Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

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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)