Glossary of Abbreviations

ADHD – Attention Deficit and Hyperactivity Disorder
ALD – Adult Learning Disabilities
AMH – Adult Mental Health
AOT – Assertive Outreach Teams
BMI – Body Mass Index
BP – Blood Pressure
CAMHS – Children and Adolescent Mental Health Services
CDI – Clostridium Difficile Infection
CHS – Community Health Services
CHS Paeds – Community Paediatric Services
COPD – Chronic Obstructive Pulmonary Disorder
CPA – Care Programme Approach
CRN – Comprehensive Research Network
CLRN – Comprehensive Local Research Network
CQC – Care Quality Commission
CQUIN – Commissioning for Quality and Innovation
DeNDRoN – Dementias and Neurodegenerative Diseases Research Network
EIP – Early Intervention in Psychosis
GADS – Greenwich Advanced Dementia Service
HSCIC – Health and Social Care Information Centre
HQIP – Healthcare Quality Improvement Partnership
KPI – Key Performance Indicator
LD – Learning Disabilities
LTC – Long Term Conditions
NICE – National Institute for Health and Care Excellence
NJHR – National Institute of Health Research
MH – Mental Health
MH & LD – Mental Health and Learning Disability
MHRN – Mental Health Research Network
Monitor – Foundation Trust Regulatory Body
MRSA – Methicillin Resistant Staphylococcus Aureus
OPMH – Older People Mental Health
POMH – Prescribing Observatory for Mental Health
QOF – Quality and Outcomes Framework
QSIP – Quality and Safety Improvement Plan
RAG – Red, Amber, Green rating
RCA – Root Cause Analysis
RIO – Electronic Clinical System
SaLT – Speech and Language Therapy
ST – Safety Thermometer
UTI – Urinary Tract Infection
VTE – Venous Thromboembolism

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Part 1

Chief Executive’s Statement on Quality

I am delighted to present to you our 2013/14 Quality Accounts. Our first and foremost organisational priority continues to be enhancing quality; ensuring excellence for every patient across the 3 quality domains of patient experience, patient safety and clinical effectiveness. The foundation of our quality plans is in our trust 4 must dos and these have been our focus for a number of years:

1. Increasing support for families and carers
2. Providing better information for our service users and carers
3. Enhancing care planning
4. Improving the way we relate to both our service users and carers.

Our ‘4 must dos’ are based on consistent feedback from our patient surveys and the outcomes of investigations into incidents and complaints; analyses of these have told us the important things for us to focus on.

My aim in the following pages is to share with you how we have fulfilled our commitment to providing high quality NHS services to all of our patients and I wish to do so by setting out:

- Our approach to quality improvement,
- Our performance against the quality priorities we have set for ourselves,
- Our priorities for 2014/15.

We have worked hard across all our services to ensure we achieve the set standards. We have slightly underachieved in 4 of our quality indicators, and we are determined to focus on continued improvement in those areas to ensure these are achieved in the year ahead.

In addition, some of our other quality initiatives undertaken during the year are highlighted in the report.

We were really delighted with our outstanding annual national staff survey results this year. Our staff rated us the best trust of our kind in the country in 8 categories. These include our staff saying their roles made a difference to patients; were satisfied with the quality of work and patient care; and would recommend Oxleas as a place to work or be treated. King’s Fund research has demonstrated that Oxleas had the highest levels of staff engagement in the NHS staff survey returns between 2009 and 2012. The review details the evidence of a strong positive relationship between staff engagement, patient experience and organisational performance.

Our Board has always been committed to making quality the focus of everything that we do and this year has been no different. The Francis report was published at the time we launched our nursing strategy which sets out our core values and our priorities over the next three years. In the strategy we have committed ourselves to meet key priorities over the next 3 years as follows:

- Deliver high quality and compassionate care
- Improve the experience of our patients and carers and keep them free from harm.

Also, and in response to the Francis report, we introduced a ‘Back to Floor’ programme of monthly visits to clinical areas by every member of the Board of Directors accompanied by a clinical and service director. These visits, which also include night visits, provide our staff and patients the opportunity to directly engage with members of the Board and executive team to share their views on the quality of our services and what it is like to work in Oxleas. Feedback about each visit is given by non-executive directors at every public Board meeting.

Our Board of Directors has given its commitment to monitoring nursing staffing on our units at every board meeting to ensure the right numbers of nurses with the right skills are available to deliver safe, quality care. To ensure safe staffing levels we will publish staffing levels and action plans put in place where shortfalls have been identified.

Looking forward to the coming year, Oxleas has been invited by the Department of Health to be at the forefront of a national safety campaign called ‘Sign up to Safety’. We have been identified as one of 12 trailblazer organisations committed to developing a patient safety improvement plan which includes engaging our staff, patients and the local community to sign up to the initiative and deliver harm-free care.

In 2014/15, we have an ambitious programme of quality, improvement and innovation. We will ensure that our focus on patient safety, improved clinical effectiveness and outcomes and positive experience of our care is maintained across all of our services.

We are grateful to all our service users, carers, commissioners, staff, trust members, GPs and other stakeholders who have supported and worked with us in reviewing and setting our quality plans for the year.

Declaration:
Our Quality Account is based on information gathered both within the trust and externally; the contents have been reviewed by our Governance and Quality Boards and I can verify to the best of my knowledge is an accurate and true account of the quality of our services.

Signed
Stephen Firn, Chief Executive
28 May 2013
Part 2

2. Quality Priorities for Improvement

This section forms Part 2 of our Quality Accounts and will provide an update on our priorities for improvement and statements of assurance from our Board of Directors.

Oxleas NHS Foundation Trust (Oxleas) is committed to delivering quality services and we have worked in partnership with staff, patients, carers, our members, commissioners, GPs and others to identify areas for improvement.

Our Quality Account gives us an opportunity to share with you our performance against our priority areas for 2013/14 and showcase notable and innovative practice.

2.1 Review of how we did – Progress made against 2013/14 priorities

Last year, our chosen goals for improvement covered the three quality areas of patient experience, patient safety and clinical effectiveness. These improvement goals were determined through a variety of processes:

- Our annual borough based focus groups across Bexley Bromley and Greenwich. These took place during the month of February this year.
- Our regular quality review meetings with our commissioners.
- Feedback from patients who have used our services.

We continue to ensure that quality is at the forefront of everything that we do and an important aspect of this is to review our performance throughout the year and share how we have performed with staff, patients and our commissioners.

This section highlights in detail our performance against some of the quality goals outlined in the tables. We will highlight areas where we have done particularly well and areas that require further focus to ensure improvement in future. The detail is provided in three domains: patient experience, patient safety and clinical effectiveness.

Where available, we have included data from previous years’ quality reports, for comparison and to evidence progress. This includes published national audit results from the Prescribing Observatory for Mental Health (POMH) and national surveys of patient care and satisfaction. With the exception of national patient surveys, we use information from our electronic patient record, RiO, our staff training database and local audits or surveys to measure achievement of these priorities. We have also included what performance data is determined by local or national definitions.

Our performance has been compared to the national average for POMH audits in the following pages however all other data has not been compared to other trusts. Comparable data for national priorities are presented in Table 10, section 2.6.9. For ease of reference, a glossary of all terms and acronyms used is provided at the end of the report.

We have used the following symbols to denote how well we performed against the quality priorities:

**Achieved:** This means the target set has been achieved

**Mostly Achieved:** This means our 2012/13 performance is 5% or less below the target set

**Not achieved:** This means our 2012/13 performance is 6% or more below the target set.

### 2.2 Patient Experience

**Table 1 - Summary of our performance against patient experience quality improvement goals**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>M.H.D.S. Forensics</td>
<td>65% of registered carers of patients on CPA to have been offered a carer’s assessment</td>
<td>284</td>
<td>469</td>
<td>631</td>
<td>841</td>
<td>984</td>
<td>1092 (80% offered)</td>
<td>945 (65%)</td>
</tr>
</tbody>
</table>
2.2 Patient Experience, continued

<table>
<thead>
<tr>
<th>Patient Experience</th>
<th>Trust Summary Directorate</th>
<th>6AMH (Adult Mental Health)</th>
<th>6OPMH (Older People Mental Health)</th>
<th>Forensic &amp; Prisons</th>
<th>Adult Community Health Services</th>
<th>Children &amp; Young People</th>
<th>Forensic &amp; Prisons Child &amp; Young People 85-89</th>
<th>April 1 2013 - March 31 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been provided with enough information about care and treatment?</td>
<td>80% of patients reporting that they have been provided with enough information about care and treatment?</td>
<td>90%</td>
<td>92%</td>
<td>97%</td>
<td>89%</td>
<td>100%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Have you been involved as much as you would like in decisions about their care and treatment?</td>
<td>80% of patients reporting that they were involved in decisions about their care and treatment?</td>
<td>92%</td>
<td>98%</td>
<td>81%</td>
<td>89%</td>
<td>95%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Has staff treated you with dignity and respect?</td>
<td>80% of patients reporting that staff have treated you with dignity and respect?</td>
<td>95%</td>
<td>99%</td>
<td>92%</td>
<td>90%</td>
<td>99%</td>
<td>93%</td>
<td>93%</td>
</tr>
<tr>
<td>Has your quality of life improved as a result of the care and treatment that you have received?</td>
<td>80% of patients reporting that their quality of life has improved as a result of the care and treatment that they have received? (From July 2013 to March 2014)</td>
<td>90%</td>
<td>95%</td>
<td>90%</td>
<td>92%</td>
<td>100%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Would you recommend our service to friends and family if they needed similar care or treatment? (Response rate of Extremely likely and Likely)</td>
<td>80% of patients reporting that they would recommend our service to friends and family if they need similar care or treatment?</td>
<td>85%</td>
<td>89%</td>
<td>74%</td>
<td>92%</td>
<td>98%</td>
<td>89%</td>
<td>89%</td>
</tr>
</tbody>
</table>

Friends and Family Test (score)
(From October 2013 to March 2014)

| 80% of patients reporting that their care/family have been supported? | 76% | 90% | 91% | 87% | 100% | 82% |

*Please note:* The responses above are an amalgamation of ‘yes definitely’ and ‘yes to some extent’

*An additional patient experience indicator which was not in last year’s Quality Accounts was chosen by our Quality Board in June 2013: “Has your quality of life improved as a result of the care and treatment you have received?” The result of this indicator has been displayed in the above table.

Please note the above indicators are new for 2013/14 and there are no comparators to previous years.

2.2.2 Patient Experience – The detail of how we have performed

As part of our drive to obtain real-time patient feedback, we continue to maintain a focus on ensuring all services and teams within Oxleas have a methodology in place to obtain feedback from patients who access services in a systematic way. Our other patient experience goals reflect our trust 4 ‘must do’s’, a quality of life indicator and if patients would recommend our service to their friends or family. These have become our 6 ‘must ask’ questions as an integral part of our focus on ensuring every patient has an opportunity to give feedback on their experience of using our services. These ‘must ask’ questions have formed the basis of patient experience questionnaires or surveys that are carried out by the different services in the trust. All teams/wards who undertake a patient experience survey regardless of method are required to include the mandated 6 questions:

1. Have you been provided with enough information about care and treatment?
2. Have you been involved as much as you want to be in decisions about your care and treatment?
3. Have staff treated you with dignity and respect?
4. Has your family and/or carer been supported by staff?
5. Has your quality of life improved as a result of the care and treatment that you have received?
6. How likely are you to recommend our service/ward/clinic to friends and family if they needed similar care or treatment?

In Oxleas, systematic coverage means that every service must carry out a method of patient experience feedback at least every 6 months at a minimum. In addition, each bedded unit must offer every patient who is discharged an opportunity to complete a survey within 48 hours of discharge. We achieved 64% coverage of our services in 2013/14 and we continue to look at innovative ways to increase coverage in all our services, particularly hard to reach groups such as house bound patients. Although there are challenges in using patient surveys, including ensuring validity and completeness of anonymous surveys, we consider these to be an invaluable means to understand the patient experience. We continue to refine how we use patient surveys and collate data across our various services to increase the effectiveness of the process, drawing on learning from our own processes and the experiences of other trusts.

This year, we had approximately 5,014 responses to our questionnaires and, to ensure that we get more responses, we are putting in place the following:

- Availability of patient survey forms with our 6 ‘must ask’ questions available at all sites
- Post cards informing patients how to leave feedback online
- Availability of feedback post boxes at all sites
- Patient experience posters with QR codes to the trust online survey
- Availability of ‘freepost’ envelopes so patients can post their responses back to us.

It is important to note that teams within our services may carry out a method of patient experience feedback over and above the 6 ‘must ask’ questions in a more specialised area. These have not been reflected in the performance table.
Note on the Friends and Family Test:
It is important to note that as a trust that provides Mental Health and Community Health Services, we were not expected to roll out the Friends and Family Test to our services in 2013/14 as part of the national initiative in England for Acute Hospitals and Maternity Care. However, this was an area that we wanted to pilot across our services prior to national roll out to mental health and community services; hence the ‘how likely will you recommend’ question being chosen as one of our patient experience priorities for 2013/14. We also got involved in NHS England’s early adopter pilots in October 2013 and have since rolled out to all services as part of our systematic coverage campaign.

2.3 Patient Safety

### Table 2 - Summary of our performance against patient safety quality improvement goals

<table>
<thead>
<tr>
<th>Patient Safety Quality Improvement Goal for 2013/14</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2013/14 Target</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH &amp; LD To ensure 100% of patients on CPA discharged from hospital followed up within 7 days</td>
<td>100%</td>
<td>100%</td>
<td>98.8%</td>
<td>96.5%</td>
<td>99.6% Monitor RiO - National target definition achieved</td>
<td>100% Monitor target - 95% RiO - National definition (MONITOR)</td>
</tr>
<tr>
<td>MH &amp; LD All patients admitted to hospital following self-harm followed up within 48 hours of discharge</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95.9%</td>
<td>RiO - Local definition</td>
</tr>
<tr>
<td>MH &amp; LD All Oxleas Maintain no incidences of MRSA*</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>RiO - Local definition</td>
</tr>
<tr>
<td>MH &amp; LD All Oxleas Maintain no incidences of CDI* (threshold of 6)</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>RiO - National definition (MONITOR)</td>
</tr>
<tr>
<td>All Oxleas 80% of staff are trained in level 1 safeguarding children</td>
<td>89.0%</td>
<td>95.5%</td>
<td>94.8%</td>
<td>80%</td>
<td></td>
<td>Local Oxleas Training database</td>
</tr>
<tr>
<td>All Oxleas 80% of staff are trained in level 2 safeguarding children</td>
<td>92.0%</td>
<td>87.8%</td>
<td>88.8%</td>
<td>80%</td>
<td></td>
<td>Local Oxleas Training database</td>
</tr>
<tr>
<td>All Oxleas 80% of staff are trained in level 3 safeguarding children</td>
<td>46.0%</td>
<td>87.0%</td>
<td>84.3%</td>
<td>80%</td>
<td></td>
<td>Local Oxleas Training database</td>
</tr>
<tr>
<td>CH &amp; OPMH Participate in the NHS Safety Thermometer to improve collection of data to promote harm free care through reductions in falls, pressure ulcers, urinary tract infections in people with indwelling catheters and venous thromboembolism (VTE)</td>
<td>Data collected and submitted</td>
<td>Data collected and submitted</td>
<td>Collection of harm free data and submission to National team</td>
<td>National data collection tool - national definitions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### 2.3.1 The detail of how we have performed – Patient Safety

In this section we would like to give further information on the following indicators summarised in the above table:

- All patients admitted to hospital following self-harm followed up within 48 hours of discharge
- Maintain no incidences of Clostridium difficile infection (threshold of 6)
- Participating in the NHS Safety Thermometer.

#### 2.3.2 48 hour follow up

48 hour follow up is a local Oxleas indicator that has been monitored in the trust as a means of reducing further the risk of suicide after discharge from hospital. The aim is to follow up all patients admitted to hospital following an attempt at suicide within 48 hours of discharge to ensure they are safe in the immediate period following their discharge. This year has seen a reduction in our performance of achieving 100% follow up within 48 hours of all identified patients. The reduction in performance was identified earlier this year and prompted us to look at our processes in each of our mental health units. As a result of this review we have now put in place a new process for followup and recording of this in our electronic patient record, RiO. To ensure robust follow up, all 48 hour follow up appointments are undertaken face to face by our home treatment teams rather than by telephone contact. Where contact at home is not possible, a welfare check is requested from the local police to ensure that the patient is safe. We will continue to embed our new process and aim for 100% follow up.

#### 2.3.3 Occurrences of Clostridium difficile infection

Clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are in hospital. Symptoms of CDI can range from mild to severe diarrhoea, high temperature (fever) of or above 38C (100.4F) and painful abdominal cramps. Ensuring that we have no new cases of CDI has been one of our patient safety indicators over the last 6 years; however there is a set threshold of 6 incidences.

In 2013/14, we have 3 reported new cases of CDI and 2 of these were identified in one patient.

The third case occurred in a community health services patient who had a previous history of CDI. Investigation into the incident also identified that this was an unavoidable CDI related to the patient’s risk factors of previous CDI history, age, previous orthopaedic surgery gastrointestinal investigations and two admissions within a healthcare setting.

The actions we have put in place following recommendations from the investigations:

- Improved handover and transfer documentation between organisations
- Staff to respond early to symptoms of diarrhoea when detected
- Increased awareness of the clinical features and management of CDI to all staff
- Improved documentation in the patient notes.
2.3.4 Participating in the NHS Safety Thermometer

The NHS Safety Thermometer (ST) is a local improvement tool for measuring, monitoring and analysing patient harms and ‘harm free’ care. The tool measures four high volume patient safety issues (pressure ulcers, falls in care, urinary tract infection (UTI) in patients with a catheter and treatment for venous thromboembolism (VTE). It is a quick and simple method that helps organisations measure and monitor local improvement based on a one day survey of the proportion of patients seen that day who have one of the four conditions (pressure ulcers, falls, UTI, VTE).

We have participated in the NHS safety thermometer (ST) over the last 2 years and made submissions to the National Information Centre on a monthly basis. We would like to give an update on data that applies to our adult community services.

In 2013/14, an average of approximately 90% of Oxleas patients surveyed each month were Harm Free. This compares to the national average of 91.5% of patients (February 2014 national data).

Overview

<table>
<thead>
<tr>
<th>HARM</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm free</td>
<td>91%</td>
<td>88%</td>
<td>90%</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>7%</td>
<td>9%</td>
<td>8%</td>
<td>7.6%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Falls</td>
<td>1%</td>
<td>1%</td>
<td>1.5%</td>
<td>0.6%</td>
<td>1%</td>
</tr>
<tr>
<td>UTI &amp; catheters</td>
<td>1%</td>
<td>1%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>1%</td>
</tr>
<tr>
<td>New VTE</td>
<td>0.2%</td>
<td>0.5%</td>
<td>0</td>
<td>0</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

In response to monitoring our data to ensure improvement, we set up an Oxleas Harm Free Care Champions Group. This group meets monthly and comprises Oxleas Harm Free leads and representatives from every team and ward taking part in the monthly ST data collection. As well as reviewing the latest ST data, the group also share good practice on improving patient care. This includes sharing and implementing protocols and processes relating to safety thermometer harms.

In addition to this group, there is a monthly pressure ulcer group that reviews root cause analyses on Grade 3 and 4 pressure ulcers. This group also looks at deteriorations between pressure ulcer grades and if a patient is on an end of life pathway thus influencing success of interventions. This group identifies key learning from pressure ulcer incidents and supports embedding learning across the trust.

2.4 Clinical Effectiveness

### Table 3 - Summary of our performance against clinical effectiveness quality improvement goals

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MH &amp; LD Ensure our patients have a recorded care plan on RiO - MH &amp; LD</td>
<td>98.6%</td>
<td>99.2%</td>
<td>98.7%</td>
<td>98.5%</td>
<td>99.3%</td>
<td>98.6%</td>
<td>RO - Local definition</td>
</tr>
<tr>
<td>CHS Ensure our patients have a recorded care plan on RiO - Community Teams</td>
<td>80%</td>
<td>87%</td>
<td>81%</td>
<td>90.3%</td>
<td>95%</td>
<td>86.8%</td>
<td>RO - Local definition</td>
</tr>
<tr>
<td>CHS Ensure our patients have a recorded care plan on RiO - District Nursing</td>
<td>15%</td>
<td>46%</td>
<td>86.8%</td>
<td>55%</td>
<td>97%</td>
<td>97%</td>
<td>RO - Local definition</td>
</tr>
<tr>
<td>MH &amp; LD Ensure 95% of our patients on CPA to have received a review in the last 6 months</td>
<td>96.1%</td>
<td>91%</td>
<td>94.3%</td>
<td>96%</td>
<td>96.4%</td>
<td>95%</td>
<td>RO - Local definition</td>
</tr>
<tr>
<td>Prisons Ensure 95% of our patients on CPA to have received a review in the last 6 months</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>95%</td>
<td>97%</td>
<td>97%</td>
<td>SystmOne - Local definition</td>
</tr>
<tr>
<td>MH &amp; LD 50% of patients with mental health illness diagnosed with hypertension to have an individualised care plan in place to support them and include lifestyle, diet, nutrition, medication advice and ways of accessing help within primary care</td>
<td>71.2%</td>
<td>50%</td>
<td>71.2%</td>
<td>50%</td>
<td>71.2%</td>
<td>50%</td>
<td>RO - Local definition</td>
</tr>
<tr>
<td>MH &amp; LD 50% of patients with mental health illness diagnosed with diabetes to have an individualised care plan in place to support them and include lifestyle, diet, nutrition, medication advice and ways of accessing help within primary care</td>
<td>80.8%</td>
<td>50%</td>
<td>80.8%</td>
<td>50%</td>
<td>80.8%</td>
<td>50%</td>
<td>RO - Local definition</td>
</tr>
</tbody>
</table>
Quality report

2.4 Clinical Effectiveness, continued

Table 3 - Summary of our performance against clinical effectiveness quality improvement goals, cont'

<table>
<thead>
<tr>
<th>Clinical Effectiveness</th>
<th>Quality Improvement Goal for 2013/14</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH &amp; LD</td>
<td>To refer patients who want to stop smoking on to local NHS stop smoking services for additional support</td>
<td>88%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
<td>RIO - Local COUN definition</td>
</tr>
<tr>
<td>CHS</td>
<td>To refer patients who want to stop smoking on to local NHS stop smoking services for additional support</td>
<td>93.9%</td>
<td>95%</td>
<td></td>
<td></td>
<td></td>
<td>RIO - Local COUN definition</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Improving Practice in line with NICE Guidance: Participate in the National Prescribing for ADHD (Attention Deficit Hyperactivity Disorder) Audit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Participation in national POMH UK audit (results shown in detail below)</td>
</tr>
</tbody>
</table>

MH & LD - Mental Health & Learning Disability
CAMHS - Children and Adolescent Mental Health Services
CHS Poeds - Community Paediatric Services
AMH - Adult Mental Health
POMH - Prescribing Observatory for Mental Health

2.4.1 The detail of how we have performed – Clinical Effectiveness

In this section we would like to give further information on the following indicators summarised in the above table:

- Improving Practice in line with NICE Guidance: Participate in the National Prescribing for ADHD (Attention Deficit Hyperactivity Disorder) Audit
- Ensuring our community health patients have a recorded care plan on RiO.

2.4.2 Monitoring prescribing for Attention Deficit and Hyperactivity Disorder (ADHD)

The National Institute for Health and Care Excellence (NICE) recommend that medication should be prescribed as part of a wider treatment package for most people with severe ADHD, and for some with moderate ADHD. Some of the medicines are stimulants which can cause cardiovascular problems, and decreased sleep and appetite as part of their adverse effect profile. This POMH programme used standards derived from NICE Clinical Guidance 72 'ADHD: Diagnosis and management of ADHD in children, young people and adults' to audit prescribing practice for drug treatment for ADHD.

Audit standards: Initiating drug treatment for ADHD

1. Before starting drug treatment, children, adolescents and adults with ADHD should have a full pre-treatment assessment, including the following:
   a. Heart rate and blood pressure (recorded as a centile in children)
   b. Height and weight (recorded on a growth chart in children)
   c. Cardiovascular risk
   d. Substance misuse risk.

2. Weight, heart rate and blood pressure should be measured within 3 months of starting treatment

3. In all patients, ADHD treatment should be reviewed at least annually, using standardised rating scales

Audit standards: Maintenance treatment

4. Height and weight should be measured every 6 months in children and young people, and recorded on a growth chart

5. Weight should be recorded every 6 months in adults.

6. Heart rate and BP should be measured every 3 months (recorded as a centile in children).

Performance in Oxleas

The results were divided according to types of clinical service; paediatrics, CAMHS and adults.

Oxleas submitted data for 246 cases from 8 clinical teams comprising 52 cases from paediatrics, 125 from CAMHS and 69 from adults. Examples of performance in Oxleas are given below.

Paediatric services

For those on maintenance treatment, 6% of Oxleas patients (n=41) had documented evidence of all 4 measures compared with a national average of 17%.

CAMHS

Before initiation of drug treatment for ADHD, 83% of Oxleas patients (n=8) had documented evidence of all 4 measures compared with a national average of 82%.

For those on maintenance treatment, 28% of Oxleas patients (n=106) had documented evidence of all 4 measures compared with a national average of 23%.

Adult services

Before initiation of drug treatment for ADHD, 58% of Oxleas patients (n=10) had documented evidence of all 3 measures (height excluded in adults) compared with a national average of 44%.
For those on maintenance treatment, 14% of Oxleas patients (n=28) had documented evidence of all 3 measures compared with a national average of 5%.

Of particular note for good practice is the prison ADHD clinic. They completed all these checks for 100% patients at baseline and 100% over the last year.

Prison Services
The results have shown excellent practice for the ADHD clinic run by the prison services. The prison ADHD clinic had completed all these checks for 100% patients at baseline, 100% within 3 months of starting treatment and 100% over the last year, compared with a national average of 44%, 39% and 5% respectively over the last year in the adult population (which included forensic services).

Documented measures of height, weight, blood pressure and heart rate over the last year in Oxleas (n = 175)

Summary – both nationally and within Oxleas, clinicians are good at doing physical health checks at the start of treatment, and plotting on growth charts, but practice tails off at 3 months and even more so after one year. Practice within Oxleas was slightly higher than the national average in most areas. An action plan to improve practice has been agreed in each clinical area; details of the action plan has been provided below under section 2.6.1.1 ‘Participation in Clinical Audits’.

2.4.3 Ensuring care plans of community health patients are on Rio
We continue to maintain a focus on recording all community patients’ clinical information in our electronic patient records system Rio. We have seen an increase of just over 9% on this quality goal since our last report in 2012/13; however we are still 4.7% under target. The majority of these patients are seen in their homes and have paper records of their care plan kept at home. However there is an added complexity of ensuring remote access to ensure care plans are also recorded electronically on Rio. We have undertaken a focussed programme of rolling out new technology to our community health teams to help us improve recording of care plans electronically on Rio.

2.5 Our Quality Improvement Priorities for 2014/15
In the following pages, we tell you about our chosen quality priorities for 2014/15. Our priorities reflect the breadth of services we provide as follows: mental health and adult learning disability services across Bexley, Bromley and Greenwich; community health services across Bexley and Greenwich; adult musculoskeletal services to Kent; and mental health in-reach to Kent Prisons.

2.5.1 How we agree our quality priorities
This section provides further understanding on how we have chosen our quality priorities for 2014/15.
Oxleas is committed to delivering quality services and we make every effort to work in partnership with our service users, carers, members, staff and commissioners to identify what our quality priorities should be each year. Every year we hold a public forum in each of our boroughs of Bexley, Bromley and Greenwich to give feedback on progress against our quality goals and receive feedback about potential areas of priority in the coming year. This year, these meetings took place in February 2014. A total of 150 participants attended the public forums: 31 patients/carers; 62 non-members/general public; 23 representatives from associate organisations; 3 Healthwatch; 2 Commissioners; and 29 staff.
The feedback we received reinforced the need to continue our focus on the our 4 must do’s, which are:

1. Increasing support for families and carers
2. Providing better information for our service users and carers.
3. Enhancing care planning
4. Improving the way we relate to both our service users and carers.

These four areas form the foundation of our patient experience priorities.

Our priority areas for patient safety and clinical effectiveness domains are influenced not just by contributions from the public forums but also by our engagement with our local health commissioners, through our regular quality meetings, our Council of Governors, patient experience surveys and lessons learned from incident reporting. We have also engaged with staff via away days, staff meetings and annual planning events; their views have had input to our trust service development strategy and our internal quality improvement initiatives.

Our quality improvement priorities for 2014/15 have been reviewed and agreed by our Quality Board (a sub group of our Governance Board) and they cover the following areas:

- Our 4 ‘Must dos’
- Monitor key quality indicators
- Commissioning for Quality and Innovation goals agreed with our commissioners
- Current priorities where trend data is available to measure improvement year on year.

- Are linked to the NHS Outcomes Framework and the 5 domains:
  - Domain 1 - Preventing people from dying prematurely
  - Domain 2 - Enhancing quality of life for people with long-term conditions
  - Domain 3 - Helping people to recover from episodes of ill health or following injury
  - Domain 4 - Ensuring that people have a positive experience of care
  - Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm.

The detail of our quality priorities for 2014/15 is shown below according to the three quality domains of patient experience, patient safety and clinical effectiveness. These have been identified as a result of reviewing data relating to the quality of care in the various forums mentioned above throughout the year. We have replaced quality indicators relating to 2012/13 CQUIN or national audits with goals relevant to this year.

### 2.5.2. Patient Experience Quality Priorities 2014/15

#### Table 4

<table>
<thead>
<tr>
<th>Quality Improvement Goal for 2014/15</th>
<th>Service Area applicable to</th>
<th>How we will monitor, measure and report progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 65% of registered carers of patients on CPA have been offered a carer’s assessment</td>
<td>Mental Health</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
<tr>
<td>2 80% of patients reporting that their care/family have been supported</td>
<td>All Oxleas Services</td>
<td>This indicator forms part of our ‘6 must ask’ questions in patient experience surveys. This will be monitored by the Patient Experience Group and bi-monthly by the Quality Board</td>
</tr>
<tr>
<td>3 80% of patients reporting that they have been involved in decisions about their care and treatment?</td>
<td>All Oxleas Services</td>
<td>This indicator forms part of our ‘6 must ask’ questions in patient experience surveys. This will be monitored by the Patient Experience Group and bi-monthly by the Quality Board</td>
</tr>
<tr>
<td>4 80% of patients reporting that they have been involved in decisions about their care and treatment?</td>
<td>All Oxleas Services</td>
<td>This indicator forms part of our ‘6 must ask’ questions in patient experience surveys. This will be monitored by the Patient Experience Group and bi-monthly by the Quality Board</td>
</tr>
<tr>
<td>5 80% of patients reporting that staff have treated them with dignity and respect?</td>
<td>All Oxleas Services</td>
<td>This indicator forms part of our ‘6 must ask’ questions in patient experience surveys. This will be monitored by the Patient Experience Group and bi-monthly by the Quality Board</td>
</tr>
<tr>
<td>6 80% of patients reporting that staff have treated them with dignity and respect?</td>
<td>All Oxleas Services</td>
<td>This indicator forms part of our ‘6 must ask’ questions in patient experience surveys. This will be monitored by the Patient Experience Group and bi-monthly by the Quality Board</td>
</tr>
<tr>
<td>7 80% of patients reporting that staff have treated them with dignity and respect?</td>
<td>All Oxleas Services</td>
<td>This indicator forms part of our ‘6 must ask’ questions in patient experience surveys. This will be monitored by the Patient Experience Group and bi-monthly by the Quality Board</td>
</tr>
<tr>
<td>8 To ensure 65% of people identified as carers of patients referred to our Specialist Long Term condition teams are registered on RiO</td>
<td>Adult Community Health Services</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
</tbody>
</table>
## 2.5.3. Patient Safety Quality Priorities 2014/15

### Table 5

<table>
<thead>
<tr>
<th>Quality Improvement Goal for 2014/15</th>
<th>Area applicable to</th>
<th>How we will monitor, measure and report progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 100% of patients on CPA discharged from hospital followed up within 7 days</td>
<td>Mental Health</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
<tr>
<td>10 Patients admitted to hospital following self-harm followed up within 48 hours of discharge</td>
<td>Mental Health</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
<tr>
<td>11 Maintain no incidences of MRSA</td>
<td>All Oxleas Services</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
<tr>
<td>12 Maintain no incidences of CDI (threshold of 6)</td>
<td>All Oxleas Services</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board, Quality Board and Patient Safety Group</td>
</tr>
<tr>
<td>13 80% of staff are trained in level 1 safeguarding children</td>
<td>All Oxleas Services</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board, Quality Board and Patient Safety Group</td>
</tr>
<tr>
<td>14 80% of staff are trained in level 2 safeguarding children</td>
<td>All Oxleas Services</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board, Quality Board and Patient Safety Group</td>
</tr>
<tr>
<td>15 80% of staff are trained in level 3 safeguarding children</td>
<td>All Oxleas Services</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board, Quality Board and Patient Safety Group</td>
</tr>
</tbody>
</table>

## 2.5.4. Clinical Effectiveness Quality Priorities 2014/15

### Table 6

<table>
<thead>
<tr>
<th>Quality Improvement Goal for 2014/15</th>
<th>Area applicable to</th>
<th>How we will monitor, measure and report progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 Ensure 95% of our patients have a recorded care plan on RIO – MH &amp; LD</td>
<td>Measures for the following services: Mental Health &amp; LD - 95% Community Services - 95% District Nursing - 90%</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
<tr>
<td>17 95% of our patients on CPA to have received a review in the last 6 months</td>
<td>Mental Health &amp; LD Kent Prisons</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
<tr>
<td>18 To ensure that 75% of patients have a goal based measure in place as part of their care and treatment plans (CAMHS Clinical Outcomes)</td>
<td>Mental Health</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
<tr>
<td>19 To demonstrate full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia (Cardio Metabolic Assessment for Patients with Schizophrenia)</td>
<td>Mental Health</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
<tr>
<td>20 To improve access for offenders with learning disabilities by implementing screening and making reasonable adjustments</td>
<td>Forensic Services</td>
<td>This will be monitored monthly by the Executive and bi-monthly by the Board and Quality Board</td>
</tr>
</tbody>
</table>
2.6 Statements of Assurance from the Board

This section includes a number of nationally mandated statements of assurances from our Board of Directors.

During 2013/14, Oxleas NHS Foundation Trust provided and/or sub-contracted seven relevant health services covering the following service lines:

- Adult Mental Health (inpatient and community)
- Older Peoples Mental Health (inpatient and community)
- Adult Learning Disabilities
- Children and Young people (mental health, community and specialist children)
- Adult Community Health
- Specialist Forensic Mental Health
- Mental health in-reach to Kent Prisons.

Mental health and adult learning disability services are provided across the London boroughs of Bexley, Bromley and Greenwich; in addition to this, our specialist forensic services also cover the boroughs of Lewisham, Sutton and Merton. Community health services are provided across Bexley and Greenwich and our mental health in-reach is to Kent Prisons only.

Oxleas has reviewed all the data available to them on the quality of care in all seven of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant health services by Oxleas for 2013/14.

The data used to review our quality priorities cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Our review for 2013/14 has not been impeded by data availability.

2.6.1 Participation in Clinical Audits

During 2013/14 eight national clinical audits and 25 national confidential enquiry covered NHS services that Oxleas NHS Foundation Trust provides.

During 2013/14 Oxleas NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries which Oxleas NHS Foundation Trust was eligible to participate in during 2013/14 are recorded in tables 7 and 8 below.

The national clinical audits and national confidential enquiries that Oxleas NHS Foundation Trust participated in during 2013/14 are also included in tables 7 and 8 below.

The national clinical audits and national confidential enquiries that Oxleas NHS Foundation Trust participated in during 2013/14 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>No.</th>
<th>National Clinical Audits (2013/14)</th>
<th>Participation</th>
<th>Number of cases submitted</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>National audit of Intermediate care (Royal College of Physicians)</td>
<td>Yes</td>
<td>100</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>Sentinel Stroke National Audit Programme (Royal College of Physicians)</td>
<td>Yes</td>
<td>10</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Mental Health Services

3 National audit of Memory Clinics
4 National audit of psychological therapies (Royal College of Psychiatrists)
5 National audit of Schizophrenia (Royal College of Psychiatrists)
6 Prescribing for ADHD POMH UK Audit (Royal College of Psychiatrists)
7 Monitoring of patients prescribed Lithium POMH UK Audit (Royal College of Psychiatrists)
8 Prescribing anti-dementia drugs POMH UK Audit (Royal College of Psychiatrists)
9 Use of anti-psychotic medication in CAMHS POMH UK Audit (Royal College of Psychiatrists)

POMH – Prescribing Observatory for Mental Health

Note: N/A means that the organising body did not stipulate how many cases must be submitted to meet the audit requirements; therefore the number of cases submitted translates to 100%.
Quality report

Table 8

<table>
<thead>
<tr>
<th>No.</th>
<th>National Enquiries (2013/14)</th>
<th>Participation</th>
<th>Number of cases submitted</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental health clinical outcome review programme (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness)</td>
<td>Yes</td>
<td>25</td>
<td>100%</td>
</tr>
</tbody>
</table>

We also participated in the following National Quality Improvement Programmes:

Service Accreditation Programmes and Quality Improvement Networks:

Table 9

<table>
<thead>
<tr>
<th>Trust Participation</th>
<th>National Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic Mental Health Services</td>
<td>1 Services 109 Services</td>
</tr>
<tr>
<td>Electroconvulsive Therapy Units</td>
<td>1 Clinics 88 Clinics</td>
</tr>
<tr>
<td>Psychiatric Liaison Teams</td>
<td>1 Teams 42 Teams</td>
</tr>
<tr>
<td>Inpatient Learning Disability Units</td>
<td>1 Units 21 Units</td>
</tr>
<tr>
<td>Memory Services</td>
<td>3 Services 80 Services</td>
</tr>
<tr>
<td>Home Treatment Teams</td>
<td>2 Teams 26 Teams</td>
</tr>
</tbody>
</table>

Oxleas NHS Foundation Trust uses clinical audit and participation in national confidential enquiries as a driver for improvements in quality. The trust aims to ensure that all clinical professional groups participate in clinical audit.

The reports of two national clinical audits were reviewed by the provider in 2013/14. These audits were reviewed at the Trust Clinical Effectiveness Group (a sub group of the Trust Quality Board) where the action plans were agreed. Two reports are scheduled to be reviewed in April 2014, and a further four reports are expected to be made available in 2014/15. The key actions for the reports reviewed in 2013/14 were:

2.6.1.1 Prescribing for ADHD (Attention Deficit and Hyperactivity Disorder)

The baseline audit as mentioned in section 2.4.2 included sub-samples from Paediatrics, CAMHS and Adult Mental Health services. The findings showed that whilst Oxleas carried out a full treatment assessment in the majority of cases, these were not routinely mapped on a centile chart for children and adolescents. It was identified that cardiovascular risk assessments were not routinely recorded for adults with ADHD prior to initiating drug treatment, and a standardised scale was not used for yearly monitoring of treatment. The following key actions were agreed to address these findings:

- ADHD treatment pack to be developed containing a checklist of what needs to be completed and documented when someone starts treatment for ADHD.
- Consultants to file centile charts in secondary paper records following outpatient appointments.
- Broaden scope of Clozapine clinics so adults with ADHD can be referred for cardiovascular risk assessment.
- Introduce yearly monitoring of ADHD symptoms in adult mental health, using a standardised assessment scale.

2.6.1.2 Monitoring of patients prescribed Lithium

Findings from the second supplementary audit highlighted further improvement on previous audits, where Oxleas performed above the national average for monitoring of serum lithium, renal and thyroid function tests. This has largely been due to the implementation of a Lithium register which was introduced following the re-audit. This has helped to improve identification of patients on Lithium, and alert clinicians when blood tests are due. In the most recent audit, the number of patients who had had 4 lithium serum level tests in the last year had risen from 35% at baseline to 52%. The number of patients who had had at least 2 lithium tests in the past year had risen from 78% at baseline to 95%, with the all patients in the sample having had at least one test in the past year. The key actions from this audit included:

- Sharing results with teams and cascading a ‘well done’ message to all who have contributed to practice in this area.
- Lithium database manager to check on electronic patient record system if purple lithium pack has been given when someone new is registered with the database.
- Continue liaising with the newly-formed local NHS Trusts to ensure we have easy access to blood results.

2.6.1.3 Local Audits

The reports of 19 local clinical audits were reviewed by the provider in 2013/14. These were reviewed by the trust wide and/or local directorate Clinical Effectiveness Groups, where recommendations and action plans are agreed and disseminated as appropriate in line with trust policy. Other clinician approved clinical audits were reviewed at a local level. The following are examples of actions that Oxleas NHS Foundation Trust has implemented or intends to take to improve the quality of healthcare provided:
2.6.1.4 Annual Care Programme Approach (CPA) Re-audit

Every year Oxleas undertakes a Care Programme Approach (CPA) audit where we measure how well we adhere to the national standards of care planning for patients with complex mental health difficulties. In 2013/14 the biggest area of improvement was seen in the involvement of patients on CPA and their carers/family members in the development of care plans, and in recording patients’ views in the CPA review. The key areas identified for improvement for the Trust as a whole included risk management for patients who are not on CPA, and documenting reasons why patients had not been given a copy of their care plan.

Findings of the CPA audit were reviewed by the trust wide / local directorate Clinical Effectiveness Groups and action plans were agreed to address the gaps within each directorate. Below is an example of some of the key actions to be implemented:

- CPA checklists developed across directorates for use by frontline clinicians, incorporating agreed standards of practice
- Review of editable care plan letters for standard patients, to ensure identified risks are highlighted and there is a corresponding risk management plan
- Screen shots provided to staff to demonstrate appropriate places to document all instances where the service user cannot or does not wish to sign their care plan

2.6.1.5 Audit of NICE quality standards for COPD (Chronic Obstructive Pulmonary Disease)

A review of our COPD services showed that we achieved 100% for half of the standards that were applicable to our service, and highlighted areas for improvement in three key areas. The following actions were agreed on the basis of these findings:

- Improve proportion of patients offered an annual assessment through nurse monitoring and improved links with the GP
- Patient information leaflet to be developed advising patients of early signs of exacerbation of COPD
- Checklist to incorporate conversations about End of Life care with patients and their carers/family

Audit of Urgent Care Centre standards

This audit was undertaken to demonstrate the effectiveness of the Urgent Care Centre against the London Health Programs “Quality and Safety Programme Urgent Care” quality standard. Twenty one of 22 standards were fully met, however a number of actions were identified to improve practice:

- Staff to pilot effective pain assessment tool suitable for patients attending the UCC
- To work alongside the IT service to look at methods of communicating patient information to GPs
- Further audit to assess the performance of staff against the London standards using the Urgent and Emergency Care Clinical Audit Toolkit

2.6.2 Participation in Clinical Research

The Trust is committed to improving the quality of the healthcare provided to our patients through clinical audit. Clinicians across all professions and disciplines are supported to undertake local clinical audit, and encouraged to share learning and good practice at our annual showcase event. The trust also works hard to promote participation from front line clinicians in both national and trust wide audits to enhance learning and practice through this process. A clear process has been put in place to log all clinical audit activity and monitor the implementation of action plans and re-audit.

Copies of the completed audit reports (inclusive of recommendations and action plans) can be requested from:

The Quality & Audit Team
Oxleas NHS Foundation Trust
Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG
Tel: 01322 625759

2.6.2 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub contracted by Oxleas NHS Foundation Trust in 2013/14 that were recruited during that period to participate in national research studies approved by a research ethics committee was 490.

We have been active members of the National Institute for Health Research (NIHR), the London South Comprehensive Local Research Network (CLRN), the Dementias and Neurodegenerative Diseases Research Network (DeNDRoN) and the Mental Health Research Network (MHRN). From April 2014, these structures will evolve and Oxleas will work closely with the new National Institute for Health Research Clinical Research Network: South London and the six new research divisions/themes to ensure that our service users, carers and staff continue to have access to research studies from within our services.

We have worked closely with the London South CLRN to ensure our governance arrangements cover quality assurance, ethics reviews, regulatory authorisations and that projects conducted by us adhere to the Department of Health’s Research Governance Framework. Our Research and Development Office has fully implemented and is compliant with the Research Support Services initiative and its Research and Development Operational Capability Statement is available on the Trust’s website. We continue to be ranked joint first within south London for the time taken to issue NHS Permission for NIHR research studies.

We have also hosted 19 locally-initiated service evaluations, 12 locally-initiated psychology quality improvement studies and 18 locally-initiated formal research studies across our services.

Research activity is supported by a full time Research and Knowledge Manager part-funded by the Clinical Research Network, whose main duties are to promote research throughout the trust and to assist clinicians with current trials and new projects in order to increase recruitment levels. Two clinical studies officers are also based at the trust and assist with study feasibility and setup, recruitment screening and follow-ups.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and our contribution to wider health improvement. It allows our service users and carers access to novel treatments that
are not available as routine NHS care and also provides an opportunity for our clinical staff to be trained in providing them. We have hosted national research in all of our services areas and are currently building our research capacity in community health.

Research and Development income for 2013/14 totalled £199,904.

2.6.3 Quality Goals Agreed with Commissioners

Over the last 5 years, we have worked in partnership with our commissioners to agree quality goals under the Commissioning for Quality and Innovation Framework (CQUIN).

A proportion of Oxleas income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Oxleas and any person or body we have entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 are in last year’s Quality Account and for the following 12 month period are available from:

Quality and Audit Team
Oxleas NHS Foundation Trust
Pinewood House
Pinewood Place
Dartford
Kent DA2 7WG
Tel: 01322 625759
Email: Quality@oxleas.nhs.uk

Our total 2013/14 CQUIN income conditional on achieving all the quality improvement and innovation goals was £3,858,202. The assumed provisional payment dependant on confirmation from our associated commissioners on achieving the goals set by the end of March 2014 is £3,786,696. Our total CQUIN income for the previous year 2012/13 was £3,912,992.

2.6.4 Summary of Oxleas 2014/15 CQUIN Goals

**National CQUINS:**
- Implementation of Staff Friends & Family Test (FFT)
- Implementation of Patients FFT
- Participation in the NHS Safety Thermometer
- Improving physical healthcare to reduce premature mortality in people with severe mental illness (SMI)

**Local Commissioner CQUINS - Mental Health:**
- Advanced Dementia Care Plan - Ensure that people diagnosed with Dementia are supported to have the required information to inform advance care planning in line with the NHS Quality Standard for Dementia
- CAMHS Clinical Outcomes - Ensure that patients have a goal based measure in place as part of their care and treatment plans
- Improving access to Annual Health Checks – to facilitate an improvement in the uptake of annual health checks for patients accessing learning disability services

Our total 2013/14 CQUIN income conditional on achieving all the quality improvement and innovation goals was £3,858,202. The assumed provisional payment dependant on confirmation from our associated commissioners on achieving the goals set by the end of March 2014 is £3,786,696. Our total CQUIN income for the previous year 2012/13 was £3,912,992.

**Local Commissioner CQUINS - Community Health Services**
- Supporting Carers of People with Long-term conditions - To ensure carers are registered for patients referred to the Specialist Long Term conditions teams
- Promotion of Health and Wellbeing (Making Every Contact Count - MECC ) – To ensure newly referred patients to integrated teams have a completed initial assessment which covers the lifestyle factors of smoking, alcohol use and physical inactivity
- To improve clinical outcomes for complex patients by attending and actively participating in multi-disciplinary team (MDT) meetings with Oxleas clinician’s, social services, specialist hospital clinician’s (if actively involved in patient treatment), Patient’s GP and other healthcare professionals.

**Specialist Forensic Mental Health Services**
- Provision of an education training package for patients and qualified staff around collaborative risk assessment and management.
- To support carer involvement with their relatives in secure care, (particularly in the first three months of care) and then on to the point of discharge
- To provide service user information detailing a formulation of both current and potential future needs and how the proposed service might best meet their needs.

**Greenwich Improving Access to Psychological Therapies (IAPT)**
- Improving access to IAPT Service - To demonstrate evidence of engagement with health care services to explain the referral pathway into the service.

**Early Years Services**
- To ensure the secure and timely transfer of clinical records between providers and the tracking of all Hep B, BCG and LAC annual reviews.
- To provide a programme of smoking cessation training for staff, provision of brief intervention to parents that smoke and signposting to local stop smoking services.

Further details of the agreed goals for 2013/14 and for the following 12 month period 2014/15 are available on request from:

Quality and Audit Team
Oxleas NHS Foundation Trust
Pinewood House
Pinewood Place
Dartford
Kent DA2 7WG
Tel: 01322 625759
Email: Quality@oxleas.nhs.uk
2.6.5 Registration with the Care Quality Commission (CQC)

Oxleas is required to register with the Care Quality Commission and its current registration status is ‘Registered with no conditions applied’.

The Care Quality Commission has not taken enforcement action against Oxleas during 2013/14.

Oxleas NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14:

- September/October 2013
  - Blantyre House
  - Oxleas House
  - Bracton Centre
  - Ivy Willis
  - Atlas House
  - Oaktree Lodge
  - Greenwood and Hazelwood
- March 2014
  - HMP Dover Immigration Removal Centre

These inspections by the CQC formed part of their targeted programme of unannounced visits to NHS providers.

Out of the eight locations visited, six were found to be fully compliant with the Essential Standards of Quality and Safety. No major concerns were found at any location. However, two locations were identified as having one moderate and four minor concerns between them. The two sites identified were Oaktree Lodge, our older people’s continuing care unit and our mental health inpatient services at Oxleas’ House.

At Oaktree Lodge there were two minor concerns relating to service user involvement and a single staffing issue and one moderate concern relating to the application of the Modified Early Warning Scoring system (MEWS) and the lack of Personal Emergency Evacuation Plans (PEEPS). MEWS is a system used to detect deterioration in physical health through the monitoring of vital signs and provides staff with direction to intervene to maintain health at an earlier stage in any deterioration found. Action plans and completion dates to address the concerns raised were agreed with the CQC who has been monitoring our progress. The deadline to complete all actions for Oaktree Lodge by March 2014 has been fully met.

At Oxleas’ House two minor concerns were identified. These were related to the use of “time-out” and the procurement of equipment in a timely manner. Again action plans and completion dates to address the concerns raised were agreed with the CQC who has been monitoring progress. The actions for Oxleas’ House in relation to ‘time-out’ were implemented with immediate effect and the actions for improved procurement processes are due for completion at the end of September 2014.

We await the CQC revisit to confirm compliance at Oaktree Lodge and Oxleas House.

2.6.6 Data Quality

Oxleas submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data that included the patient’s valid NHS Number was:

- 98.5% for admitted patient care
- 99.7% for outpatient care
- 0% for accident and emergency care. (This is not applicable as Oxleas does not submit data in relation to accident and emergency care. This is an acute trust indicator).

The percentage of records in the published data that included the patient’s valid general practitioner registration code was:

- 100% for admitted patient care
- 100% for outpatient care
- 0% for accident and emergency care. (This is not applicable as Oxleas does not submit data in relation to accident and emergency care. This is an acute trust indicator).

2.6.8 Clinical Coding error rate

Oxleas NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Oxleas will be taking the following actions to improve data quality:

- Continue to ensure all our clinicians are trained to record effectively on RiO (our patient electronic clinical system)
- Validate data provided on a monthly basis to ensure accuracy.

2.6.9 Performance against NHS Outcome Framework Priorities (Core Indicators)

In addition to our local quality improvement goals we are also required to report in our quality accounts how we have performed against quality priorities related to the NHS Outcomes Framework; its 5 domains and the national core quality indicators. The 5 domains of the NHS Outcome Framework are:

- Domain 1 - Preventing people from dying prematurely
- Domain 2 - Enhancing quality of life for people with long term conditions
- Domain 3 - Helping people to recover from episodes of ill health or following injury
- Domain 4 - Ensuring that people have a positive experience of care
- Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm.
There are 5 indicators which are relevant to the services we provide. Our performance against these indicators is shown below; this data has been obtained from the Health and Social Care Information Centre (HSCIC) and is the latest information published by the HSCIC:

Table 10

<table>
<thead>
<tr>
<th>NHS Outcomes Framework Domain</th>
<th>Quality Indicator</th>
<th>Oxleas 2011/12 Performance</th>
<th>Oxleas 2012/13 Performance</th>
<th>Oxleas 2013/14 Performance</th>
<th>National Average</th>
<th>Highest Trust Performance</th>
<th>Lowest trust Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Preventing People from dying prematurely</td>
<td>Percentage of patients CPA who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period</td>
<td>97.1%</td>
<td>97.6%</td>
<td>98%</td>
<td>97.4%</td>
<td>100%</td>
<td>99.3%</td>
</tr>
<tr>
<td>Domain 2: Enhancing quality of life for people with long-term conditions</td>
<td>Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period</td>
<td>99.8%</td>
<td>100%</td>
<td>100%</td>
<td>98.3%</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Domain 4: Ensuring that people have a positive experience of care</td>
<td>Percentage of staff employed by or, under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.</td>
<td>75%</td>
<td>70%</td>
<td>74% (agree + Strongly agree)</td>
<td>64%</td>
<td>94%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Please note:
- The information published above is taken from different reporting periods by the HSCIC
- Data for indicators 1 and 2 in the table above is the latest information available from the HSCIC, covering the period of January to March 2014
Table 10, continued

- Data for indicator 3 has been published by the HSCIC and is for the year 2013.
- Data for indicator 4 has been published by the HSCIC in December 2013.
- Data for indicator 5 has been published by the HSCIC covering a 6 month period between 1st October 2012 and 31st March 2013.
- For domain 5, comparator rates shown were not all taken from one trust but were the highest national rate for that indicator in the published HSCIC report.
- It is important to note that the data shown in the above table for indicators 1, 2 and 5 only reflects the last data available from the HSCIC and does not reflect the full year 2013/14 data submission for Oxleas. However the full year position is available for indicators 1 and 2 elsewhere in this report and for indicator 5 directly from the trust.

For indicators 1 and 2 relevant to the services we provide shown in table 10 above, Oxleas considers that this data is as described for the following reasons:

- These are Monitor targets that we report on monthly.
- It meets the NHS Outcomes Framework domains of preventing people from dying prematurely and enhancing the quality of life for people with long term conditions.
- The data for these indicators is recorded on RiO and submitted to the HSCIC and Monitor.

Oxleas intends to take the following actions to improve the percentage of 97.8% and 100% respectively, and so the quality of its services, by continuing our focus of following up patients within 7 days after discharge from psychiatric inpatient care, and ensuring all our admissions to acute wards are gatekept by our Crisis Resolution Home Treatment Teams.

For indicators 3 and 4 relevant to the services we provide shown in table 10 above:

Oxleas considers that this data is as described for the following reasons:

- These are based on our involvement in the National Patient and National Staff Surveys.
- It meets the NHS Outcomes Framework domains of enhancing the quality of life for people with long term conditions and ensuring people have a positive experience of care.
- The data for these indicators is provided by the Care Quality Commission (CQC) and Department of Health.

Oxleas intends to take the following actions to improve the percentage of 74% and rate of 82.7 respectively, and so the quality of its services, by continuing our focus on the following:

- National Patient Survey - we have put a robust plan in place to tackle areas that require further improvement as identified by the results of the 2013 survey.
- National Staff Survey - our 2013 staff survey was the best in London; we are determined to maintain these high standards throughout 2014/15.

For indicator 5 relevant to the services we provide shown in table 10 above:

Oxleas considers that this data is as described for the following reasons:

- This is patient safety information we report to the National Reporting and Learning System (NRLS).
- It meets the NHS Outcomes Framework domains of treating and caring for people in a safe environment and protecting them from avoidable harm.

- The data for this indicator is recorded on Datixweb (our local incident reporting database).

Oxleas intends to take the following actions to improve the patient safety incidents that result in severe harm or death, and so the quality of its services, by continuing our focus by reviewing trends and themes, learning from events and embedding learning across the trust.
2.6.10 Performance against the Risk Assessment Framework (Monitor)

Detailed below is our performance against Monitor’s Risk Assessment Framework.

### Table 15

<table>
<thead>
<tr>
<th>Target or Indicator (per Compliance Framework 13/14)</th>
<th>Threshold or target YTD</th>
<th>Performance</th>
<th>2013/14 Status Achieved/Not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to treatment time, 18 weeks in aggregate, admitted patients</td>
<td>90%</td>
<td>100.0%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Referral to treatment time, 18 weeks in aggregate, non-admitted patients</td>
<td>95%</td>
<td>99.8%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Referral to treatment time, 18 weeks in aggregate, incomplete pathways</td>
<td>92%</td>
<td>99.9%</td>
<td>Achieved</td>
</tr>
<tr>
<td>A&amp;E Clinical Quality - Total Time in A&amp;E under 4 hours</td>
<td>95%</td>
<td>99.8%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Cancer 62 Day Waits for first treatment (from urgent GP referral)</td>
<td>85%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)</td>
<td>90%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Cancer 31 day wait for second or subsequent treatment - surgery</td>
<td>94%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Cancer 31 day wait for second or subsequent treatment - drug treatments</td>
<td>98%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Cancer 31 day wait for second or subsequent treatment - radiotherapy</td>
<td>94%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Cancer 31 day wait from diagnosis to first treatment</td>
<td>96%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Cancer 2 week (all cancers)</td>
<td>93%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Cancer 2 week (breast symptoms)</td>
<td>93%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Care Programme Approach (CPA) follow up within 7 days of discharge</td>
<td>95%</td>
<td>98.1%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Care Programme Approach (CPA) formal review within 12 months</td>
<td>95%</td>
<td>99.8%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Admissions had access to crisis resolution / home treatment teams</td>
<td>95%</td>
<td>100.0%</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

### Table 15, continued

<table>
<thead>
<tr>
<th>Target or Indicator (per Compliance Framework 13/14)</th>
<th>Threshold or target YTD</th>
<th>Performance</th>
<th>2013/14 Status Achieved/Not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>95%</td>
<td>104.7%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Ambulance Category A 8 Minute Response Time - Red 1 Calls</td>
<td>75%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Ambulance Category A 8 Minute Response Time - Red 2 Calls</td>
<td>75%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Ambulance Category A 19 Minute Transportation Time</td>
<td>95%</td>
<td>0.0%</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Clostridium Difficile - meeting the CDiff objective</td>
<td>0</td>
<td>0</td>
<td>Not relevant</td>
</tr>
<tr>
<td>MRSA - meeting the MRSA objective</td>
<td>0</td>
<td>N/A</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Minimising MH delayed transfers of care</td>
<td>&lt;=7.5%</td>
<td>2.5%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Data completeness, MH: identifiers</td>
<td>97%</td>
<td>99.4%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Data completeness, MH: outcomes</td>
<td>50%</td>
<td>85.5%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>N/A</td>
<td>N/A</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Community care - referral to treatment information completeness</td>
<td>50%</td>
<td>100.0%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Community care - referral information completeness</td>
<td>50%</td>
<td>90.0%</td>
<td>Achieved</td>
</tr>
<tr>
<td>Community care - activity information completeness</td>
<td>50%</td>
<td>91.6%</td>
<td>Achieved</td>
</tr>
</tbody>
</table>
Part 3
Other Information
3. Other Quality Performance Information

We have used the earlier part of our quality report to inform you on how we have performed against the 2013/14 priorities and our quality goals for 2014/15 (please see sections 2.1 and 2.5). We have also provided statements of assurance on our national priorities. Please note that no changes have been made to the indicators that were published in the 2012/13 report; our performances against these have been shown in Part 2.

As mentioned earlier in Part 2, our priorities are agreed by our Quality Board taking into account the views of our stakeholders to improve the quality of our services. We identified these by working in partnership with staff, patients, carers, the wider public, our members and the local clinical commissioning groups. Not all areas of focus have been included in our quality improvement goals as some are aligned to our service development strategy and our internal quality improvement initiatives. Progress on these will be reviewed through our Quality Board and quality sub-groups: Patient Experience, Patient Safety and Clinical Effectiveness.

3.2 Quality Highlights and Case Studies

Each year we like to showcase areas of good practice that have been reported across our various services; below are some case study examples that are aligned to the three quality domains; our trust values of having a user focus, excellence, learning, being responsive, partnership and safety and to our 4 ‘must dos’.

3.2.1 The MOVE Programme

The Children and Families Bill (2013) is the latest in a line of policy initiatives setting out expectations for how disabled children and their families should be informed about and involved in decision-making regarding the provision of services to meet their needs. It aims to put children's and families’ aspirations at the heart of service delivery through person-centred planning.

Oxleas Children’s Physiotherapy Team, education staff from Willow Dene Special School and Charlton Park Academy have worked collaboratively with The MOVE Partnership to consider how best to promote independence and social inclusion for young people with significant physical disability.

MOVE is an activity based programme which uses the combined knowledge of family, education and therapy to teach children with physical disabilities, and/or complex needs, the skills of sitting, standing, walking and transferring. MOVE is designed for anyone who has not learnt to sit, stand or walk by the age that they should have done. There is no child who would be excluded from the programme due to their physical or learning difficulties being considered too severe for the MOVE programme to be effective.

The resulting Greenwich MOVE programme provides a cross-agency, integrated, family centred service that allows young people to have as many opportunities as possible to practice the movement skills they need for everyday life. The overall aim is to increase independence and integration into the community.

How we measure outcomes:

- Children’s developmental progress on the programme is measured against an incremental movement framework and captured bi-annually. This is an international method of data collection and our outcomes are shared with the central MOVE Partnership. Every child has shown a quantitative improvement in their developmental profile.
- Work has begun on recording the potential health benefits of movement opportunities within the school day, e.g. improved respiratory function.

Our successes:

- 83 children currently on the MOVE programme
- 14 educational settings active on the MOVE programme
- 5 MOVE graduates
- 2 centres of excellence
- 138 staff trained on the MOVE programme
- 3 MOVE trainers in Greenwich

What parents say about MOVE:

“The MOVE programme has helped us to have more family time together. Our daughter now sits and stands with us at the table and sits next to her sister and listens to her read a story.”

“What MOVE means to my child – a sense of independence, purpose and understanding to what he wants to achieve daily.”
3.2.2 Express Yourself

In our continuous endeavour to obtain feedback on patients’ experiences of our services, we have put in place a variety of initiatives to hear what we can do to improve our services. The ‘Express Yourself’ sessions that were held in the summer of 2013 were one of those initiatives.

The sessions were targeted at young people aged 13 to 19 and the aims were to:

- Develop young people’s understanding of concepts of participation, empowerment, children’s rights and ‘voice and influence’
- Support young people to learn and develop new creative skills
- Provide opportunities for young people to express thoughts, feelings and ideas using creative mediums
- Gather feedback about young peoples’ experiences of our services and ideas for future involvement opportunities and service developments.

The key outcomes from the events were:

- A radio show which focused on young people’s voices, this has been uploaded on to the Oxleas website
- 2 songs written, produced and recorded by the young people who attended about their experiences
- Feedback from the participants on their experiences of using our services
- A pool of motivated young people who are interested in being involved in future Oxleas projects.

What the young people said about the events:

- “It felt good to express myself and then hear it back.”
- “Something you learnt: Multi-tasking in the studio; Positive news about young people; I learnt a lot.”
- “Something you’ll take away with you: Friendships; aspects of working in radio; learning new skills.”

3.2.3 Working in Partnership to improve Quality and Outcomes in Wound Care

This case study example provides you with an overview on how we have worked in partnership with our commissioners and industry to achieve effective clinical care, improved patient experience and patient safety in wound care.

Wound care is a high cost area for patients and the NHS. Following the launch of the NHS report Innovation, Health and Wealth: Accelerating Adoption and Diffusion in 2011, a partnership steering group was set up between Greenwich commissioners, ourselves as a provider and industry (Convatec) to provide wound care dressings to patients through the community nursing service. The aim was to transform the current system of wound care product provision while maintaining integrity and transparency.

A collaborative pilot project was initiated by the steering group and a clinical audit undertaken to establish a baseline against which quality, outcomes and identification of education needs could be measured. The recommendations of the audit were implemented in the form of required formulary amendments, provision of training and education. The new formulary was uploaded onto the Convatec Online Management System (CCOMS) – this is an internet based ordering system. The use of this new system helped facilitate adherence to the formulary, improved clinical and cost effectiveness and reduction in wastage.

The outcomes of this collaboration has realised the following:

- Improved district nursing productivity
- Provision of regular reports from Convatec which has facilitated good financial management with the Greenwich CCG Medicines Management Team.

This collaborative wound care management project symbolises true partnership working between commissioners, providers and industry and has demonstrated an innovative method of wound management that has helped improve health outcomes for the patient and cost effectiveness for the stakeholders.

3.2.4 Dysphagia Management – Joint working between Oxleas Adult Learning Disability and Local Hospital Speech and Language Therapists

Dysphagia is the medical term for swallowing difficulties. A significant number of adults with learning disabilities (ALD) have swallowing difficulties (Dysphagia), which can lead to increased risk of respiratory infections, weight loss, dehydration and/or choking. These individuals are often supported by a large number of care staff across a variety of settings and partner organisations. Research and clinical experience has indicated that clinical staff may not adequately adhere to Dysphagia Care Plans, which may increase the risk of serious health consequences for the individual.

Case for change

This quality case study is an example of working in partnership with acute hospital colleagues. There was no clear agreed protocol on how to deal effectively with people with ALD and
Quality report

3.2.5 Safe Zone

One of the priorities in our Service Development Strategy is to promote innovation; this is inclusive of a continued focus on social inclusion and a drive to increase the use of assistive technologies to provide good quality care that is responsive to the needs of the patient.

Safe Zone is a closed social networking website that has been designed as a pilot in partnership with our clinical staff and patients. The site is targeted at users of the Early Intervention in Psychosis (EIP) service. These are individuals between the ages of 18 and 35 years with an early onset of psychosis, and social withdrawal is usually one of the first signs of psychosis.

What we did

A survey of this patient group was undertaken in 2013 which asked about use of social networking, access to a PC, laptop or a 3G phone and if they were interested in a social networking site open only to EIP users. Results showed that 77% of those surveyed have used social networking sites, 82% have access to a computer or laptop and 52% have access to a 3G phone. 55% were also interested in having a dedicated EIP social networking site.

A steering group of 4 clinical staff, 2 service users and representation from our communications team was set up to work on making the website a reality. The aims were to:

- To improve social networks and interaction among service users
- To facilitate social inclusion
- To improve service users experience of Early Intervention in Psychosis services.

Implementing Safe Zone

Safe Zone was launched on 11 September 2013 at our Annual Members’ Meeting at the IndigO2. We had a competition to name the site to create a buzz amongst service users. The social networking website includes:

- The opportunity for users to share their experiences
- Information on psychosis using a multimedia approach
- Blogs, videos, recovery stories and health promotion.

Ensuring Patient Safety

We have established clear site rules and this includes information about what to do in a crisis. There is a staff rota to monitor the site during working hours.

Benefits

Safe zone promotes social inclusion so that users of EIP services feel a better sense of belonging and feel less isolated. Only EIP service users and clinicians involved in their care like nurses, doctors and occupational therapists can use the site so there is an additional safety measure. We have had great feedback from the London-wide Early Intervention Network and other services are interested in copying the idea.

Our thanks to:

- All the EIP service users who helped with the survey and the development of Safe Zone
- The EIP Steering Group and teams
- Oxleas Communications Team.

3.2.6 Advanced Dementia Service – Supporting Carers and Building Resilience

2013/14 was a year that saw Oxleas awarded the NHS Innovation Challenge Prize for Dementia for its innovative Greenwich Advanced Dementia Service (GADS) which is a partnership between health, social care and the third sector. This is a model of care for people with advanced dementia which helps them to stay in the comfort of their own homes for as long as possible. This innovative piece of work has also been showcased in a report by the Kings Fund, a prestigious independent charity working to improve health and healthcare in England.

The Advanced Dementia service was developed by nurses and doctors working in Oxleas who work closely with partners from the Royal Borough of Greenwich, the Alzheimer’s Society, Greenwich Carers Centre, GPs and community health services. It aims to improve the quality of life of patients by enabling them to live in their own home with their loved ones, minimise unnecessary emergency admissions to hospital, and provide a comprehensive package of community based support for people with dementia and their families.

The Advanced Dementia Service was formed in November 2012. It brought together two services – the Greenwich Advanced Dementia

Quality report

Quality report

Quality report
Service and the Bexley Advanced Dementia Care At Home project. The current service consists of a consultant in old age psychiatry, several specialist nurses and a dementia social worker. In Greenwich, care coordination is led by a consultant old age psychiatrist, working alongside specialist nurses called community matrons. In Bexley, the same psychiatrist works with a community psychiatric nurse, an advanced practice nurse and a social worker specialising in dementia. Staff working within the service liaise with community health services and GPs to provide care in patients’ homes, focusing on supporting the carer or family, increasing their resilience to provide palliative care for the patient.

An audit of the service has shown that 70% of patients die at home, compared to figures for England and Wales of six percent for dementia patients in 2010.

The Kings Fund report says: “The existence and continued success of the Oxleas service is due to a small team of individuals who have sought to deliver an integrated service for patients and families who often experience a disjointed health and social care system.”

### 3.2.7 Ensuring Quality in our Mental Health In-Reach to Prison Services

Oxleas has delivered mental health services to prisons since 1992 and this includes services to HMP Belmarsh, HMP Brixton and Kent prisons. We have pioneered many developments now commonplace in offender mental health services such as prison in-reach and resource centre models.

We currently deliver mental health services to Kent Prisons and we would like to showcase various initiatives and areas of best practice around the quality domains of patient experience, patient safety and clinical effectiveness.

### 3.2.7.1 The Dickens Therapy Centre – Recognition for Learning

The Dickens Therapy Centre is run by a small team that provide a wide range of therapeutic groups including: depression, anxiety, emotional self control, sleep hygiene and social skills. They also provide individual support such as counselling, extended assessments on psychology and occupational therapy. Evaluation has highlighted that these activities have a significantly positive effect on the offenders who take part. The centre was nominated and awarded an Oxleas Staff Recognition Award for Learning; several of the nominations received for the team were from offenders.

One nominator wrote: “With only three full time members of staff and three part-time (who only work one day a week) we have run 402 therapeutic groups and 537 individual therapeutic sessions. We go the extra mile for our patients including spending nearly an entire day with someone who needs extra support. We recognise vulnerability and put our patients first.”

Feedback includes:

- “The groups have helped me an awful lot with my anger and stress problems.”
- “I’m a lot calmer. I had lots of anger problems and I’m chilled out at the moment.”
- “It helps you lose the ways you justified your [offending] behaviour.”
- “It helps me to relax and express my creative side. I find this helps me to sleep better and be more upbeat and it’s a new skill to have that I may need in the future. I need an outlet to be creative and expressive. I also like to learn and pass on skills that I have learnt.”

### 3.2.7.2 Mental Health Champions

We have developed a mental health awareness training package which covers topics such as personality disorder, learning disabilities and substance misuse. The package, initially designed to be delivered in three half day sessions, was condensed into one four hour course at the request of the Prison Governors in order to support the release of prison staff to attend.

72 prison staff from Kent prisons were identified to become ‘Mental Health Champions’ for their respective prison wing. We have delivered the training to 51 officers so far and activity data shows that this intervention has increased the number of appropriate referrals received by our service.

Excellent feedback regarding the quality of the training was received and comments include:

- “Should be compulsory for all staff.
  Will use [the training] to spot prisoners early and refer.
  Well delivered – interesting mix of anecdotal / informative.”

### 3.2.7.3 Pulmonary Rehabilitation Services in Maidstone Prison – Impact of a Quality Improvement Initiative

This example showcases what can be done to improve the quality of services and meet a gap in service provision when dedicated staff across various sectors come together.

**Case for Change**

In UK prisons, there are no screening programmes for COPD (Chronic Obstructive Pulmonary Disease) and there is no access to pulmonary rehabilitation for prisoners. The consequences of this are a detriment to quality...
Quality report

of life for the offender and significant financial burden to the NHS—£1139.57 per A&E visit. The Department of Health’s Outcomes Strategy for COPD and Asthma in England recommends that all people with COPD should be advised to undertake moderate exercise according to their condition. People with functional impairment should be referred for quality assured pulmonary rehabilitation. We wanted to make this a reality for patients in Maidstone Prison.

What we did
A project aimed at improving the health of prisoners through pulmonary rehabilitation was developed in partnership with the prison governor, community respiratory team physiotherapists, dieticians, fitness instructors, the local GP, Canterbury University, the mental health team, smoking cessation advisors and the British Lung Foundation.

The aims of the project were to ascertain the following:
• Can community pulmonary rehabilitation be replicated in a category C prison setting?
• Is it safe and effective?
• Can we produce equitable outcomes in the prison population as seen in a community setting?

We screened 38 prisoners (13 new diagnoses) and this identified leg fatigue/weakness, decreased exercise capacity, dyspnoea (sudden shortness of breath, or breathing difficulty); reduced health-related quality of life, poor coping strategies, anxiety and low mood, and frequent hospital admission.

We provided 2 stand alone programmes; 22 prisoners were invited to be part of the project of which 15 were full completers and 5 partial completers.

Effectiveness of care provided
How do we know that the care we provided was effective and met the aims of the project? Each participant had to complete the following standardised outcome measures:
• 6 minute walk test (6MWT)
• BCKQ - Bristol COPD Knowledge Questionnaire
• GAD-7 – Anxiety score
• PHQ-9 – Depression score
• CCQ- COPD clinical questionnaire
• Patient centred goals
• Feedback questionnaire.

Our results showed:
Clinically significant:
• 6MWT: 93% gained. Max increase 170 metres
• BCKQ: 86% gained increase in knowledge
• CCQ: 73% improvement.

Nearly clinically significant:
• GAD-7: 53% reduction in score
• PHQ-9: 60% reduction in score
• Goals: 80% achieved their goals.

What the participants said:
“...I have stopped smoking for 6 weeks and I’m keeping it that way."
“...I now have the confidence to do something and not worry about being out of breath.”
“...I am walking better and my mood is better.”
“...I can sleep through the night.”

The impact of this project is seen in these areas:
• Clinical - Medication reviews, oxygen reviews, standby medications,
• Self - Management - Written information booklet, cell based exercise, improved medication compliance
• Nutritional Needs & Lifestyle – reduced BMI, review of menus, stop smoking.

This work has been recognised at our staff Recognition Awards and as a winner of the National Nursing Times Respiratory Nursing award.

3.2.8 Improving Physical Health in our Forensic Services
Patients with serious mental illness die about 15-20 years earlier than the general population due to an increased risk in treatable physical health conditions such as diabetes and coronary heart disease. In October 2013 we introduced a smoke free environment in our inpatient settings at the Bracton and Memorial Hospitals. Since implementation, we have seen a dramatic reduction in those service users who describe themselves as “smokers”. In January 2013, the numbers of patients identifying themselves as smokers was 84%. In January 2014, four months after introducing the ban, this number had dropped to 25%. The healthcare gains will have a positive impact on the longer term physical health for this group.
3.2.9 The 6Cs in our Nursing Strategy

- Oxleas nurses are always open and involve people in their care, keeping them informed about their treatment including medication.
- Oxleas nurses always ensure patients’ fundamental needs are assessed and attended to including nutrition, hydration, comfort and hygiene.
- Oxleas nurses always engage in supervision and reflective practice sessions to improve the practice they provide.

3.2.10 Improving Lithium Monitoring

We are proud to be part of the network of trusts who participate in the POMH (Prescribing Observatory for Mental Health) national audits. We have actively participated in all of the proposed quality improvement projects and annually showcase our involvement in the Quality Account. This year we want to showcase the work we have done to improve implementation of lithium monitoring.

The National Institute for Health and Care Excellence (NICE) recommend lithium as an effective treatment for people with bipolar disorder, and those with depression who do not get better when taking an antidepressant alone. Patients who take lithium need to have regular blood tests to make sure their dose of lithium is correct and that lithium has not caused any problems with their kidneys or thyroid.

We identified lithium monitoring as an area where practice needed to improve through participation in the Prescribing Observatory for Mental Health (POMH) programme. This programme is coordinated in Oxleas through the local POMH team, which at the time of the baseline audit (2008) comprised representatives from clinical audit, pharmacy, medicine, nursing, and service users.

The service user representatives on the audit group were keen that we should participate in this topic due to their own personal experiences. One had been treated for lithium toxicity in intensive care in the past (as a consequence of not having his treatment regularly monitored), and he also knew people on lithium, from local mental health charity groups, who were not having regular blood tests. The other service user said he always had to remind his doctors to take bloods for lithium monitoring and that there did not seem to be a system in place to flag up when his tests were due.

In most of our community mental health teams (CMHTs), patients would have their prescriptions for lithium written by their GP who, it was assumed, would also order the required blood tests and share these results with the psychiatrist who may only see the patient once or twice a year.

The results of the baseline POMH audit in 2008 identified that there was indeed a need to improve practice as some of our patients did not seem to have had a blood test for a lithium level in the last year, and only 35% had had four tests in the past year as recommended by NICE. We undertook an in-depth quality programme to improve practice by doing the following:

1. **Local feedback and action planning**
   - After the baseline audit, the results were fed back to all relevant staff and patient groups through these discussions led to the development of local action plans.

2. **Overcoming barriers to change**
   - A common problem of sharing information between pathology, and primary and secondary care was identified. The POMH central team identified that this was a national problem, and not long before the re-audit in April 2010, there was a joint NPSA (National Patient Safety Agency)/POMH event to launch an NPSA alert around lithium monitoring. This included a statement that there should be an electronic interface between pathology and primary and secondary care to allow the results of lithium monitoring blood tests to be shared easily.

3. **Development of a lithium database**
   - In 2011, a lithium database was developed and this gave doctors and care coordinators the ability to register their patients on the lithium database via email to the database manager. The manager of the database liaises with the local pathology services once a month to obtain lithium results, and certain renal and thyroid function test results for all our patients prescribed lithium. This information is uploaded into the database and identifies all patients who are due for a lithium blood test and doctors are informed of this.

**Results from our audits**

The red sections in the bars in each figure overleaf show the proportions of patients in the total national sample (TNS) who have not had any checks of the amount of lithium in their blood, or of their kidneys or thyroid in the last year. Practice nationally improved between the re-audit and first supplementary audit but has remained static since. The lines in each figure show how practice in Oxleas has continued to improve over time.
Improvements seen:

1. **Identification of our patients on lithium.**
   Through liaison with pathology, we are able to identify all our patients taking lithium and record their details in a central location.

   In the most recent audit, July 2013, the number of patients who had had four lithium serum level tests in the last year had risen from 35% at baseline to 52%. The number of patients who had had at least two lithium tests in the past year had risen from 78% at baseline to 95%, with all the patients in the sample having had at least one test in the past year.

2. **Improvement to patient care.**
   The improvement to patient care, specifically patient safety, can be seen by the significant increase in the number of patients who have had regular blood tests for lithium levels, kidney function and thyroid function.

   With respect to the effectiveness of treatment, at baseline 67% of patients had a lithium level within the therapeutic range (high enough to be effective but not high enough to lead to toxicity). By 2013 this proportion had increased steadily to 86%.

Key learning points:

We have learnt that without adequate systems in place to support good clinical practice, it can be difficult to bring about change even when local clinicians acknowledge problems, engage with them and clearly see the need to improve practice. It is essential to obtain the views of staff involved in the process to understand what...
3.3 Oxleas response to the Francis recommendations – one year On

Since the publication of the Francis, Berwick, and Winterbourne View reports, we have followed a series of processes to ensure staff are aware of the recommendations and actions are in place to meet them.

Raising awareness
- The Francis report has been cascaded to staff working in all services and teams and has been discussed across the trust at professional, directorate and team meetings, with each service identifying local actions.
- As mentioned above, our nursing strategy was launched in June 2013 and responds to the events at Mid Staffordshire and Winterbourne View hospitals, setting out the core values of nursing and our priorities over the next three years:
  1. Delivering high quality compassionate care
  2. Improving the experience of service users and carers
  3. Keeping people free from harm.

Our Progress so far (action planning and implementation):
- Clinical directors for each directorate have presented their action plans to an informal Board meeting (this is a meeting that involves all Board members as well as attended by service and clinical directors, hence the term informal). These action plans covered discussions and agreements made at directorate level
  1. The Francis, Berwick and Winterbourne recommendations have been distilled into an action plan which address five key areas:
    1. To promote a culture of candour and openness and embed our values
    2. Using feedback from service users, families and carers
    3. Strengthen quality management by introducing measures for performance
    4. Facilitating and ensuring increased patient focus and contact by managers
    5. Actions for nursing: Safe Staffing; implementing nurse appraisal and revalidation that embeds the 6Cs; a continued focus on Care and Compassion.
  - In October 2013, our Board of Directors implemented a programme of monthly ‘back to the floor’ visits for each service area by groups made up of an Executive, Non-Executive, Clinical and Service Directors. These visits provide patients and staff an opportunity to give direct feedback about the experience of receiving and working in Oxleas services. Each Non-Executive Director provides feedback of their board to floor visit at the Board of Directors.
  - In January 2014, the Board visits were augmented by a programme of night visits providing an opportunity to ensure services out of hours meet the same standards as people would expect at other times.

3.4 National Patient Survey 2013

Each year we participate in the Care Quality Commission’s national survey of people who use community health services. In 2013, 251 out of 820 eligible people who used our services responded to the survey giving us a response rate of 30% (the highest response we have had in the last 4 years).

Section scores

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<tr>
<td>This trust’s score</td>
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<tr>
<th>Best performing trusts</th>
<th>About the same</th>
<th>Worst performing trusts</th>
<th>‘Better/Worse’ - Only displayed when this trust is better/worse than most other trusts</th>
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Oxleas NHS Foundation Trust
Quality report 2013/14

50

51
58 NHS trusts took part in this survey and detailed on previous page, is a summary of our performance for the 9 identified sections and this is benchmarked in comparison to the trusts who took part in 2013:

In comparison to 2012 results, we improved 5% or more in 6 indicators:
1. Access to psychiatrist (improved by 7%)
2. Understand what is in the care plan (improved by 5%).
In terms of where we did not do as well this year, in comparison to 2012 results, we performed 5% or more worse in 7 indicators:
1. Views taken into account (reduction of 6%)
2. Trust and confidence in staff (reduction of 7%)
3. Talking therapies received over last 12 months (43% which is a reduction of 11% - but better than national average of 39%)
4. MH services helped in achieving goals (reduction of 5%)
5. Care review helpful (48% which is a reduction of 6% - but same score of as national average)
6. Contact number for Out of hours (64% which is a reduction of 5% - but better than national average 54%)
7. Asked about non-prescription drugs (40% which is a reduction of 10% - compared to national average of 43%).

The survey also included three sections where patients could make comments in their own words about the care they had personally received.

The comments were under the following headings:
1. Was there anything particularly good about your care?
2. Was there anything that could be improved?
3. Any other comments?

We have highlighted below a summary of these qualitative comments made by our patients with regards to the first question:
The results of the national audit have been reviewed by our Patient Experience Group, our Quality Board and by the Board of Directors. Our attention is focused on the areas that have declined and we have action plans in place to ensure a positive improvement in the 2014 results. We will continue to ensure that our 4 must do’s will be used as the foundation to bring about improvements.

3.5 National Staff Survey

We take part in the annual Care Quality Commission (CQC) national NHS staff survey. The staff survey is an important piece of evidence in demonstrating that the trust achieves compliance with Care Quality Commission and national standards and targets. The staff survey key findings are aligned to the pledges to staff made in the NHS constitution and therefore gives assurance both internally and externally that the trust is meeting its staff obligations as set out in the constitution.

The Francis Report requires organisations to use a variety of ways to understand how ‘front line staff’ feel about their organisation and the services they provide. The staff survey is one such measure. Research by Aston University shows a direct correlation between staff survey results and patient outcomes. The areas we excelled in the survey such as whether staff would recommend the trust as a place to work and be treated; satisfaction with the level of care they provide and overall staff engagement are important indicators of staff contributions to the quality of care we provide.

**Results**

The overall response rate was 57% (481 staff). The response rate is in the top 20% when compared with other mental health and learning disability trusts.

The CQC report groups the responses of all the questions into 28 key findings with an additional composite finding about staff engagement. Despite the changed nature of Oxleas, the CQC continues to compare the trust with other mental health and learning disability services, nonetheless a number of mental health trusts in London as well as elsewhere also provide community services.

Oxleas comparative scores are:

- 15 key findings were in the top 20% of mental health trusts
- 6 key findings were above average for mental health trusts
- 4 key findings were average for mental health trusts
- 1 key finding was below average
- 2 key finding was in the worst 20%

Eight scores were the top scores nationally for any mental health or learning disability trust:

- Feeling satisfied with quality of work and patient care delivered
- Feeling that their role makes a difference
- Effective team working
- Receiving well-structured appraisals
- Fairness and effectiveness of incident reporting
- Able to contribute to improvements at work

The composite score for staff engagement places Oxleas in the top 20% of mental health and learning disability trusts. Kings Fund research has shown that over the years 2009-2012 Oxleas has had the highest aggregate staff engagement score of any NHS trust or NHS foundation trust.

Scores in the bottom 2 categories were:

**Below Average**

- Experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- Experiencing Physical violence from staff in last 12 months.
- Experiencing Discrimination in the last 12 months.

**Worst 20%**

- 1 key finding was in the worst 20%.

**Summary**

The number of staff who completed the survey represents 15% of the whole organisation and is proportionate to the relative sizes of the directorates. On that basis, therefore, we can be satisfied that the data received gives an accurate reflection as to the overall picture of our trust.

- Harassment, bullying and abuse by users and carers is the principal issue of concern and is the underlying reason behind two of the bottom three areas. Male and black and minority ethnic (BME) staff remain the most likely to suffer this abuse and harassment. Whilst the rest of the survey suggests that staff do feel supported and trust the organisation, this must be the principal area of focus over the forthcoming year. The issue of abuse towards staff by patients must be addressed both locally by clinicians and multi-disciplinary teams as well as by corporate support. The approach adopted must be consistent across all clinical teams to ensure that staff are confident that they will be supported.

- BME staff remain, as with 2012, broadly more positive and satisfied than their white counterparts. They remain disproportionately more likely to be subject to harassment and violence from patients and carers. Disabled staff, as in 2012, remain broadly less positive than their non-disabled colleagues although their scores have improved since last year.

- The numbers of staff who have reported violence from colleagues is small. There is only one formal disciplinary case currently under investigation that could be construed as physical violence by one member of staff to another. There are no reports of violence between staff recorded as an incident on datix and staff-side colleagues were not aware either formally or informally of any issues of this nature. The trust and trade union colleagues will continue to be absolutely explicit that such behaviours will not be tolerated and will, if reported, be investigated thoroughly.

The trust continues to compare well with other Mental Health and Learning Disability trusts and has again achieved the best results of any trust within this group in both London and the South East.
3.6 Oxleas Complaints Report 2013

In 2013/14 there were approximately 395,000 patient contacts with our services; in the same period of April 2013 to March 2014 we received a total of 204 formal complaints.

Of the 204 complaints received:
- 64 (31%) relate to Adult Acute Mental Health (22 Bexley, 16 Bromley, 26 Greenwich)
- 63 (31%) relate to Adult Community Health (31 Bexley, 32 Greenwich)
- 37 (18%) relate to Recovery Mental Health (3 Bexley, 21 Bromley, 13 Greenwich)
- 17 (8%) relate to Children and Young Persons (6 CAMHS and 11 Community)
- 15 (7%) relate to Older Persons (3 Bexley, 6 Bromley, 6 Greenwich)
- 5 (2%) relate to Forensic Services
- 2 (1%) relate to Corporate Services
- 1 relates to ALD.

Complaints investigated
193 complaints have been investigated for this period of which 561 concerns were raised. Of these 561 concerns raised, 243 (43%) were upheld or had elements within the complaint that were upheld.

Our review of the concerns raised has identified 3 themes:

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<th>Raised</th>
<th>Upheld</th>
<th>% upheld</th>
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<tr>
<td>Clinical Care</td>
<td>103</td>
<td>32</td>
<td>31%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>78</td>
<td>37</td>
<td>47%</td>
</tr>
<tr>
<td>Communication</td>
<td>48</td>
<td>34</td>
<td>71%</td>
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Each of these identified three areas is part of our 4 must do’s, which are:
- Increasing support for families and carers
- Providing better information for our service users and carers
- Enhancing care planning
- Improving the way we relate to both our service users and carers.

We have already started the process of ensuring we embed lessons from complaints across all our services and acknowledge that there is further work to be done.

Parliamentary and Health Service Ombudsman
Complainants who are dissatisfied with the trust response have the right to ask that the Parliamentary and Health Service Ombudsman (PHSO) reconsider their complaint. During the year, 10 complainants have asked for their case to be reviewed by the Ombudsman’s Office since April 2013. Of these, 8 were not upheld, 1 was upheld and 1 is currently on going.

The Patient Experience Group reviews action plans from each directorate and receives reports about progress with regard to implementation. This process is also reflected in each of the directorate patient experience groups.

We will continue our focus in these areas in 2014/15 to improve the quality of the services we provide.

Complaints handling
In line with the trust’s Complaints Policy the aim is to respond to complaints received within 30 working days and that extensions are agreed with the complainant when it is not possible to complete the investigation within this time frame. Of the 193 complaints investigated, 155 (80%) were completed within the agreed timescales.

Glossary of Abbreviations
ADHD – Attention Deficit and Hyperactivity Disorder
ALD – Adult Learning Disabilities
AMH – Adult Mental Health
AOT – Assertive Outreach Teams
BMI – Body Mass Index
BP – Blood Pressure
CAMHS – Children and Adolescent Mental Health Services
CDI – Clostridium Difficile Infection
CHS – Community Health Services
CHS Paeds – Community Paediatric Services
COPD – Chronic Obstructive Pulmonary Disorder
CPA – Care Programme Approach
CRN – Comprehensive Research Network
CLRN – Comprehensive Local Research Network
CQC – Care Quality Commission
CQUIN – Commissioning for Quality and Innovation
DeNDRoN – Dementias and Neurodegenerative Diseases Research Network
EIP – Early Intervention in Psychosis
GAUD – Greenwich Advanced Dementia Service
HSCIC – Health and Social Care Information Centre
HQIP – Healthcare Quality Improvement Partnership
KPI – Key Performance Indicator
LD – Learning Disabilities
LTC – Long Term Conditions
NICE – National Institute for Health and Care Excellence
NIHR – National Institute of Health Research
MH – Mental Health
MH & LD – Mental Health and Learning Disability
MHRN – Mental Health Research Network
Monitor – Foundation Trust Regulatory Body
MRSA – Methicillin Resistant Staphylococcus Aureus
OPMH – Older People Mental Health
POMH – Prescribing Observatory for Mental Health
QOF – Quality and Outcomes Framework
QSIP – Quality and Safety Improvement Plan
RAG – Red, Amber, Green rating
RCA – Root Cause Analysis
RIO – Electronic Clinical System
SaLT – Speech and Language Therapy
ST – Safety Thermometer
UTI – Urinary Tract Infection
VTE – Venous Thromboembolism
1 Background
The draft Oxleas NHS Foundation Trust Quality Account for 2013/14 is reviewed by the NHS Greenwich Clinical Commissioning Group’s Quality Committee. The coordination of feedback on the quality account has been historically undertaken across Bexley, Bromley and Greenwich CCG’s Governance Leads, who welcome the opportunity to respond to this document. This is the NHS Greenwich Clinical Commissioning Group response as part of this joint process.

2 Partnership Working
NHS Greenwich Clinical Commissioning Group is committed to working in close partnership with Oxleas NHS Foundation Trust to ensure the on-going delivery of high quality services. NHS Greenwich Clinical Commissioning Group has established processes for regularly reviewing of quality issues with Oxleas NHS Trust, via quarterly Clinical Quality Review Group Meetings (CQRG) as well as a number of other quality review mechanisms. The Terms of Reference and membership of the CQRGs were refreshed in June 2013. During 2013/14 commissioners have been actively involved in the Oxleas Pressure Ulcer Panel. Commissioners across Greenwich, Bexley and Bromley and Lewisham have initiated a Pressure Ulcer Working Group, led by the Designate Nurse for Adult Safeguarding which seeks to share good practice on pressure ulcer management across all providers.

3 Response to the Francis Report
Oxleas NHS Foundation Trust Quality Account provides detailed progress to date on the Trusts response to the Francis Report and Oxleas nursing strategy responds to the events at Mid Staffordshire and Winterbourne View.

Ensuring that all providers of NHS care are appropriately delivering safety standards and listening to patients and staff are two key strands that NHS GCCG uses to monitor progress against the Francis Report recommendations. Oxleas have invited commissioners on to the Patient Experience Group and during 13/14 commissioners undertook unannounced visits, which provide external assurance that the services inspected were fully compliant with standards. Oxleas Board of Directors implemented a monthly ‘Back to the Floor’ visit for each service group, augmented by a programme of night visits (with commissioner involvement) to ensure services out of hours services meet the same standards as the public would expect at other times. From 1st April 2014 Oxleas have been publishing and displaying daily nursing ratios.

NHS Greenwich CCG has received regular updates and reports from Oxleas NHS FT on the organisations progress against the Francis recommendations. The 6C’s have been encapsulated in the Oxleas Nursing strategy (June 2013), together with a nursing pledge for all nursing staff.

4 CQUIN monitoring and development
Oxleas have worked with Bexley and Greenwich CCGs to effectively negotiate CQUINs for 2014/15. There is evidence that CQUINs have being used as an enabler to better achievement and this has been specified. During 2014 Oxleas have agreed separate monitoring meetings with the CCGs that will focus on achievement against CQUINs and the aim is to enable fuller engagement of clinical commissioners in the development of new CQUINs for 2014/15.

5 Performance against the Quality Priorities 2012/13
Oxleas NHS Foundation Trust Quality Account outlines its performance against the Quality Priorities set against 2012/13 that span the three key domains of quality patient experience, patient safety and clinical effectiveness. The analysis of the areas in which the Trust did not achieve its targets last year is helpful and gives good assurance to commissioners that clear action plans are in place:

Patient Experience:
- Oxleas have adopted 6 ‘must ask’ questions and these have formed the basis of every patient experience questionnaire or survey that is carried out by the different services in the Trust
- It is important to note that as a Trust that provides Mental Health and Community Health Services, Oxleas were not expected to roll out the Friends and Family Test to services in 2013/14. This was an area that Oxleas wanted to pilot across services prior to national roll out to mental health and community services hence the ‘how likely will you recommend question’ being chosen as one of the patient experience priorities for 2013/14.
- It is noted that Oxleas did not meet the achievement target of 100% in follow up of patients admitted to hospital following self-harm within 48 hours of discharge to ensure they are safe and that Oxleas have reviewed its process to include face to face follow up via the Home Treatment Teams and working closely with the local police on instances of not being able to contact a patient in raising a welfare check.

Clinical Effectiveness:
- NHS Greenwich CCG notes Oxleas actions to improve practice in line with NICE Guidance on ADHD audit standards and to ensure community health patients have a recorded care plan on the electronic patient record system RIO.

6 Participation in Clinical Audits & Clinical Research
During 2013/14 eight national clinical audits and 25 national confidential enquiry covered NHS services that Oxleas NHS Foundation Trust provides. During 2013/14 Oxleas NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The Quality Account outlines research activity, research governance arrangements and resource applied to support research within Oxleas NHS Foundation Trust.
Quality report

7 Care Quality Commission (CQC)
NHS Greenwich Clinical Commissioning Group acknowledges Oxleas holds its current registration status with the Care Quality Commission as ‘Registered with no conditions applied’ and that there have been no CQC enforcement actions during 2013/14.

Oxleas NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14:

- Blantyre House
- Oxleas House
- Bracton Centre
- Ivy Willis
- Atlas House
- Oaktree Lodge
- Greenwood and Hazelwood.

Out of the eight locations visited, six were found to be fully compliant with the Essential Standards of Quality and Safety. No major concerns were found at any location. However, two locations were identified as having one moderate and four minor concerns between them. The two sites identified were Oaktree Lodge, the older people’s continuing care unit and the mental health inpatient services at Oxleas’ House.

NHS Greenwich CCG notes that the action plans and completion dates have been fully complied with and that the Trust is currently awaiting the CQC formal confirmation of compliance. The action plans are monitored through the Clinical Quality Review Groups.

8 Areas of notable good practice are outlined within the Quality Account:

- The Trust has achieved its highest score (within the last 4 years) in the National Patient Survey 2013 with a response rate of 31%, improving 5% or more in six indicators.
- The Trust is in the top 21% response rate for the National CQC Staff Survey with a response rate of 57%. Kings Fund research has shown that over the years 2009-2012 Oxleas has had the highest aggregate staff engagement score of any NHS trust or NHS Foundation trust.
- Achievement of the majority of Quality Performance targets for Patient Experience, Patient Safety and Clinical Effectiveness with action plans in place to redress the small number of targets which were not met.
- An effective series of meetings with commissioners to negotiate CQUINs for 2014/15 and early sign off. CQUIN monitoring meetings have commenced working to agreed Terms of Reference and membership.
- The Quality Account describes in detail a number of examples of Quality Highlights for the year. These include:
  - The Greenwich MOVE programme which promotes independence and social inclusion for young people with physical disability;
  - The Express Yourself initiative aimed at 13 to 19 year olds;
  - Working in partnership with the NHS Greenwich CCG Medicines Management Team in the collaborative project to improve Quality & Outcomes in Wound Care;

9 Quality Improvement priorities for 2014/15
NHS Greenwich Commissioners attended the February 2014 Oxleas event to identify quality priorities. This exercise reinforced the need to continue to focus on the Trusts 4 ‘must do’s’ which are:

1 Increasing support for families and carers
2 Providing better information for service users and carers
3 Enhancing care planning
4 Improving the way we relate to both service users and carers

In addition:

- Monitor key quality indicators
- Commissioning for Quality and Innovation goals agreed with commissioners
- Current priorities where trend data is available to measure improvement year on year.
- Are linked to the NHS Outcomes Framework and the 5 domains

- Domain 1 - Preventing people from dying prematurely
- Domain 2 - Enhancing quality of life for people with long-term conditions
- Domain 3 - Helping people to recover from episodes of ill health or following injury
- Domain 4 - Ensuring that people have a positive experience of care
- Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

Yemi Osho - Chair of the NHS Greenwich Clinical Commissioning Group Quality Committee
Dr Ellen Wright – GP Clinical Commissioner (Governance & Quality)
Nicola Moore – Director of Integrated Governance
Maggie Aiken – AD Governance & Quality

May 2014
Annex 1.2: Statement from NHS Bromley Clinical Commissioning Group

Bromley CCG Response to Oxleas NHS Foundation Trust’s Quality Accounts Report 2013/14

Thank you for submitting a draft copy of the Oxleas 2013/14 Quality Accounts for comment, to be included in your stakeholder response section of the report. Bromley CCG welcomes the report which gives us a clear indication of how the Trust prioritises and monitors quality. We can confirm that the content of the quality accounts for 2013/14 pertaining to our contractual agreement is accurate and correct, reflecting information that has been reported quarterly throughout the year.

**Highlighted Quality Areas 2013/14**

During 2013/14 the Trust has continued its commitment to implement initiatives to improve the physical health of those service users with mental health problems. Challenging targets around staff training were exceeded at an early point in the year, and this is to be commended. This commitment continues with the Trust working closely with community providers, and for 2014/15 is expanded to improve the physical health check uptake for people with a learning disability.

The CCG is pleased to see the focus on patient experience evident within the work that the trust has undertaken this year including the use of “must ask” questions and the commitment the organisation has shown as part of the pilot of the Friends and Family test for mental health.

Bromley CCG shared the trust’s concern earlier in the year at the reduction in performance against the 48 hour follow up of self-harm cases. We recognise that the trust has put in place robust actions to mitigate the reduction in performance. The CCG welcomes Oxleas approach in response to this issue to use this as an opportunity to not only regain performance but to improve the quality of the service offered, by introducing a more consistent approach and by ensuring face to face follow up.

Oxleas have provided reports to the CCG during the year on their implementation of recommendations following the Francis inquiry including their introduction of a new nursing strategy based on the Chief Nursing Officer’s “6Cs” strategy, Compassion in Practice. Oxleas presented this work to the CCG’s Francis Working Group in April 2014 and are pleased to see its inclusion within the Oxleas Quality Account.

The Oxleas Clinical Quality Review Group is a joint group across Bromley, Bexley and Greenwich representing the trusts’ main geographical footprint in terms of service provision. The engagement between the CCGs and Oxleas within this meeting is very positive, providing a forum for challenge, as well as an opportunity to focus on quality areas highlighted locally and those identified as quality priorities and subject to CQUINs. Oxleas provides high level senior clinical input through the Medical Director as well as the Head of Quality and Audit to the meeting. For 2014/15 the frequency of these meetings is increased to six times per year, Bromley CCG supports this as a positive development to ensure the focus on quality is maintained.

The CCG acknowledges that this is an area that had been developing during 2013/14, with ongoing work taking place in this area. The CCG expect to see a focus on this within the 2014/15 report.

Bromley CCG would also like an increased focus on safeguarding children and vulnerable adults within the quality account, including a summary of performance against statutory duties and as assessment of the quality of activity within the trust. As part of this we would encourage that a key strand of the work to develop support for carers should be a focus on supporting vulnerable and young carers.

The report demonstrates the trusts’ commitment to participation in national audits, research and confidential enquiries, and recognises the internal audit activity as a way of learning and driving improvement.

**Quality Priorities for 2014-15**

Bromley CCG appreciates the partnership approach taken by Oxleas in agreeing quality priorities for 2014/15. The process of agreeing priorities involved a range of stakeholders both internal and external to the organisation, and included the CCG. The CCG supports Oxleas commitment to delivering the four trust Must Do’s under each of the priority areas of; patient experience, patient safety and clinical effectiveness.

We believe Bromley CCG have worked very successfully with Oxleas, on developing challenging CQUIN’s that encourage innovation and on-going improvement. The local CQUINS agreed for 2014/15 are:

- Advanced Dementia Care Plan - Ensure that people diagnosed with Dementia are supported to have the required information to inform advance care planning in line with the NHS Quality Standard for Dementia
- CAMHS Clinical Outcomes - Ensure that patients have a goal based measure in place as part of their care and treatment plans
- Improving access to Annual Health Checks – to facilitate an improvement in the uptake of annual health checks for patients accessing learning disability services

**Areas for Development**

Bromley CCG recognises that the trust produces additional reports which cover quality issues but would like to see these also captured within this quality account. Specifically we would have liked to see a focus on Serious Incidents as an important indicator of quality; including the outcome of the internal audit carried out during 2013/14 and the learning and actions to improve SI processes as a result of this. The CCG acknowledges that this is an area that had been developing during 2013/14, with ongoing work taking place in this area. The CCG expect to see a focus on this within the 2014/15 report.

**Summary**

The draft report has been considered by members of the Bromley CCG Quality Assurance sub-committee. We look forward to working with Oxleas throughout 2014/15 including reviewing the trust’s progress in implementing the CQUIN schemes, and hope that we will continue to see on-going improvements in patient experience, patient safety and clinical effectiveness throughout the year.

**Sonia Colwill**

Director of Quality, Governance and Patient Safety

April 2014
Annex 1.3: Statement from Local Healthwatch Organisations

Commentary from Local Healthwatch on Oxleas Quality Accounts 2013/14

Local Healthwatch welcome the opportunity to comment on the Oxleas Quality Account for 2013/14. We have compiled a joint report using feedback from Healthwatch Bexley, Bromley and Greenwich due to the crossover of services across boroughs.

General comments

- We are pleased to see that the report is presented in a format that it easy for the reader to identify where the Trust has met its priorities using the RAG rating in a table format and commentary to explain the significance. The RAG acronym should be added to the glossary – lay service user may not understand what it means.

- We are pleased that the Trust has achieved successes in each of the 3 quality priority areas and urge the Trust to continue this progression in parallel with its priorities for 2014/15. It would be helpful if the priorities were clearly outlined at the beginning of the report.

- We are pleased to see that the Trust has identified the need to improve patient experience for providing more support for carers and families as ‘must do’ as the Trust is not meeting this target (by 4%).

- In section 2.4.2, it is important to note that all care plans of community health patients should be recorded electronically on RiO rather than in paper format so that these can be accessed remotely and to help monitor plans, prevent loss of information or duplication.

- Under section 3.6, we are disappointed to see the number of formal complaints about the Trust has risen over the past year. It would be useful to see what the Trust’s action plan is and how the investigation and resolution of complaints are handled as this would reassure the public that this is a Trust that listens and learns.

- Whilst we are pleased that Healthwatch were invited to the borough focus groups to help identify priorities, it is not easy to see how these borough priorities are reflected in the Quality Account.

- We applaud the use of case studies to exemplify the Trust’s quality of work and effectiveness of service delivery under section 3.2.3. It is easy to identify how improvements were implemented.

Local Healthwatch appreciates the efforts Oxleas have made in engaging and developing a working relationship i.e. bi-annual meetings with both the Chairman and Deputy Chief Executive as well as involvement on a number of committees such as the Older People’s Mental Health Services Reconfiguration Stakeholder Reference Group.

We were pleased that Oxleas responded to Local Healthwatch comments about the difficulty in navigating their website which has since improved.

We look forward to continuing to work with the Trust over the coming year to achieve the best possible patient experience across all sites and accomplish positive outcomes from the priorities identified.

Healthwatch Bexley, Healthwatch Bromley and Healthwatch Greenwich, May 2014

Annex 2: Statement of directors’ responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation Board of Directors on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation Board of Directors should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to April 2014
  - Papers relating to Quality reported to the Board over the period April 2013 to April 2014
  - Feedback from the commissioners dated April and May 2014
  - Feedback from local Healthwatch organisations dated [20/05/2014]
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated [2012/2013]

- Internal complaints reports for 2013/14
- The 2013 national patient survey
- The 2013 national staff survey
- The Head of Internal Audit’s annual opinion over the trust’s control environment dated 2013/14
- CQC quality and risk profiles dated 31/03/2014
- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).
Quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Signed
Stephen Firn, Chief Executive
28 May 2014

Signed
Dave Mellish, Chairman
28 May 2014

Annex 3: Criteria applied to mandated indicators

Our external auditors, Deloitte LLP, as part of the annual quality report requirements, have undertaken work on the two mandated indicators below.

1 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital - National Mandated indicator

2 Admissions to inpatient services had access to crisis resolution home treatment teams - National Mandated indicator

Deloitte LLP’s conclusions in relation to these indicators are outlined in Annex 4.

The Trust’s performance against these two indicators was as follows:

<table>
<thead>
<tr>
<th>Mandated Indicator</th>
<th>Monitor threshold</th>
<th>Trust performance against the national mandated indicator based on the definition outlined below</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% enhanced CPA patients receiving follow-up contact within seven days of discharge from hospital</td>
<td>95% (Trust target 100%)</td>
<td>98.1%</td>
</tr>
<tr>
<td>Admissions to inpatient services had access to crisis resolution home treatment teams</td>
<td>95%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The definition used by Oxleas when measuring and reporting performance against the national mandated indicators are set out below.

100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital

- The indicator is expressed as a proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days.
- ‘Patients discharged’ includes patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care, or to prison.
- The indicator excludes patients who die within 7 days of discharge.
- The indicator excludes patients removed from the country as a result of legal precedence within 7 days of discharge.
- The indicator excludes patients transferred to NHS psychiatric inpatient ward when discharged from inpatient care.
- The indicator excludes CAMHS (children and adolescent mental health services), i.e. patients aged under 18.
- Those that are recorded as followed up receive face to face contact or a telephone conversation.
- The 7 day period should be measured in days not hours and should start on the day after discharge.

Oxleas guidance states that in the first instance the healthcare professional should make every effort to have a face to face contact with the patient, however if this is not possible then a telephone conversation with the patient, another healthcare professional or carer depending on where the patient has been discharged to should suffice as long as assurance of patient’s safety is gained.

The Trust also adopts a policy whereby if a patient is discharged and readmitted within seven days and before follow up has occurred, they are recorded as followed up.

Admissions to inpatient services had access to crisis resolution home treatment teams

- The indicator is expressed as a proportion of inpatient admissions gate kept by the crisis resolution home treatment teams in the year ended 31 March 2014.
- The indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards.
- An admission should be reported as gate kept by a crisis resolution team where they have assessed* the service user before admission and if the crisis resolution team were involved** in the decision making process which resulted in an admission.
- An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made.
- The assessment may be made via a phone conversation or by any face-to-face contact with the patient.

* An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made.

** Involvement is where a patient is either offered an informal admission or an alternative to hospital admission: the latter means being treated in their own home environment with network support. This is always assessed with the patient and is based on ensuring adequate risk management without compromising their care/choice.
In the instances where a member of the crisis resolution home treatment team is not available and to ensure the clinical safety of a patient in crisis; an admission is also reported as gatekept where a qualified clinician (the Duty Doctor or Duty Senior Nurse) follows the agreed gatekeeping assessment 4 Qs model:

1. Is admission required?
2. Does the service user have a home?
3. Is it safe to treat the service user at his/her home?
4. Is the service user willing to be treated at home?

The outcome of the assessment is recorded on RiO and the crisis resolution home treatment team are informed of the decision.

Where the admission is from out of the trust area and where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas, the admission should only be recorded as gate kept if the CR team assured themselves that gatekeeping was carried out.

Oxleas policy is to assess all admissions to inpatient beds to ensure that such admission is in the best interest of the patient and manages relevant risks. As a result categories of patients excluded from this indicator as described in the Monitor guidance are also assessed although in practice gate keeping rarely takes place. Therefore the following exclusions, as defined for this indicator by Monitor, are not applied by the Trust:

- Patients recalled on Community Treatment Order should be excluded from the indicator.
- Patients transferred from another NHS hospital for psychiatric treatment should be excluded from the indicator.
- Internal transfers of service users between wards in the trust for psychiatry treatment should be excluded from the indicator.
- Patients on leave under Section 17 of the Mental Health Act should be excluded from the indicator.
- Planned admissions for psychiatric care from specialist units such as eating disorder unit are excluded.
Useful contact numbers:

Trust Secretary
Oxleas NHS Foundation Trust
Pinewood House
Pinewood Place
Dartford
Kent DA2 7WG

Email: anne.rozier@oxleas.nhs.uk
Tel: 01322 625700
Fax: 01322 555491

Patient Advice
and Liaison Service
If you require information, support or advice, please contact us free on:

Tel: 0800 917 7159

Trust membership
To become a member of Oxleas NHS Foundation Trust contact us on:

Tel: 0800 389 6642
Email: foundation.trust@oxleas.nhs.uk

or join online at www.oxleas.nhs.uk

Careers
For the latest information on vacancies at Oxleas, please visit our website at www.oxleas.nhs.uk

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