Our Quality Journey and Quality Improvement Priorities for 23/24

This presentation will cover

- **National quality definitions / patient safety strategy**

- **TEWV's Quality Journey – our Quality Strategy which supports *Our Journey to Change***

The National Quality Board commits us to:

'A Shared single view of quality where people working in systems deliver care that is:

- **Safe -** delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights;

- **Effective -** informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical audit

- **A Positive Experience - Responsive and personalised -** shaped by what matters to people

And….

- **Well led -** driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance

- **Sustainably Resourced** - Sustainably-resourced - focused on delivering optimum outcomes within financial envelopes, reduces impact on public health and the environment.

- **Equitable -** everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.

The NHS Patient Safety Strategy

TEWV Strategy and Priorities

Our Journey To Change

journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

1 Why we do what we do

We want people to lead their best possible lives.

2 What people have told us about the sort of organisation we were in 2020

We have a lot to be proud of, yet we don't always provide a good enough experience and at times let down those who use our services, their carers and their families.

4 The most important way we will get there is by living our values, all of the time

Respect
- Listening
- Inclusive
- Working in partnership

Compassion
- Kind
- Supportive
- Recognising and celebrating

Responsibility
- Honest
- Learning
- Ambitious

We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve and innovate together with our communities and will always be respectful, compassionate, and responsible.

3 The kind of organisation we want to be

5 We are committed to three big goals for the next five years

Goal 1
To co-create a great experience for our patients, carers and families, so you will experience:
- **Outstanding** and compassionate care, all of the time.
- **Access** to the care that is right for you.
- **Support** to achieve your goals.
- **Choice** and control.

Goal 2
To co-create a great experience for our colleagues, so you will be:
- **Proud**, because your work is meaningful.
- **Involved** in decisions that affect you.
- **Well led** and managed.
- That your workplace is **fit for purpose**.

Goal 3
To be a great partner, so we will:
- Have a **shared understanding** of the needs and the strengths of our communities
- Be **working innovatively** across organisational boundaries to improve services.
- Be **widely recognised** for what we have achieved together.

Your opinions are important to achieve our goals. Get involved

National Patient Safety Strategy

Reporting incidents directly via the new Learning From Patient Safety Events (LFPSE)

Improving Patient Safety through the transformation of the Patient Safety Incident Reporting Framework (PSIRF)

✓Patient Safety Syllabus

✓Patient Safety Specialists

✓Patient Safety Partners

Our Journey to Effective Care

NHS Tees, Esk and Wear Valleys — NHS Foundation Trust

Insight

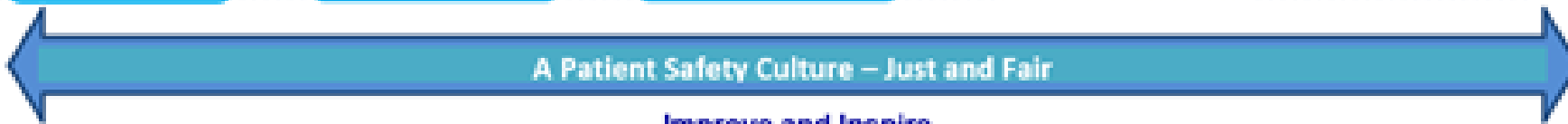| Clinical Strategy	Clinical Outcomes	Care Planning	NICE and evidence-based practice

Involve

Patient Safety Partners	Patients, Families & Carers	Experts by Experience	Ward/ Team to Board Staff	External Partners

A Patient Safety Culture – Just and Fair

Improve and Inspire
How we will achieve our goals

Academy of Caring

Provide education and training opportunities which enable all health professionals to deliver effective and compassionate care. Develop new and innovative roles across system Empathy Training

Patient Safety Faculty

Improve our understanding of safety
Build capability for safety improvement through a Patient Safety Syllabus:
- Human Factors & Safety Management
- Creating Safe Systems
Patient Safety Specialists
Patient Safety Partners

Continuously Improving Patient Safety

Measuring what matters
Team Safety Plans – local ownership
Improvement programmes enable effective and sustainable change
Intelligence for Action:
- Stop the Line
- Flash Safety Briefings
- SBARDS & Webinars
- National Safety Alerts

Maximising Technology

Digital systems and solutions
- CITO
- SafeCare
- Dialogue

New National Reporting & Learning System
Maximising Datix System
New National Patient Safety Incident Response Framework

A Learning Organisation

Opportunities for learning
- When things go well
- From incidents, complaints, litigation
- In our shoes –patient, carer and staff experiences
National Improvement Programmes
Research and Innovation
Innovative and effective ways to share and embed learning
Learning Library

✓ For each service, we will have in place a suite of clinical outcome measures and patient reported outcomes (effectiveness of care measures)

✓ We will have improved data quality with regard to the 'effectiveness of care' measures that will be utilised by clinicians to better understand the impact of different approaches to patient care and treatments

✓ Using this data, we will see an increase in the number of patients reporting an improvement in their symptoms after receiving care and treatment from the Trust

✓ There will be an increase in patients telling us they have been able to influence their care and all care plans will be co-created with patients and their families

Our Journey to Excellence in Patient Experience and Involvement

Insight

- Compassionate Care
- Co-creation
- Improving experience of care through improved data collection?/ analysis — Explore Digital Enablers
- Feeling Safe in our Care ?

Involve

Patient Safety Partners — Patients, Families & Carers — Experts by Experience — Ward/ Team to Board Staff — External Partners

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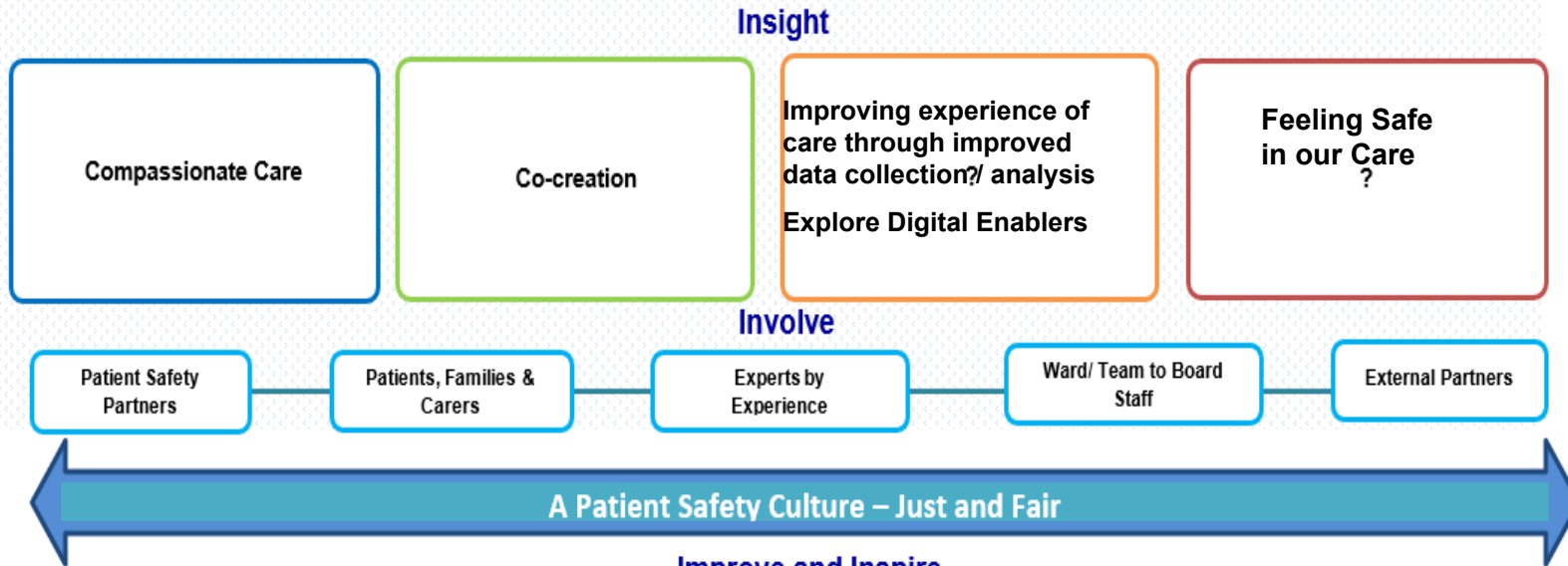
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➢ We will demonstrate significant improvements in the experiences of the people using our services through using an increased range of methods and range of quantitative and qualitative information

➢ Service users, carers and staff will see that their voice makes a difference – by speaking out about poor care and making suggestions for improvements they are continuously improving the experience people have of our services.

➢ Patients will talk positively about the impact of restrictions on their recovery

➢ Patients on our wards will feel safe

Where we are now

NHS
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NHS Foundation Trust

Summary Dashboard – December 22

Assurance / Variation / Caution legend:
- P — Consistently hit target
- ? — Hit and miss target randomly
- F — Hit and miss target randomly
- H / L — Special Cause Concern
- H / L — Special Cause Improvement
- Common Cause
- ! — Caution: The data in this chart is not normally distributed. The SPC chart should be interpreted with caution!

Reporting month: December 2022		Variation	Assurance	Target	Numerator	Denomenator	Rate/%
SAFE	Serious Incidents	(common cause)		-	11	-	-
	Incidents	! (L)		-	1868	-	-
	Incidents per 1000 OBD (Wards only)	!		-	1332	19596	67.97
	Incidents per 1000 Caseload	! (L)		-	401	52736	7.60
	Restrictive intervention incidents	(common cause)		-	446	-	-
	Restrictive intervention incidents per 1000 OBD (Wards only)	!		19.25	433	19596	22.10
	Self-harm incidents	(common cause)		-	453	-	-
	Seclusion incidents	! (H)		-	40	-	-
	All medication errors per 1000 OBD (Wards only)	(common cause)	P	2.5	66	19596	3.37
	L3 and above Medication Errors			0	1	-	-
	Falls per 1000 OBD (Wards only)	! (L)		-	53	19596	2.70
	L3 falls per 1000 OBD (Wards only)	!	?	0.35	1	19596	0.05
	Shifts greater than 13 hrs	!	F	0	58	-	-
CARING	FFT	!	?	0.94	660	722	91.41%
	Carer FFT	! (H)		-	240	258	93.02%
	Feel safe	! (L)	F	0.88	72	142	50.70%
	Complaints	(common cause)		-	29	-	-
	PALS	(common cause)		-	141	-	-
	Compliments			-	15	-	-

- 722 Patient FFT responses received for the Trust in November
- Most recent FFT benchmarking data provided by NHSI tells us 91% of people rated our services as good or very good
- A small number of patients account for 75% of all Restrictive Interventions in LD, SIS and PICU. Mean YTD data shows downward trend across all forms of restrictions
- Long Term Segregation and Restrictive Intervention Panels in place
- At the time of reporting the Trust are supporting 14 patients in LTS or prolonged seclusion (8 individual accommodation in LD)
- A reducing trend in self harm incidents following targeted improvement work

Positive & Safe Dashboard

Some Key Quality Markers

Quality Controls, Quality Assurance

NHS
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NHS Foundation Trust

Fundamental Standards Groups

Quality Assurance Programme

QA Audits
- Modern Matron Review
- MDT Walkabout
- Peer Review
- Peer & Self Audits

Restrictive Interventions

- Positive & Safe Dashboard
- RI business case
- Merseycare recommendations

Culture Assessment Process

- Phase 1 – IP Ward assessment
- Community Tool in development
- Development of a trigger tool
- PHASE 2 –follow up programme

Safe Staffing report & oversight

- Safe Care Tool
- Staffing Establishment Review (MHOST)
- Career Framework Development

Quality Metrics

Quality Metrics	Target	Whole Trust 20/21	Whole Trust Actual Q4 21/22	Whole Trust Actual 22/23 Q1	Whole Trust Actual 22/23 Q2	Whole Trust Actual 22/23 Q3
1) Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	88.00%	64.66%	64.37%	59.38%	58.54%	54.02%
2) Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	0.13	0.07	0.23	0.23	0.25
3) Number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	20.90	37.66	34.01	33.84	31.09
4) Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	85%	*Previously reported indicator: (Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care)*		91. 56%	88.46%	86.59%
5) Percentage of patients who reported their overall experience as very good or good	94.00%	93.21%	94.34%	91.76%	91.74%	91.81%
6) Percentage of patients that report that staff treated them with dignity and respect	94.00%	86.77%	89.14%	87.31%	87.16%	85.94%
7) The number of Medication Errors with a severity of moderate harm and above	2.5	-	-	2	5	4
8) Number of serious incidents reported on STEIS	-	-	-	34	32	28
9) Number of Complaints raised	-	-	-	82	62	97

KEY QUALITY RISKS

Areas for concern

NHS
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Workforce
Medical vacancies
Registered Nurse Vacancies

Reference Cost Index
tariff funding shortfall for MH, Community and Ambulance providers – pay 81% cost base

ALD
system pathways not fit for purpose (£4m+ unfunded complex packages

IP Pressures
DTOC, 104% occupancy
8 IS Beds

SI Backlogs
Lack of system resources
closure of historic backlog and themed learning

Lack of Recovery Funding
No Mental Health Recovery Fund

Prosecutions/Reputation
CQC prosecutions
Niche

Autism
not covered by MHIS and very limited new recurrent investment despite significant pressures

West Lane Hospital

Status and remedial actions for the 3 published Niche Reports

Key Actions:

- Gap analysis of improvements and evidence against recommendations in preparation for Niche Assurance review (6 months from publication-due May 2023)

- Narrative assurance statements published (and drafts prepared for 4th report)

- Quality Assurance mapping and oversight in place

- Commissioned independent Duty of Candour review

- Quality Improvement review underway for environmental risk assessment processes

- No immediate risks to delivery identified

Learnings about patient safety from West Lane Hospital

Our Trust stopped delivering inpatient children and adolescent mental health services (CAMHS) in September 2019 following a series of incidents at West Lane Hospital. Following this, NHS England commissioned an independent review looking at the care and treatment of three young woman who sadly died in our care in 2019 and 2020.

The review was clear that we needed to improve some of the ways that we work:

Improving the ward environment:

To reduce ligature risks we have made changes to some ward environments. We have:

Removed shower curtains

Replaced old taps with anti-ligature ones

Installed anti-ligature doors in some areas

Ligature risk is assessed monthly by your matron during walk-arounds

We are also piloting a system called Oxehealth in some areas. Oxehealth is an alert system designed to improve safety for the people we care for.

Improving patient safety

We have changed the way we talk about risk; we now use safety summaries and safety plans. Patients, families and carers are much more involved in this.

We used to record information about risk in multiple places. This led to mistakes. The primary place of recording risk is in the safety summary and safety plan.

The quality of our records and content are regularly checked. We use a quality assurance schedule and peer visits to do this.

Learning from these audits and visits is shared in team meetings and huddles so everybody knows how to keep patients safe.

As part of our daily ward safety review, we now share important information which helps keep our patients safe.

We have improved our response to incidents and how we learn from these.

Improving Our governance

Good governance is about having the right people in the right place with the right skills. This supports services to continuously improve and helps us to provide safe and effective care. We know we weren't getting this right and needed to make some changes:

We have changed the way we share information from ward to board.

New meeting structures have been developed.

We are improving the way we are using data and information to better understand how to improve our services.

We have introduced several new roles, so you may have noticed new faces. We have increased the clinical leadership and focus to help us inform our care.

To enhance the patient voice, we have recruited lived experience directors and increased the number of peer support workers.
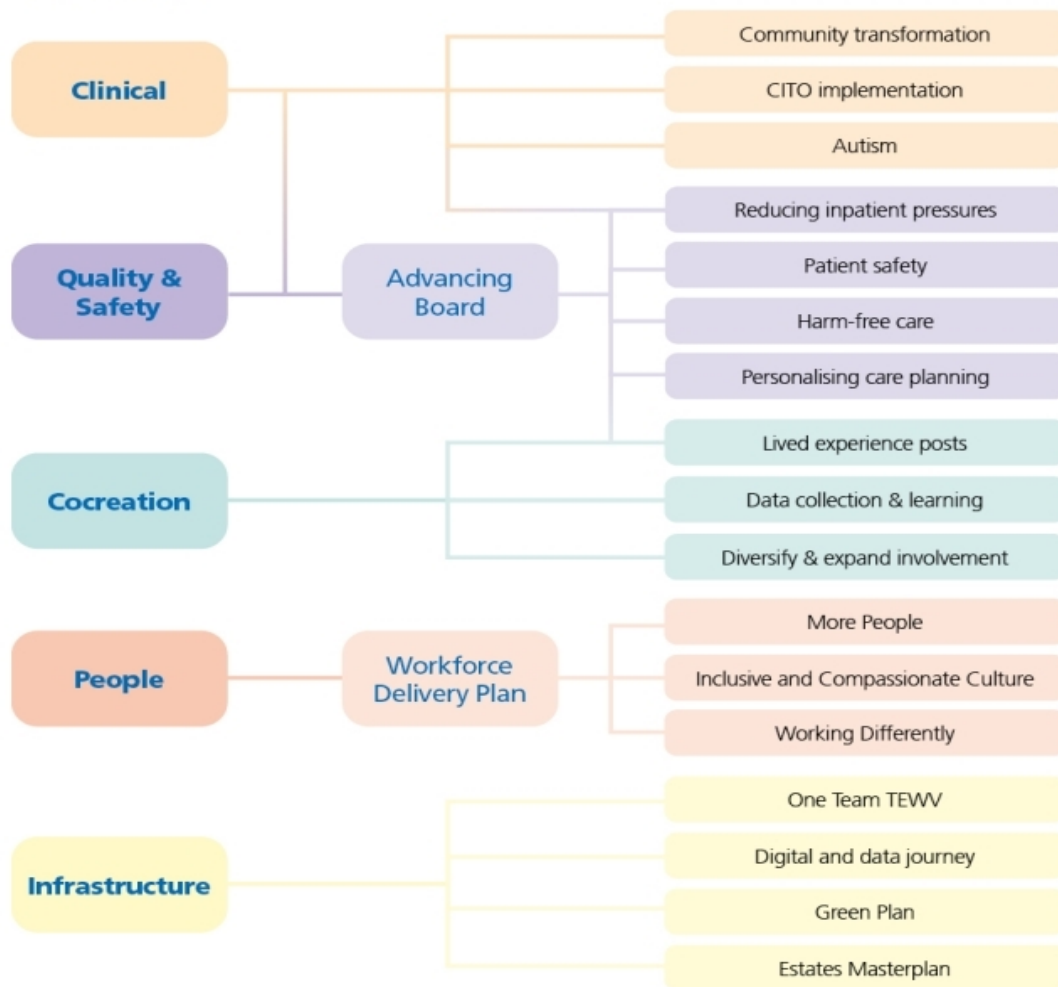
Quality Account
improvement Priorities and
Next Steps

TEWV draft Delivery Plan 23/24

Quality Account improvement priorities

- Will be specific actions in the following areas, which support improvement in the quality account metrics
a) Patient Safety
b) Harm Free Care
c) Personalising Care Planning

Quality Account Process

- **Draft to be circulated to stakeholders (including local authorities) in early May (hopefully before local authority election, but will be very tight)**

- **30 day formal consultation period**

- **We publish responses from all stakeholders**

- **So, we hope this year's Tees Valley OSC can write it's letter now, i.e.**
  a) Comment on our quality position / progress
  b) Comment on our proposed areas of improvement