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Health and Housing Scrutiny Committee Agenda

9.30 am Thursday, 16 January 2020
Committee Room No 2, Town Hall, Darlington, DL1 5QT

Members and Members of the Public are welcome to attend this Meeting.

1. Introduction/Attendance at Meeting

2. Declarations of Interest

3. County Durham and Darlington NHS Foundation Trust - Quality Accounts 2019/20 –
   Report of the Associate Director of Nursing (Patient & Safety)
   (Pages 1 - 10)

4. Tees, Esk and Wear Valley NHS Foundation Trust - Quality Account Update Quarter 2 –
   Report of Head of Planning and Business Development
   (Pages 11 - 16)

5. SUPPLEMENTARY ITEM(S) (if any) which in the opinion of the Chair of this Committee are of an urgent nature and can be discussed at this meeting

6. Questions

Luke Swinhoe
Assistant Director Law and Governance

Wednesday, 8 January 2020

Town Hall
Darlington.

Membership
Councillors Bell, Dr. Chou, Clarke, Donoghue, Heslop, Layton, Lee, McEwan, Newall and Wright

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Agenda Item 3

County Durham and Darlington NHS Foundation Trust

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 2019/2020 period. This report provides and update from April 2019 to September 2019.

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 2019/2020

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
SAFETY		
Patient Falls[1] **(Continuation)**	Targeted work continued to reduce falls across the organisation and the introduction of the dedicated falls team 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 continue the introduction of the Trust Falls Strategy, covering a 3 year period. - To agree a plan of year 2 actions. - To monitor implementation of year 2 actions against the Strategy. **Acute falls = 5.4 per 1000 bed days** **Community falls = 5.5 per 1000 bed days** **Multiagency action plan is underway and outcomes will be included in the Accounts** **Quality Improvement work continues and red zimmer frames have been introduced into key areas** **Lying/standing blood pressure has been built into the electronic observations tool to improve compliance**

Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia.	- The dementia screening tool has been incorporated into the electronic nerve centre, and removes the need for paper base assessment. - The next step is to migrate the data from nerve centre to formulate the national reporting criteria. This generates the statistics for measuring compliance with undertaking the dementia assessment. This will be migrated the end of the year. - Action plan developed from the NAD the intention is to utilise the finding from the 2018 NAD to see if there have been any changes in practice/improvements. - Carers survey has been completed. The recommendations are to be monitored alongside the national dementia audit recommendations. The action plans have been merged and form the Strategy Action Plan 2019/2020.This will be monitored. - Participate in a 5 year research project of dementia services within the Durham area to continue during 2019/2020. Participation to continue. - Continue the study in the development of a good practice audit tool for assessing patient care and services for those living with dementia. Participation to continue.
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. **One case reported since April 2019** - No more than 45 (see new reporting mechanism) cases of hospital acquired Clostridium *difficile.* **23 cases reported since April 2019** - Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee.
Pressure ulcers[1] ***(Continuation)***	To have zero tolerance for grade 3 and 4 pressure ulcers	- Implement new national reporting metrics - Review of all identified grade 3 or 4 pressure ulcers - Continued education programme **Four identified between April and September where lapses in care were identified**

Discharge summaries[1] **(Continuation)**	To improve timeliness of discharge summary completion.	- Data collected via electronic discharge letter system and monitored via monthly performance reviews and Board reporting. - Care Groups undertake consultant level audits - Train 2019 intake of new junior doctors **Compliance has remained at around 94% during the period. Work programme continues**
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. - NRLS data. Enhance incident reporting to 75th percentile against reference group. **A 38% increase of incidents reported Oct to Mar 2019 compared to the same period 2018, however still remain in the middle 50th percentile of reporters.** - Continue to embed Trustwide work to embed and improve reporting of near miss and no harm incidents.
Improve management of patients identified with sepsis[3] **(Continuation)**	To maintain improvement in relation to management of sepsis	- Continue to implement sepsis care bundle across the Trust. - Continue to implement and embed post one hour pathway. - Continue to audit compliance and programme. - Hold professional study days. **On track**
EXPERIENCE		
Nutrition and Hydration in Hospital[1] **(Continuation)**	To promote optimal nutrition and hydration for all patients.	- Continue to work closely together on hospital menu development and nutritional analysis. - Continue to work closely with Speech and Language Therapy colleagues within the Trust towards achieving International Dysphagia Diet Standardisation Initiative (IDDSI) ward menus and nutritional products. - In terms of hydration we will consider how we maintain and monitor sufficient hydration status of patients requiring both artificial (intravenous or enteral) and non-artificial hydration support. - We will explore how CDDFT might require alternative ways of measuring oral fluid intake at ward level. - **In progress**
End of life and palliative care[1]	We now have an effective strategy and measures for palliative care. The	- We will work with CCG and NEAS to agree a comprehensive approach to personalised care planning.

(Continuation)	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)"*	- We will work with regional partners to develop electronic sharing of key palliative care information (ePaCCS). - We will support and monitor new out of hours advice service. - We will continue to deliver palliative care mandatory training for all staff. - We will implement actions from postal questionnaire of bereaved relatives (VOICES). - We will implement actions and learning from Care of Dying Audit. - **In progress**
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 Integrated Quality Assurance Committee and any emerging themes monitored for improvement through the Patient Experience Forum. - The Trust will continue to participate in the national inpatient survey. **Annual response from National Inpatient Survey – local survey continues quarterly (quarter 1 result shows standard on track to deliver)**
Percentage of staff who would recommend the trust to family or friends needing care[1,2] **(Continuation and mandatory)** **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**	To show improvement year on year bringing CDDFT in line with the national average.	- 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 continue to report results for harassment & bullying and Race Equality Standard. **Annual response from Staff Survey**

provides equal opportunities for career progression or promotion[2] **(Mandatory measure)**		
Friends and Family Test[1] **(Continuation)**	To increase Friends and family response rates	- During 2019/2020 we will increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback and a quarterly report of progress and will be monitored by the Trust Board. **Improvement seen in response rates April to July**
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 embed "Learning From Deaths" policy	- To monitor for improvement via Mortality Reduction Committee. - To maintain HSMR and SHMI within expected levels. - 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. Updates will be submitted to Trust Board via the performance scorecard. - Trust mortality review process, allocation of priority reviews to central review team for completion will continue to ensure any learning, positive and negative, is embedded in patient care. - Embed "Learning from Deaths" policy. - In line with national changes the post of Lead Medical Examiner has been advertised. The successful post holder will lead the introduction of the Medical Examiner System, during the coming months. **Mortality monitoring indicators within expected range. Mortality reviews continue**
Reduction in 28 day readmissions to hospital[1,2] **(Continuation and mandatory)**	To implement effective and safe care closer to home, improving patient experience post discharge.	- Further development of multi-disciplinary Teams Around Patients (TAPS). - Safe discharge is a key theme of the Transforming Emergency Care programme.

		- Monitoring through monthly performance reviews and Board reporting. - Agreement with Stakeholders to set this threshold at a higher level and aim for year on year improvement on this. Set at 12% for 2019/2020 **Current performance 12.3%. work continues to improve on this**
To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] **Continuation and mandatory)**	To improve patient experience by providing safe and timely access to emergency care.	- Daily monitoring of performance indicators against NHSI and national 95% standards. - Monitoring through monthly performance reviews and Board reporting. - Transforming Emergency Care programme. - Review of escalation procedures. **4 hour wait indicator remains below 95%.**
Patient reported outcome measures[1,2] **(Continuation and mandatory)**	To improve response rate.	- To aim to be within national average for improved health gain. - NHS England have removed groin hernia and varicose vein from mandatory data collection, hip and knee will continue. **Annual response**
Maternity standards (new indicator following stakeholder event)	To monitor compliance with key indicators.	- Continue 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. **12 week booking 91.1%** **Breastfeeding 57.7%** **Smoking in pregnancy 15.2%**
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. **Paediatric dedicated paediatric unit now opened adjacent to Emergency Department**
Excellence Reporting (new indicator following stakeholder event)	To ensure that CDDFT continues to embed learning from excellence into standard culture and	- A monthly report to the Executive and Clinical Leadership Committee (ECL) incorporating total Excellence Reports for the preceding month, a Care Group breakdown, highlights of departments

	practice through Excellence Reporting.	with the most excellence reports and common themes. - A quarterly report to the Integrated Quality Assurance Committee (IQAC) summarising the ECL report and encompassing summary from learning from excellence group. **Embedded within Care Groups**

1 - continuation from previous year
2 - mandatory measure
3 - new indicator following stakeholder events

During 2019/2020 we will incorporate a section to include changes to services and their impact, with a particular emphasis on access to clinical services and whether their effectiveness has been diminished through service change.

Two Never Events have been reported since April 2019. Action plans are developed and monitoring is in place for completion.

Post setting this year's Accounts the Trust received correspondence from the Chief Nursing Officer to ask that the newly formed Learning Disability standards were included in the Quality Accounts. It was noted that Trusts are expected to publish their performance against these standards in their annual accounts: to demonstrate to the population they serve how they measure quality of services and whether quality is improving. We will ensure that this is included and progress monitored

Clostridium *difficile* (CDI) objectives for 2019/2020

Acute provider objectives for 2019/20 will be set using these two categories:

- **Hospital onset healthcare associated**: cases that are detected in the hospital three or more days after admission
- **Community onset healthcare associated**: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

CDI Objectives for CDDFT have been set at **45** cases or rate of **16.4** per 1000 bed days

Recommendation

The Board 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)
September 2019

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 2)

Headlines

Progress on the quality improvement actions has been good, with 49/56 (88%) either completed or on track. The most significant delays are around personalising care planning and the transitions priorities.

In terms of the Quality Metrics, **4** of **10** (**40**%) are reporting green and **6** of **10** metrics (**60**%) are red. However 3 of those red metrics saw significant improvement from Q1 to Q2 (% treated with respect, rates of physical restraint / intervention and MHSOP average length of stay). The other 3 metrics remain in a static position with small quarter to quarter fluctuations.

Key Issue: Quality Improvement Actions

The 7 actions that are behind schedule should be completed by Christmas (see Appendix 1). The delays are relatively minor, and progress is being made across the priorities of CYP-AMH transition, Personalising Care Plans; Dual Diagnosis; Urgent Care and Reducing Premature Deaths.

These minor delays include the opening of the new Durham and Darlington crisis team hub in Bishop Auckland, which should take place before Christmas now that estate issues have been resolved

Key Issue: Quality Improvement Metrics

There has been a significant improvement from Q1 to Q2 in the % of patients who report that they feel safe on our wards. It continues the trend noted during 18/19 of a decline over time in negative comments about this issue. This may reflect the focus put in this in recent months as operational services have reacted to the data, including an improvement in practice in dealing with dual diagnosis.

The physical intervention rate fell significantly from Q1 to Q2. All three geographic Localities saw significant reductions in intervention and restraint.

The average length of stay for older people has been worse than target since quarter 3 2013/14 In quarter 2 it was 64.69 days which was 5 days better than in quarter 1. In this quarter there were 11 patients discharged who had a length of stay greater than 200 days. Most had complex needs, including physical health problems (3) and finding suitable placements for patients subsequent to discharge (6). In all cases, services worked with patients and family to provide appropriate care and support.

The patient experience related metrics remain in a static position with small quarter to quarter fluctuations. There are developments within TEWV's business plan which might lead to sustained future improvements in these two issues for example the Right Staffing programme continues to focus on establishment reviews, increasing the numbers of people training to be mental health professionals, and reducing agency staff usage.

Key Issue: Priorities for 20/21

The Board of Directors have agreed the following improvement priorities for the next Quality Account:

- Personalising care planning (existing)
- Reducing preventable deaths (exisiting)
- Improving Child to Adult service transitions (existing)
- Increasing the proportion of inpatients who feel safe on our wards (new)

Detailed planning for these priorities has commenced. Governors will be able to take part in the Quality Account task and finish group in Spring 2020.

The Trust's Quality Account 2018/19 is available at:
https://www.tewv.nhs.uk/about-us/how-are-we-doing/quality-account/

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 2)

Appendix 1 – Review of Progress on Actions in the current Quality Account 30/09/2019

Green: Action is on track
Red: Action is not on track and has either been extended or wording amended
Grey: Action is not on track but is due to circumstances outside of the Trust's control

Priority	Green Actions	Red Actions	Grey Actions	Comment
Further improve the clinical effectiveness and patient experience at times of transition from CYP to AMH Services	10	2	0	• Due to competing priorities, the engagement event due to be held on 24th September 2019 has been postponed to Q3 19/20 • It has not been possible as yet to produce the report on the improvement trajectories that were agreed during Q1 19/20; however a meeting in relation to this was held on 9th October 2019, and the report will be produced during Q3 19/20
Make Care Plans more Personal	9	2	1	• As at 30th September 2019, 180 members of staff have received training on the CPA process. This training will continue throughout 2019, so it is anticipated that the target of 500 will be achieved during Quarter 3 19/20 • The work on DIALOG testing in a simulated live environment has been delayed due to Trust-wide issues with the implementation of DIALOG. It is anticipated that this will be completed during Quarter 3 2019/20 • There was a delay in the release of the new Trust-wide Change Implementation Workbooks and so this will be completed during Quarter 3 2019/20
Reduce the number of Preventable Deaths	7	0	0	• Actions on track
Develop a Trust-wide approach to Dual Diagnosis which ensures that people with substance misuse issues can access appropriate and effective mental health services	15	1	0	• The review of Dual Diagnosis networks is in progress; however as there were changes to staffing this is not yet complete. It is anticipated that this work will be completed in Quarter 3 19/20
Review our urgent care services and identify a future model for delivery	8	1	0	• There have been delays to the implementation of a new operational model for the Durham & Darlington Crisis Teams due to issues relating to the team base and car parking. The new model will commence in Quarter 3 19/20

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 2)

Appendix 2: **Performance against Quality Metrics at Quarter 2**

	Quarter 1 19/20		Quarter 2 19/20		Quarter 3 19/20		18/19	17/18	16/17
Patient Safety Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
Metric 1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	88.00%	65.59%	88.00%	79.17%	88.00%		61.50%	62.30%	N/A
Metric 2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	0.10	0.35	0.21	0.35		0.18	0.12	0.37
Metric 3: Number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	38.18	19.25	31.03	19.25		33.81	30.65	20.26

	Quarter 1 19/20		Quarter 2 19/20		Quarter 3 19/20		18/19	17/18	16/17
Clinical Effectiveness Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
Metric 4: Existing percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care	>95%	95.5%	>95%	98.23%	>95%		96.49%	94.78%	98.35%
Metric 5: Percentage of clinical audits of NICE Guidance completed	100%	100%	100%	100%	100%		100%	100%	100%
Metric 6a: Average length of stay for patients in Adult Mental Health Assessment and Treat-ment Wards	<30.2	23.25	<30.2	25.47	<30.2		24.70	27.64	30.08
Metric 6b: Average length of stay for patients in Mental Health Services for Older People Assessment and Treatment wards	<52	69.89	<52	64.69	<52		66.53	67.00	78.08
	Quarter 1 19/20		**Quarter 2 19/20**		**Quarter 3 19/20**		**18/19**	**17/18**	**16/17**
Patient Experience Measures	**Target**	**Actual**	**Target**	**Actual**	**Target**	**Actual**			
Metric 7: Percentage of patients who reported their overall experience as excellent or good	94.00%	92.12%	94.00%	90.76%	94.00%		91.41%	90.50%	90.53%
Metric 8:Percentage of patients that report that staff treated them with dignity and respect	94.00%	88.07%	94.00%	89.16%	94.00%		85.70%	85.90%	N/A

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Quality Account Update (Quarter 2)

Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	94.00%	86.60%	94.00%	86.56%	94.00%		86.9%	87.20%	86.58%

Appendix 3: Performance against Quality Metrics at Quarter 2- Locality Breakdown

Quality Metric	Trust	Durham & Darlington	Teesside	North Yorkshire & York	Forensic Services
Patient Safety Measures					
Metric 1: Percentage of patients who report 'yes, always' to the question 'Do you feel safe on the ward?'	79.17%	85.59%	64.52%	77.27%	25.00%
Metric 2: Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) - for inpatients	0.21	0.12	0.12	0.64	0.06
Metric 3: Number of incidents of physical intervention/restraint per 1000 occupied bed days	31.03	11.15	79.87[1]	16.79	15.56
Clinical Effectiveness Measures					
Metric 4: Percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care:	98.23%	N/A	N/A	N/A	N/A
Metric 5: Percentage of Clinical Audits of NICE Guidance completed:	100.00%	N/A	N/A	N/A	N/A
Metric 6a: Average length of stay for patients in Adult Mental Health Services Assessment and Treatment Wards: 30.2	25.47	N/A	N/A	N/A	N/A
Metric 6b: Average length of stay for patients in Mental Health Services for Older People Assessment and Treatment Wards:	64.69	N/A	N/A	N/A	N/A
Patient Experience Measures					
Metric 7: Percentage of patients who reported their overall experience as 'excellent' or 'good'	90.76%	89.96%	91.67%	91.32%	88.43%
Metric 8: Percentage of patients that report that staff treated them with dignity and respect	89.16%	91.21%	89.96%	89.02%	82.48%

[1] Please note that the Teesside figure includes the regional Children and Young People's wards at West Lane. These wards closed during Quarter 2.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality Account Update (Quarter 2)

Metric 9: Percentage of patients that would recommend our service to friends and family if they needed similar care or treatment	86.56%	88.11%	85.76%	86.49%	85.99%

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