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TEWV 2017/18 Quality Account update for Tees Valley Joint Health Scrutiny Committee

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Tees, Esk and Wear Valleys NHS Foundation Trust

making a difference together

Purpose

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- TEWV has a duty to consult this committee about the content of its draft Quality Account
- The Quality Account has just been sent to committee members
- This presentation summarises the key parts of the Quality Account to assist the committee in determining its response
- The Quality Account covers the whole area served by TEWV: – Tees Valley; County Durham, North Yorkshire (other than Craven); City of York

Section 1 – Chief Exec's introduction

- Sets out Trust's vision, mission (page 3) and Quality Strategy goals (page 4)
- Lists achievements from 17/18 (page 4 – 9)
- Structure of document (page 10)
- Profile and map of the Trust (page 11 & 12)

Part 2 – Quality Priorities (pages 13-30 / and 50-56)

- Looks forward to next year, as well as back to last year.
- These slides simplify the QA document by focussing on
  - 1) priorities for 18/19
  - 2) delivery in 17/18

Forward Looking Priorities for 18/19

Development Process

- July 2017 stakeholder event – identified issues and potential improvement priorities
- September 2017 – shortlist discussed by Trust's Quality Assurance Committee
- October 2017 – Trust Board agreed 4 quality improvement priorities to work up in more detail as part of Trust business planning process
- February 2018 – 2nd stakeholder event – detailed plans for each priority discussed
- March 2018 – detailed plans approved, subject to stakeholder comment within the TEWV Business Plan (which contains several other priorities that will have a positive impact on quality).

Priorities for 18/19

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QA document page 50-56

Our 2018/19 improvement priorities in our Quality Account are:

- Make Care Plans more personal; (New)
- Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services. (New)
- Reduce the number of preventable deaths (continued from 207/18)
- Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services; (continued from 207/18)

Care Planning (New)

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Expected benefits/outcomes:
❖ Personal circumstances viewed as priority when planning care/treatment
❖ Shared decision making and co-production of meaningful care plans, recorded in a way that can be understood by the person and anyone else who needs this information
❖ To receive information about getting support from people who have the same mental health needs
❖ To have help with what is important to the person and carers

Plans for 2018/19
❖ Complete and report on an audit of the Care Programme Approach, including the Care Plan, and co-produce action plan with service users/carers/staff based on the findings and recommendations
❖ Co-produce guidance about Personalised Care Planning
❖ Co-develop and co-deliver training/development packages

Dual Diagnosis (New)

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Expected benefits/outcomes:
❖ That service users with mental health and co-existing substance misuse get the same level of care than people without substance misuse
❖ Support family/carers of service users with dual diagnosis
❖ Staff to work collaboratively across organisations, with a creative, flexible and assertive approach
❖ Service users should not be discharged without taking the whole picture into account
❖ The organisation to learn from incidents if things go wrong

Plans for 2018/19
❖ Circulate Dual Diagnosis Clinical Link Pathway for integration into existing pathways
❖ Establish a process that incorporates dual diagnosis into patient safety investigations/reviews
❖ Introduce a Training Needs Analysis including dual diagnosis and identify staff who have dual diagnosis capabilities, and establish a training structure linked to directorate requirements
❖ All services have at least 1 person trained or have access to a trained clinician
❖ Complete an annual review of dual diagnosis in serious incidents
❖ Establish links with the confidential enquiry process to develop a feedback loop regarding identification of missed Mental Health factors of people who were recorded as drug related deaths
❖ Engage partners/stakeholders to agree a future approach and produce a framework/document which outlines the forward view for dual diagnosis
❖ Every 2 years complete an audit of staff dual diagnosis capabilities and skills

Preventable Deaths (continuing from 17/18)

Expected benefits/outcomes:
❖ Processes reflect national guidance and best practice
❖ Reduction in the number of preventable harm incidents/deaths of inpatients on leave
❖ To feel listened to during investigations and treated with kindness, openness and honesty
❖ Increased confidence that investigations are being carried out in accordance with best-practice guidelines and in a way that is likely to identify missed opportunities for preventing death
❖ The Trust learns from deaths, including identifying any themes early so that actions can be taken

Plans for 2018/19 onwards
❖ Develop a co-produced family and carer version of the learning from deaths policy
❖ Produce and implement engagement plan to involve family, carers and non-Executive Director(s) in the review process
❖ Hold family conference in conjunction with Leeds and York Partnership Foundation Trust
❖ Evaluate the level and effectiveness of engagement with families, carers and Non-Executive Directors

Transitions (continuing from 17/18)

Expected benefits/outcomes:
❖ An improvement in their experience during their transition from Children and Young People's to Adult services
❖ Greater involvement in decisions about the care received when they transfer into Adult services
❖ To receive care informed by NICE's evidence-based guidelines

Plans for 2018/19 onwards
❖ Implement actions from the thematic review (conducted at the end of 2017/18) of patient stories
❖ Registered CAMHS and AMH staff to undertake further specific training on the transitions process
❖ Review transition panels already in place, gain additional Service User perspective and set relevant targets and metrics
❖ Produce engagement plan to involve family and carers in the process

How did we do on 17/18 improvement priorities? (p13-30)

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- Our priorities were:
  - Implement phase two of our Recovery Strategy;
  - Ensure we have Safe Staffing in all our services;
  - Improve the clinical effectiveness and patient experience in times of transition from Child to Adult services;
  - Reduce the number of preventable deaths;
  - Reduce the occurrences of serious harm resulting from inpatient falls.
- 2 out of 37 actions under these 5 priorities were not completed by 31st March

Preventable Deaths (17/18)

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- **Red Action** – Training carried out in relation to leave and time away from the ward
- **Metric –** Compliance figures show target level has been achieved
- **Issue –** Training has been carried out: - but due to data systems issues it is not yet possible to get “real-time” compliance figures. It is hoped that real-time data will become available from Trust systems during 18/19.

Transitions (17/18)

- **Red Action** – Complete and evaluation report on the effectiveness of implementation of the new protocol and feedback to relevant stakeholders
- **Metric –** Evaluation complete
- **Issue –** An evaluation report on the effectiveness of implementation of the new protocol and feedback is being developed and will be provided to the relevant stakeholders. However this will not now be completed until 18/19 Q1 (i.e. before the end of June 2018)

Statements of Assurance (pages 31-49)

- Legally required sections on:
- Clinical audit
- Clinical research
- CQC ratings and inspection findings
- Targets and achievements agreed with commissioners
- Mental Health Act inspections
- Learning from Deaths
- Mandatory Quality indicators

Performance against Quality Metrics (page 57-60)

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Quality Metrics		2017/18		2016/17	2015/16	2014/15	2013/14
		Target	Actual	Actual	Actual	Actual	Actual
Patient Safety Measures							
1	Percentage of patients reported 'yes 'always' to the question, 'do you feel safe on the ward' ?	88%	**62.13%**	N/A	N/A	N/A	N/A
2	Number of incidents of falls (level 3 and above) per 1000 occupied bed days (for in patients)	0.35	**0.12**	0.37	N/A	N/A	N/A
3	Number of incidents of physical intervention / restraint per 1000 occupied bed days	19.25	**30.50**	20.26	N/A	N/A	N/A
Clinical Effectiveness Measures							
4	Existing Percentage of patients on Care Program Approach who were followed up within 7 days after discharge from psychiatric in-patient care	> 95.00%	**95.04%**	98.35%	97.75%	97.42%	97.86%
5	Percentage of clinical audits of NICE Guidance completed	100%	**N/A**	100%	100%	100%	97%
6a	Average length of stay for patients in Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards	AMH <30.2	**24.56**	30.08	26.81	26.67	31.72
6b		MHSOP <52	**69.47**	78.06	62.67	62.18	54.08
Patient Experience Measures							
7	Percentage of patients who reported their overall experience as excellent or good	94%	**90.38%**	90.53%	N/A	N/A	N/A
8	Percentage of patients that report that staff treated them with dignity and respect	94%	**86.12%**	N/A	N/A	N/A	N/A
9	Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94%	**87.14%**	86.58%	85.51%	N/A	N/A

Red Quality Metrics

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Metric 1: Percentage of patients reported 'yes 'always' to the question, 'do you feel safe on the ward'?

- The Trust position is 62.13% (2,128 out of 3,425 surveyed); this is 25.87% below the target of 88%
- All localities are underperforming; however Durham and Darlington are performing closest to the target with 69.56%

Metric 3: Number of incidents of physical intervention/restraint per 1000 occupied bed days

- The Trust position is 30.50 which is 11.25 above (worse than) the target of 19.25
- This relates to 7,766 incidents from 254,634 occupied bed days
- Durham and Darlington are however achieving the target

Red Quality Metrics

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Metric 6b: Average length of stay for patients in Mental Health Services for Older People assessment and treatment wards

- The average length of stay for older people has been worse than target since quarter three 2013/14 reporting 69.47 days as at February 2018, which is 17.47 worse than target but an improvement compared to the position reported in 2016/17
- The median length of stay was **54** days, which is only two days above the target of 52 days and demonstrates that the small number of patients that had very long lengths of stay have a significant impact on the mean figures reported.
- The length of stay of patients is closely monitored by all services within the Trust. The reasons for the increase in the average length of stay for patients are due to a small number of patients who were discharged after a very long length of stay, which has distorted the overall average. In total 77.77% of lengths of stay were between 0-50 days, with 14.65% between 51 – 100 days. There were 56 patients who had a length of stay greater than 200 days; the majority were attributable to the complex needs of the patients (including physical health problems) and delays in accessing suitable placements for patients subsequent to discharge.

Red Quality Metrics

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Metric 7: Percentage of patients who reported their overall experience as excellent or good

- The Trust position was 90.38% which is 3.62% below the target of 94% (12,514 out of 13,846 surveyed)
- All localities are underperforming

Metric 8: Percentage of patients that report that staff treated them with dignity and respect:

- The Trust position is 86.12% which is 7.88% below the target of 94% (13,467 out of 15,638 surveyed)
- All localities are underperforming;

Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment

- The Trust position is 87.14% which is 6.86% below the target of 94% (13,792 out of 15,828 surveyed)
- All localities are underperforming;

Other QA information

- Single Oversight Framework target performance (pages 60-62) [7 green, 1 red]
- External audit report on indicators (to follow)
- Glossary (appendix 3)
- Clinical Audit findings (to follow)
- Other Trust Business Plan priorities that support quality (appendix 5)

Next Steps

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Step	Timescales
Draft Quality Account circulated	13th April 2018
Deadline for responses	**13th May 2018**
(nb – these are pasted into the document as received!)	
TEWV Board consider QA document	22nd May 2018
Quality Account submitted to Secretary of State	30th May 2018
Quality Account Published	30th June 2018
Quality Account included in Annual Report	July 2018

Stakeholder event to identify potential priorities for the next Quality Account takes place on 10th July (am) at Scotch Corner Hotel