Agenda Item 9(a)

NHS
County Durham and Darlington
NHS Foundation Trust

Durham County Council Adults Health and Wellbeing Overview and Scrutiny Committee

Meeting – 9th May 2024

Quality Accounts Summary - Warren Edge and Lisa Ward

Introduction

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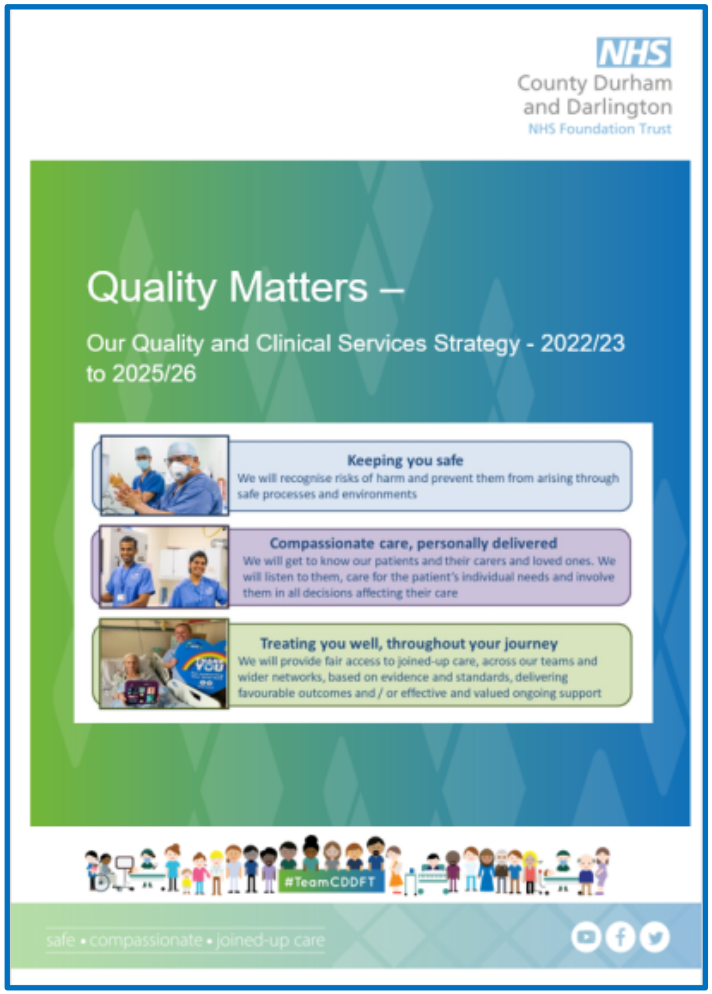
- Quality Matters – is our strategy to 2025/26 to support the achievement of our vision, **Right First Time, Every Time**, and is underpinned by our core values.
- Our priorities for 2023/24 reflected the priorities in the refreshed strategy and priorities brought forward from 2022/23 where there was further work required
- We have appointed a Director of Quality to lead on quality assurance and embedding QI in in our clinical services.
- Since our quality account priorities are driven by a four year strategy they are stretching ambitions to be achieved over the longer-term rather than in a single year. We have changed our RAG ratings to indicate whether we are tracking against our strategy and making improvements year on year
- Some content is still being worked on, in line with the national timetable.



Quality Strategy Progress

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A RAG-rating system has been used to indicate progress to date, using the following key:

On track to deliver improvements expected over the life of the strategy		Broadly on track, with some consolidation of improvements needed	
Improvements have been made; however, there remains some further work needed during the four year-strategy period to meet the objective.		Off track, with remedial work needed	

We have also added arrows to show the direction of travel i.e. whether we have made improvements compared to the prior year or deteriorated as follows:

Improving	↑	Deteriorating	↓

Please note that all ratings are provisional pending review by the Trust's Quality Committee and Integrated Quality and Assurance Committee in mid-May

Summary - Safe

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Priority	Rating	Trend	Overall summary note
Reducing Falls and harm from falls		↑	Falls per 1,000 bed days have reduced particularly on acute sites, through a range of local quality improvement work, as illustrated in the detail. Our Falls Group continues to drive improvement.
Minimising harm from pressure ulcers		↓	There has been one Grade 3 ulcer and one Grade 4 ulcer with lapses of care during the year. We still benchmark strongly; however, this is above our zero tolerance.
Reducing harm from healthcare associated infections		↓	We have seen 8 MRSA cases compared to our zero tolerance and, despite benchmarking well nationally and regionally, have breached NHSE thresholds for reportable infections. We have reinvigorated our bi-weekly HCAI Reduction Group meetings.
Improving maternity services		↑	CQC's re-inspection confirmed significant improvements. Further work is needed to increase staffing and ensure that it is resilient.
Minimising harm from invasive procedures		↑	Improvements have been made in version control, protocol documentation, education and awareness. A re-audit is planned for Quarter 1, 2023/24 to confirm improvements.
Recognising and acting on patient deterioration		↑	There is high compliance with taking of observations, but a need to reinforce use of the system for escalation and to learn from some recent incidents. A quality improvement programme is in place.
Minimising harm from sepsis		↑	Sepsis screening is automatically triggered for relevant patients. Screening rates are high and a manual audit has confirmed the same for antibiotics in one hour. Further work is focusing on embedding improvements and ensure blood cultures are timely.

Summary – Experience and outcomes

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Priority	Rating	Trend	Overall summary note
Improving services for patients with additional needs		↑	Good progress has been made in reinvigorating our network of dementia champions and establishing joint pathways for patients with MH needs with TEWV. Key areas of ongoing work are the roll out of LD & Autism training, and improving our dementia friendly environments at UHND and in community hospitals.
Improving patients' experience of discharge		↑	We continue to focus on learning from S42 referrals and are rolling out NHSE's 'SAFER' flow bundle to support effective discharge planning and prompt discharge.
Maintaining high quality end of life care		↑	The results of the National Care of the Dying Audit 2022 were positive and we continue to roll out our strategy. Challenges remain in enabling access to side rooms at UHND.
Improving nutrition and hydration		↑	We have seen improvements in compliance with MUST assessments and benefits from initiatives to improve hydration. Our focus is now on ensuring assessments take place within 4 hours of admission.
Reducing waiting times for A&E services		↑	Improved performance was seen compared to 2023/24, with improvements in ambulance handover times and less long waits. Quality improvement work continues.
Strengthening specialist paediatric services		↑	We have worked with TEWV to improve pathways of care for young people with MH issues and made staffing improvements in all areas.
Mortality indicators including SHMI		↓	The Trust is an outlier for SHMI but all other evidence relating to mortality is positive. An external review of our learning from deaths process is planned.

Reducing falls and harm from falls

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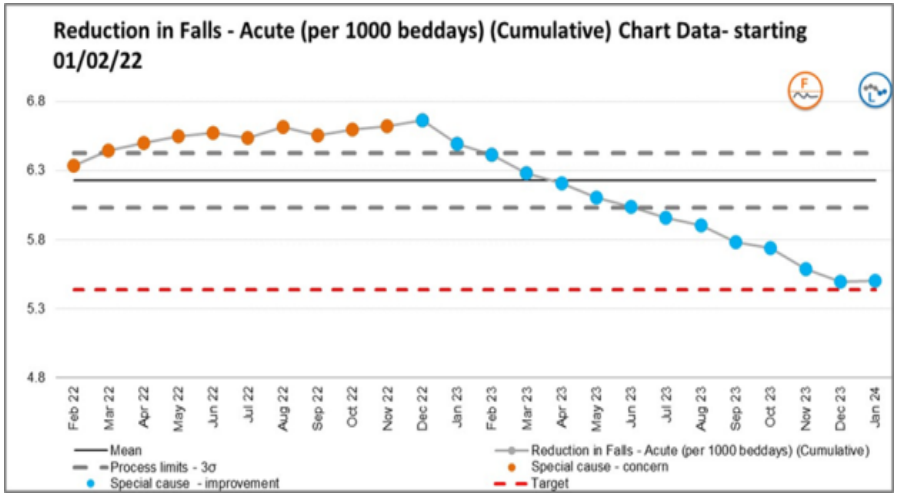
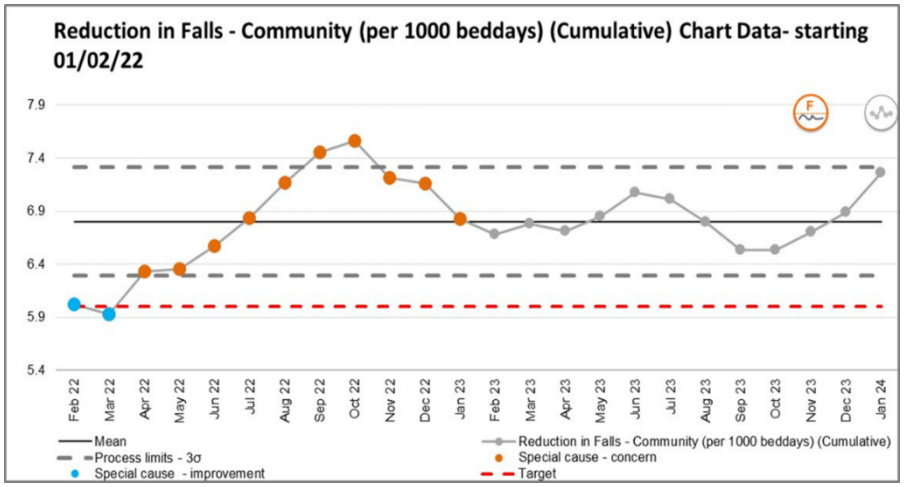
- Rolling average 12 month falls have reduced year on year in our acute hospitals with reductions sustained
- They have reduced in community hospitals overall, despite additional beds and changes to patient criteria
- Only one fall proceeded to a ‘Level 1’ investigation
- Our dedicated falls team has recorded 204 quality improvement interventions with front-line teams
- Initiatives with impact:
    - Safe Mobility Champions (over 100)
    - Use of EPR to reinforce roundings
    - Zonal nursing
    - Falls Boards – see overleaf
    - Real-time monitoring of completion of falls risk assessments (EPR places information in the hands of ward managers)
    - Visits and support to community hospitals
    - Printed resources
    - Celebrating success





Falls – Example Falls Board

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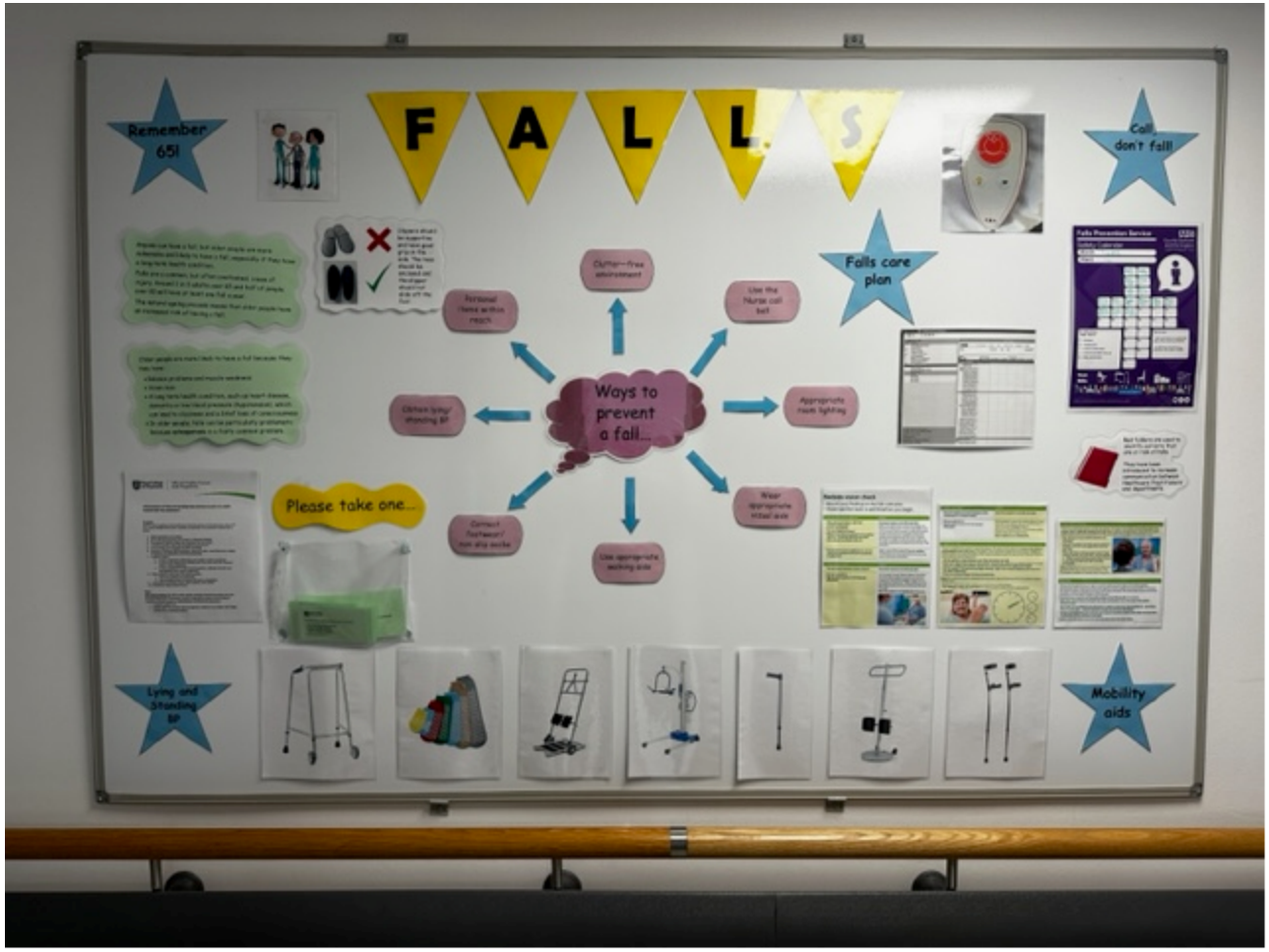

Pressure Ulcers – zero tolerance

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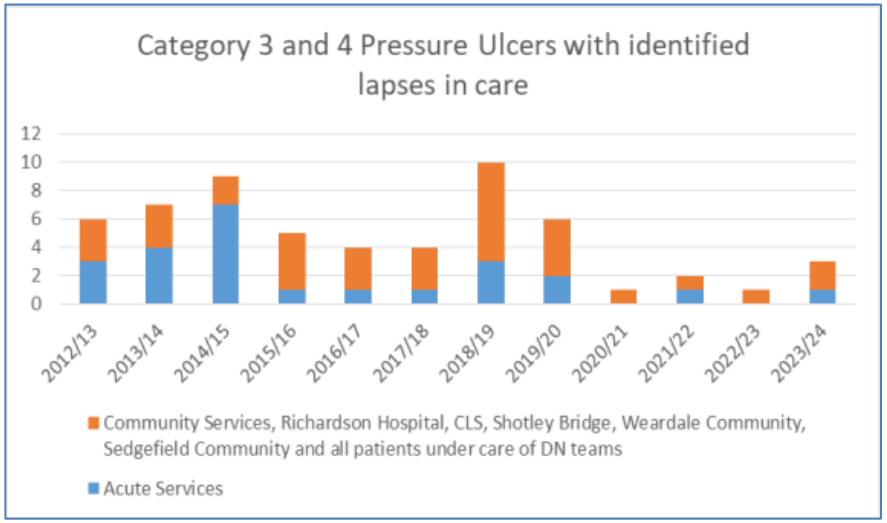
One Grade 4 pressure found to have lapses in care and two Grade 3 ulcers with lapses in care.

The Grade 4 pressure ulcer was complex with the patient suffering multiple comorbidities. The review panel found that there were no lapses in care that would have prevented the wound for developing due to patient preference. However, not all risk assessments were documented.

Lack of documented risk assessments, skin inspection and communication failures were the issues associated with the two Grade 3 ulcers.



Ongoing measures:

- Multi-disciplinary rapid reviews chaired by the Tissue Viability Matron, to ensure early learning is taken from any case
- Focused education by the TV team on pressure ulcer prevention and treatment
- Network of Wound Resource Educational Nurses (WRENS) on acute and community sites.
- Similar HCA level roles introduced
- New pathways and protocols

Reducing harm from Healthcare Acquired Infections

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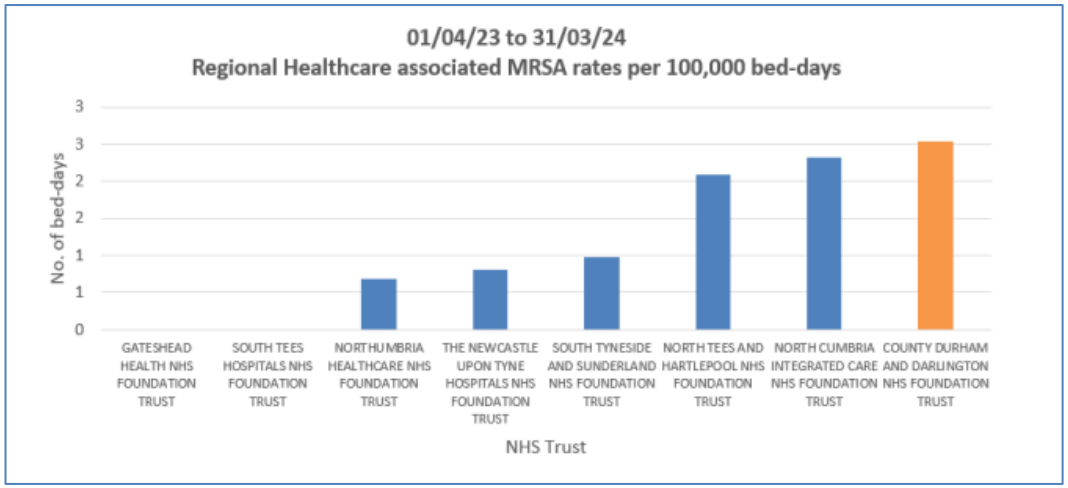
Introduction

- National thresholds seek year on year local improvement, so become more challenging where relative performance is good
- Nonetheless our ambition is to continuously improve and, therefore, to meet them
- Our trends have – other than for MRSA – been mirrored regionally and nationally as shown in the charts on subsequent slides
- Patient demand and acuity has increased (as shown on the A&E slides later) which has an impact.
- We are expanding our Infection Control team to provide a seven day service and have reinvigorated the leadership of this area with the Deputy Medical Director chairing bi-monthly HCAI Reduction meetings.
- Compliance with mandatory infection control and hand hygiene training is meeting the Trust's targets.

MRSA

- There were **eight** cases in the year
- Key improvement themes are:
  - Reducing UTIs / CAUTIs
  - Reinvigorating good practice in cannulation
  - MRSA screening and de-colonisation
- The importance of each has been reiterated and re-education provided.



Reducing harm from Healthcare Acquired Infections

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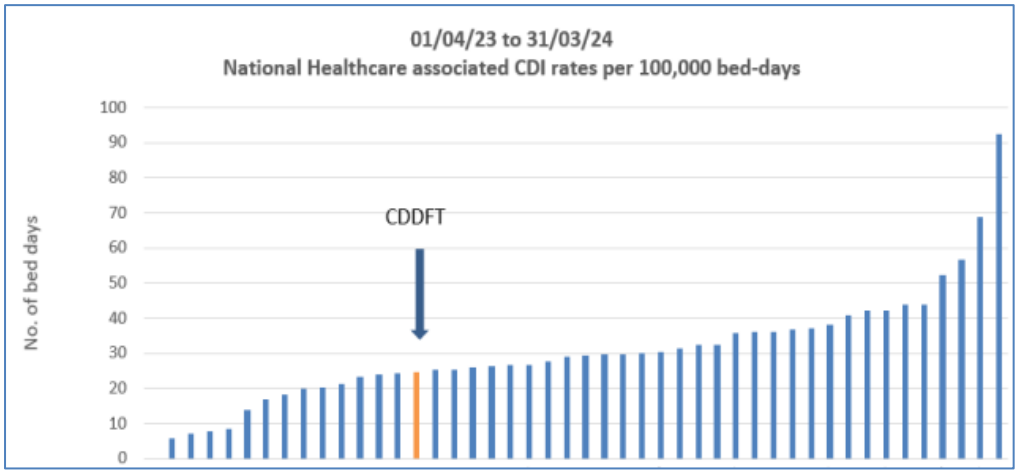
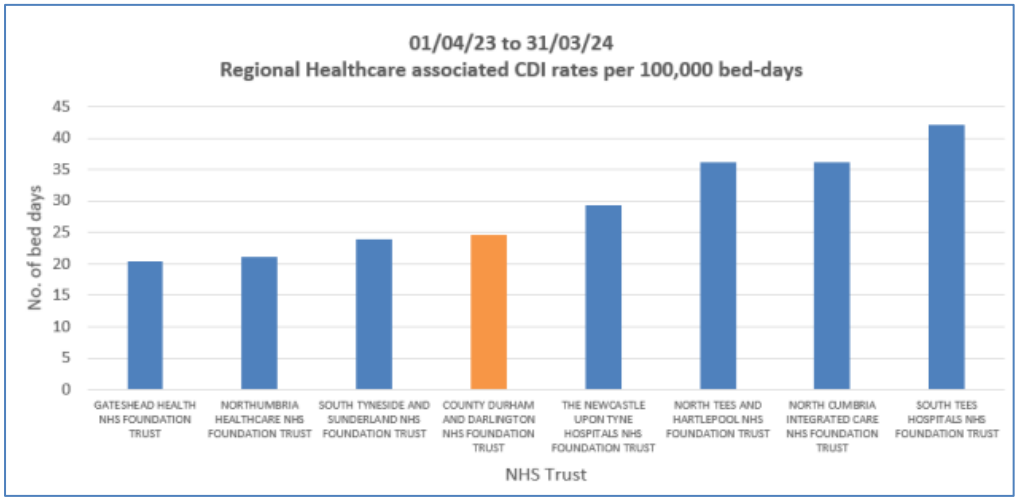
C-Diff

- Nationally, C-Diff rates have risen since the pandemic compared to before
- The Trust reported 78 cases compared to the threshold set by NHSE of 50 cases
- This was a 28% increase on the prior year
- The Trust's performance can be seen in the regional and national context in the charts.
- However, the Infection Prevention and Control team's case reviews have identified learning themes as follows:
  - "Gloves off" Hand hygiene
  - Commode cleanliness
  - Anti-microbial stewardship / use of antibiotics
  - Stool sampling protocols
- Work has taken place to reiterate the importance of the above and re-education relevant staff groups to be monitored through the bi-monthly HCAI group meetings.





Reducing harm from Healthcare Acquired Infections

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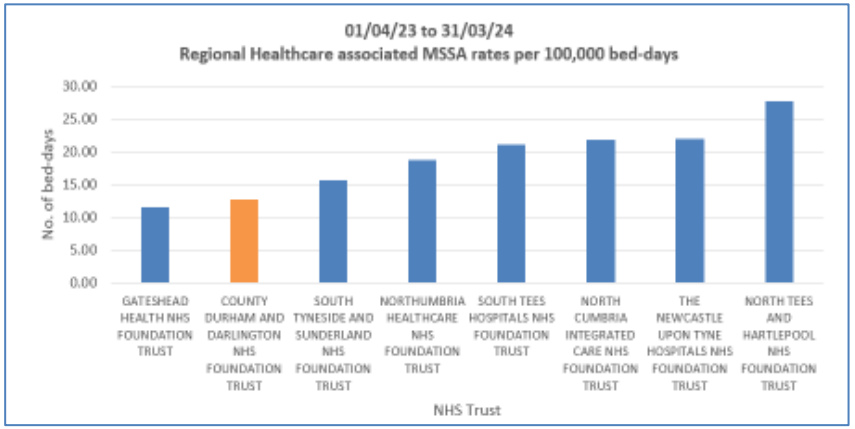
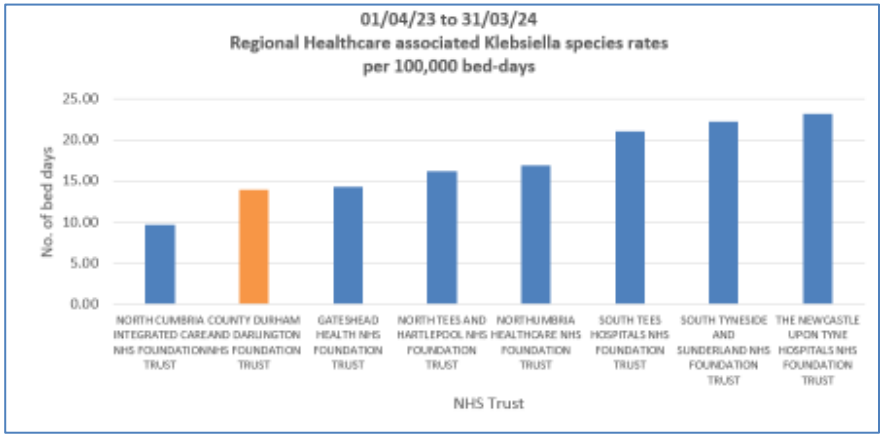
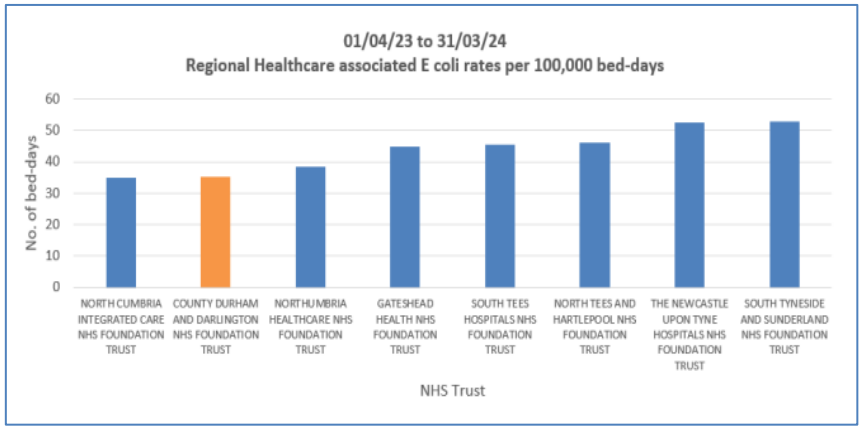
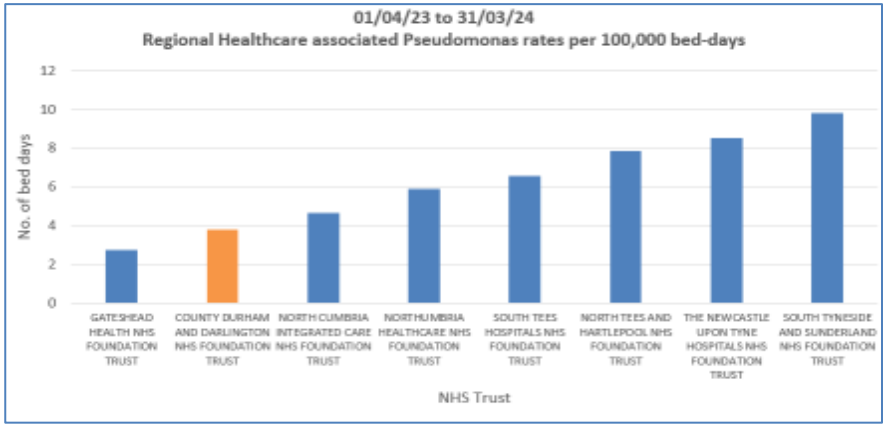
Whilst the Trust benchmarks well for other infections, it breached thresholds set by NHSE (based on continuous improvement) for Pseudomonas, Klebsiella and E coli









Reducing harm from Healthcare Acquired Infections – Other

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- We completed the upgrade of the water infrastructure at DMH, which was being undertaken in response to legionella in the water supply. Facilities such as the birthing pool are now open again and no patient or staff member suffered any harm
- We have seen outbreaks of Carbapenamase-Producing Enterobacterales at DMH, as a result of which we have:
  - Taken advice from the UK Health Security Agency and other experts
  - Deep cleaned bays and a whole ward
  - Decontaminated drains
  - Introduced an enhanced screening regime
  - Commenced changes to handwashing facilities
- A two-year refresh of the clinical environments at DMH is taking place with a budget of around £2m.

Improving Maternity Services

- We have moved to dedicated acute and community sites and are seeking to staff in line with an independent Birth Rate Plus report
- The leadership has been enhanced by the appointment of a Director of Midwifery and a second (seconded) Head of Midwifery
- A full-time, dedicated Governance Matron has been appointed and specialist midwifery posts are being advertised to lead on diabetes and Bereavement support
- Staffing is becoming more resilient with reducing red flag events and coordinators remaining supernumerary for the majority of the time while on shift
- Fill rates are around 70% and increasing, with a recruitment strategy being implemented, some experienced staff returning to the service and others in the pipeline
- The main area of improvement needed re Ockenden is ongoing strengthening of staffing
- We are enhancing our Board Safety Champion arrangements and need to consolidated our model for transitional care in line with our Maternity Incentive Scheme declarations for 2023

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	DMH MATERNITY	UHND MATERNITY
Safe	Requires improvement	Requires improvement
Well Led	Requires improvement	Requires improvement

The **overall** rating for both hospitals has improved from requires improvement to good. The trust remains rated good overall.

"Staff had clearly worked hard since our previous inspection to improve the quality of care they were delivering to people, and they know where further improvements are needed so people receive the high standard of care they deserve.

"We will continue to monitor the trust, including through future inspections, to ensure the trust builds on the improvements it has already made, and further changes are made and embedded."
CQC Press Release

Remaining Must Do actions from CQC:

- Consolidate staffing
- Embed the triage model in the PAU
- Further embed Governance improvements
- Consolidated improvements in compliance with mandatory training
- Equipment, environmental and medicines checks

Preventing harm from invasive procedures

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We have achieved the following:

- Introduced a CDDFT LocSSIPs Policy and Standard Operating Procedure;
- Updated the CDDFT internet and intranet sites to improve document management and ensure that correct versions are available; and
- Completed a full audit of the use of each LocSSIPs document in place (results from this have been fed back to Clinical Directors, Clinical Leads, Executive and Non-Executive Directors).

The LocSSIPs Task and Finish group has continued to:

- Support the development of new LocSSIPs;
- Ensure training is delivered;
- Evaluate audit results; and
- Provide service improvement recommendations where required.

In 2024/25 the LocSSIPs Task and Finish group will focus on the further development of and migration LocSSIPs into the EPR system, thereby removing paper copies from the process, enhancing audit functionality and improving compliance.

Recognising and acting on deterioration

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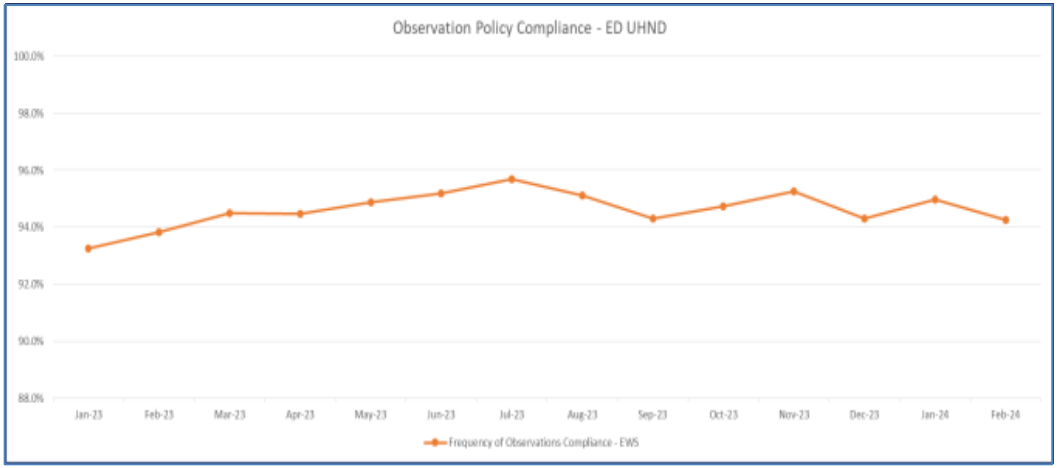
- We have optimised our EPR system to support capture of observations and early warning scores, with real-time information available to ward managers and team leaders
- Compliance with taking of observations is routinely around 95% as shown in the chart
- EPR alerts support escalation during the day and underpin our ‘Hospital at Night’ approach
- We are working to embed response to alerts on day shifts as a key safety net to routine escalation between nursing staff, and between nursing and medical staff
- There is a Safety Quality Improvement Programme in place to support learning from relevant incidents
- We have a training programme for nursing staff in the Acute Medical Unit in managing deterioration and associated essential skills
- Take up of Life Support and Patient Deterioration Training has steadily improved over the last year.



Martha’s Rule

Our Call for Concern service allows staff, patients and families access to a rapid second review from the Acute Intervention Team. We have registered interest to participate in the next wave of the national roll out, to formalise our approach to obtaining a structured assessment of each patient’s condition from the patient / their family.

Improving care of Patients with Sepsis

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- Front-line staff input observations using hand-held devices to our EPR system.
- Alerts are triggered to ensure the prompt review of patients at risk of sepsis. Staff cannot close out of the work-flow without undertaking a sepsis screen if the early warning score meets specific criteria
- Compliance with sepsis screening has improved significantly as a result.
- We do not yet have a reliable way of measuring delivery of antibiotics within one hour using the EPR system
- A manual audit of 60 patients found that 83% had received antibiotics within one hour and identified changes that we need to make to the system to design reliable monitoring reports.
- Local teaching sessions within the A&E departments are being used to reinforce policy re taking of blood cultures, along with posters and screensavers
- Four sepsis study days are run for A&E nursing staff annually (using classroom sessions and simulation exercises) and further e-learning is available
- Posters and leaflets are made available to patients and families
- Bi-weekly meetings take place to oversee ongoing quality improvement work

Requirement	Result
Sepsis screen	85%
Antibiotics within one hour	83%
IV treatment	72%
Blood cultures taken	33%

Improving care for patients with additional needs

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Aims	Progress
Dementia	• We have now appointed 85 dementia champions on wards and in front-line teams to provide a link to our Lead Dementia Nurse and promulgate good practice • Over 90% of staff have completed e-learning in Dementia Awareness • Sensory awareness training include in the nursing preceptorship programme and induction for HCAs. • We have implemented improvement actions from the last national audit of dementia • We have undertaken specific awareness campaigns covering “sun-downing” and “brain change” • We scored just below the national average score Trust’s dementia friendly environment in the PLACE 2023 inspections. DMH and BAH scored above the average but there is improvement work needed at UHND and in community hospitals.
Learning Disabilities (LD) and Autism	• We have continued to embed the role of our specialist LD Nurses in supporting wards with the assessment and care of patients with LD and Autism and with outreach and follow-up after hospital admission • We have committed to reviewing all deaths for those with learning disabilities as part of its mortality review programme and participated in panels for both Teesside and Co Durham • We have seen significant improvements in completion of DNACPR forms for LD patients in 2023/24 and continue to monitor completion closely • Executive Directors have supported the service in making the ‘DIAMONDS’ training in LD and Autism mandatory for all staff.
Patients with mental health needs as well as physical ill-health	• We have worked with TEWV to review our admission pathways for Children and Young People with mental health needs. There is now earlier intervention by TEWV and joint care plans are put in place. • We have appointed registered nurses as Mental Health Champions on our Paediatric Wards, and in the Paediatric Assessment Area and Paediatric A&E at DMH. • We have reviewed ligature risk assessments on our Paediatric Wards. • We are working closely with TEWV to embed the same principles in how we work with adult inpatients with mental health needs.

Improving Discharge

- All Section 42 safeguarding concerns are taken serious and there is work undertaken between the Safeguarding teams and Discharge Facilitators / Coordinators to embed any learning arising
- We are reinvigorating “SAFER” which promotes ongoing senior review of patients on wards and proactive discharge planning to minimise discharge delays and ensure all necessary planning and support is in place.
- We have formal mechanisms in place to take feedback from care homes on any sub-optimal discharges and use this feedback to learn and improve
- We have put in place additional capacity for discharge transport helping to minimise any delays
- Every care group has a designated lead to ensure that discharge letters are sent to primary care colleagues on time.
- We continue to work on facilitating discharge earlier in the day for patients

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SAFER – copyright: NHSE Emergency Care Improvement Programme

The SAFER patient flow bundle

S - **Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A - **All** patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F - **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E - **Early discharge. 33%** of patients will be discharged from base inpatient wards before midday.

R - **Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days - ‘stranded patients’) with a clear ‘home first’ mind set.

Improving End of Life / Palliative Care

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Aims	Progress
Development of an end of life care strategy	The Trust's End of Life Care was rated as 'Outstanding' in the most recent CQC report and the results of National Audit of Care at End of Life (NACEL) 2022/23 and quality survey data demonstrated continuing good practice in end of life care within the Trust. We continue to work on and roll out our end of life care strategy with our partners in primary care, social care and the voluntary sector.
Access to side rooms	Access to single rooms for patients who are dying is relatively good at DMH (88%) but remains more of a challenge at Durham. In some months, more than 50% of patients have died in four bedded bays because of fewer side rooms being available within the estate. There will be incremental increases in the number of side rooms in the Trust's estate as capital projects are completed year on year. The Patient Flow teams on the Acute sites do all they can to provide access to privacy for dying patients. Where possible and appropriate, we make use of community hospitals and education is provided to staff on ways to maintain privacy and dignity for end of life care patients within the wider hospital footprint when necessary.

Improving Nutrition and Hydration

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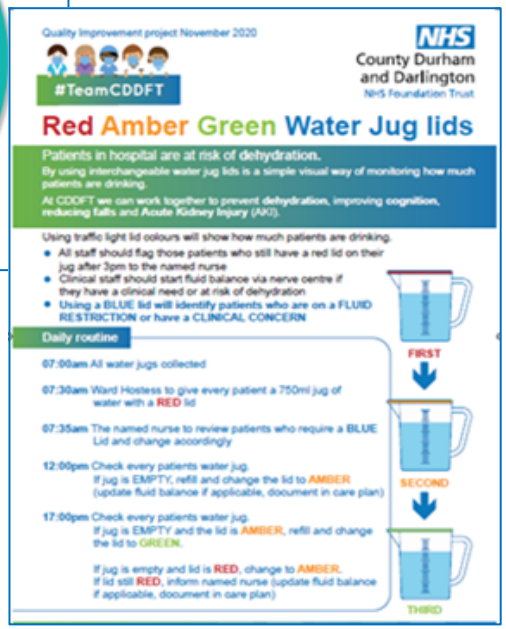
- We have reinvigorated our Nutrition Steering Group
- Dietetics continue to support wards in implementing and undertaking MUST assessments
- As of January 2024, some **89%** of patients had received a MUST assessment and **76%** of those had been assessed within four hours of admission as per policy
- Ward managers and team leaders are now able to monitor completion of assessments in real-time leading to month on month improvements
- Our Acute Kidney Injury Nurses continue to support wards and teams and the service has evaluated well with respect to staff feedback, the patient experience and improved outcomes
- We continue to promote fluid balance and hydration through our use of ‘Traffic Light” jugs and our ‘Drip or Drink’ campaign



Mortality / Learning from Deaths

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Measure / source of assurance	RAG
Summary Hospital Mortality Indicator (SHMI)	
Hospital Standardised Mortality Ratio (HSMR)	
Copeland's Risk Adjusted Barometer (CRAB)	
Completed mortality reviews – 683 for 2022/23	

HSMR measures, effectively in-hospital deaths

SHMI also includes deaths out of hospital within 30 days.

* There is a six month time lag in data being made available to support reviews hence reviews for deaths in 2023/24 are still being completed.

Comments

- SHMI is a national outlier and the Trust has commissioned external advice and assessments to enable it to determine whether there is any underlying issue with the quality of care. These reviews have identified that depth and completeness of coding is the most likely cause, partly linked to temporary staffing issues in Clinical Coding.
- All other sources of assurance are positive:
  - HSMR is within statistical limits
  - The Trust does more learning from deaths reviews than most others in the region and does not find widespread issues with the quality of care (less than 1% of reviews in 2022/23 found care to be poor)*
  - CRAB data shows surgical mortality to be well within expectations and a long-term improvement in medical care.
  - There have been no significant issues flagged by the Medical Examiner Service.
- A further external review of our learning from deaths process has been commissioned.

Development of Specialist Paediatric Services

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Aims	Progress
Children and Young People with Mental Health Needs	• We have worked with TEWV to review our admission pathways for Children and Young People with mental health needs. There is now earlier intervention by TEWV and joint care plans are put in place. • We have appointed registered nurses as Mental Health Champions on our Paediatric Wards, and in the Paediatric Assessment Area and Paediatric A&E at DMH. • We have reviewed ligature risk assessments on our Paediatric Wards. • We are working closely with TEWV to embed the same principles in how we work with adult inpatients with mental health needs.
Other Developments	• We have assessed and confirmed our compliance with British Association of Perinatal Medicine Standards, re: staffing in our Neonatal Units. • We are updating our model of transitional care for new-born babies in line with the latest best practice. • We have consolidated our community paediatric teams into larger teams and strengthened their leadership. • Ward based staffing has been strengthened following an expansion in staffing agreed in 2022/23 and recruitment in 2023/24. • We have sustained our 24/7 Front of House Paediatric Assessment area at UHND and have fully recruited specialist nursing staff to our Paediatric A&E Department at DMH.

Reducing A&E waiting times

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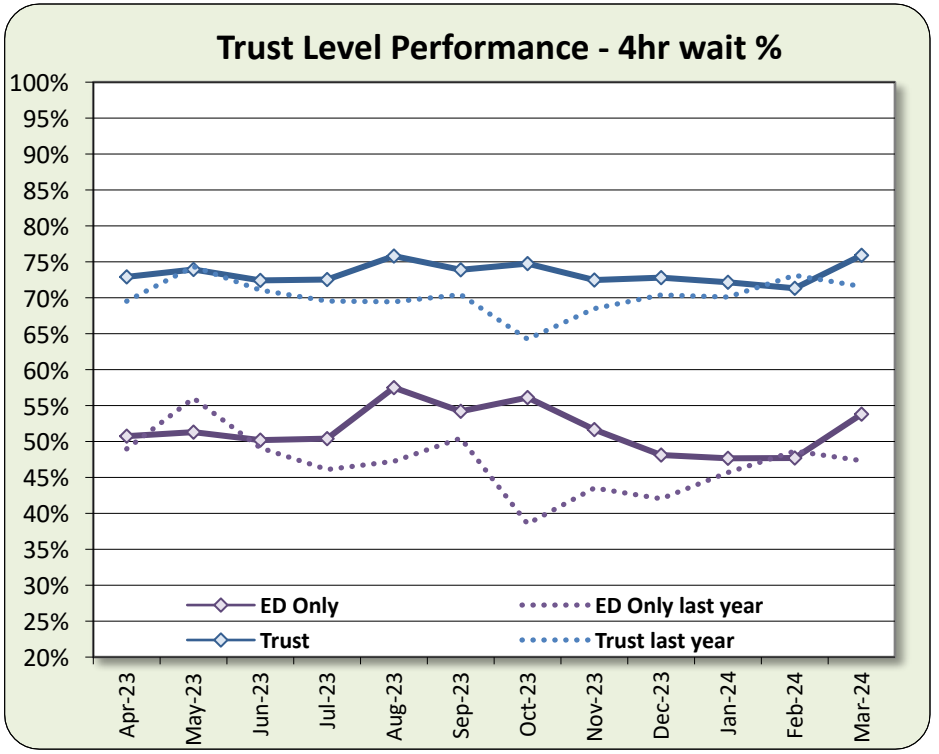
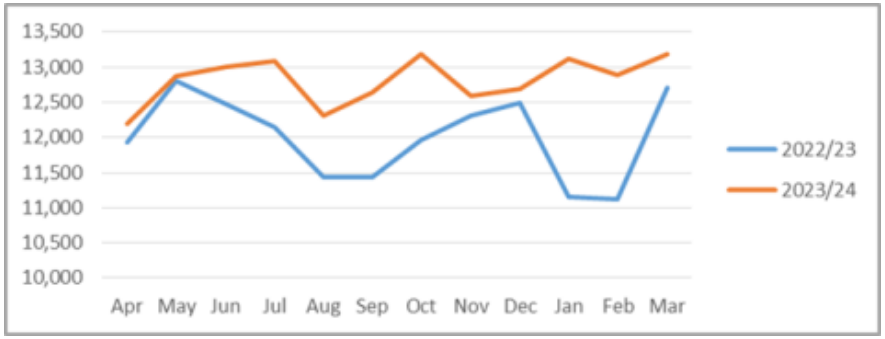
- A&E four hour waiting times performance has exceeded 2022/23 performance for the majority of 2023/24 (the adjacent chart shows this for overall activity and Type 1 attendances).
- The national target of 76% (by 31st March) was achieved.
- This is despite a significant increase in activity as shown in the chart below.
- Other than in the most pressured winter months (which saw, in January an increase of almost 30% in ambulance arrivals to UHND), ambulance handover times also improved on 2022/23 and there were further improvements in reduced 12 hour waits in the department, and for admission.





A&E developments and other access targets

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Urgent and emergency care:

- Co-located front of house same day emergency care at UHND
- Same Day Urgent Care on site at UHND
- New streaming pathways to enable patients to be seen and cared for in other facilities where appropriate
- Urgent Community Response teams developed as an alternative to A&E for suitable patients
- Ongoing improvement programmes covering end to end patient flow and discharge
- Significant improvements in performance on waiting times for Type 1 attendances over the second half of the year, other than during winter pressure peaks

Other access targets:

- The Trust met the national target to have no patients waiting over 65 weeks by 31st March.
- There were 476 patients waiting over 52 weeks at 31st March 2024 compared to 1,544 in March 2023.
- Performance on cancer services standards was ahead of national targets and the Trust had fewer patients than planned waiting over 62 days (109 versus a forecast of 127)

Indicator	Standard	Dec-23	Jan-24	Feb-24	National Feb-24
62 Day Treatment	**85.0%**	77.8%	77.0%	74.9%	63.9%
31 Day Treatment	**96.0%**	90.4%	89.8%	96.9%	91.1%
28 Days Faster Diagnosis	**75.0%**	90.1%	85.7%	90.0%	78.1%

- Diagnostics performance (six week waits) was 90% in March 2023, below the 95% national target but benchmarking well regionally and nationally, with mutual aid being offered in some areas to other trusts

Priorities for 2024/25

It is proposed to carry forward all priorities which are not RAG-rated green in the summary at the start of this presentation.

The Trust is considering adding a new priority with respect to effective engagement with patients to learn from their experience.

The Committee is asked for its views on the above proposal and to suggest any further priorities based on its overview of the Trust's services.

Any questions?

NHS
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