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Health and Housing Scrutiny Committee Agenda

10.00 am Wednesday, 13 January 2021
Microsoft Teams

1. Introduction/Attendance at Meeting

2. Declarations of Interest

3. County Durham and Darlington NHS Foundation Trust Quality Accounts 2020/2021 –
   Report of the Associate Director of Nursing (Patient Safety & Governance), County Durham and Darlington NHS Foundation Trust
   (Pages 1 - 12)

Luke Swinhoe
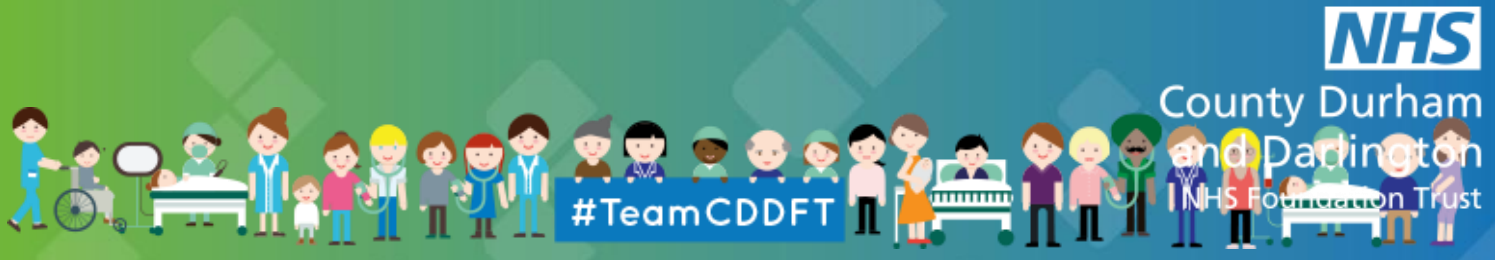**Assistant Director Law and Governance**

Tuesday, 5 January 2021

Town Hall
Darlington.

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

If you need this information in a different language or format or you have any other queries on this agenda please contact Hannah Fay, Democratic Officer, Resources Group, during normal office hours 8.30 a.m. to 4.45 p.m. Mondays to Thursdays and 8.30 a.m. to 4.15 p.m. Fridays email: hannah.fay@darlington.gov.uk or telephone 01325 405801

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Quality Accounts 2020 - 2021
April – September 2020

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 2020/2021 period. This report provides and update from April 2020 to September 2020.

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 2020/2021

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	Rationale for choice	Measure
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 3 actions. - To monitor implementation of year 3 actions against the Strategy. Acute falls = 6.52 per 1000 bed days Community falls = 7.36 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 Next 3 year Falls Strategy being populated ready for launch April 2021

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. - Data migrated from nerve centre to formulate the national reporting criteria. This generates the statistics for measuring compliance with undertaking the dementia assessment. - The finding from the 2018/2019 NAD report find an overall improvement, however there remains room for further improvement and this will be continued during 2020/21. - The action plans have been merged and are now complete but further improvements will be expected during 2020/21 - Participate in a 5 year research project of dementia services within the Durham area to continue during 2020/21. Participation to continue. - Share the findings of a good practice audit tool for assessing patient care and services for those living with dementia.
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 for April - Sept 2020 - No more than 44 (see new reporting mechanism) cases of hospital acquired Clostridium *difficile*. 27 cases reported for April – Sept 2020 - 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	- Monitor implementation of new reporting metrics - Review of all identified grade 3 or 4 pressure ulcers - Continued education programme There have been no Grade 3 or Grade 4 pressure ulcers during April – September 2020 that were unavoidable.
Discharge summaries[1]	To improve timeliness of discharge summary	- Data collected via electronic discharge letter system and monitored via monthly performance reviews and Board reporting.

(Continuation)	completion. Train 2020 intake of new junior doctors	- Care Groups undertake consultant level audits Compliance has remained at around 90% 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. - Continue to embed Trustwide work to embed and improve reporting of near miss and no harm incidents. A 3% increase of incidents reported October 2019 – Mar 2020 compared to April – September 2019; CDDFT is still higher than the regional average of 48.8 incidents per 1000 bed days (ours 50.1)
Improve management of patients identified with sepsis [3] **(Continuation)**	To maintain improvement in relation to management of patients with sepsis	- Maintain an audit programme to monitor management of patients with sepsis. - Hold multi-professional study days. - Hold a trustwide audit and monitor sepsis mortality Regional screening tool integrated into electronic systems, meaning that all patients within CDDFT are automatically screened for Sepsis
EXPERIENCE		
Nutrition and Hydration in Hospital [1] **(Continuation)**	To promote optimal nutrition and hydration for all patients.	- Continue to provide support and tailored training where audit reports indicate - Continue to work closely with catering on hospital menu development and nutritional analysis - Reinvigorate staff from all areas - Recognised nutrition subgroups Quality metrics have been introduced that provide a monitoring tool to audit compliance with nutritional standards. Audit results awaited
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,*	- Work with CCGs to develop new palliative care strategy for 2020 to 2025 - Focus intensively on recognition of dying in hospital to enhance care - Explore solutions to the relative lack of single rooms - Work with the Medical Examiner system to explore new ways to feedback to bereaved relatives - Continue quality improvement work with out of hours work - Appoint a new palliative care consultant to provide support to Care Homes

	honestly and consistently to help me and the people who are important to me, including my carer(s)"	Preferred place of death audit demonstrates continuous improvement
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 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. Results not yet available
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.	- 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.
Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months[2] **(Mandatory measure)**		In addition we will continue to report results for harassment and bullying and within the Disability and Race Equality Standard. Annual survey so results not yet available
Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion[2] **(Mandatory measure)**	To maintain high scores and remain above the national average	

Friends and Family Test[1] (Continuation)	To increase Friends and family response rates	- During 2020/21 we will increase or maintain Friends and Family response rates. All areas participating will receive monthly feedback - We will roll out the new electronic version of Friends & Family test from September 2020
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 continue to ensure the organisation reviews deaths and implements any learning into clinical practice.	- 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. - Adhere to "Learning from Deaths" policy. - Provide Care Groups with learning from deaths reviews to identify themes for learning - Triangulate mortality reviews and patient safety incidents to establish learning HMSR 98.34 (rolling 12 mths July'19-June'20), below national average SHMI 113.9 (rolling 12 mths July'19 – June'20), higher than expected Results of SHMI reviewed and shows this is due to depth of coding and acute kidney injury. A review of coding is underway and acute kidney injury nurses are now in post
Reduction in 28 day readmissions to hospital[1,2] (Continuation and mandatory)	To implement effective and safe discharges.	- Monitoring through monthly performance reviews and Board reporting.

To reduce length of time to assess and treat patients in Accident and Emergency department[1,2] Continuation and mandatory)	Safe and timely access to urgent and emergency care.	- Daily performance update against the national 95% standard. - Monitor through monthly performance reviews and Board. - IMS Transformation Programme. - Review of escalation procedures. See appendix
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. Results not yet available
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 92.2% Breastfeeding 59.2% Smoking at delivery 14.9%
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. 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 practice through Excellence Reporting.	- 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 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 monthly reports produced and shared.

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

One Never Event has been reported between April and September 2020. Action plans are developed and monitoring is in place for completion.

Clostridium *difficile* (CDI) objectives for 2020/2021

Acute provider objectives for 2020/21 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 not been confirmed for the period but we have set an internal objective of **44** cases for 2020/21, which is one case less than the previous year

APPENDIX

1. **Activity and Performance trends**

Table 1: Emergency Dept. (ED), Urgent Care attends and 4-hr wait performance

Month/Quarter	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
DMH ED attends	4,246	2,952	3,946	4,396	4,985	5,046	5,212	5,000	4,616	4,551
DMH ED 4 Hour Waits	1,272	183	104	117	247	419	548	999	953	1,015
DMH % Seen in 4 Hrs	70.04%	93.80%	97.36%	97.34%	95.05%	91.70%	89.49%	80.02%	79.35%	77.70%
UHND ED attends	5,090	3,827	5,091	5,424	5,953	6,127	5,813	5,848	5,406	5,403
UHND ED 4 Hours wait	1,504	229	268	282	455	646	900	1,566	1,575	1,937
UHND % Seen in 4 Hrs	70.45%	94.02%	94.74%	94.80%	92.36%	89.46%	84.52%	73.22%	70.87%	64.15%
Total ED attends - Type 1	9,336	6,779	9,037	9,820	10,938	11,173	11,025	10,848	10,022	9,954
Urgent Care Type 3 (Walk-Ins)	4,192	1,358	1,948	2,255	2,535	3,183	2,848	2,508	2,122	1,926
Urgent Care - Type 3 (Booked Appointments)	2,906	850	1,266	1,357	1,651	1,971	1,562	1,484	1,327	1,527
Trust Over 4 hour waits	2,776	412	372	399	702	1,065	1,448	2,565	2,528	2,952
ED Only Activity % under 4 hour waits	70.27%	93.92%	95.88%	95.94%	93.58%	90.47%	86.87%	76.36%	74.78%	70.34%
Reportable % under 4 hour waits (including UCC Booked from Jan '2020)	83.11%	95.42%	96.96%	97.03%	95.36%	93.48%	90.62%	82.72%	81.23%	77.98%

1.1.   Table 1 summarises ED performance over the period March 2020 (the last partly pre-covid month) to the end of December 2020. The two EDs have operated with separate covid and non-covid streams, supported by staff re-deployed from other services.

1.2.   ED attends and 4-hr performance exhibit a similar trend to non-elective admissions and length of stay. This demonstrates their inter-dependence. All show a sharp reduction as COVID Wave 1 became embedded from March 2020 onwards. As Wave 1 began to recede in May-June all graphs show a similar growth trend until the advent of Wave 2 in Sept – October.

Graphs 1: A&E attends and 4-hour waits
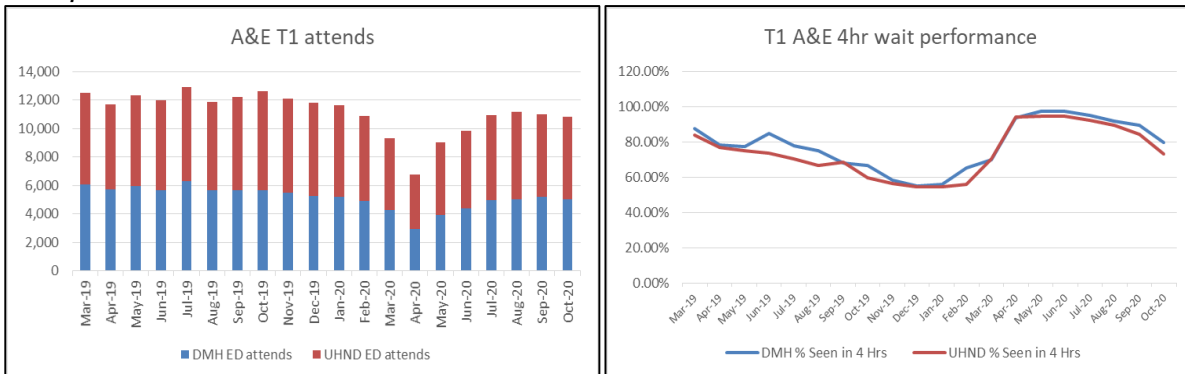
Note: all graphs are taken from a study focussing on the period Mar-Oct 2020.

1.3. During the COVID period, DMH achieved the 4-hr wait standard (95%) every month between May – June 2020; whilst total reportable performance (including Type 3 Urgent Care) exceeded the 95% standard every month between Apr-July 2020.

1.4. Although UHND did not achieve the standard it did record performance of 94% between April – July 2020. As Type 1 activity increased, 4-hr wait performance began to fall back towards pre-COVID levels.

Recommendation

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)
January 2021

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