PUBLIC

Oxfordshire and Buckinghamshire Mental Health NHS
NHS Foundation Trust

PAPER
MC 03/2011

Report to the Meeting of the Members' Council

For Information

8 February 2011

Quality Report

Executive Summary

This report provides the Trust Board with a summary of the Trust's position for December 2010 against a range of quality indicators. The report is split into three sections;

Section 1 – Key quality indicators under four domains, three representing Darzi triad of quality; Service user experience; clinical effectiveness; safety and additionally workforce indicators are included.
Section 2 – Summary of audits completed in month
Section 3 – Quarterly progress against the CQUIN agreement and the quality priorities identified in the Quality Account.

Key items to note

- The known risks around maintaining business continuity of reporting during the transition to RiO has meant that some of the indicators in the Quality Report to the Board are incomplete. Planned mitigation has been hampered due to the adverse weather and high levels of sickness absence within the Information Analysts.

  The impact is minimal due to the phasing of the RiO rollout, though Forensic Service data is missing which relates to a small percentage of overall data.

  The RiO interface is scheduled to be implemented on 31st January 2011, with no known issues which could impact on either the month end reporting or the next CDS or MHMDS submissions due on 4th February 2011.

- The Trust is meeting 8 of the 9 Monitor targets. The Trusts current performance for CPA review within 12 months is 91.4% against a target of 95.0%. There has been steady improvement throughout the year from a position of 77.9% in May 2010 and services are confident that they will reach 95.0% by year end.

	Target	**Q1**	**Q2**	**Q3**	**YTD**
MRSA	**0**	0	0	0	0
C.Diff	**0**	0	0	0	0
7 day follow up	**95.0%**	94.5%	96.1%	95.0%	95.2%
CPA within 12 months	**95.0%**	79.3%	87.3%	91.4%	91.4%
DTCs	**<=7.5%**	0.3%	0.9%	4.0%	1.6%
Access to Crisis prior to admission	**90.0%**	98.9%	96.7%	98.4%	98.0%
Early Intervention	**95.0%**	118.0%	116.0%	102.0%	102.0%
Data completeness: Identifiers	**99.0%**	99.0%	99.5%	99.1%	99.1%
Data completeness: Outcomes	**50.0%**	No submission until Q3		74.4%	74.4%

- Bank and Agency is again below target at 4.9% which is a significant achievement against current levels of staff sickness and the challenges or organisational change.

- Inpatients readmitted as an emergency within 28 days of discharge is below target for the fourth time this year

Areas requiring improvement

- Trust cancelled appointments have increased significantly in December to 5.2% but this is as a consequence of the adverse weather conditions. The Oxfordshire Adult and Older Adult Directorate are starting a piece of work to look at patient DNA's and Trust cancellations to identify any trends and implement actions as necessary.

- Staff appraisals have decreased by 2.0% this month to 75.0%. Reminders to managers and staff have been posted on the Intranet and have been included in the monthly performance reports to managers.

Recommendation

The Board is asked to review the Trust's position on the range of key quality indicators and audit results and confirm that it has received adequate assurance in this respect.

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Lead Executive Director: Caroline Birch, Acting Director of Nursing and Clinical Governance

1. *A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.*
2. *This paper provides assurance and evidence against the CQC Regulations ...*

Oxfordshire and Buckinghamshire Mental Health NHS
NHS Foundation Trust

Quality Report January 2011

Monthly Dashboard

This report provides the Trust Board with a summary of the Trust's position against a range of quality indicators. The chart below shows the ratings for those indicators measured on a monthly basis. All data relates to the month of December 2010 with the exception of Forensic services where November data has been used due to the transition to RiO. This data will be refreshed next month. Staff sickness is reported one month in arrears.

Clinical Priority	Indicator Type	Indicator	Dec-10 %	Dec-10 Number	Target/ Benchmark/ Tolerance		Red Amber Green	Trend
Service user and Carer Experience	Quality and Performance	Trust Cancelled appointments	5.2%	1191	2.0%	Trust Tolerance Level	Red	⇩
	Quality and Performance	NHS Attributable Delayed Transfers of Care	4.5%	9	7.5%	Monitor Target	Green	⇩
	Quality	Single sex accommodation breaches		0	0	Department of Health	Green	⇧
	Quality	Complaints Ratio (complaints per 1000 appointments & bed days)		0.3	0.3	Benchmark (Average of 2009/10)	Green	
	Quality and Performance	Of the patients assessed in the reported month, the percentage that had been seen within the specified time frame	93.4%	(596 Assessed) (235 waiting)	90.0%	Trust Tolerance Level	Green	⇧
	Quality	Number of patients transferred between wards for non clinical reasons		21	10	Trust Tolerance Level	Red	⇧
	Quality and Performance	Admissions with prior access to CRHT	98.5%	67	90.0%	Monitor Target	Green	⇧
	Quality and Performance	Cleanliness score for inpatient services (PEAT) Snapshot	95.0%		95.0%	Trust Target	Green	⇔
	Quality	Patient feedback - Overall, how would you rate the care you are receiving from the mental health service?	78.0%	454	80.0%	Trust Tolerance Level	Amber	
	Quality and Performance	% of adults (18-65) on CPA reviewed in last 6 months	72.1%	2416	95.0%	PCT Target	Red	⇧
	Quality and Performance	% of adults (18-65) on CPA reviewed in last 12 months	91.4%	2537	95.0%	Monitor	Amber	⇧
Clinical Effectiveness	Quality and Performance	Inpatients readmitted as an emergency within 28 days of discharge	3.0%	3	3.2%	Bencvhmark (SEPHO)	Green	⇩
	Performance	HoNOS paired scores	36.2%	3824	TBC	Contractual	Black	⇧
	Quality and Performance	Compliance with CPA metric	78.0%		80.0%	Trust Level	Amber	⇧
	Performance	Early Intervention caseload Oxon /New patients Bucks		134 Oxon 44 Bucks	134 Oxon 35 Bucks	Monitor Target/ Contractual	Green	⇔
	Performance	Percentage of inpatients with a completed ICD10 code	83.7%	87	95.0%	Monitor Target/ Contractual	Red	⇧
	Performance	Data completeness: Outcomes	74.4%		50.0%	Monitor Target	Green	⇧

Clinical Priority	Indicator Type	Indicator	Dec-10 %	Dec-10 Number	Target/ Benchmark/ Tolerance		Red Amber Green	Trend
Safety	Quality	Number of days a ward(s) is closed due to infection control YTD		0	0	Trust Target	●	⇧
	Quality	Serious Untoward Incidents Ratio (SUIs per 10,000 appointments & bed days) three month rolling average	0.8	1	1.3	Trust Tolerance Level	●	⇩
	Quality	Never Events		0	0	National Patient Safety Agency	●	⇩
	Quality	Number of cases of Clostridium Diffcile (C.diff) and MRSA		0	0	Department of Health	●	⇔
	Performance	Bed occupancy across wards excluding leave days *	87.5%	11,987	86.0%	Royal college of Psychiatrists	●	⇧
	Performance	Bed occupancy across wards including leave days *	106.7%	14,618				
	Quality and Performance	Follow up in community within 7 days from inpatient discharge	94.1%	64	95.0%	Monitor Target/ Contractual	●	⇔
	Performance	Data completeness: Identifiers	99.1%		99.0%	Monitor Target	●	⇩
Workforce	Quality and Performance	Use of bank and agency staff in Clinical Services	4.9%		5.0%	Trust Tolerance Level	●	⇧
	Performance	Staff sickness Trustwide (1 mth in arrears)	4.2%	3321 Days Lost	3.5%	Trust Tolerance Level	●	⇩
	Performance	Staff vacancies as a snapshot Trustwide	7.3%	216	9.0%	Trust Tolerance Level	●	⇩
	Quality and Performance	Mandatory Training completed in last 12 months Snapshot	84.0%		85.0%	Trust Tolerance Level	●	⇧
	Quality and Performance	Appraisals completed in last 12 months Snapshot	75.0%	1625	85.0%	Trust Tolerance Level	●	⇧
	Performance	Inpatient activity Performance	-0.8%	107,120	107,940	Contractual	●	
	Performance	Outpatient, community & group activity Performance	8.6%	174,089	160,239	Contractual	●	

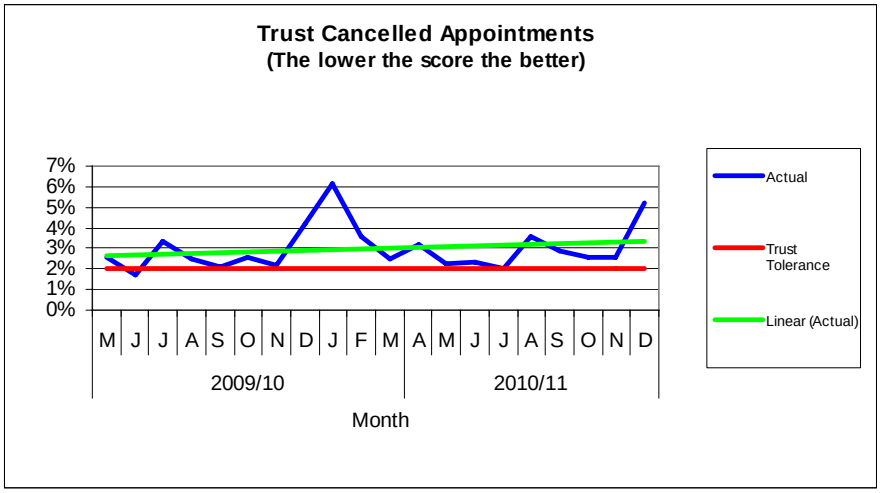
Key to trend:

⇧ Improving ⇩ Deteriorating ⇔ No change

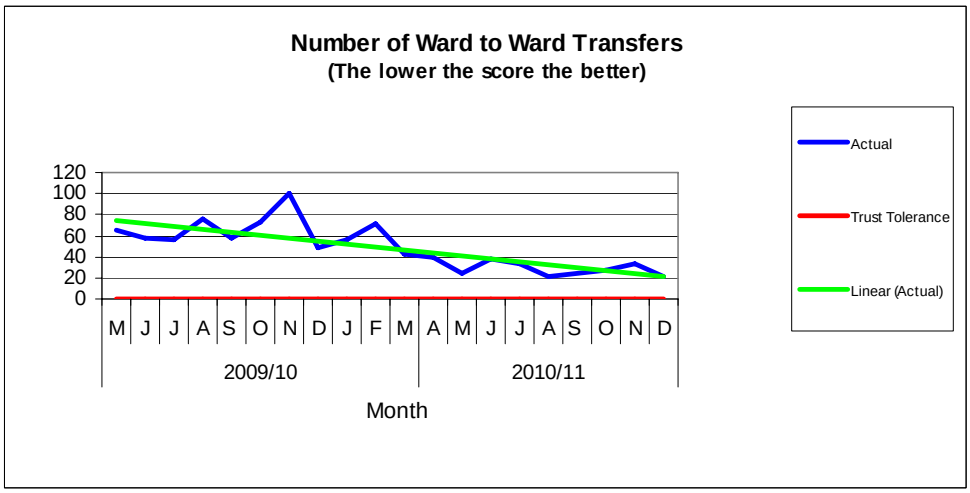
Section 1 – Key Quality Indicators

Service User and Carer Experience

- **Trust cancelled appointments –** In December the Trust cancelled 5.2% of outpatient and community appointments which is the highest number of cancellations seen this year and was due to the adverse weather conditions experienced in December 2010. Similar peaks of cancellations were seen in December 2009 and January 2010 where 4.2% and 6.2% of appointments were cancelled, again due to the adverse weather conditions.

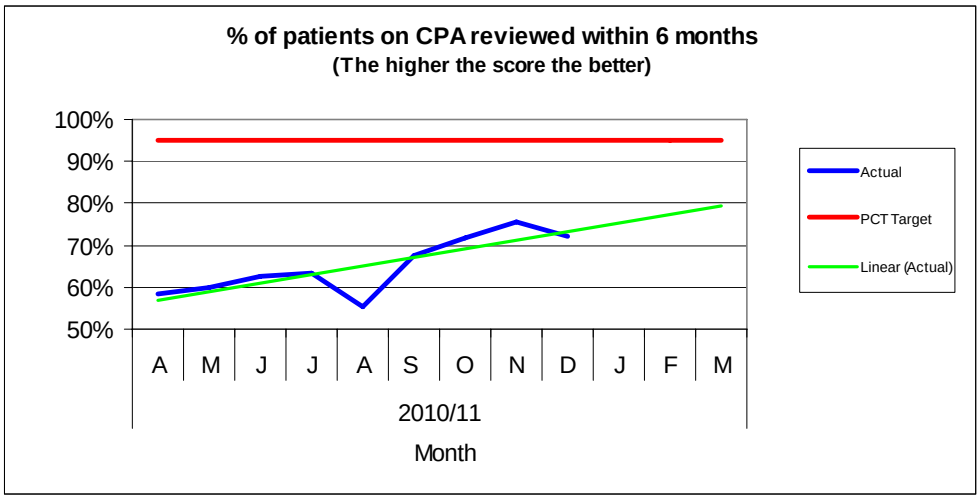


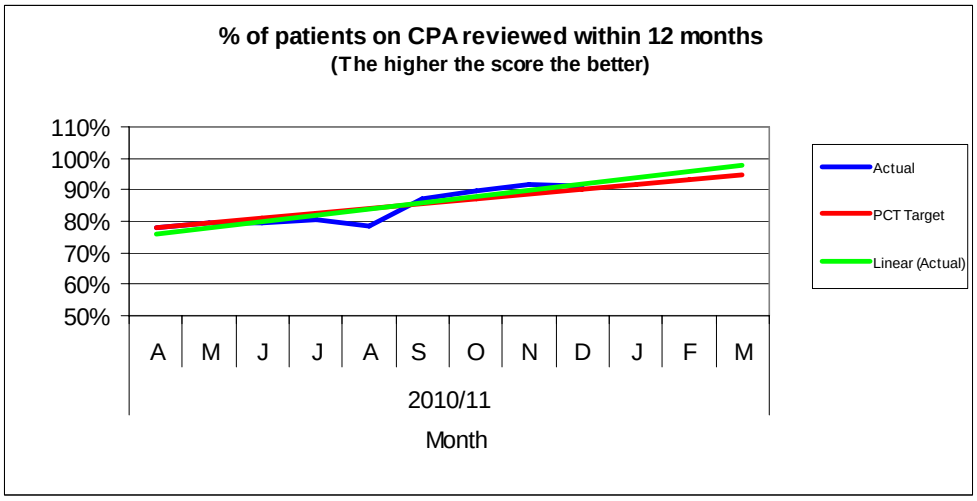
- **Number of patients transferred to another ward for non clinical reasons –** 21 patients were transferred for non clinical reasons in December 2010. This is the lowest number reported this year. There continues to be a downward trend.

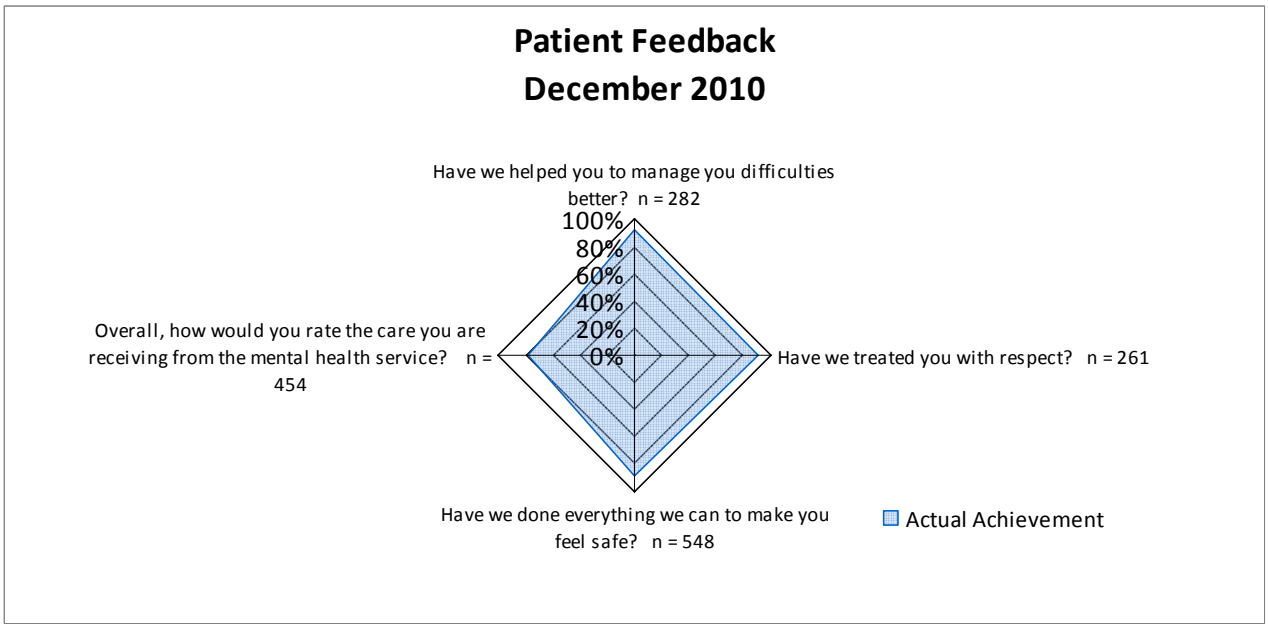


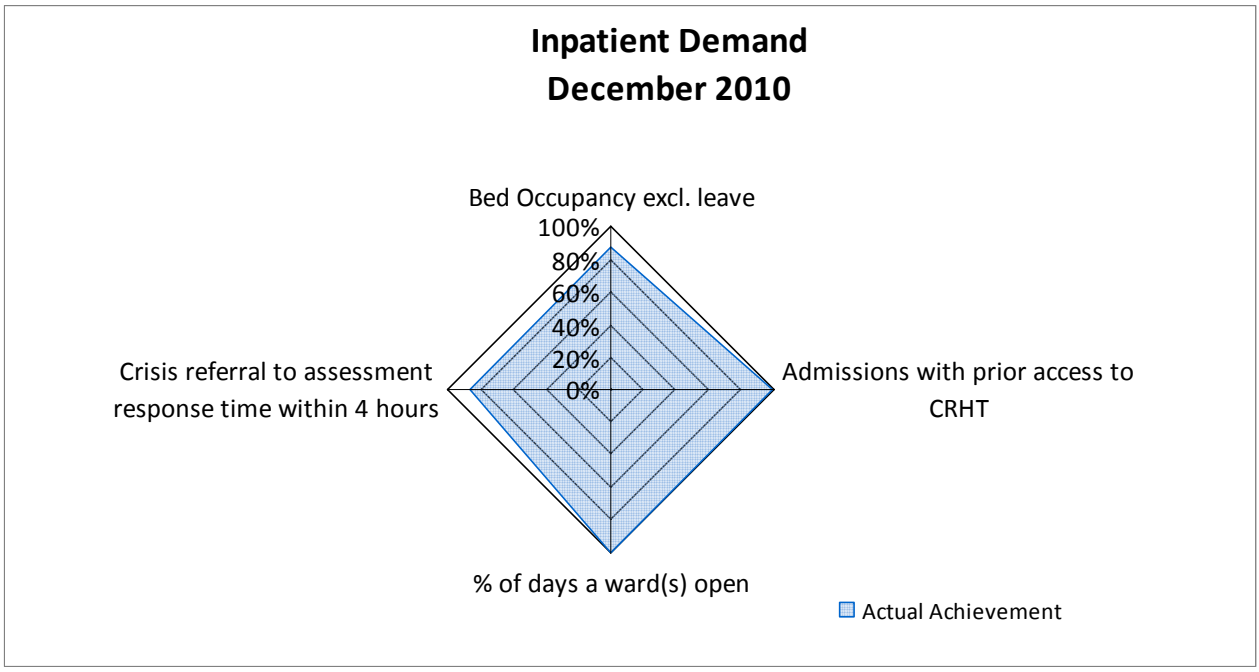
- **Percentage of Adults on CPA reviewed within six and twelve months –** Performance of these two indicators reduced slightly in December. 72.1% of patients have received a review within 6 months, a reduction of 3.3% on the November position and 91.4% within 12 months, a reduction of 0.1% on the November position. Forensic and Oxfordshire Adults have the highest performance for 6 month reviews at around 84.0% and Forensic and Oxfordshire Adults exceed the target of 95.0% for 12 month reviews. The Linear Actual (trend line) on the graph below shows that based on current

performance the Trust will not meet the PCTs target by year end but Services are confident that the target of 95.0% for both indicators will be met by year end.



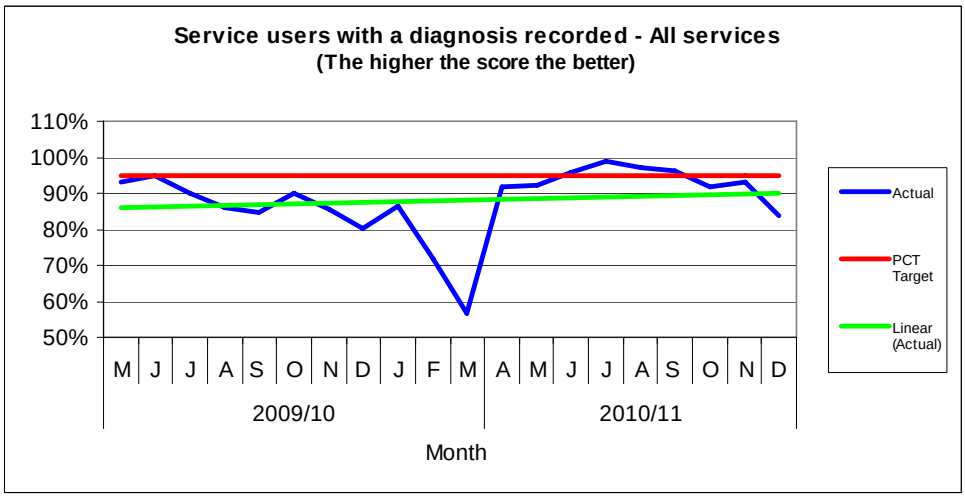


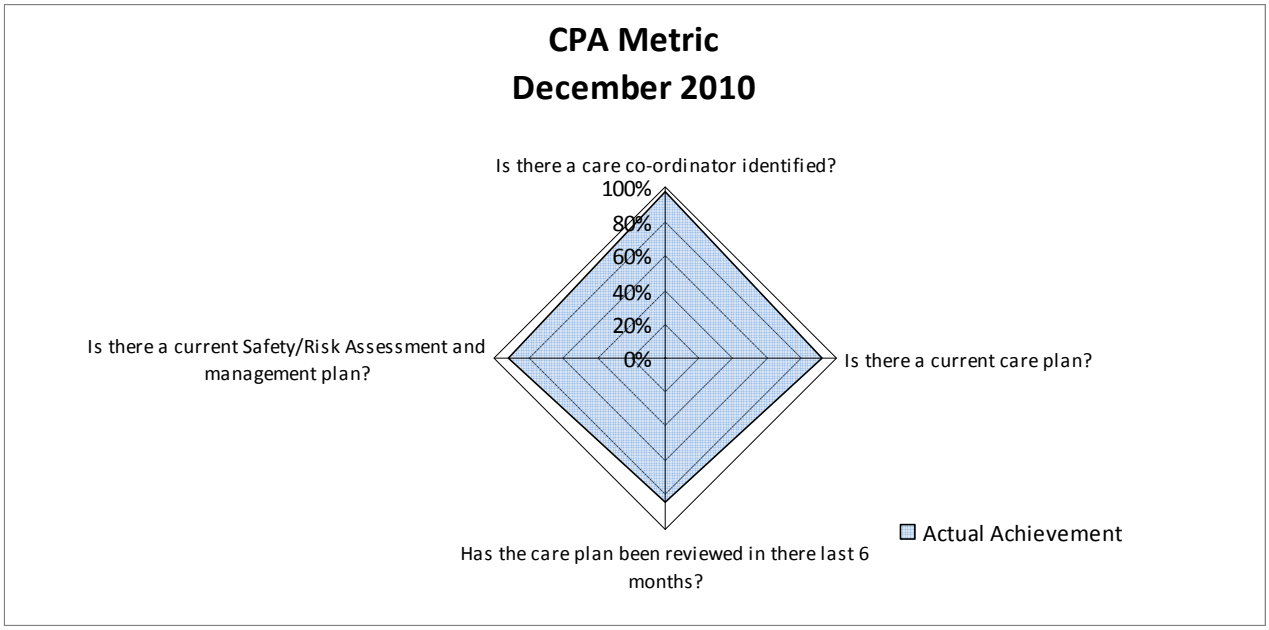




Clinical Effectiveness

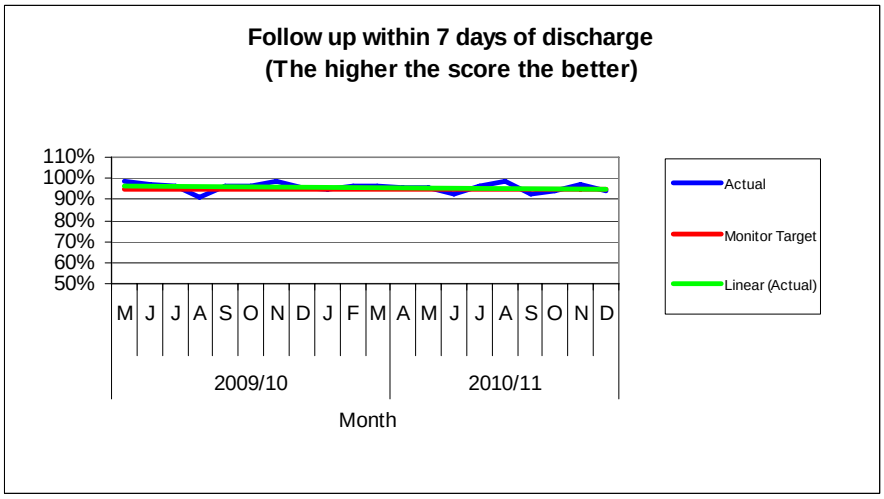
- **Percentage of inpatients with a completed ICD10 code –** Performance in December was 83.7%. The underperformance is in CAMHS and Buckinghamshire Older Adults. Buckinghamshire have recently implemented new procedures to monitor all inpatient discharges on a daily basis to ensure that ICD10, accommodation and employment coding are complete and that the Care Coordinator is alerted to the discharge to ensure a follow up contact within 7 days is undertaken.

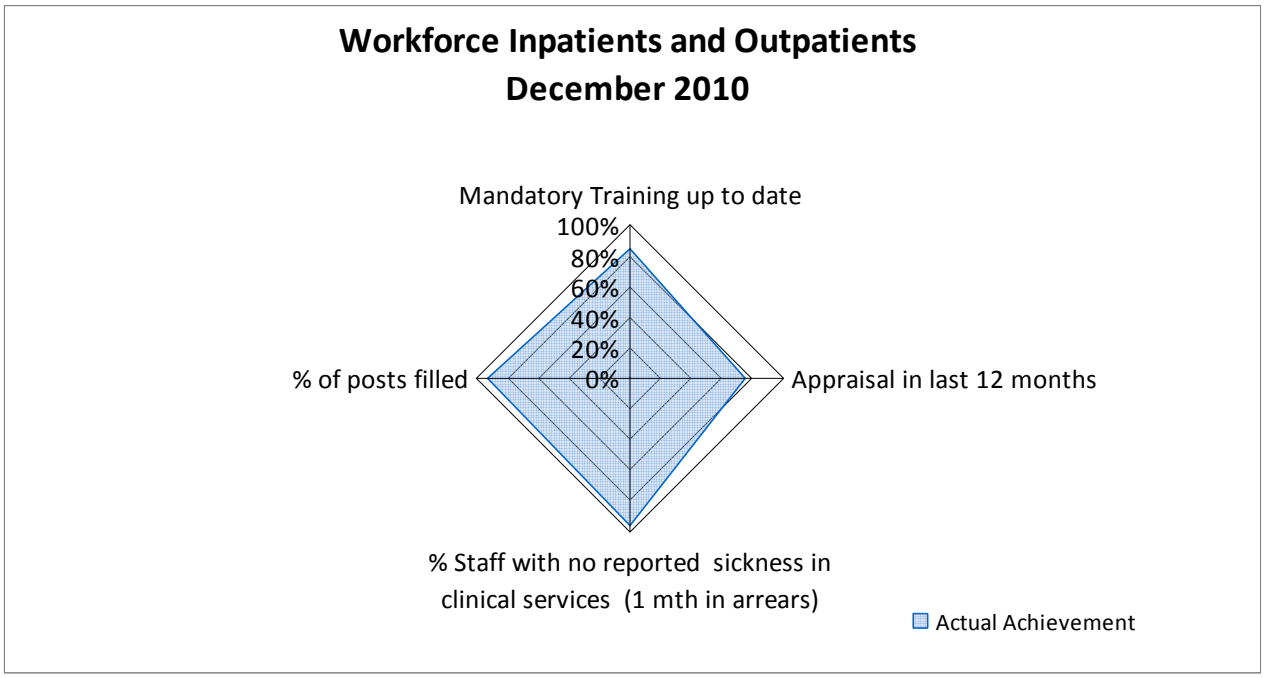




Safety

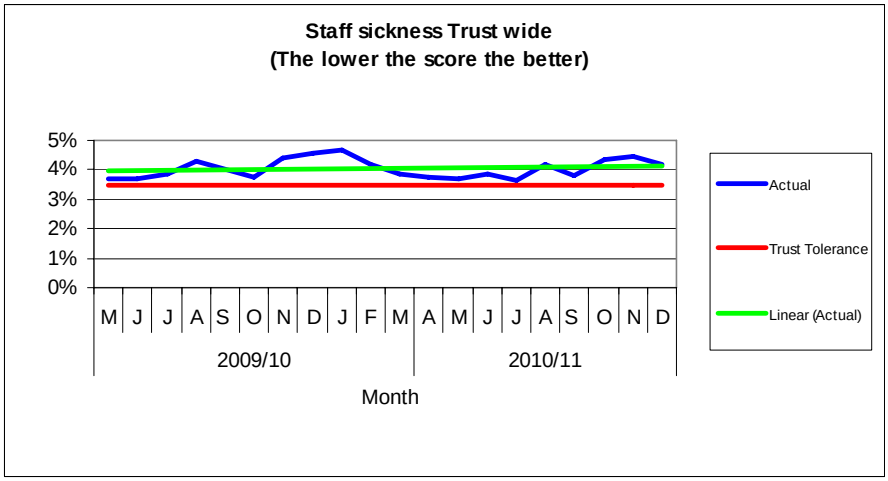
- **Follow up in the community within 7 days from inpatient –** 64 out of 68 (94.1%) discharges were followed up within 7 days of discharge. Oxfordshire Adults and Buckinghamshire Older Adults both had two breaches. Year to date this target is being achieved with 811 out of 852 (95.2%) discharges being followed up within 7 days of discharge.





Workforce

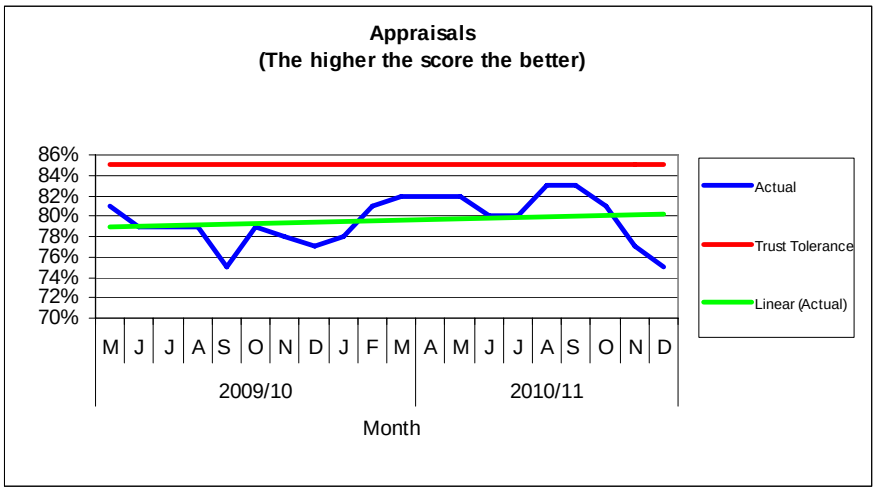
- **Staff Sickness** (one month in arrears) – Trust wide the sickness rate has reduced to 4.2% in December from 4.5% in November. The sickness rate in Operational services is 4.6% and 2.6% in Corporate services. There has been a reduction in long term sickness (episodes over 28 days) which has reduced to 1.8% from 2.2% in November. The three most common reasons for all sickness absence in December are stress/anxiety, cold and surgery. The overall trend remains level at around 4.0%.



December 2010 Sickness in clinical areas (1 month in arrears)	
Oxfordshire Adult and Older Adult	5.4%
Buckinghamshire Adult and Older Adult	6.1%
CAMHS	3.4%
Specialist	3.1%
Forensic	3.9%
Trust Clinical Areas Total	4.6%

Trust Total	4.2%

- **Appraisals –** Performance has decreased by 2.0% to 75.0% in December and is the lowest performance reported this year. The adverse weather in December, the Christmas holiday period and staff sickness have impacted on the number of Appraisals that have been undertaken. Four areas in Buckinghamshire known to have particular difficulties are being supported by the Pathway Manager and Human Resource partner to improve performance. In Oxfordshire underperforming wards have been asked to ensure that all Appraisals are up to date by next month. There are also some PDRs that have been completed that have not yet been entered onto the Online Training system. Reminders to managers and staff have been posted on the Intranet and have been included in the monthly performance reports to managers.



Section 2 – Summary of Audit results and quality monitoring activity

Audit Name	Link to CQC Outcome(s)	Frequency	Date of Audit Report	Highlight Results
Getting the Basics Right N= 22 out of 26 wards participated	1. respecting and involving people who use services 4. care and welfare of people who use services 16. assessing and monitoring the quality of service provision	Monthly	Nov 2010	- Sample size=20 wards, 6 wards did not return data - Acceptable level >95%. Three domains audited: • Observation domain achieved 83% against all 8 standards (improvement from Oct 2010) • Risk assessment domain achieved 85% against all 6 standards (improvement from Oct 2010) • Care plan domain achieved 66% against all 7 standards (improvement from Oct 2010) - Within the care plan domain the standards with the lowest compliance are service user is aware of plan (met by 81% of cases) and care plan is up to date (met by 84% of cases). - The Trust has not achieved 100% in any of the domains for observation, risk assessment or care plans. - See diagram below for overall Trust wide compliance within each domain by month between December 2009 – November 2010.
Audit of the management of service users who DNA and Cancel their appointments N=57	16. Assessing and monitoring the quality of service provision	Annual, baseline	Nov 2010	- The audit looks at service users who have been discharged from an inpatient ward (between Sept 2009-March 2010) who have DNA or cancelled their appointment within the initial 6 weeks of discharge date when the risks of suicide, self harm and/ or relapse are highest. - The audit looks at acute adult and older adult discharges from Oxfordshire and Buckinghamshire, excluding discharges from the Psychiatric Intensive Care Unit, Eating Disorder Units and the Forensic wards. - The audit period from Sept 2009 to March 2010 was when the Trust was moving to electronic note recording, possibly accounting for the data quality issues identified below. **- Key Findings:** <u>Data Quality</u> • 22% (16 cases) of original sample of 73 had no further information about the DNA or Patient Cancellation in DMC and/ or e-notes. Worse in Bucks 6 out of 19 (32%) with no further information. • In 11 of the 16 (69%) DNAs or Patient Cancellations with no further detail in DMC or e-notes the missed appointment was recorded in Oct and Nov 2009, when teams were starting to move from paper to electronic note recording.

Audit Name	Link to CQC Outcome(s)	Frequency	Date of Audit Report	Highlight Results
				<u>CPA</u> • 74% of sample recorded as Requiring CPA following inpatient discharge. Worse in Bucks 54% recorded Requiring CPA. See CPA audit action plan being led by CPA Lead Manager. <u>Profile of Person who DNAs</u> • Requiring CPA, age range between 26-55, male or female, diagnosis of schizophrenia or personality disorder, a known risk history of violence, suicide or self harm, and most likely to be of high risk of self harming/ harming others or self neglect. <u>Inpatient Discharge Planning and Community Follow Up</u> • 71% of service users received a face to face contact within 0-7 days of inpatient discharge date even through the person has DNA or cancelled their appointment. The remaining 29% of service users were seen face to face between 8-28 days. On average 2.75 appointments were missed between discharge date and face to face contact. • 81% of service users had a pre-discharge care plan (includes service users who self discharged/ did not return from home leave as planned) • 55% of service users had a discharge planning meeting. • 71% of cases a representative from the community team attended the pre-discharge meeting. • 44% of service users had recorded in their e-notes that their suicide risk had been assessed at the pre-discharge meeting. • Only 1 person (3%) was given more than 2 weeks supply of medication because the person went on holiday on day of discharge for 3 weeks. • 26% of service users had evidence their risk assessment was updated prior to discharge. • 57% (29 out of 51) the crisis team was involved in discharge. • 84% of service users were given information about their discharge follow up arrangements. • 90% of cases the risk of self harm/ harming others, suicide or self neglect were considered and recorded at time of DNA or Patient Cancellation.

Audit Name	Link to CQC Outcome(s)	Frequency	Date of Audit Report	Highlight Results
Decontamination of Commodes (older adult) N=22 commodes (1 in use at time of audit)	8. cleanliness and infection control 11. safety, availability and suitability of equipment	Monthly	Nov 2010	- 1 commode (on Cromwell) not included as in use at time of audit, 22 commodes assessed. - 14 standards are audited each month. - 1 standard scored less than 100% compliance for cleanliness (an improvement from Oct 2010): • Underside of seat cushion is visibly clean: 77% (5/22 commodes not clean), decline from Oct 2010 (86%) and Sept 2010 (78%). - See trend below of average compliance across standards by month and ward from November 2009-November 2010.
Hand Hygiene N=301 staff participated 15 out of 26 wards participated 74% (301/407) of staff included in audit	8. cleanliness and infection control 11. safety, availability and suitability of equipment	Bi-monthly	Nov 2010	<u>Hand Washing Technique</u> - 91% average across wards for hand washing technique, increase in performance from Sept 2010 (88%). Above acceptable level of 85%. Range across 15 wards: 76% (Watling) to 98% (Lambourne). - Note 11 out of 26 wards did not complete the audit in November 2010. - Seven areas are audited for hand washing technique, all areas but one (around nails) score 90% or above. Washing around nails has consistently been a poor area from Aug 2009 at 51% however this has improved to 76% in Nov 2010. - 74% of staff were included in the audit (n=478). Range from 54% to 100% participation across the wards which submitted information. - One ward out of 15 was below the acceptable level of 85%. <u>Observation</u> - 91% of staff were carrying a tottle (includes doctors but excludes staff on two of the Trust's acute Forensic wards), improvement by 5% from Sept 2010. - 95% of staff were not wearing jewellery, improvement by 2% from Sept 2010. - 90% of staff had no nail varnish, extensions or long nails, a decline by 6% from Sept 2010.
Product availability Q3 26 out of 26 wards participated	8. cleanliness and infection control	Quarterly	Nov 2010	- The audit involves visible checks. The Modern Matrons now complete the audit. - The average compliance figure across all 243 standards in the audit is 83%. - The following standards are assessed by each area/ office/ room: 1) Alcohol dispensers and/or soap dispensers should be: • Available • Full • Clean • Poster displayed

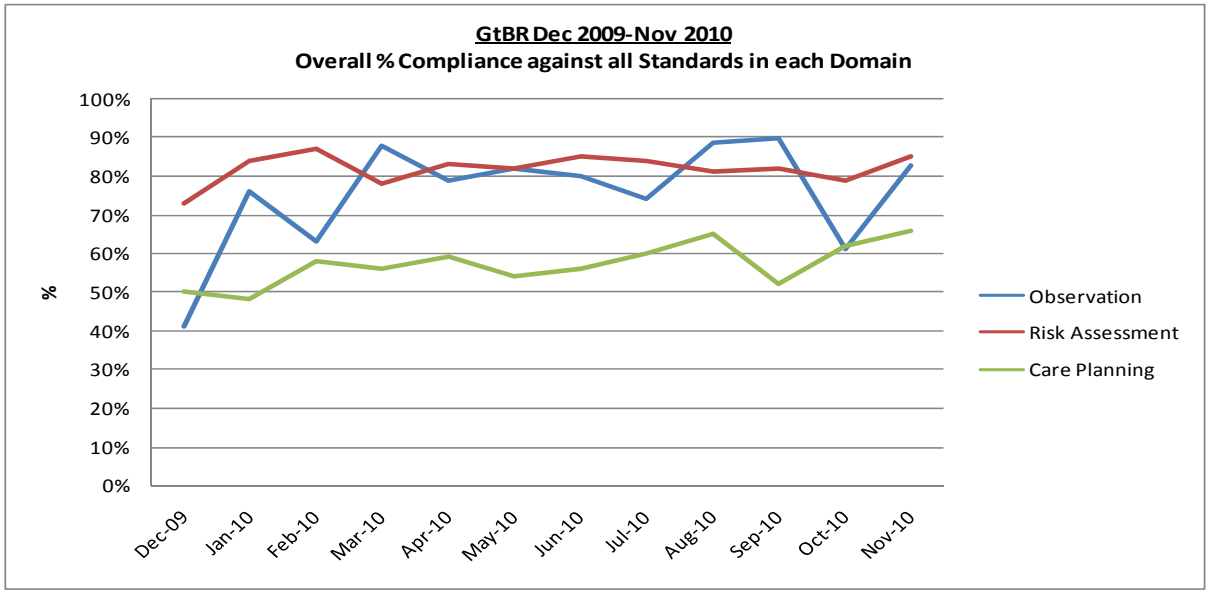
Audit Name	Link to CQC Outcome(s)	Frequency	Date of Audit Report	Highlight Results
				2) There should be a supply of replacement tottles (excluding Kestrel & Kingfisher) 3) There should be washable waste bins in patient areas 4) There should be a pedal operated waste bin next to sink 5) Access to hand wash basins should be kept clear 6) Apron & glove dispensers should be: • In place 7) The following available: • Red aprons for personal care and cleaning • White aprons for clinical procedures • Green aprons for dispensing food • Small gloves • Medium gloves • Large gloves - **Key highlights**: Ward entrances: 96% dispensers working Ward offices: 77% dispensers working (42% poster displayed) and 27% glove and apron dispensers in place Communal hand wash basin: 84% soap dispensers available (100% working), 79% paper towel dispenser available (93% working) and 37% washable plastic bin next to sink. Clinic room: 88% alcohol dispensers working (50% poster displayed), 92% soap dispenser working, 58% glove and apron dispensers in place, 100% paper towel dispenser in place, 96% orange pedal bin in place, 92% blank bin in place, 96% replacement tottles, and 92% access to hand wash basin is clear. Housekeepers room: 60% alcohol dispensers working (20% poster displayed), 68% soap dispensers in place, 12% apron and glove dispensers in place, 72% paper towel dispensers are in place (100% working), 16% had a pedal operated black bin and 61% access to hand wash basin is clear. Assisted bathroom 1 (older adult wards only): 80% alcohol and soap dispensers available (100% alcohol and soap dispensers working), 80% apron and glove dispensers in place, 80% paper towel dispenser in place (100% working) and 80% access to hand wash basin is clear.

Audit Name	Link to CQC Outcome(s)	Frequency	Date of Audit Report	Highlight Results
Staff Awareness about Decontamination and Visible Checks of Medical Devices Q3 26 out of 26 wards participated 45 staff interviewed	8. cleanliness and infection control	Quarterly	Dec 2010	- The audit involved: interviewing as many staff as possible on the ward at the time of the audit relating to staff knowledge of decontamination (n=45 staff) and visible checks of medical devices (n=26 wards). The Modern Matrons now complete the audit. - Eights domains are audited: 1) staff knowledge of decontamination, 2) visible checks on single use equipment, 3) visible checks on resuscitation equipment, 4) visible checks on respiratory equipment, 5) visible checks on medical equipment, 6) clinic room maintenance, 7) other area maintenance and 8) cleaning products availability. 1) Staff knowledge of decontamination (4 questions asked): 93% of staff are aware that there is a written comprehensive decontamination policy, slight decrease from Q1 audit (97%) and 58% of staff can name their medical devices link nurse (new question for Q3). 2) Visible checks on single use equipment: 77% evidence not re-using single use equipment (this is being investigated) 3) Visible checks on resuscitation equipment (new standard): 100% of resuscitation bag contents are in date, 92% of bags clean inside and out, 88% of bags stocked according to contents list, 100% spare oxygen cylinder full (however only in 58% of cases spare oxygen cylinder in bracket on wall), and 81% record defibrillator checked daily. 4) Visible checks on respiratory equipment: 100% oxygen saturation probes clean, 100% oxygen masks stored in packaging, 94% nebuliser device clean (n=18/18 wards), and 100% nebuliser elements stored in packaging. 5) Visible checks on medical equipment: 65% wards had a dressing trolley, 89% alcometer clean, 81% BP cuffs clean (100% BP cuffs undamaged), 88% single use disposable covers available for otoscopes, 100% single use disposal covers available for thermometers, 84% stethoscopes clean, 92% BM device is being checked daily/ weekly, and 69% ECG machine clean. 6) Clinic room maintenance: evidence of recording regular maintenance checks poor, being investigated. 7) Other Area maintenance: 80% bathroom and multi-hoist clean, 80% macerator clean, 100% catheter stands clean and 100% clings in use have patient's names written on them. 8) Cleaning products availability: 81% detergent wipes available for decontaminating equipment, 80% detergent wipes available for decontaminating commodes, 100% hazard spill kit available and 65% instructions for use of hazard spill kit displayed.

Audit Name	Link to CQC Outcome(s)	Frequency	Date of Audit Report	Highlight Results
POMH-UK Topic 7b monitoring of patients prescribed lithium N=157 cases (27 teams)	9. Management of Medicines	Annual	Oct 2010	- Data collection for re-audit completed May and reported in Oct 2010 (baseline audit Oct 2008). - Adult includes Forensic inpatients (n=6), Oxon community adult and older adult teams (n=82) and Bucks community adult and older adult (n=69) **- Key Findings:** <u>Audit standard 1</u> (treatment started less than 1 year ago), the following tests/measures should be completed before initiating treatment with lithium (2 months prior to starting lithium): 1) Renal function tests including creatinine (75% compared to TNS 78%). OBMH baseline in Oct 2008 62%. 2) Thyroid function tests (TFTs) (75% compared to TNS 79%). OBMH baseline in Oct 2008 62%. 3) Weight or BMI or waist circumference (38% compared to TNS 43%). OBMH baseline in Oct 2008 38%. - Documented evidence that the patient was informed of the side effects of lithium (78% compared to TNS 53%) <u>Audit standard 2</u> (treatment started more than 1 year ago), the following tests/measure should be conducted during maintenance treatment (only includes patients who have started lithium treatment in the last year): 1) Serum lithium level tested at least once (100% compared to TNS 90%) OBMH no data in 7% of cases. OBMH baseline in Oct 2008 79%. 2) Renal function (including creatinine) tested at least once (100% compared to TNS 77%) OBMH no data 13%. OBMH baseline in Oct 2008 75%. 3) Thyroid function tested at least once (98% compared to TNS 80%) OBMH no data for 14% of cases. OBMH baseline in Oct 2008 64%. 4) Weight or BMI or waist circumference tested in year (98% compared to TNS 32%) OBMH no data for 75% of cases. OBMH baseline in Oct 2008 32%.
Audit against Schizophrenia NICE Guidelines within Buckinghamshire Early Intervention Service	16. Assessing and monitoring the quality of service provision	Annual, baseline	Oct 2010	- The audit was completed by the clinicians in Buckinghamshire Early Intervention Service. The audit looks at current open patients with a diagnosis of schizophrenia as of 4th August 2010. Data collection was completed from 4th August to 17th September 2010. **- Key Findings:** • 96% of patients had a multidisciplinary assessment. • 96% of patients had a care plan (1 person out of 27 did not): of which 92% written in collaboration with person, 96%shared with primary care professional/ other agency

Audit Name	Link to CQC Outcome(s)	Frequency	Date of Audit Report	Highlight Results
N=27				and in 96% cases copy sent to service user • 100% had a crisis plan in care plan • 93% of people offered CBT in <12 months: of which 72% received CBT. • 100% of CBT received 1:1, 94% undertaken for >6 months and 100% for more than 10 sessions. 56% followed a treatment manual. • Excellent monitoring of usefulness/ outcomes from CBT (100% for all 4 components audited) • Where applicable family intervention offered to 85% of patients in <12 months, of which 93% involved patient, 79% for >6 months and 62% for more than 10 sessions. • Employment, education and social activities: 93% daytime activities routinely recorded; of which care plan showed education in 60%, training in 16%, employment in 48%, volunteer work 28%, structured activities 56% and other 4%. • Information for patients, good on illness/ condition (84%) and service providing treatment/ care (96%). Area for improvement patients awareness of NICE guidelines (0%) and information on the treatment/ care they should be offered (64%). Similar picture for information for carers. • Medication; 100% of patients offered oral antipsychotic medication and in 100% of cases benefits and side effects discussed with patient. • 69% of patients have recorded physical health check completed in <12 months. In 73% of cases alcohol discussed, 63% tobacco discussed, 100% prescription medication, 64% non-prescription medication, and 85% illicit drugs. • 52% of patients have been admitted during treatment. Of which 50% were re-admissions, the most common reasons non-concordance with medication (4 out of 7 patients) • 89% showed patient participates in own treatment and in 85% patients social networks maintained/ improved during treatment.

Getting the Basics Right



Decontamination of Commodes (older adult) - average compliance from November 2009 - November 2010

Key: 100% green, 95%-99% amber and 94% and under red

Wards	Nov 09	Dec 09	Jan 10	Feb 10 *(foot rest standard introduced)*	March 10	Apr 10	May 10	June 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10
Harding Ward (4 commodes)	98% (39/40)	No audit completed	100% (40/40)	93% (41/44)	No audit completed	95% (42/44)	No audit completed	98% (43/44)	95% (42/44)	*No data	93% (41/44)	100% (44/44)	93% (41/44)
Sandford (4 commodes)	100% (40/40)		100% (40/40)	98% (43/44)		93% (41/44)		95% (42/44)	93% (41/44)	100% (44/44)	100% (44/44)	95% (42/44)	95% (42/44)
Cherwell (4 commodes)	98% (39/40)		*100% (30/30)	100% (44/44)		95% (42/44)		95% (42/44)	89% (39/44)	91% (40/44)	98% (43/44)	98% (43/44)	100% (44/44)
Cromwell (7 commodes)	100% (70/70)		100% (70/70)	99% (76/77)		*98% (65/66)		99% (76/77)	96% (74/77)	*96% (73/76)	100% (77/77)	*98% (65/66)	*100% (66/66)
Fiennes (4 commodes)	98% (39/40)		100% (40/40)	*100% (43/43)		100% (44/44)		*100% (33/33)	100% (44/44)	98% (43/44)	*100% (22/22)	100% (44/44)	100% (44/44)

Section 3 – Quality Account Priorities and CQUIN progress

Quality Account Priorities

The update follows the Q2 update in the Oct 2010 Quality Report.

1. Safety

OBMH is one of 8 Mental Health Trusts participating in a Patient Safety Programme called Leading Improvements in Patient Safety (LIPS). The three objectives and current progress is shown below. Four additional staff attended the national LIPS training in November 2010 to support teams with implementation.

LIPS is a long term programme that will include many initiatives each embedded within the transformation programme. The current work streams in the transformation programme include: implementing productive wards, productive community teams, care cluster packages and reviewing the process of incident reporting. The Transformation Board monitors and approves the transformation programme.

Objective	Progress
Reduce towards zero the number of in-patient deaths from suicide by 2012	• The Modern Matrons are reviewing the current Getting the Basics Right audit tool alongside the NPSA suicide prevention toolkit. New audit tool to be implemented from Feb 2011. • The following productive ward modules agreed to be used to support work on LIPS aims: 'Well organised ward', 'Safe and supportive observations', 'Patient Status at a glance', 'Staff handover module', 'therapeutic Interventions'. • Pilot of inpatient communication tool SBARD agreed for beginning of February, discussions about roll out started. • Meetings arranged with ward managers and ward teams to discuss further work, incorporated into productive ward. • Presentations have taken place to raise awareness about LIPS aims at modern matrons meetings, Operational Directors meeting, Directorate level executive meeting in adult and older adult, Forensic team clinical governance meeting
Reduce towards zero community deaths by suicide of patients in our services, by 2014	• Discussions have taken place with productive community lead and national lead on relevant modules linked to the LIPS aims • Meetings currently being set up with teams for productive community to develop work on LIPs aims. Community productive teams starting to be rolled out from Jan 2011. • Community suicide prevention toolkit (in-line with NPSA) in the process of being discussed for development and roll out. • Discussions are in progress with health and safety team on data to support teams measuring improvement and establishing baseline data on suicides and incident reporting – data will be essential to support progress. • CRAM training is being reviewed again and LIPS aims are to be considered in the review. •

Increase reporting of lower rated incidents (less harmful) by 50% March 2012	• Transformations work stream on incident reporting has included LIPS aims in workshops held in Dec 2010 and Jan 2011 and in planned actions e.g. awareness campaign on incident reporting, trend analysis on incidents and incident data for teams to be put in place and the work on improving the system and reporting in teams

2. Patient Experience
The Integrated Governance Committee received a quarterly patient experience report this month with further detail.

2.1 National Community Patient Survey 2010 and 2011
There is an action plan in place for the national community survey results for 2010 monitored by the directorates. The data collection for the 2011 survey starts in January 2011 and the expected closing date is early May 2011.

2.2 Inpatient Survey 2010
The results of the postal in-patient survey across adult acute wards undertaken by Quality Health have been received. This survey repeated the survey carried out by the Care Quality commission in 2009. It was not a requirement of the CQC to undertake the survey this year but alongside other mental health trusts, it was decided to repeat the survey. There were 99 patients of the Trust that responded from a sample size of 314: a rate of 33%. There were also 99 respondents to the 2009 survey. The total response for all trusts was 3745. The results below compare the Trust's 2009 results with 2010 and also a benchmark comparison for all trusts based on 3745 responses.

The acute wards in both counties have had action plans addressing a number of the areas covered by the survey:

- Welcoming patients to the wards
- Provision of safe environments
- Spending quality time with the multi-disciplinary team to discuss care
- Meaningful activities, during the day and in the evening and weekends
- Information on getting help in a crisis on discharge (Oxon).

Overall, the patients in the 2010 survey rated the care they received in hospital as follows:

	OBMH 2009	**OBMH 2010**	Benchmark all Trust 2010
Excellent	13%	**19%**	19%
Very Good	30%	**31%**	31%
Good	24%	**24%**	23%
Fair	14%	**12%**	15%
Poor	19%	**14%**	12%

The survey asks 57 questions altogether. The following areas improved compared with 2009:

- Ward cleanliness
- Helping the patient to keep in contact with family or friends
- Explaining the purpose and use of medication
- Patient involvement in decisions about care and treatment
- Medical tests about physical care
- Care of existing physical problems

- Contact by a member of the mental health team following discharge
- Contact within one week of discharge

The following areas showed deterioration compared with 2009:

- Disturbance at night from hospital staff
- Rating of hospital food
- Receiving help with organising the patient's home situation
- Patients receiving talking therapy
- Explanation of MHA rights in a way the patient could understand

The Directorates have been asked to develop their action plans following the 2010 survey results. The Trust has also decided to repeat the inpatient survey to start in March 2011 (with a closure date in July 2011) on a voluntary basis as this is not a requirement of CQC.

2.3 Real Time Feedback from 7th July to 31st December 2010

The Trust has purchased 27 touch screen devices (25 mobile devices about A5 in size and 2 fixed kiosks) from 7th July 2010 for one year. The devices have been rolled out across Oxfordshire, Buckinghamshire, Swindon, Wiltshire and BaNES CAMHS, adult and older adult services. Specialist will be involved later in the implementation and Forensic are not currently using real time feedback however have developed alternative methods, see below. A bi-monthly meeting is held with the patient experience leads in each directorate to review the feedback and to focus on actions being taken as a result. Four trust wide questions are asked across all devices (note exceptions for CAMHS); the results of feedback are as follows:

Have we helped you to manage your difficulties better?
(All areas except for CAMHS. Sample size 308 responses)
Yes fully 151/308 = 49%
Yes to some extent 131/308 = 43%
Combined yes fully and yes to come extent= 92%

Equivalent CAMHS question - do you feel the person you talked to identified your needs?
(sample size 333)
Yes definitely 169/333 = 51%
Fine ok 101/333 = 33%
Combined yes definitely and fine ok = 81%

Have we treated you with respect?
(All areas except for CAMHS. Sample size 288 responses)
Always 195/288 = 68%
Mostly 66/ 288 = 23%
Combined always and mostly = 91%

Equivalent CAMHS question - Was the person you talked to kind to you?
(sample size 362)
Yes definitely 270/362 =75%
Fine ok 62/362 = 17%
Combined **yes definitely and fine ok = 91%**

Have we done everything we can to make you feel safe?
(All areas use question. Sample size 626 responses)
Always 405/626 = 65%
Mostly 143/626 = 23%

Combined always and mostly = 88%

Overall, how would you rate the care you are receiving from the mental health services?
(All areas use question. Sample size 584 responses)
Excellent 245/584= 42%
Good 209/584 = 36%
Combined excellent and good = 78%

The service leads have tended to concentrate on the practicalities of rolling out the devices. The service leads are now being asked to show evidence of changes resulting from the feedback that they are receiving.

There have been discussions with Community Health Oxfordshire (CHO) on tendering jointly for the future provision of real time patient feedback. Both organisations fund the current patient experience data collection arrangements through CQUIN monies and a decision will need to be made about future funding.

2.4 Forensic Directorate

The Forensic Directorate found difficulties with using a real time feedback method in 2009 due to the static nature of the inpatient group with an average length of stay of over two years. The difficulties included low response rate and increased negative responses over time as questions become repetitive for service users. The Forensic have developed alternative ways to collect regular and meaningful service user feedback by collating feedback and actions from the established five Patient Council Meetings which meet fortnightly and report quarterly alongside the other feedback mechanisms such as complaints and concerns, Essence of Care audits, and the Directorates internal satisfaction survey carried out with inpatients and community patients 18 monthly (the next survey is just starting in January 2011). Feedback is regularly reported to the directorate management committee including looking at themes from feedback and actions taken. The directorate are currently developing carer involvement and feedback, and piloting feedback from inpatients following seclusion. The Forensic directorate are represented at the bi-monthly patient experience leads meeting.

3. Measuring Outcomes

The directorates continue to work to embed HoNOS in adult, older adult and Forensic services. In 2009/10 the focus was on implementing HoNOS (one score) and in 2010/11 this has developed to ensuring each service user has more than one HoNOS score (paired score). The work is supported by the CQUIN goal based on increasing the number of open records with a paired HoNOS score, baseline for quarter 1 was 26.1%. Performance as of the end of Dec 2010 is 36%.

Both the CAMHS and the specialist services have implemented alternative service appropriate outcome measures.

CQUIN Goals

Oxfordshire and Buckinghamshire PCTs (predominantly adult services)

CQUIN Goal	Q3 Progress
Dementia Audit against NICE Guidelines (older adult)	- Preparation audit completed between August-October 2010. - Full audit looking at NICE guidance and the CQUIN requirements completed in December 2010, with a sample size of 10 cases per older adult community team (total sample 70). - Data currently being analysed and reported to teams.
Demonstrate all Care Groups collect, analyse and action patient feedback	- See patient experience update above within Quality Account Priorities.
Carers Survey (adult and older adult)	- Project team established, including all four Carer Governors and representatives from each directorate. Project team have: developed/ piloted the survey, led the communication around the survey, led the workshop with services to review the results and will coordinate action planning. - The survey was distributed between 25th Oct-7th Dec 2010, through a variety of methods including: community teams, carer groups, email to carers on “people bank”, email to carers and general public identified as Foundation Trust members, available and publicised via OBMH internet and the Observer newsletter with links to complete the survey in hard copy or on-line. - Response rate: 111 responses received (76 by post & 35 on-line). - Workshop held on 17th December 2010 with representatives from services and the project team to discuss the results, to prioritise areas for improvement and to start action planning. - Next steps: to finalise report, disseminate findings further to clinical areas and Trust Board, finalise action plan and then share with the PCT, feedback results and actions of what we plan “to do” to carers and feed results into the review of the Trusts Carers Strategy in 2011.
Increase the number of patients who have a paired outcome measure-HoNOS (adult and older adult)	- See measuring outcomes update above within Quality Account.
CAMHS You’re Welcome self assessment	- Baseline assessment of T3 services completed for Oxfordshire and Buckinghamshire teams by a multidisciplinary team (via three meetings) and checked by Team Managers and the Clinical Governance Group for the directorate. Assessment shared with the PCT. - Action plan has been finalised and is being implemented before repeat of self assessment in March 2011. The action plan includes: reviewing the CAMHS information leaflets available and developing information for under 16s and people with mental health issues and learning disabilities, developing how information is displayed and given around confidentiality and consent procedures, introducing a checklist for reception staff to regularly review display material, developing a system to feedback actions taken as a result of survey responses through posters " you said we did", and audit the transition arrangements between CAMHS and adult services.

CAMHS Buckinghamshire only (County Council leading commissioner)

CQUIN Goal	Q3 Progress
CAMHS Depression Audit against NICE Guidelines	- CAMHS Clinical Governance Group on 16th June 2010 agreed scope (T3 teams to audit 10 cases each) and timeframe for audit. - Audit tool agreed. - Data collection completed by teams during July 2010. - Report completed and circulated to Clinical Governance Group. Action plan developed and being implemented.
CAMHS You're Welcome self assessment	- See above update under Oxfordshire and Buckinghamshire PCT goals.
Improvement on number of admissions gate kept by Crisis/ Outreach	- Monitored by directorate regularly and through monthly commissioner contract meetings. Baseline 76% for Q4 2009/10 and target set at 80%. - Performance up to Q3 above 95%. Average length of stay and number of admissions has decreased as well further evidence of the impact of the Crisis and Outreach Team.
Outcome measurement CGAS (practitioner) and SDQ (service user)	- Assessment and review/ discharge outcome measurement forms entered onto external national CORC database by teams. Difficulties with national CORC database, information only available annually. Commissioners aware of CORC database difficulties. - The directorate have arranged for CORC to be re-launched with teams and to look at internal reporting of information. - The SQ form (which is part of CORC) is being used on the real time feedback devices across the directorate (see patient experience update). - Buckinghamshire County Council have established an outcome website for all professionals from all agencies (including CAMHS) to report on good outcomes and examples of good service provision. CAMHS are waiting for the first report to review the feedback.

Eating Disorder Service (East of England contract)

CQUIN Goal	Q3 Progress
Medicine Management	- Medicine management clinical audit completed in November/ December 2010. Results still to be analysed and reported.
Productive Ward	- Both the eating disorder units are participating in the productive ward initiative, the Modern Matron for each unit is taking a lead.
Empowerment and Involvement of service users	- Service users involved in service developments for example the change in the way food is provided. - The November 2010 commissioner contract meeting was partially chaired by service users.
Patient Experience	- See patient experience update above within Quality Account Priorities.

Forensic (Specialist commissioning)

CQUIN Goal	Q3 Progress
Medium and Low Secure providers will use: HONOS secure and HCR 20 or other structured risk assessment suitable to need (e.g. SVR-20, RSVO, SARA)	- See measuring outcomes update above within Quality Account. - Structured risk assessment in place and monitored through monthly CPA audit completed by directorate. - Over 96% of inpatients have more than one HoNOS score completed. - The recovery star tool (see last CQUIN goal) will also enable the Trust to measure and review the impact of the service being delivered, thus providing evidence to providers/commissioners about the effectiveness of treatment.
For Medium and Low secure providers to use the Climate Evaluation Schema (CES). During 2010-2011 all providers will introduce the use of the tool	- EssenCES (Essen Climate Evaluation Schema) audit which is an assessment of the social climate and atmosphere on Forensic wards. The audit involves asking current inpatients to complete a survey of 17 questions. This was been consulted on by the Patient Council and implemented in October/ November 2010. The results of the audit are currently being analysed and reported. The results will initially go to the Clinical Governance Group. - Communication around service evaluation included: discussed with Patient Council representatives, poster for both staff and patients displayed on all wards, letters sent to patients and staff, and guidance for staff.
Medium and Low secure providers to demonstrate a robust system/process that promotes the empowerment and Involvement of service users	- See patient experience update above within Quality Account Priorities. - The commissioners attended the Patient Council meeting in October 2010 to ask patients about their understanding of the CQUIN goals, to see how goals are developing and the directorate's progress against the goals.
Medium and Low secure providers will implement one new service user defined service improvement e.g. Productive Ward	- Productive ward initiative being implemented across the service and is currently running in Marlborough House, Kennet Ward and Woodlands.
Medium and Low secure providers to further develop the quality standard A81 of the Best Practice guidance for Medium Secure Units – Department of Health Offender Partnerships 2007 by developing a benchmarking tool linking 25 hours of patient activity to personalisation and recovery	- Directorate introduced system to monitor that patients are offered 25 hours of activity per week. - In Q2 evidence 35% of patients received 25< hours of activity per week. - Q3 update to still be collated.
Medium and Low	- Recovery Star Working Group is established to implement and promote

CQUIN Goal	Q3 Progress
secure providers will implement a recognised tool for recovery planning	the recovery STAR tool. - An implementation plan is in place, in summary: December 2010 is around raising awareness, promotion and initial roll out of tool with staff and patients, January 2011 roll out of staff training, February 2011 re-visit wards to monitor progress and offer additional support, March 2011 ensure all patients have a recovery star (unless reason for exception documented) which is available on RiO, and April 2011 consider other recovery measures and review use of recovery star. - A database is being developed that captures/ monitors who has had a recovery star, when completed, when next due (i.e. around the CPA date), who has not had a completed star and why.