

**Report to the Meeting of the**

**BOD 46/2016**(Agenda item: 6)

**Oxford Health NHS Foundation Trust**

**Board of Directors**

**27th April 2016**

**Quality and Safety Report**

**Quarterly Clinical Effectiveness Report**

**For: Information**

**Executive Summary**

This report provides a summary of the Trust’s position, primarily in Quarter 4 (January–March 2016) in relation to the Key Lines of Enquiry (KLOE) which are considered by the Trust’s Quality Sub-Committee - Effectiveness (QSCE).

The QSCE is now fully functioning and has reports from all meetings in relation to the Key Lines of Enquiry. The following issues are highlighted to the Board:

*2.0 CQC progress*

Over the next year one of our key priorities will be around making care a joint endeavour with patients, families and carers. Internal and external monitoring arrangements have been established for the improvement plans. The first monthly highlight report went to the Extended Executive Team meeting on 21st March 2016. Both Older Adults and Children and Young People have completed all agreed post CQC actions.

In Adults the proposal is for the actions relating to the following core services is to be prioritised for the next two months; adult acute mental health wards, rehab ward and adult mental health teams. 30 actions were due to be completed by 29th February 2016 and of these 24 have been reported as completed. Testing and evidence is required before actions can be signed off as complete. Further work will be completed in the next action plan review meeting on 18th March 2016 to follow up actions which are overdue.

*3.0 Clinical audit*

The number of outstanding improvement plans from completed audits has further reduced and at the time of writing the report all but two plans had been submitted within the target timescale and there were no outstanding actions from audits. This represents a significant and sustained improvement by all directorates. Within the last quarter, two baseline audits and seven re-audits have been completed and reported; two new audits were added and two removed from the plan.

As reported in January, the current audit plan continues to be unmanageable with twelve audits in progress but behind schedule and ten audits from 2016-17 not yet started with proposals to carry forward to the 2017-18 plan. 15 audits are in progress and on schedule.

A Paper was presented to the Board in February 2016 in regards to suggestions for a change of approach in the new financial year. The rationale for this was the scale of the commitment, the resources available to deliver the programme in a timely manner and the impact on clinical staff to be able to deliver high quality care in the context of many competing demands. The board supported in principle the proposal.

The QSCE will be asked to advise on how to take this work forward given the new draft plan has not yet been signed off and there are already approximately fifty one audits on the programme.

The main themes arising from the audits reported in Q4 15-16 were:

* Documentation (completeness and quality) in general is a recurring theme and one that is intrinsic to clinical audit as results are most commonly based on evidence found in the clinical record. The pressure ulcer audit highlighted a lack of regular reviews of the Braden pressure ulcer risk assessment score and the DNACPR audit highlighted a lack of documentation relating to the decision in the clinical record.
* Change over to CareNotes – This continues to be a challenge and the CPA results continue to highlight issues with service user and carer involvement in care planning. This is under review and work is being undertaken to embed recovery-focused care planning through the CQC action plan and the work being undertaken around the Triangle of Care.

Clinical Policies

There continues to be improvement in relation to clinical policies. There are currently no clinical policies out of date and a further one due to be reviewed by December 2016.

4.0 NICE guidance

In line with the above, a NICE Implementation Group has been set up. This group (a sub-group of the Clinical Audit Group) has now met on three occasions. This reports to the Quality Subcommittee Effectiveness (QSCE).

It has been agreed that each of the three directorates will oversee NICE implementation within their clinical services and report back to the group. Each of the three directorates are currently progressing with their gap analysis together with implementation plans and approaching this in slightly different ways.

Part of this process will include identification of the process for NICE guidance once it has been sent to the directorate. Children and Young people’s directorate and Older Adult have completed their process, which the Adult are currently reviewing.

Each of the three directorates now has active plans, systems and processes for NICE guidance and work has now commenced in each directorate. The group will produce a detailed report for the next QSCE providing an update of progress against the baseline situation reported in January 2016.

*5.0 Mental Health Act*

Associate Medical Directors are actively taking issues raised to their respective Directorates and though there is evidence that this is resulting in improved compliance by staff, the presentation of rights under Section 132 continues to require improvement. Compliance in recording of leave/CTO consideration and consent to treatment has improved.

CQC visits have resulted in a number of recommendations relating to care planning and patient involvement.

The CQC continue to make recommendations with respect to these areas of practice requiring improvement.

Directorates are not always treating the CQC reports and Trust responses as working documents. This is particularly so with any recommendations relating to environment or requiring action by estates and facilities.

6.0 Infection Control

There have been no Trust attributable MRSA or MSSA bacteraemia cases in January, February or March 2016.

There were no cases of *Clostridium difficile* infection (CDI) in January or February 2016 and two cases reported in March 2016.

There has been one E.Coli bacteraemia identified this year. In March 2016 a community CCG E.Coli bacteraemia patient was identified on 2nd March 2016 when seen in EMU at Abingdon. An RCA was completed.

In January, there were two outbreaks of diarrhoea and vomiting to report. The first was a suspected outbreak affecting four patients and two staff. Precautions were in place throughout and the ward was full. The second large suspected norovirus affected 21 patients and 27 staff. The whole ward was closed from 18th-23rd January and then began a phased reopening following a full terminal cleans of affected bays. The entire ward was open and operating normally on 28th January.

In February, there was a confirmed norovirus outbreak 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.

In March 2016 there was a confirmed norovirus outbreak affecting 15 patients and 1 member of staff. The whole ward was closed from 24th-31st March and was reopened following a full terminal cleans of affected bays.

Generally the county has had a ‘Busy’ quarter for outbreaks of norovirus. One older adult ward had two outbreaks in January and March 2016. The outbreaks were too far apart in time to link them. The Infection Control matron carried out an informal check on the ward in March 2016, a few days prior to the second outbreak. At this time there were no immediate causes for concern identified.

7.0 Aims accreditation for Older Adult mental health inpatient wards

Work continues to progress within the AIMS Project Team in the Older People’s directorate. The services have completed the ‘starter’ paperwork and are now in the self-assessment phase in the older adult mental health wards

*8.0 Learning and Development*

Following the 2015 CQC inspection, the Inspectors noted that, “Staff had good access to mandatory training and good induction programmes, as well as opportunities for continuous professional development.” The 2015 Staff Survey reported; Top ranked for the ‘Quality of non-mandatory training, learning or development’. The Quality of appraisals are ranked as ‘performed better than average’

However, there was an identified need to continue to work with staff to ensure mandatory training specifically resuscitation is completed and the Trust was bottom ranked for the ‘Percentage of staff appraised in last 12 months’.

Future Issues or concerns:

A project to review the mandatory Patient and Personal Safety Training framework has completed this year. The framework now contains only the activities that are national aligned and agreed to be statutory & mandatory by all NHS Trusts. Indicative mapping of the framework is to the Care Quality Commission Essential Standards of Quality and Safety (2010) (England).

This enables comparable benchmarking to be undertaken. The review achieved greater clarity and understanding of the requirements for the PPST framework.

From 1st April 2015 Trust policy required each employee’s PDR/appraisal to be aligned with Agenda for Change and be completed approximately 4-6 weeks before their increment date. At FY15/16 end the recorded number of completed was 74%. The 2015 staff survey reported 81% of the 49% of employees that responded. A new online PDR system is planned for launch in May 2016, which will further support the completion of high quality PDRs/appraisals.

Action plans are in place for Resuscitation, Information Governance & Fire safety training.

9.0 Medication Management

Areas of good practice:

* All current NHSE Patient Safety Alerts have been implemented
* Shared care guidelines are all in date and effective
* MSGG is effectively reviewing trends of medicines incidents
* PGDs are all up to date including those developed by NHSE for national immunisation programmes.

Areas of risk:

* The group doesn’t have a patient / carer representative as per its terms of reference.
* Ongoing issue with new format and distribution of BNFs – Edition 7- still to be distributed.
* Audit of Olanzapine LAI undertaken by one of our pre-registration pharmacists shows some deficiencies in post-injection monitoring (this audit has recently won a regional prize)
* POMH audit for ADHD (CAMHS) – monitoring requires improving
* Vortioxetine – red listed by Bucks CCG (different to rest of country)

Future Issues:

* Potential risk of misuse / abuse of clozapine – case reports from Nottingham discussed. Memo will be circulated to prescribers and clinical staff.
* Ongoing difficulties with moving medicines from hospital only use to shared care / GP prescribing e.g. pregabalin

10. Research and development

The pre-qualifying questionnaire (PQP) for the Bio-medical Research Centre application was submitted in February 2016

A decision was made to confirm that the Collaborative Research Fund (CRF) renewal

The Trust has given 6 months’ notice to terminate the D CRIS service contract with SLAM.

The Trust has agreed to move over to UK CRIS, which will not require SLAM service support. It is hoped that UK CRIS will be available in April 2016, but if this is delayed there is still access to the current D CRIS until October 2016 when the contract ceases.

R&D is still working hard to integrate the changes to governance processes regarding the Health Research Authority, through which all studies will need to be approved.

Assessing the feasibility of research studies is ongoing and progress is being made to integrate with clinical teams to understand and involve them.

Discussion with the CRN is ongoing in terms of supporting research in clinical areas other than mental health. The Trust is currently achieving 100% target of recruiting the first patient into a study within 70 days of receiving a valid research application. Last quarter this was 86%, but has a tendency to fluctuate due to low numbers of studies (typically 10).

## CRIS is operational and 3 research applications have been approved, but due to static data set there is not as much uptake as anticipated. Hopefully this will change when UK CRIS is operational.

1. Public Health

The Public Health Strategy was approved at the Quality Committee on 18.02.16

A stall was presented at the most recent senior Leaders conference to highlight work

The breadth of public health work is large – the group will continue to focus on identified priorities to manage this.

1. Human Resource

There are no clearly identified themes from HR casework with the exception of managing HR processes.

3 new investigations under the Management of Concerns policy have commenced since the October 2015 report. This brings the total number of investigations during 2015 to 5 (compared to 6 during 2014).

1. Ethics

There is nothing specific to report. The group continues to meet regularly to discuss challenging ethical issues.

1. Estates

Our current self-assessment indicates that Estates score a GOOD rating. No areas of risk have been identified.

**Recommendation**

This report is for information.

**Author and Title:**

* **Rebecca Kelly, Trust Professional Lead for Occupational Therapy,**
* **Susan Haynes, Head of Nursing;**
* **Sandra Parker, Clinical Audit Specialist;**
* **Mark Underwood, Head of Information Governance;**
* **Helen Bosley, Infection Prevention & Control Matron.**

**Lead Executive Director: Dr. Mark Hancock, 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 Key lines of enquiry (KLOE) for the Quality Sub-Committee Effectiveness (QSCE) 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 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 focus of the QSCE is to seek assurance that the organisation is compliant 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. **CQC Inspection and Improvement Plans**

Following previous monthly updates, a staff briefing from the IC:5 campaign went out in April 2016 sharing the full detail of the improvement plans and next steps. Over the next year one of our key priorities will be around making care a joint endeavour with patients, families and carers as we have seen that when people are at the heart of their own care, their care is better. Internal and external monitoring arrangements have been established for the improvement plans, the first monthly highlight report went to the Extended Executive Team meeting on 21st March 2016, a summary of the update against actions is below.

Luther Street GP has completed the actions identified and was invited by the CQC to request a review of the service rating with the hope of moving from a good to an outstanding overall rating. The evidence to show the actions have been completed was sent to the CQC in March 2016 and we are waiting for the outcome of the review.

Due to the positive findings during our inspection we have been given a chance for a focused re-inspection of some of our adult mental health services in June 2016, and we look forward to welcoming the inspection team back. This gives us a great opportunity to demonstrate that we have addressed the findings and actions identified.

Progress with the improvement plans

The last action plan review meeting prior to this report was 26th February 2016.

Adult Directorate:

The proposal is for the actions relating to the following core services to be prioritised for the next two months: adult acute mental health wards, rehab ward and adult mental health teams.

30 actions were due to be completed by 29th February 2016, and of these 24 have been reported as completed. Testing and evidence is required before actions can be signed off as complete. Further work will be completed in the next action plan review meeting on 18th March 2016 to follow up actions which are overdue.

Across all core services the majority of actions should be completed by early June 2016. The actions which will take more time to fully complete are around:

* Reducing the waiting times for patients needing specialist psychological therapy treatments
* Building work around poor ventilation on Ruby and Sapphire ward kitchens
* Continued work around embedding a culture of patient-centred care which is demonstrated in care planning meetings with patients where staff, patients and their carers/families are working in partnership.
* Proposed changes to the care plan and risk assessment format in CareNotes.

Children and Young People Directorate:

19 actions were due to be completed by 29th Feb 2016 and all have been completed. Testing and evidence is required before actions can be signed off as complete.

Older People Directorate:

13 actions were due to be completed by 29th Feb 2016 and all have been completed. Testing and evidence is required before actions can be signed off as complete

1. **Trust wide Clinical Audit**

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

There is one final audit still to report from the 2014/15 clinical audit plan. It is the National CQUIN audit of Cardio metabolic risk factors and the Trust has no control over when the report will be published. The audit report was scheduled by NHS England to be published in June 2015. This was embargoed due to the General Election and despite four attempts to request an update none has been forthcoming.

**Progress update against the trust wide audit plan for 2015/16 for audits scheduled to be undertaken during Quarter 1, Quarter 2, Quarter 3 and Quarter 4**

As reported in January, the 2015/16 Trust wide audit plan continued to be unmanageable with 12 audits that were in progress but behind schedule and ten audits that had not yet started with proposals to carry them forward to the 2016/17 plan. This is still the current status although some relate to different audits

**Changes to the 2015/16 Trust wide audit plan**

**Audits to be removed from the 2015/16 audit plan**

Since the last report to the Sub-Committee: Effectiveness in January 2016, a total of two audits are to be removed from the 2015/16 audit plan. Table 2 below provides the details of the audits to be removed and the rationale.

Table 2

|  |  |
| --- | --- |
| **Name of audit** | **Reason for removal from the 2015/16 audit plan** |
| National audit of Diabetes | This was listed on HQIP’s Clinical Outcome Review Programme and was initially identified as a possible national audit that Oxford Health may have been eligible to participate in. It has now been confirmed that community hospitals and mental health trusts were not eligible to participate. |
| Access to Healthcare for People with Disabilities (Older People’s directorate) | Director of Nursing & Clinical Standards has agreed that a local audit does not have to be undertaken by the Older People’s directorate as there are plans to create a project lead at strategic level for people with learning disabilities. |

**Audits to be added to the 2015/16 audit plan**

Since the last report to the Sub-Committee: Effectiveness in January 2016 there are two audits that need to be added to the 2015/16 audit plan. Table 3 below provides further details of the audits and the rationale.

Table 3

|  |  |
| --- | --- |
| **Name of audit** | **Reason for inclusion on the 2015/16 audit plan** |
| NCEPOD Young People's and Young Adults Mental Health study | This is a new national audit announced in December 2015 and the Trust is required to participate. |
| National audit of COPD | It was previously reported to CAG that the Trust did not participate in this national audit. There has been confusion about our Trust’s participation as there are 4 national work streams to this audit. Oxford Health participated in the Pulmonary rehabilitation: audits of patients attending pulmonary rehabilitation, and outcomes at 180 days, plus the organisational audit of the resourcing and organisation of pulmonary rehabilitation services for COPD patients. The national report is currently being summarised by the corporate audit team and it is anticipated that this will report to the next CAG. |

**Prioritisation of the 2016/17 Trust wide audit plan**

A Paper was presented to the Board in February 2016 in regards to suggestions for a change of approach towards clinical audit in the new financial year. The rationale for this was the scale of the commitment, the resources available to deliver the programme in a timely manner and the impact on clinical staff to be able to deliver high quality care in the context of many competing demands. The board supported in principle the Option 4 proposal.

* Continue to participate in all national and commissioning audits
* Continue to participate in the annual POMH-UK, Infection Control and medicine management eg controlled drug audits
* Work with commissioners to negotiate appropriate clinical audits at the start of each FY, looking to reduce the number of audits to those which will have an impact on the quality and or safety of care.
* Cease all non-mandatory trust wide clinical audits and replace with a schedule of locally developed  (directorate) improvement plans whose effectiveness are being checked by local audits.  In this way audits would be risk based and focussed on the priority issues.

An example of this proposal would be that each service would develop their own audit tool looking at the key and high risk areas for them equivalent to the Essential Standards bi-monthly audit across inpatient mental health.  These audit tools would have to incorporate identified high risk elements that we might otherwise have had to undertake a separate audit for, e.g. components of the Mental Capacity Act audit.  These new rolling audits would need to be completed at least quarterly and be subject to regular review and amendment by the service to ensure they remain relevant.  It is anticipated that the service area and directorate senior management team would fully own their audit and clinical staff would be able to address any areas for improvement immediately without the need for formal improvement plans. Findings would inform local improvement activity and further support peer to peer quality reviews.

Option 4 would require a fundamental change in the way clinical audit is conducted and will mean a gradual shift towards reducing the number of internal audits as an interim measure to reduce the frequency of some audits while the project is scoped and developed. This would release some of the pressure on the audit team to support the project but would require a formal project board chaired by the medical director with representatives from each directorate and a risk register. It is also recommended we would need a project coordinator for 12 months with extensive and detailed understanding of clinical audit and national and local requirements to work with each service area to help them to develop and implement a new ‘essential standards’ audit which supports them with ongoing improvement.

**Draft 2016/17 Trust wide Clinical Audit Plan**

Clinical audit priorities are selected on the basis of national requirements, commissioning requirements and local evidence, including where analysis of incidents and complaints have established specific areas for improvement.

There are currently a total of 45 proposed clinical audits on the draft clinical audit plan for 2016/17. This is before any consultation with the Risk Team, Complaints Team and Directorates. Sixteen of these are national ‘must do’ audits and include the national CQUIN audit requirements. Table 4 below provides further details.

**Table 4 - Draft 2016/17 Clinical Audit Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Audit Name** | **Rationale** | **Directorate** |
|  | **National audits** |  |  |
| 1 | CQUIN Mental Health - Cardio Metabolic assessment and treatment for Patients with psychoses (Q3) | National 'must do' | All Mental Health |
| 2 | CQUIN Mental Health - Communication with GPs (Q2) | National 'must do' | All Mental Health |
| 3 | POMH-UK Topic 11c Prescribing antipsychotic medication for people with dementia (April 16) | National 'must do' | Older People |
| 4 | POMH-UK Topic 7e Monitoring of patients prescribed Lithium (June 16) | National 'must do' | Adult/Older People/Forensic |
| 5 | POMH-UK 16 - Rapid tranquillisation (Sept 16) | National 'must do' | All Mental Health |
| 6 | POMH-UK Topic 1&3 Prescribing high-dose and combined antipsychotics (Jan 17) | National 'must do' | All Mental Health |
| 7 | Falls and Fragility Fractures Audit programme (FFFAP) | National 'must do' | Older People |
| 8 | Sentinel Stroke National Audit programme (SSNAP) | National 'must do' | Older People |
| 9 | National Diabetes Audit (Possibly relevant)- (footcare and possibly inpatients) | National 'must do' | Older People |
| 10 | National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary rehabilitation | National 'must do' | Older People |
| 11 | Child Health Clinical Outcome Review Programme - Chronic Neurodisability | National 'must do' | C&YP & Older People (Community Therapy) |
| 12 | Mental Health Clinical Outcome Review Programme - Suicide, Homicide & Sudden Unexplained Death and Suicide in children and young people | National 'must do' | All Mental Health |
| 13 | Learning Disability Mortality Review Programme (LeDeR) | National 'must do' | Trust wide |
| 14 | Urgent Care telephone triage NQR4 (DOH requirement) | National 'must do' | Older People |

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| --- | --- | --- | --- |
|  | **Internal audits** |  |  |
| 15 | Infection Control Programme: bi monthly hand hygiene audits | Health and Social Care Act: Code of Practice (2008) ('Must do' audit) | Trust wide |
| 16 | Infection Control Programme: annual infection control audits (Quarterly reporting) | Health and Social Care Act: Code of Practice (2008) ('Must do' audit) | Trust wide |
|  | **Bi-monthly internal audits** |  |  |
| 17 | Essential Standards (Bi-monthly reporting) |  | All Mental Health |
|  | **Quarterly internal audits** |  |  |
| 18 | DNACPR quarterly audit | This is a request from the Director of Nursing that this audit is scheduled quarterly in 2016/17 and completed by matrons. Was previously a yearly one-off audit which was rated as requires improvement in 15/16 | Trust wide |
| 19 | Review of cardiorespiratory arrests | This is a request from the Director of Nursing that this audit is scheduled to report quarterly in 2016/17. Was previously a yearly one-off audit which was not subject to the audit rating matrix. | Trust wide |
| 20 | Resuscitation equipment audit | This is a request from the Director of Nursing that this audit is scheduled quarterly in 2016/17 and completed by matrons. It was completed by the Resuscitation Officer in 2015/16 and is still due to report. | Trust wide |
| 21 | Medicines Management - Quarterly Antimicrobial prescribing audit | Health and Social Care Act: Code of Practice (2008) ('Must do' audit) *Criterion 3 is about antimicrobial use and antibiotic resistance prevention.* | Trust wide |
| 22 | Track and Trigger (Community Hospitals) | Quarterly audit | Older People |
| 23 | Full CPA Audit for Community Teams | Quarterly audit | All Mental Health |
| 24 | Safety Thermometer Adult Mental Health - reduction in harms | Quarterly audit | Adult Mental Health |
| 25 | Safety Thermometer Classic - reduction in harms | Quarterly audit | Older People |
| 26 | Community Hospitals documentation audit | Quarterly audit | Older People |
| 27 | Medicines Management - Bi-annual reporting of rolling audit of safe and secure storage of Controlled Drugs | Quarterly audit that reports 6 monthly  Controlled Drug (Supervision & Management of Use) Regulations 2013. National ‘must do’ audit – part of CDAO responsibilities. Quarterly audit that reports 6 monthly (*frequency set out in related DH guidance adopted by CQC. Local decision to report 6 monthly to allow effective action planning and implementation).* | Trust wide |
| 28 | Medicines Management - Re- audit of the Safe & secure handling of medicines (Ward visits) | Quarterly audit that reports 6 monthly  CQC essential standards requirement based on DH guidance. Annual audit that reports 6 monthly (*data collection on a rolling programme. All in-pat units audited annually but not all at same time hence 6 monthly reports. FY 16/17 extending to community teams for baseline).* | Trust wide |
|  | **Audits carried over from 2015/16 audit plan** |  |  |
| 29 | Re-audit of the management of violence and aggression | Carried over from 2015/16 | Trust wide |
| 30 | Re-audit of care standards for non CPA cases | Carried over from 2015/16 | All Mental Health |
| 31 | Mental Capacity Act re-audit | Carried over from 2015/16 | Trust wide |
| 32 | Re-audit of NICE Clinical Guideline 133 Self – Harm : Longer term management | Carried over from 2015/16 - may link to work being undertaken on NICE gap analysis | All Mental Health |
| 33 | Re-audit of the self-assessment of how ‘family friendly’ mental health wards are | Carried over from 2015/16 - Could it be picked up as part of the Peer reviews? | All Mental Health |
| 34 | Baseline audit of Long Term Segregation | Carried over from 2015/16 - now reported on at weekly review meeting | All Mental Health |
| 35 | Medicines Management - Re-audit of the prescribing and monitoring of patients on Insulin | Carried over from 2015/16 rated as requires improvement - to be completed in FY16/17 following completion of quality improvement work | Trust wide |
| 36 | Medicines Management - Re-audit of the quality of prescribing for high risk medicines - Warfarin & Low Molecular Weight Heparin | Rated as unacceptable in 2014/15 and carried over from 2015/16. To be completed in FY16/17 following completion of quality improvement work | Trust wide |
| 37 | Baseline audit of Rapid Tranquilisation (there is a POMH audit planned for RT in Sep 16) | Carried over from 2015/16 | All Mental Health |
| 38 | Medicines Management - re-audit of Allergy/sensitivity recording | NICE CG 183 implementation also relates to CQC Are we safe? |  |
| 39 | Medicines Management - Re-audit of drug prescription & administration chart which includes compliance to consent to treatment for patients subject to Section 58 of the Mental Health Act (T2 / T3) | NHS Records Code of Practice & Section 58 of the Mental Health Act requirement. Carried over from 2015/16 – Could be included in Peer review | Trust wide |
| 40 | Audit of MEWS (OAMH - Quality Account requirement in 15/16) | Quality Account requirement in 15/16 | Older People |
| 41 | Re-audit of the timeliness and quality of inpatient discharge summaries (MH) / discharge letters to GPs from community hospitals | Schedule 4 contract requirement for Community Hospitals & Mental Health wards | Older People & Mental Health |
| 42 | Nutritional Screening - Carry forward to the 2016/17 Trust wide audit plan as a new nutrition and hydration policy is being implemented. The new policy picks up both malnutrition and overweight/obesity issues. |  | Trust wide |
|  | **Audits rated as requires improvement in 2015/16** |  |  |
| 43 | Re-audit of the Safe & supportive observations of patients at risk | Rated as requires improvement in 2015/16 | All Mental Health |
| 44 | Re-audit of the quality of Section 2 assessments | Rated as requires improvement in 2015/16 | All Mental Health |
| 45 | Audit of pressure ulcer management in Older People's Directorate (CHs, DNs & OAMH) | Rates as requires improvement in 2015/16 for District Nursing Service - needs to be rolled out across OAMH wards and Community Hospitals. | Older People |

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

It was previously reported to the Sub-Committee: Effectiveness in January 2016 that there were a total of 5 improvement plans that had not yet been completed and returned within the 6 week time frame. This figure has decreased to 1.representing ongoing improvement

**Monitoring of actions from improvement plans**

The number of audit actions currently in date has reduced from 65 at the end of quarter 3 to 50 at the end of quarter 4. The number of out of date actions has decreased from 7 to 0. Similarly this represents ongoing improvement

**Service User and Carer Led CPA audit**

This is the first clinical audit project where we have tried to engage service users and carers in the clinical audit process in a meaningful way. Following a presentation by service users at the Trust Learning Event back in June 2015 from the Wellbeing Group at Chiltern Adult Mental Health Team an approach was made by the audit team about involving service users in the clinical audit process.

Subsequently, members of the Chiltern Adult Mental Health Team, led by Maria Goldson (OT) and Sandra Parker (clinical audit specialist) from the Oxford Health’s Audit Team initiated a joint piece of work to engage service users and carers in the clinical audit process.

Summary of the audit findings:

The audit results regarding care planning are also reflected in the Trust’s quarterly CPA audit results. In the last Trust audit, the number of service users that had an updated care plan within the last 12 months was 88%, compared to 80% in this audit. Although this is rated as good result it is still an area that needs improvement.

The recording of sharing of care plans with the service user and carers was also identified as an issue from the Trust’s quarterly CPA audit. This was also identified as an area for improvement following the recent Care Quality Commission (CQC) inspection. The results of this audit showed that there was documentation of the care plan being shared with the service user in 33% of cases.

The CQC report found that patients’ needs were being assessed and did observe collaborative interactions with individuals; however, some of the subsequent care plans were not personalised and did not include the service user’s views. They also highlighted the fact that not all care plans were up to date, sufficient or recovery focused. The audit results also reflect the CQC findings as the audit found the following:

* 43% had the management of physical health / health promotion recorded in the care plan
* 35% had the levels of social support / social inclusion / daytime activities recorded in the care plan
* 20% had the employment status (paid/unpaid) recorded in the care plan
* 45% had referral / sign posting to voluntary or third sector organisations recorded in the care plan

Social inclusion is at the core of the Recovery Star focusing on areas such as housing, benefits, and daytime activities. This is not an area that is covered by the Trust’s CPA audit and the results from this audit confirm that this is an area that also requires improvement as at the time of the audit only 22% of service users had a Recovery Star completed with them.

The Trust is already aware that there is an IT issue with the Recovery Star section of Care Notes and staff are unable to complete this document electronically. However, since this audit was undertaken, Chiltern AMHT now have over 450 Recovery Stars in place, which will help in improving how we record and demonstrate patients’ involvement in their own care planning as well as ensuring consistent high quality records of care plans and assessments.

The audit results for the recording of carer’s assessments is an area identified for improvement. The Trust has recently undertaken a self-assessment against the Triangle of Care and has identified actions to be taken to improve. A standard operating procedure is to be developed to standardise the recording of information about carers which will address the recording issues identified in this audit. A lack of training for clinical staff in addressing the needs of carers was also identified and a joint project is underway between MIND and Oxford Health with the input from carers to develop this training which can then be rolled out across the services.

A local action plan has been developed and will link to the Directorate’s CQC action plan.

**Summary of the results from the clinical audits reported and rated since the last Clinical Audit Group meeting in April 2016**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Audit name** | **Directorate** | **Baseline / Re-audit** | **Audit Rating** | | **Date action plan to be developed by** | **Date action plan received** |
| **Baseline audits 2015/16 audit plan** | | | | | | |
| Pilot of the new Pressure Damage Prevention Tool (District Nursing & Integrated Locality Team (ILT) Hubs) | Older People | Baseline | Good | | In place |  |
| Baseline audit of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) 2015/16 | Trust wide | Baseline | Requires improvement | | 19/4/2016 |  |
| **Re-audits 2015/16 audit plan** | | | | | | |
| Controlled drugs – Q1 – Q3 results | Trust wide | Re-audit | Q2 15/16 | Q3 15/16 | 10/5/2016 |  |
| Good | Good |
| CPA Quarter 3 results | Trust wide | Re-audit | Q2 15/16 | Q3 2015/16 | 3/5/2016 |  |
| Not completed | Requires improvement |
| Urgent and Ambulatory Care Service – National Quality Requirement 4 Audit | Older People | Re-audit | March 2015 | October 2015 | In place |  |
| Requires improvement | Good |
| Infection Control audit summary Q3 | Trust wide | Re-audit | Q2 | Q3 | In place |  |
| Good | Good |
| Essential Standards (Dec and Feb 16 results) | Trust wide | Re-audit | Dec 15 | Feb 2016 | Actions are taken at the time of the audit by matrons | |
| Good | Good |
| POMH Topic 13b Re-audit of prescribing for ADHD in children, adolescents and adults | C&YP | Re-audit | 2013/14 | 2015/16 | 31/3/2016 |  |
| Unacceptable | Unacceptable |
| Safety Thermometer Mental Health Q3 | Adult | Re-audit | N/A as point prevalence audit | | N/A | |

More detail informing the key themes highlighted from the audits listed above are given below from the two baseline audits and seven re-audits reported at the last CAG. An extremely detailed analysis of every audit was provided to CAG and is available on request.

* **Pilot of the new Braden Pressure Damage Prevention Tool (District Nursing & Integrated Locality Team (ILT) Hubs) (Good)**

The audit results provide assurance of excellent clinical practice in the following areas:

* 97% of patients were assessed for pressure damage risk on admission to services
* 95% of appropriate actions were planned and taken on the basis of risks identified
* 100% (where appropriate) of equipment was put in place to reduce the risk of pressure damage in a timely way

However, the overall audit results also identified areas for improvement in some key areas:

* 81% had regular reviews of the Braden score documented
* 67% of cases had it recorded in the clinical notes/care plan that the Trust pressure damage prevention leaflet and verbal advice had been given to the patient/carer
* 52% of cases had it recorded in the clinical notes/care plan that the Trust equipment failure leaflet and verbal advice had been given to the patient/carer

These audit results coincide with another report that was requested by the Oxfordshire Clinical Commissioning Group (Jan 2016) who requested an analysis of the high prevalence of category 2 pressure damage in Oxford Health NHS Foundation Trust as reported by the National Patient Safety Thermometer Point Prevalence Audit.

A detailed review was undertaken within the District Nursing Service (not ILT hubs) of all pressure ulcers that developed while the patient was on the District Nursing caseload (these are referred to as an acquired pressure ulcers) and how many developed while the patient was under the care of another service (these are referred to as inherited pressure ulcers). The review found that in 98% of cases where pressure ulcers were acquired whilst the patient was on the District Nursing caseload the team had correctly followed the Pressure Ulcer care pathway. Patients at risk of pressure damage had been appropriately identified, the risk of damage had been correctly assessed and appropriate plans had been put in place and monitored to minimise the potential for damage.

Action is underway to improve the reviews of the Braden scores by focussing on teams to use “care plan index and risk assessment” dates paperwork within patients notes to remind staff to complete the Braden review when due. Teams will use care notes by entering a reminder that the Braden is due as an intervention under “other”, and then schedule as appropriate. In addition, to improve Pressure ulcer prevention leaflet and advice being given to patients & What to do in event of an equipment failure leaflet will be achieved by having a full basic admission pack in one place on the intranet. 4

* **Baseline audit of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) 2015/16 (Requires improvement)**

When a patient comes in with a DNACPR in place some areas have an admission sheet which is ticked to say that there is a DNACPR present. This is not enough it needs to be documented in to the clinical record by the doctor and an alert must be raised with the DNACPR form uploaded to the correspondence section of CareNotes. The form should be checked regarding the patient/next of kin / relative awareness of the decision and correct any missing information.

When a DNACPR decision is made when the patient is under the care of Oxford Health the Trust DNACPR policy should be followed.

The DNACPR form needs to be completed correctly. There were a total of fourteen (18%) DNACPR forms where both A and B and A, B & C had been ticked on the DNACPR form as the reason for the decision. As A and B decision are 2 separate decisions this should be an impossibility.

**Explanations of decisions**

**‘A’ decision**

The A decision is a clear clinical decision (where the patient’s clinical condition is that, if the heart stops it would be near impossible to re-start) and does not require any discussion with the patient regarding benefits and burdens. The clinician, however, must inform the patient/relative (if appropriate) that the decision has been made and why. This conversation then needs to be documented in the clinical record, an alert raised and the DNACPR form uploaded to the correspondence section of CareNotes. The only exceptions to informing the patient is if the patient lacks capacity in this situation the relatives must be informed. If the patient does have capacity the Tracy v Cambridge ruling states that all patients must be informed unless informing them would cause “physical and/or psychological harm”. In 23% of decisions it was not documented on the DNACPR form that the patients/relatives were informed of the decision. This is an area rated as ‘requiring improvement’.

**‘B’ decision**

The B decision is a decision made by the patient; this is made following discussion with the clinician regarding the benefits and burdens that may occur after attempted resuscitation. If the patient lacks capacity the patient’s ‘Best Interests’ must be followed; this includes having a discussion with their next of kin/relatives to enquire what the patient would have wanted if they could make their own decision. The clinician must explain to the relative that it is not their decision but the doctor will take into consideration the information they give on what the patient would have wanted. This conversation needs to be recorded in the clinical record, an alert raised and the DNACPR form uploaded to the correspondence section of CareNotes. In 35% of decisions it was not documented on the DNACPR form that the patients/relatives were involved in the discussions for the DNACPR decision. This is an area rated as ‘requiring improvement’.

**Standard of recording on the DNACPR form**

Only 45% of DNACPR forms had the name of the institution where the form originated. Of those that originated in Oxford Health 70% **did not** have this information recorded. This standard is rated as ‘unacceptable’.

The DNACPR form requests the name of the person who has been informed/discussed with. In 57% of cases the name was not recorded, in many cases the status such as ‘son/daughter’ was recorded. This is unacceptable as there may be more than one son or daughter. The names should be recorded in the clinical record along with the DNACPR discussion.

**Standard of recording the DNACPR decision in the clinical record**

Any decision about whether or not to attempt CPR must be recorded clearly in the patient’s current health record and should be available immediately and easily to all healthcare professionals who may need to know about it (Resuscitation Council UK 2015).

Although the audit showed that 73% of DNACPR decisions were recorded in the patient’s health record this figure includes the cases where a ‘tick box’ on the admission sheet was the only evidence in the clinical notes that a DNACPR decision was present. As stated above, the decision and the informing/discussion with patient/relative should be documented fully. In only 35% of cases some evidence (more than a ‘tick box’) was found and this has been rated as unacceptable.

In addition, there were only 20% of cases where it was documented that the patient’s capacity had been assessed specifically in relation to the DNACPR decision. This has been rated as ‘unacceptable’.

* **Controlled drugs – Q1 – Q3 results (Good)**

The controlled drugs audit is undertaken quarterly and reported 6 monthly.  It is a trust wide audit covering Community Hospitals, Urgent Care, Dentistry and Mental Health Wards. In order to more clearly represent the risk within the trust, individual units have been assigned into 3 tiers of activity by the Medicines Safety Officer.

* **Tier 1(T1)** are in-patient or urgent care units that routinely stock, store, order and administer controlled drugs to patients.
* **Tier 2(T2)** are in-patient units, day care settings, urgent care units or community-based services that may, based on clinical circumstances, be required to stock, store, order and administer controlled drugs.
* **Tier 3** are any other urgent care, community or day care settings that may be presented with patient’s own controlled drugs, but that are never required to stock or order.  Staff may be required to support self-administration or administer patients own controlled drugs whilst the patient is subject to Oxford Health Foundation Trust services. **There are no Tier 3 services currently identified in OHFT.**

The audit consists of 26 standards; 16 of these are mandatory legal standards and 10 are best practice standards.

**Summary of Results: Legal Standards**

Compliance with Legal standards are mandatory; as such the target compliance is 100%. The table below summarises the number of standards where this compliance has been met in the last quarter of reporting (comparison with the previous quarter is shown in brackets).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Trust wide Target compliance (Quarter 3 FY15/16 )** | | | | |
|  | TIER 1 | TIER 2 | ADULT | CYP | OA |
| No. of legal standards with 100% compliance | 6/16 (38%)  *[4/16 or 25%]* | 13/16 (81%)  *[10/16 or 63%]* | 9/16 (56%)  *{7/16 or 44%]* | 14/16 (88%)  *[13/16 or 81%]* | 9/16 (56%)  *[8/16 or 50%]* |

As can been seen, no directorate or tier managed full compliance; the organisation is not legally compliant with all controlled drug legislative requirements. Therefore compliance against legal standards still requires improvement.

Encouragingly all areas have improved on Q2 compliance. Tier 2 services and CYP performed significantly better than other areas in Q3.

The only standard consistently met across all three reporting quarters in Tier 1 areas was Standard 11: CD stationary is retained for 2 years after the last entry.

In Tier 2 six legal standards were consistently met across all three quarters; standard 2, 4, 5, 7, 8 & 11.

**Key Points for Tier 1 areas**

Standard 3: Up-to-date signature lists remain consistent problem

Risk: Pharmacy must verify and authenticate order signatories prior to supplying controlled drugs therefore delay in patient medication possible.

Action: Ward Managers must review signature lists monthly and update with staff changes. If updated, send a copy to pharmacy.

Standard 1: Size and segregation of CD cupboards

Risk: lack of segregation between expired, in-use and patients own stock could result in expired stock being administered or patient specific CDs being administered to another patient.

Action: Ward managers and Pharmacy to risk assess and identify need for larger CD cupboards or develop a risk mitigation plan if a larger cupboard is not possible.

Standard 9: Signatures receipting CDs on to the ward in the CD Order Book. Compliance with this standard has decreased since Sept 15.

Risk: breaks in the CD accountability chain.

Action: reminders to staff. Explore possibility of a reminder sticker on the front of CD order books.

Standard 10: Received CD quantities recorded properly in CD Record Book. Compliance with this standard has decreased since Sept 15.

Risk: difficulty in accounting for CD stock if the quantity recorded and physically received differ.

Action: reminders to staff. Completion of mandatory eLearning.

**Summary of Results: Best Practice standards**

Compliance with best practice standards is subject to the normal audit strata (Target compliance remains 100%). The table below summarises the number of standards where this compliance has been met in the last quarter of reporting (comparison with the previous quarter is shown in brackets).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **TIER 1** | | **TIER 2** | |
|  | Q2 | Q3 | Q2 | Q3 |
| No. of best practice standards met (>80%) | 7/10 (70%) | 5/10 (50%) | 6/10 (60%) | 6/10 (60%) |
| No. of best practice standards met (100%) | 1/10 (10%) | 1/10 (10%) | 6/10 (60%) | 4/10 (40%) |

As can been seen, no tier managed full compliance; therefore compliance against best practice standards still requires improvement.

Two standards were consistently met (100%) across all three reporting quarters in both Tier 1 and Tier 2 areas; Standard 18: In-date and suitable for use CDs (liquids have a date opened clearly marked) and Standard 19: CD stock and administration records are fully maintained in the ward CD Record Book.

Two standards were consistently problematic across both Tiers and all quarters; Standard 23 (Amending documentation errors correctly) and Standard 24 (transferring stock balances to a new page and referencing new page on previous). These best practice standards are included in the content of the medicines management eLearning materials.

It is hoped that as more nursing staff complete the training, and with continued support from ward pharmacy teams, results against these standards will continue to improve.

**Recommendations for Pharmacy**

1. Continue to review audit results with Directorate Lead Pharmacists.
2. Continue to engage promptly with ward/unit managers to develop action plans.
3. Continue to support ward/unit managers with education sessions or other medicines management advice.

**Recommendations for Clinical Directorates**

1. Continue to liaise with Directorate Lead Pharmacists regarding controlled drug practices.
2. Ensure that nursing staff have completed mandatory medicines management education (particularly the Controlled Drugs module).
3. Ensure that any risks associated with controlled drugs are entered on to local or directorate risk registers as appropriate.
4. Ensure that any risks associated with controlled drugs are actively managed and resolved.
5. Undertake to inform the Medicines Safety Officers of any directorate medicines risks via email to [medicine.safety@oxfordhealth.nhs.uk](mailto:medicine.safety@oxfordhealth.nhs.uk)
6. Continue to liaise with Directorate Lead Pharmacists regarding controlled drug practices.
7. Ensure that nursing staff have completed mandatory medicines management education (particularly the Controlled Drugs module).
8. Ensure that any risks associated with controlled drugs are entered on to local or directorate risk registers as appropriate.
9. Ensure that any risks associated with controlled drugs are actively managed and resolved.
10. Undertake to inform the Medicines Safety Officers of any directorate medicines risks via email to medicine.safety@oxfordhealth.nhs.uk

* **CPA Quarter 3 results (Requires improvement)**

Although the overall CPA audit results are rated as requires improvement, the results for the Older Adult Mental Health teams and Children Young People teams are rated as good, as shown in the table below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Directorate** | **Audit rating for Q3 2014/15** | **Audit rating for Q4 2014/15** | **Audit rating for Q1 2015/16** | **Audit rating for Q3 2015/16** |
| Adult | Requires Improvement | Requires Improvement | Good | Requires Improvement |
| Older People | Good | Good | Good | Good |
| C&YP | Good | Good | Good | Good |
| Forensic | Good | Good | Good | Combined with Adult results |

The overall Trust wide results for Q3 have identified areas requiring improvement. These areas are not specific to each directorate, as shown in the table below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Adult (includes Forensic)  (n=69) | Older People  (n=40) | Children & Young People (n=78) | Trust wide Results  (n=160) |
| There is a record that the service user has been involved in development of the care plan | 78% | 84% | 77% | 79% |
| Where consent has been given, there is evidence of family and/or carer involvement in the development of the care plan | 43% | 88% | 74% | 65% |
| There is evidence that the service user has been offered/ given a copy of the care plan | 45% | 67% | 40% | 47% |
| There is evidence that the care plan has been shared with the GP | 69% | 65% | 72% | 69% |
| The service user has been asked to give consent for the care plan to be shared with the family and or carer | 47% | 65% | 58% | 56% |
| Where consent has been given, there is documented evidence that the care plan has been shared with family and/or carer | 58% | 95% | 83% | 78% |

**Care Planning Result over time for Adult AMHTs**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Care planning** | **Q3 14/15 results** | **Q4 14/15 results** | **Q1 15/16 results** | **Q3 15/16 results** |
| **Adult MH (n=94)** | **Adult MH (n=92)** | **Adult MH (n=51)** | **Adult MH (n=39)** |
| Service user offered/given copy of care plan | 42% | 51% | 52% | 24% |
| Evidence care plan shared with GP | 47% | 76% | 70% | 68% |
| Care plan shared with family/carer, when consent is given | 55% | 76% | 86% | 73% |

**Adult AMHTs**

* Recording that the service user has been offered/given a copy of their care plan was showing improvement over time from 42% in Q3 of 2014/15 to 52% in Q1 of 2015/16 but this has declined to 24% in Q3 2015/16.
* Recording that the care plan has been shared with the GP improved to its highest level at 86% in Q1 of 2015/6 but has since declined to 68% in Q3 of 2015/16. The decline in recording may be due to the transition from RiO to Care Notes.

**Older Adult Mental Health Teams**

* Evidence that the care plan has been shared with the service user has decreased over time from 71% in Q2 of 2014/15 to 67% in Q3 of 2015/16. However there is a marked improvement between Q1 2015/16 at 33% to Q3 2015/16 to 67%. This reflects the issues that have been reported previously around the transition from RiO to CareNotes.

**Children & Young People**

* Evidence that the service user has been involved in development of the care plan has increased over time; however fell from 90% to 77% from Q1-Q3.
* Evidence that the family and/or carer have been involved in development of the care plan has increased over time; however fell from 85% to 74% from Q1-Q3.
* Evidence that the service user has been offered/ given a copy of the care plan has been consistently rated as ‘Requires Improvement’; with a drop from 78% to 40% in Q3.
* Evidence that the care plan has been shared with the GP had increased in previous quarters; however fell from 85% to 72% from Q1-Q3.

In Quarter 1 of 2015/16 new audit questions were introduced relating to service users on psychotropic medication to review the information being provided to both service users and GPs.

|  |  |  |  |
| --- | --- | --- | --- |
| **Comparison of results between Q1 2015/16 to Q3 2015/16** | **Adult (includes Forensic)** | **OAMH** | **C&YP** |
| The care plan details the psychotropic medication prescribed | 83% to 77% | 88% to 90% | 95% to 65% |
| The care plan includes side effect monitoring needs relating to psychotropic medication | 63% to 61% | 73% to 72% | 58% to 74% |
| The GP has been informed of the need for ongoing monitoring of psychotropic medication. | 72% to 70% | 67% to 77% | 91% in Q3 |

* **Urgent and Ambulatory Care Service – National Quality Requirement 4 Audit (Good)**

Although rated as good the priority areas that require further improvement are:

1. Appropriate history taken – this relates to documentation of a full Past Medical History, Drug History and Allergies.
2. Identifies emergency or serious symptoms - the vast majority of telephone consultations have had a prior triage within the 111 service. Therefore any life threatening situations requiring an emergency ambulance transfer will have previously been discussed with the patient or caller and excluded prior to the clinician within Out of Hours speaking to them. The emergency situation described above relates to ascertaining an accurate history and probing of symptoms to be able to ascertain the seriousness of the current situation in order to be able to prioritise and manage effectively. This may still include referring to 999 if appropriate.
3. Displaying adequate safety netting – this relates to both verbal and written advice with regard to management of prolonged or worsening symptoms

These are the same categories that have required improvement from previous audit and have consistently been the areas within a consultation that the service has been concentrating feedback and training on.

In comparison to the last six monthly audit the percentages have altered as below:

* Identifying emergency or serious – **decreased** from 76.2% to 74.7% (maximium 76.2 % to date)
* Appropriate history taken – **increased** from 66.4 % to 69.44% (maximium % to date)
* Adequate safety netting – **increased** from 61.1% to 66.35% (maximum 72% in 03/14 audit)

This indicates that the service is making steady progress with improvements and no significant decreases.

* **Infection Control audit summary Q3 (Good)**

In Quarter 3 the Infection Control Team undertook a total of 31 annual infection control audits:

* 20 baseline audits
* 11 re-audits of areas who failed to achieve more than 85% at baseline

**Key issues identified:**

* No record or incomplete record of weekly medical devices checks, completed, signed and up to date
* Staff observed not bare below the elbows and/or wearing wrist watches, bracelets, stoned rings on some of the Adult and Forensic wards
* Spill cloths not available for body fluid spillages

The table below provides details of the areas where a re-audit was required.

|  |  |  |  |
| --- | --- | --- | --- |
| **Re-audits undertaken in Q3** | **Overall Score** | |  |
| **Adult Directorate** | **2014** | **2015** | **2015 Re-audit** |
| Lambourne House | 94% | 80% | 94% |
| Vaughan Thomas | 86% | 73% | 88% |
| Phoenix | 83% | 84% | 95% |
| Ashurst | 90% | 76% | 94% |
| Watling | 91% | 79% | 95% |
| Kestrel | 85% | 68% | 88% |
| Kingfisher | 86% | 76% | 93% |
| Whiteleaf Day Hospital | 73% | 84% | 100% |
| Warneford Day Hospital | 75% | 63% | 89% |
| East Oxford Out of Hours | 89% | 83% | 94% |
| Elms Day Hospital | 78% | 78% | 92% |

It was agreed that the Infection Prevention and Control audit programme should be subject to the same action planning process as other Trust wide audits. All Infection Prevention and Control audits undertaken during Quarter 3 have an action plan in place, will be recorded on Ulysses and monitored by the corporate audit team.

* **Essential Standards (Dec and Feb 16 results) (Good)**

Although the overall audit results are rated as good out of the 41 standards, eight standards are rated as requiring improvement. These are related to liaising with family and carer regarding patient’s Section 17 leave, care plan addressing children’s’ needs for adult mental health patients , involving patients in care planning and assessing capacity of patients . None of the standards were rated as unacceptable.

**Areas of excellent practice**

* Assessing physical health needs and care plan addressing physical health need
* Ensuring dignity and respect of the patient
* Nutrition
* Observation

**Areas of practice requiring improvement**

* Liaising with family and carer regarding patient’s Section 17 leave
* Patient involvement in care planning
* Addressing children’s’ needs in Mental Health wards
* Documenting one to one meetings with patients
* Appropriate therapeutic activities for patient identified in care plan
* **POMH Topic 13b Re-audit of prescribing for ADHD in children, adolescents and adults (Unacceptable)**

The results have received a rating as Unacceptable when rated using the trust audit rating scale. The clinical practice standards linked to nineteen out of the twenty six audit standards have declined in compliance in comparison to the baseline audit, which was conducted in 2013-14. The results from the baseline audit were also rated as unacceptable.

The changes in clinical practice that were implemented following the baseline audit include:

* Clinicians to use centile charts to record height, weight, heart rate & BP. Weight & height to be measured six monthly
* Substance misuse risk to be assessed and annual review of treatment using standardised tools
* Consultants in Oxfordshire to ask GP to do the three monthly monitoring of Heart rate and BP. Consultants to inform patient/parents/carer to arrange a surgery appointment for the monitoring

**Summary of re-audit results**

Out of the twenty six standards, only two standards are rated as good and these are measuring height and weight for patients prescribed medication for more than a year. All the other standards are rated as either requiring improvement or unacceptable. The lowest compliance rates are found to be for recording physical health measurements on charts.

The compliance rates for standards related to pre-treatment assessments have declined considerably compared to the baseline audit results. Clinical practice related to physical health measurements for patients who are prescribed medication for more than three months but less than a year have also declined in comparison with the baseline results.

Clinical practice related to physical health measurements for patients who are prescribed medication for more than a year have improved in comparison with the baseline results, except for recording the heart rates on centile charts. Although there is improvement, it has to be noted that only two standards are rated as good and these are measurements of height and weight. The standards that are rated as unacceptable include recording heart rate and BP on centile charts. Measurement of heart rate and recording height and weight on growth chart are rated as requiring improvement.

Clinicians have commented that teams are providing care to an increased caseload and this could be one of the reasons for the decline in standards related to reviewing physical health measures within three months. The improvement in physical health assessments for patients who are prescribed medication for more than a year might be reflecting the fact that clinicians are able to do physical health reviews at longer intervals since prescription. Factors related to capacity owing to increased caseload might be the barrier in doing the physical health reviews within three months of prescribing.

The service was not able to source the centile chart for Heart Rate and the Clinical Director had circulated a chart from Lancet to the consultants as a guide. The fact that the growth charts are not available electronically within the CareNotes has also affected compliance in the standards. Even though clinicians record measures on paper copies of growth charts, due to limited administrative support there will be delays in getting the paper copies uploaded onto Care notes.

The Children & Young People’s Directorate was very surprised by the results of this audit as a number of actions were taken following the baseline audit to improve the results and achieve a status of good or excellent.

After reflecting on the results, the lack of improvement and specifically on what may be the root cause of the poor result, the consensus is that the high reliance on locum doctors within the directorate at present has an impact on the results. Therefore the directorate needs to ensure robust and clear communication to locum doctors about the expected standards and tools at induction and whilst working within Oxford Health.

An action plan had been developed and a new tool will be included in the induction pack/process for new/locum doctors. The results and action plan/tool will be discussed at the consultants meeting and will be circulated to the quality leads/team managers to ensure they are fully embedded in practice.

The Clinical Practice Lead and Audit Facilitator within the directorate will also attempt to contact team managers at intervals to ask them to discuss implementation at team meetings and to provide an update regarding the overall view on the process of implementation. This would then help the directorate to address any issues in a timely way and ensure no young people are left in a vulnerable situation. These updates would be fed into the directorate Clinical Advisory Group meetings to update the directorate senior team on the process of implementation.'

* **Safety Thermometer Mental Health Q3 (Not subject to audit rating matrix as point prevalence audit)**

The Chair of CAG confirmed that the Director of Nursing & Clinical Standards is keen for the Safety Thermometer to remain on the 2016/17 Clinical Audit Plan with more detailed analysis of how the Oxford Health benchmarks against other organisations.

**Key themes arising from Clinical Audit**

Key themes identified were around:

* **Documentation (completeness and quality)** in general is a recurring theme and one that is intrinsic to clinical audit as results are most commonly based on evidence found in the clinical record. The pressure ulcer audit highlighted a lack of regular reviews of the Braden pressure ulcer risk assessment score and the DNACPR audit highlighted a lack of documentation relating to the decision in the clinical record.
* **Change over to CareNotes** – This continues to be a challenge and the CPA results continue to highlight issues with service user and carer involvement in care planning. This is under review and work is being undertaken to embed recovery focused care planning through the CQC action plan and the work being undertaken around the Triangle of Care.

1. **NICE Guidance**

In January 2016 a report was submitted to the QSCE in relation to the implementation of NICE guidance and quality standards. This report highlighted that as of December 2015, there were a total of 372 NICE guidelines, standards, technology appraisals and interventional procedures.

Of the 372 guidelines, 142 have been identified as being of direct relevance to Trust services (37 in Adults, 75 in Older Peoples and 25 in Children and Young Peoples).

An up-to-date gap analysis had been conducted in each Directorate, which highlighted that a considerable amount of work had been undertaken and there was a degree of assurance. This process also highlighted a number of issues and areas for improvement, including:

* A current backlog in conducting a number of gap analysis
* An up-to-date record has not been maintained by the clinical audit department
* The existing status of applicability need to be revisited in line with service and contract changes
* Services are currently struggling to cope with the workload associated with the NICE implementation process.

It was agreed that a project group be set up which would oversee the implementation of NICE guidance within the three directorates in order to move to a position of full compliance by the end of the year in the areas appropriate to the organisation. It was also agreed that directorates would appoint NICE guidance leads. It was suggested RA looks at NICE support as part of her governance restructure.

Priorities:

Whilst correspondence with NICE has highlighted that with the exception of technology appraisals and highly specialist technology evaluations, which carry a funding directive for commissioners, NICE guidance is not mandatory. NICE have stated that ‘Healthcare professionals should take NICE guidance fully into account when exercising their clinical judgement, but it does not override their responsibility to make decisions appropriate to the circumstances and wishes of the individual patient’.

With regards to Technology Appraisals (TA) and Highly Specialised Technology (HST) guidelines, however, the NHS is legally obliged to fund and resource medicines and treatments as recommended by NICE's technology appraisals.

This is reflected in the NHS Constitution, which states that ‘patients have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if their doctor believes they are clinically appropriate.’

When NICE recommends a treatment 'as an option', the NHS must make sure it is available within 3 months (unless otherwise specified) of its date of publication. This means that, if a patient has a disease or condition and the doctor responsible for their care thinks that the technology is the right treatment, it should be available for use, in line with NICE's recommendations.

NICE Implementation Group:

In line with the above, a NICE Implementation Group has been set up. This group (a sub-group of the Clinical Audit Group) has now met on three occasions. This group reports to the Quality Subcommittee Effectiveness (QSCE). The implementation group will provide a six-monthly update report to the QSCE. The Terms of Reference for the group outline that its aims are to

* Work in conjunction with senior managers and clinicians and Clinical Directors of the Directorates to facilitate the implementation of NICE guidance within the trust
* Promote NICE guidance criteria, to audit the implementation of NICE criteria and to assist with the sustainable implementation of NICE guidance within defined time scales.
* Ensure that all Directorates have a robust process for the implementation and governance of NICE guidance.
* Review NICE compliance assessments/gap analysis
* To receive all NICE and clinical effectiveness evidence of compliance from Directorates
* Identify directorate leads for all relevant upcoming guidance
* Identify resources to support implementation of NICE guidance
* Refer risk - related to NICE guidance - to relevant Trust sub-committee. Compile and monitor the implementation of NICE action plans
* Recommend and participate in the clinical audit of NICE guidance, as appropriate

Progress within Directorates

It has been agreed that each of the three directorates will oversee NICE implementation within their clinical services and report back to the group. The three directorates are currently progressing with their gap analysis, together with implementation plans, and approaching this in slightly different ways.

Part of this process will include identification of the process for NICE guidance once it has been sent to the directorate. Children and Young people’s directorate and Older Adult have completed their process which the Adult are currently reviewing.

Each of the three directorates now has active plans, systems and processes for NICE guidance and work has now commenced in each directorate. The group will produce a detailed report for the next QSCE providing an update of progress against the baseline situation reported in January 2016.

1. **Mental Health and Mental Capacity Acts**

Since the last report there have been three CQC visits on Amber, Sapphire and Ruby wards at Whiteleaf

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Ward | Issue | Agreed Action |
| 17/02/2016 | Ruby ward | Comprehensive patient centred care plans  Consistently informing patients of rights  Consistent section 17 leave forms, copies to patients  Recording capacity  Environmental issues (showers, noise, etc) | Checks and monitoring,  Checklist re-issued, monitoring by Modern Matron, AMHP report requested by MHA Office  Process re-inforced, monitoring by Modern Matron  Phone replaced  Review by MHA Office and Modern Matrons  Works ordered, immediate action taken with showers |
| 18/02/2016 | Sapphire ward | Comprehensive patient centred care plans  Consistently informing patients of rights,  AMHP report missing  Consistent section 17 leave forms, copies to patients  Phone uses, restrictive practice  Recording capacity  Environmental issues (showers, noise, etc) | Checks and monitoring,  Checklist re-issued, monitoring by Modern Matron,  AMHP report requested by MHA Office  Process re-inforced, monitoring by Modern Matron  Phone replaced  Review by MHA Office and Modern Matrons  Works ordered, immediate action taken with showers |
| 24/02/2016 | Amber ward | Comprehensive patient centred care plans  Access to s136 suite via ward  Consistently informing patients of rights, informing patients about IMHAs  Consistent section 17 leave forms, copies to patients  Recording capacity at admission, with respect to admission  Access to SaLT and Podiatry services  Environment, ligature free, utilities difficult to operate, ceramic hob unfamiliar to patients | Checks and monitoring, personalising training attended by staff and training by Clinical Practice Educators  136 suite closed  Checklist re-issued, monitoring by Modern Matron,  IMHA to facilitate session with staff  Process re-inforced, monitoring by Modern Matron  Purpose of admission document, monitoring by Modern Matron  SOP for podiatry re-inforced, basic standards applied, referral to specialised services where required  Walk round with estates, patient community meetings |

**Areas of compliance/good practice**

Associate Medical Directors are actively taking issues raised to their respective Directorates and though there is evidence that this is resulting in improved compliance by staff, the presentation of rights under Section 132 continues to require improvement. Compliance in recording of leave/CTO consideration and consent to treatment has improved.

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

CQC visits have resulted in a number of recommendations relating to care planning and patient involvement.

Risks remain in that compliance is not consistent or comprehensive. Areas of concern are in relation to the recording of leave, rights, consent to treatment, and patient involvement and empowerment with respect to care planning.

The CQC continue to make recommendations with respect to these areas of practice requiring improvement.

Directorates are not always treating the CQC reports and Trust responses as working documents. This is particularly so with any recommendations relating to environment or requiring action by estates and facilities.

**Future Issues or concerns**

The main concern is that although corrective actions are taken at the time, these do not continue to be maintained and monitored sufficiently at ward/team level. This leads to the same issues being raised by CQC on a regular basis.

Action taken: in addition to MHA Office processes, escalation to clinical director and medical director, AMDs and Heads of Nursing are provided with information relating to omissions or gaps on a weekly basis.

**6. Infection Prevention and Control**

***Clostridium difficile***

There were no cases of *Clostridium difficile* infection (CDI) in January or February 2016 and two cases reported in March 2016

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

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-retested known positive patient | 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 |
| March 2016 | Ward 1 Abingdon hospital | 8 | Unavoidable | 1 |
| Ward 2  Abingdon hospital | 9 | Unavoidable | 1 |

The Trust concluded the year on 9 cases, one of which was avoidable.

**MRSA bacteraemia/MSSA bacteraemia**

There have been no Trust attributable MRSA or MSSA bacteraemia cases in January, February or March 2016.

**E.Coli bacteraemia**

There has been one E.Coli bacteraemia identified this year. In March 2016 a community CCG E.Coli bacteraemia patient was identified on 2nd March 2016 when seen in EMU at Abingdon. An RCA was completed.

**Outbreaks**

In January, there have been two outbreaks of diarrhoea and vomiting to report in January. The first was a suspected outbreak on Glyme ward affecting four patients and two staff. Precautions were in place throughout and the ward was full. The second large suspected norovirus outbreak was on Linfoot ward, Witney hospital affecting 21 patients and 27 staff. The whole ward was closed from 18th -23rd January and then began a phased reopening following a full terminal cleans of affected bays. The entire ward was open and operating normally on 28th January.

In February, there was a 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.

In March 2016 there was a confirmed norovirus outbreak on Linfoot ward, Witney hospital affecting 15 patients and 1 member of staff. The whole ward was closed from 24th-31st March and was reopened following a full terminal cleans of affected bays.

Generally the county has had a ‘Busy’ quarter for outbreaks in norovirus. Linfoot ward has had two outbreaks in January and March 2016. The outbreaks were too far apart in time to link them. The

Infection Control matron carried out an informal check on the ward in March 2016 a few days prior to the second outbreak. At this time there were no immediate causes for concern identified.

**7.0 Aims for Older Adults Mental Health**

Work continues to progress within the AIMS Project Team in the Older Peoples directorate. The services have completed the ‘starter’ paperwork and are now in the self-assessment phase in the older adult mental health wards

1. **Learning and Development**

Areas of compliance/good practice:

Following the 2015 CQC inspection the Inspectors noted that, “Staff had good access to mandatory training and good induction programmes, as well as opportunities for continuous professional development.”

The 2015 Staff Survey reported; Top ranked for the ‘Quality of non-mandatory training, learning or development’.

The Quality of appraisals are ranked as ‘performed better than average’

Areas of unsatisfactory compliance/areas of risk:

There was a need to continue to work with staff to ensure mandatory training specifically resuscitation is completed.

Bottom ranked for the ‘Percentage of staff appraised in last 12 months.

Future Issues or concerns:

The L&D department are currently preparing their annual report and information has been extracted for this report.

A project to review the mandatory Patient and Personal Safety Training framework has completed this year. The framework now contains only the activities that are national aligned and agreed to be statutory & mandatory by all NHS Trusts. Indicative mapping of the framework is to the Care Quality Commission Essential Standards of Quality and Safety (2010) (England).

This enables comparable benchmarking to be undertaken. The review achieved greater clarity and understanding of the requirements for the PPST framework.

**PDR/Appraisals**

From 1st April 2015 Trust policy required each employee’s PDR/appraisal to be aligned with Agenda for Change and be completed approximately 4-6 weeks before their increment date. At FY15/16 end the recorded number of completed was 74%. The 2015 staff survey reported 81% of the 49% of employees that responded.

Previously the Trust policy required all PDRs to be completed within a 3 month period (Apr – Jun). The transition to the new alignment with increment date will have affected some individuals who would have exceeded 12 months since their previous PDR. This would have affected the recording of dates on OTR and answering the survey question ‘have you had an appraisal/KSF review in the last 12 months’. Now, a year on, the transition process will conclude. A new online PDR system is planned for launch in May 2016 that will further support the completion of high quality PDRs/appraisals.

Action plans are in place for Resuscitation, Information Governance & Fire safety training.

1. **Medication Management**

Areas of compliance/good practice:

* Implementation of all current NHSE Patient Safety Alerts
* Shared care guidelines are all in date and effective
* MSGG is effectively reviewing trends of medicines incidents
* PGDs are all up to date including those developed by NHSE for national immunisation programmes.

Areas of unsatisfactory compliance/areas of risk:

* The group doesn’t have a patient / carer representative as per its terms of reference.
* Ongoing issue with new format and distribution of BNFs – Edition 7- still to be distributed.
* Audit of Olanzapine LAI undertaken by one of our pre-registration pharmacists shows some deficiencies in post-injection monitoring (this audit has recently won a regional prize)
* POMH audit for ADHD (CAMHS) – monitoring requires improving
* Vortioxetine – red listed by Bucks CCG (different to rest of country)

Future Issues or concerns:

* Potential risk of misuse / abuse of clozapine – case reports from Nottingham discussed. Memo will be circulated to prescribers and clinical staff.
* Ongoing difficulties with moving medicines from hospital only use to shared care / GP prescribing e.g. pregabalin

1. **Research and Development**

Areas of compliance/good practice

The pre-qualifying questionnaire (PQP) for the Bio-medical Research Centre application was submitted in February 2016

A decision was made to confirm that the Collaborative Research Fund (CRF) renewal application will continued to be administered via the OUH but will be led from Oxford Health

Work continues on the joint appointment of a research nurse fellow between Brookes University

The Trust has given 6 months’ notice to terminate the D CRIS service contract with SLAM. The Trust has agreed to move over to UK CRIS which will not require SLAM service support. It is hoped that UK CRIS will be available in April 2016, but if this is delayed there is still access to the current D CRIS until October 2016 when the contract ceases

R&D is still working hard to integrate the changes to governance processes regarding the Health Research Authority, through which all studies will need to be approved.

Assessing the feasibility of research studies is ongoing and progress is being made to integrate with clinical teams to understand and involve them

Discussion with the CRN is ongoing in terms of supporting research in clinical areas other than mental health.

The Trust is currently achieving 100% target of recruiting the first patient into a study within 70 days of receiving a valid research application. Last quarter this was 86%, but has a tendency to fluctuate due to low numbers of studies (typically 10).

## CRIS is operational and 3 research applications have been approved, but due to static data set there is not as much uptake as hoped. Hopefully this will change when UK CRIS is operational.

# Areas of unsatisfactory compliance/areas of risk:

## There are some issues regarding the move to the Health Research Authority (HRA). One key point is that the HRA will be providing “NHS permission” for studies that cover the whole of the NHS and these are not site specific. This has the potential to give the green light to researchers to start studies and approach clinical teams within the Trust without it actually coming through the R&D department. This puts the Trust at risk of being unaware of what studies are ongoing within the organisation. This is to be discussed at the next Research Governance Group meeting in April 2016.

## R&D support services, including governance and sponsorship for non NIHR portfolio studies is undergoing review due to workload of the team and lack of resource to be able to support the function going forward as this is currently unsustainable. Additional support has been requested from the Clinical Psychology Doctorate course as this is the source of the majority of the workload and meetings have been set up for April.

## R&D is still struggling to meet the time to target for recruiting a set number of patients for individual studies within the recruitment period (25%). This will take time to change as studies generally run over a minimum of 12 to 24 months.

# Future Issues or concerns:

## The financial year end position was being worked on at the time of producing this report however it is predicted that R&D will report a small favourable variance against its budgeted £70k contribution to overheads. This has primarily been generated from studies (mainly commercial) running within the Clinical Research Facility. This is the only opportunity R&D has to generate a contribution because all other funding needs to be used, accounted for by individual or returned to the funder

## The CRN has requested that the Trust review the funding for staff. The CRN want to reduce the funding support to CRF delivery staff to zero during the next year (7 member of staff, 4.3 WTE, £132k), with this being gradually reduced throughout the coming year. This has the potential to put cost pressures on other R&D income sources, although this will be included in the CRF renewal bid when funding starts in April 2017.

## The CRN have requested a review of support for pharmacy and research governance during the next year aiming at reducing their contribution during this time. Some of this will be absorbed in the BRC and CRF applications.

## If the CRF and BRC applications are unsuccessful this may cause cost pressures within R&D from April 2017.

1. **Public Health**

The Public Health Strategy was approved at the Quality Committee on 18.02.16

The six work streams which are established and functioning in their set tasks are:

1. Promoting Mental Wellbeing & reducing the risk of suicide
2. Reducing Physical Inactivity
3. Promoting Smoke Free within Oxford Health NHS Foundation Trust
4. Consistent use of
   1. Supporting Health Promotion across the organisation, promoting the use of and access to the Health Promotion Unit to increase the use of resources
   2. Developing Intranet page for Public Health which would link to existing pages for the health promotion unit, artscape, support for staff after serious incidents, health and wellbeing which would provide more accessible and consistent information for staff
   3. The use of MECC (Making Every Contact Count) consistently within Oxford Health
5. Wellbeing at Work; the Workplace Charter, promoting the health of staff for example via activity challenges and healthy snacks, accessing funds from the health and wellbeing fund to support staff improve their own health and so support them to model wellbeing to patients, support staff to engage with the staff wellbeing questionnaire and wellbeing champions initiative.
6. Partnership working with other agencies, including Change 4 Life and the Active Buckinghamshire Campaign

A stall was presented at the most recent senior Leaders conference to highlight work

Areas of unsatisfactory compliance/areas of risk:

Smoke free project group reconvened on 09.02.16 as outstanding issues and NICE guidance to be fully implemented

Future Issues or concerns:

The breadth of public health work is large – the group will continue to focus on identified priorities to manage this.

1. **Human Resource**

There are no clearly identified themes from HR casework with the exception of managing HR processes.

3 new investigations under the Management of Concerns policy have commenced since the October 2015 report. This brings the total number of investigations during 2015 to 5 (compared to 6 during 2014).

1. **Ethics**

Nothing specific to report. The group continues to meet regularly to discuss challenging ethical issues.

1. **Estates**

Areas of compliance/good practice:

Our current self-assessment indicates that Estates score a GOOD rating. No areas of risk have been identified.