Our year 2017/18

Good
We improved the quality of our services through the year and our Care Quality Commission rating is good across all domains.

£261m
We spent in 2017/18

3,600
At our annual recognition awards in March 2018, we highlighted the dedication of our inspiring staff across Oxleas. Around 3,600 people work across our physical and mental health services.

Our partnerships continue to flourish
In April 2018, we launched our trustwide Quality Improvement programme

We're here for you
We celebrated Queen Mary's Hospital centenary in September 2017

Our partnerships continue to flourish

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Part 1

1.0 Chief Executive's Statement on Quality

Providing high quality services and ensuring excellence for every patient has been our focus every year. I am pleased to present to you our Quality Accounts for 2017/18 which give 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. The following pages demonstrate:

- Our approach to quality improvement,
- Our performance against the quality priorities we set for ourselves in 2017/18,
- Our priorities for 2018/19,
- A showcase of notable and innovative practice that has taken place across our services this year.

We have worked hard across all our services to ensure we achieve our quality priorities. We have achieved 17 of our 19 quality indicators. We are determined to focus on continued improvement in those areas to ensure these are achieved in the year ahead. Our goal is for continuous quality improvement across all services.

Our Board has always been committed to making quality the focus of everything that we do and this year and we are determined to maintain these high standards throughout 2018/19.

1.1 Quality Improvement

Looking forward to the coming year, we have launched an ambitious programme of quality improvement and innovation (QI). This is a programme that we hope will lead to sustained cultural change within Oxleas ensuring that quality improvement is incorporated into the practice of all our staff and QI initiatives are routinely implemented, reviewed and learning scaled up across the organisation. This will involve comprehensive training for staff across Oxleas, with quality improvement initiatives undertaken in all directorates tackling issues identified by staff and promoting joy at work. This is an exciting new step for us and we look forward to sharing our quality outcomes with you in 2018/19.

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 proud to have had another successful year and we are determined to maintain these high standards throughout 2018/19.

1.2 Quality Accounting

Following these steps, to my knowledge, the information in the document is accurate with the exception of the matters identified in respect of the Early Intervention in Psychosis and Inappropriate out of area placements for adult mental health services indicators as described in section 3.1 and Annex 3 of this report.

Signed by
Helen Smith
Acting Chief Executive and Accounting Officer
25 May 2018

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. However, there are a number of inherent limitations in the preparation of the Quality Accounts which may impact the reliability or accuracy of the data reported.

These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.
- Data is collected by a large number of teams across the Trust, alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust, its Board and management team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognise that it is nonetheless subject to the inherent limitations noted above.
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 2017/18 performance is 5% or less below the set target
- **Red/Not achieved**: This means our 2017/18 performance is 6% or more below the set target

We have provided summary of our trust-wide performance against each of the 6 quality objectives below 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 1

<table>
<thead>
<tr>
<th>Quality 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>Patient Safety</td>
</tr>
</tbody>
</table>

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

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 2017/18 priorities, describe our areas of focus for 2018/19 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:
2.2.1 Quality Objective 1 – Meeting our patient promise (Patient Experience)

Our patient promise is the foundation of our patient experience 6 ‘must ask’ questions that must be used in every Oxleas patient survey. We recognise the importance of asking the following questions and ensuring that we respond to what patients tell us about the care, service and treatment that they have received:

1. Patients reporting that they have been provided with enough information about care and treatment
2. Patients reporting that they been involved in decisions about their care and treatment
3. Patients reporting that staff have treated them with dignity and respect
4. Patients reporting that they have been helped/quality of life has improved as a result of the care and treatment they have received
5. Patients who reported that they wanted friends/relatives involved in their care/treatment did feel that they were involved
6. Patients reporting that they would recommend our service to friends and family if they need similar care or treatment

Our overall Trust performance against all 6 questions over the last 3 years is shown below (the data source is from the results of our internal patient experience surveys):

Chart 1 – Meeting our patient promise – Oxleas Overall Position

The directorate level breakdown is shown in Table 1 below (please note that we moved from functional directorates to borough directorates on the 1st of April 2017, hence our data below has been shown according to the new directorates, however the indicators are still the same as per previous years):

<table>
<thead>
<tr>
<th>Service Directorate Summary for 2017/18</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Forensic &amp; Prisons</th>
<th>Adult Learning Disabilities (ALD)</th>
<th>Children &amp; Young People (CYP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of patients surveyed are reporting they have been provided with enough information about care and treatment?</td>
<td>99%</td>
<td>96%</td>
<td>98%</td>
<td>91%</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td>90% of patients surveyed are reporting that they been involved in decisions about their care and treatment?</td>
<td>98%</td>
<td>96%</td>
<td>98%</td>
<td>87%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>90% of patients surveyed are reporting that staff have treated them with dignity and respect?</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>94%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>90% of patients surveyed are reporting that they have been helped as a result of the care and treatment they have received</td>
<td>98%</td>
<td>93%</td>
<td>98%</td>
<td>88%</td>
<td>99%</td>
<td>97%</td>
</tr>
<tr>
<td>90% of patients who reported that they wanted friends/relatives involved in their care/treatment did feel that they were involved</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>78%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Friends and Family Test</td>
<td>90% of patients surveyed are reporting that they would recommend our service to friends and family if they need similar care or treatment</td>
<td>2% not recommend</td>
<td>4% not recommend</td>
<td>2% not recommend</td>
<td>15% not recommend</td>
<td>5% not recommend</td>
</tr>
<tr>
<td>Total number of responses</td>
<td>3729</td>
<td>1114</td>
<td>9617</td>
<td>3076</td>
<td>893</td>
<td>434</td>
</tr>
</tbody>
</table>
Section three
Quality Accounts

Our 2017/18 overall trust performance shows that we have achieved over the 90% target for each of the 6 must ask questions – patients who respond to our surveys reporting that they have been provided with enough information about their care and treatment, have been involved in decisions about their care and treatment, staff have treated them with dignity and respect, that they have been helped as a result of the care and treatment they have received, friends/relatives involved in their care/treatment feel that they were involved; and that they would recommend our service to friends and family if they need similar care or treatment. However some exceptions are seen in the Forensic & Prisons and Adult Learning Disability Directorates. We will continue to review performance against these goals in the previous year.

Number of patients who have responded to our surveys
We have made significant effort over the last year to improve the coverage of teams who ask patients to give us feedback as well as to increase the numbers of patients who respond to our patient experience surveys and 6 must ask questions. For 2017/18, we have seen an 88% increase in the number of patients who have responded to our surveys compared to the previous year.

Chart 2 – number of patients providing feedback

2.2.2 Quality Objective 2 – Involving families, carers and people important to our patients (Patient Experience)

Please note: Progress for objective 2 indicator that states “to ensure 90% of patients who reported 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.

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

In 2016/17, we launched a new carers and support network strategy which took into account our wider range of services; helping us to identify and meet the needs of carers in our community health services as well as in our mental health and learning disability services. One of the outputs from the strategy was to implement a support network engagement tool (SNET) which captured who was important to patient and details recorded within the care record. This assessment tool asks the following questions:

- Who is most important to you at the moment?
- How would you like those identified as most important to be involved in your treatment?
- If there is an emergency, who would you want involved?
- How would you want them to be involved in an emergency?

Our improvement goal was to ensure 80% of patients have their support network identified and noted within their care record; disappointingly this has not been achieved this year. Our achievement at the end of 2017/18 was 35.2%. This is disappointing to note as we achieved 80% in 2016/17 but this was just specific to our inpatient bedded services and community mental health teams. In 2017/18, this was expanded to include all Oxleas services which was a greater challenge for us.

To help us achieve this next year, there will be continued effort to help our staff move from just thinking about the individual patient presenting for a service, to thinking more widely to also supporting their network, those who are important to them. This is a challenging task for any healthcare provider given the high pace of work required within services.

We will increase the number of reminders to staff including updating the clinicians’ task list on Ifox (our information & performance dashboard) to indicate whether the SNET form has been completed as well as ask services to include this indicator as one of the performance areas discussed in their team huddles.

Our aspiration is for all patients/service users and their support networks to be offered the opportunity to be included, involved and engaged; every staff member makes it a priority to ensure that support is provided for the identified network for their patients; and for the inclusion of patients’ support networks to become everybody’s business. This will continue to be our focus in the coming year and we aim to achieve this across all identified Oxleas services in 2018/19.
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)

Ensuring that patients are involved in discussions and decisions about their care and have a plan that is personal to them continues to be a key quality priority for Oxleas. We have implemented over the last few years a transforming personalised care planning programme, working with clinicians to understand and resolve issues identified with RiO (our clinical records system), provide essential training that creates confidence and assurance on how to engage patients effectively and worked in partnership with service users to understand the best way to improve engagement.

Chart 3

**Quality indicator - To ensure 95% of our patients will have a recorded care plan on RiO.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of Patients with a Care Plan on RiO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>98.5%</td>
</tr>
<tr>
<td>2013/14</td>
<td>99.3%</td>
</tr>
<tr>
<td>2014/15</td>
<td>98.7%</td>
</tr>
<tr>
<td>2015/16</td>
<td>95.0%</td>
</tr>
<tr>
<td>2016/17</td>
<td>96.1%</td>
</tr>
<tr>
<td>2017/18</td>
<td>98.4%</td>
</tr>
</tbody>
</table>

Objective 3 comes under the clinical effectiveness domain and has two quality goals; we have provided our 2017/18 performance below:

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

This quality indicator had consistently been achieved over the previous four years and we are pleased to see that there is continuous improvement in this area. Our goal is for at least 95% of our patients to have a comprehensive and personalised care plan on RiO and this will continue to be a focus for the Trust and has been added as a priority indicator for the coming year.

Quality indicator - To ensure 95% of our patients on CPA (Care Programme Approach) will receive a 12 monthly review.

*Please note: The data source for this indicator is from RiO our electronic patient care record and is a national core definition.*

Chart 4

**Percentage of patients on CPA who received a 12 month review**

In 2016/17, we were 0.8% under the 95% target; we are pleased to note that the 2017/18 status is almost at 100% with an achievement of 99.7%.
2.2.4 Quality Objective 4 – Ensure we put the safety of our patients first (Patient Safety)

For 2017/18, we stated that we will continue our improvement focus on our sign up to safety plan. There are 7 identified areas of focus under the quality objective and we have provided a highlight below on each goal. These have been regularly been reviewed by the Trust Safety Committee.

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

- Preventing the physical deterioration of people with enduring mental illness

In 2017, we reviewed and introduced new physical health monitoring forms to 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 has provided teams with ease of accessibility to record and monitor physical health.

We continue to promote Sepsis awareness throughout the trust and are using an e-learn package for staff to access additional training. In June 2017 an electronic version of the Modified Early Warning Score (MEWS) was added to the electronic patient record system. This has an inbuilt sepsis alert tool, which triggers a warning to staff if an abnormal physical health reading is recorded. However we will be moving to NEWS2 in 2018. This is the national early warning scores.

We have a robust plan and relevant package of training to be able to successfully and safely roll out NEWS2 to all inpatient wards by the end of 2018.

- Supporting an open and honest culture throughout the Trust (duty of candour)

Duty of candour is about being open, honest and transparent when providing care and treatment at all times. It is also a statutory requirement for all health organisations that are registered with the Care Quality Commission.

It is our legal duty to inform a patient and their family if we have made a mistake in their care or treatment that has led to harm and to provide an apology.

Compliance with Duty of Candour continues to be embedded throughout our services. Staff have shown increased confidence in contacting the Duty of Candour Lead to ask about incidents where it may be applicable and show greater understanding overall. In 2018/19, there will be a Duty of Candour refresh to further improve staff awareness; this will include ward visits by the Duty of Candour Leads. We will continue to work with the Health Innovation Network and colleagues from neighbouring London trusts to focus on learning from deaths and ensuring Duty of Candour.

- Suicide prevention

The Oxleas Suicide Prevention Group was originally set up as a task and finish group to create our Suicide Prevention Strategy: http://www.oxleasstrategies.com/suicidepreventionstrategy/ which has had almost 20,000 page views.

We have carried out two audits of concordance with the trust’s observation policy forms, our results show that further improvement is required and work has been some improvement; however, further improvement is required and we are working in partnership with the South London Partnership partners to deliver e-observations rather than to continue to use paper forms. The e-observations forms will synch with our patient electronic record RiO. This will save an enormous amount of admin time scanning and uploading observation forms; it will make recording of observations more accurate, and will stop amended forms being used by wards.

In 2017/18 we also held an embedded learning event for prison staff. The event showcased a film that had been commissioned form prison staff. The aim of the film was to promote awareness of suicide prevention in prison settings.

Work is underway to conduct a trust-wide suicide audit. The aim is to identify any local factors associated with suicide, and any learning that might come from this. The finding of this audit will be reviewed by our Trust Safety Committee in 2018/19.

- Reducing risk and harm of violence in our mental health wards/Restrictive Practice

Restraint 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 61A). On occasion physical restraint may be necessary either to safeguard a patient from harming themselves or others. In these circumstances staff will need to be able to affect a consistent 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.

Restraint may take many forms. It may be both verbal and physical and may vary in degree starting from a verbal request to calm down to assisting someone to a safe low stimulus environment.

Oxleas aims to reduce incidences of violence and aggression through increased awareness and training and the appropriate management of violent and aggressive behaviour. In its guidance the Department of Health (2014) outlines its aims to develop a culture across health and social care where physical interventions are only ever used as a last resort when all other alternatives have been attempted and only then for the shortest possible time. This means that we aim to only use restraint when absolutely necessary and aim to reduce the use of prone restraint and use a supine option when giving IM emergency medication in the place of prone restraint if required. The Trust’s PMVA policy (prevention management of violence and aggression) was updated in September 2017 to include this new option and to ensure new supine training for staff.

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. The overall position for supine training is shown below:
Our restraint data shows that there has been a reduction in prone restraints and an increase in supine restraints, as shown in the chart below. Quarter 4 in 2017/18 was the first time we reported more supine restraints than prone restraints.

We are working in partnership with ResearchNet (a service user group) to co-design a restraint reduction strategy, we continue to roll out the safer wards initiative across all our wards and we are participating in the South London Partnership violence reduction Quality improvement programme.

- **Ligature management**
  We continue to implement a robust programme of ligature risk assessments across all our services. This now includes audits completed in CAMHS, Learning Disabilities and Adult Mental Health community sites.

- **Falls**
  We continue to focus on reducing the incidences of falls on our wards. We conducted a longitudinal study towards the end of 2017/18; this reviewed how many falls a patient had, their falls risk and the use MFRAT (multi factorial falls risk assessment tool) and care plans for every patient admitted in a three month time frame in the following units: Greenwich Intermediate Care Unit, Meadow View Unit and Holbrook Ward. The study aims to develop a deeper understanding of why and how our patients are falling. The results of this study are currently being analysed during the writing of this report. The findings will be presented at the Trust Safety Committee and we aim to share with our CCGs at the Clinical Quality Review Meeting.

- **Pressure ulcers**
  To promote best practice we continue to use our well embedded Pressure Ulcers Prevention Strategy (PUPS). We have PUPS champions across all areas within the directorates and all staff are aware of the strategy and how to put it into practice. We continue to ensure pressure ulcer reviews occur for all incidences of Grade 3 and 4 pressure ulcers. The review meetings ascertain if the pressure ulcers were avoidable, and any learning is identified and embedded.

2.2.5 Quality Objective 5 – Providing care in line with national best practice and guidelines

This objective is in line with one of our trust values which is to ensure excellence in everything that we do by providing services and delivering care in line with national best practice and guidelines.

There are 2 quality goals under objective 5:

- We will continue to engage in national audits that permit benchmarking such as POMH UK and the NHS Benchmarking network. We participate in the national programme of improving the physical health of patients with SMI and we will achieve the set targets of comprehensive cardio-metabolic risk assessment using the Lester Tool and interventions in patients at high risk. (Data source – national clinical audit utilising data from RiO in line with national guidance)

- We will participate in the national programme of improving the physical health of patients with SMI and we will achieve the set targets of comprehensive cardio-metabolic risk assessment using the Lester Tool and interventions in patients at high risk. (Data source – national clinical audit utilising data from RiO in line with national guidance)

2.2.5.1 Engagement in National Audits

We have made every effort to participate in national audits that are applicable to the services that we provide. We participated in 14 national audits in 2017/18 as described in section 2.4.1 below. We have provided a summary of one of the national POMH (prescribing observatory for mental health) audits that we participated in last year:
Prescribing high dose and combined antipsychotics national audit
Prescribing high dose and combined antipsychotics is a quality improvement programme that has been running for 11 years. The audit standards are derived from the NICE Schizophrenia guidelines and the Royal College of Psychiatrists consensus statement for the use of high dose antipsychotics.

The standards are:
• Standard 1 - The dose of an individual antipsychotic should be within its licensed/BNF limits.
• Standard 2 - Individuals receive only one antipsychotic at a time.
• Standard 3 - Where high-dose antipsychotics are prescribed, there should be a clear plan for regular clinical review including safety monitoring.

In 2017, 58 Trusts participated in the national audit submitting data for 10,072 patients on acute, rehabilitation and forensic wards; the Oxleas sample was for 257 patients.

Summary and key local issues
Nationally, there has been a steady but modest reduction over time in the proportion of patients prescribed high-dose and/or combined antipsychotic medication; Oxleas services benchmark very well compared to the Total National Sample (TNS) both at the baseline and subsequent audits (see the diamonds on the figure below in chart 7).

The reduction seen in the prevalence of combined antipsychotics (antipsychotic polypharmacy) over time seems to be largely attributable to fewer prescriptions for ‘as required’ antipsychotic medication.

In the 2017 Oxleas sample, regular high-dose antipsychotic medication was prescribed for only 5% of patients. Our practice with respect to ensuring patients have physical health checks and side-effects are monitored was largely better than the national average; however 1 in 4 of our patients in this group had no documented ECG (electrocardiogram) in the last year. Our action plan to improve on this position includes the procurement of hand held ECG machines for teams to use, thus not requiring leads to be attached to the patient which can sometimes be a detriment. This will help to improve ECG screening rates for these patients. As per date of writing this report, hand held ECG machines have been bought and disseminated to all identified teams.

2.2.5.2 Participation in the national programme of improving the physical health of patients with Serious Mental Illness
We continue to participate 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 are offered a comprehensive cardio-metabolic risk assessment, have access to the appropriate treatments/interventions and the results are recorded in their electronic record and reviewed regularly as part of their care plan. 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.

In terms of our 2017/18 goal, we participated in the national CQUIN which this year was undertaken as part of the National Clinical Audit of Psychosis (NCAP) in December 2017. 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.
As can be seen from the above table, our results show that the target was not achieved in our community mental health teams. Following our self-assessment we have taken steps to ensure we are better placed to meet the physical health needs of SMI patients in the community going forward. We have undertaken meetings with all community teams to identify and address gaps in processes for physical health screening and interventions; we will be providing a refresh of training and recording in this area as well as update standards for physical health clinics and the roles of physical health leads/champions.

<table>
<thead>
<tr>
<th>Service</th>
<th>Total no. of clients in national sample</th>
<th>No. of clients not seen, screened for one or more of the 7 indicators</th>
<th>% screening compliance</th>
<th>No. client with one or more missing interventions</th>
<th>% Interventions compliance</th>
<th>% Overall compliance</th>
<th>National target 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services</td>
<td>31</td>
<td>1</td>
<td>97% (30/31)</td>
<td>1</td>
<td>97% (28/29)</td>
<td>97% (30/31)</td>
<td>90%</td>
</tr>
<tr>
<td>Community Mental Health Services</td>
<td>55</td>
<td>36</td>
<td>35% (19/55)</td>
<td>15</td>
<td>91% (40/44)</td>
<td>31% (117/55)</td>
<td>65%</td>
</tr>
<tr>
<td>Early Intervention in Psychosis</td>
<td>211</td>
<td>5</td>
<td>98% (206/211)</td>
<td>15</td>
<td>92% (140/155)</td>
<td>90% (190/211)</td>
<td>90%</td>
</tr>
<tr>
<td>Total</td>
<td>297</td>
<td>42</td>
<td>86% (255/297)</td>
<td>31</td>
<td>91% (208/228)</td>
<td>90% (237/237)</td>
<td>-</td>
</tr>
</tbody>
</table>

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

Our vision was to extend this to all of our clinical directorates and eligible teams and to make the outcomes data accessible for frontline teams to use to inform clinical care. We started rolling out routine measurement of clinical outcomes according to the service lines and have provided an update according to each service area; our progress against these are reviewed within local directorate Clinical Effectiveness Groups (CEG) and at the Trustwide CEG.

**Data source is from RiO and manual local databases. Definitions are based on nationally agreed clinical outcome definitions.**

**Children & Young People’s Services**

The culture of routine outcome measurement has become embedded across our CYP services. All Health Visiting teams who provide a universal plus service collect goal-based outcomes at the point of taking on a case and they review these at 3 - 6 months to achieve paired outcome data. This is also seen within the public health nursing team in schools across Greenwich.

Speech and Language therapists use Goal-based outcomes (GBOS). GBOS are a way to evaluate progress towards a goal in clinical work with children and young people, and their families and carers. They simply compare how far a young person feels they have moved towards reaching a goal they set at the beginning of an intervention, compared to where they are at the end of an intervention (or after some specified period of input (Law & Wolpert, 2013). Occupational therapists and physiotherapists use CGAS (the children’s global assessment scale) this is like the GBOS but specific to improvements in functioning.

Within our CAMHS services (Family therapy, clinical psychology, child psychotherapy and nursing) goal based outcomes and a range of CYP IAPT clinical measures are recorded at the beginning and end of an intervention. We have provided a case study on CYP IAPT below in section 3.2.7.

**Forensic Services**

Across our Forensic services, two self-report clinical outcome measures are collected from service users, the CORE-10 and Locus of Control. The CORE-10 is a 10-item outcome measure focussed on psychological distress. The Locus of Control provides a proxy measure of risk to others, by virtue of the extent to which they perceive themselves as irresponsible for events in their lives. It is a 40-item questionnaire and is the only known self-report measure to gauge risk.

The two questionnaires are collected by the psychology teams during the assessment process and the teams encourage service users to complete the measures every three months thereafter. In the inpatient services, assistant and trainee psychologists collect the measures. For outpatients, the lead clinician is responsible collecting the measures.

In addition, we also record HoNOS (Health of the Nation Outcome Scale) for our inpatient services (This is a clinician rated tool developed by the Royal College of Psychiatry to measure the health and social functioning of people experiencing severe mental illness. This is completed at each CPA (3 months and every 6 months thereafter).

**Mental Health Services (Adults and Older People)**

Our mental health services have used a number of approaches to measure clinical outcomes such as those described above (Core-10 and HoNOS), however HoNOS is the outcome measure that we aim to use consistently across all our services with the flexibility for teams to still continue with the other approaches.

**Adult Learning Disability Services**

In our ALD services we use a variety of core outcome measures depending on the pathway. For our mental health/challenging behaviour...
(MH/CB) pathway we use HoNOS LD and for the complex physical health pathway we use TOMS (the Therapy Outcome Measure which is used to describe the relative abilities and difficulties of a service user in the 4 domains of ‘impairment’, ‘activity’, ‘participation’ and ‘wellbeing’. We also use Dementia- QOMID – this is a quality outcome measure that is designed to measure the quality outcomes for an individual with dementia. The measure explores the key areas that ensures that the person with dementia is experiencing a good quality experience (Dodd and Bush, 2013).

The use of these clinical outcome measures are embedded across all our ALD services.

**Adult Community physical health services**

In our community physical health services, there are a variety of clinical outcome measures used to cover the wide breath of services that are provided however there are two key clinical outcome measures that have been agreed for consistent use across these are:

- The PHQ-9 which is a patient health questionnaire that screens, diagnoses, monitors and measures the severity of depression. This measure is used within our musculoskeletal, COPD, cardiac and intermediate care services
- The EQSD-5L – this is a standardised approach to measure health related quality of life and is consistently used in our musculoskeletal services and our community rehabilitation teams

### 2.3 Our Quality improvement priorities for 2018/19

In the following section, we tell you about our chosen quality priorities for 2018/19. 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. These meetings had a total attendance of 115 people and as per our usual practice, we asked our members and members of the public who attended these forums if we should continue with our 6 quality objectives for 2018/19 and if there were any other areas we should consider. There continues to be overwhelming support for us to continue with our 6 objectives with an additional focus on supporting families, carers and the support network of people who use our services.

Our priority areas have been influenced by our public forums, our engagement with our local and national commissioners, through our quality meetings, our council of governors, patient groups such as Healthwatch, feedback from patient experience surveys and lessons learned from incidents. We also engage with staff at away days, staff meetings and annual planning events. The 2018/19 quality priorities have also been reviewed and agreed by the Trust’s Performance & Quality Assurance Committee (a sub-committee of the Board).

### Table 3 – Oxleas Quality Priorities 2018/19

<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>
<tbody>
<tr>
<td><strong>Quality Objective 1:</strong> Ensure we meet our patient promise</td>
<td>To ensure 90% of patients who respond to our surveys are reporting they have been provided with enough information about care and treatment</td>
<td>All Oxleas Services</td>
<td>Patient Experience</td>
<td>These indicators will be monitored by the Trust Patient Experience Group and monthly by the Trust Performance &amp; Quality Assurance Committee</td>
</tr>
<tr>
<td></td>
<td>To ensure 90% of patients who respond to our surveys are reporting that they have been involved in decisions about their care and treatment</td>
<td>All Oxleas Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To ensure 90% of patients who respond to our surveys are reporting that staff have treated them with dignity and respect</td>
<td>All Oxleas Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To ensure 90% of patients who respond to our surveys are reporting that they would recommend our service to friends and family if they need similar care or treatment</td>
<td>All Oxleas Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Objective</td>
<td>Quality Indicator</td>
<td>Service area applicable to</td>
<td>Quality Domain</td>
<td>How these will be monitored</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------</td>
<td>----------------------------</td>
<td>----------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Quality Objective 1: Ensure we meet our patient promise continued</td>
<td>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</td>
<td>All Oxleas Services</td>
<td>Patient Experience</td>
<td>These indicators will be monitored by the Trust Patient Experience Group and monthly by the Trust Performance &amp; Quality Assurance Committee</td>
</tr>
<tr>
<td>Quality Objective 2: Ensure we involve families, carers and people important to our patients</td>
<td>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</td>
<td>All Oxleas Services</td>
<td>Patient Experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To ensure 80% of patients have their support network identified and noted within their care record</td>
<td>All Oxleas Services</td>
<td>Patient Safety</td>
<td></td>
</tr>
</tbody>
</table>

<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>
<tbody>
<tr>
<td>Quality Objective 3: Ensure we involve patients in planning their care and they have a care plan that is personal to them</td>
<td>To ensure 75% of Oxleas eligible teams participate in the care planning audits</td>
<td>All Oxleas Services</td>
<td>Clinical Effectiveness</td>
<td>These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance &amp; Quality Assurance Committee</td>
</tr>
<tr>
<td></td>
<td>To ensure 95% of our patients have a recorded care plan on RiO</td>
<td>All Oxleas Services</td>
<td>Mental Health Services, ALD Forensic &amp; Prisons</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To ensure 95% of our patients on CPA will receive a 12 monthly review</td>
<td>All Oxleas Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Objective 4: Ensure we put the safety of our patients first</td>
<td>We will maintain a trustwide focus on the following safety areas: ● Falls ● Deteriorating physical health ● Violence reduction ● Reduce the use of prone restraint by ensuring the following: 1. Increase percentage of staff trained in supine restraint to 80% 2. Increase the use of supine restraint 3. When prone restraint is used, reduce the duration of such restraint</td>
<td>All Oxleas Services</td>
<td>Patient Safety</td>
<td>These indicators will be monitored by the Trust Safety Committee and monthly by the Trust Performance &amp; Quality Assurance Committee</td>
</tr>
</tbody>
</table>
### Quality Accounts

#### Table 3 – Oxleas Quality Priorities 2018/19 continued

<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>
<tbody>
<tr>
<td>Quality Objective 5: Ensure we provide care in line with national best practice and guidelines</td>
<td>We will continue to engage in national audits that permit benchmarking of Oxleas services</td>
<td>All Oxleas Services</td>
<td>Clinical Effectiveness</td>
<td>These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance &amp; Quality Assurance Committee</td>
</tr>
<tr>
<td>Quality Objective 6: Ensure we routinely measure clinical outcomes so that we know that our care makes a difference to patients</td>
<td>We will 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</td>
<td>All Oxleas Services</td>
<td>Clinical Effectiveness</td>
<td></td>
</tr>
</tbody>
</table>

#### 2.4 Statements of Assurance from the Board

This section includes a number of nationally mandated statements of assurances from our trust board.

During 2017/18, 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 2017/18 represents 100% of the total income generated from the provision of relevant health services by Oxleas for 2017/18.

#### 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 2017/18, 14 national clinical audits and 27 national confidential enquiry 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 2017/18 are as follows in tables 4 and 5 below.

The national clinical audits and national confidential enquiries that Oxleas participated in, and for which data collection was completed during 2017/18, 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 4

<table>
<thead>
<tr>
<th>No.</th>
<th>National clinical audit title 2017/18</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>NCEPOD Young People's Mental Health study</td>
<td>Yes</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>National Audit of Psychosis</td>
<td>Yes</td>
<td>150</td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>National Parkinsons Audit</td>
<td>Yes</td>
<td>302</td>
<td>100%</td>
</tr>
<tr>
<td>4</td>
<td>National Audit of Anxiety and Depression</td>
<td>Yes</td>
<td>N/A²</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>Yes</td>
<td>60</td>
<td>56%¹</td>
</tr>
<tr>
<td>6</td>
<td>POMH: 15b: Prescribing valproate for bipolar disorder</td>
<td>Yes</td>
<td>233</td>
<td>100%</td>
</tr>
<tr>
<td>7</td>
<td>National Audit of Cardiac Rehabilitation (NACR)</td>
<td>Yes</td>
<td>N/A²</td>
<td>N/A</td>
</tr>
<tr>
<td>8</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Yes</td>
<td>51</td>
<td>100%</td>
</tr>
<tr>
<td>9</td>
<td>POMH: 17a: Use of depot/LA antipsychotic injections for relapse prevention</td>
<td>Yes</td>
<td>151</td>
<td>100%</td>
</tr>
<tr>
<td>10</td>
<td>POMH: 1g &amp; 3d: Prescribing high dose and combined antipsychotics</td>
<td>Yes</td>
<td>135</td>
<td>100%</td>
</tr>
<tr>
<td>11</td>
<td>POMH: 16a: Rapid Tranquilisation</td>
<td>Yes</td>
<td>100</td>
<td>100%</td>
</tr>
<tr>
<td>12</td>
<td>Early Intervention in Psychosis National Audit</td>
<td>Yes</td>
<td>289</td>
<td>100%</td>
</tr>
<tr>
<td>13</td>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>Yes</td>
<td>30</td>
<td>100%</td>
</tr>
<tr>
<td>14</td>
<td>Maternal, Newborn &amp; Infant Clinical Outcome Review Programme (MBRRACE)</td>
<td>Yes</td>
<td>0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

1. This national audit is in 3 parts: case note audit, patient reported experience measures, and organisational audit. Figures displayed are for the case note audit for Bexley Neuro-Disability Team. Greenwich Neuro-Disability Team did not participate.
2. This audit started in 2017/18 but submission of data to occur during 2018/19 as per audit schedule.
3. Percentage of submitted cases is less than 100% as community teams cannot register patients onto community SSNAP until the discharge hospital have closed their acute SSNAP episode and marked as transferred to community. This is a nationally recognised issue that the SSNAP is working to amend for teams who participate.
4. During 2017/18 Oxleas developed a form for capturing data on our electronic record system specifically tailored to the needs of NACR. The next data upload is scheduled for June 2018.

Table 5

<table>
<thead>
<tr>
<th>No.</th>
<th>National Enquiries (2017/18)</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 [NCISH])</td>
<td>Yes</td>
<td>27</td>
<td>100%</td>
</tr>
</tbody>
</table>

The reports of five national clinical audits were reviewed by Oxleas in 2017/18 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 (a sub-group of the Trust Performance & Quality Assurance Committee) where results are presented and action plans are agreed for each applicable service. We undertake a review of actions to ensure that these are completed in a timely manner and have met the recommendations set. Furthermore we participate in re-audits to check compliance with standards. We have provided one example of a national audit reviewed by the Trust Clinical Effectiveness Group in section 2.2.5.1 above (copies of all Trust clinical audit reports are available on request).

2.4.2 Trustwide Clinical Audit Programme

The reports of 48 local clinical audits were reviewed by Oxleas in 2017/18 and we intend to take the following actions to improve the quality of healthcare provided: Recommendations and action plans to improve the quality of healthcare provided have been agreed across each of our directorates. We continue to maintain a focus on improving clinical practice in accordance with national and local guidance. We have provided a summary below on one of our local priority clinical audits.

2.4.2.1 Trustwide Audit of Care Plans (Risk & Service User Involvement)

During financial year 2017/18 we took on a new approach to our annual care planning audit by converting it to a monthly audit and expanded to include a wider variety of teams (for example for the first time our prison services are involved in this audit). Every team within Oxleas is now expected to undertake an audit of a minimum of 5 care plans each month. 280 clinical staff have completed audits since the audit began, this means that approximately 15% of our clinical workforce have participated in the audit as auditors.

To date 115 of teams have participated since July 2017, with over 2200 audits completed. We expect to see this gradually increase and have set a participation target for 2018/19.
All staff can access their results online, they have the opportunity to see trends, and focus on achieving better results. Care planning workshops have been set up across the Trust and results are reviewed regularly at local Clinical Effectiveness Groups and at Quality Improvement Meetings allowing staff to identify gaps, and drive improvement. Materials such as the Care Planning Strategy with its 7 principles and our ‘Writing Good Care Plans Guide’ have been distributed, and emphasised. Results of the audit are used during staff supervision, and as part of peer reviews.

Overall results have been positive as shown by the results shown below (data given covers the period to the end of March 2018):

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1. Has a risk assessment been completed during this episode of care?</td>
<td>85%</td>
</tr>
<tr>
<td>Q2. Has the risk assessment been reviewed following significant risk incidents, changes in presentation or within the last 6 months?</td>
<td>97%</td>
</tr>
<tr>
<td>Q3. Does the care plan address specific factors identified in the risk assessment associated with increased risk?</td>
<td>86%</td>
</tr>
<tr>
<td>Q4. Is there evidence that the service user has been involved in development of their care plan?</td>
<td>85%</td>
</tr>
<tr>
<td>Q5. Is there evidence that the service user’s support network has been involved in the development of the care plan?</td>
<td>55%</td>
</tr>
<tr>
<td>Q6. Has a copy of the care plan been given to the service user?</td>
<td>67%</td>
</tr>
<tr>
<td>Q7. Has a copy of the care plan been given to the service user’s support network?</td>
<td>34%</td>
</tr>
</tbody>
</table>

* The online audit tool is designed so questions only appear for services that the question is relevant to. There are also options to exclude various patients under certain circumstances e.g. for Q5 above, auditors are able to exclude patients who do not have a support network, or who have stated that they do not want their support network involved in their care. Where these answers are available they have been removed from the denominator for the “Yes %” calculation.

Results vary depending on the services who respond however it is clear that our focus in the coming months of 2018/19 will be on involvement of patients’ families, carers and support networks.

Copies of 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 2017/18 that were recruited during that period to participate in national research studies approved by a research ethics committee was 348, which represents a 126% increase on the previous financial year. We have also hosted 49 locally initiated service evaluations and 7 locally initiated formal research studies across our services.

Our ongoing 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 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Oxleas and any person or body we have entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically from our Quality and Governance Department (oxl-tr.quality@nhs.net).

Our total 2017/18 CQUIN income conditional on achieving all the quality improvement and innovation goals was £4.13m. The assumed provisional payment dependant on confirmation from our associated commissioners on achieving the goals set by the end of March 2017 is £3.63m. Our total CQUIN income for the previous year 2016/17 was £3.31m.

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 not taken enforcement action against Oxleas during 2017/18.

Oxleas has not participated in any special reviews or investigations by the CQC during the reporting period. However our Forensic inpatient/secure wards underwent a comprehensive inspection on the 24th -26th April 2017 and the last Oxleas dashboard, rated by the CQC on the 6th of July 2017 provided below:

Table 7

<table>
<thead>
<tr>
<th>Oxleas CQC Ratings Dashboard – last rated 6 July 2017</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Community health services for adults</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>2 Community health inpatient services</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>3 End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>4 Community services for children, young people and families</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>5 Community mental health services for children, young people and families</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>6 Community mental health services for working age adults</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>7 Mental health crisis services</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>8 Mental health wards for adults of working age</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>
### Table 7

<table>
<thead>
<tr>
<th>Description</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Rehabilitation mental health wards for working age adults</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>10 Forensic inpatient wards</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>11 Wards for people with a learning disability</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>12 Community services for people with a learning disability</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>13 Wards for older people with mental health problems</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>14 Community mental health services for older people</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

#### 2.4.6 Data Quality

Oxleas submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

- 98.5% for admitted patient care
- 99.9% 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:

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

#### 2.4.7 Information Governance Toolkit

Oxleas Information Governance Assessment Report overall score for 2017/18 was 84% and was graded ‘green’.

#### 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 2017/18, all NHS Trusts have a requirement to publish learning from deaths data. The Oxleas 2017/18 position is provided below:
2.5.1 Number of patients who died in 2017/18

During 2017/18, 1214 Oxleas patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 292 in the first quarter
- 314 in the second quarter
- 251 in the third quarter
- 357 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

0 representing 0% 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:
- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for 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 incorporated structured judgement reviews into the investigation reports to form a view of avoidability. None of the deaths reviewed have been considered avoidable.

2.5.4 Summary of what Oxleas has learnt from case record reviews and investigations undertaken in 2017/18, 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

Appointments with the Early Intervention in Psychosis Team were not always convenient for services users in full time employment.

- Action taken: Appointments are now available out of hours.
- Assessment of the impact of the actions: There is now increased engagement and service user satisfaction

Lesson 2

The provision of generic falls prevention training did not always improve staff competencies.

- Action taken: Staff now receive falls prevention training in their two week supernumerary induction in the workplace.
- Assessment of the impact of the actions: Improved understanding and compliance with falls prevention strategies

Lesson 3

Multidisciplinary team members were not always able to attend ward rounds which could lead to less effective care planning.

- Action taken: An inpatient ward round template was developed to enable input by the multi-disciplinary team ahead of the meeting. This included family/carrier involvement, service user involvement.
- Assessment of the impact of the actions: There is increased multi-disciplinary input into care planning.

Lesson 4

Crisis plans were not always developed with the service user

- Action taken: “My Crisis Plan” was developed which is a patient-centred document that is collaboratively devised with the patient, and where appropriate, family and carers.
- Assessment of the impact of the actions: This has helped to ensure personalised crisis plans.

Lesson 5

Staff required more specialised training on risk assessing an individual’s risk of suicide

- Action taken: The trust commissioned STORM training which is a 3 day accredited suicide prevention skills training that encompasses:
  - Assessment of Risk
  - Safety Planning
  - Problem Solving
  - Future Safety Planning
- Assessment of the impact of the actions: Personalised and competency based risk assessments
Lesson 6
Service users in communal areas without staff supervision may be vulnerable if unsupervised.

• Action taken: CCTV has been installed in the gardens of the low security forensic services.
• Assessment of the impact of the actions: Improved safety.

Lesson 7
A systematic approach was required to reduce the incidence of pressure ulcers.

• Action taken: Staff were trained to use the SSKIN tool kit (Surface, Skin, Keep Moving, Incontinence and Nutrition).
• Assessment of the impact of the actions: A systematic approach was in place to reduce the incidence of pressure ulcers.

Lesson 8
There was sometimes a delay in the receipt of information from GP’s.

• Action taken: Staff now have access to Connect Care which enables identified staff to access the electronic records across GP’s.
• Assessment of the impact of the actions: Having immediate access to key clinical information in Connect Care, and details about others involved in a person’s care has assisted clinicians to:
  • Prevent unnecessary admission/readmission to hospital
  • Prevent delayed discharges
  • Support faster rehabilitation
  • Prevent unnecessary referrals
  • Prevent unnecessary home visits
  • Enable better triage of referrals
  • Support faster and more effective assessment

• Reduce administrative tasks freeing up time for clinical care
• Improve patient experience as it reduces repetitive questions

Lesson 9
Information documented in the clinical record was not always used to inform care planning.

• Action taken: The electronic record is now able to pull through information into the care plan.
• Assessment of the impact of the actions: Increased compliance with the involvement of service user/support network involvement to inform care planning.

2.5.5 The number of case record reviews or investigations not included in section 2.5.2

0 case record reviews and 5 investigations completed after 31st March 2017 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.

2.5.7 Revised estimate of the number of deaths in 2017/18 taking account of deaths referred to in section 2.5.6 above

0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.6 Performance against National Core Indicators

One of our requirements as an NHS Foundation Trust is to report our performance against a core set of indicators, which is published by NHS Digital (an arms-length body of the Department of Health and are the national provider of information and data)

There are 5 indicators, which are relevant to the services we provide, and our performance against these indicators is shown below. This is the latest information published by NHS Digital:
### Table 8

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1 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>97.5%</td>
<td>99.5%</td>
<td>97.6%</td>
<td>99.0%</td>
<td>95.4%</td>
<td>100.0%</td>
<td>69.2%</td>
</tr>
<tr>
<td>2 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>100.0%</td>
<td>100%</td>
<td>99.2%</td>
<td>99.5%</td>
<td>98.5%</td>
<td>100.0%</td>
<td>84.3%</td>
</tr>
<tr>
<td>3 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>74%</td>
<td>75%</td>
<td>65.4%</td>
<td>67%</td>
<td>67% (combined MH &amp; Community Trusts)</td>
<td>76% (combined MH &amp; Community Trusts)</td>
<td>55% (combined MH &amp; Community Trusts)</td>
</tr>
<tr>
<td>4 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>7.8/10</td>
<td>7.2/10</td>
<td>7.5/10</td>
<td>7.6/10</td>
<td>Not provided</td>
<td>8.1/10</td>
<td>6.4/10</td>
</tr>
</tbody>
</table>

### Table 8 continued

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>5 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>Rate per 1000 days</td>
<td>27</td>
<td>27</td>
<td>45</td>
<td>24</td>
<td>2,476</td>
<td></td>
</tr>
<tr>
<td>Severe harm or Death</td>
<td>0.36</td>
<td>0.36</td>
<td>0.59</td>
<td>0.35</td>
<td>Comparison with Mental Health Trusts Rate per 1000 days - not provided nationally (data shown for England)</td>
<td></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

Q3: National NHS Staff Survey 2017: NHS England, NHS Survey Co-ordination Centre 06/03/2018
Q4: Care Quality Commission: Patient experience of community mental health services. Published 15 November 2017 http://www.cqc.org.uk/content/community-mental-health-survey
Q5: NHS National Reporting and Learning System, Organisation Patient Safety Incident workbook. Published November 2017 Data for incidents 1 October 2016 and 31st March 2017

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 NHS Improvement (NHIS) 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 NHIS
Oxleas intends to take the following actions to improve the percentage of 99%, 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 99.5% to 100%.

For indicators 3 and 4 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 domains of enhancing the quality of life for people with long term conditions and ensuring people have a positive experience of care
  - The data for these indicators are provided by the CQC and Department of Health

Oxleas intends to take the following actions to improve the percentage of 67% and rate of 7.6 respectively and so the quality of its services, by continuing our focus on the following:

- National Staff Survey - Our 2017 staff survey continues to place us above average and a high performer compared with other organisations. 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:
  - 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.

### Part 3 - Other Information

#### 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 2017/18.

In the earlier part of our report (please see section 2.2), we presented how we have performed against the 2017/18 quality priorities with reference to our performance in previous years where available. No changes have been made to the indicators published in the 2016/17 report, however we have provided directorate level data for objective 1 quality indicators by boroughs instead of by functional directorate (please refer to section 2.2.1 for further detail).

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 6 indicators applicable to the services that we provide and our performances against these are provided below:
Section three

Quality Accounts

Table 9

<table>
<thead>
<tr>
<th>Single Oversight Framework indicator for disclosure</th>
<th>2017/18 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>70.0%¹</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>90% for a, 90% for b, 65% for c</td>
</tr>
<tr>
<td>a. inpatient wards</td>
<td>a. 97%</td>
<td>90%</td>
</tr>
<tr>
<td>b. early intervention in psychosis services</td>
<td>b. 90%</td>
<td>90%</td>
</tr>
<tr>
<td>c. community mental health services</td>
<td>c. 31%</td>
<td>65%</td>
</tr>
<tr>
<td>(people on care programme approach)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of people completing treatment who move to recovery (from IAPT dataset)</td>
<td>57.0%</td>
<td>50%</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time to begin treatment (from IAPT minimum dataset)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Within 6 weeks of referral</td>
<td>96.6%</td>
<td>75%</td>
</tr>
<tr>
<td>ii. Within 18 weeks of referral</td>
<td>99.9%</td>
<td>95%</td>
</tr>
<tr>
<td>Core Programme Approach (CPA) follow up: proportion of discharges from hospital followed up within 7 days</td>
<td>98.0%</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>502 bed days (35 patients)²</td>
<td>0</td>
</tr>
</tbody>
</table>

¹ EIP Indicator - External audit assurance undertaken by Deloitte has shown limitations in the reliability and accuracy of the published data. Please refer to Annex 3 for further detail.
² Inappropriate Out of area placement indicator - External audit assurance undertaken by Deloitte has shown limitations in the reliability and accuracy of the published data. Please refer to Annex 3 for further detail.

3.2 Oxleas Quality Highlights and Case Studies

Over the course of the year, we are delighted 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 improve lives. These examples are seen and shared as part of the Board to floor visits or by teams highlighting what they are proud of. In this section of our Quality accounts, we would 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.

3.2.1 Partnership working across two different providers

Case for change

Many of the service users of the Oxleas Bromley Community Learning Disability Team have complex physical health problems, which require input from multiple professionals. Some require enteral feeding (tube feeding) or nutritional support and are on Bromley Healthcare’s Community Dietsetics Team’s caseload. People with Learning Disability are known to experience disadvantage when accessing mainstream services (Allerton and Emerson, 2012). This is often due to lack of joint working between different care providers, and mainstream services lacking expertise in making reasonable adjustments and navigating issues such as mental capacity.

One of the most vulnerable groups are people with dysphagia (eating, drinking and swallowing difficulties), who often require support to meet their nutrition, hydration and medication requirements (RCSLT, 2010).

As the community dietetics service are based in Bromley Healthcare (a separate organisation to Oxleas), joint working had proved challenging, leading to breakdown in communication, delays in service users accessing appropriate services and poorer outcomes for patients.

Following a particularly complex case, we reflected on how we can work together to improve outcomes for the patients (Fairclough et al, 2008).

What we did

In March 2017, Clinical Lead Speech and Language Therapist, Kirsty Meehan, arranged an inaugural meeting which has now led to regular, 3 monthly meetings. This meeting involves as many of the members of the Bromley Health Care Dietsetics Team as are available to attend and any professionals from the Community Learning Disability Team who are involved with Service users accessing both services.

At these meetings, we discuss service updates and our joint cases. Guest speakers attend the meetings such as an Epilepsy Nurse Specialist, who came to talk about their service. This gives an opportunity for all to learn more about each other’s roles and how nutrition and hydration can impact on other aspects of health.

We now often carry out joint visits, which ensure a consistent message to the service users, and cuts down on the number of appointments they have. We have implemented a register of all our joint patients; this ensures that information is shared between the two services, to provide more joined up and holistic care. The Clinical Lead Speech and Language Therapist is leading the development of a joint working protocol. When complete, this document will set out the roles and responsibilities of each of the professions, and establish what ‘best practice’ looks like, to ensure that we continue to work collaboratively.
Quality Accounts

Results
Knowing each other better has allowed more open channels of communication. We are able to easily seek support and advice, and have increased our knowledge about the roles of the other professions. This has helped to ensure that referrals are appropriate and timely and information is shared consistently. All attendees agree that the meetings have had a positive effect on our practice and look forward to continuing to develop our services.

References
Allerton, L. and Emerson, E. (2012) ‘British adults with chronic health conditions or impairments face significant barriers to accessing health services,’ Public Health, 126: 920-927.

3.2.2 Developing a Trustwide ‘Adults with Learning Disabilities Position Paper,’ RCSLT.

3.2.2 Developing a Trustwide crisis pathway for people with personality disorder

Case for change
Following the deaths by suicide of two patients with a primary diagnosis of personality disorder who had been under the care of inpatient services, concerns were expressed about the care received by patients with personality disorder during periods of crisis. A project was established with the aim of developing a crisis care pathway for people with personality disorder that considered their needs at every step from assessment by crisis services, during periods of hospital admission, as patients moved back through the pathway into the community and when the patient returned again in crisis.

The remit of the project was to develop a model that offered consistently good quality compassionate care, while drawing on resources in a lean and effective manner, with its main emphasis in a community location. The centre of the pathway was to be embedded in three trust day treatment teams. The focus of the pathway was to be on positive relationships, rather than therapy with a shift from “discharge” to “pathway progression”

What has been done differently to improve patient care?
An 18 month service improvement project was agreed and a project team was established consisting of a part-time project lead supported by a clinical psychologist and assistant psychologist. On commencing in role, the project team spoke to patients with a diagnosis of personality disorder about their experiences of care. They clearly described the barriers to accessing early support during periods of crisis and difficult experiences of attending the Emergency Department (ED) during periods of crisis and facing stigma and long waits to see someone from the Mental Health Team. The team also interviewed day treatment staff about their experiences of working with people with personality disorder. The staff spoke of the challenges that they faced, including a feeling that 6-8 weeks was not long enough to support somebody with a personality disorder and that longer term support was needed.

In addition to speaking to patients and staff, the project team visited other London NHS services to ascertain what services currently existed to support people with personality disorder that may be different to what was currently being offered within Oxleas. The team were clear that the model that they wished to develop needed to be patient-centred supporting patients to draw on their own skills and resources, as well as being flexible and rapidly accessible.

The team visited the SUN (service user network) service operated by South London and Maudsley Foundation Trust (SLAM) within Craydon and the SUN service provided at South West London and St Georges NHS Trust. The SUN Project is for people who have longstanding emotional and behavioural problems (personality disorder), and who may feel they do not get adequate support from mainstream services.

The SUN model offers staff-facilitated peer-support groups for people with difficulties associated with personality disorder. The groups run frequently (several times each week) in non-NHS community settings. They are open-access, meaning that the member can attend a group whenever they choose. They offer the members lifelong membership with no threat of discharge “if they get better”. The groups are based on the principles of the therapeutic community and cognitive theory and offer members the opportunity to receive support from other group members, as well as offering support to others with any stresses they may be experiencing. The frequent operation of the group enables members to access support rapidly during times of crisis thus helping to prevent an escalation which might in result in the member needing to attend the ED or receive care from home treatment or inpatient services.

Impressed by their visits to other London SUN services, the project team decided to incorporate SUN groups into a personality disorder crisis care pathway, that also included other groups and interventions already operating within the day treatment teams. Nominated staff working within both the day treatment and home treatment teams undertook training in the facilitation of the SUN groups. The groups were then rolled out across the trust, starting in Bromley in July 2017, extending to Greenwich in October 2017 and then to Bexley in January 2018. The groups run twice weekly in each borough and all are sited in church halls.

What have been the benefits in terms of positive outcomes?
The project team are currently evaluating the impact of the crisis pathway, but in particularly the SUN groups, both in terms of patient and staff experience, and use of mental health crisis services. Initial results appear very favourable.

Patients speak highly of the groups and how much they value them, an example from one member being “I have been waiting for a group like this for years”. Further evaluation of patient feedback is currently being planned by Bromley ResearchNet. Evaluation of the impact of the SUN groups on reducing the use of mental health crisis services is still in its initial stages but again the results appear to be favourable. The project team have looked at the use of mental health crisis services by patients attending the SUN groups in Bromley in the 3 months before and after attending their first group. Attendances at the ED in mental health crisis fell from a collective total of 34 in the 3 months pre-first group attendance to 9 in the 3 months post-group attendance; inpatient episodes fell from 13 to 1 with a reduction in collective bed days from 204 to 6. Referrals to the Home Treatment Team (HTT) also fell from a collective of 43 episodes in the three months pre-first group attendance to 16 in the three months post-first group attendance. This was accompanied by shorter episodes of care with a reduction in the collective number of HTT care days from 389 to 44 and a reduction in the average length of HTT care episode from 15 to 4 days. It is likely that the presence of the SUN groups enabled members to feel able to be discharged earlier from the HTT knowing that they could continue to receive on-going support. Evaluation will continue and it is hoped that the early apparent success in Bromley will be sustained, as well as replicated in Greenwich and Bexley.
The project team hopes that the SUN groups meets the original brief of the project, namely that they offer consistently good quality compassionate care, while drawing on resources in a lean and effective manner, with a main emphasis in a community location, and a focus of on positive relationships, rather than therapy. They move away from the terminology of “discharge” to “pathway progression”, and offer the patient-centred, flexible, rapidly-accessible model that patients with personality disorder stated that they valued, and the ongoing support that day treatment reported was lacking.

3.2.3 Implementing the Forensic Service Recovery College

Case for Change
Recovery Colleges bring an educational approach to patients learning about their mental health and wellbeing. They provide a sense of empowerment and normality as courses are provided in a classroom style setting, participants are referred to as students and they often assist in the production and facilitation of the courses. This minimises the observable differences between colleagues and students as both provide a different type of expertise.

What We Did
We launched the Oxleas Forensic Recovery College in June 2017. SLAM were invited to help deliver their 'Train the Trainer' programme, resulting in us having several students trained in the production and facilitation of courses. The courses provided so far have included:

- **Choices for Change** addresses the specific skills we need to bring about changes in our own lives. This can vary from life skills like budgeting and employment, to personal things like relationships and self-esteem.
- **Mood Boost** is an hour long session designed for students and colleagues to attend as much or as little as they would like; either every week, or just when they need a pick-me-up. Each session involves watching pre-approved funny videos to make students laugh, learning different strategies to boost moods outside of session, and guided relaxation exercises.
- **The Mindfulness** course teaches students and colleagues mindfulness skills to use in their everyday lives and through meditation, particularly as a way of managing stress and other difficult emotions.

Results
A new tool named the Oxleas Forensic Wheel was developed specifically to assess any particular areas of life that students find challenging, so that specific goals can be set and courses attended can be picked to address these challenges. Students are given a score from 1-5 according to how able they feel to deal manage different areas, with higher scores showing more ability to manage an area. The areas included to be assessed are mental health, moving on, identity and self-esteem, relationships, physical health, managing emotions, skills & activities, substances & addiction, hoping & believing, and risk.

The graph below shows the change in scoring for 15 different students who have attended the Oxleas Forensic Recovery College. Eight students overall scores have increased and three have remained the same, meaning that only four student scores have decreased since they began engaging with the Forensic Recovery College:

Feedback from participants:

- “I feel a lot more comfortable in courses now”.
- “I enjoy activities like the quizzes using the quiz buzzers”
- “Everyone tries to be genuine and use their interpersonal skills so we learn a lot from each other”
- “I just like being in these sessions with everyone here”
What Next
We currently have three students delivering courses with colleagues a week, one for each session at The Bracton Centre. We are also delivering courses at the two wards at Memoria
l Hospital and plan to train students to co-
" producing and co-delivering the courses here too. We are looking to begin an Unusual Experiences course and a Drama course during the next term.

3.2.4 The Fresh Air Project
Case for Change
The Bracton Centre and Memorial Hospital became a smoke-free environment on the 5th September 2013. The Fresh Air Project had started one year earlier in order to prepare service users for the September smoke-free date. Colleagues received training in smoking cessation support to assist the service users in cutting down and giving up smoking. Increased supplies of nicotine replacement therapy (patches, nasal spray, lozenges, gum and mouth spray) were made available, and Smoking Cessation Advisors began to visit weekly to support the service users giving up. The Fresh Air Project was part of the process preparing to go smoke-free in September. It aimed to support the service users giving up. The Fresh Air Project sessions around the following areas:

- **The Smokescreen** – How big tobacco companies subtly target people with product placement and mass media to promote smoking
- **Sport Performance** – How the dangers of smoking adversely affects performance in sporting capacity e.g. healing from an injury
- **Physical Fitness** – How smoking impacts the respiratory and cardiovascular systems
- **Anatomy** – Educating service users a base understanding of the body, for example functions of the skeleton, muscles and energy systems.

Results
Since facilitating the Fresh Air Project on Friday evenings, attendance of service users has risen; average attendance is now around ten each week actively engaging in the session. Carbon monoxide readings remain low (must score below 5 to attend), which indicates whether service users have smoked tobacco either on an unescorted leave or within the grounds. When asked if attending the Fresh Air Project had helped them to stop smoking and remain smoke free twenty service users indicated it had, six said it had not and seven were non-smokers (table below).

What We Did
Prior to joining Oxleas in July 2017, the Trust-wide Sports and Fitness Lead had extensive experience of working in smoking cessation across London, in particular working in partnership with East London Foundation Trust and preparing colleagues and service users to go smoke free. Utilising this experience along with the knowledge and expertise in health and fitness, the Trust-wide Sports and Fitness Lead updated, revised and structured the Fresh Air Project sessions around the following areas:

- **The Smokescreen** – How big tobacco companies subtly target people with product placement and mass media to promote smoking
- **Sport Performance** – How the dangers of smoking adversely affects performance in sporting capacity e.g. healing from an injury
- **Physical Fitness** – How smoking impacts the respiratory and cardiovascular systems
- **Anatomy** – Educating service users a base understanding of the body, for example functions of the skeleton, muscles and energy systems.

Feedback
- "I like learning about health and fitness and the human body, I find it really interesting" Joydens service user
- "Helps give me reasons to stop smoking through learning about the body and how smoking is counterproductive to my health" Crofton service user

What Next
To further support the Oxleas' Smoke-Free Policy, it has been agreed by the Trust-wide Sports and Fitness Lead and the Directorate Lead Occupational Therapist to set up a new weekly smoking cessation drop-in clinic, open to all service users and colleagues, similar to what was introduced in the preparation of the service going smoke free in 2013. This now takes place on a Monday afternoon in the GP surgery at The Bracton Centre, which is an additional offshoot of the Fresh Air Project. It gives the opportunity for service users and colleagues to receive one-to-one smoking cessation support, to discuss withdrawal symptoms, craving strategies and nicotine replacement therapy options, similar to the community based module run by local stop smoking services.
Section three

Quality Accounts

ACIS, MOHOST, Sensory Profile) and non-standardised assessment tools are used.

Interventions are graded according to service users’ functional abilities and aim to support them to reduce problematic behaviours through sensory strategies, to practice communication and interaction skills in a structured environment, to practice process skills by engaging in 2-3 step low demand tasks, to maintain good physical health by engaging in exercise and educational short sessions. All these functional skills are the baseline for the next step in the service users’ recovery journey, which is the open ward and community.

What we did
The current OT program was developed based on service users and staff views, PICU OT programs within London NHS Trusts (ELFT & SLAM), recent literature review and National programs within London NHS Trusts (ELFT & SLAM), recent literature review and National Association of Psychiatric Intensive Care & low secure Units (NAPICU) (2014) guidelines.

The current OT group sessions are:
- **Physical Exercise** group is an important activity for acutely unwell patients as it promotes physical and psychological wellbeing and it is a way to channel hyperactivity and aggression constructively.
- **Relaxation** group offers an opportunity for service users to explore various sensory stimuli through relaxing activities and they are assisted to in the development of coping strategies and trigger-recognition.
- Service users have the opportunity through creative activities to mask their feelings and improve their functional skills within a supportive and safe environment.
- **Creative group**: Service users have the opportunity through creative activities to practice alternative ways to deal with their distress, express their feelings and improve their functional skills within a supportive and safe environment.
- **Men’s Health group**: Patients have the opportunity through discussion to learn about their illnesses and their symptoms, drug and alcohol misuse, medication, balanced routine, diet, smoking cessation and exercise.
- **OT input** is respected and considered in care planning, MDT reviews, hand overs, MDT assessment and risk management plans promoting a holistic approach within the team.
- **Additional funding** has been utilised for new leisure activities on the ward.

Next Steps
We aim to evaluate the therapeutic timetable frequently by getting daily verbal and written feedback from our service users and staff and we make amendments accordingly in order to maintain best evidence practice. Our efforts are an on-going progress and will continue to be in order to make sure that we offer the best service to our service users.

Outcome
- Professionals from different disciplines are more involved in our therapeutic weekly timetable and thus the levels of engagement with the service users are increased and bridges within MDT and services within and outside Trust have been created.
- We have introduced two new group activities in the weekly timetable.
- We have raised awareness within the ward multi-disciplinary team (MDT) presenting on the role of OT in PICU and relevant assessment tools.

Qualitative and quantitative data have been collected for each group activity since June 2017 from the evaluation forms that service users have completed anonymously. Also, a questionnaire reflecting on the OT program on the Tarn was handed by fellow OTs on the Greenwich acute open wards to previous service users to complete anonymously. An example statement provided by a patient:

“The OT took my mind off of things that make me sad and stressed and unhappy and even made my mom happy because she likes painting and flowers and the OT got me to paint flowers for my mom”

References

3.2.6 Bromley Medicines Optimisation Service—helping patients get the best from their medicines

Case for change
One third to a half of medicines prescribed for long-term conditions are not taken as intended, and this is both a lost opportunity for improving health, and a known cause of waste in the NHS. The Bromley Medicines Optimisation Service (MOS) aims to support community-based patients to self-manage their medicines so that the benefits of these medicines can be maximised whilst harms and waste are minimised.

What we did
The MOS team supports patients who are unable to visit their community pharmacy to discuss the problems they have with their medicines. Following a referral from a health or social care professional, a member of the MOS team visits the patient at home. An assessment is conducted to understand the difficulties the patient has in taking their medicines as prescribed, and solutions are put in place that are acceptable to the patient and/or family carers.

The MOS team has worked closely with Bromley CCG to jointly agree key measures that demonstrate the benefits of the service for patients, GPs and commissioners. An expert clinical panel that included a Bromley GP reviewed care plans that had been put in place and this panel agreed that the MOS service delivers a range of positive outcomes.

The figure below provides a summary of the number of patients seen by the MOS service and the ways in which these patients benefit from the service.
What a patient said about their experience of the service:
So impressed by the efficient, professional, knowledgeable and friendly support I received. This service has had a positive impact on me and I hope the result will be that I am able to consistently manage my medication and therefore avoid another crisis.

What a GP said about the service:
A really helpful service. I hope it continues.

3.2.7 Improving access to psychological therapies for children and young people

Case for change
Children and Young Peoples (CYP) IAPT (Improving Access to Psychological Therapies) was launched in November 2011 and Greenwich Child and Adolescent Mental Health Service (CAMHS) was a wave 1 site for implementation. The CYP IAPT collaborative is a service transformation programme that aims to improve CAMHS through the following principles:

- Participation
- Delivering evidenced based practice
- Raising awareness
- Clinical outcomes
- Improving access

These principles are co-dependent and applied within a culture of collaboration and shared decision making.

What has been done differently to improve patient care
Changes to the service are predominantly aligned to the five principles detailed above with the addition of governance and leadership. There is a robust Greenwich management team who review and embed the principles of IAPT on a regular basis through management structures and a CYP IAPT lead in the service.

Participation
Parents and carers have been involved in staff training and videos have been created to support this. Young people have also been involved in designing individual support plans for specific symptoms and were involved in the design of the new Greenwich CAMHS base.

Qualitative feedback from the Child Experience of Service questionnaire (CHI-ESQ) demonstrates the positive way in which young people view the service. Comments that are made and actions implemented accordingly are used to create ‘You Said, We Did’ feedback posters at service user level. All feedback is shared in clinical teams and in the management meetings to ensure an overview.
Section three
Quality Accounts

All feedback, positive and negative is fed back to young people and their families/carers in waiting rooms via a feedback board. These display boards were designed in collaboration with young people from the Bursting Stigma Participation Group.

Evidence based practice
Evidenced based pathways are in place for parenting, Depression, Anxiety, Learning Disabilities, Neurodisabilities and Self-Harm. A number of staff have completed IAPT training in the above evidenced based pathways, and all of these have remained working within the service since the time of training. When posts do become vacant, they are reviewed by the management team and decisions are made on the post based on skill mix, treatment needs and service needs. Staff are supported in training opportunities within the IAPT initiative and decisions are made based on service clinical requirements.

Raising awareness
The CYP IAPT programme supports improved access to services. Early intervention and prevention work is also offered in schools, children’s centres and in social care to provide training and supervision, brief intervention and consultation for children and young people presenting with emotional health and well-being concerns.

Clinical outcomes
Greenwich CAMHS has a long history of using outcomes within its services. Clinical outcomes are used at assessment, review, session by session and discharge to help assess a young person’s mental health difficulties and review their progress. They are also used within sessions to help track a young person’s progress in four key areas: goal tracking, symptom tracking, feedback tracking and impact tracking. Five key outcome reports are produced on an annual basis, these are as follows:

- Goals: Rated by the young person or their family/carer
- SDQ: Mental health outcome reported by the young person or their family carer
- RCADS: Mental health outcome reported by the young person or their family carer
- CGAS: Clinician rated measure of global functioning
- CHI-ESQ: Patient satisfaction questionnaire
- Clinician Complexity Tool: Clinician rating of problem descriptions, complexity factors, contextual problems and attainments/attendance difficulties

With regards to goal based outcomes for initial assessment and review, Greenwich CAMHS has been over 80% compliant in both areas.

Accessibility
Following feedback from young people, professionals, commissioners, parents and carers Greenwich CAMHS service opening hours changed from 9am – 5pm to 8am – 7pm. Service locations have also been informed by want young people and families have said would be helpful. Services are now delivered at The Point (youth hub), schools, social care, young people’s homes and other community settings. This flexibility means that young people who are high risk or who cannot attend a service base can still access Interventions and treatment.

Access targets for assessment to treatment have also changed within Greenwich CAMHS from 12 to assessment and 18 weeks to treatment, to 8 for initial assessment to 12 weeks for treatment. At present the service is in fact averaging six weeks to initial assessment. The management team also regularly reviews waiting lists and if the wait is higher in one part of the service than another, resources will be deployed there to manage this and there are quick waiting list management plans put in place.

Self-referrals are also accepted via Headscape.

Awards and recognition
Greenwich CAMHS have recently been informed that out of the London and South East CYP IAPT programme, within which are 43 partnerships, they have been rated within the top five. Greenwich CAMHS are now a beacon site for embedding and continuing to deliver an IAPT compliant service. They are the only Community CAMHS Tier 3 service to have been selected as a beacon site. Greenwich CAMHS will be producing a presentation in partnership with the CCG Commissioner that will get submitted to NHS England and be shared with other collaboratives. They will also help to mentor other partnerships to support them in becoming IAPT compliant.

3.2.8 Improving Physical Health Competency in Forensic Services

Case for Change
It was highlighted through observation and discussion with nurses and healthcare assistants, that some of our mental health trained staff lacked basic skills required for physical health assessment and/or the confidence in their abilities to use skills and report effectively. There was also a variety of equipment being used or in situ on wards that staff needed additional competency training in order to use safely and effectively.

What we did
We recruited a nurse with a general nursing/physical health background to support staff and patients on our Forensic unit and to help improve the areas that we had identified as needing an additional focus.

To improve staff training, the physical health lead nurse initially created a standardised device list that staff required training for. The aim was to have all members of staff on the ward

Feedback from young people and family

“I would recommend Greenwich CAMHS because you can talk about all the bad things and the good things and you will be happy”
Young Person

“I like how in-depth we looked at things that were not obvious to me but which have had an impact on my son’s emotional wellbeing”
Parent

“XX really listened about what I had to say and then helped me expand and explain certain problems that I had. I felt really safe and reassured”
Young Person
trained to use all in-house devices including ECG Machines and to move the focus away from electronic blood pressure monitors and back onto manual BP monitoring. A training programme was set up on set days commencing with ECG device training and competencies and these sessions were well attended. To work around the issue of staff having to leave the ward, additional training days were provided where the physical health lead nurse attended the wards and provided training on a range of physical health subjects such as Airways (basics), Manual BP, Blood sugar monitoring, and ECG.

Following feedback a decision was made to hold a specific Forensic & Prisons Directorate skills based competency event. We devised a plan to encourage staff to attend to pick up a skill/revise old skills and take back to the ward to practice, the onus would then be on ward doctors/ward managers and senior nurses to ensure that staff were being signed off as competent. The plan focused around a reward card system, the idea was that at each skills station they get their card stamped, they take the card and relevant competency document away with them and practice that skill, they then ask Doctors/ senior nurses to sign them as competent on the ward and the senior nurses add them to the forensic and prisons inpatient spread sheet for competencies. Instructions were printed on the reverse of the reward card so all were aware of what to do and where to find the spread sheet. We had eight tables in total:

- Case Scenarios
- Lifesaver app
- RIO/MEWS
- GCS (Glasgow coma scale)
- What is in your Drugs box
- What is in your resuscitation bag?
- ECG

We made each table as interactive as possible for example the resus bag was a game - who can label the items in the quickest time and results were retained so that certificates could be issued at a later time. A similar strategy occurred at the ECG table, we made magnetic counters which correlated to the leads of an ECG machine and staff had to place them on the “patient” in the quickest time possible (like pin the tail on the donkey!). The GCS table used the official website for Glasgow coma scale and staff members were able to have the system explained and test their knowledge. The other tables were much more about facts and skills, for example at the manual BP table, staff needed the practice and the table focused on the skill rather than trying to make this “fun”.

We had volunteer trainers from pharmacy, ward doctors/consultants, nurses and healthcare assistants who helped to teach on the day and we all supported one another and worked well as a team to provide the learners with a positive experience.

100% of feedback was that the day was a positive experience and enjoyable with staff using words such as “excellent” or “good” 30 members of staff gained at least 2 new skills and the knowledge to support them and we hope these new skills will be practiced at all given opportunities on the wards.

**Next steps**

- To repeat the skills event as a full day event targeting staff on the early and late shifts
- To use the same formula and hold similar events at other sites and directorates across the Trust targeting our staff who work on our acute wards

**3.3 Our Staff Survey 2017**

We take part in the Care Quality Commission’s (CQC) annual national NHS staff survey. The staff survey is an important piece of evidence which demonstrates our compliance with CQC’s national standards and targets. The overall response rate to the 2017 survey was 42% (1364 staff) of all staff. The response rate was average when compared with other combined mental health/learning disability and community trusts and was slightly lower than the response rate in 2016 (44%). The Care Quality Commission report groups the responses of all the questions into 32 key findings with an additional composite finding around staff engagement.

When compared with similar organisations, our comparative scores are as follows:

- 13 key findings were above average
- 8 key findings were average
- 11 key findings were below average

We were rated as better than national average on the composite score for staff engagement at 3.84 (out of a maximum of 5). The score is based on a composite of staff responses in relation to three key findings – staff recommendation of the trust as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work.

NHS England have requested that Trusts include in the Quality Account Report their results for the following two indicators of the national staff survey:

- Percentage of staff believing that the trust provides equal opportunities for career progression or promotion (KF21)
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26)

We have provided our score for 2017, in comparison to the 2017 national staff survey average for combined mental health and learning disability and community trusts and are undertaking key pieces of work with our teams to improve staff perceptions by the next year.
Oxleas has remained a high performer in comparison to other organisations in terms of overall results. The results have generally stagnated reflecting a challenging year with significant organisational change. We are keen to work with our staff to ensure that we achieve the excellence that we have come to expect.

Our directorates are working with their teams on specific local concerns and action plans. We will however embark on organisation wide programmes to address two key areas of concern.

- Working in partnership with our Equality and Diversity leads and Bullying and Harassment advisers we will be working on a programme to address perceptions of discrimination and staff experience of bullying and harassment. We initiated successful programmes in 2016/17, including the BME coaching programme, and expect to take these and new initiatives forward to support our staff and improve their experience of working at Oxleas.

3.4 Oxleas Complaints Report 2017/18

Complaints received
In 2017/18 there were approximately 960,000 patient contacts with our services; in the same period of April 2017 to March 2018 we received a total of 179 formal complaints (0.02% of overall patient contacts) and 111 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.

Of the 290 complaints received:-
- 63 (22%) relate to Bexley
- 62 (21%) relate to Bromley
- 89 (31%) relate to Greenwich
- 33 (11%) relate to Children and Young Persons (16 Bexley, 11 Bromley, 6 Greenwich)
- 40 (14%) relate to Forensic and Prison services
- 3 (1%) relate to Corporate services

Complaints investigated
Within the 290 complaints, 780 concerns were raised. Of these 780 concerns raised, 50 are still under investigation. Of the 730 concluded, 101 (14%) were upheld, 160 (22%) partly upheld, 424 (58%) not upheld, and 45 (6%) were indeterminate.

Our review of the concerns raised has identified 3 significant themes:

Table 11

<table>
<thead>
<tr>
<th>Category</th>
<th>Investigated</th>
<th>Upheld/ partly upheld</th>
<th>Not upheld</th>
<th>Indeterminate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Care</td>
<td>192</td>
<td>60</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>158</td>
<td>43</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>114</td>
<td>65</td>
<td>57%</td>
<td></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 140 actions identified for 2017/18, 13 remain due to be completed, 19 were pending (as they are not yet due), at the time of writing this report and 108 (78%) have been completed.

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 290 complaints, 170 complaints (59%) were completed within the agreed timescales. This is 5% decrease on last year.

Robust procedures are in place for following up with the Directories 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 a continued improvement in achieving the target against timescales.

This year a rolling programme of Complaints investigation training has been initiated. There have been 51 members of staff trained so far to complete complaints investigations. It is hoped this will mean that, with a greater number of investigating officers, investigations will be completed quicker. A new on-line training programme has also been created to train investigating officers in using Datixweb (the Trust’s Risk Management System), with a view to using the system live to complete investigations and build the audit trail of a given complaint within the Complaints procedure. It is hoped this will streamline the process and make the complaint audit trail more robust.
Work continues to embed and disseminate lessons from complaints across all our services. In addition we have a library of case studies for services to use in embedded learning events, and to share at team meetings to encourage discussion and promote good practice.

We will continue our focus in these areas in 2018/19 to improve the quality of the services we provide.

**Parliamentary and Health Service Ombudsman (PHSO)**

Complainants who are dissatisfied with the Trust response have the right to ask that the PHSO reconsider their complaint. Since April 2017, five complainants asked for their case to be reviewed by the Ombudsman’s Office. One was not upheld, one was referred back to the Trust as a formal complaint, as it had been sent to the PHSO prematurely, and three investigations are currently on-going.

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**Glossary of Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACS</td>
<td>Adult Community Services</td>
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<tr>
<td>AMH</td>
<td>Adult Mental Health Services</td>
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<tr>
<td>ALD</td>
<td>Adult Learning Disability Services</td>
</tr>
<tr>
<td>CAMHS Services</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>
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<tr>
<td>CHTT</td>
<td>Crisis and Home Treatment Team</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning For Quality And Innovation</td>
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<tr>
<td>CYP</td>
<td>Children and Young People Services</td>
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<tr>
<td>Datix</td>
<td>Incident Reporting System</td>
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<tr>
<td>DIALOG</td>
<td>a service user rated outcome measure which focuses on the quality of life, treatment satisfaction and care needs</td>
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<tr>
<td>EIP</td>
<td>Early Intervention in Psychosis</td>
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<tr>
<td>F&amp;P</td>
<td>Forensic and Prisons</td>
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<tr>
<td>FFT</td>
<td>Friends And Family Test</td>
</tr>
<tr>
<td>HMP</td>
<td>Her Majesty’s Prison</td>
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<tr>
<td>HONOS</td>
<td>Health of the National Outcome Scales</td>
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<tr>
<td>HONOSCa</td>
<td>Health of the Nation Outcome Scales Child and Adolescent Mental Health</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>LD</td>
<td>Learning Disabilities</td>
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<tr>
<td>NACR</td>
<td>National Audit of Cardiac Rehabilitation</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health And Care Excellence</td>
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<tr>
<td>NHSE</td>
<td>NHS England</td>
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<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
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<tr>
<td>NRLS</td>
<td>National Reporting and Learning System</td>
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<tr>
<td>MDT</td>
<td>Multi Disciplinary Team</td>
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<tr>
<td>MH</td>
<td>Mental Health</td>
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<tr>
<td>MH &amp; LD</td>
<td>Mental Health &amp; Learning Disability</td>
</tr>
<tr>
<td>NO</td>
<td>Electronic Clinical System</td>
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<tr>
<td>OPMH</td>
<td>Older People Mental Health Services</td>
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<tr>
<td>PHSO</td>
<td>Parliamentary and Health Service Ombudsman</td>
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<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>
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<tr>
<td>STORM</td>
<td>a self-harm mitigation skills based training in risk assessment and safety planning</td>
</tr>
</tbody>
</table>
Greenwich and Bexley CCGs welcome the opportunity to comment on the Oxleas Quality Account 2017/18. The report highlights the work the trust has undertaken over the past year to improve quality and safety for patients/service users highlighting the breadth of services delivered to the population they serve. The CCG mechanism to review quality to provide assurance on the services commissioned is through a Clinical Quality Review Group which includes Greenwich, Bexley and Bromley CCGs as part of South East London Commissioning Alliance.

The quality account shows progress in most aspects of service and illustrates some areas for improvement. The CCG notes the increase by 88% (18,863 people) in the number of patients responding to trust surveys; which is encouraging to understand how people view the services which provide their care and treatment. The trust has expanded feedback on involving families, carers and people important to service users to encompass all the trust services and this has reduced the total percentage of feedback the trust received. As the trust is working on this, the CCG would wish to see an improvement in 2018/19 in this important area.

Greenwich CCG fully supports the trust quality objective to increase the use of outcome measures by clinical teams in order to improve the quality of care patients receive and would like to see the expansion of both individual and whole system outcome measures for the future to promote improved service quality. Care planning is a vital component of quality care for patients and the performance on this measure has declined to 2012/13 levels in the last year. The CCG will continue to work with the trust to ensure the improvement made in previous years is restored for care planning and that the positive steps the trust has made for patients receiving six monthly review of their care plan is maintained.

The CCG welcomes the work the trust describes on reducing the use of restraint, implementation of the ligature reduction strategy, reducing the incidence of falls and pressure ulcers and including positive learning all contribute to an improved patient safety environment. In addition, the continued focus on clinical audit to improve quality and the introduction of monthly care plan audits is encouraging. The CCG fully supports the ‘joined up approach’ to the expansion of the audits and the good practice of closing the audit cycle to ensure more clinical staff are involved in clinical audit to drive improvements thereby enhancing the quality of patient care.

Learning from deaths and the work the trust has undertaken in improving the process is positive, along with dissemination of the learning to improve clinical care for patients.

Overall the trust continues to work on improving the quality of care for patients. The examples of clinical quality in action in clinical teams highlight this approach and the involvement of staff in devising and promoting quality improvements are building blocks for the future.

Greenwich and Bexley CCGs will continue to work with partner CCGs in the South East London Commissioning Alliance and the trust to promote and drive quality initiatives, innovation and improvements to enhance the quality of care commissioned for the population of Greenwich and Bexley. The CCG looks forward to continuing to work in partnership with Oxleas to achieve this aim.
We were pleased to read through the report's case studies and quality highlights; these outline several excellent initiatives which have been put in place this year and the wide-ranging, positive effects they have had for patients.

We were pleased to read the lessons Oxleas has learned from case record reviews and investigations this year and that several significant improvements have been put in place as a result; including the extension of opening hours for the Early Intervention in Psychosis team and the development of a person-centred crisis plan.

Areas for improvement

We were disappointed to see that prison and forensic patients scored significantly lower than all other groups for the involvement of friends and family members where involvement was desired (78%), as well as for recommending services to friends and family (73%) with 15% not recommending the service. These results are comparable to last years and indicate little improvement in these areas. We would therefore like to see additional attention paid to this demographic going forward in the areas of patient engagement and the involvement of friends and family members.

We note that adults with learning disabilities scored 81% on the friends and family recommendation test- significantly less than average. Again, we would like to see additional attention paid to this group over the coming year.

Last year the Trust set a target of achieving 80% of patients to have a support network identified and noted within their care record for 2017/18. We hope the result of 35.2% will be significantly increased next year due to the plans outlined to improve this within the quality account. It would be additionally useful to understand which services are currently managing this better than others, particularly considering the low family and friends' involvement feedback from prisoners and forensic patients in QO1.

We were disappointed to see a decrease of 6.5% this year in the number of patients with a care plan recorded on RiO, especially as the 95% target has been met every other year since 2012/13. There was no rationale for the decrease offered in the narrative of this quality account; we would be interested to know which specific services are falling behind in this area and why.

Over the coming year we hope to see improvements in the national physical health screening and intervention standards for patients in community health services, as this was significantly lower than inpatient and early psychosis inpatient results.

We were disappointed to see that 21% of staff reported experiencing bullying or harassment over the last year from other staff (a slight increase from 20% the previous year), although we recognise this remains close to the national average of 20%.

Joint Healthwatch Response to Oxleas Quality Accounts 2017/18

Areas of success

Healthwatch is pleased to see that the trust reached their 90% targets across all elements of quality objective 1 and are additionally impressed to see an 88% increase in patients providing feedback across the trust compared to 2016/17. However, it would be useful to see this as a percentage of overall patient feedback, especially given next year’s target of receiving 10% response rates for patient experience surveys.

We were pleased to see a significant increase in those on a CPA receiving their six-monthly review- a 5.5% increase from last year.

Healthwatch welcome the number of initiatives which were implemented in 2017/18 concerning patient safety. However, we note that while these have been outlined, limited outcomes from these initiatives were recorded in the quality account. It would be interesting to know more about their success/ areas for improvement.

We were pleased to see Oxleas have proactively engaged in all the national audits they were eligible for over the last year. Positive findings included that physical health checks and side effect monitoring for those on high-dose and/or combined antipsychotic medication is higher than national average; and that initial findings from the National Clinical Audit of Psychosis (NCAP) show met standards for physical health screenings and interventions in inpatient and early intervention in psychosis services.

We are pleased to see Oxleas are now embedding a culture of routine outcome measurement across an additional five service areas, particularly where goal-based outcomes are being assessed in partnership with the patient. We are particularly glad to see this rolled out with prison and forensic patients, given that they scored between 5-11% lower than all other groups in QO1 for the target of feeling as though their care and treatment has helped them (and narrowly missing the 90% target). We wonder if an additional person-centred goal-based outcome could also be used with this group as is being implemented with Children and Young People, to assess patients' own views of progress and to explore why.

We were disappointed to see that 21% of staff reported experiencing bullying or harassment over the last year from other staff (a slight increase from 20% the previous year), although we recognise this remains close to the national average of 20%.
Response to quality Improvement priorities for 2018-19
Healthwatch are pleased to hear that next year’s priorities were discussed and agreed via engagement with patients and the wider community. We note some comments on the following Quality Objectives for the coming year:

QO1
Given that the trust’s 90% QO1 targets have been met consistently over the last three years (as an average across all patients), we question whether this target could be increased going forwards.

QO3
It seems that the target ‘to ensure 75% of Oxleas eligible teams participate in the care planning audits’ has replaced the previous target of ensuring that 95% of all patients have a recorded plan on RiO. Given this target was missed in 2017-18, we would encourage that it stays in as a priority.

QO4
We welcome the target to increase supine restraint in the place of prone restraint. We question whether the wording ‘increase supine restraint’ ought to be changed to ‘increase supine restraint as a percentage of overall restraints’.

Other
Given that 55% of complaints made about communication from the trust were upheld and this remains an issue from 2016/17’s account, we wonder whether communications could be an area for quality targets going forwards.

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 2017/18 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 2017 to May 2018
  ○ papers relating to quality reported to the board over the period April 2017 to May 2018
  ○ feedback from commissioners dated 21/05/2018
  ○ feedback from local Healthwatch organisations dated 17/05/2017

• 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

• here 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
25 May 2018

Signed by
Helen Smith
Acting Chief Executive
25 May 2018

Annex 3: Criteria applied to mandated indicators

As part of the annual quality report requirements, our external auditors, Deloitte LLP have undertaken work on two mandated care indicators below as described below:

1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

2. Inappropriate out-of-area placements for adult mental health

The aim of the review is to sample test the mandated indicators and check for accuracy, validity, reliability, timeliness, relevance and completeness. Both indicators require further improvement on the accuracy of the data.

The Early intervention in psychosis indicator - ("people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral") requires accurate recording of start and end times of the indicator. Determining whether the pathway and treatment commenced depends on assessment against criteria as to whether a service user is under the definition of this indicator, and whether the stage of contact with the service user is sufficient to constitute commencement of treatment. In some instances, the application of the guidance has led to pathways being stopped before the national criteria were met, which will in some cases overstate performance against the indicator. The Trust is reviewing its guidance and training for staff to improve recording against these criteria.

Inappropriate out-of-area placements for adult mental health services - Data for this indicator is collected through a series of manual processes operating across each of our three boroughs that we provide services. This is currently a manual process tracked outside of the Trust’s reporting IT systems, which inherently has a greater risk of error and of issues in reporting data. The current national guidance includes limited reasons for an “appropriate” placement, which typically do not apply to the Trust’s placements. The Trust considers these definitions may not fully reflect the circumstances of use of other providers in a London context. We are reviewing potential process improvements to support reporting in the future.
About us

We aim to improve lives by providing the best quality health and social care for our patients and carers.

We care for people across South East London and Kent by providing a wide range of health care including community services such as district nursing and physiotherapy and mental health and learning disability services. Our staff work in many places including people’s homes, community health centres, schools, prisons and hospitals. We manage Queen Mary’s Hospital in Sidcup and Memorial Hospital in Woolwich.

We are in the Health Service Journal top 10 places to work in the NHS and the King’s Fund named Oxleas as the best organisation in the NHS for staff engagement. This is important because higher levels of staff satisfaction have been shown to result in better patient care.

Our values are:

Having a user focus
We try to see things from your point of view

Being responsive
We try to care for you as quickly as possible in the way that suits you best

Excellence
We are never content with a service that is second best

Learning
We constantly review and improve how we do things

Partnership
We work with others to ensure you get the help you need

Safety
We seek to protect you and our staff from harm

Become a member

If you are aged 14 and over, you can become a member of Oxleas. This enables you to shape how our services develop and to get regular updates from us.

For more information, go to our website at: oxleas.nhs.uk/membership

Telephone
0300 123 1541
Calls to this number are the same as making a local call from a landline and are usually included within your inclusive minutes if calling from a mobile.

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