Public Document Pack

Health and Partnerships Scrutiny Committee Agenda

9.30 am Wednesday, 12 December 2018
Committee Room No 2, Town Hall,
Darlington. DL1 5QT

Members of the Public are welcome to attend this Meeting.

1. Introductions/Attendance at Meeting

2. Declarations of Interest

3. County Durham and Darlington NHS Foundation Trust - Quality Accounts 2018/19 –
   Report of the Associate Director of Nursing (Patient Safety and Governance)
   (Pages 1 - 10)

4. Tees, Esk and Wear Valleys NHS Foundation Trust - Quality Accounts Quarter 2 Update and 2019/20 Improvement Priorities –
   Report of Chris Lanigan, Head of Planning Development and Laura Kirkbridge, Planning and Business Development Manager
   (Pages 11 - 20)

Luke Swinhoe
Assistant Director Law and Governance

Tuesday, 4 December 2018

Town Hall
Darlington.

Membership
Councillors Newall, J Taylor, Copeland, Crichlow, Grundy, Haszeldine, Heslop, Nutt, E A Richmond, Mrs H Scott and Tostevin

If you need this information in a different language or format or you have any other queries on this agenda please contact Allison Hill, Democratic Officer, Resources Group, during normal office hours 8.30 a.m. to 4.45 p.m. Mondays to Thursdays and 8.30 a.m. to 4.15 p.m. Fridays email: Allison.hill@darlington.gov.uk or telephone 01325 405997

County Durham and Darlington NHS
NHS Foundation Trust

Adults Wellbeing and Health Overview and Scrutiny Committee

Quality Accounts 2018 - 2019

December 2018

Joanne Todd
Associate Director of Nursing (Patient Safety and Governance)

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with you all the way

QUALITY ACCOUNTS UPDATE

PURPOSE OF THE REPORT

To update the committee on progress of County Durham & Darlington NHS Foundation Trust with regards to the agreed priorities for improvements for the 2018/2019 period. This report provides and update from April 2018 to September 2018.

WHAT ARE QUALITY ACCOUNTS?

Quality Accounts are annual reports to the public from the providers of NHS healthcare about the quality of the services they deliver. The primary purpose is to encourage leaders of healthcare organisations to assess the quality of care they deliver. The Quality Accounts for County Durham & Darlington NHS Foundation Trusts includes indicators set by the Department of Health and those we have identified as local priorities.

PRIORITIES FOR 2018/2019

The table below sets out the priorities and position (where data is available). The priorities were agreed through consultation with staff, governors, local improvement networks, commissioners, health scrutiny committees and other key stakeholders.

Where progress can be reported at this point this has been colour coded as follows;

RED – not on track
AMBER – improvement seen but not to level expected
GREEN – on track

Priority	Goal	Position/Improvement
SAFETY		
Patient Falls[1] **(Continuation)**	Targeted work continued to reduce falls across the organisation. To ensure continuation and consolidation of effective processes to reduce the incidence of injury. To continue sensory training to enhance staff perception of risk of falls. To continue a follow up service for patients admitted with fragility fractures.	- To introduce the new Trust Falls Strategy, covering a 3 year period. - To agree a plan of year 1 actions. - To monitor implementation of year 1 actions against the Strategy. Multi agency action plan mapped out and agreed. Part of national NHS Improvement falls collaborative. Falls per 1,000 bed days within limits. Quality Improvement work underway. Reduction in falls resulting in serious incident see for the period
Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia.	- Continued adherence to the national standards on assessment of patients aged 75 and over to ensure they are asked about their memory on admission; and measure ongoing referral rate. Monitoring to continue. Explore feasibility of introducing the screening tool into existing electronic

Priority	Goal	Position/Improvement
		assessment tool will continue through this period. - Action plan developed from the results of the National Dementia audit to be monitored for improvement. - Carers survey has been completed. The recommendations are to be monitored alongside the national dementia audit recommendations. The action plans have been merged and form the Strategy Action Plan 2018/2019.This will be monitored. - Participate in a 5 year research project of dementia services within the Durham area to continue during 2018/2019. Participation to continue. - Continue the study in the development of a good practice audit tool for assessing patient care and services for those living with dementia. Participation to continue. All workstreams in place and being delivered
Healthcare Associated Infection **MRSA bacteraemia**[1,2] **Clostridium *difficile***[1,2] ***(Continuation and mandatory)***	National and Board priority. Further improvement on current performance.	- Achieve reduction in MRSA bacteraemia against a threshold of zero. Two cases reported since April 2018 - No more than 18 cases of hospital acquired Clostridium *difficile.* Nine cases reported since April 2018 - Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee.
Venous thromboembolism risk assessment[1,2] **(Continuation and mandatory)**	Maintenance of current performance.	- Maintain VTE assessment compliance at or above 95% within inpatient beds in the organisation. This mandated indicator will continue during 2017/2018. - Assessment will be captured onto a Trust database and reported weekly to wards and senior managers. Performance will be reported and monitored at Trust Board using performance scorecards. This indicator will move to part 3 of the report as background monitoring as process is now well developed. Compliant
Pressure ulcers[1]	To have zero tolerance for	- Full review of any identified grade 3

Priority	Goal	Position/Improvement
(Continuation)	grade 3 and 4 avoidable pressure ulcers.	and 4 pressure ulcers to determine if avoidable or unavoidable. - Reduce incidence from last year to zero avoidable grade 3 or 4 pressure ulcers. 1 in acute services and 3 in community setting
Discharge summaries[1] **(Continuation)**	To continue to improve timeliness of discharge summaries being completed.	- Monitor compliance against Trust Effective Discharge Improvement Delivery Plan. - Enhance compliance to 95% completion within 24 hours. - Data will be collected via electronic discharge letter system and monitored monthly with compliance reports to Care Groups and Trust Board via performance scorecards. Although not yet consistently at 95% good progress made with task & finish group now reviewing quality of discharge summaries. Deep dive audit undertaken regarding quality of discharge summaries
Rate of patient safety incidents resulting in severe injury or death [1,2] **(Continuation and mandatory)**	To increase reporting to 75th percentile against reference group.	- Cascade lessons learned from serious incidents. - NRLS data. Enhance incident reporting to 75th percentile against reference group. - Carry out bespoke Trustwide work to embed and improve reporting of near miss and no harm incidents. October 17 to March 18 - remain in 50 percentile. Near miss reporting improvement work stream underway with support from Care Groups. Early results show significant improvement but formal report awaited
Improve management of patients identified with sepsis[3] **(Continuation)**	To monitor roll out of sepsis screening tool via electronic system.	- Continue to implement sepsis care bundle across the Trust. - Roll out of sepsis screening tool via electronic system. - Continue to implement post one hour pathway. - Continue to audit compliance and programme. - Hold professional study days. Screening compliant Time to administration of antibiotics requires further improvement in EDs

Priority	Goal	Position/Improvement
		but improvement made on the trajectory. This continues to be closely monitored
Local Safety Standards for Invasive Procedures (LOCSSIPS) **(new indicator from Stakeholder event)**	To ensure full implementation of national guidance embedding Local Safety Standards into all areas conducting Invasive Procedures trust-wide.	- The Trust has formed a LocSSIP Implementation and Governance Group (LIGG) which brings together members of the Corporate Governance body with Care Group representatives in order to develop LocSSIPs. - The LIGG will work with procedural teams to support the implementation of developed LocSSIPs ensuring all individuals understand why the programme is required and how the additional steps are to be conducted. - The LIGG will co-ordinate both quantitative and qualitative audits to ensure procedural LocSSIPs are being conducted to a high standard providing reports to IQAC and the Trust Board. Project on track and recognised as good practice by NHS Improvement
EXPERIENCE		
Nutrition and Hydration in Hospital[1] **(Continuation)**	To promote optimal nutrition for all patients.	- Focus on protected meal times. - Continue to use nutritional bundle for weekly nutritional care planning of patients nutritionally at risk for inpatients – move the nutritional assessment tool to Nerve Centre and once embedded move the care planning bundle to nerve centre also. - Trust wide menu implementation of finger foods. - Report and monitor compliance monthly via Quality Metrics. Monitoring in place and nutritional assessment into Nervecentre piloted and ready to roll out
End of life and palliative care[1] **(Continuation)**	We now have an effective strategy and measures for palliative care. The measures are derived from the strategy and will support each patient to be able to say: *"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me*	- CQC action plan for palliative care 100% complete. - Deliver at least 75% of strategic plan for end of life and palliative care. - Responses to VOICES survey should be as good or better than 2012 benchmark. - Continuing improvement in palliative care coding and "death in usual place of residence".

Priority	Goal	Position/Improvement
	and the people who are important to me, including my carer(s)"	End of Life Steering Group now embedded to ensure agenda moves forward
Responsiveness to patients personal needs[1,2] **(Continuation and mandatory)**	To measure an element of patient views that indicates the experience they have had.	- Continue to ask the 5 key questions and aim for improvement in positive responses in comparison to last years results. - Quarterly Reports to Integrated Quality and Governance Committee and any emerging themes monitored for improvement through the Patient Experience Forum. - The Trust will continue to participate in the national inpatient survey. Results not yet available
Percentage of staff who would recommend the trust to family or friends needing care[1,2] **(Continuation and mandatory)** **Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months**[2] **(Mandatory measure)** **Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion**[2] **(Mandatory measure)**	To show improvement year on year bringing CDDFT in line with the national average by 2018/2019.	- To bring result to within national average. - Results will be measured by the annual staff survey. Results will be reviewed by sub committees of the Trust Board and shared with staff and leaders and themes considered as part of the staff engagement work. - In addition we will continue to report results for harassment & bullying and Race Equality Standard. Staff survey results are not yet available. Draft report expected December 2017.
Friends and Family Test[1] **(Continuation)**	Percentage of staff who recommend the provider to Friends and Family.	- During 2018/2019 we propose to increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback and a quarterly report of progress and will be monitored by the Trust Board This is a quarterly report with focus on 2 care groups at each quarter. Quarter 2 results show an improvement of staff recommending the Trust to friends and family from 62% to 66%, however there has been a slight increase in those not

Priority	Goal	Position/Improvement
		recommending from 11% to 13%
EFFECTIVENESS		
Hospital Standardised Mortality Ratio (HSMR)[1] **Standardised Hospital Mortality Index (SHMI)[1,2]** **(Continuation and mandatory)**	To closely monitor nationally introduced Standardised Hospital Mortality Index (SHMI) and take corrective action as necessary.	- To monitor for improvement via Mortality Reduction Committee. - To maintain HSMR and SHMI at or below 100. - Results will be captured using nationally recognised methods and reported via Mortality Reduction Committee. We will continue to benchmark both locally and nationally with organisations of a similar size and type. Monthly updates will be submitted to Trust Board via the performance scorecard. - Weekly mortality reviews led by the Medical Director will continue, and any actions highlighted monitored through Care Group Integrated Governance Reports. - Embed “Learning from Deaths” policy. Within expected range. Mortality reduction committee now embedded along with “Learning from Deaths” process. Mortality reviews being undertaken and linked with incident monitoring process
Reduction in 28 day readmissions to hospital[1,2] **(Continuation and mandatory)**	To improve patient experience post discharge and ensure appropriate pathways of care. To support delivery of the national policy to continue to ensure patients receive better planned care and are supported to receive supported self – care effectively.	- To aim for no more than 7% readmission within 28 days of discharge. - Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard and any remedial actions measured and monitored through the performance framework.
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] **Continuation and mandatory)**	To improve patient experience. To improve current performance.	- No more than expected rate based on locally negotiated rates. Monthly measure. - Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard.

Priority	Goal	Position/Improvement
		Quarter 1 = 91.2% Quarter 2 = 89.1%
Patient reported outcome measures[1,2] **(Continuation and mandatory)**	To improve response rate.	- To aim to be within national average for improved health gain. - NHS England are removing groin hernia and varicose vein from mandatory data collection, hip and knee will continue. Results not yet available
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators.	- Continue to monitor for maintenance and improvement in relation to breastfeeding, smoking in pregnancy and 12 week booking. - Monitor actions taken from gap analysis regarding "Saving Babies Lives" report. On track and priorities of "Each baby Counts" policy in place
Paediatric care (new indicator following stakeholder event)	Embed paediatric pathway work stream.	- Continue development of more direct and personal relationships with individuals within Primary and Secondary care by building on the work already undertaken.
Excellence Reporting (new indicator following stakeholder event)	To ensure that CDDFT continues to embed learning from excellence into standard culture and practice through Excellence Reporting.	- A monthly report to the Executive and Clinical Leadership Committee (ECL) incorporating total Excellence Reports for the preceding month, a Care Group breakdown, highlights of departments with the most excellence reports and common themes. - A quarterly report to the Integrated Quality Assurance Committee (IQAC) summarising the ECL report and encompassing summary from learning from excellence group. Now embedded in practice

1 - continuation from previous year
2 - mandatory measure
3 - new indicator following stakeholder events

During 2018/2019 we will incorporate a section to include changes to services and their impact, with a particular emphasis on access to clinical services and whether their effectiveness has been diminished through service change.

Four Never Events have been reported since April 2018. Action plans are developed and monitoring is in place for completion

Recommendation

The Committee receives the report as evidence of ongoing commitment to improve quality outcomes for patients under our care.

Joanne Todd
Associate Director of Nursing (Patient Safety & Governance)
October 2018

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Quality Account Quarter 2 Update

Quality Account 19/20 Improvement Priorities

1. INTRODUCTION AND PURPOSE

1.1 This report presents updates against each of the four key quality improvement priorities for 2018/2019 identified in the current TEWV Quality Account as well as performance against the agreed quality metrics up to 30th September 2018. Some comparisons are made with 2018/19 Q1 to give an indication of the direction of travel.

1.2 It also sets out the priorities for next year's Quality Account which were approved by TEWV's Board of Directors on 30th October 2018.

2. BACKGROUND INFORMATION AND CONTEXT

2.1 NHS Trusts and Foundation Trusts are required to produce a Quality Account each year. The document must include between 3 and 5 quality priorities and a number of quality metrics (measures) and targets.

2.2 Trusts must engage and involve stakeholders in the production of their Quality Account. Although there is only a legal obligation to engage the largest local authority and CCG (by contract value) for each Foundation Trust, TEWV has an annual process that gives representatives of all of the overview and scrutiny committees, health and wellbeing boards, commissioners and Healthwatch bodies in the areas served by the Trust the opportunity to help the Trust identify issues and to shape the priorities. Trust governors are also engaged in this process.

2.3 The Stakeholder engagement events that we hold each February and July are the most visible part of this process, but we also deliver progress reports, such as this Quarter 2 report to Overview and Scrutiny Committees (on request), CCGs and to our Council of Governors.

3. KEY ISSUES

3.1 Progress on the four Quality Priorities for 2018/2019

3.1.1 Within the 2017/2018 Quality Account the Trust agreed the following four quality improvement priorities for 2018/2019:

- Reduce the number of Preventable Deaths
- Improve the clinical effectiveness and patient experience in time of transition from Child to Adult services
- Make our Care Plans more personal
- Develop a Trust-wide approach to Dual Diagnosis, which ensures that people with substance misuse issues can access appropriate and effective mental health services

3.1.2 There are a total of 46 actions set out in the Quality Account to deliver these priorities. **40 of these 46** quality improvement actions were **Green** at 30/09/2018 (87%). The paragraph below shows that these are spread across all four priorities.

3.1.3 Actions that were reporting red at 30/09/2018:

- ***Further Improve the clinical effectiveness and patient experience at times of transition from CYP to Adult services - Implement actions from the thematic review of patient stories:*** Although all patients who transition from CYP to Adult services are asked 3 months later to complete a post-transitions survey so far there have only been three responses received. There are actions in place to ensure transferees are better targeted; this is still work in progress but there is not enough data available to be able to complete to complete a thematic review. It is expected that this will be delivered in Quarter 3 2018/2019 after we have collected more patient stories.

- ***Improve the personalisation of care planning – Co-develop training and development packages and align to, and incorporate where possible, the training and development work of other programmes, projects and business as usual – these must include evaluation measures:*** The development of the training packages is currently underway but is not yet complete. They are being co-produced with the Trust's Experts by Experience. It is expected that this will be now be delivered in Quarter 3 2018/2019.

- ***Develop a Trust-wide approach to Dual Diagnosis which ensure that people with substance misuse issues can access appropriate and effective mental health services – Directorates and specialties to confirm their use of Dual Diagnosis Clinical Link Pathway (CliP) within relevant pathways:*** The Dual Diagnosis Clinical Link Pathway has been circulated but all feedback has not yet been obtained from all parts of the Trust. It is expected that this will now be delivered in Quarter 3 2018/2019.

- ***Develop a Trust-wide approach to Dual Diagnosis which ensure that people with substance misuse issues can access appropriate and effective mental health services – To introduce a Training Needs Analysis (TNA) which includes dual diagnosis and identify those staff who have dual diagnosis capabilities:*** The Dual Diagnosis staff competency and training audit is currently in draft format however it is expected that this will be delivered in full in Quarter 3 2018/2019.

- ***Reduce the number of Preventable Deaths – To produce an engagement plan to involve family, carers and non-Executive Director within the review process:*** Guidance was published by the National Quality Board in late July. An initial paper was taken to Patient Safety Group in August. The resulting plan is being discussed by TEWV's Patient Safety Group in October (just after the end of quarter 2 when this was due) and will be implemented by the end of Quarter 3 2018/2019.

3.2 Performance against Quality Metrics at Quarter 2

Our full Quality improvement metric performance is set out in Appendix 1. The following table shows the number and percentage of the Quality Metrics in each RAG Category as at Quarter 2. The RAG ratings used to monitor the metrics are simply green if the target is met and red if the target is not met.

RED	GREEN
Patient Safety Measures	
67%	33%
Clinical Effectiveness Measures	
33%	67%
Patient Experience Measures	
100%	0%

Patient Safety Measures – Information regarding Red metrics

Metric 1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'

The Trust position for Quarter 2 is 59.67%, which relates to 466 out of 781 surveys. This is 28.33% below the Trust target of 82.00% and represents reduction of just under 3 percentage points compared to the previous quarter. All localities are underperforming this quarter. North Yorkshire are performing highest with 70.48% and Forensic Services are performing lowest with 43.75%. Our data generally indicates that the most frequent reason that people feel unsafe is due to other patients on the wards.

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

The Trust position for Quarter 2 is 34.43, which relates to 2,391 incidents out of 69,451 Occupied Bed Days (OBDs). This is 15.18 above the Trust target of 19.25 - almost identical to Q1. Forensic Services, North Yorkshire and Durham & Darlington are achieving the target this Quarter. Of the underperforming localities York & Selby had 30.89 incidents per 1000 OBDs and Teesside are performing furthest away from the target at 88.59 per 1000 OBDs. The Teesside figures are significantly higher than the rest of the organisation due to the frequency of incidents involving physical intervention that were reported from Trust's West Lane Hospital.

West Lane is TEWV's hospital for children and young people. This is located in Middlesbrough but admits patients from the whole of the North East and north Cumbria, and occasionally from elsewhere in the UK. 1,407 incidents were reported across the West Lane site during Q2. These incidents represent 59% of the Trust's total usage of physical intervention. The majority of these incidents are linked to a small group of individuals, with 6 patients involved in 1,040 incidents. The complex needs of this group regularly require physical intervention to be utilised as part of their clinical treatment in providing them with nutrition. 2 of the 6 patients alone, due to the level and complexity of their needs, were involved in 531 of the reported incidents.

Services at West Lane continue to work closely with the Trust's Positive and Safe team to develop Behaviour Support Plans for patients and to implement Safewards intervention access there wards. In addition to further support the wards, TEWV has successfully applied for all 3 wards at that hospital to take part in a National Service Improvement Project facilitated by NHS England and NHS improvement. This will commence on 23rd November. It is hoped that this will help TEWV to reduce the levels of restrictive intervention.

Clinical Effectiveness Measures

Metric 6: Average length of stay for patients in Adult Mental Health Services and Mental Health Services for Older People Assessment and Treatment Wards:

The average length of stay for patients in Mental Health Services for Older People for Quarter 2 is 65.50 days. This is 13.5 above the Trust target of <52, and very similar to the Q1 position.

The median length of stay within MHSOP was **49** days, which is within the target threshold of less than 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. A small number of patients have long lengths of say which impact on the average figure. The two drivers of long stays tend to be clinical complexity and a lack of suitable care home placements for patients to be discharged into. The Trust is engaging with some local authorities on locality specific schemes to reduce delayed discharges.

Patient Experience Measures

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

The Trust position for Quarter 2 is 91.34%, which relates to 4,337 out of 4,748 surveys. This is 2.66% below the Trust target of 94.00%. There has been an improvement of just over half a percentage point from Q1 to Q2.

All localities are underperforming this quarter. North Yorkshire are performing highest with 93.38% and Forensic Services are performing lowest with 84.40%.
There are a number of initiatives taking place which may improve patient experience. These include training forensic patients in quality improvement techniques and involving them in quality improvement work. The Trust has also invested in environmental improvements to the café and created a family room at West Park Hospital, Darlington.

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

The Trust position for Quarter 2 is 86.08%, which relates to 3,796 out of 4,410 surveyed. This is 7.92% below the Trust target of 94.00%, but represents an improvement of over 2 percentage points on Q1.

All localities are underperforming this quarter. North Yorkshire are performing highest with 89.74% and Forensic Services are performing lowest with 73.81%.

The Trust continues to communicate the need for managers and staff to reflect the Trust's values in their day to day behaviours, and has been using expert by experience testimonies to increase both corporate and clinical staff understanding and empathy. The Trust is also delivering an autism awareness training programme so that staff can better understand how best to interact with, and take account of the needs of this particular service user group.

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

The Trust position for Quarter 2 is 87.76%, which relates to 4,203 out of 4,789 surveys. This is 6.24% below the trust target of 94.00%, but is an improvement of just under 2 percentage points on Q1

All localities are underperforming this quarter. North Yorkshire are performing highest with 90.27% and Forensic Services are performing lowest with 81.20%

In relation to the Patient Experience Measures, the Trust is working hard to try and ensure that these targets are met in future. If there are areas/teams where specific issues are identified then action plans are put in place to address these.

3.3 Improvement Priorities for 2019/20 (2018/19 Quality Account)

3.3.1 Following a process which has gathered views from Trust governors, stakeholders, service users and carers, managers and staff; analysed current activity and other quantitative data and created future forecasts; and considered local and national policy priorities, the Trust Board has determined that the existing four Quality Account priorities will be extended into 19/20 and a new 5th priority added as shown in the table below:

	Improvement Priority	Lead Director	Completion Date
A	*Further improve the clinical effectiveness and patient experience at times of transition from CYP to AMH services*	*Director of Quality Governance*	*Q4 19/20*
B	*Make Care Plans more personal*	*Director of Nursing and Governance*	*Q4 19/20*
C	*Develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services*	*Chief Operating Officer*	*Q4 19/20*
D	*Reduce the number of preventable deaths*	*Director of Quality Governance*	*Q4 19/20*
E (new)	*Review our urgent care services and identify a future model for delivery*	*Chief Operating Officer*	*Q4 19/20*

3.3.2 The detailed actions and milestones for each priority will now be worked up and presented to TEWV's Quality Account Stakeholder event at Scotch Corner on 5th February, TEWV's Quality Assurance Committee on 7th February prior to the completion of the draft Quality Account document and the formal consultation with stakeholders on this in April and May.

4. IMPLICATIONS

4.1. Compliance with the CQC Fundamental Standards

The information in this report highlights where we are not achieving the targets we agreed in our 2018/2019 Quality Account and where improvements are needed to ensure our services deliver high quality care and therefore meet the CQC fundamental standards.

4.2. Financial/Value for Money

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 (including the NHS Constitution)

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

The Trust does monitor quality data for protected characteristic groups where possible, and takes action at Trust or Locality level to address issues as they are identified.

4.5. Risks

There are no specific risks associated with this progress report

5. CONCLUSIONS

5.1 The current quality priorities are on track for delivery with only a few slight delays to specific actions.

5.2 In terms of Quality Metrics, 3 of 9 (33%) are reporting green. We are reporting red on 6 of 9 metrics (66%). Although there have been some encouraging trends since the last quarter the issues that have to be addressed if the Trust is to hit its ambitious

quality targets remain complex, and many of the initiatives we are taking will have an impact only in the long term. The national support about to be received at West Lane Hospital should help the Trust to reduce the instances of restraint.

5.3 The report also notes that Stakeholder engagement outcomes have been fed into the Trust's planning process and that the Trust's Board of Directors has agreed to extend the four current quality account improvement priorities into 2019/20. It has also added reviewing our urgent care delivery model added as a 5th improvement priority.

Chris Lanigan
Head of Planning and Business Development

Laura Kirkbride
Planning and Business Development Manager

Appendix 1: Performance with Quality Metrics at Quarter 2 2018/2019

Quality Metrics											
Patient Safety Measures											
	Quarter 1 18/19		**Quarter 2 18/19**		**Quarter 3 18/19**		**18/19**		**2017/2018**	**2016/2017**	**2015/2016**
	Target	**Actual**	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	88.00%	62.40%	88.00%	59.67%	88.00%		88.00%		62.30%	N/A	N/A
2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) - for inpatients	0.35	0.17	0.35	0.19	0.35		0.35		0.12	0.37	N/A
3: Number of incidents of physical intervention/restraint per 1000 occupied bed days	19.25	34.23	19.25	34.43	19.25		19.25		30.65	20.26	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 inpatient care	>95%	98.07%	>95%	97.03%	>95%		>95%		94.78%	98.35%	97.75%
5: Percentage of clinical audits of NICE Guidance completed	100%	0%	100%	100%	100%		100%		100%	100%	100%
6a: Average length of stay for patients in Adult Mental Health Assessment and Treatment Wards	<30.2	24.76	<30.2	21.73	<30.2		<30.2		27.64	30.08	26.81
6b: Average length of stay for patients in Mental Health Services for Older People Assessment and Treatment Wards	<52	65.89	<52	65.50	<52		<52		67.42	78.08	62.67

Patient Experience Measures											
7: Percentage of patients who reported their overall experience as excellent or good	94.00%	90.82%	94.00%	91.34%	94.00%		94.00%		90.50%	90.53%	N/A
8: Percentage of patients that report that staff treated them with dignity and respect	94.00%	84.60%	94.00%	86.08%	94.00%		94.00%		85.90%	N/A	N/A
9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94.00%	85.81%	94.00%	87.76%	94.00%		94.00%		87.20%	86.58%	85.51%

Appendix 2: Performance against Quality Metrics by TEWV Operational Locality

Quality Metric	Trust	Durham & Darlington	Teesside	North Yorkshire[1]	Forensic Services	York & Selby
Metric 1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	59.67%	64.06%	53.45%	70.48%	43.75%	60.56%
Metric 2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) - for inpatients	0.19	0.24	0.17	0.31	0.00	0.49
Metric 3: Number of incidents of physical intervention/restraint per 1000 occupied bed days	34.43	14.80	88.59[2]	13.05	12.00	30.89
Metric 4: Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care:	97.03%	N/A	N/A	N/A	N/A	N/A
Metric 5: Percentage of Clinical Audits of NICE Guidance completed:	100%	N/A	N/A	N/A	N/A	N/A
Metric 6a: Average length of stay for patients in Adult Mental Health Services Assessment and Treatment Wards:	21.73	N/A	N/A	N/A	N/A	N/A
Metric 6b: Average length of stay for patients in Mental Health Services for Older People Assessment and Treatment Wards:	65.50	N/A	N/A	N/A	N/A	N/A
Metric 7: Percentage of patients who reported their overall experience as 'excellent' or 'good'	91.34%	92.35%	91.09%	93.38%	84.40%	90.43%
Metric 8: Percentage of patients that report that staff treated them with dignity and respect	86.08%	88.62%	84.34%	89.74%	73.81%	87.07%
Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	87.76%	89.43%	87.14%	90.27%	81.20%	85.63%

[1] Services covering Hambleton, Richmondshire, Whitby, Scarborough, Harrogate and Rural District and Ryedale. The Wetherby area of Leeds is also served by these teams.
[2] Teesside statistics include the children and young people's wards at West Lane, which serves the North East and north Cumbria (and also admits patients from Yorkshire and elsewhere)