Oxford Health FT Response to the Robert Francis Inquiry for Oxfordshire OSC.

Review of progress following the second report of the Francis Inquiry (February 2013)

1. Application of Francis Inquiry findings to Oxford Health Foundation NHS Trust

Oxford Health FT provides a range of integrated mental health and general community health and social care services to people of all ages in Oxfordshire, mental health and social care services for all age groups in Buckinghamshire, specialist mental health services for the Thames Valley and children and young people's mental health services across five counties.

The second Francis report into the wider system failings associated with the events at Mid Staffordshire Hospital made the two following recommendations:

All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;

Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;

2. Overall findings of the Inquiry

The events at Mid Staffordshire were related both to specific failings associated with the way in which the organisation was functioning at that time; and to flaws in monitoring, communicating and addressing concerns within the wider system.

Specific criticisms within the report included:

- A lack of Board awareness of the reality of the way in which care was delivered in the organisation and experienced by patients and those close to them.
- Tolerance of poor standards of care (with stories of "appalling" provision of care).
- A focus on targets, finance and the FT application to the detriment of quality and safety.
- Little attempt to collect or review quality data in a systematic way.
- A focus on positive information and a failure to respond to information which suggested a cause for concern.
- Failure to remedy long standing deficiencies in staffing and governance.
- A lack of transparency and openness about issues and concerns.
- Failure to deal effectively with complaints and serious incidents.
- No culture of listening to patients and those close to them.
- Failure of external agencies to communicate and to tie together a range of information which suggested serious issues with the safety and quality of care being delivered at the Trust.

3. Our approach in Oxford Health FT to delivering quality and minimising harm

In line with a number of other NHS organisations Oxford Health FT has looked in detail at the findings of both Francis reports. We have analysed the ways in which the organisation proactively minimises the extent and impact of safety and quality issues in the standard of care provided. Part of this process involved a Board level review of the key findings and recommendations, this took place in three seminars, one with the whole Board , the Senior Management Team and Governors Council supported by a series of meetings with staff across the organisation.

Our approach to fully embrace the Francis report and its recommendations is to focus forwards on the integrated care we are currently providing to patients in 2013 including imminent plans to remodel our services to improve the integration of health and social care and improve outcomes and experience for patients; rather than to look back at the unfortunate set of events in Staffordshire occurring between 2005-9. We are planning our future with these key lessons identified by Robert Francis in mind.

Our Trust's core purpose is to ensure patients have a positive experience of care whilst enhancing outcomes, recovery and quality of life through services which aim to be caring, safe and excellent. We are taking full advantage of the opportunities to integrate physical and mental health care to produce better outcomes for patients as an integrated community and mental health service provider in Oxfordshire and in partnership with other stakeholders in Buckinghamshire, Swindon, Bath and NE Somerset.

There are some important principles which underpin our Trust's approach to quality and safety, which take account of the recommendations from the Francis Report namely:

- Strong Board engagement with and oversight of the safety and quality of care being delivered by the organisation.
- Placing patients and quality at the heart of decision-making.
- Fostering a culture of openness and transparency.
- Proactively soliciting feedback from staff and patients.
- Responding quickly to concerns and issues.
- Timely investigation of serious incidents.
- Full compliance with CQC Outcomes and Inspections. To date we have had four formal inspections of the John Hampden Unit, Bullingdon prison, Wintle Ward at the Warneford and Littlemore Mental Health Centre. We have responded and met the Minor concerns which were raised in two inspection reports at the Warneford and Littlemore.

A clear oversight of the quality and safety of care is reviewed proactively in a number of ways:

We hold an expectation that clinical staff are responsible for the quality of care being delivered to patients by themselves or their team members, understanding about what to do if they have concerns which they cannot address. Being caring, compassionate, person centred and evidence based is a standard expected of all staff. Significant resources are committed to training staff and percentages of staff trained in personal and professional education is high. We aim to maximise engagement in the persons own care and recovery which are fundamental and we are focussing on achieving the right clinical outcome for the person first time ,together with zero tolerance of harms. Individual patient feedback in every team at regular intervals also occurs.

We have developed a range of standards and measures with patients and staff to audits to check engagement, safety, outcomes and experience to underpin this proactive approach, and we are developing this in detail within each team this forthcoming year.

In the event of anything untoward happening ensuring a culture of reporting and acting immediately on service quality issues is in place underpinned by a developing culture of learning .Staff discuss local issues, incidents and concerns in team meetings and in regular management and clinical supervision sessions. These feed in to service level team meetings which review these issues across a number of services/clinical areas, and these are discussed in turn within the divisional safety and governance meeting. Risks to quality and safety are captured in the local and divisional risk registers and are managed or escalated as appropriate.

Our Trust has a formal governance structure organised around key safety and quality agendas – this is being reviewed to ensure it continues to provide a dynamic risk management process, aligned with rapid and robust reporting and monitoring of the quality and safety of the care delivered by our staff.

We have quality systems that capture this information at team level through a number of key measures which are reported both monthly and quarterly, including:

- The safety thermometer- this is a national measure of four patient harms including pressure ulcers, urinary tract infections, falls and VTE.
- Productive ward measures- a range of clinical standards, staff utilisation metrics and patient and staff experience feedback.
- Essential standards of care audit- in our mental health inpatient wards monitoring quarterly basic standards of care.
- Key performance indicators set nationally and locally by our CCG and Local Authority colleagues.
- Safer care collaborative measures-include a range harm reduction measures and uses improvement science to reduce prevalence.

- Friends and family test- this is a national question that is asked in all acute hospitals and community hospitals including urgent care services.
- Regular clinical audits- an annual programme is agreed with commissioners and the Board.
- Incident reports- frontline staff report potential or actual harms so immediate issues can be addressed which are reported through to the national reporting and leaning system.
- Patient Experience feedback collected through a programme of surveys.
- Complaints and PALS reports in all clinical teams.
- The Quality Account- which has been reviewed by the OSC Committee on an annual basis.

Oxford Health FT's annual Quality Account was developed in collaboration with our staff, the Governors and service user representatives and was submitted to the OSC. This document draws together a range of safety and quality indicators and measures, as well as qualitative examples of the standards of care delivered to patients and those close to them. This is reported to all stakeholders with a half year update and is in the public domain through our website .

Looking forward, improved dedicated safety and quality dashboards are being developed to pull together key measures which will be available at a ward/service level as well as across the whole Trust. Our aim is for all staff to have access to this information on a daily basis.

We emphasise the importance of patient involvement and feedback as a key component of quality care. Patient views are solicited in a variety of ways in our diverse patient population through "have your say" community meetings for inpatients; patients councils; patient satisfaction surveys; essential standards of care audits; friends and family test; and through PALS surgeries and formal complaints. We publish through our Board reports what patienst have told us about their experiences of care- good and poor in our Quarterly report to the Board and Governors Council .

We have had a longstanding incident reporting and serious incident investigation process. Compared with national data we are in the median range for similar Trusts for reporting incidents. Staff are actively encouraged to report all and any patient and staff safety incidents and these are all reviewed on a daily basis by the health and safety team. Serious incidents are subject to a detailed root cause analysis investigation which is overseen by senior clinical staff. Serious incidents are only closed following a review by the Clinical Commissioning Group. The implementation of recommendations is reviewed on a weekly basis and learning events are co-ordinated across our Trust to share learning and best practice.

4. Improving the culture of care – developing staff and a patient safety culture

Oxford Health FT aspires to ensure outstanding care is delivered by outstanding people. This ambition is supported by objectives we have framed in our Quality Account 2013/14 having taken account the Francis Recommendations. These have already been shared with OSC which include:

- Values based recruitment for undergraduates and developing this approach for all employees.
- Development of clear standards to define and measure care.
- No tolerance for poor standards of care and a rapid response where substandard care is considered to be identified.
- Developing a new Strategy for Caring, and establishing a process to test this.
- Effective multidisciplinary teams – Aston Teamwork embedded.
- A development programme for Effective clinical leadership in all teams.
- Commitment to the NHS Constitution - Staff Charter.
- Strong professions who uphold standards of professional practice in every clinical contact and staff actively pursue their on-going professional development.
- A strategy for the professions particularly nursing, including effective nurse leadership in ward areas and review of staffing levels in inpatient wards.
- Remodelling of services to provide more integrated models of care for all patients. This is already in place for children and young people and is going through a process of discussion and agreement with key stakeholders for adults and older people with distinct pathways being agreed to standardise and reduce variation and improve quality
- Within the remodelling of services particular attention to strengthening clinical leadership at the point of care and work on staffing levels is part of this work. We have undertaken a detailed review of staffing within the last two years in Community Hospitals. Within the mental health inpatient re-modelling we are looking at the number of patients and type of conditions requiring inpatient care and the levels of staffing required to effectively care for patients including further strengthening the range of health and social care services we provide out of hospital to prevent avoidable admissions to hospital in community and mental health settings.
- Working collaboratively with staff to embed a patient safety culture in all areas of the organisation.
- Public Board meetings and publication of all non- confidential Board papers to ensure the Trust is transparent and open to scrutiny. Over the next year reporting the quality of each service line detailing the safety, clinical outcomes and experience

5. Quality and safety improvements

Oxford Health is undertaking a substantial remodelling programme to provide integrated health and care services involving a complete review of current service provision. This change programme will deliver:

- Patient centred care and improved patient safety.
- Services designed along pathways of care (for example, services for adults , and older people with distinct care packages that follow the patient journey based on the National Institute for Clinical and Care Effectiveness public health and treatment guidance and standards.
- Integration of care (for example, services for children) and improved links with primary care.
- Care closer to home.
- A greater emphasis on outcomes based commissioning and patient reported outcome measures (PROMs).
- Enhanced and strengthened clinical leadership.
- Enhancing our care environments. A substantial capital programme will be completed in the winter of this year to deliver a purpose built centre in Aylesbury, the Whiteleaf Campus which will include acute inpatient units and will house local community mental health teams for north Buckinghamshire . We are also investing in enhancing our older estate at the Warneford and Littlemore Hospitals in Oxfordshire, and Marlborough House in Milton Keynes. Our purpose built regional centre for children and young people at Highfield on the Warneford Hospital site is a service for young people needing inpatient care opened in January 2013. We have just taken possession of the Community Hospital estate from the dissolving Oxfordshire PCT these will be developed into integrated care hubs in the future, starting with the recent development of the Emergency Multidisciplinary Unit in Abingdon Community Hospital with an extended range of community services such as hospital at home which are starting to provide alternatives to attendance at A and E for older and frail patients who may otherwise need to go to OUH.

In addition the Trust is supporting a number of local quality and safety projects and programmes, including the Productive Ward programme and the Safer Care (collaborative) programme.

The productive ward programme works with local ward teams to release more time to care through a review of working practices, provision of timely and up to date information on the safety and quality of care, and a rapid response to issues or incidents.

The South of England Safety Collaborative aims to reduce harm to patients using community and mental health services by focusing on improvement on:

- Senior leadership for safety.
- Safe and reliable delivery of mental health services.
- Getting medicines right.
- Improving physical care of patients.

We have also worked with 70 Teams using the Aston University team based working approach to improve the effectiveness of these teams. We are planning to roll tis out to all teams.

6. Summary

This paper is intended to be background briefing for the presentation and discussion we will be having in the forthcoming Committee. We have given careful consideration to the Francis Recommendations and we have a forward facing response to ensure and assure patients, carers, the public and our staff that the care we aspire to deliver is caring safe and excellent for all who use our services and work within them.