9. Quality Report

Governor Tom Scott at a Quality Council meeting

9.1 Statement by the Chief Executive

I am pleased to present the Quality Report for 2010/11. The Trust is committed to continuously improving the quality of all the services that we provide. We have established great foundations to build on as we look to improve things further in 2011/12.

The improvements delivered over the last year and described in this Quality Report are indicative of the efforts put in by staff across the Trust. Thanks to their contribution, we have delivered achievements against priorities for improvement set in our 2009/10 Quality Report and secured the Commissioning for Quality and Innovation (CQUIN) income that was dependent on a number of these priorities.

The Make a Difference Group sponsored in 2009/10, continue to meet monthly. They have completed the development of a questionnaire to elicit feedback form people using the Trust's services and have progressed to interviewing service users and carers. The information gathered from these interviews has been used to help managers and clinicians develop the Directorate Quality Improvement plans that truly reflect what people who use our services would like to see improved. This is a unique group of service users who have received training in questionnaires develomnet and audit methodology to provide them with the skills to support the invaluable work.

The Quality Council established in 2009/10 has continued to grow from strength to strength. It continues to meet twice yearly in March and October. The themes for the meetings to date have been quality initiatives in the Trust (with a display showcasing innovative work undertaken in the Trust), and service user involvement. The Board of Directors sees the Quality Council as a major forum for engaging with members and governors on the subject of quality. It provides an opportunity for key stakeholders to offer a challenge to the organisation in respect of its internally generated view of quality.

The Trust has continued to undertake monthly Service Quality Review Meetings with senior officers of the Trust and senior members of the Primary Care Trust. These meetings provide an opportunity for our commissioners to regularly monitor the quality of the services offered. It has also been agreed that commissioners would undertake ward inspections throughout the year and produce reports with recommendations for improvements.

Throughout 2010/11 the Trust has continued to work on the initiative commenced in 2009 called The Productive Mental Health Ward that focuses on finding ways to increase the amount of direct care time given to people who use mental health inpatient services. The programme is designed to improve the safety and effectiveness of mental health wards. This scheme is an excellent example of how high quality care can be achieved alongside improvements in productivity.

Last year we identified a number of areas where we wanted to show improvements. Below is an account of how we are doing in these areas and our plans for future activities during 2011 and into 2012.

In publishing this report the Board of Directors have reviewed its content and verified the accuracy of the details contained therein. I therefore confirm, in accordance with my statutory duty, that to the best of my knowledge, the information provided in this Quality Report is accurate.

Karen Dowman
Chief Executive

9.2 Priorities for Improvement

9.2.1 Smoking Cessation

In 2009/10, the Board of Directors identified a local health economy priority where approximately 30% of the general population continue to smoke. It is likely that this figure will be higher for people using our services. An increase in the numbers of patients quitting smoking / reducing tobacco use will lead to reduction in ill health, premature mortality and healthcare need.

During 2009/10, work focused primarily on inpatient areas and it was agreed that for 2010/11 this should be extended to ensure people attending outpatient appointments have access to information and support to stop smoking. It was therefore agreed to provide patients attending outpatient clinics, who were recorded as smokers / users of tobacco, with a brief intervention to reduce tobacco use including being given written advice as per NICE guidance. **Table 1** Below shows our performance in this area

9.2.2 Providing better information on medicines for patients and their carers

National surveys of people who use mental health services consistently show they have a perception that they do not receive adequate information about the side effects of prescribed medication. Inadequate information is often cited by people who use services as a factor which may contribute to poor adherence with medication regimes, including prematurely stopping taking the prescribed medication. Providing patients and their carers with written information when they receive new medications and any potential side effects will greatly improve compliance and therefore outcomes. Cessation of medication by patients due to side effects and inappropriate action thereafter has a big impact on patients and the mental health service.

In the self-assessment carried out in 2009/10 in preparation for the organisation's application for registration with the Care Quality Commission, paucity of information in relation to medicines was acknowledged as a shortfall by the Board of Directors.

The Board therefore supported a scheme that would increase the amount of information people received when they were given new medication. The provision of information would be measured by audits conducted twice during the year. This data would give the Board a baseline against which improvement could be measured. See **Table 2** below.

Table 1: Interventions to reduce tobacco use

Requirement	Baseline Audit QTR 2 2010	2nd Re-Audit QTR 4 2011
90% of smokers / users of tobacco attending outpatient clinics to receive a brief intervention to reduce tobacco use	58% of smokers / users of tobacco attending outpatient clinics received a brief intervention to reduce tobacco use	100% of smokers / users of tobacco attending outpatient clinics received a brief intervention to reduce tobacco use

Table 2: Patients receiving information on a new medication

Requirement	Baseline Audit May 2010	2nd Re-Audit Jan 2011
Patients receiving new medication to be provided with an information leaflet	6 out of 40 15%	23 out of 25 92%

9.2.3 Understanding and improving the experience of service users

In 2009/10, the Board of Directors recognised that auditing the quality of the experience of people who use our inpatient services has provided a wealth of information which helped to inform priorities in a number of areas. The Board agreed that this work which cuts across a number of the priority areas identified in the previous Quality Report should continue to be an activity that supports quality improvement. The most practical source of data collection would be through the completion of a questionnaire and although this is a continuous process, specific audits were undertaken twice during the year. See **Table 3** below.

9.2.4 Looking Ahead - Priorities for Improvement 2011/12

2011/12 will be a challenging year with the establishment of the newly configured Black Country Partnership NHS Foundation Trust. The Board will aim to ensure the vision of Transforming Community Services is embedded throughout the organisation to provide better health outcomes for patients, families and communities and to become more efficient, by providing modern, personalised, and responsive care of a consistently high quality that is accessible to all.

Sandwell Mental Health and Social Care NHS Foundation Trust undertook a process of involvement and engagement with key stakeholders to establish views on priorities for improvement in 2011/12. These priorities reflect the three domains of quality set out in 'High Quality Care for All'.

9.2.5 West Midlands Quality Review for Dementia, Acute In-patient Mental Health and Learning Disability Services

The Board of Directors has consented to reviews of the Trust's services by the West Midlands Quality Review Service (WMQRS) as these quality standards are designed to improve the quality of health services for service users, their families and carers.

More specifically the standards will ensure that:

- Service users, their families and carers will know more about services they can expect
- Commissioners will have better service specifications
- Service providers and commissioners will work together to improve service quality
- Quality review visits will give an independent view of service quality
- Reviewers will learn from taking part in review visits
- Good practice will be shared
- Service providers and commissioners will have better information to give to the Care Quality Commission and Monitor

The reviews will require the submission of evidence in respect of the different standards prior to visits by an inspection team. Inspectors will carry out site inspections and hold interviews with managers, staff and service users. WMQRS will then present their findings and assessment of these services to the Trust.

9.2.6 Understanding and improving the experience of service users

The Board of Directors is committed to continuing and developing systems to receive continual feedback about the quality of the experience of people who use our inpatient services. Previous years have provided a wealth of information which helped to inform priorities in a number of areas.

The Board agreed that this work should continue to be an activity that supports quality improvement. The most practical source of data collection will be through the completion of a questionnaire and specific audits will be undertaken twice during the year to measure the progress to inform the Board as well as local clinical practice and service users groups.

Table 3: inpatient satisfaction surveys completed

Requirement	Baseline Audit May 2010	2nd Re-Audit Jan 2011
Patients receiving hospital based mental health services completed questionnaires on level of satisfaction with service	19 inpatients surveyed score of 66%	20 inpatients surveyed score of 81%

9.2.7 Safety - Absconds

In 2008/09 the number of absconds by patients from inpatients areas was 146. In 2000/10 the number was 132 and in 2010/11 it rose again to 162. The majority of all absconds originate from the three wards at Hallam Street Hospital and the level of risk to self and others is mainly moderate or low. Nonetheless, the Trust recognises the need for work to be undertaken in this area to reduce the continuing upward trend. A project has already begun to address this issue by asking all staff working on these wards for their views and ideas on reducing the current number of absconds.

This work will continue during 2011/12 to look at

- the motivators for leaving: what reason did people give for leaving
- why and how people left what made it possible for people to abscond / how they left
- tisks: processes in place that made absconding possible/more likely
- solution / potential solutions to reduce the number of absconds taking place from Hallam Street Hospital.

Regular reporting of absconds via the Trust's Datix Incident Reporting System will ensure the progress and success of this project will be monitored by the Operational Risk Group throughout 2011/12.

9.3 Statements of Assurance from the Board

9.3.1 Review of services

During 2010/11 Sandwell Mental Health and Social Care NHS Foundation Trust provided services for both inpatient and community services for people with mental health problems and people with learning disabilities. The Trust has reviewed all the data available to them on the quality of care in all of these services.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Trust.

9.3.2 Participation in clinical audits

During 2010/11, 5 national clinical audits and 0 national confidential enquiry covered NHS services provided by Sandwell Mental Health and Social Care NHS Foundation Trust (SMHFT).

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

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

Table 4: National clinical audits and confidential enquiries held in 2010/11

HQIP	National Audit of Psychological Therapies for Anxiety and Depression
NICE	National NICE Audit for Health and Work
NCI	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
HQIP	National Falls and Bone Health Audit
POMH	Topic 1e Prescribing of high dose and combination antipsychotics on adult acute wards
POMH	Topic 2e Screening for metabolic side effects of anti-psychotic drugs
POMH	Topic 7b Lithium Monitoring
POMH	Topic 8b Medicines Reconciliation
POMH	Topic 10a Prescribing anti-psychotics for children and adolescents

The national clinical audits and national confidential enquiries that Sandwell Mental Health and Social Care NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 5: Clinical Audits and Confidential Inquiries Participated in 2010/11

Title	Start	Finish	Criteria	Cases Submitted
POMH-UK Topic 1e Prescribing of high dose and combination antipsychotics on adult acute wards	Feb 2010	April 2010	Data for all patients within the period 4 January - 5 February 2010, who occupied a bed and were being prescribed one or more anti-psychotic drugs.	100%
POMH-UK Topic 2e Screening for metabolic side effects of anti-psychotic drugs	Feb 2010	April 2010	AOTs were asked to review the clinical records of every patient on their case load who was prescribed anti-psychotic drugs during the audit period April 2010	100%
POMH-UK Topic 7b Lithium Monitoring	Feb 2010	Sept 2010	Monitoring of patients prescribed lithium 13 teams, patient records from April 2009-March 2010	100%
POMH-UK Topic 10a Prescribing anti-psychotics for children and adolescents	June 2010	Sept 2010	All children and adolescents prescribed anti-psychotic medication	100%
POMH-UK Topic 8b Medicines Reconciliation	Aug 2010	Nov 2010	Recommended minimum sample: 5 recent consecutive admissions to each participating ward, which had stayed for at least 7 days. A minimum of 5 patients per ward, recently admitted and stayed for at least 7 days	100%
National Falls and Bone Health Organisational Audit	Aug 2010	Sept 2010	Participated in organisation audit but mental health excluded from clinical audit	100%
National Audit of Psychological Therapies for Anxiety and Depression Part 1. Service Questionnaire	May 2010	Oct 2010	By every service providing or delivering NHS funded psychological therapies for anxiety and / or depression in primary and / or secondary care. 1 x service questionnaire submitted for Primary Care Liaison Service	100%
Part 2. Therapists Survey	June 2010	Dec 2010	Every therapist / worker, whose service is taking part in NAPT. 29 x therapists took part but the Trust experienced problems participating in this audit due to staff sickness	0%

The Trust uses clinical audit and participation in national confidential enquiries as a driver for improvements in quality. The Trust aims to ensure that all clinical professional groups participate in clinical audit.

The reports of five national clinical audits were reviewed by the Trust in 2010/11 and the Trust intends to take the following actions, shown in **Table 6** below, to improve the quality of healthcare provided.

Table 5: Clinical Audits and Confidential Inquiries Participated in 2010/11 (continued)

Title	Start	Finish	Criteria	Cases Submitted
Part 3. Retrospective Audit	Dec 2010	Feb 2011	Trust experienced problems participating in this audit due to staff sickness	0%
National NICE Audit for Health and Work	Nov 2010	Jan 2010	On-line organisation audit tool	100%
National confidential inquiry into Suicide and Homicide by people with mental illness		2010	Information is provided on request	100%

Table 6: Actions arising from audits 2010/11

Title	Report	Actions Taken
HCC Schizophrenia	3	Audit of information held on Trust system / re-circulation of relevant policies / review of CPA supervision tool / revision of standard letter sent to service users
National Continence Audit	3	Attendance at the National Audit of Continence Care to obtain additional information for Good Practice
POMH Topic 1e Prescribing of high dose and combination anti-psychotics on adult acute wards	3	Improvement on last audit discussed at D&T Committee
POMH Topic 2e Screening for metabolic side effects of anti-psychotic drugs	3	Poor results but improvement since
POMH Topic 7b Lithium Monitoring	3	Generate discussion on how to improve particularly weight checks / BMI
POM Topic 10a Prescribing anti-psychotics for children and adolescents	3	Mixed results but continued monitoring
POMH Topic 8b Medicines Reconciliation	3	Small sample

The reports of 13 local clinical audits were reviewed in 2010/11 and Sandwell Mental Health and Social Care NHS Foundation Trust intend to take the following actions to improve the quality of healthcare provided.

- Programme of additional training for staff
- Detailed discussion at relevant committees to ensure actions are embedded
- Completion of multidisciplinary audits
- Provision of workshops on record keeping

Information from the National Confidential Inquiry into Suicide and Homicide by people with mental illness indicated that the response rate for SMHFT was 100% which compares with a national average of 97.36%. The response rate for Sudden Unexplained Death Study (SUDS) for SMHFT was 100% which compares to a national average of 95.60%.

A paper produced by NHS West Midlands, following an overview of suicides throughout England, identified that Sandwell Mental Health and Social Care NHS Foundation Trust was one of two Trusts that had the lowest suicide figures and indicated that both Trusts are following best practice from the National Suicide Prevention Strategy for England (updated 2008).

9.3.3 Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 45.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest treatments and techniques. It further ensures that our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The level of research activity has prompted an agreement with both the Birmingham & Black Country Comprehensive Local Research Network and the Mental Health Research Network for a full time Clinical Studies Officer (CSO) to work at the Trust for a trial period of twelve months. This is the first time that a research post has been created for the Trust. The CSO's main duties will be to promote research throughout the Trust and to assist clinicians with current trials and new projects in order to increase recruitment levels.

9.3.4 Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of the Sandwell Mental Health and Social Care NHS Foundation Trust's income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation Payment Framework (CQUIN). Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at: http://www.monitornhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/

9.3.5 Care Quality Commission (CQC)

Sandwell Mental Health and Social Care NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is, Registered with no conditions applied.

The Care Quality Commission has not taken any enforcement action against the Trust as of the 31st March 2011.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

9.3.6 Data Quality

NHS Number and General Medical Practice Code Validity

The 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 99.0% for admitted patient care and 99.9% for out patient care.

The percentage of records in the published data, which included the patients valid General Medical Practice Code was 100% for admitted patient care and 100% for out patient care.

Information Governance Toolkit attainment levels 2010/11

The Trust's Information Governance Assessment Report overall score for 2010/11 was 59% and was graded red. This is shown in **Table 7** on page 102.

Feedback from these audits will be used to identify areas for local quality improvements for the forthcoming year.

The Information Governance Statement of Compliance is a formal document setting out obligations on organisations to have the necessary infrastructure and information governance requirements in place. There are 22 key standards on which specific assurance is sought to confirm that the Trust has robust and effective systems in place for handling information securely and confidentially. The Trust has attained at least the minimum required rating of level two in each of these key standards.

The Trust aims to deliver a standard of excellence in Information Governance by ensuring that information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care to our service users. The Information Governance Toolkit sets national standards for achievement to ensure that organisations maintain high levels of security and confidentiality of information at all times.

The Trust will take the following actions to improve data quality :-

1. A Roll out of Monitor identifiers and outcomes data integrity reporting showing missing required data including NHS Number

2. Development and roll out of CPA 12 month formal review monitoring

3. Remodelling of current manual performance housekeeping / checking process using new web business objects

Clinical Coding Error Rate

The Trust was subject to the Payment by Results clinical coding audit during March 2010. The error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

- Primary diagnosis correct 91.92%
- Secondary Diagnosis correct 49.28%

Clinical data must be accurately and consistently recorded to well defined national standards to enable it to be used for statistical analysis. Information drawn from accurate clinical coding better reflects the pattern of practice of clinicians and provides a sound basis for the decision making process. Of the 97 episodes audited, 0 were unsafe to audit.

9.4 Review of Quality Performance

Two of the indicators for safety have changed from 2009/10. Changes to the two indicators **Physical health checks for patients with a length of stay for 6 months** and **Reduction of violence and aggression experienced by staff and service users** were made as we were unable to establish data collections and reporting systems in a timely fashion.

9.4.1 Safety - Review of the number and nature of safeguarding referrals made

As people with mental health difficulties and learning disabilities may be vulnerable, the Trust completed a piece of work to develop robust safeguarding referral systems to increase the number of referrals. The number of referrals increased from 21 in 2008/09 to 127 referrals in 2009/10 to 184 in 2010/11.

Table 7: Information Governance Assessment Report 2010/11

Initiative	Results
Information Governance Management	60%
Confidentiality and Data Protection Assurance	62%
Information Security Assurance	64%
Clinical Information Assurance	53%
Secondary Use Assurance	58%
Corporate Information Assurance	33%
Overall	**59%**

The dramatic increase in recorded incidents over the last three years correlates directly to the increased investment by the Trust into this priority area. In 2009, the Trust invested in a new software incident reporting system for clinical areas. This was swiftly followed by the appointment of a full time Named Nurse for Safeguarding Adults and Children. In 2010, a further full time Named Nurse for Safeguarding Adults and Children was appointed to reflect the Trust's continued commitment to doing everything it reasonably can to protect vulnerable adults in its care.

The extra resources have resulted in an increase in staff awareness and training as well as improved and increased reporting using the new incident reporting system. The Named Nurses investigate and instigate a review of each case. The nature of referrals has so far been classified into the following main categories: physical abuse, financial abuse, sexual Abuse, absconds but this work is continuing as more data becomes available.

9.4.2 Safety - The correct usage of Lithium in line with national best practice

Lithium has been used as a mood stabiliser for many years and can be used to treat both manic and depressive episodes. Lithium is a safe drug when taken at the correct dose. The difficulty is getting the level of Lithium in the body right as the amount of Lithium in the blood is very sensitive to levels of water in the body. Regular blood tests are therefore required to check the amount of Lithium in the body and to ensure the kidneys and thyroid gland are working properly. Testing is required weekly for newly commenced patients but less frequently for established patients.
The quality improvement target for the correct usage of Lithium in line with national best practice involved three audits carried out at identified intervals in all inpatient areas and to improve on the baseline audit in May 2010 by 20%.

Table 8a: Correct usage of Lithium – baseline audit May 2010

Hospital	Type of Patients	Number	Percentage Achieved	Weighted Average
Heath Lane	Existing	4	45%	180%
	Newly Prescribed	1	100%	100%
Hallam Street	Existing	0	N/A	-
	Newly Prescribed	1	83%	83%
Edward Street	Existing	4	25%	100%
	Newly Prescribed	0	N/A	-
		10		463%
Overall weighted average				46%

Table 8b: Correct usage of Lithium – first re-audit October 2010

Hospital	Type of Patients	Number	Percentage Achieved	Weighted Average
Heath Lane	Existing	1	75%	75%
	Newly Prescribed	0	N/A	N/A
Hallam Street	Existing	5	57%	283%
	Newly Prescribed	0	N/A	N/A
Edward Street	Existing	3	48%	143%
	Newly Prescribed	0	N/A	N/A
Newton House	Existing	1	71%	71%
	Newly Prescribed	0	N/A	N/A
		10		572%
Overall weighted average				57%

9.4.3 Safety - Delayed and missed doses of medication

Medicine doses can be omitted or delayed in hospital for a variety of reasons including non-availability of medicines. Although these incidents do not often lead to significant harm, the omission of critical medicines has the potential to result in severe harm to patients and the Trust is committed to learning as much it can from theses occurrences both nationally and locally. The quality improvement required three audits to be carried out at identified intervals in Adult Outpatients and to improve on the baseline audit at May 2010 by 10%. See **Table 9** below

One of the indicators for patient experience has changed from 2009/10. The change to the indicator **Undertaking quality of life audits with people with learning disabilities and older people** was made as we were unable to establish data collections and reporting systems in a timely fashion.

There has been also been a slight change in emphasis regarding the indicator Formalising regular service user feedback with regards to dignity and respect. This has already been covered earlier in priorities for improvement so the indicator has been amended to include **Understanding and improving the experience of community mental health service users instead.**

9.4.4 Patient Experience - PEAT Scores

Key individuals in the Trust worked closely with facilities staff and contractors to monitor and improve the patient environment, quality of food and privacy and dignity for service users. The aim was to ensure that the PEAT scores achieved were at least good. These scores were achieved in 2009 but unfortunately were not sustained for 2010. An action plan was developed to address theses issues and the scores improved in 2011. The Trust PEAT scores are shown in **Table 10** opposite.

Table 8c: Correct usage of Lithium – Second re-audit January 2011

Hospital	Type of Patients	Number	Percentage Achieved	Weighted Average
Heath Lane	Existing	1	100%	100%
	Newly Prescribed	0	N/A	N/A
Hallam Street	Existing	4	71%	286%
	Newly Prescribed	0	N/A	N/A
Edward Street	Existing	0	N/A	N/A
	Newly Prescribed	0	N/A	N/A
Newton House	Existing	1	100%	100%
	Newly Prescribed	0	N/A	N/A
		6		486%
Overall weighted average				81%

Table 9: Delayed and missed doses of medication 2010/11

Requirement	Baseline Audit May 2010	Re-Audit Sept 2010	2nd Re-Audit Jan 2011
Patients with missed or delayed doses critical medication	0 out of 151 0.0%	1 out of 141 0.7%	0 out of 100 0.0%
Patients with missed or delayed doses non-critical medication	13 out of 151 8.6%	8 out of 141 5.6%	4 out of 100 4%

Patient Experience - Understanding and improving the experience of community mental health service users

Improving the experience of those patients who receive a community mental health service is an extension of the work undertaken with inpatient services. This work will ensure that all service activities and improvements are orientated towards improving the experience of these patients. The most practical source of data collection was through the completion of a questionnaire and audits were undertaken twice during the year.

Patient Experience - The support of detained patients by Independent Mental Health Advocates (IMHA)

Patients detained under the Mental Health Act have the right to be supported by an Independent Mental Health Advocate (IMHA). This vulnerable group of people do not always take advantage of the IMHA service that is available to help them as necessary. They have the choice not to do so but are always encouraged to utilise this service where possible.

The quality improvement required an improvement in the number of referrals to IMHA compared to the baseline audit at May 2010 by 20%. The Trust's performance in this area is shown in **Table 12** overleaf.

Table 10: PEAT scores 2010/11

YEAR	Hospital	Environment	Food	Privacy & Dignity (new category for 2009)
2011	Edward Street	Good	Excellent	Excellent
	Hallam Street	Good	Good	Good
	Heath Lane	Good	Excellent	Excellent
2010	Edward Street	Good	Excellent	Good
	Hallam Street	Acceptable	Acceptable	Good
	Heath Lane	Good	Excellent	Good
2009	Edward Street	Excellent	Excellent	Good
	Hallam Street	Good	Good	Good
	Heath Lane	Good	Excellent	Good
2008	Edward Street	Good	Excellent	Not included in assessment between 2006 -8
	Hallam Street	Good	Good	
	Heath Lane	Good	Excellent	
2007	Edward Street	Good	Good	
	Hallam Street	Good	Good	
	Heath Lane	Acceptable	Good	
2006	Edward Street	Poor	Acceptable	
	Hallam Street	Acceptable	Good	
	Heath Lane	Poor	Poor	

Table 11: Completion of questionairre on Community Mental Health Services 2010/11

Requirement	Baseline Audit May 2010	2nd Re-Audit Jan 2011
Patients receiving community mental health services completed questionnaires on level of satisfaction with service	25 patients surveyed score of 89%	30 patients surveyed score of 91%

There have also been changes to the indicators for Clinical Effectiveness from 2009/10. Changes to the two indicators **95% of all new referrals have a HONOS and score by Q4** and **Maintain re-admission rate below 5% at 28 days post discharge** were made as we were unable to establish data collections and reporting systems in a timely fashion. The indicator **Ensure delayed discharges are less than 7.5% across inpatient services** is covered later in the report under National Targets.

9.5 Clinical Effectiveness

9.5.1 Duration of untreated psychosis (DUP)

Early Intervention in Psychosis focuses on the early treatment of psychosis during the formative years of the illness. The first three to five years are believed to be a critical period. The duration of untreated psychosis has been shown as an indicator of more positive prognoses, with a longer DUP associated with increased likelihood of long term disability. The Early Intervention Service (EIS) aims to reduce delays to treatment for those in their first episode of psychosis.

Requirement

To reduce the duration of untreated psychosis (DUP) by providing effective early intervention services.

- Audit and analysis of early intervention services at Quarter 2 and Quarter 4.
- An action plan for working with referrers who associate with the longer DUPs and those referrers who associate with lowest referral rates, in order to reduce the duration of untreated psychosis.

Outcome

Both audits showed only minimal referrals from General Practitioners (2) of which one was inappropriate and the need to continue to promote the Early Intervention Service (EIS) to local General Practitioners. Results also revealed that the majority of referrals are made to the Early Intervention Service from other mental health services within the Trust and most long delays in the duration of untreated psychosis occur before a referral is actually made to EIS. There were also some delays between the date of referral to EIS and the date of assessment due to staffing issues. There was also the need for a system to be put in place for all staff to clearly understand how to calculate and record the date of the onset of psychosis from the date of the onset of criteria treatment in order to record the duration of untreated psychosis. An action plan identifying all of these issues has been put in place and work is continuing.

9.5.2 Clinical Effectiveness - treatment of schizophrenia with talking therapies

Anti-psychotic medications can have pronounced side effects that have profound effects on the wellbeing of a patient and may not always be the best choice of therapy. Patients who suffer with schizophrenia may therefore benefit from Cognitive Behavioural Therapy (CBT) sometimes referred to as 'talking therapies' as described in NICE guidance rather than medication.

The locally agreed quality improvement was an audit to ascertain the extent to which clients with a diagnosis of schizophrenia or suspected schizophrenia are receiving Cognitive Behavioural

Table 12: Number of referrals to Independant Mental Health Advocates (IMHAs) 2010/11

Requirement	The number of detained patients who were offered a referral to the IMHA service whilst under the care of the Trust
Baseline Audit May 2010	16 patients detained across all inpatient units. All of them received information on their rights which includes access to IMHA service. However systems not in place during May to record if this IMHA information was explained to service users by nursing staff
Re-Audit Sept 2010	18 patients detained across all inpatient units. Systems now in place to record relevant information. 9 were offered a referral. 1 patient was transferred out of service on the same day as admitted. 4 patients not offered as too ill but not clear if offered at a later date. 4 patients not recorded.
2nd Re-Audit Jan 2011	21 patients detained of which 19 were offered a referral to IMHA service. This equates to a 90% success rate.

Therapy (CBT) in adult community mental health services. A sample of 100 randomly selected clients with a diagnosis of schizophrenia were selected from the five adult community mental health teams

i.e. Assertive Outreach, Early Intervention, Rowley Regis and Tipton, Oldbury and Smethwick and Wednesbury and West Bromwich CMHTs, to look for evidence that CBT has been offered. An electronic questionnaire was devised against the guidance outlined in NICE CG082 Schizophrenia 1.3.4.12 for each care co-ordinator to complete. 100 completed questionnaires were received back for the initial audit in May 2010 and again for the re-audit undertaken in January 2011.

The quality improvement required audits to be carried out at Month 2 and Month 10 and to improve on the baseline audit at Month 2 by 50%. 61% of 100 randomly selected clients with a diagnosis of schizophrenia were offered Cognitive Behavioural Therapy (CBT) at January 2011 compared to 40% at May 2010, thus meeting this target.

For a comparison of results between January 2011 and May 2010, see **Table 13** below.

9.5.3 Clinical Effectiveness - Infection Prevention and Control

Surveillance is an essential component in the prevention and control of infection within the Trust, the main objectives of surveillance are:

- The prevention and early detection of outbreaks in order to allow timely investigation and control.
- The assessment of infection levels over time in order to determine the effectiveness of prevention and / or control measures.

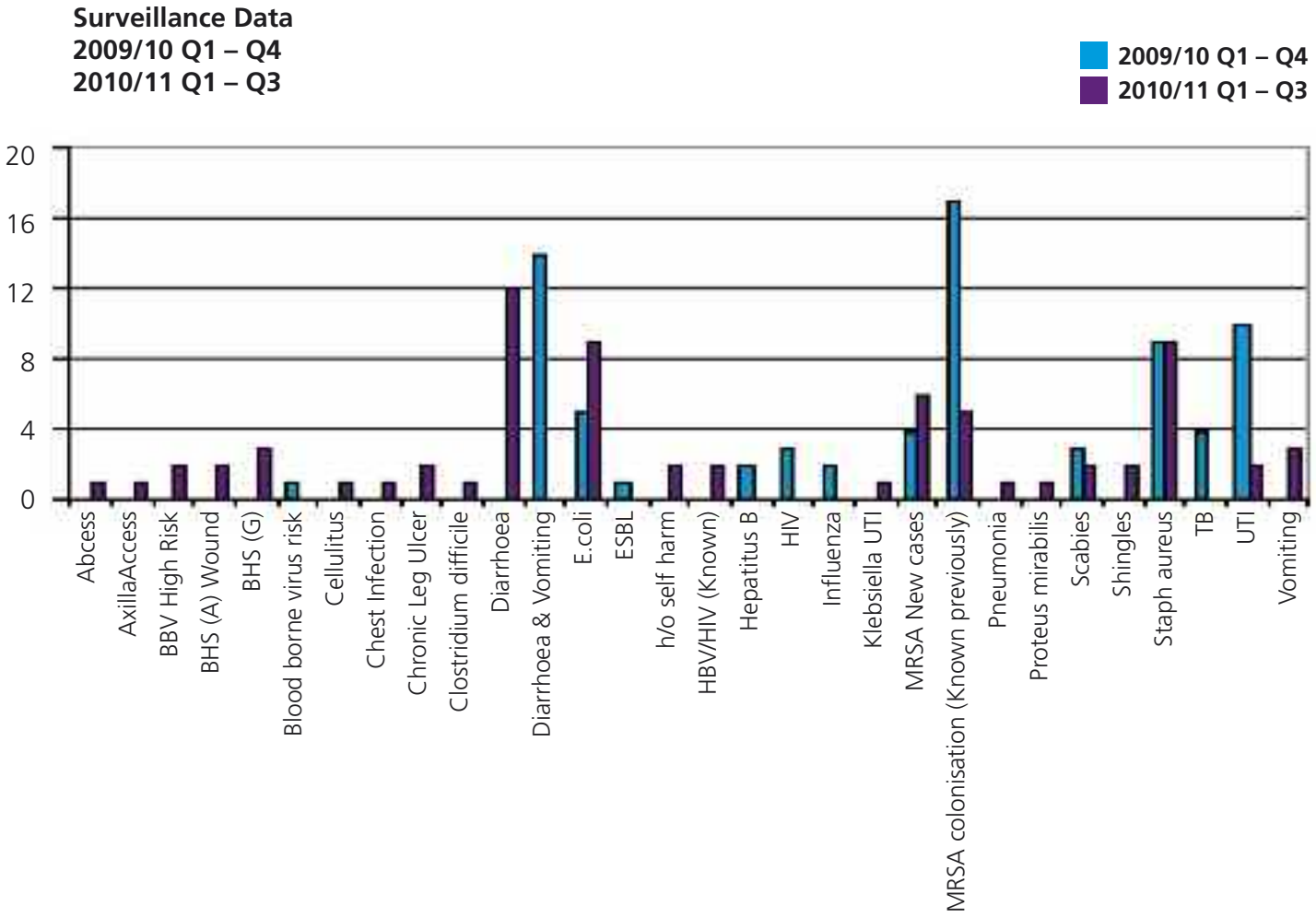
The Infection Prevention & Control Committee meets quarterly to review the annual work plan to ensure a safe environment is provided for patients, staff and visitors in terms of infection risk as required by the Health Social Care Act 2008. The Director of Infection Prevention & Control reports directly to the Board of Directors and presents quarterly reports to the Executive Committee and Quality Assurance Committee, with the annual report presented to the Board of Directors. Any gaps in compliance, identified via the auditing and inspection processes are addressed via clear action plans which are presented in a timely manner and monitored by the Infection Control Nurse Specialist (ICNS). Exception reports are presented to the above committees as / when necessary.

The Trust works with the wider health economy to reduce Health Care Acquired Infection (HCAI) incidence, agree targets and monitor performance. Cases of MRSA bacteraemia and C. difficile remain very low and are monitored weekly by the ICNS. Due to continued low numbers, the Trust has not been set a trajectory target. However, should an incident occur, systems are in place to ensure that a Root Cause Analysis (RCA) is undertaken and action is taken to reduce the incidence of recurrence across the health economy.

Table 13: Clients with a diagnosis of schizophrenia offered CBT during 2010/11

Teams	Number of randomly selected clients with a diagnosis of schizophrenia		CBT offered as per NICE CG82	
	Jan 2011	May 2011	Jan 2011	May 2010
Assertive Outreach Team	22	23	13 (59%)	12 (52%)
Early Intervention Team	21	9	19 (90%)	6 (67%)
Oldbury & Smethwick CMHT	24	25	17 (71%)	16 (64%)
Rowley Regis & Tipton CMHT	17	17	8 (47%)	4 (24%)
Wednesbury & West Bromwich CMHT	16	26	4 (25%)	2 (8%)
Total Number	100	100	61 (61%)	40 (40%)

Figure 1: Infection prevention and Control Surveillance Data



9.6 National Targets 2010/11

We report our performance against key national priorities to the Board of Directors and our regulators throughout the year. Actions to address any areas of under performance are put in place where necessary. The patient related performance measures and outcomes shown in table 14 opposite help us to monitor how we deliver our mental health services.

9.6.1 Meeting commitment to serve new psychosis cases by early intervention teams

According to the World Health Organization schizophrenia and other forms of psychoses which affect young people represent a major public health problem. Worldwide, they rank as the third most disabling condition and pose an enormous burden, both in terms of economic cost and of human suffering. Yet, in spite of the availability of interventions that can reduce relapses by more than 50%, not all affected individuals have access to them, and when they do, it is not always in a timely and sustained way. Among the goals of care to these people, the identification of the illness and its treatment, as early as possible, represents a high priority. Comprehensive programmes for the detection and treatment of early psychosis and in supporting the needs of young people with early psychosis carry the important function of promoting recovery, independence, equity and self-sufficiency and of facilitating uptake of social, educational and employment opportunities for those young people. These programmes can be provided by individuals and teams with specialised skills, with a full range of primary health care services for every young person with early psychosis.

9.6.2 Admissions to inpatients services had access to crisis resolution home treatment teams

A crisis resolution team (sometimes called a crisis resolution home treatment team) provides intensive support for people in mental health crises in their own home: the team stays involved until the problem

is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. This measure refers to the number of admissions to the trust's acute wards that were gate kept by the crisis resolution home treatment teams.

9.10.3 Delayed Transfers of Care

This measure refers to the number on non - acute patients aged 18 and over who's transfer of care was delayed each week. Although the Trust is not required to monitor delayed discharges in social care, nevertheless it does so in recognition of the wider health and social responsibility to work jointly in preventing delayed discharges.

The Trust believes that it is important to carry out monitoring because once a service user no longer requires hospital treatment, they should not unnecessarily continue to be in hospital waiting for discharge or transfer of care. Furthermore, when a service user's transfer to their next care setting is delayed, it has an impact upon the quality of care they receive.

The monitoring of this target has enabled the Trust to enter into discussions with commissioners in attempts to rectify the high number of delayed discharges relating to social care.

9.10.4 - 7 Day Follow up

This measure refers to the number of people under adult mental illness specialties on CPA receiving follow up (by phone or face to face contact) within seven days of discharge from psychiatric inpatient care. Follow up within 7 days for service users discharged from hospital is important because it is during the early days after discharge that service users and their carers can feel especially vulnerable. This process contributes to reducing the overall rate of death by suicide across the NHS.

Once a service user no longer requires hospital treatment, they should not unnecessarily continue to be in hospital waiting for discharge or transfer of care. The delay of a service user's transfer to the next care setting has an impact on the quality of care they receive. This contributes to what is a wider health and social care responsibility to work jointly to prevent delays in all patients receiving the right care in the right place at the right time.

9.11 Annex

9.11.1 Statement from Stakeholder Sandwell Primary Care Trust (PCT)

Sandwell PCT is the main commissioner of services at Sandwell Mental Health and Social Care NHS Foundation Trust and as such is responsible for monitoring the quality of services provided for Sandwell patients.

We believe that this Quality Report is factually accurate and a good reflection of the Sandwell inpatient and community services provided for people with mental health problems and people with learning disabilities. We have established close working relationships with the Trust which have ensured that we have had good timely access to information. Quality of care is monitored in a variety of ways using various sources and data types. We look forward to developing the quality agenda further with the Trust in the coming year.

Table 14: Patient related performance measures 2010/11

Target	Meeting commitment to serve new psychosis cases by early intervention teams	Admissions to inpatients services had access to crisis resolution home treatment teams	Delayed Transfers of Care %	7 Day Follow up %
	53	90%	< 7.5%	95%
Achievement	Year to Date - 67	Quarterly average 100%	Excluding Social Care – quarter to date 0.3% Including Social Care – quarter to date 15.2%	Quarterly average 98%

9.11.2 Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

In preparing the quality report, directors have taken to steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011
  - Papers relating to quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated 18/05/2011
  - The Trust's Complaints Report published under regulation 18 of the Local Authority
  - Social Services and NHS Complaints Regulations 2009, dated 25/05/2011
  - The latest national patient survey
  - The latest national staff survey
  - The Head of Internal Audits annual opinion over the trust's control environment dated 20/04/2011
  - CQC quality and risk profiles dated 25/05/2011.
- the Quality Report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

This Quality Report has been prepared in accordance with Monitor's annual reporting guidance as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board,

Bob Piper, Chairman
25 May 2011