HEALTH AND PARTNERSHIPS SCRUTINY COMMITTEE
18 FEBRUARY 2014

ITEM NO

QUALITY ACCOUNTS – PROGRESS REPORT

SUMMARY REPORT

Purpose of the Report

1. To advise Members of the recent meeting in respect of the County Durham and Darlington NHS Foundation Trust Quality Accounts.

Summary

2. Members will recall that this year this Scrutiny Committee has decided to be more involved, at an early stage, with local Foundation Trusts Quality Accounts. This will enable Members to have a better understanding and knowledge of performance when asked to submit a commentary on the Quality Accounts at the end of the Municipal Year 2013/14.

3. As a result, Members have committed to attending the Stakeholder events hosted by Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and County Durham and Darlington NHS Foundation Trust and established a Working Group with members of Healthwatch Darlington to receive six monthly performance reports from both Trusts.

4. This report brings to the Committee's attention, the information gathered and Members are asked to note the detailed information in preparation for its response to the Quality Accounts in April/May 2014.

Recommendations

5. It is recommended that the notes of the meeting held on 15th January 2014 in respect of County Durham and Darlington NHS Foundation Trust be noted.

Paul Wildsmith
Director of Resources and Neighbourhood Services

Background Papers

There were no background papers used in the preparation of this report.

Abbie Metcalfe : Extension 2365

S17 Crime and Disorder	This report has no implications for Crime and Disorder
Health and Well Being	This report has implications to the address Health and Well Being of residents of Darlington, through scrutinising the services provided by the NHS Trusts.
Carbon Impact	There are no issues which this report needs to address.
Diversity	There are no issues relating to diversity which this report needs to address.
Wards Affected	The impact of the report on any individual Ward is considered to be minimal.
Groups Affected	The impact of the report on any individual Group is considered to be minimal.
Budget and Policy Framework	This report does not represent a change to the budget and policy framework.
Key Decision	This is not a key decision.
Urgent Decision	This is not an urgent decision
One Darlington: Perfectly Placed	The report contributes to the delivery of the objectives of the Community Strategy in a number of ways through the involvement of local elected members contributing to the Healthy Darlington Theme Group.
Efficiency	The Work Programmes are integral to scrutinising and monitoring services efficiently (and effectively), however this report does not identify specific efficiency savings.

MAIN REPORT

Quality Accounts 2013/14

6. The Health Act 2009 requires Foundation Trusts to publish an Annual Quality Account Report.

7. The purpose of the Annual Report is for Trusts to assess quality across all of the healthcare services they offer by reporting information on annual performance and identifying areas for improvement during the forthcoming year and how they will be achieved and measured.

8. The priorities for improvement are divided into the three components of quality; safety, experience and effectiveness.

9. Overview and Scrutiny Committee's play an important role in development and providing assurance on Quality Accounts reports. The Health Act requires Trusts to send a copy of their report to be considered by their appropriate Overview and Scrutiny Committee.

10. In advance of the Trust's report being considered by Overview and Scrutiny Committees it is vital that the priority areas identified are considered and that discussion takes place. Comments or views from Overview and Scrutiny Committees should be reflected in the final report and involvement should be credited within the document.

Working Group

11. A Working Group was established into 2012 and Members agreed to continue with the same format for 2013/14 but meet six monthly rather than quarterly as they did last year.

12. Representatives of Healthwatch Darlington are invited to attend meetings of the Working Group to enable representatives and Members to receive updates on performance information from the Foundation Trust in a timely manner and avoid duplication.

County Durham and Darlington NHS Foundation Trust

13. At the Working Group's first meeting held on 10th October 2013, Members requested more information in respect of the priorities in relation to patient falls and discharge.

14. As a result the Working Group has met with the Clinical Standards Matron and Falls Lead and Associate Director of Nursing and the notes of the meetings are attached as **Appendix 1**.

15. The next meeting of the Group will take place at 10.00am on Friday, 14th March 2014 in Committee Room 3.

Appendix 1

2nd Meeting Quality Accounts Briefing with County Durham and Darlington NHS Foundation Trust – Quality Accounts Working Group

15th January 2014, at 10.00am, Committee Room 3

Present: - Councillor Newall in the Chair; Councillors Francis, Macnab, Nutt, H. Scott and J. Taylor.

Healthwatch: - Andrea Goldie.

County Durham and Darlington NHS Foundation Trust: - Eileen Aylott, Clinical Standards Matron and Falls Lead and Julie Race, Associate Director of Nursing.

The Working Group specifically considered the priorities in relation to Patient Falls and Discharge with the Trusts Quality Accounts for 2013/14.

Discharge summaries	To improve timeliness of discharge summaries being completed
Development of discharge guarantee	Development of discharge guarantee/ transfer agreement

Going Home Policy and Going Home Guarantee

Julie Race, Associate Director of Nursing explained that the Trust are committed to improving the patients experience of discharge and as a result the Discharge and Transfer Policy has been spilt into separate Policies. The newly implemented Going Home Policy focuses staff and patients minds on planning to go home, from the moment they are admitted. The new Policy has been successfully implemented and is NHSLA (NHS Litigation Authority) compliant with no issues reported. An audit tool is being developed to internally monitor compliance and it was hoped that the tool would be complete and fit for purpose towards the end of the month. As part of the Going Home Policy a Going Home Guarantee has been drafted and would be piloted on four Wards, including medical and surgical wards including a mix of ages during the last two weeks of January 2014. The Associate Director was hoping for positive feedback about the design, whether there was enough information or there too much? to enable the document to be tweaked prior to the launch. Members requested a copy of the Guarantee when it had been successfully launched.

The Going Home Guarantee was a document produced for the patient and with input from patients. The Guarantee is spilt up into three sections and enables both the patient and professionals to complete the document, providing patients with a document which outlines where they are in terms of being ready to go home. Part 1 of the form is completed on Admission, Part 2 details progress of up to 48 hours prior to discharge and Part 3 focuses on the day of discharge and includes medication, social care provision, point of contact for hospital staff and GP details, etc. The Guarantee enables the patients to complete sections themselves and log questions to ask the staff,

provides information to answer any questions they may have and presents an opportunity for patients to offer feedback, views, comments and opinions. The Associate Director explained that the Going Home Guarantee was a patient focused document and that a Discharge Plan / Checklist would still be used by staff.

Members welcomed the Going Home Guarantee and hoped that is would help alleviate patients anxieties about when they are going home. Particular reference was made about delays in patients being discharged and Members were advised of the multitude of reasons that delays occurs and that often medication delays were used as a reason when often there were other reasons such as internal mechanisms and discharge letters requiring sign off. Members noted that the Going Home Policy outlined to staff the need to record an estimated date of discharge (EDD) and how they should manage the patient and the Guarantee explained the process to the patient. The EDD should be regularly reviewed and the patients should be made aware if the date changes and why, to ensure that discharge is well planned. The Associate Director acknowledged that the patients' notes and the board behind the bed needed to be updated as well if the date of discharge was changed, as not to confuse the patient. It was explained that the initial date of discharge was usually based on the national length of stay figure but each patient case is different and therefore dates are sometimes increased or even reduced.

Communications

The Associate Director tabled a copy of the 'Nurse to Nurse Handover Report on Patient Discharge and Transfer' which was due to be introduced in either February or March 2014. The form provides a summary of key aspects of the patients care in an understandable format and has a body map on the reverse which will enable staff to highlight where the problem area is. It was envisaged that this would improve communications between nurses and departments and is highlighted in the Transfer Policy.

Members were pleased that the Trust were taking the opportunity to review all nursing documentation and were pleased that the Associate Director was driving the review. The Associate Director reported examples of work being undertaken:-

- Reviewed Nursing documentation, including assessment and care plans is in development. A booklet format will allow all patient assessments to be kept in one place.

- Electronic Document Management System (ECDM) has been introduced to enable patients' records to be managed more effectively. There was now the facility to scan patient records into the ECDS to make them available for their arrival for a planned procedure and if a patient is admitted in an emergency situation Live documentation will be paper based and these will be scanned into ECDM within 48 hours of discharge. Eventually all patient records will be stored electronically.

- A Multi Professional Admission Document was being developed and this would be one document to be used by everyone. This would avoid confusion and time wasting by professional updating many documents. The Trust believes that

nationally they are the first to develop this type of document and through NHS Quest would share the document as it develops.

Discussion ensued about patients records kept at the end of patients bed and the need to standardise live documents. Patients are able to look at their own records and share them with the families, although, records are able to be protected if required, for example dementia patients. Members suggested that patients should be encouraged to familiarise themselves with their patient records.

Members were delighted about the review of the documentation and asked if they could be regularly updated as the work progressed.

Discharge Letters – timeliness and quality

The Associate Director reported that the Trust was regularly achieving 80 – 90% compliance regarding timeliness of discharge letters when the actual target was 95%. The Trust is striving to achieve the high target while improving the quality of the discharges letters at the same time. Members were reminded that the Discharge Letter is the professional medical handover from the Hospital to the GP and therefore it was an important document.

It was noted that to produce a discharge letter was a lengthy process and that the entire medical staff who have treated the patient may contribute to the letter including the pharmacist. It is logged who has contributed to the letter and the discharging doctor makes the final sign off. There are sometimes technical reasons why a discharge letter doesn't reach the GP within 24 hours of discharge due to the last person not pressing the sign off button to actually electronically send the letter. Sometimes a hard copy is printed off and given to the patient upon discharge but there is a delay in the GP receiving the letter. The timeliness of discharge letters is still being reviewed.

The Associate Director explained that as part of the newly qualified doctors training (F1s) she leads a lesson on record keeping. The session provides F1 doctors with an understanding their role and responsibility to maintain record keeping standards to enable safe continuity of care. The session focuses a great deal on discharge letters and outlines the purpose of a discharge letter, content and timeliness of a discharge letter and tests their understanding of what a good discharge letter is. The Associate Director explained that the next session she will take recently produced discharge letters and asks the participants to audit the quality of the letters. In the past she has used anonymous old letters which has provided useful feedback but an internal audit would be more valuable.

Voluntary discharge was discussed and sometimes the patient and or family/carers refuse to sign themselves out of hospital. Staff try their best to discourage voluntary discharge at every opportunity but sometimes patients are adamant to want to go home, against professional advice. In these circumstances the risks are fully explained and recorded. There is a section in the Going Home Policy which addresses this.

The Associate Director reported that patient discharge for homeless patients is being informed by work is being informed from First Stop.

Patient falls	To reduce the number of inpatient falls that occur in inpatient facilities across the organisation

Eileen Aylott, Clinical Standards Matron and Falls Lead tabled a copy of the Falls Care Bundle Booklet and introduced a brief powerpoint presentation. Members noted that there was beginning to be a gradual decline in the numbers of falls, however, the number of beds days was increasing, but falls were reducing. It was explained that the patients who stay in hospital are very poorly, elderly and frail with often multiple and complex needs and usually prone to falling and as a result of the harm rates are not reducing. The number of patients who fall suffer from dementia or delirium due to a pre-existing condition or a Urinary Tract Infection (UTI) etc. which can cause delirium. The majority of falls occur when patients are trying to go to the toilet. Every fall is recorded on the Trust safeguard System and any harm is recorded, even a bump or cut is recorded as harm. A toilet survey has been undertaken as and a result the layout of the toilet facility has been improved to ensure that patients do not to stretch to reach what they need.

Members acknowledge that staff do as much as they possibly can to reduce to risk of falls but they still occur. The Falls Care Bundle Booklet enables staff to alleviate as many of the risks as possible, such as:

- Use of correct beds – Patients may require a High/low bed which can be as low as 30com from the floor and in extreme cases patients can be nursed on a mattress on the floor, if it is safer from them, but the family or carer should be included in those discussions.

- Individual roundings – The Booklet includes daily individualised care rounds for high risk patients and asks questions in relation to pain, position, patient needs and possessions.

- Safe footwear – Older people wearing unsafe footwear such as slippers or slipper socks can be very dangerous and increase the risk of falls. There are bed socks with grips on both sides that are provided to reduce the risk of falls.

- Referral to Mental Health Services for Older People – Mental Health Liaison. Patients with any cognitive impairment are referred to the liaison nurse and this is working well, with some 600 patients contacts to the Tees, Esk and Wear Valleys NHS Foundation Trust. Members were reminded that confused patients take greater risks than they usually would, which is why the risk of falls increases. Once patients have been diagnosed with a cognitive impairment, the patients' risk of falls would be reassessed. Members were reassured that staff are proactive and regularly dip urine to test for UTIs if they notice a change in a patients behaviour or urine colour or smell.

- Walking Aids – Some patients don't bring into hospitals their walking sticks, etc. which increases their risk of falls.

- Falls Alarms – Pressure pads are used for patients if they are prone to getting out of bed on their own when they require assistance. Some can be voice activated and family members can record their own message which helps a great deal. I.e. 'Dad, please sit down and wait for someone'. The familiar voice of a loved one often reassures the patient and they follow the instruction.

Members were reminded that it was sometimes a difficult decision for staff to balance dignity and safety risks. For example, a patient requiring assistance to go to the toilet may not want assistance once in the bathroom, even though, they are at risk of falling. By not allowing patients to do things unaided could be seen as staff being over cautious and not allowing patients to rehabilitate quickly. Patients must be assessed based on their cognitive ability as to whether it is appropriate for them to be left alone.

Members were apprised of the recent additions to the Falls Policy including rails on trolleys, use of high/low beds, nursing on the floor, co-horting patients (reducing the risk of falls by placing all patients prone or at risk of falling into one bay to be staffed by a different nurse on an hourly rotation) and use of falls alarms. Post falls actions were discussed and a full reassessment of the patient's condition is undertaken after a fall which Members very much welcomed.

Members were reassured that patient's family and carers were made aware if a patient has fallen and it was well documented. Particular reference was made to the fact that sometimes a patient was reported to have fallen when they had suffered a blackout or collapsed and older people in particular, may be found on the floor and it might be because they feel dizzy and it is where they feel safest. Training makes staff aware of the serious differences and the consequences if conditions are not diagnosed early. It was noted that there is an e-learning package that over 300 staff nurses was undertaken and the Health Care Assistants would be carrying out the training in the next few months, to remind them of their responsibilities associated to falls.

Agreed:-

a) **That the Going Home Guarantee be shared with Members once launched.**

b) **That Members receive regular updates on the progress of the Going Home Guarantee and reviewing of Nursing documentation.**

c) **That's the Officers be thanked for their attendance at the meeting**

d) **That the information gathered be used to inform members when preparing their commentary for the Trusts Quality Account for 2013/14**

e) **That the notes be submitted to the health and Partnerships Scrutiny Committee for approval.**