Quality Report Q4 and Performance Report Month 1

COM 15/2012

Quality And Performance Committee

This report is for publication

EXECUTIVE SUMMARY

This report provides a summary of Quality Indicators at Month 12 (Quarter 4) and Performance Indicators at Month 1 and identifies management plans that are in place to address any areas of underachievement.

Performance Highlights:
- All Monitor targets were achieved as at the end of Month 1 with the exception of EIS New cases and 7 Day Follow Up.
- Community Services achieved all targets, including the newly introduced Monitor target around data completeness for Community Information Dataset (CIDS).
- There was an overall increase in performance to Q4 in the Quality Indicators
- Results just published on vaccine uptake in London from the Health Protection Agency indicate particularly positive results for Hillingdon Community Health

THE COMMITTEE IS ASKED TO

Review this report.

REGULATORY FRAMEWORK

This report highlights Key Performance Indicators against Monitor targets, CQUIN, Commissioners and Quality.

RESPONSIBLE DIRECTOR: John Vaughan and Dr Alex Lewis
DATE: May 2012
Quality Report Q4 and Performance Report Month 1

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1.0 Summary

This report covers Month 1 (April) performance against the Trust’s Key Performance Indicators, the Q4 (11-12) performance against the Trust’s Quality Indicators as well as the exceptions for the Community Services. As agreed by the Quality and Performance committee, a full Scorecard in the old style was not produced for April data to enable essential work to be undertaken to report by Service Line. The report highlights all instances where a target has been achieved or underachieved with a trend analysis between the position at end of April and the previous 2 months and a snapshot Quarter position for the Quality Indicators. The April Trustwide dashboard can be seen on p9 and the Q4 Quality Dashboard can be seen on pp 10-11.

1.1 Monitor Targets

With the exception of CPA 7 Day Follow up and EIS New Cases, the other 10 Monitor Targets were achieved.

- CPA 7 Day Follow-Up: (93.5% against target of 95%) 3 areas of the Trust did not achieve this target; further detail can be found on p4.
- EIS New Cases: (58.8% against target of 95%). 2 areas of the Trust did not achieve this; further detail can be found on p5.

The latest publication of the Mental Health Minimum Dataset (MHMDS) benchmarking information reports that CNWL is 2nd in London on (5th in the country) in recording ethnicity and the 3rd lowest in London behind South West London and North East London for the AWOL of patients on section. The full benchmarking report can be found on Trustnet under the Performance and Information section.

1.2 PCT Targets

Due to the pause in full reports we do not have a month 1 position for these indicators.

1.3 Community Services

Community Services achieved all targets, including the newly introduced Monitor target around data completeness for Community Information Dataset (CIDS).

In Camden Provider Services (CPS) CQUIN targets have not yet been fully agreed for 12/13 and therefore there is nothing to report at present.

In Hillingdon Community Health (HCH) eight CQUIN targets have been set for 2012-13. All targets will have an associated action plan which will be agreed by Executive Committee and a Senior Manager lead.

1.4 Quality Targets

It is pleasing to report that there has been an increase in performance overall to Q4, with indicators achieving the best results for the year in this quarter. However, the Q4 position shows that the Trust were not meeting 5/12 of the Quality Priority indicators and there is some room for improvement in Clinical Safety, Clinical Effectiveness as well as Patient Experience. Further detail and analysis can be found on pp 6-8.

1.5 CQUINs

The final position on CQUINs has not been signed off by commissioners at report submission (23.5.12). This is due to take place on 28th May when the final results will be presented. CQUINs have been agreed for 2012-13. Each has a clinical lead and investment by the Trust and a CQUIN Project Manager will facilitate a monitoring and improvement programme this year. There are some significant achievements as well as some areas for improvement and these are discussed further on p8.

1.6 Vaccine uptake in London

Results just published on vaccine uptake in London from the Health Protection Agency indicate particularly positive results for Hillingdon Community Health. They are in the top cohort, having achieved WHO-recommended 95% coverage for children at 12 and 24 months. At 12 months they achieved this for DTaP/Hib/PV, PCV and MenC. At 24 months this was for DTaP/Hib/PV.
2.0 Directorate Performance (Prev 3 Months)

2.1 7 Day Follow up
Target 95% (Performance 93.5%)

Three areas did not achieve this target:
- **Harrow (85.71%)** This was due to late data entry and will be rectified.
- **Hillingdon (92.3%)** This was also due to late data entry and will be rectified.
- **Westminster (77.8%)** This is due to inaccurate recording of CPA levels. Teams are reminded to check CPA levels for accuracy and ensure these are updated as appropriate.

On re-running the report as at 21st May the position improved by 0.5%. Further investigation will be carried out by the Information Team to ascertain whether the above action plans have been implemented prior to Month 2.

2.2 CPA Reviews
Target 95% (Performance 95.4%)

Trustwide this target was achieved, however 7 areas underachieved:
- **Older Adults, Brent (91.6%), Harrow (94.8%), K&C (91.7%) and Westminster (88.2%)** are reviewing their processes to ensure compliance going forward.
- **Westminster Adults (94.8%)** have identified the individuals with the most number of CPA Review breaches and this is being discussed in supervision to identify any training and support requirements.
- **ED (83.8%)** - This relates to 6 breaches, which have resulted due to a lack of clarity around processes and communication. Staff have been reminded about the appropriate use of CPA levels and the processes that surround this pathway.
- **LD (82.4%)** are reviewing their processes to assess the impact of the JADE changes which were implemented to enable LD in recording CPA Reviews in support of their care pathways.
2.3 CRT Gate Keeping
Target 90% (Performance 90.8%)

This target was achieved in all but one area.

**Hillingdon Adults (58.3%)** Performance in this indicator has fallen since the change from a 24-hour Home Treatment Team that provided gate keeping to a separate A&E liaison service and Home Treatment Team Service. The Matrons are working on locating evidence of the 5 breaches having been gate kept during April in an effort to back date entries prior to quarter end if evidence is found. Systems have been reviewed and results for May 2012 are currently 100%.

2.4 EIS New Cases
Target 95% (Performance 58.8%)

This target was not achieved in 2/5 Boroughs.

**Brent EIS team** did not have any new cases in April despite their target of 5. Brent over-performed in the previous month, which may subsequently have impacted this month's performance. However, the EIS team are working hard to ensure that the target is achieved by the end of Q1.

**Westminster EIS team** also did not have any new cases, despite their target of 3. The teams have requested detailed business rules to ensure that cases are allocated and recorded appropriately going forward. Next month's data should show improvement.

*The Information Team are monitoring the situation closely and working with the Service Line Director and Business Manager to address the situation.*
3.0 Quality Performance Indicators

3.1 Summary
The Quality dashboard includes 34 indicators, structured as follows:
- Section 1: Quality Priorities (12 indicators)
- Section 2: Clinical Safety (14 indicators)
- Section 3: Clinical Effectiveness (3 indicators)
- Section 4: Service User Experience (5 indicators)

The chart shows a comparison of the performance across all 34 indicators for Q1-Q4. There has been an increase in performance overall to Q4, with indicators achieving the best results for the year in this quarter.

3.2 Quality Priorities Measures for 2011/12
The Quality priorities are a sub-set of all the quality measures and are agreed in consultation with service users and stakeholders.

The chart indicates the RAG ratings of the Quality Priorities over the four quarters of 2011/12. 5/12 Quality Priorities were not met in Q4:

a) Patients report that they have received a crisis card (IP and community): 53% (Target: 85%) (CQUIN). Over 30,000 crisis cards have been sent out in Q3 so it is expected that this measure will improve over coming quarters.

b) Patients report that they ‘definitely’ received an informed response from the crisis line: 44% (Target: 65%). Implementing the new Out of Hours Project: this aims to provide a consistent, reliable and clinically safe response to urgent situations for service users and carers regardless of the time of day. This will have one telephone number for service users, carers and GPs.

c) Community patients report that they ‘definitely’ were involved as much as they wanted to be in decisions about their care: 41% (Target: 65%). The new Care and Support Plan has been rolled out since November, and is expected to facilitate and encourage improvements in both c and d above, as well as the drives by the Recovery College.

d) Community patients report that they had been given a copy of their care plan: 51% (Target: 80%) (CQUIN). Local actions are being implemented by Business Managers to ensure that inpatients have a physical health assessment after admission and to ensure that inpatients are offered a copy of their care plan.

e) Inpatients report getting enough care for their physical health: 59% (Target: 65%). This is being referred to the Physical Healthcare Steering Group for action.
3.3 Clinical Safety Measures

Overall there was an increase in performance to Q4 for clinical safety indicators. The areas where improvement is required are:

a) Community risk assessment completed and linked to care plans: 90% (Target: 95%). The position has improved over the four quarters for this indicator, and work is continuing via service lines to strengthen this area.

b) Incidents of violence between patients (ALL and level 3 upwards): Increase on last quarter (Target: QtQR)

c) Incidents of violence by patients on staff (ALL and level 3 upwards): Increase on last quarter (Target: QtQR)

Incident reporting overall has increased as CNWL remains a low reporter of incidents compared to our peers as reported by the NPSA. However, we are reporting an increase in severity (although low numbers) compared to previous Qs. Reducing levels of violence in our inpatient settings is the subject of a programme being undertaken by the health and safety team under the leadership of the Board. The Board have set a target of a 25% reduction over a four year period. The number of incidents of violence on staff (level 3 upwards) remains similar to the end of year position for 10-11.

3.4 Clinical Effectiveness Measures

Recording of inpatients having a nursing physical health care assessment after admission increased from Q3, achieving achieved 96% (Target: 95%).

Area for improvement:

a) Inpatients receive a medical physical health care assessment after admission: 80% (Target: 95%). The medical director is writing to all consultants highlighting the need for medical staff to undertake physical health assessments post each admission as per policy.
3.5 Service User Experience Measures

This has been varied across the four quarters, however shows an increase in performance from Q3, reflecting performance in Q2.

Areas for Improvement:

a) We record inpatients have been offered a copy of their CPA care plan: 86% (Target: 95%)
b) We record community patients have been offered a copy of their CPA care plan: 89% (Target: 95%)
c) Service users report that they ‘definitely’ understand what is in their care plan: 48% (Target: 75%)

d) Number of complaints which have been upheld/partially upheld: Increase on last quarter (Target: QtQR)

The organizational learning group is reviewing the complaints that are being upheld.

3.6 CQUINs

There have been significant achievements in key areas:

- Physical healthcare including collecting data on physical healthcare and medication
- Care plans written with patients
- Patients saying that they understood their care plan
- Paired HoNOS - that is HoNOS which is recorded more than once, to indicate recovery
- Carers – including a 67% satisfaction rate, and 98% of carers audited were found to have been offered an assessment.
- Response in a crisis – while we did not hit our 85% target for patients saying they had a crisis cards, we saw a dramatic increase in those who responded positively, averaging at 68% with a lift of 16% between Q3 and Q4.

The outcome was disappointing in relation to patient reported measures of care, as reflected in the Quality Priorities above. In particular, we saw a drop in Q4, together with a low response rate. There are a number of issues here including survey fatigue and small cohorts. It is hard to see where these issues impact on the results, and where it is a real issue of quality. There is discussion underway with Dr John Green to improve how data is gathered from patients and carers, both for the Quality Priorities and CQUINs, so that we can truly discover where to improve and what is needed.

3.7 Next Steps

The Quality and Information Teams are currently working to create Trustwide and Service Line scorecards, which will merge and incorporate the Quality and performance indicators and streamline the exception and action plan process. It is envisaged that this will be in place from Q2 onwards.

It should be noted that going forward next year, the “amber” category will be within 10% of the set target. In the Quality Account however, we will report indicators as either met or not met.
### Trustwide Balance Scorecard
**2012/13**

**Apr-12**

<table>
<thead>
<tr>
<th>Strategic Areas</th>
<th>Key Performance Indicator</th>
<th>Targets</th>
<th>YTD Position</th>
<th>Apr-12</th>
<th>Change</th>
<th>Mar-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor Targets</td>
<td>7 Day Follow-Up (CPA Only)</td>
<td>&gt;= 95.0%</td>
<td>93.5%</td>
<td>93.5%</td>
<td>▼ 94.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CPA Reviews within 12 months</td>
<td>&gt;= 95.0%</td>
<td>95.4%</td>
<td>95.4%</td>
<td>▼ 95.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delayed Transfers of Care (Exclude social care - Cumulative Position)</td>
<td>&lt;= 7.8%</td>
<td>5.3%</td>
<td>5.3%</td>
<td>▼ 3.10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gate Keeping by Crisis Resolution Teams</td>
<td>&gt;= 90.0%</td>
<td>90.8%</td>
<td>90.8%</td>
<td>▼ 95.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meeting Commitment to serve New Psychosis Cases by Early Intervention Teams (% Of Commissioners target met)</td>
<td>&gt;= 95.0%</td>
<td>58.8%</td>
<td>58.3%</td>
<td>▼ 100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data Completeness: Identifier</td>
<td>&gt;= 97.0%</td>
<td>99.2%</td>
<td>99.2%</td>
<td>▲ 99.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Data completeness: Outcomes (CPA only=Employment, Accommodation, HoNOS in 12 months &amp; Diagnosis)</td>
<td>&gt;= 50.0%</td>
<td>88.6%</td>
<td>88.6%</td>
<td>▼ 97.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to Healthcare for People with a Learning Disability</td>
<td>&gt;= 100%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>△ 100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referral to Treatment Waiting Times - non-admitted (HCH &amp; CPS)</td>
<td>&gt;= 95.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>△ 100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients waiting less than 18 weeks from point of referral to treatment - incomplete pathway (%)</td>
<td>&gt;= 50.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>▲ 95.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Treatment Activity - Referral to treatment</td>
<td>&gt;= 50.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>△ 100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Treatment Activity - Referral Information</td>
<td>&gt;= 50.0%</td>
<td>98.0%</td>
<td>98.3%</td>
<td>△ 98.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Treatment Activity - Activity Information</td>
<td>&gt;= 50.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>△ 100.0%</td>
<td></td>
</tr>
<tr>
<td>Other Priority Areas</td>
<td>Emergency Readmissions</td>
<td>&lt;= 11.0%</td>
<td>3.1%</td>
<td>3.1%</td>
<td>▲ 2.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PbR Clustering</td>
<td>= 100.0%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>▲ 96.2%</td>
<td></td>
</tr>
</tbody>
</table>
## CNWL Quality Dashboard 2011/2012 for Mental Health and Allied Specialties

### Quarter 4 March 2012

#### Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Borough/Adult Service</th>
<th>Older Adult</th>
<th>Others</th>
<th>YEAR TO DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Quality Priorities 2011/2012</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Patients that reported feeling safe during their most recent inpatient stay (CRUIN)</td>
<td>GP &gt; 75%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Patients reporting that they received critical care with an emergency number and where to receive support in a crisis (CRUIN)</td>
<td>GP &gt; 65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Community patients reporting that they have a phone number to call in a crisis (out of hours) (CRUIN)</td>
<td>GP &gt; 65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Patients reporting that they DEFINITELY received informed consent (CMUIN)</td>
<td>GP &gt; 65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Patients who have had a medication reconciliation against more than one source within 72 hours of admission (CRUIN)</td>
<td>GP &gt; 75%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Inpatients who report getting enough care for their physical health</td>
<td>GP &gt; 65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Community patients reporting that they were DEFINITELY involved as much as they wanted to be in decisions about their care</td>
<td>GP &gt; 65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Community patients reporting that they were given (or offered) a written or printed copy of their care plan (CRUIN)</td>
<td>GP &gt; 65%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Percentage of patients that have a carer identified (CRUIN)</td>
<td>GP &gt; 55%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Percentage of cases recorded as having been offered a care review report (CRUIN)</td>
<td>GP &gt; 40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Percentage of cases that report feeling involved in crisis care planning for the person they care for (baseline Feb)</td>
<td>GP &gt; 67%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Other indicators of quality

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Borough/Adult Services</th>
<th>Older Adult</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed days</td>
<td>55 45 40 30 15 10 24</td>
<td>15 10 5 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>2.1 Cases of MRSA in the Trust (MRSA infection)</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>2.2 Cases of MRSA in the Trust (MRSA bacteraemia)</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>2.3 Deaths of Clostridium difficile in the Trust</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>2.4 Patients on CPA who have an extended stay</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>2.5 Extended stay assessments completed and linked to care plan</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>2.6 Community care assessments completed and linked to care plan</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>2.7 Number of hospital sex surgery deaths reported</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>3. Clinical effectiveness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1a Incidence of sepsis in patients with physical health assessment after admission (matched)</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>3.1b Incidence of sepsis in patients with physical health assessment after admission (unmatched)</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>3.1c Incidence of sepsis in patients with physical health assessment after admission (by other methods)</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>4. Service user experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 We record hospital heard as part of their care plans</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>4.2 We record Community/Patient offered a copy of their CPA care plans</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>4.3 Service users on CPA who state that they definitely understand what is in their care plan (Sure)</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>4.4 No. of active patient surveys distributed (cumulative figure from the year)</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
<tr>
<td>4.5 No. of active patient surveys distributed (cumulative figure for the year)</td>
<td>12 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
<td>0 0 0 0 0 0</td>
</tr>
</tbody>
</table>