# HEALTH AND PARTNERSHIPS SCRUTINY COMMITTEE

Wednesday, 12 December 2018

**PRESENT** – Councilllors Newall (Chair), Copeland, Crichlow, Haszeldine and Heslop

**APOLOGIES** – Councillors J Taylor, Mrs H Scott and Tostevin,

**ABSENT** – Councillors Grundy, Nutt and E A Richmond

**ALSO IN ATTENDANCE** – Councillors Todd (County Durham and Darlington NHS Foundation Trust), Dr Chris Lanigan (Tees, Esk and Wear Valleys NHS Foundation Trust), Leanne McCardle (Tees, Esk and Wear Valleys NHS Foundation Trust) and Diane Lax (Healthwatch Darlington)

**OFFICERS IN ATTENDANCE** –

## HP32 DECLARATIONS OF INTEREST

There were no declarations of interest reported at the meeting.

## HP33 COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST - QUALITY ACCOUNTS 2018/19

The Associate Director of Nursing (Patient Safety and Governance) submitted a report (previously circulated) to update Members on the progress of improvements against the agreed priorities for 2018/19 during the period April 2018 to September 2018 outlined in the Quality Accounts briefing (previously circulated).

Members were advised that the Quality Accounts for County Durham and Darlington NHS Foundation Trusts include indicators set by the Department for Health and local priorities agreed through consultation with staff, governors, local improvement networks, commissioners, health Scrutiny Committees and other key stakeholders.

### Patient Safety

### Patient Falls

Members were pleased to note that target work continues to reduce falls across the organisations with the introduction of the Trust Falls Strategy and the multi agency action plan has been mapped out and agreed.

Members discussed the non-slip red sock scheme on each ward to avoid patient falls and the sensory training to enhance staff perception of risk of falls.

### Care of Patients with Dementia

Members welcomed the continued development and roll out of the dementia pathway alongside monitoring of patients with dementia and that all work streams were in place and being delivered.

**Healthcare Associated Infections**

MRSA - Members noted that there had been two cases reported since April 2018 and although within the national average, Members confirmed the threshold of zero tolerance.

Clostridium Difficile (C-Diff) – the target for C-Diff is 18 and the trust had reported 13 cases since April 2018. Members questioned the role of the Infectious Disease Control Team within the community and their work in Care Homes and with the General Practitioners.

Members also noted that the Trust were fully compliant with maintenance of Venous thromboembolism risk assessment.

**Pressure Ulcers**

Members noted that the Trust was striving for zero tolerance and that there had been one avoidance grade 3/4 pressure ulcers reported in acute service and three cases reported in community services. Members also noted that there was good reporting of skin damage.

**Discharge Summaries**

Members noted that the Trust target was 95 per cent completion within 24 hours and were making good progress towards this target with a task and finish group now reviewing quality of discharge summaries and a deep dive audit had been undertaken regarding quality of discharge summaries.

**Rate of Patient Safety Incidents Resulting in Severe Injury or Death**

National Reporting and Learning System (NRLS) shows the Trust remains within the 50 percentile of reporters of incidents however it was the aim of the Trust to reach 75$^{th}$ percentile.

Members discussed Near Miss reporting in place within the Trust.

**Improve Management of Patients Identified with Sepsis**

Members were pleased to note the roll out of the sepsis screening tool via electronic system and the implementation of the sepsis care bundle across the Trust. Screening was compliant however Members were disappointed to learn that the time to administer antibiotics required further improvement.

**Local Safety Standards for Invasive Procedures (LoCSSIPS)**

The Trust had formed a LoCSSIP Implementation and Governance Group bringing together Members of the Corporate Governance body with Care Group representatives and the Trust was on tract and recognised as good practice by NHS Improvement.

**Experience**

**Nutrition and Hydration in Hospital**

Members welcomed the aim to promote optimal nutrition for all patients with the introduction of a finger food menu and following the pilot to move the nutritional assessment tool to Nervecentre to improve quality metrics for nutrition for all patients, this was now ready to roll out.

The Associate Director of Nursing offered Members an invitation to see the Nervecentre in operation.

**End of Life and Palliative Care**

Members noted that the Trust now had an effective strategy and measures for palliative care and that there were no concerns and the End of Life Steering Group was now embedded to ensure the agenda moves forward.

The Chair referred to a Review Group established by this Committee to look at End of Life Care for those with Dementia.

**Responsiveness to Patients Personal Needs**

Members noted that the results were not yet available.

**Percentage of Staff who would recommend the trust to family and friends needing care**

Members noted staff survey results were not yet available.

**Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months**

Members noted staff survey results were not yet available.

**Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion**

Members noted staff survey results were not yet available.

**Friends and Family Test**

Members noted an increase in the number of staff recommending the Trust to friends and family from 62 per cent to 66 per cent although there had been a slight increase in those not recommending from 11 per to 13 per cent.

**Clinical Effectiveness**

**Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Index (SHMi)**

Members were advised that this priority was as expected. Weekly mortality reviews

were held led by the Medical Director and any actions highlighted were monitored through Care Group Integrated Governance Reports. The Trust continues to benchmark both locally and nationally with organisations of a similar size and type.

**Reduction in 28 day readmissions to hospital**

Members noted that the goal was set at 7 per cent but the Trust were now at around 12 per cent readmission with a realisation that the goal had been set too low. Information will be submitted to the national database so that national benchmarking can continue and results will be monitored via Trust Board using the performance scorecard and any remedial actions measured and monitored through the performance framework.

**Reduce the Length of Time to Assess and Treat Patients in Accident and Emergency Department**

Members were informed that at Quarter 1 performance was 91.2 per cent compared to Quarter 2 at 89.1 per cent. Members were advised that there were a number of projects in operation to improve current performance including a change to shift patterns at times of surge and Ambulatory Rapid Access Teams.

**Patient Reported Outcome Measures**

Members noted that the results were not yet available.

**Maternity Standards**

Members were pleased to note that compliance with key indicators was on track and priorities of 'Each Baby Counts' policy was in place.

The Trust continue to monitor for maintenance and improvement in relation to breastfeeding, smoking in pregnancy and 12 week booking; and to monitor actions taken from gap analysis regarding 'Saving Babies Lives' report.

**Paediatric Care**

Members noted that the Trust continue to develop more direct and personal relationships with individuals within Primary and Secondary care by building on the work already undertaken.

**Excellence Reporting**

Members were advised of this new indicator to ensure that CDDFT continues to embed learning from excellence into standard culture and practice through excellence reporting.

Members also discussed the four Never Events that had been reported since April 2018 and the actions taken.

**RESOLVED** – (a) That the report be noted.

(b) That the Associate Director of Nursing (Patient Safety and Governance) be thanked for her informative report.

## HP34 TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST - QUALITY ACCOUNTS QUARTER 2 UPDATE AND 2019/20 IMPROVEMENT PRIORITIES

The Head of Planning and Business Development and the Planning and Business Development Manager submitted a report (previously circulated) to provide Members with an update against each of the four key quality improvement priorities for 2018/2019 identified in the current Tees, Esk and Wear Valleys (TEWV) Quality Account including performance against the agreed quality metrics up to 30 September 2018.

The submitted report also set out the priorities for next year's Quality Account approved by the TEWV Board of Directors on 30 October 2018.

Members were advised that the four quality improvement priorities for 2018/19 were supported by 46 actions to assist delivery of those priorities, 40 of which were Green at 30 September 2018. The actions that were reporting Red at 30 September 2018 were outlined in the submitted report.

The submitted report also detailed the performance against the 9 Quality Metrics at Quarter 2 using RAG ratings and Members were advised that 33 per cent (3 metrics) were reporting green and 66 per cent (6 metrics) were reporting red.

Representatives from the Trust provided further information in relation to those six red Quality Metrics which were Metric 1 – percentage of patients who report 'yes always' to the question 'do you feel safe on the ward?'; Metric 3 –number of incidents of physical intervention/restraint per 1000 occupied bed days; Metric 6 – average length of stay for patients in Adult Mental Health Services and Mental Health Services for Older People Assessment and Treatment Wards; Metric 7 – percentage of patients who reported their overall experience as 'excellent' or 'good'; Metric 8 - percentage of patients that report that staff treated them with dignity and respect; and Metric 9 percentage of patients that would recommend the Trusts service to friends and family if they needed similar care or treatment,

In relation to Metric 1 which was 28.33 per cent below the Trust target of 82 per cent it was reported that the main reason or patients feeling unsafe was due to other patients and patient's vulnerability.

In relation to Metric 3 it was reported that the Trust's position for Quarter 2 was 15.18 per cent above the Trust target of 19.25 almost identical to Quarter 1.

With regard to Metric 6 it was reported that the target was not being met in relation to older people having to remain on the Ward for longer and the Trust were engaging with some local authorities on locality specific schemes to reduce delayed discharge. It was reported however that the median length of stay within Mental Health Services for Older People was 49 days which was within the target threshold of less than 52 days which demonstrates that the small number of patients that had very long lengths of stay had a significant impact on the mean figures reported.

In relation to Metric 7 Members were advised that there had been an improvement from Quarter 1 and a number of initiatives were taking place to improve patient experience. The Trust were currently at 91.34 per cent for Quarter 2, just below the target of 94 per cent.

With regard to Metric 8 Members were advised that the Trust position for Quarter 2 was 86.08 per cent, which was 7.92 per cent below the Trust target of 94 per cent. An Autism Awareness Training Programme was being delivered so staff can better understand how best to interact with, and take account of the needs of this particular service user group so adjustments to services can be made.

In relation to Metric 9 it was stated that the Trust position for Quarter 2 was 87.76 per cent, 6.24 per cent below the target of 94 per cent. However this was an improvement on Quarter 1.

Member were advised that the Trust were working hard to try and ensure that the targets in relation to Patient Experience were met in future and that action plans are put into place to address any issues.

With regard to the improvement priorities for 2019/20 Members were advised of the introduction of a fifth priority – Review of urgent care services and identify a future model for delivery.

Members noted that the Trust's Draft Quality Accounts would be presented to TEWV's Quality Account Stakeholder event at Scotch Corner on 5 February 2019; and TEWV's Quality Assurance Committee on 7 February prior to the completion of the daft Quality Account document and formal consultation with stakeholders in April and May 2019.

**RESOLVED** – (a) That the report be noted.

(b) That the Head of Planning and Business Development and the Planning and Business Development Manager be thanked for their informative presentation.