Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

Trust Board Meeting (Part 1)	Date: 25th September 2013

Title:	**Quality and Performance Report**
Item:	**BD/13/173**

Executive Director lead and presenter	**Director of Business Development**
Report author(s)	**Director of Operations, Head of Academy, Head of Information and Performance Management**

History:	Executive team

This report is for:	
Decision	
Discussion	
To Note	X

Executive summary of key issues:

To report to the Board on the Trust's

1. Month 5 performance position against each quality domain
2. Month 5 Monitor Compliance risk scores

This report addresses these Strategic Objectives:	
Consolidate	X
Integrate	
Expand	

This report addresses these Values:		
Passion	Doing our best, all of the time	
Respect	Listening, understanding and valuing what you tell us	
Integrity	Being open, honest, straightforward and reliable	
Diversity	Relating to everyone as an individual	
Excellence	Striving to provide the highest quality support	X

1. Introduction

This report provides commentary on the month five position for each of the seven 'domains of quality' reported in the scorecard (and within the Trust's IQ system). Appendices A and B provide the Trust level scorecard and the Monitor Compliance Dashboard respectively for reference.

The body of this report is organised under the seven domain headings.

2. Friends and family (Quality & Safety Committee)

2.1 **The question asked**

The Trust continues to seek feedback from service users in relation to the care the Trust has provided, with the 'friends and family' question asked at key stages in their care pathway (i.e. discharge or transfer from a team or ward, or as part of care plan review meetings).

2.2 **Month 5 results**

The results are analysed and the Friends & Family (FFT) score is created and shown in IQ, which for August 2013 was 44 (where the range of possible scores is -100 to +100, where the more positive the score the better). The response rate for M5 was 4.8% (up marginally from M4). *By M6, the IQ system will be updated to provide the split between inpatient and community response rates*.

The Quality Academy is running FFT workshops for operational staff to facilitate implementation and share good practice. In addition the Trust staff bulletin has an article and associated splash screen to promote the survey and the benefits of reviewing, sharing and acting on the service user feedback. The Engagement Steering Group will discuss the FFT at the next meeting to include the involvement coordinators and HoPPS to consider local and Trust level actions to improve the response rate.

Finally, whilst it is pleasing to see a continued 'positive' score, as noted previously, the greatest value being derived from this indicator currently by Local Delivery Units comes from the comments received from service users when they complete the Friends and Family questionnaire - these comments are being taken to local governance forums for discussion.

3. CQC Compliance (Quality & Safety Committee)

As can be seen in Appendix A the overall compliance score at Trust level is 90.5%, a drop of 0.6% from month four.

The completion rate for the August audit was 95%.

Levels of compliance since the implementation are on an improving trajectory with lowest scores in April at 73% versus 83% in August. The lowest team score is at 66.1% and the highest at 100%.

The standards that stand out as scoring lower on a consistent basis since April are as follows:

- Outcome 1 – Respecting and involving people (82.6%)
- Outcome 2 – Consent to care and treatment (82.2%)
- Outcome 7 – Safeguarding (83%)
- Outcome 21 – Records (84.5%)

Locality management are reviewing this information; focusing on ward and team detail to identify local actions to support improvement and share good practice. Local approaches to drive improvement are evolving with some areas completing peer reviews for the CQC and Records Management standards. This work is being supported by the Lead Nurse for Standards and Compliance, who will be providing additional support relating to practice improvement or evidence collation to ensure compliance. Alongside this support, the Lead Nurse also carries out a series of mock-inspections designed to provide a second check over consistency of self-assessment.

4. Records Management (Quality & Safety Committee)

The percentage of 'good quality' records audited during August remains consistent with the audit completed the month before, at 82.2% (green). With the exception of B&NES who are at 74.5%, all areas are on or above the 75% target threshold.

The completion rate for the July audit was 93%.

Levels of compliance since the implementation are on an improving trajectory with lowest scores in April at 53% versus 68% in August. The lowest team score is at 26% and the highest at 100%.

The three standards that are consistently performing least well are:

- RM5 Client and carers understanding of assessment
- RM6 Formulation/Summary recorded
- RM9 Crisis, relapse and contingency plan

Improvement action is being led locally as per CQC above (see section 3). The Nursing and Quality Directorate is developing a clinical toolkit that will provide a web-based resource for practitioners and will support improvement across these areas. An additional CPA training day is being developed to particularly focus on the assessment, formulation and care-planning.

5. Contract / Monitor (Finance & Planning Committee)

For the purposes of this report, performance against this theme is split into two sections. Firstly, those indicators that are included in the Monitor Compliance Framework (so that the Trust's governance and financial risk ratings can be reported) and secondly those indicators that are either National requirements or those that were locally defined and agreed.

5.1. Monitor Compliance Dashboard

Governance Risk

The Trust's governance risk score is presented in Appendix B. As can be seen, for month 5, the Trust's risk score is zero (green)

Finance Risk

The Trust's finance risk score for month 4 is also presented in Appendix B and as can be seen, the Trust is compliant with all five measures (green). This risk score is separate to Theme 7 within IQ, which is discussed below.

5.2. National and locally defined Key Quality Indicators

The full list of indicators in this category is included in Appendix C below and as at M5; all but three are on or above target. The details of those 'below target', are as follows:

5.2.1. Care clusters: timeliness of review (Red)

High level analysis has been completed to understand the extent to which national cluster review periods (e.g. service users on cluster 19 need to be reviewed every six months) jar with clinical need for review – where in 2012-13 the Trust agreed with Commissioners to use different maximum review periods in some cases. The analysis suggests that c50% of 'breaches' fall into this category (mainly in the 'dementia' clusters, 18 and 19) and as such service users are being reviewed appropriately, but this results in a less timely review of their cluster than recommended by the DH. This will need to be explored with Commissioners to consider how this is best approached.

That said, there remain a large number of service users in other clusters where the cluster has effectively expired, notably clusters 4, 7, 11 and 12.

5.2.2. Discharge protocols: GPs and Carers to receive a discharge summary (Amber)

Overall the Trust's performance has dropped since M4 and now shows 96% (target is 98%). On investigation, a number of primary care liaison teams had stopped completing and uploading their discharge summaries, as they thought they had been excluded from this indicator and this resulted in the dip in performance in a number of key areas (e.g. B&NES). The Clinical Director for B&NES has confirmed the appropriateness of PCLS continuing to be included in this indicator, and the value / assurance in doing so (and has sought to achieve a consensus with the other CDs). This being the case, and following clear instruction in each area, it is expected that this indicator will be back on track by the M7 report – given that performance is based on a three month rolling cohort.

5.2.3. Four hour wait for crisis assessment

This indicator is showing as Amber at M5, the third month in a row where performance was below the 98% target. As with M4, the under-performance relates to small numbers of referrals (c11) with Swindon representing the majority of this number.

The Swindon management team have investigated the situation and confirmed that a number of factors are impacting on reported performance; these are detailed below with associated actions:

Record Keeping: new members of the intensive service not up to speed with RiO requirements, coupled with existing staff showing less diligence in their record keeping than is required. Community Service Manager, Team Leader and Senior Practitioner have met with the team to emphasise the importance of maintaining a high quality record, agreed basic standards and emailed confirmation to staff following the meeting (supported by visual reminders around the office). This will be reinforced one to one with each member of staff via monthly supervision.

In addition, the administrator within the team will also liaise with the Community Services Manager regarding potential breaches and actions planned to prevent them.

Clarity in assigning priority: as noted last month as a general issue across the organisation, Swindon confirmed that there's a lack of clarity in how the priority (i.e. emergency, urgent) should be assigned to a crisis referral. Community Service Manager and HoPP to meet with the Intensive Consultant Nurse, to consider developing a Trust-wide audit to increase awareness, understanding and develop a standardised approach (including input from the Academy if required).

6. Supervision & Appraisal (Employee Strategy & Engagement Committee)

6.1. Supervision

The Trust's overall percentage is up slightly compared to M4, to 48.6%. Importantly however, in frontline clinical services, there are clear signs of improvement in a number of areas. A rough calculation suggests that the percentage of frontline staff (clinical and admin within each LDU) to have received supervision during August was closer to 66%, with North Somerset showing 'on target' performance at 86.5%. B&NES and South Gloucestershire are not far behind with 78% and 75% respectively, and Swindon and Wiltshire both showing an increase of c15% between July and August.

Performance in Specialised LDU varies significantly between the different services, with very good performance in some areas (e.g. Eating Disorders, WADS, N Somerset IAPT) and lower performance in other areas, notably Medium and Low Secure where ongoing staffing issues were expected to result in the lower rates of supervision seen in August. The Board will be aware that processes are in place to address both cultural and performance issues identified in secure services and these are being managed closely.

Overall, lower performance in Bristol, Specialised and 'corporate' services, serves to counter balance the good / improving performance in many areas and therefore it is important to recognise that progress is clearly being made in many parts of the Trust.

6.2 Appraisal

Appraisal rates are showing as 67% at Trust level; which falls below the Trust's 85% required standard. However, as noted above for supervision, the picture within many parts of the clinical frontline is good. A rough average suggests that M5 LDU appraisal rates stood at 75%, with North Somerset and South Gloucestershire both at 86% (green). In fact, the B&NES, Bristol and Swindon are all showing amber with 71%, 77% and 82% respectively, leaving Specialised and Wiltshire with the lowest scores (65% and 61%).

All services will now be asked to create detailed plans (including trajectories) to achieve 85% for both supervision and appraisal by December 2013. This is alongside the changes agreed by the IQ project team to modify the capture of supervision on to the system.

7. Sickness / Absence (Employee Strategy & Engagement Committee)

The Trust level sickness / absence rate rose for the second month in a row, to 5% (July figure).

8. Finance (Finance & Planning Committee)

8.1. This indicator within IQ shows the budget variance; and results in ratings**:**

- Green are considered to have favourable variance
- Amber have a small adverse variance (e.g. less than the larger of 5% or £500, but less than £5000)
- Red have a large adverse variance (e.g. greater than the larger of 5% or £500, but more than £5000)

8.2. The 'year to date' positions for July 2013 show the Trust as red against the above parameters.

Appendix A & B (Trust Scorecard & Monitor Compliance Dashboard):

See separate documents

Appendix C - Indicators not included in the Monitor Compliance Framework:

Area	Name
Access	4hr wait for crisis services
Access	Referral to assessment
Access	Referral to treatment
Access	Criminal Justice Liaison Team: waiting time for assessment
Effective	% service users in employment
Effective	% service users in settled accommodation
Personalised	Discharge protocols: summaries to be sent to patients and GPs
Personalised	Service users with a review (non-CPA)
Safe	Total admissions of service users under the age of 16
Users & carers	% of carers with a carer assessment within 4 weeks
Users & carers	% of carers with a carer care plan within 4 weeks of assessment
Users & carers	% of service user who have been asked if they have a carer
Care clusters	% compliance with red rules
Care clusters	% compliance with transition protocols
Care clusters	% on CPA with a crisis plan (clusters 14 and 15 only)
Care clusters	% with an ICD 10 code (clusters)
Data Quality	% with ethnicity recorded (clusters)
Data Quality	% with accommodation status recorded (clusters)
Data quality	Care clusters: completion
Data quality	Care clusters: timeliness of review
Data quality	Data quality: timeliness