

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

**BOD 111/2019**

(Agenda item: 15)

# Board of Directors

**4th December 2019**

**Effectiveness Report Q1 and 2 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 Q1 and 2 2019/20 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 Q1 and 2 2019/20 are as follows:

* An increase in the number of outstanding improvement/action plans following audits with a larger number of actions that were out of date for completion. This has seen a substantial increase from Q 4 2018/19. A big part of this has been the lack of directorate governance support which is now in place. This should see an improvement in the action planning and completion for clinical audit.
* CQUIN 3abc: Alcohol and tobacco-screening and brief advice was rated as excellent while Non-medical prescribing and Essential Standards audit were rated as good.
* CPA and psychosis in EIS (NCAP) audits rated as requiring improvement. For the NCAP audit the Trust requested the CCGs to undertake an independent review for assurance purposes.
* Assessment of the side of effects of Depot Anti-psychotics was rated as unacceptable with many areas below the National average. Plans have been put in place to address this.
* As has been previously reported, the last 12 to 18 months work on NICE has been impacted by the availability of resources to coordinate and monitor NICE work within directorates. This has been further impacted by organisational changes within the directorates necessitating changes in service lines and handover between teams. This is now resolved, and all directorates have identified leads for NICE and coordination support to deliver this. The scale of the task is big, and the current trust status is given in the body of the report
* Joint work is being undertaken with the OUH as part of the National Tissue Viability Collaborative
* The National Early Warning Score 2 (NEWS) was launched at the Senior Nurses forum and documentation is available through SharePoint
* A small amount of funding has been agreed between the CCG and OH to provide a GP surgery for patient living in the mental health recovery campsite to help improve their physical health and easy access to primary care
* A Written Instruction has been developed and approved to enable appropriately trained staff to deliver Flu vaccines.
* A self-assessment of OHFT governance arrangements regarding controlled drugs has been undertaken in response to the Gosport Inquiry finding processes in the Trust are robust.
* Ongoing variability in some areas for PPST but broadly much improved. Supervision, whilst improving slightly has remained very low. A Trust lead for Supervision has now being appointed and is in post.
* Apprenticeship activity with NATs continues with plans for the delivery of Psychological Wellbeing Practitioners, Advanced Clinical Practice and Operational Manager apprenticeships.
* Functional Skills training has been offered to staff enabling them to access higher level progammes
* OHFT was the fourth highest mental health Trust in FY19 for recruiting participants to research studies.
* Several issues have arisen regarding CDAs and Contracts which expose the Trust to unlimited liability. CDA/Contracts with unlimited liability are reviewed by the executive.
* The ability to generate the required level of income from clinical research studies will 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 linked to the BRC where funding is not so generous.
* The End of Life Strategy and Personalisation has been launched and workshops taken place
* The Green Spaces Strategy was launched in September highlighting some of the projects already in place in many of our sites across the Trust. There are lots of health and wellbeing initiatives happening across the Trust supported by the Oxford Health charity, volunteering, Artscape, Creating with Care etc and joint partnerships with other agencies eg BBOWT
* Authorisation’ for the Place of Safety to be used as an admission bed or otherwise is monitored and reviewed weekly. Challenges remain around moving patients, particularly younger patients within this timeframe often because of a lack of beds elsewhere.
* Numbers of patients subject to the Mental health Act in the Trust are consistently high, and turnover is high. The introduction of ‘red and green’ days and a daily bed availability conference has tempered the pressure on beds.

**Governance Route/Approval Process**

This report is the quarterly update to the board from the last Clinical Effectiveness Sub Committee held on 10th October 2019.

**Recommendation**

The board is asked to:

Note the contents of the report;

**Author and Title:**

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**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)*

*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)*

*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 give 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.

There were 8 audits due to be undertaken by the end of Quarter 2 2019/20:

* 2 national audits
* 1 CQUIN audit
* 5 high priority internal audits

Table 1 below provides further details of the audits that were due to be undertaken in Q2 that are either in progress or completed. There were no audits behind schedule.

**Table 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Audit Title** | **Type of Audit** | **Frequency** | **Status** |
| 1. UK Parkinson's audit 2019 | National | Biennial | Data collection stage. Awaiting national report |
| 1. Sentinel Stroke National Audit programme (SSNAP) | National | Annual | On-going data submission. Annual update to September CAG |
| 1. CQUIN 3abc- Preventing Ill Health by Risky Behaviours- alcohol and tobacco | CQUIN | Quarterly | Q1 reported to September CAG. Q2 report writing in October (to be shared at January CAG) |
| 1. Controlled Drugs (Q1-2) | High priority internal | Bi-annual | Data collection stage. Plan to report to January CAG |
| 1. CPA Audit for Community MH Teams (Q2) | High priority internal | Quarterly | Q1audit reported to September CAG. Q2 data collection stage (to be shared at January CAG) |
| 1. Essential Standards | High priority internal | Bi-monthly | August report to September CAG |
| 1. Resuscitation Equipment Audit (Q1-2) | High priority internal | Bi-annual | Preliminary report was reported to September CAG. Final report to January CAG |
| 1. Inpatient Physical Health Assessment on Admission to a MH Ward | High priority internal | 4-year cycle | Data collection stage. Report to January CAG |

* 1. In the last report to CAG in July 2019 there were 18 outstanding improvements with 26 actions that were out of date for completion. This has seen a substantial increase from Q 4 2018/19. A big part of this has been the lack of directorate governance support which is now in place. This should see an improvement in the action planning and completion for clinical audit.
  2. Seven audits were overdue and being actively followed up with action plans updated. There were four completed audits with action plans in place where improvements had been identified. In the Forensic service action plans are now being closedor updated (many are long term due to changes in Carenotes and training provision) with two new audits added. In Dentistry it was reported that audits were up to date and reviewed within the dental service but they are now beginning to link in with the wider specialised directorate.
  3. Clinical audit training has been delivered to over 150 staff since the last report in Q4 18/19. Much of this has taken take over Trust induction and the separate Junior doctor induction training programme.
  4. In Q1/2 19/20 there were 7 audits reported. These are detailed in table 2 and a brief summary of actions for improvements are given below: CQUIN 3abc will be reported in section 5.1

**Table 2**

|  |  |  |
| --- | --- | --- |
| **Audit Title** | **Directorate** | **Audit Rating** |
| Essential Standards audit August 2019 | Bucks Mental Health, Oxon & West Mental Health and Specialised Directorate | Good |
| CPA audit, Q1 2019/20 | Bucks Mental Health, Oxon & West Mental Health and Specialised Directorate | Requires Improvement |
| National Audit of Diabetes Footcare | Community Services Directorate | *n/a* |
| POMH Topic 6d: Assessment of the side of effects of Depot Anti-psychotics | Bucks Mental Health, Oxon & West Mental Health and Specialised Directorate | Unacceptable |
| National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) Spotlight Audit#1 | Bucks Mental Health and Oxon & West Mental Health | Requires Improvement |
| CQUIN 3abc: Alcohol and tobacco-screening and brief advice, Q1 19/20 | Bucks Mental Health, Oxon & West Mental Health and Community Services Directorate | Excellent |
| Non-medical prescribing | All directorates | Good |

* 1. **Essential standards**, a bimonthly audit undertaken in all inpatient mental health wards, has continued to be rated as good or excellent over the last 5 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 in the most recent audit were around capacity and patients on older adult mental health forms 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. **The Care Programme Approach (CPA)** audit is a quarterly audit undertaken by the three Directorates (Adults and Older People mental health services and Children & Young People) across Oxford Health NHS Foundation Trust. Following significant changes to the audit in CAMHS to bring it in line with the other directorates it was not possible to compare some standards across all areas. Those that could be combined focussed on the following areas:
* Up-to-date risk assessments
* Elements of care planning
* Psychotropic medication monitoring
* Consent/Sharing of care plans
* Involvement of family/carers and carer’s assessments.

All services were rated as requiring improvement with the exception of Older adults in mental health who have been rated good over 3 consecutive audits. Dierctorates will be developing improvement plans.

* 1. **National Audit of Diabetes Footcare** This a new audit with only 25 cases. Recommendations come from the national report and have already been met.
  2. **POMH Topic 6d: Assessment of the side of effects of Depot Anti-psychotics.** The Prescribing Observatory for Mental Health (POMH-UK) runs national audit-based quality improvement programmes open to all specialist mental health services in the UK. The aim is to help mental health services to improve the prescribing practice in discrete areas (‘Topics’). This report contains the results of a supplementary audit for POMH-UK Topic 6: The requirement is that 100% of patients prescribed depot/long-acting injection antipsychotics should be reviewed for side effects once a year. Many of the results were rated as below the national average. Some key actions agreed to address improvements include:
* Improve access to side-effect rating scales and patient information regarding side-effects and medications via the intranet: Send out communication and links to pharmacy resources regarding medication.
* Ensure that OHFT template documentation is used in patient reviews, both in-patient and out-patient which includes prompts regarding side-effect and physical health monitoring, and that use of these templates is encouraged
* The AMHT/CMHTs prompt sheet to be amended (community depot prescription card) for depot antipsychotic monitoring.
* Trial use of prompt form in Older Adult CMHTs/inpatient settings as a pilot and then review pilot results in smaller re-audit to ascertain effectiveness of prompt forms. Roll out prompt forms to all areas following review of re-audit.
  1. **National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) Spotlight Audit** This audit continued to be rated as requiring improvement. As a Trust we did less well than anticipated. We have informed Oxford and Bucks CCGs and have requested the CCGs undertake an independent review for assurance purposes. An action plan is in place for EIS and the main cause for poor figures relates to patients going to their GP for blood tests. This information is not captured on the audit forms. This could be improved with the development of point of care testing which is currently being costed.

A range of plans are in place and some gaps in resources highlighted that are needed to address some of the improvement:

* Part time physical health leads are currently working in teams however more funding is needed to have dedicated physical health leads in each team to achieve the physical health monitoring standards.
* The Oxon EIS team is currently trialling a machine (a project for one year to do blood tests in homes) – this may improve the physical health monitoring standards.
* Currently there is one full-time IPS worker in each team funded within the existing provision for the service. More funding is needed for IPS workers to improve employment opportunities for clients.
* More staff have been trained in CBTp, however there is limited caseload capacity in order to provide this additional CBTp to patients.
* There is currently a Carers worker (one day a week) in Oxon EIS however no worker in Bucks EIS. Bucks EIS is looking to develop a Carers group and new webpages for carers are being developed.
* More staff have been trained in BFT more training for clinicians however there is limited caseload capacity in order to provide this additional BFT to patients. Both EIS teams currently have a BFT lead.
* Research project Eye2 underway (for 2 years) which may increase ROMs completion.
  1. **Non-medical prescribing** This audit reviewed the current practice and experiences of any healthcare professional (Nurses and Pharmacists and certain Allied Health Professionals) who are successfully qualified and who are authorised as Non-Medical Prescribers, to undertake prescribing as part of their role. The Trust had a rating of good with improvements for Managers and clinical supervisors to take actions around providing further support to NMPs.
  2. **NICE**

As has been previously reported, the last 12 to 18 months work on NICE has been impacted by the availability of resources to coordinate and monitor NICE work within directorates. This has been further impacted by organisational changes within the directorates necessitating changes in service lines and handover between teams. This is now resolved, and all directorates have identified leads for NICE and coordination support to deliver this.

The volume of work in relation to the review and gap analysis for directorates continues to present a challenge. It was agreed in discussion with the regional NICE lead that a safe and pragmatic approach to address the volume of guidance would be to identify a **minimum** of five high priority/high risk guidance to report on a quarterly basis.

In addition to the guidance the pharmacy department review all of the mandatory TA’s. Since March 2018 there have been 108. Of these 106 were assessed as not being relevant. The remaining 2 we are compliant with.

There is very substantial work required in identifying and addressing gaps in NICE guidance across our services. In addition to the guidance, further work is undertaken in ensuring advice and consultation requests are distributed where appropriate. The details of NICE guidance and advice which has come through the NICE Implementation between March 2018 and November 2019 is given in Table 3. Table 4 gives the numbers by directorate of NICE guidance identified as being relevant since March 2018. Some of these (23) are relevant to all directorates.

At the current time there are 15 overdue NICE guidance. To be recorded as overdue, gap analyses may still have been completed in many areas but are outstanding in others. For example, Type 2 diabetes is relevant across most of our services, but we are only waiting for one service area to report. Also, where gap analyses are outstanding this could mean that a gap analysis has been completed but the completion of a related action plan is outstanding. The current number overdue is a reduction from 25 at the end of 18/19 demonstrating the progress being made in both overdue and in date guidance.

Where there are both QS and NG issued for the same condition, services are prioritising the NG as this is the broader guidance which encompasses the QS. All of these are being monitored and updated monthly as progress is made.

Table 1 Table 2

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| |  |  | | --- | --- | | **NICE guidance and advice issued since March 2018** | **Number by type** | | Clinical Guideline | 15 | | Diagnostic Guidance | 5 | | Evidence Summaries | 2 | | Highly specialised Technologies guidance | 3 | | Interventional procedures guidance | 57 | | Key Therapeutic Topics | 14 | | Medtech Innovations Briefings | 42 | | Medical technologies guidance | 15 | | NICE Guidance | 66 | | Quality Standards | 39 | | Technology appraisal guidance | 108 | | **Grand Total** | **366** | | |  |  | | --- | --- | | **Directorate** | **Number of guidance \*relevant by directorate** | | Community | 69 | | Mental Health | 39 | | Specialised | 24 |   \*This relates only to CG, NG and QS |

We are aware that there are times that NICE guidance will be assessed as being compliant although there are areas where we could and should be able to deliver services but are not commissioned to do so. We have not formally recorded all of these to escalate to commissioners and this is something we intend to do going forward. However, we do know of a couple of examples whether this has been relevant:

* CG162 Stroke rehabilitation in adults. This guideline was published in June 2013 and was reviewed by the Oxfordshire Stroke Rehabilitation Unit (OSRU). NICE recommends that the multidisciplinary team should include clinical psychology. This is not currently funded so remains a gap.
* NICE Clinical Guideline CG186 Multiple sclerosis in adults: management. The update of this guideline was published in July 2019 and the original gap analysis was reviewed and updated by the Physical Disability Physiotherapy Service (PDPS). The gap analysis identified three recommendations where the service is unable to achieve compliance due to gaps in commissioning:
  1. The National Early Warning Score 2 (NEWS) Taskforce set up to consider the implementation of NEWS2 across Oxford Health has resulted in a testing and finalization of the tool. Additions have included BMI recording and sepsis guidance added and the process for escalation if the tool triggers has been added to the back of the chart. It was launched at the Senior Nurses forum and documentation is available through SharePoint.
  2. The Trust is taking part in the National Tissue Viability Collaborative. The team that are part of the collaborative are in the process of developing driver diagrams and tests of change to reduce pressure damage. Collaborative meetings are taking place between OUH and OHFT. Areas identified for improvement work relate to improving healing of pressure damage through effective nutrition and the management of frequent attenders across OH and OUH.
  3. A new medical devices safety officer has been appointed. This role sits with corporate risk team. A planned replacement programme is needed for medical devices. They will be invited to the physical health group to help identify medical devices issues.
  4. OH and CCG have agreed to make a small amount of monies available to pay for GP’s to come in to see patients on the mental health recovery campus. This is a pilot for a year. It is anticipated that this will help to support the most vulnerable patients in supported living improve their physical healthcare
  5. A new nasal spray of Esketamine has been developed for treatment-resistant depression which is expected to be licensed later this year. OHFT has been approved as one of a limited number of sites (across eight trusts) to have early access to this drug under a named-patient scheme. Treatment will be provided free of charge until local funding is agreed (up to a maximum of 40 patients nationally) and will be delivered in the Interventional Psychiatry Suite at the Warneford Hospital.
  6. A self-assessment of OHFT governance arrangements regarding controlled drugs has been undertaken in response to the Gosport Inquiry. As part of our regular reports to NHSE, the trust has to declare that we have reviewed national guidance and reports regarding CDs. The Chief Pharmacist has reviewed the self-assessment and considers the internal governance to be robust.
  7. Owing to a legal technicality, PGDs cannot be used for the purposes of peer vaccination of staff. A Written Instruction has therefore been developed and approved.

1. **How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?**
   1. In July it was noted that PPST compliance was much improved although both local induction and resuscitation remained in the red. It was thought that the lack of local induction may be a recording issue. An audit of resuscitation was being undertaken over the summer which would help identify why some people were not attending. It was also noted that PDR compliance was much improved and had achieved 90%, although had fallen back to 87%, but Supervision, whilst improving slightly remained very low. A Trust lead for Supervision has now being appointed as is in post.
   2. Work has been underway over the last 6 months to forward plan numbers of Nursing Associates Trainees for the next cohort in December 2019 with an intake of 50. A number of these will be expected to go on to “top up” as qualified nurses. It was noted that planned apprenticeship activity included the delivery of Psychological Wellbeing Practitioner, Advanced Clinical Practice and Operational Manager apprenticeships. The Trust is also delivering Functional Skills training to staff that have not achieved Level 2 in English and Maths thus enabling them to access higher level progammes.
   3. The development of an AHP apprenticeship pathway is being developed to match the one established for nursing.
   4. multi-disciplinary advanced clinical practice group is being set up to move forward opportunities for this higher-level apprenticeship.
   5. The learning and development team are still awaiting notification of an OFSTED visit.
   6. OHFT was the fourth highest mental health Trust in FY19 for recruiting participants to research studies. The Older Adults Team have successfully opened the first study that involves an intervention being delivered by AHPs within the Trust
   7. Several issues have arisen regarding CDAs and Contracts which expose the Trust to unlimited liability. While a cap on liability is preferable it has been acknowledged that this may not always be possible. CDA/Contracts with unlimited liability are reviewed by the executive.
   8. The newBiomedical Research Centre(BRC): manager, is now in post. A successful mid-term review took place on 10 October 2019.
   9. After almost a decade as Director of the Clinical Research Facility (CRF), Professor John Geddes has stepped down and Professor Andrea Cipriani has taken over as Acting Director.
   10. MedTech and In Vitro Diagnostic Co-operatives (MIC) (previously the DEC)**:** A new standardized risk assessment tool for studies completed on the unit is under development to improve the documentation and review of risks.
   11. CLAHRC \ ARC:The Applied Research Collaborative (ARC), which replaces the CLAHRC, officially started on 1October 2019. This will provide £9m of funding over five years.
   12. A research SOP is being developed with OUH which will be adopted within OHFT
   13. Case Records Interactive Search (CRIS):The CRIS team is managing the transition of supplier from the University to CRIStal Health Ltd and exploring a potential strategic relationship with the new company.
   14. The pharmacy department has recently supported local NIHR colleagues in delivering training for Thames Valley primary care nurses around managing clinical trial medicines (IMP) according to GCP. They plan to offer similar training to research interested GPs in the new year
   15. The ability to generate the required level of income from clinical research studies will 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 linked to the BRC where funding is not so generous.
   16. Updated Standard Operating Procedures for controlled drugs have been approved, reinforcing recent recommendations.
   17. Nursing Associates and the registered nurse application (RNA) processes: Owing to national delays with the RNA registration process and subsequent delays in updating the trust medicines policy to reflect the new RNA role, a risk note has been issued to highlight that currently qualified RNAs can only administer medicines covered by the five core routes of administration that have been agreed nationally. Work is ongoing to develop processes to allow other routes to be included via a local competency-based sign-off similar to that used for PGDs (patient group directions).
   18. A number of guidelines have been updated, including the following:

* Depression guidelines – updated and standardised across Oxon and Bucks and now consistent across CCGs.
* First Episode Psychosis Guidelines – developed by EIS and approved.
* Clozapine shared care guidelines (Oxfordshire)

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 3abc: Alcohol and tobacco-screening and brief advice, Q1 19/20** This is the Q1 19/20 audit linked to the CQUIN goal 3a, b & c preventing ill health by risky behaviours – alcohol and tobacco. The rationale for this CQUIN is to ensure patients’ smoking status and alcohol consumption are documented and advice is given in relation to stopping smoking and referral to specialist alcohol services are offered where appropriate. The Trust rating was excellent with a score of 99.85%. The uptake of interventions for patients who smoke is still currently low, therefore further work is required in ensuring our patients are regularly asked and offered advice and interventions
   2. The End of Life Strategy and Personalisation has been launched across services and resulted in five workshops with feedback being collated. More workshops are planned before the end of the year.
   3. The Green Spaces Strategy was launched in September highlighting some of the projects already in place in many of our sites across the Trust. Some of these projects have been supported by third sector organisations such as Good Gym and Chiltern Rangers
   4. Funding for a small number of hours for a patient engagement coordinator at the Warneford site has been agreed to create activities that can be engaged in across all settings and to run a regular group to support knowledge and confidence in delivering activities. This post is managed by the Artscape coordinator
   5. A volunteer started to work at Warneford site with Tom Cox in the Summer of this year. They have worked with Artscape to develop a poster display about birds and wildlife. Oxford Health Charity has developed a specific Green Spaces appeal to seek funding and volunteer support for further activities. <https://www.oxfordhealth.charity/appeal/green-spaces>
   6. The University of Oxford Dept of Psychiatry run a monthly bird walk on the Warneford meadow and report on birds seen.
   7. Annual apple day was held in October 2018 in collaboration with DRARA and will be held again on 13th October 2019. Apple Juice from the Warneford apples is for sale and available at the Community Hub at the Warneford produced in collaboration with Tiddly Pommes.
   8. There are plans for the development of a proposed bid with BBOWT to develop community hubs for conservation work that are supported and accessible for people with health and well-being needs.
2. **Is consent to care and treatment always sought in line with legislation and guidance?**
   1. ‘Authorisation’ for the Place of Safety to be used as an admission bed or otherwise is monitored and reviewed via the Weekly Review Meeting and Problems in Practice. Continued vigilance is required so that the 24-hour time period for section 136 and 135 is not exceeded. Challenges remain around moving patients, particularly younger patients within this timeframe often because of a lack of beds elsewhere.
   2. Change to Deprivation of Liberty Safeguards is being implemented in October 2020. Preparatory work is underway, and the Mental Capacity Act is also the focus of specific work led by the Head of Social Care. It is expected that the implementation of the code of practice will be a challenge.
   3. Numbers of patients subject to the Mental health Act in the Trust are consistently high, and turnover is high. Capacity is a significant issue across the Trust, although introduction of ‘red and green’ days and a daily bed availability conference has tempered the pressure on beds.
   4. The Mental Health Act office have introduced an action plan status for CQC recommendations and are considering how to make use Ulysses to improve completion of actions.