County Durham and Darlington NHS
NHS Foundation Trust

Adults Wellbeing and Health Overview and Scrutiny Committee

Quality Accounts 2018 - 2019

December 2018

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with you all the way

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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 2018/2019 period. This report provides and update from April 2018 to September 2018.

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 2018/2019

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. 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 introduce the new Trust Falls Strategy, covering a 3 year period. - To agree a plan of year 1 actions. - To monitor implementation of year 1 actions against the Strategy. Multi agency action plan mapped out and agreed. Part of national NHS Improvement falls collaborative. Falls per 1,000 bed days within limits. Quality Improvement work underway. Reduction in falls resulting in serious incident see for the period
Care of patients with dementia[1] **(Continuation)**	Continued development and roll out of a dementia pathway and monitoring of care for patients with dementia.	- Continued 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 to continue. Explore feasibility of introducing the screening tool into existing electronic

Priority	Goal	Position/Improvement
		assessment tool will continue through this period. - Action plan developed from the results of the National Dementia audit to be monitored for improvement. - 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 2018/2019.This will be monitored. - Participate in a 5 year research project of dementia services within the Durham area to continue during 2018/2019. 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. All workstreams in place and being delivered
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. Two cases reported since April 2018 - No more than 18 cases of hospital acquired Clostridium *difficile.* Nine cases reported since April 2018 - Both of these will be reported onto the Mandatory Enhanced Surveillance System and monitored via Infection Control Committee.
Venous thromboembolism risk assessment[1,2] **(Continuation and mandatory)**	Maintenance of current performance.	- Maintain VTE assessment compliance at or above 95% within inpatient beds in the organisation. This mandated indicator will continue during 2017/2018. - Assessment will be captured onto a Trust database and reported weekly to wards and senior managers. Performance will be reported and monitored at Trust Board using performance scorecards. This indicator will move to part 3 of the report as background monitoring as process is now well developed. Compliant
Pressure ulcers[1]	To have zero tolerance for	- Full review of any identified grade 3

Priority	Goal	Position/Improvement
(Continuation)	grade 3 and 4 avoidable pressure ulcers.	and 4 pressure ulcers to determine if avoidable or unavoidable. - Reduce incidence from last year to zero avoidable grade 3 or 4 pressure ulcers. 1 in acute services and 3 in community setting
Discharge summaries[1] **(Continuation)**	To continue to improve timeliness of discharge summaries being completed.	- Monitor compliance against Trust Effective Discharge Improvement Delivery Plan. - Enhance compliance to 95% completion within 24 hours. - Data will be collected via electronic discharge letter system and monitored monthly with compliance reports to Care Groups and Trust Board via performance scorecards. Although not yet consistently at 95% good progress made with task & finish group now reviewing quality of discharge summaries. Deep dive audit undertaken regarding quality of discharge summaries
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. - Carry out bespoke Trustwide work to embed and improve reporting of near miss and no harm incidents. October 17 to March 18 - remain in 50 percentile. Near miss reporting improvement work stream underway with support from Care Groups. Early results show significant improvement but formal report awaited
Improve management of patients identified with sepsis[3] **(Continuation)**	To monitor roll out of sepsis screening tool via electronic system.	- Continue to implement sepsis care bundle across the Trust. - Roll out of sepsis screening tool via electronic system. - Continue to implement post one hour pathway. - Continue to audit compliance and programme. - Hold professional study days. Screening compliant Time to administration of antibiotics requires further improvement in EDs

Priority	Goal	Position/Improvement
		but improvement made on the trajectory. This continues to be closely monitored
Local Safety Standards for Invasive Procedures (LOCSSIPS) **(new indicator from Stakeholder event)**	To ensure full implementation of national guidance embedding Local Safety Standards into all areas conducting Invasive Procedures trust-wide.	- The Trust has formed a LocSSIP Implementation and Governance Group (LIGG) which brings together members of the 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. Project on track and recognised as good practice by NHS Improvement
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. Monitoring in place and nutritional assessment into Nervecentre piloted and ready to roll out
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*	- 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".

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	and the people who are important to me, including my carer(s)"	End of Life Steering Group now embedded to ensure agenda moves forward
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 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. Results not yet available
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 provides equal opportunities for career progression or promotion**[2] **(Mandatory measure)**	To show improvement year on year bringing CDDFT in line with the national average by 2018/2019.	- 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. Staff survey results are not yet available. Draft report expected December 2017.
Friends and Family Test[1] **(Continuation)**	Percentage of staff who recommend the provider to Friends and Family.	- During 2018/2019 we propose to 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 This is a quarterly report with focus on 2 care groups at each quarter. Quarter 2 results show an improvement of staff recommending the Trust to friends and family from 62% to 66%, however there has been a slight increase in those not

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		recommending from 11% to 13%
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. - To maintain HSMR and SHMI at or below 100. - 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. - Weekly mortality reviews led by the Medical Director will continue, and any actions highlighted monitored through Care Group Integrated Governance Reports. - Embed "Learning from Deaths" policy. Within expected range. Mortality reduction committee now embedded along with "Learning from Deaths" process. Mortality reviews being undertaken and linked with incident monitoring process
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 better planned care and are supported to receive supported self – care effectively.	- To aim for no more than 7% readmission within 28 days of discharge. - Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard and any remedial actions measured and monitored through the performance framework.
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 improve current performance.	- No more than expected rate based on locally negotiated rates. Monthly measure. - Information will be submitted to the national database so that national benchmarking can continue. Results will be monitored via Trust Board using the performance scorecard.

Priority	Goal	Position/Improvement
		Quarter 1 = 91.2% Quarter 2 = 89.1%
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 are removing 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. On track and priorities of "Each baby Counts" policy in place
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.
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. Now embedded in practice

1 - continuation from previous year

2 - mandatory measure

3 - new indicator following stakeholder events

During 2018/2019 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.

Four Never Events have been reported since April 2018. Action plans are developed and monitoring is in place for completion

Recommendation

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

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October 2018