Introducing a rapid improvement process to address safety challenges and improve multidisciplinary work, patient risk assessments and care plans

June 2017

<table>
<thead>
<tr>
<th>Trust name</th>
<th>Oxleas NHS Foundation Trust</th>
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<tbody>
<tr>
<td>Provider type</td>
<td>Mental health</td>
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<tr>
<td>Site (if applicable)</td>
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<tr>
<td>Core service</td>
<td>Acute inpatient mental health wards</td>
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<tr>
<td>CQC rating (SAFE)</td>
<td>Good</td>
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<td>CQC rating (Overall)</td>
<td>Good</td>
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The challenge

Oxleas NHS Foundation Trust provides a wide range of health and social care services in south east London, specialising in community health, mental health and learning disability services. It employs around 3,500 people including many skilled health and social care professionals and has over 125 sites across the London boroughs of Bexley, Bromley and Greenwich, and into Kent.

Services include physical health services to adults and children in the community in Bexley and Greenwich. These range from health visitors working with the very young to district nurses and therapists meeting the physical health needs of older people. The trust has also been the main provider of specialist mental healthcare in Bexley, Bromley and Greenwich for over 10 years and provides specialist forensic mental healthcare across south east London and in Kent prisons.

Over the past two years, the trust has faced an unprecedented increase in activity, resulting in challenges managing bed flow. Over time, it became ‘normal’ for patients to have to wait longer for a bed. The trust also experienced a series of serious untoward incidents and although these were fully investigated, the learning wasn’t always sufficiently applied to practice. The gravity of the situation came to light during a Care Quality Commission (CQC) inspection in March 2016 when the trust was rated ‘inadequate’ in safety, with significant concerns about acute inpatient mental health wards, forensic wards and child psychiatry services.
Several challenges were identified, including issues with multidisciplinary team (MDT) work, patient risk assessments, insufficiently personalised care plans, multiple breaches of same sex accommodation and delays in care provision.

The solution

Senior executives in the trust identified the priority challenges. The deputy chief executive, HR, medical and nursing directors chose a priority clinical area each and worked with local teams on a rapid improvement process for 12 weeks between October and December 2016.

Every week, the executive 'sponsor' chaired a meeting in that specific area and together with the local teams. They co-produced and launched a series of improvement initiatives, and reviewed progress each week.

The result of this intensive support was a series of improvement programmes, some of which are highlighted below:

- They reviewed all care plans, introduced a new policy and training for care planning, and developed and disseminated a purpose-built self-audit tool staff could use to audit their care plans and ensure all planned care was patient centred. As part of the care planning process, staff always talk to patients about their views and record these under a specific section of the care plan. Evidence of such discussions is also available in progress notes.

- They addressed the challenge of providing adequate weekly MDT input to each patient and aligning everyone's diaries by developing a purpose-built information-gathering tool. This helped clinicians gather information before the weekly meeting, so that all patients would benefit from full MDT input when agreeing their treatment plan. The new template and way of working are reviewed every six weeks and feedback on improving it is acted on.

- They reviewed all patient risk assessments and the reasons why these were not updated regularly. After identifying issues with the electronic record system in the trust, which had been designed for chronic care but was not ideally set up for use on wards, they designed a new inpatient template. This was first rolled out in paper form and is also being integrated into the electronic documentation solution.

- They addressed patient flow and same sex accommodation breaches by ensuring that all planned discharges happen by 3pm, commissioning extra bed capacity from a neighbouring trust, discontinuing sleepovers, and introducing single sex wards and gender-designated individual patient rooms. Moreover, the trust is piloting a pre-admission suite (PAS) in Oxleas House, for patients who have been assessed in
A&E. The PAS has been established to meet the immediate needs of up to four patients already assessed as requiring inpatient admission, for whom no bed is immediately available, and who are not subject to the Mental Health Act. It provides a safe waiting area outside A&E, giving an opportunity for further active review with the patient (and any involved carers) of their presenting situation, with the aim of transferring them to home treatment or other services as an alternative to admission, if appropriate.

Once they had completed these sessions, the team was aware what standard of quality and safety was expected of them and was able to continue working at this level, even once the executive chair handed back leadership to the clinical team. Appropriate reporting mechanisms were introduced, so that the trust executive team would be able to monitor ongoing compliance with the interventions.

**Enablers and challenges**

The focus on a culture of improvement rather than blame was a key enabler in driving engagement and ensuring buy-in from ward-level staff.

There were challenges, and some members of staff took longer than others to embrace new ways of working. Sensitivity towards their concerns and a nurturing relationship combined with support for the enthusiasts helped to ensure the whole team was able to move forward quickly.

**Impact**

It is still too early for a full evaluation but since introduction of the focused improvement initiatives, these clinical services have not experienced any serious untoward events. This is a significant improvement considering there were several such incidents over the preceding two years.

Anecdotal evidence in the trust also suggests there is more effective team-working and improved quality of care plans and risk assessments.

The most recent CQC inspection in May 2017 commended the team’s efforts, securing a safe domain rating of ‘good’.
Next steps and sustainability

To ensure the changes were fully embedded and sustainable, the trust introduced reporting mechanisms to provide the quality committee oversight on progression in these areas. They also added the interventions to the ‘board to ward review checklist’, so that members of the trust leadership team are prompted to review these each time they conduct a ‘board to ward’ review.

Want to know more?

Have a look at the trust’s resources here:

- care plan self-audit tool

For more information, contact:

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To see the other case studies in this series: visit the NHS Improvement website at: Improving quality and safety in healthcare.