County Durham and Darlington NHS
NHS Foundation Trust

Quality Accounts
1 April 2011 – 31 March 2012

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with you all the way

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PART 1

Statement on Quality from Chief Executive – To insert once comments received from Stakeholders

A statement signed by the chief executive summarising the NHS Foundation trust's view of the quality of the NHS services that it provided or sub-contracted during 2011/12. The statement must outline that to the best of that person's knowledge the information in the document is accurate

A Guide to the Structure of this Report

The report summarises our performance against the quality priorities we identified in the 2010/11 Quality Account to cover the 2011/12 period. It also outlines those we have agreed for 2012/13

As reported in the Quality Account last year, this is the first report since the merger between hospital and community services. The report outlines our progress in 2011/12 on the 14 objectives that were identified in the former acute and community setting. The report is separated into the three sections of Patient Safety, Effectiveness and Experience.

The report will also outline our priorities for 2012/13 under the same categories. We have detailed the rationale for inclusion of these and how we will measure performance against these. In addition, the regulated statements of assurance are also included in this part of the report.

In the final part of the report we will include detail of newly mandated key national priorities for 2012/13. This section will also detail involvement with our patients during the year, initiatives that have been implemented and statements from Commissioning Primary Care Trusts, Overview and Scrutiny Committees, and Local Involvement Networks that show their response to this Quality Account.

PART 2 Priorities for Improvement and Statements of Assurance from the Board

Quality Improvement Priorities for 2011/12

The section below summarises the specific priorities and objectives we set for Safety, Patient Experience and Clinical Effectiveness in 2011/12.

Priority	Rationale for choice	Measure
SAFETY		
Patient Falls	National QIPP priority High levels of falls reported in the hospitals NPSA monitoring falls resulting in fracture	Reduction in falls per patient bed day Reduction in falls resulting in injury
Safeguarding Training	Identified in serious case review and compliance assessment of the standards	Numbers of staff trained in accordance with the training strategy
Discharge Communication	Concerns of OSC and GP consortia Poor quality of discharge information identified through audit Patient complaints	Reduction in complaints and incidents regarding discharge Higher levels of patient satisfaction

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	regarding lack of information	
HCAI	Maintenance of current improvement Board and national priority	Achieve reduction in line with target
EXPERIENCE		
Nutrition and Hydration in Hospital	Features in complaints National attention High level of support by OSCs	%Completion of nutritional assessment %Completed food charts %Completed fluid balance charts
Complaints about the Attitude of Staff	Feature of complaints	Reduction in complaints related to staff attitude
Boarding of Patients on other Wards	CQC assessment critical of boarding policy Board debate and concern	Cessation of boarding patients outside of normal working hours IR1s completed and monitored for breaches of the policy
EFFECTIVENESS		
Mortality of Specific Conditions	Performance in Dr. Foster Review. Strategic objective to reduce avoidable injury or death	Maintain mortality at or below SMR of 100
Compliance with NICE Recommendations	Essential compliance for registration	Audit evidence of compliance
Medications Management	Concerns of OSC. Audit evidence from pharmacy details high level of error	Audit of omitted medication. Audit of discharge medication
Compliance with Sentinel Audit Standards for Stroke	National priority. Local priority following stroke discussion	Audit of stroke pathway and monthly returns

Community Priorities

Prior to merging with the Foundation Trust the community services identified their priorities. These are similar to the priorities of the acute hospitals and are:

1. Reducing falls in community hospitals
2. Reduction in the numbers of pressure sores
3. Focus on under-nutrition of patients in community hospitals

PATIENT SAFETY

Priority 1 – Patient Falls

The section below summarises the targets we set ourselves in relation to patient falls, what we did throughout the year to achieve reduction and the improvements we plan to make for 2012/13.

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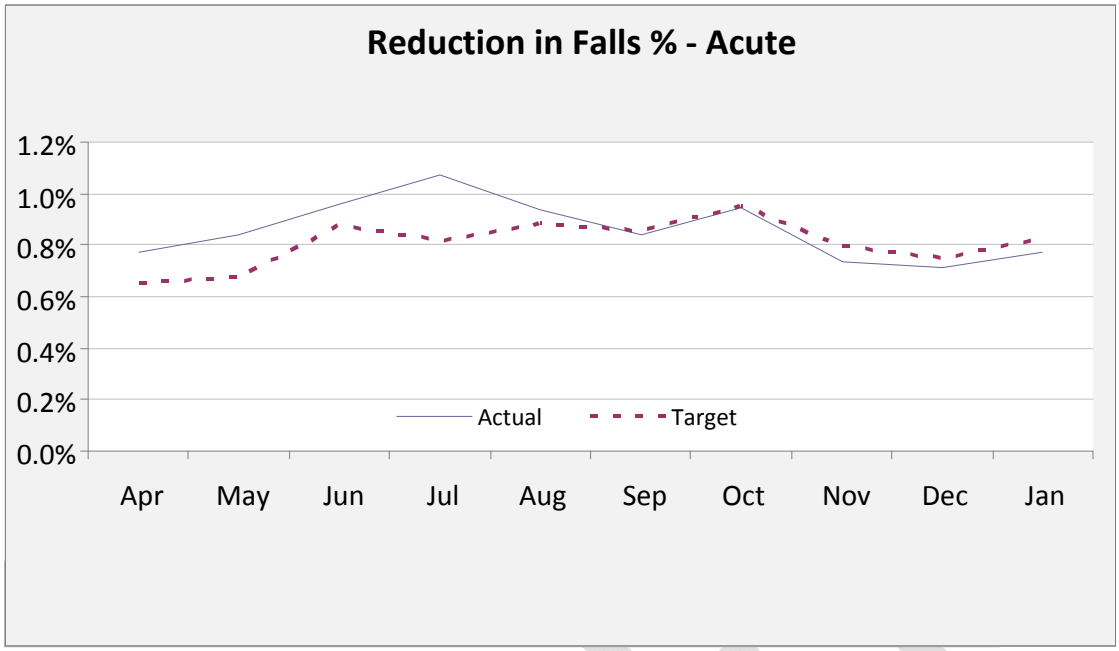

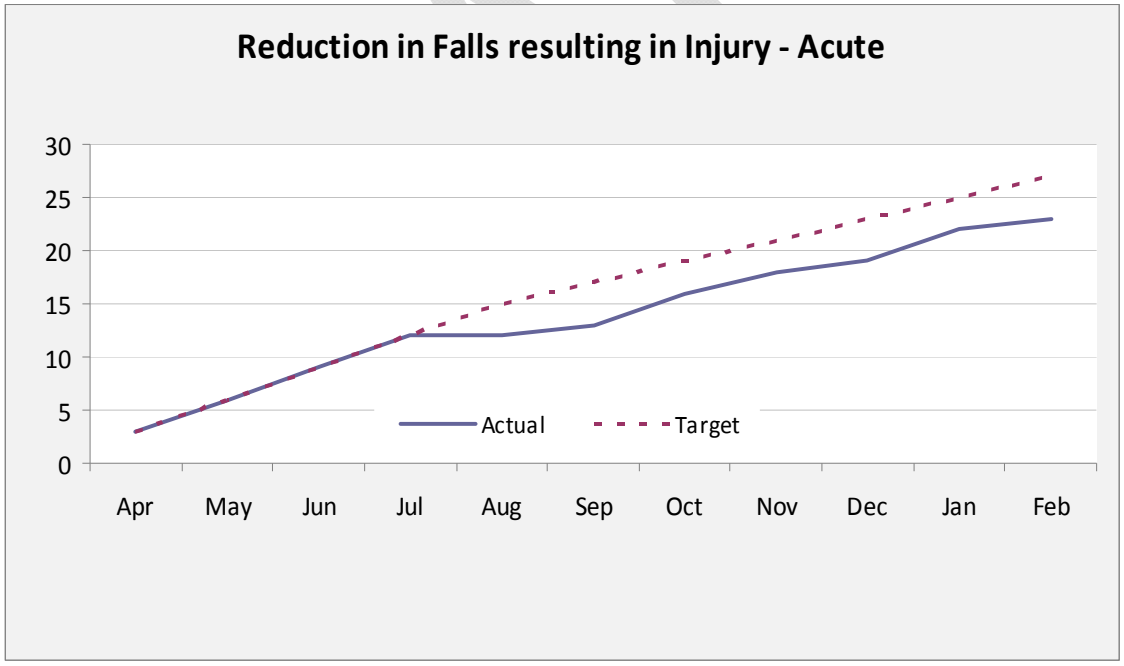

Falls within Acute Hospital Setting

During 2010/11 there were a high number of falls experienced by our patients within the inpatient setting. When we compared ourselves nationally and against patient bed days we were at a higher level than the national average for falls.

Our Quality Challenge

We needed to build on previous improvement projects and spread standardised and evidenced best practice across the integrated organisation. This was done using Rapid Spread Solution technique. This technique is an evidence based improvement programme that is used when key measures that are required to bring about improvement have already been identified. We set out to reduce in patient falls by 10% from November 2011 to March 2012. We set out to reduce in patient falls resulting in harm (measure by fractured neck of femur) by 10% in the same time period.

How Did We Do It?

- A project team resource was identified and approved by the Board.
- All evidenced falls prevention interventions were collated and a care bundle was introduced based on the Royal College of Physicians "FallSafe Care Bundle". A falls prevention bundle compliance tool has been developed and communicated out to staff.
- A launch event took place to introduce the newly formatted care bundles so that all staff are working to the same criteria for falls prevention.
- We identified the areas known to be high risk and these were targeted for enhanced intervention in the initial stages of the programme. This included an education programme at service delivery level and included assistance from the falls co-ordinator, physiotherapy, mental health liaison team and moving and handling team.
- Training was provided to our staff on prevention of falls and post fall care management and regular audits of falls care bundle compliance introduced.
- The falls reduction work will continue next year as we move towards sustainability of the actions that were implemented from the targeted focus of last year. We wish to see a continued reduction in falls and those resulting in injury so will continue to report monthly the position, using the incident monitoring system.
- The coming year will also build on work commenced this year in the following areas:
  - Falls data and compliance dashboard to be available on a dedicated falls intranet page.
  - Compliance data to be input directly from ward base.
  - Continue with the falls steering group to maintain, monitor and progress improvement.
  - Build on intentional rounding work which has been introduced to ensure that patients are formally reviewed for any care needs at agreed intervals.
  - Roll out the work to Emergency Departments.
  - Falls conference to review and share lessons learnt.

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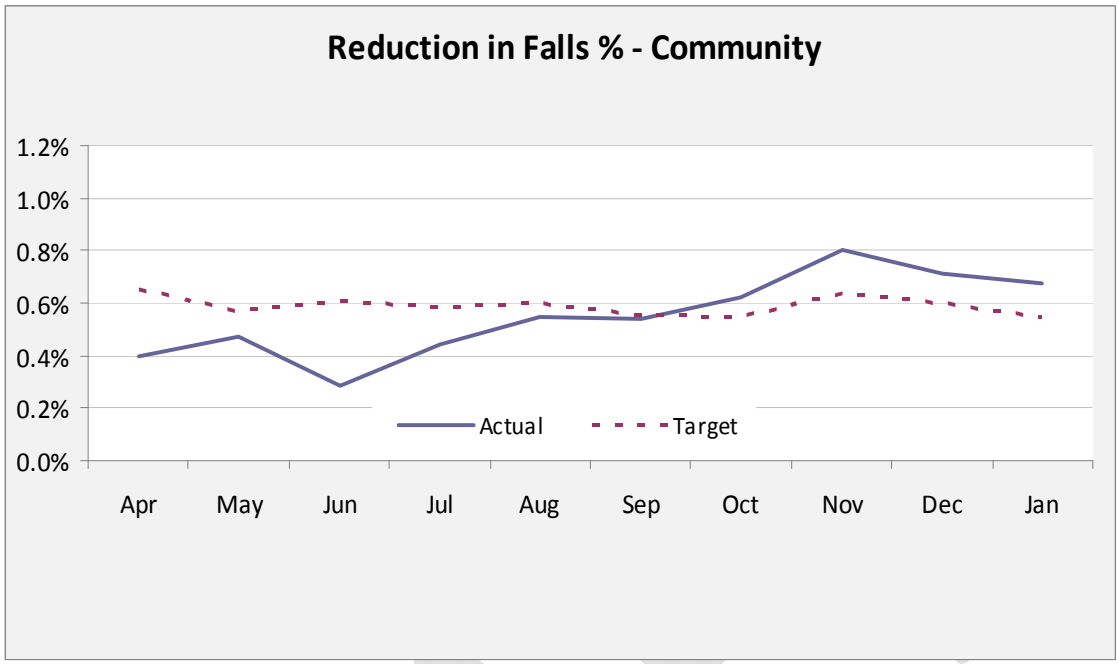
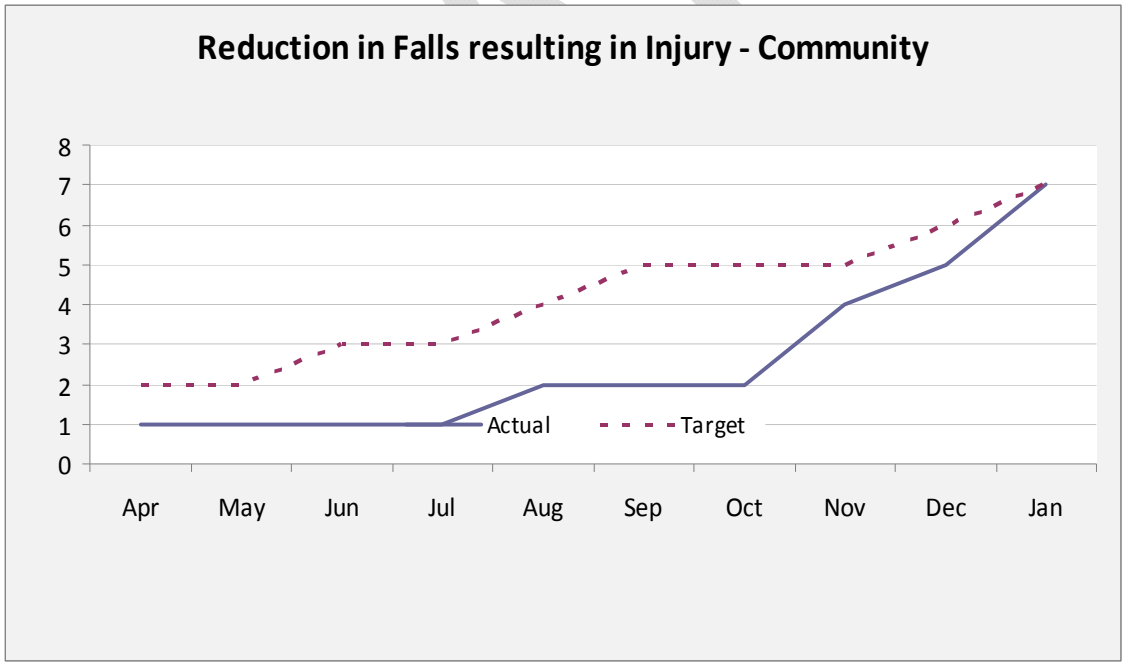
Falls within Community Hospitals





Analysis of reported incidents has provided an indication that the proposed target reduction may be difficult to achieve despite significant effort on behalf of the Community Hospital staff and wider support mechanisms. This is largely attributed to the changing profile of the patients, with all community hospitals anecdotally reporting an increase in the number of EMI patients they now care for.

However this remains very high profile and close monitoring and intervention will continue.

Interventions undertaken across all Community Hospitals during the year

- All hospitals are now part of the Falls Care Bundle programme initiated by the trust and disseminated via Rapid Spread Solutions
- Staff have been trained in the use of the Falls Care Bundle.
- Staff are contributing to the continued refinement of falls classification
- All falls are reported on the Safeguarding System even those with no harm
- To provide evidence of the shifting patient profile all hospitals have commenced recording the number of admissions who have existing or have developed Mental Health Problems.

In addition each of the hospitals has identified their unique requirements and undertaken a range of activities. These are inclusive of:

- The installation of dimmer lighting in all patient rooms.
- Joint project with the Medical Physics Team at JCUH to make a prototype patient call bell, which will have small LED lights.
- A Falls Prevention day service is now available 2 days per week within the hospital.
- Purchase of ultra low beds with crash mats.
- Floor and chair alarms.
- A baby alarm that can be used for those who can't use nurse call bell.
- A hand bell to be used in patients areas where bell cord does not reach i.e. sitting room.
- Standard patient chairs have adjustable height.
- Electric and manual armchairs.
- Bariatric Chairs.
- Neurological armchairs.
- Purchase of slippers for patients who do not have suitable footwear.
- Orthotic shoes obtained for those who have very swollen feet or have bandages.
- Rooms and toilet areas are clearly signed.
- Coloured toilet seats have been purchased for patient areas.
- All staff have completed Dementia Awareness training.

Priority 2 - Safeguarding Training

During 2010/11 the Trust has increased the number of staff trained in both Safeguarding Children and Safeguarding Adults. We have a Safeguarding Children training strategy action plan detailing how we train staff to the appropriate level in line with the training strategy which was launched in November 2011. From April 2012 both level 1 Safeguarding Children and level 1 Safeguarding Adults training will be part of essential training for all staff. Training uptake will continue to be monitored throughout 2012/13

Priority 3 - Discharge Communication

Post Discharge Survey

Post discharge surveys are carried out quarterly, analysed and reported to Senior Managers at the Quality & Healthcare Governance Committee.

CQUIN indicator questions are included. Results are compared to the National Inpatient Survey scores. This allows Care Groups to identify emerging themes and areas where improvements are required. Thematic action plans have been developed and are monitored and reviewed.

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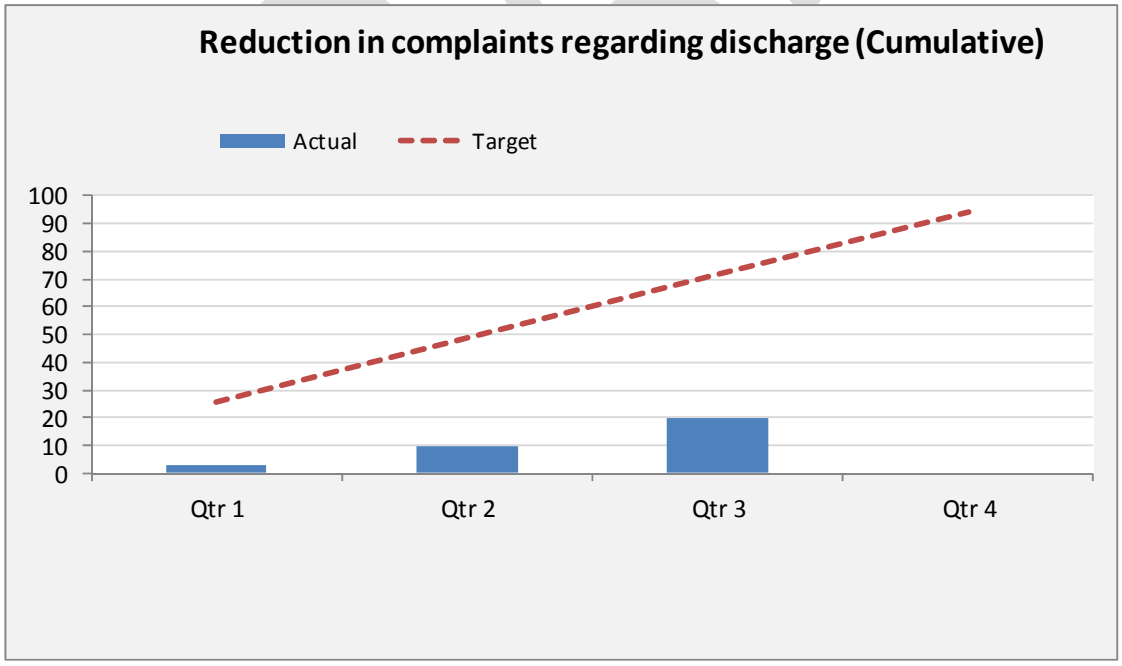
Patient Experience Indicator Questions	National Survey 2010/11	Q1 2011	Q2 2011	Q3 2011	Q4 2011
Did you feel involved enough in decisions about your care and treatment?	74%	78%	85%	72%	76%
Were you given enough privacy when discussing your condition or treatment?	78%	87%	84%	88%	84%
Did you find a member of staff to discuss any worries or fears that you had?	83%	84%	84%	80%	84%
Did a member of staff tell you about any medication side effects that you should watch out for after you got home in a way that you could understand?	63%	63%	76%	75%	69%
Did hospital staff tell you who you should contact if you were worried about your condition or treatment after you left hospital?	73%	78%	88%	79%	78%

It is evident from the above table that CDDFT scores higher on all 5 patient experience indicator questions and consistently scores higher for:

- Privacy and dignity.
- Contacts following discharge.



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How Did We Do It?

A transitional care steering group has been set up within the organisation to focus on issues raised around safe discharge procedures. An area of weakness has been identified during 2011/12 with regard to timeliness of completion of electronic discharge letters.

Commissioners have requested that this is monitored for improvement throughout 2012/13 and as part of the Quality Report for the coming year improvements against actions will be closely monitored and reported on.

Priority 4 - Reducing Healthcare Associated Infections

Trajectory for 2010-2011:

- No more than 3 MRSA Bacteraemia cases attributable to the Trust.
- No more than 59 Clostridium difficile positive cases attributable to the acute trust and no more than 5 cases attributable to the community hospitals.

Outcome:

- 3 cases of MRSA bacteraemia.
- 53 cases of Clostridium difficile acute inpatient areas.
- 1 case of Clostridium difficile in community hospitals.

The Trust has made excellent progress in reducing both MRSA bacteraemia and Clostridium difficile cases.

Period	No of Bacteraemias	% Rate/10,000 bed days	Trajectory
2004/2005	**47**	**1.20**	**36**
2005/2006	**36**	**1.00**	**30**
2006/2007	**64**	**1.77**	**22**
2007/2008	**21**	**0.67**	**15**
2008/2009	**38**	**1.24**	**19**
2009/2010	**7**	**0.23**	**18**
2010/2011	**3**	**0.10**	**7**

ADD UP TO END OF MARCH DATA

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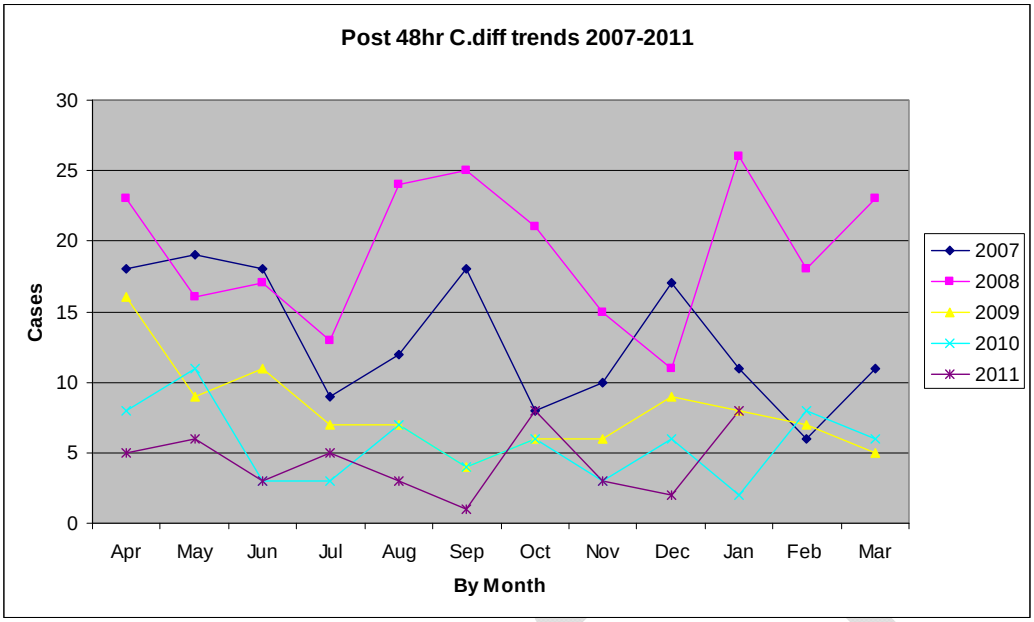

How Do We Plan to Continue to Improve Performance?

The new ambitions for 2012-2013 are even more challenging but the trust have a zero tolerance of avoidable HCAI and have planned strategies to sustain and improve on this level of reduction.

An action plan has been developed and includes areas such as environmental cleaning, Hand hygiene, Education and audit around antibiotic prescribing, and focusing on the management of patients with Clostirdium difficile

A root cause analysis is carried out on all cases of MRSA bacteraemia and Clostridium difficile attributed to the trust. Ensuring that any lessons learnt are shared at the weekly clinical escalation meeting and are cascaded throughout the organisation as Key messages

Audits of the clinical environment, Hand hygiene and clinical practice are carried out on a monthly basis by the ward matrons and Infection Control Nurses.

The Trust antimicrobial team will continue their work in developing the Antimicrobial policy and guidelines, evaluating antimicrobial use, and providing feedback to physicians. The team are responsible for optimizing antimicrobial use in the hospital by improving compliance with the guidelines, through education and constant audit of practice.

The team are looking at the use of social media and other forums to ensure messages are cascaded to the right people.
In addition the Infection control team are currently working in collaboration with the Strategic Health Authority and organisations in the region to ensure that all improvement techniques are applied consistently with regard to reduction in Clostridium difficile

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EXPERIENCE

Priority 1 - Nutrition and Hydration in Hospital

Apr	May	Jun	Cumulative	Cumulative	Cumulative	Jan	Feb	Mar	Cumulative	
98	98	98	98	97	97	99	94		96	Percentage of patients with completed nutritional assessment
Establish Baseline				98	98	98	98	98	98	
97	94	74	88	89	81	97	85		91	Percentage of patients with evidence of food intake
Establish Baseline				90	92	95	95	95	95	

Blue shaded boxes relate to compliance aimed for.
White shaded boxes show actual compliance.
#
In excess of 90% of patients received appropriate nutritional risk assessment using the MUST risk assessment tool. Performance has been less than we expected, however since a low of 92% in September of 2011 this compliance has been improving and care groups have agreed an action plan in order to ensure that all patients receive this important nursing assessment on admission to hospital.

Performance in relation to this standard for recording food intake has been variable, with performance exceeding expectation in some months and being less than expected in others. As with all actions relating to nutritional risk assessment and nutritional care, a comprehensive action plan has been developed by the care groups and corporate clinical standards team with an aim to improve performance and reach the target of 95% of high risk patients having their food intake recorded.

The trust places extreme importance on nutrition and hydration for patients within the hospital setting. During 2012/13 we will continue to closely monitor and address any issues highlighted. As in the previous year the monitoring will be via monthly audit against the ward performance framework.
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Priority 2 - Complaints about Attitude of Staff

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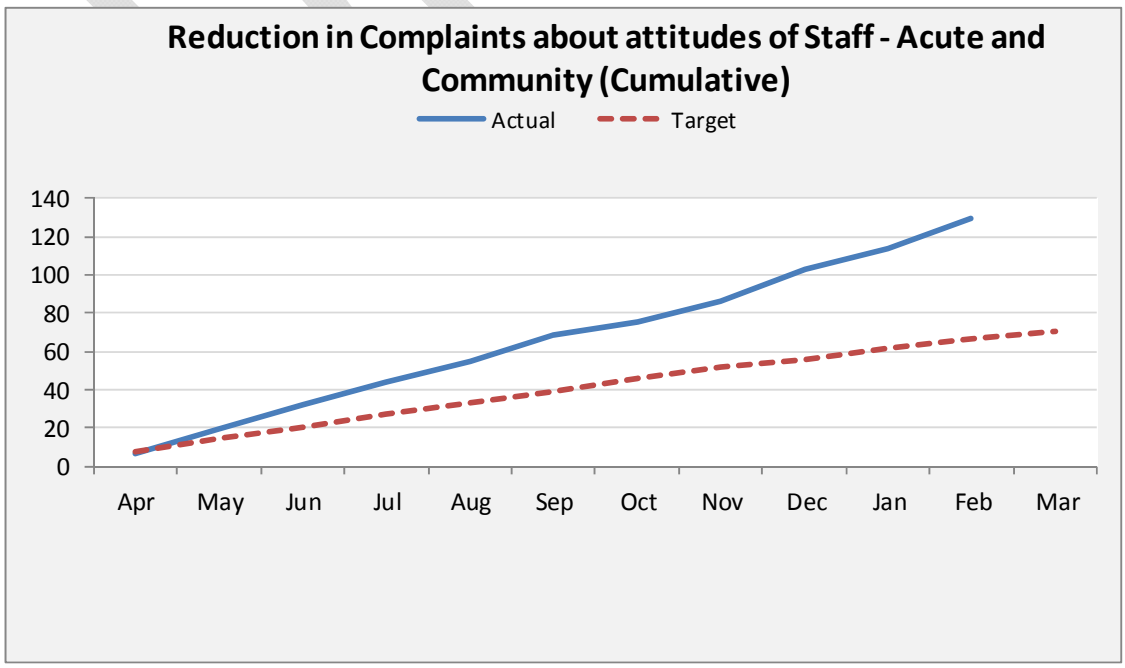

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We have continued to monitor complaints about staff attitude during 2011/12 and are very disappointed that these complaints remain above trajectory. We have undertaken detailed analysis of the complaints to ensure there are no obvious patterns or trends. The Trust is determined to address this issue and work is on-going to enhance core values and behaviours of all of our staff. This important work will continue throughout 2012/13 with patient stories being introduced to enable us to gain more understanding of how patients view the quality of care that they receive.

Priority 3 - Boarding of Patients on Other Wards

The 2010/11 Quality Account stated that we would aim to cease boarding of patients outside of normal working hours. This is a very challenging ambition due to the complexities of emergency presentations and unpredictability of patient needs in the acute environment.

As an organisation, however it is important that if boarding of patients is necessary then it is only those that are clinically appropriate who are boarded to other specialities. It was already established that patients would not be boarded unless they were clinically stable but in addition it was agreed that patients with the following conditions were not appropriate to be boarded to other specialities:

- Patients with MRSA**.**
- Patients with cellulitis or acute/chronic skin conditions.
- Patients with chest infections/pneumonia **(**if productive cough with blood stained, muco-purulent or purulent sputum, or if they are on nebuliser therapy).
- Patients who have had diarrhoea within the last 48hrs.
- Patients who have dementia and are unable to consent to the transfer.

This is reported daily to senior staff in the organisation by the bed management team who, identify and report the number of patients who are boarded after 10pm. A monthly report is submitted to Safety Committee. The data has not identified any patients boarded who fall into that category since targeted reporting commenced in July 2011.

The measurement of the number of patients boarded in general has also been very useful in a bed modelling exercise that has taken place within the trust, specifically to measure whether the correct number of beds are allocated to the correct speciality. There will be a further bed modelling exercise during 2012/13

EFFECTIVENESS

Priority 1 - Mortality of Specific Conditions

The Dr Foster report, published in November 2010 identified that the Trust had a significantly higher than expected standardised mortality ratio for Stroke. A full review of stroke mortality was carried out with assistance from CHKS and North East Quality Observatory Unit. There was nothing specific found on review and risk adjusted mortality for stroke in 2011 has reduced. Risk adjusted mortality figures are designed to give an indication that there may be a problem but are not designed to be conclusive and the most important factor is that reviews take place when any anomalies occur.

For the 2010/11 Quality Accounts it was agreed that we would continue to monitor risk adjusted mortality with the aim of maintaining overall mortality at or below 100, which is within the expected range. This has been achieved and is monitored monthly.

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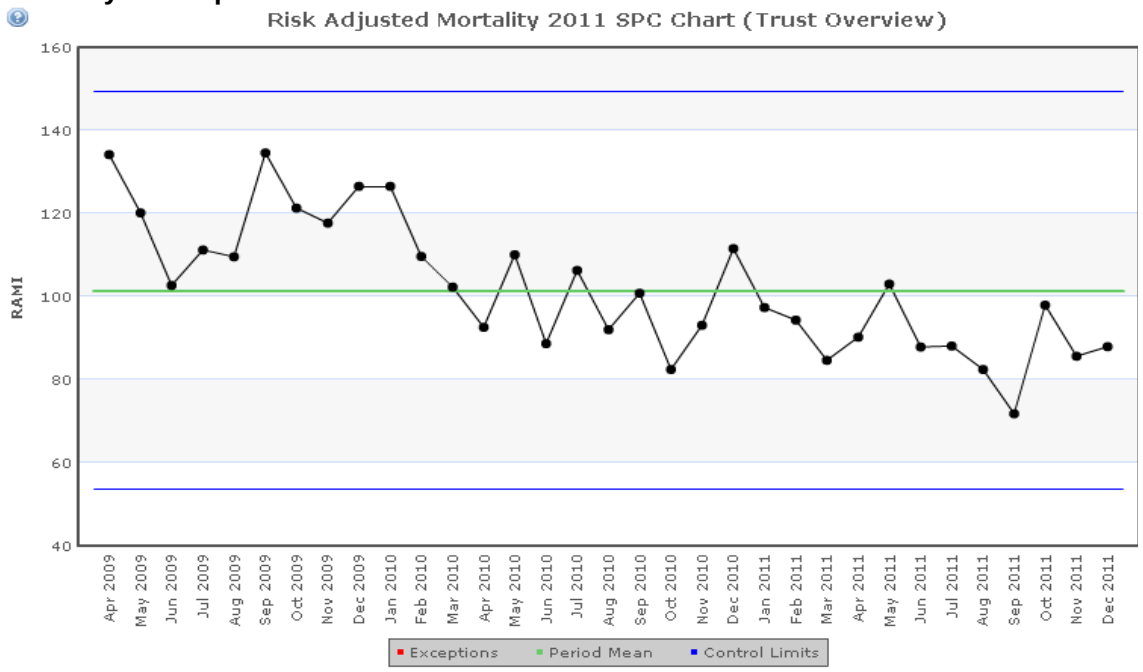
Mortality Data April 2009 – December 2011

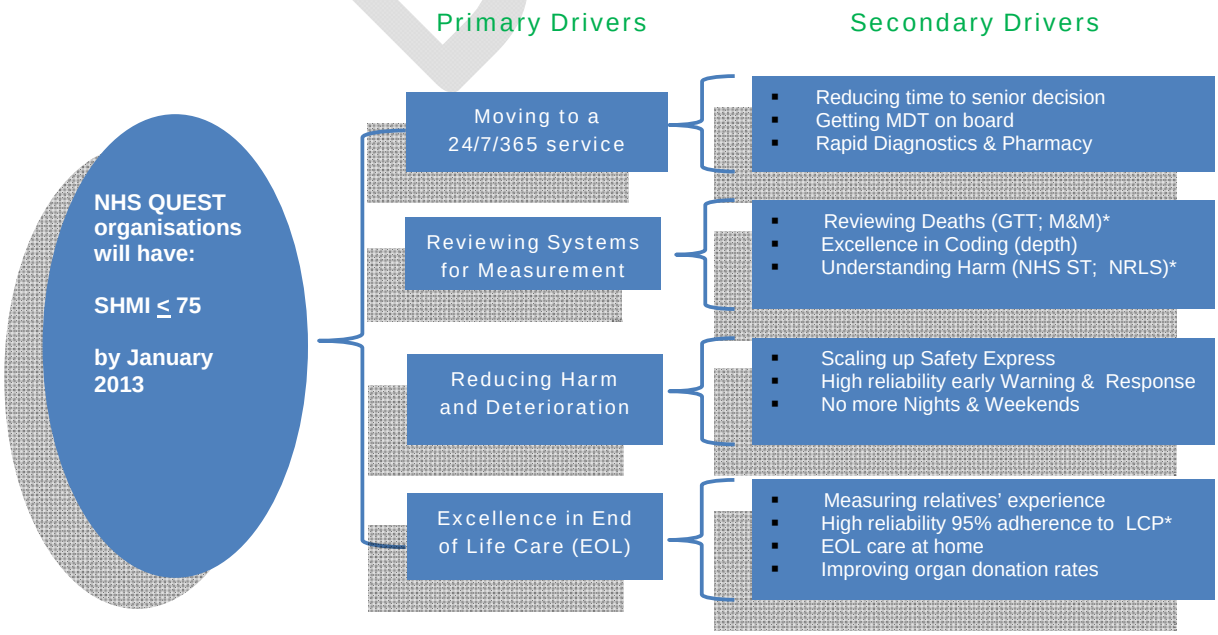


Throughout the 2012/13 period mortality will continue to be reported and monitored using the new national indicator, Standardised Hospital Mortality Index, and this will be reported on a monthly basis. These reports will assist clinical staff in identifying any area that requires further investigation.

The Trust has also committed to be part of a Department of Health improvement programme called NHS QUEST. We are one of 13 organisations in the country that have committed to work together to drive quality performance above that which is expected. One of the work streams is to reduce SHMI to below 75. This is a very ambitious goal but is a real benefit to our local community and all patients receiving care, that we will be monitoring and introducing new methods of working with other organisations to ensure that we introduce best practice initiatives.

Below is a diagram to demonstrate the initiative that members of NHS Quest will undertake during 2012/13 with regard to mortality reduction.

Reducing Mortality Driver Diagram



Priority 2 - Compliance with National Institute of Clinical Excellence (NICE) audits

A priority highlighted in 2010/11 Quality Accounts was the inclusion of audits to show compliance with NICE recommendations.

The following NICE clinical guidelines were reviewed:

- Hip fracture – The Trust is partially compliant with this guideline. Further work continues to ensure that the actions identified in the action plan are addressed
- Colorectal cancer – The Trust is compliant with this guideline and this has been shown at peer review. The last peer review was in November 2011 and compliance remains
- Anaphylaxis – The Trust is compliant with this guideline. The cardiac arrest policy has been updated in line with this guideline.
- Organ Donation – The outstanding element to achieve full compliance is the development of policy. This policy will be submitted for approval in April 2012.
- Epiretinal brachytherapy for wet age related macular degeneration (a condition of the eye) – The Treatment for this is being delivered as part of a research study. Adherence to the study conditions show compliance with this NICE guideline
- Lung cancer – Compliant Guideline mirrors the regional guideline and required no change in practice. Practice is audited via National Lung Cancer Audit.
- Hyperglycaemia in acute coronary syndrome - Treatment follows that established as part of the national MINAP audit relating to cardiac care

Priority 3 - Medications Management

Audit of Omitted Medication

An audit was carried out early in the reporting period and this did identify some areas where further action could be taken to reduce the incidence of omitted medications. From the audit a simple checklist was introduced to ward areas as a reminder of actions to take when medicines were unavailable as outlined below

A re-audit was carried out and showed that omitted medicines were still a problem in some instances. Long term aims have been set to include a goal to have electronic prescribing introduced and to increase the use of patients own medication.

Audit of discharge medication

The audit highlighted the ongoing issues of timely communication between services. The audit also suggested that the quality of discharge is better when a pharmacist was involved.
Areas for improvement were highlighted including transcription of medication onto the discharge summary, information on short courses and allergy information.
These areas will continue to be the subject of further work during 2012/13.

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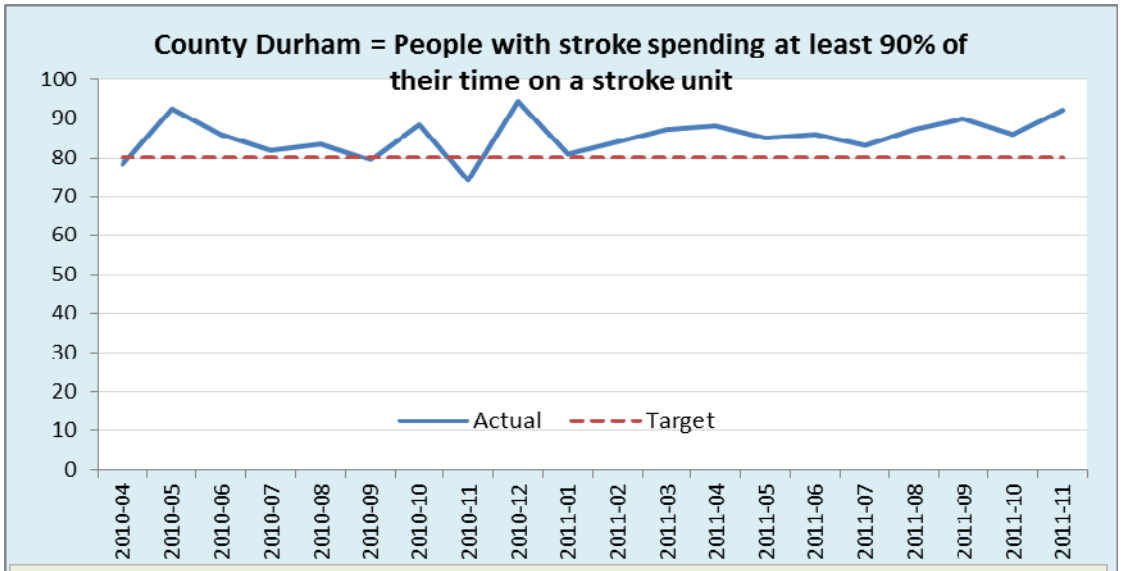
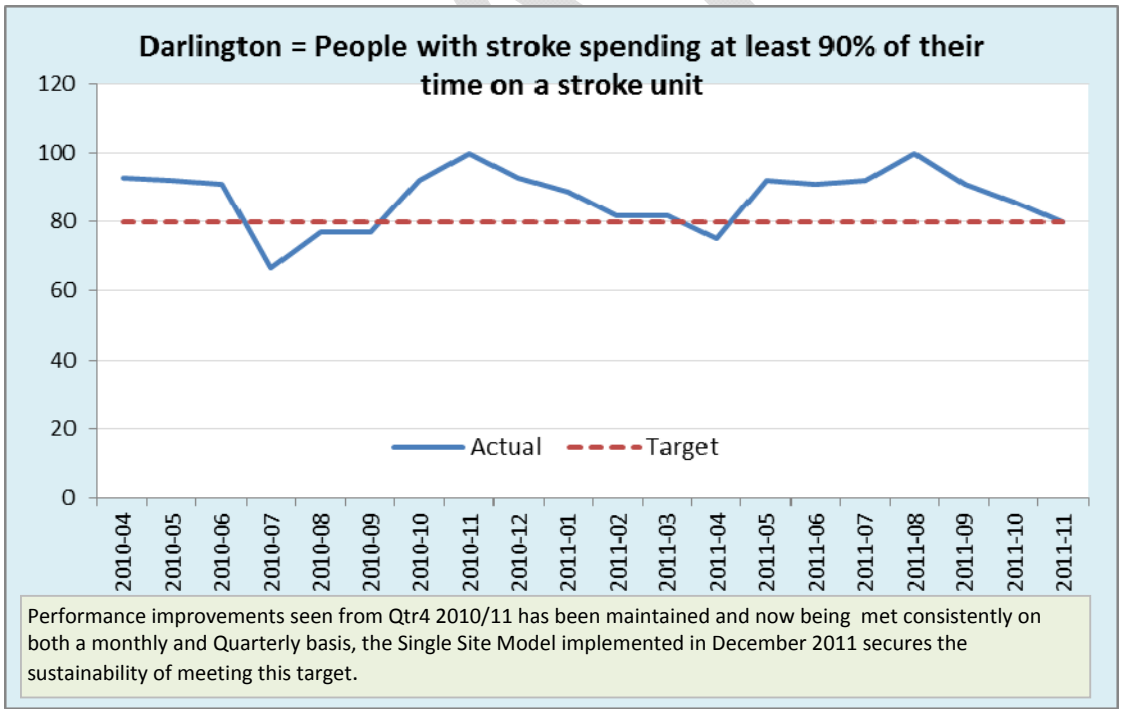
Priority 4 - Compliance with Sentinel Stroke Audits



Performance improvements seen from Qtr4 2010/11 has been maintained and now being met consistently on both a monthly and Quarterly basis, the Single Site Model implemented in December 2011 secures the sustainability of meeting this target.



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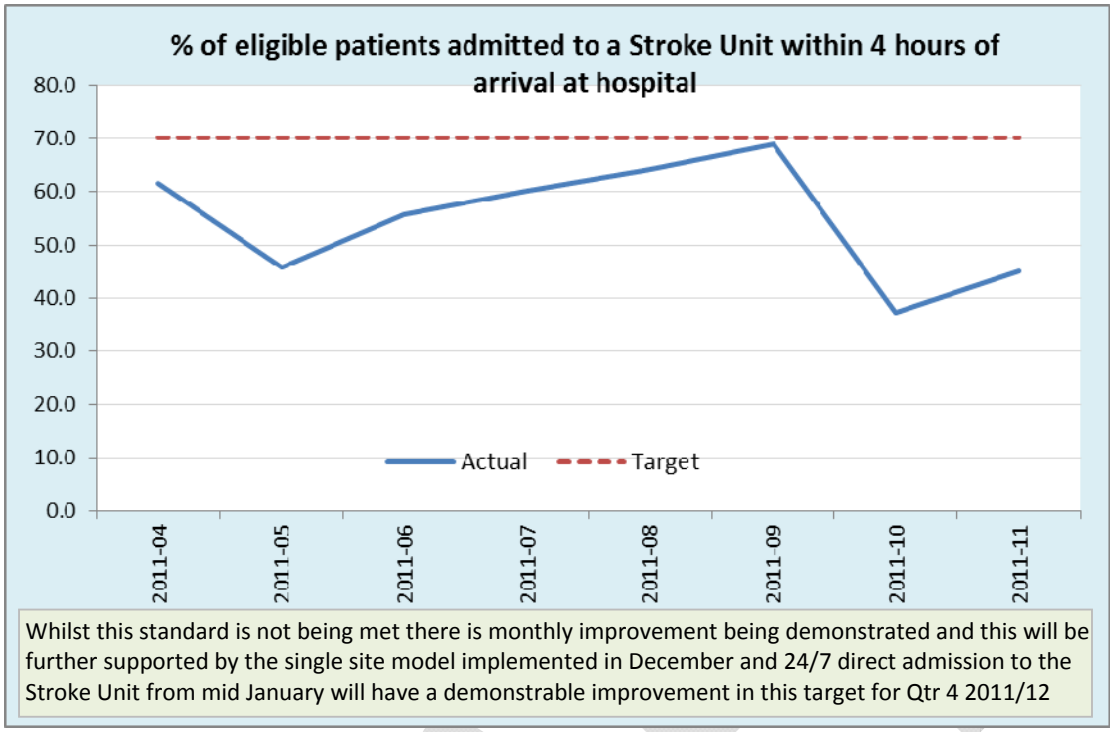
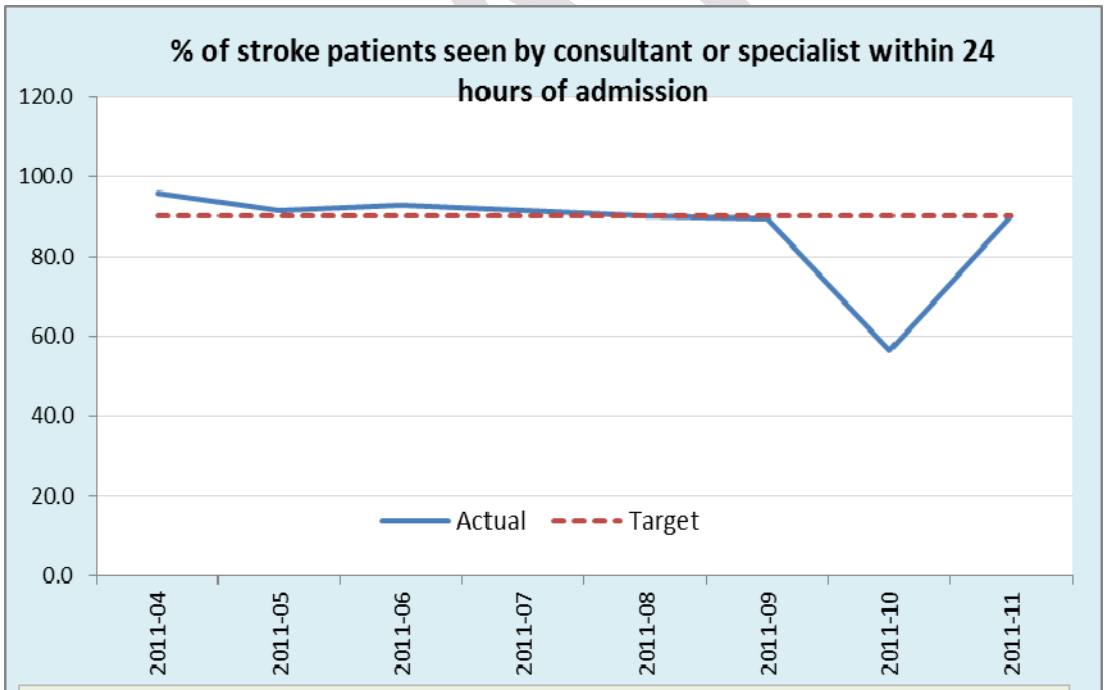


Whilst this standard is not being met there is monthly improvement being demonstrated and this will be further supported by the single site model implemented in December and 24/7 direct admission to the Stroke Unit from mid January will have a demonstrable improvement in this target for Qtr 4 2011/12



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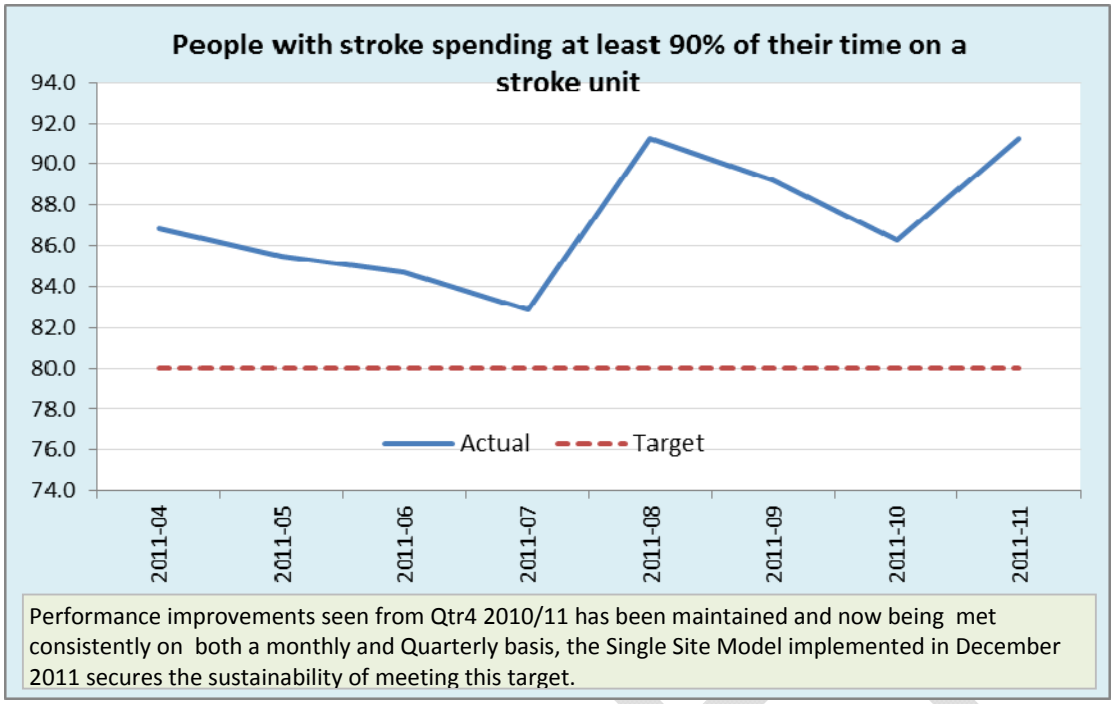

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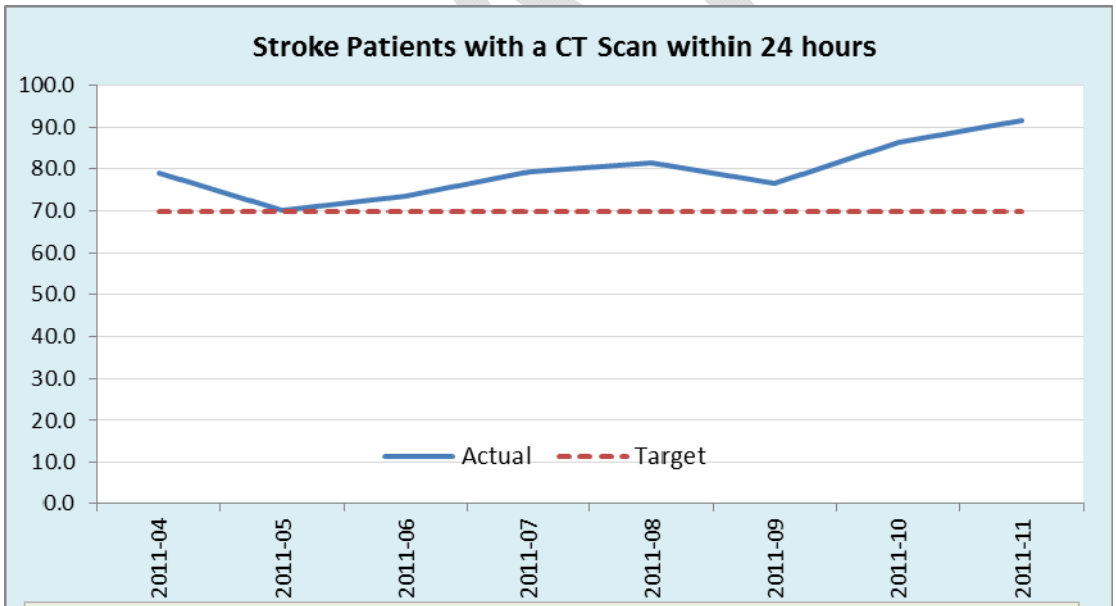
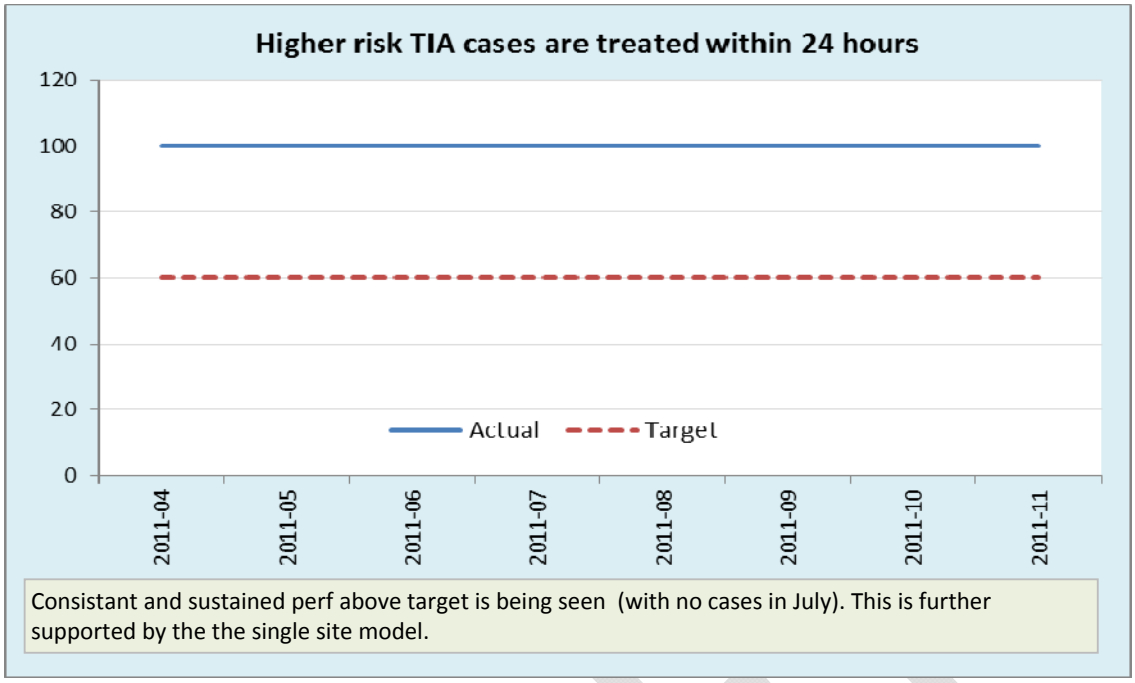


Performance improvements seen and has been maintained and now being met consistently on both a monthly and Quarterly basis, the Single Site Model and direct access to radiology policy has been implemented since December will have a further positive effect on performance.



Three months after stroke services were centralised in Durham, figures show that more patients are receiving specialist care within twenty four hours and more patients are being given life-saving drugs to quickly restore blood-flow to the brain after a stroke.

Since centralising hyperacute stroke care at University Hospital of North Durham, County Durham and Darlington NHS Foundation Trust has seen:

- More patients being seen by a stroke team within 24 hours
- More patients being admitted to the specialist stroke unit within 4 hours
- More patients being given clot-busting thrombolytic drugs. This treatment is proven to reduce lasting disabilities and could save hundreds of lives every year.

Hyperacute services are one of the most critical components of stroke care that patients need when they are at their most seriously ill.

Since the services were centralised, patients have been receiving high quality care which is meeting the national standards for hyper acute treatment. As the hyperacute stroke unit has been running for only 3 months it is important that we continue to monitor progress throughout 2012/13 and this will be reported in next year Quality Account.

Priorities for 2012/13

Priorities for improvement are divided into the three components of quality and additional detail has been included earlier in the report on the rationale for inclusion, where appropriate

- Safety
- Experience
- Effectiveness

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Priority	Rationale for choice	Measure
SAFETY		
Patient Falls Patient falls resulting in fractured neck of femur	Targeted work commenced to reduce falls and those resulting in fractured neck of femur across the organisation. To ensure continuation and consolidation of effective processes to reduce the incidence of injury	Reduction in falls Reduction in falls resulting in fractured neck of femur
Healthcare Associated Infection	National and Board priority. Further improvement on current performance	Achieve reduction in line with target
Venous thromboembolism (VTE) assessment Venous thromboembolism treatment	Maintenance of current performance. To prepare for mandatory inclusion in next year's Quality Account	Maintain VTE assessment compliance at above 90% within inpatient beds in the Organisation Audit of compliance with VTE prophylaxis and treatment
Discharge summaries	To improve timeliness of discharge summaries being completed To support request from Commissioners to include in Quality Report	Monitor compliance against Trust Effective Discharge Improvement Delivery Plan
EXPERIENCE		
Nutrition and Hydration in hospital	CQC assessment critical of some observations made with regard to nutrition and hydration National attention To continue close monitoring as Trust priority	% completion of nutritional assessment % completion of food charts % completion of fluid balance charts Roll out of dementia collaborative work
End of life care	To understand whether patients at end of life receive their care in preferred place and build on findings to provide this whether in acute or community setting As part of NHS QUEST programme	To ensure implementation of any actions identified on completion of the current national audit
Compassion and dignity for patients	Feature of complaints To improve understanding so that improvements can be made Area of national focus especially in respect of elderly care	Patient stories from both the acute and community hospital settings to assess how safe their care was. Action plan implementation from findings
EFFECTIVENESS		
Reduction in Risk Adjusted Mortality	Part of NHS QUEST programme to review methods to reduce risk adjusted mortality to below 100	To continue RAMI and run alongside SHMI mortality monthly measure
Discharge planning for patients with	To reduce length of stay To provide care closer to home To measure effectiveness of working	Readmission rates within 30 days of discharge from hospital

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chronic obstructive pulmonary disease	between acute and community services	Review of discharge care bundle
Compliance with stroke pathways	To monitor improvements following introduction of hyper acute stroke unit within the trust To provide assurance of the standard of care following the placement of hyperacute stroke services to one site of the trust	% stroke patients assessed by stroke specialist % patients admitted to stroke unit Availability of stroke rehabilitation services following acute intervention

Participation in Clinical Audits and National Confidential Enquiries

During 2011/12 35 national clinical audits and 4 national confidential enquiries covered NHS services that County Durham & Darlington NHS Foundation Trust provides

During 2011/12 County Durham & Darlington NHS Foundation Trust participated in 85% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in

The national clinical audits and national confidential enquiries that County Durham & Darlington NHS Foundation Trust was eligible to participate, participated in, participated in and for which data collection was completed during 2011/ 12 are contained within the table below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

National Audit/National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
Peri and neonatal				
Perinatal mortality (HQIP) –	✓	✓	Ongoing	100%
Neonatal intensive and special care(NNAP) -	✓	✓	✓	Obtaining
Children				
Paediatric pneumonia (British Thoracic Society)	✓	✓	✓	18 = 90% 21/03/2012 Data collection still progressing Submission date 10th April 2012
Paediatric asthma (British Thoracic Society)	✓	✓	✓	*90%
Pain management in children (College of Emergency Medicine) –	✓	✓	✓	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit) –	✓	✓		100%
Paediatric intensive care (PICANet)	X			
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	X			
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	✓	100% cases on database sent

*18 from required sample of 20 patients collected

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
Acute Care				
Emergency use of oxygen (British Thoracic Society)	✓	X		
Adult community acquired pneumonia (British Thoracic Society) -	✓	✓	✓	Data collection in progress submission date 31/5/2012
Non invasive ventilation (NIV) - adults (British Thoracic Society)	✓	X		
Pleural procedures (British Thoracic Society)	✓	✓	✓	*100%
Cardiac arrest (National Cardiac Arrest Audit)	✓	X		
Severe Sepsis and Septic Shock (College of Emergency Medicine) -	✓	✓	✓	100%
Adult critical care (Case Mix Programme) –	✓	✓	✓	Obtaining
Potential donor audit (NHS Blood & Transplant) –	✓	✓	✓	100%
Seizure Management	✓	X		
Long Term Conditions				
Diabetes (National Adult Diabetes Audit)	✓	✓	✓	100% of cases on database

*Required sample of 20 patients collected

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	✓	✓	9.3% Recruitment figure form RCOG. Audit lead raised concern over the large denominator figure which did not take into consideration the very large number of women who declined to participate.

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
Chronic pain (National Pain Audit)	✓	✓	✓	PROMs and Outcome data submitted for patients who consented to take part over the 3 months but there was not a sample figure to achieve therefore 100%
Ulcerative colitis & Crohn's disease	✓	✓	✓	74%

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(National IBD Audit)				
Parkinson's disease (National Parkinson's Audit)	✓	✓	✓	100%
Adult asthma (British Thoracic Society) –	✓	✓	✓	*100%
Bronchiectasis (British Thoracic Society)	✓	X		

*Required sample of 20 patients collected

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
Elective procedures				
Hip, knee and ankle replacements (National Joint Registry)	✓	✓	✓	67% (819/1224) Apr 11- Dec 12. Jan-Mar 12 data not submitted This is being addressed.
Elective surgery (National PROMs Programme)	✓	✓	✓	42.5% Participation Apr 2011-Sep 2011
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	X			
Coronary angioplasty (NICOR Adult cardiac interventions audit)	X			

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
Peripheral vascular surgery (VSGBI Vascular Surgery Database) –	✓	✓	✓	Obtaining
Carotid interventions (Carotid Intervention Audit) – percentage of eligible	✓	✓	✓	Obtaining
CABG and valvular surgery (Adult cardiac surgery audit)	X			
Intra-thoracic Transplantation	X			
Liver Transplantation	X			
Coronary Angioplasty	X			
Cardiac Arrhythmia	✓	✓	Ongoing	100%
Cardiovascular Disease				
Acute Myocardial Infarction & other ACS (MINAP) –	✓	✓	✓	100% Unable to verify

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National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
Heart failure (Heart Failure Audit)	✓	✓	**Ongoing	64% For data collection until Dec 2012 out of total possible eligible 462 Apr 11- Mar 12 Data collection to be submitted 31/05/2012 for the above period
Acute stroke (SINAP)	✓	✓	Ongoing data collection	To be completed

National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
Renal disease				
Renal replacement therapy (Renal Registry)	X			
Renal transplantation (NHSBT UK Transplant Registry)	X			
Patient transport (National Kidney Care Audit)	X			
Cancer				
Lung cancer (National Lung Cancer Audit)	✓	✓	**✓	100%
Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	**✓	100%
Head & neck cancer (DAHNO)	✓	✓	**✓	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	No cut off date for first data collection	N/A
Trauma				
Hip fracture (National Hip Fracture Database)	✓	✓	✓	*100% data validated up to Dec 2011
Severe trauma (Trauma Audit & Research Network)	✓	X		
Psychological conditions				
Depression & anxiety (National Audit of Psychological Therapies)	X			
Prescribing in mental health services (POMH)	X			

- * Validation of cases not totally complete for data in 11/12 but 100% indicated.
- **Data collection deadline in 2011/12 for patients covering period 10/11.

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National Audit/ National Confidential Enquiry Title	Applicable to Trust Services	Participation	Data collection completed Apr 11 – Mar 12	% cases submitted
National Audit of Schizophrenia (NAS)	X			
Blood transfusion				
Bedside transfusion (National Comparative Audit of Blood Transfusion)	✓	✓	✓	100%
Medical use of red cells (National Comparative Audit of Blood Transfusion)	✓	✓	✓	100%
Health Promotion				
National Health Promotion in Hospitals	✓	✓	✓	100%
End of Life				
Care of the Dying in Hospitals	✓	✓	✓	97%
National Confidential Enquiries				
Alcoholic Liver Disease Study	✓	✓	✓	100%
Subarachnoid Haemorrhage	✓	✓	✓	100%
Cardiac Arrest Study	✓	✓	✓	100%
Bariatric Surgery Study	✓	✓	Organisational data submitted but no patients identified for the study period	100%

- The reports of (*18) national clinical audits were reviewed by the provider in 2011/ 12 and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

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National Clinical Audits reviewed in 2011/12	Action
National Sentinel Audit of Stroke	Percentage of patients treated for 90% in a stroke unit Action: Continue to Increase awareness in A&E and with medical teams about importance of patients being transferred to a stroke unit
CEM Renal Colic	Advise doctors about pain standards and document review analgesia
National Joint Registry	Audit of PF joint replacement to investigate low participation rate in NJR
BTS Adult Community Acquired Pneumomnia	Teaching and awareness of local and national guidelines to junior doctors
IBD	Sites to continue to ensure appropriate use of specialist ward areas, all patients should be admitted directly to specialist Gastroenterology wards
National Heart Rhythm Management	Education event to remind medical staff of the indications for permanent pacing
CEM Fever in Children	Improve education and documentation by nursing staff. Increased awareness of the ED Drs to assessing the feverish child
CEM Vital signs in majors	Disseminate results to ED team. Improve awareness of vital signs
MINAP	Plan to undertake a notes review, to revisit this data re the prescribing of clopidogrel
UK Carotid Endartrectomy Audit	Develop validation process to confirm patients on HES with the patient identified on the vascular database and Carotid Pathway to support changes in outpatients
National Vascular Database	Re-review services against self-assessment checklist to attain position from Aug 2011
Hip Fracture Database	Appoint an Orthogeriatrician to support pre-assessment. The audit highlighted that the Orthogeriatric pre-assessment was limited due to recruitment
CEM Pain Data	All patients to have pain score and re-evaluation plan. To provide more training to Nurses and Doctors in relation to this.
PROMS	Work with pre-assessment to develop an alternative model of data collection for Hernia and Varicose veins to improve current participation rates
DAHNO	Standard form for CNS contact Diagnosis
Bowel Cancer	Review submitted data and consider undertaking in depth analysis using casenotes and local audit
Potential Donor Audit	Reminders to refer appropriate patients to the SN-OD have been added to the ITU documentation. ITU morning handovers will incorporate a discussion on any patients that may reach the trigger points for referral.
National Comparative Blood Bedside Transfusion	Re-audit practice at a local level to ensure improvement in practice by giving feedback in relation to Stop and Start times, observations not being recorded and patients not wearing wristbands

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Confidential Enquiries

Enquiries published in 2011/12 and which are applicable to County Durham & Darlington NHS Foundation are currently in the gap analysis stage.

The reports of 102 local clinical audits were audits reviewed by provider in 2011/12 and County Durham & Darlington NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Local Clinical Audits reviewed in 2011/12	Action
'Compliance and outcome following introduction of 1 hour Sepsis Care Bundle	Neutropaenic sepsis pathway (NSP) recently introduced. Have direct reference to NSP in the generic bundle. Liaise with Oncology team and plan a parallel approach.
Use of oxytocin in labour	To record maternal obs and state when to stop Syntocinon (New CNST guidelines).
'Nasogastric Tubes Audit (NPSA)	Teaching e-module regarding X-ray interpretation to be disseminated.
'Pelvic and acetabular fracture management	Early referral for advice. Dept staff alerted to availability of advice in tertiary referral centre and advised to take advice early when presented with these cases.
'Management of Severe Pre-Eclampsia	Guidelines group to review and merge NICE Guidelines, RCOG and regional guidelines
Compliance with MRSA decolonisation	Inaccurate and incomplete prescribing. Consideration of pre-printed prescription labels
Re-audit of electronic fetal monitoring in labour	Incomplete information on CTG. Reinforce information to be written on CTG- at mandatory days. Proforma on CTG / self audit. Increased use of sticker / fresh eyes.
Audit of oxygen usage on the Acute Medical Unit	Education for the nursing staff as part of annual mandatory training. This will be done within the pharmacy focus for training.
'Audit of Punch biopsies of BCC & SCC: are we meeting 18 week and NICE skin cancer targets	For those patients requiring a plastics referral: refer without biopsy if diagnostic certainty.
'Rituximabfor the treatment of Rheumatiod Arthritis	Incorporate Igs as routine pre-treatment test for RA patients on Rituximab at each cycle of treatment, to identify those at potentially increased risk of infection; to update treatment protocols accordingly.
'Audit of staff nurse awareness of compartment syndrome in plastic surgery	Display flowcharts in wards.
'Audit of Anaesthetic Records	In short term it was recommended that Abbreviated chart should be discontinued. In the longer term, a new chart is being developed
'Neonatal referral letters to community paediatrics	Poor quality of discharge letters from NNU with many areas of information not completed. Guidance on writing letters to be produced.

'To ascertain compliance with the IMER regulations	Potential low compliance with IMER regulation in Oral Surgery records. Share finding with key staff in oral surgery. Share expectation of IMER regulations with medical teams. Conduct validation audit
Missed acute medical co-morbidities using the UHND fractured neck of femur pathway	Liaise with A&E with regards to implementing a proforma of important medical issues to score patients before transfer to the orthopaedic wards to ensure prompt medical review and reduce theatre delays.
'Audit of compliance with NICE paediatric head injury guidelines at UHND	To feedback to A/E team through joint paeds/ED clinical governance meeting to reduce the number of unnecessary skull X-rays
'VTE audit	Inform appropriate staff of audit results and tell to tick VTE form to indicate risk assessment being done

The number of patients receiving NHS services provided or sub-contracted by County Durham & Darlington NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was - 1452

County Durham & Darlington NHS Foundation Trust's commitment to participation in clinical research demonstrates our desire to improving the quality of care we offer and to making our contribution to wider health improvement. Through research our clinical staff remain abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

During the period County Durham & Darlington NHS Foundation Trust was involved in conducting NIHR Portfolio clinical research studies in the following areas -

- Cancer
- Cardiovascular
- Child Health
- Dementias and Neurodegenerative
- Diabetes
- Eye
- Generic Health Relevance
- Infection
- Musculoskeletal
- Oral and Gastrointestinal (inc. Colorectal_
- Reproductive Health and Childbirth
- Skin
- Stroke

and in Non- NIHR clinical research studies CDDFT conducted studies in -

- Cardiovascular
- Child Health
- Lung Cancer
- Orthopaedics
- Sexual Health

In the last four years our involvement as a participant site in NIHR Portfolio Research has increased from 62 studies in 2008/09 to 136 studies in 2011/2012. This again demonstrates our commitment and desire to improve patient outcomes and experience. Engagement with clinical research demonstrates our commitment to testing and offering the latest medical treatments and techniques.

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Information on the use of CQUIN framework
A proportion of County Durham & Darlington NHS Foundation Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between County Durham & Darlington NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at:

http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/ openTKFile.php?id=3275

The total sums conditional on CQUIN were:

Acute contract	£4,408,976
Community contract	£1,614,660
Total	£6,023,627

In 2010/11 County Durham & Darlington NHS Foundation Trust did not have the community contract, however the outrun sum payable to the Trust for CQUIN for the acute contract was £4,021,883 which was 89.39% of the total that would have been paid to the Trust (£4,498,939) if we had achieved 100% of all indicators

Registration with Care Quality Commission
County Durham & Darlington NHS Foundation Trust is required to register with the Care quality Commission and its current registration status is registered to deliver the following from the following locations:

University Hospital of North Durham
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Family planning
Maternity and midwifery services
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

Chester-le-Street Community Hospital
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Family planning
Treatment of disease, disorder or injury

Shotley Bridge Community Hospital
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Family planning
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Richardson Community Hospital
Diagnostic and screening procedures
Treatment of disease, disorder or injury

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Weardale Community Hospital
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Sedgefield Community Hospital
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Bishop Auckland Hospital
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Family planning
Maternity and midwifery services
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

Darlington Memorial Hospital
Assessment or medical treatment for persons detained under the Mental Health Act 1983
Diagnostic and screening procedures
Family planning
Maternity and midwifery services
Personal Care – registered as HQ for delivery in the community
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

Registration has been extended to include Transport services, triage and medical advice provided remotely for delivery in the community during 2011.

County Durham & Darlington NHS Foundation Trust has no conditions on its registration

The Care Quality Commission has not taken enforcement action against County Durham & Darlington NHS Foundation Trust during 2011/12

County Durham & Darlington NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Data Quality

County Durham & Darlington NHS Foundation Trust submitted records during 2011/12 to the secondary Uses services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patients valid NHS number rates for all record sets above National rates. Admitted patient Care is : 99.2% (better than National rate of 98.75); Outpatient Care is 99.5% (better than National rate of 99.0%) and Accident and Emergency Care is 95.6% (better than National rate of 92.9%)

- Valid General Practitioner Registration Code was:

  99.98% (better than National rate of 99.9) for admitted patient care; 100.0% (better than National rate of 99.7%) for outpatient care; and 99.96% (better than National rate of 99.4%) for accident and emergency care.

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County Durham & Darlington NHS Foundation trust Information Governance Assessment Report overall score for 2011/12 was 71% and was graded green

County Durham & Darlington NHS Foundation Trust will be taking the following actions to improve data quality (insert actions)

County Durham & Darlington NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were midwife led Primary Diagnosis 95% Secondary Diagnosis 98% Primary Procedure 100%, Secondary Procedure 100%.

Random sample audit Primary Diagnosis 98%, Second Diagnosis 96%, Primary Procedure 93%, Secondary Procedure 94% and an overall error rate of only 3.9% (better than National rate of 9%).

It is to be noted these results should not be extrapolated further given the sample sizes and specified areas do not constitute a representative sample of overall Trust performance but are an indication of sound controls and processes .

Part 3 – Additional information

Incident reporting

The trust identified the need for the current incident reporting system to be replaced by a web based system which would allow for more timely reporting and investigation of incidents as they would be reported at the point of occurrence.

The introduction of a web-based system facilitates ownership at ward/department and care group level. A web-based system notifies nominated persons within the care group of the incident immediately and monitors whether action has been taken and escalates to the next named person when this occurs. The system also allows the generation and monitoring of action plans. With a web-based system managers have easy access to reports, enabling them to analyse trends and respond accordingly to enhance patient safety and experience.

A web-based system had been in use within the former Community Health Services since 2009. This system provided all of the features of the current acute trust system but with the benefit of being web-based. In addition, by adopting this system it ensured that there was the same process in place across the newly merged trust

The introduction of a web-based system across the acute part of the trust required a project plan and this was successfully rolled out over a 9 month period. In addition, the system also provides better integration of complaints, litigation, incidents and PALS themes to be identified and acted upon.

Safety Thermometer

As part of Department of Health safety project the organisation from the onset took part in Safety Thermometer pilot and then Safety Express. The project was to reduce harm from pressure sores, catheter acquired infections, venous thromboembolism events and falls.

The data is collected monthly point prevalence. This initiative has now been agreed nationally and will rolled out to all organisations during 2013. Please see charts below to show results from the pilot work.

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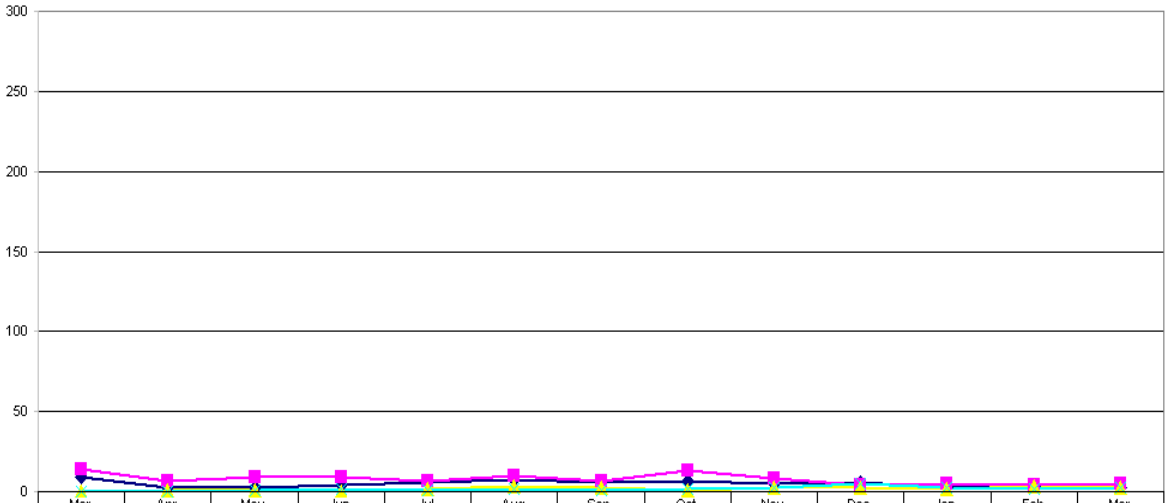
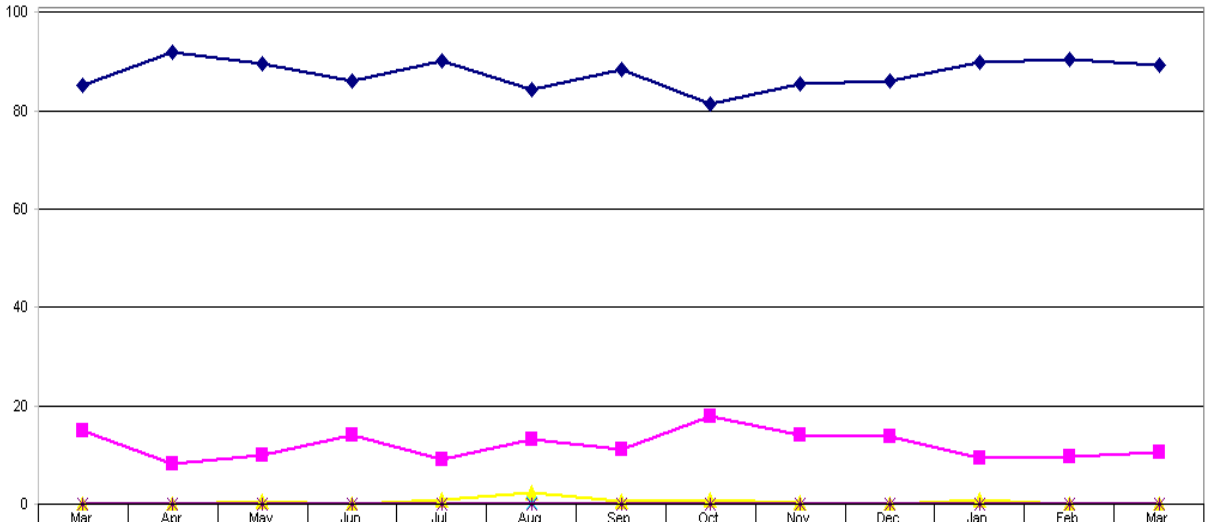
Safety Thermometer: Proportion of patients with each type of Harm
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST; All Wards and Teams; All Settings; All Services; All Ages; All Sexes



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Pressure Ulcers	9	2.06	2.63	4.28	5.74	7.52	5.41	6.37	4.69	5.74	2.43	3.64	2.77
Falls	14	6.19	8.95	9.09	6.97	10.15	6.76	13.15	8.59	4.31	5.34	4.05	4.74
Catheters & UTIs	0	1.03	1.05	0	1.64	3.38	2.7	1.2	2.73	2.39	1.46	3.64	2.77
VTEs	0	0	0.53	1.6	1.23	1.88	0.9	1.59	2.73	4.78	2.43	2.02	2.37
Sample	100	97	190	187	244	266	222	251	256	209	206	247	253

Safety Thermometer: Proportion of patients by number of harms
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST; All Wards and Teams; All Settings; All Services; All Ages; All Sexes



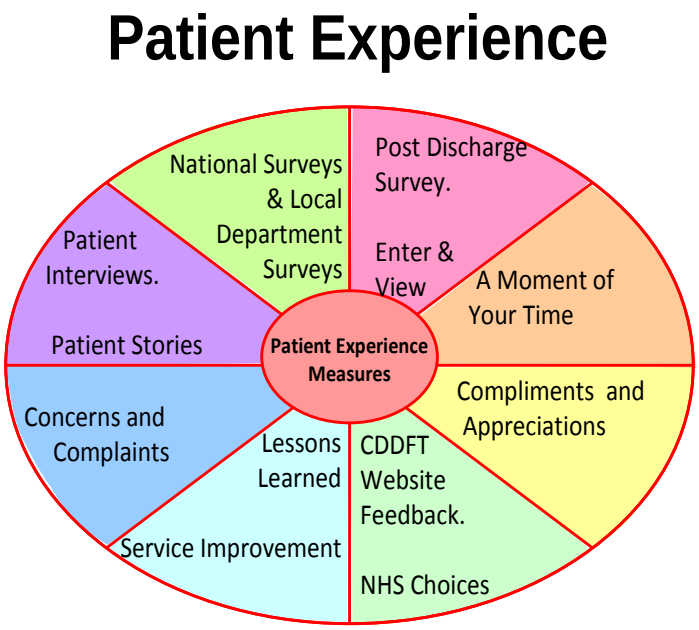
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No Harms	85	91.75	89.47	86.1	90.16	84.21	88.29	81.27	85.55	86.12	89.81	90.28	89.33
1 Harm	15	8.25	10	13.9	9.02	13.16	11.26	17.93	14.06	13.88	9.22	9.72	10.67
2 Harms	0	0	0.53	0	0.82	2.26	0.45	0.8	0.39	0	0.97	0	0
3 Harms	0	0	0	0	0	0.38	0	0	0	0	0	0	0
4 Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Sample	100	97	190	187	244	266	222	251	256	209	206	247	253

Statement of assurance from the Board – To be completed
During 2011/12 County Durham & Darlington NHS Foundation Trust provided and/ or sub-contracted (number) NHS services.
The County Durham & Darlington NHS Foundation Trust has reviewed all of the data available to them on the quality of care in (number) of these NHS services.
The income generated by the NHS services reviewed in 2011/12 represents (number) per cent of the total income generated from the provision of NHS services by the County Durham & Darlington NHS Foundation Trust for 2011/12

Review of Services – to be completed
The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience – and indicate where the amount of data available for review has impeded this objective

Patient Involvement Activity

CDDFT is committed to listening to patients and carers. It is essential that feedback provided by patients and carers is acted upon in order to ensure safe, effective practice and enhance the patient experience.



Local Care Group Patient Satisfaction Surveys

Local surveys are carried out by Care Group staff. Reports and action plans are received into the Patient Experience Team where a repository is held.

In 2011 we received a number of reports from a variety of services. As well as the reports action plans are developed and implemented by the services in response to identified issues.

A Moment of Your Time

The Patient Experience Team are currently piloting a new real time patient feedback initiative for 2011/12. Patients are asked to complete a comment card at discharge on pilot wards. The team analyse and report on the comment cards, findings are presented to ward management to provide immediate action responses to any issues. The reports are then uploaded on to the CDDFT website.

This initiative will be reviewed in 2012 prior to extending the project to other areas.

Date W/C	Ward/ Department	What did we do well	What could we improve	Would you recommend us to family and friends	Did you feel you were treated with dignity and respect
12.09.11	Ward 32	Everything	No comments received	Yes	Yes at all times
12.09.11	Ward 32	Attention to detail	No comments received	Yes	Yes
12.09.11	Ward 32	The care and attention received	By having more staff ACTION – ward is currently covering maternity leave and secondment. Staffing levels are as set by financial budget N	Yes	Definitely at all times
12.09.11	Ward 32	General personal care as necessary polite and friendly staff, Good feedback from procedures	I appreciate that this is a particularly busy ward but at times especially meal times there just wasn't enough staff ACTION – staff are allocated to meals each meal time. Minimum of two are allocated	Yes	Yes
12.09.11	Ward 32	I was looked after well by all the staff very helpful and had time to answer questions	Information quicker ACTION – staff give information as they receive it	Yes	Yes
12.09.11	Ward 32	Caring and understanding nursing staff good at listening	Response time to the buzzer ACTION – we have introduced hourly intentional ward rounding and have seen a reduction in the amount of bells	Yes	Yes thank you

Patient Interviews

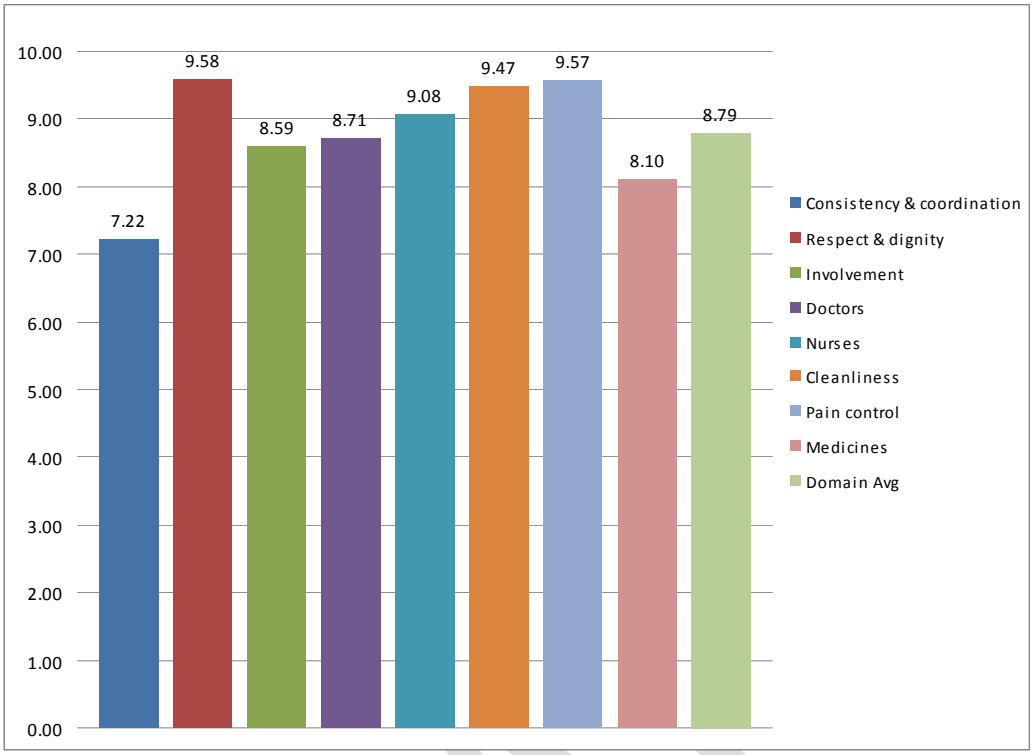
A further real time patient experience initiative has also been introduced across all wards and community hospitals within CDDFT.

On a quarterly basis over 50% of patients are interviewed by Patient Experience staff in the ward area during their stay. The information obtained is based on the core domains for measuring inpatient experiences of care as identified by the Picker Institute (2009).

After interviewing 800 patients over a three month period, baseline data has been collected. Each ward is provided with feedback on a one to one basis and encouraged to utilise patient comments to deliver improvements and to display information on ward performance boards.

The results by site are illustrated below:

UHND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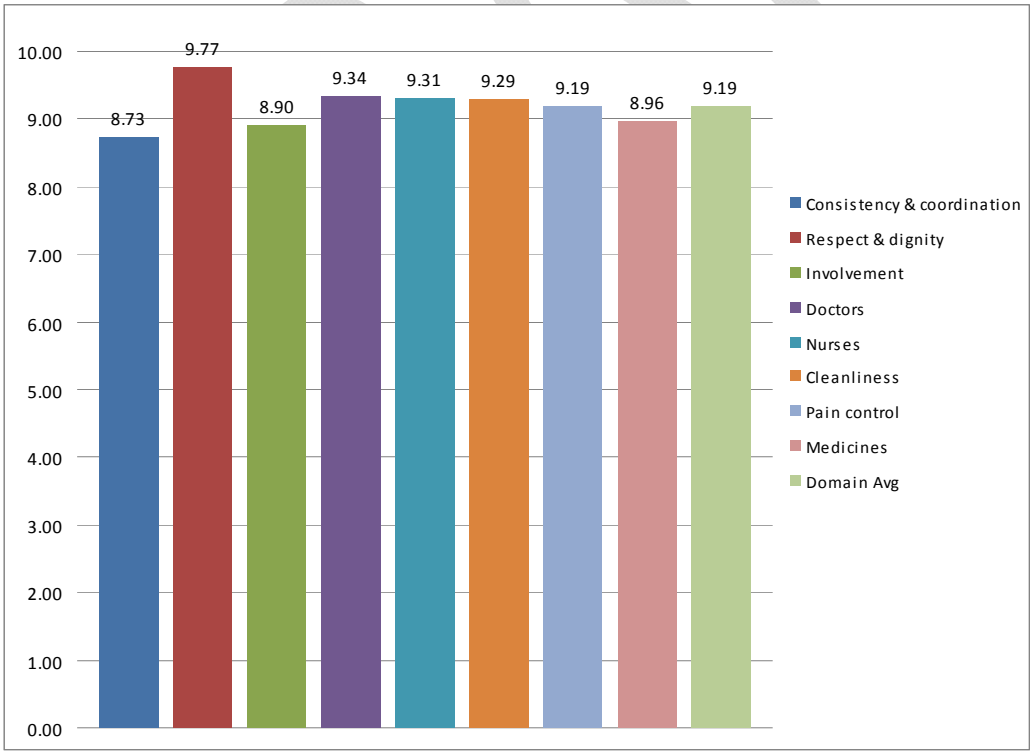
Consistency & coordination
Respect & dignity
Involvement
Doctors
Nurses
Cleanliness
Pain control
Medicines
Domain Avg

DMH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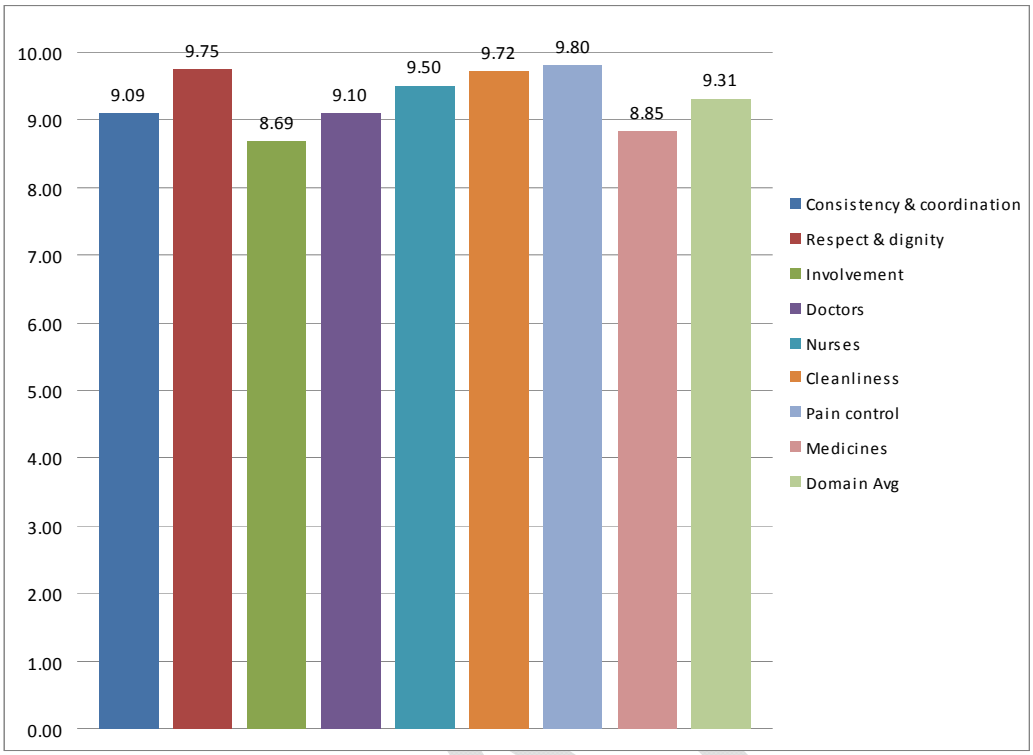
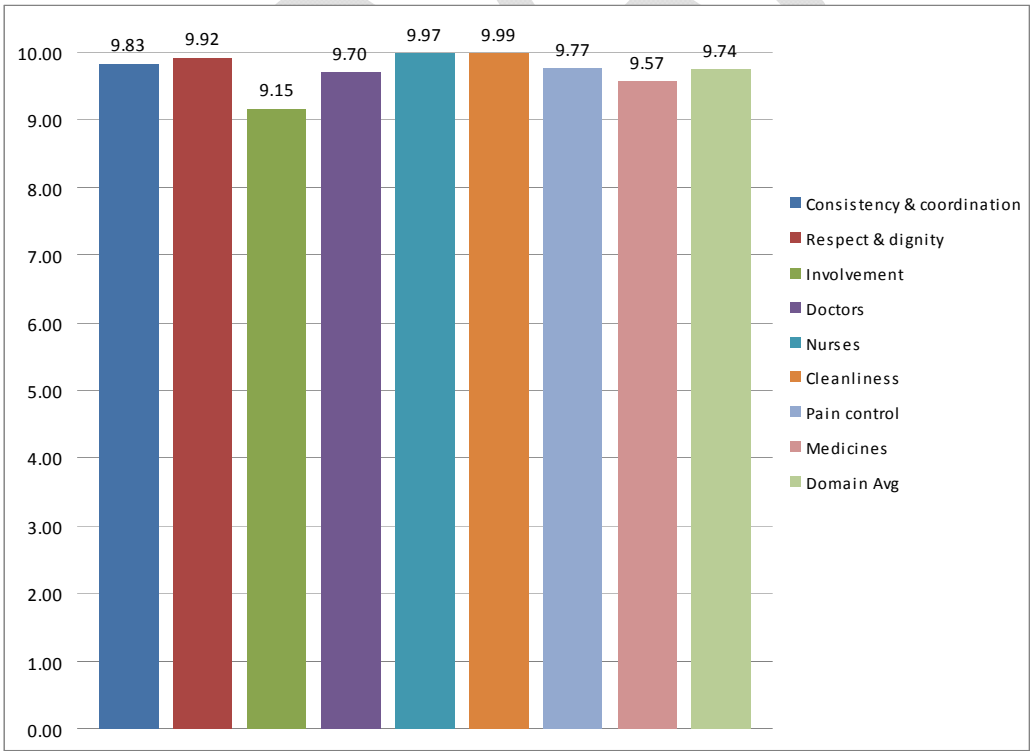
9.19
8.96
9.19
Consistency & coordination
Respect & dignity
Involvement
Doctors
Nurses
Cleanliness
Pain control
Medicines
Domain Avg

BAH



Community Hospitals



Emergency Department UHND

In November 2011 members of the Patient Experience Team interviewed 64 patients attending the ED department at UHND. Following analysis of the information a report was prepared for the Matron and Service Manager to formulate an action plan in response to patient feedback.

NHS Choices

Quarterly reports are collated and presented at the Quality & Healthcare Governance Committee. Themes are identified, in line with all patient experience measures in order to ensure appropriate actions are developed and monitored.

National Surveys

The National Outpatient Survey undertaken in 2010 was reported by the CQC in 2011.

CDDFT had improved in patients receiving copies of letters sent between hospital doctors and GP's.

Areas of improvement included wait times whereby patients experienced wait times of more than 15 minutes (38%), more than one hour (8%) and more than 2 hours (3%).

The National Inpatient survey is currently active and the CQC report is due in April /May 2012.

Bereavement Booklets

The Bereavement Booklets have been reviewed and updated after consultation with patient experience volunteers. Booklets are available throughout all CDDFT areas.

Interpreter Services

Interpreter services are provided for CDDFT by Everyday Language Solutions. Care Group teams can arrange for language interpreters and BSL interpreters. Information is available in Braille as required and documents can be converted into other languages upon request.

Throughout 2011/12 there were on average 70 interpreter bookings arranged per month throughout CDDFT. Approximately 20 requests per month are for BSL interpreters.

The Patient Experience Team are currently undergoing a patient satisfaction survey of BSL interpreter services. Results will be available from May 2012 and displayed on the CDDFT website.

The interpreter services have recently been transferred to the Equality and Diversity team.

Appreciations

On average CDDFT receive between 3500 and 4500 appreciations per quarter across acute and community services.

Patients and carers are also encouraged to share their comments on the CDDFT website "patient and visitor" section, as well as NHS Choices. All comments are received by the ward / community team and are displayed in patient areas.

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LINks: Enter and View Reports

Throughout 2011/12 the Patient Experience Team have been liaising with both LINks groups across Darlington and Durham. A number of Enter and View sessions have taken place across CDDFT. Reports and recommendations have been actioned. Review visits are now taking place to ensure actions are monitored and reviewed.

Completed Enter and View visits throughout 2011/12:

Emergency Department – UHND
Emergency Department – DMH
Audiology Department – DMH
Outpatients Department – UHND
Urgent Care Centre - Peterlee
Urgent Care Centre – Bishop Auckland.

An example of recommendations and actions:

Enter & View Recommendations: Emergency Departments, University Hospital of North Durham and Darlington Memorial Hospital.

UHND

To improve status updates
The traige nurse will ensure the information board is up to date with appropriate waiting times. Patients are to be informed of this during the triage assessment.
This has been actioned with immediate effect.

To delegate contact with staff at times of sickness, to a non-clinician to release nurses for clinical duties
Senior nurses are aware that they can delegate this task to a non-clinical member of the team as and when required. All Senior Nurses have been reminded of this.

Improvements could be made to the children's waiting area
Improvements have been made to the paediatric area. A quote has also been obtained to paint a wall freeze in the paediatric waiting and treatment area.

Monitoring of hand gel dispensers could be monitored more closely and members of the public encouraged to use them
Signage in the waiting area has been improved to encourage use of the hand gels and staff have been made aware of the importance of this.

DMH

To improve status updating. Provide verbal updates and keep the board up to date
The board that provides the waiting times has been relocated to a more prominent position. The detail of waiting times will be updated every two hours. This will be monitored closely to ensure accuracy. This has been actioned with immediate effect.

The card/triage system, was not actively in use and there was a lack of understanding of the process

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Patients are provided with an orange or green card as part of the triage system. The reception staff are being monitored on a daily basis as to the use of the cards and how effectively the system is working.

Monitoring of hand gel dispensers could be monitored more closely and members of the public encouraged to use them.
The dispensers are checked on a daily basis. Staff are routinely reminded of the importance of this function

NHS foundation trusts can also choose to use Part 3 to include other additional content relevant to the quality of NHS services. NHS foundation trusts may choose to include the indicators that the Department of Health intends to require in quality account for the 2012/13 reporting year, together with commentary covering their own performance.
During 2012/13 the areas that will be included as a requirement by the Department of Health are as follows
MRSA
Clostridium difficile
Maximum waiting times of 62 days from urgent GP referral to first treatment for all cancers

Annex: Statements from Primary Care Trusts, Local Involvement Networks and Overview of Scrutiny Committees

NHS foundation trusts must send copies of their quality reports to their relevant lead commissioning primary care trusts (PCTs), Local Involvement Networks (LINks) and Overview and Scrutiny Committees (OSCs) for comment prior to publication, and should include these comments in their published quality reports.

The lead commissioning PCTs will have a legal obligation to review and comment, while LINks and OSCs will be offered the opportunity to comment on a voluntary basis.

Annex: Statement of Directors' Responsibility in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to June 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated XX/XX/20XX
  - Feedback from governors dated XX/XX/20XX
  - Feedback from LINks dated XX/XX/20XX
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
  - The (latest) national patient survey XX/XX/20XX

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- The (latest) national staff survey XX/XX/20XX
- The Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/2011
- CQC quality and risk profiles dated XX/XX/20XX

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, confirms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the requirements in preparing the Quality Report.

By Order of the Board:

NB: Sign and date in any colour ink except black

……Date ……..Chairman

……Date …… Chief Executive

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