QUALITY ACCOUNT 2015/16 QUARTER 2 PROGRESS REPORT

1. INTRODUCTION & PURPOSE

1.1 This report sets out the Trust's progress on achieving the quality priorities and quality metric targets contained within the 2015/16 Quality Account as at the end of Quarter 2 (September) 2015.

2. BACKGROUND INFORMATION

2.1 The Trust is required each year to produce a Quality Account - a report about the quality of services provided by the Trust during the previous year and what quality priorities the Trust has committed to for the forthcoming year. The aim of the Quality Account is to enhance accountability to the public and engage the leaders of the Trust and its stakeholders in the quality improvement agenda.

2.2 As part of the Quality Account for 2014/15, the Trust identified and agreed four quality priorities and a set of quality metrics for 2015/16. This process involved consultation with our key stakeholders including members of our Council of Governors.

3. KEY ISSUES:

Progress on the 4 Quality Priorities for 2015/16

3.1 The Trust's current Quality Account includes four quality priorities for 2015/16, which are:

- Priority 1: Delivery of the recovery project in line with the agreed plan
- Priority 2: To implement our policy with regard to Nicotine Management and Smoking Cessation
- Priority 3: To continue to provide the recovery model across Adult Learning Disabilities services via the implementation of Positive Behavioural Support (PBS)
- Priority 4: Implementation of age appropriate risk assessments and care plans for Children and Young People Services

3.2 Priorities 2 and 3 are likely to deliver all their current planned actions on time.

There is a low to moderate risk that Priority 1 might not be fully completed on time. This is because the equality and diversity mandatory training must be re-written to incorporate recovery principles. While this may be completed by March 2016 it is possible that it may need a longer timescale.

Priority 4 is largely on track for delivery: however three of its actions are reporting a low level of risk to delivery against them. This is because they are reliant on the timescales identified within the PARIS Programme. The PARIS programme is currently on track. However, there is still some design work to complete and a large

amount of training to be delivered across the Trust during 2015/16 Q4. There is a slight to moderate risk of delay linked to this. If the PARIS programme is delayed this would lead to delays when clinicians could start using the revised risk assessments. This is reflected in the low level of risk to delivery that has been highlighted for this action.

3.3 The Trust is achieving its targets for 4 of our 10 quality metrics in quarter 2 2015/16 as shown within **appendix 1**, but we are not on target for 5 of them – these are explained below (there is also one metric linked to the National Patient safety where we will not be able to report on the metric until Q3 which is explained further on page 5):

- **Number of unexpected deaths classed as a serious incident per 10,000 open cases**: The Trust position for quarter 2 2015 is 3.68 which is 0.68 above the target of 3.00 but an improvement on quarter 1 performance. This rate relates to 20 unexpected deaths reported during quarter 2. No patterns or trends have been identified. The Trust position for the financial year to date is 8.42, which is 2.42 above target. It is therefore still likely that we will exceed the "target" of 12 unexpected deaths per 10,000 open cases for the whole of 15/16.

- **Patient falls per 1000 admissions**: The Trust position for quarter 2 is 48.75, which is 20.96 above target which is a 13.41 increase since quarter 1. It is also an 11.99 increase in the position report at quarter 4 2014/15. The quarter 2 position relates to 76 falls during the quarter: 26 (34%) in Teesside, 15 (20%) in Durham and Darlington, 13 (17%) in North Yorkshire and 22 (29%) in Forensics. Of the falls reported, 64 (84%) were classified low with minimal harm (patient required extra observation or minor treatment), 11 (14%) were reported as moderate short term harm (patient required further treatment) and 1 (1%) was reported as Severe (permanent or long term harm). No patterns or trends have been identified.

  The Trust 'Falls Executive Group' was reintroduced in January 2015 and steers and monitors Trust falls-management across the Trust, reporting into the Patient Safety Group. Whilst it is still determining what regular data reports they and services require to facilitate ongoing monitoring, the group has approved an audit tool for 2015. Within Mental Health Services for Older People (MHSOP), the audit was completed June 2015, measuring compliance against 6 standards. To summarise, in:
  - 60% (27) of cases patients did not have a multifactorial falls assessment.
  - 24% (11) of cases patients did not have an intervention plan for falls.
  - 89% (40) of cases patients did not receive verbal and written information.
  - 31% (8) of cases patients did not have clear documentation of being assessed before moving.
  - 19% (5) of cases the Early Warning Score had not been completed for patients who had a fall or were found on the floor.
  - 23% (6) of cases patients did not have Glasgow Coma Scale completed.
  - 60% (27) of cases patients did not have a multi-factorial falls assessment.

Although North Yorkshire did not achieve 100% compliance for the completion of the multifactorial falls assessment, they did complete the Clinical Link Pathway (CLiP) which contains the same sections as the falls assessment. The teams have a very clear process for monitoring and completing the CLiP in comparison to other localities. It was agreed that all ward managers would send a representative to the Falls Spread and Share event to agree an action plan for their wards; identifying processes for ensuring up to date, person centred falls intervention plans are completed. The patient information leaflet (Age UK: *A practical guide to healthy ageing*) is to be included in admission/discharge packs and ward managers are to devise/provide an aide-memoire/process description in line with the post falls proforma for reviewing falls/found on floor entry.

Audits within Adult Learning Disabilities, Forensics Mental Health & Learning Disabilities and Adult Mental Health are planned for November 2015.

In addition to the audits, Services are to be required to provide 6 monthly assurance reports to the Falls Executive Group and when injurious falls have occurred, they are required to provide evidence in clinical notes of strategies around harm minimisation. The falls decision tool and a falls CLiP document became available on PARIS on the 29th July 2015 and, together with the existing falls-tagged casenote, this has made clinical management of falls much easier to evidence.

A quality improvement event for selected stakeholders in order to develop a shared falls strategy is proposed for quarter 4 15/16 or quarter 1 16/17.

- **Percentage of clinical audits of NICE Guidance completed**: There was 1 NICE audit scheduled to be completed during quarter 2 which was on antipsychotic prescribing for people with a learning disability. This audit was not completed on time due to other key priorities reducing the project leads capacity. This audit will be completed by the end of Q3.

- **Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards:** The average length of stay for adults has remained steady and below target since Q1 2014/15. However, for MHSOP the average length of stay has been above target since Q3 2013/14. The Trust position for Quarter 2 in MHSOP is 63.68 which is 11.68 above target, this is 2.7 higher than what was reported at quarter 1 but an improvement of 2.06 from what was reported in quarter 4 2014/15. 46% of lengths of stay were between 1-50 days, with 35% between 51 – 100 days; and four patients had a length of stay greater than 200 days. Of these four patients, two required longer lengths of stay due to physical health problems and challenging behaviour. A further patient's length of stay way caused by the instability of her illness and consequent poor response to treatment regimes. It was difficult for the ward to move the final patient as they had specific risks that meant discharge in to a community setting was not appropriate.

- **Percentage of complains satisfactorily resolved**: The Trust position for Quarter 2 is 78% which is 12% below target, this position is a further 3.82% below target from what was reported at quarter 1, and 9.18% below what was

reported at quarter 4 2014/15. Trust-wide there were no specific trends or patterns identified in the reasons given for dissatisfaction other than disagreement with elements of the information given and conclusions reached (i.e. whether a complaint was upheld or not) and wanting to raise further questions relating to the Trust's written response.

- **National Patient Survey**: The Community Mental Health Survey 2015 was carried out on behalf of the Trust by Quality Health. The data provided has been analysed by the Care Quality Commission and benchmarked against 55 other NHS Mental Health Trusts. The report was published on the Care Quality Commission website on 21st October 2015. Due to this, we are only able to include narrative on the results with a fuller comparison against previous years to be included in quarter 3.

  A total of 238 people took part in the survey giving a response rate of 29%. The report identifies how the Trust scored compared to the range of scores achieved by all Trusts taking part in the survey.

  The survey is divided in to 10 sections and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) scored highly overall in all areas. There are four areas where TEWV has scored significantly above what would be expected when compared with most other Trusts within the survey. These are:
  - Organising care
  - Planning care
  - Reviewing care
  - Crisis care

  There were no areas that scored worse than other Trusts: however scores where there is greatest room for improvement were in the section relating to 'Other areas of life' where the scores nationally were low and TEWV scored in the mid-range (score 4-5 out of 10). Elements with the most room for improvement were:
  - Providing help with finding support for financial advice or benefits
  - Providing help or advice for finding or keeping work
  - Support in taking part in an activity locally
  - Giving information about getting support from people with experience of the same mental health needs

  The data in the report is compared with the 2014 survey data and whilst there are subtle changes in scores for the better or worse, the report indicates that there is no statistically significant change in any of the scores.

Quality Priorities for 2016/17

3.6 As part of the Trust's annual business planning process, the Board has considered the views expressed at the Stakeholder Event of 21st July 2015 and identified four quality priorities to be included within the 2015/16 Quality Account as quality priorities for 2016/17, they are:

- Continue to develop and implement recovery focussed services through delivering the agreed project plan and identifying further work for the future by Q4 2018/19;
- Implement and embed the revised harm minimisation and risk management approach by Q4 2016/17;
- Further implementation of the nicotine replacement programme and smoking cessation project by Q4 2016/17;
- Improve the clinical effectiveness and patient experience at times of Transition by Q4 2016/17.

4. IMPLICATIONS / RISKS:

4.1 **Quality:** This is the performance report against the 2015/16 Quality Account for the period July to September 2015 and includes an update against each priority and performance against the quality metrics.

4.2 **Financial:** There are no direct financial implications associated with this report, however, there may be some financial implications associated with improving performance where necessary. These will be identified as part of the action plans as appropriate.

4.3 **Legal and Constitutional:** There are no direct legal and constitutional implications associated with this paper, although the Trust is required each year to produce a Quality Account and this paper contributes to the development of this.

4.4 **Equality and Diversity:** All the action and project plans will be impact assessed for the equality and diversity implications associated with the Quality Account.

4.5 **Other Risks:** There are no further risks associated with this paper.

5. CONCLUSIONS

The Trust is on track with low levels of risk associated with completion for **100% (27 of 27)** of its actions to deliver its quality priorities in 2015/16, although some risks around embedding Recovery principles into Trust training programmes have been identified.

The Trust is achieving its targets for **40% (4)** of its quality metrics in Quarter 2 2015/16. We are not achieving **50% (5)** of our targets. There relate to unexpected deaths, patient falls, average length of stay, completed clinical audits and complaints satisfactorily resolved.

6. RECOMMENDATIONS

6.1 The Council of Governors is asked to:

- Receive and comment on this report on the progress made against the Quality Account 2015/16 as at Quarter 2 2015/16.
- Note the Board's initial proposals for Quality Account priorities for 2016/17.

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Background Papers:
2014/15 Quality Account

APPENDIX 1: PERFORMANCE WITH QUALITY METRICS AT QUARTER 2 2015/16

	Quality Metrics	QUARTER 1 2015/16		QUARTER 2 2015/16		QUARTER 3 2015/16		2015/16		2014/15	2013/14	2012/13
		Target	Actual	Target	Actual	Target	Actual	Target	Full Year Effect	Actual	Actual	Actual
Patient Safety Measures												
1	Number of unexpected deaths classed as a serious incident per 10,000 open cases *(target remains unchanged from 13/14)*	< 3.00*	4.74	< 3.00*	3.68	< 3.00*		< 6.00*	8.42	12.16	11.88	15.91
2	Number of outbreaks of Healthcare Associated Infections *(target remains unchanged from 13/14)*	0	0	0	0	0		0	0	0	0	0
3	Patient falls per 1000 admissions *(new target for 14/15 agreed by QuAC in July 14 in line with CQUIN)*	< 28.79	35.34	< 28.79	48.75	< 28.79		< 28.79	42.11	44.54	35.99	34.09
Clinical Effectiveness Measures												
4	Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care (validated) *(target set in Trust Dashboard)*	> 95.00%	98.12%	> 95.00%	97.57%	> 95.00%		> 95.00%	97.84%	97.42%	97.86%	97.18%
5	Percentage of clinical audits of NICE Guidance completed *(target remains unchanged from 13/14)*	100%	N/A	100%	0%	100%		100%	0%	100%	97%	89.47%
6	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards *(new targets for 14/15 agreed by QuAC in July 14)*	AMH <30.2	29.35	AMH <30.2	26.14	AMH <30.2		AMH <30.2	27.70	26.67	AMH: 31.72 MHSOP 54.08	35.22
		MHSOP <52	60.98	MHSOP <52	63.68	MHSOP <52		MHSOP <52	62.32	62.18		
Patient Experience Measures												
7	Delayed Transfers of Care *(target set in Trust Dashboard)*	< 7.50%	1.88%	< 7.50%	1.88%	< 7.50%		< 7.50%	1.88%	2.11%	1.89%	2.07%
8	Percentage of complaints satisfactorily resolved *(target remains unchanged from 13/14)*	> 90.00%	81.82%	> 90.00%	78.00%	> 90.00%		> 90.00%	80.00%	75.38%	65.77%	76.36%

Quality Metrics		QUARTER 1 2015/16		QUARTER 2 2015/16		QUARTER 3 2015/16		2015/16		2014/15	2013/14	2012/13
		Target	Actual	Target	Actual	Target	Actual	Actual	Full Year Effect	Actual	Actual	Actual
National Patient Survey												
9	Trust performing >2 points over 80% percentile			Improvement on 2014 survey				Improvement on 2014 survey		4		
	Trust performing within 2 points of 80% percentile									9		
	Trust performing <2 point of 80% percentile									2		

*The number shown here is the maximum level of unexpected deaths that we would expect to see rather than a target number we are trying to achieve

Notes on selected metrics

1. Data for this metric is taken from Incident Reports which are then reported via the National Strategic Executive Information System (STEIS).
2. Outbreaks of healthcare associated infections relates to those of MRSA bacteraemia and C Difficile. The Infection Prevention and Control Team would be notified of any outbreaks direct by the Ward and would then be recorded on an 'outbreak' form before being reported externally.
3. Patient falls excludes the categories 'found on floor' and 'no harm'. Data for this metric is taken from Incident Reports which are then reported via the Trust's Risk Management System, DATIX.
4. Data for CPA 7 day follow up is taken from the Trust's patient systems and is aligned to the national definition.
5. Implementation of NICE Guidance is based on the number of audits of NICE guidelines completed against the number of audits of NICE guidelines planned each quarter expressed as a percentage. Data for this metric is taken from audits undertaken by the Clinical Directorates supported by the Clinical Audit Team.
6. Data for average length of stay is taken from the Trust's patient systems.
7. Delayed transfers of care are based on Monitor's definition and therefore exclude children and adolescent mental health services. Data for this metric is taken from the Trust's patient systems.
8. Complaints data is compiled from the number of negative responses to resolution letters sent out to complainants expressed as a percentage of the total number of resolution letters sent out.
9. The CQC has now published the 2014/15 national patient survey results but further work is required to translate their reported figures into the format required by our quality metrics :