Part 2

Mental Health Services
Quality Accounts 2010/11

DRAFT

Insert photos

Description of Business Unit and Services

NELFT provides mental health services for people living in the London Boroughs of Havering, Barking & Dagenham, Redbridge and Waltham Forest. The population of almost one million people is spread over urban and rural areas, and is ethnically diverse.

The range of specialist services we provide include hospital based services and services in the community; for adults, older and frail adults, young people (Child and Adolescents Services) and for people with a learning disability.

What Service Users have told us in the last year:-

“Havering Service User Reference Group (SURG), User Quality Action Team (UQAT) and Carer Quality Action Team (CQAT) and service user involvement is a positive thing”

“I think it is great that you are working hard to continuously improve services and taking on board comments/suggestions made”

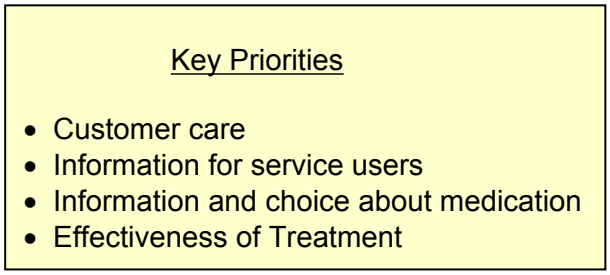
"Appointments seem accessible, staff in the community are great, and hospital staff are a bit laid back"

"Staff are good at supporting me in time of crisis/upset. Good communication, empathy, good professional attitude from staff"

Improvement Priorities 2011/12

This section reports on our planned improvement priorities for 2011/12 and they are presented under the three domains of quality.

Our improvement priorities have been identified from a number of sources as follows:-



PALS	Complaints	Quality Accounts Consultation
• Seeing different Psychiatrist/Psychologist • Mix up with appointments • Medication issues • Waiting lists	• Communication • Staff attitude • All aspects of clinical treatment (includes diagnosis, medication) • Aggression and violence	• Staff attitude and communication • Effectiveness of treatment • Information for service users • Range of services available

This section also includes our improvement priorities agreed with commissioners – see Page 6.

A) Service User Experience

Improvement priority
Improve customer care

How the priority was identified
Staff attitude and communication was highlighted as the main priority in the Quality Accounts consultation, and is a theme emerging from complaints and the national patient survey.

Action

- Provide additional support to teams in delivering the Dignity, Respect and Equality Service User Standards
- Incorporate the Staff Charter into the supervision process
- Implement quarterly supervision quality audits to ensure the delivery of good quality staff supervision
- Roll out the Equality and Diversity training which addresses staff attitude
- Ward managers development programme focusing on managing poor performance.

How progress will be measured

- Through the Service User Standards audits, particularly the Communication and Engagement Standards and the Dignity and Respect Standards.
- Through local and national in-patient survey results
- Through the number of complaints and Patient Advice and Liaison Services (PALS) issues focused on this theme.

How progress will be monitored and reported

- Quarterly reports to the Integrated Governance and Performance Groups
- SURG, who report back to Trust Board

Improvement priority
Improve information for service users

How the priority was identified

Information for service users was highlighted as the second highest priority on the Quality Accounts consultation and also as an area of concern on the national patient survey.

Action

- We will continue to develop information in a range of accessible formats, which can be given out in printed form and on the Trust website.
- We will continue to work towards the standards set out in the Department of Health Information Standard.
- The Service User and Carer Involvement Coordinator will recruit a Service User and Carer Reading Panel during 2011 who will have the role of developing and reviewing new and existing information.

How progress will be measured

- Through the Service User Standards audit on Care Planning and Information.
- Through local and national patient survey results.

How progress will be monitored and reported

- Quarterly reports to the Integrated Governance and Performance Groups
- SURG, who report back to Trust Board

B) Patient Safety

Improvement priority

Improve information and choice about medication

How the priority was identified

This priority has been identified through the Quality Accounts consultation, PALS, themes from incidents and audit results.

Action

- Promote and incorporate into clinical practice use of the 'choice and medication' web based information site
- The chief pharmacist will work with Operational Directors to agree and implement a plan to encourage staff to use the website and integrate medicines information into care plans
- The Medical Director will work with prescribers to ensure systems are agreed and pit in pace regarding giving medicines information to service users
- Pharmacists to continue working with in-patient staff and service users in information groups

How progress will be measured

- Through in-patient surveys, Service User Standards audits, Productive Ward audits and local audits.

How progress will be monitored and reported

- Report to the Trusts Integrated Governance and Performance Groups and the Drugs and Therapeutics Committee.

C) Quality and Clinical Effectiveness of Treatment

Improvement priority

Improve effectiveness of treatment

How the priority was identified

This priority has been identified through the Quality Accounts consultation, and themes from complaints**.**

Action

- Through our focus on Employment, Education and Training (EET) we will be ensuring that service users get the right support at the right time. This is based on survey findings and should improve effectiveness and efficiency in these areas.

- We are exploring Social Inclusion Web and Recovery Star' to help staff to better … identify outcomes and clinical support / intervention outcomes

- The Occupational Therapy (OT) professional group are using a structured approach' to identify the progress each service user has made following OT support.

- Evidence based group plans will be developed for all ward based groups and activities as part of the Star Wards programme.

- A Cognitive Behavioral Therapy (CBT) survey currently being undertaken, which will inform the CBT services provided in the future.

- The Improving Access to Psychological Therapies (IAPT) model of measuring effectiveness will be extended to all psychological services in the Trust. In addition, and in collaboration with the University of East London, a programme of collecting user-defined qualitative outcomes will be extended across psychological services.

How progress will be measured

- The number of referrals to the different points on the EET pathway and outcomes against them will be recorded.

- The use of Occupational Therapy outcomes tools and the types of outcomes that are achieved will be audited.

- The percentage of completed evidence based group plan will be recorded against ward activity programmes.

- Psychological services collect both quantitative outcomes (e.g. symptom measures) and qualitative outcomes (e.g. user's descriptions of their levels of satisfaction following psychological therapy). IAPT services routinely collect quantitative outcomes at each psychological therapy session. Secondary care psychological therapies routinely collect quantitative outcomes at assessment and at the end of treatment.

How progress will be monitored and reported

- Through the Change Management Implementation group, Social Inclusion and Recovery Task Group and Operational Integrated Governance Groups.

- Through the Psychological Services Implementation.

- Through the Acute Care Implementation Group

Improvement Targets Agreed with Commissioners – 2011/12

A proportion of NELFT Mental Health Service income in 2011/12 is conditional on achieving quality improvement and innovation goals agreed with our commissioners through the commissioning for Quality and Innovation (CQUIN) payment framework. This framework aims to support to the cultural shift towards a real and meaningful focus on quality.

CQUINS 2011/12

The following key targets related to quality have been identified by commissioners

CQUIN TARGETS			
Area for Quality Improvement	**Why this is important**	**The improvement we expect to see**	**How will we achieve this**
All people diagnosed with Dementia should have a care plan	To ensure that a full assessment of need is made and needs addressed		
Self assessment of Liaison Services based on Royal College of Psychiatry accreditation Scheme	To ensure the delivery of high quality care based on national standards	Assess current services and identify gaps Complete a business case for quarter 4 to enable accreditation	An audit tool based on PLAN (Psychiatric Liaison Accreditation Network) has been developed with commissioners
Review of mental health and unscheduled care in general acute hospitals	To improve the care pathway between general acute hospitals and mental health services	Reduced number of 4 hour breaches in A&E. Reduced number of delayed discharges from acute hospital beds	Assess liaison services – format yet to be agreed with commissioners
Physical health and medicines reconciliation	To improve the physical health care of people with mental health problems	90% of all patients to have a complete set of mental health ICD 10 codes recorded for their episode of care 60% of patients on CPA supported to access relevant physical health checks	PIPs to support and work with in-patient staff in improving practice in identified areas Revised business processes to support universal collection of physical health information using LMC approved

		70% of patient discharge letters sent to GPs within one week of discharge	proforma Learning lessons from the “Find the 5000” project in Yorkshire Support from pharmacists on the wards Sustained GP engagement around project and channels of communication (e.g. ‘Safehaven’)
Patient experience	To ensure high quality care and an improved experience for service users	This construct is yet to be agreed	
Service user self defined recovery outcome measures	To promote service user engagement, involvement and decision making in planning care	To demonstrate that 30% of all care plans are written in first person singular with at least two self defined recovery goals.	PIPs to support clinical staff in delivering recovery orientated practice

Nationally Required Information

The following information is required to be included in Quality Accounts in this format. The aim is to give information to the public which will be common across all Quality Accounts.

Clinical Audit

Participation in clinical audits

During 2010/11 four national clinical audits and one national confidential enquiry covered NHS services that NELFT Mental Health services (MHS) provides.

During that period NELFT MHS participated in 100% national clinical audits and 100% national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that NELFT MHS was eligible to participate in during 2010/11 are as follows:-

National Falls and Bone Health Audit (Organisational Audit)
National Audit of Continence Care (Organisational & Clinical Audit)
POMH: prescribing topics in mental health services
NAPT: National Audit of Psychological Therapies
National Audit of Schizophrenia (NAS) (recruiting March 11)

National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

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The national clinical audits and national confidential enquiries that NELFT MHS participated in, and for which data collection was completed during 2009/10 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- National Falls and Bone Health Audit - Organisational Audit Proforma Only (not eligible for full clinical audit this round) – Percentage N/A
- National Audit of Continence Care (Organisational & Clinical Audit) – 41 cases submitted (40 required) – 100%

- POMH: Prescribing topics in mental health services – POMH UK'S Quality Improvement Programme for Medicines Reconciliation (Topic 8): Audit of clinical practice in adult and elderly acute psychiatric wards – 45 cases – 100%

- National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

The report of one (100% of all national clinical audit reports available) national clinical audit was reviewed by the provider in 2010/11 and NELFT MHS intends to take the following actions to improve the quality of healthcare provided

Case-finding and coding:
- To be incorporated into Physical Health Policy.
- To investigate whether this should be linked to Nurse Sensitive Indicators
- Highlight issues to RiO Managers

Pathway issues:
- To develop a pathway around Continence Care that involves colleagues in both mental health and community health services.
- Proposed care pathway needs to recognise the importance of Ward Managers in areas where continence issues are more prevalent.

Training and provision of pads and products:
- To look at including basic continence assessment in Physical Health Policy.
- To look at consistency around products, standardising equipment and incorporate in current in-house training and evaluate suppliers.

Clinical Assessment:
- To review current continence assessment protocols.

Quality of Life Measures:
- Review of quality of life to be included in continence assessment and review of treatment effects to be incorporated in proposed care pathway.

Treatment:
- Ensure healthcare professionals full discuss treatment options with patients regarding continence issues. This should be reflected in Physical Health Policy.

The reports of 78 local clinical audits were reviewed by the provider in 2010/11 and NELFT MHS intends to take the following actions to improve the quality of healthcare provided.

Actions vary with individual audits but each audit has a recommendations and action plan with identified lead for each recommendation as well as timeframe. There are a number of forums to promote learning from clinical audit not only in the team that the audit is carried out in but also across the unit area so that lessons can be learnt. These include:

- Presentation of audits at academic programmes
- Quarterly Trustwide clinical audit presentation sessions
- Annual Clinical Audit Conference
- Directorate Audit Away Half Days
- Clinical Audit Matters bimonthly audit summaries publication

Research

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by NELFT MHS that were recruited during that period to participate in National Institute for Health Research portfolio studies approved by a research ethics committee was 1185.

Participation in clinical research demonstrates NELFT MHS commitment to improving the quality of care we offer and to making our contribution to health improvement. Our clinical staff stay abreast of the latest possible treatments and active participation in research leads to successful patient outcomes.

NELFT MHS was involved in conducting 23 NIHR clinical research studies in mental health during April 2010 to March 2011, and involved in conducting 31 local clinical research studies during the same period.

The improvement in patient health outcomes in NELFT MHS demonstrates that a commitment to clinical research leads to better treatments for patients.

As well, in the last three years at least 90 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates NELFT MHS commitment to testing and offering the latest medical treatments and techniques.

Statements from the CQC

NELFT MHS is required to register with the Care Quality Commission and its current registration status is that it is registered to carry out the following regulated activities:-

Assessment or medical treatment of people detained under the Mental Health Act
Diagnostic and screening procedures
Nursing Care
Treatment of Disease, disorder or injury

The Care Quality Commission has not taken enforcement action against North East London NHS Foundation Trust during 2010/11.

North East London NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data Quality

NELFT MHS will be taking the following actions to improve data quality.

Data Quality is monitored on an ongoing basis, with reports made available and discussed with clinical teams, at monthly performance group meetings and at directorate performance meetings. The Trust also undertakes an annual health record audit to assess standards of data quality and this provides an action plan to drive forward improvements.

There is a separate Data Quality Action Group that meets monthly to provide strategic direction and monitor the Trust's progress on improving Data Quality. This group has senior management attendance and has action plans to monitor, improve and maintain data quality standards across the Trust. This group is responsible for ensuring Information Assurance Frameworks for all key targets are in place and monitored.

NHS Number and General Medical Practice Code Validity

North East London NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

99.4% for admitted patient care
99.9% for outpatient care
The percentage of records in the published data which included the patient's valid General Medical practice code was:

100% for admitted care
100% for outpatient care

Information Governance Toolkit attainment levels

NELFT MHS Information Governance Assessment Report score overall for 2010/11 was 57% and graded Amber (this means requiring some action)

Clinical Coding error rate

NELFT MHS was subject to the Payments by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:-

Primary diagnosis incorrect coding	-	22.5%
Secondary diagnosis incorrect coding	-	56.69%

Part 3

This section reports on progress with the improvement priorities we identified in our 2009/10 Quality Accounts, and is divided into the three domains of quality.

1) Service User Experience

Area for Quality Improvement:

Improve Carer satisfaction

Improvement actions Implemented

- A Carers Action group was set up to address specific Carers issues. The group has worked with clinical teams on increasing awareness of Carers and the need to offer Carers Assessments and reported on progress on a monthly basis.
- A welcome pack has been developed for Carers, which will be used in all services.
- The Carers Standards were launched in 2009 and these continue to be implemented in teams.

Current Performance

- Figures have been gathered (by borough) on the Identification of Carers and Offering Carers Assessments.
    - Local targets were set at:-
    - Identification of Carers – 30%
    - Offering Carers an Assessment – 80%
    - The results are increasingly positive and the targets have now been exceeded for several months.
    - Performance in February 2011 are:- identification of cares – 34% offering an assessment – 81%
- Implementation of the Carers Standards has continued in teams and a Carers Quality Action Team has been developed.

How we intend to sustain/make improvements

- Funding has been identified to provide more training and Carers UK have trained two staff members to become trainers
- The Carers Welcome Pack is to be launched in June 2011
- Work continues to increase numbers of Carers getting involved in Trust activities

- Carers Standards continue to be implemented and audited by the Practice Improvement Team and the Carers Quality Action Team
- An action plan is being implemented by the Practice Improvement Team to identify and develop support for young carers.

Area for Quality Improvement:

Improve Information about Medication

Improvement actions implemented

- Choice and medication subscription web-site introduced across mental health services. Information about this website has been in the weekly staff bulletin, featured as a screen saver, posters has been distributed across teams.

Current performance

- Limited staff take up of using the web site to date. At the Sunflowers Court staff Development Day, feedback indicated that less than 10% had looked at the website.

How we intend to sustain/make improvements

- Staff in the newly formed in-patient teams at Sunflowers Court have had a re-introduction to the web-site and it is a standing item on induction for junior doctors.
- Pharmacy staff will continue to work with teams to encourage its use.

Area for Quality Improvement:

Increase Employment, Education and Training

Improvement actions implemented

- Increased the number of recorded employment status for those on CPA.
- Increased number of service users in paid employment
- Provided training to staff on the importance of assessing employment needs.
- Obtained baseline survey results of service user's needs and experiences of employment, education and training.
- Established directorate 'Employment, Education and Training (EET) strategy implementation groups' with local partner agencies represented.
- Facilitated partnership working with additional employment support staff in teams in Waltham Forest.

Current Performance

- Recorded employment status (on CPA only) is 99.2% (Dec 2010) compared to 85% in April 2010
- Recorded number of people in employment (on CPA only) is 6.1% (Dec 2010) compared to 3.5% in April 2010.
- Directorate implementation groups with partners held monthly in boroughs.
- Findings of a random sample including those not on CPA (ages 18-65) indicate that we have
    - 15% service users currently in paid employment
    - 13% service users in voluntary work (unpaid)
    - 15% service users in education or training

How we intend to sustain/make improvements

Sign off and gain agreement on a draft EET pathway

- Ensure pathway works with the structure of other mental health services
- Provide targeted training to service areas on assessing and meeting EET needs
- Continue directorate implementation groups for EET strategy

2) Patient Safety

Area for Quality Improvement:

Increase the reporting of medication errors

Improvement actions implemented

- ❑ The medicines management working group reviewed all errors and discussed the likely causes, recommended actions and feedback to the Drug and Therapeutics Group. This has proved to be a good way to separate systems errors from training needs/competency.

Current performance

- It is thought that levels of reporting are still low but this is difficult to assess.
- Missed dose reporting has increased
- Error reporting constituted part of the pharmacy talk on the development days for staff at Sunflowers Court.

How we intend to sustain/make improvements

- A medicines management e-learning programme will be launched later in 2011
- Introduction of a Practice Improvement Practitioner competency package for dealing with training needs discovered as a result of errors.
- The medical director to liaise with senior medical staff to discuss how best to improve reporting of incidents by medics
- Pharmacy staff will continue to encourage staff to report all errors.

Area for Quality Improvement:

Increase the take up of Smoking Cessation Programmes

Improvement actions implemented

- Ninety mental health service staff have been trained by the Barking and Dagenham CHS Smoking Cessation Team in how best to advice and offer support to service users.
- A Smoking Cessation care pathway has been developed and a leaflet on quitting smoking devised for service users.

Current performance

- ❑ The impact of the care pathway and the training will be evaluated in June 2011

How we intend to sustain/make improvements

- Smoking Cessation will continue to be part of the MHS Healthy Lifestyles agenda.
- Smoking cessation will be a standing item in ward team meetings.
- Team smoking cessation leads will continue to be supported by the Community Smoking Cessation Team.

Area for Quality Improvement:

To be compliant with the Hygiene Code

Improvement actions Implemented

- ❑ Infection prevention and control frameworks are in place with specialist advice and support provided by an external contractor until an in-house specialist is appointed.

Current Performance

- Compliance with the Hygiene Code of Practice is monitored quarterly and reported through governance groups to the Board of Directors. This process includes identifying and managing incidents of infection.
- A full audit programme to assess our compliance with Trust policies has been undertaken with action plans in place to drive standards still higher.

How we intend to sustain/make improvements

- Routine and regular audits of staff compliance with infection prevention and control policies are conducted, this includes Hand Hygiene and equipment decontamination.

- Training for MHS staff was conducted by Barking and Dagenham CHS.
- The annual report of Infection Prevention and Control activity and outcomes will be available on the Trust website.

Area for Quality Improvement

To ensure compliance with Safeguarding Children and Adults, Policies and Procedures

Improvement actions Implemented

- A Safeguarding Children and Adults action plan is held by the Safeguarding Adults and Children group and progress reported monthly.
- Quarterly Safeguarding reports go to the Trust Board reporting on the above and highlighting any exceptions.
- Clear roles and reporting structure have been implemented. Directorate Leads facilitate Link Worker meetings.
- The Trust Board Lead chairs the Safeguarding Children and Adults monthly meeting, Operations Directors attend to report from the Local Authority Safeguarding Children Boards and Safeguarding Adults Boards.

Current Performance

- ❑ The Safeguarding Children and Adults action plans are progressed each month.
- Senior staff attend the Safeguarding Adults and children's meetings in each of the four boroughs.
- There is senior staff in attendance at MAPPA and MARAC meetings in each of the four boroughs.
- Monthly audits show that supervision is taking place, and an audit tool is being developed to examine the quality of this. The Safeguarding lead has specific Safeguarding supervision monthly.
- Policy and procedures are reviewed to take account of changes to national legislation and local procedures.
- Level 1 training is face-to-face and e-learning training is in development. Level 2 training in place. Level 3 training started in 2011.
- The Human Resources Department reports on Criminal Records Bureau (CRB) compliance every month in the Safeguarding meeting.

How to sustain/make improvements

- Development of a dashboard system to inform reporting to the Trust Board and highlight areas that indicate compliance and/or risk for the organisation.
- Continuing development of Link Worker role to ensure systems in clinical teams are robust.
- Implementation of Level 1 e-learning package that can be delivered to all staff.
- Reporting of continued progress against Safeguarding Adults/children's Action Plan.

3) Quality and Clinical Effectiveness

Area for Quality Improvement:

Increase direct care time for service users in the community by participating in the Productive Community Programme

Improvement actions implemented

- The two pilot teams have completed five modules of the programme. They have agreed a team vision involving service users and identified areas where productivity can be improved

- An action plan has been agreed.
- Team performance measures are displayed in public areas to engage staff and service users in the improvements.

Current performance

- The teams have established that current direct patient contact time (the amount of time staff spend with service users) is:
  - Upminster CMHT = 32%
  - CRT East = 26%
- A range of actions have been agreed and will be implemented over the coming months to improve the amount of direct patient contact time.

How we intend to sustain/make improvements

- There are a series of workshops planned for staff in the participating teams to introduce new modules and review progress on previous modules.
- Practice Improvement staff provide regular support.

Area for Quality Improvement:

Increase access to Psychological Therapies

Improvement actions implemented

- Four IAPT services have now been established (one in each Borough) as part of Wave III of the national programme.
- Several members of staff have recently completed their IAPT training and are now embedded into community teams as planned.

Current performance

- ❑ The IAPT teams are small but expanding. They offer NICE recommended evidence-based psychological treatments to increasing numbers of individuals.

How we intend to sustain/make improvements

- There are new cohorts of trainees undergoing formal IAPT training in all four IAPT teams. On qualifying they will further boost the levels of fully qualified staff.
- The quality of the treatments offered is being monitored by close supervision from senior clinicians and work is recoded to allow close scrutiny of quality.
- Top-up IAPT training for qualified staff is also being undertaken.

Monitor Compliance targets

Monitor, who are the Foundation Trust regulators, have set a number of mandatory performance indicators. They have also set out that Foundations Trusts can choose one locally determined indictor:-

Mandating:-

1. Minimising delayed transfers of care

2. Admissions to inpatient services had access to crisis resolution home treatment teams

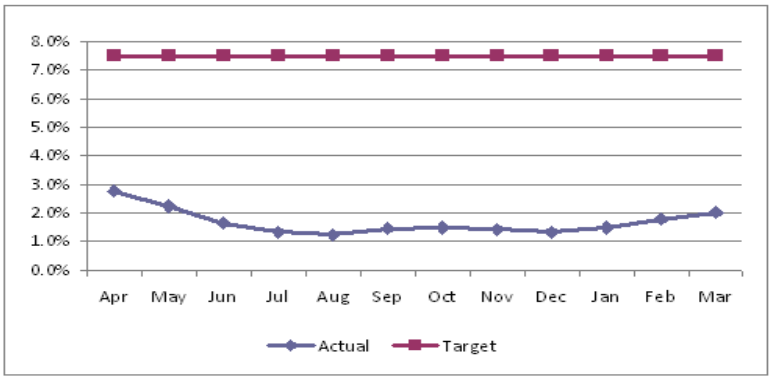
Locally determined:-

3. Improvement in Service User experience

1. Minimising delayed transfers of care

Delayed transfer of Care 2010-11

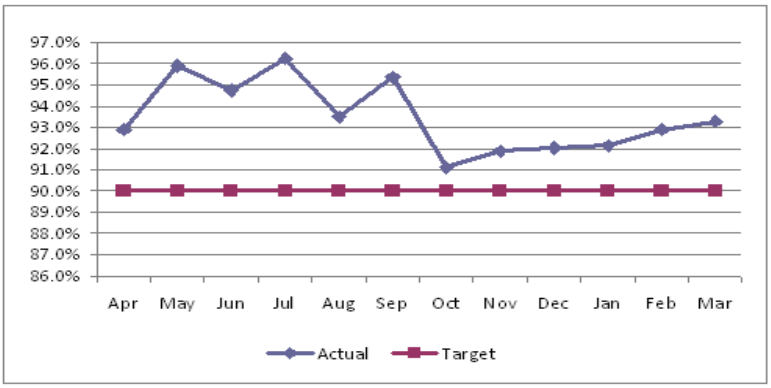
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	2.75%	2.24%	1.64%	1.33%	1.22%	1.45%	1.48%	1.42%	1.32%	1.49%	1.77%	2.00%
Target	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%



2. Admissions to inpatient services had access to crisis resolution home treatment teams

Gatekeeping 2010-11

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	92.9%	95.9%	94.7%	96.3%	93.5%	95.4%	91.1%	91.9%	92.0%	92.1%	92.9%	93.3%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



3. Improvements in service user experience:

The Practice Improvement Directorate (PID) were asked to coordinate a survey of inpatients discharged from NELFT MHS during the period 1 July to 31 December 2010. The baseline was established using the results from the 2009 CQC MH Inpatient Survey. The table below shows the baseline score and the 5% CQUIN improvement target set.

Question	Baseline (July 2010)	5% Improvement Target	Scores at December 2010	6month Cumulative scores
During your most recent stay were there enough activities available for you to do during evenings and/or weekends? ***Required response "Yes all of the time"***	10%	15%	40%	29%
During your most recent stay were you made aware of how you could make a complaint if you had one? ***Required response "Yes"***	36%	41%	65%	64%
Do you have the number of someone from your local NHS Mental Health Service that you can phone out of hours ***Required response "Yes"***	47%	52%	74%	72%
Before you left hospital were you given information about how to get help in a crisis, or when urgent help is needed? ***Required response "Yes"***	49%	54%	83%	82%
Overall, how would you rate the care you received during your recent stay in hospital? ***Required response "Excellent" or "Good"***	35%	40%	89%	82%

At the end of the 6 month reporting period, all the CQUIN Inpatient satisfaction targets have been achieved.

We are confident that the new inpatient unit at Sunflowers Court will significantly improve the inpatient experience still further and look forward to reviewing this with service users and carers over the coming months.

Two particular areas where work is ongoing to improve satisfaction levels further, are

- Evening and weekend activities, and
- Access to mental health staff out of hours

The Practice Improvement Directorate will continue to monitor and report on inpatient satisfaction. PIPs are working with the Acute Services Directorate and service users to develop a questionnaire, which will monitor areas where satisfaction levels need improving.

Workforce development

Staff Survey 2010

The Care Quality Commission (CQC) requires that the national staff survey be carried out annually by all the NHS Trusts. Because the core format has been largely the same for five years in succession, analysis allows for comparison with other mental health Trusts, and for year on year comparison within the Trust.

The CQC ranks Trusts overall for Staff Engagement, and staff have placed the Trust is in the top 20%, with above average or top 20% scores in all three key measures of staff engagement (p4 of CQC summary report). The Trust has now maintained this top 20% high performance for three years since becoming a Foundation Trust in 2008.

Nationally, high staff engagement is widely linked to the achievement of a range of positive quality of service and care measures.

The following is an overview of the Key Findings (KFs):

The top four ranking scores where the Trust compares most favourably with others are:

- KF1 % staff feeling satisfied with the quality of work and care they can deliver
- KF23 % staff experiencing physical violence in the last 12 months
- KF2 % of staff agreeing that their role makes a difference to patients
- KF35 staff motivation at work

The bottom four ranking scores are:

- KF9 % of staff using flexible working options
- KF11 % of staff receiving job relevant training in last 12 months
- KF12 % of staff appraised in the last 12 months
- KF14 % of staff appraised with personal development plans in last 12 months

Where staff experience has improved since 2009:

- KF22 fairness and effectiveness of incident reporting procedures
- KF36 % of staff having equality and diversity training in last 12 months
- KF27 perceptions of effective action from employer towards violence and harassment
- KF16 % of staff receiving health & safety training in last 12 months

Where staff experience has deteriorated since 2009

- KF32 staff job satisfaction
- KF18 % of staff suffering work related stress in last 12 months
- KF15 support from immediate managers
- KF4 quality of job design

CARE QUALITY COMMISSION EXECUTIVE REPORT AND COMPARISON WITH OTHER MENTAL HEALTH TRUSTS IN ENGLAND

The Care Quality Commission report results are reported against the four pledges to staff in the NHS Constitution which was published in January 2009, together with the themes of equality & diversity, and an overall rating for staff engagement.

Staff pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

The Trust is generally high scoring in this domain, being in the top 20% of all mental health trusts in the 3 of the 9 KFs concerning job design, team environment and work pressure, above average or average on a further four.

It is below average on two KFs; the use of flexible working and feeling valued by work colleagues where Barking & Dagenham Community Health Services (CHS) and Waltham Forest Mental Health Services (MHS) scored comparatively poorly.

Staff pledge 2: To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.

Staff report good opportunities to develop their potential at work (KF10). Yet they also report low levels of job-relevant training and appraisal in this period. Use of electronic learning (Q4e) has risen from 34% to 58% within the year. The Trust is better than average in providing health and safety training (Q5b) with 85% of staff receiving such training in the past year.

The percentage of staff reporting formal appraisal in the last 12 months was 57% in 2007, 61% in 2008, 65% in 2009 and still 65% in 2010. Despite full implementation of the agreed action plan, there is no change in the use of formal appraisal overall.

Staff pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety

In 2008 the Trust performed poorly in this domain with only 2 above average KF scores and 6 below average. In 2009 significant progress was made but with 6 still below average. The 2010 survey shows very good progress, with 10 of the 16 KFs now above or well above average. Only work related stress has worsened.

Staff pledge 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services

The Trust again performs exceptionally well in this domain. There are two key findings above or well above average around senior management communication and contributing towards improvement.

Staff satisfaction

This is a high scoring domain. The Trust is in the top 20% of mental health trusts for recommendation as a place to work or receive treatment and for motivation. However, staff report less job satisfaction and a greater intention to leave their jobs compared to the previous year.

Equality and diversity

In 2010 the Trust commissioned additional equality and diversity training resulting in a significant increase in the numbers of staff having such training. It was a particular disappointment that only 20 MHS staff had undertaken the e-learning made available by the Trust. The role out of e-learning shows that, by 11 April 2011, 957 MHS staff had undertaken the equality & diversity e-learning, and rollout is continuing, together with three other new face to face diversity training initiatives.

Leadership Development

In 2010 the Trust commissioned and commenced an innovative organisational development programme with London South Bank University. The programme will run for one year for groups of senior leaders from both management and clinical backgrounds. A total of 55 leaders have participated in the programme which brings together study of real issues within NELFT with academic analysis of these issues

both inside and outside healthcare. This collaborative approach between NELFT and the University is unusual, and together with the opportunity for participants to study to masters level, allows leaders in all areas of the Trust to learn from each other in resolving real healthcare issues by combining theory and practice. Trust Executive Directors participate to contribute to peer group learning.

This investment in leadership development will be a model for future staff development.

A new ward manager development programme will commence in 2011 aimed at ensuring that ward managers have the necessary skills to lead and manage wards of excellence. The aim is to roll out the programme to other team managers after the evaluation.

NHSLA

The NHSLA assesses Trusts against five Risk Management standards at three levels

MHS achieved Level 1 in February 2009 and Level 2 in February 2010.

MHS achieved the following scores for the Standards at Level 1 & 2

	Level 1	Level 2
Std 1 (Governance)	9/10	7/10
Std 2 (Competent workforce)	8/10	8/10
Std 3 (Safe Environment)	9/10	9/10
Std 4 (Clinical Care)	8/10	7/10
Std 5 (Learning from Experience)	7/10	10/10

Compliance with the NHSLA Risk Management Standards demonstrates that a Trust's approach to clinical risk management is strong.

CQUINS 2010/11

CQUIN TARGETS			
Area for Quality Improvement	**Improvement actions implemented**	**Current performance**	**How will this be sustained**
% HoNOS PbR **Target = 80%**	Training and guidance was implemented for clinical staff on the completion of the HoNOS PbR and clustering New reporting system implemented to inform Trust of progress	Target achieved currently 81.5%	Continued staff training, support and awareness raising
% Physical Health Care Checks for patients with mental health problems **Target =**	Staff training delivered to ensure physical health assessments completed for all admissions Standardisation of physical health and emergency equipment Venepucture training delivered to identified	Target is on track to be achieved by year end	Trust wide Physical Health Lead to co-ordinate sustained improvements

	staff		
1a. CPA service Users with a GP Registered **Target = 90%**	Ensure through RiO records all service users have a GP	The target of 90% has been achieved	All care coordinators to check and confirm service users have a registered GP
1b. Sharing CPA registers with GP **Target =100%**	Letters/E-mails sent to GPs	Target of 100% has been achieved	Care coordinators will liaise with GPs to share care records
1c. CPA request physical long term conditions also reflected in Care Records **Target =80%**	Emails to GPs to request information on Physical Health	Target of 80% has been achieved - **Currently 95.5%**	Care coordinators to take the lead in coordinating care with GP and Primary Care
1d CPA with known physical health conditions supported via quality and outcomes framework **Target =60%**	Confirmed that all CPA clients had physical health checks with in 15 months	Target of 60% has been achieved - **Currently 75%**	Care coordinators to take the lead in coordinating care with GP and Primary Care
% Prescribing of antipsychotic for people with dementia **Target = Audit completed**	Trust wide audit undertaken	The audit recommendations shared and discussed with the Drugs and Therapeutics committee	Raise clinicians awareness A checklist for all prescribers Re-audit in 12 months time
5% Improvement in Service User experience (Inpatient Satisfaction Survey)	Practice Improvement staff worked along side in-patient staff to improve weakness identified in local survey	The target has been achieved (See monitor compliance targets on page…)	PIPs to continue to work with and support in-patients staff in improving practice All wards to focus on improvements in monthly quality meeting

Statements

Appendix 1

North East London NHS
NHS Foundation Trust

Confidential

Quality Account 2010/11 Consultations - MHS

Service area/Forum

In June 2010 all Trusts were required to publish their first Quality Accounts. Quality Accounts are our opportunity to share what our organisation is doing well, where we need to make improvements and how we intend to bring about the improvements.
We are keen to engage with and hear the views of everyone with an interest in the Trust in setting our improvement priorities.

Below are a set of areas where we would like to hear your views. Can you rank each item from 1 – 8 in terms of its priority for improvement. We intend to use this feedback to inform what goes into our Quality Accounts and they will become areas for change and improvement.

Please rank 1 as the highest areas for improvement and 8 for the least.

	Rank 1 - 8
• Effectiveness of treatment	
• Staff attitude and communication	
• Information for service users	
• Service user involvement/engagement	
• Carer involvement and satisfaction	
• Range of services available	
• Waiting times	
• Access to buildings	
Comments:	

Can you tell us:-

The one thing you would like us to focus on to bring about improvements in Mental Health Services:-
Comments:

The one thing you think we are currently doing well in Mental Health Services:-

Comments:

Thank you for your contribution. Please return completed form to:-
Sue Merchant
Maggie Lilley Suite
Goodmayes Hospital, Barley Lan

Appendix 2

Quality Accounts Questionnaire (Mental Health Services) Consultations Results

Priority Order for MHS (In order of importance)

	TOTAL RANK FOR MHS
Staff attitude and communication	1 (Highest need for improvement)
Effectiveness of treatment	2
Information for service users	3
Range of services available	4
Waiting times	5
Service user involvement/engagement	6
Carer involvement and satisfaction	7
Access to buildings	8 (Lowest need for improvement)

Key

Name	Code	Name	Code
The Public - Sunflower Court	SUN CT	Waltham Forest SURG	WF S
Joint OSC	J.OSC	Havering SURG	HAV S
MHS Staff	MHS	Barking & Dagenham SURG	BD
Havering General Practitioners	HAV G.P	Trust-wide	TW
Carers Strategy	CS	Governors	GOV
Senior Leaders Forum	SLF	Use Involvement	UI
Co-Commisioning	CC	Faith Forums	FF
UOAT	UOAT		

Collated Scores for MHS across all Services

	UI	TW	BD	HV S	WF S	UOAT	CC	SLF	CS	J.OSC	HAV G.P	F.F	SUN CT	MHS	GOV	LINKS	TOTAL
Effectiveness of treatment	3.40	3.27	4.57	2.25	0	4.53	1.00	3.40	4.33	3.33	2.38	5	2	3.45	1	1.60	2.84
Staff attitude and communication	2	3.82	1.57	3.5	0	3.06	2.00	2.00	3.33	2.33	3.62	6	2.13	4.09	4	2.6	2.88
Information for service users	2.2	3.91	2	4.5	0	3.88	7.00	2.20	2.33	4.42	5.23	1	3.63	4.09	3.5	5.4	3.46
Service user involvement/engagement	4.2	4.27	5.29	5.5	0	4.29	6.00	4.20	6	3.17	5	2	3.25	4.55	3	5	4.11
Carer involvement and satisfaction	6	4.45	5.14	3.5	0	4.53	4.00	6.00	5.67	4.50	5.85	3	5	4.91	6.5	5.2	4.64
Range of services available	4.4	4.45	4.71	5.25	0	4.35	3.00	4.40	6	5.00	3.46	4	6	4.82	6.5	3.8	4.38
Waiting times	6	4.73	5	4.5	0	4.29	5.00	6.00	5	5.58	2.77	7	8	5.09	4.5	4.6	4.88
Access to buildings	7.8	7.09	7.71	7	0	6.71	8.00	7.80	6.33	7.50	7.31	8	7	5	7	7.8	6.75

Quality Accounts Questionnaire - B&D Community Health Services Consultation Results

Priority Order for CHS (In order of importance)

	TOTAL RANK FOR CHS
Carer involvement and satisfaction	1 (Highest need for improvement)
Effectiveness of treatment	2
Range of services available	3
Waiting times	4
Information for service users	5
Staff attitude and communication	6
Access to buildings	7 (Lowest need for improvement)

Key

Name	Code	Name	Code
Senior Leaders	SL	Urgent Care Team	UCT
Community Dietician	CD	Health Visitor	HV
Community Rehab	CR	PPI	PPI
Speech & language therapies	SLT	Anonomous	ANON
Governors	GOV	LINKS	LK
Physio Therapy	PT	Performance Group	PERF
Dental Department	DD		

Collated Scores for CHS across all Services

	PERF.	ANON	PPI	HV	UCT	DD	PT	GOV	SLT	CR	CD	SL	LK	TOTAL
Effectiveness of treatment	4.57	4.29	3.25	3.25	3.25	3.25	3.46	3.35	3.35	3.32	3.32	3.36	1.75	**3.50**
Staff attitude and communication	4.14	2.86	5	5.00	5.00	5.00	4.57	4.79	4.79	4.86	4.86	4.77	3.50	**4.64**
Information for service users	3	3.79	4.25	4.25	4.25	4.25	4.16	4.20	4.20	4.22	4.22	4.20	4.50	**4.08**
Carer involvement and satisfaction	3.57	3.43	2.75	2.75	2.75	2.75	2.89	2.82	2.82	2.80	2.80	2.82	5.25	**2.91**
Range of services available	4.29	4.57	3.25	3.25	3.25	3.25	3.51	3.38	3.38	3.34	3.34	3.39	5.00	**3.52**
Waiting times	3.14	3.64	3.75	3.75	3.75	3.75	3.73	3.74	3.74	3.74	3.74	3.74	2.00	**3.68**
Access to buildings	5.29	5.43	5.75	5.75	5.75	5.75	5.69	5.72	5.72	5.73	5.73	5.72	6.00	**5.67**

Appendix 3

NELFT AQMAR ACTION PLAN 2011

	Link	OBJECTIVES	KEY TASKS	Person Responsible	Time Frame	PROGRESS
1	1.1.5	EMT report identifying financial resources to support appraisal and revalidation for doctors	Trust requires clearer instructions to enable it to quantify resources dependant on agreed action plan	CEO		Action Plan sent to Deanery
2	3.2.4, 4.2.1, 2c, 2d, 2e, 2f, 3d, 4b, 5b,	Procurement Process commences to identify training provider; handbook; web-bsed appraisal system	Contact supplies department to commence procurement process	SB	Nov 10 -Jan 11	Presentations made by three providers on AQMAR solution
3	1.1.5	Report to EMT identifying financial resources required	Compilation of Report following receipt of figures from procurement process	AH & MED	Jan-11	Annually
4	8a - 8e	Cascade of Information from Medical Director to all doctors	Establishment of information cascade	AH	Jan-11	Ongoing
5	4	Indemnity arrangements	Indemnity clause to be inserted into contract of employment	Medical personnel	Jun-11	Med Personnel in agreements regarding clause. Awaiting legal wording
6	2.1.2, 2.1.3	Appraisal skills to be built into Job Descriptions & Recruitment Process	Appraisal skills to be built into job descriptions	AH & Medical Personnel	Mar-11	Progress in line with time frame
7	2.3.2, 3.3.1-3, 3.4.2	Appraisal Training programme Delivered including appraiser support	Appraisal Training delivered to all doctors within the Trust (this includes training in the on-line appraisal system)	IT	Jun-11	
8	2.3.3	Appraisals to include Trust Objectives	Trust objectives circulated to appraisers	AH & MED	Apr-10	Apprails in line with Trust Objectives
9	1.1.7	E&D Impact Assessment Carried out		AH	Mar-11	
10	4.1.7	Secure Facilities for Documentation Provided		AH, MED, IT	May-11	Partially completed
11	2.2.2, 2.2.3, 3.1.1,- 3.2.2, 4.1.5, 5e, 5f	Monitor and Evaluate Appraisal Training	Sampling of 20% of appraisals to ensure conformation to GMC and Royal College Standards and measured against the attributes in Good Medical Practice	AH & MED	Mar-11	Annually
12	2.3.1	Report of Sample Appraisals send to Medical Director	MED to prepare report from 20% sample appraisals	AH & MED	Apr-11	Annually
13	1.1.3, 1.1.4, 3.4.1	Training Plan Produced with Recommendations	AH to take to EMT	AH	Jun-11	Annually
14	1.1.2, 4.1.6	Undertake 3 yearly Independent Review	Oustide Regulator to be appointed by AH	AH	Apr-13	three yearly

Please Note: All of our objectives will need to be ratified by NHS Medical Directors - London Medical Directors have agreed to wrok together in order to achieve a consistent approach