Oxford Health NHS
NHS Foundation Trust

Report to the Meeting of the Oxford Health NHS Foundation Trust Board of Directors

For Approval

BOD 151/2015
(agenda item: 10)

25 November 2015

Quality Account 2015/16 Quarter 2 report on progress

Executive Summary

The attached report summarises progress to date on the quality account priorities (2015/16) and provides a overview from directorates on the five CQC questions (IC5).

The Quarter 2 report is traditionally reviewed at the Quality Committee, and following subsequent approval by the Board of Directors is then circulated to external stakeholders and partners, including commissioners, overview and scrutiny committees and Healthwatch. For this reason the report contains more contextual information about the quality account priorities than the Q1 report and repeats some information from Quarter 1 to provide a more complete picture.

Progress has been made on a large number of the objectives we set ourselves for 2015/16 and this is summarised on pages 5-6. There are, however, some areas requiring further improvement and these are summarised on page 6. A brief overview of the recent CQC visit is also provided.

The rest of the report reviews in some detail the individual priorities, objectives and activities. Please note there is still some outstanding data which will be added before the report is circulated.

Governance Route/Approval Process

This report was considered at the Quality Committee meeting on November 17th and was approved for further circulation subject to a minor amendment which has now been made.

Recommendation

The Board of Directors is asked to approve the report for wider circulation.

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

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

Introduction to the 2015/16 Quality Account

In our Quality Account 2015/16 we describe four quality priorities for the year, which were developed in discussion with our clinical directorates, our Governors, commissioners, and Healthwatch. We have retained those priorities from 2014/15 which remain key for us because of the nature of the service we provide (for example, prevention of suicide and reduction in the need to use restraint); which had an end date beyond the end of the financial year (for example, pathway remodelling); or where we consider we have further improvement to make (for example, patient and carer experience and involvement).

They also include some new development objectives across a range of services which have been defined by our clinical services. These priorities represent the key areas we monitor and report on through the quality account. This list is not exhaustive and work on a wider range of quality and safety initiatives continues across all of our services.

1. Enable our workforce to deliver services which are caring, safe and excellent

This will enable the service to be caring, safe, effective, responsive and well led. This builds on last year's workforce priority and the staff engagement priority.

1.1 Ensure we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams.

1.2 Review actions to improve recruitment into vacant positions including implementation of the values-based recruitment framework.

1.3 Improve staff wellbeing (including reduction of harm to staff related to musculoskeletal injury and work-related stress), motivation, engagement between patient facing staff and more senior management and involvement in improvement activities.

2. Improve quality through service remodelling

This will enable the service to be effective and responsive. This builds on last year's service remodelling priority.

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

2.2 Monitor specific projects to improve outcomes, for example the extension of the Street Triage project; the work to extend A&E in-reach services; a partnership approach to managing patients frequently accessing services; implementation of the integrated locality teams; improve access for Looked After Children (LAC).

2.3 Monitor the impact of implementation of new electronic health record. Pilot the new quality dashboard at directorate level.

3. Increase harm-free care

This will enable the service to be safe and effective. This builds on last year's harm reduction priority.

4. Improve how we capture and act upon patient and carer feedback

This will enable the service to be caring and responsive. This builds on last year's patient experience priority

4.1 Capture and demonstrate how we act upon patient and carer feedback and improve our care environments.

4.2 Implement the Triangle of Care to improve carer involvement in planning and delivery of care.

Summary of progress in Quarter Two

This report describes our progress between July and September 2015 against our four priorities. It is clear that staff across the organisation have engaged very positively with the five questions for quality (IC5) and there are many examples of effective local and service wide improvement and change activities evidenced through patient, carer and staff feedback and improved performance against quality measures. However, we have selected our priorities specifically because they are challenging; inevitably we have further work to do in some areas of improvement.

1. Enable our workforce to deliver services which are caring, safe and excellent

We have made progress in these areas:

- All wards maintained minimum staffing levels during quarter 2
- Increase in percentage of PDRs achieved, although target not yet achieved
- Very successful staff recognition awards event
- Expansion of OxonBike scheme
- System set up to monitor working time directive
- Very successful pilot to reduce sickness as result of musculoskeletal injury and there has been positive feedback from staff
- Range of improvement projects across the organisation and projects have sustained improvement, for example healing rates in the venous leg ulcer pathway and reduction in deliberate self harm in Marlborough House, Swindon

We need to make further progress in these areas:

- Improving attendance at skills development courses (which do not include mandatory and statutory training) which is lower than in the same period last year
- Further work on the development of a collective leadership strategy although a number of leadership initiatives continue to progress e.g. Planning for the Future
- The number of vacancies has increased in comparison to the baseline set last year – this is a challenging issue to address, however there are a number of proactive recruitment activities underway including targeted recruitment days

2. Improve quality through service remodelling

We have made progress in these areas:

- AIMS accreditation in three adult wards
  MSNAP accreditation in four memory clinics, three with excellence
- Increase in patients on the care programme approach (CPA) feeling involved in setting and achieving goals
- Successful launch of a Recovery College in Oxfordshire and Buckinghamshire
- 588 recovery stars completed in adult service

- Dental cognitive behavioural therapy pilot is on track
- 100% of Children notified by the local authority to the LAC team as new to care were offered a health assessment within 20 working days
- 40% reduction in use of section 136 compared to the same period in 2014 as a result of Street Triage in Bucks

We need to make further progress in these areas:

- Developing staff confidence and addressing issues with new Care Notes system
- Increasing the percentage of patients on CPA in employment or settled accommodation which has reduced since quarter 1.

3. Increase harm-free care

We have made progress in these areas:

- Reduction in the number of suicides
- Reduction in the number of absences without leave, specifically failure to return from leave
- Reduction in number of falls in physical health services
- Increase in the percentage of patients with a falls risk assessment on admission and after 28 days
- Reduction in reported seclusions and restraints although there was a slight increase in the number of prone restraints
- Very positive feedback on PEACE training
- Increase in the percentage of patients given a venous thromboembolism assessment
- Increase in the percentage of patients given a physical health needs assessment, in the monitoring of side effects in patients on psychotropic drugs and in communication with their GP
- Positive smoking cessation patient stories

We need to make further progress in these areas:

- Reducing the number of reported grade 3 and 4 pressure ulcers – the number of pressure damage serious incidents has not yet reduced – this will require work across the system to impact on the multifactorial root causes to the issue
- Increasing the percentage of patients who had a review of their care plan after a fall

4. Improve how we capture and act upon patient and carer feedback

We have made progress in these areas:

- Myriad examples of gathering patient and carer feedback, of patient involvement activities, and of actions taken as a result of feedback
- Progress made to implement the Triangle of Care and Carers Strategy
- Between January and September 2015 95% of people who have answered the FFT question have said they are extremely likely or likely to recommend the service they received.
- 23 patient experience champions have been identified in Children and Young People's services
- 25 patients have been contacted as part of the community hospitals patient discharge pilot

We need to make further progress in these areas:

- Developing proactive patient involvement activities
- Roll out patient and carer engagement strategies across all services

Care Quality Commission inspection

At the end of September the Care Quality Commission undertook an inspection of our services. During this process we hosted approximately 100 inspectors who visited 124 clinical teams including three unannounced visits. There were approximately 387 information requests, 47 senior staff were interviewed and 29 staff focus groups were attended by 164 staff.

We received some initial observations at the end of the week. The formal report, findings and rating will be received in the new year.

Inspectors commented on the excellent organisation of the inspection week and the welcome provided by staff. They perceived the Trust to be exceptionally innovative, committed to partnership working, well led and on a sustained journey of quality improvement. They also cited several examples of good practice including our Street Triage service, children's community nursing and the district nursing service "workshare" initiative.

They did however identify some areas for improvement, many of which we are already aware and addressing. These include:

- patient and carer involvement in care planning Trust-wide
- a strategy for patient involvement in service design and delivery
- consistency in the robustness of clinical risk assessments
- staff confidence in using the new CareNotes electronic patient record system
- bed management processes and discharge planning

IC5 – CQC five questions for quality

Are our services safe?

Areas of good practice

- September Safety Thermometer[1] results for adult mental health show an overall increase in harm free care, including 0% of patients self harmed in the previous 72 hours; highest proportion of patients YTD reporting feeling safe; 0% of patients had been the victim of violence/aggression in the previous 72 hours.
- Introduction of standard agenda item around learning from incidents in District Nursing countywide clinical lead meetings
- 96% of older adults have diabetes management plans in place for those receiving insulin administration

[1] The Safety Thermometer is a national "point prevalence" tool which requires all NHS organisations to provide a count of patients who have experienced "harm" (using specified definitions) on a given day each month. This was recently expanded from physical health services to include mental health inpatient and community services. Adult mental health services now regularly submit data which allows for an immediate comparison with previous months and quarters and retrospectively to benchmark against other similar organisations.

- Monthly reviews of patient referrals to the Emergency Medical Unit that have been declined by the service to ensure this was an appropriate decision
- Minor Injuries Unit guidelines revised and in use
- Diabetic foot pathway & Low Amputation Rate - close working relationship with the OUH to provide the best outcomes for patients
- Learning from Child Deaths workshops for frontline CAMHS staff from Professor Paul Stallard will now be offered in January 2016 following the published review of deaths across five local authority areas.
- Highfield Unit Safer Care work continues to reduce number of restraints Last years (April 2014-March-2015) average restraints total per week was 10 and our current average this year is 5.4 so the Unit has almost achieved their aim for a 50% reduction. The prone restraint data last year was 3.1 per week and the unit is currently averaging 0.7 a significant reduction.

Areas for Improvement

- Recent information provided by CQC highlighted that our VTE guidelines needed reviewing in our Minor Injuries Units
- Ward/EMU handover and link role when a patient is admitted. Much work being focused on the wards taking over this responsibility including Productive Wards input for communication and team working workshops and weekly meetings between ward managers and EMU clinical lead
- Improve guidance and pathways for patients who present to Minor Injuries Units with self harm injuries and domestic abuse.
- High demand for the podiatry service and the challenge with meeting that demand with the current staffing levels and meeting the NICE guideline for required return times for patients in the at-risk pathway

Are our services caring?

Areas of good practice

- Baseline data has been collected using the triangle of care self-audit tool in all adult inpatient settings, including forensic, all AMHT's and from each partner organisation.
- Carers leads have been identified
- Meeting and greeting protocol for impatient services agreed
- Carers packs developed with inpatient group in line with triangle
- Review of patient feedback questionnaires in adult services to make them more relevant and meaningful to patients
- 100% for privacy and dignity in patient survey, and many comments from patients in all areas of the county who found their district nurses friendly, helpful, kind and caring
- Single point of Access working with Age Concern to offer support to patients where previous gaps in support had been identified.
- Dementia environmental work on community hospital wards
- Patient involvement within the Children & Young People's Directorate continues to develop with a current focus for some services on engaging ways to involve service users in "knowing what to expect" when they are referred to receive care or treatment. This follows a learning theme from both patient experience and complaints where clients can be unsure what the service can provide for them.

- The Family Nurse Partnership and Oxfordshire Children's Integrated Therapies are currently producing films with service users giving their views, alongside staff explaining what these services do. These should be completed by January 2016 and uploaded to the CYP website and used directly by staff.

Areas for improvement

- Training relating to the Triangle of Care
- Provision of information/service to those patients who do not engage for any number reasons, including recruitment within certain areas and increased working with GP practices who may refer into the service
- Time allowed for assessments in Memory Clinics sometimes feels pressured.

Are our services effective?

Areas of good practice

- We now have 588 recovery stars[2] completed in our adult services.
- Introduction of the recovery star into our forensic services in Q3 as our patient reported outcome measure; this will enable us to understand how we are supporting our patients to meet their goals and whether any changes are needed to the service to do this.
- Development of a new physical health form following a pilot in the wellbeing clinics in Oxford City.
- Safer Care project in Henley district nursing team to reduce pressure ulcers by 50%
- Development of a patient information guide as a generic info source for MIU/out of hour waiting rooms.
- Introduction of discharge summary sheet to be given to each patient on discharge from the EMU telling them what assessments and treatments they have received and the on-going plan for their care. This is completed by the nurse who has been responsible for their care and co-ordinates all aspects of the MDT that have been involved
- Nutrition Action Group established to improve nutritional care for patients.
- Exercise and Education groups for people with neurological disability
- Development and delivery of Insulin Management courses for District Nurses.
- An education session was held at the John Radcliffe Hospital by the Modern Matron from Cotswold House Oxford for their staff in relation to the care of Eating Disorder patients, this was held in response to learning from an incident

Areas for Improvement

- Patients knowing when their next visit from the district nursing services will be
- Increasing the percentage of patients with pressure ulcers and leg ulcers who are given a pain assessment
- Requirement to conduct documentation audits to standardise medical notes.
- Demand and capacity in community hospital services

[2] The star enables our patients to set their own goals against the 10 domains; this creates the foundation of their care plan. At each review, their star is reviewed to understand how they feel they are progressing towards their goals.

- Delays to transfers of care (DTOC) including patients awaiting Social Services and Care Home placements
- The ability to ensure our skill level encompasses the increasing diversity and complexity of the patient's conditions referred to us.

Are our services responsive?

Areas of good practice

- New urgent message hub for all patient phone calls in district nursing teams in West Locality
- Band 5 preceptee development programme for new district nursing starters in the South locality
- An Information TV in Abingdon MIU waiting room showing local information, public health campaigns
- Translating older peoples service patient information leaflets translated in to languages other than English.
- Changing rota to provide better cover for the busier times of day in EMU
- Single Point of Access partnership working with OUH and Discharge Liaison Nurses

Areas for Improvement

- Provision of information leaflets in EMU describing the services offered.
- Further engagement with all age groups in urgent care services.
- The Service Director, Head of Service for Bucks Speech and Language services and commissioners are working with a group of parents who raised concerns about services for children with Down's syndrome children and specific needs in relation to commissioned contract

Are our services well-led?

Areas of good practice

- Adult services have a shortened version of the staff survey to enable more frequent surveys to measure the impact of changes.
- Leadership development courses in adult services for staff in bands 7-8a
- leadership strategy in adult services to support all staff and consider development pathways from apprentice level through to senior managers.

- Apprenticeships have started in children and young people and adult services are commencing using apprentices in both Oxfordshire and Buckinghamshire supported by trained mentors
- New clinical lead team for community nursing in place and vision for team agreed
- Representatives from Urgent Care have been asked to present at senior leaders conference to showcase the Facebook and Twitter patient engagement project
- Regular bi monthly quality newsletters to staff in older people's services
- Development of 'champion roles' in EMU to lead on specific areas.
- Doctor in EMU nominated for Thames Valley health Education teaching award.
- EMU staff nominated for 'placement of the year' from OBU.
- Practitioner completing Advanced Practitioner Fellowship in MIU
- A formal induction programme for all new Drivers /Receptionists in older peoples services to improve their welcome, support and knowledge.

- Recognition for dental services staff - this multi-skilled team supports dentists in providing care for patients with complex needs. They excel as leaders of the nursing team across 10 clinical sites, supporting patients with, for instance, dental phobia through every step of their care, reducing failed attendance.

Areas for Improvement

- Development for Band 6 clinical staff
- Engagement with front line staff during the Out of Hours period.
- Soft services in community hospitals; there has been significant change to how cleaning, meals, portering etc are managed and delivered. This is still bedding down and likely to bring some benefits long term such as clinical staff being more involved in patient nutrition, ward environment audits etc.
- Ensuring the well being of staff during periods of reduced staff resources

Quality priorities – review of progress July-September

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

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

Review and measure the impact of the Aston team working model using interviews, impact assessment questionnaires, team stories and repeated effectiveness audits / team temperature checks; and align effective team working into the Trust organisational development strategy.

Following on from the delivery of effective team based working training and bespoke support delivered to over 90 teams across the trust, we have been looking at ways to measure the impact of effective team based working methodologies. Measuring impact will help us to think about how we continue to embed the approach across the trust, and how effective team based working fits with the organisational development strategy.

An impact questionnaire has been piloted, but in the test the response rate was low, and it will now be supported by additional methods to collect feedback, including a structured interview to complete with teams; a review of the staff survey feedback using the score as a baseline (in 2014 Oxford Health's overall results for this set of questions averaged at 3.81 (out of 5.0); and analysing team and staff stories.

The evaluation will also use the Aston team-working tools to assess changes and improvement in team effectiveness, for example a team temperature check is completed as

part of the bespoke support provided to teams, and as a measure of impact, are to be repeated with a sample of teams across the trust to understand where effective team based working has made a difference. The check uses a series of statements and teams are asked to rate themselves using a 1-5 scale (1= very inaccurate and 5 = very accurate).

The Bladder and Bowel service used the team temperature check as part of their bespoke team development; and repeated it six months later. The overall score increased by 4% with improvements in the following areas:

- ⇧ We know who the team leader is
- ⇧ We are committed to meeting the team's objectives
- ⇧ We trust each other
- ⇧ We meet regularly enough to ensure effective communication and cooperation
- ⇧ We help each other out
- ⇧ We can safely discuss errors and mistakes
- ⇧ We work flexibly
- ⇧ We have the right knowledge and skills for what we need to do
- ⇧ We continuously look for ways to improve how we work
- ⇧ We have mutual accountability for delivery

Other areas where they had not made any improvement were:

- ⇔ We are clear about what we are trying to achieve
- ⇔ We have influence over decisions
- ⇔ We have high energy
- ⇔ We seek feedback
- ⇔ We manage conflict positively

In order to embed effective team based working across the trust, and ensure a centralised approach to the delivery of the methodology, team development training and bespoke support for teams will be included in the learning and development leadership and management training pathways planned for launch in April 2016.

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

Summary position

When looking at the number of shifts which were fully staffed to expected levels, 10 out of 33 wards were identified as having the most difficulties across September 2015 in achieving expected staffing levels on every shift (only achieving 75% or less of shifts fully staffed to expected levels). However

A dialogue with ward staff, Heads of Nursing and Service Directors is continuing to develop plans to support safe staffing and patient care at a ward level. Wintle, Vaughan Thomas and Opal ward have recently achieved AIMS accreditation which included looking at staffing and patient experiences. All our forensic wards are externally accredited following an annual peer review cycle. The number of matrons has been increased for the forensic mental health

wards from two to four and the addition of two Service managers to strengthen the senior nursing support.

The Board is now reviewing the % of direct care time spent with patients. To date there does not appear to be a correlation between the amount of direct care time being delivered and actual staffing levels on the wards. Similarly we have not identified any trends or direct correlation with any of the quality indicators we measure and staffing levels.

Why are there challenges

The main reason wards have been unable to fully staff every shift is due to vacancies related to recruitment difficulties in some geographical areas and some specialties, and increasing establishments to which we have given more strategic attention. Retention of staff is also a strategic priority and solutions to reduce turnover are proposed in the Organisational Development, Workforce and Nursing Strategies. The secondary reasons are due to a rising level of sickness in some wards which are being actively reviewed ward by ward with support from HR advisors, and maternity leave in one ward. There remains a need to understand more about the reasons behind staff leaving, to support staff where services have high demands, and to ensure we are actively managing career aspirations to retain staff within the trust.

Management of staffing levels

Escalation processes are in place to manage staffing safely on a shift by shift basis with senior staff giving appropriate support to ward teams. The staffing levels by ward are reviewed daily by Modern Matrons and weekly by the Heads of Nursing, Director of Nursing and Chief Operating Officer to ensure there is an appropriate level and skill mix of nursing staff to match the acuity and needs of patients to provide safe and effective care. Throughout September 2015 all wards were staffed to achieve safe staffing levels; however this has been achieved in some wards by our staff working additional hours and shifts and the high use of temporary staff both from NHSP bank and external agencies.

To ensure minimum safe staffing on every ward on a shift by shift basis a number of actions were taken specific to each ward these include:

- Managing capacity and levels of agency staff by reducing bed numbers in wards temporarily i.e. beds have been temporarily reduced across the community hospital wards and on the PICU to maintain safe staffing levels.
- Temporary suspension of admissions
- Taking level of need into account when deciding to which ward to admit patients
- Staff who are normally supernumerary to the nurse staffing numbers such as modern matron, ward manager and deputy ward manager have worked as part of the nursing shift numbers
- Staff were borrowed from other wards to increase the staff to patient ratio
- Staff worked flexibly, e.g. working an extra hour at the beginning or end of a shift
- Increased use of temporary staff including the use of 'long lines of work' with agency staff on five wards to improve continuity of care and reliability of temporary staff

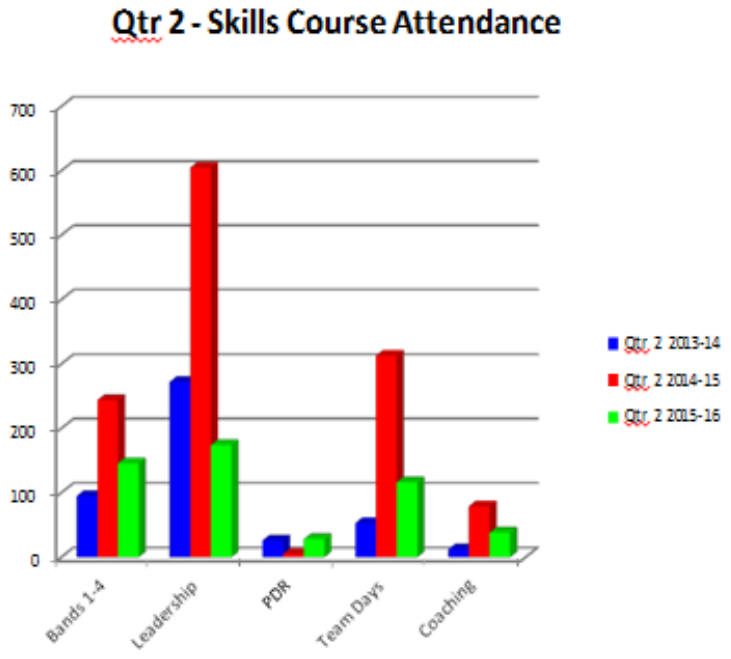
Percentage of shifts fully staffed

	Day time Shifts (Early, Late, Twilight and cross shifts)		Night time Shift	
	Registered nurses	**Unregistered staff**	**Registered nurses**	**Unregistered staff**
September 2014	95.6%	93.9%	95.5%	96.4%
October 2014	96.1%	95.1%	96%	96.3%
November 2014	95.5%	94%	94.8%	98.1%
December 2014	95.1%	94.1%	95.1%	97.3%
January 2015	95.2%	94.7%	96%	97.8%
February 2015	94.7%	93.2%	95.2%	97.9%
March 2015	94.7%	92.9%	95.2%	98.7%
April 2015	96.1%	96.2%	94.7%	98.6%
May 2015	95.1%	93.4%	95.9%	98.2%
June 2015	94.3%	94.2%	95.6%	97.7%
July 2015	94.4%	95.5%	95.6%	99.1%
August 2015	94.7&	95.4%	95.2%	98.7%
September 2015	94.6%	95.4%	94.1%	98.5%

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

indicator	source	frequency	target	14/15	Q1	Q2
Performance development reviews completed in last 12 months	Learning and development records	Quarterly	95%	84%	69%	73%

Skills course attendance is compared in the graph below with 13/14 and 14/15 levels in the same quarter. Whilst the 13/14 levels have been maintained or exceeded in this quarter, they are lower than the same quarter last year.



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Trust services are managing a difficult balance between providing safe staffing levels and enabling time for training. Directorates have ensured a sustained improvement in the uptake of mandatory training. However, it has been more difficult to facilitate attendance at other training courses. For these other areas of development, more attention will be needed to understand the changing needs of services to ensure that learning solutions are effectively planned and fully utilised. Despite this, there are a number of development initiatives underway or being planned.

Leadership development

- 20 newly appointed or developing managers have completed the First Line Management programme and are waiting for the results. If successful, they will receive Masters Level credits with Brookes University.
- A fifteenth cohort of the First Line Management commenced in September 2015. This leads to credits at masters Level with Oxford Brookes University.
- New leadership Development pathways for bands 5 -8 are being designed to integrate all leadership activity previously delivered across the trust into a single pathways including the Leading the Way programme and Champions programmes from the Innovations team. This will also include new Managers to ensure that every new manager will have the relevant skills to lead their teams in all HR related instances and PDR.

National Leadership Programmes

- One staff member started Nye Bevan, and 4 staff started Elizabeth Garrett- Anderson.

PDR Review Update

- An on-line PDR tool has been created by the TEL Team in L&D and it will go for sign-off for a soft launch on 1/1/16.

Future plans

- The launch of clear development pathways for all bands from 1 to 8. Starting with apprenticeships and leading up the pathways to Strategic Leadership.

Review actions to improve recruitment into vacant positions including implementation of the values based recruitment framework.

Take proactive action on recruitment to vacancies and monitor the impact of the new values based recruitment framework.

Indicator or measure	*Data source*	*Target and lead*	*Baseline 14/15*	*Q2*
Reduce vacancies as % of establishment	ESR	Target tba	*5.66%*	*11.85%*

A number of designated recruitment open days have taken place in Adult and Children's service with some success. An Open Day for Older People's directorate is planned on 7 November with more Open Days planned for Adult Services and Older People's in January 2016. We are also attending the Southampton Recruitment Fair in November 2015. Although we have some success in recruiting to our vacancies the turnover rate remains high at 13.85%. Retention is one of the main focusses of the Workforce Strategy.

Values Based Recruitment has not yet been fully implemented. A meeting is taking place with TVWLA in early November to identify some assistance with resource and funding to move this project forward.

Implement actions to improve staff wellbeing and motivation at work

Staff Recognition Awards

The aim of the annual staff awards was to recognise and to celebrate the achievements and commitment of individuals and teams who work at Oxford Health NHS Foundation Trust, at all levels and across all professions.

The awards were held on Thursday 10 September at the Kassam Stadium, Oxford following on from the trust's AGM. The winners from our eight categories were announced to over 200 attendees. Staff enjoyed the atmosphere of the event and meeting other nominees and hearing their stories and were proud of hearing about the excellent work being done across the trust.

NHS Annual Staff Survey

The Annual Staff Survey was sent out to all members of staff on Wednesday 30 September. The majority of staff received an email and 2% received a paper copy from the Picker Institute with instructions of how to complete their survey, before the deadline of 30 November. Directorate response rates are sent out to all staff through the weekly email. Picker will be sending out the results of the survey at the beginning of 2016 and an action plan has been formulated on how to communicate the results with staff.

Expansion of OxonBikes

We have secured Department for Transport funding with local partners to add electric hire bikes to our OxonBike (similar to '*Boris*' Bikes) docks in Oxford, to support staff who are not presently regular cyclists.

Cycle to work day

The trust supported national cycle to work day on Thursday 3 September and various sites across the trust hosted bike breakfasts for those that cycled in to work. The breakfasts received a really positive response from staff and many sites are now in the process of forming bike user groups to help improve facilities and support cyclists.

Working time directive and how we can use e-rostering to monitor

Thresholds are set up in the workforce management system which enable the monitoring of hours worked by employees, flexible workers and agency workers across all contracts and units within the Trust.

Thresholds monitor the total number of hours worked in a week and the average number of hours worked over a 17 week period. The manager is warned each time a shift is booked that breaks these thresholds. Reports can be pulled to support the monitoring of this.

Evaluate trio leadership development and assess impact on leadership capability

To understand how our leadership teams have been functioning in the services, the adult services senior leadership team (part of the SMT) have been undertaking visits to the different triumvirates to provide coaching to the teams and help them assess the impact they have had. During the sessions, the teams consider several elements:

- What has been achieved, in terms of
  - How they are forming a leadership team
  - Valuing and motivating the team
  - Considering service design
- Considering the challenges they need to overcome
- What is to be progressed, in terms of
    - How they are forming a leadership team
    - Valuing and motivating the team
    - Considering service design

This information is being collected to understand the on-going challenges for the teams and how the senior team can support the different areas to overcome these.

Delivery of a collective leadership strategy

The development of a collective leadership strategy has not progressed as planned; however a wide range of leadership development initiatives are underway across the Trust. Alongside Leadership Trios and formal leadership development training, Planning for the Future aims to bring leadership teams together and give them time to create a collective leadership approach, learn leadership concepts and design plans that support staff to deliver high quality patient care. The programme has involved working through the following concepts:

- Working together as a leadership team – using the Effective Team Working research to support team effective functioning.
- Understanding motivating and valuing individuals and teams – understanding the Careful research and the link between engaged staff and good patient experience.
- Understanding leadership style and using the coaching tool – using this approach to support the movement away from a directional leadership to an engaged working culture and aid decision making being made at a closer point to patient care.
- Strategic thinking approach used to design service delivery plans.

The Adult Directorate undertook five 1-day and two x ½ day workshops in 2014-2015 involving seventeen leadership teams from the Directorate. This year we are focusing on 25 Leadership teams from the Children and Young People's Directorate. Older People's Services will undertake the programme in 2016-2017.

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

The six month pilot, providing very rapid access to musculoskeletal (MSK) physiotherapy to Older People's Directorate staff, concluded on the 31 July 2015. The intended benefits of the pilot were to reduce the overall absence rates for MSK conditions in the Directorate, reduce agency costs and improve staff satisfaction, wellbeing and morale.

From 2 February 2015 to 31 July 2015:

- A total of 144 staff were referred to the Fast Track Physiotherapy Service.
- Of the 144 staff referred, four cancelled the assessments as their symptoms resolved, one cancelled as they did not want treatment and 1 could not be contacted to book the assessment.
- 86% of staff (119) were offered an assessment within seven calendar days of receiving the referral.

- 30% of staff (41) were assessed within three calendar days, 19 of which were seen on the same or following day.

The HR metrics, comparing data in 2014 to 2015 between 1 March – 31 July, revealed:

- A reduction of 50 episodes of sickness relating to back and other MSK problems.
- A reduction of 875 WTE days lost due to sickness absence.
- A reduction of 1.4 days on the average duration of absence.
- A saving of £36,743 in the cost of days lost due to sickness absence (using the mid pay-point of each pay band).

The clinical metrics revealed:

- 79% of staff who completed repeat Patient Specific Functional Scale scores demonstrated an improvement with their function.
- 82% of staff who completed repeat Numerical Pain Rating Scores showed a significant reduction in pain.
- 69% of staff who completed repeat EQ-5D-5L questionnaires showed an improved health status score.
- 78% of staff referred with low back pain who completed the repeat Keele STarT Back Screening Tool had improved scores.
- There were five episodes of non-attendance (did not attend/DNA).
- There were twelve instances where staff have cancelled their appointments (unable to attend/UTA).
- The mean number of treatments per staff equated to three (including the assessment).

The staff well-being metrics revealed:

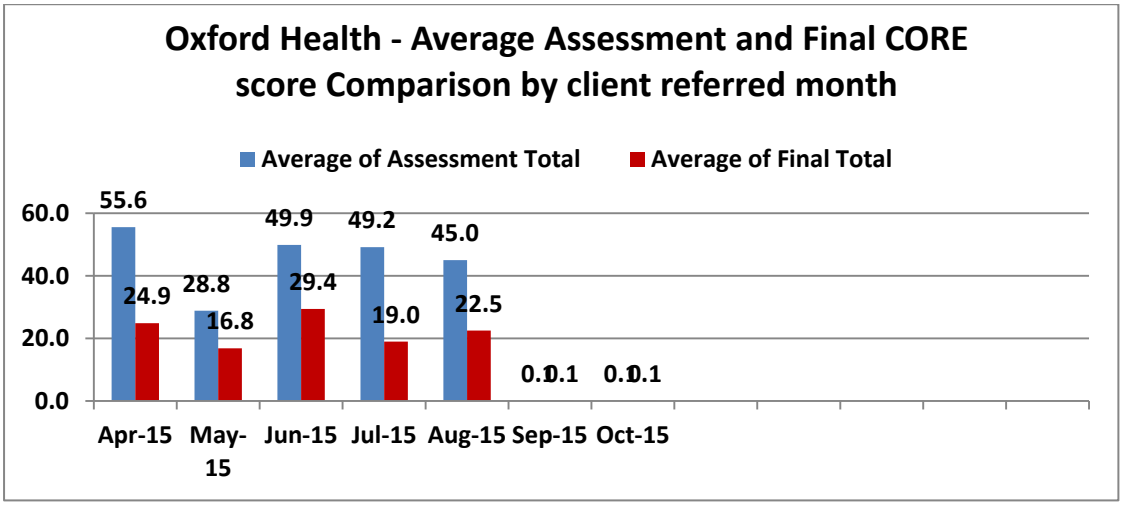
- 64% of staff reported at least a 75% perceived improvement score.
- 29% of staff admitted to some anxiety and depression on the initial assessment compared to 21% of patients on follow up.
- 17 staff members referred with low back pain scored medium to high risk on the Keele STarT Back Tool. 13 of these staff members completed their treatment and all scored low risk by the time they were discharged.

Feedback from the Patient Satisfaction Questionnaires has been extremely positive with comments including:
'I have been given hope at a time when pain was restricting my movements'
'I have recommended the service to other staff'
'Being able to stay at work and have this treatment was excellent'
'I was impressed with the speed of response to my referral'
'The physiotherapist was sensitive to my needs and identified how I could improve my health'

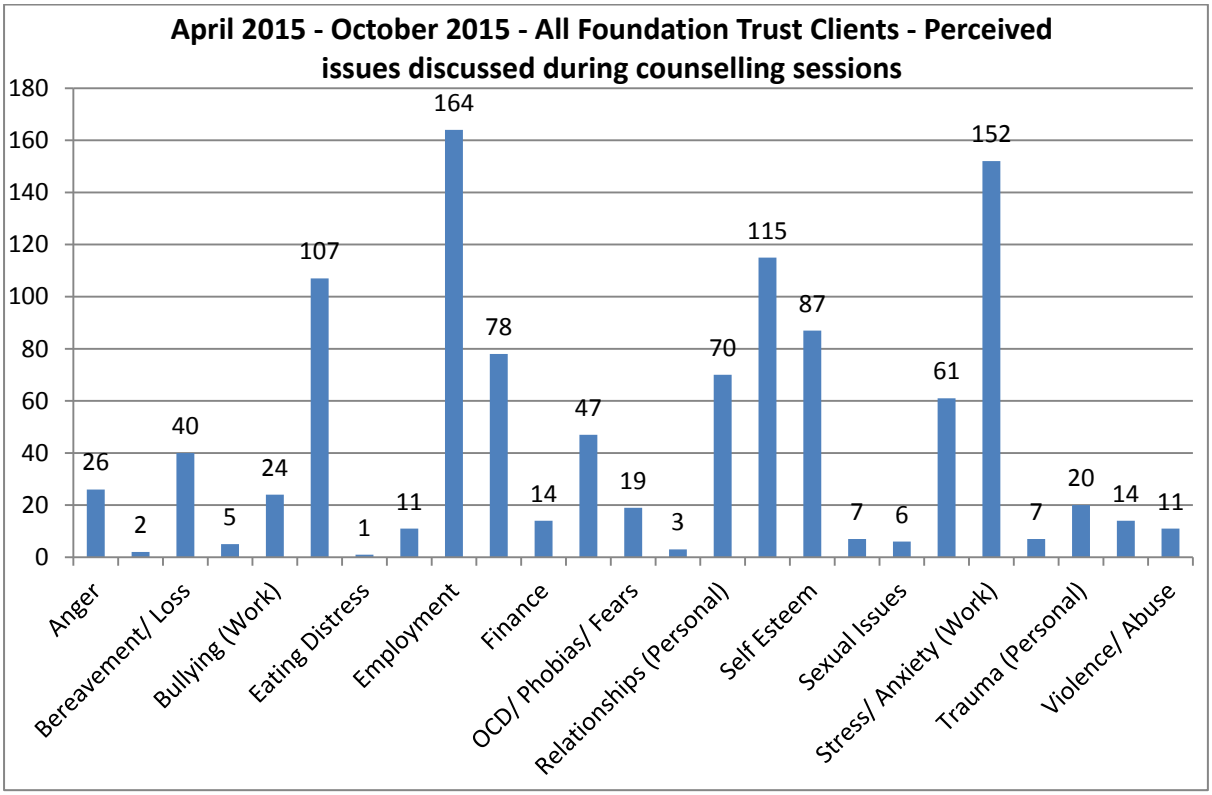
The pilot has now concluded and a final presentation is due to the Charity Committee in February 2016. Many staff have approached the team to see if the services are still available having clearly valued them. It is anticipated that the self-referral model will be adopted as part of the MSK Review as the results have clearly demonstrated a benefit to the Directorate.

Reduce work related stress through improved access to psychological therapies.
When employees are referred onto our external counselling service, we only refer for standard counselling. The Counsellor will complete a CORE assessment at the first session

which indicates risk factors and type of counselling required i.e. standard, post-traumatic stress, CBT. At the end of the six sessions, a repeat CORE assessment is completed which evidences impact of sessions. A positive impact is evidenced by a reduction in the CORE assessment score.



The following graph shows the range of issues which were discussed.



- Staff may also be referred via the occupational health department to external therapies for perceived work related stress
- The Head of Spiritual & Pastoral care provides a voluntary service for both work related and non-work related stressors.

- Occupational Health are also working with IAPT to explore the potential for providing a fast track referral process for OHFT employees to in house psychological services.

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

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

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

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

Senior leaders visit wards and teams routinely.

Ensure staff involvement in designing and delivering improvement activities

Staff across the Trust are regularly involved in improvement activities, initiated and supported from within their directorate, by the innovation and improvement/productive team and by the Safer Care team. Some examples include:

Development of a competency workbook which has been piloted on 4 wards and will be reviewed in November 2015. This will promote safe administration of medications with the goal of improving patient safety and reducing medication incidents. This is now being used as a starting point for the trust wide Medicine Safety and Governance Group to develop a similar workbook for all registered nurses in all settings.

Multi-agency workshops between the Psychiatric In-reach Liaison services and Police Street Triage in Buckinghamshire to support and improve the communication between all the services involved in this new initiative.

Continued work to support a Smoke-Free Trust including sourcing e-learning package for Level 1 and Level 2 smoking cessation advisors. The presence of well-trained smoking cessation advisors on each of the wards and units is key to support both staff and patients manage their nicotine dependency whilst being looked after on our wards.

Joint clinics with the OUH are underway to deliver the Autistic Spectrum Diagnostic pathway to improve waiting times and improve the service for families.

The Children's Community nursing service has mapped the 'End of Life' patient pathway to ensure a seamless service for children and young people facing life limiting illness and their families.

The venous leg ulcer pathway has been embedded within the district nursing teams. Improvement in healing rates have been maintained with an average healing time for a patient placed appropriately on the pathway coming down to under 7 weeks.

The City Older Adult CMHT have taken a structured approach to reviewing their processes and systems that support their referral / duty process and the teams approach to medication management. Through this process they are reducing non-value added tasks, providing clearer expectations of the process to referrers and other services, enabling supporting effective risk review and management at the point of referral triage and limiting variation between clinicians.

The wound formulary group and community hospital wards in Abingdon and Witney are now using the 'Traffic Light System' as promoted by NHS supply chain and the RCN. This will promote reducing waste and raise staff awareness of product costs.

Quality priority 2: Improve quality through pathway remodelling and innovation

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

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

All staff in adults services have been trained in using the recovery star and the directorate have been working with IT to have this available in CareNotes. Whilst this is underway, staff have been completing paper copies of the form with patients; the star is then used to help shape their care plan using their formulated goals. There are completed 588 stars.

Work is continuing on the care packages for clusters; we aim to have these available to teams by the end of November 2015. All packages of care have been reviewed to ensure they have the correct interventions for patients depending upon their cluster.

Older People's Mental Health Service Remodelling Evaluation

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

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

The older people's acute mental health inpatient wards have streamlined assessment processes and the delivery of inpatient care, to ensure treatment and care is focused and

timely. Staffing on the older people's mental health acute inpatient wards have been improved. The expected outcome is reduced length of stay for patients. There will be continued emphasis on rehabilitation and recovery, or the achievement of optimum functioning.

Indicator or measure	*Data source*	*Frequency*	*Target*	*Baseline 1415*	*Q1*	*Q2*
% of patients with a CPA to be in employment or meaningful activity	CPA audit	Quarterly	11.8%	n/a	14.7%	12%
% of patients with a CPA in settled accommodation	CPA audit	Quarterly	78.7%	n/a	78%	71.3%
% of patients involved in setting and achieving goals	CPA audit	Quarterly	100%	88%	84%	89%

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

We are delighted that four of our memory services have achieved accreditation, three accredited as excellent. A further service has been deferred until January 2016 to enable them to gather evidence for three standards. The process of applying for accreditation has allowed the services to reflect on areas of good practice and proactively to improve quality.

N Oxon – Deferred until 4/1/2016
S Bucks – Accredited
Central – Accredited as Excellent
S Oxon – Accredited as Excellent
N Bucks- Accredited as Excellent

Accreditation for Inpatient Mental Health Services (AIMS)

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

Wintle, Vaughan Thomas and Opal wards have all achieved accreditation.

Evaluate the integration of physical and mental health pathways for older people and monitor impact on agreed quality measures.

A commitment was made by the Older People's Directorate to participate in the Oxfordshire Community Integration Programme overseen by the Oxfordshire Clinical Commissioning Group (OCCG). The aim of the programme is to deliver Integrated Community/Locality

Teams across Oxfordshire, between Primary Care, Social Care and Community Healthcare for adults in partnership with volunteer organisations.

The Older People's Directorate took the first steps to integration last year; restructuring its services and management arrangements to bring together community physical and mental health services in to 6 integrated localities. In December 2014 the directorate launched the commencement of 6 integrated locality teams hubs that have been set up as single access points to joined up and well-co-ordinated community physical and mental health care services within the localities.

Oxfordshire Clinical Commissioning Group (OCCG) and the Older People's Directorate have agreed which integration developments it will focus on during 2015/16 in order to contribute to the above overarching programme objectives, which are:

(1) Integrated 'Front Door'
(2) two hour response
(3) MDT reviews of top ten High Risk Users
(4) Single (Crisis) Care Plan
(5) Voluntary Sector/Partnership Working
(6) Shared Skills Training

At the September Project Board;

- the two hour response criteria was approved
- information reporting requirements have been agreed in principle and await final sign off following front line staff review. Data reporting is due to start on 1 November
- The directorate aims to implement an audit cycle to monitor the effectiveness of the ILTs and adherence to operating guidelines
- A report is due back to the next Project Board to report on progress in relation to the MDT reviews pilot and implementation of a single crisis care plan
- A draft competencies and shared skills training strategy is due to be presented to the November Project Board
- A social worker is due to be co-located in the Single Point of Access in October

Evaluate the goals based outcomes toolkit and impact of personalised outcomes and circles of support on patients' achievements in speech and language therapy services in Bucks.

Although we have been using goal-based outcomes for school aged children in Bucks speech and language therapy services we have found that children with severe language problems and/or limited self-awareness or confidence found selecting and reviewing goal-based outcomes difficult. The success of the intervention for these groups has been more dependent on the level of engagement / experience of the school staff than on the therapy itself and it has been difficult to show universal improvements in outcomes.

As result we now moving to TOMS (Therapy Outcomes measures) to target therapy needs. TOMS is reliant on having a clear understanding of impairment, activity, participation, well being and the Speech Therapist is then able to find the best match therapy solution which still working closely with parent/carers/support staff in settings (AUDITED via cases studies). We will report on this in future reports.

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

The new outcome based commissioning contract for Oxfordshire commenced in October, which will allow us to create a baseline for outcomes measurements. The outcomes for the contract are:

- People will live longer
- People will improve their level of functioning
- Carers feel supported in their caring role
- People will maintain a role that is meaningful to them
- People continue to live in stable accommodation
- People will have fewer physical health problems related to their mental health

Over the last few months, we have launched the Recovery College, one of the key goals of the partnership. The college will allow service users, carers and staff to study together. The college commenced on the 7th September with 4 courses available:

- Introduction to Recovery College
- Understanding mental health
- Introduction to the caring role
- Peer support and tutor training

The courses are available at various locations throughout Oxfordshire, including Abingdon, Banbury, Farringdon and Oxford City.

Internal Peer Review Programme

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

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

The Cognitive Behaviour Therapy pilot in the dental service continues to progress. 12 dental staff have received training from Oxford Cognitive Therapy Centre (OCTC) (completed July 2015) and from September the CBT service has started to be delivered to dentally anxious adult patients. Monthly supervision sessions with OCTC and Talking Space are taking place for the next 12 months. Evaluation of the data has commenced and over the next 12 months it should be possible to see how successful this service is at reducing the number of dentally anxious adult patients required treatment with sedation or general anaesthesia.

Review opportunities for increasing CAMHS in-reach into schools.

Each secondary school will have an identified PCAMHS link worker. The directorate is piloting weekly sessions with a PCAMHS worker in three secondary schools over three terms.

Implementation of Dementia Strategy

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

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

An inaugural Bucks Dementia Charter Project Board meeting took place in July to agree the project framework, leads and teams.

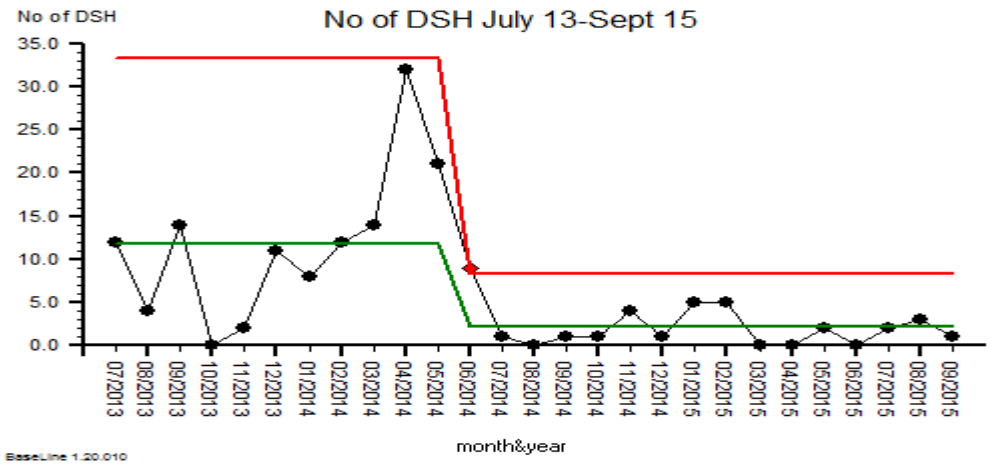
Reduce the number of frequent attendances to urgent care services by 5% and ensure care plans/special notes are available for 95% of frequent attenders' notes.

The urgent care service now has baseline figures for the frequent attendances to urgent care services and availability of care plans/special notes (see table below). This demonstrates the need for further work to improve practices and reduce attendances. The services will work with partners to identify appropriate interventions for these patients to reduce the number of their attendances.

indicator	Baseline figures
% of frequent attenders of urgent care where care plan/special notes are available	45%
Number of frequent attenders	23

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

Marlborough House has continued to sustain the reduction in DSH requiring physical intervention with an average of two DSH incidents a month from July 2015. Case management and communal areas continue to be a focus for improvement. Additional attention is now being placed on the quality of engagement in key working with a young person and their family. The team are currently in the process of completing a driver diagram to identify specific areas of improvement.



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

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

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

	June	May	June	July	August	September
%	100%	88%	64%	100%	100%	100%
Numerator	30	29	23	18	19	25
Denominator	30	33	36	18	19	25

During June the service experienced a significant and unexpected increase in new to care children in one week, which resulted in a performance dip in this area. Performance has recovered, however, in quarter 2. Fifteen children were taking into the care system, which is an unusual number.

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

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

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

Oxon and Bucks LD teams are now working to take forward a new carers group commencing Q2 2015. A group already exists in Swindon.

Letters are sent to all patients and carers within LD services explaining the services and acknowledging referrals, and there are links to the new Trust Website. Staff continue to tailor

the website to meet the specific needs of their client group (specific to the service specialism) and therefore to encourage knowledge and accessibility of services within and related to the Trust.

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

In Q2 the Buckinghamshire Street Triage team had 104 referrals (41 in July, 19 in August and 44 in September). Of these, 65 were for advice, 34 face-face contact and five telephone contacts.

Thames Valley Police provide an update on the use of s136 detentions, at the end of Q1 (June 15), there had been a 40% reduction in use of s136 compared to the same period in 2014.

S136 and Inpatient Admissions

Month	Apr-14	May-14	Jun-14	Jul-14	TOTALS
S136 (Adult)	26	21	23	26	96
Formal Admission	9	10	5	6	30
Informal Admission	2	2	2	1	7
Admitted	42%	57%	30%	27%	39%
Month	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**TOTALS**
S136 (Adult)	25	28	26	27	106
Formal Admission	9	9	8	10	36
Informal Admission	1	0	2	0	3
Admitted	40%	32%	38%	37%	37%

Qualitative review of 10% of caseloads in AMHTs to understand whether the packages of care are being delivered in line with the cluster allocation

The care packages have not yet been agreed; therefore, the service was unable to complete an audit in Q2. It is expected, however, that they will be shared during November enabling the service to audit in Q4.

Pilot the new quality dashboard at directorate level

Adults services have been testing the quality dashboard for the last few months to understand if we are able to collect the information easily and to identify any trends. Due to some on-going data issues, it has not been possible fully to complete the dashboard.

Older people's services have begun work on the development of service level dashboards for the community hospitals and district nursing teams which will link with the Directorate dashboard. The Allied Health Professional (AHP) Lead is also developing a dashboard to review AHP performance across a number of services.

Monitor the impact of the new electronic health record against planned benefits. This is expected to make significant differences to staff in their ability to deliver accessible and comprehensive recording

Since the implementation of the new health records we have been identifying areas for optimisation within the system with our teams to improve how this works; this has included a

request for a patient dashboard which indicates all of the measures required for each patient so teams can see at a glance what is required/outstanding, the development of the recovery star and the revision of the physical health form.

We have been working with our teams to understand the issues they have been experiencing and providing support to them where possible or seeking advice and support from the central EHR team. As we undertake the optimisation work, we hope to be able to make improvements to the system and user-interface which will allow our staff to see more benefits from the new system.

In the South AMHT we have been piloting the App to see how this enables staff to access their records via their iPads – following the pilot some improvements were made and this has now been rolled out to all teams. The App will have a positive impact on the timely access to information for our staff when they are out and about with patients.

In OPS the Directorate's project structure continues to support the delivery of CareNotes in a number of ways including:

- Team and champion involvement to inform/design functionality of CareNotes, including design of specific forms for community services to meet clinical needs, for example the caseload management tool for district nursing.
- The delay in Go Live date for community services provided the opportunity for the EHR team to contact/meet with all services to review any issues, concerns and areas for change within CareNotes. These have been collated into a central issue log and those not resolved at the point of Go Live will be taken forward during optimisation.
- Communications have been sent to champions and all staff via newsletters, FAQs and verbal updates.
- For the Community Go Live a fortnightly meeting of the project team is held to monitor actions e.g. training status and development of cut over plans.
- For OP Mental Health Services a review of their experience of using CareNotes has been undertaken. Members of the EHR Transformation Team have met with services to identify issues, areas of concern and areas for change/optimisation. A process for taking forward optimisation of OPMH CareNotes has been agreed at project board and is currently being implemented.
- Lessons learnt from the mental health rollout have been applied to Community for example provision of in-patient recording SOPs to ensure in-patient bed stay information is accurately captured. This was an issue during early use of CareNotes for mental health.

Quality priority 3: Increase harm-free care

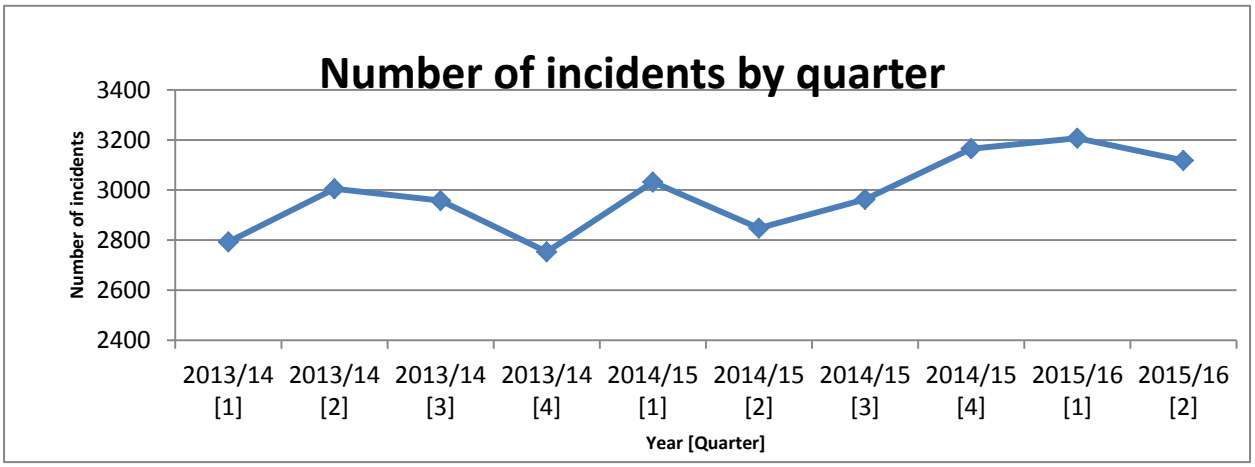
Safety remains one of our key priorities. For our patients this means both reducing self-harming behaviour and ensuring we deliver harm-free care. A renewed national emphasis on prevention and health promotion is reflected in a new priority to improve physical health management. As well as six specific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

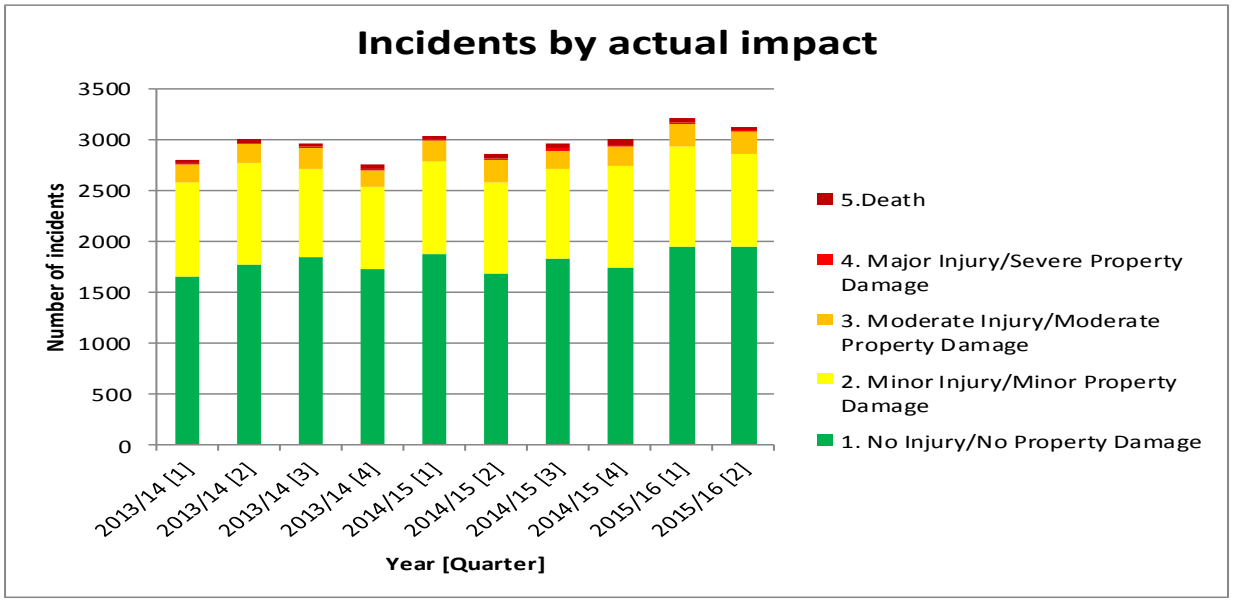
thermometer measures for physical and mental health services. This will enable the service to be safe and effective.

Incidents, including serious incidents occurring in quarter 2

Incidents

The overall number of reported incidents remains higher than the same period last year. The numbers of reported green and yellow incidents (low/minor injury or property damage) continues to represent the highest proportion of total reported incidents. Both death and major injury/property damage have seen a fall in numbers reported. There have been 28 deaths reported this quarter compared with 48 in Q1 and 59 in Q4 2014-15.

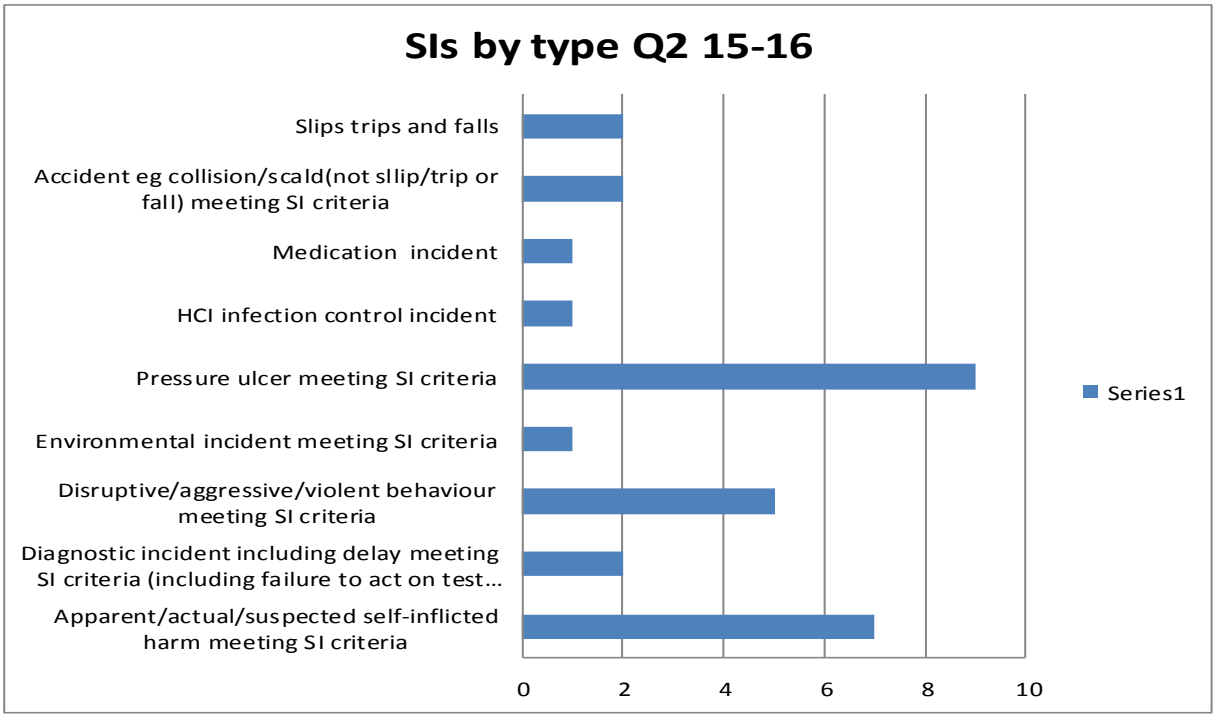




Health (which includes pressure damage),violence and aggression and self-harm continue to be the most commonly reported type of incident. Fall related incidents still appear in the top six incident types but actual numbers continue to fall.

The number of reported serious incidents is higher than in the same period last year.

The highest number of serious incidents relate to pressure damage and to self harm



There have been no inpatient suicides and the drop in the number of community suicides in Q1 has been sustained in Q2.

3.1 Prevention of suicide

Implement rapid multi-disciplinary consultant-led reviews in clinical teams following a patient (suspected) suicide within ten days of the incident being known

The ten day time frame for the multi-disciplinary review is proving challenging to achieve, and there remains some confusion about the difference between this, a debrief and a root cause analysis investigation. This has resulted in some anxiety locally about the purpose of the review and its consequences. The suicide prevention lead is continuing to work with the deputy medical director to consider the most appropriate way to roll this out and evaluate its impact.

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

Clinical Risk Assessment and Management includes the interpersonal theory of suicide. The next stage is to review the advanced assessment skills training and deliver the suicide awareness and reduction module within that – this is underway. Tailored training continue to be provided to teams – most recently psychological services, including IAPT. Suicide and self-harm awareness is embedded in the University of West London minor injuries modules run by the Trust. Suicide awareness, assessment and risk management takes place in years 2 and 3 of the pre registration mental health nursing programmes at Brookes. We are due to review progress with suicide education with the universities involved. In the meantime suicide awareness training has been shortlisted for the HSJ awards in the category "improving outcomes through learning and development".

Develop a suicide prevention strategy, aligned with Bucks and Oxon public health-led suicide risk reduction strategies

This is now in progress as part of the Trust's Public Health steering group. A draft strategy for wider consultation will be circulated in December.

The community teams which have not achieved 300 days between probable suicide can be found in the table below. There have been no inpatient suicides.

Team	*Incident date*	*Days between*
Wycombe CMHT	*12/09/2015*	*18*
AMHT Aylesbury Team	*18/08/2015*	*43*
Chiltern AMHT	*11/08/2015*	*50*
Psychological Therapies-Oxfordshire	*31/08/2015*	*30*
EDPS	*04/09/2015*	*26*
Prison Service Huntercombe	*10/08/2015*	*51*

3.2 Reduce the number of missing patients from inpatient services

Indicator or measure	*Data source*	*Frequency*	*Target*	*Baseline 14/15*	*Q1*	*Q2*
Number of incidents where patients do not return on time from approved leave	Ulysses	Quarterly	50% reduction	218	62	46
Number of patients absent without permission	Ulysses	Quarterly	25% reduction	153	43	39
Days between harm to patients or other people arising from absence without permission	Ulysses	Quarterly	300 days between	Start count from Q1	91	183[3]

The Safer Care work relating to patients who fail to return on time from leave and time away from the ward was initially tested on Phoenix Ward and now 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 original aim of the work was to reduce the number of times patients fail to return on time to the ward by 50% by 1st April 2015. Seven wards achieved this aim (the following percentages are a median):

- Allen Ward 90% of the time
- Phoenix Ward 90% of the time
- Vaughn Thomas 90% of the time
- Opal 90% of the time
- Wintle 85% of the time

[3] There has been no harm reported as a result of an AWOL in Q2

- Sapphire 70% of the time
- Ruby 68% of the time

Allen Ward are presenting their work at the Patient Safety First Conference in November 2015

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

Roll out SSKIN[4] bundles to increase reliability of prevention damage prevention and management.

As a result of challenges to implementing SSKIN bundles in community services, SKINtelligence as a platform for this work has now been discontinued, with the Patient Safety Collaborative (AHSN) pressure ulcer prevention steering group now leading on the work.

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

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

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

At the end of Q1 43% of appropriate staff had been trained and 48% in Q2. There has been a gradual increase in numbers of staff attending the Pressure Ulcer Prevention and Management training, although there continues to be non-attendance at the events with either last minute or no cancellation on the day. The additional sessions have been facilitated (Unipart and Whiteleaf centre) but the maximum numbers expected were not achieved. Courses for 2016 have been agreed and are now available on the L&D site. Availability should meet the demand so managers should identify gaps within their service areas and support/ facilitate attendance.

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

Now that the SKINtelligence programme has been discontinued key members of the AHSN project group will work alongside identified teams to implement quality improvement methodology linked to pressure ulcer prevention. It is anticipated that the first sites will be in Didcot and work is expected to start in the autumn 2015.

[4] tool that acts as a prompt to staff to undertake a risk assessment and provide management of the risk with patients

Improve coordination of care through the introduction of risk stratification of patients and use of safety rounds for patients on district nursing caseloads

District Nursing services have been proactive in introducing changes to practice that enable early identification and management of risk in those patients on the caseload that are a risk of pressure damage. Primary among these are the use of a safety round at handover. A colour coding system is used to stratify patient risk within the caseload and allocate resources more effectively. The tool that enables this is a visual display system 'The T Board'. Some of the challenges to workload planning have been addressed by ensuring that there is a nurse in the office during the morning that manages incoming calls from patients and requests from GP practices. Previously these demands would have been dealt with when nurses returned to the office and introduced delays to treatment, inefficiencies and extended the hours nurses worked.

The new processes have enabled the development of services and systems that are more responsive to patient needs. This has also contributed to better morale in teams that often feel the challenge of demand versus capacity very acutely.

Introduce the SOAPIE model for care planning and the Braden Pressure Ulcer Risk Assessment Tool across all services

The SOAPIE model for care planning was rolled out across the county for District Nursing earlier in the year however, it became clear that ILT hubs were using SBARD. The Trust determined that to ensure consistency of approach all teams should be using the same model. The models have now been reviewed and a decision has been made to relaunch SOAPIE with district nursing teams and integrated locality hubs during quarter 3.

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

Joint work between the Modern Matron (Highfield Unit), Tissue Viability and the Urgent Care Lead has resulted in a new care pathway being developed for wound care and pressure damage for patients who self harm, and for eating disorder patients who are at risk of pressure damage. Staff training will continue in Quarter 3.

Indicator or measure	*Data source*	*Frequency*	*Target*	*Baseline 14/15*	*Q1*	*Q2*
Reduce avoidable grade 3- 4 pressure tissue damage	Ulysses	Quarterly	10% reduction	12	9	8
% of required staff attending level 4 training	L&D	Quarterly	tba	71% of phased target[5]	43%	48%

[5] Phased targets have been removed and replaced by a target of 90% of staff in post

We have started to use the *days between* measurement measurements for individual teams

Team	Incident date	Days between grade 3 or 4 pressure damage assessed as being a serious incident
NDW Burford & Broadshires	03/07/2015	89
PODS City Kidlington	10/08/2015	51
PODS City Kidlington	10/08/2015	51
DNSW Didcot Health Centre	13/08/2015	48
DNNE Montgomery House Surgery	21/08/2015	40
DNN Chipping Norton	04/09/2015	26
DNSE Henley	15/09/2015	15
PODS SE Abingdon	22/09/2015	8
DNSW Wantage	28/09/2015	2

3.4 Reduce harm from falls

Indicator or measure	*Data source*	*Frequency*	*Target*	*Baseline 14/15*	*Q1*	*Q2*
Number of falls/number resulting in harm by 1000 bed days	Ulysses	Quarterly	3.5 (0.3 harm) MH 8.6 (0.3 harm) PH	3.7 (0.3 harm) MH 12.6 (0.5 harm) PH	8.9 (0.2 falls with harm) PH	2.8 (0.4 falls with harm) PH
% patients in older adult inpatient services to have falls risk assessment on admission	Audit	Quarterly	100%	95% (based on 3 data points)	88%	92%
% patients in older adult inpatient services to have a further falls risk assessment after 28 days	Audit	Quarterly	100%	60% (1 quarter's data)	57%	92%
% of patients to have a review of care plan after a fall	Audit	Quarterly	100%	69%	89%	CH: 73% OPMH: 59% OPD: 66%

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

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

The falls team have also been working with Sandford and Cherwell wards in relation to assessment of postural blood pressure readings. During hand over meetings on Sandford and Cherwell wards the physiotherapists have raised awareness of the need to measure

postural blood pressure. Weekly random patient notes checks are taking place to ensure appropriate risk assessment and preventative actions are taken for those at risk of falling. Retrospective reviews of harm from falls will be carried out quarterly.

Additionally, staff on Cherwell ward have begun to use the 'Improvement Model' to assess current practice in order to implement improvements.

3.5 Reduce the need for restraint and monitor use of seclusion

Report on and monitor use of seclusion.

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

The number of reported restraints and seclusions has reduced since quarter 1. There has been a slight increase in the number of reported prone restraints in the same period.

Indicator or measure	*Data source*	*Frequency*	*Target*	*Baseline 14/15*	*Q1*	*Q2*
Reduce number of reported incidents of V&A resulting in harm (rated 3, 4, 5 impact)	Ulysses	Quarterly	25% reduction	69	21	16
Number of prone restraints out of all restraints	Ulysses	Quarterly	Towards 0	374/1679	56/511	61/452
Number of restraints involving hyper-flexion	Ulysses	Quarterly	Towards 0	39	8	8
Number of incidents where patients secluded	Ulysses	Quarterly	25% reduction	336	166	122

Highfield Unit

The project to reduce incidences of restraint by 50% is close to being achieved. This has been linked to a plan to reduce incidents of self harm, which is a frequent precipitant of restraint. The unit has reduced the average number of restraints per week from 10 to 5.4 and the average number of prone restraints from 3.1 down to 0.7 as part of a long term project.

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

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

The directorate has promoted the need for improved incident reporting for prone restraints following the detailed study of data for one month in the Autumn of 2014.

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

3.6 Improve the physical health management of patients

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

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

Develop a physical health policy and implementation and guidance.

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

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

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

We are now auditing a number of indicators relating to effective physical health assessment, management and monitoring of patients

Indicator or measure	*Data source*	*Frequency*	*Target*	*Baseline 1415*	*Q1*	*Q2*
% of adult and older adult inpatients to have MEWS, track and trigger, physical health assessment, VTE and MUST within 24 hours of admission	EPR/audit	Quarterly	100%	VTE 92% PHA 99%	VTE 88.7% PHA 100%	MEWS 30%[6] T&T 95% VTE 96% MUST 85% NNA 64%
% of patients have their physical health needs assessed	CPA audit	quarterly	95%	New audit 15/16	54%	97%
% of those care plans address the PH needs identified			95%		89%	89%
% of patients prescribed psychotropic medication are monitored for side effects relating to that medication	CPA audit	quarterly	95%	New audit 15/16	62%	63%
% of patients prescribed psychotropic medication where their GP has been informed of the need for ongoing monitoring by primary care in the community	CPA audit	quarterly	95%	New audit 15/16	70%	72%

Monitor patient experience of smoking cessation and impact/perceived benefits at six months and twelve months for those in long term care.

Low secure forensic ward

A female patient was undergoing dental treatment for severely decayed teeth. The dentist explained that dental implants would not be feasible if the patient continued to smoke, which prompted the patient to continue her efforts to stop smoking whilst on community leave. Subsequently the patient was able to undergo successful dental implants of her front teeth. This has improved the quality of her life as prior to this she was very reluctant to join in social or training activities as she was self-conscious about her appearance.

Opal Rehabilitation ward

A patient with a keen interest in astronomy was able to use the money he saved by stopping smoking to purchase his own telescope. He was able to stop with the support of the smoking cessation advisor and group on the ward.

[6] The Trustwide audit of MEWS is behind schedule, so this figure is for Amber ward only. We will be able to review this figure retrospectively to include the other 2 wards. Although only 30% recorded a total MEWS score for each of the 3 consecutive days audited, 70% of cases showed that the MEWS document had been used for one or two of these days.

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

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

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

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

Indicator or measure	*Data source*	*Frequency*	*Target*	*Baseline 1415*	*Q1*	*Q2*
Nutritional needs assessment completed	Essential standards audit	quarterly	tba	n/a	70%	?

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

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

Capture and act upon patient experience

To progress the work across the organisation to capture and act upon patient experience we have appointed a Patient Experience and Involvement Project Lead.

We have good examples of how we routinely involve patients, service users and carers in service developments and changes. These include a comprehensive network of user groups across services, such as: 'friends of a ward'; patient councils; 'Have Your Say' groups: service user and carer forums linked to each adult mental health team: patient participation groups at Luther Street GP: empowerment, training and recovery groups in the Complex Needs service: an education and research network group for older people: Article 12 young people and parent groups: there are trust wide as well as directorate learning and sharing events for staff and patients.

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

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

Some of the service wide actions being taken include:

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

The Family Nurse Partnership and Oxfordshire Children's Integrated Therapies are currently producing films with service users giving their views, alongside staff explaining what these services do. These should be completed by January 2016 and uploaded to the CYP website and used directly by staff.

The children and young people services have developed a series of films with young people, where they have produced and appeared in the films, some examples are listed below;

- CAMHS Swindon community team – what to expect http://www.oxfordhealth.nhs.uk/children-and-young-people/young-people/south-west/swindon/camhs-community-service/
- Anti stigma films 'me, myself and mental health' https://www.youtube.com/watch?v=4YbfrlssRGU
- Food for thought for young people about eating disorders https://www.youtube.com/watch?v=09TI7JhW_Xc
- Family Nurse Partnership, with mothers talking about their experiences to recruit other mothers onto the programme (in production)

The older people's directorate is working on two key initiatives around embedding personalised care; one project is working with Thames Valley Strategic Clinical Network to look at its application in primary care and within our Integrated Locality Teams; the second project on improving personalisation of care is being supported by the Kings Fund and is being implemented within one of the District Nurse teams. The aim is to support patients to

identify their goals, and to describe what helps and hinders them with their health problems to support the development of their care.

Patient Opinion is an independent feedback website, enabling patients to share their experiences of healthcare services. In addition to Web based reporting, Patient Opinion provide freepost leaflets for service users so that those people who are not confident with Web based reporting are equally able to provide feedback. During the next six months the use of Patient Opinion will be developed with six pilot sites. Team managers will be supported to self-manage the responses and use the feedback as a catalyst for improvement.

Friends and family test

Between January and September 2015 95% of people who have answered the FFT question (n=6681) have said they are extremely likely or likely to recommend the service they received. The results by month are shared below based on how they are submitted to NHS England, split by mental health and community physical healthcare services as defined nationally. They include don't know answers in the denominator.

Mental health services

Month of data	Number of responses	Extremely Likely to recommend	Likely to recommend	Combined extremely likely and likely to recommend
Jan 2015	231	41%	39%	80%
Feb 2015	432	41%	35%	76%
March 2015	498	53%	33%	86%
April 2015	365	60%	30%	90%
May 2015	282	72%	23%	95%
June 2015	264	64%	28%	92%
July 2015	492	59%	30%	89%
August 2015	301	64%	26%	91%
September 2015	174	61%	31%	94%

Community physical health services

Month of data	Number of responses	Extremely Likely to recommend	Likely to recommend	Combined extremely likely and likely to recommend
Jan 2015	846	57%	26%	83%
Feb 2015	626	49%	28%	77%
March 2015	737	68%	25%	93%
April 2015	359	69%	25%	94%
May 2015	237	77%	21%	98%
June 2015	155	78%	17%	95%
July 2015	409	72%	21%	93%
August	82	76%	22%	98%
September 2015	191	69%	26%	95%

In August 2015 the trust received 130 open comments from patients and 61 responses in September 2015 about why they would or would not recommend the care received. The vast majority were positive. In recent months the urgent care service has taken positive steps to improve communication and is piloting the use of social media which has resulted in fewer negative comments about waiting times.

The quality of relationships between staff and patients (described as the relational aspects of care) are a key factor to a patient's experience, and the areas for improvement show the importance of getting this right to be able to achieve a positive experience. We recognise the link between patient experience and staff wellbeing and that plans need to be developed to improve both.

The results of the staff survey to the two FFT questions are shown below. In general a higher number of patients are likely or extremely likely to recommend receiving care when compared to staff.

Staff FFT results

	Recommend organisation if needed care or treatment		Recommend organisation as place to work	
Quarter	Number of responses	Combined extremely likely and likely to recommend	Number of responses	Combined extremely likely and likely to recommend
Q1	316	73%	313	59%
Q2	723	69%	702	58%
Q4	987	73%	963	57%
Q.1 (2015)	500	72%	491	55%
National staff survey	1646	61% (based on answer of yes)	1646	55% (based on answer of yes)

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

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

In Cotswold House Oxford patients have made a training video for staff in relation to management of the dining room. This was successfully premiered at an event organised by current patients and will now be held on the learning and development portal as a training tool.

On Wenric ward patients had requested access to the kitchen and tea/coffee facilities which had been restricted to certain times each day; after discussions it was agreed that the kitchen areas would be open at all times and patients could be given unsupervised access to hot water so they could make hot drinks. The Forensic service has also begun a project to redevelop the quiet lounge and patient communal areas following feedback that the ward areas had become unkempt and needing uplifting. A small change underway is the introduction of art on the windows to brighten the space and make it more appealing; the room will also be redecorated and new furniture purchased. The patients are being involved

in choosing the colours and furniture for the area. The garden was also identified as an area of improvement, to support this work we have asked Restore if they can support the ward and provide gardening workshops so the patients can help create a more therapeutic and welcoming garden areas.

Memory Clinic patients asked for appointment reminders and they are now phoned in advance of appointments.

In our community wards relatives told us they did not always understand the stroke terminology used by staff after their relative , so staff have developed a poster to explain stroke related terms.

Community patients feedback suggested that improvements were needed in how we assess and manage pain and as a result staff have revised pain assessment and management documents.

Directorate (service)	You Said	We Did
Adult services		
Forensic team	It would be helpful to set up a social group in the restore café.	Staff have supported this and are helping to create a social group at the cafe.
Adult acute, rehab and PICU wards	Alternative menu choices needed to include an option of jacket potatoes Patients wanted to use the garden more as the no smoking on wards was introduced	Ruby ward -. Jacket potatoes are now available on request. Vaughan Thomas - following requests and since no smoking on wards the team has been using the garden more for activities during the day. This is working well.
	It was reported that service users would like porridge as a warm meal at breakfast time It was reported in the 'have your say' meeting that there were not enough visible clocks on the ward	Sapphire ward have introduced porridge as a warm alternative and received positive feedback about this Clocks were ordered and have been positioned all across the ward
IAPT	Need to improve the collection of feedback from patients	Questionnaires are now being used as are the FFT postcards.
Children and Young People		
	Patients said they felt the guidelines surrounding fresh air were perhaps feeding into their compulsive exercise Patients asked for takeaway meals sometimes	We introduced a compulsive exercise group and reduced the time out/fresh air guidelines. Supper group has been introduced following request from patients to try takeaways on the

Directorate (service)	You Said	We Did
	Patients said they would like to be able to see the consultant or matron in clinics We would like a different dining area when in recovery Not all people want to speak out at the 'you said meetings' Patients regularly ask for recovered patient talk,	unit. Introduction of consultant/modern matron weekly clinic. This has proved very successful. Patients can either request to attend this or be requested to attend. Introduction of the low support dining room for patients who require limited staff support. The dining room can accommodate up to 4 patients at a time. We introduced a community book with the statement "you say we do " – patients are able to make comments in this book, it is then discussed within the team then fed back to patients in a community meeting on a weekly basis with rationale for decisions made. We now offer talks by recovered patients when possible.
Older People		
Memory Clinics	A concern was raised regarding continuity of care when a staff member was on leave	Procedure developed to manage unplanned absences of Memory Clinic Nurses
OA CMHT	Cognitive Stimulation Therapy (CST) requested	North OACMHT staff have completed CST training, and have run a successful taster session.
Urgent Care	Communication with patients in urgent care services need to be improved.	The service has started to use social media as way of engaging and involving patients There were 240 'page likes' during the first weekend on Facebook. Posts have reached 2674 users (5310 total reach) The service has 33 followers on Twitter and Tweets have made 3200 impressions.
Community Hospitals Abingdon ward 1	The speech and language therapy team had feedback from patients saying that they were becoming bored and lacked stimulation which hindered improvements in communication	The service will start a group for patients to practice their communication. Each bay has a mini wipe board for use by patients who have problems with communication
	Families said that they felt stressed by the referral process to continuing health care (CHC) as they didn't know who to go to for	The ward and CHC now work more closely together and CHC has provided a named person to liaise with the ward – they have also been invited to attend MDTs Circles of support are informed as soon as it is clear that a patient might be referred to CHC so

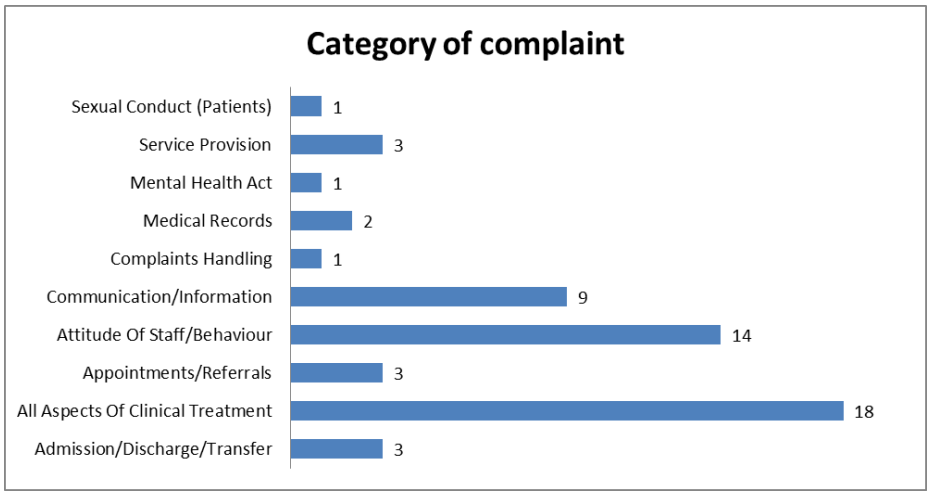
Directorate (service)	You Said	We Did
	information	they can introduce themselves before the process starts
Community Hospitals Abingdon ward 2	Feedback from patients suggested that the ward was too noisy at night	They are exploring the installation of a night call bell system to reduce the volume
District Nursing	Patients said they did not always know what was in their care plan	There is a pilot project in one of the District Nursing teams to help improve the personalisation of care. This project includes the patients identifying their goals, what helps and hinders them with their health problem to inform the development of their care

Monitor themes from complaints/concerns and implementation of actions

The Trust has received 55 formal complaints (excluding those withdrawn) during Quarter 2 compared with 51 in Q1 (an increase of 7%). Complaints were distributed as follows:
Adult Services 35
Older People's 9
Children and Young People 9
Corporate Services 2.

Sixteen (29%) complaints were responded to within the initial timescale agreed with the complainant; 18 (33%) were responded to within an extension agreed with the complainant; and two (4%) were responded to outside of the agreed timescale. At the time of writing this report 19 (34%) complaints remain open and under investigation.

The following table shows the primary categories of the complaints (upheld and not upheld)



Adult Services

Complaints concerned a range of services across the adult service directorate, including AMHTs, Ashurst PICU, acute inpatient wards, Complex Needs, IAPT, Forensic community services. They concerned the following broad areas – these include concerns that were not subsequently upheld.

- Concerns raised in relation to staff behaviour, attitude, professionalism and conduct towards patients and carers
- Poor communication and advice provided by staff
- Behaviour of other patients
- Effectiveness of therapy
- Changes to service model in complex needs
- Decision-making relating to medication
- Poor or no communication with GP and other services
- Lack of support or action provided variously by consultant staff, care coordinators and community teams – in two cases this was attributed by complainant to subsequent self harm
- Delays in accessing mental health services and in receiving an assessment
- Decision-making relating to placement
- Precipitate discharge and poor support post-discharge
- Unlawful mental health act assessment
- Poor risk assessment relating to danger presented by patient to their family and failure to take account of family concerns
- Actions relating to the treatment and transfer of a patient
- Information being shared without consent

Children and Young People

Complaints concerned a range of services across the directorate, including dental services, CAMHs, speech and language therapy and eating disorder services. They concerned the following broad areas – these include concerns that were not subsequently upheld.

- Lack of communication at time of treatment and subsequent distress this caused
- Lack of appropriate treatment and failure to follow treatment plan
- Lack of engagement between therapist and patient
- Waiting too long for an appointment
- Inaccuracies in referral to social services
- Poor communication between unit and MHA office and subsequent delays in tribunal hearing
- Poor communication, ineffective treatment plan, poor staff attitude, lack of support
- Poor planning and coordination during transition between services

Older People's Services

Complaints concerned a range of services across the directorate, including musculo skeletal services, minor injuries unit, out of hours, podiatry. They concerned the following broad areas – these include concerns that were not subsequently upheld.

- Pain following physiotherapy treatment
- Assessment not thorough enough and doctor not reassuring
- Failure to diagnose condition which later required hospital admission and/or surgery and failure to take account of relative's concerns
- Cancelled and delayed appointments
- Staff attitude
- Failure to carry out proper examination and request for payment by clinician
- Long waits for appointments

- Inaccuracies in report

Of the 34 complaints investigated, 14 actions have been identified relating to the recommendations made by the investigator. Of these, seven actions have been completed within time and seven actions are due to be completed over the next couple of months. Examples of actions include:

Recommendation	Action
To add to the procedures when referrals are received, an assessment of the suitability of planned / current other psychological interventions.	When the Single Point of Access (SPA) receives a referral discussion takes place to ensure suitability for step 4 intervention. Clear evidence of discussion of therapy plan and evidence that choice of therapy intervention is clearly discussed with the patient. Efforts must be made to acknowledge the patient choice for intervention.
Consideration be given to a system for keeping patients informed on a regular basis about their wait for treatment	Discussed at team meeting in June. Letters to include a sentence explaining wait times.
Psychological services at Step 4 to discuss the options of working with clients, who are in treatment, but unable to attend set appointments ,	Discussed at team meeting in June. Therapy needs to be offered face to face , however if an occasional phone contact is required this will be decided on a case by case basis.
feed back to day Hospital staff regarding confidentiality and lack of sound proofing of day hospital office	Discussion about confidentiality in team meeting ate Day Hospital
Ruby Ward staff to revisit the admission documentation that guides how to engage with carers and relatives.	Discussion in team meeting and review requirements with staff
All staff to ensure there is clarity around discharge plans	All AMHT staff to discuss clear plans for discharge and confirm with patients how best this is communicated - i.e followed up in writing

Children and Young People (C&YP) to establish patient experience champions and involve service users in service development and recruitment.

There are now 23 PE champions in place across a range of CYP services

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

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

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

In Children and Young People a self-assessment for the Carers strategy has been taken in the following teams:

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

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

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

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

Report on domains of patient experience

We have been reviewing the patient experience measures over the last few months and involving service users and carers in this work. This work has been reviewing the experience questionnaires as part of our partnership work. We have also revised our carers questionnaire and re-issued this to our teams, we will be able to report against this in Q3.
In EDPS, they have introduced forums to gather feedback on patients experience and involvement, this is still in its early stages and once we have feedback for the quarter, we will be able to share this.

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

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

During quarter 2 a pilot of the community hospitals patient discharge follow-up programme took place at Witney community hospital. This has proved successful with the Therapy teams telephoning recently discharged patients to follow-up and identify improvements and 25

patients have been contacted. The therapists are able to note any issues or concerns raised during the call and appropriate actions which may be required referrals or advice given. There has been only one re-admission. This added support has been positively received by the patients.

Consideration is now been given to how the project can be extended.

Evaluate the impact of communication protocol toolkit in the Oxon Integrated Therapy Service on creating joint outcomes for children and improving communication with carers and carer involvement in care planning

Oxon Integrated Therapies uses the communications protocol to evaluate the efficacy of joint working with parent/carers/support staff and to identify ways in which the service could be improved e.g. developing more or different ways of engaging/planning therapy for better outcomes. Feedback has been very positive and the early indication is that parental knowledge of involvement in the care of their child is having a significant effect on Therapy achievements (audited via surveys).