

# Report to the Meeting of the

**BOD 148/2017**

(Agenda item: 9)

# Oxford Health NHS Foundation Trust

# Board of Directors

**29 November 2017**

**Quality and Safety Report:**

**Quarterly Clinical Effectiveness Report**

**For Information**

This report provides a summary of the Trust’s position, primarily in Quarters 2 and 3 (July-December 2017-18) in relation to the Key Lines of Enquiry (KLOE) which are considered by the Trust’s Quality Sub-Committee - Effectiveness (QSCE).

The board is asked to note the contents of the report.

**1.0 Executive Summary**

* 1. **Clinical Audit**

Three audits covering July and October periods which were reported in October 2017 were rated as good (NEWS community hospitals Q1, community hospitals documentation Q1 and infection control Q4 16/17 and Q1 17/18.) Smoking and alcohol screening Intervention Q1 was rated as requires improvement with improvements needed in the recording of interventions offered.

The resuscitation audit was not able to report due to data accuracy issues. Matrons are reviewing equipment on a monthly basis. A full re-audit will be undertaken in January 2018.

There are some capacity issues across the system impacting on medication related audits. The audits are however prioritised with good oversight of the risks and issues by pharmacy.

* 1. **Learning advisory group (LAG)**

There has been a further significant reduction in CPPD money with the assumption that the apprenticeship levy will replace this. This has left a gap in funding that a subgroup has prioritised focusing on directing training funds for clinical priorities. Leadership and coaching training programmes are now being provided in house.

Mandatory training is at 80% overall with a current Trust wide focus on improving compliance with infection control as a priority. High dropout rates are a key area of concern that is being explored.

Guidance updates for PDRs is being undertaken following lack of robust assurance from a small audit sample of PDRs. Development of a system to review the quality of PDRs is underway.

The associate nursing cohort is working well and a second cohort is anticipated soon.

* 1. **Mental Health Act and DOLs legislation and compliance**

Ongoing themes from CQC visits in relation to care planning and patient involvement, section 17 leave and section 132 re presentation of rights indicate that there is still inconsistency in in these areas albeit with a compliance rate of between 90 and 95%. A range of actions have been implemented which have resulted in improvements and the CQC does give positive feedback in regard to the care patients receive.

The Trust continues to wait and prepare for the section 135 and 136 legislative changes and changes to the Deprivation of Liberty safeguards to come into force.

* 1. **Physical Health group**

The first draft of a physical health strategy will go out to consultation soon. The strategy will be delivered through annual objectives and a work plan details of which are in the body of the report. The physical health policy is also under review and will be updated to reflect national and local priorities.

Sustainable training resources for ILS is being discussed at the Resuscitation subgroup; pressure damage prevention work and end of life care planning is progressing well and a focus going forward will be on support staff to improve nutrition and hydration care.

The Group has announced that there will be a physical health in mental health settings workshop in January and this will be supported by the Public Health group.

* 1. **Public health group**

The public health group is working with the overlap areas also covered by the physical health group in particular around CQUINs and the quality account priority 4 - promoting the health and wellbeing of patients and staff in addition to supporting the workshop as already stated.

‘Making every contact count’ e-learning will be rolled out to support staff in the AMHT wellbeing clinics.

The public health pages on the intranet are progressing with further work needed.

* 1. **Research management group**

Details of the progress in work streams are given in the body of the report and a full six month report has been shared with the Trust Board.

The new Research Management Group is now established. This will oversee the collaborative research strategy across the Trust and will meet monthly to review dashboard reports of activity.

* 1. **POSTG Group**

The Psychological services have now completed a period of organisational change with implementation of changes anticipated in January 2018.

A number of innovations, training and practice models were discussed and approved with details given in the body of the report.

A psychosocial emergency response plan has been drawn up and a response group will convene to move this forward.

* 1. **Drugs and therapeutics group**

Work has been undertaken on developing a range of guidelines for shared care and with CCGs. Details are given in the report.

Concerns have been raised about the national shortage of some non-branded antipsychotic medications. This has a financial impact as branded and more expensive medications are needed to be dispensed by pharmacies who are unhappy about this.

* 1. **Policy review**

A small number of policies are out of date. The meeting reviewed and confirmed action was being taken and where necessary that policies remained fit for purpose in the interim.

**Recommendation**

The Board is asked to note the report.

**Author and Title: Rebecca Kelly: Trust Professional Lead Occupational**

**Therapist and deputy chair of the QSCE**

**Lead Executive Director: Dr Mark Hancock: Medical director and chair of the QSCE**

1. *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*
2. ***Strategic Objectives*** *– this report relates to or provides assurance and evidence against the following Strategic Objective(s) of the Trust*

*1) Driving Quality Improvement*

*(Goals: patients will be safe from harm; patients will achieve the clinical outcomes they want; and patients and carers will have an excellent experience)*

*2) Delivering Operational Excellence*

*(Goals: our services will be effective and efficient; information will be translated into knowledge; and our planned surplus will be delivered)*

*3) Delivering Innovation, Learning and Teaching*

*(Goals: the impact of the AHSN, AHSC and CLAHRC will be maximised; we will collaborate in research and innovation; and we will deliver high quality teaching)*

**1.1 Clinical audit**

1.1.1 The meeting did not take place in July 2017 as the group was not quorate. This was escalated and a meeting was held on 9/10/2017 representatives from all directorates present.

1.1.2 Of the four audits to report three were rated as good and one as requires improvement:

**NEWS Community Hospitals Q1 17/18**

Although the audit was rated good overall for Q1, the audit identified area requiring improvement relating to the appropriate escalation of the deteriorating patient.

Discussion and scrutiny took place at CAG regarding this finding. The older people directorate confirmed, in response to the audit findings, the appropriate escalation is now being monitored monthly via the community hospital safety matrix dashboard.

**CH Documentation Audit Q1**

Although the audit was rated good overall for Q1, there were 5 standards that were rated as requiring improvement, these included: Pt contact number, pt consent for use of bed rails, continence assessment completed within 48 hours of admission, care plan for pain completed within 24 hours of admission and weekly review of core care plans.

The directorate confirmed that the compliance of weekly review of core care plans will be monitored through the CH safety metric dashboard.

**Infection Control summary Q4 and Q1 2017/18 report**

This audit is reviewed and scrutinised at the Infection Control Committee, and is only received by CAG for information and follow up by the directorates. It was rated good.

**CQUIN 9 Smoking & Alcohol Screening Intervention Q1 17/18 report (rated** as requires improvement**)**

Audit result shows that we are good at screening patients smoking status. However, improvements are required in the recording of interventions offered for smoking cessation.

Furthermore, screening of alcohol consumption and interventions is an area that also requires improvement.

The resuscitation audit report had significant accuracy data issues and information in report was therefore not reliable. The resus committee has been made aware of this. Modern Matrons review equipment on monthly basis. There are plans to undertake a full re-audit in January. It was agreed that any risk areas would be reviewed in the interim and the issue would go to the safety committee for further approval of the plan.

1.1.3 Future Issues or concerns

* Data collection is being undertaken and report writing and analysis undertaken by pharmacy. The audits are prioritised and Pharmacy gave assurance that there is good oversight of risks and issues. Some reports are delayed due to capacity across the system.
* Risk Register- it was discussed and agreed at CAG that a mechanism for the review of risks will be undertaken and monitored regularly. This is to ensure that re-audits demonstrate improvement.

1.1.4 Progress update against the 2016/17 Trust wide audit plan

There are a total of seven audits still to report from the 2016/17 audit plan; four of which are national audits and the Trust has no control over their reporting timeframes. An update on the outstanding audits is provided in table 1 below.

Table 1

|  |  |
| --- | --- |
| **National audits** |  |
| 1. CQUIN Mental Health - Cardio Metabolic assessment and treatment for Patients with psychoses
 | Awaiting publication of national report.  |
| 1. National Chronic Obstructive Pulmonary Rehabilitation (COPD)
 |
| 1. POMH-UK Topic 1&3 Prescribing high-dose and combined antipsychotics
 |
| 1. NCEPOD Young People's Mental Health Study
 |
| 1. Resuscitation equipment audit
 | Data collection was undertaken during quarter 4 of 2016/17. Currently at report writing stage, the delay is due to capacity issues within the audit team. |
| 1. POMH re-audit of monitoring of patients on Lithium
 | POMH published report in February 2017. Currently at report writing stage, the delay is due to capacity issues within the audit team. |
| 1. POMH-UK 16 - Rapid tranquillisation
 | POMH published report in June 2017. Currently at report writing stage, currently with the pharmacy team to action.  |

1.1.5 Progress update against Quarter 1 and Quarter 2 of the 2017/18 Trust wide audit plan

There were a total of seventeen audits scheduled to be undertaken during quarter 1 and quarter 2:

* Six national audits
* Six quarterly audits
* Two bi-monthly audits
* Three six monthly audits

The national audits, quarterly audits and bi-monthly audits are in progress and on schedule. The audits that are falling behind their scheduled time frame are the quarterly reporting audits. Table 2 below provides further details.

Table 2

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of audit** | **Project Title** | **Quarter to be undertaken** | **Progress update** |
| National | POMH NEW Topic 17: Use of depot/LA antipsychotic injections for relapse prevention. | Quarter 1 | Data entry completed in May 17, awaiting publication of national report |
| National | CQUIN 9a Preventing ill health by risky behaviours - alcohol and tobacco | Quarter 1 | Completed and reported to CAG Oct 17 |
|  | Quarter 2 | In progress and on schedule for Q2 |
| National | Sentinel Stroke National Audit programme (SSNAP) | 4 monthly reporting | Still awaiting publication of 4 monthly report, the Trust has no control over reporting timeframes as this is a national audit. |
| National | UK Parkinson's AuditHost Organisation: Parkinson's UK  | Quarter 1 & Q2 | In progress and on schedule |
| National | POMH Topic 15: Prescribing valproate for bipolar disorder  | Quarter 2 | In progress and on schedule |
| National | Physiotherapy Hip Fracture Sprint Audit | Quarter 2 | In progress and on schedule |
| CCG requirement | Inpatient and Outpatient Discharge Summaries to GP  | Quarter 1 | In progress but behind schedule |
| CCG requirement | Review of patients with dementia on psychotropic medications | Sept 17 & Jan 18 | In progress but behind schedule |
| Internal(Quarterly) | Infection Control Programme: annual infection control audits | Quarter 1 | In progress and on schedule |
| Quarter 2 | In progress and on schedule |
| Internal(Quarterly) | Medicines Management - Quarterly Antimicrobial prescribing audit | Quarter 1 | In progress and behind schedule as not received report |
| Quarter 2 | In progress and on schedule |
| Internal(Quarterly) | Full CPA Audit for Community Teams | Quarter 1 | In progress but behind schedule |
| Quarter 2 | In progress but behind schedule |
| Internal(Quarterly) | Track and Trigger/NEWS (Community Hospitals) | Quarter 1 | Completed and reported to CAG Oct 17 |
| Quarter 2 | In progress and on schedule |
| Internal | Infection Control Programme: bi monthly hand hygiene audits  | Bi-monthly | In progress and on schedule |
| Internal | Essential Standards (Bi-monthly reporting) | Bi-monthly | In progress and on schedule |
| Internal | Resuscitation Equipment Audit | 6 monthly | Not yet started as previous audit has not yet been reported |
| Internal | DNACPR audit | 6 monthly | Behind schedule, now completed and reported to CAG Oct 17 |
| Internal | Medicines Management - Controlled drugs audit | 6 monthly | In progress and on schedule |

1.1.6 Changes to the 2017/18 draft Trust wide audit plan

One additional audit has been requested to be added to the 2017/18 Trust wide Clinical Audit Plan: The Triangle of Care

Learning Disability services are also reviewing their national and local auditing requirements to move in line with other parts of the Trust.

1.1.7 Reported audits with no action plan in place

There are no outstanding improvement memo’s recorded on Ulysses- This report is inaccurate, because a number of audits have been completed for this financial year (for example CPA Q1 report), but not yet updated on Ulysses.

This information is uploaded on Ulysses, and audits leads are required to record this information, in order to run a report.

1.1.8 Action Plan Monitoring

In the last report to CAG in July 2017 there were no actions that were out of date; this has now increased to 28. Directorate audit leads reported that many of these actions were now complete. Staff cannot go in and close actions on Ulysses (electronic reporting system) without permission so the process is currently dependent on audit leads receiving evidence and then closing actions down themselves.

1.1.9 Clinical Audit Training quarterly update

Table 5

|  |  |  |
| --- | --- | --- |
| **Type of training** | **Date** | **Number of staff attended** |
| Using Clinical Audit to Improve Patient Care(3 hour training session) | 19/7/17 | 5 |
| Using Clinical Audit to Improve Patient Care(1 hour condensed session | 25/9/17 | 2 |

**1.2 Learning advisory group (LAG)**

1.2.1 The last sub group meeting was held on August 22nd 2017. At this meeting the terms of reference for the Group were reviewed and it was agreed that they needed updating. This work is underway.

1.2.2 There has been a 30% reduction in CPPD money from HETV (this is in addition to last year’s 40% reduction). The Trust received £192,000 from HETV but have bids for £400,000 of training. In addition there is no money available from HETV for Bands 1 – 4 separately as the assumption is that their training needs will be covered by the apprenticeship levy going forward. A sub-group has met to address training priorities. It was agreed that most areas would receive funds but at a reduced level with the priority given for training with a clinical focus, STP Bids rather than for CPD development. Mentoring nurse training is classed as business as usual.

1.2.3 Mandatory training is currently at around 80%. The Well led Committee agreed that the focus would be ensuring Infection Control was completed as a priority area. This was also raised at the Quality committee in July 2017. This can be completed online by users or face-to-face, dependent on requirement. ELearning is accessible and encouraged in order to achieve increase in figures.

1.2.4 Information Governance training compliance has slipped slightly in June to 90% from 94%.

1.2.5 All but one of the 26 associate nurse trainees remain on the programme (the employee who has discontinued did so for personal reasons). Learning support has been offered.

1.2.6. There are suggestions that a second cohort of associate nurse trainee funding is about to be announced. We are preparing to ensure that potential trainees are ready to be recruited including providing literacy and numeracy practice where appropriate.

1.2.7. The main areas highlighted for concern are:

* The reduction of funding for training and the possible impact this may have on recruitment and retention and long term development of staff. Some of this will be addressed by providing in house non-accredited programmes for leadership and offering coaching as part of this.
* The high dropout rates of staff for some face to face training.
* The lack of robust assurance from an audit relating to PDRs. The audit was based upon a small sample however actions have been commenced to update guidance, consider how the Board receives compliance data and implement a system to review the quality of PDRs undertaken.
	1. **Mental Health Act and DOLs legislation and compliance**

The last sub group met on 28 September 2017

1.3.1 The CQC continue to make recommendations relating to care planning and patient involvement, section 17 leave, and section 132 rights re-presentation. A number of actions have been taken:

* The presentation of rights under Section 132 has improved and a new Rights form has been introduced which is now available on Carenotes making the process much more efficient. A new Section 17 leave form has also been implemented and an improvement in recording CTO consideration is evident.
* A more effective and streamline system to record responsible clinician (RC) to RC transfers and ensuring handover between professionals has been introduced and is working well.
* In addition to MHA Office processes, escalation to clinical director and medical director, AMDs and Heads of Nursing are provided with information relating to omissions or gaps on a weekly basis and Associate Medical Directors are actively taking issues raised from CQC visits to their respective Directorates.

There is evidence that these actions are resulting in improved compliance by staff up to 90-95%.

1.3.2. Areas of concern raised by the CQC continue to be in relation to the recording of leave, rights, consent to treatment, and patient involvement and empowerment with respect to care planning. The CQC do, however, give positive comments and feedback in regards to the care patients receive.

1.3.3. Patients deprived of their liberty may not always be subject to a standard authorisation because of resource issues outside of the control of the Trust.

1.3.4. Section 135 and 136 legislative changes have not yet been implemented– this has been delayed from 1st April 2017. The main change which will impact the Trust will be the timeframe reduction from 72 hours to 24 hours (with the allowance of a 12-hour extension on clinical grounds). Regulations supporting the legislative change are still to be published. Directorates and relevant wards with Places of Safety attached are in the process of revising processes in order to incorporate changes to section 135 and 136.

1.3.5 Deprivation of Liberty Safeguards changes are also not yet implemented, with no clear timeframe as to when Parliament will progress this.

* 1. **Physical Health group**

The subgroup last met on 6 Sept 2017

1.4.1 There was a discussion at QSCE on the risks associated with the sustainability and resourcing for Immediate Life Support (ILS) training. This issue is under discussion at the Resuscitation Committee. Some resource has been found for this year but this is a temporary solution.

1.4.2 A paper on competencies for Administration of Emergency Drugs was presented to QSCE for validation of competencies with the plan to attach to the resuscitation policy. It was agreed and supported by the group as a robust way of moving forward.

1.4.3 Physical health policy (CP22) in need of review and updating. Now out of date. Does not take into account national and local drivers and include Learning and development. Work in progress for ratification in January QSCE.

1.4.4 The first draft of the physical health strategy will go out to consultation in the next few weeks. A progress update was given to the Quality subcommittee –effectiveness in October 2017.

1.4.5 The Physical Health Strategy will be delivered through prioritised and targeted annual objectives. Planned activity for 2017/18 is outlined in the work programme; this annual plan will be developed and updated each year.The Trust’s Physical Health Group will oversee implementation of the Strategy, reporting via the Quality subcommittee - Effectiveness to the Quality Committee. The work plan includes:

* Continue work on improving the monitoring of identified cardio-metabolic risk factors
* Standardisation of the model for the AMHT physical health clinics
* Embed the physical health clinics offered by the adult/ forensic wards
* Improve sharing of discharge information with GPs and test methods to do this electronically and set up access to view limited information held by GPs on patients also being treated by the trust
* Recruit to RGN physical health leadership posts to support the AMHTs and adult wards
* Continue the work led by the IAPT services as early implementer sites for better integrated pathways for people with a long term physical health condition.
* Improve engagement with junior doctors on physical health in mental health settings
* Develop and introduce an electronic MEWs form for the wards on CareNotes and frequency of use of MEWs to be standardized.
* Development of bedside handovers in appropriate clinical areas
* NEWs rolled out, currently in paper and electronic form in development. PSAG board used to monitor completion.
* SEPSIS training
* Human factors simulation training – CDLs to sustain as ‘train the trainers’
* Care and comfort bundles being used include review of pain management and fluid/ food intake
* Physical health competencies developed for ILT sub teams
* Build on initiatives such as the Wallingford community hospital catheter clinic
* Increase level of pharmacy support
* Medic involvement, linking NEWs monitoring into ward rounds
* Develop NG feed competencies for relatives
* Embedding the use of SBARD
* Diabetes management and pathway particularly on discharge
* Embed training and work around swallowing assessment and management
* Establishing a falls steering group to coordinate and lead work on falls management
* Dietetic input for obese patients
* Embed the ‘knowing me’ passport/ form for patients with a mental health condition
* End of Life care plan being rolled out. Develop competence and training across mental health services. Work with all professionals around understanding of End of life care
* Reduce acquired pressure damage grade 3 and 4 to zero by April 2018, use of quick time learning has been positive
* Skills based work with staff around patient motivation and to access psychological support as needed. Links to making every contact count and questions around healthy lifestyle.
* IT systems and interoperability
* Clinical simulation
* Dentistry in physical health
* Expansion of Immediate Life Support training
* Assess the use of peer workers in long term physical conditions.
* Consider opportunities for development a Frailty Nurse Consultant and Learning Disabilities Consultant Nurses
* Achievement of physical health CQUINS 3a cardio-metabolic and 3b collaboration with primary care in preventing ill health
* Full implementation of a physical health review form
* Review all physical health policies

1.4.6 A Trustwide physical health in mental health settings workshop is planned for 26th January 2018.

1.4.7 It was reported that the pressure damage prevention programme is progressing well within the DN services and IR reports are now being carried out on category 2 pressure ulcers. Some improvement has been noted. Supervision has been offered from IAPT to district nurses around motivational interviewing and improving compliance. Pressure damage SI’s are now discussed for closure at the end of the trust pressure ulcer prevention project group this allows for more detailed feedback on actions that have been taken following SI’s and wide sharing of learning.

1.4.8 The end of life care plan is now being implemented across older people’s services and the effectiveness of its implementation will be evaluated at a meeting in November

1.4.9 Work to support staff in relation to improving nutrition and hydration care has not progressed at the rate required.

1.4.10. The development of a faculty approach to clinical simulation training needs to be progressed to ensure that improvements in recognising the acutely ill and deteriorating patient are sustained

* 1. **Public health group**

The last Public health sub group met on 29th September 2017

1.5 1 The Trust now has representation in the STP prevention work stream via the public health group chair.

1.5.2 The STP Making Every Contact Count (MECC) on line training roll out is to be accessed by staff to support work with AMHT well- being clinics.

1.5.3 Work is underway to ensure there is cross cutting work with Physical Health including CQUINs and Quality Account priority 4 ‘to promote health and wellbeing of patients and staff ’continues.

1.5.4 The public health intranet webpage has progressed – further work is required to continue to develop. <http://intranet.oxfordhealth.nhs.uk/publichealth/>

1.5.5 The Public Health group will link with the Physical health group to deliver the physical health day on 26.01.17.

1.5.6 Progress with Smoke free work requires ongoing monitoring with adult services reviews yet to be completed.

* 1. **Research management group**

1.6.1 The OHFT Trust Board has received its 6 monthly R&D report. These are generally scheduled for March and September

* + 1. A new **Research Management Group** (RMG) has been established. It is a high level committee that will the collaborative research strategy across the Trust that will meet monthly. Dashboard reports of activity from the various components of research - BRC, CRF, CLAHRC, DEC, TV&SM CRN, Case Records Interactive Search (CRIS), Research Feasibility, Set-Up, Delivery and Management (including quality assurance), Pharmacy and Research were presented at the April and September meetings.
		2. The **BRC Steering Committee** has been established and meets on a monthly basis. A carer/patient representative has joined the group. Work continues to develop the themes in line with the application objectives.

Work is ongoing at OUH to modify Studyline (Research Governance database) to be able to capture and identify BRC supported studies.

Work continues with OUH to identify clinical space at the John Radcliffe Hospital for clinical research in line with the CRF application

The focus for the CRF over the next five years will be the delivery of experimental and translational medicine studies and aligned to the BRC.

* + 1. The **Diagnostic Evidence Cooperative** (DEC) has been replaced by the **MedTech and In Vitro Diagnostic Co-operatives** (MIC) within the NIHR infrastructure awards. The OHFT MIC application was successful and funding for the MIC starts in January 2018.
		2. Work is ongoing to bring OHFT **CRN** funded staff into the governance structures within the Trust. Funding for this year has been reduced and R&D SMT are looking closely as requirements for R&D going forward.

The cost centre used by DENDRON and managed by the Research Delivery Manager (employed by OUH) has been identified as a potential risk and is now being managed within the Trust and R&D governance processes.

Recruitment to research studies is going well

* + 1. Access to **D CRIS** has now ceased and replaced fully by **UK CRIS.** UK CRIS is live and attached to CareNotes data. The system is used for anonymised research, clinical audits and service evaluations. Work continues to develop training material for users internally and externally across the CRIS network. To date 22 applications have been approved, 17 of which were research questions, one service evaluation, three clinical audit questions and one feasibility.
		2. Work is ongoing to assess the capacity and capability of **Pharmacy** going forward due to CRN funding reductions

The Lead pharmacist has agreed initial plans for costing and delivering BRC adopted studies based on BRC funding for the pharmacy team. This will be reviewed as BRC research develops over the coming years as support for the BRC increases

* + 1. The new Research Set Up and Management **Pipeline meetings** are going well, where all studies are assessed for feasibility and PI engagement before being agreed to being set up.
		2. OHFT continues to meet targets for the NIHR metrics in Performance in Initiating (70 day target for receiving full data set to first patient recruited) and Delivering (number of participant recruited with the time frame of the study) studies. Both are reaching 100%.
		3. The Research Governance Manager supporting the **set-up of research** studies and provision of advice to researcher resigned from post in June and was then on long term sickness. The Head of R&D is taking on the role on a temporary basis, but there has been no handover, which poses a potential risk in the delay to setting up of studies.
		4. The ability to generate the required level of income from the clinical research facility will need to be closely monitored because there is a potential that the proportion of commercial studies will reduce in favour of non-commercial studies such as those related to the BRC which are not funded as generously. This may restrict the opportunity to meet the contribution to overheads target.

**1.7 POSTG Group**

The group last met in September 2017.

* + 1. The period of organisational change for psychological services is now complete. All staff have been offered and accepted slot in posts. Bid to the EU has been put in for workforce development in psychological services across the Trust (£150,000). Implementation teams for the changes are being led by AMHT managers. It is hoped that the new arrangements will be in place early 2018.
		2. The meeting reviewed a number of NICE guidance and summaries were sent to the Nice Implementation group
		3. The group reviewed and agreed the Terms of Reference.
		4. A number of Innovations were discussed including:
* DBT Treatment for PTSD. A feasibility pilot started in September 2017.
* Protocol for use of Acupuncture in the Dental Service. POSTG agreed a 12 month pilot, with a review after this time.
* RO-DBT for CAMHS. Approved for 1 year from April 2018, with a review after 12 months.
* Silver Cloud Open Access. Agreed trial for 12 months, with internal review after 6 months and brief feedback to POSTG about whether continuing.
* EMDR (Adults) and Interpersonal Psychotherapy approved for a further 3 years each
	+ 1. MECC (Making Every Contact Count) training was discussed and supported to be included as part of apprenticeship training.
		2. Developing Psycho-Spiritual Care in Health Care – plans for training development supported
		3. VdT MOCA – an occupational therapy model of practice supported
		4. All Party Parliamentary Inquiry – Arts and Dementia report circulated for information
		5. Emergency Response Planning – Psychosocial Plan was discussed. A response group will be set up so that local teams have opportunity to prepare in the event that an emergency response is required.
	1. **Drugs and Therapeutics**
		1. Physical health monitoring guidelines for patients on antipsychotics has been agreed with Bucks CCGs. It is hoped that Oxfordshire will adopt this when signed off.
		2. Recent NICE guidance was reviewed for relevance to OHFT.
		3. Shared Care Guidelines were updated.
	+ ADHD
	+ Melatonin (Bucks)
	+ Lithium (Oxon)
		1. Patient Safety Alert – Valproate. Actions are underway to complete alert requirement by the deadline. CRIS is being used to identify patients. Critical mitigation will be getting electronic prescribing in the trust
		2. Guidelines for medicines in S136 Suite have been developed
		3. GAD Guidelines agreed with CCGs. Pregabalin can now be prescribed by GPs
		4. There are ongoing national shortages of olanzapine and quetiapine tablets. This applies to non-branded medicines. However this does impact costs and pharmacies agreeing to dispense branded product.
		5. Two PGDs have had to be extended for six months pending full review
		6. The Medical Gases Group has not met for six months. This is mainly due to capacity issues. Many of the issues are relating to estates and medicine management. The Head of pharmacy is addressing this.

**1.9 Policy update**

Policies due for renewal by September 2017 which are now out of date with updates:

Table 6

|  |  |
| --- | --- |
| CP 102 | Venous Thromboembolism Policy. Fit for purpose |
| CP 29 | Restrictive Interventions Policy. Paul Dobson |
| MM 08 | Independent Non-Medical Prescribing Policy.  |
| CP 22 | Physical Assessment and Examination of Service User. This is still fit for purpose. Extensions agreed |
| CP 48 | Advance Statements:  |
| CP 94 | Nutrition and Hydration Policy.  |
| MM 02 | Medicines Reconciliation Policy. Still fit for purpose. New policies and approved by quality committee in May 2016. |
| MM06 | Covert Administration Policy. New policies approved by quality committee in May 2016. |

CP 11 resuscitation policy was tabled and approved at the meeting.

The meeting confirmed that the following were approved from the previous QSCE:

* Paper 38) MM01 Medicines Management Policy Safe & Secure use of Controlled Drugs Policy
* (Paper 39) MM03 Prescribing policy
* (Paper 40) MM04 Medicines Administration Policy including Patients’ Own Drugs (PODs) & Self-administration
* (Paper 41) MM05 Safe & Secure use of Controlled Drugs Policy