NHS
County Durham and Darlington
NHS Foundation Trust

Darlington Health and Housing Scrutiny Committee

Quality Accounts 2019/2020

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PURPOSE OF THE REPORT

To update the Scrutiny 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 March 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 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 = 5.8 per 1000 bed days** **Community falls = 5.8 per 1000 bed days** **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. **Six cases reported during 2019/20** - No more than 45 (new reporting mechanism) cases of hospital acquired Clostridium *difficile.* **49 cases reported during 2019/20** 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 in community setting and two identified in acute setting for 2019/20 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 2020 intake of new junior doctors **Compliance is 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. - NRLS data. Enhance incident reporting to 75th percentile against reference group. **Rate no longer reported** **Remain within national average for incidents resulting in serious harm or death** - 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. **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 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. **Quality metrics have been**

		introduced that provide a monitoring tool to audit compliance with nutritional standards.
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)"*	- We will work with CCG and NEAS to agree a comprehensive approach to personalised care planning. - 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. **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 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. **Remains within national average**
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)**	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. **Significant improvement in Trust score but still below the national average.** - In addition we will continue to report results for harassment & bullying and Race Equality Standard. **Significant improvement in the Trust score and better than the national average.**

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion$_2$ **(Mandatory measure)**		**Trust score improved and higher than national average.**
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 - sustained increase seen in Emergency department but no improvement seen in maternity department rates**
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. **SHMI is increased and review shows this is due to depth of coding and acute kidney injury. A task & finish group is established to review depth of coding and two acute kidney injury nurses are now**

		employed. **HSMR within expected range**
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 12.9%. 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. **Knee responses within national average. Hip response rates outside of national average**
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 90.8%** **Breastfeeding 57.3%** **Smoking in pregnancy 16.6%**
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

Three Never Events have been reported since April 2019. Action plans are developed and monitoring is in place for completion. The report also identifies that the Trust received a Regulation 28 during the year. Action plans have been developed and completed to address this.

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. This is included in the report this year and progress will be 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

Timeframes

As you are aware Quality Accounts this year have been delayed due to COVID-19 pandemic. Providers have a revised deadline of 15th December 2020 for submission and are no longer expected to obtain assurance from external auditor.

We would however be very grateful if you would still sent us your overarching comment on the Quality Accounts as in previous years so that these can be inserted into the back of the report to be received 12th October 2020 for inclusion in the report.

Governor Responsibilities

The local indicator for audit from the Governors was stood down due to Covid-19 pandemic and the report will not be the subject of external audit for the same reason.

Recommendation

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

Joanne Todd
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October 2020