Oxleas NHS
NHS Foundation Trust

Quality Report

2011/12

improving lives

Contents

1 Statement by the Chief Executive

We are committed to improving continuously the quality of all the services that we provide. As you will see from this report, we have established great foundations to build on and we look to improve things further in 2012/13.

The improvements delivered over the last year and described in this quality report are indicative of the efforts put in by staff across the organisation. Thanks to their contribution, we have delivered achievements against priorities for improvement set out in our 2010/11 Quality Report and secured Commissioning for Quality and Innovation (CQUIN) income that was linked to a number of these priorities.

The Care Quality Commission (CQC) visited three of our locations during 2011/12: The Bracton Centre (specialist forensic inpatient service), Atlas House (adult learning disability service) and Kent Prisons (where we provide mental health in-reach services). The CQC reports confirmed that we met all 16 essential CQC standards of quality and safety in these services. The visit to Atlas House was undertaken as part of the national programme of 150 visits as a result of the concerns raised in the media in relation to patient welfare in learning disability services. Feedback from CQC visits and National Patient Surveys, where 77% of the respondents rated the care they received in the last year as good to excellent, help us to continue to improve the quality of services we deliver.

We have continued to undertake quarterly clinical quality meetings with our local business support units. These meetings provide an opportunity for our commissioners to monitor the quality of the services offered by reviewing information pertaining to the three quality domains of Patient Experience, Patient Safety and Clinical Effectiveness. We also meet regularly with our commissioners to jointly develop future quality targets.

We continue to promote and support the Productive Series: Releasing time to care, which was launched by the NHS Institute for Innovation and Improvement. It enables NHS teams to redesign and streamline the way they manage and work thereby achieving significant and lasting improvements, predominately in the extra time that can be given to patients, as well as improving the quality of care delivered whilst reducing costs.

The key to the success of the Productive Series is that clinicians work as a team and with patients drive improvements, by asking difficult questions about practice and making positive changes to the way they deliver care. The process promotes a continuous improvement culture leading to improved clinical care through releasing time for face to face care, reducing waste and improving staff morale.

Productive work began in Oxleas in January 2009 with three showcase wards on the Productive Mental Health Ward programme. Oxleas is now engaged in the Productive Mental Health (19 wards), Productive Community Hospital (two intermediate care wards) and Productive Community Services programmes (in community health services, learning disability and mental health teams). We plan to extend this programme to 30 wards and 100 community teams over the next two years.

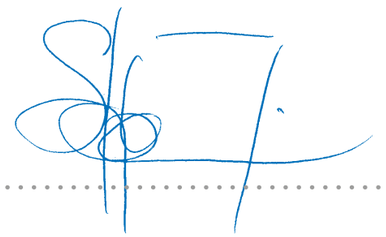
The Patient Experience Volunteer programme that uses the Oxleas Patient Experience Questionnaire to gather feedback from people using services has delivered over 1000 service user and carer interviews. The information gathered from these interviews is used to develop robust directorate quality improvement plans that will reflect what people who use our services would like to see improved. This volunteer programme is run by a dedicated group of service users, governors, carers and non-executive directors who have received training in questionnaire development and audit methodology to do this invaluable work. We have been asked to publish this work in the Health Service Journal and we look forward to sharing this innovative approach with the wider health economy.

We were delighted with the results of the recent National Staff Survey where staff rated us the best non-acute trust to work for in the country and the best of any kind of NHS trust in London and the South of England. Staff rated Oxleas in the top 20% for 28 out of the 38 areas covered in the survey. We received top scores nationally for any mental health or learning disability trust for staff feeling satisfied with the quality of work and patient care delivered and being able to contribute to improvements. These results are outstanding but we also recognise there are areas for improvement.

Last year, we identified a number of areas to improve and an account of how we did in these areas and our plans for 2012/2013 follows below. It includes piloting the 'Buddy Scheme' and our Care, Compassion and Engagement initiative, and strengthening our commitment to service users through their invaluable feedback.

In publishing this report the Board of Directors has reviewed its content and verified the accuracy of the details contained therein. I therefore confirm, in accordance with my statutory duty, that to the best of my knowledge, the information provided in this quality report is accurate.

Signed



29 May 2012

Stephen Firn, Chief Executive

2 Quality priorities set for 2011/12 and achievement against them

Our Quality Report will make reference to a number of acronyms and these have been detailed in the glossary at the end of this report (page 120) for ease of reference.

Our Quality Account last year identified 21 priority areas for 2011/12: 12 relating to mental health (MH) and learning disability (LD) services and nine to community health services. In this section, we will report what we achieved in these areas and how this has been done.

Where available, for comparison and evidence of progress, we have included data from previous years' quality reports, which includes results from published Prescribing Observatory for Mental Health (POMH) audits and national surveys. With the exception of national patient surveys, we utilise data held in our electronic patient record RiO, to measure achievement against the indicators.

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment and the national patient survey is one way the Care Quality Commission gets the opinion and experiences of people who have recently used local mental health services. The national patient survey does not set targets for achievement but does however show how each trust scored for each question in the survey, compared with the national average for that question. Using the National Patient Survey to judge our performance against our key indicators/targets demonstrates that with respect to:

- Staff listening carefully – we were in the top 20% of trusts;
- Given information about side effects of medication – we were in the mid range 60% of trusts;
- Being involved in care planning – we were in the mid range 60% of trusts;
- Being treated with respect and dignity – we were in the mid range 60% of trusts.

The tables following show our progress against the priority goals set out in the 2010/11 Quality Report covering the three quality domains of patient experience, patient safety and clinical effectiveness.

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

● Achieved

▲ Mostly Achieved

■ Not achieved

2.1 Patient experience - Mental health and learning disabilities - How have we performed?

Mental Health and Learning Disabilities Quality Priorities 2011/12

Quality Domain		Improvement Goal	08/09	09/10	10/11	11/12	Target Improvement 11/12
Patient experience	**Increasing support for families and carers**	To ensure that 60% of registered carers of service users on CPA* have been offered a carer's assessment as recorded from the March 2011 baseline.	284	469	631	841 (64%) (See 2.1.1) ●	284 (60%)
	Providing better information to patients and carers	To undertake a trust - wide inpatient experience survey with particular focus on information provided to patients admitted to our acute inpatient units who were:		2009 National Inpatient Survey	2010 CQUIN* Audit	2011 National Patient Survey	Patient experience survey to be completed showing increased number of patients compared to the 2009 national patient survey reporting that they have been: given information about side effects of medication; and involved in their care plan
		- Given information on side effects of medication		38%	82%	72% ●	
		- Involvement in care plan		66%	88%	86% ●	
	Enhancing assessment and care planning	To ensure that 95% of our service users have their care plans recorded on RiO*	98.60%	99.20%	98.70%	98.5% ●	95%
	Improving the way we relate to patients and carers	To improve the way we relate to our patients by improving our scores on patient surveys that ask questions about:			2009 National Inpatient Survey Baseline for 10/11	2011 National Patient Survey	To improve on our 2010/11 position
		- Listening			83%	Yes definitely 82% ● Yes to some extent 16%	
		- Respecting and being treated with dignity			88%	Yes definitely 86% ● Yes to some extent 13%	

**CPA – Care programme approach; RiO – Electronic patient record system; CQUIN – Commissioning for Quality and Innovation*

2.1.1 - Carers' Strategy

During the year, 2011/2012, we have undertaken further work that will help us to focus what we do next in continuing and increasing our support to families and carers.

Our carers lead has been pivotal in driving the importance of recording carers for patients on CPA onto our clinical system with current recording at 92.9%. We recognise that a carer's assessment is essential for identifying carers' needs, and providing information and support to carers. We have trained our staff to carry out carers' assessments and have measured implementation through monthly reports; this has helped support staff in identifying gaps in their recording and ensured they update the electronic patient record in a timely manner. As a result, we achieved this target by February 2012.

Our first Oxleas Carers' Strategy 2008 – 2011 focused on involving carers as partners in care; thus improving outcomes for people with mental illness or learning disabilities. We have made good progress against the objectives set out in the first strategy. Carer's support groups have been set up across all our inpatient mental health services, we have developed a range of carers' information packs and handbooks, and we have invested in the skills of our staff, through "Family Inclusive Practice" training. The Memory Service consultation checklist has now been updated to include the carers assessment and this initiative has been used as a helpful reminder to ask about caring responsibilities and offer carers assessment at the point of the consultation.

Since 2008, we have grown considerably and taken on community health services, this has been a key driver in developing a new strategy that includes carers of people who use our physical health services as well as mental health and learning disability services.

Our new strategy going forward will:

- Apply to everyone who receives services from Oxleas or works for Oxleas;
- Take forward the objectives set out in the Government's National Carers' Strategy published in 2010;
- Incorporate the guidelines provided by the Triangle of Care developed by the National Mental Health Development Unit and Princess Royal Trust for Carers.

It will cover the following key areas:

1 Recognising carers
2 Involving carers
3 Supporting carers
4 Informing carers
5 Developing staff to work with carers
6 Working in partnership.

As part of the strategy implementation, a trust wide Family and Carers Strategy Group has been formed to monitor progress. The group consists of representatives from local partners such as carers' centres, Oxleas service directorates and Oxleas governors and carers.

Each key area above will have an action plan highlighting the activities, person(s) responsible and planned completion dates. (Further detail can be obtained from our website: www.oxleas.nhs.uk).

2.1.2 - Care, Compassion and Engagement

In response to our quality goal of 'improving the way we relate to our patients and carers' we are launching a 'Care, Compassion and Engagement Initiative' in Adult Acute Services. This is because there are indications that there has been an improvement in process in how we collect information, but not in the experience of service users as evidenced by their feedback and common themes from incidents.

The evidence indicates that we need to empathise more with our service users and their carers, putting ourselves 'in their shoes'. We have termed this: Care, Compassion and Engagement and we aim to base the values of the care, compassion and engagement work on our four must do priorities:

- Support families and carers
- Provide information for service users and carers
- Improve care planning
- Improve relationships with service users and carers.

We want to ensure care, compassion and engagement is at the forefront of every aspect of our services.

The work on care, compassion and engagement will begin in four key areas:

1 Values in recruitment and practice

2 Co-designing services with service users and staff

3 Engagement with service users and carers, both in terms of ward activities and care planning

4 Complaints management.

The initial phase of the project will focus on the inpatient units as these areas currently receive the most complaints. The project will then focus on the community teams, home treatment crisis teams, intake and liaison teams, short intervention teams, day treatment and psychotherapy services.

2.2 Patient safety - Mental health and learning disabilities - How have we performed?

Mental Health and Learning Disabilities Quality Priorities 2011/12

Quality Domain		Improvement Goal	08/09	09/10	10/11	11/12	Target Improvement 11/12
Patient safety	**Monitor Target (National Definition)**	To follow up all patients on new CPA* discharged from hospital within 7 days	100%	100%	98.8%	97.9% March 2012 ● 96.5% (annual average) ● (See 2.2.1)	100% (Monitor* - target - 95%)
	Monitor Target (National Definition)	To follow up all patients admitted to hospital following self harm within 48 hours of discharge from an acute inpatient ward	100%	100%	100%	100% ●	100%
	Management of HCAI Infections (National Target)	To maintain our position of no incidences of MRSA* and CDiff* being acquired on our wards	1 C Diff 0 MRSA	0	0	2 CDiff ■ (See 2.2.2) 0 MRSA ●	0 (Up to 6)
	Safeguarding Children (National Target)	To maintain our position of 80% or more of our staff being trained in levels 1, 2 and 3 of safeguarding children (National Target)				Level 1 89% ● Level 2 92% ● Level 3 46% ● (See 2.2.3)	Level 1 80% Level 2 80% Level 3 80% (over 3 years) 2011/12 Trajectory Target 33%

**CPA – Care programme approach; MRSA - Methicillin Resistant Staphylococcus Aureus; CDiff – Clostridium Difficile; Monitor – is the foundation trust regulatory body that has set a target of 95% for all mental health foundation trusts in the country.*

2.2.1 - CPA discharge follow up

The Monitor (foundation trust regulatory body) threshold for this indicator is 95% and we have achieved against this target. There were 1,009 discharges of patients with complex needs who were therefore subject to the Care Programme Approach framework between 1 April 2011 and 31 March 2012 for whom a follow-up was required within seven days of discharge. There was documented evidence for 972 discharges in the clinical system that provided assurance of follow up. Thirty five patients were not followed up but in the majority of cases unsuccessful attempts were made within the seven days.

2.2.2 - Clostridium Difficile (CDiff)

Oxleas has no threshold set by Monitor against this indicator; however we do have an internal threshold of no more than six incidences per annum.

The target set for 2011/12 was to have no incidents but we recorded two cases. Both incidents were investigated and, in one case, the root cause analysis identified the use of antibiotics as the most likely cause. The antibiotics were prescribed appropriately and no action plan was required. In the second case, staff training in relation to the Clostridium Difficile policy and the general management of patients with diarrhoea was implemented.

2.2.3 - Safeguarding Children Training Level 3

In September 2011, Oxleas' Safeguarding Children Committee adopted the Intercollegiate Document (2010) training guidance, requiring all qualified mental health staff to undertake level 3 training. This increased the number requiring level 3 training from around 400 to 1,500 staff. More than 1,000 staff, who previously accessed level 2 e-learning now require face-to-face training. The committee therefore agreed a phased approach to achieving full level 3 compliance; the three year trajectory plan is illustrated below.

Baseline (October 2011 actual)	**Target Year 1** (October 2012)	**Target Year 2** (October 2013)	**Target Year 3** (October 2014)
25%	**more than 44%**	**more than 63%**	**more than 80%**

Based on the table above the end of March target was 33% and we achieved 53%.

Furthermore, the local safeguarding children boards (multi agency – police, education, local authority and health) expressed confidence in the effectiveness of our safeguarding arrangements as demonstrated by the Section 11 (Children's Act 2004) self-assessment audit.

2.3 Clinical effectiveness - Mental health and learning disabilities - How have we performed?

Mental Health and Learning Disabilities Quality Priorities 2011/12

Quality Domain		Improvement Goal	09/10	10/11	11/12	Target Improvement 11/12
Clinical effectiveness	**Waiting Times and Access**	To improve access to therapies by increasing the numbers of patients by 5% on the March baseline who are in receipt of psychological therapies.	3090	3149	3882 (Actual increase 17%) ●	3306 (Target increase 5%)
	Improving the physical health of our patients	To ensure 60% of our patients on inpatient wards and on CPA* are supported to have access to relevant physical health checks and/or screening		71.7% of patients on CPA (CQUIN*)	Inpatients 97.6% Community 65.4% ●	60%
	Improving practice in line with NICE Guidance (National Standard)	To improve the monitoring of patients prescribed Lithium according to NICE* audit standards by ensuring tests/measures are completed before initiating treatment with lithium and during maintenance of treatment (POMH* UK audit)	**Before Initiation tests** Std 1a: U&E* =82% Std 1b: TFT* =75% Std 1c: BMI* =43% **Maintenance Treatment Tests** Std 2a: Serum lithium =36% Std 2b: U&E =55% Std 2c: TFTs =53% Std 2e: BMI =32%	**Before Initiation tests** Std 1a: U&E =78% Std 1b: TFT =84% Std 1c: BMI =70% **Maintenance Treatment Tests** Std 2a: Serum lithium=28% Std 2b: U&E =54% Std 2c: TFTs =61% Std 2e: BMI =41%	**Before Initiation tests** Std 1a: U&E =67% ■ Std 1b: TFT =66% ■ Std 1c: BMI =46% ■ **Maintenance Treatment Tests** Std 2a: Serum lithium=35% ● Std 2b: U&E=62% ● Std 2c: TFTs=64% ● Std 2e: BMI=34% ■ (See 2.3.1)	To improve on our 2010/11 baseline position
	Improving practice in line with NICE Guidance (National Standard)	a. To ensure that for all children and adolescents prescribed antipsychotic medication the indication(s) for treatment with antipsychotic(s) are documented in the clinical records. b. To ensure that for all children and adolescents prescribed antipsychotic medication, the side effects are reviewed at least once every six months. POMH* Audit		Baseline Audit Sept 2010 100% 96%	Re- audit March 2012 100% ● 98% ●	To improve on our 2010/11 baseline position

**CPA – Care programme approach; CQUIN – Commissioning for Quality and Innovation; NICE – National Institute for Health and Clinical Excellence; POMH – Prescribing Observatory for Mental Health; U&E – Urea and Electrolytes; TFT –Thyroid Function Tests; BMI – Body Mass index*

2.3.1 - Lithium Audit

Lithium is an established and widely used medicine that is known to be effective in normalising mood in people with bipolar illness and in depression. Regular blood tests are needed to check that there is the correct amount of lithium in the blood, and that the kidneys and thyroid are working well. The National Institute for Health and Clinical Excellence (NICE) recommends that these tests are done but the National Patient Safety Agency (NPSA) has received reports of harm being caused to patients because the tests are not done. The NPSA therefore issued a patient safety alert to remind all doctors of the importance of conducting regular blood tests in all patients who take lithium. The NPSA alert can be found at:- http://www.nrls.npsa.nhs.uk/resources/?entryid45=65426

Oxleas has undertaken a number of initiatives to strengthen the 'monitoring of patients on lithium'; by ensuring our process for the monitoring of patients on lithium is as robust as possible, creating and maintaining a central record of all patients on lithium and by ensuring these patients are monitored in line with best practice. We have made significant inroads in establishing processes to support these patients since 2008 as outlined below.

At the time of the baseline audit (2008), it was quite challenging to identify a sample of patients prescribed lithium in our services, and to know what monitoring was taking place. Two major systems problems contributed to this: first, our electronic patient record does not have a dedicated section for medication that can be interrogated to produce reports, and second, many areas have no electronic access to pathology results and obtaining test results remains challenging. At that point we could identify 240 who were in contact with our services and prescribed lithium.

What we did

A great deal of effort was put into: (1) raising awareness of the standards for lithium monitoring in the NICE guideline for the treatment of bipolar disorder, and (2) presenting the audit results at team meetings to encourage teams to take ownership of the issues. We raised awareness of the NPSA purple lithium pack and encouraged teams to discuss the contents with their patients who were prescribed lithium. This pack became available just prior to re-audit.

At re-audit (2010), teams could more easily identify who was receiving treatment with lithium (approximately 320) but very little had changed with respect to the level of monitoring these patients received.

What we did

Our Medicines Management Committee (MMC) made two major decisions:

The first was that six monthly monitoring of serum lithium (rather than three monthly as required by NICE) seemed reasonable in adults who were physically healthy (the elderly require three monthly testing).

The second was that a trust wide lithium database would be developed and that this database would serve as both a live list of who is receiving treatment with lithium, and when their next biochemical tests are due. This has been achieved. We also agreed to facilitate real-time access to test results, and this is ongoing.

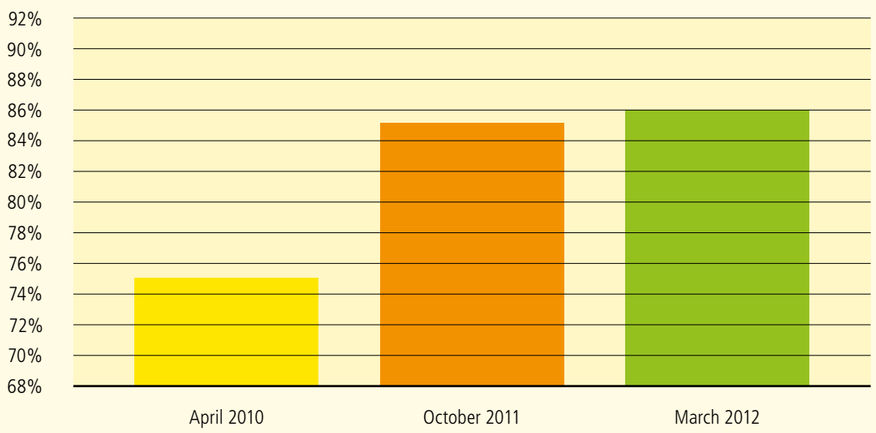
The most recent supplementary audit (2011), showed considerable progress has been made:

- First, we are reasonably confident that all patients who are in contact with us and are prescribed lithium are registered on the database. Currently the number is over 500.
- Second, we have made progress with respect to the six month standard for serum lithium tests agreed by the MMC with this standard met for 85% of patients.

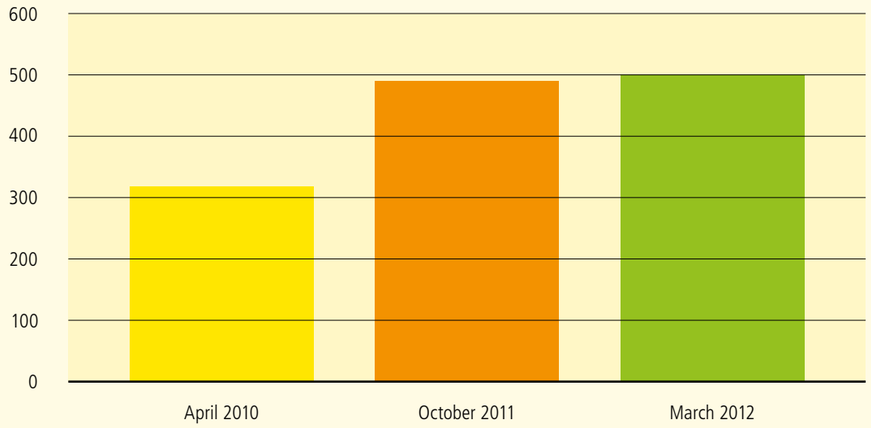
What we plan to do now

We will continue to use the lithium database to issue reminders that tests are due and are confident that, at the next audit in June 2013, we will meet our standard for at least 2 plasma lithium tests per year in 100% of patients.

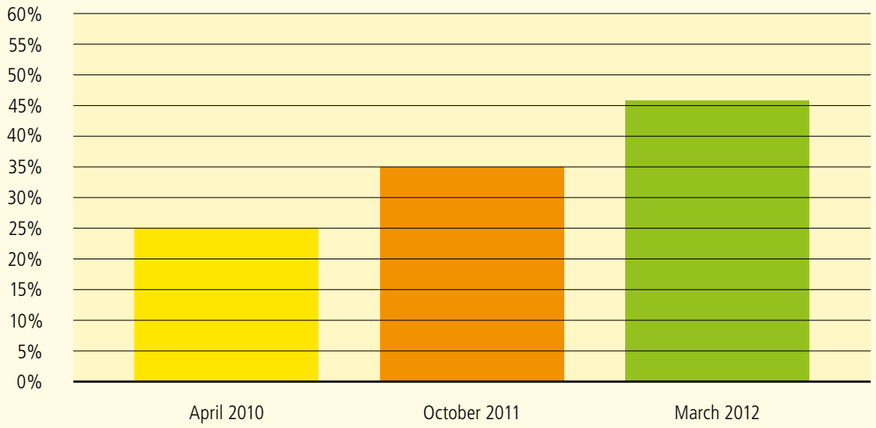
Proportion of patients who had a lithium test every 6 months



No of patients known to be prescribed lithium



Proportion of patients who had a lithium test every 3 months



2.4 Patient experience – Community health services - How have we performed?

Community Health Services Quality Priorities 2011/12

Quality Domain		Improvement Goal	09/10	10/11	11/12	Target Improvement 11/12
Patient experience	**Providing better information to service users & carers**	To improve the number of patients who say they have received enough information about their treatment and care		**Bexley** 45% **Greenwich** No current process in place	**Bexley** 83% ● **Greenwich** Bevan Unit 80% ● (See 2.4.1)	To improve on our 2010/11 baseline
	Enhancing assessment and care planning	To increase the number of patients who have a community care plan recorded within RiO* for our Long Term Conditions and Intermediate Care Teams. This is also a CQUIN*		**Bexley** Rehab 79% Podiatry 100% Specialist Nursing 96% Speech & Language Therapy 86% Step Up Step Down 80% District Nursing 50%	**Bexley** Long Term Conditions Teams 87% ● District Nursing 15% ■ (See 2.4.2)	Bexley - Maintain community Long Term Condition teams achievements and reach a target for district nursing
				Greenwich No baseline	**Greenwich** Long Term Conditions teams 90% ● Intermediate Care 100% ●	Greenwich – Long Term Conditions and Intermediate Care Teams = 50%

RiO – Electronic patient record system; CQUIN – Commissioning for Quality and Innovation

2.4.1 - Patient experience - Extension to Greenwich Community Health Services

As part of the integration of Greenwich Community Health Services, our goal was to ensure that patient experience surveys capture information that will help us to measure 'number of patients who say they have received enough information about their treatment and care'. The Patient Experience Tracker, the real-time feedback system is now in place in the Bevan Unit, and has provided positive results as shown above.

2.4.2 - Bexley Community Nursing Care Planning

We have had an extensive roll out programme to ensure all teams record all clinical information in our electronic patient record system. The implementation was completed in December 2011 and district nursing teams were included in this last phase. The electronic patient record system is located at Oxleas' sites which mean our district nurses have to, following home visits, return to base to record the information. New ways of working and new technologies are being explored to support staff in the recording of this in the future. The migration from paper records to electronic recording has been a challenge but there is an on-going commitment to continue to embed electronic record keeping in our community health services.

2.5 Patient safety – Community health services - How have we performed

Community Health Services Quality Priorities 2011/12

Quality Domain		Improvement Goal	09/10	10/11	11/12	Target Improvement 11/12
Patient safety	**To increase child immunisations**	To ensure 90% of consenting girls aged 12-13 attending Greenwich or Bexley schools are immunised for HPV*		**Bexley** 11/12 First year **Greenwich** HPV1 93% HPV2 90% HPV3 80%	**Bexley** HPV1 91% HPV2 83% HPV3 42% ■ **Greenwich** HPV1 99% HPV2 97% HPV3 37% ■ (See 2.5.1)	90%
	Management of HCAI Infections (National Target)	To maintain our position of no incidences of MRSA* and CDiff* being acquired on our wards		0	0 ●	Maintain no incidences
	Safeguarding Children (National Target)	To maintain a position of 80% or more of our staff being trained in levels 1, 2 and 3 of safeguarding children		**Bexley** 84.44% **Greenwich** 95%	**Bexley** 83% ● **Greenwich** 91% ●	Level 1 = 80%
				Bexley 70.7% **Greenwich** 97%	**Bexley** 85% ● **Greenwich** 90% ●	Level 2 = 80%
				Bexley 71.59% **Greenwich** 82%	**Bexley** 84% ● **Greenwich** 81% ●	Level 3 = 80%
Patient safety	**Pressure Ulcers (National Standard)**	To work towards a 75% reduction of grade 2 and 3 pressure ulcers and a reduction of 95% of grade 4 ulcers from June 2011 baseline		**Grade 2** Baseline 152	**Grade 2** Actual 122 ■	**Grade 2** - 75% reduction from baseline – **no more than 38**
				Grade 3 Baseline 76	**Grade 3** Actual 44 ■	**Grade 3** - 75% reduction from baseline – **no more than 19**
				Grade 4 Baseline 8	**Grade 4** Baseline 5 ■ (See 2.5.2)	**Grade 4** – 95% reduction from baseline – **no more than 0**

HPV - Human Papilloma Virus; MRSA - Methicillin Resistant Staphylococcus Aureus; CDiff – Clostridium Difficile

2.5.1 – HPV - Human Papilloma Virus

HPV immunisations take place over an academic year and require each female in the school year 8 cohort (aged 12-13) to have had a course of three doses. Data for this indicator shows low uptake of the third dose; the child is only eligible to have the next dose if the previous one has been administered (i.e. dose two can only be given if dose one has been given). We will continue to monitor this quality goal in 12/13.

2.5.2 - Pressure Ulcers and Root Cause Analysis

Community health services commissioners set this indicator as a CQUIN goal for 2011/12, to measure reductions in the number of incidences of pressure ulcers against a defined baseline. This measurement was only applicable to those that developed in our services whilst patients were in our care. It was accepted that this aspect of the indicator was not a true representation of quality. The key focus was to ensure the 'root cause analysis' were undertaken (specifically for those assigned a clinical grading of 3 or 4) to understand what needs to be done differently and to embed the learning from these investigations by putting in action plans to reflect the recommendations and thereby avoid onset/improve the care. Root cause analyses are undertaken and learning from these is shared with commissioners.

The monitoring of pressure ulcers will continue as part of our Quality and Safety Improvement Plan and will remain a focus of the 'Harm Free Care' national patient safety agenda. It aims to deliver harm free care to each and every patient cared for in the NHS. In particular it will eliminate harm from pressure ulcers, falls, urinary catheter infections and venous thromboembolism.

2.6 Clinical effectiveness – Community health services - How have we performed?

Community Health Services Quality Priorities 2011/12

Quality Domain	Quality Domain	Improvement Goal	09/10	10/11	11/12	Target Improvement 11/12
Clinical effectiveness	**Improving practice in line with NICE Guidance (National Standard)**	To undertake an audit across our community health services to assess compliance with NICE* guidance on diabetes care.			Baseline Year Achieved 4 of the 5 standards at 95% ▲ (Target 95%) (See 2.6.1)	Undertake audit in line with NICE standards
	Improving practice in line with NICE Guidance (National Standard)	To improve wound care assessment and planning by ensuring 80% of patients presenting with leg ulcerations receive a Doppler assessment within two weeks of a referral to our services.		Bexley 50% of patients Greenwich 11/12 first year of reporting	**Bexley** 45% ■ **Greenwich** 50% ■ (See 2.8.2)	80%
	Screening	To ensure all young people who attend our contraceptive and sexual health services are offered Chlamydia screening kits.			97% ▲	100%

NICE – National Institute for Health and Clinical Excellence

2.6.1 - Diabetes Audit

The purpose of this audit was to measure the care of diabetes patients in Greenwich and Bexley community health services against standards set in National Institute for Health Clinical Excellence (NICE) Guideline 87. Many of the audit criteria in the NICE guidelines related to data held by GPs and it was therefore difficult to access. The data in this audit is taken from data collected as part of Quality and Outcomes Framework (QOF) and is available from the NHS Information Centre website.

The audit measured the number of diabetes patients who had recorded measurements relating to five key indicators. Both Bexley and Greenwich community health services achieved at least 95% (the audit standard) against four of these areas, with the exception of micro-albuminuria testing.

Measurement	Audit standard	BCHS	Achieved?	GCHS	Achieved?
BMI recorded	95%	96%	**Yes**	96%	**Yes**
HbA1c recorded	95%	97%	**Yes**	96%	**Yes**
BP recorded	95%	98%	**Yes**	98%	**Yes**
Micro-albuminuria testing	95%	88%	No	87%	No
Cholesterol recorded	95%	96%	**Yes**	95%	**Yes**

Oxleas will be participating in the two national diabetes audits, which will cover both adult and children.

2.6.2 - Doppler Assessment Audit

This audit demonstrated that we did not achieve the goal set which was to ensure that '80% of patients presenting with a leg ulcer receive a Doppler assessment within two weeks of referral'. In light of this performance, this goal will be carried forward to 2012/13.

2.7 Quality Priorities for Improvement in 2012/13

This section of the report will set out the rationale for the selection of the priorities agreed by the Oxleas Board to improve the quality of care of our services in 2012/13. These will continue to cover mental health and learning disabilities, community health services and now include prison mental health services.

We utilised a number of sources to help determine the quality priorities for 2012/13. In January and February 2012, as in previous years, we held three borough based (Bexley, Bromley and Greenwich) focus groups to ensure:

We give feedback on how we are progressing in delivering the priorities set out for 2011/12;

and

Give our stakeholders (staff, patients, carers, our members, the wider public and local primary care trusts) an opportunity to comment on the areas we needed to focus on in the coming year.

The key themes for improvement in 2012/13 reinforced the need to continue to work on our four must do priorities:

- 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.

Our compliance framework, patient experience surveys and incident reporting have also contributed to this process and during the year there has been engagement via service user groups, our Council of Governors, health commissioners (via quality meetings), local involvement networks and overview and scrutiny committees.

In summary, our Quality Board (a sub group of our Governance Board) on the 30 March 2012 agreed that the priorities for 2012/13 should be those that recognise one or more of the following key aspects:

- Link to our four must do priorities (see above)
- Are defined by Monitor as key quality indicators
- Are subsets of the Commissioning for Quality and Innovation goals agreed with commissioners
- Link to current priorities where trend data is available to measure improvement year on year.

Our quality priorities for the coming year reflect the make-up of the organisation:

- Mental health and learning disabilities
- Community health services
- Prison mental health services.

2.7.1 - Mental Health and Learning Disabilities Services Quality Improvement Priorities for 2012/13 - Measuring, Monitoring and Reporting

The following three tables set out the quality priorities for mental health and learning disabilities services in the three quality domains of patient experience, patient safety and clinical effectiveness.

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
Patient experience	**Increasing support for families and carers** **Trust MUST DO** To ensure that 60% of registered carers of service users on CPA* have been offered a carer's assessment as recorded from the March 2012 baseline.	841	967 (as at 31/03/2012 there were 1612 registered carers of patients on CPA)	This will continue to be a Key Performance Indicator and reported on the QSIP* This is reported on a monthly basis to Trust Executive and will be monitored quarterly by the Trust Quality Board
	Providing better information to service users and carers **Trust MUST DO** To undertake a trust-wide inpatient experience survey with particular focus on information provided to patients admitted to our acute inpatient units who were - - Given information on side effects of medication - Involvement in care plan	 72% 86%	Increased number of patients compared to the 2011 national patient survey	Conduct inpatient audit to be presented to Trust Quality Board and actions implemented by the identified inpatient wards One-off report
	Enhancing assessment and care planning **Trust MUST Do** To ensure that 95% of our service users have their care plans recorded on RiO*	98.5%	95%	This will continue to be a Key Performance Indicator and reported on the QSIP*. This is reported on a monthly basis to Trust Executive and will be monitored quarterly by the Trust Quality Board
	Improving the way we relate to patients and carers **Trust MUST DO** To improve the way we relate to our patients by improving our scores on patient surveys that ask questions about - - Listening - Respecting and being treated with dignity	98% 99%	To improve on our 2011/12 position	Conduct National Patient Survey to be presented to Trust Quality Board and actions implemented by the identified inpatient wards One-off report

**CPA – Care programme approach; RiO – Electronic patient record system; QSIP – Quality and Safety Improvement Plan*

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
Patient safety	**MONITOR target (National Definition)** To follow up all patients on new CPA* discharged from hospital within 7 days	97.9	100%	These will continue to be a Key Performance Indicator This is reported on a monthly basis to Trust Executive and will be monitored quarterly by the Trust Quality Board and bi-monthly by the Patient Safety Group
	MONITOR target (National Definition) To follow up all patients admitted to hospital following self harm within 48 hours of discharge from an acute inpatient ward	100%	100%	
	MONITOR target (National Definition) To maintain our position of no incidences of MRSA* and CDiff* being acquired on our wards	2 CDiff 0 MRSA	Threshold of up to 6 incidences of CDiff 0 incidences of MRSA	
	Oxleas Priority (National Target) To maintain our position of 80% or more of our staff being trained in levels 1, 2 and 3 of safeguarding children (National Target)	Level 1 89% Level 2 92% Level 3 46%	Level 1 and 2 > 80% To ensure 3 year trajectory to achieve 80% staff trained for Level 3 maintained	

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
Clinical effectiveness	**Waiting Times and Access – Oxleas priority** To improve access to therapies by increasing the numbers of patients by 5% on the March baseline who are in receipt of psychological therapies.	3882	5% increase on March 12 baseline 4076	This will continue to be a Key Performance Indicator. This is reported on a monthly basis to our Executive and will be monitored quarterly by the Quality Board and quarterly by the Psychological Therapies Board
	Improving the Physical Health of our patients – **CQUIN*** To ensure 75% of patients on our inpatient wards and on CPA* are supported to have access to relevant physical health checks and/ or screening	Inpatients 97.6% Community 65.4%	75%	This continues to be a CQUIN goal for 12/13 and will be monitored quarterly by the Oxleas Quality Board and quarterly by PCT Commissioners, and also reported on a monthly basis to the Trust Executive. This is also a CQUIN goal
	Improving practice in line with NICE* Guidance - **CQUIN*** Screening for metabolic side effects of antipsychotic drugs		Set Baseline	This will be measured through a re-audit and monitored by Oxleas Clinical Effectiveness Group with recommendations and action plans implemented. This is also a CQUIN goal One-off report
	Improving practice in line with NICE Guidance - (National Standard) **CQUIN*** Prescribing antipsychotic for people with dementia	Baseline 10/11 results **Less than 3 months** Std 1 > =95% Std 2 > =95% Std 3 > 39% Std 4 50% **More than 6 months** Std 1 > =95% Std 5a &b > =75%	To improve on results 10/11 of audit	This will be measured through a re-audit and monitored by the Oxleas Clinical Effectiveness Group with recommendations and action plans implemented. This is also a CQUIN goal One-off report

**CPA – Care programme approach; MRSA - Methicillin Resistant Staphylococcus Aureus; CDiff – Clostridium Difficile; CQUIN – Commissioning for Quality and Innovation; NICE – National Institute for Health and Clinical Excellence*

2.7.2 - Community Health Services Quality Improvement Priorities for 2012/13 - Measuring, Monitoring and Reporting

The following three tables set out the quality priorities for community health services against the three quality domains of patient experience, patient safety and clinical effectiveness.

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
Patient experience	**Providing better information to patients & carers** **Trust MUST Do** To improve the number of patients who say they have received enough information about their treatment and care	**Bexley** Step-up Step-down 86% Urgent Care Centre 72% **Greenwich** Bevan Unit 80%	Broaden reach to improve population coverage	This will be measured through patient experience surveys and monitored bi-monthly by Oxleas Patient Experience Group and quarterly by the Quality Board
	Enhancing assessment and care planning **Trust MUST Do** To increase the number of patients who have a community care plan recorded within RiO (the Trust clinical information system) for Long-term Conditions teams and District Nursing	**Bexley** Long term conditions 87% District nurses 15% **Greenwich** Long term conditions 90% District nurses New Target	**Bexley** Long term conditions - 90% District nurses - 40% (End of Life Care pathways) **Greenwich** Maintain Long term conditions - 90% District nurses - 50%	This will be monitored on quarterly basis by the Oxleas Quality Board and will be reported on a quarterly basis to Bexley community health services Commissioners

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
Patient safety	**Oxleas priority** To ensure 80% of consenting girls aged 12-13 attending Greenwich or Bexley schools are immunised for HPV*	**Bexley** HPV1 91% HPV2 83% HPV 3 42% **Greenwich** HPV1 99% HPV2 97% HPV 3 37%	80%	This will be reported and monitored by the community services monthly local Quality Board
	MONITOR target (National Definition) To maintain our position of no incidences of MRSA* and CDiff* being acquired on our wards	**Bexley** 0 **Greenwich** 0	Threshold < = 6	This is reported on a monthly basis to Trust Executive and will be monitored quarterly by the Oxleas Quality Board and bi-monthly by the Patient Safety Group
	CQUIN* (National Definition) To ensure data is collected and submitted into the National Safety Thermometer (Harm Free Care Strategy)	12/13 first year of reporting	Ensure complete and timely submissions for Bexley and Greenwich Community Services (see below)	This is reported on a monthly basis to Trust Executive and will be monitored quarterly by the Oxleas Quality Board and bi-monthly by the Patient Safety Group This is a CQUIN goal and will be reported on a quarterly basis to Community Health Services Commissioners (CQUIN*)
	Oxleas priority (National Target) To maintain a position of 80% or more of our staff being trained in levels 1, 2 and 3 of safeguarding children	Level 1 Bexley 83% Greenwich 91% Level 2 Bexley 85% Greenwich 90% Level 3 Bexley 84% Greenwich 81%	80%	These will continue to be a Key Performance Indicator This is reported on a monthly basis to Trust Executive and will be monitored quarterly by the Oxleas Quality Board and bi-monthly by the Patient Safety Group

HPV - Human Papilloma Virus; MRSA - Methicillin Resistant Staphylococcus Aureus; CDiff – Clostridium Difficile ;CQUIN – Commissioning for Quality and Innovation

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
Clinical Effectiveness	**National audit (National Standard)** Audit of Intermediate Care	12/13 First year of reporting	Set baseline	This will be measured through the results of the audit and monitored by the Trust Clinical Effectiveness Group with recommendations and action plans implemented One off report
	National audit (National Standard) To undertake the HQIP* Diabetes audit across Community Health Services to assess compliance with NICE* guidance.	New National Audit	Undertake audit in line with NICE guidance	
	Oxleas priority To improve wound care assessment and planning by ensuring 80% of presenting with leg ulcerations receive a Doppler assessment within 2 weeks of a referral to our services	Bexley 45% Greenwich 50%	80%	
	Oxleas priority To ensure all young people who attend our Contraceptive and Sexual Health Service are offered Chlamydia screening kits	97%	100%	

NICE – National Institute for Health and Clinical Excellence; HQIP – Health Quality Improvement Programme

2.7.3 - Prison Health Services Quality Improvement Priorities for 2012/13 - Measuring, Monitoring and Reporting

The following table sets out the quality priorities for prison mental health services against the three quality domains of patient experience, patient safety and clinical effectiveness.

Patient experience

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
	CQUIN* Service User defined CPA standards	12/13 First Year of reporting	Set baseline for Improvement	Annual Prison CPA to be undertaken against standards as defined in the Kent Prison MH Services CQUIN Goal Reviewed in Clinical Governance structure in prisons, update to Commissioners at quarterly review meeting and reported at Trust Quality Board

Patient safety

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
	CQUIN* Discharge planning and supporting release / intra prison transfer / transfer back to wing from inpatients	12/13 First Year of reporting	Put process in place	Audit of clinical records to pick up effective discharge planning/linking with other prison and links with prison officers One off report

Clinical effectivness

Quality Domain	Improvement Goal	11/12	Target Improvement 12/13	How will we monitor and measure and report progress?
	Oxleas priority No of Triage assessments	12/13 First Year of reporting	Set baseline for 11/12 and demonstrate 10% improvement	Monthly reporting to commissioners, and Oxleas Quality Board

CQUIN – Commissioning for Quality and Innovation

2.8 Statements of Assurance from the Board

2.8.1 - Review of Services

During 2011/12, Oxleas NHS Foundation Trust provided and/or sub-contracted seven NHS services covering the following service lines:

- Adult mental health (inpatient and community)
- Older peoples mental health (inpatient and community)
- Adult learning disabilities
- Children and adolescent mental health
- Specialist forensic mental health
- Mental health in-reach into prison
- Community health.

Mental health and adult learning disability services are provided across the boroughs of Bexley, Bromley and Greenwich. In addition, specialist forensic services also cover the boroughs of Lewisham and Sutton and Merton. Mental health in-reach is provided to Kent Prisons only and, with effect from 1 April 2011, Oxleas started to provide community health services to Greenwich building on the community services already delivered in Bexley.

Oxleas NHS Foundation Trust has reviewed all the data available to them on the quality of care in seven of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 100 percent of the total income generated from the provision of NHS services by Oxleas NHS Foundation Trust for 2011/12.

The data used to review the priorities for 2011/12 covering the three quality domains of patient experience, patient safety and clinical effectiveness was not impeded by data availability.

2.8.2 - Participation in Clinical Audits

During 2011/12 eight national clinical audits and 21 national confidential enquiries covered NHS services that Oxleas NHS Foundation Trust provides.

During 2011/12 Oxleas NHS Foundation Trust participated in 89% of national clinical audits and 100% of 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 that Oxleas NHS Foundation Trust was eligible to participate in during 2011/12 are recorded in the table below.

The national clinical audits and national confidential enquiries that Oxleas NHS Foundation Trust participated in during 2011/12, are also included in the table opposite.

The national clinical audits and national confidential enquiries that Oxleas NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, 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.

No.	National Clinical Audits (2011/12)	Participation Yes/ No	Number of cases submitted	% of cases submitted
1	National Audit of Schizophrenia (Royal College of Psychiatrists)	Yes	102	100%
2	National Audit of Continence Care (Royal College of Physicians) - PILOT	Yes	20	100%
3	Monitoring of patients prescribed lithium POMH* UK Audit - Topic 7	Yes	172	N/A
4	Prescribing antipsychotics for people with Dementia POMH UK audit – Topic 11	Yes	359	N/A
5	Assessment of side effects of depot antipsychotic medication POMH UK Audit – Topic 6	Yes	439	N/A
6	Use of antipsychotics in Child and Adolescent Mental Health Services POMH UK Audit – Topic 10	Yes	72	N/A
7	Prescribing high dose and combined anti-psychotics on adult acute and Psychiatric Intensive Care Unit wards POMH UK Audit – Topic 1	Yes	195	N/A
8	* Prescribing of high dose antipsychotics on forensic wards POMH UK Audit – Topic 3	No		
9	Falls and Bone Health – Royal College of Physicians	Yes	20	50%
	National Enquiries (2011/12)	**Participation Yes/ No**	**Number of cases submitted**	**% of cases submitted**
10	National Confidential Inquiry into Suicide and Homicide	Yes	21	100%

POMH – Prescribing Observatory for Mental Health

Note: The trust participated in the National Audit of Psychological Therapies for Depression and Anxiety and this was reported in the 2010/11 Quality Accounts.

Note: N/A mean 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%.

** The organisation made a decision that this audit was not a priority (Prescribing of high dose and antipsychotics on forensic wards). The trust will be focusing on the 2012/13 POMH audit 'Prescribing for people with borderline personality disorder'.*

Oxleas 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 four national clinical audits were reviewed by the provider in 2011/12 and Oxleas NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. These audits were reviewed at the Clinical Effectiveness Group (a sub group of the Trust Quality Board) where the action plans were agreed. These action plans were then disseminated to the local Directorate Clinical Effectiveness Groups for implementation. The key actions for the reports reviewed in 2011/12 were:

Prescribing Observatory for Mental Health – Monitoring of patients prescribed lithium *Key action – To continue the use of the lithium database to ensure robust and consistent monitoring of at least 2 plasma lithium tests per year in 100% of patients.*

Prescribing Observatory for Mental Health – Prescribing antipsychotics for people with Dementia
Key action: – To institute a protocol to ensure that all patients with dementia prescribed an antipsychotic have a three monthly medication review as recommended by the National Institute for Health and Clinical Excellence best practice guidance.

Prescribing Observatory for Mental Health - Assessment of side effects of depot antipsychotic medication
Key action: –To ensure regular monitoring of side effects of depot medication and improve quality of documentation of such side effects.

Prescribing Observatory for Mental Health - Use of antipsychotics in Child and Adolescent Mental Health Services
Key action: To regularly measure and record levels of blood glucose, plasma lipids and plasma prolactin for all children and adolescents who are prescribed anti-psychotics

One report was published in April 2012, this will be reviewed at the next Clinical Effectiveness Group (June 2012), and we await the publication of the remaining three.

The reports of 75 local clinical audits were reviewed by the provider in 2011/12 and Oxleas NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. These were reviewed by the trustwide / local directorate Clinical Effectiveness Groups. 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 key audit undertaken is the annual 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. The key areas which required further improvements were:

- Evidencing patient engagement and participation in care planning.
- Ensuring patients with any form of disabilities have equal access to healthcare and that reasonable adjustments are made to ensure they are able to fully engage with the services they receive.

Key action: – To deliver care-planning workshops reiterating the importance of the above and using this forum to develop a focused mandatory e-learning package for all mental health clinicians.

A clear process has been put in place to improve the quality of the healthcare provided to our patients through monitoring 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 and Audit Team
Oxleas NHS Foundation Trust
Pinewood House
Pinewood Place
Dartford
Kent

DA2 7WG
Tel: 01322 625759

2.8.3 - Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by Oxleas NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 279, which represents a 34% increase on the previous year.

19 national research studies were hosted by the trust in this period, together with 36 local research studies, 17 local quality improvement projects and 34 local service evaluation projects.

Participation in clinical research demonstrates Oxleas' commitment to improving the quality of care we offer and to making our contribution to wider health improvement. It further ensures that our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

We are a member of the National Institute of Health Research (NIHR) London South Comprehensive Local Research Network (CLRN) and the Mental Health Research Network (MHRN). We work 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 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 from its website.

Research activity is supported by a full time Research and Knowledge Manager funded by the Comprehensive Local Research Network. The 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 based at the trust and assist with study feasibility and setup, recruitment screening and follow-ups. The ongoing development of the infrastructure required for successfully hosting national research studies has contributed greatly to the vastly reduced study approval time and continued increase in recruitment and the overall number of studies hosted. Oxleas has worked hard in providing an environment conducive for research is evidenced by its Research and Knowledge Manager being awarded the Mental Health Research Network (MHRN) Associate Award 2012 in recognition of the significant contribution made by the trust in supporting mental health and learning disability research in South London and Southern England.

Research and Development income for 2011/12 totalled £193,915.

Details of research studies are available from:

Knowledge and Research Manager
Oxleas NHS Foundation Trust
Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG
Tel: 01322 625759

2.8.4 - Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of the Oxleas NHS Foundation Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between Oxleas NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online electronically at: http://www.monitor-nhsft.gov.uk/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275, alternatively you can contact the following:

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

Our total income conditional on achieving all the quality improvement and innovation goals was £2,319,790. The assumed associated payment dependant on confirmation from the primary care trusts on achieving the goals set by the end of March 2012 is £2,016,192.

Development of 2012-13 Commissioning for Quality and Innovation Schedule

The focus areas for the 2012/13 CQUIN schemes are in response to national and regional suggestions and joint discussion between with our commissioners about areas for improvement across our services. Some CQUINs will be embedded into services beyond 2013 in order to ensure quality gains are sustained in these areas, alongside an agreement of more joint working across a range of agencies to promote and engage appropriate stakeholders with the CQUIN initiatives.

For the coming year, 2012/13, income linked to Commissioning for Quality and Innovation goals will increase from 1.5% to 2.5%, £3,933,000, and this will be generated upon demonstrating achievement against the following headline themes:

Mental health and learning disabilities

- Improve the physical health of patients with mental health problems and practice good communication (continuation and extension to 2011/12 goals)
- Improve information to inform future clinical commissioning priorities (continuation of 2011/12 goal)
- Strengthen the ongoing local assurance regarding safeguarding children
- Improve dementia care
- Review and ensure vulnerable adults are receiving fair access to mental health services
- Screening for metabolic side effects of antipsychotic drugs.

Bexley community health services

- Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and venous thromboembolism (Harm Free Care)
- Improve access to care plans (continuation and extension to 2011/12 goal)
- Urinary tract infections management and prevention as a result of a catheter
- Falls management and prevention
- Improve physical health - smoking cessation (continuation and extension of 2011/12 goal).

Prison mental health services

- Improve links between prison officers and mental health services – to lead to a better understanding of mental health issues, reduce stigma and improve access to services
- Service user defined care programme approach standards implemented
- Discharge planning and support.

Greenwich community health services

- Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and venous thromboembolism (Harm Free Care)
- Strengthen the ongoing local assurance regarding safeguarding children
- To implement a robust quality governance reporting process
- Improve physical health - support smokers who access chronic obstructive pulmonary disease services to quit smoking
- 'Healthy Child Programme' needs assessment and progress against 'Health Visitor Implementation Plan 2011-2015'.

Greenwich improving access to psychological therapies

CQUIN goal/(s) for this service will be agreed over the coming months.

2.8.5 - Care Quality Commission (CQC)

Oxleas NHS Foundation Trust 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 NHS Foundation Trust during 2011/12.

Oxleas NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12: our residential service for people with learning disabilities, Atlas House. This was one of the 150 services inspected by the Care Quality Commission (CQC) as part of their targeted programme of unannounced inspections of hospitals and care homes that care for people with learning disabilities. Atlas House was found to be fully compliant with the reviewed standards.

Oxleas NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission: the national report into the Care Quality Commission's findings from the programme of visits will be published later in 2012. The trust will take action as appropriate, based on the recommendations of the national report, to address the conclusions or requirements reported by the Care Quality Commission. Oxleas NHS Foundation Trust has made the following progress by 31 March 2012 in taking such action: no action plan is in place as the trust is awaiting the publication of the national Care Quality Commission report.

2.8.6 - Data Quality

Oxleas NHS Foundation Trust submitted records during 2011/12 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:

- which included the patient's valid NHS Number was: 99.1% for admitted patient care; 99.6% for outpatient care; and 0% for accident and emergency care*.
- which included the patient's valid General Medical Practice Code Code was: 100% for admitted patient care; 100% for outpatient care; and 0% for accident and emergency care*.

* Oxleas does not submit data in relation to accident and emergency care as this is an acute trust indicator.

2.8.7 - Information Governance Toolkit Attainment levels 2011/12

Oxleas NHS Foundation Trust Information Governance Assessment Report overall score for 2011/12 was 76% and was graded 'Red'. This was due to us attaining two Level 1 scores for clinical coding.

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

- To improve our level of attainment on secondary clinical coding diagnosis, we have revised clinical practice to ensure clinicians code appropriately at discharge;
- The new clinical director for clinical informatics will host 'Train the Trainer' clinical coding awareness sessions to ensure all clinicians can code effectively and improve data quality.

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

3 Other information

3.1 - An overview of the quality of care based on performance against indicators set for 2011/12

The priority areas were agreed by our Board and took into account the views of our stakeholders to improve the quality of our services in 2011/12. We identified these by working in partnership with staff, patients, carers, the wider public, our members and the local primary care trusts. Public focus forums in the local boroughs of Bexley, Bromley and Greenwich were held to gain input on how we could improve the quality of our services for 2011/12. The feedback was summarised into nine themes: service users, partners, staff, carers, social inclusion, therapies, child and adolescent mental health, health promotion and data and new techniques.

By listening to our stakeholders, we put together the quality improvement goals for the trust, broken down into the three quality domains or patient experience, patient safety and clinical effectiveness. In addition some of the areas of focus were included in the quality priorities; however others were included in our targeted internal quality improvement initiatives and progress was reviewed through the quality sub groups aligned to the three quality domains.

The quality priorities chosen for 2010/11 were not completely replicated in 2011/2012, we undertake an annual priority setting process which reviews how things have gone and gives consideration to any new information that may be forthcoming from the stakeholder engagement focus groups, Commissioning for Quality payment framework or other sources such as new mandatory quality targets.

The table below sets out the 2010/11 quality priorities, mapping whether these were continued into 2011/12 and providing an explanation as appropriate:

	Quality Priority 2010/2011	2011/12
Patient Experience	To increase the number of carers of patients on care programme approach who have been offered a carer's assessment by 50%	Continued quality priority for 2011/12 with an increase in target to 60%
Patient Experience	To report on patient experience feedback with a particular focus on information provided to patients admitted to our acute inpatients units who were given information about side effected of their medication	Continued quality priority for 2011/12 with an additional focus on 'Involvement in care planning'
Patient Experience	To continue our focus on increasing the % of patients on new care programme approach with a crisis plan	Replaced by focus on evidence of Care Planning on electronic clinical system. Crisis plan monitoring was moved onto the internal Quality Safety Improvement Plan. The trust set a target of 95% and achieved 95.7%
Patient Experience	To reduce the number of complaints received relating to staff attitude	The Patient Experience Group now reviews this. The total number of complaints highlighting this as an issue dropped to 48 on like for like basis (this excludes Greenwich Community Health Services as responsibility for these services did not transfer to Oxleas until 1 April 2011
Patient Safety	To provide an appropriate ward within the trust for emergency admissions of 16-17 year olds	An age appropriate bed base has been established
Patient Safety	To follow-up all patients on new care programme approach discharged from hospital within 7 days	Continued quality priority for 2011/12
Patient Safety	To follow up all patients admitted to hospital following self harm within 48 hours of discharge from an acute inpatient ward	Continued quality priority for 2011/12
Patient Safety	To identify patients who are 17 years of age and confirm support arrangements are in place at age of 18 To ensure that all identified 17 year olds who need to be transferred to adult mental health services have had a transfer care programme approach	This has been monitored on the Quality Safety Improvement Plan during 2011/12

	Quality Priority 2010/2011	2011/12
Clinical Effectiveness	Compliance with National Institute for Health and Clinical Excellence guidelines for schizophrenia and bipolar disorder	This was a Commissioning for Quality and Innovation framework goal in 2010/11. In 2010/11 this was covered by the national Prescribing Observatory for Mental Health UK audit 'Screening for metabolic side-effects of antipsychotic drugs' and demonstrated improvements in all 5 standards. The next national Prescribing Observatory for Mental Health UK audit is due in 2012/13 and this is also a Commissioning for Quality and Innovation goal for 2012/13
Clinical Effectiveness	To increase the number of patients receiving psychological therapies by 10% on the 2010 baseline	Continued quality priority for 2011/12, with a revised target of 5%
Clinical Effectiveness	To undertake a baseline audit of number of patients prescribed antipsychotics as a proportion of total number of patients with dementia and other identified national indicators	This was a Commissioning for Quality and Innovation framework goal in 2010/11. In 2010/11 this was covered by the national Prescribing Observatory for Mental Health UK audit 'Prescribing Antipsychotics for people with dementia' and an action plan agreed The next national Prescribing Observatory for Mental Health UK audit is due in 2012/13 and this is also a CQUIN goal for 2012/13
Clinical Effectiveness	To ensure that 60% of patients on care programme approach who suffer from long term physical health conditions like diabetes or coronary heart disease receive annual physical health checks	Continued quality priority for 2011/12

Details of our 2011/12 quality priorities and our performance can be found in **Section 2 above**.

3.2 Performance against national targets 2011/12

In addition to our achievements of quality priorities above, we are monitored on our compliance against national targets and standards, as set out below. We have included the proposed indicator set for 2012/13 (i.e. those relevant to the services we provide) with reference to: Compliance Framework for 2012/13. Some indicators are no longer required in the coming year and have been replaced by a new set with a revised focus.

Indicator	Threshold 2011/12	2009/10	2010/11	2011/12	2012/13 (Target)
Clostridium (C.) Difficile	Target 0 Threshold no more than 6		2	2 ●	Not Relevant see 2.2.2 above
Methicillian-resistent Staphylococcus aureus (MRSA)	0		0	0 ●	Continuing (0)
Care Programme Approach (CPA) patients receive follow-up contact within 7 days of discharge *	95%	100%	98.8%	97.9 % March 2012 ● 96.5% (Annual Average) ●	Continuing (95%)
Care Programme Approach (CPA) patients have a formal review within 12 months	95%		97%	97.8% ●	Continuing (95%)
Minimising mental health delayed transfers of care	< = 7.5%	2.8%	0.5%	2.4% ●	Continuing (< = 7.5%)
Admissions to inpatient services had access to crisis resolution/ home treatment teams **	90%	99%	100%	99% ●	Continuing (95%)
Meet commitment to serve new psychosis cases by early intervention teams	95%		100%	100%	Continuing (95%)

3.2 - Performance against national targets 2011/12, *cont'*

Indicator	Threshold 2011/12	2009/10	2010/11	2011/12	2012/13 (Target)
Mental health minimum dataset – data completeness	99%	98.8%	99%	99%	Continuing (97%)
Mental health minimum dataset – data completeness – outcomes for patients on CPA	50%		56.4%	69.1% ●	Continuing (50%)
Certification against compliance with requirement regarding access to healthcare for people with a learning disability	N/A		Compliant	Compliant ●	Continuing (N/A)
Waiting Times in A&E (This is relevant to our Urgent Care Centre only)	< = 4 hours			3hrs 11 Mins ●	Removed
Referral to treatment waiting times – admitted ***	23 weeks			27.06 ■	Removed
Referral to treatment waiting times – non-admitted	18.3 weeks			11.71 ●	Removed
Maximum time of 18 weeks from point of referral to treatment in aggregate - admitted					New (90%)
Maximum time of 18 weeks from point of referral to treatment in aggregate – non - admitted					New (95%)
Maximum time of 18 weeks from point of referral to treatment in aggregate – on an incomplete pathway					New (92%)
A&E Maximum waiting time of four hours from arrival to admission/transfer/discharge (This is relevant to our Urgent Care Centre only)					New (95%)
Community Services – data completeness					New (50%)

** 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. This is particularly important where a patient has gone to stay with a relative some geographical distance away from the service or has returned to prison or moved into another healthcare or residential facility.*

*** 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.*

**** We achieved 12 of the 13 indicators applicable to our services. We did not meet, referral to treatment waiting times – admitted, but we are ensuring our capacity meets the demands of the care pathway and that our data and reporting accurately reflect this. In 2012/13 this indicator has been replaced to mirror the Department of Health definition and work is underway to ensure delivery of this new target.*

3.3 Quality highlights

Below are initiatives that provide further insight into what else we have been undertaking to measure and review our commitment to quality.

Oxleas Patient Experience Group receives regular feedback from all service directorates highlighting the initiatives they have been implementing to: capture patient feedback or improve the patient experience.

3.3.1 – Oxleas Patient Experience Questionnaire

An innovative way of measuring patient experience in mental health and community health settings known as the Oxleas Patient Experience Questionnaire (OPEQ) has been singled out as an exciting piece of work gathering intelligent data by involving patients in the process. This work is due to be published in the Health Service Journal as a testament to how novel and important it is.

The Patient Experience programme at Oxleas has become a central component of our quality agenda. We have devised an innovative methodology to measure both qualitative and quantitative aspects of service user and carer experience in both mental health and community health services within the trust.

This methodology involves trained volunteers interviewing service users and carers using the OPEQ, which was developed to meet the need for a standardised questionnaire (structured around the four 'must do' priorities for improving patient care) which covers a systematic set of questions, yet also allows for open-ended responses.

Participants are invited to give a sense of their experiences at the beginning of the questionnaire without being constrained by specificities, which we believe is a key component to our methodology. Furthermore, in being interviewed rather than traditionally completing a questionnaire, volunteers and participants are able to develop a rapport through which service users feel that their opinions and experiences are truly valued by the trust.

Using this approach, almost 1000 service users and carers have been interviewed across twenty teams since September 2010. Each interview takes approximately 5-10 minutes to complete and is usually conducted whilst service users are waiting for their appointment.

Patient Experience Visits are facilitated by working closely with the teams that are being assessed and providing extensive support to volunteers throughout the process. Clinics are identified where volunteers invite service users and carers to take part in an anonymous OPEQ.

After the completion of the interviews for each team, the questionnaires are analysed, and themes are extracted which represent common experiences of service users and carers. These are combined with observations from volunteers who provide additional insight into the dynamics of the team. These findings are fed back to directorate-specific Patient Experience Groups (PEGs) within the trust, who work alongside staff to produce action plans to be implemented within the teams.

The truly ground breaking element of our programme is that the interviews are not administered by professional staff, but by trained volunteers with experience of using Oxleas' services. The use of service users and carers, in addition to governors and non-executive directors, as trained volunteers has proved vital to the success of our programme.

Using this approach, service users and carers feel able to speak more freely to those who have experience of using services rather than those providing it. They have less fear of being judged and subsequently feel able to speak more freely about their experience to our volunteers. This is reflected in our response rate of those who are asked to take part, which is typically 70% compared to the national average of around 33% obtained in the National Patient Survey.

The methodology with its groundbreaking use of volunteers has been a win-win for the service. This benefits both the trust, because it finds out what people are thinking, and service users who know that their needs are being taken into account. Importantly, they know that they are being listened to by people who are involved in the service but not actually in the care that is being discussed. This enables a more open exchange of information and provides a more accurate picture of the trust's services. Service users and carers also know that their views will be acted upon as part of the trust's patient experience initiatives. Most importantly, it has enabled targeted actions to be taken to improve services.

Patient Experience Volunteers have also derived personal benefits from being involved in this unique project. Many volunteers have gained tremendously in confidence as a result of their participation and have acquired numerous transferable skills, which have enabled those who are service users to enhance their own recovery journey.

As a direct result of the programme, we too have made key changes. These include:

- Changing shift patterns in an acute ward to enable qualified staff to spend more time with service users
- Implementing a new appointment system for service users of health visitor clinics
- Clarifying the signage within a podiatry clinic.

The methodology offers a high response rate, encourages volunteer development and represents a cost effective way of collecting meaningful patient experience data, which can be acted upon at all levels within the organisation.

Source - Natalie Cook (Assistant Psychologist, Patient Experience Project) and Keith Miller (Trust Lead for Patient Experience)

3.3.2 - Children's Experiences of Oxleas Child and Adolescent Mental Health Services

Our Child and Adolescent Mental Health Services are members of the Child and Adolescent Mental Health Services Outcomes Research Consortium. This is collaboration between child and adolescent mental health services across the UK with the aim of instituting a common model of routine outcome evaluation and analysis.

Child and Adolescent Mental Health Services Outcomes Research Consortium is progressing outcome evaluation in Child and Adolescent Mental Health Services in the following ways:

- Using an agreed common set of measures to routinely evaluate clinical outcomes and patient experience from at least three key perspectives (the child, the parent/carer and the practitioner);

- Collect this information on outcomes from member services so that it can be analysed centrally, in such a way as to help services reflect on their practice in comparison with baseline and other norms;

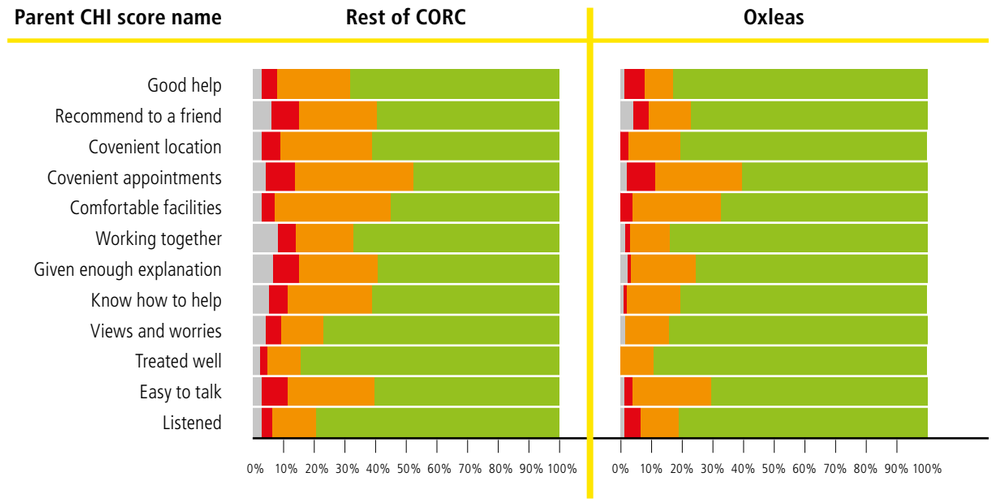
- Helping services share information about outcomes in their service in an appropriate form, and by providing guidance as to interpretation, so that it can be shared and explored meaningfully with all stakeholders;

- Supporting the dissemination and future refinement of the national dataset, to ensure all services are collecting comparable information.

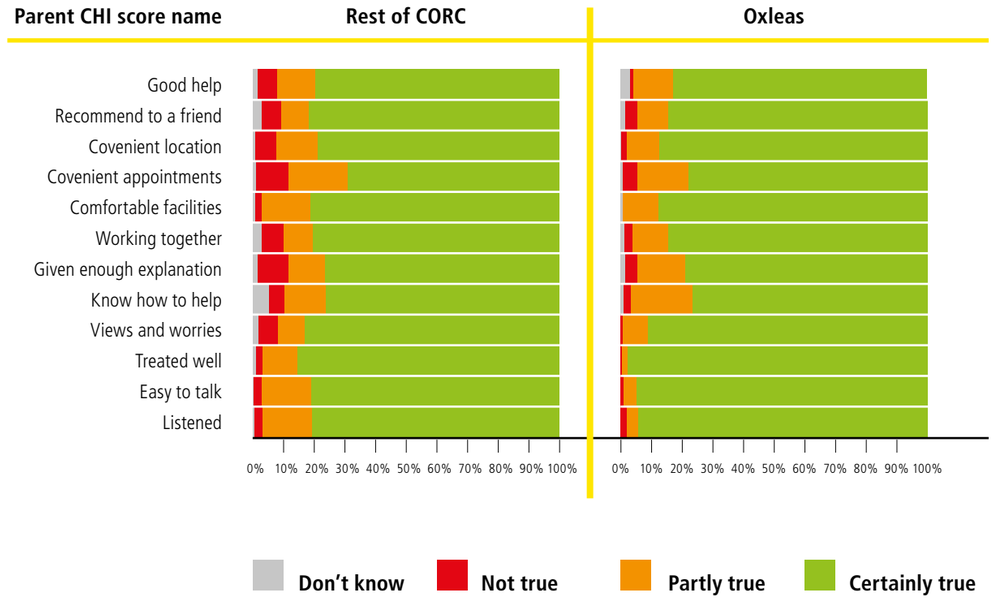
The summary of this year's results is included below and shows that our Child and Adolescent Mental Health Service is clinically effective in improving the emotional wellbeing and health of those receiving a service and that it has out-performed the rest of the member participants in respect of providing a good patient experience. The full report is available from:

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

Child/young people's responses on the Experience of Service Questionnaire, completed either 6 months after first contact or case closure if this is sooner



Parental responses on the Experience of Service Questionnaire, completed either 6 months after first contact or case closure if this is sooner



Below are a selection of comments received from children and parents and these are real qualitative measures of how well we are doing in delivering services to this patient group.

What was good about your care?

"They were open and treated me with respect. When I answered their questions they listened non-judgmentally."

"Everything was discussed properly and suggestions that we had were taken seriously. The staff are very friendly and make our child feel at ease."

Was there anything you didn't like or anything you felt needs improving?

"It's a shame that CAMHS doesn't have power to tell schools what to do."

Is there anything else you want to tell us about the service you received?

"Finally recognising that there were major problems, and finally receiving a diagnosis, thus allowing us to be able to move forward and gradually tackle all the issues which needed to be dealt with. Thank you (a huge one) to CJ for listening and identifying the problems. If it wasn't for CJ, I believe J would probably still be undiagnosed and I'd continue to have a 'bad parent' label."

"You spoke to both parents individually to get their point of view. You gave us the opportunity to comment on a draft report before it was finalised - we felt this was very important."

"On a couple of occasions when I found it hard to cope or an appointment had been cancelled I emailed B who always responded either by email or telephone call. This was a great help. I shall miss the support when I finish here."

"I felt well supported and listened to throughout my son's therapy sessions and even though his therapy has not finished I feel able to speak to CAMHS if it became necessary."

Was there anything you didn't like or anything that needs improving?

"Never knowing what room we would be in."

"The logistics of getting an appointment was quite a big problem, but we realised that in this day and age of cutbacks these things will take longer."

Source - CAMHS Services

3.3.3 – Community health services – Patient Comfort Rounds (PCR)

The Step up, Step down (SUSD) intermediate care unit is a 24 bedded service at the Queen Mary's Hospital, Sidcup, which is staffed by nurses and healthcare assistants with a physiotherapist and occupational therapist attached to the unit. Medical cover is also provided for four hours a day.

Patients in this unit, generally, have one of the following admission sources:

- from home (step up) because health problems may require short term nursing help, occupational therapists or physiotherapist support;
- from a hospital ward (step down) following a short or long stay where extra nursing support or therapy is needed to enable a safer return home.

Older people need some form of regular checks to see if they require any particular care and attention. Research has recently shown that there is a need for this systematic process and that the patients appreciate the care and attention which is given. (Castledine, Grainger and Close, 2005)

Comfort round checks have been introduced following feedback from families and carers. They provide a documented, structured and systematic process for evidencing the care that is routinely provided to patients by healthcare professionals.

Each comfort round check consists of asking the patient a number of questions including:

- Do you want to use the toilet?
- Can I get you a drink?
- Are you comfortable, can I help you change your position?
- Are you in pain?
- Is there anything else I can get you whilst I'm here?

Research has shown that patient comfort rounds "can have a positive effect on the nursing practice environment, and therefore potentially on patient safety and satisfaction measures such as call bell usage, patient falls and pressure injury rates." (Gardner G, Woollett K, Daly N and Richardson B. 2009)

The use of this process also supports the most recent Department of Health (DH) patient safety initiative, Harm Free Care. This has evolved from what is previously known as Safety Express. Safety Express is the name of the Quality Innovation Productivity and Prevention (QIPP) safe care work stream that is an amalgamation of existing programmes such as Energising for Excellence, High Impact Actions, Patient Safety First, Productive Series and the National VTE Implementation group.

The overall aim of the Harm Free Care initiative is to reduce harm from pressure ulcers, falls, catheter acquired urinary tract infections and venous thromboembolism. This is measured using a tool known as the 'NHS Safety Thermometer' included as a CQUIN goal for the coming year.

The SUSD Patient Comfort Round Standard Operating Procedure was introduced in September 2011.

A simple audit of compliance was carried out and recommendations were made from the results.

Three main areas for improvement were identified:

- Irregularities within the operating procedure need to be addressed to clarify the process to reflect the actual way of working.
- A new recording tool is to be developed for staff to use which is easily accessible to staff, patients and their families/carers.
- Raise the profile of this key process amongst patients/families/carers to ensure that the care our staff provide is more widely recognised and valued.

3.3.4 - Cross Borough Model for Point of Care Testing Clozapine Services

An increasing number of Oxleas service users are being maintained on oral Clozapine and by March 2012, there were 473 people recorded as receiving this treatment across the three boroughs. A pilot project was undertaken in the Bexley Recovery Team, based at the Bexleyheath Centre to see whether we could provide a single point of care testing for those patients on Clozapine being cared for by this team.

Prior to this pilot, patients were required to attend for blood tests at a busy local general pathology service site to then return and collect medication at a later date. Amongst others, there were ongoing issues with access to blood test results and maintaining services on public holidays. Combinations of the above factors were leading to a high number of patients defaulting on their treatment regime with high levels of reactive/contingency care becoming necessary.

The proposed/revised service set out with a vision:

- To have on-site point of care blood analysing equipment
- Allow immediate dispensing of medications
- Book a single appointment for the service user
- Give appointment times - no waiting 'next in line' for service user in busy phlebotomy departments
- Put in place a standardised coordination and monitoring of Oxleas patients on clozapine
- Ensure regular physical health checks provided during consultations.

The initial evaluation has shown that this improvement project has changed the care pathway for patients taking oral clozapine by achieving the following:

Service delivery

- ✔ A consistent way of managing a particular service user population
- ✔ Standardised coordination and monitoring of service users
- ✔ An efficient way of managing increasing numbers of people prescribed Clozapine.

Patient experience

- ✔ Provide a stable and familiar environment where service users can access support if required
- ✔ Is more convenient to attend for one appointment rather than two
- ✔ No waiting for service users
- ✔ Improved focus on physical health status.

Clinical outcomes

- ✔ Reduction in anomalous results caused by the transporting of blood samples for testing; which may be delayed or quality of sample affected by inclement weather – less amber results
- ✔ Safe system has resulted in improved clinical outcomes.

Benefits to staff

- ✔ Improved concordance reduced the amount of time that Care Coordinators spent following up service users who have not attended either for blood tests or for collection of medication
- ✔ A consistent coordinated approach reduces the risks that go with human error.

Following this evaluation the service redesign is to be rolled out to the Greenwich Recovery Team Clozapine Clinic based The Heights on 14th May.

For patients, the great advantage of the new service has been that the whole process has been streamlined and made more comfortable and we have been able to deliver a clinically effective service.

Oxleas takes part in a number of national audits so that we can understand our own year on year improvement against clinical standards, and allow comparison against national and peer performance. This has always been an effective way of understanding where clinical practice is good and where we need to focus further attention against any given standard.

3.3.5 - Use of Text Messaging Service in Young People Services

The text messaging service was launched following a survey across a selection of secondary schools asking young people how they would like to receive health advice. In the survey, 57% of the respondents stated that they would prefer to use the text messaging method of communication with a further 15% stating that they would use this method although it would not be their first choice.

The team developed a standard for receiving and responding to text messages and additional training was undertaken to ensure that the advice given was consistent and of a high quality. Working with the communications department, information about the services was advertised using posters and credit card size cards. Individual schools had specific issues, for example the religious make-up of students, so it was essential that such aspects were considered in order to ensure this covered and was acceptable to the widest population across Bexley.

Since the launch, over 373 young people have accessed the service. The main areas of advice are in relation to contraception, sexually transmitted infections as well as young people seeking advice where to get help in relation to weight and smoking.

Automated patient experience texts have been set up which are sent following the advice and to date all the young people who have responded have been very positive about the service they have received.

The text messaging service has enabled young people to contact a school health advisor throughout the year rather than the traditional route of term time only contact. It has enabled more young people to seek advice who may not have done so through the latter. The service has been nominated for an excellence award this year.

3.3.6 – Community Falls Specialist Team

This section demonstrates the effectiveness of the Community Assessment and Rehabilitation team (CAR). This captures the broader elements of the falls team's work, including user feedback and admission avoidance, via a regular review which covers a mixture of qualitative and quantitative outcomes.

The Community Assessment and Rehabilitation Team:

- Awarded two Health Service Journal awards as part of the integrated health and social care community teams;
- Received excellent patient feedback;
- Is a member of the Virtual Admission Avoidance Team Work collaboratively with partner organisations, including the development of alternative care pathways;
- Set up a falls and bones steering group;
- Attended several local public events to promote falls awareness and falls prevention.

Falls training was provided to a number of care homes and district nursing teams to raise awareness and share best practice with other healthcare staff.

During the last calendar year (January to December 2011) the team received 1,090 referrals, an average of 91 per month. A total of 210 reviews were undertaken and 86% of patients had not fallen following a six month review, demonstrating the impact of good falls management. There were no serious injuries or fractures reported.

At the point of case closure, it is standard practice to send a satisfaction questionnaire to patients which focuses on getting responses in relation to a series of questions about their recent experience with the falls team. 231 questionnaires were returned and all but six stated that they had benefitted from the service and for the six that felt they had not benefitted the main reason was 'the team did not spend enough time with them'. The six most valued aspects of the service as perceived by the patients were:

- Advice and information
- Encouragement
- Equipment for the home
- Having someone to contact
- Exercises
- Time to practice activities
- Being able to do things for myself.

3.4 Complaints

During 2011/12, we received and investigated 179 complaints, raising 437 issues. The investigation of a complaint in any one month may not be completed until the following month, so there will inevitably be a difference between the number of complaints raised and the number investigated.

Of the 437 issues raised, 185 were upheld or had elements within the complaint that were upheld, the main areas of concern raised were as follows:

	Raised	Upheld	% upheld
Care planning	144	46	32%
Staff attitude	81	28	35%
Communications	43	36	84%

All complaints are fully investigated and actions are taken to avoid similar issues occurring again.

3.5 Staff Survey

Oxleas takes part in the annual Care Quality Commission national NHS staff survey and has an ongoing process for reviewing the results and developing improvement initiatives that recognise areas where we performed less variably in against our peer group (i.e. trusts that provide similar services to us) and the national picture.

An overall indicator of staff engagement is provided for each organisation with possible scores ranging from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged. Our score of 3.88 was in the highest (best) 20% when compared with trusts of a similar type. We also achieved the top scores nationally for any similar trust in seven areas.

- Feeling satisfied with the quality of work and patient care
- Feeling able to contribute to improvements at work
- Feeling the trust is committed to achieving good work life balance
- The percentage of colleagues who received training in the last 12 months
- Colleagues' perception of fairness and effectiveness of incident reporting
- Feeling clear about job content, feedback and staff involvement
- Number of colleagues experiencing harassment and abuse from other staff (low).

There are areas where we did not fare as well and we will look at these in order to determine what local action needs to be taken to improve as an employer in these areas. Further details and results are available at: www.nhsstaffsurveys.com and are summarised under the Employee Review section of the annual report.

3.6 Same sex accommodation

We are committed to same sex accommodation and, in 2011, we established a rigorous internal peer review process to check on a number of quality standards. The peer review teams are multi-professional and focus on meeting the standards set out by the Care Quality Commission across a range of areas including privacy and dignity (including same sex accommodation), engaging, consent, safeguarding and record keeping. The outcomes of the reviews are used to support staff to improve practice and the care provided to our patients. The peer reviews are now part of our routine quality assurance programme.

3.7 S132 - Recording the giving of rights information

The trust endeavours at all times to maintain good communication with patients (and carers) about the care they receive by ensuring they are giving information that is easy to understand in a timely way. This is one of our 'four must dos' which is measured in a variety of ways including surveys.

For patients who are detained against their wishes in hospital we monitor our compliance with providing timely information about their rights on a Mental Health Act Section. We require all records for those on a mental health section to clearly state that the patient has received and understood the information given regarding their rights. As part of our internal quality and safety improvement plan we ensured in 2011/12 that an average of 95% of patients had documented evidence of having had their rights explained to them. However, this was 5% below our target of 100% and will continue to be a focus during 2012/13.

Annex 1 Statement from Stakeholders – Lead Commissioning Primary Care Trusts

Thank you for submitting a copy of Oxleas Quality Accounts for 2011/12, received by mental health commissioners at Bexley, Bromley and Greenwich (BBG) Business Support Units on 8th May 2012. Please see the below response and comments on behalf of (BBG) Business Support Units.

We confirm that the content of the quality accounts for 2011/12 pertaining to our contractual agreement is accurate and correct, reflecting information that has been reported quarterly throughout 2011/12. Oxleas have also taken into account comments that were made on the draft quality accounts and included these as part of the final quality accounts for 2011/12.

We have been particularly pleased with the outcomes of the 2011/12 CQUIN scheme which have produced a rich source of information and strong recommendations for implementation in the coming year; we make particular reference to the BME work that was successfully completed as part of the CQUIN scheme. We have also been pleased to see innovative efforts to improve clinical outcomes and patient experience with regards to the Clozapine Project model which we look forward to introducing to our GP's in the future.

Bexley, Bromley and Greenwich look forward to working with Oxleas throughout the coming year and continuing to build on the quality achievements to date and their commitment to working jointly with commissioners to ensure on-going improvement across all 3 quality domains.

Yours sincerely

Pam Creaven
Joint Managing Director
Bexley Business
Support Unit

Angela Bhan
Managing Director
and Joint Director of
Public Health
Bromley Business
Support Unit

Langley Gifford
Executive Director
Non-Acute Commissioning
and Partnerships
Greenwich Business
Support Unit

Annex 2 Statement from Stakeholders – Comments from Bexley, Bromley and Greenwich LINk

Bexley, Bromley and Greenwich LINks welcome the opportunity to comment on the Oxleas Quality Account for 2011-12. As in last year's report we have compiled a joint response to the Account using feedback from members of all three LINks.

General comments

We wish to congratulate the Trust on a number of specific points:

- We recognise that the Quality Account is an impressive and comprehensive piece of work presenting a huge amount of data, however, we feel that the Trust's significant achievements are not immediately evident to the public
- The presentation of the report has improved since last year but we recognise that there is still room for further improvement
- Following the LINks' suggestion, we are very pleased to see the inclusion of a traffic light system in this year's report so that it is easy for the reader to see immediately where the Trust has achieved or not its priorities and would welcome the traffic light system being used consistently throughout all tables within the report
- It is also easy to see how each of the priority areas were identified and by whom, for instance whether or not targets are inspired by Monitor, Trust or CQUIN
- We recognise a number of areas where the Trust has overachieved its targets as mentioned under specific topics areas below
- We were pleased to be invited to a meeting to discuss the Quality Account and be involved in the writing of the Quality Account, which is an improvement on the process from last year. However we would hope for more involvement next year so that we can better influence the structure, language and design of the document to ensure it is user-friendly.

We also wish to comment on a number of specific areas for improvement:

- We understand that the deadline for completion of the Annual Report was set by Monitor but are disappointed that as a result LINks were only given 18 days to comment, contrary to the guidance from the Department of Health for compiling Quality Accounts which stipulates LINks should have 30 days. Regrettably, the result is that we have not been able to consult LINk members as widely as we would want in order to consult specific expertise within our membership. We have issued correspondence to Monitor to document our disappointment in the hope that this will be addressed in next year's Quality Accounts process.
- The performance against national targets for 2011-12 provide the trends across the last few years and it would be helpful if this could be replicated across all tables (point 3.2 page 41). consistency in tables would be helpful
- We are concerned that 84% of complaints were upheld around communications (36 out of 43). It would be useful to see what the Trust's action plan is (3.4) as this would reassure the public that this is a listening Trust that listens and learns
- We realise that work is being done around same sex accommodation, however it is not clear what the Trust wanted to achieve, nor whether it has been achieved
- Whilst we are pleased that LINks were invited to the borough focus groups to help to identify priorities, it is not easy to see how these borough priorities are reflected in the Quality Account
- Despite the changes the Trust has made to improve presentation, we are disappointed to see that the three LINks' combined comment from last years report remains difficult to read and understand.

Mental Health and Learning Disabilities

As in last year's report we are pleased to report that the Trust is overachieving on ensuring that registered carers of service users on CPA have been offered a carer's assessment

- We also recognise the effort Oxleas are putting into the monitoring of patients on lithium
- We note the hard work that the Trust has done in improving patients' access to psychological therapies and congratulate the Trust on improving access by 17% this year. We also congratulate the Trust on over achieving its target to ensure that at least 60% of patients have improved access to physical health checks and / or screening
- Following our concern documented in our comment last year - that only 83% of young people being transferred to adult services were provided with a CPA – it was not possible to see how this item is currently being dealt with by the Trust.

Community health services, Bexley and Greenwich

- We applaud the use of new technology by text messages to reach out to young people who are often viewed as a hard to reach group
- We are disappointed to read that HPV immunisation targets for girls aged 12-13 have not been met this year
- We are disappointed that Oxleas are not able to report whether patients are coming to harm under their care by acquiring pressure ulcers. We feel strongly that the Trust should seek to improve communication between service providers to allow respective Trusts to monitor and respond appropriately. We are keen to monitor this in the future as pressure is a high profile priority for all three LINks
- We are pleased to note that Bexley as well as Greenwich are now meeting all three levels of safeguarding training for children
- We note that the target to increase the number of patients who have a community care plan on RiO by the District Nursing team has not yet been met, however we do recognise that the RiO recording system was only launched in December last year (2011). We will continue to monitor progress on this next year.

As in previous years the LINks welcome the opportunity to respond to the Trust's Quality Account and hope to work in partnership with the Trust to deliver the best possible patient experience across all of its sites over the coming year. In conclusion we would like to congratulate the Trust in the improvements in performance and quality which includes partnership and collaborative working with Bexley, Bromley and Greenwich LINks.

Annex 3 Statement from Stakeholders – Comments from Greenwich Overview Scrutiny Panel

Comments from Greenwich Healthier Communities and Older People Scrutiny Panel on the Oxleas Quality Report 2011/12

1 Introduction

The mental health, learning disability and community services provided by the trust are important contributors to the health and wellbeing of local people and therefore remain an ongoing priority for the panel. Members of the panel are planning a number of visits to trust services and will continue to feedback any concerns to senior management.

2 Statement by the Chief Executive

The panel welcomes the Patient Experience Volunteer Programme and its use of the Oxleas Patient Experience Questionnaire which will use feedback from service users to develop quality improvement plans. This programme has rightly received national recognition and the panel looks forward to its continued development.

The panel is pleased to note that the Care Quality Commission visited three of the trust's services providing respectively specialist forensic services, adult learning disability and mental health in-reach services and found that all were meeting the standards of quality and safety.

The panel were also pleased to note that that in the recent National Staff Survey staff rated the trust best non acute trust to work for in the country and the best of any kind of trust in London and South of England.

3 Carers Strategy

The panel recognises the importance of identifying carers' needs and welcomes the improvements the trust has achieved in recording carers' assessments.

4 Care, Compassion and Engagement

The panel notes the trusts' "4 must do's" of:

- Support families and carers
- Provide information for service users and carers
- Improve care planning
- Improve relationships with service users and carers.

The panel looks forward to assessing how effectively they are informing the trust's priority setting and performance.

5 Lithium Audit

The panel recognises the good work that has been done to strengthen the monitoring of patients on lithium however, more work is needed in this area and this is something the panel may revisit.

6 Quality Priorities for Improvement 2012/13

The panel is pleased to note stakeholders' involvement in determining the trust's priorities for 2012/13 but would also welcome greater engagement in this process.

7 MH and LD Services Quality Improvement Priorities for 2012/13

In terms of clinical effectiveness the panel is pleased to note the priorities to improve patients' access to therapies and relevant physical health checks and screening. This is an area that it will monitor closely in the future.

Annex 4 Statement of directors' responsibilities in respect of Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards 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 2011-12;
- the content of the Quality Report is not inconsistent with internal and external sources of information

including:

- Board minutes for the period April 2011 to April 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to March 2012;
- Feedback from the Commissioners dated 18/05/2012;
- Feedback from LINKS dated 18/05/2012;
- Internal Complaints Report for quarter 1, 2, 3 and 4;
- Care Quality Commission Patient Survey Report 2011;
- 2011 National NHS staff survey;
- Care Quality Commission quality and risk profiles dated 02/04/2012; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated 10/05/2012

- 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).

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 ..... **29 May 2012**

David Mellish, Chairman

Stephen Firn, Chief Executive

Glossary

MH - Mental Health
LD – Learning Disabilities
CPA – CPA
CQUIN – Commissioning for Quality and Innovation
RiO – Electronic Clinical System
Monitor – Foundation Trust Regulatory Body
CAMHs – Children and Adolescent Mental Health Services
MMC – Medicines Management Committee
LTC – Long Term Conditions
ICT – Intermediate Care Teams
OPEQ – Oxleas Patient Experience Questionnaire
HPV – Human Papilloma Virus
QSIP – Quality Safety Improvement Plan
GCHS – Greenwich Community Health Services
BCHS – Bexley Community Health Services
CLRN – Comprehensive Local Research Network
HQIP – Healthcare Quality Improvement Partnership
QOF – Quality and Outcomes Framework
BMI – Body Mass Index
CQC – Care Quality Commission
POMH – Prescribing Observatory for Mental Health
BP – Blood Pressure
PCT – Primary Care Trust
HCI – Healthcare Quality Improvement Partnership
CORC – Child and Adolescent Mental Health Services Outcomes Research Consortium
RCA – Root Cause Analysis
KPI – Key Performance Indicator
CDiff – Clostridium Difficile
MRSA – Methicillin Resistant Staphylococcus Aureus
CHI – Child and Adolescent Mental Health Services Outcomes Research Consortium Scoring System
U&E – Urea and Electrolytes
TFT – Thyroid Function Tests
VTE – Venous Thromboembelism
QIPP – Quality Innovation Productivity and Prevention

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Patient Advice and Liaison Service
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