ST PATRICK'S UNIVERSITY HOSPITAL OUTCOMES REPORT

2011

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SECTION 1

Introduction

1. Introduction

The 2011 Outcomes Report is the first of its type produced by St Patrick's University Hospital (SPUH). This report represents an attempt to collate, analyse and synthesise information relating to the hospital outcomes with respect to its clinical care pathways, clinical governance processes and clinical process. The purpose of the report is to promote an organisational culture of excellence and quality through engagement in continual service evaluation in relation to efficacy, effectiveness and quality. By routinely measuring and publishing the outcomes of the services we provide, we can begin to understand what we do well and what we need to improve.

The Report is divided into 8 sections. This Section 1 provides an introduction and summary of the report's contents. Section 2 outlines information regarding how SPUH's mental health services are structured and were accessed in 2011. This includes how services are accessed through the hospital's three distinct care pathways. The Dean Clinic Community Mental Health Clinic Network provides our community pathway, the Wellness & Recovery Centre provides our day-patient pathway and our three approved centres provide our inpatient care pathways. These include St Patrick's University Hospital (SPUH), St Edmundsbury Hospital (SEH) and Willow Grove Adolescent Unit (WGAU).

Section 3 summarises the measures and outcomes of the organisation's clinical governance processes. Section 4 provides an analysis of clinical outcomes for a number of selected clinical programmes. This information provides practice-based evidence of interventions and programmes delivered to service users during 2011. These outcomes are not generated from applied research protocols but rather reflect the use and measurement of evidence-based mental health practice in SPUH. Section 5 summarises efficiency outcomes for SPUH's Laboratory clinical blood testing service.

St Patrick's University Hospital considers service user participation and consultation a valued and integral aspect of clinical service development. By measuring and monitoring service users' experience of its services, the organisation works continually towards ensuring that more people have a positive experience of care, treatment and support at SPUH. In addition, service user evaluation provides a method of involving and empowering service users to improve mental health service standards. In 2011, SPUH participated in a national service user survey and also carried out numerous service user evaluations and focus groups to garner feedback. Section 6 summarises the outcomes of these service user evaluations and feedback in relation to service user experience and satisfaction of SPUH services.

Finally, Section 7 summarises the Report conclusions about the process and findings of outcome measurement within the organisation.

SECTION 2

Operational Measures

2. St Patrick's University Hospital Care Pathways

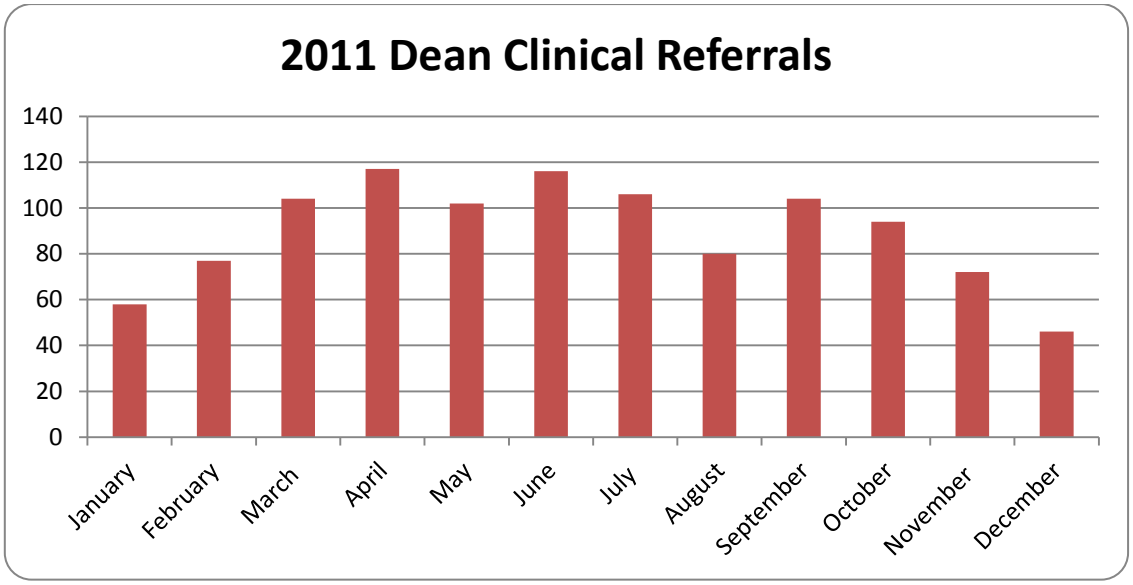
St Patrick's University Hospital is the largest independent not-for-profit mental health service provider in Ireland. Our mental health services are accessed through three distinct but integrated care pathways. These include our out-patient care pathway accessed through our Dean Clinic network of community mental health clinics, our day-patient care pathway accessed through our Wellness and Recovery Centre and our in-patient care pathway accessed through our three approved centres. This Section provides information about how our services were accessed through these pathways in 2011.

2. 1. Dean Clinic Pathway

St Patrick University Hospital's strategy, Mental Health Matters (2008-2013), has committed the organisation to the development of community mental health clinics. Over the past four years, a nationwide network of multi-disciplinary community mental health services known as Dean Clinics has been established by the hospital. Three Dean Clinics opened in 2011 including Dean Sandyford, Dublin, Dean St Patrick's and Dean Galway. Significantly in January 2011, a decision was taken to offer free multi-disciplinary mental health assessment through the Dean Clinic network to improve access to service users.

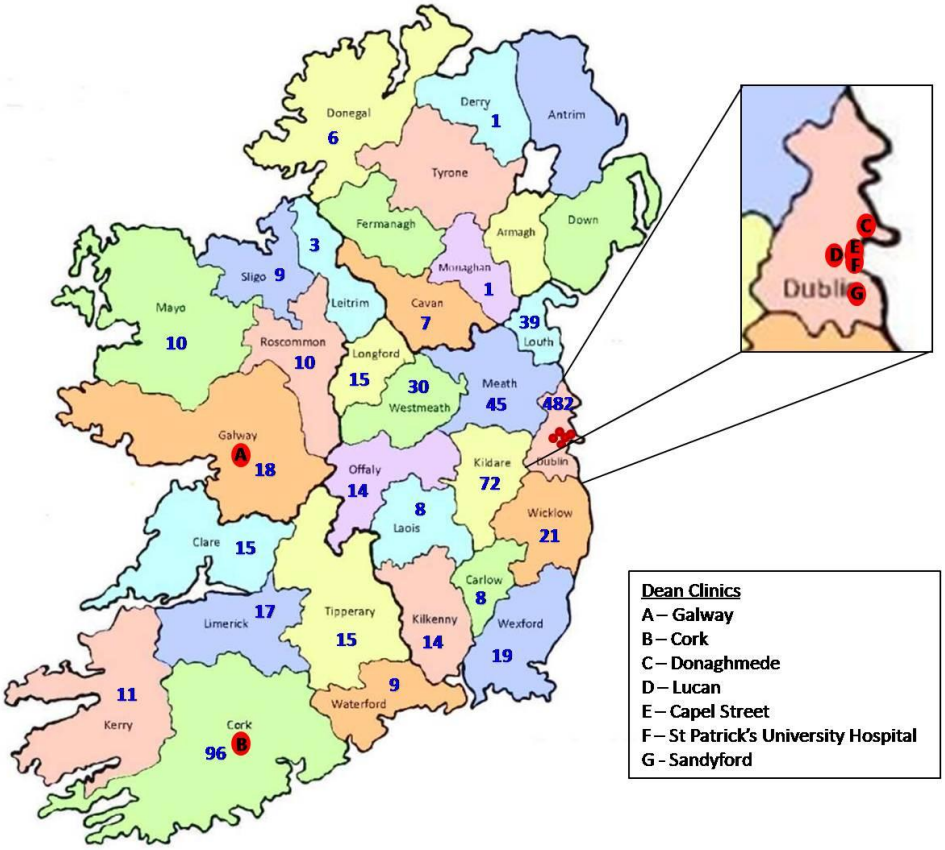
2.1.1. Number of Dean Clinic Referrals in 2011

A total of 1376 Dean Clinic referrals were received for the period 01/01/11 to 31/12/11. The following tables summarise Dean Clinic monthly referral totals for the same period. Demand for Dean Clinic services peaked in April and June 2011.



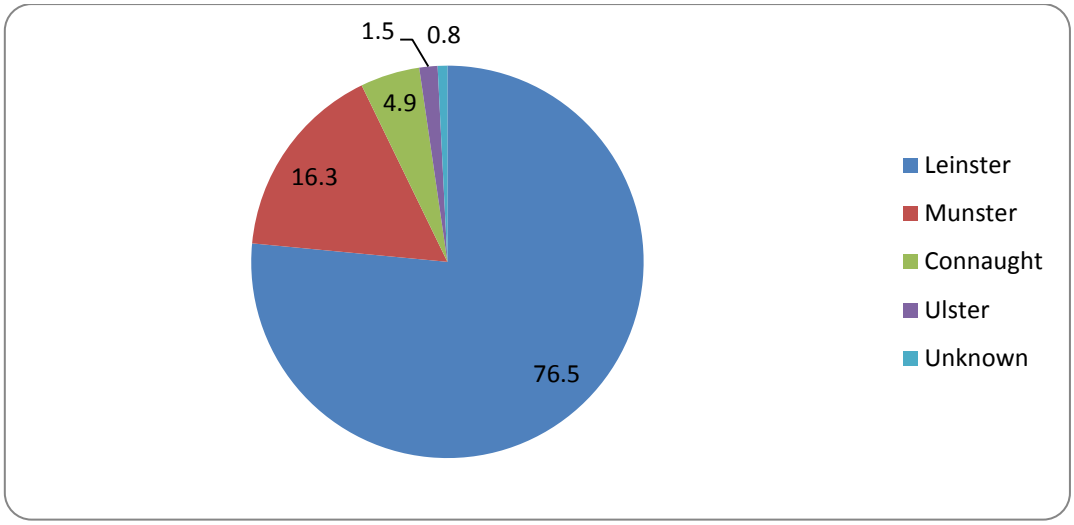
2.1.2. Referral Source (Geographical Spread)

The following figure illustrates the geographical spread of Dean Clinic Referrals by county.



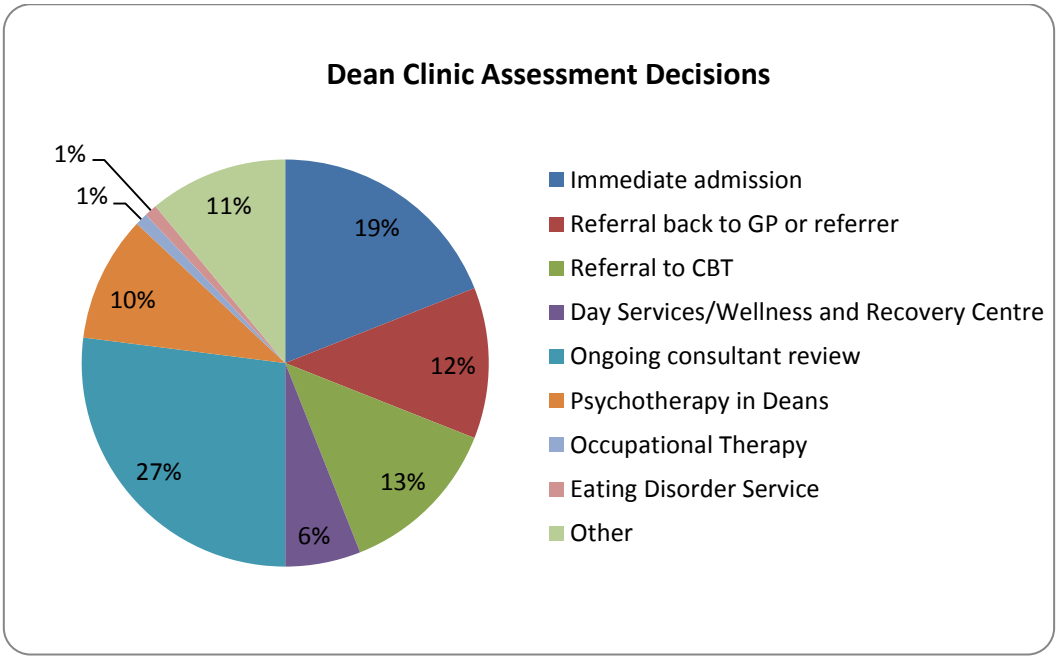
2.1.3. Referral Source (Provincial Spread)

The chart below summarises the percentage of Dean Clinic referrals by Province.



2.1.4. Outcome of Dean Clinic MDT assessments

The following chart illustrates assessments and interventions provided through Dean Clinics arising from individualised care plans.



2.2. 2011 Inpatient Care Pathway

SPUH comprises three separate approved centres including St Patrick's University Hospital (SPUH) with 238 inpatients beds, St Edmundsbury Hospital (SEH) with 50 inpatient beds and Willow Grove Adolescent Unit (WGAU). For the period 01/12/10 to 01/12/11, there were a total of 2981 admissions across the organisation's three approved centres.

2.2.1. 2011 Inpatient Admission Rates by Approved Centre

The following tables summarise inpatient admission information including gender ratios, age and average length of stay (ALOS) across the hospital's three approved centres; St Patrick's University Hospital, St Edmundsbury Hospital and Willow Grove Adolescent Centre. Unit.

Admissions 2011 by gender, across centre								
	SEH	%	**SPUH**	%	**WGAU**	%	**Total**	%
Female	**333**	11.2	**1417**	47.5	**50**	1.7	**1800**	60.4
Male	**165**	5.5	**993**	33.3	**23**	0.8	**1181**	39.6
Total	**498**	**16.7**	**2410**	**80.9**	**73**	**2.4**	**2981**	**100**

The table below shows that the average age of service user, by gender across approved centres admitted during the period was 47 years. The average age for WGAU was 15 years, 52 years for SEH and 48 years for SPUH.

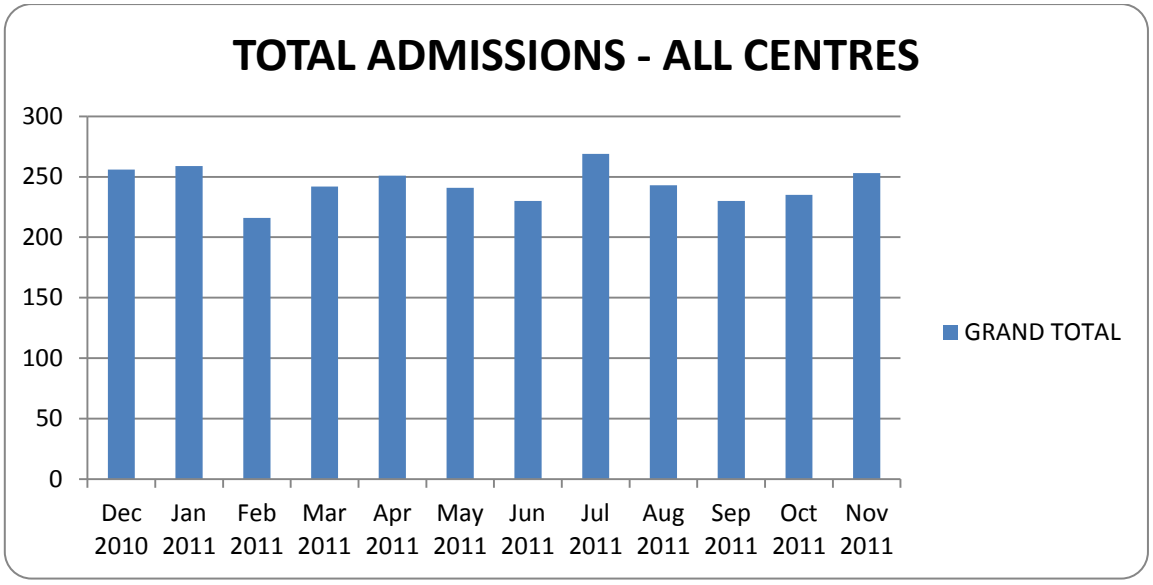
Average Age at Admission				
	SEH	**SPUH**	**WGAU**	**Total**
Female	52.44	49.22	15.70	48.88
Male	50.56	46.41	15.52	46.39
Total	**51.82**	**48.06**	**15.64**	**47.90**

The table below presents the average length of stay (ALOS) by gender for current inpatients - the period was 32 days, with 31 days for SEH and SPUH and 45 days for WGAU.

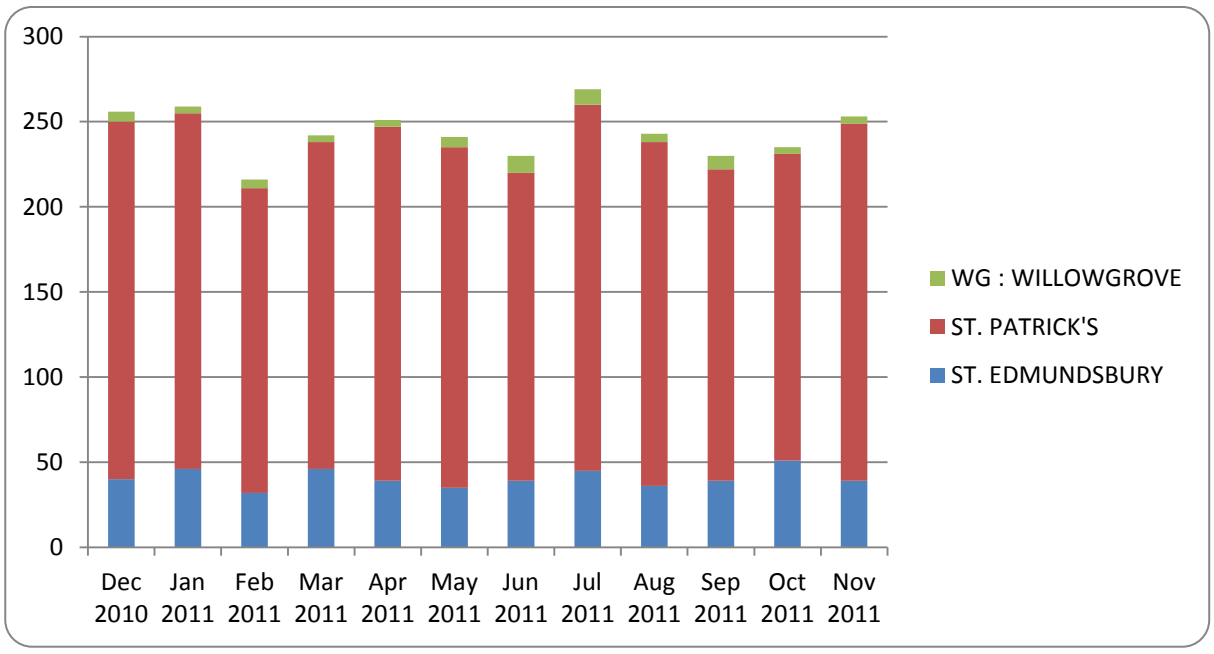
ALOS* Current Inpatients				
	SEH	**SPUH**	**WGAU**	**Total**
Female	32.28	31.95	48.06	32.46
Male	28.93	31.41	38.70	31.20
Total	**31.17**	**31.72**	**45.11**	**31.96**

2.2.2. 2011 Monthly Admission Rate for Approved Centres

The following tables illustrate inpatient monthly admission rates across St Patrick's University Hospital's three approved centres.



The table below presents proportional admission rates across three approved centres for each month of period 01/12/10 to 01/12/11.



2.3. Day-patient Pathway: Wellness & Recovery Centre (WRC)

The Wellness & Recovery Centre (WRC) was established in November 2008, following a reconfiguration of SPUH's Day Services. As well as providing a number of recovery-oriented programmes, the Centre provides service users with access to a range of specialist clinical programmes which are accessed as a step-down service following inpatient treatment or as

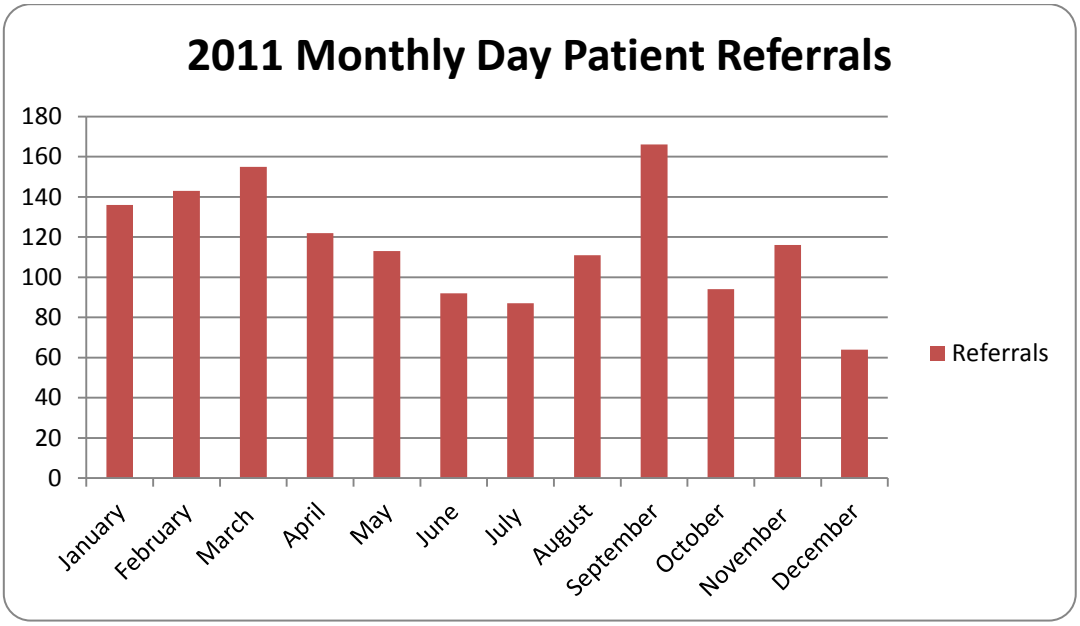
a step-up service accessed from the Dean Clinic Referral Pathway. Clinical programmes are delivered by specialist multi-disciplinary teams and focus primarily on disorder-specific interventions, psycho-education and supports and include the following:

1. Anxiety Programmes
2. Bipolar Disorder Programmes
3. Depression Programme
4. Addictions Programme
5. Eating Disorder Programme
6. Men's Mental Health Programme
7. Mental Health Support Programme
8. Recovery Programme
9. Young Adult Programme
10. Psychosis Recovery Programme
11. Living through Distress Programme
12. Radical Openness Programme
13. St Edmundsbury Programme

The data below provides a clear indication of the types of services required of and provided by SPUH.

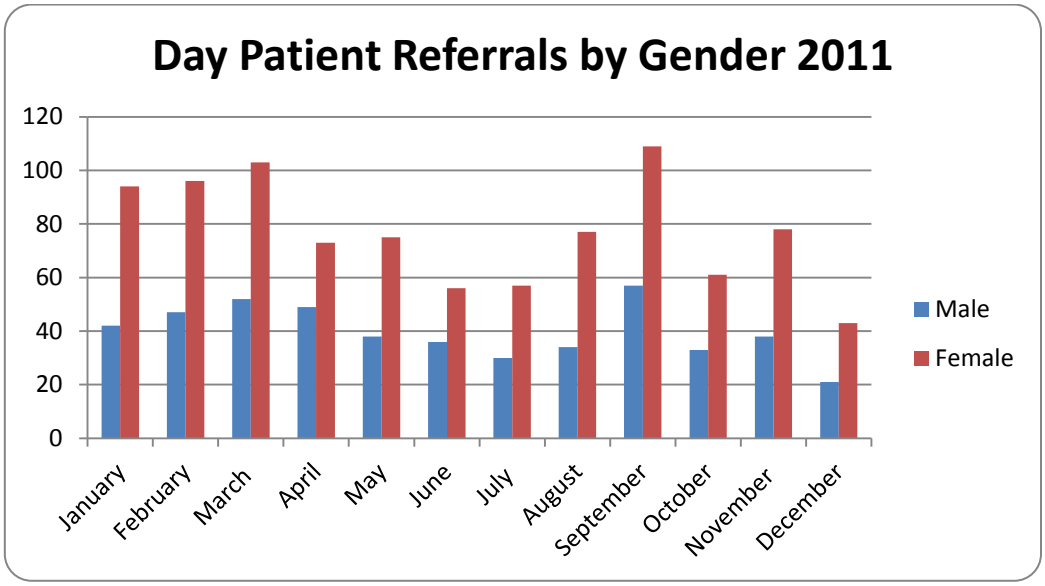
2.3.1. 2011 Day-patient Referrals through the Wellness and Recovery Centre

In 2011, a total of 1399 day patient referrals were made to the Wellness & Recovery Centre. The table below shows total monthly referrals to all day programmes accessible through the Wellness & Recovery Centre.



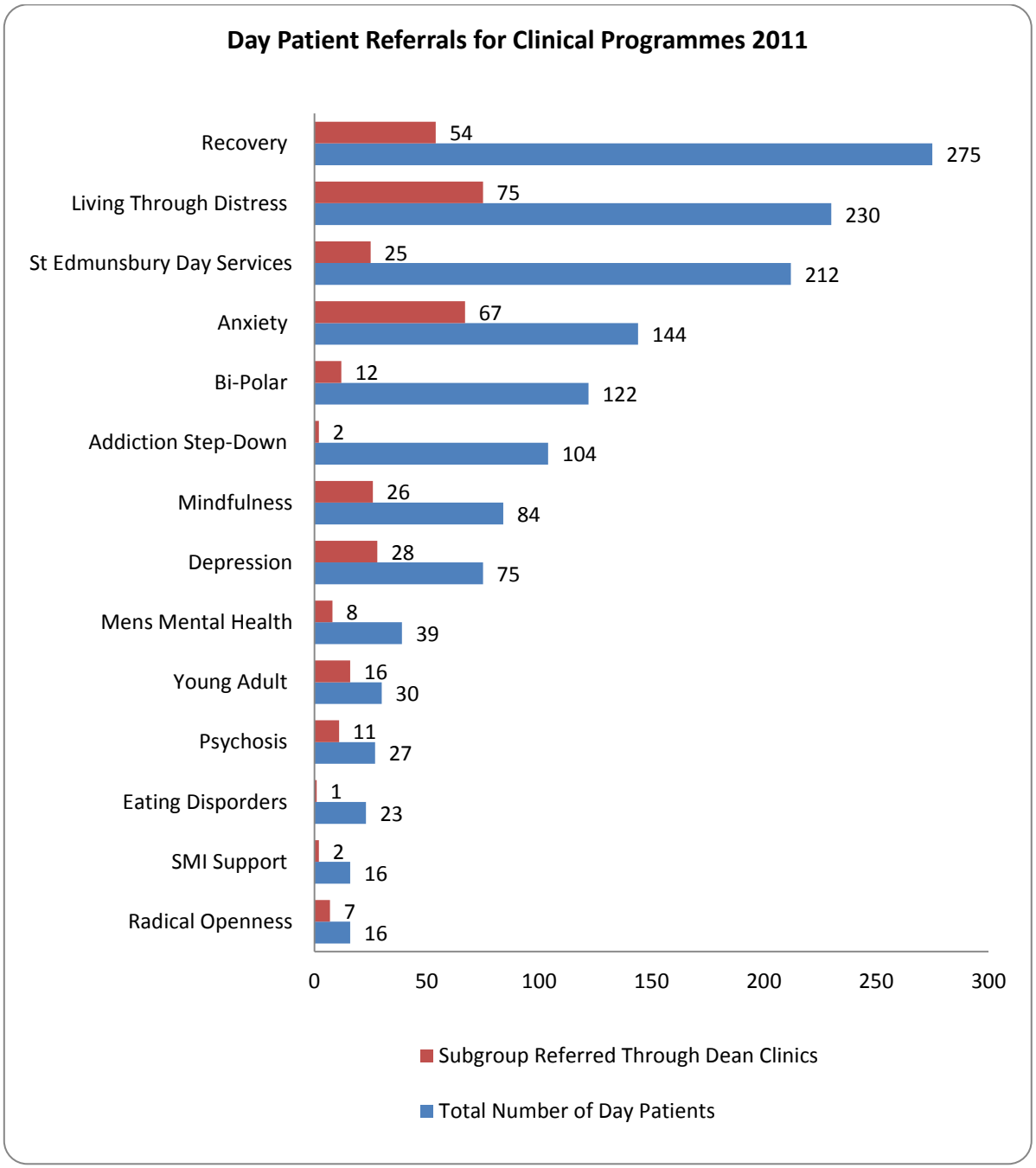
2.3.2. 2011 Day-patient Referrals by Gender

The table below shows male and female day-patient referral rates to all programmes during 2011.



2.3.3. 2011 Day-patient Referrals by Clinical Programme and Dean Clinic Referral Pathway

The total number of referrals by programme (in blue) and the subset of referrals made through the Dean Clinics (in red) are shown in graph below.



2.4. Operation Measures Section Summary

In 2011, service users received a range of clinical programmes and services accessed through structured and defined inpatient, day-patient and outpatients care pathways based on need, urgency and service user preference. Whilst measures of access do not define the quality or outcomes of programmes and services, they do provide information about how the organisation structures and resources its services within the Hospital campus and through its community clinics network.

SECTION 3

CLINICAL PROCESS & GOVERNANCE MEASURES

3. Clinical Governance & Process Measures

SPUH Organisation aspires to provide service to the highest standard. Through its Clinical Governance structures, it ensures regulatory, quality and relevant accreditation standards are implemented and monitored within Quality Framework.

3.1. Measures of Clinical Governance & Quality Management

The following table provides a summary of the clinical governance and quality management measures and outcomes for the year 2011.

3.1.1. Summary of Clinical Goverance Measures and Outcomes.

2011	Num
Number of Clinical Audits	**12**
Number of Complaints	**606**
Number of Incidents An event or ciscumstance that could have or did lead to unintended/unexpected harm, loss or damage or deviation from an expected outcome of a situation or event.	**1374**
Number of Deaths	**1**
Root Cause Analyses commenced in 2011 A thorough and credible examination of a critical incident in order to determine whether systemic or organisational factors contributed to the occurrence of an incident.	**4**
Number of Section 23s Where a voluntary service user indicates that he/she wishes to leave but a consultant psychiatrist, registered medical practitioner, or registered nurse on staff is of the opinion that the person is suffering from a mental disorder, he/she may be detained for up to 24 hours for the purpose of examination by two consultant psychiatrists to decide whether discharge or involuntary stay is required.	**51**
% Section 23s which progress to Involuntary admission	**39%**
Number or Section 14s Where a recommendation from a registered medical practitioner outside of the approved centre is received, a consultant psychiatrist on staff carries out an examination of the person and—(*a*) if he or she is satisfied that the person is suffering from a mental disorder, make an involuntary admission order for the reception, detention and treatment of the person or (*b*) if he or she is not so satisfied, refuse to make such order.	**31**
% Section 14s which progress to Involuntary admission	**74%**
FORM 6 Admissions Details of the above examination and the outcome are entered onto the Mental Commission form which is faxed to the MHC as notification of an involuntary admission. The MHC will then appoint a legal representative to the patient and set a tribunal to review the detention. A consultant psychiatrist, a medical practitioner or a registered nurse shall be entitled to take charge of the person concerned and detain him or her for a period not exceeding 24 hours for the purpose of carrying out the examination.	**23**
Form 6 Assisted Admission	**13**
Form 6 Non-Assisted Admission	**10**
FORM 10 Admissions Where a patient is transferred to an approved centre under *Section 20 or 21* of the Mental Health Act 2001, the clinical director of the centre from which he or she has been transferred shall, as soon as possible, give notice in writing of the transfer to the MHC on Statutory Form 10.	**8**
FORM 10 Assisted Admission	**4**
FORM 10 Non-Assisted Admission	**4**

3.2. Clinical Audit Summary

The following section provides a summary of audits and re-audits carried out during 2011.

3.2.1. Audits Reported on in 2011

a. Pick-up and intervention rates of abnormal lab results in 1st admissions to SEH

The results of this audit highlighted that routine testing is highly justified. On foot of the audit findings, clear-cut policies on abnormal results to diagnose hyper/hypothyroidism and hyperlipidaemia was to be put in place by clinical staff in order to avoid ambiguity and to create a homogenous response when detecting abnormal findings.

b. Vitamin Supplementation for patients on alcohol withdrawal – re-audit

An initial audit was carried out due to an identified inconsistency of approach to prescribing B-complex vitamin replacement in alcohol withdrawal patients. The baseline audit revealed an overall **46%** compliance with standards as well as confusion among staff over prescribing policies and guidelines, resulting in clinical teams working on ensuring appropriate prescribing of vitamin B to service users undergoing alcohol detoxification. Re-audit was carried out in 2011 and reported **67%** compliance with standards. On foot of this result, the Clinical Governance Committee planned to develop a formal protocol referring to this area of practice.

c. Audit on the use of Benzodiazepines and Hypnotic Z-Drugs

This audit was carried out to assess current practice relating to benzodiazepine and z-drug prescribing. The findings of this audit were presented in 2011 and, on foot of those findings, the action plan and recommendations are currently a work in progress. Re-audit is scheduled for mid-2012.

d. Lithium Prescribing and Monitoring

On foot of SPUH's participation in a POMH-UK[1] audit, an action plan for improving the Hospital's practice on initiating and maintaining Lithium treatment was approved. A Lithium working group was established

[1] **POMH-UK** *The national Prescribing Observatory for Mental Health (POMH-UK) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice. POMH-UK, with its member organisations, identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes (QIPs). Organisations are able to benchmark their performance against one another and identify where their prescribing practice meets nationally agreed standards and where it falls short. St Patrick's University Hospital is the only Republic of Ireland-based Mental Health Service to be a member of this UK-based organisation.*

and is currently working on implementing actions to improve protocol within SPUH. Re-audit is scheduled for 2012.

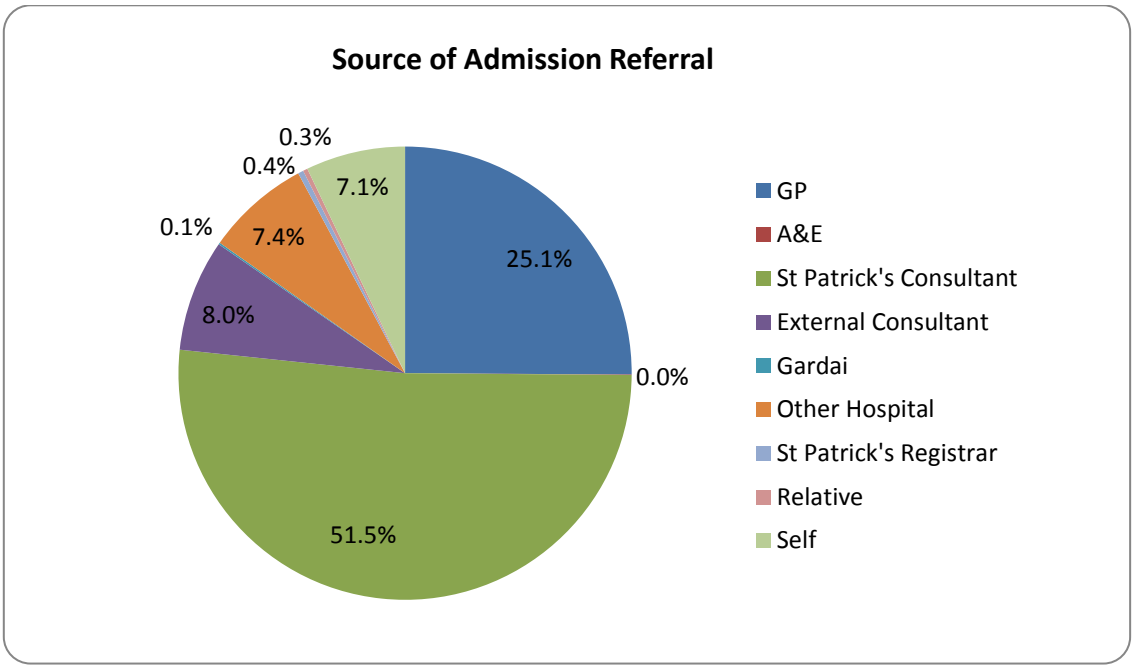
e. Appropriateness and effectiveness of antibiotic prescribing practice

This audit was designed to increase the effectiveness of infection control and management and to ensure that antibiotics are prescribed appropriately. The audit report was presented in October 2011 and action plan was decided to address the findings of the report. Re-audit is scheduled for early 2012.

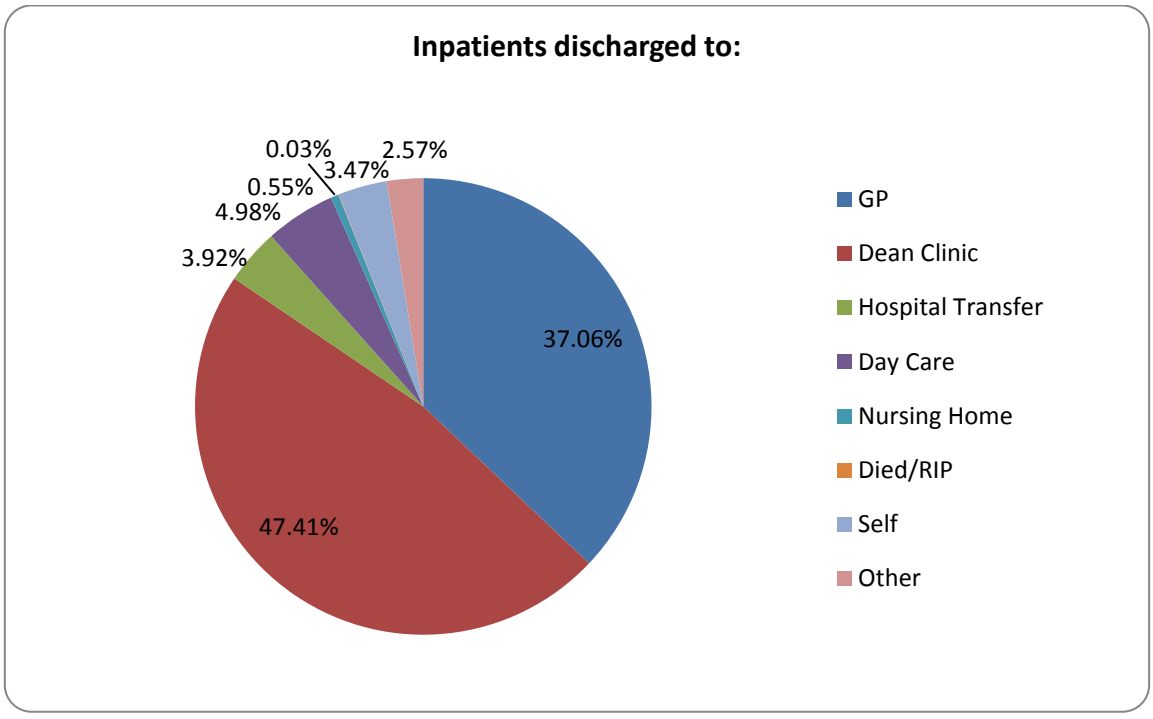
f. ICD-10 Diagnostic Codes

An analysis of completion rates of Admission and Diagnosis ICD codes was completed through a re-audit in November 2011. The objective of this re-audit was to assess the recording of admission and discharge ICD-10 diagnostic codes in both the service user's medical record and on the hospital's electronic Patient Administration System (PAS). The recording of ICD codes is an integral part of the clinical governance processes in the organisation. The accurate recording of these codes allows us to analyse the services we provide, with a view to improving them. It also allows the organisation to appropriately report and contribute to national databases containing information on mental health services, most specifically the National Psychiatric Inpatient Recording System, administered by the H.R.B. Findings showed that 98% of the medical records reviewed had an initial ICD code recorded at some point within the body of the file (89.4% had the ICD code recorded in the Psychiatric Admission Form). A report generated from the hospital's electronic PAS, with detail of all discharges from 01/01/2011 to 30/06/2011, was analysed. PAS Report findings showed that 69.5% of episodes entered had both admission and discharge ICD code recorded. Overall, 98.2% of episodes for the period had at least an admission ICD code recorded. On foot of these findings, action was taken to clearly identify the process in place for capturing the discharge ICD code on PAS.

The following data relating to diagnosis was collected for the period from 01/11/10 to 01/11/11. A total of 3091 discharges were recorded for this period. The chart below presents the source of referral for each admission by referrer category.



The chart below presents where inpatients were discharged to by category.



The table below summarises ICD completion rates at admission and discharge for this period.

Hospital Total for Period	Totals	%
Total Discharges for period	3091	100%
Total number with Admission ICD Code	3021	97.7%
Total number with Admission and Discharge Code	1920	62.1%

- **Percentage Diagnosis change between admission and discharge code**

Of the 1920 (62.1%) episodes with both an admission and discharge code recorded against them, the following table illustrates the percentage of diagnostic codes which changed between the admission and discharge.

Pre- and Post-Inpatient ICD Code Change Rate		
Total change between admission and discharge code	869	45.3%
Total with no change between admission and discharge code	1051	54.7%

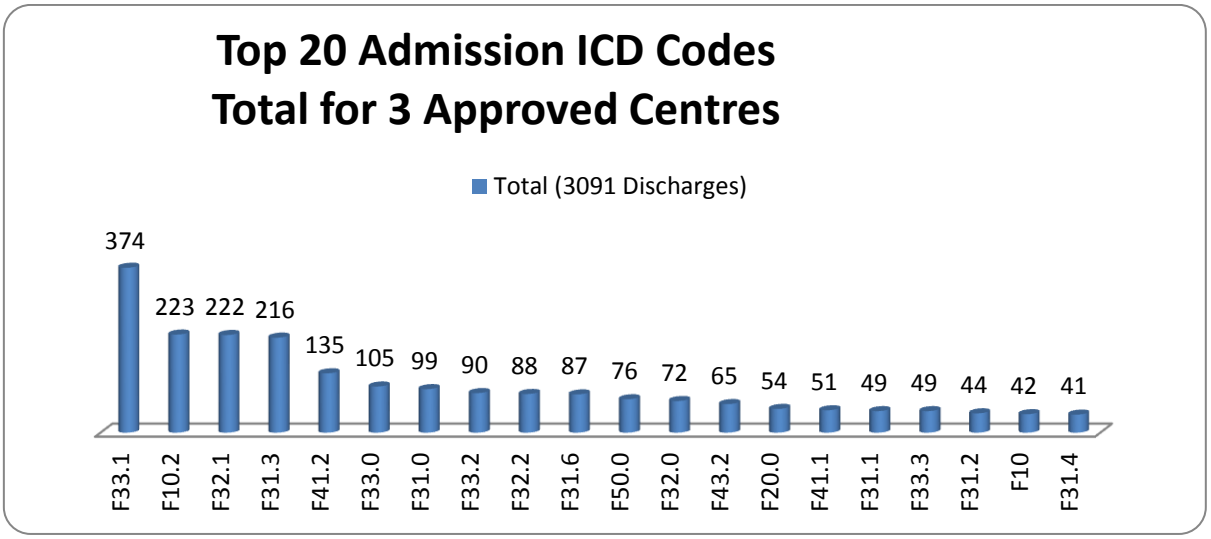
- **ICD Completion Rates by Approved Centre Comparisons for period**

Approved Centre	WGAU	SEH	SPUH	Hospital Total
Total Discharges	71	524	2496	3091
% Total Discharges	2.3%	17.0%	80.7%	100.0%
With Adm ICD Code	65	516	2440	3021
% With Adm ICD Code	91.5%	98.5%	97.8%	97.7%
With Adm and Dis ICD Code	1	319	1600	1920
% with Adm & Dis ICD Code	1.4%	60.9%	64%	62.1%
With NO ICD Code	6	8	38	52
% With NO ICD Code	8.5%	1.5%	1.5%	1.7%

- **Top 20 most common ICD Codes**

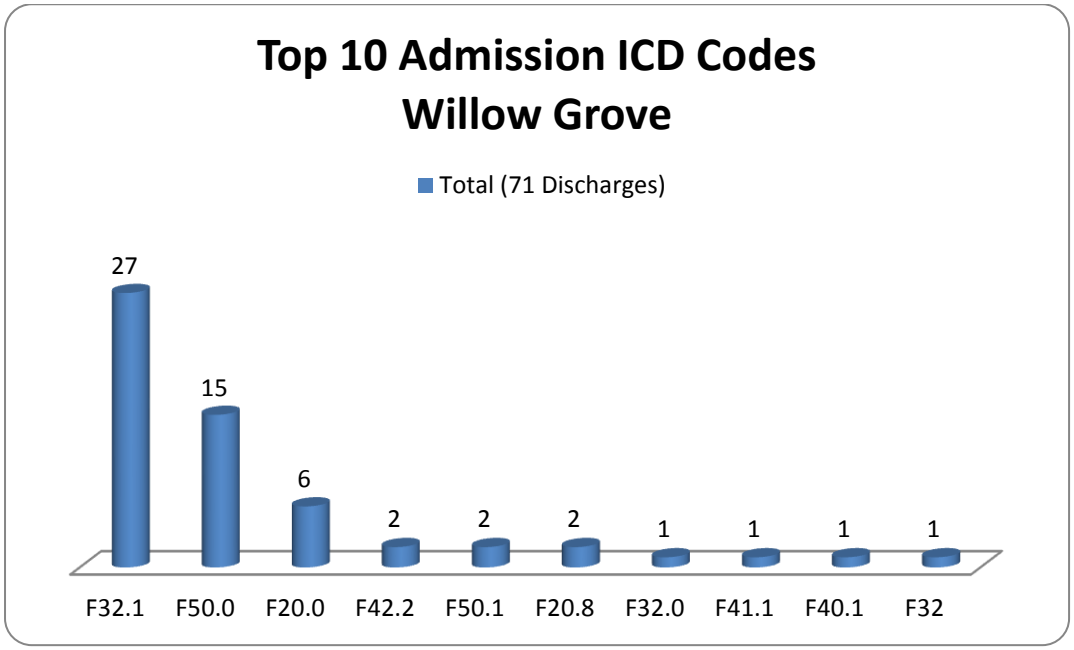
ICD Code	Total	% (N=3091)	Description
F33.1	374	12.1	Recurrent Depressive Disorder, current episode moderate
F10.2	223	7.2	Alcohol Dependence Syndrome
F32.1	222	7.2	Depressive Episode, moderate
F31.3	216	7.0	Bipolar Affective Disorder, current episode, mild or moderate
F41.2	135	4.4	Other Anxiety Disorders, mixed anxiety depressive disorder
F33.0	105	3.4	Recurrent Depressive Disorder, current episode mild
F31.0	99	3.2	Bipolar Affective Disorder, current episode hypomanic
F33.2	90	2.9	Recurrent Depressive Disorder, current episode, severe without psychotic symptoms
F32.2	88	2.8	Severe depressive episode with psychotic symptoms
F31.6	87	2.8	Bipolar Affective Disorder, current episode, mixed
F50.0	76	2.5	Anorexia Nervosa
F32.0	72	2.3	Mild Depressive Episode
F43.2	65	2.1	Reaction to Severe Stress, and adjustment disorders
F20.0	54	1.7	Paranoid Schizophrenia
F41.1	51	1.6	Generalised Anxiety Disorder
F31.1	49	1.6	Bipolar Affective Disorder, current episode, manic without psychotic symptoms
F33.3	49	1.6	Recurrent Depressive Disorder, current episode, severe with psychotic symptoms
F31.2	44	1.4	Bipolar Affective Disorder, current episode, manic with psychotic symptoms
F10	42	1.4	Mental and Behavioural Disorders due to use of alcohol
F31.4	41	1.3	Bipolar Affective Disorder, current episode, severe depression without psychotic symptoms

- **Ranked Frequency Table of Admission ICD Codes**

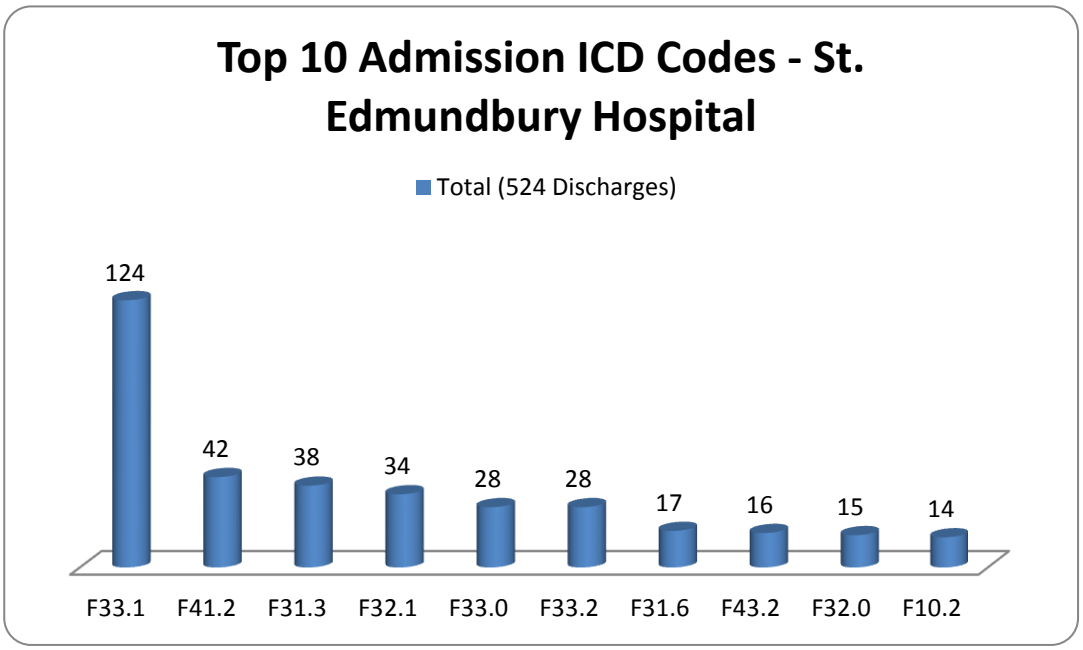


- **Top 10 most common ICD-10 Code by Approved Centre**

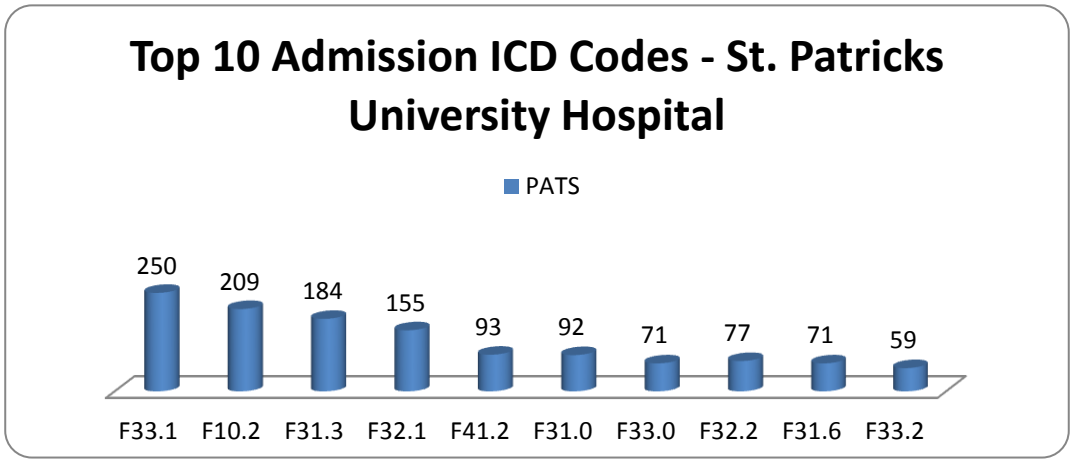
The three frequency tables below present the top 10 ICD admission codes by approved centre.



St. Edmundsbury (in box below)



St Patrick's (in box below)



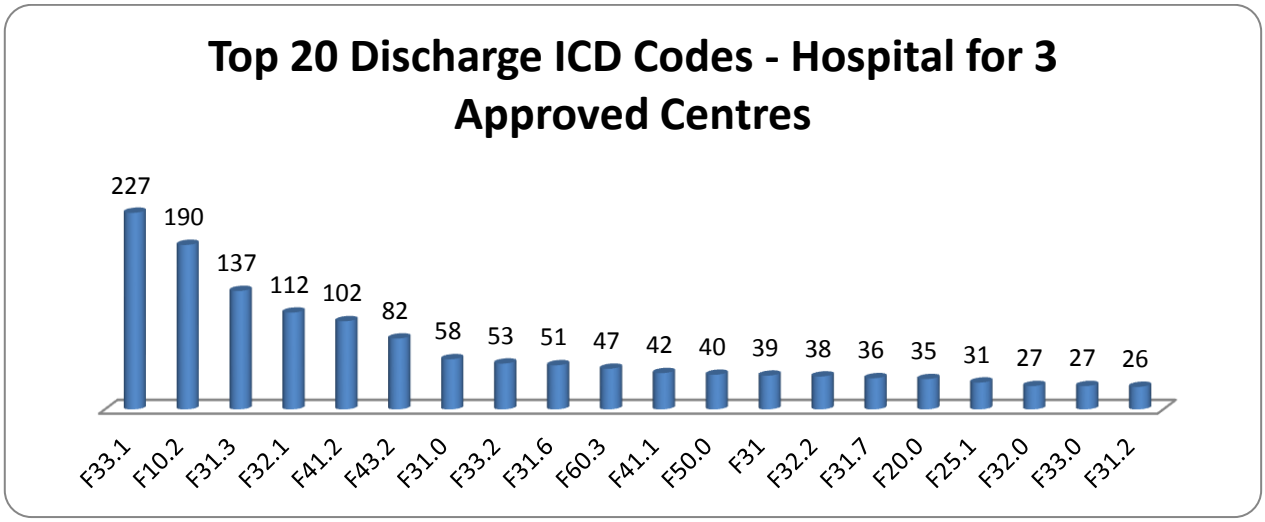
- **Top 20 most common Discharge ICD Codes**

The legend below provides a description of the top most common Discharge ICD Codes in ranked order of frequency.

ICD Code	Total	Description
F33.1	227	Recurrent Depressive Disorder, current episode moderate
F10.2	190	Alcohol Dependence Syndrome
F31.3	137	Bipolar Affective Disorder, current episode, mild or moderate
F32.1	112	Depressive episode, moderate
F41.2	102	Other Anxiety Disorders, mixed anxiety depressive disorder
F43.2	82	Reaction to Severe Stress, and adjustment disorders
F31.0	58	Bipolar Affective Disorder, current episode hypomanic
F33.2	53	Recurrent Depressive Disorder, current episode, severe without psychotic symptoms
F31.6	51	Bipolar Affective Disorder, current episode, mixed
F60.3	47	Emotionally Unstable Personality Disorder
F41.1	42	Generalised Anxiety Disorder
F50.0	40	Anorexia Nervosa
F31	39	Bipolar Affective Disorder – unspecified
F32.2	38	Severe Depressive Episode with psychotic symptoms
F31.7	36	Bipolar Affective Disorder, currently in remission
F20.0	35	Paranoid Schizophrenia
F25.1	31	Schizoaffective Disorder, depressive type
F32.0	27	Mild Depressive Episode
F33.0	27	Recurrent Depressive Disorder, current episode mild
F31.2	26	Bipolar Affective Disorder, current episode, manic with psychotic symptoms

- **Top 20 most common Discharge ICD Codes**

The frequency table below presents the number of admissions for each of the top 20 ICD Discharge codes across all approved centres during 2011.



g. Photographic I.D. of Service Users

This re-audit was carried out in November 2011 to assess SPUH's compliance with the Mental Health Commission's standard and hospital policy of service user safety and identification practice within the organisation. Findings for this period showed 80% compliance as evidenced by a photographic I.D. of service users in place in medical files. This compares with a compliance rate of 64% on the previous audit.

h. Infection Control Audits

These audits measure the implementation of policies and procedures relating to infection control. In 2011, the Clinical Audit Facilitator reported the results of fifteen regular audits carried out to the Infection Control Committee. The audits included Ward Environment, Ward Kitchens, Inspection of Catering Facilities in St. Edmundsbury Hospital and Inspection of Waste Management. Reported findings led to appropriate actions taken by the relevant Heads of Departments.

SECTION 4
Clinical Outcomes Measures

4. Clinical Outcomes

The outcome measures reported here are not research but provide a good platform from which to develop research questions and studies. Statistical significance analysis was carried out on the data in this report. However, as this depends on a number of factors such as the variance of scores, the number of people in the programme and the sensitivity of the measure, it was felt that including this data might be misleading as it does not equate to clinical significance. Throughout 2012, it is hoped that outcome measurements will be extended across all programmes and services so that it becomes standard practice across the organisation. Using outcome measures within programmes and services will support the evaluation of their effectiveness. It is important to note that the outcome measures will be used to measure each programme individually and will not be used to compare one programme with another.

Although the outcome measures are measuring change over the course of treatment, it cannot be assumed that all change assessed is due to the programme itself. There are many other factors that cannot be controlled as that may influence the patient's scores. The programmes already using outcome measures have started to integrate their measures within individualised patient care plans; this will allow services to look at whether the programme is working or not working for the service user. We would like to thank the programmes that have already started implementing outcome measures within their programmes and our aim for 2012 is that a culture of measurement will be fostered throughout the hospital and that we will have pre- and post-treatment/intervention scores for all people attending clinical programmes within the hospital.

4.1. Clinical Outcomes for Inpatient Treatment 2011

The Clinical Global Impression (CGI) (1976, Guy) is a clinician-rated mental health assessment tool used to establish the severity of illness of a service user before treatment and a subsequent rate of global improvement or change following treatment. The CGI is used as a routine outcome measure by all 16 multi-disciplinary teams across the three approved centres in SPUH, on a weekly basis. The process assists in evaluating each service user's response to treatment during inpatient admission. The CGI is a 2-item observer scale. The first item rates the severity of illness on a 7-point scale from 1 (not at all ill) to 7 (extremely ill). The second item rates clinical improvement on a 7-point scale also from 1 (being very much improved) to 7 (being very much worse).

SPUH CGI clinical improvement rates were evaluated for 2011 by selecting a randomised sample from the total 2981 admissions across the three approved centres in SPUH. The CGI scores completion rates and CGI outcomes were evaluated from each of the 200 service user records randomly selected. In particular, rates of illness severity at point of admission and rates of improvement at point of discharge from hospital were analysed. The purpose of the evaluation was to establish clinical outcomes for inpatients as evidenced in a sample of CGI baseline and global improvement scores, indicating improvement rates and response to treatment for the sample group following inpatient treatment and intervention.

4.1.2. Data Collection Strategy

The following analysis of clinical outcomes is based on data collected from 200 service user medical records. These records were randomly selected to include inpatient episodes with an admission between 01/01/2011 and the 30/06/2011.

4.1.3. Findings

Calculations are based on the entire dataset derived from the sample of 200 inpatient episodes

Total dataset:	200
Average age:	55.4 years
Average LOS:	40 days
Average re-admission rate:	7.9 admissions
Gender breakdown:	Male - 35%. Female - 65%.

4.1.4. ICD-10 Admission Diagnosis Breakdown

The table below presents the ranked primary and secondary admission ICD-10 diagnostic codes recorded in the sample:

ICD-10 Admission Diagnosis Categoy		Primary Diagnosis	Additional Diagnosis
F31	Bipolar affective disorder	74	1
F33	Recurrent depressive disorder	39	2
F10	Mental and behavioural disorders due to the use of alcohol	25	17
F25	Schizoaffective disorders	10	2
F42	Obsessive compulsive disorders	10	0
F41	Other anxiety disorders	9	5
F32	Depressive episode	9	3
F43	Reaction to severe stress and adjustment disorders	7	3
F20	Schizophrenia	6	1
F22	Persistent delusional disorders	3	0
F41	Other anxiety disorders	9	5
F50	Eating disorders	1	3
F13	Mental and behavioural disorders due to the use of sedatives / hypnotics	1	2
F00	Organic mental disorders	1	1
F02	Dementia in other diseases	1	0
F03	Unspecified dementia	1	0
F23	Acute and transient psychotic disorders	1	0
F60	Specific personality disorders	0	4
F11	Mental and behavioural disorders due to the use of opioids	0	1
F19	Mental and behavioural disorders due to multiple drug use	0	1
Total number of episodes with more than one admission ICD-10 diagnosis recorded 47 or 24%			

4.1.5. Breakdown of baseline and final CGI scores recorded

The following table presents the frequency and percentage rates of the 7 baseline CGI scores at point of admission and the final CGI Global improvement scores at point of discharge

Baseline CGI - Severity of illness			
		Total	%
1	Normal, not at all ill	0	0%
2	Borderline mentally ill	5	2.5%
3	Mildly ill	16	8%
4	Moderately ill	48	24%
5	Markedly ill	53	26.5%
6	Severely ill	30	15%
7	Extremely ill	2	1%
0	Not Recorded	46	23%

Final CGI - Global improvement			
		Total	%
1	Very much improved	29	14.5%
2	Much improved	89	44.5%
3	Minimally improved	41	20.5%
4	No change	13	6.5%
5	Minimally worse	1	0.5%
6	Much worse	0	0%
7	Very much worse	0	0%
0	Not Recorded	27	13.5%

Note that of the 200 charts audited, 46 records (23%) *had no baseline CGI score recorded and* 27 records (13.5%) *had no final CGI score recorded – therefore there was a total of* 38.5% *of imperfectly completed records.*

4.1.6. Service User Improvement Rates

The breakdown of improvement rates from initial baseline CGI to final improvement rate.

Baseline Score	Total	CGI Improvement Rate							
		Very much improved	Much improved	Minimally improved	No Change	Minimally worse	Much worse	Very much worse	Final CGI Not Recorded
Normal, not ill	**0**								
Borderline ill	**5**		4						1
Mildly ill	**16**	2	5	6	1				2
Moderately ill	**48**	10	25	6	1	1			5
Markedly ill	**53**	7	25	14	3				4
Severely ill	**30**	3	10	9	2				6
Extremely ill	**2**		1						1
First CGI Not Recorded	**46**	7	19	6	6				8

Very much and much improved – 59% **Minimal / No change – 27%** **Worsened – .5%** **No final CGI – 13.5%**

4.1.7. Data per Age Range

The table below provides a breakdown of data per age range. The two age ranges used are <60 years and ≥ 60 years of age.

Age range comparisons

	< 60 years	≥ 60 years
Total in sample	118	82
Average Age	45 years	70.2 years
Average LOS	38 days	42 days
Average re-admission level	7.2 times	8.9 times

4.1.8. Illness Improvement rate per Age Range - *The breakdown of improvement rates from initial baseline CGI to final improvement rate.*

<60 years – n=118, of which 29 records had no baseline CGI score recorded

	Very much improved	Much improved	Minimally improved	No Change	Minimally worse	Much worse	Very much worse	Not Recorded
Borderline ill								1
Mildly ill		1	4					1
Moderately ill	5	13	4	1				1
Markedly ill	4	17	11	3				4
Severely ill	3	5	4	1				4
Extremely ill		1						1

≥60 years – n=82, of which 17 records had no baseline CGI score recorded

	Very much improved	Much improved	Minimally improved	No Change	Minimally worse	Much worse	Very much worse	Not Recorded
Borderline ill		4						
Mildly ill	2	4	2	1				1
Moderately ill	5	12	2		1			4
Markedly ill	3	8	3					
Severely ill		5	5	1				2
Extremely ill								

4.1.9 Overall Baseline Score completion rates

The table below presents CGI Baseline completion rates according to *number of days **from admission to first MDT meeting** and the overall completion rate of initial CGI data capture.*

Total	0-5days	6-7days	≥8 days	Previous Admission[1]	Baseline CGI Not Recorded[2]	% Completion*
200	121	12	11	10	46	77%

*Including previous admission

4.1.10. Overall CGI Improvement Score completion rates –

The table below presents CGI completion rates in relation to the number of days between the final MDT review meeting and service user discharge date and the overall completion rate of improvement CGI score data capture.

Total	0-5days	6-7days	≥8 days	MDT Review Date not recorded [3]	Final CGI Imp. score not recorded [4]	% Completion
200	145	13	12	3	27	87%

Notes:

*[1] **Previous Admission** – refers to records identified where the baseline/severity of illness score **was recorded** at a MDT meeting on a **previous admission**. The previous admission individual care plan was still in use following re-admission.*

The total number of records identified in this instance is 10 – with an initial Individual Care Plan MDT meeting date ranging from 8 days to 127 days prior to the audited admission.

*A further 9 records were found to have used the individual care plan from a previous admission with **NO Baseline CGI score recorded** – these records were found to have an initial individual care plan MDT meeting date ranging from 2 days to 147 days prior to the audited admission.*

*[2] **Baseline CGI Not Recorded** – refers to records identified where baseline/severity of illness score was not documented in the individual care plan.*

*[3] **MDT review date not recorded** – refers to the final MDT review document where the date of the review was omitted and therefore the number of days prior to discharge could not be calculated.*

*[4] **Final CGI Improvement score not recorded** – refers to the final service user improvement score omitted from the final MDT review meeting post-discharge.*

4.1.11. Conclusions

- Of the sample of 200 medical records, only 61.5% were found to have both the baseline and improvement CGI score fully completed.
- 23% of the records were found to have no baseline CGI score recorded at the first MDT meeting.
- 13.5% of the records were found to have no final improvement CGI score recorded at the final MDT review meeting post-service user discharge.
- Of the 200 records audited – 118 (59%) records showed a significant improvement of which:
- 14.5% - Very Much Improved
- 44.5% - Much Improved

4.2. Anxiety Disorders Programme (Mar – Dec 2011)

The Anxiety Disorders Programme was established in 2005 to provide a clinical intervention programme for service users with primary anxiety disorders. The Anxiety Programme provides group and individual psycho-education, intervention and support based on the cognitive behaviour therapy (CBT) model. All programme facilitators are CBT and Mindfulness trained.

The programme is structured into two levels. Level 1 is a 5-week programme and includes group-based psycho-education and CBT treatment to assist service users to understand their anxiety disorders. Level 1 also provides group-based experiential work to address an individual's specific anxiety difficulties. Service users with more complex clinical diagnoses of anxiety are referred to Level 2 of the programme, a closed group programme which builds on therapeutic work carried out during Level 1. Level 2 provides a structured 4-week programme which is also based on a CBT approach focusing on shifting core beliefs, emotional processing and exposure work. Service users typically attend Level 2 following discharge from hospital as an inpatient.

4.2.1. Anxiety Outcome Measures

The following section presents a summary of the routine clinical outcome measures for the Anxiety Disorders Programme achieved in 2011. For the purpose of this report, three

measures which all service users attending the Anxiety Programme completed were analysed. These are the Beck Anxiety Inventory (Beck & Steer, 1990), the Clinical Global Impression Scale (CGI) and the Work and Social Adjustment Scale.

- ## Beck Anxiety Inventory

The Beck Anxiety Inventory (BAI) (Beck & Steer, 1990) is a 21-item multiple-choice self-report inventory that measures the severity of an anxiety in adults and adolescents. The respondent is asked to rate how much each of the 21 symptoms has bothered him/her in the past week. The symptoms are rated on a four-point scale, ranging from ‘‘not at all’’ (0) to ‘‘severely’’ (3). The instrument has excellent internal consistency (α= .92) and high test–retest reliability (r = .75) (Beck & Steer, 1990).

- ## Clinical Global Impression Scale

The Clinical Global Impressions (CGI) Scale (Guy 1976) is a standardised assessment tool. It is used by clinicians to rate the severity of illness, change over time, and efficacy of medication, taking into account the patient’s clinical condition and the severity of side-effects. The first sub-scale, Severity of Illness, assesses the clinician’s impression of the patient’s current illness state and it is often used both pre- and post-treatment. The second sub-scale, Global Improvement, assesses the patient’s improvement or worsening from baseline. The third sub-scale, the Efficacy Index, attempts to relate therapeutic effects and side-effects by deriving a composite score that reflects both the therapeutic effect and the adverse reactions or side-effects. Scores on the Severity of Illness sub-scale range from 1 = not ill at all to 7 = among the most extremely ill. The Global Improvement sub-scale also goes from 1 = very much improved to 7 = very much worse.

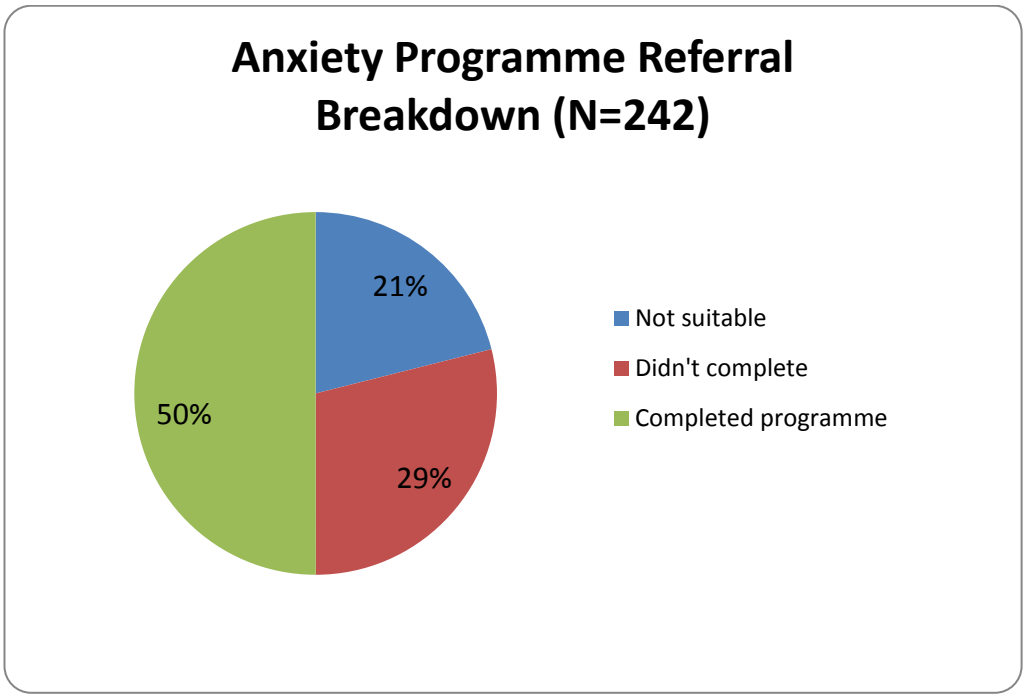
- ## Work and Social Adjustment Scale

The Work and Social Adjustment Scale (WSAS) is a simple 5-item patient self-report measure, which assesses the impact of a person’s mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. The WSAS is used for all patients with depression or anxiety as well as phobic disorders and has shown good validity and reliability (Mundt, Mark, Shear &

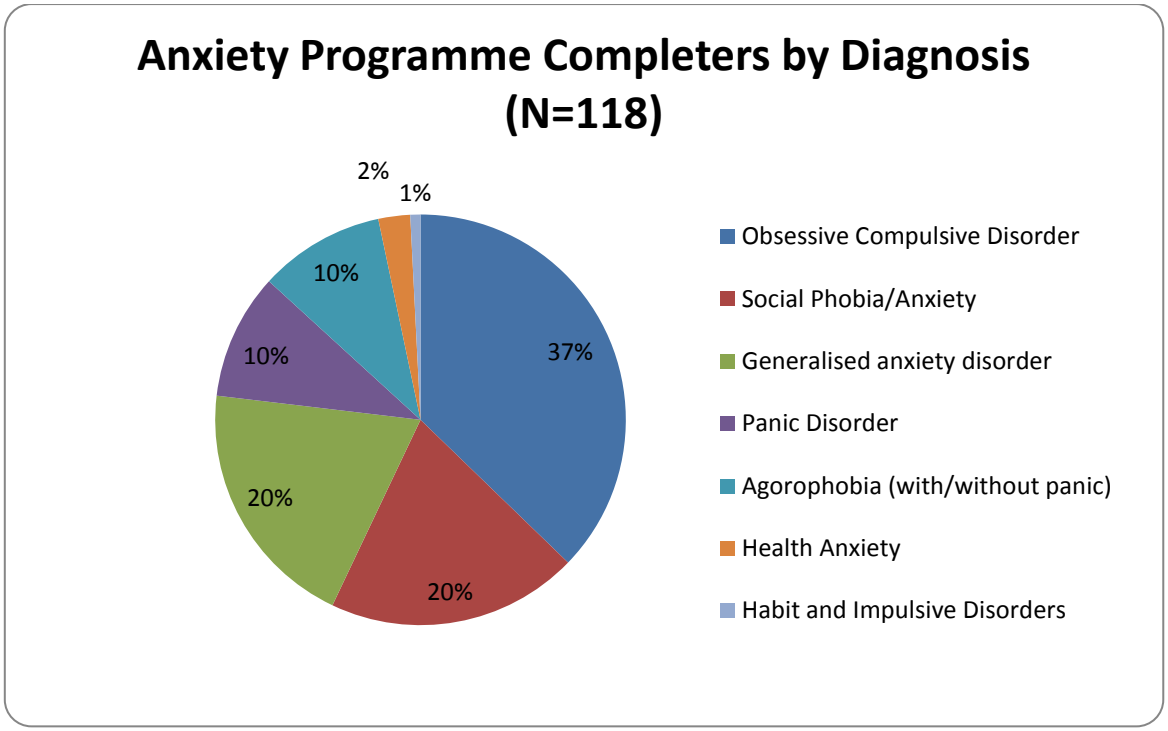
Greist, 2002). The scores on the WSAS have been shown to be sensitive to patient differences in disorder severity and treatment-related change.

4.2.2. Descriptors

The pie chart below shows that there were 242 people referred to the Anxiety Programme from 01/03/11 to 02/12/11. Of these, 51 were assessed as not meeting the referral criteria for the programme. In addition, 70 did not complete the programme. Of the 121 people who completed the anxiety programme, 114 completed pre- and post-programmes measures.



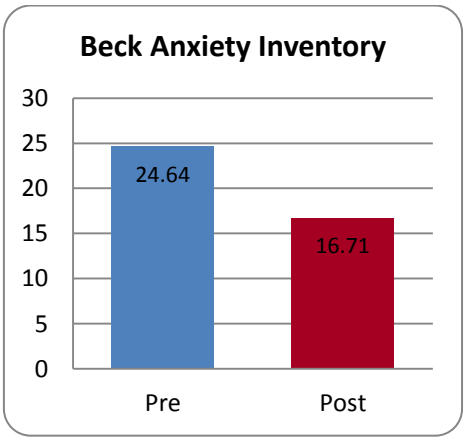
There were seven primary anxiety diagnoses represented within the group who had pre- and post-measures attending the anxiety programme during this period. Agoraphobia (with/without panic) accounted for 9.9%, Social Phobia/Anxiety accounted for 19.8%, Panic Disorder accounted for 9.9%, Generalised Anxiety Disorder 19.8%, Obsessive Compulsive Disorder 37.2% , Health Anxiety 2.5% and Habit and Impulsive Disorders 0.8% .



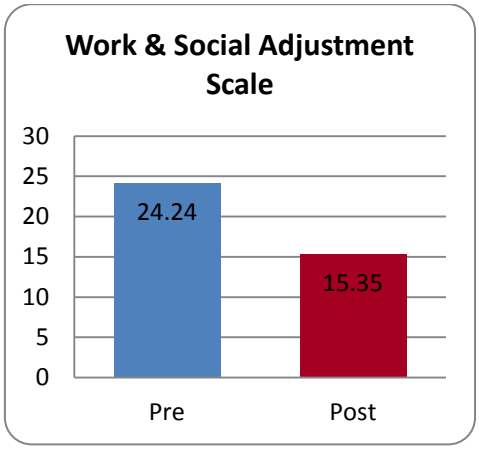
4.2.3. Results

The results for the three outcome measures used routinely within the Anxiety Programme are presented below.

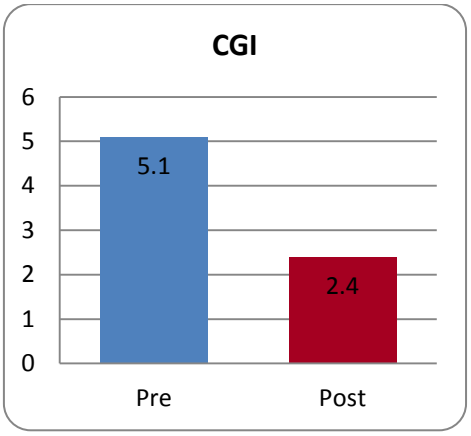
From the 114 people who completed pre- and post-measures on the Anxiety Programme, the Beck Anxiety Inventory (BAI) showed a decrease between pre-scores (N=114, Mean=24.65, SD=10.25) which places them in the *moderate* range of anxiety and post-scores (Mean=16.71, SD=12.81) which places them also in the *moderate* range . Moderate Anxiety Scores fall between 16 and 25 on the BAI. Therefore, average pre- and post-measures scores for Anxiety Programme completers shifted from the upper limit of moderate anxiety to the lower limit of moderate anxiety range.



There was a reduction in scores on the Work and Social Adjustment Scale for the 89 people who completed pre-measures (N=114, Mean=24.24, SD=9.28) and post-measures (N=114, Mean=15.35, SD=9.25).



When looking at the Clinical Global Impression Scale, pre-CGI scores (N=114, Mean=5.07, SD=.71) placed people in the *markedly ill* range, while post-scores (N=114, Mean=2.48, SD=0.87) placed people in the *much improved* category on the rating scale.



4.2.4. Summary

Clinical outcomes for the 114 service users who completed the Anxiety Programme between March and December 2011 were positive, as measured by CGI, BAI and Work and Social Adjustment Scale. The improvement rates experienced by service users as measured are useful in validating the CBT approach for those who completed the programme.

Programme facilitators in 2012 will focus on measuring the outcomes of a pilot programme specifically for service users with Obsessive Compulsive Disorder (OCD) which commenced in November 2011. In addition, systems to improve completion and capture rates of pre- and post-programme measures will continue to be updated and reviewed in relation to data collection, data coding and data entry systems.

4.3. Eating Disorders Programme 2011

The Eating Disorders Programme is a service specifically oriented to meet the needs of people with Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder. The objective of the programme is to address the physical, psychological and social issues arising as a result of an eating disorder in an attempt to resolve and overcome many of the struggles associated with it. The programme is structured into 3 stages. Stage 1 involves 4 to 6 weeks of inpatient treatment which includes;

- Stabilisation of Weight
- Medical Treatment of physical complications where present.
- Meal supervision
- Nutritional assessment and treatment
- Dietetics group: discuss nutrition, meal planning, shopping, food portions, etc.
- Methods to improve self-assertiveness and self-esteem
- Enhancement of self-awareness
- Body image group
- Occupational therapy groups: weekly groups addressing lifestyle balance, stress management, and social, leisure and self-care needs. A weekly cookery session is also included in the programme.
- Family therapy
- Individual Psychotherapy

Following inpatient treatment, Stage 2 or day treatment commences which typically lasts for 8 weeks. Once the person has successfully completed day treatment, they progress to Stage

3 or Aftercare, which includes weekly outpatient support groups and on-going individual and family therapy, if necessary. The outpatient group is usually for 1 year.

4.3.1. Eating Disorder Inventory-III Measure

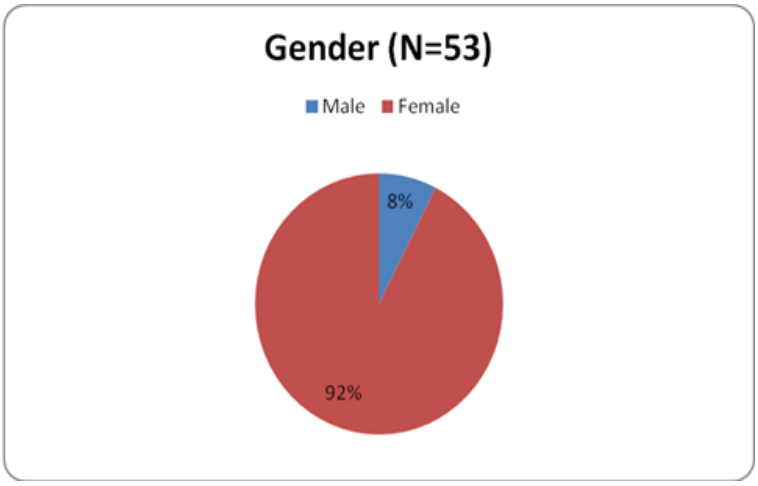
The Eating Disorder Inventory (EDI) was the chosen 2011 outcome measure for the Eating Disorder Programme. It is a self-report questionnaire widely used both in research and in clinical settings to assess the symptoms and psychological features of eating disorders. The original version of the EDI was developed in 1983 by Garner, Olmsted, and Polivy. The EDI-3 represents an expansion and improvement of the earlier versions of the EDI. It contains 91 items divided into twelve sub-scales rated on a 0-4 point scoring system. Three items are specific to eating disorders and nine are general psychological scales that, while not specific, are relevant to eating disorders. It yields six composites: Eating Disorder Risk, Ineffectiveness, Inter-personal Problems, Affective Problems, Over-control, General Psychological Maladjustment.

The three sub-scales specific to eating disorder symptoms include *drive for thinness* (DT), *bulimia* (B) and *body dissatisfaction* (BD). The reliability of these index scores collected from eating disorder patients appears excellent (Cronbach's $\alpha = .90–.97$; test–retest $r = .98$) (Garner 2004; Wildes et al. 2010). In addition, the EDI-3 consists of eating disorder relevant psychological trait sub-scales: *low self-esteem* (LSE), *personal alienation* (PA), *inter-personal insecurity* (II), *inter-personal alienation* (IA), *interceptive deficits* (ID), *emotional dysregulation* (ED), *perfectionism* (P), *asceticism* (AS) and *maturity fear* (MF).

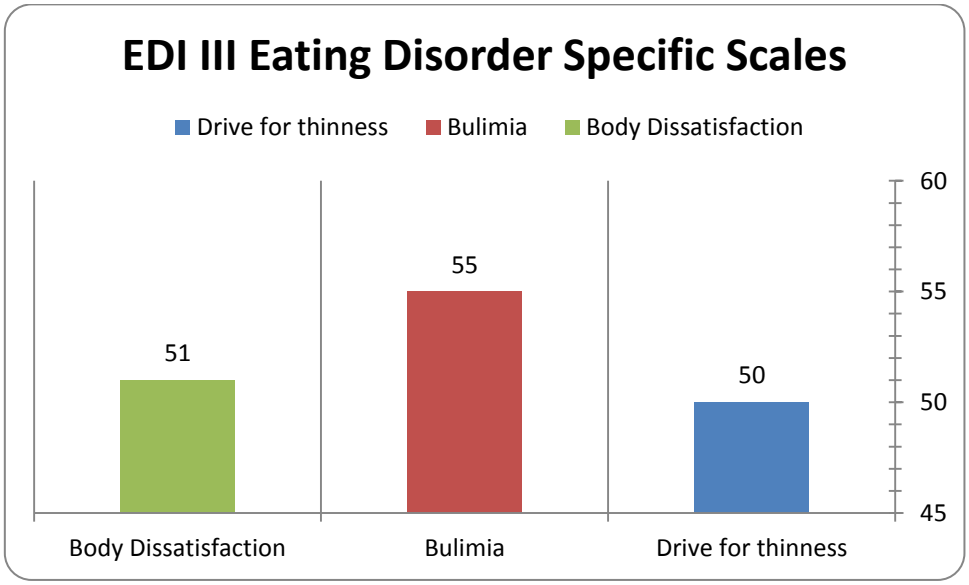
4.3.2. Results

From 01/01/11 to 01/11/11, there was a total of 118 admissions to the Eating Disorder Unit. Out of the 118 admissions, pre-programme outcome measurement data was gathered for 53 inpatients. Only 13 inpatients had post–programme measures captured and for this reason, it was decided not to include a pre- and post-measure analysis.

Out of all 53 people who received an initial EDI, 7.5% (N=4) of these were men, and 92.5% (N=49) were women as illustrated in the chart below.



The pre-measures for the 53 service users provide some indication of illness severity on admission. The graph below shows the mean t-scores for the three Eating Disorder Symptom sub-scales that all 53 people had completed including: Drive for thinness (Mean t score=50), Bulimia (Mean t score=55) and Body Dissatisfaction (Mean t score=51) which all fall into the *Typical Clinical* classification.



4.3.3. Summary

Given the insufficient completion rates of the EDI at post-treatment stage, it is not possible to comment on the clinical outcomes in 2011 for the ED service. In November 2011, the clinical measures, data collection processes and data entry systems were substantially changed to ensure completion rates improve pre- and post-treatment. Changes include:

a) The replacement of EDI-3 measures with the Eating Disorder Examination Questionnaire (Fairburn and Beglin 2008) as a primary outcome measure.

b) The addition of Beck Depression Scale, Body Mass Index and other measures to provided a more comprehensive pre- and post-treatment assessment.

c) A standardised process to collect measures at point of outpatient assessment, inpatient admission (where appropriate) and at the point of inpatient discharge and finally at outpatient follow-up is now in place.

4.4. Recovery Programme 2011

The recovery programme is a structured 12-day programme based on the Wellness and Recovery Action Plan (WRAP) approach designed by Mary Ellen Copeland of the Copeland Centre (1992). The WRAP approach focuses on assisting service users who have experienced mental health problems to regain hope, personal responsibility through education, self-advocacy, and support. The recovery model emphasises the centrality of the personal experience of the individual and the importance of mobilising the person's own resources as part of treatment. It emphasises the development of individualised self-management plans rather than compliance with a standard treatment regime. The Recovery Programme at SPUH is delivered through the Wellness and Recovery Centre for day-patients.

The programme is aimed at service users who are either recently discharged and need structured and continued support to stay well or are anxious to avoid coming in to hospital but again need formal and structured support to do so.

The programme is primarily group based, but each participant works individually with a key worker to manage their progress through the programme. The group dimension to the programme focuses on accessing good health care, managing medications, self-monitoring their mental health using their WRAP; using wellness tools and lifestyle, keeping a strong support system, participating in peer support; managing stigma and building self-esteem. The option of attending fortnightly meetings at the recovery-focused 'Connections Cafe' is available to all participants.

The programme is delivered by three mental health nurses and two part-time social workers with sessional input from a pharmacist, a service user who is drawn from a panel of experts by experience, consumer council and carer representatives.

4.4.1. Recovery Assessment Scale

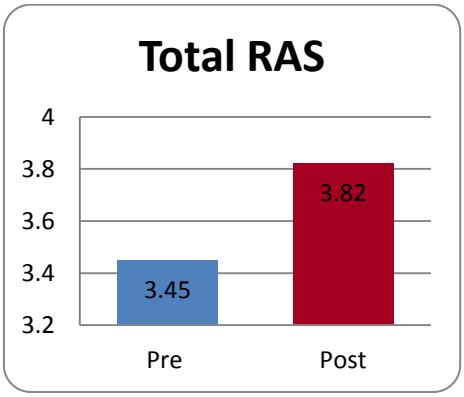
The Recovery Assessment Scale (RAS) (Giffort, Schmook, Woody, Vollendorf, & Gervain, 1995) is an outcome measure which tests for service user empowerment, coping ability, and quality of life. The RAS is a 41-item survey rated on a 5-point scale. The RAS was found to have good test-retest reliability (r = 0.88) along with good internal consistency (Cronbach's alpha = 0.93). The scale showed recovery to be positively associated with self-esteem, empowerment, social support, and quality of life, indicating good concurrent validity. It was inversely associated with psychiatric symptoms suggesting discriminate validity (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999).

4.4.2. Descriptors

From 30/06/11 to 30/12/11, 122 people were referred to the Recovery Programme. Out of these, 62 people began the Recovery Programme and completed pre-measures, but post-measurement data was only gathered from 41 of these. The following tables present analyses of the 41 pre- and post-measures completed.

4.4.3. Results

Total RAS scores increased from pre-measurement (N=41, Mean=3.45, SD=0.62) to post-measurement (N=41, Mean=3.82, SD=0.67) on the Recovery Assessment Scale as illustrated in the figure below.

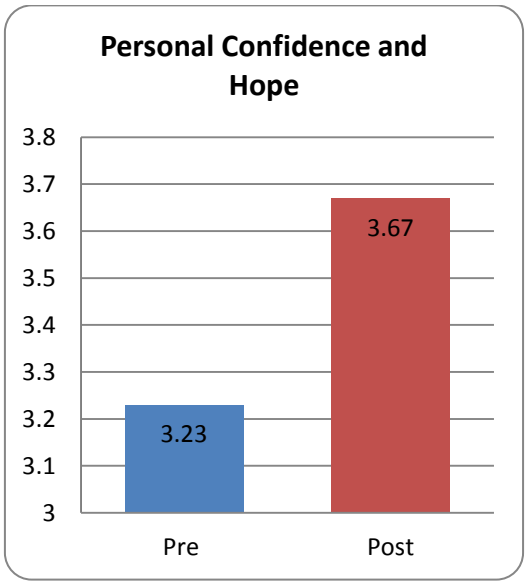


- **Sub-scales of the Recovery Assessment Scale**

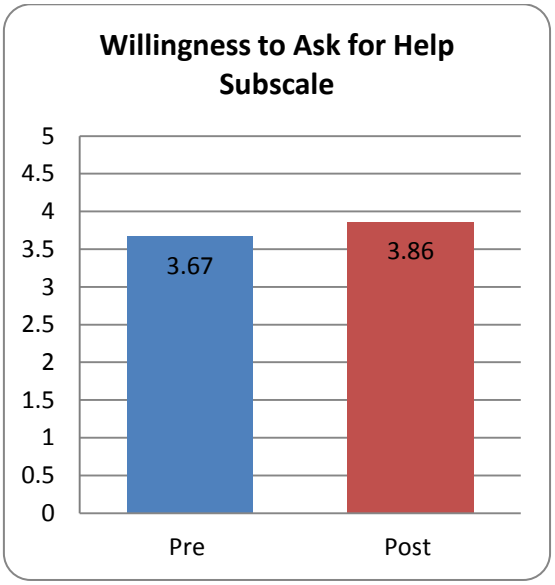
There are five sub-scales within the RAS and the figures below provide the mean pre- and post-scores on each of the five subscales including:

1. Personal Confidence and Hope Sub-scale
2. Willingness to ask for Help
3. Ability to rely on others
4. Not dominated by symptoms
5. Goal and Success Orientation

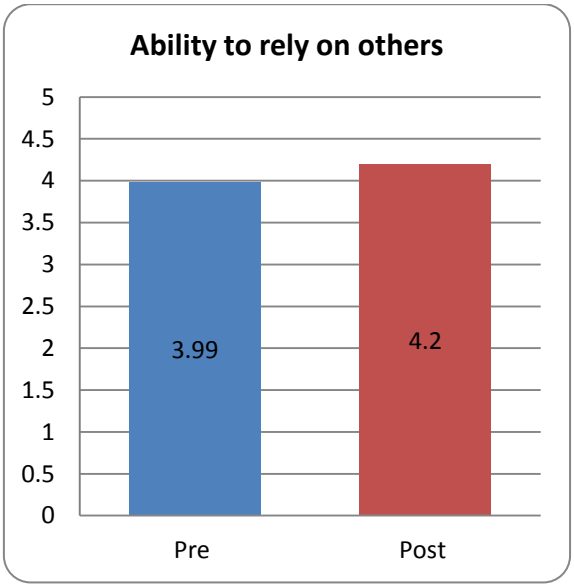
1. Scores on the Personal Confidence and Hope sub-scale improved pre-programme (N=41, Mean=3.23, SD=.6460) compared to post-programme (N=41, Mean=3.6791, SD=.625).



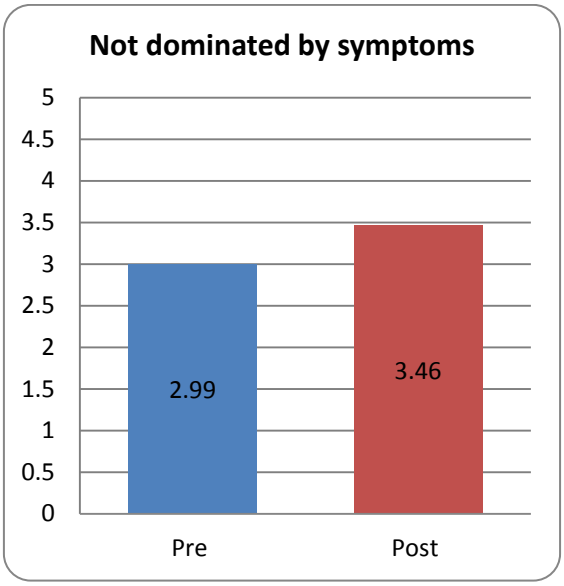
2. Scores on the Willingness to Ask for Help Sub-scale were measured pre- (N=41, Mean=3.67, SD=.99) and post-programme (N=41, Mean=3.86, SD=0.806).



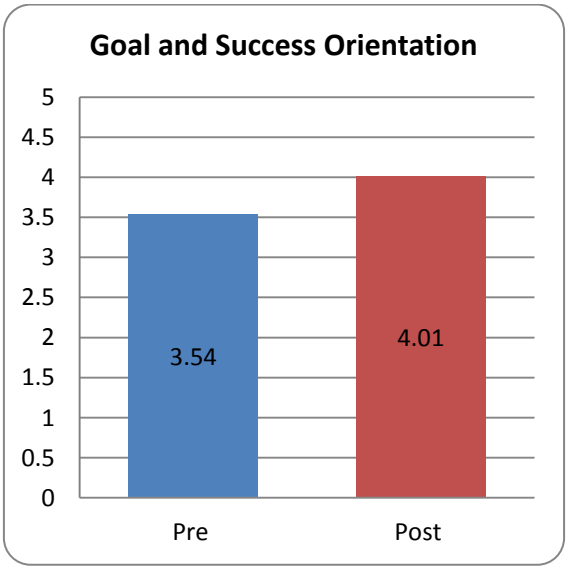
3. The Ability to rely on others (Support) sub-scale was measured pre- (N=41, Mean=3.99, SD=7.18) and post-programme (N=41, Mean=4.208, SD.703).



4. The RAS sub-scale: Not Dominated by Symptoms was measured pre- (N=41, Mean=2.995, SD=.983) and post the Recovery programme (N=41, Mean=3.468, SD=.743).



5. Scores on the Goal and Success Orientation sub-scale changed from pre- programme (N=41, Mean=3.54, SD=0.777) to post-programme (N=41, Mean=4.008, SD=.735).



4.4.4. Summary

For the six month period in 2011, when the RAS was used in pre- and post-Recovery Programme measurement, 41 out of 62 service users completed the programme. It is not possible to make any conclusions about the particpants and whether the programme positively affected their recovery. The mean pre- (3.45) and post-scores (3.82) on the RAS suggest marginal improvement. These outcomes have prompted clinicians facilitating this programme to a) re-evaluate the suitability of the RAS as an outcome measure and b) re-evaluate the timing of pre- and post-measurement which at present is five weeks. Clinicians have also implemented systems to improve measure completion and capture rates as in 2011 only 2/3 of participants completed pre- and post-measures.

4.5. Acceptance & Commitment Therapy Programme SEH 2011

ACT is an evidence-based psychotherapy which aims to teach people "mindfulness skills", to help them live in the "here and now" and manage their thoughts and emotions more effectively. ACT supports participants to identify and connect with their core personal values and integrate them into everyday action. ACT aims to change people's relationship to anxiety and depression and increase values-based behavioural activation, rather than symptom reduction. The ACT group in St Edmundsbury Hospital (SHE) runs over an 8-week period, for one afternoon a week.

4.5.1. Descriptors

Out of the 90 new referrals to the ACT programme in St Edmundsbury, 21 people who had both pre- and post-measures completed were used for analysis.

4.5.2. ACT Outcome Measures

Three measures were used pre- and post-ACT programme and include the Acceptance and Action Questionnaire (AAQ2), Beck Anxiety Scale and Beck Depression Scale.

- **Acceptance & Action Questionaire 2 (AAQ2)**

The Acceptance and Action Questionnaire (AAQ2) (Bond et al., 2011) is a measure of experiential avoidance, or the tendency to avoid unwanted internal experiences. The measure was developed to establish an internally consistent measure of ACT's model of mental health and behavioural effectiveness. The AAQ2 validity shows Cronbach's alpha is .84 (.78 - .88), and the 3- and 12-month test-retest reliability is .81 and .79, respectively (Bond et al., 2011)

- **The Beck Anxiety Inventory**

The Beck Anxiety Inventory (BAI), created by Aaron T. Beck, MD, and colleagues (1990), is a 21-item multiple-choice self-report inventory that measures the severity of an anxiety in adults and adolescents. The respondent is asked to rate how much each symptom has bothered him/her in the past week. The symptoms are rated on a four-point scale, ranging from ''not at all'' (0) to ''severely'' (3). The instrument has excellent internal consistency (α= .92) and high test–retest reliability (r = .75) (Beck & Steer, 1990).

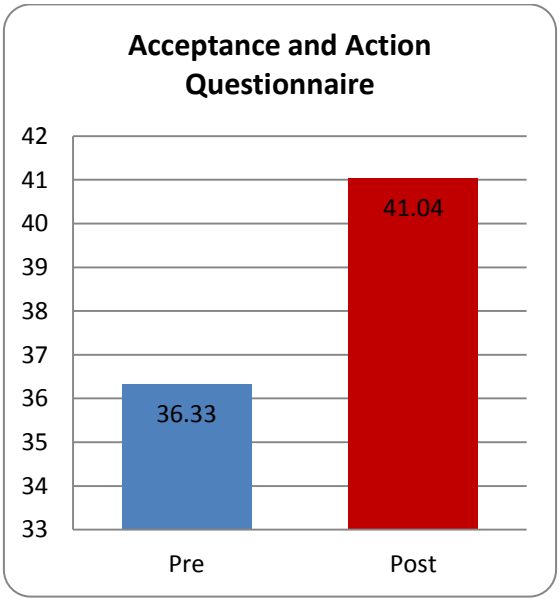
- **The Beck Depression Inventory**

The Beck Depression Inventory (BDI) (Beck et al 1996) is a series of questions developed to measure the intensity, severity, and depth of depression in patients with psychiatric diagnoses. The Cronbach alpha of the full BDI-II (items 1-21) was 0.94. Its long form is composed of 21 questions, each designed to assess a specific symptom common among people with depression. Individual questions on the BDI assess mood, pessimism, and sense

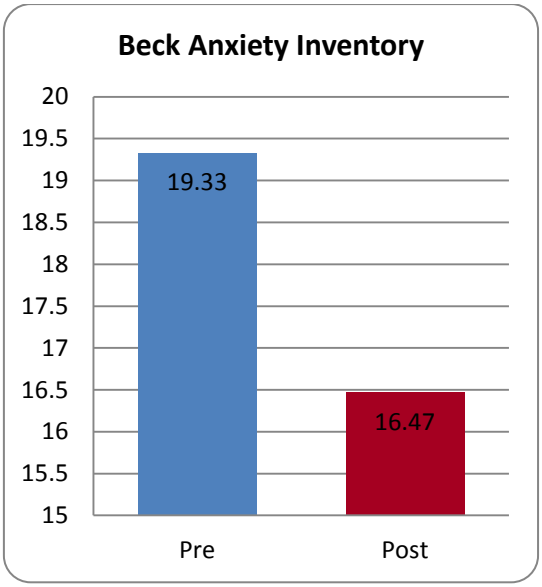
of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, body image, work difficulties, insomnia, fatigue, appetite, weight loss, bodily pre-occupation, and loss of libido. Items 1 to 13 assess symptoms that are psychological in nature, while items 14 to 21 assess more physical symptoms.

4.5.3 Results

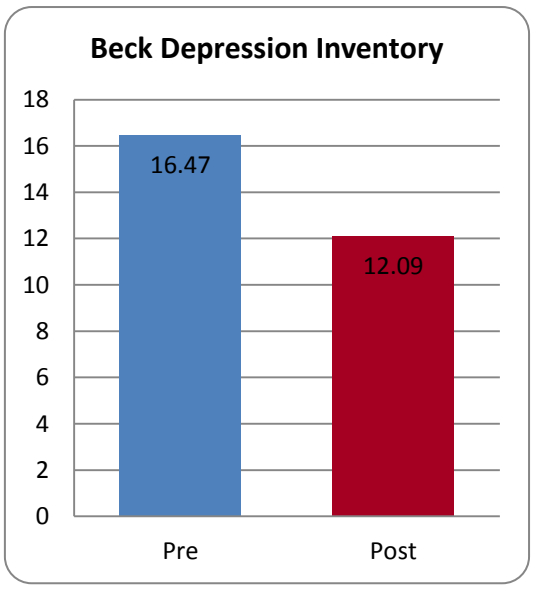
Scores on the Acceptance and Action Questionnaire (AAQ2) were measured pre-programme (N=21, Mean=36.33, SD=8.16) and post-programme (N=21, Mean=41.047, SD=10.86) showing an improvement in psychological flexibility post-ACT treatment.



Out of the 21 people who had completed the ACT programme, scores on the BAI had decreased from pre-programme (N=21, Mean=19.33, SD=13.26) which placed them in the *moderate* range, to post-programme (N=21, Mean=16.47, SD10.684) which also placed them in the *moderate* anxiety range.



Scores on the Beck Depression Scale decreased from pre-treatment (N=21, Mean=16.47, SD=10.16) to post-treatment (N=21, Mean=12.09, SD8.78) and remained in the *mild mood disturbance* level.



4.5.4. Summary

Only 21 of the 91 referred service users completed before and after measures for the ACT programme in SEH. Therefore, it is difficult to evaluate whether the mean pre- and post-scores are comparable to the mean for the total group. For the 21 people who completed the pre- and post-measures, their scores suggest improvement in psychological flexibility as

measured by the AAQ2 and marginal decrease in symptoms of anxiety and modest decrease in the symptoms of depression.

However, it is not clear if these improvements are clinically significant. The process of evaluating the ACT outcomes has lead the clincian facilitating this programme to review the suitability of the BAI and has replaced it with a quality of life measure. Once again, focus on establishing more robust systems and processes for improving the completion rates of outcome measures has lead to a comprehensive database being created which allows for standardisation of data collection.

4.6. Living through Distress Programme 2011

The "Living through Distress" programme was developed as a brief intervention to meet the needs of the service users of St. Patrick's University Hospital in 2008. The group utilises core skills from Dialectical Behaviour Therapy (DBT) which helps individuals who use maladaptive behaviours, such as self-harm, to cope with distress. The focus of the group is on communicating skills which patients can utilise to aid them in managing their distress in a more functional way. The group aims to impart an atmosphere of validation, empathy and pragmatism, something which research shows is not always afforded to patients dealing with distress in maladaptive ways (James & Cowman, 2007).

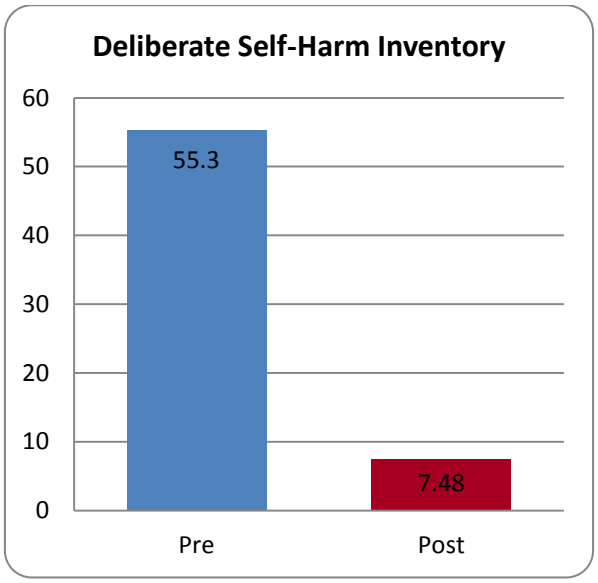
4.6.1. Living through Distress Outcome Measures

The Deliberate Self-Harm Inventory (DSHI; Gratz, 2001) is a 17-item questionnaire which assesses various aspects of self-harm, including type, frequency, severity, and duration. The outcome variable considered in this analysis is the frequency of all types of physical self-harm for the previous six weeks. The measure is designed to be self-administered but, for clinical and ethical reasons, questions are asked in an interview format. The measure has shown high internal consistency (α=.81) and test-re-test reliability along with adequate construct, convergent and discriminate validity reported. For the purpose of this report,

scores reflect frequency of Deliberate Self-Harm at periods of six weeks prior to the assessment and six weeks prior to debriefing post-group.

4.6.2. Results

From the 71 people who completed pre- and post-measures on the Living Through Distress Programme for 2011, the Deiberate Self-Harm Inventory showed a decrease between pre-scores (N=71, Mean=55.3, SD=101.9) and post-scores (N=71, Mean=7.48, SD=17.4).



4.7. Section Summary

This section has summarised the clinical outcomes associated with inpatient treatment and with five clinical programmes during 2011. The CGI outcome analyses identified that for the 200 records analysed, over 59% of service users had either been discharged from hospital either much improved or improved.

The outcomes for the five programmes vary. Programmes evaluated included the Anxiety Programme, the Eating Disorder Programme, the Recovery Programme, the ACT Programme (SEH) and the Living through Distress Programme. While there are weaknesses in the level of outcome data completeness, analyses carried out on programme completers show outcome improvements across all evaluated programmes. The range of improvement is variable and it is not clear in all cases whether improvements were clinically significant.

What is important is that this initial outcome measurement process is valued as an integral aspect to establishing the effectiveness of our services and needs to be become a routine and standardised practice for all programmes in 2012.

This Clinical Outcomes Section represents the first attempt to collate such information both at an individual programme level and at an organisational level. There has been much learning regarding the process of measuring outcomes. Firstly, outcome measurement of any service requires the selection of measures which are appropriate and suitable to what the service aims to achieve. Secondly, data collection requires a systems approach so that information is captured routinely at the beginning and at set points along the care pathway. Such systems require clarity of purpose and unity of effort, across the team delivering the service, so that everyone involved understands the importance of their role in collecting data in a timely and consistent manner. Outcome measurement without systems can become an unnecessarily time-intensive process. Finally, attention to detail in data entry is critical, so that errors and omissions in records and databases are reduced to a minimum, ensuring the dataset is as complete as possible to allow credible and efficient analysis.

Now that the organisation has begun the process of outcome measurement, clinicians are visibly more engaged and committed to evaluating their services. The process has informed service development, so that outcome measurement is not an end in itself but rather a means through which we can continue to improve the effectiveness of what we do and the outcomes for our service users.

In 2012, the outcomes project will be extended to all programmes so the outcomes report for next year will represent a more comprehensive evaluation of the clinical outcomes our services have achieved.

Section 5

Laboratory Efficiency Outcomes

5. Laboratory Efficiency Outcomes 2011

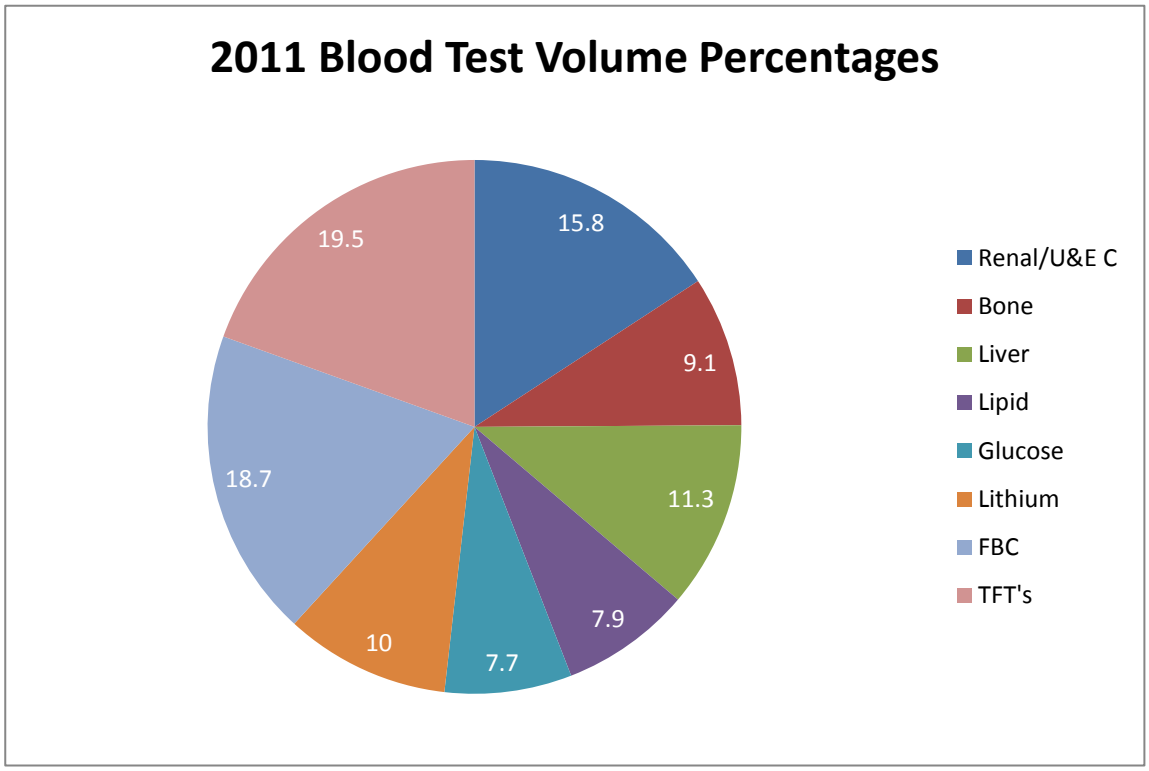
In October 2009, SPUH Laboratory leased and commissioned three new blood test analysers to provide an expanded in-house blood testing service. The service transition was completed in June 2011. This decision was taken following the introduction of a Service Level Agreement in January 2008 between SPUH and St. James's Hospital Medical Laboratory (SJH) where blood testing costs carried out by SJH were to be invoiced to SPUH. The expanded in-house blood testing service was intended to and has achieved cost savings to SJH invoices.

In addition to the cost savings achieved, test turnaround times (TATs) for those tests carried out in-house has also improved. The table below summarises actual volumes of blood tests carried out in-house in 2011, which previously would have been carried out in SJH. Excluding Thyroid Function Tests which are batch-tested twice weekly, there has been an eight-fold improvement in TATs, from 48 hours + to 6 hours.

5.1. SPUH Laboratory In-house blood test volumes and turnaround times (TATs)

Test Profile	Tests to Date	Volume of Tests (Monthly Average) [A]	Current TAT [B] (Hrs)	Previous TAT (Hrs)
Renal/U&E [C]	2608 [D]	417	6	48+
Bone	1508 [D]	239	6	48+
Liver	1877 [D]	299	6	48+
Lipid	1307 [D]	208	6	48+
Glucose	1277 [D]	203	6	48+
Lithium	1662 [E]	148	6	24
FBC	3094 [E]	274	6	24
TFTs	3224 [E]	287	48-72	72+
Notes				
A: Monthly Average Volumes for FBC, Lithium and TFT taken from Jan to Nov 2011, Biochemistry Volumes taken Jun to Nov 2011				
B: Turnaround Time (TAT) in hours since from time sample received into lab to time result authorised and available on electronic system				
C: Renal and U&E combined for ease of referencing				
D: 9 Jun to 9 Dec 2011				
E: 4 Jan to 9 Dec 2011				

The following chart illustrates volumes of blood test types as percentages. Thyroid Function Tests (TFTs) account for almost 20 percent of all blood tests carried out in 2011, while Full Blood Counts (FBCs) were the second most common test carried out in-house.



5.2. Summary

The evaluation of service efficiencies gained through the expansion of in-house blood testing is shown in improved test turnaround times with SPUH. The majority of clinical chemistry tests now are reported back on the same day. This represents a substantial improvement for clinicians for early detection of physical complications and early diagnosis.

Section 6
Service User Measures and Outcomes

6. Service User Outcomes from Feedback – SPUH 2011

St Patrick's University Hospital's five-year strategy, Mental Health Matters, commits the hospital to actively seek the views of service users on all aspects of service delivery, policy and service development. Our service users constitute key stakeholders who can provide information on what they need and want, which guides development of services and policies to meet and exceed their needs.

In 2011, a number of service user feedback initiatives were undertaken which provided information on the experiences, needs and requirements of our service users. These sources of service user feedback provide an invaluable resource in guiding existing service improvements and new service developments.

These service user feedback initiatives carried out in 2011 included:

1. Mental Health Commission/Irish Society for Quality and Safety in Healthcare National In-Patient Perception Study
2. Service User Feedback Survey
3. Dean Clinic Feedback
4. Day Services/Dean Clinic Feedback
5. Choice and Medication – Service User Feedback
6. St Patrick's University Hospital On-Line: An evaluation of what service users want.
7. Young Adult Unit Feasibility Study: Young adult service users' views on what is important to them in Hospital

6.1. Mental Health Commission / Irish Society for Quality and Safety in Healthcare (ISQH) National Inpatient Perception Project

6.1.1. Purpose

This survey carried out by the ISQSH was commissioned by the MHC and was the first national inpatient survey to be undertaken in Mental Health. SPUH participated in this national survey, the purpose of which was to obtain the views of discharged service users nationally on their views of their care and treatment during their inpatient stay and post-discharge.

6.1.2. Distribution

Service users discharged between 1st November 2010 and 1st February 2011 formed the survey sample. Each consultant psychiatrist was asked to review the survey sample list and exclude those that they viewed as unable to participate. Service users themselves could opt out prior to commencement of the survey or at any stage during the survey by contacting the ISQSH. The survey was mailed out with accompanying information and followed by two reminders which were sent to all participants.

6.1.3. Response

379 SPUH service users participated in this National Survey, 77 of which had been inpatients in St Edmundsbury Hospital. The average response rate for Approved Treatment Centre was circa 35% nationally.

6.1.4. Results

The survey data has been analysed by the ISQSH on behalf of the Mental Health Commission and a report will issue. This report was published on 7th February 2012 and an individual report providing data for St Patrick's and St Edmundsbury Hospital was also provided. For St Patrick's University Hospital, the response rate was 40% and for St Edmundsbury, the response rate was 38%.

Participants in the study completed a detailed questionnaire and were asked for their views of their care and treatment under the following categories listed in the table below:

- Demographics
- Admission Process
- Staff Responsiveness
- Dignity, Respect and Rights
- Personal Safety
- Hospital Visiting Hours
- Service User Rights
- Discharge Procedures
- Overall Evaluation
- Health Status
- Care Plans
- Symptom Management and Relief
- Medication Safety
- Hospital Facilities
- Pastoral Care
- Service User Complaints
- Transition
- Information on Admission
- Communication and Information
- Community and MDT Access
- Tests and Procedures
- Hospital Ward and Food
- Service User Involvement
- Length of Stay
- Service User / Provider Relationship

6.1.5. Key Findings

Overall, the St Patrick's and St Edmundsbury results showed that service users' perception of the services provided were higher than the national average results. The following tables present the key findings for the SPUH and St Edmundsbury Hospital.

Health Status

Following my Hospital stay on this occasion my health status is....	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Greatly disimproved	6.7%	5.1%	4.2%
Disimproved	4.2%	2.5%	4.2%
Slightly disimproved	4.8%	5.9%	4.2%
Neither improved or disimproved	11.0%	7.6%	8.3%
Slightly improved	16.1%	15.3%	8.3%
Improved	32.3%	34.7%	41.7%
Greatly improved	25.0%	28.8%	29.2%
Overall, since I was discharged from the hospital my situation is...	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Worse than Before	7.1%	6.9%	0.0%
Unchanged	16.6%	12.1%	13.0%
Better than before	47.2%	48.3%	43.5%
Much better than before	29.1%	32.8%	43.5%

• Service User Involvement

I was involved in decisions made about my care and treatment as much as I would have liked	National (n=710)	SPUH (n=120)	SEH (n=24)
Strongly Agree	38.4%	44.4%	58.3%
Agree	37.2%	34.2%	25.0%
Disagree	16.4%	14.5%	16.7%
Strongly Disagree	7.9%	6.8%	0.0%
Hospital staff encouraged me to voice my opinions about the service I received	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Strongly Agree	33.4%	34.2%	45.8%
Agree	29.8%	30.7%	29.2%
Disagree	28.4%	28.9%	20.8%
Strongly Disagree	8.4%	6.1%	4.2%
Members of my healthcare team asked me what they should tell my family / how much information they should provide them regarding my Hospital stay	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Strongly Agree	24.6%	24.4%	29.4%
Agree	31.1%	38.4%	41.2%
Disagree	31.8%	26.7%	23.5%
Strongly Disagree	12.5%	10.5%	5.9%

• Service User Rights

Were / are you aware that under the Freedom of Information Act you can access your patient records?	National (n=710)	SPUH (n=120)	SEH (n=24)
Yes	45.5%	51.7%	54.2%
No	54.5%	48.3%	45.8%
Were you aware of the complaints procedure in the Hospital?	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Yes	47.0%	54.6%	56.5%
No	53.0%	45.4%	43.5%
Did you receive written information on your rights when you entered hospital?	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Yes	25.5%	29.4%	41.7%
No	56.0%	40.3%	37.5%
Don't know /Can't remember	18.4%	30.3%	20.8%
Were you told about your rights when you entered Hospital?	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Yes	43.1%	50.0%	50.0%
No	39.5%	30.5%	29.2%
Don't know /Can't remember	17.4%	19.5%	20.8%

- ## Length of Stay

I feel my length of stay as a service user was appropriate	National (n=710)	SPUH (n=120)	SEH (n=24)
Strongly Agree	43.2%	48.3%	62.5%
Agree	39.3%	35.0%	33.3%
Disagree	11.1%	10.8%	0.0%
Strongly Disagree	6.4%	5.8%	4.2%

- ## Overall Evaluation of Stay in Hospital

Overall, were you satisfied with the treatment you received?	National (n=710)	SPUH (n=120)	SEH (n=24)
Yes	84.4%	87.5%	95.8%
No	15.6%	12.5%	4.2%
If I had to re-enter hospital and have a choice, I would prefer to return to this hospital	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Strongly agree	53.0%	65.5%	72.7%
Agree	33.0%	25.9%	13.6%
Disagree	7.7%	5.2%	9.1%
Strongly Disagree	6.4%	3.4%	4.5%
The service I received at the Hospital matched my perception of my ideal hospital	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Strongly agree	30.2%	34.2%	54.2%
Agree	41.5%	46.2%	29.2%
Disagree	21.1%	12.8%	12.5%
Strongly Disagree	7.2%	6.8%	4.2%
The level of service I received while a service user in the hospital met my expectations	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Strongly agree	45.3%	50.8%	62.5%
Agree	38.7%	33.9%	25.0%
Disagree	10.7%	11.9%	8.3%
Strongly Disagree	5.3%	3.4%	4.2%
I would recommend this hospital to a friend or family member if they needed similar medical attention	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Strongly agree	51.0%	61.7%	73.9%
Agree	33.5%	32.2%	8.7%
Disagree	9.1%	4.3%	13.0%
Strongly Disagree	6.3%	1.7%	4.3%
I was confident about the treatments I received	**National (n=710)**	**SPUH (n=120)**	**SEH (n=24)**
Strongly agree	45.3%	37.8%	52.2%
Agree	38.7%	45.4%	39.1%
Disagree	10.7%	12.6%	4.3%
Strongly Disagree	5.3%	4.2%	4.3%

6.2. Service User Experience of Inpatient Admission Survey 2011

6.2.1. Purpose

- To improve understanding of service experience of assessment/admission.
- To obtain feedback on service users' views of their physical environment in the Hospital
- To obtain feedback on the service users' perception of discharge and
- To understand how service users view their treatment by staff during their stay in Hospital.

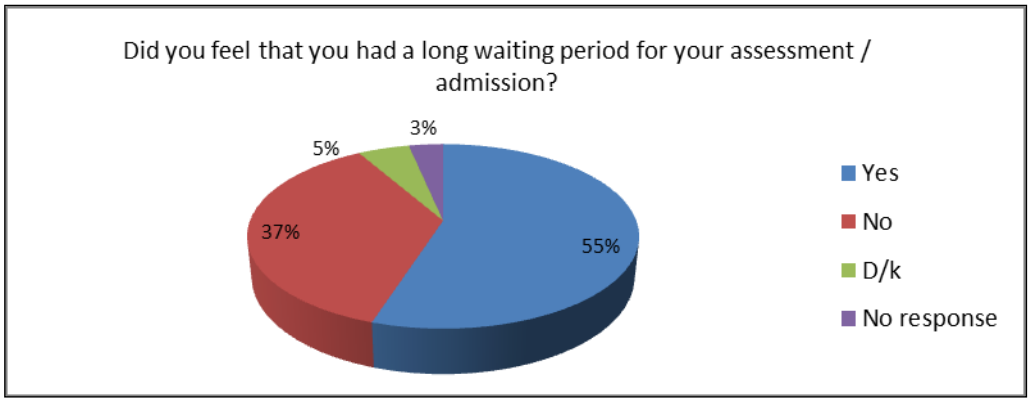
6.2.2. Distribution

The survey was a voluntary self-completion paper survey. Forms were made available on all Wards between August 2010 and January 2011. The initial response level was very low and wards were then contacted on a bi-weekly basis for discharge numbers. Service users were then contacted directly and asked to participate. The survey was ceased due to the MHC/ISQSH National in-patient perception survey.

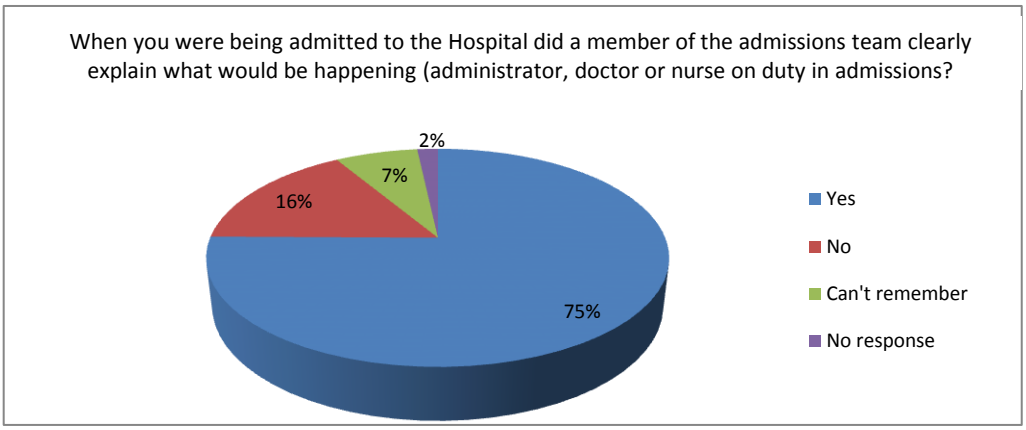
6.2.3. Results

289 surveys were collected in total from all wards in SPUH and from SEH. Service users were asked to complete the survey close to point of departure. 197 females and 93 males completed the surveys.

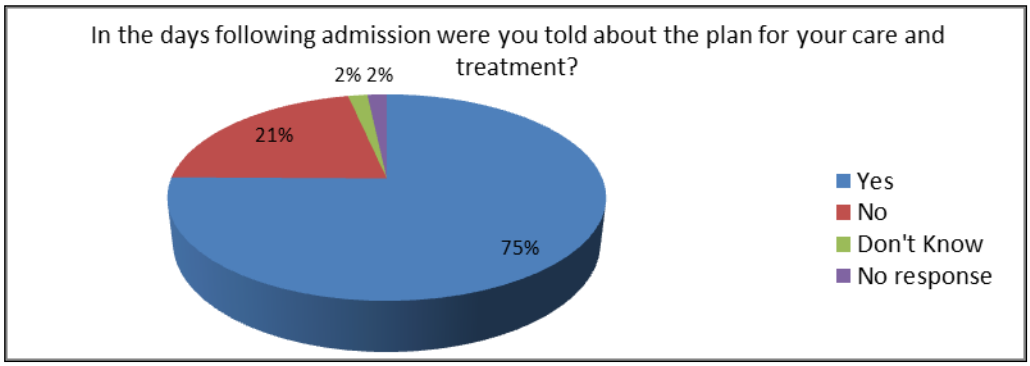
55% of service users reported that they felt they had a long waiting period for assessment/admission and 37% reported that they had a short waiting period for assessment/admission.



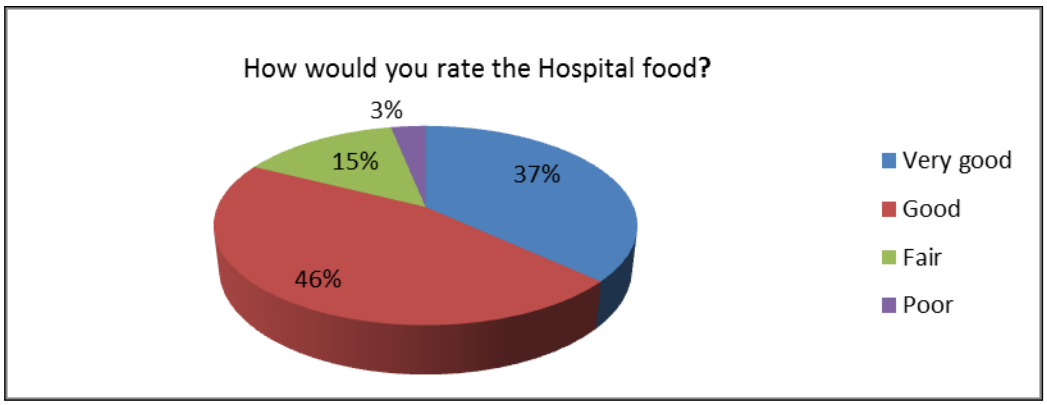
- 75% of service users agreed that their admission was clearly explained to them.



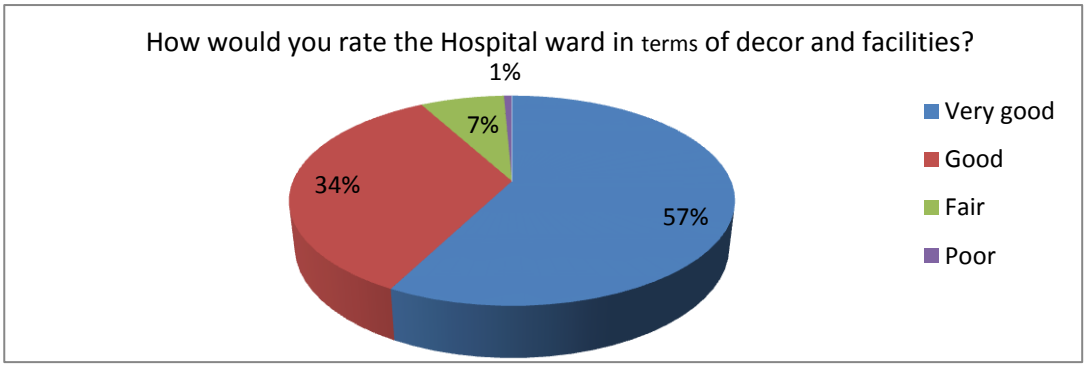
- 21% of service users did not feel that they had been told about the plan for their care and treatment in the days following admission but 75% of service users responded in the affirmative regarding their care and treatment in Hospital.



- 83% of service users rated the Hospital food as very good (37%) or good (46%) with 18% rating is as fair (15%) or poor (3%).

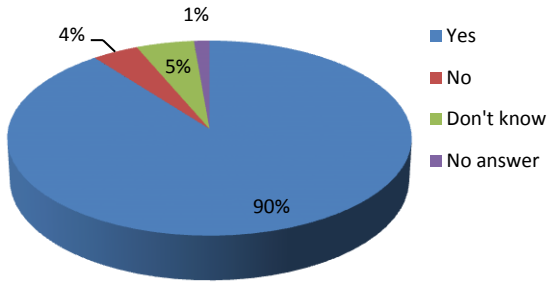


- 91% of service users rated the Hospital ward decor and facilities as either very good or good. 7% rated decor and facilities as fair with 1% or respondents giving a rating of poor.

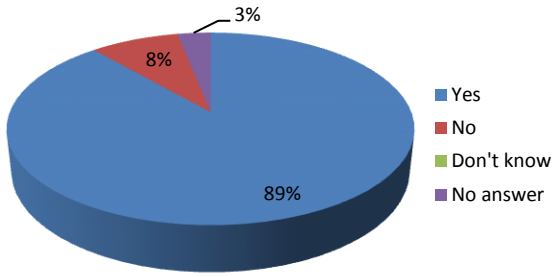


- 80% of service users were either very satisfied or satisfied with how their day was organised in Hospital during the week.
- 79% of service users were either very satisfied or satisfied with the services available in the Hospital.
- 90% and 89% of service users felt that they were treated with dignity and respect by healthcare professionals and non-healthcare professionals respectively. 4% and 8% of service users did not feel they were treated with dignity and respect by healthcare professionals and non-healthcare professionals respectively.

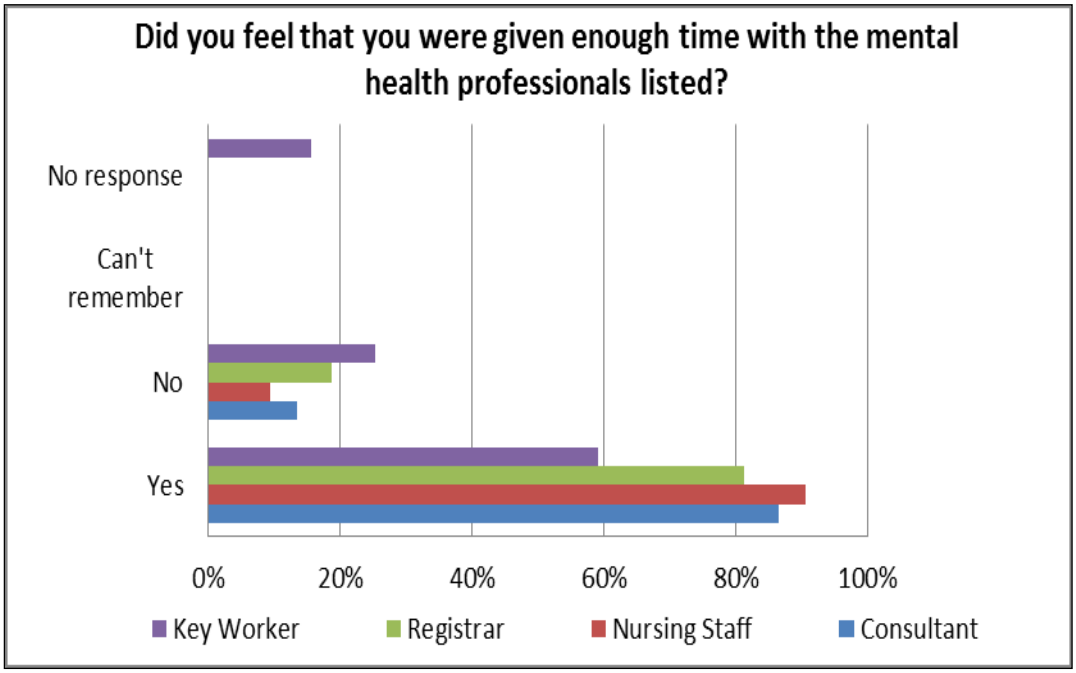
Did you feel that you were treated with dignity and respect by the healthcare professionals looking after your care?



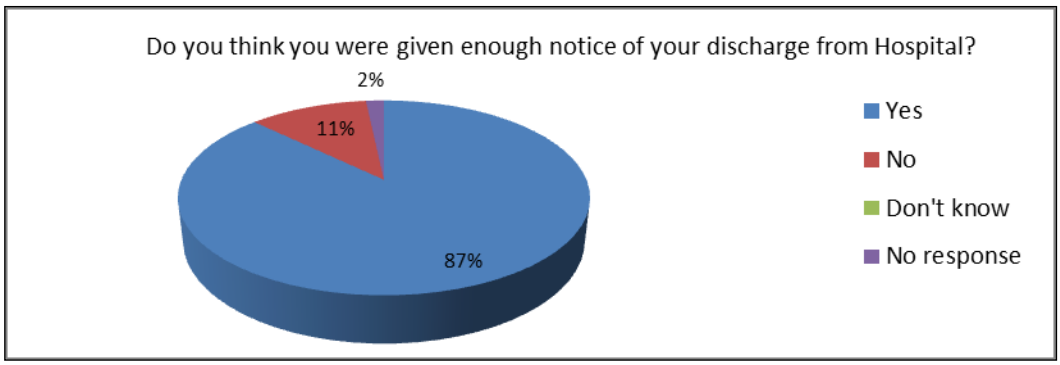
Did you feel that you were treated with dignity and respect by the non-healthcare professionals looking after your care?



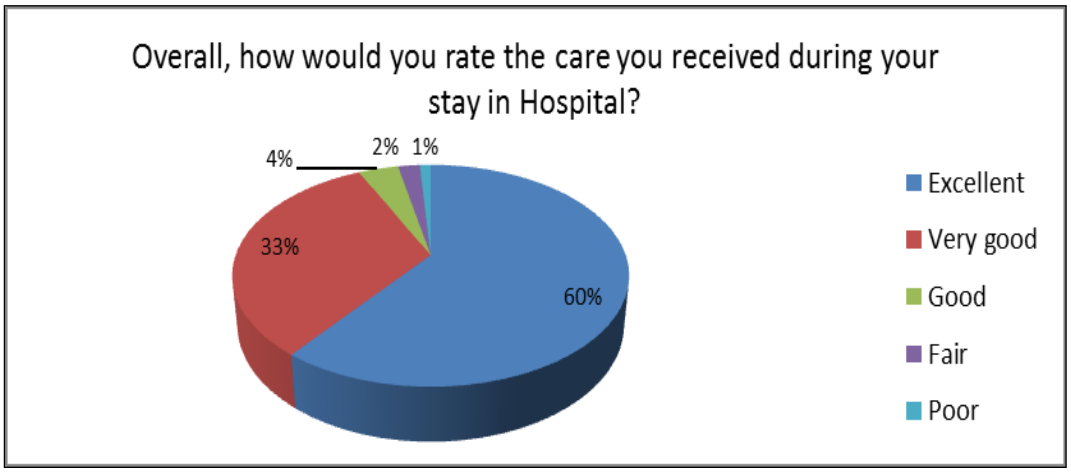
- 87% of service users felt they were given enough time with their consultant
- 90% of service users felt that they were given enough time with nursing staff
- 81% of service users felt that they were given enough time with their registrar
- 59% of service users felt that they were given enough time with their key worker
- 15% of service users did not respond to the key worker question.



- 97% of service users reported that they had been given enough notice of their discharge from Hospital and 11% reported that they had not.



- 60% of service users rated the care they received during their stay in Hospital as excellent and 33% rated their care in Hospital as very good.



6.3. Dean Clinic Service User Survey 2011

6.3.1. Purpose

- To identify how service users accessed Dean Clinics
- To gain an understanding of how service users viewed their visit to the Dean Clinics
- To understand how service users perceived the current Dean Clinics and to identify areas of concern which could be improved?
- To review the service users' perspective on the value for money aspects of the Dean Clinics

6.3.2. Distribution:

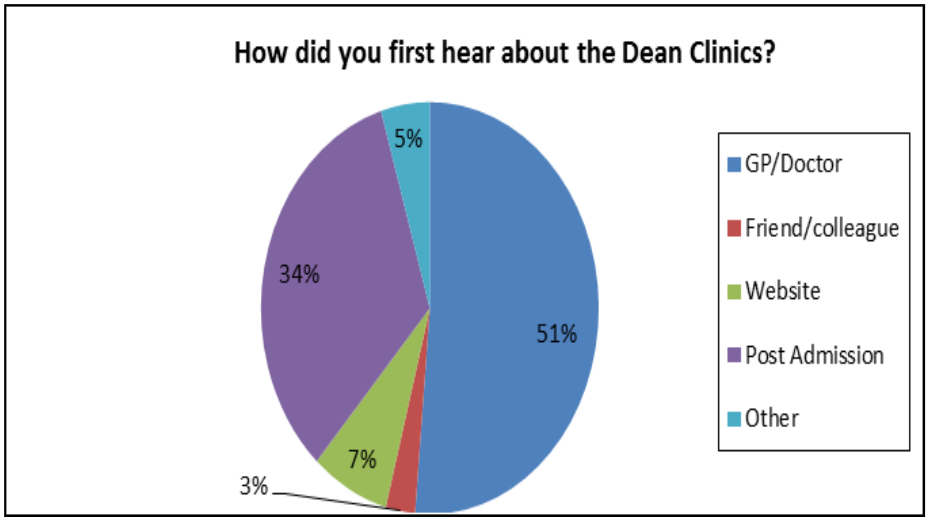
The survey was a voluntary self-completion paper survey. Forms were made available in all Dean Clinics from May 2010 to January 2011. This survey was distributed through the Dean Clinics Co-ordinator to all of the Dean Clinics

6.3.3. Response

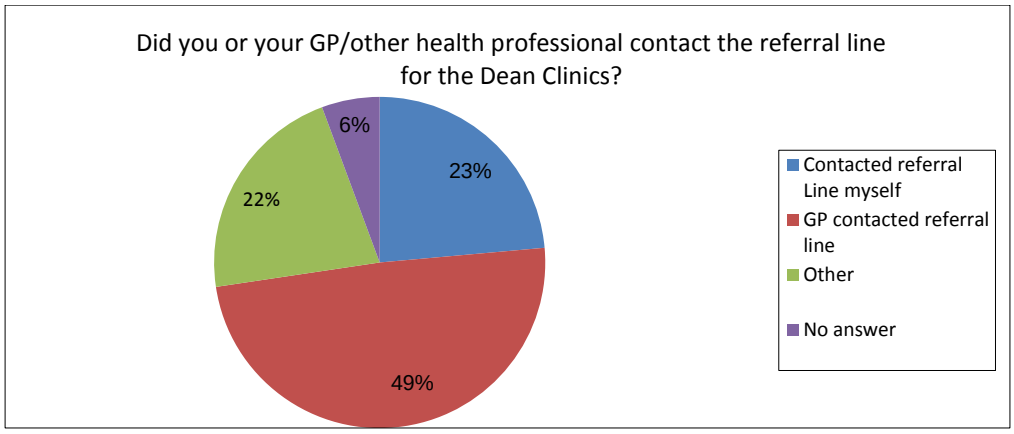
107 surveys were collected in total. The survey was answered by 31 male respondents and 76 female respondents.

6.3.4. Key Findings

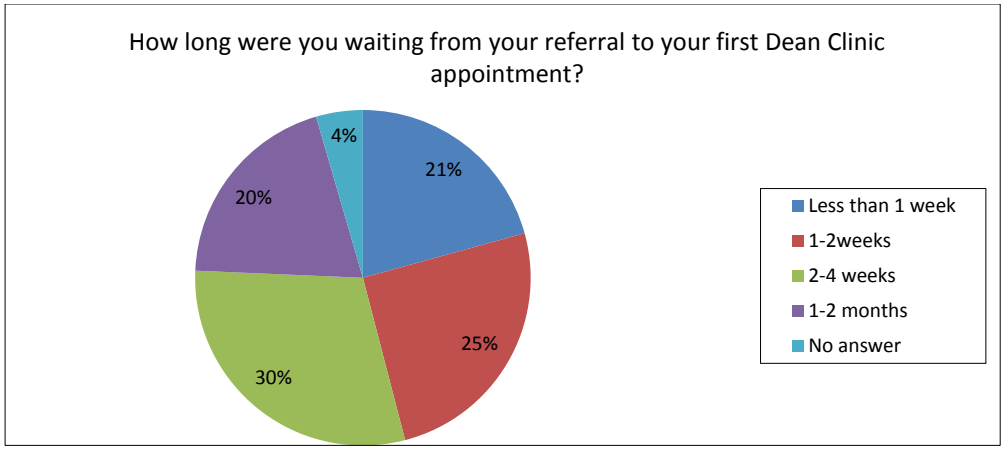
51% of service users heard about the Dean Clinics through their GP with 34% attending post discharge from Hospital. Only 7% found out about the Dean Clinics from the web.



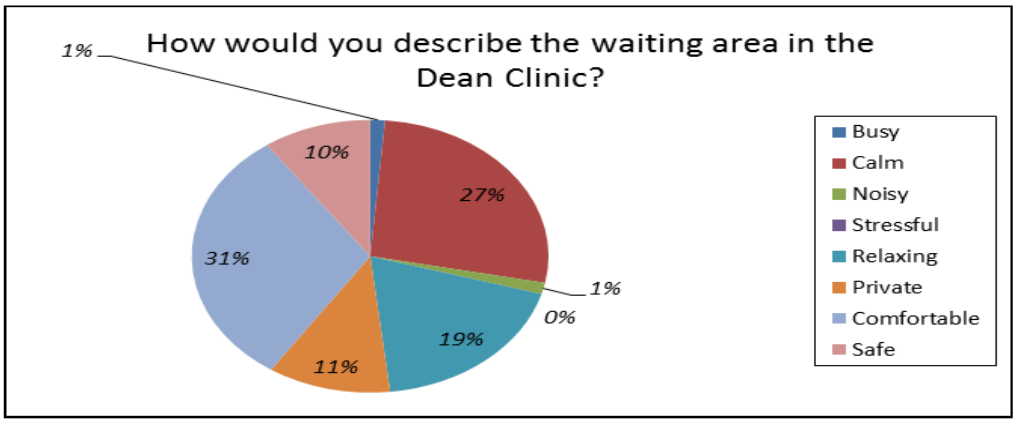
- 23% of service users contacted the Dean Clinic referral line themselves and for 49% the GP contacted the referral line.



- 20% of service users were waiting between 1 and 2 months for their appointments, 25% received an appointment within 1-2 weeks and 30% within 2-4 weeks.



- 2% of respondents noted that the Dean Clinic waiting area was busy or stressful. The remaining respondents described it as comfortable (31%), calm (27%), relaxing (19%), private (11%) and safe (10%).



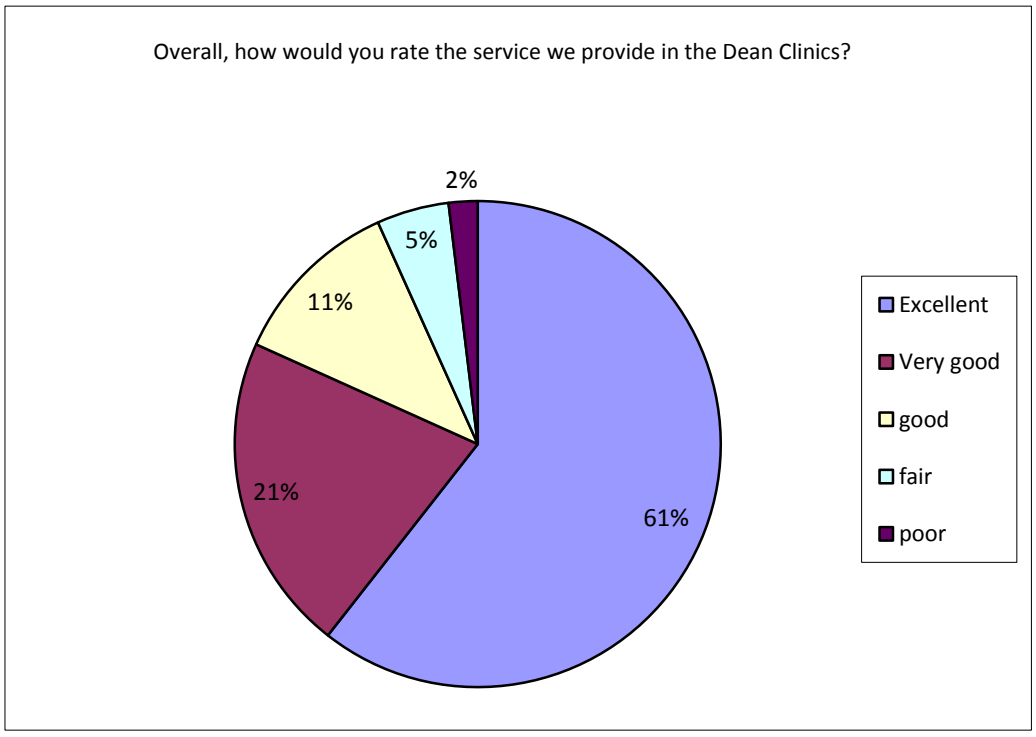
- 98% of service users perceived that they were treated with dignity and respect by healthcare professionals and 97% response with regard to non-healthcare professionals.

Were you treated with dignity and respect by:	Healthcare professionals	Non-healthcare professional
Yes	98%	97%
No	1%	2%
Can't remember	0	1%
Not answered	1%	0

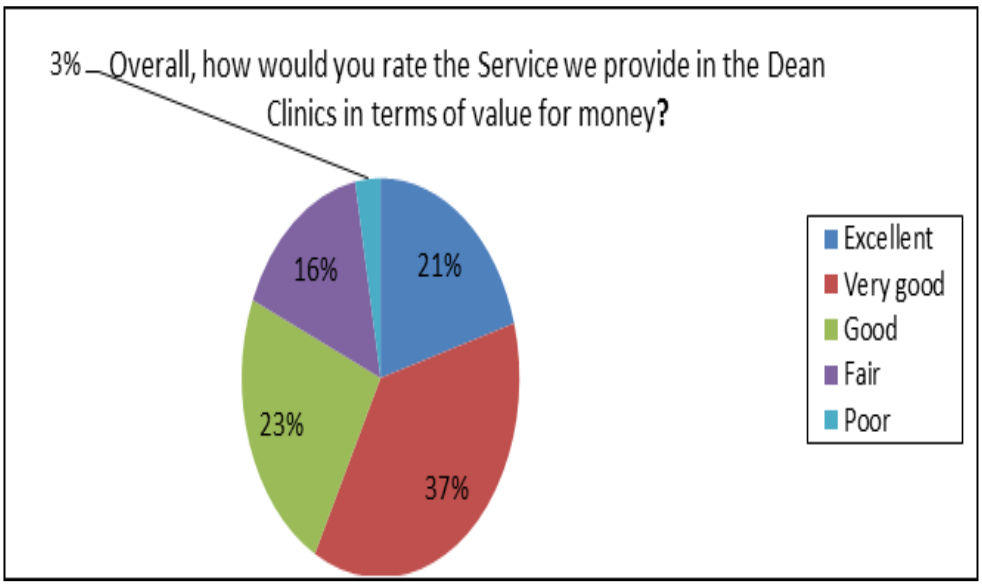
- 92% of respondents believed that they were given enough time with their consultant / registrar, with a corresponding figure of 82% for other healthcare professionals.

During your visit to the Dean Clinic, were you given enough time with	Registrar / Consultant	Other healthcare professionals
Yes	92%	82%
No	2%	1%
Can't remember	4%	3%
Not answered	2%	15%

- 61% of service users rated the overall level of service as excellent and 21% rated overall level of service as very good. 7% rated the service as either fair or poor.



- 21% of service users believed that the Dean Clinics provided excellent value for money, 60% rated this as very good or good and 19% felt that this was fair/poor.



6.4. Service Development Survey – The Views of Service Users in the Dean Clinics and Day Services- June 2011

6.4.1. Purpose

- St Patrick's University Hospital introduced the Dean Clinics as part of the Mental Health Matters Strategy (2008-2013) to strengthen the community services provided by the Hospital.
- This short survey was designed to elicit the views and feedback of service users on their needs for future Dean Clinic and Day Services in the St Patrick's University Hospital Group.

6.4.2. Distribution:

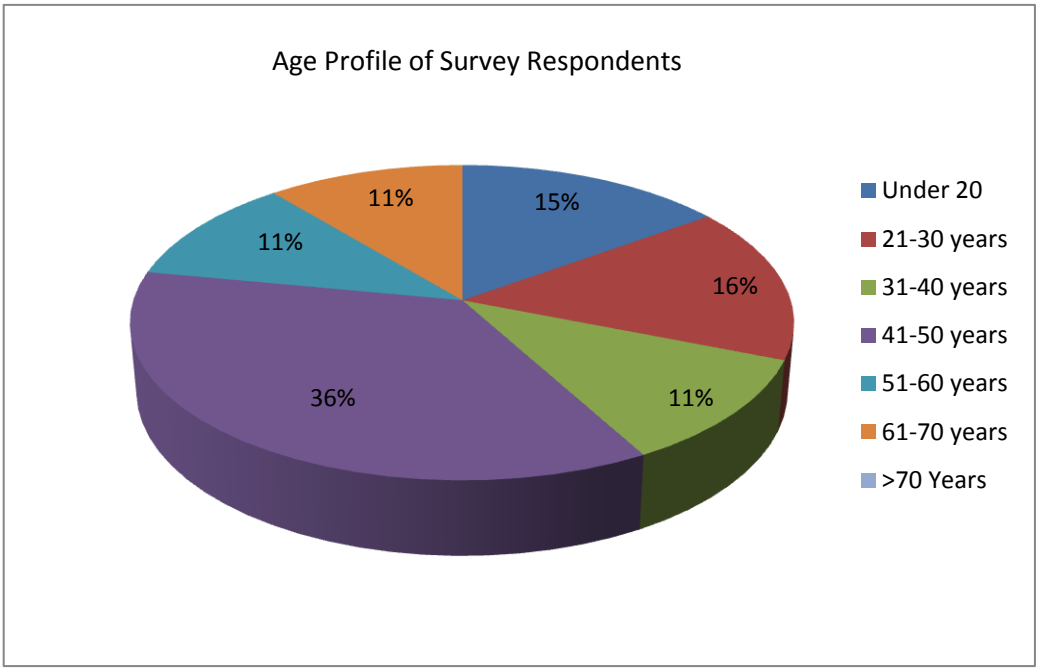
The survey was a voluntary self-completion paper survey. Forms were made available in all Dean Clinics and in the Day Services over a three-week period.

6.4.3. Response

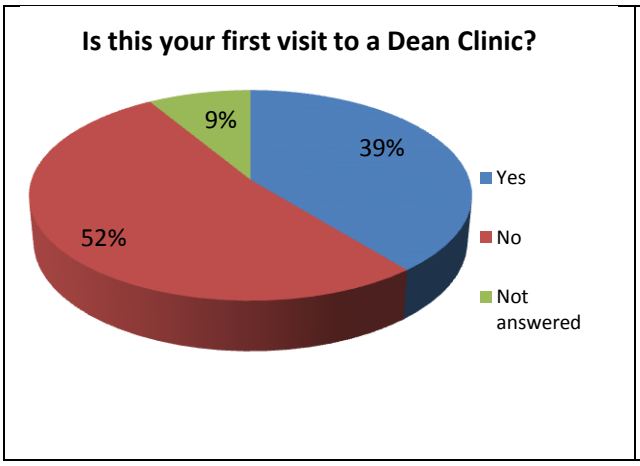
23 responses were received in total: 61% male and 39% female.

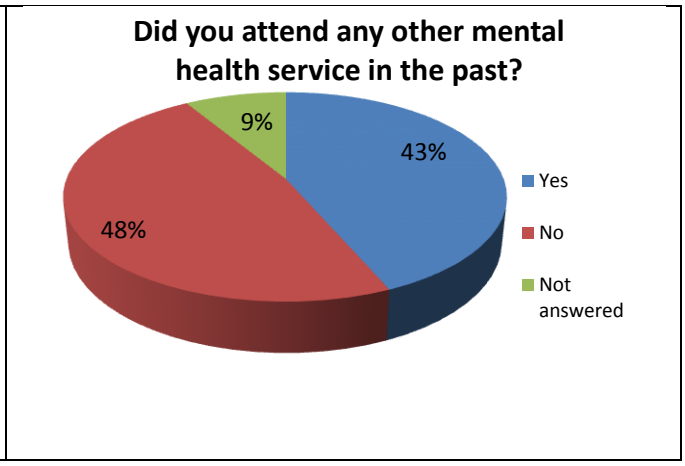
6.4.4. Key Findings

47 % of service users who completed the survey were in the 30 – 50 year age group



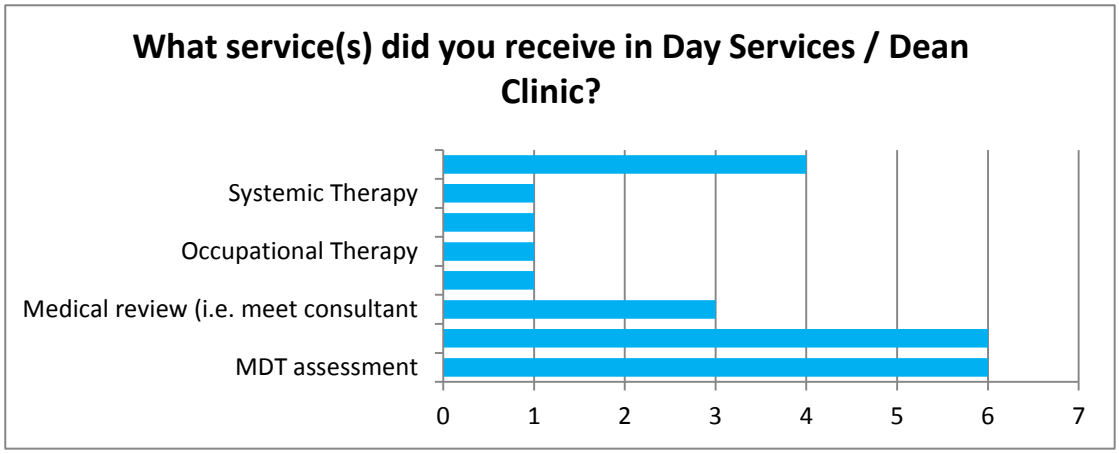
- 37.5% stated that this was their first attendance at a Dean Clinic and 48% had not previously attended a mental health service.





- There was a 95.5% satisfaction rate with the services offered would also indicate that service users' needs and expectations are being met when they do attend the Dean Clinics.

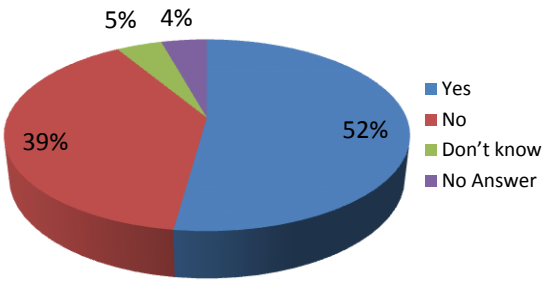
- Service users were attending primarily for MDT assessment, CBT and medical review.



- 55% of service users advised that the stigma of a mental health hospital was an issue for them when asked if they would be willing to travel to the SPUH campus to attend services if they were not available in the Dean Clinic.

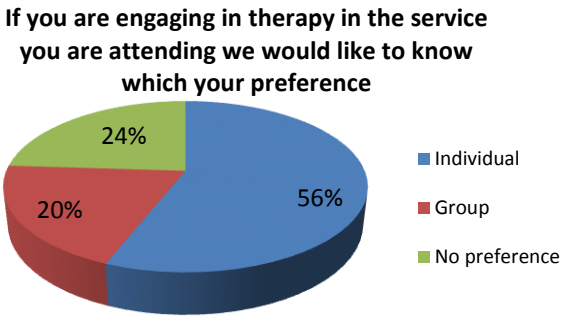
Would you be willing to travel to St Patrick's to avail of the services there if these services were not available in the Dean Clinic?

Response	No	%
Yes	12	52%
No	9	39%
Don't know	1	4.5%
No Answer	1	4.5%



- 56% of service users surveyed indicated that if they were engaging in therapy in the service they were attending that they would prefer individual therapy.
  Confidentiality, privacy and difficulty with speaking in groups were cited as reasons for preferring individual therapy. 44% of respondents would opt for either group or individual therapy either on a cost basis or because they found it helpful to have peer support and to be with others in the same situation.

Response	No	%
Individual	14	56%
Group	5	20%
No preference	6	24%



6.5. Choice and Medication – A Feedback Survey of the Proposed Choice and Medication Website by Service Users

6.5.1. Purpose

- To ensure service users' views and opinions were represented as part of the Hospital-wide review of Choice and Medication prior to purchase by the Hospital.
- To assess service users' views about the operation of the site, the ease of information retrieval and their views on the navigation and design of the site.

6.5.2. Distribution

An online and paper survey was developed for this feedback.

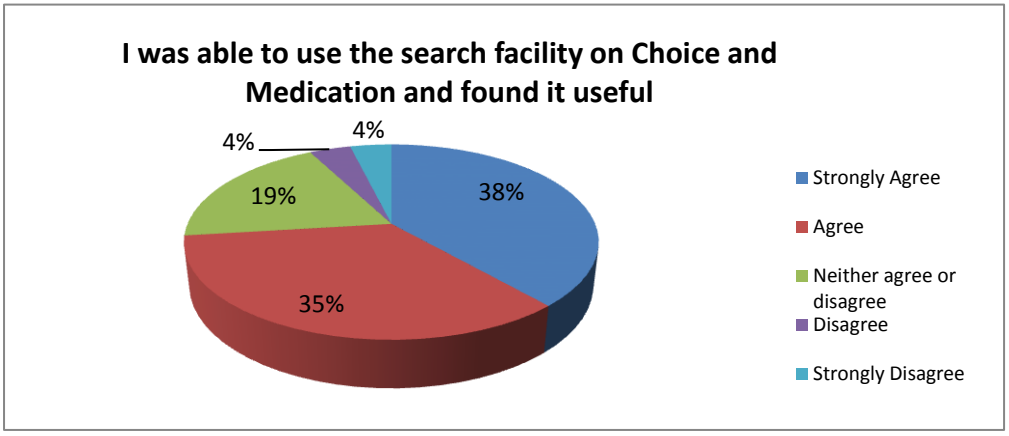
Service users and the Consumer Council were guided to the online survey and paper copies were made available in the Computer Room. Service users were asked at the morning lecture and in the Computer Room to review the site and to complete the short online questionnaire. The survey was available over a three-week period at the end of February and beginning of March 2011.

6.5.3. Response

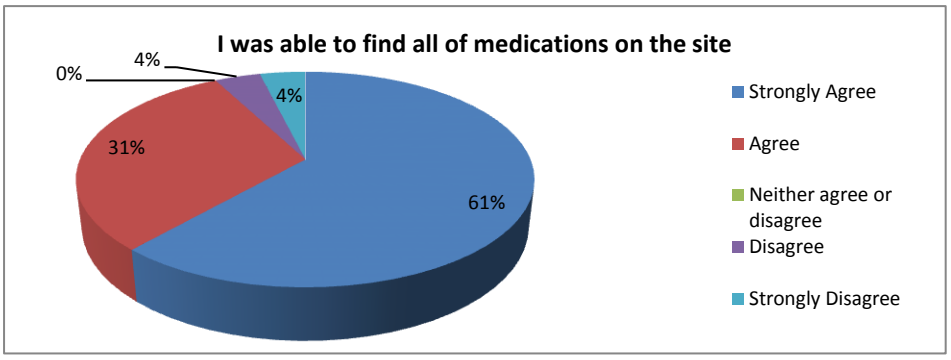
A total of twenty-six responses were received: 23 from the online survey and three paper copies of the survey.

6.5.4. Key Findings

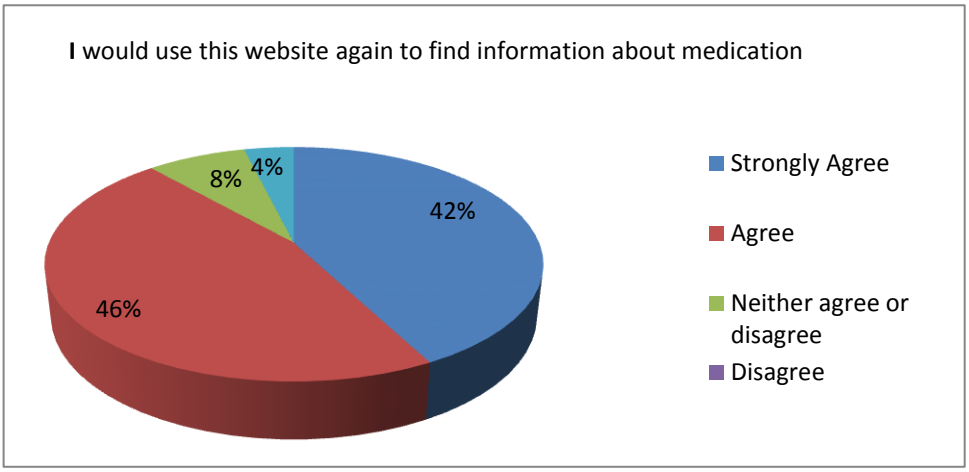
- 73% of service users were able to use the search facility on the Choice and Medication website and found it useful.



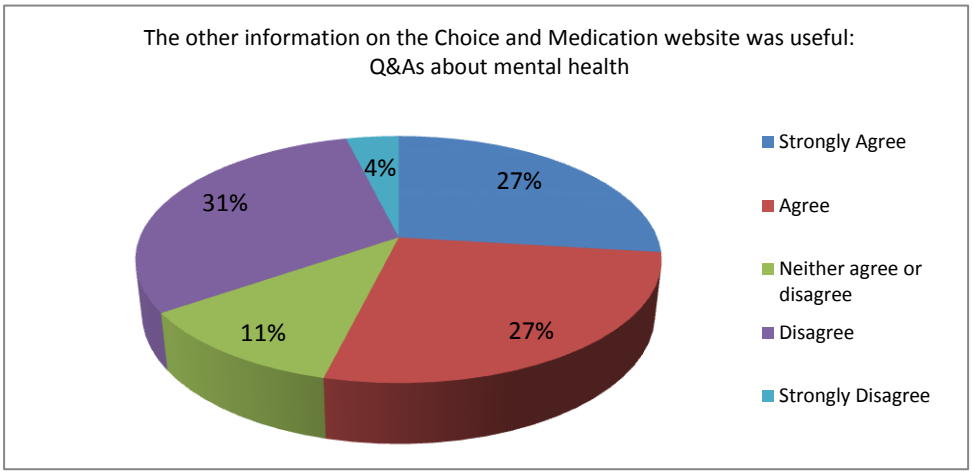
- 92% of service users were able to locate all of the medications they were prescribed on the Choice and Medication website



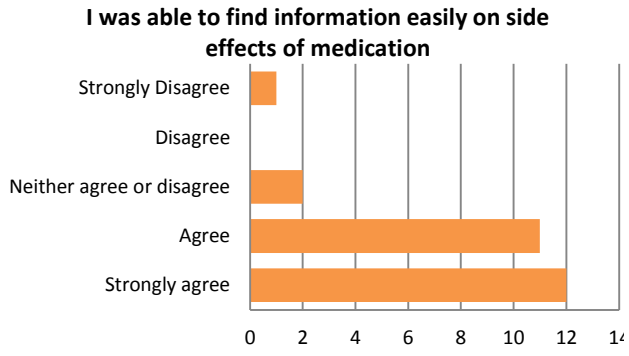
- One respondent would not use the website again to find information about medication. Two respondents neither agreed nor disagreed to the question and the remaining 23 would use the website again.

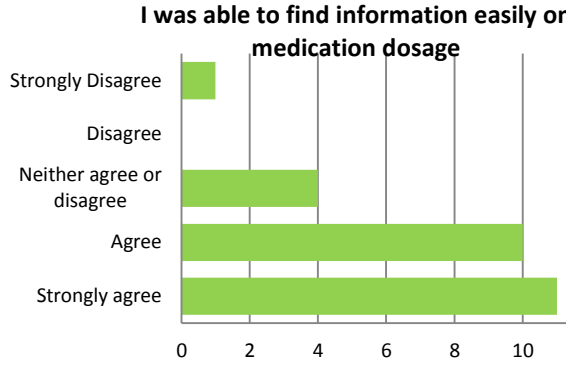


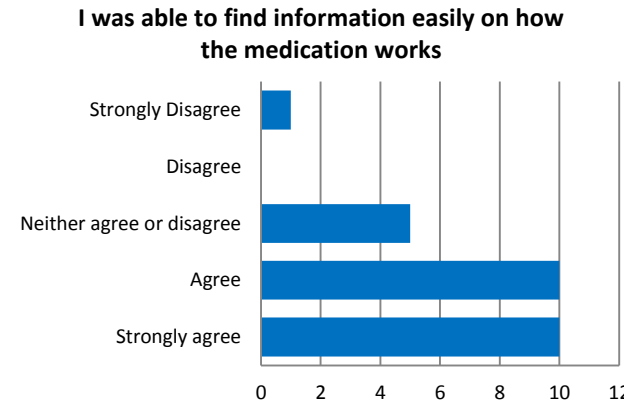
- 35% of respondents in this survey did not find the additional mental health information useful to them. 54% found the information useful and the remaining 11% were neutral in their response.

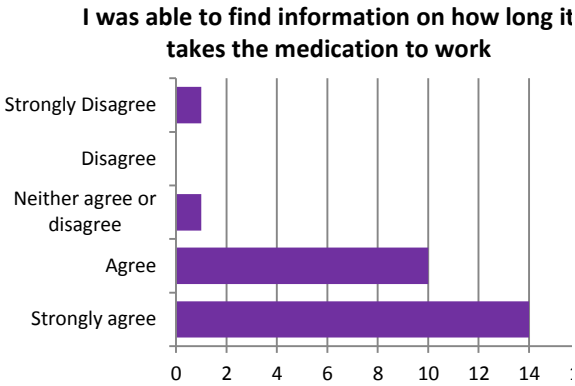


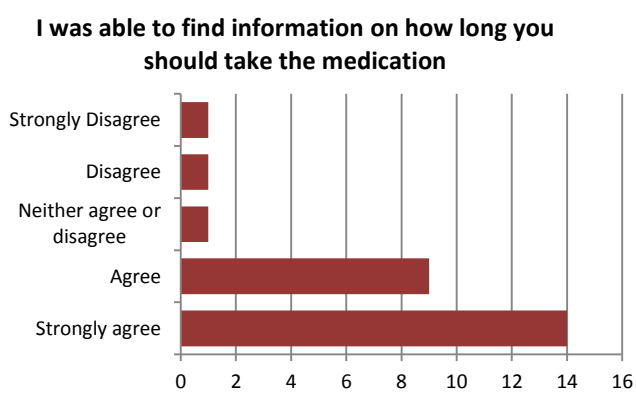
Service users were very positive about being able to find the relevant information on side-effects of dosage, uses, length of use and cessation of medication on the website

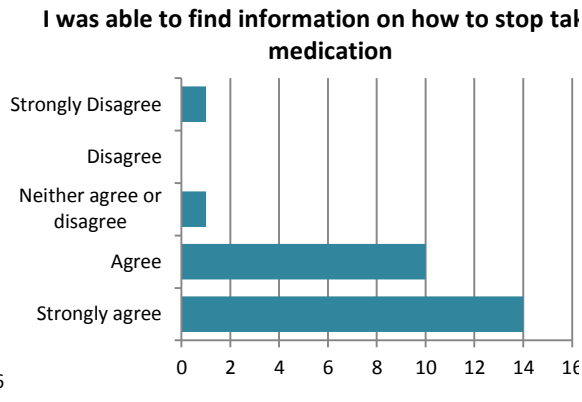












Overall, service users felt that the Choice and Medication website was a useful resource for information about medication. Despite the fact that 35% did not find the additional mental health information useful, the overall positive responses with regard to use and information on the website ensured that this website is now available to all service users in SPUH and SEH.

6.6. SPUH On-Line: An evaluation of what service users want from the hospital website and web-based mental health supports

An evaluation of service users' perceptions of the SPUH website was carried out between November 2010 and January 2011 by survey and follow-on focus groups.

6.6.1. Purpose

- To gain an understanding of how service users use the internet to obtain mental health information and how the SPUH website is perceived.
- To establish the content which service users would like to be available on a mental health website.
- To establish service user's affinity for mental health services delivered using online technologies.

6.6.2. Distribution:

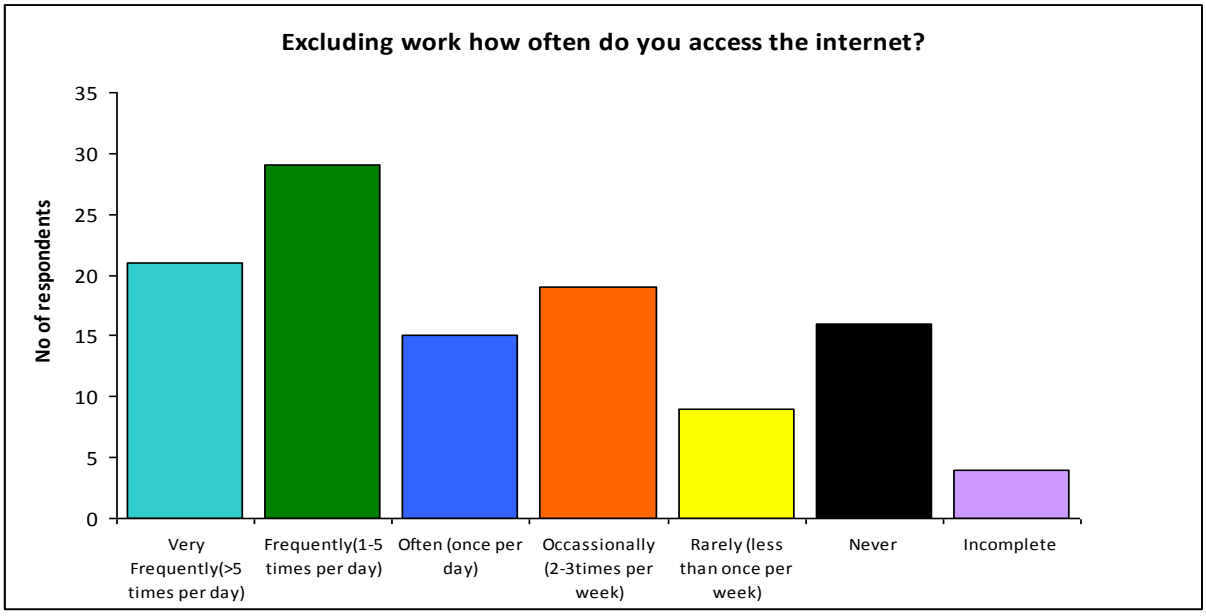
This service users' survey took place over a ten-day period at the end of November 2010. Paper versions of the questionnaire were distributed to inpatients and day-patients attending clinical programmes and morning lectures in both SPUH and St Edmundsbury Hospitals during this timeframe. In addition, an online version of this survey was made available on the home page of the SPUH website to site visitors. Results were collated and analysed using Excel software and are presented in the results section of this paper.

6.6.3. Response

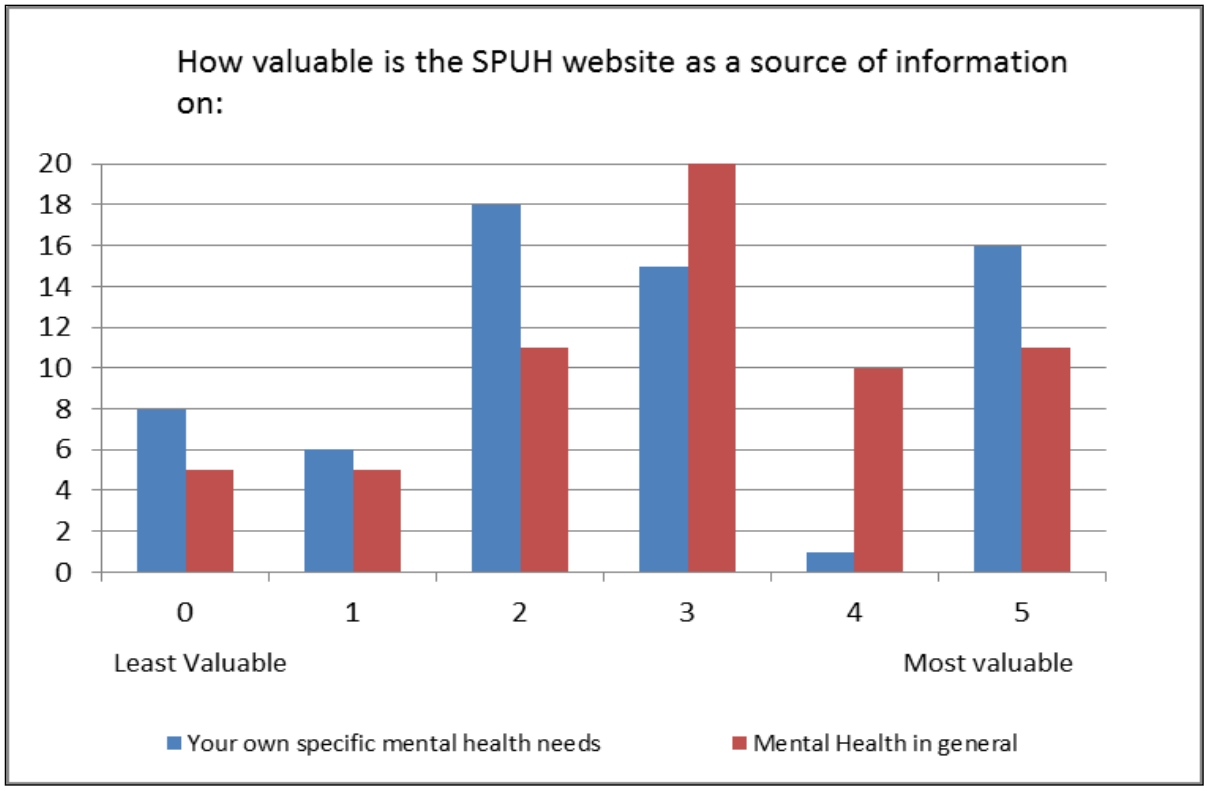
The service user consultation process included a survey of 122 service users, followed by three service user focus groups.

6.6.4. Key Findings

The majority of respondents were internet literate and readily engage in online searching to meet their mental health information needs.

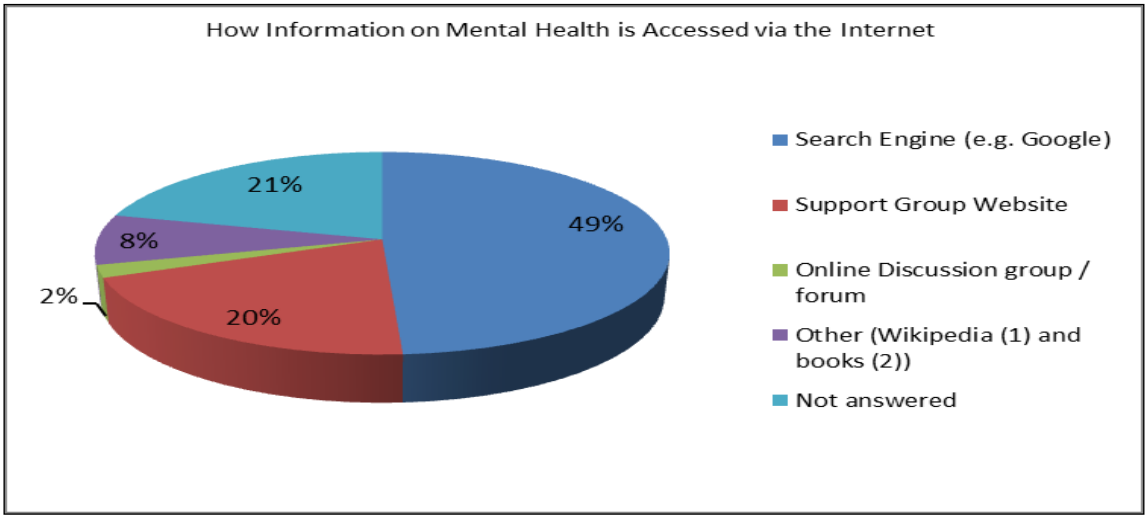


- Service user feedback suggested that the SPUH website content does not currently provide the breadth and quality of information they are looking for in relation to their mental health.

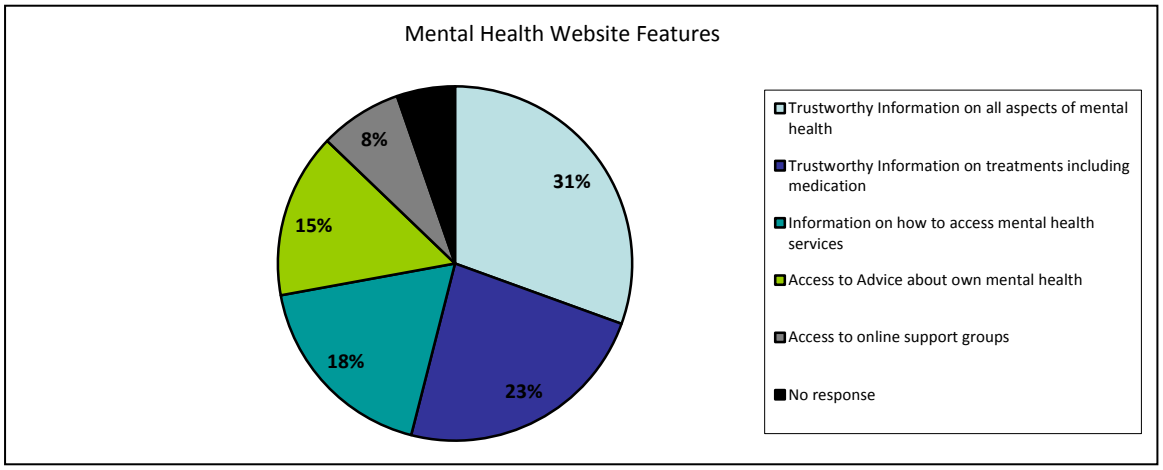


- Service users were asked how they would access information on mental health via the internet. 50% of respondents said that they would access information via a search engine

(e.g. Google) followed by a support group website at 21%. The pie chart below shows how service users accessed information on mental health via the internet.



- Service users want jargon-free information on diagnosis, treatment, services and the people who deliver them.
- The expressed service user demand for online support and counselling is not strong.



- Service users see the GP as their primary source of mental health information and mental health service as the second most popular source of information.

Source Preferences for Mental Health Information

	GP/Doctor	Mental Health Service	Friends / Family	Internet	Support Groups	HSE Website
1st Preference	55%	12%	8%	23%	2%	0%
2nd Preference	19%	40%	13%	19%	9%	0%

6.7. Section Summary

The above service user evaluations and analyses provide invaluable feedback on how service users experience our services. They provide a practical and structured approach to involving service users proactively in service improvement and development which is cornerstone of SPUH's strategy Mental Health Matters. By measuring and monitoring service users' experiences, the organisation works towards more people having a positive experience of care, treatment and support at SPUH. In addition, it provides a method of involving and empowering service users to improve service experience.

In 2012, SPUH will continue to evaluate, measure and monitor service user perspectives on its services and use these service user experience outcomes as key indicators of relevance, quality and satisfaction.

Section 7

Conclusions

7. CONCLUSIONS

1. This report contains a significant amount of information regarding the organisation's clinical activity, outcomes and service user evaluation. However, there is potential to improve the depth, quality and comprehensiveness of this information for 2012. As such, this report should be seen as a first step in the organisation's efforts to report on the effectiveness of its services.

2. The practice of measuring the effectiveness of clinical interventions, programmes and services is not as systematised throughout the organisation as it could be. A number of programmes had asserted that they were measuring clinical outcomes but the data was of poor quality and insufficient to warrant detailed analysis.

3. Existing clinical information systems within the organisation are not integrated. While there are hundreds of programme and service spreadsheets recording referrals, attendances and some outcome data, there is no integrated database to generate clinical service reports. Therefore, the effort required to generate the information within this report was hugely time-consuming. A number of clinical and non-clinical staff are to be commended for the work they have done in collecting, collating and analysing data. The disparate nature of this information made this work difficult and time-consuming. This report would not have been possible without the work of these individuals. It is critical that the planned Patient Electronic Record has functionality to electronically record core outcome measures routinely along care pathway points and generate service reports.

4. There is a need to identify and integrate a service user satisfaction indicator which monitors the service user experience of SPUH services routinely.

5. Outcomes measures used within programmes and services were not always fit for purpose or psychometrically robust. It is recommended that all programmes in 2012 work with the Programme Manager in selecting appropriate measures and extend the outcomes initiative across the entire organisation.

6. There is a need for in-house training of front-line clinicians in relation to outcome measurement to improve the use, recording and analysis of routine outcomes measures within their clinical programme and service.

7. At present, there are no minimum standards within the organisation in relation to clinical outcomes. It is recommended that at the point of initial assessment and the point of discharge as a minimum, the use of outcomes should be standard.

8. Outcomes information needs to be integrated into SMT Dashboard to provide headline indicators of care pathway activities, programmatic outcomes and service user satisfaction levels.

9. The inconsistency in I.T. competencies among administrators can cause variability in the quality of data input into Excel spreadsheets and SPSS databases. It is necessary to train a small number of administrators in relevent statistical and database software applications in 2012, to support improved capture rates of chosen clinical outcome measures in the short term.

10. The Registrar grouping generates a considerable amount of applied research within the organisation that is not captured and integrated within the organisation's operational reports. It is recommended that Registrar audit and research output is integrated into the 2012 Outcomes Report.

Section 8

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