## Contents

1 **Chief Executive’s Statement on Quality** 5  
2 **Quality Priorities for Improvement** 6  
   2.1 **Review of our how we did: Progress against 2017/18 priorities** 6  
   2.2 **Our performance against our 2018/19 Quality Objectives** 7  
      2.2.1 **Quality objective 1 - Meeting our patient promise** 8  
      2.2.2 **Quality objective 2 – Involving families, carers and people important to our patients** 12  
      2.2.3 **Quality objective 3 – Involving families, carers and people important to our patients** 13  
      2.2.4 **Quality objective 4 - Ensure we put the safety of our patients first** 18  
      2.2.5 **Quality Objective 5 – Providing care in line with national best practice and guidelines** 23  
      2.2.6 **Quality Objective 6 – Ensure we routinely measure clinical outcomes** 24  
   2.3 **Our Quality Improvement Priorities for 2019/20** 25  
   2.4 **Statements of Assurance from the Board** 30  
      2.4.1 **Participation in clinical audits** 30  
      2.4.2 **Oxleas clinical audit programme** 34  
      2.4.3 **Participation in Clinical Research** 34  
      2.4.4 **Quality Improvement and Innovation Goals agreed with Commissioners** 34  
      2.4.5 **Registration with the Care Quality Commission (CQC)** 35  
      2.4.6 **Data Quality** 38  
      2.4.7 **Information Governance Toolkit** 38  
      2.4.8 **Clinical Coding** 38  
      2.4.9 **Improving Data Quality** 38  
   2.5 **Learning from deaths** 38  
   2.6 **Performance against National Core Indicators** 41  
3 **Other Quality performance information** 44  
   3.1 **Performance against NHS Improvement’s Single Oversight Framework Indicators** 44  
   3.2 **Additional NHS Improvement Reporting Requirements** 46  
   3.3 **Oxleas Quality Highlights and Case Studies** 48  
   3.4 **Our Staff Survey 2018** 59  
   3.5 **Oxleas Complaints Report 2018/19** 61  
   **Glossary of Abbreviations** 64  
   **Annex 1** 66  
      Feedback from our Stakeholders 66  
   **Annex 2** 74  
      Statement of directors’ responsibilities in respect of the Quality Report 74
1.0 Chief Executive Statement on Quality

I am pleased to present to you our Quality Accounts for 2018/19 which gives you an insight to our commitment to improve lives by providing the best quality health and social care for patients, their families, carers and those identified as important to them. Our first and foremost organisational priority continues to be enhancing quality – ensuring excellence for every patient across the 3 quality domains of patient experience, patient safety and clinical effectiveness. The following pages demonstrate:

- Our approach to improving quality
- Our performance against the 2018/19 quality priorities both local and national
- Our priorities for 2019/20
- A showcase of notable and innovative practice that has taken place across our services this year

Since taking up the role of Oxleas Chief Executive I have spent considerable time out in services, speaking to frontline staff and to our patients and I am delighted to see how committed our staff are to providing good quality patient care.

The Care Quality Commission (CQC) carried out a thorough inspection of our services in November and December 2018, visiting six of our service lines and undertaking a well led review in January 2019. I am delighted that the results of our latest CQC inspection rate us as ‘Good’ overall, thus maintaining our previous rating. A number of our services were however, rated as outstanding in some domains: ‘Outstanding for caring’ in our inpatient mental health services and ‘Outstanding for effectiveness’ in our community-based mental health services for older people. These latest ‘Outstanding’ service ratings build on those awarded in 2017 when our forensic inpatient wards were rated ‘Outstanding for responsiveness’ and our community services for adults with a learning disability received ‘Outstanding for caring’. Further detail on areas for improvement and what we aim to do to ensure continuous improvement is provided in section 2 of the quality accounts.

Our Quality Improvement (Qi) programme was launched in 2018/19 with staff across Oxleas taking part in training, Qi projects and putting learning from those projects into practice. The programme continues to grow from strength to strength and we have provided some examples of innovative Qi projects in section 3 of the quality accounts.

In terms of looking back at the previous year, we have not achieved 2 of our 19 quality indicators and slightly underachieved in 1 of them. We will continue to focus our efforts to improve on these areas and have chosen them as priorities again for 2019/20.

Looking forward to the coming year, we have an ambitious programme of quality, improvement and innovation. We will ensure that our focus on patient safety, improved clinical effectiveness and outcomes and positive experience of our care is maintained across all of our services.

Each year, we work in partnership with staff, patients, carers, members, commissioners, GPs, Healthwatch and other stakeholders and we are grateful to all who have supported and worked with us in reviewing and setting our quality plans. We are delighted to have had another successful year and we are determined to maintain these high standards throughout 2019/20 and aim for ‘Outstanding’.

Declaration

In preparing our Quality Accounts, we have endeavoured to ensure that the information and data presented within is accurate and provides a fair and balanced reflection of our performance this year.

To the best of my knowledge, the information in the document is an accurate and true account of the quality of our services.

Signed by:

Matthew Trainer
Chief Executive
24 May 2019
2.0 Quality Priorities for Improvement

In this section, we provide an update on our priorities for improvement and statements of assurance from our trust Board of Directors.

Oxleas is committed to delivering good quality care and we have worked in partnership with our staff, patients, carers, members, commissioners, GPs and others to identify areas for improvement.

Our annual Quality Account gives us an opportunity to share our performance against our 2018/19 priorities, describe our areas of focus for 2019/20 and showcase notable and innovative practice that has taken place across our services this year.

2.1 Review of our how we did: Progress against 2017/18 priorities

We have highlighted below our performance against last year's goals which cover the three quality domains of patient experience, patient safety and clinical effectiveness. We determine our quality goals through a variety of processes:

- Our annual borough based focus groups across Bexley, Bromley and Greenwich
- Our regular quality review meetings with our commissioners
- Feedback from patients, service users, carers and families of people who have used our services
- Regular review at our Performance & Quality Assurance Committee and associated quality sub-groups

Where available, we have included data from previous years’ quality reports for comparison and to evidence progress. With the exception of national surveys or audits, we use information from our electronic patient record, RiO, our staff training database and local audits or surveys to measure achievement of our priorities. We have also included what performance data is determined by local or national definitions.

Our local performance has not been compared to other trusts. Comparable data for national priorities are presented in Table 8, section 2.6. For ease of reference, a glossary of all terms and acronyms used is provided at the end of the report. We also aim to show our performance in comparison to the last 3 years where this data is available.

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

- Green/Achieved: This means the target set has been achieved
- Amber/Mostly Achieved: This means our 2018/19 performance is 5% or less below the set target
- Red/Not achieved: This means our 2018/19 performance is 6% or more below the set target

2.2 Our performance against our 2018/19 - Quality Objectives

Our quality priorities are split across 6 quality objectives.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
<th>Quality Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Objective 1</td>
<td>Ensure we meet our patient promise</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Quality Objective 2</td>
<td>Ensure we involve families, carers and people important to our patients</td>
<td>Patient Experience</td>
</tr>
<tr>
<td>Quality Objective 3</td>
<td>Ensure we involve patients in planning their care and they have a care plan that is personal to them</td>
<td>Clinical Effectiveness</td>
</tr>
<tr>
<td>Quality Objective 4</td>
<td>Ensure we put the safety of our patients first</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>Quality Objective 5</td>
<td>Ensure we provide care in line with national best practice and guidelines</td>
<td>Clinical Effectiveness</td>
</tr>
<tr>
<td>Quality Objective 6</td>
<td>Ensure we routinely measure clinical outcomes so that we know that our care makes a difference to patients</td>
<td>Clinical Effectiveness</td>
</tr>
</tbody>
</table>

We have provided below a summary of our trust-wide performance against the 6 quality objectives however further detail on each objective is provided in sections 2.2.1 to 2.2.6.

We have 19 quality goals across the 6 quality objectives:

<table>
<thead>
<tr>
<th>Achieved</th>
<th>Mostly Achieved</th>
<th>Not Achieved</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 (84%)</td>
<td>1 (5%)</td>
<td>2 (11%)</td>
<td>19</td>
</tr>
</tbody>
</table>
2.2.1 Quality Objective 1 - Meeting our patient promise (Patient Experience)

Our first quality priority is to ensure we meet our patient promise; this consists of 6 ‘must ask’ questions that are used in every Oxleas patient experience survey. We ask patients to respond on the following:

- Have you been provided with enough information about your care and treatment?
- Have you been involved as much as you would have liked in decisions about your care and treatment?
- Have staff treated you with dignity and respect?
- Did you want any friends/relatives involved in your care/treatment? If yes, were they involved?
- We would like you to think about your recent experience of this service. How likely would you be to recommend this team to friends and family if they needed similar care or treatment?

Our target for each of the 6 questions is to have at least 90% of patients reporting that we have met our patient promise. We have consistently met our goal of 90% achievement or more since 2015/16 when we started reporting this data as part of our quality priorities.

We are pleased to see that this target has been achieved again in 2018/19 as shown in the chart 1 below.

We have also provided our patient experience feedback broken down by directorate and can be seen (as shown below) that we do have some services in the trust where not all patient promise indicators have been achieved. This is the case for our Forensic services, Prison Services and Adult Learning Disability Services and specific to ‘friends/relatives involved in care/treatment’, ‘if they found the service helpful’ and the ‘will you recommend the service to friends and family’ questions. It has been identified that due to the nature of the Forensic services it is unlikely that the patients would select the “Extremely likely” or “Likely” responses.

Some of the comments that service users provide us is that they would not like for their friends or relatives to be “locked up” in a forensic inpatient ward; this is despite the question asking “if they needed similar care or treatment”. We survey a wide range of patients who do not choose or want to be in the forensic setting and are detained against their will with often very serious offences and in acute wards ongoing trials and sentencing hearings. However we have put plans in place to make further improvements such as introducing positive events such as ‘Bracton’s got talent’ and holding stalls to provide clearer information to patients about their medication.

In terms of our Adult Learning Disability Services (ALD), the FFT question does not work as well with this client group. Some of the ALD service users select the “Unlikely”, “Extremely unlikely” or “Don’t know” responses for the FFT question but the comments they provide are very positive. We have shared this with NHS England and provided some examples showing the positive free texts that are not included in the calculations stating that the FFT question does not work as well in these service areas.

NHS England have begun work to identify ways to make it a stronger tool to support local service improvement and to also increase the FFTs accessibility to all service users. We expect the revised FFT question and guidance to be published by NHS England early 2019/20 with the plan for trusts to implement in October 2019.

The revised question and guidance will be released by the end of April and the plan is for trusts to implement this in October.

Table 1

<table>
<thead>
<tr>
<th>‘Must Ask’ Questions</th>
<th>Beoley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>CYP</th>
<th>Prisons</th>
<th>ALD</th>
<th>Trust wide Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of enough information about care &amp; treatment</td>
<td>99%</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
<td>90%</td>
<td>92%</td>
<td>95% 97%</td>
</tr>
<tr>
<td>Involvement in decisions about care &amp; treatment</td>
<td>98%</td>
<td>95%</td>
<td>97%</td>
<td>98%</td>
<td>95%</td>
<td>87%</td>
<td>96% 97%</td>
</tr>
<tr>
<td>Have been helped or quality of life has improved</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>92%</td>
<td>96%</td>
<td>99% 99%</td>
</tr>
<tr>
<td>Treated with dignity &amp; respect</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>92%</td>
<td>96%</td>
<td>99% 99%</td>
</tr>
<tr>
<td>Friends &amp; relatives involved in care/treatment (if wanted)</td>
<td>95%</td>
<td>97%</td>
<td>94%</td>
<td>98%</td>
<td>79%</td>
<td>Question not asked</td>
<td>93% 95%</td>
</tr>
<tr>
<td>Service was helpful</td>
<td>98%</td>
<td>94%</td>
<td>98%</td>
<td>99%</td>
<td>88%</td>
<td>93%</td>
<td>97% 97%</td>
</tr>
<tr>
<td>Friends &amp; family feel involved in care</td>
<td>96%</td>
<td>89%</td>
<td>92%</td>
<td>93%</td>
<td>66%</td>
<td>Question not asked</td>
<td>82% 92%</td>
</tr>
<tr>
<td>Recommend service to friends &amp; family</td>
<td>1%</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
<td>19%</td>
<td>Question not asked</td>
<td>5% 2%</td>
</tr>
<tr>
<td>% Recommend</td>
<td>90%+ target achieved</td>
<td>Less than 5% below target (89-85%)</td>
<td>more than 5% below target (84% or less)</td>
<td>FFT % Not Recommended</td>
<td>0% - 4%</td>
<td>&gt;5%</td>
<td></td>
</tr>
</tbody>
</table>
Quality indicator – to have a minimum of 10% response rates to our patient experience surveys

The other quality indicator that falls under our patient promise objective is to have a minimum of 10% response rates to our patient experience surveys. As an organisation, we see approximately 29,000 patients in a given month and we aim for at least 10% of those who have been in contact with our services to give us feedback on the ‘must ask’ questions. We continue to see an increase in the numbers of people who respond but we have not met the 10% mark as shown in the chart below (2018/19 performance is at 8%):

Chart 2 - Patients Experience Feedback Response Rates (2017/18 and 2018/19)

However there has been significant increase on the numbers of patients who do respond to our patient surveys. The chart below shows the annual figures since 2015/16. We continue to work with our teams to encourage patients to give feedback following contact with services. We have also updated our feedback technology making it easier for patients to respond via various methods which include text messaging, online and on paper for those who are homebound and prefer to send in their response via post.

Chart 3 - Number of Patients Providing Feedback
2.2.2 Quality Objective 2 – Involving families, carers and people important to our patients (Patient Experience)

There are two indicators which come under our second quality objective. 2018/19 progress for ‘ensuring 90% of patients report that they wanted friends/relatives involved in their care/treatment did feel that they were involved’ has been captured in section 2.2.1 above. Progress on the second indicator is provided below.

Quality indicator – to ensure 80% of patients have their support network identified and noted within their care record

Please note: The data source for this objective is from RiO our electronic patient care record and is a local definition.

Our improvement goal for 2018/19 was to ensure that 80% of patients who have been assessed with the previous year achievement at 35.2%. This is an area that has been challenging for certain services to achieve and it is disappointing that we have not achieved this improvement goal.

Provided below is the functional service breakdown:

Table 2 - The Functional Service Breakdown

<table>
<thead>
<tr>
<th>Metric</th>
<th>Category</th>
<th>Unique Directorate Caseload</th>
<th>Support Network Identified</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of patients have their support network identified and noted within their care record</td>
<td>Community</td>
<td>60851</td>
<td>11511</td>
<td>18.9%</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>39913</td>
<td>25234</td>
<td>63.2%</td>
</tr>
<tr>
<td></td>
<td>Forensic</td>
<td>1719</td>
<td>1195</td>
<td>69.5%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>102483</td>
<td>37940</td>
<td>37.0%</td>
</tr>
</tbody>
</table>

During the year we have undertaken a piece of work to ensure those teams that are expected to complete the tool are clearly identified and specific criteria were adopted to achieve this. This has not yet had a significant impact on reaching the target of 80%, although we have started to see an increase in the number of Support Network Tools (SNETs) completed. A new Patient Experience Coordinator has been in post since September 2018 and part of the role is to ensure that the SNET is being completed by teams and that the 80% target is being reached. The Patient Experience Coordinator visits teams that are underperforming and reminds them of the importance of asking the 4 questions and recording the outcome in the patient record. A guidance sheet with step-by-step visual instructions on how the tool should be completed has been made available to teams.

Our aspiration remains for all patients/service users and their support networks to be offered the opportunity to be included, involved and engaged in our services. The key to achieving this is for every member of staff to actively identify and involve the support network to ensure better outcomes for their patients. We have seen good performance across our mental health and forensic services but still have a lot to do to embed across our community services. We will continue to focus on this as a quality priority in 2019/20.

2.2.3 Quality Objective 3 – Involving patients in planning their care and that they have a care plan that is personal to them (Clinical Effectiveness)

Our third quality objective for 2018/19 was to ensure we involve patients in planning their care and that they have a care plan that is personal to them. There are 3 quality indicators under this objective and our performance for 2018/19 is shown in the table below:

Please note: The data source for these indicators is RiO our electronic patient care record and is a local definition:

2.2.3.1 Quality indicator – to ensure 75% of Oxleas teams participate in care planning audits

In July 2017, we put in place monthly care planning audits that all services and teams participate in. Teams are expected to complete a minimum of 5 care plans audited per month, with the audit tool and results accessible to all staff via an online portal. The care planning audit is one of our trustwide priority audits and we now have approximately 500 care plans audited per month across 128 teams. This regular data collection means that we are in a better position of understanding the current state of practice and pick up on trends. Teams also have easy access to view their results online and discuss these as part of their monthly team meetings.

Our improvement goal for 2018/19 was to ensure that at least 75% of our teams participate in these monthly audits and as shown in the graph below, we have had an average of 63% of our teams participating in the monthly audits.
We are disappointed that despite the increased focus on this in 2018/19 we have been unable to increase the number of teams who participate in the monthly audits and maintain consistency. This has been discussed at the trust’s Clinical Effectiveness Group and the Performance & Quality Assurance Board Sub-Committee. A mitigation plan has been put in place to support teams who have not participated in the monthly audits. We have also made this a trust quality priority for 2019/20.

Even though our improvement goal was about participation, we have provided below the results of our care planning audits. As we have been collating care planning audit results consistently over time, we are now in a position to demonstrate statistically significant Oxleas wide improvements.

<table>
<thead>
<tr>
<th>Question</th>
<th>Average Result Per Month (Oxleas wide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a risk assessment been completed during this episode of care?</td>
<td>90%</td>
</tr>
<tr>
<td>Has the risk assessment been reviewed following significant risk incidents, changes in presentation or within the last 6 months?</td>
<td>90%</td>
</tr>
<tr>
<td>Does the care plan address increased risks that have been identified in the risk assessment?</td>
<td>86%</td>
</tr>
<tr>
<td>Is there evidence that the service user has been involved in development of their care plan?</td>
<td>86%</td>
</tr>
<tr>
<td>Is there evidence that the service user’s support network has been involved in the development of the care plan?</td>
<td>63%</td>
</tr>
<tr>
<td>Has a copy of the care plan been given to the service user?</td>
<td>70%</td>
</tr>
<tr>
<td>Has a copy of the care plan been given to the service user support network?</td>
<td>40%</td>
</tr>
</tbody>
</table>

Our 2018/19 achievement for the other two indicators under this objective is shown in the graphs below. As can be seen, both of these improvement goals have been achieved.
2.2.3.2 Quality indicator – to ensure 95% of our patients have a recorded care plan on RiO

Please note: The data source for this objective is from RiO our electronic patient care record and is a local definition.

Chart 5 - Percentage of Patients with a care plan on RiO

2.2.3.3 Quality indicator – to ensure 95% of our patients on CPA will receive a 12 monthly review

Please note: The data source for this objective is from RiO our electronic patient care record and is a local definition.

Chart 6 - Percentage of Patients on CPA who received a 12 month review
2.2.4 Quality Objective 4 – Ensure we put the safety of our patients first (Patient Safety)

Our 4th quality objective is to ensure we put the safety of our patients first and the goals linked to this objective are integral to our improvement safety plan. There are four key areas that come under this objective:

- Falls
- Deteriorating physical health
- Violence reduction
- Reducing the use of prone restraint

We have provided progress each safety goal below. Please note, the data source for our patient safety goals are from RiO our electronic patient care record, Datix (our incident recording system) and from local clinical audit.

2.2.4.1 Falls

In 2018/19 we continued our focus on reducing the incidences of falls on our inpatient wards. This focus was founded on the outcomes of the longitudinal study that we conducted at the end of 2017/18 which helped us to gain a deeper understanding of why and how patients fall. As a result we have put in place the following:

- We have updated the Falls Policy and reviewed training, assessment and management of falls. We are also looking to introduce a core group of Falls Champions who will attend training and then roll out the information to colleagues in their specific workplace.
- We have updated the Falls Assessment Tool for in-patient settings and this will be rolled out in 2019/20. This tool gives more direction to Staff and patients as to what they should do with the information gathered to help prevent falls. We have also updated the Falls Screening Tool (FSA) for community settings.

We continue to encourage an open and safe culture of reporting of falls and an example of this is to ensure unwitnessed falls in the community will be recorded on Datix (our incident reporting system) within 24 hours of the clinician contact. In addition and due to our focus on this workstream, we have seen a significant reduction in level 4 falls in our inpatient services in 2018/19 compared to the previous year. There were 3 serious falls in this reporting period compared to 8 in 2017/18; a reduction of 62.5%.

2.2.4.2 Preventing the Deterioration of Physical Health

Since 2017, we have included physical health monitoring forms in the patient’s electronic record system to ensure the monitoring of physical health observations, including blood glucose and blood lipids, BMI, Malnutrition, smoking status and substance and alcohol misuse. This enables teams to effectively record and monitor physical health.

All our inpatient wards have been trained in NEWS2 (the National Early Warning System). Training slides have been developed circulated to all wards following training, with the expectation that these are used to train other staff on the wards who are unable to attend the face to face training due to shift patterns.

The Malnutrition Universal Screening Tool (MUST) has been implemented in line with NICE guideline QS24. The MUST enables clinicians to identify patients who are at risk of malnutrition or obesity and to write personalised care plans that address the issues identified. Posters have been designed to support staff with completing the forms and will be circulated to teams. MUST audits measuring the number of patients who have a completed Screening Tool are undertaken regularly by our inpatient wards which are overseen by the trust’s lead nurse for practice development. An average of 85% of patients had a completed screening tool completed; there is still further improvement to be done in this area and this is why we have chosen this as a quality improvement goal for 2019/20 with a target of 100% completion by all wards.

2.2.4.3 Reduction of violence

Reducing the incidents of violence and aggression is one of our quality improvement goals. In the last few years we have seen an increase in the number of incidents recorded in our inpatient units and we took on board feedback staff as seen in our staff surveys and as part of our Board to floor visits to wards. As part of the launch of our Quality Improvement (Qi) Programme we put in place a trustwide reducing violence Qi project with at least one ward from each unit represented as part of the pilot. The aim of the project is to reduce incidents of physical violence by 25% by July 2019.

Provided below is a driver diagram that details our drivers identified for the project and what we want to test and put in place as a result.

---

**Chart 7**

<table>
<thead>
<tr>
<th>AIM</th>
<th>PRIMARY DRIVERS</th>
<th>SECONDARY DRIVERS</th>
<th>CHANGE IDEAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff experience</td>
<td>Patient experience</td>
<td>Patient Safety</td>
<td>Staff and Patient engagement</td>
</tr>
<tr>
<td>Patient experience</td>
<td>Patient experience</td>
<td>Patient Safety</td>
<td>Staff and Patient engagement</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Staff and Patient engagement</td>
<td>Staff Safety</td>
<td>Planning for crisis</td>
</tr>
<tr>
<td>Staff Safety</td>
<td>Staff and Patient engagement</td>
<td>Staff Safety</td>
<td>Environment</td>
</tr>
<tr>
<td>Box setting checklist</td>
<td>Staff and Patient engagement</td>
<td>Staff Safety</td>
<td>Safe staffing levels</td>
</tr>
<tr>
<td>Staff and Patient engagement</td>
<td>Staff and Patient engagement</td>
<td>Staff Safety</td>
<td>Coordinating staff and patients</td>
</tr>
<tr>
<td>Staff and Patient engagement</td>
<td>Staff and Patient engagement</td>
<td>Staff Safety</td>
<td>Continue to learn from</td>
</tr>
<tr>
<td>Staff and Patient engagement</td>
<td>Staff and Patient engagement</td>
<td>Staff Safety</td>
<td>unavoidable incidents</td>
</tr>
<tr>
<td>Staff and Patient engagement</td>
<td>Staff and Patient engagement</td>
<td>Staff Safety</td>
<td>Letters to staff &amp; patients to</td>
</tr>
<tr>
<td>Staff and Patient engagement</td>
<td>Staff and Patient engagement</td>
<td>Staff Safety</td>
<td>stick ideas &amp; promote engagement</td>
</tr>
</tbody>
</table>

---

Oxleas NHS Foundation Trust
Quality Report 2018/19

18

Oxleas NHS Foundation Trust
Quality Report 2018/19

19
We have seen the incidents of violence and aggression to staff and patients fall since 2016 as shown in the graphs below, this is as a result of the work we have done with the Qi programme and our trustwide staff engagement programme looking at how we can reduce violence and aggression on our inpatient wards.

*Chart 8 - Number of Assaults - Patient to Patient (April 2016 - March 2019)*

We have also provided a Qi project example that has taken place on the Tarn in section 3.3.2. We are aware that this is work in progress and there is more to do to reduce violence and aggression on our wards. We will continue to embed Safe Wards on our inpatient wards and ensure roll-out of best practice from the Qi pilots to other wards.

*Chart 9 - Number of Assaults - Patient to Staff (April 2016 - March 2019)*
2.2.4.4 Reducing the use of prone restraint

For the last indicator in our safety first objective, we put forward a goal to reduce the use of prone restraint on our wards. Restrained is the use of force or a threat to use force to make someone do something they are resisting, or the restriction of a person’s freedom of movement, whether they are resisting or not (Mental Capacity Act 2005, section 6(4)). There may be occasions where physical restraint is necessary to safeguard a patient from either harming themselves or others. In these circumstances staff will need to be able to adopt a coherent team approach to physical restraint to ensure effective and safe management of the situation for both staff and service users.

Nationally accepted training on physical restraint techniques is provided to trust staff in accordance with the Training Needs Analysis. PAMOVA (the trust’s PMVA training provider) have included in their PMVA training, risks to airways in respect of prone restraint and are now training staff in supine restraint for the administration of IM rapid tranquilisation. It is our priority that 80% of staff receives the supine restraint training.

In 2018/19, 90.3% of staff completed training in supine restraint. There has also been a reduction in the number of prone restraint as shown in chart 10 below:

![Chart 10 - Use of prone vs supine restraint 2018/19](chart)

The chart shows that not only is there a reduction in the use of prone restraint, there is also a reduction in the use of both prone and supine restraint overall.

2.2.5.2 Quality Indicator – Participation in the national programme of improving the physical health of patients with Serious Mental Illness

In 2018/19, we participated in the national CQUIN programme of improving the physical health of patients with serious mental illness (SMI). Patients with SMI like schizophrenia, bipolar disorder and schizoaffective disorder die about 15–20 years earlier than the general population due to an increased risk of treatable physical health conditions such as diabetes and coronary heart disease.

Our aim is to improve the physical health care of our patients with SMI by ensuring that they have a comprehensive cardio-metabolic risk assessment, have access to the necessary treatments/interventions and the results are recorded in their care record and shared appropriately with the patient, the treating clinical teams and the GP.

In order to ensure that all patients have ease of access and in the instances where patients have not engaged or attended annual physical health checks with their GPs in primary care, we have put in place physical health clinics. We continue to ensure that results of screening are shared with the patient’s GP and have developed systems to improve the exchange of information with primary care, particularly around physical health.

We participated in the national CQUIN which this year was co-ordinated by the Royal College of Psychiatrists in January 2019. This included standards on physical health screening and intervention for our patients. Whilst we have submitted data to the national team, the official results are yet to be made available. However we have provided details of our achievement against the national target based on our own internal self-assessment of the data submitted. Please note that these figures are subject to change following publication of results from NHS England in June 2019.

2.2.5.1 Quality Indicator – Engaging in national audits

One of our trust values is to ensure excellence in everything that we do by providing services and delivering care in line with national best practice and guidelines. One of the ways to do this is to engage in national audit. In 2018/19, we have made every effort to participate in national audits applicable to the services that we provide. As described in section 2.4.1 below, we participated in 12 national audits.

We are also part of the NHS Benchmarking network and participated in the Mental Health Benchmarking Project and the CAMHS workforce national stocktake. Highlights of two national audits we participated in during the reporting period is provided in section 2.4.1.
1. Performance Report

Performance Overview

1. Performance Report

Performance Overview

2.2.6 Quality Objective 6 – Ensure we routinely measure clinical outcomes (how our care makes a difference to patients) – Clinical Effectiveness

The 6th and final quality objective is to ensure that we can routinely measure clinical outcomes and assess if care delivered to patients have made a difference.

For 2018/19, our improvement goal was to undertake a benchmark of Oxleas teams who regularly use clinical outcome measures and increase the coverage to ensure all Oxleas clinical directorates routinely measure the outcome of care delivered to patients.

We carried out a benchmark of all directorates in November 2018, determining which clinical outcome measures were being used by teams, what outcomes were being recorded electronically and which of these could only be collated manually. Our survey shows that there are 88 Oxleas eligible teams that can adequately use clinical outcome measures, however only 46 (52%) of these teams use clinical outcome measurement as part of routine practice.

<table>
<thead>
<tr>
<th>Number audited</th>
<th>Number of compliant records</th>
<th>% compliance</th>
<th>National target</th>
<th>CQUIN performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient services</td>
<td>50</td>
<td>45</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Early Intervention in psychosis teams</td>
<td>81</td>
<td>78</td>
<td>96%</td>
<td>90%</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>100</td>
<td>91</td>
<td>91%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Ensuring we routinely measure clinical outcomes remains an area of ongoing focus for the trust and we have identified quality goals for 2019/20.

2.3 Our Quality improvement priorities for 2019/20

In the following section, we tell you about our chosen quality priorities for 2019/20. Our priorities reflect the breadth of services we provide as follows: mental health and adult learning disability services across Bexley, Bromley and Greenwich; community health services across Bexley and Greenwich, specialist forensic mental health and prison healthcare across Kent and Greenwich.

Oxleas is committed to delivering quality services and we make every effort to work in partnership with our service users’, carers, members, staff and commissioners to identify what our quality priorities should be each year. Every year we hold public meetings in each of our boroughs of Bexley, Bromley and Greenwich to give feedback on progress against our quality goals and invite opinion about potential areas of priority in the coming year. In addition, our priority areas are influenced by our engagement with local and national commissioners, through our quality meetings, our council of governors, patient groups such as Healthwatch, feedback from patient experience surveys, lessons learned from incidents and the outcome of our CQC inspection.

We also engage with staff at away days, staff meetings and annual planning events. Oxleas quality priorities for 2019/20 have also been reviewed and agreed by the trust’s Performance & Quality Assurance Committee (a sub-committee of the Board).
### 1. Performance Report

#### Performance Overview

<table>
<thead>
<tr>
<th>Quality Objective</th>
<th>Quality Indicator</th>
<th>Service area applicable to</th>
<th>Quality Domain</th>
<th>How these will be monitored</th>
</tr>
</thead>
</table>
| **Quality Objective 1**  
Ensure we meet our patient promise | To ensure 90% of patients who respond to our surveys are reporting they have been provided with enough information about care and treatment | All Oxleas Services | Patient Experience | These indicators will be monitored by the Trust Patient Experience Group and monthly by the Trust Performance & Quality Assurance Committee |
| | To ensure 90% of patients who respond to our surveys are reporting that they have been involved in decisions about their care and treatment | All Oxleas Services | | |
| | To ensure 90% of patients who respond to our surveys are reporting that staff have treated them with dignity and respect | All Oxleas Services | | |
| | To ensure 90% of patients who respond to our surveys are reporting that their quality of life has improved as a result of the care and treatment that they have received/was the service provided helpful? | All Oxleas Services | | |
| | To have a minimum of 10% response rates to our patient experience surveys | All Oxleas Services | | |
| | To ensure 90% of Oxleas teams undertake patient experience surveys | All Oxleas Services | | |

<table>
<thead>
<tr>
<th>Quality Objective</th>
<th>Quality Indicator</th>
<th>Service area applicable to</th>
<th>Quality Domain</th>
<th>How these will be monitored</th>
</tr>
</thead>
</table>
| **Quality Objective 2**  
Ensure we involve families, carers and people important to our patients | To ensure 90% of patients who respond to our surveys and who reported that they wanted friends/relatives involved in their care/treatment did feel that they were involved | All Oxleas Services | | |
| | Ensure we involve families, carers and people important to our patients | All Oxleas Services | Patient Experience | These indicators will be monitored by the Trust Patient Experience Group and monthly by the Trust Performance & Quality Assurance Committee |
| | To ensure 80% of patients receiving care and treatment from our mental health services (inpatients and community) have their support network identified and noted within their care record | All Oxleas Services | | |
| | To ensure 50% of patients receiving care and treatment from our community physical health services have their support network identified and noted within their care record | All Oxleas Services | | |

<table>
<thead>
<tr>
<th>Quality Objective</th>
<th>Quality Indicator</th>
<th>Service area applicable to</th>
<th>Quality Domain</th>
<th>How these will be monitored</th>
</tr>
</thead>
</table>
| **Quality Objective 3**  
Ensure we involve patients in planning their care and they have a care plan that is personal to them | To ensure 75% of Oxleas eligible teams participate in the care planning audits | All Oxleas Services | Clinical Effectiveness | These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance & Quality Assurance Committee |
| | Ensure we involve patients in planning their care and they have a care plan that is personal to them | All Oxleas Services | | |
| | To ensure 95% of our patients will have a recorded care plan on RiO | All Oxleas Services | | |
| | To ensure 95% of our patients on CPA will receive a 12 monthly review | All Oxleas Services, ALD Forensic & Prisons | | |

Table 5 – Oxleas Quality Priorities 2019/20
1. Performance Report

Performance Overview

We will maintain a trustwide focus on the following safety areas:

**Restraint**
- Ensure a 10% reduction on numbers of physical restraint (baseline data - March 2019)
- Ensure 95% physical health monitoring is recorded in the care records following rapid tranquilisation
- Ensure 95% of patients' debriefing is documented in the care records following a restraint

**Physical Health Monitoring**
- 100% of wards undertaking NEWS2 monitoring and recording

**Falls**
- To ensure we achieve 80% of older inpatients in our community intermediate units receive the national three impact actions to prevent falls:
  - Lying and standing blood pressure recorded at least once.
  - No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics).
  - Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit.

**Suicide prevention**
- Ensure we meet 100% of the year 1 (2019/20) STORM training target for the identified eligible staff

These indicators will be monitored by the Trust Patient Safety Committee and monthly by the Trust Performance & Quality Assurance Committee.

---

**Quality Objective 5**
Ensure we provide care in line with national best practice and guidelines

- Inpatients – 90%
- Community Mental Health – 80% for patients on CPA
- Early Intervention in psychosis teams – 90%

These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance & Quality Assurance Committee.

---

**Quality Objective 6:**
Ensure we routinely measure clinical outcomes so that we know that our care makes a difference to patients

- We will ensure 60% of the eligible teams in our Children & Young People, Forensic and Adult Learning Services routinely measure and record paired clinical outcomes in the patient record
- We will undertake a pilot of the use of DIALOG in our ICMP and EIP community mental health teams
- To ensure the use of the Modified Barthel Index (MBI) clinical outcome measure on admission and discharge of patients to our Community intermediate care units to determine level of dependency
- We will ensure implementation of the following patient experience measures:
  - 90% of patients who respond to our surveys to report that they would recommend our service to friends and family if they need similar care or treatment
  - 90% of patients who respond to our surveys to report that their quality of life has improved as a result of the care and treatment that they have received/was the service provided helpful?

These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance & Quality Assurance Committee.
2.4 Statements of Assurance from the Board

For this section of the Quality Accounts, we provide a number of nationally mandated statements of assurances from our trust board.

During 2018/19, Oxleas NHS Foundation Trust provided and/or sub-contracted seven relevant health services covering the following directorates:

- Greenwich Services (mental health and community physical health)
- Bexley Services (mental health and community physical health)
- Bromley Services (mental health)
- Adult Learning Disabilities Services (inpatient and community)
- Children and Young people Services (mental health, community and specialist children)
- Specialist Forensic Mental Health Services (inpatient and community)
- Prison health care (Kent and Greenwich)

Mental health and adult learning disability services are provided across the London boroughs of Bexley, Bromley and Greenwich; in addition to this, our specialist forensic services also take referrals from any area nationally if clinically appropriate. Community physical health services are provided across Bexley and Greenwich, and community health visiting services are provided across Bromley and Greenwich only.

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

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Oxleas for 2018/19.

2.4.1 Participation in Clinical Audits

Oxleas NHS Foundation Trust uses participation in national clinical audit programmes and confidential enquiries as a driver for improvements in quality. Initiatives like these not only provide opportunities for comparing practice nationally, they play an important role in providing assurances about the quality of our services. We are committed to ensuring that all clinical professional groups participate in clinical audit.

During 2018/19, 12 national clinical audits and 21 national confidential enquiries covered NHS services that Oxleas NHS Foundation Trust provides.

During this period, Oxleas participated in 100% of the 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 was eligible to participate in during 2018/19 are as follows in tables 6 and 7 below.

The national clinical audits and national confidential enquiries that Oxleas participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>No.</th>
<th>National clinical audit title 2018/19</th>
<th>Participation (yes/no)</th>
<th>Number of cases submitted</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>Yes</td>
<td>116</td>
<td>94%</td>
</tr>
<tr>
<td>3</td>
<td>National Audit of Cardiac Rehabilitation (NACR)</td>
<td>Yes</td>
<td>385</td>
<td>56%</td>
</tr>
<tr>
<td>4</td>
<td>National Audit of Intermediate Care (NAIC)</td>
<td>Yes</td>
<td>259</td>
<td>62%</td>
</tr>
<tr>
<td>5</td>
<td>National Clinical Audit of Psychosis – spotlight audit</td>
<td>Yes</td>
<td>150</td>
<td>100%</td>
</tr>
<tr>
<td>6</td>
<td>6D. Assessment of side effects of depot antipsychotics (POMH)</td>
<td>Yes</td>
<td>139</td>
<td>100%</td>
</tr>
<tr>
<td>7</td>
<td>7f. Monitoring of patients prescribed lithium (POMH)</td>
<td>Yes</td>
<td>113</td>
<td>100%</td>
</tr>
<tr>
<td>8</td>
<td>16B. Rapid Tranquilisation (POMH)</td>
<td>Yes</td>
<td>36</td>
<td>100%</td>
</tr>
<tr>
<td>9</td>
<td>National Audit of Anxiety and Depression</td>
<td>Yes</td>
<td>83</td>
<td>100%</td>
</tr>
<tr>
<td>10</td>
<td>National Audit of Anxiety and Depression Spotlight Psychological Therapies</td>
<td>Yes</td>
<td>228</td>
<td>100%</td>
</tr>
<tr>
<td>11</td>
<td>18A. Use of Clozapine (POMH)</td>
<td>Yes</td>
<td>95</td>
<td>100%</td>
</tr>
<tr>
<td>12</td>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>Yes</td>
<td>15</td>
<td>83%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>National clinical audit title 2018/19</th>
<th>Participation (yes/no)</th>
<th>Number of cases submitted</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mental Health Clinical Outcome Review Programme (National Confidential Inquiry into Suicide and Homicide (NICH))</td>
<td>Yes</td>
<td>21</td>
<td>100%</td>
</tr>
</tbody>
</table>
The reports of 8 national clinical audits were reviewed by Oxleas in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided. All national and trust wide priority audits are reviewed at the trust Clinical Effectiveness Group (CEG - a sub-group of the trust Quality Committee) where results are presented and action plans are agreed

2.4.1.1 – National Parkinson’s Audit

The Oxleas Neuro Rehabilitation Team is a community based multi-disciplinary service seeing anyone with an acquired neurological condition who would benefit from rehabilitation. The team visits people in their own homes or nursing homes and in addition runs therapy groups. The team is made up of Occupational Therapists, Physiotherapists, Speech and Language Therapists, Neuro nurses, Therapy assistants and a nurse specialist for Multiple Sclerosis and one for Parkinson’s.

We participated in 2017 Parkinson’s UK audit of services providing care for people with Parkinson’s; the review of the findings occurred during the 2018/19 reporting period. The aim of the audit was to outline the current state of Parkinson’s services with reference to the new guidelines, Parkinson’s disease in Adults (National Institute for Health and Care Excellence, NICE, 2017) and identify areas for quality improvement.

The audit was conducted by therapists and nurses in the Bexley Neuro Rehabilitation Team, with the main data collection via:

- A retrospective notes audit – patients with a confirmed diagnosis of Parkinson’s disease open on the team caseload
- Patient Reported Experience Measure (PREM) – a selection of patients were sent a survey to provide feedback on the service provided

The results of the audit showed that we offered a service that met the key areas stipulated in the Parkinson’s guidelines however the following areas were highlighted for improvement:

- Identifying Parkinson’s specific competencies for completion during team induction
- Referrals to Occupational Therapy for leisure-based goals
- A consistent approach to measures taken at initial assessment and each review point for communication.
- Waiting times for physiotherapy to continue to be monitored and patients to be prioritised on the basis of need
- Ensuring a full assessment of leisure, work and family roles is explored at initial assessment

The results of the audit have been reviewed by the trust Clinical Effectiveness Group (CEG) and we have agreed the following actions:

- We will identify competencies specific to Parkinson’s for inclusion at the team induction.
- We will review current documentation and training to ensure referrers and staff within the team are aware of the importance of leisure, work and family roles
- We will continue to monitor & manage the waiting times for physiotherapy to ensure that all patients are seen on the basis of need, meeting the locally agreed standard waiting times
- We will identify minimum communication and swallowing measures to be taken at initial assessment and at each review as appropriate.

2.4.1.2 Prescribing Observatory for Mental Health Audit (POMH) – prescribing valproate for bipolar disorder

Valproate is a medicine used to treat epilepsy and bipolar disorder. There are risks to the foetus if a woman takes valproate when she is pregnant. In women who are prescribed valproate for bipolar disorder and do not have epilepsy, 2-3 babies out of every 100 may have a birth defect, for example spina bifida, and around 30-40 out of every 100 may have developmental problems.

The national audit standards state the following:

- Do not routinely prescribe valproate for women of child-bearing age
- If valproate is prescribed for a woman of child-bearing age, there should be documented evidence that the woman:
  - is aware of the need to use adequate contraception, and
  - has been informed of the risks that valproate would pose to an unborn baby.

Prior to initiating treatment with valproate, the following should be documented in the clinical records: weight and/or BMI, the results of liver function tests (LFTs), and a full blood count (FBC).

Body weight and/or BMI, blood pressure, plasma glucose and plasma lipids should be measured at least annually during continuing valproate treatment.

In addition to standards around prescribing for women of child-bearing potential, there is the treatment target:

‘Serum valproate levels should not be routinely monitored unless there is evidence of ineffectiveness, poor adherence or poor tolerability/toxicity.’

Where we did well:

- For women of child-bearing potential with a diagnosis of bipolar disorder, valproate was prescribed for 23% in the total national sample (TNS) compared to only 18% in the Oxleas sample; for both the TNS and Oxleas there has been virtually no change since the baseline audit.
- When valproate was started in women of child-bearing potential in Oxleas (n=2) there was documented evidence regarding use of contraception and evidence that safety issues were discussed in both cases.
- Of 3 early on-treatment reviews in Oxleas patients, all had therapeutic response documented though with some gaps in adherence assessment, weight, side-effect and blood monitoring (FBC/LFTs).

Where there is room for improvement:

Valproate levels were measured for 16% of the subsample in Oxleas; 10% for non-indicated clinical reasons. This compares to 8% and 4% in the total national sample respectively.

Summary of actions:

- A ‘valproate’ page on the trust intranet page, explaining the rationale for the new national guidance, with links to all resources required.
- Feedback to teams/trust governance meetings with feedback pamphlet, summarising results.
- Pharmacy newsletter item in December 2018 explaining why valproate plasma levels should not be analysed routinely.
2.4.2 Oxleas Clinical Audit Programme

The reports of 28 local clinical audits were reviewed by Oxleas in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided:

- Ensure recommendations and action plans are agreed across each of our directorates to improve the quality of healthcare provided. We will continue to maintain a focus on improving clinical practice in accordance with national and local guidance; and ensure that these form part of our local clinical effectiveness group work plans.

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

Quality & Governance Department
Oxleas NHS Foundation Trust
Pinewood House, Pinewood Place
Dartford, Kent, DA2 7WG
Tel: 01322 625770

2.4.3 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Oxleas in 2018/19 that were recruited during that period to participate in national research studies approved by a research ethics committee was 461, which represents a 32% increase on the previous financial year. We have also hosted 35 locally initiated service evaluations and 6 locally initiated formal research studies across our services.

Our on-going participation in clinical research both national and local demonstrates our commitment to improving the quality of care we offer and our contribution to wider health improvement. It allows our service users and carers access novel treatments that are not available as routine NHS care and also provides an opportunity for our clinical staff to be trained in providing them.

2.4.4 Quality Improvement and Innovation Goals agreed with Commissioners

A proportion of Oxleas income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between Oxleas and any person or body we have entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework (CQUIN). Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically from our Quality and Governance Department (oxl-tr.quality@nhs.net)

Our total 2018/19 CQUIN income conditional on achieving all the quality improvement and innovation goals was £4.16m. The assumed provisional payment dependant on confirmation from our associated commissioners on achieving the goals set by the end of March 2019 is £3.4m. Our total CQUIN income for the previous year 2017/18 was £3.35m.

2.4.5 Registration with the 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 taken enforcement action against Oxleas during 2018/19. Oxleas has participated in investigations relating to services provided at Oaktree Lodge by the Care Quality Commission during 2018/19. Oaktree Lodge is a 17 bed ward providing continuing care to older adults with mental health problems. The ward provides care and treatment to male and female patients, and most patients also have physical health problems. CQC's investigation was a focussed unannounced inspection of Oaktree Lodge which took place on the 9th of April 2018. Oxleas was issued with a S29A Warning Notice in relation to the following areas:

- Person Centred Care – the care and treatment of patients was not always appropriate
- Dignity and Respect – there were incidences where patients were not always treated with dignity and respect
- Safe Care and Treatment – there were incidences where assessment of risks to the health and safety of patients were not done in a timely way
- Good governance – The trust had not effectively assessed, monitored and improved the quality and safety of the service provided.

Oxleas took the following actions to address the requirements reported by CQC:

- We put in place an immediate improvement action plan that was shared with CQC, NHS Improvement, NHS England and our local Clinical Commissioning Group (Greenwich CCG)
- A taskforce group chaired by the Deputy Chief Executive met weekly to oversee progress against each area
- We put in place a staff development and support programme to improve morale, purpose and recognition
- We increased senior leadership and visibility to the unit
- The trust Performance & Quality Assurance committee (a sub-committee of the Board) maintained oversight of the improvement plan.

Oxleas has made the following progress by 31 March 2019. We were disappointed that the above areas had been identified for improvement and worked with staff to ensure that significant changes could be made to improve patient care. We are pleased to report that CQC came back and re-inspected Oaktree Lodge on the 20th of June 2018 and their findings showed that each regulation breach had been resolved and that significant improvements had been made within a 3 month period. As a result the S29A notice has been lifted.

In addition, Oxleas underwent a comprehensive inspection by the Care Quality Commission between 21 November 2018 and 11 January 2019; 6 of our 14 core services were visited and a well led inspection also took place. Their inspection report was published in March 2019 giving Oxleas an overall rating of Good and rated some of our services as outstanding for caring and effectiveness.
Joint Her Majesty's Inspectorate of Prisons (HMIP) and CQC Inspections

Oxleas provides services to Greenwich and Kent Prisons and during 2018/19, the HMIP and CQC'S Health and Justice Team carried out joint inspections of the following prisons:

- HMP Isis – 23 July to 2 August 2018
- HMP Thameside – 16-17 August 2018
- HMP Maidstone – 8, 9 and 15-19 October 2018
- HMP Rochester – 8 November 2018

Oxleas has put in place improvement action plans for the following areas where regulations were not met:

- Person-centred care – management of patients with long term conditions
- Good governance – ensuring systematic monitoring of quality and safety of services being provided

Progress against these improvement plans is monitored by the trust Executive and the Performance & Quality Assurance Committee (a sub-committee of the Board)

Provided across is the updated CQC ratings dashboard for the trust:
2.4.6 Data Quality

Oxleas submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data that included the patient’s valid NHS Number was:
- 99.23% for admitted patient care
- 99.88% for outpatient care
- 0% for accident and emergency care. (This is not applicable, as Oxleas does not submit data in relation to accident and emergency care. This is an acute trust indicator)

The percentage of records in the published data that included the patient’s valid General Practice Code was:
- 99.23% for admitted patient care
- 99.88% for outpatient care
- 0% for accident and emergency care. (This is not applicable, as Oxleas does not submit data in relation to accident and emergency care. This is an acute trust indicator)

2.4.7 Information Governance Toolkit

The information governance toolkit has been superseded by the NHS Digital Data Security and Protection (DSP) Toolkit. There are 100 mandatory requirements in the NHS Digital DSP toolkit and Oxleas DSP overall submission for 2018/19 was ‘Standards met’.

2.4.8 Clinical Coding

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

2.4.9 Improving Data Quality

Oxleas will be taking the following actions to improve data quality:
- Continue to ensure all our clinicians are trained to record effectively on RiO (our patient electronic clinical system)
- Use our clinician tasklist on Ifox (Information for Oxleas)* to check completeness of recording information on RiO
- Validate data provided to teams and directorates on a monthly basis to ensure accuracy.
- Continue an ongoing programme of audit through our Clinical Data Governance Group

*Ifox – This is the Oxleas Business Information System.

2.5 Learning from deaths

For 2018/19, all NHS trusts have a requirement to publish learning from deaths data. The Oxleas 2018/19 position is provided below:

2.5.1 Number of patients who died in 2018/19

During 2018/19, 1,068 of Oxleas patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
- 286 in the first quarter
- 263 in the second quarter
- 263 in the third quarter
- 256 in the fourth quarter

These numbers have been estimated using the root cause analysis methodology. The panel considered whether the incidents could have been predicted or prevented. Since October 2017, our investigation panels have also used The Royal College of Physician’s Structured Judgement Review to form a view of avoidability. None of the deaths reviewed have been considered avoidable.

2.5.2 Number of deaths subjected to a case record review or an investigation

By 24th April 2019, 1,021 case record reviews and 47 investigations have been carried out in relation to 1,068 of the deaths included in item 27.1.

In 1,068 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:
- 286 in the first quarter
- 263 in the second quarter
- 263 in the third quarter
- 256 in the fourth quarter

2.5.3 Estimate number of deaths for which a case review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided

In 1,068 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a death investigated were more likely than not to have been due to problems in the care provided was:
- 17 representing 1.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

- In relation to each quarter, this consisted of:
  - 1 representing 0.3% for the first quarter;
  - 2 representing 0.7% for the second quarter;
  - 12 representing 4% for the third quarter;
  - 2 representing 0.8% for the fourth quarter

2.5.4 Summary of what Oxleas has learnt from case record reviews and investigations undertaken in 2018/19, actions taken and assessment of impact

We have provided below some examples of what we have learnt from some of the case reviews and investigations undertaken, the actions taken and the assessment of the impact of the actions taken. This covers 27.4, 27.5 and 27.6 of the ‘learning from deaths’ quality account regulations.

Lesson 1

There continues to be variation in care planning. Care plans do not always adequately reflect current care needs and changing risks, including physical health needs.
- Action taken: All services are expected to complete an audit of 5 patients care plans every month. The results of the audits are shared with the team.
- Assessment of the impact of the actions: All services are expected to complete an audit of 5 patients care plans every month and these are monitored via the CEG.
Lesson 2
In some cases there was a requirement for more robust completion of physical health monitoring during admissions.

- Action taken: Heads of nursing have developed a template to assess and monitor physical health care on the mental health wards.
- Assessment of the impact of the actions: The Heads of nursing now use this template to audit how the physical health of patient’s on the mental health wards are monitored each month. This information is then shared with the team and support provided where identified.

Lesson 3
There were instances where carers could have been involved in a discussion about overnight leave. It was also identified that there needs to be better checking and updating of next of kin details on admission to hospital.

- Action taken: Heads of nursing have developed a template to assess and monitor physical health care on the mental health wards.
- Assessment of the impact of the actions: The Heads of nursing now use this template to audit how the physical health of patient’s on the mental health wards are monitored each month. This information is then shared with the team and support provided where identified.

Lesson 4
In one case it was identified that there was poor engagement in outcomes monitoring.

- Action taken: Psychological therapists are developing a protocol for management of poor engagement in evaluating outcome measures.
- Assessment of the impact of the actions: This has been completed and the CORE 10 is now reviewed as part of psychotherapy sessions.

Lesson 5
In a number of incidents the risk assessment did not reflect the current risks, in particular after every significant event.

- Action taken: Risk assessments are to be reviewed with staff during supervision to monitor the quality and accuracy of the assessment.
- Assessment of the impact of the actions: Heads of Nursing continue to review the quality and completeness of risk assessments.

Lesson 6
In two cases The Safe and Therapeutic Observation policy was not adhered to. Staff were not engaging with patients during observations.

- Action taken: The teams have been reminded to engage with service users when carrying out observations.
- Assessment of the impact of the actions: Staff have read ‘The Safe and Therapeutic Observation policy’ with their manager and sign a competency form.

Lesson 7
Teams are to implement the recently approved trust wide action plan in relation to the management of co-morbid substances misuse.

- Action taken: An embedded learning event on substances misuse and alcohol took place on 22 February 2019. The event focused on joint working with substance misuse services, expectation of staff, overcoming barriers to engagement, legal highs and key themes from serious incidents.
- Assessment of the impact of the actions: 42 staff attended the Substance Misuse and Alcohol event. The event incorporated 5 sessions; Joint working with substance misuse services, (Not so) legal highs: what you need to know about Novel Psychoactive Substances, The expectation of Adult Mental Health Staff in supporting patient who have substance misuse problems, Overcoming barriers to engagement, and Key Themes from Serious Incidents. The overall event was rated as; Excellent – 50%, Good – 50%.

2.5.5 The number of case record reviews or investigations not included in section 2.5.2
0 case record reviews and 0 investigations completed after 31st March 2018 which related to deaths which took place before the start of the reporting period.

2.5.6 Estimate number of deaths for which a case review or investigation has been carried out in section 2.5.5 above for which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided
0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.
Table 8

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period</td>
<td>97.6%</td>
<td>99.0%</td>
<td>97.0%</td>
<td>95.5%</td>
<td>100.0%</td>
<td>81.6%</td>
</tr>
<tr>
<td>The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period</td>
<td>99.2%</td>
<td>99.5%</td>
<td>98.2%</td>
<td>97.8%</td>
<td>100.0%</td>
<td>78.8%</td>
</tr>
<tr>
<td>Percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. (question 21d)</td>
<td>65.4%</td>
<td>67.0%</td>
<td>66.2%</td>
<td>66.2%</td>
<td>79.1%</td>
<td>55.9%</td>
</tr>
<tr>
<td>The trust’s ‘patient experience of community mental health services’ indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period</td>
<td>7.5/10</td>
<td>7.6/10</td>
<td>7.0</td>
<td>Not provided</td>
<td>7.7/10</td>
<td>5.9/10</td>
</tr>
<tr>
<td>The number and where available, the rate of patients safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death</td>
<td>No.</td>
<td>45</td>
<td>24</td>
<td>27</td>
<td>Not available on NHS Digital website</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>0.59</td>
<td>0.35</td>
<td>1.5</td>
<td>Not available on NHS Digital website</td>
<td></td>
</tr>
</tbody>
</table>

Please note: The information published above are taken from differing reporting periods by the NHS Digital, NHS England or the Care Quality Commission.

Q4: Care Quality Commission: Patient experience of community mental health services. Published November 2018 http://www.nhssurveys.org/Filestore/MH18/MH18_RPG.pdf

For indicators 1 and 2 relevant to the services we provide shown in table 8 above:

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

- These are based on our involvement in the National Patient and National Staff Surveys
- It meets the NHS Outcomes Framework
- The data for these indicators is provided by the CQC and NHS England.

Oxleas intends to take the following actions to improve the percentage of 66.2% and rate of 7.0 respectively and so the quality of its services, by continuing our focus on the following:

- National Patient Survey - we have put a robust plan in place to tackle areas that require further improvement as identified by the results of the 2018 survey; this is overseen by our trust Patient Experience Group.
- National Staff Survey - We have engaged with staff to enquire what we can do better and have put in place action plans for the identified areas that require further improvement. Our Workforce Committee will monitor these and report to the Board of Directors.

For indicator 5 relevant to the services we provide shown in table 8 above:

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

- These are NHS Improvement (NHISI) targets that we report on monthly
- It meets the NHS Outcomes Framework domains of preventing people from dying prematurely and enhances the quality of life for people with long term conditions
- The data for these indicators are recorded on RIO and submitted to NHS Digital and NHISI

Oxleas intends to take the following actions to improve the percentage of 97%, and so the qualities of its services by continuing our focus of following up patients within 7 days after discharge from psychiatric in-patient care. Our aim is to improve this to 100% although we recognise that there may be occasions when our staff cannot meet this goal for reasons outside their control. In terms of ensuring that all of our admissions to acute wards are gate kept by our Crisis Resolution Home Treatment Teams, we will maintain our focus and improve our position from and 98.2% to 100%.
Oxleas considers that this data is as described for the following reasons:

- This is patient safety information we report to the National Reporting and Learning System (NRLS)
- It meets the NHS Outcomes Framework domains of treating and caring for people in a safe environment and protecting them from avoidable harm
- The data for this indicator is recorded on Datixweb (our local incident reporting database)

Oxleas intends to take the following actions to improve the patient safety incidents that result in severe harm or death and so the quality of its services, by continuing our focus by reviewing trends and themes, learning from events and embedding learning across the trust. We will also review all reported deaths at our Mortality Surveillance Group on a monthly basis.

3.0 Other Quality Performance Information

In this section of the Quality Accounts we present other information relevant to the quality of the services provided in 2018/19.

In the earlier part of our report (please see section 2.2), we presented how we have performed against the 2018/19 quality priorities with reference to our performance in previous years where available. No changes have been made to the indicators published in the 2017/18 report.

We have provided statements of assurance on our national priorities and how we have performed against the relevant indicators. We have also looked forward to 2018/19 and highlighted our quality goals that have been agreed by our Performance & Quality Assurance Committee taking into account the views of our stakeholders to improve the quality of our services. Not all areas of focus have been included in our quality improvement goals as some are aligned to our service development strategy and our internal quality improvement initiatives within the trust. Progress on these will be reviewed through our Performance & Quality Assurance Committee, the Quality Improvement and Innovation Committee and the trust quality sub-groups of Patient Experience, Patient Safety and Clinical Effectiveness.

3.1 Performance against NHS Improvement’s Single Oversight Framework Indicators

In accordance with NHS Foundation Trusts requirements from NHS Improvement (NHSI), we have detailed below our performance against the NHSI indicators that appear in the single oversight framework. There are 7 indicators applicable to the services that we provide and our performances against these are provided below:

### Table 9

<table>
<thead>
<tr>
<th>Single Oversight Framework Indicator for disclosure</th>
<th>2018/19 Performance</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:</td>
<td>Awaiting publication of national audit results from NHS England (internal self-assessment provided below. This is subject to change)</td>
<td></td>
</tr>
<tr>
<td>a. inpatient wards</td>
<td>a. 90%</td>
<td>90%</td>
</tr>
<tr>
<td>b. early intervention in psychosis services</td>
<td>b. 96%</td>
<td>75%</td>
</tr>
<tr>
<td>c. community mental health services (people on care programme approach)</td>
<td>c. 91%</td>
<td></td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT): Proportion of people completing treatment who move to recovery (from IAPT dataset)</td>
<td>58.9%</td>
<td>50%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT): Waiting time to begin treatment (from IAPT minimum dataset)</td>
<td>a. 94.2%</td>
<td>a. 75%</td>
</tr>
<tr>
<td>a. Within 6 weeks of referral</td>
<td>b. 99.6%</td>
<td>b. 95%</td>
</tr>
<tr>
<td>b. Within 18 weeks of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Programme Approach (CPA) follow up: proportion of discharges from hospital followed up within 7 days</td>
<td>96.6%</td>
<td>95%</td>
</tr>
<tr>
<td>Admissions to adult facilities of patients under 16 years old</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inappropriate out-of-area placements for adult mental health</td>
<td>652.7 average bed days per month</td>
<td></td>
</tr>
</tbody>
</table>
3.2 Additional NHS Improvement Reporting Requirements

Trusts are required to provide additional information in the 2018/19 Quality Accounts. For Oxleas, these cover our arrangements for ‘Freedom to speak up’ - how we support staff to openly speak up without blame or suffer of detriment and our improvement plans to reduce gaps in our medical rotas:

3.2.1 Oxleas Freedom to Speak up Approach

The trust undertook a focused programme of work in 2018/19 to encourage staff to speak up and emphasise the fact that no victimisation or harassment would follow concerns being raised. The programme was initiated with publicity on the role of the Freedom to Speak up (FTSU) guardians through videos and poster. ‘Let’s talk’ sessions with the Executive were publicised which allowed any individual in the trust to seek an audience with an Executive Director at any time.

A revised workflow was designed in April 2018 which made it easier for staff to understand the process and clearly highlighted the routes that they could follow to raise concerns within and outside the trust. The role of the guardians and the importance of staff raising concerns is emphasised at all new starter corporate inductions by the FTSU Guardian and the Director of Workforce and Qi as the Executive lead for speaking up. A copy of the workflow is also handed out to every new starter in the trust. In addition, an anonymous reporting portal was launched in January 2019 which allows all employees to raise concerns anonymously but continue to engage in a dialogue on actions taken.

3.2.3 Improvement Plan for Doctors rota gaps

Trainees in Oxleas NHS Foundation Trust are on a shared training scheme (the Maudsley Training Scheme) with South London and Maudsley NHSFT. Rota gaps inevitably occur from time to time where posts have not been filled.

In this and other instances, the trust will endeavour to fill vacancies and the resulting gaps on rotas firstly through the appointment of NHS locum doctors. In order to ensure services are not disrupted, where positions remain unfilled, gaps in the rotas are covered through the use of trust bank, Medical training Initiative (MTI) or agency doctors.

The trust has participated in Health Education England (HEE) South London meetings to raise awareness of the ongoing implications of late running regional/national recruitment cycles and the adverse impact this is likely to have on our ability to recruit locally to posts unfilled by these recruitment campaigns. We continue to liaise closely with HEE to improve recruitment timescales.
3.3 Oxleas Quality Highlights and Case Studies

Each year, in this section of our Quality accounts we showcase a few examples of good practice from our services which align to our trust values of having a user focus, excellence, learning, being responsive, partnership and safety.

We are delighted to continue to see evidence of good practice and teams going the extra mile for the benefit of the patient, making sure we make a difference and improving lives.

3.3.1 Oxleas Quality Improvement Programme

We have a vision of creating a culture of continuous quality improvement across the whole organisation. In order to achieve this we have put in place a systematic Quality Improvement (Qi) Programme that is underpinned by the improvement techniques, systems and practices and Improvement Science. The Oxleas Qi programme was officially launched in April 2018, following investment by the trust Board of Directors. Our Qi programme focuses on the following key areas:

- Improve patient and carer experience and eliminate harm
- Improve access to care at the right location and in a timely manner (and therefore reduce delays)
- Improve reliable adoption of evidence-based care such as personalising care planning and implementing NICE guidance
- Reduce (delays) and eliminate inefficiencies and therefore costs attributable to re-work, repeated assessments, repeated checks and addressing concerns and complaints
- Consistent delivery of our quality priorities and improved outcomes across the organisation
- High staff engagement, a valued workforce, joy at work with improved recruitment and retention
- Developed data systems that effectively capture data to drive decision making at clinical and managerial levels
- Improved patient engagement and education
- Reduction in waste across the organisation

The Oxleas Qi framework is the Model for Improvement which asks the following questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

These three fundamental questions are underpinned by the plan, do, study, act (PDSA) cycle.

Qi Training – Building Staff Capability in Qi

In order to make Qi successful in Oxleas, to create a culture of continuous quality improvement and ensure improvement is everyone’s business, we have put in place a clear learning/training strategy for Qi. We want a culture whereby Oxleas staff become empowered to focus on where they can make improvements to the work they do: no matter if it be in clinical care, finance, IT, estates and facilities or human resources. Based on this we have put in place a range of training/awareness options that will cover the whole trust. These range from online learning, half day or full day to advanced expert level training. Since the launch of the programme in April 2018, 10% of Oxleas staff have received some form of Qi training and we expect to see a further 17% of staff trained in 2019/20.

We expect our Qi programme to help deliver the following:

- Local teams engaged in locally led and owned improvement processes
- Permanent staff were moved to day shifts, apart from at least one permanent registered nurse on each night shift. This initially caused some upset for permanent staff who were not happy about losing their night shift enhancements, however 12 months later the Tarn saw a reduction in staff sickness and eliminated agency spend. Staff also felt much happier coming to work.
- Occupational Therapy Interventions on the ward: We started a new occupational therapy (OT) programme which was run by our new OT. This involved patients and staff working together to select activities structured around daily routines. These activities included relaxation, physical exercise, creative groups and one-one sessions. A timetable was then created. Service users were encouraged to identify their mood difference before and after an OT session.

Evidence of improvement:

Significant improvement has been made as a result of the Qi programme. We have seen:

- a reduction in the use of agency staff,
- a co-produced OT interventions programme that patients have been involved in
- OT interventions are having a positive impact on service users’ mental wellbeing, promoting stability in mental state and recovery. Results show that implementation of a timetable of OT activity had a significant positive impact on the wellbeing of service users.
- Improvement in roster and shift patterns to enable effective staffing levels,
- A reduction in physical violence incidents and a reduction on spend as a result of violence and aggression on the wards.
- A daily community meeting now takes place where service users and staff plan their day.

Case for change:

This project was focussed on reducing violence, aggression and agency spend on a 16 bedded Psychiatric Intensive Care Unit (PICU), the Tarn. It was observed that the Tarn was experiencing challenges relating to financial overspend, staff absence and recruitment and retention as well as incidents of violence and aggression and subjecting this to a quality improvement framework was seen as a good way forward.

What we did:

- We made some changes to how staffing was provided on the ward, such as:
  - Floating bank staff were offered block bookings of 4 weeks at a time of night shifts to cover vacancies. This encouraged bank staff to work on the Tarn ward instead of other locations / trusts.
We have provided below some charts that visually show the improvements made as a result of the work done by the team.

**Chart 11 - Tarn - Count of Incidents of Physical Violence reported on Datix - (C Chart)**

- Sep & Oct 2017 heightened violence. Oct 17 new OT starts & implements therapeutic timetable

**Chart 12 - Staff absence data: count of calendar days lost per month**

**Chart 13 - Number of incidents of restraint (Tarn)**

**Feedback from patients**

“Gina (OT) took my mind off things that make me sad, stressed and unhappy. It even made my mum happy because she likes painting and flowers. Gina got me painting flowers for my mum.”

Tarn service user

**Next steps:**
- Share learning with other Oxleas Qi projects focussed on violence reduction
- Plan for more structured activities for weekends to improve patient engagement
- Continue shared learning across London for PICU OT peer meetings
3.3.3 Bexley Intensive Case Management in Psychosis (ICMP) Qi Project – Increasing blood lipid screening for patients with serious mental illness

**Case for change**

NHS England (2017) state in their national CQUIN guidance that people with severe mental illness (SMI) are at an increased risk of poor physical health, and their life expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking. Screening cholesterol level is important in the early identification of cardiac disease, and we wanted to increase early identification and management of possible cardiac disease, improve the physical health of patients with SMI and improve patient experience.

Our overall aim was to increase the uptake of lipid monitoring for patients on CPA to 80% within 6 months as this was an area that we were struggling with. Patients were not attending appointments due to fear of needles, they did not see physical health as a priority and majority would only engage in home visits. We also found out that a lot of clinician time was lost on tasks such as booking appointments and sending clinic letters for patients who would not turn up, documentation of DNAs on the patient system or escorting patients to hospital.

**What we did:**

We trialled the use of a mobile blood lipid testing machine; the machine can test blood lipid levels with a finger prick test rather than a full venepuncture blood test. We also offered patients who declined a full blood test as an alternative.

**Results of the project:**

The table and graph below show the outcome of our improvement project:

- By November 2018 the team were reporting 100% compliance for all seven physical health CQUINS
- Blood screening compliance had risen from 64.1% to 100% in a 6 month period
- Of the 42 clients that were screened, 12 were identified as having high cholesterol
- Additional time was also created for staff by reducing the need to book appointments, send letters and complete blood forms
- Feedback from our service users say that the process is much quicker, easier and they were able to get their results in just three minutes

**Future plans:**

- Share learning with other teams across Oxleas
- Provide advice and training
- Scale up project to other teams within the borough and then across the trust

<table>
<thead>
<tr>
<th>Physical Health Indicator</th>
<th>Number of Patients for Screening</th>
<th>Number of Patients who had Screening</th>
<th>% of Patients who had Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking status screening</td>
<td>108</td>
<td>107</td>
<td>99.07%</td>
</tr>
<tr>
<td>Substance use screening</td>
<td>108</td>
<td>108</td>
<td>100%</td>
</tr>
<tr>
<td>Alcohol use screening</td>
<td>108</td>
<td>108</td>
<td>100%</td>
</tr>
<tr>
<td>Blood lipids screening</td>
<td>108</td>
<td>108</td>
<td>100%</td>
</tr>
<tr>
<td>Glucose regulation screening</td>
<td>108</td>
<td>108</td>
<td>100%</td>
</tr>
<tr>
<td>BMI screening</td>
<td>108</td>
<td>108</td>
<td>100%</td>
</tr>
<tr>
<td>BP screening</td>
<td>108</td>
<td>108</td>
<td>100%</td>
</tr>
</tbody>
</table>
3.3.4 Improving clinical outcomes in a Musculoskeletal Service

Exercise groups within physiotherapy departments have become increasingly popular in recent years, with the emergence of evidence supportive of therapeutic exercise as an effective treatment modality for many conditions including osteoarthritis, shoulder pathologies and widespread pain syndromes. Group exercises classes have been shown to be a cost effective way of treating people, reducing waitlist and having effective clinical outcomes. The use of supervised exercise therapy use is advocated by a number of NICE Guidance documents and Cochrane reviews.

The introduction of exercise classes also improves patient choice in terms of available treatments and many people find exercising within a supervised group beneficial for reasons such as improving confidence in exercise technique, motivation and adherence to rehabilitation programmes. The following have been comprised from audits of these classes. The classes resulted in the MSK team winning employee of the quarter. This improvement example also showcases one of our quality objectives – ensuring we measure clinical outcomes so that we know that our care had made a difference to patients.

**Greenwich Square**

12 month review most instruction of group exercise class – all class data has been combined

**Chart 15**

Between all classes at Greenwich square:
- 124 completed EQ5D-5L scores
- 108 of them had improvements of their EQ5D-5L score
- 270 PSFS scores were collected 249 of these scores were improved from prior to the class
- 103 out of the 129 recorded patient outcomes (80%) have been discharged to self management
- 1 has been referred to rheumatology, 2 to pain clinic, 1 to orthopaedics and 5 to circle
- 14 has been referred back to their HCP and 3 had phone reviews

**Chart 16**

From patient experience questionnaire:
“Very helpful re-motivating me to believe that I can improve my situation”
“It was good exercises and I believe I benefited from it and the staff were amazingly professional and helpful”
“I have received all the help and even more of what I needed. I am now returning to the gym. It’s something I have not been able to do for a while. I was consulted in every stage of my care”

**Patient Experience Feedback**

We also collated patient experience feedback following attendance at these classes. We have provided a snapshot from two sites (Greenwich Square and Eltham Community Hospital) below.

How likely are you to recommend this service (the group exercise class) to your family and friends?

Do you feel you can manage your condition better today as a result of today’s consultation (group class)?

“The wide range of exercises improve my range of movement, the physio spent time explaining the exercises”

“I am very happy with the service I have received so far. Very professional and friendly staff willing to go the extra mile to help me”
3.3.5 Bromley Memory Service Case Study – Improving dementia diagnosis

The Dementia 65+ estimated diagnosis rate indicator compares the number of people thought to have dementia with the number of people diagnosed with dementia. NHS England target is for at least two thirds of people with dementia to be diagnosed. This indicator is updated every month and figures published by NHS England.

Case for change
The Bromley Memory Service was commissioned as a diagnostic service in 2013 in line with NHS England guidelines and the Prime Ministers challenge on Dementia 2020. The service has been MSNAP Accredited since 2014 and we adhere to these standards and in line with the NICE guidelines for dementia. Bromley Memory Service had fallen below the diagnosis rate indicator which was set at 66.7% by NHS England. Early diagnosis helps people to have access to medication, support, information and plan for their future to assist them to live well with dementia.

What we did
We wanted to improve the diagnosis rates for Bromley and the following was put in place

- a Task and Finish group was set up with commissioners
- joint GP visits were conducted to match diagnostic data
- We promoted the memory service to GPs by updating them with services which are available to support people with dementia.

Results

**Handheld ECG machines which are set up via the iPad**

**CT Scans are now requested at point of referral**

**An A5 laminated sheet has been given on the GP visits of the Read Codes for the top 8 dementia diagnoses as recognised by NHS England and we have now included these in the GP Letters**

**Systems have been set up to access Indigo and Connect Care which gives us quicker result information and allows us to view the images**

**Chart 19 - Bromley Dementia Diagnosis Rate (Dec ’17 - Dec ’18)**

Clients comments on the Memory Service

- I was very apprehensive at going but now I feel very different and feel I have benefitted and will do. I am very grateful thank you
- It has been very beneficial and has definitely improved my quality of life
- I gained an understanding of my mother’s condition
- It has been very different and feel I have benefitted and will do. I am very grateful thank you
3.3.6 Trimipramine Review — a collaborative approach to medicines management

**Case for Change**
In 2016 the Bromley CCG Medicines Management (MM) team identified that prescribing of trimipramine, an older tricyclic antidepressant, was higher relative to other CCGs in England, despite more effective, better tolerated, and cost-effective medicines being available. A project began to review and optimise patients’ treatment with the aim of reducing trimipramine prescribing when appropriate. Initial work took place between the MM team and GP practices, providing educational and practical support to identify patients prescribed trimipramine, resulted in a 30% reduction in prescribing. This initial review highlighted a number of more complex patients, some of whom had been prescribed trimipramine for many years. A collaborative service with Oxleas NHS Foundation Trust was commissioned in September 2017 to support GPs review complex patients to improve quality, safety, and patient experience. Soon after guidance from NHS England and NHS Clinical Commissioners was published recommending that patients treated with trimipramine be reviewed and advised that GPs should no longer start this treatment in new patients.

**What we did**
- 132 patients across 33 GP practices were identified, each case was discussed with their GP to decide if the GP would review or refer to Oxleas specialist pharmacist (complex cases or those requiring additional support with considering changes)
- Referrals to the specialist pharmacist were made September 2017– April 2018
- A specialist pharmacist assessed patients either face-to-face, by telephone consultation, or a case note review. When necessary, the pharmacist discussed the case with a psychiatrist or the GP before an assessment letter, containing treatment recommendations, was sent to the GP

**Outcomes:**
- Improved collaborative working between Oxleas and GP Practices
- Following review and embedding individualised treatment plans, we were able to get a significant proportion of patients to either gradually stop treatment as it was no longer considered necessary or to switch over to other treatments (this was of benefit as we had multiple contacts with patients - pharmacist face-to-face assessments averaged 1 hour, with some patients requiring more than 1 follow-up contact to provide support)

Since the initial work started, trimipramine prescribing in Bromley CCG area has reduced by approximately 80% as seen in the chart below.

<table>
<thead>
<tr>
<th>Outcome summary</th>
<th>Proportion of patients reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient switched to alternative treatment</td>
<td>41%</td>
</tr>
<tr>
<td>Plan to reduce and stop, treatment not indicated</td>
<td>36%</td>
</tr>
<tr>
<td>Continue trimipramine</td>
<td>8%</td>
</tr>
<tr>
<td>GP to follow-up</td>
<td>15%</td>
</tr>
</tbody>
</table>

3.4 Our Staff Survey 2018

The results of the National Staff Survey 2018 (conducted between October and December 2018) were published on 26 February 2019. The national staff survey reports have changed significantly this year. Most particularly, the report no longer includes details on key findings. These have now been replaced by 10 themes, all of which are scored on a 0 – 10 scale. The themes include:
- Equality, diversity and inclusion
- Health and well-being
- Immediate managers
- Morale (new in this year’s survey)
- Quality of appraisals
- Quality of care
- Safe environment – bullying and harassment
- Safe environment – violence
- Safety culture
- Staff engagement

Benchmarking data is provided in the report against comparator trusts for each question. Our comparator profile for the national staff survey is Combined Mental Health / Learning Disability and Community Trusts and there are 31 trusts in this comparator pool.

**National Highlights**
At a national level, all 230 trusts in England participated with an overall average response rate of 46%.
Quality Report 2018/19

1. Performance Report

Performance Overview

Oxleas results
There was an improved response rate of 49% which was better than our response rate last year of 42%, and also better than the average for our comparator trusts (45%).

We saw significant improvement in two themes: Safe environment – Violence and Safety Culture. Staff perceptions in relation to violence from patients, service users and relatives / public has improved significantly from 16.5% to 19% but this remains below the comparator average. Equally, staff perceptions in relation to the organisation treating staff fairly following incidents, taking action to prevent recurrence and being given feedback have all improved and are better than the average.

Staff Engagement remains above the average. On the new 0-10 scale, the Oxleas scored 7.1, where the best trust scored 7.5 and the average was 7.0. Of the nine questions that feed into the score, there were marginal improvements on all bar one.

Scores were better than the comparator average for themes relating to staff engagement, safety culture, quality of care, quality of appraisals and immediate managers. We were worse than the average for perceptions relating to equality and diversity, health and well-being, bullying and harassment, safe environment – violence.

BME staff (510 staff) generally reported better levels of satisfaction than white staff in most questions relating to their job, support from managers, health and well-being, personal development, appraisals. They had worse perceptions in relation to their experience of violence from patients/service users, bullying and harassment from patients and colleagues/ managers, fairness in career progression. LGBT staff (57 staff) also reported worse perceptions than the average in relation to violence from patients, and bullying from patients and colleagues.

3.5 Oxleas Complaints Report 2018/19

In 2018/19 there were 924,371 patient contacts with our services; in the same period of April 2018 to March 2019 we received a total of 223 formal complaints (0.02% of overall patient contacts) and 104 informal complaints (0.01% of overall patient contacts). The trust reports on all complaints received in writing both formally and informally. We record any complaint that is made in writing to any member of the trust, CQC or CCG staff, or is originally made orally and subsequently recorded in writing. Once this is recorded, we treat it as though it was made in writing from the outset. Complaints and comments/suggestions that do not require investigation are not included in complaints reporting.

Chart 21 - The chart below shows the Directorate breakdown of the 327 complaints received

Next Steps

- We will undertake a centrally coordinated programme to address issues perceived by staff in relation to health and well-being. It is recognised that this will have an impact on retention levels and staff recommendation of Oxleas as a place to work. This will be taken forward through senior staff events in the first quarter of 2019/20.
- We will continue to focus on issues affecting poor staff perceptions regarding equality and diversity and bullying and harassment. These programmes will continue to be led centrally by the workforce team with monitoring and oversight through the Executive and Workforce Committee.
- The programme of work undertaken to address concerns relating to violence and aggression at work have started to have an impact on staff perceptions. It will be important to maintain this work and learn lessons from the work that has taken place to date.
- Our Service Directorates will also review their reports and work with their staff to identify issues that need to be addressed at a local level.
1. Performance Report

Performance Overview

Chart 22 - The chart below shows the breakdown of complaints received by Children and Young Peoples Services by borough.

Complaints investigated

Within the 327 complaints, 1024 concerns were raised. Of these 1024 concerns raised, 145 concerns are still under investigation.

The chart below shows the percentage of issues, of the 879 concluded, that were upheld, partly upheld, not upheld and those that were indeterminate.

Chart 23

Chart 23 - The chart below shows the breakdown of complaints received by Children and Young Peoples Services by borough.

Our review of the concerns raised has identified 3 significant themes Clinical Care, Attitude and Behaviour of Staff and Communication. The table below shows the number of upheld/partly upheld issues relating to these subjects.

Table 12

<table>
<thead>
<tr>
<th>Subject</th>
<th>Investigated</th>
<th>Upheld/partly upheld</th>
<th>% upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Care</td>
<td>228</td>
<td>68</td>
<td>30%</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>179</td>
<td>48</td>
<td>27%</td>
</tr>
<tr>
<td>Communication</td>
<td>150</td>
<td>83</td>
<td>55%</td>
</tr>
</tbody>
</table>

Following the completion of an investigation, when an issue has been upheld or partially upheld, a remedial action must always be identified. Of the 330 actions identified for 2018/19, 58 remain due to be completed, 16 were pending (as they are not yet due), at the time of writing this report and 256 (82%) have been completed. There are approximately 150 actions that have not been uploaded to Datix following conclusion of investigations had these been included in the data our completion rate would fall to 55%

Complaints handling

In line with the trust’s Complaints Policy the aim is to respond to complaints received within 30 working days, and agree extensions with the complainant when it is not possible to complete the investigation within this time frame. Of the 327 complaints, 283 complaints have concluded their investigations (16 complaints are outstanding, 28 were not due to be concluded as at time of writing). Of those 283 concluded, 182 (64%) were completed within the agreed timescales, a 1% decrease on last year.

Robust procedures are in place for following up with the Directorates both those complaints that are overdue with the complainant and those that are due with the complaints team; this is done on a weekly basis. It is hoped this will show an improvement in achieving the target against timescales.

Work continues to embed and disseminate lessons from complaints across all our services with the Complaints team supporting embedded learning events across Directorates. The Complaints and PALS Team will be involved in a series of short videos on learning from complaints using case studies and running sessions during team meetings across Directorates.

We will continue our focus in these areas in 2019/20 to improve the quality of the services we provide.

Parliamentary and Health Service Ombudsman (PHSO)

Complainants who are dissatisfaction with the trust response have the right to ask that the PHSO reconsider their complaint. Since April 2018, 9 complainants asked for their case to be reviewed by the Ombudsman’s Office. 2 were upheld, 4 were not upheld and three investigations are currently on-going.
## 4.0 Glossary of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACS</td>
<td>Adult Community Services</td>
</tr>
<tr>
<td>AMH</td>
<td>Adult Mental Health Services</td>
</tr>
<tr>
<td>ALD</td>
<td>Adult Learning Disability Services</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Children And Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CEG</td>
<td>Clinical Effectiveness Group</td>
</tr>
<tr>
<td>CHTT</td>
<td>Crisis and Home Treatment Team</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning For Quality And Innovation</td>
</tr>
<tr>
<td>CYP</td>
<td>Children and Young People Services</td>
</tr>
<tr>
<td>Datix</td>
<td>Incident Reporting System</td>
</tr>
<tr>
<td>DIALOG</td>
<td>a service user rated outcome measure which focuses on the quality of life, treatment satisfaction and care needs</td>
</tr>
<tr>
<td>EIP</td>
<td>Early Intervention in Psychosis</td>
</tr>
<tr>
<td>F&amp;P</td>
<td>Forensic and Prisons</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends And Family Test</td>
</tr>
<tr>
<td>HMP</td>
<td>Her Majesty's Prison</td>
</tr>
<tr>
<td>HONOS</td>
<td>Health of the National Outcome Scales</td>
</tr>
<tr>
<td>HONOSCa</td>
<td>Health of the Nation Outcome Scales Child and Adolescent Mental Health</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disabilities</td>
</tr>
<tr>
<td>NACR</td>
<td>National Audit of Cardiac Rehabilitation</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health And Care Excellence</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
</tr>
<tr>
<td>NRLS</td>
<td>National Reporting and Learning System</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi Disciplinary Team</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MH &amp; LD</td>
<td>Mental Health &amp; Learning Disability</td>
</tr>
<tr>
<td>RIO</td>
<td>Electronic Clinical System</td>
</tr>
<tr>
<td>OPMH</td>
<td>Older People Mental Health Services</td>
</tr>
<tr>
<td>PHSO</td>
<td>Parliamentary and Health Service Ombudsman</td>
</tr>
<tr>
<td>POMH</td>
<td>Prescribing Observatory for Mental Health</td>
</tr>
<tr>
<td>RAG</td>
<td>Red, Amber, Green rating</td>
</tr>
<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
</tr>
<tr>
<td>SMI</td>
<td>Serious Mental Illness</td>
</tr>
<tr>
<td>STORM</td>
<td>a self-harm mitigation skills based training in risk assessment and safety planning</td>
</tr>
</tbody>
</table>
Annex 1.1– Feedback from our Stakeholders
Greenwich & Bexley CCG Response to Quality Accounts

Greenwich and Bexley CCGs are responsible for the commissioning of Mental Health services and Community services from Oxleas Foundation Trust. The CCGs work collaboratively with Oxleas to ensure that the services they provide meet the contractual requirements for quality and that they are working to continuously improve the quality of care provided to residents across these varied geographies. The CCGs welcome the opportunity to provide this statement on the Trust’s 2018/2019 Quality Account.

Greenwich and Bexley CCGs share the commitment to quality set out by Oxleas NHS Foundation Trust (Oxleas), to deliver good quality care and support the broad vision for quality improvement set out in the annual Quality Account. It is evident within the Quality Account that there is a strong focus on quality assurance and quality improvement though this appears to be more mental health focussed. The CCGs would welcome evidence of priorities particularly for Children and Young People and Community services.

The CCGs were pleased that following a CQC inspection in 2018 the trust was rated as “good” with some services rated as outstanding for caring and effectiveness. We will continue to work with the Trust on maintaining assurances of safe services, driving quality improvement and its ambition to achieve an outstanding CQC rating.

As part of the Trust’s commitment to the quality agenda, in April 2018 the trust launched the Trust Quality improvement programme (QI). The CCGs note the excellent work undertaken by this programme particularly in relation to the ability to impact on organisational change and delivery of improved patient outcomes. There have been positive results in reducing incidents of violence and aggression to staff and patients and a reduction on spend as a result of violence and aggression on the wards. We would however welcome more effective activities on mental health wards which will contribute to a reduction in aggression and violence. To create a culture of continuous quality improvement and ensure improvement is everyone’s business, the Trust has put in place a clear learning/training strategy for QI. Most importantly the ideas for the quality improvement programme are initiated by front line staff, who are the group of staff that have the most contact with patients.

The National Quality Indicators within the accounts demonstrate a downward trend for 2018/19 when compared to 2017/18. However the commissioners note that Oxleas remain at or above the national average in this area. The CCGs would welcome more discussions on this.

The CCGs applaud the progress made with the 19 quality goals developed across the 6 quality objectives with 84% (16) of the goals achieved. The CCGs support the quality priorities for 2019/20, which were developed following a period of staff and user engagement. As part of the commissioning process the CCGs will continue to take an active interest in supporting improvements where the very highest standards have yet to be achieved. We look forward to working with the Trust to achieve these priorities.

The trust are to be congratulated on its staff engagement score which remains above the average. However, we are concerned about the challenges highlighted in the staff survey results on perceptions relating to equality and diversity, health and well-being, bullying and harassment, safe environment and violence. BME staff (510 staff) had worse perceptions in relation to their experience of violence from patients/service users, bullying and harassment from patients and colleagues/managers and fairness in career progression. We are encouraged by the progress made by the Trust CEO and senior management team to address these concerns and look forward to seeing the further improvements in these areas.

It is disappointing to see that the recording of patient feedback utilising a variety of methods, has been undertaken across the trust to increase patient feedback utilising a variety of methods, the CCGs would like to see an improvement in feedback across all areas particularly from currently under-represented groups.

In relation to care planning and risk assessments, the CCGs agree with the trust that it is disappointing that the trust is unable to evidence that all patients have an up to date care plan and where relevant a risk assessment. Given the number of Serious Incidents where this has been identified as a recurrent theme, the CCGs are pleased that this remains a priority for the trust.

The CCGs note the wide range of clinical audit work that Oxleas has engaged with during the year. Clinical audit is a key tool for monitoring and improving the quality of patient care and the CCGs welcome the holistic and joined up approach to developing improvement plans.

We confirm that we have reviewed the information contained within the Quality Account and checked this against data sources where this is available to us as part of existing quality and performance monitoring discussions. We look forward to continuing to work with colleagues at Oxleas to monitor quality and safety and increased service user input in the wide range of service provision across mental health and community services for patients in Greenwich and Bexley.

Yvonne Leese
NHS Greenwich CCG
Deputy Managing Director and Director of Quality

Michael Boyce
NHS Bexley CCG
Deputy Managing Director and Director of Quality

NHS Bexley CCG and NHS Greenwich CCG – members of the NHS South East London Commissioning Alliance (Bexley, Bromley, Greenwich, Lambeth, Lewisham & Southwark CCGs)
Bromley CCG Response to Quality Accounts

Bromley CCG welcomes the opportunity to comment on the Oxleas Quality Accounts 2018/19. The restructure into borough-based teams has continued to enhance closer working relationships between Oxleas and commissioners which is demonstrated this year around the work undertaken with the CCG’s medicines management team and the significant improvement in rates of dementia diagnosis in Bromley which the Trust should be congratulated on achieving. In addition sharing of intelligence across Bromley, Bexley and Greenwich continues via the quarterly 3-borough Clinical Quality Review Group.

The CCG notes the focus on putting patients at the centre of service planning and delivery and the good engagement work that has taken place. However, the results around involvement of patients and carers are disappointing and we welcome the continued focus on this area into 2019/20.

Bromley CCG is aware of the emphasis that the Trust has placed on safety of staff and patients and is pleased to note the significant achievements in reduction in incidents of violence and aggression and restraint. The Qi work at the Tarn shows a real commitment which we hope will continue into 2019/20.

There are a number of areas that Oxleas can be justifiably proud. For Bromley CCG, we continue to be impressed by the work around supporting service users with personality disorder via community models and the achievements in EIP despite a higher than predicted number of cases. In addition, the significant improvement in dementia diagnosis rates in Bromley is particularly impressive and the work involved in this achievement is recognised.

Bromley CCG would welcome a greater focus on collaborative working with partners across Bromley to include health and local authority partnerships as the Bromley ICS evolves and, in particular, working across Bromley on suicide reduction and around prevention of urgent care admissions.

The Trust continues to develop and embed robust procedures around Learning fromDeaths which will enable the Trust to identify any gaps or service improvement areas in order to drive up clinical care standards.

Sonia Colwill
Director of Quality and Governance
Bromley CCG

Bexley Council Communities Overview and Scrutiny Committee Response to Oxleas NHS Foundation Trust Quality Accounts 2018/19

The Communities Overview and Scrutiny Committee (OSC) welcomes the opportunity to comment on Oxleas NHS Foundation Trust’s Quality Accounts 2018/19; the report provides Members of the Bexley Communities OSC with a good overview of the range of work undertaken by the Trust and the measures taken to evaluate the quality and effectiveness of the care given by the Trust to residents in the borough over the last year.

The Committee notes that 16 of the quality goals set for 2018/19 were achieved and that one was mostly achieved and it is hoped that progress will be made in 2019/20 towards achieving the two goals that were not reached.

The Committee are pleased to see further improvement in the percentage of patients with a care plan (on the electronic patient care record – RiO) and the focus of reducing falls and improving physical health for in-patients in mental health wards.

In view of the national concern about the dangers of prone restraints, it is pleasing to see a further reduction in the use of restraint overall and the shift towards supine restraint, where restraint still remains necessary and appropriate.

Participation in the national clinical audits is welcomed as are the targets set for 2019/20; the Committee notes the summary of the latest CQC inspection dashboard that shows that a good or outstanding rating was achieved in 82 of the 84 domains but it is hoped that early progress will be made in improving services in the two domains that require improvement.

The detail provided on the latest Oxleas staff survey is noted, but there is concern that the proportion of staff who feel that the organisation takes positive action on health and wellbeing has declined from 32% to 29%. It is worthy of note that one focus of the developing Bexley System-Wide Prevention Strategy is the role of major local employers, which includes Oxleas NHS Foundation Trust, in maintaining the well-being of the local population, which will be key to achieving positive public health outcomes in the coming years.

Overall, the Committee believes this to be a positive report which recognises that there are areas for improvement, the Communities OSC looks forward to continuing to work collaboratively with Oxleas NHS Foundation Trust over the next year as a key partner of the Council.
1. Performance Report

Performance Overview

Annex 1.2– Statement from Local Healthwatch Organisations

Healthwatch Bromley Response to Oxleas Quality Accounts 2018/19

Healthwatch Bromley is pleased to see that the trust reached their target for quality objective 1 – “Meeting our patient promise” and that each of the 6 questions were clearly defined as:

1. Have you been provided with enough information about your care and treatment?
2. Have you been involved as much as you would have liked in decisions about your care and treatment?
3. Have staff treated you with dignity and respect?
4. Was the service provided helpful?
5. Did you want any friends / relatives involved in your care/treatment? if yes, were they involved?
6. We would like you to think about your recent experience of this service. How likely would you be to recommend this team to friends and family if they needed similar care or treatment?

The trust attained at least 90% of patients reporting against the criteria and that they have consistently met their goal of 90% achievement or more since 2015/16.

Quality objective 2 focussed on “Involving families, carers and people important to our patients” to ensure 80% of patients have their support network identified and noted within their care record. It is disappointing that this has fallen some way short of target at 37% with no real identification of causation or remedial action. An aspirational target is maintained but there is concern that while the target remains aspirational without substance it will consistently fall short.

Quality objective 3 is defined as involving patients in planning their care and that they have a care plan that is personal to them. The participation figures for this are disappointing at 63% especially as the focus was to improve participation in the audit process but concerning from a Healthwatch perspective under this quality objective is the average results. Significantly a copy of the care plan had been given to the service user in only 70% of cases from a limited audit and only 40% of the user support network had been given a copy. Additionally, being given a copy does not necessarily constitute involving patients in planning their care.

Quality objective 4 is to ensure they put the safety of patients first and the goals linked to this objective are integral to their improvement safety plan. There are four key areas that come under this objective:

- Falls
- Deteriorating physical health
- Violence reduction
- Reducing the use of prone restraint

It is positive to note improvement in all these areas particularly a 62.5% reduction in serious falls and a reduction of incidents of violence.

Quality objective 5 looks to provide care in line with national best practice and guidelines and it is pleasing to note that for audited services in early intervention in psychosis, inpatient services and community mental health services Oxleas compliance was on a par with or exceeded the national standard.

It is positive to note that Oxleas Quality improvement priorities for 2019/20 are undertaken to continue to ensure the patient promise is met and that they ensure families, carers and people important to the patient are involved in their care. However, the aspirational targets attached to quality objective 2 are not made with a clear and concise implementation plan to improve on the previous attained 37% of an 80% target. Without a clear idea of how this result will be obtained Healthwatch are concerned this will result in poor performance against this objective.

Objective 3 continues to focus on involvement in care planning which is positive to view commitment to this however again remedial action to support improvement in this area is not clearly stated.

Finally it is very positive to see suicide prevention identified as a quality objective when putting the safety of patients first.

Mina Kakaiya
Operations Manager
Healthwatch Bromley
Date 15-05-2019
Healthwatch Bexley and Healthwatch Greenwich
Response to Oxleas Quality Accounts 2018/19

Areas of success

- Healthwatch is pleased to see that the trust has again reached their 90% target across all elements of quality objective 1 and it is good to see the number of patients providing feedback has increased in 2018/19 by 35%. We are pleased to see that feedback technology has been updated making it easier for patients to respond, however we would like to see more joint working with Healthwatch to offer a greater variety of ways Oxleas patients can comment on the service received.

- We were pleased to see that with a care plan on RiO and patients on CPA who receive a 12 month review are both above target at 99% and over.

- Healthwatch welcome the continued focus on reducing the incidence of falls in inpatient wards and the updated falls policy, reviewed training, assessment and management of falls, has led to a significant reduction of serious falls by 62.5% in 2018/19.

- We are pleased to see the reduction of violence and aggression to staff and patients has fallen since 2016 and work is continuing to accelerate further reduction.

- We are pleased to see that in 2018/19 you participated in the national programme of improving the physical health of patients with Serious Mental Illness and that in all 3 areas you exceed the national target.

- We are pleased to see that Oxleas NHS Foundation Trust was rated overall as ‘Good’ in their last CQC inspection in March 2019, and four areas were rated as ‘Outstanding’.

- We were pleased to see a focus on encouraging staff to speak up and share concerns without fear of victimisation or harassment and as a result there has been a significant increase in the number of concerns raised. We welcome further work to embed this approach.

- We are impressed with the results achieved from the introduction of group exercise classes to improve outcomes in musculoskeletal services and the very positive reports from patients.

- We are pleased to see the improvement made in diagnosis rate in the Bromley Memory Service which achieves in excess of national targets.

- We are pleased to see the reduction in trimipramine prescribing in Bromley as a result of improved collaborative working and embedding individualised treatment plans.

- We are pleased to see an improved response rate of 49% in the staff survey for 2018 which is better than the average for comparative trusts (45%) and the national average response rate of 46%.

- We were pleased to see staff perceptions in relation to treating staff fairly following incidents, taking action to prevent reoccurrence and being given feedback have improved and are better then the average for comparative trusts.

- We were pleased to see staff perceptions were better than the comparator average for themes relating to staff engagement, safety culture, quality of care, quality of appraisals and immediate managers.

- We were pleased to see that the patient promise indicators were not met in prison, forensic and adult learning disability services. Healthwatch accept there may be additional complexity in gaining favourable ratings from patients who may not choose or want to receive Forensic or Prison services and that comments provided by patients using the Adult Learning Disability service contradict the ratings given. However, without comparing against results achieved by other Forensic, Prison and Adult Learning Disability services it is difficult for Healthwatch to have confidence in this explanation. We look forward to the revised FFT question and expect to see improvements in ratings as a result.

- We were disappointed to see that two areas were highlighted as ‘requiring improvement’ in the Trusts last CQC inspection in March 2019.

- We were disappointed to see staff perceptions in relation to violence from patients, service users and relatives/public remains below the average when compared to similar trusts.

- We were disappointed to see staff perceptions in relation to equality and diversity, health and well-being, bullying and harassment, safe environment –violence remains below the average when compared to similar trusts.

- We are concerned to see that despite BME staff generally reporting better levels of satisfaction than white staff relating to their job, they had worse perceptions in relation to their experience of violence, from patients/service users, bullying and harassment from patients and colleagues/managers, fairness in career progression.

- We are concerned to see that LGBT staff reported worse perceptions than the average in relation to violence from patients, and bullying from patients and colleagues.

- We are concerned to see the higher level of complaints from Greenwich residents in comparison to Bexley and Bromley and would like further explanation on this issue.

- We note that a higher proportion of complaints on communication were upheld in comparison with complaints on clinical care or attitude of staff and further work is clearly required in this area.

- We were disappointed to see that the overall 10% response rate was not met for quality indicator 1 (8% achieved).

- We were disappointed to see the patient promise indicators were not met in prison, forensic and adult learning disability services. Healthwatch accept there may be additional complexity in gaining favourable ratings from patients who may not choose or want to receive Forensic or Prison services and that comments provided by patients using the Adult Learning Disability service contradict the ratings given. However, without comparing against results achieved by other Forensic, Prison and Adult Learning Disability services it is difficult for Healthwatch to have confidence in this explanation. We look forward to the revised FFT question and expect to see improvements in ratings as a result.

- We were disappointed to see that the 75% target for identifying and noting patient’s support network within the care record has not been met. Despite improvement (37% in 2018/19 compared with 35.2% in 2017/18) progress is worryingly slow. Indeed, on this trajectory, it will take many decades to reach the 80% target, which is unacceptable. We look forward to seeing a significant improvement in 2019/20 as a result of the work of the new Patient Experience Coordinator and increased awareness of the importance of this task amongst all staff.

- We were disappointed to see that the 75% target for participation in care planning audits has not been met (63%) despite an increased focus on this area in 2018/19. We look forward to seeing this target met in 2019/20 as a result of the mitigation plan now in place.

- We are concerned that HMIP and CQC joint inspection identified two areas where regulations were not met and we look forward to seeing improvements as a result of the improvement plans in place.

- We were concerned to see the lower level of complaints from Bexley residents in comparison to Greenwich and we would like further explanation on this issue.

- We were concerned to see that despite BME staff generally reporting better levels of satisfaction than white staff relating to their job, they had worse perceptions in relation to their experience of violence, from patients/service users, bullying and harassment from patients and colleagues/managers, fairness in career progression.

- We are concerned to see that LGBT staff reported worse perceptions than the average in relation to violence from patients, and bullying from patients and colleagues.

- We note that a higher proportion of complaints on communication were upheld in comparison with complaints on clinical care or attitude of staff and further work is clearly required in this area.

- We were concerned to see that despite BME staff generally reporting better levels of satisfaction than white staff relating to their job, they had worse perceptions in relation to their experience of violence, from patients/service users, bullying and harassment from patients and colleagues/managers, fairness in career progression.

- We are concerned to see the higher level of complaints from Greenwich residents in comparison to Bexley and Bromley and would like further explanation on this issue.

- We note that a higher proportion of complaints on communication were upheld in comparison with complaints on clinical care or attitude of staff and further work is clearly required in this area.

- We were disappointed to see that two areas were highlighted as ‘requiring improvement’ in the Trusts last CQC inspection in March 2019.

- We were disappointed to see staff perceptions in relation to violence from patients, service users and relatives/public remains below the average when compared to similar trusts.

- We were disappointed to see staff perceptions in relation to equality and diversity, health and well-being, bullying and harassment, safe environment –violence remains below the average when compared to similar trusts.

- We are concerned to see that despite BME staff generally reporting better levels of satisfaction than white staff relating to their job, they had worse perceptions in relation to their experience of violence, from patients/service users, bullying and harassment from patients and colleagues/managers, fairness in career progression.

- We are concerned to see that LGBT staff reported worse perceptions than the average in relation to violence from patients, and bullying from patients and colleagues.

- We are concerned to see the higher level of complaints from Greenwich residents in comparison to Bexley and Bromley and would like further explanation on this issue.

- We note that a higher proportion of complaints on communication were upheld in comparison with complaints on clinical care or attitude of staff and further work is clearly required in this area.

- We were disappointed to see that the overall 10% response rate was not met for quality indicator 1 (8% achieved).

- We were disappointed to see the patient promise indicators were not met in prison, forensic and adult learning disability services. Healthwatch accept there may be additional complexity in gaining favourable ratings from patients who may not choose or want to receive Forensic or Prison services and that comments provided by patients using the Adult Learning Disability service contradict the ratings given. However, without comparing against results achieved by other Forensic, Prison and Adult Learning Disability services it is difficult for Healthwatch to have confidence in this explanation. We look forward to the revised FFT question and expect to see improvements in ratings as a result.

- We were disappointed to see that the 75% target for identifying and noting patient’s support network within the care record has not been met. Despite improvement (37% in 2018/19 compared with 35.2% in 2017/18) progress is worryingly slow. Indeed, on this trajectory, it will take many decades to reach the 80% target, which is unacceptable. We look forward to seeing a significant improvement in 2019/20 as a result of the work of the new Patient Experience Coordinator and increased awareness of the importance of this task amongst all staff.

- We were disappointed to see that the 75% target for participation in care planning audits has not been met (63%) despite an increased focus on this area in 2018/19. We look forward to seeing this target met in 2019/20 as a result of the mitigation plan now in place.

- We are concerned that HMIP and CQC joint inspection identified two areas where regulations were not met and we look forward to seeing improvements as a result of the improvement plans in place.

- We were concerned to see the lower level of complaints from Bexley residents in comparison to Greenwich and we would like further explanation on this issue.

- We were concerned to see that despite BME staff generally reporting better levels of satisfaction than white staff relating to their job, they had worse perceptions in relation to their experience of violence, from patients/service users, bullying and harassment from patients and colleagues/managers, fairness in career progression.

- We are concerned to see that LGBT staff reported worse perceptions than the average in relation to violence from patients, and bullying from patients and colleagues.

- We are concerned to see the higher level of complaints from Greenwich residents in comparison to Bexley and Bromley and would like further explanation on this issue.

- We note that a higher proportion of complaints on communication were upheld in comparison with complaints on clinical care or attitude of staff and further work is clearly required in this area.

May 2019
Annex 2: Statement of directors’ responsibilities in respect of the Quality Report

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

NHS Improvement 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 NHS 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 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from commissioners dated 15/05/19 and 22/05/19
  - feedback from local Healthwatch organisations dated 15/05/19 and 18/05/09
  - the internal complaints reports for 2018/19
  - the 2018 national patient survey
  - the 2018 national staff survey
  - the Head of Internal Audit’s annual opinion of the trust’s control environment dated 21/05/19
  - CQC inspection reports dated 26 March 2019

- 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 NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Signed by
Andrew Trotter
Chair
24 May 2019

Signed by
Matthew Trainer
Chief Executive
24 May 2019