HEALTH AND PARTNERSHIPS SCRUTINY COMMITTEE
16th APRIL 2013

ITEM NO 8

QUALITY ACCOUNTS – PROGRESS REPORT

SUMMARY REPORT

Purpose of the Report

1. To advise of Members of the recent Stakeholder events in respect of the local Foundation Trust Quality Accounts.

Summary

2. Members will recall that this Scrutiny Committee has decided to be more involved, at an early stage with local Foundation Trusts Quality Accounts. This will enable Members to have a better understanding and knowledge of performance when asked to submit a commentary on the Quality Accounts at the end of the Municipal Year 2012/13.

3. As a result Members have committed to attending the Stakeholder events hosted by County Durham and Darlington NHS Foundation Trust (CDDFT) and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV).

4. This report brings to the Committee's attention the information gathered and Members are asked to note the detailed information to respond to the Quality Accounts in April/May 2013.

Recommendations

5. It is recommended that the briefing notes from the Stakeholder events hosted by County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust be noted.

Paul Wildsmith
Director of Resources

Background Papers

There were no background papers used in the preparation of this report.

Abbie Metcalfe : Extension 2365

S17 Crime and Disorder	This report has no implications for Crime and Disorder
Health and Well Being	This report has implications to the address Health and Well Being of residents of Darlington, through scrutinising the services provided by the NHS Trusts.
Carbon Impact	There are no issues which this report needs to address.
Diversity	There are no issues relating to diversity which this report needs to address.
Wards Affected	The impact of the report on any individual Ward is considered to be minimal.
Groups Affected	The impact of the report on any individual Group is considered to be minimal.
Budget and Policy Framework	This report does not represent a change to the budget and policy framework.
Key Decision	This is not a key decision.
Urgent Decision	This is not an urgent decision
One Darlington: Perfectly Placed	The report contributes to the delivery of the objectives of the Community Strategy in a number of ways through the involvement of local elected members contributing to the Healthy Darlington Theme Group.
Efficiency	The Work Programmes are integral to scrutinising and monitoring services efficiently (and effectively), however this report does not identify specific efficiency savings.

MAIN REPORT

Quality Accounts 2012/13

6. The Health Act 2009 requires Foundation Trusts to publish an Annual Quality Account Report.

7. The purpose of the Annual Report is for Trusts to assess quality across all of the healthcare services they offer by reporting information on annual performance and identifying areas for improvement during the forthcoming year and how they will be achieved and measured.

8. The priorities for improvement are divided into the three components of quality; safety, experience and effectiveness.

9. Overview and Scrutiny Committee's play an important role in development and providing assurance on Quality Accounts reports. The Health Act requires Trusts to send a copy of their report to be considered by their appropriate Overview and Scrutiny Committee.

10. In advance of the Trust's report being considered by Overview and Scrutiny Committees it is vital that the priority areas identified are considered and that discussion takes place. Comments or views from Overview and Scrutiny Committees should be reflected in the final report and involvement should be credited within the document.

Tees, Esk and Wear Valleys NHS Foundation Trust

11. TEVW hosted a stakeholder event on 13th February 2013, the Vice-Chair and Democratic Officer – Health attended on behalf of this Scrutiny Committee. A summary of the event has been produced and is attached at **Appendix 1**.

County Durham and Darlington NHS Foundation Trust

12. CDDFT hosted a stakeholder event on 4th March 2013 the Chair Democratic Officer – Health attended on behalf of this Scrutiny Committee. A summary of the event has been produced and is attached at **Appendix 2**.

APPENDIX 1

Tees Esk and Wear Valley NHS Foundation Trust : Quality Account Stakeholder Workshop, Middlesbrough.
14th February 2013

Attendance: Councillor J Taylor, Health and Partnerships Scrutiny Committee and Neneh Binning, Democratic Services.

Officers: Dr Ruth Briel, Acting Chief Officer, Chris Stanbury, Director of Nursing and Governance and Sharon Pickering, Director of Planning and Performance.

Quality Accounts: Introduction

As a result from the stakeholder event previously held on 16th July 2012, seven themes had been identified which stakeholders felt needed to be prioritised. These themes were; communication and engagement, care plans, crisis service, access to service, staff engagement and caseload management, patient transfers, and dual diagnosis.

The themes were subsequently fed into a Board Workshop, held in October 2012. The Board then identified the organisation's priorities for the next three years. The Board decided that three of themes should be prioritised (communication and engagement, care plans, and crisis service) and four quality priorities for 2013/14 were identified and would be included in the Quality Account 2012/13. The Board further agreed that the other themes would be reflected in the business plan for 2013/14 which would impact on communication and engagement, access to service and dual diagnosis.

A stakeholder event was held on 14th February 2013, to inform stakeholders of the priorities and ascertain feedback.

Performance Against Quality Priorities 2012/13

The Director of Nursing and Governance gave stakeholders a presentation and outlined the following quality priorities:

- **Priority 1:** To undertake a comprehensive review of the Care Programme Approach (CPA), care co-ordination process and care planning.
- **Priority 2:** To improve how we gain feedback from patients on their experience and improve our services and the feedback we receive.
- **Priority 3:** To sustain an improvement in all transfers of care with standard work practices and improved communication between professionals implemented.
- **Priority 4:** To develop broader liaison arrangements with Acute Trust around physical health needs of mental health patients.

In relation to **Priority 1**, the aim is to improve the CPA. Care co-ordination and care planning by improving compliance against agreed best practice by 31st March 2013. Stakeholders were informed that due to complexities of the multi-agency review the plan, attempt to complete the review, embed the changes and evidence improvement within a 9 month project plan), would be too rushed and may not result in best outcomes for good quality and safety of patient care. Therefore the review has been

changed to 'development of implementation and embedding plan' in 2012/13 with implementation from 2013/14.

The actions identified in 2012/13 Quality Account that have been delivered include:

- Established a multi-agency steering group and project group with wide consultation of service users and carers.
- Established 10 themes for review and project plan.
- Used staff, service user and carer consultation plus document review.
- Explored themes raised by patient surveys, serious incidents and complaints.
- Identified findings and made 22 recommendations.

The key findings of the CPA review since 2008 were:

- Service users felt they were not engaged with partners of their care.
- Significant administrative workload generated to meet a wide range of performance indicators and a lack of clarity of the most important indicators.
- Inconsistent capacity and skill mix in teams across the Trust unmatched to variations in local demand despite the fact different referral rates or demands.
- Overall feedback was poor communication and lack of time spent on interventions
- Lack of clarity of roles for care co-ordinators, lead professionals and non-registered care staff.
- No standard, shared best practice guidance.
- Variance in transfer process.
- A perception that not all core assessment documentation are appropriate for all clinical specialities.
- Care documentation has grown in an ad-hoc way.
- Lack of clarity and agreed processes regarding the management of section 117 (the aftercare of those detained under the mental health act).

The Stakeholders were then informed of **Priority 2** in detail. The aim of the priority was to maintain the number of service users and carers who were asked about their care in 2011/12 and demonstrate improvements in the feedback we receive on their experience of care by 31st March 2013.

In 2010/11, 1,147 were asked, in 2011/12, 3,054 were asked and between 1st April 2011- 31st Aug 2012, 1,269 were asked with an expected 3,045 by financial year end. Stakeholders were informed that once feedback has been received, it is reported to Ward Managers who take responsibility and input actions.

The Director of Nursing and Governance stated the actions that were identified in 2011/12 Quality Account had been delivered. The actions being delivered were:

- Routinely reviewing feedback from inpatient areas in adult mental health aswell as functional areas of mental health service for older people and taking action.
- Piloting a system for capturing the experience of service users and carers in community services.
- Report on plans for gathering feedback from children and young people and those with learning disabilities. The trust is working with the Learning Disability Service User Group in planning a process to ascertain feedback.

The Director of Nursing and Governance added that whilst it was intended to fully embed the service across the whole of the Trust it has been decided that more time needs to be spent on the planning and implementation phase for children and young people and learning disabilities, this will be carried out in Quarter 1 2013/14. Pictorial and graphical elements will be used to capture children and young people.

With Priority 3, the aim is to ensure all transfers of care meet the agreed set of best practice standards by 31st March 2013. During 2012 a series of audits were undertaken and led to a set of standards of best practice in December 2012. It was decided that audits should be carried out every 6 months; the next audit is due in June 2013.

With actions identified on 2011/12 Quality Account, the Trust has:

- Established a project group and reviewed our audit of standards and progress with plans to date.
- Produced a report on outstanding key areas for improvement.

The audits have created 21 standards, the Trust are aiming to achieve 90% with those standards.

In relation to Priority 4, the initial aim was to deliver the priority through a single Trust-wide project. However, following commissioners decisions to support two projects in the enhanced acute liaison services in County Durham and Darlington, (University Hospital North Durham) and Tees (with James Cook University Hospital and North Tees Hospital), the priority has been transferred to the projects.

Both projects will:

- Combine existing adult and older people liaisons services into Acute Trusts.
- Provide more specialist assessment and intervention into A&E, medical wards and community hospitals encouraging better liaisons with Acute Trust Staff.
- Ensure that a person's mental health needs are met when they are in Acute hospital for treatment for their physical health needs, thus removing one of the potential barriers to provision of good physical health care.

Benefits include:

- Early detection and intervention for people with physical and mental health needs.
- Reduction in attendees and re-attendance to A&E and Urgent Care Centres
- Reduction in admittance for A&E to Acute Hospital Wards, especially for those relating to self-harm
- Reduce lengths of stay in Acute Hospital wards and in Darlington this will include community hospitals
- Increase proportion of patients returning to their usual place of residence
- Reduce re-admissions to Acute Hospital wards

Actions plan for County Durham and Darlington project included:

- All element of service have been implemented or are on track for 2012/13.
- The outstanding action is to finalise accommodation for the new team within the Acute Trust in Durham.

Actions plan for the Tees project included:

- All elements of service are on track to have extended hours, then a 24/7 service in 2012/13
- The outstanding action is to resolve with the Acute Trust data collection and data sharing issues.

The Director of Nursing and Governance informed stakeholders that the evidence of improvement will not be available until the service has been fully established; this is estimated by Quarter 3 2013/14.

Performance Against Quality Metrics 2012/13

The Director of Planning and Performance, informed Stakeholders, that alongside the four priorities there were indictors the Trust has to report against.

The Quality Metrics that were outlined were Patient Safety Measures. Clinical Effectiveness Measures, Patient Experience Measures and National Patient Surveys. The Stakeholders were informed of the latest position at Quarter 3.

Patient Safety Measures

In relation to 'number of unexpected deaths classed as serious incidents, the target was 3 per quarter, the trust has gone above that target. Stakeholders were informed that if a patient was on the Trusts case load, within six months of the death (even if they were not on the caseload at the time of death), they will still be reported.

In relation to a number of outbreaks of Healthcare Associated Infections, the target was 0 and the Trust is currently on target. In relation to Patient Falls per 1000 admissions, the target was 37.44, the Trust is currently at 37.2 and therefore below target.

Clinical Effectiveness Measures

The trust set a target of 95% for Care Plan Approach follow up within 7 days, the Trust has excelled in this target and are at 96.5%. The Trust had a target of 100% in implementing NICE guidelines, and are below target at 12.5%, the figure is expected to increase drastically however the Trust has only been able to evidence and validate the guidance, the rest remains to be audited.

In relation to average length of stay for Patients in Adult Mental Health and Mental Health Services for Older People assessment and treatment wards, the Trust had set a target of 37, the Trust are currently at 34 and below target.

Patient Experience Measures

The Trust has set a target of 7.5% for Delayed Transfer of Care, at Quarter 3 the Trust is 2.12%. Stakeholders were informed that Monitor had set the target of 7.5% as a national standard.

In relation to the percentage of complaints resolved, the Trust has set a target of 90%, the Trust is currently at 83.67%. The Director of Planning and Performance highlighted

that in investigating complaints, a letter is written to the complainee with a response and result of the investigation. If the complainee remains unhappy this is counted as not being resolved. Sometimes the complainants submit their complaint to the Ombudsman but of those that have involved the Ombudsman none have been upheld.

National Patient Survey

Stakeholders were informed that a number of questions where the Trust' score was within 5% of the highest scored Mental Health trust was 29% in Quarter 3. The number of questions where the Trust was scored within the middle 90% of scored Mental Health Trust was at 71%.

In relation to the number of questions where the Trusts' score was within 5% of the lowest scored Mental Health Trusts, the result was 0 as the Trust has not been scored low.

The results cannot be compared to the previous years, due to a change in the system in how data is presented.

National and Regional Requirements

The Trust set a target to register with Care Quality Commission with no conditions. This target has been met.

In relation to the number of occupied bed days of under 18s admitted to adult wards, the target was 0, although the data illustrate there has been 28, 16 -18 year olds were admitted to adult wards, Stakeholders were told this was 'where clinically appropriate' and under instructions of clinicians, such as the patient would have turned 18 by the end of their treatment, maturity and with parental permission. The Trust has not admitted children to adult beds where it was not clinically appropriate.

In addition, the Trust is above target on the following Quality Metrics:

- Number of early intervention in psychosis new cases
- Number of crisis resolution home treatment episodes
- Percentage of admissions to inpatient services that had access to crisis resolution home treatment teams
- Care Programme Approach, 7 day follow up
- Maintaining level of crisis resolution teams set out in 2003/06 planning round

Quality Priorities 2013/14

The Acting Chief Operating Officer outlined the Quality Priorities for 2013/14:

- **Priority 1:** Implement recommendations of the CPA review, including improving care planning.
- **Priority 2:** Implement recommendations of CPA review, including improving communication between patients and staff.
- **Priority 3:** To improve the delivery of crisis service through implementation of the Crisis reviews recommendations
- **Priority 4:** To improve clinical communication with GPs

Following on from the Quality Priority 1 2012/13, the Stakeholders were informed of the actions for 2013/14 which were to develop a detailed implementation plan by Quarter 1 of 2012/14 and implement in line with project plan by Quarter 2 2013/14.

The key themes for CPA review recommendations for 2013/14 were also outlined. The Acting Chief operating Officer emphasised the need for a holistic care approach where a patients physical health is looked after from medication, to psychological therapies and treatment and then a focus on understanding the patient in a wider context.

The themes included; clarifying the roles and the functions of the care co-ordinator, lead professional and other team staff, embed values and principles of care coordination, develop standard operational processes, embed a risk management approach and clarify arrangements of section 117 aftercare.

Following on from Quality Account Priority 2 for 2012/13, the actions developed for 2013/14 are to develop a detailed implementation plan by Quarter 1 in 2013/14 and implement in line with the project plan by Quarter 2 2013/14.

The key themes that were highlighted were:

- Increase service user and carer involvement and engagement in the patient's care, by improving verbal and written communication, in order to maximise direct contact care time.
- Implement the 'My Shared Pathway' across all divisions.

Stakeholders commented that clinician and patient relationship could be improved, although clinicians need the technical competencies it is important that they adequately translate to patients.

Views were made in relation to documentation, as professionals have different roles, it is important for professionals to be care focused than document focused.

In discussing **Priority 3** 'to improve the delivery of crisis service through implementation of the Crisis reviews recommendations', Stakeholders were informed that the Trust is working on a new policy for the crisis team, to be more inclusive. In carrying out the review, the Trust was involved with LINk, GPs and Trust staff.

The following recommendations had been made, and will be implemented by Quarter 4, 2013/14:

- A new / revised operational policy
- New out of hours / night time arrangements, putting in place resources for out of hours service
- New day shift arrangements – where by the appropriate staff is matched to the appropriate referral
- A new role for shift co-ordinator – making sure there is a separate professional dealing with the assessment and a separate professional seeing the patients previously, making home visits
- Better working with the wards
- Training needs assessment

Stakeholders were informed of the actions following Priority 4 'to improve clinical communication with GPs:

- Agree a standard template and complete project scope by Quarter 1 2013/14, whereby every contact with a service will be made straight forward, all service providers will be asked to agree and use the standard template
- Agree a business case for the implementation of standard templates by Quarter 2 2013/14
- Ensure all electronic templates function effectively
- Establish Trust wide use of templates via senior clinical directors and directors of operations by Quarter 3 2013/14
- Develop a standard process for telephone and email access for clinical advice by Quarter 3 in 2013/14 and pilot in Quarter 4 2013/14
- Establish what are the most effective lines of communications with GPs by Quarter 4 2013/14

Summing up Quality Accounts 2012/13

Stakeholders were informed that the Quality Accounts document will include the latest review on performance of the Quality Priorities, Quality Metrics and National Indicators, for 2012/13. The report will cover the priorities of 2013/14 and stakeholder comments.

Timetable

- Quality Accounts will be written March/ April 2013
- Quality Accounts will be sent to the Board of Directors on 16th April 2013
- Quality Account will be sent to Stakeholders including Darlington Borough Council, Health and Partnerships Scrutiny Committee on 19th April 2013.
- Stakeholder comments will be due back by 19th May 2013.
- The audit Committee will then see the Quality Accounts on 25th May.
- Annual Report will include the Quality Accounts and be sent back to the Board of Directors on 30th May 2013.

Publication of the Quality Accounts will be 31st May 2013.

APPENDIX 2

County Durham and Darlington Foundation Trust : Quality Accounts Event
4th March 2013
The Work Place, Newton Aycliffe

Attendance: Councillor Newall and Neneh Binning, Democratic Services.

Quality Accounts Event

The Director of Nursing welcomed Stakeholders to the event and outlined the purpose of the Quality Accounts. Quality Accounts has become mandatory, endorsed by legislation in 2010, whereby the NHS must report the quality of the service provided to enhance accountability and transparency.
The NHS Trust sets out targets, measures and exposes to community the results. The structure of the Quality Accounts is determined by the Department of Health and is strictly followed. The Quality Accounts compilation procedure contains:

- A statement by the provider
- Set of priorities for improvement in patient safety, patient experience and service effectiveness
- How the Trust has done in the previous year
- Clinical audit compliance
- Publish stakeholder comments on the Quality Accounts
- Data collected, the legitimacy and follow due diligence processes
- Independently audited assessment of the Quality Accounts
- Submit to the Secretary of State
- Publication on the NHS Choice website

Stakeholders were informed that the 1st draft will be available at the end of March. The aim of Quality Accounts was putting Quality Accounts on the same footing as financial reporting and collating data nationally.

The Achievements so far were outlined:

- Patient falls have been reduced and the Trust is on track. However fractured neck femur has not reduced so this will be a quality for next year
- HSI/ MRSA was set at a target of no more than 2 cases, currently the Trust is at zero
- Clostridium Difficile was above Target and assessments were going well
- Discharge Summaries were variable and need substantial work on-going, the Trust are not happy with the summaries so far
- Nutrition and Hydration was being monitored monthly and currently data is variable. The Trust will be included this priority in next year's Quality Account
- Work was still on-going with End of Life Care

- Compassion and Dignity, patient stories were impacting on staff as an excellent vehicle for change and the Trust are on track with delivery. A priority for the coming year is to continue patient engagement.
- In relation to complaints on attitudes of staff the Trust was on track
- Risk Adjusted Mortality, work was on track
- Discharge Planning was on track and compliance was well underway with the Stoke Pathway
- Reduction in average re-admission was variable

Stakeholders were then asked to move around the room to various boards and collate what each area was doing to tackle a priority.

Patient Experience

There has been an introduction of 'moment in your time' comment card. As of the 1st April will include friends and family test, every patient will have a right to pass comments on care received. The patient will give a grading score and the card will then be entered into a sealed box. The patient experience team will collect the cards monthly and then actioned by Ward Manager. Comments will also be posted on the intranet.
All wards will be under review and will include Emergency Departments, Community Hospitals and services.
Patient's stories are rich data and patient outcomes may be great but if the experience is not good that will take precedent. If a story is made on COPD or Obesity this can be brought to Committee.

Attitudes of Staff

Working towards interviewing 20 patients per ward, in 2011-12, 2,500 patients were interviewed the Trust want to excel in this number.
In relation to post discharge survey, 400 questionnaires per ¼ were circulated and the Trust had a 30% response rate.
The survey mirrors the national input survey and results are due in April of those questioned from last May. The data collection does take a year and wanted a more up to date systems so now do quarterly surveys. The Trust further works in partnership with LINk in undertaking enter and views and value the importance of feedback to identify positive action plans.

Every quarter the Patient Experience Team draws together information complains, accidents data and feedback actions. In responding to the patient's complaint a copy of the action plan is sent.

Pressure Area – Chronic Illness, Home Setting and Care Setting

Pressure Area team trains district Nurses and go in as a specialist team to home and care settings, to avoid patients from being admitted. The team covers Durham and Darlington and provide training to care homes and practice nurses.
The team also cover the issuance of equipment for instance Bariatric Assessment tools to help patients with mobility issues; these tend to be for patients that are chronically unwell.

Within the acute setting the team oversees patients that are acutely unwell and visit those who have pressure ulcers, making sure there is adequate care, meeting their holistic care (equipment, hydration, nutrition) needs are being met, in order to prevent for instance further tissue damage.
It was emphasised that training is important and not just for nurses but carers too. Comments were made that the area needed ownership as had long term investment potential.

MRSA / Clostridium Difficile

This area was explained as mandatory as MRSA and Clostridium Difficile have knock on effects for other aspects of Quality Accounts.
Work has started heavily on hand washing, audits were undertaken on various sites, where staff were observed and immediate feedback was given. Work is underway to pilot hand washing station in ward corridors, one will be placed in Durham and one in Darlington, to avoid spills on corridors flow work will be concentrated on looking at the flow and possibly automatic taps.
Comments were made that challenging behaviours need to be tackle and staff should feel that they are able to say to one another to wash hands. Foam sanitizers combat against most diseases even Nora Virus, the only disease left to cover is Clostridium Difficile, which is being addressed by soap and water as the most effective solution.

Mortality and Re-admissions

It was explained that Summary Hospital Mortality Index (SHMI) the national position is set by the Department of Health for patients that die 30 days post discharge. The Risk Adjusted Mortality Index (RAMI) must remain below 100. Currently the Trust is on target.

In relation to re-admissions it as reported that the Trust is doing fine, there have been some peaks however beginning to level off. For re-admission avoidance over 6 weeks, nationally a 30 day target is set and locally a 28 day target is set, both targets are being monitored by the Trust.

The main reason for re-admissions had been 48 hours post discharge and as result of patients not understanding their medication, anxiety over care plan, and care package. This seems common with elderly people. The Trust recognises the need for robust communication and integration with community team, comment made that it should not be classed as discharge but transfer of care to an appropriate team.

Information and Governance

A tool kit has been designed for information and governance and is graded between 0-3, 0 being non complaint and 3 being fully compliant and is monitored three times a year, allowing for improvement and final submission.
There are 45 criteria's and the Target was training 95% of staff available, and currently the Trust is on 93%.The training involves outlining policy and procedures, risks within the trust, reporting incidents and record management. Every member of staff will

undertake training and central issues are mandatory such as health and safety and Trust wide, if further training is needed it will be identified by Managers.
Corporate records are then externally audited, to measure the Trust and give assurance or help devise action plans where faltering.

Safeguarding, Training Engagement with Patients and Carers

4 areas had been identified:

1. Dedicated safeguarding strategy - that links with patient safety, patient experience and service effectiveness
2. Process of feedback - the reporting back needs to engage patients, carers and professionals to keep them adequately involved
3. Case File Audits - the system for recording capacity needs to be more robust. The duty and responsibility can be met in a more robust way
4. Training – making sure all staff are appropriately trained to the right level.

Safeguarding will be mandatory and training will be inclusive and maintained ½ day every three years.

Learning Disabilities

Audits are being undertaken quarterly, measuring how the Trust is measuring and performing against adults with learning difficulties.

A drop is seen in the data during the period of August 2012, however this was due to a change in the auditing method rather than any targets not being met.

A tool kit has been complied to support staff to manage risk and deliver good care, The Target is as a minimum 90% however the Trust is aiming for 100%. Focus will be made on carers, looking at what support they may need and identifying a way forward.

A 'Hospital Passport' is now underway, which the patient will carry around with them and outlines the patient's needs, carers and family members have been asked to fill in the 'Hospital Passport'. The card is lent to the professional and is given back t the patient to be carried around and used through their journey in care.

General Patients Incident Report

Such incidents include near misses, serious untoward incidents, falls resulting in fractures, pressure sores and other measures for staff such as sharps injuries and physical assaults (commonly through engagement with Dementia patients).

Staff comply with the 6 Cs; competence, courage, compassion, communication, commitment and challenge. The focus is harm free care and reducing harm.

Where harms are reported, a root cause analysis will be undertaken and incident review will be conducted. The Trust has done an initial gap analysis following the Francis report and has undertaken a safety culture audit. There has been a whistleblowing

policy and the Safeguard Risk Management System allows staff to report anonymously. A safety culture is encouraged at all levels.

NHS QUEST

12 organisations are in the NHS Quest programme, a voluntary group forming collaboration. Each organisation may have a different priority for safety and quality, but where there is a similar situation the organisations will help one another to get there faster.

The programme looks at leadership, improvement programmes, building capabilities and developing skills. The programme also involves peer site visits where each organisation would welcome the other organisations to visit them and outline what they are doing well and what they are not doing well in, to encourage support from one another.

Falls Dementia and Malnutrition

Quality indictors assess overall number of falls, and falls with serious injuries. The Trusts Target was to reduce falls by over 10% due to assessment of falls and falls bundles in place based on national best practice. The Trust is on target.
In relation to falls that result in injury, the Trust is below target and want to maintain threshold at 25%.

In relation to dementia, now a national focus, it is important to attract early diagnosis and intervention to reduce risk. National screening questions have been compiled to ascertain if the patient is suffering from memory loss, a full assessment is undertaken, then referral to specialist service. The Target is 90%.

With Malnutrition, Staff must ensure nutritional risk is assessed, if the patient will be in longer than 7 days a re-assessment will be undertaken. Where the patient is at risk they will be referred to specialist dietician. The Trust is currently at 98%.

Cardiac Arrest Prevention

The Trust is currently looking at reducing cardiac arrest. So far 1/3 could have been prevented, 1/3 should have not be resuscitated and 1/3 nothing could have been done.
Key recognitions before cardiac arrest are blood pressure, temperature and speed of heartbeat.

The public perception of not resuscitating is negative, these patients are terminally ill and have requested not to be resuscitated, the Trust are then responsible to make sure everything is done to prevent them from arresting and work hard on that instead.

End of Life Care and Palliative Care

The Trust aims to improve on the number of patients that receive their preferred place of care through the End of Life Care pathway. The Target was to improve on findings.
In April 2011- March 2012, 397 patients were referred to the service, 92% of patients received their place of care, those who didn't, their symptoms become problematic, or the patients had changed their minds.

Actions

a) That the information at the event be noted..

b) That the notes be forwarded to the Members of the Health and Partnerships Scrutiny Committee.