smallest number of patient safety incidents.

*Chart 1: Incidents by Directorate*

**5. Analysis of restraints**

Previous reports have provided analyses of the physical restraint of patients and the use of seclusion from January 2011 to September of 2015. This report provides another three months of data. Particular attention is drawn to:

* A rise in the number of restraints in November 2015 and therefore the quarter due to therapeutic holds being used to feed patients by naso-gastric tube.
* A rise in prone restraints when looked at as a total rather than a percentage of all restraints. This is disappointing. Systems remain in place to review individual incidents and report use on a weekly basis and by exception.
* An update on the third round of national benchmarking of use of restraint and seclusion has taken place and
* An update on the change from PMVA to PEACE training.
* The second quarterly breakdown of use of long term segregation and handcuffs.

**5.1 Number of restraints**

There were 549 reported incidents of physical restraint in quarter one.

The gender of restrained patients has been a consistent finding with around 65% involving female patients. This figure had risen during 2014 to 75%, partly due to the repeated restraint of a small number of female patients.

The number of patients restrained five times or more is 24 this quarter (marginally higher than typically found for a three month period).

The PEACE training team have reviewed the incident data relating to the Highfield patient and the persons care plan as well as discussing the level and frequency of the intervention and the confidence of staff currently administering these interventions with senior clinical leads. The existing NPSA and NHS England guidance is clear that where nasogastric feeding is considered necessary that physical restraint or sedation may be needed. Mental health nurses trained in ‘safe control and restraint techniques’ can use these interventions to manage administration of the nasogastric tube, supported by the appropriate legal framework (it’s notable that there is no specific guidance on the level or types of holds that can or should be used).

**5.2 Restraints by Ward**

The five wards with the highest number of restraints are Highfield, Kestrel, Sandford, Kingfisher and Ruby. In the previous three quarters, Ashurst had a higher number of incidents than Ruby. All restraints are discussed weekly in the governance team’s meeting and the need for follow up of incidents identified. Debriefing incidents is a key part of our approach to the Trust’s overview of restrictive interventions and is available from matrons or the chaplaincy service. The PMVA/Peace team regularly attend areas experiencing an increase in the level of restraints to help with individual patients’ care plans or the team’s overall resilience and training needs.

**5.3 Reasons and Causes**

The incident form requires a ‘cause group’ to be selected for each incident. Many different types of cause group were selected but violence and aggression (42% of all incidents) followed by self harm (25%) remain the main reasons for restraint. The third highest cause this quarter was ‘helath’ at 22.5%, reflecting restraint for NG tube feeding. The other causes relate to restraints for administering medication and to prevent absconding.

Each quarter we report both the number of prone restraints and the percentage of all restraints that are prone. This does show a rise in this quarter that will need to be examined next quarter to see if the number of prone restraint is rising to previous levels and if so, why.

In quarter four, the recorded duration of restraint ranged from 1 minute to 24 minutes. No restraints lasted longer (compared to 2.9% -13% being an hour or more in previous reports).

*Reduction of restraint*

On the Highfield unit work is focussed on 50% reduction of restraint and is close to being achieved. Current focus is to reduce incidents of self harm which are a frequent precipitant of retraint. Examination of incident data informed the current test of change which consists of bringing forward evening break and night staff providing structured activities after the break.

**6. Use of Seclusion**

The total number of reported seclusions in Quarter 3 was 78 compared to an average of 99.5 incidents over the previous eight quarters. The previous three quarters have had higher numbers of seclusions due to the care plan of a young man on the Highfield unit.

In the past, the highest reporting ward has consistently been Ashurst with Ruby and Kestrel often following. Highfield Oxon had the highest number of seclusions for the last four quarters but with the discharge of the young man cared for in their ICA have not been using seclusion at all.

**6.1 Time in seclusion**

The recorded duration, according to the incident form ranged from 20 minutes to 8 days. The patient on Kestrel with 12 seclusions has spent several days in seclusion on more than one occasion. The persons care and care plan has been reviewed with the CQC on their two recent visits and confirmed as appropriate.

**7. Reduction in restrictive practice and Practice in Oxford Health- PEACE education**

Our review of our Trust’s training and practice around the physical restraint of patients has been reported on in previous reports. After a successful pilot of training for the Highfield team, a timetable to roll out PEACE training by grouped teams during 2016 has been agreed with teams.

**8. Analysis of deaths**

Our Trust assesses expected and unexpected deaths through the weekly clinical review meeting which is informed of all new deaths, the group reviews whether the death is a SI and as appropriate will review the initial incident reports (IIR) on these and determine which cases need to go to further RCA investigation. In Q3 overall there were 37 deaths reported (expected and unexpected, as well as those in our care and recently discharged). Detail of all deaths was provided to the Quality Committee in February 2016.

In December 2015 NHS England published a report into the deaths of people with a learning disability or mental health problems at Southern Health NHS Foundation Trust. A gap analysis is being done to review and improve our processes and procedures around investigating deaths (expected and unexpected), the outcome of the gap analysis will be reported to the Board of Directors in April 2016. The analysis is considering the extent of board leadership and scrutiny, quality of reporting and investigations, information management and involvement of families and other agencies involved in the patient’s care.

In January 2016 NHS England also asked all NHS organisations to submit information on the number of deaths and those deaths which were found to be potentially preventable over a 12 month period. Alongside our data submission we provided accompanying notes to explain the definitions and business rules used as very limited national instructions were provided and from conversations with three other providers information was being reported differently. The information on avoidable mortality rates is likely to be published identifying NHS organisations.

**9. Serious Incidents (SI)**

The total number of SI’s in Q2 was 31 and the number in Q3 currently was 23. This represents a further quarterly reduction following the peak seen in Q1 of 2015.

As previously reported, as part of the new SI framework introduced from April 2015 the Trust is reporting more incidents at an earlier stage and then, and when more information becomes available requesting downgrades.

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

The number of suspected suicides in Q3 has fallen further to five. Of these five, three are being managed as SI’s and two are currently not. The trend continues downwards. If the trajectory remains the same there will be a year on year reduction in the number of suspected suicides over the last five years. All of the reported suspected suicides reported as SIs in Q3 occurred in the community in the following teams: South Oxon AMHT, Prison Service Woodhill and CAMHS South.

**11. Never Events**

There have been no incidents meeting the never events criteria for three years.

**12. Summary of homicide investigations**

* + 1. In Q3 one new homicide was reported.
    2. In Q2 a historical external homicide review was reported which had been subject to an external review of the impact of service remodelling has been completed and the draft follow up report is completed.
    3. A Domestic Homicide Review (DHR) has been commissioned into the homicide of a man who had been known to our services. A male unknown to our services has been charged with murder, and his ex-partner and another woman have been charged with conspiracy to commit murder.
    4. A DHR was commissioned into a triple homicide that took place in May 2015. A man killed three members of his family then died by suicide before he could be located by police. Oxford Health is contributing to the DHR as there had been brief historic contact with both the alleged perpetrator. The process is ongoing. Our involvement was reviewed and was historical, did not meet the SI criteria and therefore has not been included in the SI data.

**13. Fire Safety**

In the last three months (up to FY15 Q3) there have been 94 reported incidents relating to fire safety, broken down into the below types.25 out of 94 incidents in total were smoking related. The Smoke Free Programme Group has met in February and the need to increase the work in AMHTs to promote smoking cessation out of hospital and ensure staff remains confident and actively to educate patients throughout their admission has been identified as areas to improve.

The majority of the incidents relate to inpatients smoking indoors. Over the last 12 months the wards reporting the highest number of smoking related incidents are; Sapphire Ward (19), Lambourn House (21), Phoenix Ward (29) and Watling Ward (86). Smoking related detected incidents are down from 53 (Q2) to 25 this quarter; however this is believed to be due to two main reasons; under-reporting of incidents, and patients are smoking in areas that are not covered by smoke detectors e.g. bathrooms and shower rooms (wet areas) and therefore not activating the fire alarm system.

In the last quarter (Q3) there has been a reduction of fire incidents. Only 1 incident has been recorded, which occurred on Ruby ward Aylesbury as a result of arson because a patient became distressed and set light to a towel which was extinguished by ward staff.

The trust was issued with a notice to take action relating to Phoenix Ward and the main admin building at Littlemore on 15th December 2016 due to an increase in false alarms, contractors not following fire safety regulations during the refurbishments, an issue with the air lock downstairs when the fire alarms were activated and how the trust has acted on advice previously given.

Following an increase of false alarms, mostly from the Littlemore site, the Oxfordshire Fire and Rescue Service have attended over a number of quarters. The Trust met with the Fire Service in January 2016 to provide reassurance that appropriate management is in place and that actions are being taken particularly around the number of unwanted fire signals they are attending. The reasons for the increased unwanted fire signals relates to a number of factors including a number outside the control of the trust, all of which have now been resolved. The issue surrounding how we manage unwanted fire signals has become problematic over the past few years, however with the re-introduction of site managers (previously called building managers) with clearer responsibilities, closer working between the estates and facilities team and the fire advisors through weekly meetings and a planned change to the membership of the fire safety group to include more senior managers, the monitoring and response to issues is improving.

**14. Duty of candour ‘being open’**

In Q3 2015-16 there were 36 SI investigation reports reviewed at 34 SI panels. The increase in the number of panels being scheduled is as a consequence of the peak in SI reporting in Q1 and Q2 this year.

* For 27 of the SIs contact was made with the patients/families.
* In 20 cases the patient and/or family contributed to the investigation.
* In 14 cases the patient and/or family did want feedback after the investigation. In the remaining cases there were a number who did not want feedback as they had no concerns about the care and a number who had been contacted but not responded so it was unknown whether they wanted feedback or not. It is our routine practice to write again at the end of the investigation to advice that the investigation is complete.
* In three cases no contact was made, either because the incident did not directly and significantly harm a patient or the incident was found not to meet the criteria for an SI and no harm was sustained. These decisions are made by Directors at the panel and the rationale recorded.

**15. Themes from serious incident investigations and panel activity**

Of the 36 SI investigated the themes by directorate are shown below. Of the 36 SI reports reviewed in Q3, 4 have been downgraded by CCG’s and a further review is being considered for downgrade by NHS England (relating to and SI of serious self-harm in HMP Huntercombe). This accounts for 14% of all of the reviewed reports, which has been a consequent of the introduction of the new national SI framework introduced in April 2015.

The themes from the SI investigation reports are detailed below.

* Communication and handover
* Risk assessment at the point of a change in patient condition and care planning
* Management of diabetes
* Management of the deteriorating patient
* Clinical leadership and oversight of caseload
* Training attendance and competence assessments
* Lack of a holistic approach to care
* Documentation e.g. incomplete care plans, missing assessments, not copying letters to GPs
* Effect of the migration of electronic patient records to Care notes
* Patients leaving the Emergency Department
* Referral for specialist advice e.g. tissue viability service
* Care coordination
* Gap in provision for people with a hearing deficit or who are deaf
* Staff work pressure, fatigue and capacity
* Fire system design and wider fire management concerns (see 4. Fire safety)
* PMVA and staff security

**16. Engagement with the SI process**

Of note is the continued good level of engagement that SI reviewers report from clinical teams across all specialities. Additionally, the engagement of subject experts across the Trust has supplemented the quality of reports and the emerging learning. Developing the skills of reviewers in utilising internal and external experts will continue through 2016 alongside enhanced and consistent contact with families during and after the RCA process which will be monitored through a quality audit applied to all RCA investigations.

Over the next few months actions are being taken to improve the timeliness and quality of investigation reports and to review the effectiveness of SI panels.

**17. Infection Prevention and Control February 2016**

**Community health services**

There have been no cases of *Clostridium difficile* infection (CDI) in February.

The health economy review meetings are held on the 2nd Monday of every month and will continue to review all cases for avoidablitity.

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Month | Location | Running total of cases | Avoidable/Unavoidable | Running total of avoidable |
| November 2015 | City | 6 | Avoidable-restested known positive | 1 |
| December 2015 | Linfoot ward, Witney | 7 | Unavoidable | 1 |
| January 2016 | No cases | 7 | N/A | 1 |
| February 2016 | No cases | 7 | N/A | 1 |

**MRSA bacteraemia/MSSA bacteraemia**

There have been no Trust attributable MRSA or MSSA bacteraemia cases in February.

**E.Coli bacteremia**

There have been no E.Coli bacteremia’s identified.

**Outbreaks**

There has been confirmed norovirus outbreak on Ward 1, Abingdon hospital affecting 14 patients and 4 staff. The whole ward was closed from 20th-25th February and then began a phased reopening following a full terminal cleans of affected bays. The entire ward was open and operating normally on 7th March.