

**Report to the Meeting of the**

**BOD: 04/2017**(Agenda item: 6)

**Oxford Health NHS Foundation Trust**

**Board of Directors**

**25 January 2017**

**Quality and Safety Report**

**Quarterly Clinical Effectiveness Report**

**For: Information**

**Executive Summary**

This report provides a summary of the Trust’s position, primarily in Quarter 2 (July to October 2016) in relation to the Key Lines of Enquiry (KLOE) which are considered by the Trust’s Quality Sub-Committee - Effectiveness (QSCE).

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

1.0 Clinical Audit

* The number of audits still to report from 15/16 plan has reduced from sixteen to seven at the end of quarter two 16/17.
* Following the reduction of audit reporting requirement agreed in Q1 only one was behind schedule.
* Changes to the 16/17 plan reduced the number of audits from 95 to 77.
* Key themes from clinical audit identified were around:
* How we demonstrate that information is shared with patients and carers
* Escalation of the deteriorating patient
* Monitoring of physical health care checks particularly cardio metabolic risk factors
* Communicating patient’s allergy status to their GP
* Documenting that patients continue to be involved in decision making once they are assessed as lacking mental capacity to make the relevant decision

2.0 Research and Development

* Oxford Health has been awarded 12.8 million of funding from the BRC bid over five years starting in April 2017
* UK CRIS has been further delayed
* There is a risk of CRN funding reductions which may affect key support posts.
* A review of the R&D governance meeting structure is underway for R&D in light of the successful BRC big and work in the CRN

3.0 Physical Health Group

* Work relating to CAS alerts concerning recognising acutely ill and deteriorating patients is progressing slowly. Some money has been identified to support simulation training for recognising the acutely ill and deteriorating patient (RAID). It is likely that areas will be prioritised to access this first.
* Uptake of the diabetes e-learning programme has not been as successful as hoped. The group will re-visit marketing of this.
* The executive meeting agreed to the roll out of Immediate Life Support training (ILS) to replace the basic life support training. A review of the extra costs involved with this is being undertaken together with a programme for roll out.

4.0 Public Health

* Public Health and Wellbeing groups to be reviewed due to the high level of overlap and attendance. The group chair will also review the workplan with the chair of the physical health group to cross reference areas for work
* The Public Health agenda is too broad. Work is needed to agree the best way to agree priorities that reflect the wide range of national and local priorities.

5.0 Human Resources

* The QSCE were informed that the well led subcommittee had agreed that the HR report would no longer need to come to this sub group and reports would only go to the Well Led subcommittee.

6.0 Ethics

* Reporting has moved to annual. It is noted that the Clinical Ethics Advisory Group (CEAG) also provide training for staff. These will be advertised via L&D going forward.

7.0 Estates

* Improvements required around Transport ad sustainability are mainly due to the car park management project, however a plan is in place to look at different transport options and a green travel plan.

8.0 Learning and development

* Ongoing technical issues are impacting on performance figures for online mandatory training. This is being addressed but may take some time before it takes effect.
* The apprenticeship levy begins from April 2017 ad it is expected that money will be drawn down as part of HCA apprenticeships subject to the successful application to become an Apprenticeship provider.
* There is a risk in future of reduced numbers of students taking up training due to the removal of the NHS bursary funding. The scale of this is not yet known.

9.0 Consent and Mental health legislation

* There are no significant issues to report.

10.0 Drugs and Therapeutics

* There are operational issues that need to be overcome to enable full compliance with Resuscitation Council Standards (accessibility ad competency for emergency drugs). Proposals are being developed to address this.

11.0 Psychological, Occupational and Social Therapies

* There are no significant issues to report

**Recommendation**

This report is for information.

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**Lead Executive Director: Dr Mark Hancock, Medical Director**

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

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

*THIS PAPER MAY BE PUBLISHED UNDER FOI*

1. **Clinical Audit**

**Progress update against the Trust wide audit plan for 2015/16**

In the last report to CAG in July there were a total of sixteen audits still to report from the 2015/16 Trust wide audit plan; six national audits, two quarterly reporting audits and eight annual internal audits. This has now reduced to seven audits still to report, as shown in table 1 below.

Table 1 – audits still to report from the 2015/16 Trust wide audit plan

|  |  |
| --- | --- |
|  | **Total number of audits** |
| **National audits still to report** | **2** |
| 1. CQUIN Mental Health - Cardio Metabolic assessment and treatment for Patients with psychoses | |
| 1. NCEPOD - Mental Health Conditions in Young People | |
| **Annual internal audits** | **5** |
| 1. Audit of MEWS – Trust wide | |
| 1. Baseline audit of Long Term Segregation | |
| 1. Non-medical prescribing | |
| 1. Re-audit of care standards for non CPA cases | |
| 1. Re-audit of the management of violence and aggression | |
| **Total number in progress but not yet reported** | **7** |

It is worth noting that NHS England did not publish a report for the national CQUIN Mental Health audit – Cardio metabolic assessment and treatment for patients with psychosis in 2014/15 and 2015/16. However, in April 2016 NHS England emailed all Trusts with their performance against the audit which was presented as a single percentage figure for each provider.

Performance against the CQUIN is presented by NHS England as a single percentage figure for each provider, calculated on the basis of the following:

1. The denominator will be the total number of patients in the sample.
2. The numerator will be the total number of patients in the sample for whom there was documented evidence that:

* they were screened for all six measures listed in the CQUIN guidance during their inpatient stay; and
* where clinically indicated, they were directly provided with, or referred onwards to other services for interventions for each identified problem (with thresholds for intervention being as set out in NICE guidelines).

The figure of 44% compliance has been calculated without taking into account cases where the doctor has stated that 'no intervention was needed' if the screening measure was above the threshold for intervention. As data collection was undertaken by trainee doctors, speciality doctors and in some cases consultant psychiatrists this compliance figure does not take into account the clinical decision for why no intervention was needed at that time.

Table 2 below provides a comparison of the results provided by NHS England and Oxford Health’s results if you take into account the cases where a clinical decision not to offer an intervention is not treated as a ‘non-compliance’. The results have been colour coded according to the Trust’s audit rating matrix.

Table 2

| **2014/15** | **Number of forms received** | **% refusal to undergo screening** | **Analysis 1 Final % score** |
| --- | --- | --- | --- |
| Oxford Health NHS Foundation Trust | 100 | 4.14 | **31.00** |
| **2015/16** | **Number of forms received** | **% refusal to undergo screening** | **Analysis 1 Final % score** |
| Oxford Health NHS Foundation Trust | 100 | 4.71 | **44.0** |
| The figure of 44% compliance has been calculated without taking into account cases where the doctor has stated that ‘no intervention was needed’ if the screening measure was above the threshold for intervention. This doesn’t take into account the clinical decision for why no intervention was needed at that time. | | | |
| Oxford Health NHS Foundation Trust | **Revised compliance 2015/16** | | **54%** |

**Progress update against the Trust wide audit plan for Quarter 1 of 2016/17**

It was previously reported to CAG in July that there were a total of sixteen audits scheduled to be undertaken in Quarter 1. Following the special CAG meeting in August it was agreed that five of the thirteen quarterly reporting audits could go to six monthly reporting.

This reduced the audit reporting requirements in Quarter 1 to a total of eleven audits:

* 1 national audit
* 2 bi-monthly audits
* 8 quarterly audits

Of the eleven audits scheduled to be undertaken during quarter 1 there is only one that is currently behind schedule. This is a new quarterly reporting requirement of all cardiorespiratory arrests. This audit previously reported annually and there is a summary for 2015 included in this report.

**Changes to the 2016/17 Trust wide audit plan**

It was previously reported to CAG that there were a total of 95 proposed audits on the 2016/17 plan. Following the special CAG meeting in August this number has been reduced to **77**, as shown in table 3 below.

Table 3

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of audit** | **Number of audits** | **Total** | **Number of audits** | **Revised total** |
| National | 13 | 13 | 13 | 13 |
| Internal - Quarterly reporting | 13 | 52 | 8 | 32 |
| Internal Bi-monthly | 2 | 12 | 2 | 12 |
| Internal - 6 monthly reporting | 2 | 4 | 5 | 10 |
| Internal – one off | 14 | 14 | 10 | 10 |
| **Total** | **44** | **95** | **38** | **77** |

* **Audits to be removed from the 2016/17 audit plan**

Following the special CAG meeting in August a total of seven audits were removed from the 2016/17 audit plan. Table 4 below provides a list of the audits that have been removed and the rationale for that decision.

Table 4

|  |  |
| --- | --- |
| **Audit Title** | **Rationale for removing from 2016/17 plan** |
| Audit of MEWS (OAMH - Quality Account requirement in 15/16) | It was confirmed that this audit needs to continue quarterly as it provides assurance and is reported in the Quality Account. It can be removed from the Trust wide audit plan but will be monitored on the Older People’s directorate audit plan. |
| Medicines Management - Re-audit of drug prescription & administration chart which includes compliance to consent to treatment for patients subject to Section 58 of the Mental Health Act (T2 / T3) | Pharmacy confirmed that the new Management of Health Records in Health and Social Care (2016) document which replaces the NHS Records Code of Practice does not require an audit it discusses good record management systems. It was agreed this information did not provide any meaningful assurance. |
| Falls and Fragility Fractures Audit programme (FFFAP) | Following consultation with the national project team the Trust is not eligible to participate in the National Falls & Fragility Audit Programme as it is only applicable to Acute Trusts. |
| Re-audit of NICE Clinical Guideline 133 Self – Harm : Longer term management | Special CAG agreed that this could be removed as a full gap analysis of this guideline was being undertaken by the Adult Directorate which will identify any future audit requirements. |
| Re-audit of the self-assessment of how ‘family friendly’ mental health wards are | Special CAG agreed that this was an area of high priority for mental health wards but another audit was not required as this is an area that is being picked up as part of the ‘AIMS accreditation project’. |
| Nutritional Screening - Carry forward to the 2016/17 Trust wide audit plan as a new nutrition and hydration policy is being implemented. The new policy picks up both malnutrition and overweight/obesity issues. | Special CAG agreed to refer this to the Nutritional Group led by Ann Brierley. |
| Re-audit of the quality of Section 2 assessments | This was an audit requirement following a domestic homicide review and narrowly missed an audit rating of good by a percentage point. Special CAG agreed that this audit should be linked with the CPA audit and discussed when reviewing the CPA audit tool. |

* **Audits to be added to the 2016/17 audit plan**

There is one audit that was reported to CAG in October that needs to be added to the 2016/17 audit plan. The re-audit of the Mental Capacity Act audit which was rated as ‘requires improvement’.

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

In the last report to CAG in July 2016 there were six improvement memos that had past the completion time frame of 6 weeks, this figure has now increased to eight.

Table 5 below provides a breakdown by Directorate of the reported audits with no action plan in place.

Table 5 – Number of improvement memos outstanding by Directorate

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Older People** | **C&YP** | **Adult** | **Total** |
| Number of reported audits in date within the 6 week time frame for action planning | 3 | 1 | 5 | 9 |
| Number of reported audits that have past the completion timeframe of 6 weeks | 2 | 1 | 4 | 7 |
| Total | 5 | 2 | 9 | 16 |

The seven improvement memos outstanding relate to four audits

|  |  |
| --- | --- |
| **Audit Title** | **Improvement memos outstanding** |
| 1. Quarterly controlled drugs audit Q3 & Q4 results | Forensic Wards |
| Community hospitals/Urgent Care |
| Older Adult mental Health wards |
| 1. Seclusion audit | Adult Mental Health |
| Forensic Wards |
| 1. Resuscitation Equipment Audit 15/16 | Forensic Wards |
| 1. Inpatient physical health assessment | SWB |

**Monitoring of actions from improvement plans**

In the last report to CAG in July 2016 there were eleven audit actions that were out of date; this has now reduced to seven.

Table 6 below provides a breakdown of the number of audit actions outstanding. The information has been extracted from Ulysses and relies on the audit leads updating the information.

Table 6

|  |  |  |  |
| --- | --- | --- | --- |
| **Division** | **Total number of actions outstanding** | **Number of actions in date** | **Number of actions out of date** |
| Trust wide actions relating to all directorates | 10 | 7 | 3 |
| Adult Directorate | 20 | 16 | 4 |
| Older People’s Directorate | 2 | 2 | 0 |
| Children & Young People | 1 | 1 | 0 |
| **TOTAL** | **33** | **26** | **7** |

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

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Audit name** | **Directorate** | **Baseline / Re-audit** | **Audit Rating** | | **Date action plan to be developed by** | | | | **Date action plan received** |
| **Baseline audits 2015/16 audit plan** | | | | | | | | | |
| Health Records audit | Adult Mental Health & C&YP | Baseline | Good | | 7/11/16 | | | |  |
| National Audit of Early Intervention in Psychosis | Adult Mental Health | Baseline | Unacceptable | | \*In progress | | | | |
| \*The action plan required for this audit has been taken on board by the leadership team of EIS. It will involve embedding the audit standards into routine clinical practice and will involve producing clearly defined systems and processes. The date for the action plan to be developed has therefore been extended beyond the usual 6 week deadline. | | | | | | | | | |
| POMH Topic 15a Prescribing Valproate for Bipolar Disorder | Adult Mental Health | Baseline | Unacceptable | | \*In progress | | | | |
| \*There have been a series of audits (usually POMH) around prescribing of medicines e.g. lithium, valproate, prescribing in Personality Disorder patients. There are some common themes such as documentation, information provision, monitoring etc. In the past there have been action points for each audit but the plan is to look at medical prescribing as a whole rather than focus on individual drugs and develop an overarching action plan in conjunction with pharmacy. The date for the action plan to be developed has therefore been extended beyond the usual 6 week deadline. | | | | | | | | | |
| **Re-audits 2015/16 audit plan** | | | | | | | | | |
| POMH Re-audit of prescribing for substance misuse: alcohol detoxification | Adult Mental Health | Re-audit | 2014/15 | 2015/16 | \*In progress – see above statement | | | | |
| Requires improvement | Good |
| Cardiorespiratory arrests 2015 | All | Re-audit | 2014 | 2015 | In place | | |  | |
| Good | Excellent |
| Quarterly Controlled Drugs audit Q4 15/16 results | All | Re-audit | Q3 15/16 | Q4 15/16 | CYP | | | In place | |
| Good | Good |
| OP | | | 1/9/16 | |
| Forensic | | | 1/9/16 | |
| Inpatient discharge summary AMH & OP (2015/16) | Mental Health | Re-audit | 2014/15 | 2015/16 | 10/11/16 | | |  | |
| Good | Good |
| **Audit name** | **Directorate** | **Baseline / Re-audit** | **Audit Rating** | | **Date action plan to be developed by** | | | | **Date action plan received** |
| **2016/17 audit plan** |  |  |  |  |  | | | | |
| Safety Thermometer Mental Health Q1 16/17 results | Mental Health | Monthly data | Not subject to audit rating as point prevalence audit | | Not required | | | | |
| Safety Thermometer Classic Q1 16/17 results | Older People | Monthly data | Not subject to audit rating as point prevalence audit | | Not required | | | | |
| CPA Q1 results | Mental health | Re-audit | Q4 15/16 | Q1 16/17 | 11/10/16 |  | | | |
| Requires improvement | Good |
| Re-audit of the Mental Capacity Act | Older People | Re-audit | 2014/15 | 2016/17 | 28/10/16 |  | | | |
| Not compliant | Requires improvement |
| Quarterly Community Hospitals Documentation audit Q1 16/17 | Community hospitals | Re-audit | Q4 15/16 | Q1 16/17 | In place | | | | |
| Good | Excellent |
| Track and Trigger Q1 16/17 | Community hospitals | Re-audit | Q4 15/16 | Q1 16/17 | In place | | | | |
| Good | Good |
| Essential Standards | Mental health | Re-audit | Jun16 | Aug 16 | Actions are taken at the time of the audit | | | | |
| Good | Good |
| Quarterly Antimicrobial Prescribing Audit Q1 16/17 results | Trust wide | Re-audit | Q4 15/16 | Q1 16/17 | 4/11/16 | |  | | |
| Requires improvement | Requires improvement |
| Infection Control audit summary Q1 16/17 | Trust wide | Re-audit | Q4 15/16 | Q1 16/17 | Action plans are monitored through the Infection Control Team | | | | |
| Good | Good |
| The Sentinel Stroke National Audit Programme (SSNAP) (Quarterly reporting) | Abingdon & Witney Community Hospital | Re-audit | This audit is currently not subject to the audit rating as the results are scored nationally into domains of care on a scale of A declining to E. | | | | | | |

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

**Health Records (Adult Mental Health & CYP)** (Rated as **Good**)

There were 5 audit standards, adapted from the guidance produced by the HSCIC “Standards for the clinical structure and content of patient records”, selected for their generic applicability across the services and not covered in other audits. The audit was completed by inpatient and community clinical teams in CYP and Adults. The standards were all rated as excellent or good except future plan, which was rated as requires improvement (CYP Directorate was rated as good, Adult Directorate was rated as unacceptable).

In adults a statement regarding the future plan was completed well within the 2 community teams, but the wards were not consistently stating the plan. There was a discussion at CAG around applying the ‘future plan’ as an audit standard for inpatient clinical notes as this would not be recorded in the clinical notes it would be recorded in the ward round entry and when any changes were made to the care plan.

**National Audit of Early Intervention in Psychosis** (Rated as **Unacceptable**)

All NHS mental health providers in England with a specialist Early Intervention in Psychosis (EIP) service were expected to take part in this audit. Providers were asked to submit retrospective data on a sample of up to 100 patients who were accepted onto the caseload of EIP services between 30/06/2014 and 31/12/2014 and the treatment they received over the following six months. They were also asked to provide service-level information for each of their EIP teams. Data was submitted in December 2015.

Nationally, most people in England assessed as having first episode psychosis waited more than two weeks before they were allocated to and engaged by an EIP care coordinator. The results for Oxford Health are rated as requiring improvement at 50% of our referrals in that time period waited more than 2 weeks but are better than the national average of 33%. The introduction of the access and waiting time standard together with other initiatives such as the EIP accreditation network and the new Mental Health Services Data Set (MHSDS) will help services to continue building on their work to deliver treatment to patients in a timely manner. It is worth noting that during the period June to August 2016 76% of referrals were allocated to and engaged by an EIP care coordinator.

NICE quality standard QS80 state that patients should have access to psychological treatments. The data shows nationally that only 41% of patients were offered CBTp, and under 1/3 (31%) of families were offered Family Interventions. Results for Oxford Health were below the national average at 26% for CBTp and 24% for Family Interventions.

Nationally the audit findings highlight the need to improve physical health screening and intervention in keeping with NICE standards of care. All patients should be screened and offered relevant interventions for physical health in line with NICE quality standard QS80 and other national programmes such as Commissioning for Quality and Innovation (CQUIN).

The results for Oxford health show that there is good practice around the screening of smoking, alcohol and substance misuse. Areas for improvement are around the cardio metabolic screening; BMI, Blood pressure, Glucose and Cholesterol.

Physical health interventions are defined by the Lester tool which provides parameters for interventions for tobacco smoking status, BMI or change in weight, blood pressure, glucose and cholesterol. Parameters for harmful alcohol use and substance misuse are provided by the NICE guidelines CG115 (2011) and CG51 (2007). The patient must have been referred for or offered the intervention for these measures up until the day the data collection tool was completed.

Nationally only 13% of patients were offered relevant interventions for all even physical health measures. Oxford Health results were lower than the national average at just 9%. When you look at the results in respect of each individual intervention Oxford Health results demonstrate excellent practice in respect of alcohol intervention but require improvement in the remaining areas; smoking, substance misuse, weight and hypertension.

The action plan required for this audit has been taken on board by the leadership team of EIS. It will involve embedding the audit standards into routine clinical practice and will involve producing clearly defined systems and processes. Some staff have already undertaken the four day physical health training courses via Learning & Development and more staff will be attending courses in September and December 2016. The date for the action plan to be developed has therefore been extended beyond the usual 6 week deadline.

**POMH Topic 15a Prescribing Valproate for Bipolar Disorder** (Rated as **Unacceptable**)

Fifty-five specialist mental health Trusts within the UK participated in the baseline audit of this quality improvement programme to address the prescribing of valproate in people with bipolar disorder. Data were submitted for 6,705 patients from 648 clinical teams. A clinical records audit of the use of valproate in people with a primary clinical diagnosis of bipolar disorder was conducted. Sample was identified by random sampling. Data collection was done by Consultant Psychiatrists and trainee doctors within the teams and was coordinated by Quality and Audit Team. Data was entered onto online database and data analysis was done by POMH. Data was submitted for ninety four patients. Valproate was prescribed for twenty four patients.

Out of the fourteen standards, twelve standards are rated as unacceptable and two are rated as either requiring improvement. The lowest compliance rates are found to be for providing information about contraception and risks of the medicine to child bearing women who are prescribed valproate and also for physical health monitoring prior to prescribing valproate. The audit found that four women of fifty years of age or younger were prescribed valproate.

Review of therapeutic response within 3 months of prescribing valproate was found to be done in 75% of the sample and documented evidence of medication adherence as a part of early on-treatment review was found in 50% of the sample. Physical health monitoring as a part of early treatment review and also as annual review for patients who have been prescribed valproate longer than one year was found to be done only in a small proportion of the sample. Reasons for measuring plasma valproate were found to be recorded only in 11% of the sample.

There have been a series of audits (usually POMH) around prescribing of medicines e.g. lithium, valproate, prescribing in Personality Disorder patients. There are some common themes such as documentation, information provision, monitoring etc. In the past there have been action points for each audit but the plan by the Adult Directorate is to look at medical prescribing as a whole rather than focus on individual drugs and develop an overarching action plan in conjunction with pharmacy. The date for the action plan to be developed has therefore been extended beyond the usual 6 week deadline.

**POMH Re-audit of prescribing for substance misuse: alcohol detoxification** (Rated as **Good**)

The overall results for this re-audit have improved from a rating of ‘requires improvement’ at baseline to a rating of ‘good’ at re-audit.

It has to be highlighted that the clinical practice related to prescribing for alcohol detoxification has improved considerably and also that the compliance level of six out of seven standards have improved in the current audit. The only standard which shows decline in compliance is the one related to the documented assessment of drinking history and current daily alcohol intake.

Although the standards related to patients receiving relevant blood tests to identify alcohol-related physical health problems (For e.g. - Wernicke’s encephalopathy) and patients being prescribed thiamine parenterally for acute alcohol withdrawal have improved from 53% to 60% in the current audit, there is still considerable scope for further improvement.

**Cardiorespiratory arrests 2015** (Rated as **Excellent**)

All reported incidents of cardiac/respiratory arrests in 2015 were reviewed in this audit. There may be more as some incidents go unreported due to staff not completing the audit questionnaire; under reporting is a national problem (Resuscitation Council 2008). There are two standards measured in this audit.

**Standard 1: For all arrests 999 should be called within 5 minutes of discovery**

The time 999 was called was not documented on the audit form for 2 arrests; 1 which occurred at Abingdon Ward 2 and the other arrest occurred at the patient’s home. For the remaining 8 arrests it was documented in 100% of cases that 999 had been called within 5 minutes. This is an improvement from 84% in 2014.

**Standard 2: For all areas within Oxford Health that have access to a defibrillator this should be attached in 100% of cardiorespiratory arrests.**

There were a total of eight out of the ten reported arrests from areas that have access to a defibrillator on site. One of the eight arrests has been excluded as the patient was on a mental health ward and came round before the AED was attached.

**Outcome**

The audit form collects data on the outcome of the arrest. Unfortunately, this section is often not completed for a variety of reasons. In the majority of cases the patient is transferred by ambulance to A&E at Oxford University Hospital and the staff involved in the arrest may not know the outcome or be informed of the outcome.

National survival rates (survival to discharge home) are as follows:

* 18%-20% in hospital survival (usually Acute Trusts)
* Less than 5% in outer hospital arrests

Therefore Oxford Health is above the national average for survival to discharge.

* 20% of (2/10) attempted CPR’s were successful

**Quarterly controlled drugs audit Q4 15/16 results** (Rated as **Good**)

To aid risk management, in addition to the trust wide results, the trust results have been categorised into different tiers based on the unit/wards controlled drug activity. The Medicines Safety Officer has identified 3 tiers of activity and allocated each ward/unit to one of these tiers;

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

**Key Areas for Improvement**

* **Tier 1**

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

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

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

**Standard 9**: Signatures receipting CDs on to the ward in the CD Order Book. Compliance with this standard has decreased since Q3.

Risk: breaks in the CD accountability chain.

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

**Standard 12**: Procedures for the destruction and disposal of CDs.

Risk: Potential for destruction which is not in keeping with legal and trust policy. Trust Accountable Officer (CDAO) may not be able to provide necessary assurance to Trust Board and CD Local Intelligence Network (CD LIN).

Action: Develop and implement clear trust-wide procedures to reduce local variation. Ensure that all unit managers have a list of staff authorised by the CDAO to destroy expired stock CDs.

**Standard 13**: Procedures for the return of CDs to pharmacy

Risk: Unsafe transport of CDs which is not in keeping with trust policy resulting in a lack of audit trail and gaps in CD accountability. Trust CDAO may not be able to provide necessary assurance to Trust Board and CD Local Intelligence Network (CD LIN).

Action: Develop and implement clear trust-wide procedures to reduce local variation. Ensure that all units have access to necessary materials to ensure procedure followed.

* **Tier 2**

**Standard 1**: There is a satisfactory arrangement of stock within the cupboard i.e. segregation of stock, patient’s own, TTOs and expired CD stock. There has been an improvement over the past two quarters but further work is necessary (Q3 =40% compliance, Q4 = 64%).

Risk: inadvertent use of expired medication or use of a patient’s own medication for another patient (non-legal use of a prescription only medication).

Action: Pharmacy and unit managers to undertake local risk assessment and wherever possible improve segregation. Consider larger CD cupboards where local environment allows.

**Standard 3**: Up-to-date signature lists remain consistent problem and has shown improvement from Q3 (64%) to Q4 (67%).

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

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

**Standard 9**: Signatures receipting CDs on to the ward in the CD Order Book. Compliance with this standard has remained at 33% in Q4.

Risk: breaks in the CD accountability chain.

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

**Standard 14**: procedures for the documentation and disposal of part-used doses

Risk: Potential for destruction which is not in keeping with legal and trust policy. Trust Accountable Officer (CDAO) may not be able to provide necessary assurance to Trust Board and CD Local Intelligence Network (CD LIN).

Action: Develop and implement clear trust-wide procedures to reduce local variation. Ensure that all units have access to necessary materials to ensure procedure followed.

* **Best Practice Standards**

In Tier 1 all but two best practice standards were audited to show more than 90% compliance. Four standards had 100% compliance, of which two had been maintained at this target compliance from the previous quarter.

In Tier 2 two standards were maintained at 100% compliance and one standard (25) showed significant improvement (Q3 = 57% vs Q4 = 89%).

**Key Areas for Improvement (Trust-wide)**

Two standards were consistently problematic across both Tiers;

* Standard 23 (Amending documentation errors correctly) and
* Standard 26 (There is evidence of daily CD reconciliation).

These best practice standards are included in the content of the medicines management eLearning materials. It is hoped that as more nursing staff complete the training, and with continued support from ward pharmacy teams, results against these standards will continue to improve. A trust-wide procedure for CD reconciliation is under current development and once approved and implemented this should improve compliance with this standard.

In addition Tier 2 units need to focus on work to improve compliance with;

* Standard 20 (Information is available about medicines to identify the product and its uses); Q4 result was 36%
* Standard 22 (Entries in ward CD Record Book demonstrate details of receipt of drugs) which showed a drop in compliance from 100% (Q3) to 64% (Q4)
* Standard 24 (Good record keeping – Balances accurately transferred and cross-referenced on previous and current page. Index updated); Q4 result was 33%.

**Conclusion**

The trust audits show a mixed but improving picture for the safe management of controlled drugs. The audit has not highlighted any significant risks regarding the safe keeping or safe custody of controlled drugs in the trust but procedures which ensure the accountability and governance of controlled drugs must be maintained at the highest level possible. Further work to standardise procedures and ensure high quality implementation is required to provide this consistent assurance.

**Re-audit of inpatient discharge summaries (AMH, OAMH & CYP)** (Rated as **Good**)

This is a re-audit following an audit in 2014/15 which was rated good. The audit is undertaken of all the discharges from the mental health wards of Oxford Health NHS Foundation Trust during January 2016, who were discharged to their normal place of residence (or temporary non hospital setting) and who are registered with a GP. The main concern following the previous audit, related to the timeliness of the discharge summaries being sent. This audit has seen an improvement with 74% being dated as sent within 2 weeks (51% within a week) compared to 28% (8% within a week) in 2015. There has been a rise in the number of discharge summaries which were not dated (18% in 2016, compared to 8% in 2015).

The results show an improvement in the timeliness of part 2 inpatient discharges being sent to the GP with 74% now being sent within 2 weeks of discharge compared to 18% in 2015.

The new standards for this audit, show good practice for providing a contact number in case of query. Although the results for including an ICD 10 code and diagnosis are rated as requires improvement, we are good at including a diagnosis (97% had at least a diagnosis recorded). The communication of medication monitoring requirements is similar to findings in other audits and appears to be a similar trend between both inpatient and community correspondence with the GP.

The communication to GP’s regarding allergies is rated as unacceptable. This audit has not looked at whether the information has matched the patient record i.e. a known allergy has not been communicated, but whether there was any indication e.g. no known allergy (NKA) or an allergy listed within the summary**.**

There is inconsistent practice with regards the signing of discharge summary audits. Some wards are still either physically signing or stating that it is electronically signed, but others, like the practice in Older People’s Directorate are not signed (either physically or electronically).

The inpatient discharge summary to the patient is not consistently copied to the patient and within this audit we have not checked to ensure where there is a change to the care plan, that this has been communicated/ given to the patient i.e. information about any routine blood tests they may now need.

There is inconsistent practice with regards when a section 2 discharge summary is sent. Some patients have a discharge summary sent, if they are going on S17 leave or community treatment order (i.e. physically leaving the ward, but not our care) not when they are administratively discharged from the ward, whereas others are sent when they are administratively discharged from the ward. For those where the discharge summary was sent prior to formal discharge, there was no check if a letter was sent updating the care required by the GP. It is good practice for patients from mental health wards to have a period of time off the ward prior to discharge

**Safety Thermometer Mental Health Q1 16/17 results** (Not subject to audit rating)

The usefulness of the tool was discussed again and whether we can use the data in a different way to get more value.

**Safety Thermometer Classic Q1 16/17 results** (Not subject to audit rating)

The usefulness of the tool was discussed again and whether we can use the data in a different way to get more value.

**Quarterly CPA audit Q1 16/17 results** (Rated as **Good**)

**Summary of Results for the Adult Directorate**

**Initial Assessment / CPA Review**

There are 16 audit standards relating to the initial assessment / CPA review. Adult services have consistently been rated as either good or excellent in 15 out of the 16 standards (94%). The one area rated as requiring improvement relates to the recording of consent to share information. However, this has improved from 63% in Q4 of 2015/16 to 77% in Q1 of 2016/17. It is worth noting that when consent to share has been given by the service user and it is recorded in the electronic record, there is excellent practice (96%) in involving family/carers in the assessment/CPA review process.

**Risk Assessment**

There are 3 audit standards relating to the quality of the risk assessment, which were introduced following the transition from RiO to Carenotes during 2015/16. The Adult Directorate has consistently achieved a rating of either good or excellent in all areas.

**Care Plan**

There are 19 audit standards relating to the quality of care plans. Adult services have consistently been rated as either good or excellent in 14 out of the 19 standards (74% in Q1). There has been a significant improvement in the recording of service user involvement in the development of their care plan from 66% in Q1 2015/16 to 86% in Q1 of 2016/17.

There has been improvement in the recording of sharing of care plans with service users, family/carers and the GP; however this remains an area rated as requiring improvement.

* Evidence that the service user has been offered/given a copy of the care plan – this has improved from 24% in Q3 15/16 to 48% in Q1 16/17.
* Evidence that the care plan has been shared with family and/or carer (where applicable) – this has improved from 73% in Q3 15/16 to 81% in Q1 16/17
* Evidence in the records that the care plan has been shared with the GP – this has decreased from 68% in Q3 15/16 to 63% in Q1 16/17

**Care Plan – Physical health needs and psychotropic monitoring**

* Where physical health needs have been identified for patients, the standard for the care plan addressing the physical health needs has consistently been rated as good.
* For service users who are on psychotropic medication, the standard relating to the care plan detailing the medication prescribed was also rated as good in both Q4 15/16 and Q1 16/17.
* Informing the GP about the need for ongoing monitoring of psychotropic medication issues has improved from requiring improvement (70%) in Q3 15/16 to a rating of excellent (95%) in Q1 of 16/17.
* Ensuring that the care plan details the side effect monitoring requirements relating to psychotropic medication remains an area rated as requiring improvement; however this has improved from 61% in Q3 15/16 to 70% in Q1 16/17.

**Summary of Results for Older Adult Mental Health**

The results for Quarter 1 provided in this report should be interpreted with caution as the three Oxon teams were given the wrong audit tool by the audit team in error. The tool that the teams used in Quarter 1 was significantly different to the audit tool that they had completed in previous quarters and this is likely to have had an impact on the results.

* **Initial/current assessment / CPA Review**

As the incorrect audit tool was given to teams it is not possible to analyse the questions relating to initial / current assessment / CPA review in this quarter.

* **Risk Assessment**

There are three audit standards relating to the quality of the risk assessment, which were introduced following the transition from RiO to Carenotes during 2015/16. The OAMH teams have consistently achieved a rating of either good or excellent in all areas.

* **Care Plan**

There are five standards relating to care planning that are rated as requiring improvement in Q1, and one standard rated as unacceptable.

Two of the six standards are rated as requiring improvement/unacceptable for only two of the teams. Appendix 1 provides a breakdown of the results by team. The remaining four standards rated as requiring improvement/unacceptable relate to the involvement of family and sharing of care plans with service user.

* **Care Plan – Physical health needs and psychotropic monitoring**

Where physical health needs have been identified for patients, the standard for the care plan addressing the physical health needs has been consistently rated as good. The standards relating to psychotropic monitoring have declined in Q1.

**Summary of Results for Children & Young People**

**Initial Assessment / CPA Review**

There are 18 audit standards relating to the initial assessment / CPA review, with 3 new standards being added to the Q1 audit tool. CYP services have consistently been rated as either good or excellent in 13 out of the original 15 standards (87%). The one area rated as requiring improvement in Q1 relates to the recording of consent to involve the family/carer in the assessment. It is worth noting that when consent to involve the family/carer has been given by the service user; there is excellent practice (100%) in involving family/carers in the assessment/CPA review process.

**Risk Assessment**

There are 4 audit standards relating to the quality of the risk assessment, which were introduced for Q1 2016/17. The CYP Directorate has consistently achieved a rating of either good or excellent in the one original question, as well as achieving good for the 3 new questions.

**Care Plan**

There are 20 audit standards relating to the quality of care plans, with 3 new standards being added to the Q1 audit tool. CYP services have consistently been rated as either good or excellent in 12 out of the 17 original standards (71%). There has been an improvement in the evidence of a formal CPA review within the last year: from 74% in Q3 2015/16 to 83% in Q1 of 2016/17. Furthermore, when the service user has not consented to the care plan, there has been an improvement in the evidence that alternative options about the care plan been discussed with the patient: from 18% in Q4 2015/16 to 38% in Q1 of 2016/17 (although this is still rated as unacceptable).

There has been improvement in the recording of sharing of care plans with service users; however this remains an area rated as requiring improvement.

* Evidence that the service user has been offered/given a copy of the care plan – this has improved from 41% in Q3 15/16 to 67% in Q1 16/17.
* Evidence in the records that the care plan has been shared with the GP – this has decreased slightly from 76% in Q4 15/16 to 74% in Q1 16/17.
* Moreover, where it is clear that the service user has given consent for family/carer involvement, the evidence of family and/or carer involvement in the development of the care plan has decreased slightly from 89% in Q4 15/16 to 79% in Q1 16/17.

**Care Plan – Physical health needs and psychotropic monitoring**

Where physical health needs have been identified for patients, the standard for the care plan addressing the physical health needs has consistently been rated as good or excellent.

For service users who are on psychotropic medication, the standard relating to informing the GP about the need for ongoing monitoring of psychotropic medication issues has also been consistently rated as good. However, issues around care planning for psychotropic medication require improvement:

* The care plan detailing the medication prescribed has improved from 65% in Q3 15/16 to 72% in Q1 of 16/17.
* Ensuring that the care plan details the side effect monitoring requirements relating to psychotropic medication decreased from 74% in Q3 15/16 to 52% in Q1 16/17.

**Future changes to the quarterly CPA audit**

Following feedback from clinicians it has been agreed by the Trust wide Clinical Audit Group that a review of the CPA audit questions will be undertaken in September in consultation with all directorates.

**Re-audit of the Mental Capacity Act audit** (Rated as **requires improvement**)

|  |  |
| --- | --- |
| **Community Hospital Wards** | **Audit rating** |
| 2016/17 | Requires improvement |
| 2014/15 | Not compliant |
| 2013/14 | Not compliant |

A baseline audit of the Mental Capacity Act was first undertaken in 2013/14. Applying the audit rating matrix to this audit was discussed at the Clinical Effectiveness Committee on 23/6/2014 and it was agreed that audits which included standards that are a legal requirement should not be rated using the matrix but as either ‘Compliant’ or ‘Not compliant’ at the time of the audit. However, the audit tool was amended in 2016 to identify evidence that the five statutory principles of the MCA Act have been implemented and the mental capacity assessment process is being used while looking at specific decision points. The rating of ‘requires improvement’ has been calculated on the results of 48 individual audit standards.

The Matrons in the Community Hospitals have audited the implementation of the Mental Capacity Act 2005 (MCA) during July and August 2016. This has demonstrated an overall improvement in the implementation of the MCA.

**Areas of improvement**

Over 90% of situations where someone is believed to be unable to make their own decision have a mental capacity assessment completed in line with the Mental Capacity Act.

**Areas of good practice**

* Staff from across professions and bands are participating in assessing a patient’s mental capacity.
* Staff are confident to ask when they are not sure.

**Areas for improvement**

There does not appear to be a consistent understanding of the best interest’s decision making process. The audit would appear to indicate:

* that not all patients continue to be involved in decision making once they are assessed as lacking mental capacity to make the relevant decision
* family and friends are not always consulted in decision making
* staff are not considering risks and benefits to the person for the possible options available
* Staff are not confident about identifying possible harms and ensuring any restriction/deprivation of liberty is proportionate to the seriousness and likelihood of harm that might otherwise occur.

Given Deprivation of Liberty Authorisations are in place, this information is available. It seems likely that the issue is about how the information is recorded rather than not being available.

**Recommendations**

1. It is recommended that the Matrons work with the Ward Managers to:
   1. Clarify the reasons why a person is not involved in decisions where it is assessed that they lack mental capacity and develop a strategy to ensure this is achieved
   2. Clarify the reasons why a person’s family have not been consulted in best interests decision making (Abingdon Hospital) and develop a strategy to ensure this is achieved

To clarify the understanding of staff of the use of restrictions and deprivation of improvement’.

* 1. liberty under the Mental Capacity Act
  2. To evidence that arrangements constituting restriction or deprivation of liberty are proportionate to the seriousness and likelihood of harm that might otherwise occur.

1. It is recommended that the Safeguarding Adults Manager will amend the Audit tool to include a question about the involvement of the Independent Mental Capacity Advocacy Service.

**Quarterly Community Hospitals Documentation audit Q1 16/17** (Rated as **Excellent**)

The overall rating for Q1 has improved from a rating of ‘good’ to ‘excellent’. This audit will move to annual reporting but data will continue to be collected and reviewed quarterly by the directorate.

In Q1 all hospital sites were rated either ‘good’ or ‘excellent’ which is an improvement on last quarter’s audit where Wallingford was rated as ‘requires During quarter 4 after significant deterioration in quarter 3 the rating improved on the question relating to the weekly care plan review from 73% to 88%.

During this quarter this has deteriorated to 83% therefore actions will be put in place to address this and ensure this improves rather than deteriorates further.

Although still falling within the ‘Good’ rating the Pressure ulcer care plans have deteriorated further from 96% in Q3, 86% Q4 and this quarter to 85%, again action plans will be put in place to address this.

In relation to the falls care plan being put in place this is shown a significant improvement from 88% to 98%.

During quarter 3 there were 5 specific questions that were rated as requiring improvement which reduced to 3 specific questions during quarter 4.

During quarter 1 of 1617 this has further reduced to 1 specific question as follows:

* Was a mini memory assessment carried out by the Doctor?

This is a new question after a new tool being created and being used for the first time during quarter 1.

After discussion with Unit Managers it would seem that the scoring of this question is due to the different ways within community hospitals that mini memory assessments are carried out and interpretation of the question by the staff carrying out the audit.

To ensure this is consistent for the results for quarter 2 work will take place to ensure that this is clarified with the teams carrying out the audits.

Although there is only this one specific question that stands out across the board there are specific areas (wards) that have scored lower than others, actions are in place to ensure that this improves for the next quarter’s audit.

**Quarterly Track & Trigger Q1 16/17** (Rated as **Good**)

The Track & Trigger Tool is an escalation tool which enables clinical staff to identify and act upon deteriorating patients. In reviewing the effectiveness and escalation of patient deterioration and subsequent actions to support the on-going care of the patient an audit was also developed to determine the effectiveness of the use of the escalation tool and identify areas for education and training.

The audit is rated as ‘**good’** (87%) for Quarter 1 2016/17 a slight 1% decrease from the 88% reported in Quarter 4 2015/16. The tool has recently been revised to ensure that this captures the areas that require attention and will be used going forward in quarter 2. This should improve the audit results as there will be more clarity and understanding in the way that the questions are answered across all Community Hospitals.

It was noted at CAG that the question ‘Has the patient’s condition been escalated?’ had a compliance of 67% which is an area requiring improvement.

**Essential Standards bi-monthly audit (Aug 16 results** (Rated as **Good**)

**Areas of excellent practice**

* Patient information given out on admission to the ward
* Patient received a physical health assessment completed within 24 hours of admission
* Patients physical health needs are identified at assessment are included in care plan
* Previous Section 17 forms been crossed through and uploaded onto Carenotes
* Paper copy of the current Section 17 leave form(FS17 form) in nursing office
* Patient’s rights have been read in accordance with section 132 and understood
* Staff always knock on patients bedroom doors prior to entering
* Patients report that staff are courteous towards them
* Patients are given a choice of food that meets their specific needs (exclude Eating Disorder Units)
* Date and level of observation clearly documented
* Where appropriate patients on close observations can explain why these are in place

Out of the forty one standards, three standards are rated as requiring improvement:

1. Clear documentation of whether the patients capacity to be involved in care and decision making has been assessed/ reviewed either at or since the last ward round
2. Documentation of how decisions about patient’s capacity were made
3. Completion of nutritional needs assessment.

Documentation of how decisions about patient’s capacity were made and completion of nutritional needs assessment were rated as requiring improvement in the last audit also and hence can be identified as areas that are showing consistent poor practice.

**Quarterly Antimicrobial prescribing audit** (Rated as **Requires improvement**)

The audit was undertaken by Pharmacy Technicians and Pharmacists. A two page data collection tool was used alongside detailed guidance on antimicrobial standards. The audit reviewed all antimicrobials prescribed within a specific week to provide a snapshot of prescribing practice.

A major problem within this audit was that a full set of results were not obtained for each quarter so a direct comparison between mental health and Community Hospitals per quarter has not been possible. Actions will be taken to ensure that full and timely audit is completed for the next quarter.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Q4 2015/16** | | **Q1 2016/17** | |
| Antimicrobial prescribed according to current guidelines | CHs (n=42) | Mental Health (n=22) | CHs (n=24) | Amber (n=5) |
| 79% | 77% | 67% | 80% |

**Areas requiring improvement**

There was one are that was rated as ‘unacceptable’ relating to prescription review at 48-72 hours. This relates to the fact that many of the sites do not actually have visits from prescribers within that timeframe.

|  |  |  |  |
| --- | --- | --- | --- |
| **Standards requiring improvement** | **Q4 16/17**  **Mental Health (n=22)** | **Q1 16/17**  **CHs (n=24)** | **Q1 Amber (n=5)** |
| Prescription chart has a clear stop or review date | 65% (13/20) | 75% (18/24) | 100% (5/5) |
| Prescription reviewed at 48-72 hours | 42% (5/12) | 24% (5/21) | No data\* |
| Treatment with antimicrobials should not continue beyond 7 days (IV plus oral) unless recommended by a local guideline or consultant microbiologist /infectious diseases specialist | | | |
| Total course length >than 7 days | 71% (12/17) | 68% (15/22) | No data\* |
| \*The audit tool included additional information on the dosage, review and duration. This information was recorded on page 2 of the audit tool and was not completed for the 5 cases from Amber. Auditors had not realised there was a second page of the audit tool- majority of the ‘usual’ antimicrobial guidance related needs were on page 1. | | | |

**Infection Control audit summary Q1 16/17** (Rated as **good**)

The Infection Control Audit programme consists of four audits:

* Annual Infection Prevention and Control Audits
* Hand Hygiene audit results
* ATP results
* MRSA swabbing

**Annual Infection Prevention and Control Audits**

There were no annual Infection Control audits undertaken in Q1. The annual programme of audits will be starting in Q2.

**Community Hospitals & Urgent Care – Observational Hand Hygiene Audit Results**

Bi-monthly hand hygiene audits are completed across all Community Hospitals/MIU/EMUs and all mental health wards.

|  |  |  |  |
| --- | --- | --- | --- |
| Overall compliance | Jan-16 | Mar-16 | May-16 |
| Hand Hygiene | 100% | 99% | 98% |
|  | Jan-16 | Mar-16 | May-16 |
| Bare Below Elbows | 100% | 99% | 100% |

**Mental Health – Practical Hand Hygiene Audit Results**

|  |  |  |  |
| --- | --- | --- | --- |
| **Mental Health/Inpatient wards/Units** | **Jan-16** | **Mar-16** | **May-16** |
| % of staff "bare below elbow" | 93% | 93% | 96% |
| % of staff carrying a tottle | 85% | 85% | 88% |
| % of staff not wearing jewellery | 96% | 97% | 97% |
| % of staff no nail varnish, extensions or long nails | 97% | 97% | 98% |
| Overall compliance with hand washing technique | 96% | 96% | 96% |

There were no issues identified at CAG with the ATP results or the MRSA screening results.

**The Sentinel Stroke National Audit Programme (SSNAP)** (not rated)

Abingdon and Witney Community Hospital Stroke Units registered to participate in the initial Sentinel Stroke National Audit Programme (SSNAP) in 2012. Performance standards are monitored by the Royal College of Physicians in a quarterly survey – this measures performance across the whole stroke pathway, looking at 10 domains of treatment, and utilising 44 indicators, on a performance scale of A declining to E. Individual services must provide a minimum data set of 20 discharged patients per Quarter to have a report generated. Oxford Health continue to submit data quarterly but due to the numbers being less than 20 per site per quarter the most recent set of results published was in Q1 2015/16 for Abingdon and in Q3 of 2015/16 for Witney. Results for each domain are provided in the table below.

|  |  |  |
| --- | --- | --- |
| **Quarter** | **Abingdon Q1 15/16** | **Witney Q3 15/16** |
| **Overall SSNAP Level** | C | C |
| Stroke Unit | B | B/C |
| Occupational Therapy | A | B/C |
| Physiotherapy | B | C |
| Speech and Language Therapy | B/C | B |
| MDT working | D | D |
| Discharge Standards | A | A |
| Discharge process | D | B |
| Audit compliance | 75% | 49% |
| Follow up at 6 months | 24% | 43% |

The lack of psychological input brings the overall score down and this is due to the fact that we are not commissioned to provide this service. In addition, the follow up at 6 months was always undertaken by Social Services and they have now stopped doing this.

SSNAP also published their [post-acute organisational audit](https://www.strokeaudit.org/results/PostAcute.aspx) in late 2015 which provided an overview on the availability and structure of post-acute stroke services within England, Wales and Northern Ireland as of 1 April 2015.

**Key themes arising from clinical audit**

Key themes identified were around:

* How we demonstrate that information is shared with patients and carers
* Escalation of the deteriorating patient
* Monitoring of physical health care checks particularly cardio metabolic risk factors
* Communicating patient’s allergy status to their GP
* Documenting that patients continue to be involved in decision making once they are assessed as lacking mental capacity to make the relevant decision
* Documentation of how decisions about patient’s capacity were made
* Documentation of a review at 48-72 hours and clear stop or review date on antimicrobial prescriptions
  1. **Research and Development**

Developments include:

* The Trust has been awarded £12.8m for BRC. This is a 5% cut from what was requested so finances are being reviewed. The DoH has confirmed that the application was very good and was the only new BRC awarded. Funding is expected to start from April 2017.
* The BRC Steering Committee is being re-established.

* An outcome is awaited for the joint CRF application with OUH.

The main risks and issues are:

* The low attendance at R&D Governance Meetings. The meeting structure will be reviewed alongside the Biomedical research Centre (BRC) and Clinical Research Facility (CRF) work. Meetings are being held with all Directorate leads to discuss BRC and will also explore opportunities for research governance.
* UK CRIS have been delayed further. The expected roll out is now November/December 2016. The Trust continues to use static data set through D CRIS. There are currently 14 Researchers using this and 6 studies. A workshop on CRIS will be provided to consultants at the Medical Staffing Committee Away Day in November 2016.
* Thames Valley CRN are trying to reduce funding for governance roles. The CRN want to redirect money to delivering research. At a meeting with the CRN on 20/10/16 Prof Geddes explained that the priority was the BRC and that the CRF would be supporting this. He said that if the CRN no longer fund these posts then they will focus on the BRC. It is not clear what will happen with the staff currently employed by the Trust if this funding is lost and they may be at risk.
* Work is ongoing regarding the contracting and governance processes for studies that primarily take place within OHFT, but where some study activity (imaging, lumbar punctures etc) need to be conducted at the OUH or University, as this is currently delaying study set up. It has taken several months to contract for lumbar punctures for one specific study, which was affected by a number of factors including the identification of clinical staff to undertake the procedures, contracting process with the University. Going forward the process should be more streamlined and timely.
* Currently there are significant delays to HRA processes for research studies, with priorities being given to commercial studies. There appears to be no process within the HRA for escalating these concerns, but it is outside of the control of the Trust. It is estimated that there are currently 10 studies that have been delayed.
  1. **Physical health group**

Developments include:

* Discussions have taken place between Chairs of the Physical Health and Public Health Groups with the intention of linking the work plans. The plan is to hold a joint meeting annually.
* Pressure damage prevention work is progressing slowly.
* Money has been identified to support simulation training in relation to RAID patients.
* End of Life resources have been collated in one area of the intranet site to make access easier.
* Progress has been made in identifying some additional resources for diabetes training in community hospitals.

The main risks and issues are:

* Work relating in relation to CAS alerts concerning recognising acutely ill and deteriorating patients is progressing slowly.
* Uptake of the diabetes e-learning programme has been poor. The group will re-visit marketing of this.
* The last two Resuscitation Committee meetings have not been quorate. More input is needed from the adult directorate in particular.
* The executive meeting agreed to the roll out of Immediate Life Support training (ILS) to replace the basic life support training. A review of the extra costs involved with this is being undertaken together with a programme for roll out.

The QSCE approved the request for emergency medicine boxes to be put in EMUs and MIUs to ensure compliance and safer care.

An incident relating to the failure of a battery on an electronic defibrillator. This issue will be reported to Quality Sub Committee Safety.

**4.0 Public Health**

Developments include:

* The plan to link the Well Being work to Public Health work. This would prevent duplication and improve integrated working.
* The Public Health England manager continues to engage with the group.
* The Smokefree group was reconvened 6 months ago as it was recognised that more work is needed. The chair for the Public Health group has requested representatives from Pharmacy and Estates.
* Chairs of the Public Health and Physical Health Groups are reviewing each groups workplan to cross reference areas of work

The main risk currently is that the breadth of public health work is too large. A recommendation was made to revisit Trust approach to public health priorities to reflect the Five Year Forward, STP prevention work and other national & local priority areas. The medical director and Director of Nursing will discuss ad agree a way forward.

* 1. **Human Resources**

At the last Well Led Sub Committee there was a discussion about the reports that HR takes to each of the sub-committees. A proposal was made and agreed that the HR Casework & Whistle Blowing report would only be tabled to Well Led going forward. The aim of this is to reduce duplication. It has been confirmed that the ToR for Effectiveness Sub Committee do not require the report to go to that group. It was agreed at the QSCE that the HR report will be presented it at the Well Led group going forward.

1. **Ethics**

The CEAG is an advisory group which meets monthly to answer ethical questions submitted by clinicians across the Trust. The membership includes clinicians, Ethicists, Philosophers, an Anthropologist, and patient, carer and Spiritual and Pastoral Care reps. Patients are able to attend the meeting, and it is the decision of the relevant clinician whether to invite them.

Minutes from the meetings only go to internal staff on the meeting group. It is up to the individual clinicians whether to upload minutes to care notes

The group also provide training for staff of all levels across the Trust. SP will link with L&D to advertise future training sessions.

The QSCE agreed that CEAG would report annually in October.

1. **Estates**

Estates reported that out of the six areas of reporting two require improvement: These are E5 Transport and E6 Sustainability. The improvements required are mainly due to the car park management project, however a plan is in place to look at different transport options and a green travel plan. This should improve when the new car park management system is underway.

The Chair of the QSCE has requested that areas of unsatisfactory compliance/ areas of risk are highlighted in future reports.

1. **Learning and development**

* There have been some technical issues with the online training record which are preventing some people from completing mandatory training at busy times. This affects the quality of the performance data. The OUH own the system and the fault has now been rectified but it will take time before figures will improve.
* The Apprenticeship levy will begin next year and the Trust is expected to have an allocation of £1.1m. However, to utilise this levy the Trust will have to increase apprenticeship numbers from 37 to 367. It will be possible to put all HCAs through apprenticeship route (250 HCAs went through care internship last year), however this would mean one day a week of classroom sessions. The Trust needs to use the money otherwise it will be lost
* The Trust is considering applying to become an apprenticeship provider which would mean apprenticeship levy would stay with the Trust, rather than going to an external provider.
* Student nurse capacity controls are being removed in universities which will increase the number of nursing spaces available. Funding from the NHS has also changed and students will now need to fund themselves/through student loans. It is possible that fewer students will apply for places creating a possible risk in the future of fewer newly qualified nurses.
* A new nursing student mentoring pilot is being introduced which will have third year students managing first and second year students. This will allow more nursing students to train in one area at a time, and will also give students more experience of support and mentoring when they qualify.

1. **Consent and Mental Health Legislation Group**

There has not been a meeting since last QSCE. However there are ongoing issues around section 17 leave, recording of rights, consent to treatment and involvement in care planning

1. **Drugs and therapeutics Group**

Developments include

* Using CRIS for reviews of prescribing.
* A review of Loxapine inhalation.
* An initial review of Dasotraline for ADHD.
* Naloxone guidelines have been approved. There will replace the current PGD.
* Alcohol detoxification guidelines have been updated and approved
* The CCG has requested General Anxiety Disorder guidelines to support the prescribing of Pregabalin by GPs. DTG have pushed back as this is already covered by NICE guidance etc.
* The net formulary is being used more.
* Pharmacy is looking at better ways of keeping pharmacists up-to-date with changes, particularly in community settings.
* The medicine safety officer is reviewing the main contributory factors in medication incidents, Serious Incidents and Initial Reviews.
* PGDs are all in place.

Currently the main risks and issues are:

* Electronic prescribing
* The medicine management policy is now overdue. QSCE have agreed an extension to January 2017.
* There is a need for more authorised witnesses to destroy controlled drugs.
* GPs are asking the Trust to pick up the prescribing of medications prescribed out of area or by private clinics. The CCG has existing guidance to help push back.
* There are operational issues in ensuring full compliance with Resuscitation Council standards on emergency drugs (accessibility and competency). Solutions are to have a ‘cardiac drug box’ and ‘deteriorating patient drug box’ in relevant areas.

**11.0 Psychological, Occupational and Social Therapies Group**

Developments include:

* The Step 4 Psychology review process and clinical model is progressing as planned.
* The Innovation process has been updated. This enables a review of local practice based evidence and review of changing national evidence
* The Guidance for OH Practitioners wishing to use Psychological Treatments not currently part of NICE Guidelines has been updated and is now on the intranet.
* The Use of Family Therapy Suite protocol on use of video recording has been approved for a further 3 years.
* RO-DBT innovation protocol has been approved for use in the Eating Disorders service.
* BPS Guidance on managing non-recent child sexual abuse disclosure will be available on the intranet
* A Suicide prevention app and a proposed research evaluation has been proposed. This will follow the usual R&D process.
* Review of training frameworks for therapies enables identification of standards and discussion of variations in practice
* Update on proposed new clinical model of Psychological Service enables discussion and monitoring of impact on practice of all professional groups and potential training needs and opportunities.

The main areas of risk are not high: The quality of reports of innovation updates is variable. A new process to support authors of updates has been identified to address this

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