County Durham and Darlington NHS
NHS Foundation Trust

Health and Partnerships Scrutiny Committee
Quality Accounts 2014/15
23 April 2015

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with you all the way

PURPOSE OF REPORT

- To provide an update on the outcome of previous year's Quality Accounts.
- To provide information to Health and Partnerships Scrutiny Committee on the outcome of the Stakeholder Events held in December and March 2015.
- To agree mandated indicators for limited assurance audit.
- To agree local indicator with Governors of the Trust.

The table below summarises the specific priorities and objectives that were agreed for inclusion in the 2014/2015 Quality Accounts. The table also indicates where this was a new or mandatory objective and where this was a continuation of previous objectives. While most of the priorities are not new we did introduce different methods for monitoring where the priority had changed or the service objectives had changed.

The table is coloured for key areas as follows:

Green = on track to deliver Trust ambition
Amber = Improvements seen but Trust ambition not achieved
Red = Trust ambition not achieved

Priority	Rationale for choice	Measure
SAFETY		
Patient Falls[1] **(Continuation)**	Targeted work continued to reduce falls across the organisation. To ensure continuation and consolidation of effective processes to reduce the incidence of injury To introduce sensory training to enhance staff perception of risk of falls To introduce a follow up service for patients admitted with fragility fractures	To collect data on number of falls reported internally onto Safeguard incident management system and report to Safety Committee via the Incident Report on a monthly basis. To aim for a further reduction in falls to bring in line with national average. To aim for 5.6 per 1000 bed days in acute ward areas and 8 per 1000 bed days in community bed areas. Report monthly figures via monitoring charts to Trust Board. To introduce sensory training into staff education programmes To follow up patients identified as

		having fragility fractures To continue to carry out full root cause analysis of falls resulting in fractured neck of femur and report monthly to Safety Committee
Care of patients with dementia[1] **(Continuation)**	Continued development of a dementia pathway	Continued production and roll out of a dementia pathway year 2. Audit of use of the dementia pathway following its introduction to be reported to Quality & Healthcare Governance Committee using a bespoke audit tool. For completion by December 2014
Healthcare Associated Infection **MRSA bacteraemia**[1,2] **Clostridium *difficile***[1,2] ***(Continuation and mandatory)***	National and Board priority. Further improvement on current performance	Achieve reduction in MRSA bacteraemia against a threshold of zero. No more than 37 cases of hospital acquired Clostridium *difficile* Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee
Venous thromboembolism risk assessment[1,2] **(Continuation and mandatory)**	Maintenance of current performance	Maintain VTE assessment compliance at or above 95% within inpatient beds in the organisation. This mandated indicator will continue during 2014/15 Assessment will be captured onto a Trust database and reported weekly to wards and senior managers. Performance will be reported and monitored at Trust Board using performance scorecards

Pressure ulcers[1] ***(Continuation)***	To have zero tolerance for grade 3 and 4 avoidable pressure ulcers	Full review of all identified grade 3 and 4 pressure ulcers to determine if avoidable or unavoidable Reduce incidence from last year to zero avoidable grade 3 or 4 pressure ulcers All identified pressure ulcers will be reported onto the Trust internal incident reporting system and numbers reported to Safety Committee via monthly incident report
Discharge summaries[1] **(Continuation)**	To continue to improve timeliness of discharge summaries being completed	Monitor compliance against Trust Effective Discharge Improvement Delivery Plan Enhance compliance to 95% completion within 24 hours Data will be collected via electronic discharge letter system and monitored monthly with compliance reports to Care Groups and Trust Board via performance scorecards
Rate of patient safety incidents resulting in severe injury or death [1,2] **(Continuation and mandatory)**	To increase reporting to 75th percentile against reference group	Cascade lessons learned from serious incidents Introduce specific monthly monitoring to highlight and action poor compliance with timeliness of reporting and investigating serious incidents via Incident Report to Safety Committee. Upload patient safety incidents to NRLS each month Measure compliance against NRLS data. Enhance incident reporting to 75th percentile against reference group
EXPERIENCE		
Nutrition and Hydration in	To enhance and improve monitoring of nutrition and	% adult patients (>18 years old) that are correctly screened for

Hospital$_1$ **(Continuation)**	hydration in hospital To ensure that ward based quality metrics provide an accurate tool for close monitoring	undernutrition within 6 hours of admission using the 'MUST' nutritional screening tool % adult patients (>18 years old) rescreened weekly for undernutrition using the 'MUST' nutritional screening tool % adult patients (>18 years old) identified at moderate or high risk of undernutrition have evidence that an appropriate nutrition care plan has been implemented, which fulfils the recommendations on the 'MUST' nutritional screening tool (such as nourishing snacks, fortified diet, food record charts, nourishing drinks). % adult patients (>18 years old) identified at moderate or high risk of undernutrition have evidence of well completed food and fluid record charts % adult patients (>18 years old) identified at high risk of undernutrition have evidence of a referral to the dietitian % adult patients (>18 years old) receiving oral nutritional supplements (such as Fortisip, Calogen) have evidence of involvement from the dietitian % adult patients (>18 years old) receiving oral nutritional supplements (such as Fortisip, Calogen) are at high risk of Undernutrition Report and monitor compliance monthly via ward performance framework followed by Quality Metrics on introduction later in the year and review via Senior Nurse Leadership Group quarterly

End of life and palliative care[1] **(Continuation)**	To ensure that we recognise when a patient may benefit from palliative care both at the end of life and earlier in their illness.	We will measure the proportion of people who die each year where we have recognised this earlier in their illness and communicated to the general practitioner about the potential need for a palliative care approach. We will monitor what proportion of patients are recognised in advance to be dying and whether we have agreed individualised plans for their care with themselves or their family. Information will be collected and monitored via the Trust End of Life Steering Group
Development of a Learning Disabilities outreach service[1] **(Continuation)**	To follow up all patients with a learning disability upon discharge into the community setting, initially with a telephone call, followed by a visit in their own home where appropriate	Monitor admission and readmission rates so that any recurring themes can be reported on and raised with the appropriate partner agencies A biannual report will be produced and submitted to Quality & Healthcare Governance Committee to show progress and remedial action taken.
Responsiveness to patients personal needs[1,2] **(Continuation and mandatory)**	To measure an element of patient views that indicates the experience they have had	Continue to ask the 5 key questions and aim for improvement in positive responses in comparison to last year's results Quarterly reports to Quality & Healthcare Governance Committee and any emerging themes monitored for improvement. The Trust will participate in the national inpatient survey
Percentage of staff who would recommend the trust to family or friends needing	To assure ourselves that staff have a positive view of working at the trust	To bring result to within national average Results will be measure by the annual staff survey. Results will be reviewed by sub committees of the

care[1,2] **(Continuation and mandatory)**		Trust Board and shared with staff and leaders and themes considered as part of the staff engagement work
Friends and Family Test[3] **(New indicator following stakeholder events)**	Percentage of staff who recommend the provider to Friends and Family	During 2014/15 we propose to increase or maintain Friends and Family response rates and to rollout the questionnaire to other areas within the Trust. All areas participating will receive monthly feedback and a quarterly report of progress will be monitored by Quality and Healthcare Governance Committee
EFFECTIVENESS		
Risk Adjusted Mortality (RAMI)[1] **Standardised Hospital Mortality Index (SHMI)**[1,2] **(Continuation and mandatory)**	Part of NHS QUEST programme. To closely monitor nationally introduced Standardised Hospital Mortality Index (SHMI) and take corrective action as necessary	To monitor for improvement via Mortality Reduction Committee To maintain RAMI and SHMI at or below 100 Results will be captured using nationally recognised methods and reported via Mortality Reduction Committee. We will continue to benchmark both locally and nationally with organisations of a similar size and type. Monthly updates will be submitted to Trust Board via the performance scorecard Weekly mortality reviews led by the Medical Director will continue, and any actions highlighted monitored through Care Group Integrated Governance Reports
Reduction in 28 day readmissions to hospital[1,2] **(Continuation and mandatory)**	To improve patient experience post discharge and ensure appropriate pathways of care To support delivery of the national policy to continue to ensure patients receive	To aim for no more than 7% readmission within 28 days of discharge Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust

	better planned care and are supported to receive supported self – care effectively	Board using the performance scorecard and any remedial actions measured and monitored through the Task & Finish Group
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] **Continuation and mandatory)**	To improve patient experience To improve current performance	No more than expected rate based on locally negotiated rates. Monthly measure Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard and any remedial actions measured and monitored through the Task & Finish Group
To reduce length of time for ambulance services to hand over patients in Accident and Emergency department[3] **(New indicator following stakeholder events)**	To improve patient experience To improve current performance	Reduction in ambulance handover delays (measured at reduction of 2 hour delay) Data collection via Emergency Department data collection system Measure baseline quarter 1 then agree reduction target from baseline for the rest of the reporting period
Patient reported outcome measures[1,2] **(Continuation and mandatory)**	To improve response rate	Response rate for all 4 indicators to be in line with the national average by 2014/15 Data submitted via national database and monitored with Care Groups using performance scorecards so that any action can be monitored To aim to be within national average for improved health gain. To monitor by care group performance meetings as data is released

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

POINTS OF NOTE

- **Patient Falls** (reduction in incidence per 1,000 bed days)

  Remains higher than national average per 1000 bed days

- **Patient falls resulting in injury (defined as falls resulting in fractured neck of femur)**

  On track to deliver Trust ambition

- **Development of Dementia Pathway**

  Work commenced as dementia lead now employed

- **MRSA Bacteraemia**

  Not on track to deliver -

  Case 1 = contaminant

  Case 2 = Probable wound infection

  Case 3 = Sampling issue

  Case 4 = Possibly line related

  Case 5 = under review

- **Clostridium *difficile***

  Best performance in the region

- **Pressure ulcers**

  Improvement on hospital acquired grade 2 incidence

  Not on track to deliver ambition for grade 3&4 hospital acquired pressure ulcers

- **Reduction in re-admission rate to hospital within 28 days**

  Ambition not on track to deliver

  Key actions

  Intensive short term intervention services, working in partnership with local health and social care partners
  Improved front of house and ambulatory care services at our acute sites

- **Nutrition and Hydration**

  Quality Metrics in pilot stage which includes compliance monitoring for nutrition and hydration

  A Trust wide review of food and food service has been undertaken

New menus have been developed with patients for patients – to be launched this week (National Nutrition and hydration week)

A pilot of the provision of a small thermal flask as appropriate to patients so that they can make their beverage when it suits them

Work is underway to update the Malnutrition Screening Tool (MUST) to make it more user friendly

Work is underway to ensure patients identified as needing nutritional support commence first stage support while waiting review

FEEDBACK FROM STAKEHOLDER EVENTS DECEMBER 2014 AND MARCH 2015

Agreement reached to include the following indicators:

- **Ensure positive messages are included in the report, including examples of patient stories and case studies**
  Examples to be included in this year's report
- **Sepsis**
  This is also a mandated indicator for CQUIN for 2015/16. The first year will focus on identification of sepsis and management
- **Documentation**
  The new Trust documentation has been rolled out and will be amended dependant on feedback from staff across the organisation
- **E observations**
  Roll out will continue and its use monitored throughout the year
- **Learning & Disabilities further work**
  As further work with discharge follow up the team will work with providers to develop "coming into hospital" packs for the care delivery of patients with complex needs. This will use a partnership care planning approach
- **Staffing levels**
  Meeting National Quality Board standards and will aim to continue to deliver against these standards.
- **End of life care**
  We will continue to roll out the principles of "Deciding Right" and monitor progress through the newly established End of Life Steering Group
- **Duty of Candour**
  We will continue to monitor performance for this using moderate harm and above incidents as the framework for compliance as nationally mandated
- **Serious incidents/Complaints**
  We will incorporate key learning from serious incidents into next year's report

AUDITORS ASSURANCE ON PERFORMANCE INDICATORS FOR 2014/15

For NHS Foundation trusts providing a mix of different types of services should follow the guidance for the category of services from which they receive the majority of their

income. This has been confirmed as the category of NHS Foundation trusts providing acute services so the mandated indicators are as follows:

1. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
2. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

LOCAL INDICATOR FOR AGREEMENT WITH GOVERNORS OF THE TRUST

Emergency Department timeliness indicators.

RECOMMENDATION

That the above indicators are agreed for inclusion in the forthcoming Quality Accounts.