# Quality Account 2021-22

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improving lives

## Glossary of abbreviations

- ADAPT – Anxiety, Depression, Anxiety Disorders, Personality Disorders and Trauma
- AMH – Adult Mental Health Services
- BAME – Black, Asian and Minority Ethnic
- CAMHS – Children and Adolescent Mental Health Services
- CCG – Clinical Commissioning Group
- CEG – Clinical Effectiveness Group
- CPA – Care Programme Approach
- CPAG – Care planning action group
- CQC – Care Quality Commission
- CQUIN – Commissioning for Quality And Innovation
- CYP – Children and Young People Services
- Datix – Incident Reporting System
- DIALOG – a service user rated outcome measure which focuses on the quality of life, treatment satisfaction and care needs
- DSP – Digital Data Security and Protection (toolkit)
- ECG - Electrocardiogram
- EIP- Early Intervention in Psychosis
- EPRR – Emergency Preparedness Resilience and Response
- FFT – Friends And Family Test
- GASS – Glasgow Anti-psychotic Side-Effect Scale
- HMIP – Her Majesty's Inspectorate of Prisons
- HONOS – Health of the National Outcome Scales
- HQIP – Health Quality Improvement Partnership
- IAPT - Improving Access to Psychological Therapies
- ICC – Incident Coordination Centre
- ICMP - Intensive Case Management in Psychosis
- iFox – Oxleas' business information system
- IPC – Infection prevention and control
- IRP – Incident Response Plan
- MCA – Mental Capacity Act
- MH - Mental Health
- MHRA – Medicines and Healthcare Products Regulatory Agency
- MUST – Malnutrition Universal Screening Tool
- NEBOSH – National Examination Board in Occupational Safety and Health
- NEWS – National Early Warning Score
- NICE – National Institute for Health And Care Excellence
- NCISH – National Confidential Inquiry into Suicide and Safety in Mental Health
- NHSE – NHS England
- NHSI – NHS Improvement
- NHSEI – NHS England and NHS Improvement
- NIHR – National Institute for Health Research
- NRLS – National Reporting and Learning System
- RiO – Electronic Clinical System
- PEG – Patient Experience Group
- PocHi – Blood analyser

- POMH – Prescribing Observatory for Mental Health
- PPE – Personal Protective Equipment
- PQAC – Performance and Quality committee
- PSG – Patient Safety Group
- Qi – Quality Improvement
- QIIC – Quality Improvement and Innovation Committee
- QMF – Quality Management Framework
- RA – Risk Assessment
- RCA – Root Cause Analysis
- RIDDOR – Reporting of injuries, diseases, and dangerous occurrences regulations
- SEL – South East London
- SNET – Service User Network Engagement Tool
- SNOMED – Systemised nomenclature of medicine clinical terms
- SSKIN – Surface, skin inspection, keep moving, incontinence and nutrition
- STORM – a self-harm mitigation skills based training in risk assessment and safety planning

# PART ONE: INTRODUCTION

## 1.0 Statement on quality from our chief executive

I am proud to present our Quality Account for 2021-22 which illustrates our commitment to improving lives by providing the best possible care to our patients and their families. NHS trusts are required to produce a statutory account of the quality of care provided, aligned to a specific format which has been followed throughout this report.

Our commitment to improving lives is supported by the 2021-2024 Oxleas strategy where three main priorities have been identified. These are:

- **Achieving zero delays**: well defined, evidence led waiting times, understood by both patients and staff. We want Oxleas to be known for delivering the right care at the right time with zero delays.
- **Delivering great out of hospital care:** co-designed services and partnership working with local GPs, prisons, the voluntary sector and our local providers. We will support our service users to have greater choice and control and to be supported to live well in their communities.
- **Making Oxleas a great place to work:** we will only deliver outstanding care to our patients if we take the best possible care of our staff. We want staff to have opportunities to develop, thrive and to feel supported to give their best every day.

Eight building blocks for change will help us to achieve these priorities:

1. Delivering quality management
2. Bolstering our service user, patient, carer involvement and co-production
3. Creating a safety and learning culture
4. Increasing our focus on service inequalities
5. Effective partnership working
6. Reducing violence, aggression, and abuse against our staff

7. Increasing digital and remote service delivery
8. Making best use of our resources.

This strategy was developed drawing on extensive feedback from service users, carers, trust members and members of staff, and was agreed by the Board of Directors and Council of Governors in May 2021. The Oxleas Annual Report and Accounts 2021/22 provides further detail on this strategy.

Further to our strategy, our trust values help us to achieve our purpose of improving lives. They are the lens we look through to guide our behaviours, our decisions and how we work with patients, families, carers and colleagues. Our values are:

**We're Kind:** We show consideration, concern and thoughtfulness towards everyone.
**We're Fair:** We embrace difference, treat everyone with respect and promote diversity, equity and inclusion.
**We Listen:** We always seek to understand, learn, and improve.
**We Care:** We work together and innovate to put our service users at the heart of everything we do.

The past year has been a challenging time for all in response to the global pandemic. Despite the pressures, we have continued to focus on enhancing quality - ensuring excellence for every patient across the three quality domains of patient experience, patient safety and clinical effectiveness. This account demonstrates:

- Our approach to improving quality
- Our priorities for 2022/23
- Our performance against the 2021/22 quality priorities

Our dedicated staff of Oxleas NHS Foundation Trust, alongside colleagues from all parts of the health and social care system and supported by our local communities, continue to rise to the challenges posed by the Covid-19 pandemic. Our services have responded and adapted to innovative ways of working to ensure we continue to provide care for those most in need.

The pressures and restrictions created by Covid-19 have, unfortunately, had an impact on achieving some of our targets outlined for 2021/22. However, these will continue to be taken forward by the trust through monitoring and seeking assurance that patient safety, improving clinical effectiveness and outcomes and positive experience of our care is maintained and enhanced across all of our services. We will endeavour to achieve our targets and sustain this performance as we move through 2022/23

Each year, we work in partnership with staff, patients, carers, members, commissioners, GPs, Healthwatch and other stakeholders and we are grateful to all who have supported and worked with us in reviewing and setting our quality plans. We are delighted, that overall, we have had another successful year and we are determined to maintain these high standards throughout 2022/23.

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

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

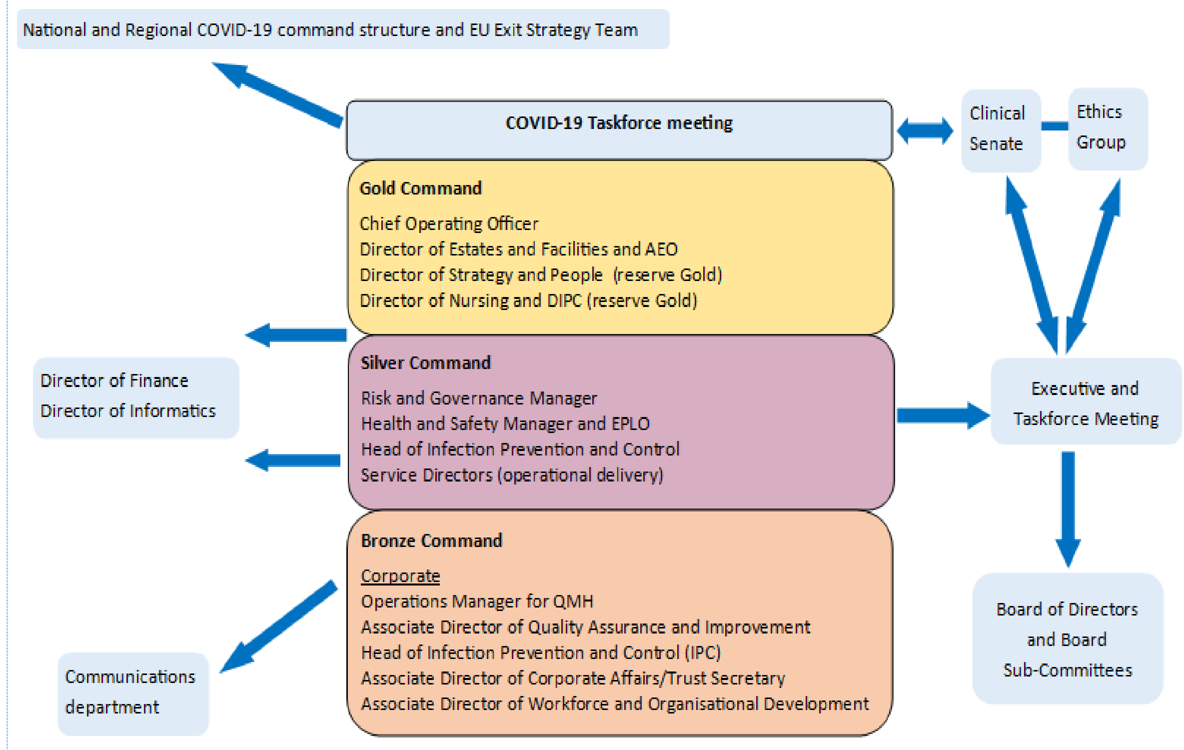
Signed by

Dr Ify Okocha
Chief Executive
June 2022

## 1.1 Oxleas response to COVID-19 – April 2022

On the 30th of January 2020, NHS England and NHS Improvement (NHSEI) declared a Level 4 national incident, triggering the first phase of the NHS pandemic response. Oxleas set up an Incident Coordination Centre (ICC) and appointed specific people in key roles, including the Gold, Silver and Bronze Command positions. The ICC has continued to remain operational and the current structure and how it fits with our existing governance system is shown in diagram 1.1a below. This diagram shows how Oxleas has deployed key experience and skillsets at appropriate seniority into crucial roles within the ICC command structure.

## Diagram 1.1a: ICC structure



**Oxleas ICC Command**
As with any major Incident, we have followed our Incident Response Plan (IRP) throughout the pandemic. Guidance within this plan has been considered over the last two years and continues to be operational and managed within the strategic structure. We continue to work in coordination with our regional South-East London Command Centre Team and partner organisations within SEL.

The NHS remains at the highest incident level - level 4, whereby the NHS response to COVID-19 is still coordinated nationally. We have however scaled down our ICC resources to be proportionate to our current risk, but the main strategic structure remains unchanged. We continue to have regular ICC meetings (twice weekly) and a weekly COVID-19 Service Directors meeting.

The trust Gold Commanders are the Chief Operating Officer and the Director of Estates and Facilities. They lead the ICC and the trust response to COVID-19 and take responsibility for decision making. Decisions are logged in line with our legal obligations. Gold (strategic) Commanders are supported by Silver (tactical) Commanders and Bronze (operational) Commanders.

Each Service Director is part of the ICC and they are influential links between the Command Centre and front-line services. They raise any issues arising within service provision so that focus, direction and resources can be given to resolve any problems promptly. Service Directors support teams in invoking business continuity plans to keep priority services operational.

The success of the ICC has been based on co-operation and close working between all directorates; supported by regular meetings and frequent, clear communication to the entire workforce. Meeting frequency is increased in times of higher prevalence of the virus.

**PPE Hub**
We continue to supply COVID-19 related PPE items and associated consumables via our PPE hub at Queen Mary's Hospital. The PPE team deliver stock to all directorates except for the Prison directorate who collect supplies directly from the hub. We are currently making plans to secure staffing for the PPE hub up to the end of March 2023. This is in line with plans by NHS Supply Chain to continue delivering COVID-19 related PPE via centralised push deliveries until March 2023.

**Infection, Prevention and Control (IPC) Team**
The IPC team form an integral part of the ICC and have been instrumental in ensuring the safe management of patients and staff during the pandemic. The team review the extensive and frequently amended infection control related guidance and interpret this to meet the needs of our services. They have led the trust in an advisory and operational capacity throughout the pandemic. All outbreaks of COVID-19 are thoroughly investigated, and the team work closely with regional IPC colleagues and partner organisations to ensure consistency of approach and sharing of best practice. Oxleas IPC response has been monitored by the Care Quality Commission (CQC) during the pandemic and has been deemed appropriate with no areas of concern noted.

**Emergency Planning Team**
Emergency Preparedness, Resilience and Response (EPRR) oversee operations within the ICC ensuring all regional and national requirements are met. EPRR monitor and distribute guidance issued by a wide range of NHS organisations. This is achieved using a dedicated emergency planning email inbox that is monitored seven days a week. RIDDOR reporting of COVID-19 positive staff

members is coordinated through the EPRR Team, as is the coordination of all trust business continuity plans and situation reporting.

**Situation Reporting (SitRep)**
During a major incident it is a requirement for all NHS funded commissioning and provider trusts to provide accurate and timely data as requested. During the COVID-19 pandemic it has been necessary to provide SitRep data daily covering a range of areas, including but not limited to, infection levels, vaccination uptake and PPE stock and use.

# PART TWO: OUR QUALITY PRIORITIES

**Priorities for improvement and statements of assurance from the Board of Directors**

## 2.0 Priorities for improvement

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 describe our areas of focus for 2022/23 and share our performance against 2021/22 priorities.

## 2.1 Our quality improvement priorities for 2022/23

Our 2022/23 priorities reflect the diversity of services that the trust provides: mental health, children and young people’s services 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, Greenwich and South London.

### 2.1.1 Quality priorities and directorate quality goals for 2022/23

The Quality Management team have utilised the Quality Management Framework (QMF) in identifying the quality priorities for 2022/23. The framework is a flexible way to define our approach to continuous quality improvement, enabling improvement methodology which delivers sustained improvements in the quality, safety, and experience of the care that we provide. Further, the QMF helps to empower staff to provide better and safer care, cultivating a continuous improvement culture and promoting the cultures and behaviours that are seen in other high performing organisations.

### 2.1.2 Identification and implementation of the quality priorities aligning with the Quality Management Framework (QMF)

We have applied the principles of the framework to support the selection and implementation of the quality priorities. In previous years, the six quality outcomes have been used to determine the areas of focus such as the patient promise. This has provided a good focus on the areas that matter to Oxleas and the population we serve, however it has led to a plethora of metrics (up to 29 a year) which have proven to be unmanageable and reduced the importance being placed by staff on what is the priority.

The three Darzi quality dimensions are patient experience, clinical effectiveness, and patient safety. These directly align to our governance groups that in turn report into Board via the Performance and Quality Assurance Committee (PQAC). Under each group is a set of focus areas, identified through

analysis of our quality control, assurance, improvement, and planning information from a range of sources such as experience, complaints, incidents, risks etc.

The trust quality priorities (2.1.3) and directorate quality goals (2.1.4) will inform the quality improvement efforts that take place throughout the year 2022/23. Improvement projects will be monitored through the relevant directorate and trust level subgroups – Patient Safety Group (PSG), Clinical Effectiveness Group (CEG) and Patient Experience Group (PEG). They will also be reported regularly to PQAC to provide assurance of improvement.

Metrics will be devised to measure progress and provide updates on improvement projects that relate to the trust quality priorities and the directorate quality goals. As part of the quality control processes there will be continued work to ensure all relevant quality metrics are reported on local dashboards and monitored via the relevant directorate governance groups.

On an annual basis, the trust quality priorities and the directorate quality goals will be updated and reviewed in consultation with staff, partners and the population we serve. From the areas of focus, a minimum of three metrics will be chosen from each Darzi dimension to be the trust quality priorities for the following year.

### 2.1.3 Our quality improvement priorities and directorate goals for 2022/23

We continue to be committed to delivering high quality services, and every effort is made to work in partnership with our service users, carers, members, staff, and commissioners to identify what our quality priorities should be each year. 2022/23 has seen the identification of directorate, service specific quality priorities.

Our trust quality priorities and directorate goals have been selected by engagement with local and national commissioners. This has been achieved through discussion at our quality meetings, our Council of Governors, patient groups such as Healthwatch, feedback from patient experience surveys, lessons learned from incidents, the outcome of our CQC inspections and in collaboration with Service Directors, Clinical Directors, and directorate Quality leads. As part of this collaboration process, the 2021-22 Quality priority performance outcomes and quality control data, discussed potential contributory risks on performance and quality and have listened to our colleagues as to where the focus and priority for each directorate should be for each quality domain. The overall decision has been with directorate colleagues in selecting their service specific quality goals for improvement.

As an organisation, and following consultation, one overarching quality priority has been identified from each of the three quality domains. These form the overall trust quality priorities.

- **Patient experience:** Improving the experience of care by increasing family and carer involvement and experience
- **Clinical Effectiveness:** Improving the outcome of care through effective care planning
- **Patient Safety:** Preventing harm through the identification and effective management of the deteriorating patient

### Table 2.1.3a: Directorate level quality goals

| | | Acute & Crisis | CMHT | ALD | CYP | Forensic | Prison | ACS |
|---|---|---|---|---|---|---|---|---|
| **Patient Experience** | Improving patient feedback | X | | | X | | X | X |
| | Reducing complaints | X | | | | | | X |
| | Increase family & carer involvement & experience | X | X | X | | X | | |
| **Clinical Effectiveness** | Physical health in mental health | X | X | | | | | |
| | Outcome measures | X | | X | | | | |
| | Care planning | | X | | X | X | | X |
| **Patient Safety** | Reducing violence and aggression | X | | | | X | | |
| | Deteriorating patient | | | X | | X | X | X |
| | Risk assessments | | | | | | | X |
| | Shared learning | X | | | X | | | |
| | Suicide prevention | | | | | | X | |
| | Safeguarding – Think family | | X | | | | | |

Oxleas quality priorities for 2022/23 and directorate quality goals have been reviewed and agreed by the trust's Performance & Quality Assurance Committee (PQAC) - a committee of the Board of Directors. The following directorate level quality goals have been selected.

Our quality priorities follow an established governance structure which monitors and measures performance and progress. Each individual trust quality priority has a responsible executive lead that monitors and reports progress. This happens quarterly at a minimum to the trust's Performance and Quality Assurance Committee (PQAC). The PQAC is responsible for providing information and assurance to the Board of Directors that the trust is safely managing the quality of patient care and experience, the effectiveness of quality interventions and the safety of patients.

## 2.2 Statements of assurance from the Board of Directors

During 2021/22, Oxleas provided, commissioned and/or sub-contracted eight relevant health services covering the following service lines:

- Adult Acute & Crisis Mental Health
- Adult Community Mental Health
- Adult Community Physical Health
- Adult Learning Disabilities Services (inpatient and community)
- Children and Young Peoples Services (mental health, community and specialist children)
- Specialist Forensic Mental Health Services (inpatient and community)
- Prison health care (Kent, Greenwich & Wandsworth)
- Lead Provider Collaborative for Adult Secure Services

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 also provided across Bexley and Greenwich. We have reviewed all the data available to us on the quality of care in all eight of these relevant health services. The income generated by the relevant health services reviewed in 2021/22 represents 93% of the total income generated from the provision of relevant health services by Oxleas for 2021/22

### 2.2.1 Participation in clinical audits

At Oxleas we use participation in national clinical audit programmes and confidential enquiries as a driver for improvements. These initiatives provide opportunities for comparing practice nationally and 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.

The effects of the COVID-19 pandemic have still been felt during 2021/22. During 2021/22, 13 national clinical audits and two national confidential enquiries covered NHS services that we provide. We participated in 100% of the national clinical audits but had to withdraw from one of the national enquiries due to data issues.

The national clinical audits and national confidential enquiries that we were eligible to and participated in during 2021/22 are in tables 2.2.1a and 2.2.1b below. Further, in these tables are the number of cases submitted to each audit or enquiry (where known), as a percentage of the number of registered cases required.

### Table 2.2.1a: eligible national clinical audits 2021/22

| No: | Eligible national clinical audits 2021/22 | Participation | No. of cases submitted | % of cases submitted |
|---|---|---|---|---|
| 1 | Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls | YES | _ | _ |
| 2 | LeDeR - Learning Disabilities Mortality Review | YES | 20 | _ |
| 3 | Mental Health Clinical Outcome Review Programme - Real-time surveillance of suicide by patients under mental health care | YES | - | - |
| 4 | National Adult Diabetes Audit (NDA) - National Diabetes Foot Care Audit | YES | - | - |
| 5 | National Asthma and COPD Audit Programme (NACAP) – Pulmonary Rehabilitation Audit | YES | 22 | - |
| 6 | National Audit of Cardiac Rehabilitation | YES | - | - |
| 7 | National Audit of Care at the End of Life (NACEL) | YES | 0 community<br>1 mental health | - |

| No: | Eligible national clinical audits 2021/22 | Participation | No. of cases submitted | % of cases submitted |
|---|---|---|---|---|
| 8 | National Clinical Audit of Psychosis - 2021/22 National Clinical Audit of Psychosis | YES | 181 | 100 |
| 9 | Prescribing Observatory for Mental Health - Use of Clozapine re-audit | YES | - | - |
| 10 | Prescribing Observatory for Mental Health - Prescribing high-dose and combined antipsychotics on adult psychiatric wards | YES | - | - |
| 11 | Prescribing Observatory for Mental Health - Prescribing for depression in adult mental health services | YES | - | - |
| 12 | Prescribing Observatory for Mental Health - Prescribing for substance misuse: alcohol detoxification | YES | 15 | 100 |
| 13 | Sentinel Stroke National Audit Programme (SSNAP) | YES | 186 | - |

Please note: Where there is no data detailed in the table above, that is because that information is not available/has not been supplied by the audit programme provider.

### Table 2.2.1b: national enquires 2021/22

| No: | National Enquiries (2021/22) | Participation | No: of cases submitted | % of cases submitted |
|---|---|---|---|---|
| 1 | NCEPOD Child Health Clinical Outcome Review Programme - Transition from child to adult health services | YES | 10/15 | 67 |
| 2 | Physical healthcare of inpatients in mental health hospitals (NCEPOD) | NO (Withdrew due to issues with data) | | |

Oxleas reviewed the reports of four national clinical audits in 2021/22 and we intend on taking the following actions to improve the quality of healthcare provided:

### Table 2.2.1c: actions to improve from four national clinical audits

| Audit title | Actions to improve |
|---|---|
| Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls | • All inpatient hip fractures are classed as severe harm and they all have a Root Cause Analysis completed<br>• The falls policy states that all adults over 65 should have a Falls Assessment Tool (FAT) completed within 24 hours of admission. It is a multi-factorial risk assessment on RIO. It includes all areas outlined in the NICE guidelines<br>• FAT completion compliance is monitored monthly |

| | |
|---|---|
| Mental Health Clinical Outcome Review Programme - Real-time surveillance of suicide by patients under mental health care | • To Improve skills to respond to clinical complexity<br>• NCISH have extended offer for support for suicide prevention during the pandemic. Additional support may be needed for vulnerable groups |
| Prescribing Observatory for Mental Health - Use of Clozapine re-audit | • Despite results being better than the national average, for 25% of patients (n=8) prescribed clozapine off-label, there was no documented record of a discussion<br>• Use of Clozapine GASS weekly (also found in RiO, Specialist assessments) for the first month of treatment<br>• Measurement of BMI, plasma glucose and lipids for patients treated for >1 year could be improved - new PocHi clinics planned at Ferryview & for forensics should bring us to 100% for measurement of BP and BMI, with improvements in plasma glucose and lipid levels |
| Sentinel Stroke National Audit Programme (SSNAP) | • Initiative taken across the whole of SEL to improve the transfers of record from acute to community<br>• Continue to use this report to benchmark against other teams nationally<br>• Waiting list management initiative, monitoring length of stay |

A quarterly report on all national and trust wide audits is presented at the trust Clinical Effectiveness Group (CEG) - a sub-group of the trust's Performance and Quality Assurance Committee (PQAC). This report provides assurance on the status of each audit, its progress, findings, and what improvements are suggested.

**Trust (mandatory) audit**
Oxleas are required to provide assurance that we comply with requirements under the Health and Social Care Act 2008 and the Care Quality Commission and NHS England Contract 2019/20 regarding patient safety and risk via audit.

The table below is a list of trust audits carried out in 2021/22 together with the planned and/or completed improvements. Actions from audits are monitored via relevant groups such as the Patient Safety Group, Safeguarding Committee, and the trust Clinical Effectiveness Group.

### Table 2.2.1d: improvements completed from trust audits

| Audit title | Improvements completed |
|---|---|
| **Care planning audit** | • Overall, 5,805 audits were undertaken across all directorates. This is a reduction of 936 audits since last year.<br>• The Care planning action group (CPAG) was established to review standards, revise the policy, ensure audit tool fit for purpose and oversee a Qi project to identify and improve barriers to care planning<br>• Directorate standards are updated and appended to the revised Care Planning Policy<br>• Audit questions have been reviewed and a pilot for a new audit tool is underway<br>• Looking at how to scale up the Qi project across the Trust |

| Audit title | Improvements completed |
|---|---|
| **Documentation audit - ALD** | • Pilot audit undertaken by Adult Learning Disabilities Team.<br>• Professionals inputting to RA increased by 10% from Oct-Dec 21<br>Care plan addressing specific risk factors improving month on month |
| **Clinical Coding** | Completion of a bespoke four-day mental health coding refresher course on the NHS Digital National Clinical Coding Standards |
| **Mental Capacity Act re-audit of consent** | • MCA Steering Group restarted after pandemic disruption<br>• A review of audit tool<br>Guidance on recording mental capacity on records issued |
| **Do Not Attempt Resuscitation** | • Mandatory DNACPR training arranged, including train the trainer for Managers<br>Bi-annual audit in place |
| **Pressure ulcer audit** | • Yearly pressure ulcer audit is underway<br>• Named team members who are responsible for completing the PUIT |
| **NEWS2 Deteriorating patients** | Data is collected by the Patient Safety Team and analysed by directorate. |
| **Nutrition and hydration (MUST)** | Data is collected by the Patient Safety Team and analysed by directorate. |
| **Falls audit** | • Falls training put in place<br>• Audit will be repeated in quarter 3 of 2022/23 |
| **Resuscitation equipment audit** | • Extensive training and support for staff<br>• Updated resus council guidelines added to red resus folders<br>• Healthcare Assistants trained to undertake the checks of the resus bags<br>• Doctors' induction includes a run through of our equipment and emergency process, policies, and a recap on DNACPR<br>Resus equipment section added to the non-medical staff local induction checklist |
| **Duty of candour audit** | • The Duty of Candour policy has been re-worded and updated to make it clearer for staff to follow<br>• A template letter has been designed for use specifically with pressure ulcer incidents<br>• Visit photos and information have been shared on Twitter to help publicise the subject<br>• Patient Safety Lead and Tissue Viability Nurse Lead have completed training with the District Nursing Teams on how to complete Datix correctly<br>• Datix has been revised so that it is easier for staff to record Duty of Candour compliance |
| **Medical devices audit** | Report unavailable at time of reporting |
| **Data Protection & Security Toolkit** | Report unavailable at time of reporting |
| **Section 11 audit** | • Raising a matter of concern policy (whistleblowing), reviewed Dec 21<br>• Safeguarding children and young people policy updated May 2021<br>• Business Continuity Plans updated December 2021 |

| Audit title | Improvements completed |
|---|---|
| | • Safeguarding Record Keeping Guidance (September 2021)<br>• In 2021, all CAMHS teams received a 1 hour training on record keeping and information sharing |
| **Safeguarding children referrals (scorecard)** | Data shared directly with the Safeguarding Committee |
| **Safeguarding adult referrals** | Data shared directly with the Safeguarding Committee |
| **Record keeping audit (safeguarding)** | Report unavailable at time of reporting |
| **Annual Assurance Process** | • Incident Response Plan updated to include new modules -a Storm Plan and a Cyber Attack Plan<br>• Update to our structure of Business Continuity Plans and our prioritised list of services to ensure the new directorate structures are fully covered with business continuity plans |
| **Ligature audit** | • Estates have worked on ligature reduction works within the Queen Mary's Hospital Woodlands unit. Specifically, our high-risk acute wards, Lesney and Millbrook<br>• Work has been undertaken within our two older adult patient level 1 wards for the two designated rooms within Oaktree Lodge at Memorial Hospital |
| **Health & Safety audit** | • There has been a significant increase in total compliance identified with the trust average scoring between our first two cycles of auditing, via our new automated I-Auditing programme<br>• We have in place our new NEBOSH HSE Leadership Excellence Course. This training is aimed at our Directors and Governors |
| **Unannounced audit on wards/clinical teams** | The IPC Team work directly with ward or team managers regarding action plans and re-audits |
| **Mattress audit** | Report unavailable at time of reporting |
| **Sodium valproate PREVENT programme** | • Valproate page developed on the intranet, including links to MHRA advice, information materials, and RCPsych guidance<br>• The Healthcare professionals booklet updated<br>Increased support provided to teams by community mental health pharmacists |

### Table 2.2.1e: improvements planned for trust audits

| Audit title | Improvements planned |
|---|---|
| **Documentation audit - ALD** | • Risk assessment being reviewed – noncompliance average 16%<br>• Crisis being reviewed – noncompliance average 37%<br>• Care Plan review compliance average 69.1%<br>• Out of date care plans not closed average 26% |

| Audit title | Improvements planned |
|---|---|
| **Clinical Coding** | To liaise with RiO Transformation Team regarding the implementation of SNOMED CT/cross-mapping with ICD-10 |
| **Pressure ulcer audit** | • Monthly review of all pressure ulcers<br>• Increase use of SSKIN bundle and embedded into practice<br>• Patients need to be kept on the team caseloads for SSKIN assessments |
| **CAS audit** | The aim for 2022/23 is to provide training on the CAS system and ensure that all leads are aware of their responsibly to respond and how to use Datix to do this |
| **Quality observation audit** | A re-audit to be undertaken to reflect adaption of questions, and description of what 'good' looks like |
| **Safeguarding supervision** | • For team to ensure groups sessions are prepared with access to current and relevant safeguarding children case studies for optimum learning opportunities<br>• To pilot a new model of safeguarding supervision for Young Greenwich nurses within their hubs<br>• Continue to work on improving our completion rate for enquiries |
| **Health & Safety audit** | The Team Managers training is being finalised. This should further support team managers to understand their responsibilities and how to competently discharge them |
| **Hand hygiene audit** | • Average compliancy score of 96%<br>• Need to increase response rate average of 65% |
| **Safe storage of medicines audit** | • Remind all staff with access to medicines storage keys that all medicines cupboards should remain locked after use, even if they are situated within a locked clinical room.<br>• That the recording of medicines refrigerator temperatures is assigned to staff members and deputies and teams should have a system in place to check these records have been completed and staff know to record the action taken if temperature are found to be out of range. |

### 2.2.2 Local clinical audit

Registration of local clinical audits has increased over the last year. This is due partly to the stabilisation of the pandemic but can also be attributed to the clinical effectiveness team being in post. Essential local audits have been completed, however due to some areas being in business continuity, those local audits with lower priority (although registered) were not always completed.

In total, 43 local audits were opened during 2021/22 (compared to 20 in 2020/21). Eleven local audits were closed during this period and a total of 29 audits were cancelled/not completed. A breakdown of audits opened/closed/cancelled by directorate is included below.

### Table 2.2.2a: local clinical audits opened/closed/cancelled in 2021/22

| | Opened | Completed | Incomplete |
|---|---|---|---|
| **Adult Learning Disabilities** | 5 | 1 | 4 |
| **Forensic and Prison Services** | 6 | 3 | 3 |
| **Children and Young People** | 12 | 4 | 8 |

### Table 2.2.2b: the transfer of directorates into new directorates during quarter 3

| Quarters 1 and 2 | Opened | Completed | Incomplete |
|---|---|---|---|
| **Bexley** | 3 | 1 | 2 |
| **Bromley** | 7 | 0 | 7 |
| **Greenwich** | 5 | 1 | 4 |
| **Quarters 3 and 4** | | | |
| **Adult Acute and Crisis Mental Health** | 2 | 1 | 1 |
| **Adult Community Physical Health** | 2 | 0 | 2 |
| **Adult Community Mental Health** | 1 | 0 | 1 |

Local audits are discussed and shared at directorate level Clinical Effectiveness Groups to ensure recommendations and action plans are agreed to improve the quality of healthcare provided. We will continue to maintain a focus on improving clinical practice in accordance with national and local guidance; and ensure that these form part of our local clinical effectiveness group work plans.

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

Quality Assurance and Improvement Team
Oxleas NHS Foundation Trust
Pinewood House,
Pinewood Place
Dartford
Kent
DA2 7WG
Tel: 01322 625770

During April 2021 – March 2022, our clinical effectiveness team has been able to increase our focus on audit at Oxleas. We have worked on and embedded a trust-wide clinical audit programme, developed the audit process and templates to reflect those recommended by Healthcare Quality Improvement Partnership (HQIP) and begun delivering training to ensure our clinicians are confident in producing an effective local audit. The Clinical Effectiveness Team launched its Clinical Audit Workshop this year to support clinicians in understanding the audit process and how to ensure the creation of effective audit. The sessions have been well attended and feedback on its content has been positive.

**Priorities for 2022/23**

- **Clinical audit champion role:** we will be launching our Clinical Audit Champion role during the HQIP Clinical Audit Awareness Week in June. This role is to recognise those clinicians with a passion for audit who have undertaken the clinical audit training and completed their own effective local audit in their service. A pin and a certificate will be issued.
- **Prisons audit programme in line with the trust programme:** the prisons directorate have developed their own clinical audit programme for 2022/23 based on the trust clinical audit programme. Work will be required to ensure that the corporate audit co-ordinators link up with the appropriate prison leads to make sure the audits are undertaken and reported.
- **Documentation audit:** roll out of the documentation audit across all services.
- **Triangulation of data:** ensuring relevant data works together i.e., dashboards, audit, NICE, Qi projects, patient experience data and patient safety data.

### 2.2.3 Participation in clinical research

The number of patients receiving relevant health services, provided or sub-contracted by Oxleas in 2021/22, that were recruited during that period to participate in national research studies approved by a research ethics committee, was 96. This represents a 358% increase on the previous financial year. We also hosted four locally initiated formal research studies across our services.

Oxleas is committed to the ongoing development of its research function. It allows service users and carers to access novel treatments that are not available as part of routine NHS care as well as an opportunity for clinical staff to be trained in providing them. To this end, we have recruited a dedicated Clinical Research Nurse and regularly review the National Institute for Health Research (NIHR) Portfolio for suitable studies for us to host.

### 2.2.4 Quality Improvement and Innovation Goals agreed with commissioners (CQUIN)

There have been no CQUIN's for the financial year 2021/22. This has been since the notification from NHSE in July 2020 in response to the global Covid-19 pandemic. The trust continues to focus on the agreed trust quality priority deliverables across patient safety, patient experience and clinical effectiveness.

Further details of the agreed goals for 2021/22 and for the following 12 month period are available electronically from our Quality Assurance and Improvement Team. (oxl-tr.quality@nhs. net)

### 2.2.5 Registration with the Care Quality Commission (CQC)

Oxleas is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered with no conditions applied'.

During 2021/22, the CQC conducted one inspection of Oxleas services. The CQC returned to the Older Adults Mental Health inpatient services in April 2021, after issuing requirement notices, Regulation12 HSCA (RA), Regulations 2014 Safe care and treatment, Regulation17 HSCA (RA) and Regulations 2014 Good governance and a Warning Notice (29a), in October 2020. This re-inspection saw the Older Adults Mental Health inpatient services re-rated as 'Good'. A great achievement welcome by the service and organisation. Oxleas' overall rating was not altered in April 2021 on receipt of the core service inspection. The core service however did receive amended ratings. The current CQC dashboards of ratings for the trust are provided in table 2.2.5a below.

**Table 2.2.5a: Oxleas NHS Foundation Trust CQC ratings, June 2021**

Overall rating: Inadequate | Requires improvement | **Good** | Outstanding

| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Community health inpatient services | Requires improvement | Good | Good | Good | Good | Good |
| Wards for older people with mental health problems | Good | Good | Good | Good | Good | Good |
| Community-based mental health services for adults of working age | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Mental health crisis services and health-based places of safety | Good | Good | Good | Good | Good | Good |
| Wards for people with a learning disability or autism | Good | Good | Good | Good | Good | Good |
| Acute wards for adults of working age and psychiatric intensive care units | Requires improvement | Good | Outstanding ☆ | Good | Good | Good |
| Community-based mental health services for older people | Requires improvement | Outstanding ☆ | Good | Good | Good | Good |
| Forensic inpatient or secure wards | Good | Good | Good | Outstanding ☆ | Good | Good |
| Community health services for children, young people and families | Good | Good | Good | Good | Good | Good |
| Specialist community mental health services for children and young people | Good | Good | Good | Good | Good | Good |

| | Safe | Effective | Caring | Responsive | Well led | Overall |
|---|---|---|---|---|---|---|
| Community mental health services with learning disabilities or autism | Good | Good | Outstanding ☆ | Good | Good | Good |
| Long stay or rehabilitation mental health wards for working age adults | Good | Good | Good | Good | Good | Good |
| Community end of life care | Good | Good | Good | Good | Good | Good |
| Community health services for adults | Good | Good | Good | Good | Good | Good |

### 2.2.6 Her Majesty's Inspectorate of Prisons (HMIP) and CQC Inspections

Oxleas provide services to prisons across Greenwich, Kent, and HMP Wandsworth. Prison services are inspected through a joint model with HMIP and although not rated by the CQC, are inspected using the same regulatory framework. A number of HMIP/CQC inspections have been conducted over the last 12 months. These are detailed in table 2.2.6a below.

**Table 2.2.6a: HMIP/CQC inspections 2021/22**

| Establishment | Inspection Date | Outcome |
|---|---|---|
| **HMP Wandsworth** | September 2021 | Some recommendations for Oxleas primary care services - medicine management. |
| **HMP Belmarsh** | August 2021 | No recommendations |
| **HMP Thameside** | November 2021 | Requirement notice for Oxleas (medicines management and complaints management) |
| **HMP Rochester** | October 2021 | Requirement notice for Oxleas (dental environment, incident reporting and governance) |
| **HMP Swaleside** | October 2021 | Recommendations for waiting times for Oxleas mental health services |
| **HMP Elmley** | March 2022 | Recommendations for waiting times for Oxleas mental health services |

### 2.2.7 Data Quality

Oxleas submitted records during 2021/22 to the secondary uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

- 99.55% for admitted patient care
- 99.98% 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 which included the patient's valid General Practice Code was:

- 99.72% for admitted patient care
- 99.99% 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)

### 2.2.8 NHS Digital Data Security and Protection Toolkit

Each year, we review our performance against the NHS Digital Data Security and Protection Toolkit. The submission for data relating to 2021/22 is due at the end of June 22. In last years submission, we met all 110 mandatory standards and we are on course to achieve the same this year.

A recent external audit on Oxleas' DSP toolkit by KPMG has been completed and whilst the final report is pending, the preliminary draft report states that there is 'significant assurance with minor improvement opportunities'.

### 2.2.9 Clinical Coding

Oxleas was not able to undertake its annual Data Security and Protection audit during 2020/21 due to the global COVID-19 pandemic restrictions. As restrictions eased, an audit was able to be conducted this financial year covering inpatient admissions from 1st April – 30th June 2021.

The audit evidenced that the trust has met the requirements for achieving attainment of mandatory and advisory levels for clinical coding analysis within information quality assurance. The overall quality of coded data was good, and coders demonstrated great knowledge of clinical coding standards and guidance.

### 2.2.10 Improving Data Quality

In 2021 Oxleas signed off a new Data Governance Framework which aims to make sure data is fit for purpose. The framework outlines our approach to make the best use of people, the processes we use and technology to benefit our patients.

As part of this framework, each service directorate now has a Data Owner in place. This is a senior staff member, usually a Service Director or their direct report, who is responsible for setting priorities for the development of data within their area. A Data Owner maintains an up to date view of the state of the data in their area along with priorities for improvement - drawing on support from informatics where required. This plan may include data quality improvement, replacement of data collection systems, creation of new reports and training of staff. Data owners will agree and commission any support they need from the directorate and from informatics to increase the value of data and reduce its cost.

The Information Governance Group, which is a long-standing part of the formal governance arrangements of the trust, has extended its remit to cover Data Governance each time it meets.

The trust has also put in place a Workforce Data Governance Group. This group is focused on improving data related to our staff and organisational structures.

In addition, Oxleas will be continuing to undertake the following actions to improve data quality:

- Ensure all our clinicians are trained to record effectively on RiO (our main patient electronic clinical system)
- Use our clinician task list on Ifox (Information for Oxleas)* to check completeness of recording clinical information
- Develop our iFOx dashboards that we make available to staff to help validate our performance data

*iFOx – This is the Oxleas Business Intelligence System.

## 2.3 Learning from deaths

NHS trusts have a requirement to publish learning from deaths data. The 2021/22 position for Oxleas is provided below.

### 2.3.1 Number of patients deaths in 2021/22

During 2021/22, the trust recorded 1156 patient deaths. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 292 in quarter 1
- 290 in quarter 2
- 282 in quarter 3
- 292 in quarter 4

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

By 26 April 2022, 1119 case record reviews and 37 investigations had been carried out in relation to 1156 of the deaths included in item 2.3.1 above. In 37 cases, a death was subjected to both a case record review and an investigation

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 292 in the first quarter
- 290 in the second quarter
- 282 in the third quarter
- 292 in the fourth quarter

### 2.3.3 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

This section considered the number of patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient. (Those scoring 5 and above using the Structured Judgment Review/Royal College of Physicians method).

In relation to each quarter, this consisted of:

- One for quarter 1
- Zero for quarter 2
- Three for quarter 3
- Quarter 4 information not available until June 2022

### 2.3.4 Summary of how Oxleas has learnt from case record reviews and investigations undertaken in 2021/22, actions taken and assessment of impact

We have provided below some examples of learning from some of the case reviews and investigations undertaken. Also detailed are the actions taken and the assessment of the impact of these actions.

**Learning point 1:** A comprehensive assessment of patient’s family circumstances must be completed in line with the ‘Think Family’ approach.

**Action taken**
The Safeguarding Children's team have been carrying out team-based awareness sessions. The team-based awareness sessions contain information on safeguarding, the principles of the Think Family approach, record keeping and information sharing. At the same time, promoting the new 7-minute briefing on Think Family Safeguarding and demonstrating to staff how to document 'children in adult network' details on RIO. (The form is used to document details of children of service users in a consistent way).

**Assessment of impact of actions**
To date, 23 teams across the two directorates have been trained. This demonstrates a consistent increase in completion of the children in adult network form on RIO, therefore evidencing the use of the Think Family approach to assessment and risk assessment through the patients journey through AMH services. Engagement with AMH has been excellent and we are pleased with the progress made to date.

- **Acute and Inpatient**
  09/11/2021 % Children in Adult Network Form Completed - 24.1%
  09/02/2022 % Children in Adult Network Form Completed - 29.9%
  26/04/2022 % Children in Adult Network Form Completed - 36.6%
- **Adult Mental Health Community**
  09/11/2021 % Children in Adult Network Form Completed - 17.6%
  09/02/2022 % Children in Adult Network Form Completed - 22%
  26/04/2022 % Children in Adult Network Form Completed - 25.9%

**Learning point 2:** Waits for initial screening, and Outpatient Appointments within the ADAPT pathway

**Action taken**
Review of service users on current ADAPT wait list with a view to signposting appropriate cases to MIND and One Bexley. Further, recruitment of an assistant psychologist to increase availability of the psychological therapies group programme. ADAPT workforce plan to include actions to recruit to current vacancies to deliver interventions required. Interventions available in ADAPT are to be reviewed and agreed and added to the operational policy. Waiting list protocol is to be implemented and detailed in the operational policy. There is currently a piece of work underway within the Oxleas strategy in relation to 'zero delays'.

**Assessment of impact of actions**
Impact of actions to be reviewed.

### 2.3.5 The number of case record reviews or investigations not included in section 2.3.4
There were no case record reviews and no investigations completed after 31 March 2022 which related to deaths which took place before the start of the reporting period.

### 2.3.6 Estimate number of deaths for which a case review or investigation has been carried out in section 2.3.5 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

None 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. Since October 2017, our investigation panels have used the Royal College of Physician's structured judgement review to form a view of avoidability, where it has been appropriate to use this tool. None of the deaths reviewed have been considered avoidable.

### 2.3.7 Revised estimate of the number of deaths in 2021/22 taking account of deaths referred to in section 2.3.6 above

One of the patient deaths during 2021/22 is judged to be more likely than not to have been due to problems in the care provided to the patient.

## 2.4 Performance against National Core Indicators

As an NHS foundation trust, we are required 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 Social Care and are the national provider of information and data)

There are six 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 2.4a: performance against national core indicators**

| | National Quality Indicator | Oxleas 17/18 | Oxleas 18/19 | Oxleas 19/20 | Oxleas 20/21 | Oxleas 21/22 | National average | Highest trust | Lowest trust |
|---|---|---|---|---|---|---|---|---|---|
| 1 | The % of patients on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during reporting period | 99.0% | 97.0% | 96.6% | 97.2% | 96.09% | Data not available in this format | | |
| 2 | The % of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period | 99.5% | 98.2% | 97.6% | 99% | 97.9% | Data not available in this format | | |
| 3 | The % of patients aged: 0-14 | - | - | n/a | n/a | n/a | Data not available in this format | | |
| | 15 or over<br>Readmitted to a hospital within 28 days of being discharged from a hospital which forms part of the trust during the reporting period | - | - | 5.97% | 5.14% | 3.56% | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **4** | The % 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 | | 66.4% | 66.3% | 68.3% | 70.7% | 65.7% | 64.9% | 82.4% | 45% |
| **5** | 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 | | 7.6 | 7.0 | 6.8 | 7.2 | 6.9 | Data not available in this format | | |
| **6** | The number and where available, the rate of patient 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 | No: | 24 | 27 | 30 | 42 | 59 | Not available on NHS Digital website | | |
| | | % | 0.35 | 1.5 | 1.2 | 1.2 | 0.67 | | | |

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

**Data sources (where applicable):**

No:4 - NHS staff survey results 2021
NHS Staff Survey 2020 Benchmark Reports (nhsstaffsurveyresults.com)

No:5 - Care Quality Commission: Patient experience of community mental health services. Published 2021 All Files - NHS Surveys

No:6 - NHS Improvement, National Reporting and Learning System, Organisation Patient Safety Incident workbook. Published September 2021
NHS England » Organisation patient safety incident report up to March 2021

For indicators 1, 2 and 3 relevant to the services we provide shown in table 2.4a above:
Oxleas considers that this data is as described for the following reasons:

- These are NHS Improvement (NHSI) targets that reported on a monthly basis
- 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 NHSI

For indicators 4 and 5 relevant to the services we provide shown in table 2.4a 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 NHS England.

For indicator 6 relevant to the services we provide shown in table 2.4a 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 will continually strive to improve a reduction in patient harm 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 monthly.

# PART THREE: Overview of Quality of Care

## 3.0 Other Quality Performance Information

In section 2 we provided statements of assurance on our national priorities and looked forward to 2021/22, highlighting our quality goals that were developed taking into account the views of our stakeholders and agreed by our Performance and Quality Assurance Committee. Progress on these will be monitored via our Performance and Quality Assurance Committee, the Quality Improvement and Innovation Committee and the trust quality groups of Patient Experience, Patient Safety and Clinical Effectiveness. Not all areas of trust focus are included in our quality improvement goals as some are aligned to our service development strategy and internal quality improvement initiatives within the trust.

In Oxleas the quality improvement team utilises the IHI Model for Improvement to support staff through a systematic, bottom-up approach to improving services. Trust priorities for the Qi team are reviewed and agreed by the Quality improvement and innovation Committee (QiiC) - to build a culture of continuous quality improvement in every directorate across the organisation, and to be a centre for clinical excellence providing best practice and best outcomes for our patients and service users. In this section of the Quality Account, we present information relevant to the quality of the services provided in 2021/22.

## 3.1 Progress against 2021/22 priorities

This progress report follows our Quality Management Framework (QMF) structure which has four components:

- **Quality planning:** understanding the priorities for improvement and design appropriate interventions
- **Quality control**: maintaining quality and know when it slips away
- **Quality assurance:** independently check the quality
- **Quality improvement:** deliver the improvement

In addition to these four quality components, there are three key enablers:

- **Clear vision and purpose:** aligning our work with the organisation's priorities and having a shared purpose
- **Enabling leadership:** beliefs, attitudes, skills, and behaviours that enable improvement
- **Co-design and co-productions:** a culture of listening and action

### Table 3.1a: key to support understanding of the compliance of quality priorities

| Assurance Symbol | Description | Variation Symbol | Description |
|---|---|---|---|
| P | Has consistently passed target | | Use when performance varies from month to month with no discernible pattern but still performing well |
| F<br>? | Has consistently failed to meet target<br>Performance is up and down, hitting target one month failing the next | H<br>L | Performance is deteriorating over time, in this case a low number is good performance<br>Performance is deteriorating over time, in this case a high number is good performance |
| | | L | Performance is improving over time, in this case a low number is good performance |
| | | H | Performance is improving over time, in this case a high number is good performance |

### 3.1.1 – Trust Patient Experience quality priorities

**Table 3.1.1a: trust patient experience quality priorities**

| Quality Objective | Quality Indicator | Outcome at Q4 | Assurance | Variation |
|---|---|---|---|---|
| **Improving patient experience – ensuring we meet our patient promise** | **1.1** To ensure 90% of patients who use our mental health service rate our services overall as 'good' or 'very good' | Not achieved for Q1 -Q4.<br><br>No variation suggesting any improvement from average of 20/21 or Q2 results. Q3 range achieved: 68%-76% | F | L |
| | **1.2** To ensure 95% of patients who use our physical health services rate our services overall as 'good' or 'very good' | Not achieved for Q1-Q4.<br><br>However, Q2 and Q3 results suggest improvement from 20/21 average. Q3 range achieved: 87% - 89% | F | H |
| **Ensure we involve families, carers and people important to our patients** | **1.3** To ensure 80% of patients have their support network identified and noted within their care record (mental health and forensic) | Target achieved | P | |
| | **1.4** To ensure 50% of patients have their support network identified and noted within their care record (Community health services) | Target achieved and improving performance | P | H |

**Quality Planning – reasons for continuing with these quality priorities**

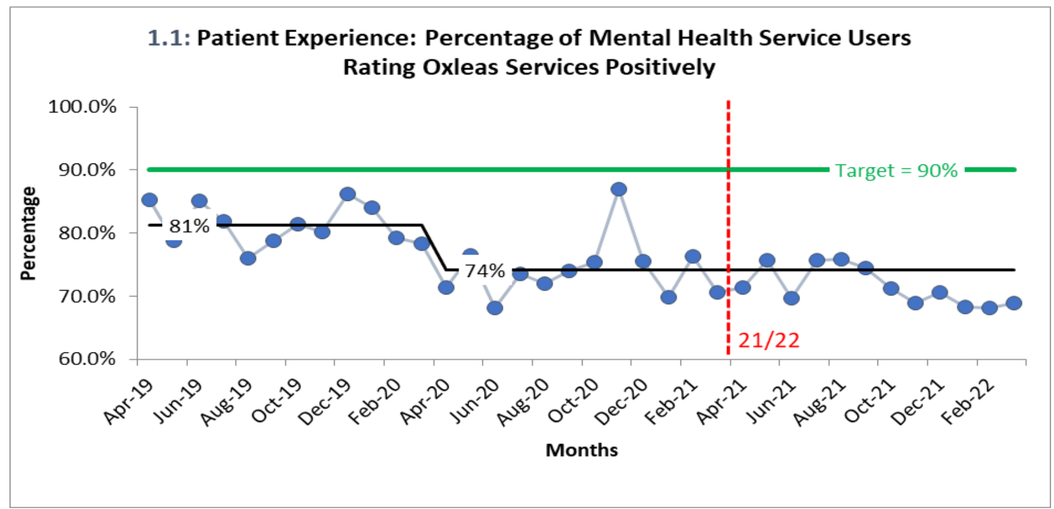
1.1: Patient experience feedback from mental health services dropped sharply following the first COVID lockdown starting in March 2020, and again during the six months starting October 2021. Our scores are below the national average for comparable services.

1.2: As with mental health services, our physical health services experienced a decline in patient experience feedback received following the first COVID lockdown. These services have however seen an increase again although feedback is still lower than it was historically. Further, our scores are lower the national average for comparable services.

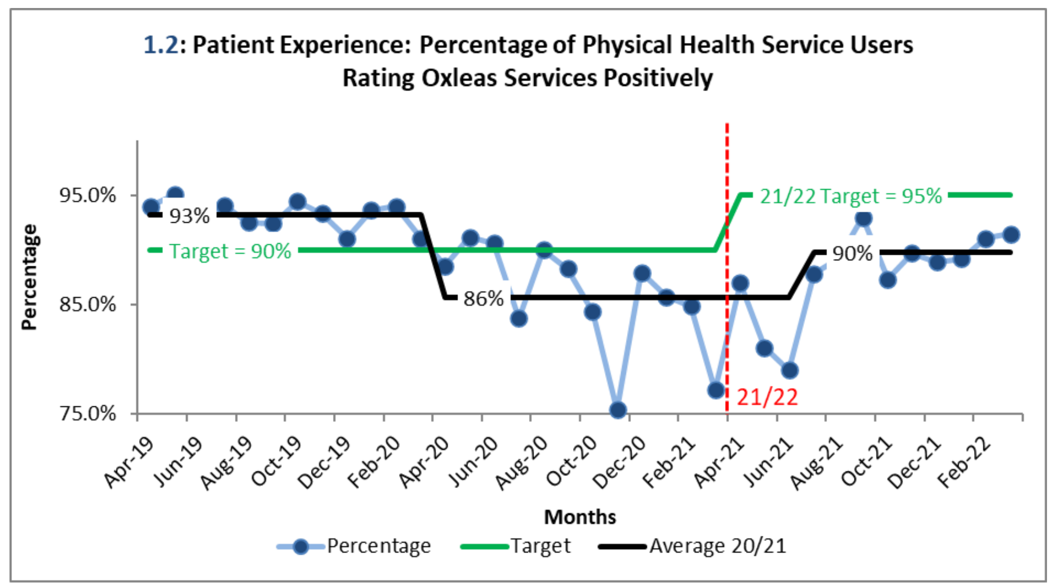
1.3 & 1.4: During 2021/22 the targets set for Service user Network Engagement Tool (SNET) completion was, on average, achieved. Research suggests that involving the support network in patient care improves outcomes and it is important to us that we actively seek to engage the support network in the care we provide. It is important to note that potentially support network involvement has reduced during the pandemic due to national guidelines on isolation and disallowing visitors. This will be monitored through the Patient experience group.

**Quality Control – real time monitoring of how we are doing is achieved through service user feedback**

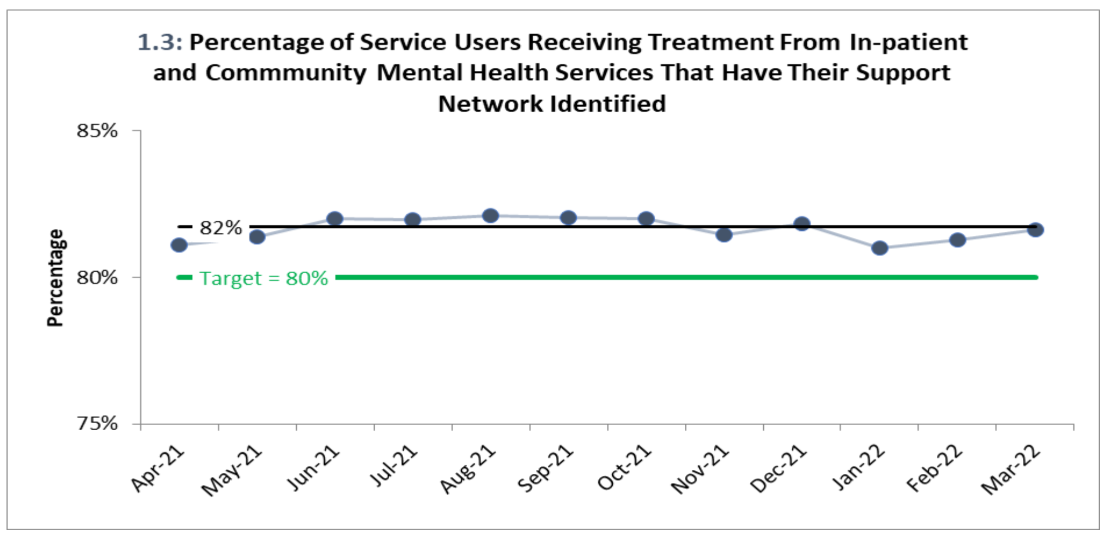
1.1: The overall rating of positive feedback is calculated as follows: total number of mental health patient experience surveys completed that responded, 'very good' or 'good' to the question *"Overall, how was your experience of the service?"*, divided by the total number of mental health patient experience responses. The target of 90% has not been attained across Q1-Q4 and data suggests positive feedback continues to decline. The phrasing and response options for this question were amended in June 2020 which may be attributable to a decline in feedback and we are moving towards using more text message reminders which are also associated with lower average scores.



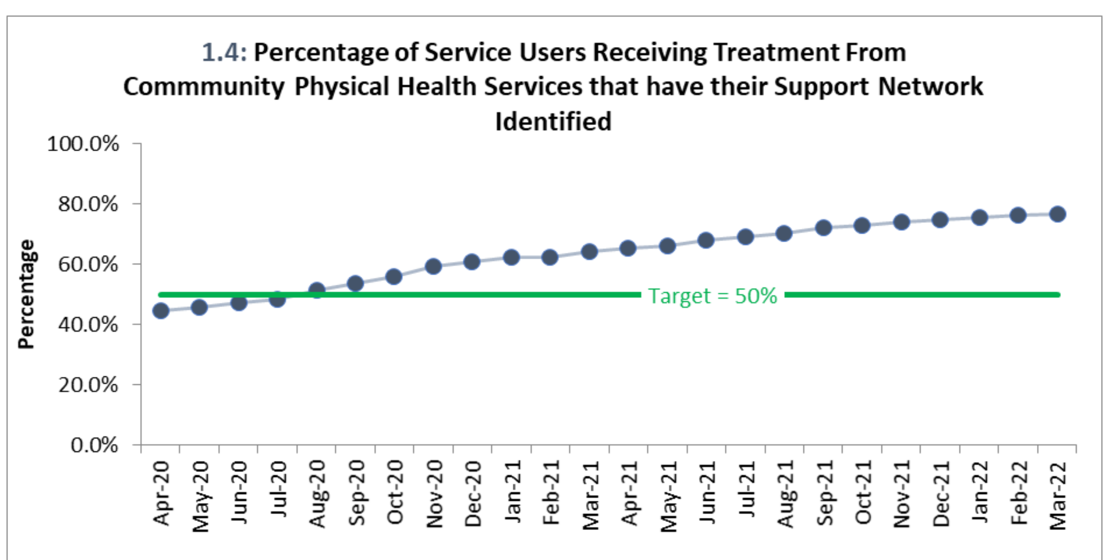

1.2: The total number of community physical health service users who rate their experience as positive is calculated in the same way as is detailed in 1.1 above. The chart below details that the target of 95% has not been attained however there is evidence of a significant, sustained improvement in performance for Q2-Q4 2022 with an average of 90% compared to the average of 86% observed in 2020/21.



1.3: The chart below details the percentage of service users from inpatient and community mental health services that have a completed SNET. To arrive at this figure, the total number of service users with completed tools is divided by the total number of eligible service users. Data for this metric is stable and has exceeded the target of 80%.




1.4: The chart below details the number of service users accessing community physical health services, with a completed SNET. The data is determined using the same method as is detailed in point 1.3 above. The data demonstrates that service users with completed SNETs has been on a steady upward trajectory and has exceeded the target of 50%.




## Quality Assurance - Independently check the quality

- Service user feedback is collected via multiple platforms following the challenging circumstances around COVID-19 restrictions.
- Response data is sent to directorates monthly. Patient Experience leads from each directorate seek assurance and develop improvements plans which are shared at trust PEG.

- Continued work with services, clinical staff and service users to optimise outcomes for the upcoming year.
- Compliance against all four patient experience priorities will continue to be monitored through our patient experience group.

**Quality Improvement – deliver the improvement**

- We continue to strive for all service users and their support networks to be offered the opportunity to be included, involved, and engaged in their care and treatment. We aim for every member of staff to actively identify and involve the support network to ensure better outcomes for our service users.
- All teams should review their patient experience feedback on a regular basis and seek ways to improve, thereby ensuring continuous improvement of services in response to feedback.
- The corporate patient experience team are currently working on a collaborative project with academic institutions to analyse the free text response data that is obtained from patient experience surveys. It is expected that this data will allow clinical teams to understand potential improvement areas that are important to our patients. This will support improvement efforts and help achieve excellent patient experience in Oxleas.

## 3.1.2 – Trust Patient Safety quality priorities

### Table 3.1.2a – trust patient safety quality priorities

| Quality Objective | Quality Indicator | Outcome at Q4 | Assurance | Variation |
|---|---|---|---|---|
| ***Reducing restrictive practice** | **2.1** 10% reduction in the use of restraint (baseline 2020/21 figures) | Not achieved for Q1-Q4.<br><br>No variation is present that suggests improvement. | F | |
| | **2.2** Achieve a reduction in Prone restraint | The current percentage of prone restraints, as a percentage of overall restraints, are at their lowest levels recorded in Oxleas.<br><br>No criteria have however been met in order to identify a statistically significant reduction in prone restraint, however the data indicate that this is moving in the right direction. | P | |
| | **2.3** Reduced time spent in prone restraint | New system and data collection phase. This data will be collected and analysed going forward. | N/A | N/A |
| | **2.4** Enable a reduction in disproportionate restraint of BAME service users | New system and data collection phase. This metric is currently being investigated and formalised | N/A | N/A |
| **Prevention, early identification and management of physical deterioration and sepsis** | **2.5** Ensure 95% physical health monitoring is recorded as per the policy, in the care records following rapid tranquilisation | The target has not been achieved consistently for Q1-4.<br><br>No variation is present that suggests improvement. | F | |
| | **2.6** 100% of community and MH inpatients with twice daily physical health monitoring for the first 3 days of admission using NEWS tool | The target has not been achieved consistently for Q1-Q4.<br><br>This year's performance is however significantly higher than the previous years. | F | H |

**Quality Planning - reasons for continuing with these quality priorities**

2.1: Overall, the use of restraint in 2021/22 was consistent with the amount of restraint recorded in the previous financial year. Use of restraint continues to be monitored through the Patient Safety Group.

2.2: To achieve a reduction in prone restraint. This is because this form of restraint poses an increased risk of injuries and asphyxiation, when compared to other forms. Data illustrates that a significant reduction in prone restraints has been observed.

2.3: When prone restraints are utilised it should be for a minimal amount of time to reduce risk of harm. The monitoring of all prone restraints and the duration allows for data analysis and further understanding of the risk.

2.4: the metric to measure disproportionate restraint of BAME service users is currently being investigated and formalised.

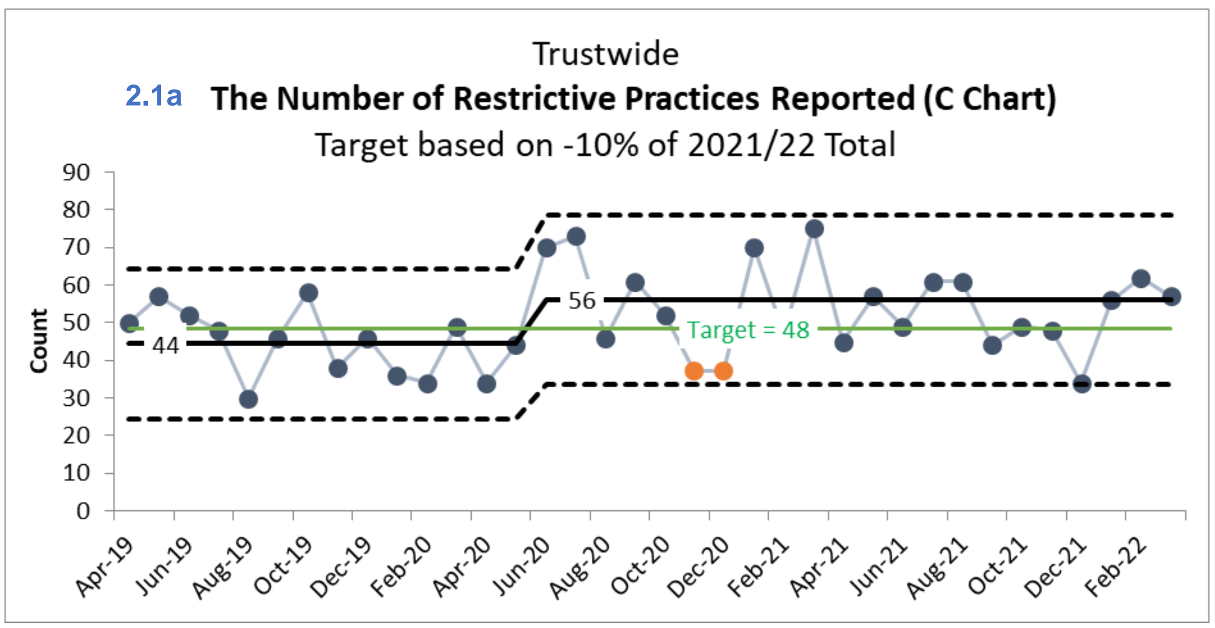
2.5: rapid tranquilisation poses an increased risk to service users as vital signs, such as blood pressure, can drop significantly. As a result of this, Oxleas policy dictates that all service users should have their physical observations monitored and recorded for the first hour following rapid tranquilisation. Tracking this metric displays the trust compliance against this policy.

Work has continued over the last year to improve the quality of the NEWS2 reporting post rapid tranquilisation. Patient Safety drop-in sessions were organised on the wards and virtual sessions organised so staff could ask questions and work through examples. A weekly audit is completed and sent to the Heads of Nursing and Practice Development Nurses who disseminate the information and then receive updates from the wards.

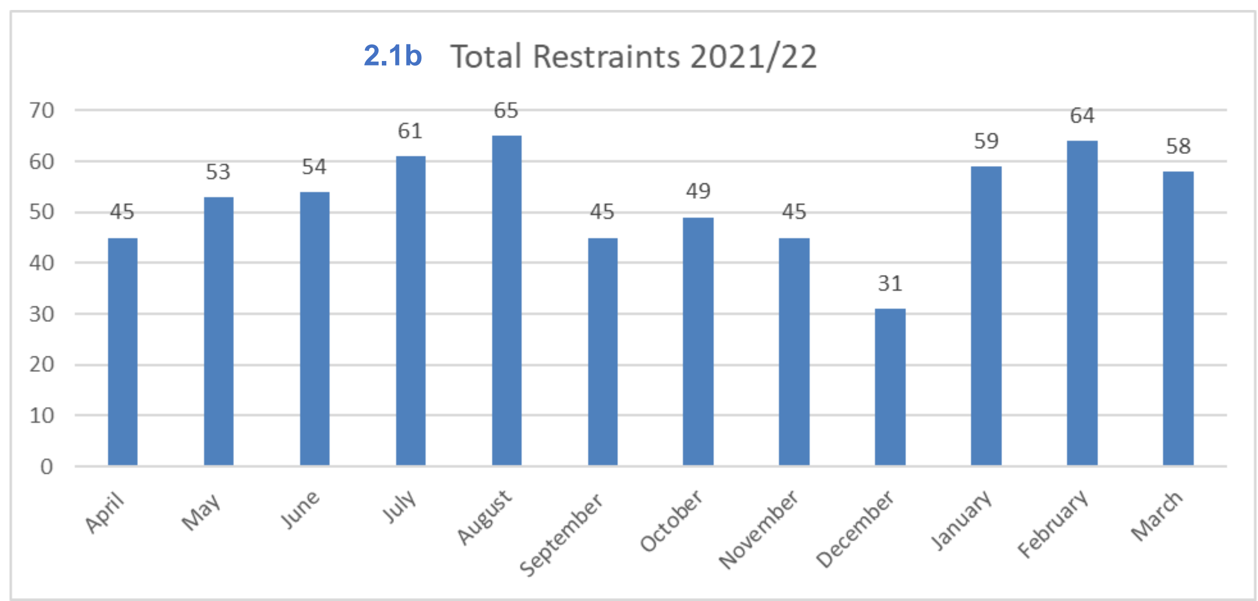
2.6: Use of the National Early Warning Score (NEWS) improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. Ward visits have been completed to help the staff to understand the purpose of completing a NEWS2 form and how to complete the form. Virtual Patient Safety drop-in sessions were also organised.

**Quality Control - real time monitoring of how we are doing**

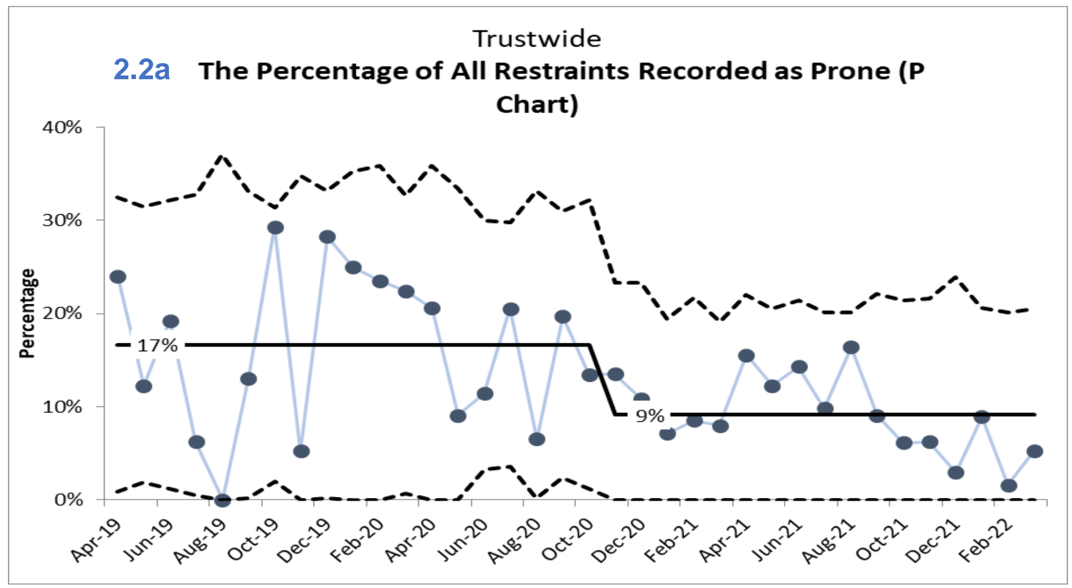
2.1a: This statistical process control (SPC) chart details the number of reported incidents of restraint, via Datix. Work with the patient safety lead has led to a change in the way that this data is collected. The data suggests performance for Q1-Q4 2021/22 has consistently missed the target of 10% reduction and there has been no sustained improvement towards reaching this target.



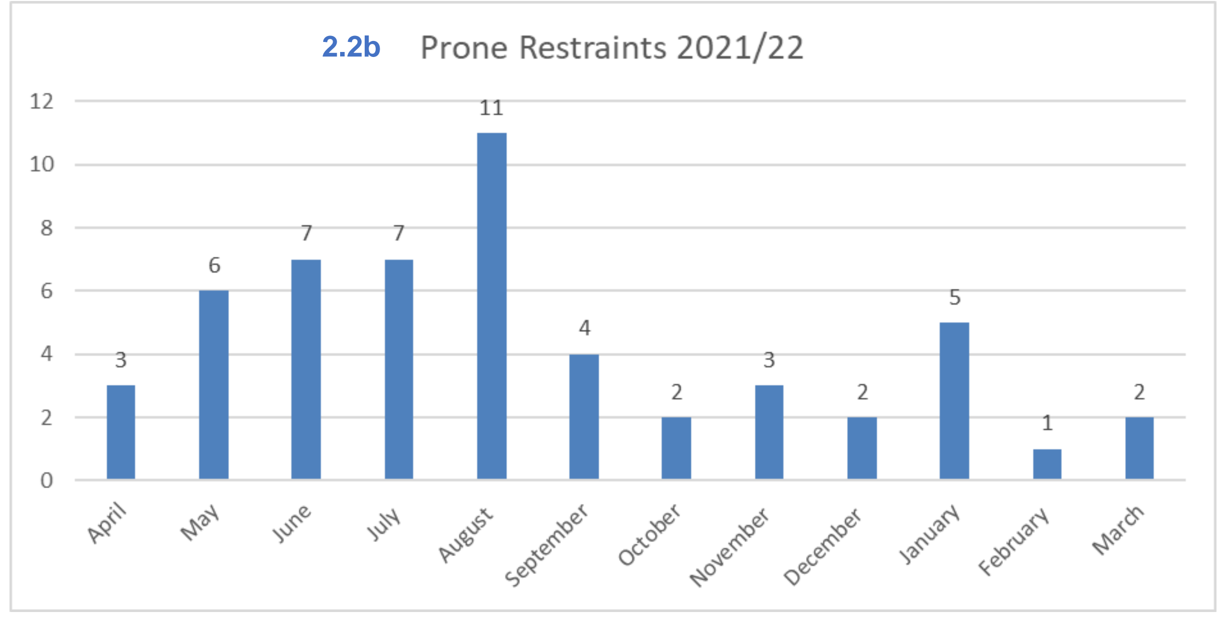

2.1b: This data can also be considered using averages (as is in the Annual Patient Safety Report). When averages, opposed to data plotted over time (chart 2.1a above) are used, the average number of total restraints per month in 2021/22 is 52.4. The baseline was 50 (average of Q1 incidents), therefore we are 4% above the baseline for total restraints. This can be seen in chart 2.1b below.




2.2a: This chart details the percentage of all restraints reported via Datix where a prone technique was used. The current target is a reduction from the average of 15%. The evidence suggests that performance for Q1-Q4 has consistently achieved the target reduction in prone restraint.




2.2b: As like chart 2.1b above, prone restraints can also be viewed using data averages (as in the Annual Patient Safety Report). When averages, as opposed to data plotted over time, are considered, the average number of prone restraints per month is 4.4. The baseline was 5 (average of Q1 incidents) therefore we are 12% below the baseline target of reducing incidents of prone restraint. This can be seen in chart 2.2b below.

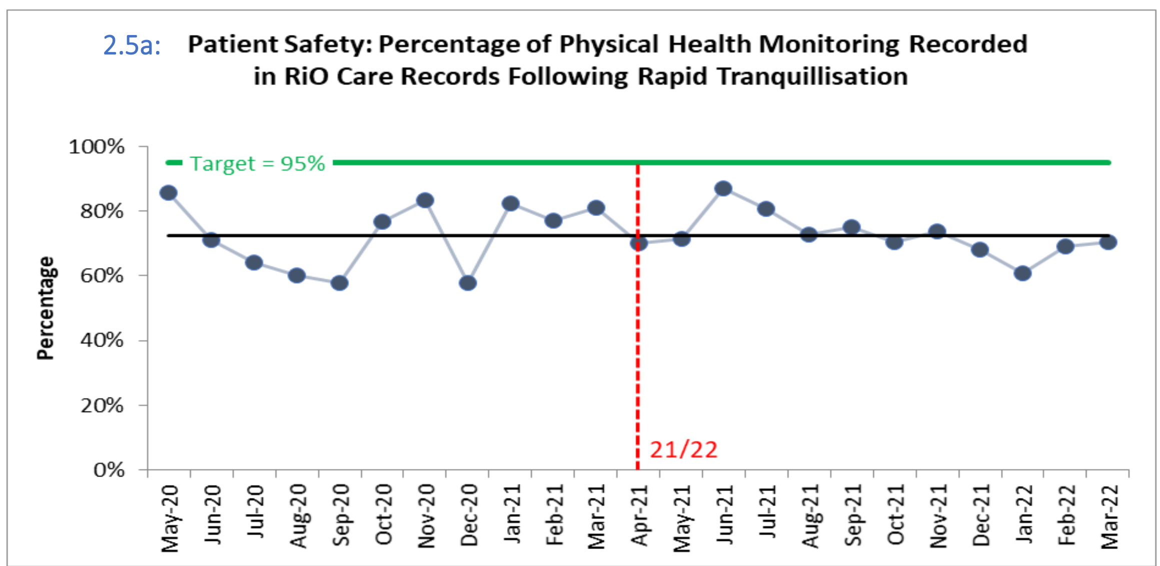



2.3: A new data collection drop-down box has been implemented into Datix to capture the amount of time spent in prone restraint. The Quality Team are working to start analysis of this data, and it will be subsequently detailed on the patient safety quality priority dashboard.

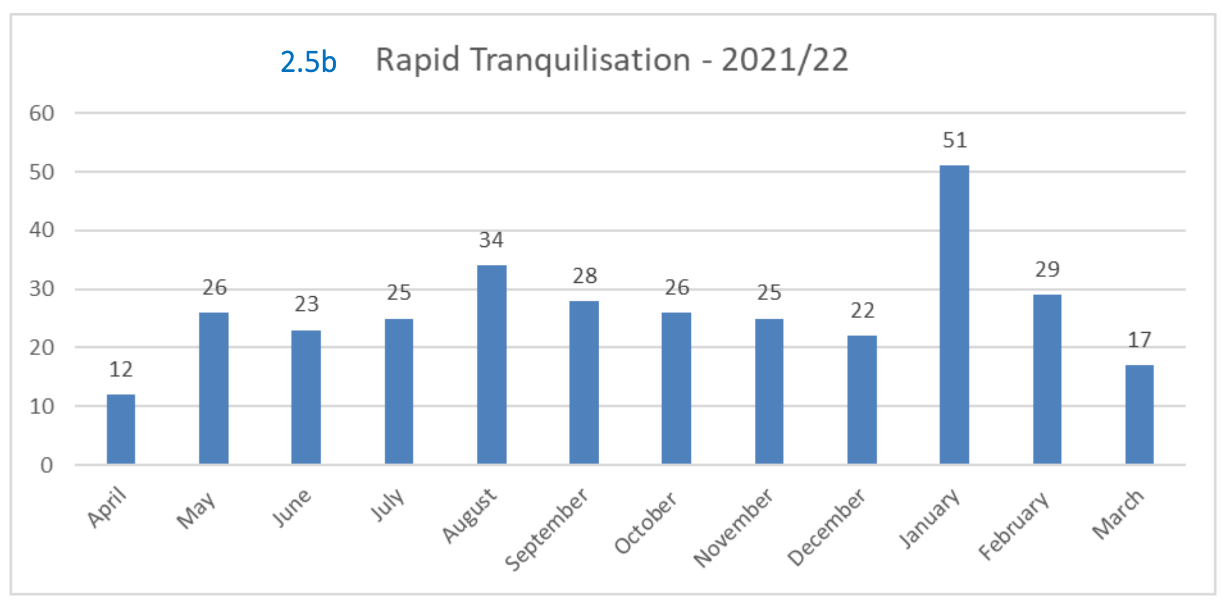
2.4: The metric to allow analysis of ethnicity data relating to all restraints recorded on Datix, and the identification of disproportionate BAME restraints, is currently being formalised. Whilst ethnicity

data is currently captured in both Datix and Rio, it is important to create a specific metric that suggests whether ethnic groups are more frequently restrained by comparison.

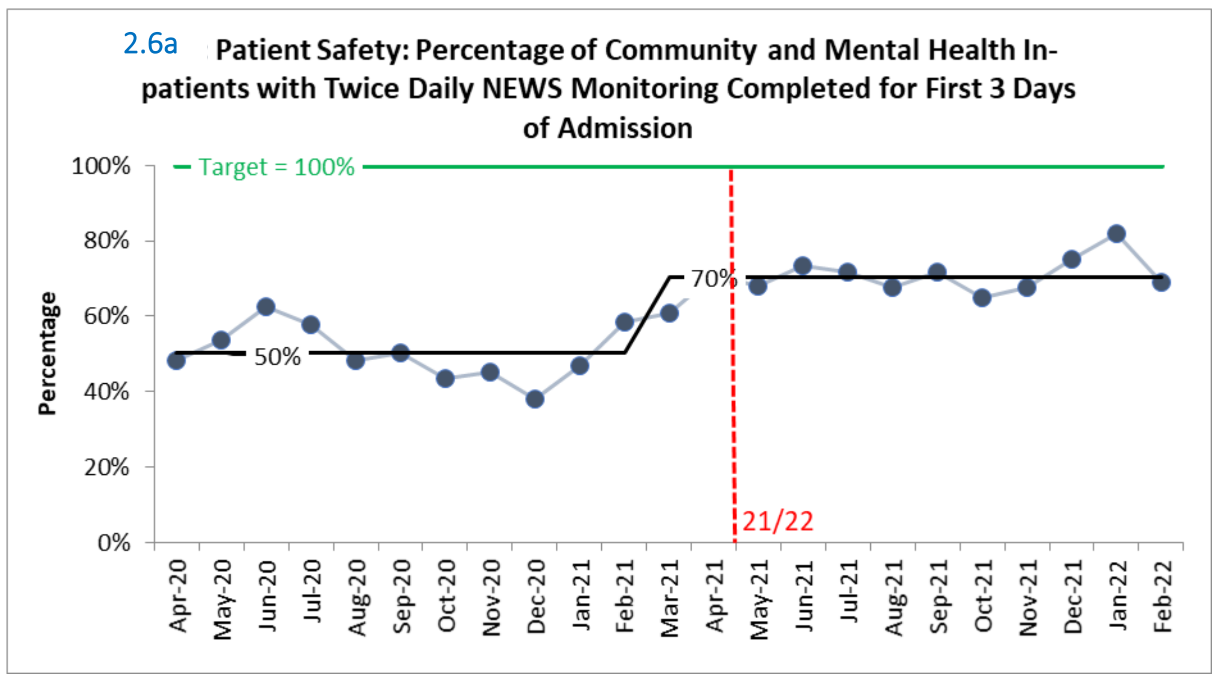
2.5a: This chart details the number of incidents where a patient has been administered rapid tranquilisation and physical health monitoring has been recorded. The target is 95% but evidence suggests performance is just below this level.




2.5b: Physical health reporting following incidents of rapid tranquilisation can also be viewed using data presented as averages, as opposed to data plotted over time (chart 2.5a). This is presented in chart 2.5b below. During 2021/22 there were a total of 318 rapid tranquilisations across Oxleas. Of these 318 incidents, 15 (4.7%) did not have physical health monitoring documented in the care records. When average data is considered, 95.3% of patients had physical health monitoring completed following rapid tranquilisation – suggesting compliance with this priority.



2.6a: This chart details NEWS completions. Whilst the target of 100% has not been reached, the data details that an improvement from 50% (2020/21) to 70% (2021/22) has been attained.




2.6b: The table below details the number of admissions per ward combined with the number of these admissions that had a total of 6 NEWS2 forms completed in the first 72 hours once the service user was on the ward.

**Table 2.6b – ward admissions and NEWS2 form completions within 72 hours**

| Ward | Admissions | 6+ NEWS2 72Hrs | % 6+ NEWS2 72Hrs |
|---|---|---|---|
| Atlas House - Greenwich | 5 | 0 | 0% |
| Avery - Greenwich | 201 | 136 | 68% |
| Betts - Bromley | 188 | 141 | 75% |
| Birchwood - Bracton | 1 | 1 | 100% |
| Burgess - Bracton | 17 | 9 | 53% |
| Crofton - Bracton | 15 | 4 | 27% |
| Eltham Community Beds | 287 | 217 | 76% |
| Goddington - Bromley | 155 | 46 | 30% |
| Greenwood - CB Memorial | 5 | 3 | 60% |
| Hazelwood - CB Memorial | 7 | 1 | 14% |
| Heath - CB Bracton | 5 | 0 | 0% |
| Holbrook - Bexley | 29 | 14 | 48% |
| Joydens - Bracton | 4 | 3 | 75% |
| Lesney - Bexley | 257 | 223 | 87% |
| Meadow View | 374 | 359 | 96% |
| Millbrook - Bexley | 259 | 208 | 80% |
| Oaktree Lodge - Greenwich | 3 | 3 | 100% |
| Scadbury - Bromley | 89 | 55 | 62% |

| Shepherdleas - Greenwich | 69 | 52 | 75% |
|---|---|---|---|
| Shrewsbury - Greenwich | 157 | 86 | 55% |
| The Tarn - Greenwich | 52 | 22 | 42% |
| Maryon - Greenwich | 1 | 0 | 0% |
| Barefoot Lodge | 6 | 4 | 67% |
| Norman - Bromley | 47 | 29 | 62% |
| **Grand Total** | **2233** | **1616** | 72% |

**Quality Assurance - Independently check the quality**

- Reports highlighting data for all quality priority areas is shared with directorates weekly so that they can review, monitor, and improve performance.
- Prone restraints have been added to the trust risk register and Board Assurance Framework. Three wards are participating in a programme to improve relational security capabilities as part of the London ‘safety in mental health settings’ work stream.
- All prone restraints require a desk top review to be completed to ensure learning.
- Heads of Nursing have been asked to review the rapid tranquillisation action plans and agree a governance structure for these to be overseen by the directorate management team going forward. The Patient Safety Lead attends the Ward Managers meetings to help staff work through any problem areas.
- An in-depth audit of the reasons why NEWS forms were not completed will be carried out. This has been highlighted in monthly Patient Safety reports.

**Quality improvement – delivering the improvement**

- Acting on lessons learnt from desk top reviews and the adoption of successful ideas from other units has been found to be successful in improving care. Teams are encouraged to test ideas for improvement and share the findings.
- Lesney, Goddington and Avery wards are currently participating in the South London Mental Health Safety Improvement Programme. This is an improvement initiative to reduce restrictive practices across the south London region. It is hosted by the Health Innovation Network and progress of the project teams will be tracked and supported by the Quality Improvement team.

## 3.1.3 – Trust Clinical Effectiveness quality priorities

### Table 3.1.3a – trust clinical effectiveness quality priorities

| Quality Objective | Quality Indicator | Outcome at Q4 | Assurance | Variation |
|---|---|---|---|---|
| **Effective risk identification, and personalised care planning** | **3.1** 95% of patients (where applicable) have an up-to-date care plan, risk assessment and crisis plan | Data not currently available | N/A | N/A |
| | **3.2** 95% of care plans address increased risks identified in the risk assessment. | Currently at 86% against a target of 95%. There is no variation in the data at present which could indicate further improvement. | F | |
| | **3.3** 95% of care plans showing evidence of service user involvement in their care plan development | Have not yet achieved the target of 95%. There is no variation suggesting any improvement from average performance. Q3 range achieved 88%-90%. | F | |
| | **3.4** To ensure that 95% of Care Programme Approach (CPA) service users have a review of their care plan every six months | Currently at 93% against a target of 95%. Further, Q2-Q3 data (93%) suggests a sustained improvement compared to 20/21 (91%). | F | H |
| **Improving physical health care in mental health** | **3.5** To ensure 90% of physical health screening and interventions are completed for patients admitted to mental health inpatient wards or who have a CPA in the community. | Have not yet met the target of 90% | F | N/A |

### Quality Planning - reasons for continuing with these quality priorities

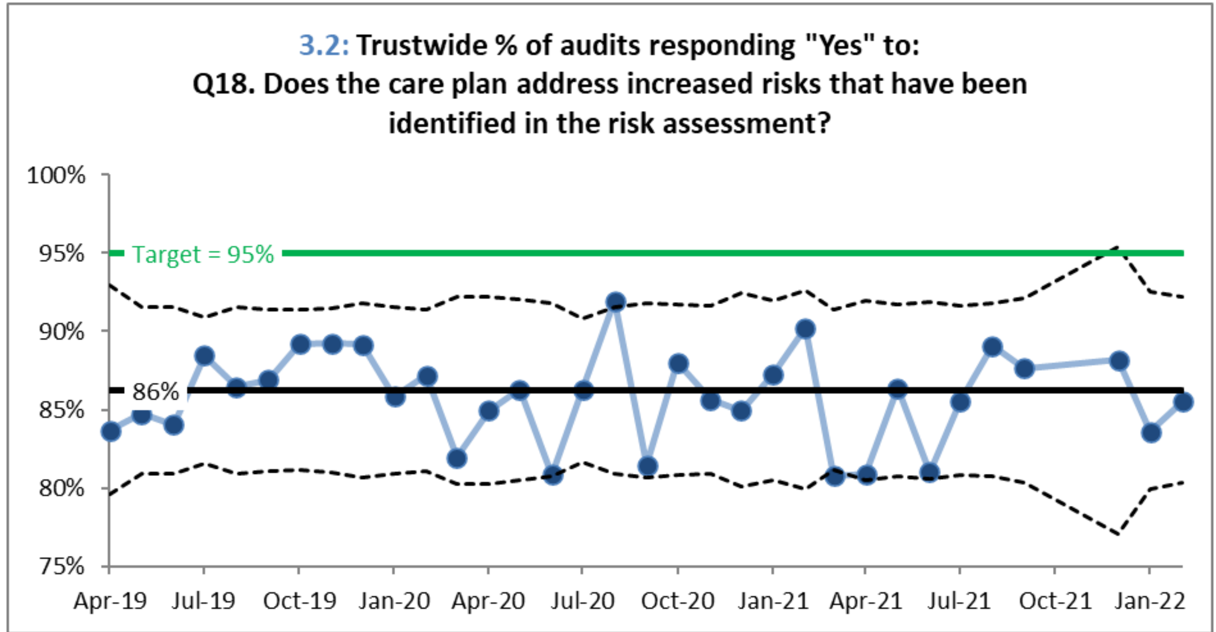
3.1 to 3.4: These have been priorities for several years and were recognised as 'should do' actions from the CQC inspection in March 2019. They were also identified as 'must do' actions from the CMHT focused inspection in 2020 - mainly for ensuring risk assessment outcomes are updated in the care plan. Risk assessment completion and personalisation of care planning continue to be key themes in complaints and serious incidents. This is monitored through the clinical effectiveness group.

3.5: This quality goal for 2021/22 is a continuation and expansion of the 2020/21 physical health screening priority. This now also includes all physical health screening as this was raised as a 'must do' action during a CQC inspection. This goal now covers the screening and intervention of all applicable service users and will be monitored via the physical health steering group.

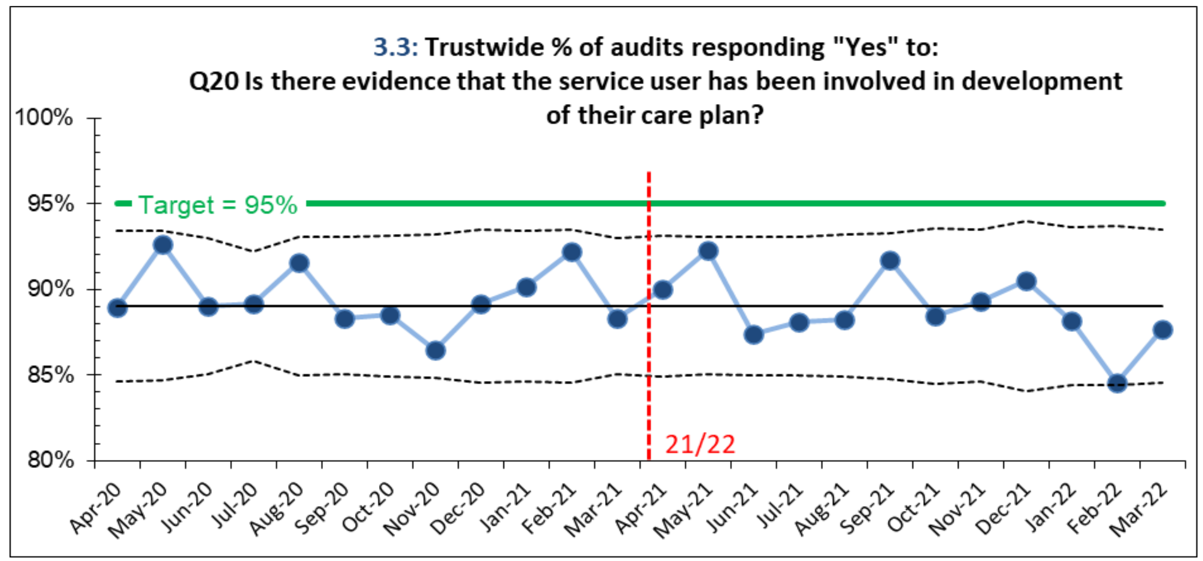
### Quality Control - real time monitoring of how we are doing

3.1: Care plan data will be pulled from Rio records for all patients to identify whether an up-to-date care plan, risk assessment and crisis plan are in place. This metric is currently being formalised and when finalised, will be displayed on the quality priority dashboard.

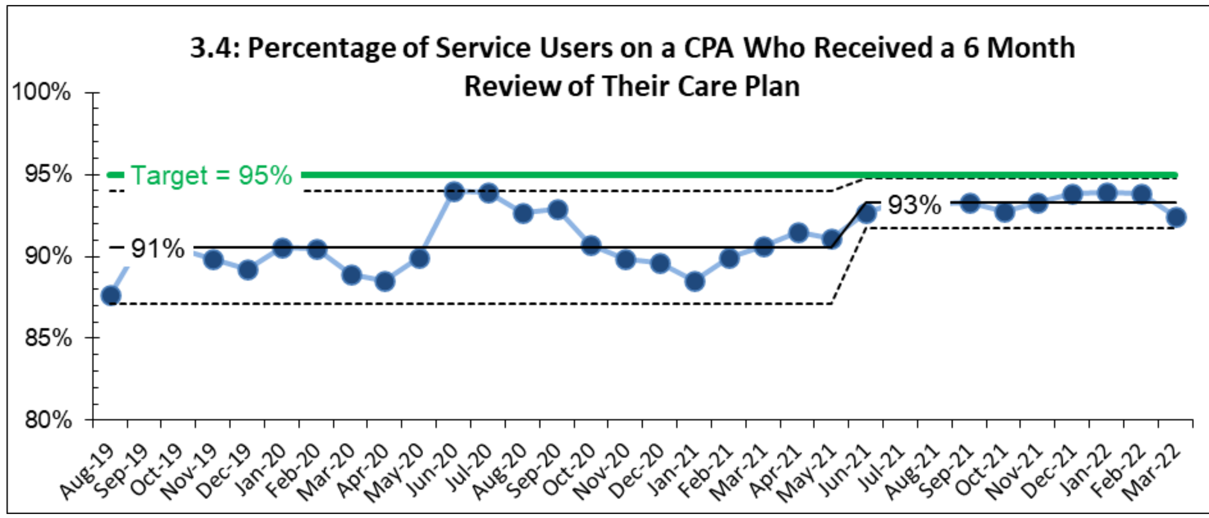
3.2: All eligible teams will audit five clinical records using 'SNAP survey' software, monthly. The chart below details compliance with a care plan addressing increased risk being identified in the risk assessment. This will be used to illustrate some of the quality of the risk assessment and care plans audited. Due to changes in directorate structure and the care plan audit system, data for the months of October and November 2021 were not collected. The data suggests that we are falling short of the target of 95%, with an average score of 86%.



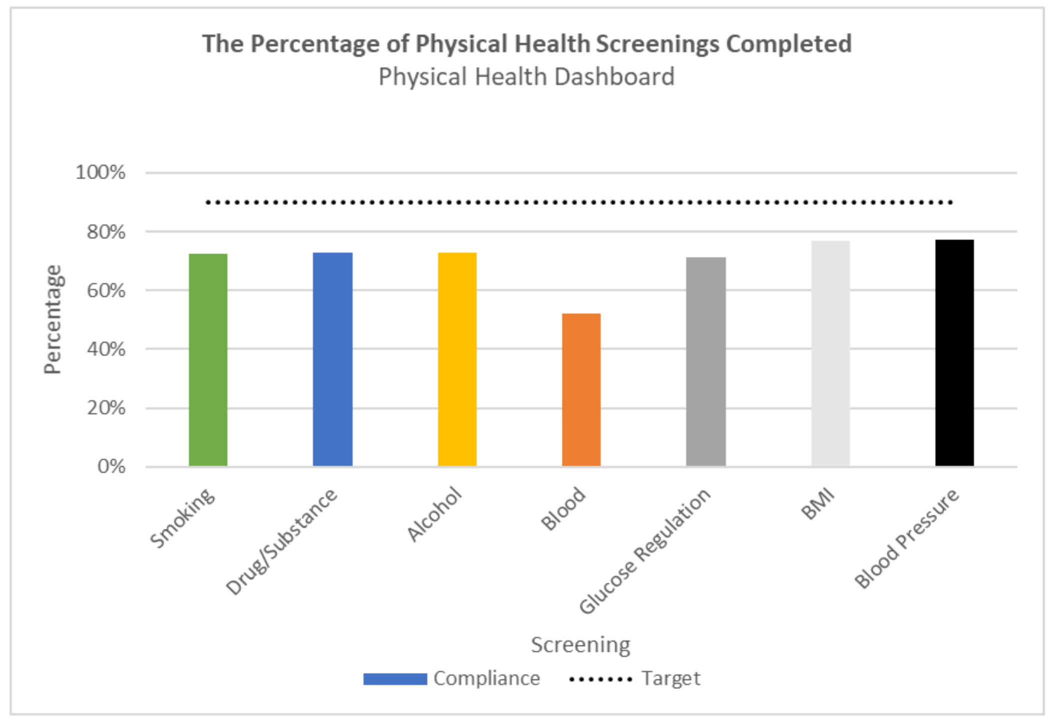

3.3: All eligible teams will audit five clinical records using 'SNAP survey' software, monthly. The chart below details the percentage of cases where there is evidence that a service user has been involved in the development of their care plan. The data shows that achievement of this metric is below the target of 95%.

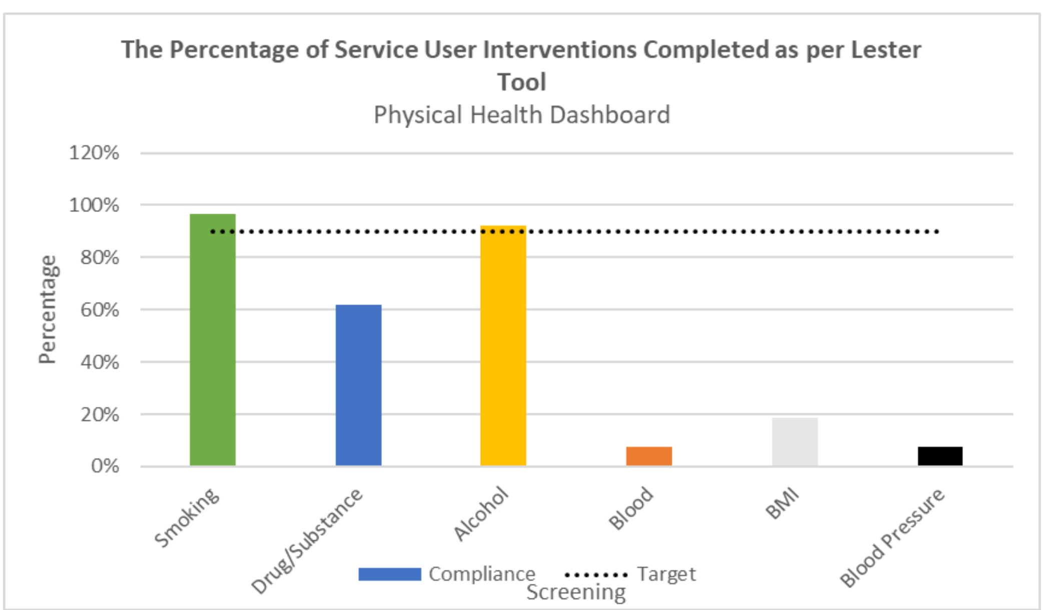


3.4: This chart details the percentage of service users on a CPA who received a 6-month review of their care plan. Whilst the target of 95% has not yet been attained, there is significant evidence of improvement from June 2021, towards meeting this target.




3.5: The two bar charts below detail the percentage of service users that have had all physical health screenings completed, and of those identified as red on the Lester tool, the percentage that have had relevant interventions. Chart 1 shows that across all areas, the target of 90% screenings has not been met. At present the data is obtained from the physical health dashboard on iFox and takes a snapshot in time. The Quality Team are currently working with Informatics to make changes to this dashboard so that data can be visualised over time and improvements can be displayed. ECG monitoring will also be added to this dashboard.






**Quality Assurance - Independently check the quality**

- Monthly directorate and trust level data are routinely circulated to the Clinical Directors and Service Directors, directorate Clinical Effectiveness Group leads and directorate Quality Assurance colleagues. This is to enable discussion and planning at directorate Clinical Effectiveness Groups to drive improvements where required.
- The directorate Clinical Effectiveness Group leads present results to the trust Clinical Effectiveness Group for assurance purposes. Additionally, a care plan action group has been developed to support directorates with an overall trust improvement approach.
- Clinical and Service directors continue to receive participation information and audit results monthly. The Quality Assurance Leads also receive this information which is discussed and monitored via local Clinical Effectiveness Groups, incorporating a qualitative review of the records during the Improving Lives programme and deep dive audits.
- Further CQC Inspections and MHA reviews will also seek assurance.

**Quality Improvement – delivering the improvements**

- Our improvement goal for 2021/22 continues from previous years - to ensure that at least 75% of our eligible teams participate in monthly care plan audits.
- A care planning action group has been established for clinicians and managers that are responsible for leading and implementing practice improvements within their service. The action group will oversee and facilitate improvements in care planning and risk assessment across all specialist services. The group will provide a highlight report to the Clinical Effectiveness Group.
- Focused sessions were held with clinical teams to understand what the challenges are to completing risk assessments and care plans. The findings from these sessions are being explored as a Qi project. The title of this Qi project is: Care planning in Greenwich ICMP teams. The project aim is: To have 80% of the staff in the ICMP Greenwich teams feeling confident and competent writing care plans using Dialog+ by December 2021. This project is ongoing and is currently exploring the problem and identifying potential improvements.
- The implementation of the Oxcare project will be a positive addition to improving service user engagement and inclusion in personalised care planning. Once a service user is set up

on Oxcare, care plans will go from RiO into the care plan section of Oxcare. If the service user sets up their community with friends and family, the information can be shared with that support network. There is also a free text box for service users to enter information onto their care plan.

### 3.2 Performance against NHS Improvement and NHS England's Oversight Framework indicators

In accordance with NHS foundation trust's requirements from NHS Improvement and NHS England (NHSI/E), we have detailed below our performance against the NHSI indicators that appear in the single oversight framework. There are seven indicators applicable to the services that we provide. Our performances against these are provided below.

#### Table 3.2a: performance against NHSI indicators

| | Oversight Framework indicator for disclosure | 2019/20 Performance | 2020/21 Performance | 2021/22 Performance | Threshold |
|---|---|---|---|---|---|
| **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 | 67.9% | 83.82% | 82.1% | 50% |
| **2i** | Improving Access to Psychological Therapies (IAPT): Proportion of people completing treatment who move to recovery (from IAPT dataset) | 54.6% | 55.45% | 59.93% | 50% |
| **2ii** | Improving Access to Psychological Therapies (IAPT): Waiting time to beginning treatment (from IAPT minimum dataset)<br>Within 6 weeks of referral | 91.4% | 97.86% | 77.41% | 75% |
| | Within 18 weeks of referral | 99.3%% | 99.87% | 99.52% | 95% |
| **3** | Care Programme Approach (CPA) follow up: proportion of discharges from hospital followed up within 7 days | 97.0% | 97.21% | 96.27% | 95% |
| **4** | Admissions to adult facilities of patients under 16 years old | 0% (no admissions) | 0% (no admissions) | 0% (no admissions) | 0 |
| **5** | Inappropriate out-of-area placements for adult mental health | 542.1 average bed days per month | 777 average bed days per month | 375 Average bed days per month | |

## Annex 1 – Feedback from our Stakeholders

**South East London CCG response to 2021/22 Quality Accounts**
South East London Clinical Commissioning Group (SEL CCG) commissions a range of healthcare services from Oxleas NHS Foundation Trust (Oxleas) on behalf of the population we serve across six boroughs in south east London (SEL).

SEL CCG wishes to thank Oxleas for sharing their 2021/22 Quality Account with us and welcomes the opportunity to provide a commissioner statement. We commend the Trust for its resilience and continued commitment to delivering quality healthcare despite the challenges posed by the Covid 19 pandemic through an effective Incident Coordination Centre. We also commend the Trust for their effort in compiling this Quality Account given the pressure being experienced across the entire healthcare system. We confirm that we have reviewed the information contained within the Quality Account and, where possible, information has been cross referenced with data made available to commissioners during the year.

During 2021/2022 the Care Quality Commission (CQC) returned to the Older Adults Mental Health inpatient services and re-rated as 'Good'. The CCG would like to congratulate the Trust on this improvement and acknowledge the work undertaken by all to achieve this. During their joint visit to Her Majesty's Prison Wandsworth, with Her Majesty's Inspectorate of Prisons (HMIP), a service at which Oxleas is commissioned to provide both physical and mental health services to inmates. The CQC proffered some recommendations which the Trust is already working on. It is pleasing to note that there has been significant improvement since the visit with the Trust Board providing the required support.

Over the course of the year, the Trust recorded significant improvement in the use of restrictive practices, documentation of pressure ulcers and duty of candour. It is impressive to see that the patient safety specialist role has been filled and plans are already in motion to conduct thematic reviews of keys issues of concern to be shared with teams to embed learning across the organisation. Of great importance is the Trust's plan to triangulate all learning cultures from serious incidents, complaints, and patient experience to embed learning. We acknowledge the quality improvement work on engagement with patients and carers and the collaborative work the Trust is doing with partners across SEL in this regard to further improve patient experience and wait times. The shortage of skilled staff in the market makes recruitment into some specialist services difficult and has inevitably contributed to the pressures within the system.

SEL CCG recognises that the priorities for 2021/22 may have been impacted by the Covid 19 pandemic but commends the Trust for the progress they have made in the last year. The works being done regarding risk assessments and care planning, clinical audits and research, physical health monitoring, staff training and wellbeing and identifying the support network of patients are commendable. We also recognise the continued focus on co-production and the innovative service development programmes outlined for the year.

We support Oxleas with the priorities chosen for 2022/23 and we are committed to working collaboratively with the Trust and other partners to drive healthcare improvements across SEL as we move into the new world of Integrated Care System (ICS). This will be achieved through the

establishment of the System Quality Group to develop system responses to enable ongoing improvement in the quality of care and services across the ICS.

Kate Moriarty-Baker
Chief Nurse Caldicott Guardian
NHS South East London CCG

**Healthwatch Bexley response to 2021/22 Quality Accounts**

Areas of success

- *Quality Priority - Patient Experience*: Healthwatch Bexley notes the improvement the Trust has achieved in Q3 Quality Indicator 1.2 – 'to ensure 95% of patients who use our physical health services rate our services as 'good' or 'very good' – range achieved 87-89%.
- Healthwatch Bexley is pleased to see that Quality Objective, 'Ensure we involve families, carers and people important to patients', with Quality Indicators 1.3 and 1.4 targets both being met. We look forward to seeing continuing monitoring into 2023 through the Patient Experience Group augmented by any local Healthwatch involvement.
- We are pleased to see that the Trust aims for every staff member to actively identify and involve patient support networks to ensure better outcomes for their service users, and that teams should be reviewing their patient experience feedback on a regular basis in order to find ways to improve and thereby ensure continuous improvement of services.
- Healthwatch Bexley look forward to the outcome of the collaborative project between the Corporate Patient Experience Team and academic institutions on the analysis of free text response data obtained from patient experience surveys.

Areas for improvement

- We were concerned to see that 'Quality Objective, Improving Patient Experience – ensuring we meet our patient promise', Quality Indicator – 'to ensure 90% of patients who use their mental health services rate our services as 'good' or 'very good' was not achieved for Q1-Q4, with Q3 range achieved – 68-76%. However, we do note that patient experience feedback dropped sharply following the first and second COVID lockdowns, and thus look forward to this increasing.

**Healthwatch Greenwich response to 2021/22 Quality Accounts**

Healthwatch Greenwich welcomes the opportunity to comment and provide an assurance statement on the Oxleas NHS Foundation Trust Quality Account 2021/22. Firstly, we would like to thank Oxleas Foundation Trust and all its dedicated staff, for their continued hard work and commitment over the last twelve months. We recognise the legacy of the pandemic, and recovery of services, provides significant pressure for the organisation, and challenges the ambitions of service delivery and progress.

In your Quality Account, we find assurance that despite the additional recovery pressures, the Trust continues to meet its aspirations. We have reviewed the 2021/22 Oxleas NHS Foundation Trust Quality Account to assess the extent to which it:

1. reflects peoples' real experiences as shared with Healthwatch Greenwich.
2. demonstrates a learning culture that uses people's real experiences to drive improvements.
3. identifies challenging priorities for improvement, focused on improving patient experience, and appropriate measurements to assess change.

Accessibility of the Trust's Quality Account
The Trust is required to write the Quality Account in a way that makes it easy for a lay reader to understand. Overall, the report is written in a non-technical way, however there are opportunities to improve accessibility and understanding for the lay reader. Healthwatch Greenwich would welcome the opportunity to support the Trust at a formative stage in the development of its Quality Account to improve clarity and accessibility for the lay reader.

- While excellent detailed information is provided on the governance and decision-making process to identify 2022/23 priorities (2.0, 2.1, 2.1.1, 2.1.2, 2.1.3, 2.1.3a) more information is needed on quality indicators and outcomes/targets. As such Healthwatch Greenwich is unable to give assurance on the Trusts 2022/23 quality priorities.
- It is not clear if (or how) priorities/targets are the same as, or different from, the 2021/22 priorities, (as set out in table 3.1.1a, 3.1.2a, 3.1.3a).
- Bringing performance on 2021/22 priorities and targets together, consecutively, with priorities and targets for 2022/23, rather than at each end of the Trust's Quality Account would aid the lay reader.
- Table 2.2.5a (CQC Ratings) is too small to be legible
- The Trust's rating key (table 3.1a) is confusing.

Introduction
We welcome the positive statements from the Trust's Chief Executive and commitment to providing the best possible care for patients and their families. We are pleased that 'bolstering service user, patient, carer involvement and co-production' is recognised as a key enabler to achieve Oxleas priorities. Healthwatch Greenwich would welcome the opportunity to work with the Trust in relation to this.

Quality Priorities (section 2, 2.0 to 2.2)
While excellent detailed information is provided on the governance and decision-making process to identify 2022/23 priorities (2.0, 2.1, 2.1.1, 2.1.2, 2.1.3, 2.1.3a) more information is needed on quality indicators and outcomes/targets (for example see table 3.1.1a on 2.21/22 quality priorities). As such Healthwatch Greenwich is unable to give assurance on 2022/23 priorities.

Clinical Audits
Trust has participated in 13 clinical audits. However, a significant amount of information has not been provided in the Quality Account, specifically - the number of cases submitted (not provided for 7 of the 13 clinical audits, including 3 of the 4 national clinical audits), and the proportion of registered cases required (not provided for 11 of the 13 clinical audits, including 4 out of 4 of the national clinical audits). Given the lack of information, it is not possible to offer comment on how meaningfully the Trust has participated in all the clinical audits listed.

National Enquiries
No information is provided in the Quality Account on what learning has been gained or what action will be taken as a result of participation in 'child health clinical outcome review programme – transition from child to adult health services.

We are concerned to note the Trust withdrew from the national enquiry into the 'physical healthcare of inpatients in mental health hospitals' (NCEPOD). Physical health disparities for people living with mental health conditions are well known, often leading to higher levels of premature

mortality. Withdrawal from this audit represents a missed opportunity to drive quality improvement initiatives for patients, carers, and the wider community.

<u>Actions to Improve from four Clinical Audits (table 2.2.1c)</u>
We are pleased to see learning, and direct impact on service improvement, from four national clinical audits. It is not clear what learning, or service improvement, has been developed as a result of the remaining eligible 9 (of 13) clinical audits listed in table 2.2.1a.

<u>Trust Audits (table 2.2.1d)</u>
The description of 28 audits with planned or completed improvements is welcomed. Some, but not all, provide measurable performance metrics. However, some of the improvements appear weak and would benefit from strengthening and use of measurable metrics, for example – under Clinical Coding - 'to liaise with…' or under Falls Audit – 'falls training put in place'. We note that no information has been provided for improvements under four headings, 'Medical Devices', Data Protection', 'Record Keeping', and 'Mattress Audit'. A reduction of 936 care planning audits have been carried out this year – in comparison to last year. No information is provided on if, or how, this reduction might (or might not) impact on service development or improvements for service users.

<u>Local Clinical Audit (table 2.2.2)</u>
We are pleased to see the establishment of the Clinical Effectiveness Team and the more than doubling of local clinical audits this year. The increase in local clinical audits will support the Trust by giving assurance that treatment and care is being provided in line with standards, give indications for where improvements can be made, and ultimately improve outcomes for patients. As such, it is disappointing to see that a third of local clinical audits were not completed. We would have liked to have seen a commitment to a higher completion rate for local clinical audits as one of the priorities for 2022/23

<u>Registration with the Care Quality Commission (section 2.2.5 and 2.2.5a)</u>
After previously receiving a Warning Notice served under Section 29A of the Health and Social Care Act (HSCA) 2008 in 2020, the Trust has done excellent work to achieve a rating of 'Good' in 2021 from the Care Quality Commission (CQC) in relation to the Older Adults Mental Health Inpatient services.

In addition, we are pleased to see the Trust has maintained its overall rating of 'good' and we note the positive comments from the CQC made in 2021. In particular, the Trust:

• is well-led with a committed leadership team
• has adequate staffing and a positive staff culture
• operates good risk management and has reduced violent incidents
• is commitment to learning from complaints, incidents and near misses
• provides person-centred, holistic and a recovery-oriented approach to care
• strives for continuous improvement

The CQC report notes areas for additional attention within specific areas or wards, such as:

• safety of patients after receiving rapid tranquillisation
• maintenance of medical equipment
• staff compliance with medicines management policies

- documentation and record keeping
- environmental improvements
- timely access to services
- overarching strategy to address equality, diversity and human rights, linking and sharing learning across the organisation

The Trust's Quality Account is an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. We are disappointed that the Trust's Quality Account does not set out how improvements have been, or will be, made with regards to comments made by the regulator (CQC).

We also note that the size of the table (CQC ratings June 2021) is too small to read on hard copy print. While it may be possible for those reading the Trust's Quality Account online to expand the table, access to digital facilities or digital confidence to access documents on-line is not universal.

<u>Prison Services</u>
We note a number of requirement notices. The Trust's Quality Account does not set out how improvements have been, or will be, made with regards to the requirement notices. While detailed information is not expected or required, a summary table would be helpful for local communities, stakeholders, and the lay reader.

<u>Patient Experience Quality – 2021/22 Priorities</u>
Table 3.1.1a: We found the key used by the Trust to define success, or otherwise (table 3.1.1a, 3.1.2a, 3.1.3a), confusing, and overly complicated. While 'consistently passed' and 'consistently failed' is clear and intuitive, an additional category of 'up and down' and further subdivision into four more sub-categories is baffling and not as accessible as it could be for the lay reader.

Two of the four priorities have been met and two have not been met. We congratulate the Trust on meeting its targets on 'involving families, carers, and people important to our patients'. We note the much lower target of 50% for patients using community services (as compared with mental health and forensic services) to have their support network identified and noted within their care record. We encourage the Trust to consider inclusion of a more challenging threshold in future years.

It is clear there is still work to be done on improving patient experience and increasing the proportion of services users who rate the Trust's services as 'good' or 'very good'. Healthwatch Greenwich would welcome the opportunity to support the Trust in this work.

<u>Patient Safety – 2021/22 Priorities</u>
One of the six priorities has been met and five have not been met. We are concerned by the low level of achievement demonstrated by the Trust on patient safety.

<u>Clinical Effectiveness – 2021/22 Priorities</u>
None of the five priorities has been met. We are concerned by the low level of achievement demonstrated by the Trust on clinical effectiveness.

<u>Performance against NHS Improvement and Oversight Framework</u>
The Trust has performed well against six of the seven targets, particularly within the pandemic recovery context and the additional pressures on mental health services locally and nationally. There

has been a significant decline in the proportion of patients able to access psychological therapies within 6 weeks of referral. While still meeting national targets, it is both disappointing and possibly a result of the additional need and demand for these services as a result of communities, families, and individuals living through the pandemic.

Healthwatch Greenwich. May 2022

## Annex 2 - Statement of directors' responsibilities for the Quality Account

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 Accounts (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 Account.

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

- The content of the Quality Account meets the requirements set out in the NHS foundation trust annual reporting manual 2021/22 and supporting guidance
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2021 to May 2022
    - papers relating to quality reported to the board over the period April 2021 to May 2022
    - the trust's complaints report published under regulation 16 of the Local Authority's Social Services and NHS Complaints regulations 2009
    - the 2021 national patient survey
    - the 2021 national staff survey
    - CQC inspection reports
- The Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account are robust and reliable and they conform to specified data quality standards and prescribed definitions and are subject to appropriate scrutiny and review

- The Quality Account 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 Account.

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

By order of the board

.............................Date...........................................................Chair

.............................Date...........................................................Chief Executive