County Durham and Darlington NHS
NHS Foundation Trust

Health and Partnerships Scrutiny Committee Darlington

Quality Accounts Briefing

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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 2017/2018 period. This report provides and update from April 2017 to September 2017.

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 2017/2018

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 - Produce a thematic to assist with action planning in 2017/18. - To continue to produce Trust bulletins to include the importance of key practices to improve the

		compliance with lying and standing blood pressure. - Continue to include 1:1 supervision guidelines in essential training. - Participate in National Falls audit in May 2017 - Develop a post falls management tool for use in the community. - Explore the use of a falls assessment tool for day centres. This remains an ongoing risk in the Trust. A substantive post has been approved to lead the agenda, a falls strategy is being developed and the falls group has been revamped and are monitoring bespoke quality improvement initiatives for their effectiveness
Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia	- Adherence to the national standards on assessment of patients aged 75 and over to ensure they are asked about their memory on admission; and measure ongoing referral rate Monitoring continues - Develop/implement further education in screening of dementia and on-ward referral staff have, Refresher sessions offered to staff and included in F1 training, now looking at implementing the screening tool to the electronic hand held devices which should improve compliance. - National dementia audit, report due July 2017, action plan to be developed and implemented as appropriate to the findings of the report. Action plan developed and at present going through trust committees for agreement, - Implement carer's access and support based on the ethos of the Johns campaign. Funding identified to pay for printing of 200 copies, of the passport; copies now need to be distributed to the wards along with the poster. - Carers survey, report due April 2017, action plan to be developed and implemented as appropriate to the findings of the report. - Report was written in Feb 2017 along with recommendations; the

		recommendations from the report mirror those in the national audit of dementia action plan and recommendations. - To arrange four taster sessions throughout the year offering the nursing staff an opportunity to participate in a full study day as a group based on the inside out of mind work-book. To evaluate the potential of including such sessions on a recurrent basis in the lifelong learning directory. - This has not so far been achieved , due to access to the training for the trainer to enable to facilitate the sessions and permission to use and adapt - Participate in a 5year research project of dementia services within the Durham area. On going - Participate in a 1 year study in the development of a good practice audit tool for assessing patient care and services for those living with dementia. On going
Healthcare Associated Infection **MRSA bacteraemia**[1,2] **Clostridium *difficile***[1,2] ***(Continuation and mandatory)***	Achieve reduction in line with target: MRSA = 0 Clostridium difficle = 19	CDDFT has reported 3 cases of MRSA Bacteraemia since April 2016. A full review has been carried out on each case with no recurrent themes identified. Work on-going reviewing practices such as IV line care and aseptic technique CDDFT have reported 12 cases of Clostridium *difficile,* with one case successfully upheld at appeal with CCG. Work is ongoing within the organisation to share lessons learned via engagement events and focussed education and training at ward level. Trust is holding a number of events as part of National antibiotic awareness week.
Venous thromboembolism risk assessment[1,2] **(Continuation and mandatory)**	Maintain VTE assessment compliance at or above 95% within inpatient beds in the organisation.	Current achievement is above 95% for assessment.

Pressure ulcers[1] ***(Continuation)***	To have zero tolerance for grade 3 and 4 avoidable pressure ulcers	The acute and community team have now merged. Service level agreement with Tees, Esk & Weir Valley Trust continues. There have been no avoidable pressure ulcers within acute services during the period There have been two avoidable grade 3/4 pressure ulcers in community services during the period
Discharge summaries[1] **(Continuation)**	To continue to improve timeliness of discharge summaries being completed Enhance compliance to 95% completion within 24 hours	Since April 2016, the Trust has dispatched an average of 93.2% of summaries per month within 24 hours. The only month this has fallen below 90% was in September 2017 and it is thought this may be associated with the changeover of junior doctors in August. A working group has been set up to identify actions which will help the Trust make the final push to reach the 95% target consistently.
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 2016 – March 2017) shows the Trust remains within the 50 percentile of reporters of incidents. Improvement on timeliness of reporting has been maintained.
Improve management of patients identified with sepsis[3] **(Continuation)**	Continue to implement sepsis care bundle across the Trust Continue to implement post one hour pathway Continue to audit compliance and programme Hold professional study days Roll out electronic method of monitoring patient's for sepsis	Sepsis screening is now a mandatory field on the Trust's Nervecentre system. This is being rolled out across all in-patient wards and resulted in 100% compliance with the CQUIN screening target in Q1 and Q2. The Emergency Department does not use Nervecentre and fell short of the CQUIN target in Q1 and Q2, but sepsis is now a mandatory field on their Symphony system so latest results show 100% compliance. Consistently providing treatment within one hour is now the focus of attention, although it was successfully achieved in Q1 and Q2.
Duty of candour (Continuation)	To monitor compliance with statutory Duty of Candour compliance	Duty of Candour compliance is currently 96% and continues to be monitored via fortnightly Patient Safety Forum meetings
Local Safety Standards for	To ensure full implementation of national guidance embedding Local	- The Trust has formed a LocSSIP Implementation and Governance Group (LIGG) which brings together members of the

Invasive Procedures (LOCSSIPS) **(new indicator from Stakeholder event)**	Safety Standards into all areas conducting Invasive Procedures trust-wide.	Corporate Governance body with Care Group representatives in order to develop LocSSIPs. - The LIGG will work with procedural teams to support the implementation of developed LocSSIPs ensuring all individuals understand why the programme is required and how the additional steps are to be conducted. - The LIGG will co-ordinate both quantitative and qualitative audits to ensure procedural LocSSIPs are being conducted to a high standard providing reports to IQAC and the Trust Board. - The project is progressing well with the majority of checklists and safety notices either in an advanced stage of development or being trialled in procedural areas. - The scope of the groups development work was extended to include urgent re-development of the theatre WHO surgical safety checklist which is complete. - From the priority checklists, the full implementation of 'extraction of tooth' is slightly behind schedule due to the complexity of approval across multiple oral surgery and community dental groups. - The audit programme continues to develop with a trial audit planned within the next month to ensure the audit tool and process is fit-for-purpose.
EXPERIENCE		
Nutrition and Hydration in Hospital$_1$ **(Continuation)**	To promote optimal nutrition for all patients	- Focus on protected meal times - Continue to use nutritional bundle for weekly nutritional care planning of patients nutritionally at risk for inpatients – move the nutritional assessment tool to Nerve Centre and once embedded move the care planning bundle to nerve centre also. - Trust wide menu implementation of finger foods - Report and monitor compliance monthly via Quality Metrics Nerve centre currently under pilot, metrics are improving and close

		scrutiny continues of QM nutrition metrics, finger food menu in place
End of life and palliative care[1] **(Continuation)**	We now have an effective strategy and measures for palliative care. The measures are derived from the strategy and will support each patient to be able to say: *"I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)"*	- CQC action plan for palliative care 100% complete - Deliver at least 75% of strategic plan for end of life and palliative care - Responses to VOICES survey should be as good or better than 2012 benchmark - Continuing improvement in palliative care coding and "death in usual place of residence" Action plan from 2015 CQC inspection completed. Substantial improvement on 2017 CQC self-assessment and initial feedback from CQC. Local VOICES survey planned for 2018 (February) Continued increase in proportion of patients with palliative care input (palliative care coding) Increase in proportion of patients dying in usual place of residence
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 Integrated Quality and Governance Committee and any emerging themes monitored for improvement through the Patient Experience Forum - The Trust will continue to 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	- Trust score 59% in 2016 compared to the national average score of 68% for the same period. - Results for this question will be monitored via the quarterly Staff Friends and Family test along with the annual staff survey results for 2017 when published. Actions have been identified in staff matter action plans both trust wide and at a corporate level. As the

Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months[2] **(Mandatory measure)** **Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion[2]** **(Mandatory measure)**		new staff survey results are not due to be released until early January 2018 it is not possible to compare at this point in time. However the responses to this question in the SFFT show improvement as the score for the first half of the year is 61%. - Results from the 2016 staff survey show that staff reporting **never** having experienced harassment, bullying or abuse from other staff is 84.5% which is higher than the national average of 82.6%. - Results will be measured by the annual staff survey and any actions incorporated into staff matter action plans at both local and trust wide level. These plans are monitored on a quarterly basis by strategic change board and IQAC. - In addition we will continue to report results for harassment & bullying as part of our WRES annual report - The trust score for 2016 is 90% of staff believe there are equal opportunities for career progression compared to 87% nationally. The Trust has been consistently above the national average in the staff surveys for 2014, 2015 and 2016.
Friends and Family Test[1] **(Continuation)**	Percentage of patients who recommend the provider to Friends and Family	- Our response rate to the SFFT has improved greatly this year. The staff response rate for Q1 and Q2 in 2017 was 550 staff compared to only 216 for the same period in 2016 representing a 61% improvement rate. - Based on the responses received to date: The percentage of staff who would recommend CDDFT to friends and family if they needed care or treatment is 61% for the first two quarters of 2017. - The percentage of staff who would recommend the provider to friends and family as a place to work?' is

		47% of staff who responded in the first two quarters of 2017 Each quarter a SFFT report is sent to each Care Group highlighting areas of concern and these are included in their Staff Matter action plans which are monitored by the Strategic Change Board and IQAC
EFFECTIVENESS		
Hospital Standardised Mortality Ratio (HSMR)$_1$ **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 – Mortality Reduction committee receives and considers the mortality data. - To maintain HSMR and SHMI at or below 100 – HSMR is below 100 at 97.29, and whilst trending downwards SHMI remains over 100 at 101.66 - 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 – Monthly updates are submitted to Trust board, and the Trust Learning from Deaths Dashboard has been developed and will be submitted to the December Trust board in line with national guidance. - Weekly mortality reviews led by the Medical Director will continue, and any actions highlighted monitored through Care Group Integrated Governance Reports – Work is on-going to re-invigorate the weekly mortality review group and recruit to a central mortality review pool.
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	Information is submitted to the national database so that national benchmarking can continue. Results are monitored via Trust Board and any remedial actions will be monitored through the performance framework.

	better planned care and are supported to receive supported self – care effectively. To aim for no more than 7% readmissions within 28 days of discharge	Performance in 2017-18 has fluctuated around the 7% target. The Trust and commissioners are reviewing the impact of the health and social care schemes which received investment from re-admissions penalties to help determine future investment priorities. A further re-admissions audit is planned to establish the penalty threshold for 2018-19.
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 achieve 95% 4-hour wait target and trajectory agreed with NHSI. Improve current performance	The Trust achieved its 4-hour targets in Q1 and Q2, in the process significantly reducing the time wasted by ambulance crews waiting to handover patients. The Trust's Transforming Emergency Care Programme, including particularly the Perfect Month initiative, the roll out of SAFER care bundles, and the extension of the bronze command rota to cover w/ends, is the main reason for the improvement.
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 - To aim to be within national average for improved health gain. Improved compliance for questionnaire 1 demonstrated from Oct 16 – Oct 17. Care group to present nationally, how improved clinical engagement has resulted in improved compliance to understand patient outcomes. Due to retrospective data, this impact unlikely to be fully realised in specific patient outcomes until Q1 18/19. The provisional figures for 2016/17 show a rise in the health gains for the Trust in both hip and knee replacement, with performance at or above the national average. However, while health gains in groin hernia's have improved year on year from 0.064 in 2014/15 to 0.075 in 2015/16, this is still below the national average of 0.088.
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 - Monitor actions taken from gap analysis regarding "Saving Babies Lives" report

		Ongoing work to protect, promote and support breastfeeding across services. Both UHND and DMH have undergone successful UNICEF UK Baby Friendly Initiative reaccreditation. CDDFT remain the exemplar Trust within the region in relation to smoking in pregnancy and the implementation of the BabyClear Initiative. In-depth work currently ongoing in relation to putting in place sustainable solution to the 12 week booking target. All aspects of the Saving Babies Lives initiative are being implemented and embedded within practice.
Paediatric care (new indicator following stakeholder event)	Embed paediatric pathway work stream	Continue development of more direct and personal relationships with individuals within Primary and Secondary care by building on the work already undertaken Work ongoing and this is a key part of the emerging clinical strategy for Paediatrics

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

To complement the above the Trust has continued to commit to the pledges made in October 2014 to NHS England's "Sign Up To Safety" programme. To celebrate the work accomplished in 2015/16, the patient safety team presented at the International Nurses and Midwives conference on the 5th and 12th May 2016. This showcased the successful improvement achieved in line with the national programme and five pledges – putting safety first, be honest, collaborative and continually learn and supporting staff.

During 2017 the Patient Safety Team are leading on the Sign Up To Safety National Kitchen Table Week to further explore the art of conversation and developing different ways to enable people to talk to each other about what they know about keeping people safe.

All future improvement will continue to be monitored as a measure of the Trust's commitment to safety and quality, against the national Sign Up To Safety pledges:-

- **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 & 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.

For the June 2018 Quality Accounts, providers will be expected to report their progress in using learning from deaths to inform their quality improvement plans. This would be an annual summary of monthly/quarterly Trust Board reports on reviewing and learning from deaths. This builds on the work of the Royal College of Physicians2 in developing a methodology to support this process. Other resources to support this learning and process will be explored and implemented throughout the year.

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

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