

# PAPER

BOD 98/2013

(Agenda Item: 9)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**25 September 2013**

**Quality Account Quarter 1 report**

**For: Information**

This report outlines the Quarter 1 performance against the measures outlined in the Quality Account for 2013/14. This report has previously been considered at the Integrated Governance Committee

The purpose of the report is to note the areas where the Trust is making good progress in avoiding harm and delivering quality in service provision; and to identify any areas of concern requiring action or improvement.

1. *A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.*
2. *This paper (including all appendices) has been assessed against the Freedom of Information Act and the following applies:*
* *THIS PAPER MAY BE PUBLISHED UNDER FOI*
1. *This paper provides assurance and evidence against the following Care Quality Commission Outcomes 1, 4, 7, 8, 9, 10, 11, 16, 17, 20:*

**Report**

**The key points of the report are as follows:**

**Improving Patient Safety**

### *Objectives*

* People will not die prematurely.
* Patients will be protected from harm.
* Patients will be treated and cared for in a safe environment.

Overall the Trust is making acceptable progress in minimising harm from infections assuming the rate of Clostridium Difficile infections does not increase; further work is required in mental health settings to improve hand hygiene scores. Harm from falls is within the tolerances set in the quality account. The incidence of avoidable pressure ulcers in the first quarter of this year is equivalent to the number for the first 6 months of last year. The number of apparent community suicides in quarter 1 is equivalent to the same quarter last year. The rate of absences without leave for quarter 1 suggests the threshold of no more than 96 in 12 months will be exceeded by year end. The number of reported incidents has increased (the aim is to increase the number of incidents which are reported).

**Improving Clinical Outcomes**

### *Objectives*

* The quality of life for people with long-term conditions will improve.
* Patients/service users will feel supported to manage their own conditions.
* People with long-term conditions will spend less time in hospital.

The measures below outline the proportions of patients on CPA in various settings and indicate that more than 95% of patients received a follow-up contact within 7 days of discharge. Approximately 25% of patients had access to talking therapies in the first three months. Fewer than 10% of patients were readmitted within 28 days of discharge and overall almost 100% of patients admitted to acute mental health wards had access to crisis resolution home treatment teams.

**Improving Patient and Carer Experience**

### *Objectives*

* Patients’ experiences of inpatient/outpatient services will improve.
* Responsiveness to patients' needs will improve.
* Patients’ access to community-based services will improve.

The Trust received 48 complaints in the first quarter. The number of complaints of itself does not indicate the quality of a service provider. We should proactively seek comments on our service, both positive and critical. The aim is not therefore to reduce the number of complaints, but to ensure that complaints are not repeatedly about the same issue, that they are responded to in a timely manner and that agreed actions are implemented. Subsequent reports will include information on response times and actions closed.

**Delivering Efficient and Effective Services**

### *Objectives*

* Utilisation of resources will be maximised.
* Time spent on patient care will be maximised.
* Patients/service users will progress through the care system in a timely way.

The productives programme continues to be rolled out across the Trust, with continuing support to ensure sustainability as well as spread. The programme to enhance the use of technology is currently on track to achieve milestones for the year, including availability of laptops for staff, trialing of iPADs and tablets to enhance self managed care and use of text messaging to communicate with patients.

**Recommendation**

The Board is asked to note the report

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**Oxford Health NHS Foundation Trust**

**Quality Account 2013/14**

Report for the 1st Quarter 2013

September 2013

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| Summary |

The Quality Account is organised around the following key themes.

It reports quarterly on performance against specific metrics and measures, some of which are nationally proscribed and some of which have been developed locally. It also outlines safety and quality improvement initiatives and projects underway within the Trust, which will be reported on a six monthly basis. Audits will be reported on a six monthly cycle (at six and twelve months). RAG rating has been applied only to those measures with a specific target.

Part of the process of developing the quality account is to identify as a Trust (including at a team, service and patient level) what is meaningful and important to understand about our services. A key activity over the past few weeks has been to check and interrogate the measures which have been included in the quality account, and to identify any further measures we would like to report on. The test of any report is whether it tells a story that enables us to understand how we are doing and to take some action as a result (recognising and spreading success and acknowledging and addressing areas for improvement). Subsequent quarterly reports will use the refined measures to review trends, compare results with 2012/13 and look ahead as well as retrospectively.

During the first quarter the Trust has been developing a safety and a quality dashboard linked to the corporate objectives. These dashboards will describe the key indicators associated with quality and safety, and a range of measures to help us understand not only how effectively we are avoiding harm to patients but also how we are maintaining safety and improving outcomes.

In the last few weeks the Keogh Report has been published, outlining a number of key findings and associated recommendations. The Trust is reviewing and analysing these reports, alongside the Francis reports, for key transferable lessons on ensuring the safety and quality of our services.

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|  **Key highlights for Quarter 1** |

1. The work to redesign and remodel pathways of care and the functions that support them has made significant progress over the past few months and has involved considerable consultation and involvement of a range of stakeholders (Delivering effective services/improving clinical outcomes)

2. To ensure that services are aware of and can address any incidents involving harm to patients or staff, it is critical that any and all incidents are reported, reviewed and acted upon in a timely manner. The aim of the incident reporting process is therefore to increase the overall number of incidents reported whilst decreasing the number of serious incidents requiring investigation (the ratio of severity of incident decreases). The data for quarter 1 suggests a trend is developing of increased reporting and reduced severity. (Improving patient safety)

3. The number and rate of incidents of clostridium difficile infection (CDI) continues to fall, with two reported incidents in the first quarter. (Improving patient safety)



4. There has been a significant increase in the response rate to the Trust wide survey ( 4 core questions) which creates increased confidence in the ratings we have been given. (Improving patient and carer experience)

5. There is some pressure on the targets associated with the number of AWOLs; the intention is to reduce the number of AWOLs to 96 across the year; however there have been 66 in the first quarter alone. (Improving patient safety)

6. The number of reported pressure ulcers rose in April and May. This has included a rise in grade 3 and 4 ulcers (see chart below). (Improving patient safety)

Recurrent themes from the investigation of these incidents have included:

* Need to ensure holistic assessment
* Timeliness of assessments/re-assessments
* Need to ensure consistent standard of documentation
* Communications between services

The community division is implementing a plan to reduce the number of incidents and prevent the development of avoidable pressure ulcers.

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| Improving Patient Safety |

### Objectives

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* Patients will be treated and cared for in a safe environment.

Overall the Trust is making acceptable progress in minimising harm from infections assuming the rate of Clostridium Difficile infections does not increase; further work is required in mental health settings to improve hand hygiene scores. Harm from falls is within the tolerances set in the quality account. The incidence of avoidable pressure ulcers in the first quarter of this year is equivalent to the number for the first 6 months of last year. The number of apparent community suicides in quarter 1 is equivalent to the same quarter last year. The rate of absences without leave for quarter 1 suggests the threshold of no more than 96 in 12 months will be exceeded by year end. The number of reported incidents has increased (the aim is to increase the number of incidents which are reported).

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| Measures and Targets | Current Position |  |
| Unexpected deaths and serious harm (rated as SIRIs) in inpatients (mental health services) reduced to 0, or greater than 300 days between deaths over 2 years | 0 |  |
| Absence from wards without permission reduced by 50% from 192 detained patients in 2012/13 to 96 in 2013/14 | 66 |  |
| Reduction in number of medication near miss events which results in harm (defined as 3,4 or 5 in severity) | 6 (28 in 12/13) |  |
| Harm from falls (defined as 3, 4 or 5 in severity of outcome) reduced by 50% from 2.9 per 1,000 bed days in Mental Health Hospitals and 10.1 per 1,000 bed days in Community Hospitals in 2012/13 to 1.5‰ and 8.6‰ respectively in 2013/14[[1]](#footnote-1) | 1.27%  |  |
| Avoidable pressure ulcers (grade 3-4) reduced to 0 | 8 (19 in 2012/13) |  |
| 95% compliance with VTE (venous thromboembolism) risk assessment and appropriate prophylaxis in all Trust services | 97.51% trust wideCommunity hospitals 93%OA inpatients 87.5% |  |
| 95% compliance with triggering of physical deterioration intervention in all community services | 95% |  |
| Number of new catheter associated urinary tract infections (UTIs) infections in all Trust services | Trust wide 6 Community hospitals 1OA inpatients 0Community nursing 5 |  |
| No inpatients to commit suicide | 0 |  |
| Reduction in the number of (apparent) community suicides towards 0 or greater than 300 days between deaths | 8 |  |
| Level of hand hygiene scores maintained at greater than 95% in inpatient settings | Overall compliance in mental health was 93% and 100% in community hospitals (conducted in May 2013) |  |
| Number of bacteraemia infections developed 48 hours post-admission should not exceed 2 | 0 |  |
| Reduce overall number of Clostridium Difficile infections (CDI) developed 72 hours post admission (should not exceed 8) | 2 |  |
| Number of incidents (with a view to improving incident reporting and therefore increasing the number of incidents reported) | There were a total of 2763 incidents reported in quarter one against a mean in the previous year of 2470.  |  |
| Number of serious incidents requiring investigation | 21 |  |

**Safety thermometer measures**

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| **Measure**  | **April May June Q1** |
| Harm free care | 88.75% 88.65% 88.3% 88.9%  |
| Pressure Ulcers – allNumber of patients | 8.46% 9.72% 9.36% 9.18%1064 1348 1239 |
| Pressure ulcers - new | 2.31% 3.41% 2.58% 2.77% |
| Falls with harm | 0.99% 1.04% 1.78% 1.27%  |
| Catheters and UTIs | 1.07% 0.74% 0.65% 0.82% |
| Catheters and new UTIs | 0.74% 0.15% 0.48% 0.45% |
| New VTEs | 0.17% 0.15% 0.24% 0.18% |
| All harms | 10.25% 11.35% 11.7% 11.1% |
| New harms | 4.13% 4.6% 5% 4.6%  |
| Sample size  | 3797 patients/223 surveys |
| Track and Trigger tool – 85/95%Abingdon 1Abingdon 2BicesterCityDidcotHenleyWallingfordWantageWitney LinfootWitney Wenrisc | April May June Q196% 96% 96% 96%95% 96% 96% 95.7%95% 92% 99% 95%83% 89% 99% 90%96% 96% 96% 96%99% 96% 100% 98%100% 91% 96% 95.7%95% 97% 92% 94.7%92% 92% 95% 93%97% 97% 98% 97.3% |

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| Improving Clinical Outcomes |

### Objectives

* The quality of life for people with long-term conditions will improve.
* Patients/service users will feel supported to manage their own conditions.
* People with long-term conditions will spend less time in hospital.

The measures below outline the proportions of patients on CPA in various settings and indicate that more than 95% of patients received a follow-up contact within 7 days of discharge. Approximately 25% of patients had access to talking therapies in the first three months. Fewer than 10% of patients were readmitted within 28 days of discharge and overall almost 100% of patients admitted to acute mental health wards had access to crisis resolution home treatment teams.

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| Measures and Targets | Current Position |
| % of adult service users on CPA in settled accommodation | 7.4% |
| % of adult service users on CPA in employment | % in Employment is 13.1%, the % in other Employment (voluntary, further education etc.) is 50.4%, total 63.5% |
| Number and % of Patients receiving follow-up contact within seven days of discharge from mental health wards | 96.4% |
| Number of patients with long term conditions receiving psychological therapies (IAPT) | Bucks Healthy MindsReferrals with LTC            357 = 19.48%Entered Treatment with LTC 383 = 26%Talking SpaceReferrals with LTC            433 = 24.55%Entered Treatment with LTC 322 = 26.70% |
| Number and % of patients readmitted within 28 days of discharge (mental health services) | Adults - 7.6% (21 patients readmitted out of 277 discharge)Older adults - 3.4% (3 patients readmitted out of 88 discharges) |
| Number of patients admitted to acute wards who had access to crisis resolution home treatment teams acting as gatekeeper | 99.1% - 223 admissions of which 221 had access to crisis resolution prior to admission |
| Number of patients/service users with Personal Health Budgets (PHB) | 22 (Continuing Healthcare – Direct Payments)15 (Continuing Healthcare – notional budgets)5 (Shared Care Direct Payments)1 (Fast Track Direct Payments)50 (Physical Disability Physiotherapy Service one-off payments to support pilot)2 (Children’s Continuing Healthcare Direct Payments)Total = 95 |

### Develop & Implement Integrated Care Pathways for Children and Young People

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| **Reasons for inclusion**To improve the quality of care and efficiency by providing a better integrated service for children and young people rather than having separate discrete services. |
| **Aims** | **Current Position** |
| Integration of Children’s Services | Integrated management structure in place across physical and mental health pathways. Work streams in place looking at integration across care pathways – this includes integration with children’s health and social care services. |
| Managing transitions for children and young people into adult services | Projects established to review ASD and ADHD pathway. Pathway for young people with complex physical health needs. Pilot to begin in September in Oxfordshire for young people with emerging personality disorder to remain in CAMHS until 25yrs |
| Development of CAMHS inpatient pathway | Work underway to ensure pathways working within new commissioning arrangements and across community and inpatient pathways. |
| **Milestones*** Integration by March 2014.
* Completion of transition and inpatient pathway by March 2015.
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### Develop & Implement Integrated Care Pathways for Adults of Working Age

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| **Aims** | **Current Position** |
| Reasons for inclusion: To improve the quality of care and efficiency by providing a better integrated service for adults of working age rather than having discrete services |
| Review and redesign Early Intervention Service | Service model agreed currently reviewing staffing models |
| Review and redesign Complex Needs Service | Care pathway agreed, reviewing staffing models for reductions in costs. Business case to be agreed end of July. |
| Improve inpatient experience and outcomes | Move to inpatient Consultants will be completed in both counties by September 2013. Through Service remodelling programme increasing the numbers and skill mix on the acute wards, adding a modern matron for every ward and increasing the charge nurse numbers to enhance the experienced clinical leadership and patient experience improving their clinical pathway. |
| Improve long-term conditions pathways for adults | Vision developed for supporting the physical and psychological wellbeing or people with long term conditions. New integrated approaches are being tested with patients in Bucks and Oxon with cardiac disease, COPD, stroke, diabetes and other conditions. |
| Integrate locality-based community mental health services | Model of care defined. Operational policy agreed, consultation with staff underway. Model to be implemented by Sept 13 |
| Develop psychological medicines services care pathway | Project group established consultant in post by Oct 13. |
| Review of provision and associated estates issues in Forensic Services | Not included in service remodelling programme |
| Develop eating disorders service care pathway | Options paper due to be delivered in August |
| Develop integrated psychological therapies pathway | Organisational change aspect of work is complete. Further work required to develop an integrated pathway |
| Improve inpatient adult mental health pathways | Model developed and awaiting staff consultation |
| **Milestones*** Milestones being developed as part of the project planning.
* All adult wards to achieve AIMS accreditation by 2015.
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### Develop & Implement Integrated Care Pathways for Older Adults

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| **Reasons for inclusion**To improve the quality of care and efficiency by providing a better integrated service for older adults and those with long term conditions rather than having separate discrete services. |
| **Aims** | **Current Position** |
| Integration of locality beds | Consultation document drafted awaiting decision to proceed with consultation |
| Develop integrated pathway for dementia care | Model agreed and costed |
| Implement emergency multidisciplinary assessment unit care pathway | Options appraisal being considered for estates use at Witney and planning for Witney EMU underway |
| Integration of locality teams | Engagement with CCGs and staff has commenced. SPNCC meeting in August and formal consultation will commence thereafter. Case management consultation commenced. |
| Integration with partnership working in Buckinghamshire | Discussions initiated with BHT and BCC |
| Development of rehabilitation therapies care pathway | Cross use of sessional/cover posts. Joint H&SC business case and pathway agreed, Frail elderly pathway redesign commenced |
| Development of long term conditions care pathway | Completed and agreed |
| Implement next phase of the Single Point of Access initiative | Phase 2 of the project has been completed now and signed off.  The project as it stands is being moved to be part of the pathways.  We’re now working on phase three this will involve DPT to mental health wards etc. |
| Develop new pathways and processes | Work on the agreed areas is currently planned to complete end of September 2013. |
| **Milestones*** Overall milestones being developed as part of the project planning.
* Completion by March 2015.
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| Improving Patient and Carer Experience |

### Objectives

* Patients’ experiences of inpatient/outpatient services will improve.
* Responsiveness to patients' needs will improve.
* Patients’ access to community-based services will improve.

The Trust received 48 complaints in the first quarter. The number of complaints of itself does not indicate the quality of a service provider. We should proactively seek comments on our service, both positive and critical. The aim is not therefore to reduce the number of complaints, but to ensure that complaints are not repeatedly about the same issue, that they are responded to in a timely manner and that agreed actions are implemented. Subsequent reports will include information on response times and actions closed.

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| Measures and Targets | Current Position |
| Number of complaints  | 48 excluding MP queries and local concerns. |
| Delayed Transfers of Care (DTOC)  | Mental health 1.5% (540/35042 occupied bed days)Community hospitals snapshot April 35, May 44, June 26 |
| Friends and Family measures | 315 responded in total, giving a response rate of **3.6%** (with the top response rate as % of activity from Didcot Community Hospital)F&F Test net promoter score = +**73.8 in June out of a range from -100 to +100** |

**What patients told us about our services**

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The above table summarises responses to the 4 Trust wide core questions both from postal surveys and electronic surveys. The information is refreshed back to April 2013 each month to allow for any time lag in receiving postal responses or uploading results from electronic devices. The start of the postal survey programme has contributed 644 responses in June. The responses have remained broadly the same, apart from a minor reduction in the number of patients who received adequate information about their condition and treatment.

### Improve Patient & Public Engagement

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| **Reasons for inclusion**Understanding the experiences of all users of our services and all stakeholders in the Trust is essential to identify the strengths and weaknesses of what we provide. We must therefore ensure that the mechanisms by which we communicate with these groups are as effective as possible, whilst at the same time promoting an environment of transparency in what we do. |
| Implement the Carers’ Strategy | The Trust has now developed a new carers strategy to support carers across all our services. The update was required to ensure the new strategy reflected community services carers as well as mental health services carers.The draft strategy was shared with carer FT members as well as partner organisations including Age UK, Mind, Oxfordshire Carers Forum and Carers Bucks. All comments received were amalgamated into the final strategy.  |
| **Other work**As part of the service remodelling work taking place in divisions an evidence log of engagement and involvement activity is being regularly updated. This includes communications and engagement with staff, patients, carers, public and partners. More broadly, involvement across the divisions is being reviewed as part of the cross cutting workstream to ensure a consistent approach.  |

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| Delivering Efficient & Effective Services |

### Objectives

* Utilisation of resources will be maximised.
* Time spent on patient care will be maximised.
* Patients/service users will progress through the care system in a timely way.

### Productive Care

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| **Reasons for inclusion**To release increasing amounts of time to care, thus improving quality and patient/service user experience. |
| **Aims** | **Current Position** |
| Roll out improvement programme to clinical services within the remaining parts of Community Services Division | Community Services launched in countywide services and second tier nursing services |
| Implement the Productive Care foundation module in Universal Services Children and Families Division | Launch commenced and to be completed by end of quarter two |
| Implement the Productive Care sustainability model in Mental Health | Sustainability model in place in the CMHTs  |
| Inpatient settings, Community Mental Health Teams (CMHT), Community Nursing Service and community hospitals | Sustainability model working in Buckinghamshire MH inpatient wards. Oxon Wards to implement quarter three |
| Develop and cascade quality assurance tools along with appropriate measurements for improvement | Quality Assurance tools completed and in place for Community Hospital wards, MH inpatient wards and Community Nursing  |
| Support Specialised Services Division: Forensic Wards and Mental Health services in prisons | Support in place for Bullingdon and Huntercombe prisons and regular planned support in place for forensic inpatient services  |
| Roll out of e-rostering to designated community services and other areas as appropriate | E-Rostering rolled out to all inpatient wards. Embedding still in progress. 4 units paid through system in June remainder to be paid in August.  |
| **Milestones*** 100% coverage of Trust-wide clinical teams by end of 2013/14.
* E-rostering in designated community services by end of quarter 2 2013/4.
* E-rostering in other areas to complete by end of 2013/14.
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### Use of Technology to Support Care

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| **Aims** | **Current Position** |
| **Reasons for inclusion** To ensure the Trust makes best use of IT/communication opportunities to maximise time available for direct patient care, to improve communication and to enhance self-managed care |
| Improve mobile technology to reduce duplication and cut down travel | Deployed estate:* Circa 2500 laptops.
* More than 1400 Smartphones.
* 150 iPads (soon to be 500).
* Resilient VPN connectivity to allow secure online access to the Trust’s network domain, systems and applications from a Trust provided laptop that is connected to the Internet.
* Outlook Web Access to allow secure access to Trust email from any computer connected to the Internet.

A formal pilot project to determine whether expansion of the laptop estate for front line clinical staff use has just been completed.  This concluded that the device format is only a partial solution as the form factor and the mobile data network proved to be unacceptable and unreliable.  Therefore, further roll-out will not occur.The Trust has commenced the procurement of its Next Generation Electronic Health record.  A key element of this procurement will be support for mobile working.  Once the preferred supplier has been selected the necessary enabling mobile infrastructure and devices can be procured. |
| Develop remote patient monitoring and recording | Roll out of True Colours mood monitoring system across Mental Health division to enable patients to self-report their symptoms using mood rating scales.Two year randomised controlled trail commenced with DOSH and OH using a tablet device to assist patients in the self-monitoring and management of moderate to severe COPD. |
| Promote increased self-help and use of on-line or telephone contacts replacing face-to-face contacts where appropriate | Use of iPads in Melksham CAMHS service to increase contact time with young people to help support self-management and reduce the need for home visits and staff travel.Text messaging system for appointment reminders across CMHTs, Podiatry, and MSK Physiotherapy services to be introduced to reduce DNAs and further increase self-help.Introduction of self-help via use of podcasts in identified community service teams.Use of potential Apps to promote increased self-help and reduction in unnecessary face to face time in identified services. |
| Roll out of Choose & Book to agreed services | Implement Phase 1 with agreed services - by end of Q2Commence implementation of Phase 2 with agreed services - by end of Q4 |

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| Statements from the Care Quality Commission |

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| Quality Risk Profiles |
| **Outcome** | **4Q 2012** | **1Q 2013** |
| **Section 1 - Involvement & Information** |  |  |
| 1. Respecting and involving people who use services | High Yellow | High Yellow |
| 2. Consent to care and treatment | Low Yellow | Low Yellow |
| **Section 2 - Personalised Care** |  |  |
| 4. Care and welfare of people who use services  | High Green | Low Yellow |
| 5. Meeting nutritional needs  | High Green | Low Yellow |
| 6. Cooperating with other providers | High Yellow\* | Low amber\* |
| **Section 3 - Safeguarding and Safety** |  |  |
| 7. Safeguarding people who use services from abuse | High Yellow | High Yellow |
| 8. Cleanliness and infection Control | Low Green | Low Green |
| 9. Management of medicines | High Yellow | High Yellow |
| 10. Safety and suitability of premises | High Yellow | Low Yellow |
| 11. Safety, availability and suitability of equipment | Low Yellow | Low Yellow |
| **Section 4 - Suitability of Staffing** |  |  |
| 12. Requirements relating to Workers | Low Yellow | Low Yellow |
| 13. Staffing | High Yellow | High Yellow |
| 14. Supporting staff | Low Yellow | Low Yellow |
| **Section 5 - Quality & Management** |  |  |
| 16. Assessing and monitoring the quality of service provision | Low Yellow | Low Yellow |
| 17. Complaints | Low Yellow | Low Yellow |
| 21. Records | Low Green | Low Green |

\* risk rating due to delayed transfers of care in Community Hospitals attributable to social care.

Appendix 1

**Proposed amendments to Quality Account measures**

The following measures have been included in the Quality Account for 2013/14. To ensure they are meaningful, reportable and consistent with how these safety measures are reported elsewhere the following amendments/additions have been approved

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| **Measurement in QA** | **Proposed measurement if different** |
| Unexpected deaths and serious harm in inpatients reduced to 0, or greater than 300 days between deaths over 2 years | Unexpected deaths and serious harm (rated as SIRIs) in inpatients (mental health services) reduced to 0, or greater than 300 days between deaths over 2 years |
| Absence from wards without permission reduced by 50% from 192 detained patients in 2012/13 to 96 in 2013/14  |  |
| Reduction of medication adverse events by 50% in 2013/14 to 12 | Reduction in number of medication near miss events which results in harm (defined as 3 (moderate harm), 4 (severe harm) or 5 (death) in severity) |
| Harm from falls reduced by 50% from 2.9 per 1,000 bed days in Mental Health Hospitals and 10.1 per 1,000 bed days in Community Hospitals in 2012/13 to 1.5‰ and 5.1‰ respectively in 2013/14[[2]](#footnote-2)  | Harm from falls (defined as 3, 4 or 5 in severity of outcome) reduced by 50% from 2.9 per 1,000 bed days in Mental Health Hospitals and 10.1 per 1,000 bed days in Community Hospitals in 2012/13 to 1.5‰ and 8.6‰ respectively in 2013/14[[3]](#footnote-3) |
| Pressure ulcers (grade 2-4) reduced to 0, or greater than 300 days between incidents over 2 years | Avoidable pressure ulcers (grade 3-4) reduced to 0 |
| 95% compliance with VTE (venous thrombo-embolism) risk assessment and appropriate prophylaxis | 95% compliance with VTE (venous thrombo-embolism) risk assessment and appropriate prophylaxis in all Trust services |
| 95% compliance with triggering of physical deterioration intervention | 95% compliance with triggering of physical deterioration intervention in community services |
| No inpatients to commit suicide  |  |
| **Measurement in QA** | **Proposed measurement if different** |
| Catheter associated urinary tract infections (UTIs) with a view to establishing a baseline for targeted reduction in subsequent years | Number of new catheter associated urinary tract infections (UTIs) infections in all Trust services |
|  | Reduction in the number of urinary catheters used |
| Reduction in the number of community suicides  | Reduction in the number of community suicides towards 0 or greater than 300 days between deaths |
| Number of bacteraemia infections contracted should not exceed 2 | Number of bacteraemia infections developed 48 hours post-admission should not exceed 2 |
| Number of C. Diff infections contracted by inpatients should not exceed 10 | Reduce overall number of Clostridium Difficile infections (CDI) developed 72 hours post admission (should not exceed 8)Manage towards 0 the number of patients who develop Clostridium Difficile infections (CDI) 72 hours post admission i) where the care provided did not contribute to the infection and ii) where the care may have contributed to the infection |
| Number of unsatisfactory environmental infection control audits and number of re-audits with a view to establishing a baseline for targeted reduction in subsequent years | Number of unsatisfactory environmental infection control audits and number of re-audits (overall score below 85%) |
| Level of hand hygiene scores maintained at greater than 95% | Level of hand hygiene scores maintained at greater than 95% in inpatient settings |
| Number of patients/service users treated in community setting  | Number of patients/service users assessed and/or treated at home as part of the Hospital at Home initiativeNumber of patients/service users assessed and/or treated in [specific community based services to be agreed] |
| **Measurement in QA** | **Proposed measurement if different** |
| % of adult mental health service users on CPA in settled accommodation. |  |
| % of adult mental health service users on CPA in employment. |  |
|  | Number and % of Patients receiving follow-up contact within seven days of discharge from mental health wards |
| Number of patients/service users with Long Term Conditions receiving. Improvement of Access to Psychological Therapies (IAPT). | Number of patients with long term conditions receiving psychological therapies (IAPT) |
| % engagement of patients/service users with care plan. | 100% of MH service users to have opportunity to be engaged in development of care plan |
| Responses to specific survey questions |  |
| % mental health readmission to hospitals | % of adult mental health emergency readmissions within 28 days of discharge% of older adult mental health emergency readmissions within 28 days of discharge |
|  | Number of patients admitted to acute wards who had access to crisis resolution home treatment teams acting as gatekeeper |
| Number of patients/service users with Personal Health Budgets (PHB). |  |
| Number of complaints |  |
|  | Number of complaints resolved within timeframes agreed with complainant and number of agreed actions closed |
|  | Number of patient safety incidents resulting in severe harm or death (rated as a SIRI |
| Monthly average number of Delayed Transfers of Care (DTOC). |  |
| **Measurement in QA** | **Proposed measurement if different** |
| Responses to specific survey questions.  |  |
| Environmental cleanliness assessments. |  |
| Friends and Family measures. |  |
| Carers’ assessments. |  |

**Proposed additional measures to include from 12/13 Quality Account**

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| Number of patients who died at home as proportion of those who indicated this choice |
| % of patients screened for risk of falling on admission |
| Number of PALS queries |
| Number of reported incidents |
| Number of SIRIs |
| % of staff trained in PMVA |
| % of patients admitted to psychiatric wards with a complete physical health assessment (target 98%) |
| 100% of patients treated by the district nursing services to be assessed for pressure ulcers on first visit (Walsall assessment) |
| % of patients with (MUST) nutritional assessment (Target 85%) |
| 100% of MH service users on CPA to have:Current care planCare reviewed in last 6 monthsCare co-ordinatorRisk assessment reviewed in last 12 months |

1. [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)