

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

**BOD 65/2019**

(Agenda item: 16)

# Board of Directors

**24 May 2019**

**Effectiveness Report Q4 2018/19**

**For: Information/Assurance**

**Executive Summary**

This report provides an overview of effectiveness using the CQC key lines of enquiry (KLoE) including Care and Treatment; Outcomes; Staff skills, experience and knowledge; joint working; support for healthier lives and consent to care and treatment.

It reports on key areas in Q4 2018/19 reflecting the work reported by the QSCE sub groups; findings from the recent CQC well led reviews; areas where improvements have been made and areas needing improvement and actions being taken to close the quality gap.

The main themes from Q4 2018/19 are as follows:

The Trustwide audit programme continues and is on track with no outstanding improvement plans and a reduction in the number of outstanding actions.

Seven audits were reported in Q4. Five were subject to ratings, and four achieved good or excellent. One audit that requires improvement (POMH 16b- Rapid tranquilisation) has a number of recommendations, which are being progressed (section 2.12).

The position with NICE remains largely unchanged in Q4. Recruitment to governance posts has been undertaken, and the new postholders have started or are due to start soon. The Ulysses system update happened in April, and all the published NICE guidelines as from 1st January 2019 will be updated on Ulysses.

Oxford Health is actively involved in the Medicine Optimisation Board of the Buckinghamshire ICS. Some of the processes and decision making around medicines are being streamlined, and it is hoped that some of the outstanding issues (e.g. GPs not being able to prescribe some mental health medicines) will be addressed shortly.

A National Early Warning Score 2 (NEWS2) Taskforce has been set up to consider the implementation of NEWS2 across Oxford Health. This followed a Patient Safety Alert issued in April 2019. Although not directly aimed at community services, the trust has decided to follow the recommendations, as they represent best practice.

The Trust has been awarded the status of co-host of the Excellence Centre subject to achieving the Quality Mark accreditation

The first cohort of Nursing Associates Trainees (NATs) are completing their training and being employed by the Trust.

Although closer to target, full compliance has not been achieved in the majority of Personal and Professional Statutory Training, PDR and supervision. Although still red, resuscitation training targets are at their highest level for some time since L&D started overbooking training by one staff member per session. Information governance training hit 95% at the end of March 2019.

In the CQC Inspection in 2016, Community End of Life Care services at Oxford Health NHS Foundation Trust were rated as “good’’ in the safe, caring, responsive and well-led domains but “required improvement’’ to be effective. A work plan with priorities has been agreed to drive further improvement (section 5.3)

The focus on diabetes in the Trust has seen a work programme underway based upon the ‘NG17 Type 1 diabetes standards’ and ‘PH38 type 2 diabetes standards’ (section 5.4).

There has been vigilant monitoring of patients transferred under section 136 of the Mental Health Act to ensure that the start time of the detention is recognised and that the 24-hour period is not exceeded. This period has rarely been exceeded within the trust, and ‘authorisation’ for the Place of Safety to be used as an admission bed is being closely monitored and reviewed.

**Governance Route/Approval Process**

This report is the quarterly update to the board from the last Clinical Effectiveness Sub Committee held on 11th April 2019.

**Recommendation**

The board is asked to:

Note the contents of the report;

**Author and Title:**

Rebecca Kelly, Associate Director of Allied Health professions

**Lead Executive Director:**

Dr Mark Hancock, Medical Director

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)*

*4) Developing Our Business through Collaboration and Partnerships*

*(Goals: we will work in collaborative partnerships; we will maintain and grow our services where we add value; and we will have strong relationship with our stakeholders)*

*5) Developing Leadership, People and Culture*

*(Goals: staff satisfaction will be in the top 20% of Trusts nationally; our staff and teams will be high-performing; and we will recruit and retain an excellent workforce)*

*6) Getting the most out of Technology*

*(Goals: our patients and staff will have the right technology available; our workforce will have the necessary IT skills to do their jobs well; and an outstanding IT service will be delivered)*

* 1. ***MAIN BODY OF THE REPORT***
  2. The Quality Subcommittee Clinical Effectiveness (QSCE) is responsible for ensuring the Trust is compliant with the CQC domain “effective”; ensuring that there is an objective and systematic approach to the identification and assessment of risk; and, delivery of the effectiveness priorities in the context of all national standards. The CQC defines effective as: *“people’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.”*

The main sub-groups feeding into the QSCE are:

* clinical audit (including NICE);
* Drugs and Therapeutics Group (DTG);
* Research and Development;
* Learning and Development;
* Psychology, Occupational and Social Therapies (POSTG);
* Mental Health Act/Mental Capacity Act compliance;
* Physical Health Group;
* Public Health Group;
* Clinical Ethics Advisory Group (reporting annually).
  1. The format of this report provides detail around the key issues and gives an indication of some of the actions underway for assurance. It reports by areas aligned with the CQC key lines of enquiry (KLoE).

1. **This section addresses two areas in the KLOE around care and treatment and outcomes**
2. *Are people’s needs assessed and care and treatment delivered in-line with current legislation, standards and evidence-based guidance to achieve effective outcomes?*
3. *How are people’s care and treatment outcomes monitored, and how do they compare with other similar services?*
   1. The key areas in which the Trust can assess whether its services are effective and lead to improved patient outcomes is through the review and update of policy and procedures; clinical audit; and, engagement with NICE guidance and standards and relevant accreditations.
   2. There were 25 audits due to be undertaken by the end of Quarter 4. All of these are on schedule to be completed. These consist of 6 national audits, 4 CQUIN audits and 15 high priority internal audits.
   3. Table 1 gives further details of the audits that were due to be undertaken in Q4 that are either in progress or completed. There are six high priority internal audits, which were not undertaken in 2018/19 for the reasons listed in Table 3. Four of these six audits have been rolled over to the 2019/20 audit plan.

**Table 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Audit Title** | **Type of Audit** | **Frequency** | **Current Status** |
| 1. National Audit of Anxiety and Depression (NCAAD) Spotlight 1 | National | Annual | All data submitted and awaiting National report |
| 1. POMH Topic 7 Monitoring of Pts on Lithium | National | Annual | All data submitted and awaiting National report |
| 1. Sentinel Stroke National Audit Programme (SSNAP) Aug-Nov 18 | National | Three times a year | In Progress (continuous data entry) |
| 1. National Audit of Inpatient Falls 2018-2020 | National | Annual | In Progress (continuous data entry) |
| 1. NCEPOD Long term ventilation (LTV) | National | Annual | Initial data entered. Awaiting further questionnaires |
| 1. National Audit of Diabetes Footcare | National | Annual | In Progress (continuous data entry) |
| 1. CQUIN 9a Preventing Ill Health by Risky Behaviours- alcohol and tobacco | CQUIN | Quarterly | Reported to April 2019 CAG |
| 1. CQUIN 3a Improving physical healthcare to reduce premature mortality in people with serious mental illness (BUCKS) | CQUIN | Annual | Awaiting national report to be published (expected Jun/Jul 19) |
| 1. CQUIN 3a Improving physical healthcare to reduce premature mortality in people with serious mental illness (OXON) | CQUIN | Annual | Awaiting national report to be published (expected Jun/Jul 19) |
| 1. CQUIN 3b Collaborating with primary care clinicians BUCKS | CQUIN | Q2 & Q4 | Data analysis currently in progress (expected to be completed 10th April) |
| 1. Secure Medication Management (pharmacy) | High Priority Internal Audit | Annual | Reported to April 2019 CAG |
| 1. Anti-Microbial Prescribing Audit (pharmacy) | High Priority Internal Audit | Annual | Reported to April 2019 CAG |
| 1. Controlled Drugs Audit (pharmacy) | High Priority Internal Audit | Bi-annual | Reported to July 2019 CAG |
| 1. Drug Allergy Audit (pharmacy) | High Priority Internal Audit | Annual | Decision taken by pharmacy team currently not to undertake this audit as satisfactory actions have not been implemented. |
| 1. CPA Audit for Community Teams Q4 | High Priority Internal Audit | Quarterly | Report writing in progress – report to July 2019 CAG |
| 1. Essential Standards Feb | High Priority Internal Audit | Bi-monthly | In Progress - Feb results reported to April 2019 CAG |
| 1. Resuscitation Equipment Audit | High Priority Internal Audit | Bi-Annual | Meeting in January 2019 to organise re-audit in Q4. Data collection to commence in July 2019 |
| 1. Review of Cardiorespiratory Arrests | High Priority Internal Audit | Annual | Report writing in progress – report to July 2019 CAG |
| 1. Non-CPA | High Priority Internal Audit | Annual | To be developed alongside CPA audit in 2019/20 |
| 1. Mental Capacity Act Audit (TBC) | High Priority Internal Audit | Annual | Advised to wait until the MCA addition to care notes is completed and implemented. Added to 2019/20 audit plan. |
| 1. Long Term Segregation | High Priority Internal Audit | Annual | Report writing in progress – report to July 2019 CAG |
| 1. Inpatient Physical Health Assessment on Admission to a MH Ward | High Priority Internal Audit | Annual | Awaiting policy update to be signed off by committee (expected to complete Q2/3 19/20 |
| 1. Seclusion | High Priority Internal Audit | Annual | Report writing in progress – report to July 2019 CAG |
| 1. Triangle of Care | High Priority Internal Audit | Annual | Decided audit team input was not needed |
| 1. Eliminating mixed sex accommodation | High Priority Internal Audit | Annual | Reported to April 2019 CAG |

* 1. There were no audits with out-of-date improvement plans in Q4.
  2. In the last report to CAG in January 2019 there were a total of 11 actions that were out of date; this has now reduced to 4.
  3. In Q4 clinical audit training has been delivered to staff on trust induction, Junior Doctors’ induction and two team bespoke training sessions. A total of approximately 120 staff have accessed this in Q4.
  4. In Q4 there were 7 audits reported. CQUIN 9a will be reported in section 5. These are detailed in table 2 and a brief summary of actions for improvements are given below:

**Table 2**

|  |  |  |
| --- | --- | --- |
| **Audit Title** | **Directorate** | **Audit Rating** |
| Physiotherapy Hip Fracture 2017 | Community Services | No rating given |
| Essential Standards Feb-19 | Mental Health & Specialist | Good |
| National Audit of Care at the End of Life | Community Services | No rating given |
| POMH 16b-Rapid tranquilisation | Mental Health & Specialist | Requires Improvement |
| CQUIN 9a, Q4 2018/19 | Mental Health & Community Services | Excellent |
| Eliminating mixed sex accommodation 2018/19 | Trust wide | Good |
| Safe and Secure Handling of Medicines 2018/19 | Trust wide | Good |

* 1. The Physiotherapy Hip Fracture Sprint Audit (PHFSA) ran from May 1st 2017 to October 31st October 2017 and captured a high volume of data on rehabilitation, pathways, frequency and type for hip fracture patients over 60. This data was then linked to the National Hip Fracture Data Base (NHFD) to understand the whole patient pathway. The standards for physiotherapy hip fracture rehabilitation were launched at Physiotherapy UK 2018. Community Therapies Service and Community Hospitals plan to set up a working party to address the improvements needed based on the audit results and care across the pathway. A focus will be on reducing the gap between discharge and start of therapy in the community.
  2. At the time of the National Audit of Care at the End of Life, a new End of Life Care Plan had just been re-launched and was not fully embedded across Community Hospitals. The End of Life and Palliative Care Steering Group are in the process of continuing to embed this care plan, which will support the areas of documentation highlighted in the audit. Some key actions include:
* Plans are underway to increase the number of End of Life link nurses and deliver training to staff, so that they can offer psychological support to patients.
* A larger project is underway across Community Hospitals to improve care planning on Carenotes, which will support person-centred care plans.
* During 2019 the directorate will also be part of the system-wide project looking at End of Life needs assessment across all providers. This work will inform a new commissioned provider collaborative model across Oxfordshire.
* The Trust is working with Sobell House to run a staff development day in relation to meeting spiritual needs at the end of life.
  1. Essential standards, a bimonthly audit, has continued to be rated as good over the last 4 audits undertaken. This audit evaluates the care provided in mental health inpatient units against 32 standards of care. Many standards were rated as excellent. There were 2 that required improvement. The first was in relation to care planning for patients identified at risk of pressure ulcers and the second related to patients on older adult mental health wards having a "knowing me form" completed as part of the assessment process. Actions are taken to address improvements at the time of the audit.
  2. Elimination mixed sex accommodation: The provision of same-sex accommodation (same-sex bedrooms, bed bays and toilet and bathing facilities) across the NHS is a visible affirmation of the health service’s commitment to respecting the dignity and privacy of those who use its services. Services are rated as good with some work needed to appropriately develop facilities on two wards, where there are no separate women-only lounges as part of the wider Warneford development plans and the development of a protocol for staff to follow in event of a breach.
  3. POMH 16b- Rapid tranquilisation (RT) in the context of the pharmacological management of acutely-disturbed behaviour was rated as requiring improvement. In particular, standards regarding physical health monitoring, prompt debriefing following an episode of rapid tranquilisation and updating care plans have decreased from the baseline audit. A number of recommendations have been made and are being progressed. These include:
* The development and implementation of a Trust education package for RT (package identified, development and implementation awaiting trust RT policy ratification). An eLearning package is being developed.
* Rapid Tranquilisation flowchart detailing practice following rapid tranquilisation to be sent to all clinical rooms in the Trust.
* A Rapid Tranquilisation form is to be developed for Carenotes.
* A MEWS/NEWS form is to be developed for Carenotes.
  1. The position with NICE remains largely unchanged in Q4. The NICE Implementation group continued to highlight risk and governance arrangements within the new directorates. Although work on NICE continues, until the new directorates all have established governance teams there is a risk that the identification of gaps in the implementation of NICE will be missed in some areas. Recruitment has been undertaken and the new postholders have either started or are due to start soon. This will help progress work. The plan to move reporting to align with the new Directorates and streamline NICE through an automated system is underway using Ulysses. The Ulysses system update happened in April, and all the published NICE guidelines as from 1st January 2019 will be updated on Ulysses. The guidelines relevant to services will sent to the directorates electronically. The directorate NICE leads will then disseminate these further to services for gap analysis (or upload a completed gap analysis) and then the action plans. The remainder of the guidance will be updated over time following the initial upload.
  2. Oxford Health is actively involved in the Medicine Optimisation Board of the Buckinghamshire ICS. Some of the processes and decision making around medicines are being streamlined, and it is hoped that some of the outstanding issues (e.g. GPs not being able to prescribe some mental health medicines) will be addressed shortly. Progress is being made.
  3. Melatonin for children: new licenced preparation of melatonin (Slenyto) will be available shortly, which may facilitate the agreement of shared care arrangements. This is being looked at nationally via the Regional Medicines Optimisation Committees (RMOCs);
  4. The physical health monitoring guidelines for patients on antipsychotic medications have been approved for Oxfordshire. The two counties are now consistent in what is recommended and where responsibilities lie;
  5. Best practice guidance for shared care in Oxfordshire has been approved between OHFT, OCCG and OUH;
  6. Pregabalin and gabapentin changed legal classification to Schedule 3 Controlled Drugs in April 2019. It has been agreed that these drugs will now be managed as other Controlled Drugs within the trust, though the strict legal requirements are lower. A guidance document for clinical staff has been distributed;
  7. Intravenous lorazepam for catatonia: a proposal to use this intervention in the ECT suites has been approved. This is a very effective treatment but requires close monitoring and access to emergency drugs. It provides an alternative to transferring patients to acute hospitals.
  8. In January 2018, the Physical Health Group agreed to set up a National Early warning Score 2 (NEWS) Taskforce to consider the implementation of NEWS2 across Oxford Health. This was following a Patient Safety Alert issued in April 2019. Although the target group for this alert was all acute hospital trusts and ambulance trusts caring for adult patients the Physical Health Group have taken the approach that this alert should be implemented in Oxford Health as a good practice initiative and have been an active community services partner in webinars organised by the NEWS2 Network. Several workstreams have been initiated to ensure the standards are met.
  9. BRC: A mid-term review is planned for October 2019, which will provide the basis for the renewal. The BRC Steering Committee has started to consider additional themes to be included in the renewal application.
  10. The Trust applied for £9m over five years to host an Applied Research Collaborative (ARC) which would replace the current CLAHRC. We expect to hear the outcome in May and, if successful, for this to commence in October 2019;
  11. Study Delivery:A new Research Delivery Management Team is now in place to integrate and streamline the work of the three research delivery teams;

1. **How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?**
   1. The Trust has been awarded the status of co-host of the Excellence Centre subject to achieving the Quality Mark accreditation
   2. The first cohort of Nursing Associates Trainees (NATs) are completing their training and being employed by the Trust
   3. There is a continued expansion of apprenticeship numbers.
   4. Great improvements have been made in mandatory training numbers over this quarter with Information Governance training achieving 95% compliance by the end of March 2019.
   5. Although improved, compliance was still not at target levels in the majority of Personal and Professional Statutory Training, PDR and particularly supervision. Although still red, Resuscitation training compliance is at its highest level for some time since L&D have started to overbook training by one for each session. This has helped to mitigate for non-attendees.
   6. As many areas are now close to training targets the plan is to continue with the present actions. L&D are also considering employing somebody for a year to work with teams to improve compliance with supervision targets.
   7. As reported in Q3 the Trust is an employer-provider of apprenticeships and are expecting a monitoring visit from Ofsted to rate the quality of our provision. No date has yet been given.
   8. The following policies were approved at the Quality Sub-Committee Effectiveness meeting held on 11th April 2019 or sent for fast tracked approval following the last meeting in January 2019:

Fast tracked

* CP 01/ Seclusion
* CP 102 / Venous Thromboembolism Policy (additional appendix to be added)
* CP 85/ Medical Gas Systems Safety
* CP 22/Assessment and Examination of Service Users
* MM08 / Independent Non-Medical Prescribing Policy (additional comments to be added)
* CP 24/ Management of Dysphagia Policy
* CP 04/ Rapid Tranquillisation (Adults & Older Adults) updated and approved by DTG.
* CP 71/ Community Practitioners Providing Intravenous Therapy

Actions agreed for the following:

* MHA 07/ Interagency Policy for Section 117 (Mental Health Act 1983) update required from Mary Buckman regarding changes in social care which impact on the updating of this policy
* CP 53/ Dual Diagnosis update being sought from the lead author and follow up from the clinical director.
* CP 50/ Clinical Procedures Policy – This is under review. The Royal Marsden procedures link will be shared with QSCE group.
* HR 34/ Preceptorship Policy for Non-Medical Staff - This is under review, to be signed off by the preceptorship steering group.
* MHA 01/ Mental Health Act Policy – QSCE agreed that the current policy was fit for purpose with a further review scheduled in 3 years.
* CP 03/ Safe and Supportive Observations of Patients at Risk Policy– An update from CAHMS is being followed up

1. **How are people supported to live healthier lives and, where the service is responsible, how does it improve the health of its population?** 
   1. CQUIN 9a Q4, 18/19 - Preventing ill health by risky behaviours- Alcohol and Tobacco: The rating for this quarterly audit has maintained its rating of excellent in Q4. There has been significant improvement in recording across all levels of this CQUIN; wards are now regularly recording smoking and alcohol status. However, the audit continues to highlight that there are high numbers of people declining support offered by the service (smoking cessation advice and the uptake of NRT medication).
   2. The One Chance to Get it Right Taskforce has largely completed its workplan but has now been renamed the End of Life and Palliative Care Steering Group to reflect outstanding work priorities
   3. In the CQC Inspection in 2016, Community End of Life Care services at Oxford Health NHS Foundation Trust were rated as, “good’’ in the safe, caring, responsive and well-led domains but “required improvement’’ to be effective. Improvements to awareness and education had not yet had an impact on patients. It was determined that the Trust must demonstrate how they assess patients’ needs and deliver care and treatment in line with evidence-based guidance. The development of the new End of Life Care Plan in partnership with a patient group has been instrumental in achieving this.

Following a review of work, it has been agreed to:

* strengthen the elements of the improvement plan that related specifically to NICE Quality standard [QS144] Care of Dying Adults in the Last Days of Life.
* make progress against the CQC requirement that the Trust must demonstrate how they assess patients’ needs and deliver care and treatment in line with evidence-based guidance more explicit
* ensure that the links between the Palliative Care and End of Life Improvement Plan and the Trusts Dementia Strategy are clear within the Improvement Plan
* Identify effective actions to address the findings from the NACEL audit and internal audits (noted in section 2.9)
* identify a methodology that builds upon work on care planning undertaken in adult mental health services and previous work with the Older Peoples Directorate on the House of Care and personalisation in long term conditions to embed and improve the effective use of the End of Life Care Plan.

Recently work has been undertaken to review the End of Life Policy, develop and undertake a programme of internal audit of standards of care at the End of Life and participate in the National Audit of Care at the End of Life (NACEL).

* 1. The focus on diabetes in the Trust has seen a work programme underway based upon the ‘NG17 Type 1 diabetes standards’ and ‘PH38  type 2 diabetes standards’:
* A 'Risk Score' form has been developed and launched on Community CareNotes. This will be used across all services for all patients seen by OHFT community staff. It will facilitate an assessment of the risk of diabetes and appropriate signposting to information and referral back to the GP, where a blood test is required. This form is currently being tested on CareNotes.
* A link nurse role is being developed, which will mean that a nurse in each ward/community team will have an additional element to their job description to liaise with the specialist diabetes team around practice and education.
* A new diabetes steering group will be launched, which will have a wider remit to consider all the trust’s services, including mental health.
* The creation of a Diabetes Nurse Specialist
* Approval of a new contract for the procurement of glucometer devices and testing strips
* The launching of a new Public Health and Physical Health Group (Population Health Group)
* Re-audit of diabetes care once the Diabetes Nurse Specialist is in post.

1. **Is consent to care and treatment always sought in line with legislation and guidance?**
   1. There has been vigilant monitoring of patients transferred under section 136 of the Mental Health Act to ensure that the start time of the detention is recognised and that the 24-hour period is not exceeded.
   2. The 24-hour period has rarely been exceeded within the trust, and ‘authorisation’ for the Place of Safety to be used as an admission bed is being closely monitored and reviewed.

.