County Durham and Darlington NHS
NHS Foundation Trust

Special Health and Partnerships Scrutiny Committee Darlington

Quality Accounts Briefing

November 2016

Joanne Todd
Associate Director of Nursing (Patient Safety and Governance)

QUALITY ACCOUNTS UPDATE

PURPOSE OF THE REPORT

To update the committee on progress of County Durham & Darlington NHS Foundation Trust with regards to the agreed priorities for improvements for the 2016/2017 period. This report provides and update from April 2016 to September 2016.

WHAT ARE QUALITY ACCOUNTS?

Quality Accounts are annual reports to the public from the providers of NHS healthcare about the quality of the services they deliver. The primary purpose is to encourage leaders of healthcare organisations to assess the quality of care they deliver. The Quality Accounts for County Durham & Darlington NHS Foundation Trusts includes indicators set by the Department of Health and those we have identified as local priorities.

PRIORITIES FOR 2016/2017

The table below sets out the priorities and position (where data is available). The priorities were agreed through consultation with staff, governors, local improvement networks, commissioners, health scrutiny committees and other key stakeholders.

Where progress can be reported at this point this has been colour coded as follows;

RED – not on track
AMBER – improvement seen but not to level expected
GREEN – on track

Priority	Goal	Position/Improvement Work
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 continue sensory training to enhance staff perception of risk of falls To continue 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 continue sensory training into staff education programmes To follow up patients identified as having fragility fractures

		To investigate the causes of preventable falls Produce key actions from the results of the national falls audit Roll out 1:1 supervision guidelines Policy updates and supervision guidelines distributed. Falls remain within national average parameters
Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia	Pathway in place Development of the service following employment of dementia nurse lead Dementia friendly signage to be rolled out to all inpatient wards 18 inch faced clocks to be in place in all high volume dementia areas Review and update mental health intranet site to include dementia workstreams and resources Engage in national dementia audit and act on analysis of findings when available Sensory garden to be established on DMH site Continue rollout of coloured toilet seats, coloured door frames to complete in all appropriate areas All ward areas to have a supply of coloured crockery, adapted cutlery and opaque jugs and glasses to meet the needs of patients with dementia as determined by ward manager Roll out of orientation boards to all areas that care for patients with dementia as determined by ward/department manager

		Develop and roll out dignity leaflet once agreed through relevant stakeholders Relevant staff to engage in "Inside out of mind" video and discussion session Review content of workbook attached to "Inside out of mind" to establish whether any aspects need to be incorporated into current training Goals for CDDFT are being implemented as planned and good improvement seen in recent PLACE assessments
Healthcare Associated Infection **MRSA bacteraemia**$_{1,2}$ **Clostridium *difficile***$_{1,2}$ ***(Continuation and mandatory)***	Achieve reduction in line with target: MRSA = 0 Clostridium *difficile* = 19	CDDFT has reported 2 cases of MRSA Bacteraemia since April 2016. The first review identified contaminated specimen, the second review is underway. CDDFT have reported 8 cases of Clostridium *difficile*
Venous thromboembolism risk assessment$_{1,2}$ **(Continuation and mandatory)**	Maintain VTE assessment compliance at or above 95% within inpatient beds in the organisation.	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 Current achievement is above 95% for assessment.
Pressure ulcers$_{1}$ ***(Continuation)***	To have zero tolerance for grade 3 and 4 avoidable pressure ulcers	CDDFT have reported one pressure ulcer since April 2016
Discharge summaries$_{1}$	To continue to improve timeliness of discharge summaries being completed	The Trust continues to operate just below the standard, although in an increasing number of weeks

(Continuation)	Enhance compliance to 95% completion within 24 hours	performance exceeds this threshold.
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	NRLS data (October 2015-March 2016) shows the Trust remains within the 50 percentile of reporters of incidents. Dramatic improvement on timeliness of reporting compared to previous reports. The main improvement seen during this period is an improvement in timeliness of uploading incidents to NRLS to top end of reporters
Improve management of patients identified with sepsis [3] **(Continuation)**	To implement sepsis care bundle and audit effectiveness	The new bundle has been built and a baseline audit of performance is underway. The e observations system is being upgraded to allow a trigger of patients who fall into the category of assessing for sepsis. This is expected to go live mid-February.
Duty of candour **(**New indicator)	To demonstrate introduction and compliance with statutory Duty of Candour	Duty of Candour monitored for continued compliance via fortnightly Patient Safety Forum meetings
EXPERIENCE		
Nutrition and Hydration in Hospital [1] **(Continuation)**	To promote optimal nutrition for all patients	Re-energise protected meal times Increase the use of volunteers for mealtime assistance Continue to use nutritional bundle for weekly nutritional care planning of patients nutritionally at risk for inpatients Trust wide menu review of finger foods Report and monitor compliance monthly via Quality Metrics

		Quality Matters audits now embedded and review of results underway to inform any further interventions required
End of life and palliative care[1] **(Continuation)**	We want our workforce to be equipped to provide high quality end of life care. We want patients approaching the end of life to be confident in receiving high quality care in accordance with their wishes.	Survey targeted staff groups about their confidence in delivering end of life care before and after delivery of end of life education. This was not undertaken as there are no valid & reliable methods of measurement & it would be difficult to evidence. Monitor the proportion of staff accessing end of life training and to continue in pilot areas Care of patients who are identified as approaching the end of life will be audited against the regional guidance for the care of patients ill enough to die will continue in pilot areas Carry out a survey of bereaved relatives. Proposal shared at EOL Steering Group & methodology being refined prior to launch in the coming year Work stream underway through established End of Life steering Group
Learning disabilities[1] **(Continuation)**	As a continuation from the work developed through the learning disability guarantee and outreach service we have highlighted that not all service users arrive into the acute hospital setting with enough information to support staff in delivering reasonably adjusted care. Readmission rates could be further reduced with the implementation on emergency health care plans in specific cases.	This goal is now embedded within the organisation and will move to "business as usual" from this year. Compliance remains embedded in practice

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 years results Quarterly reports to Quality & Healthcare Governance Committee and any emerging themes monitored for improvement. The Trust will participate in the national inpatient survey Improvement goals continue to be monitored with actions in place to address any issues identified.
Percentage of staff who would recommend the trust to family or friends needing care[1,2] **(Continuation and mandatory)**	To show improvement year on year bringing CDDFT in line with the national average by 2017-18	To bring result to within national average Results will be measured by the annual staff survey. Results will be reviewed by sub committees of the Trust Board and shared with staff and leaders and themes considered as part of the staff engagement work In addition we will show results for harassment & bullying and Race Equality Standard as suggested by Monitor for this year and coming years Results are not available at this point
Friends and Family Test[1] **(Continuation)**	Percentage of staff who recommend the provider to Friends and Family	During 2016/17 we propose to increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback and a quarterly report of progress will be monitored by Quality and Healthcare Governance Committee Work is continuing to increase response rates however the percentage of patients who would recommend the service to others remains high

EFFECTIVENESS		
Risk Adjusted Mortality (RAMI)[1] **Standardised Hospital Mortality Index (SHMI)**[1,2] **(Continuation and mandatory)**	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 CDDFT remains within expected limits and mortality review group continues
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 better planned care and are supported to receive supported self – care effectively	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 Board using the performance scorecard and any remedial actions measured and monitored through the performance framework. Challenge continues and improvement not yet seen in percentage rate. Collaborative work continues
To reduce length of time to assess and treat patients in	To improve patient experience To improve current	No more than expected rate based on locally negotiated rates. Monthly measure

Accident and Emergency department[1,2] **Continuation and mandatory)**	performance	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 Front of House Task Group This remains challenging and data shows there continues to be growth in attendances to the departments. Escalation frameworks have been updated and Transforming Emergency Care Programme continues to be the key internal improvement process with continued review in Director led assurance meetings
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 2016/17 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 Results not available at this point
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators	To monitor for maintenance and improvement in relation to breastfeeding, smoking in pregnancy and 12 week booking Complete gap analysis against "Saving babies lives" NHS England document Review of maternity services complete and action plan produced. Work surrounding the action plan underway

Paediatric care (new indicator following stakeholder event)	Improved paediatric pathways for urgent/emergency care	To monitor and report on changes to the pathways

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

To complement the above the Trust has embarked on the 'Sign up to Safety' campaign and aligned the priorities closely with the Quality Account. The priorities for 2016/17, which follow through from 2015/16, are as follows:

- **Put safety first -** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally, in particular, reducing sepsis, providing safe staffing levels, introducing e-observations and reviewing the serious incident levels.
- **Continually learn –** make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.
- **Honesty –** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- **Collaborate –** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
- **Support –** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

RECOMMENDATION

That the Committee receives the report as evidence of ongoing commitment to improve quality outcomes for patients under our care.

Joanne Todd
Associate Director of Nursing (Patient Safety & Governance)
November 2016