Minutes of the Health Scrutiny Committee

Monday 15th February, 2016 at 6.00 p.m.
in Committee Room 2 at the Council House, Dudley

Present:-

Councillor C Hale (Chair)
Councillors N Barlow, K Casey, K Finch, S Henley, Z Islam, M Miller, S Phipps, N Richards, D Russell, E Taylor.

Officers

A Sangian (Senior Policy Analyst – People Directorate) and K Buckle (Democratic Services Officer – Resources and Transformation Directorate).

Also in Attendance

Ms Marsha Ingram – Dudley and Walsall Mental Health Partnership Trust
Ms Rosie Musson – Dudley and Walsall Mental Health Partnership Trust
Mr Derek Eaves – Dudley Group NHS Foundation Trust (DGNHSFT)
Ms D Wardell – Dudley Group NHS Foundation Trust (DGNHSFT)
Mr N Bucktin – Dudley Clinical Commissioning Group.
Mr C Barron – Healthwatch Dudley.

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42. **Apologies for Absence**

Apologies for absence from the meeting were submitted on behalf of Councillors M Attwood and A Goddard and P Bradbury.

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43. **Appointment of Substitute Members**

It was reported that Councillors N Barlow and P Miller had been appointed to serve in place of Councillors M Attwood and A Goddard respectively and C Barron had been appointed to serve in place of P Bradbury for this meeting of the Committee only.

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44. **Declarations of Interest**

No Member declared an interest in any matter to be considered at this meeting.

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45. **Minutes**

Resolved

That the minutes of the meeting of the Health Scrutiny Committee held on 21st January, 2016 be approved as a correct record and signed.

46. **Public Forum**

No issues were raised under this agenda item.

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47. **National Health Service (NHS) Quality Account**

Quality account summary reports were submitted from the Dudley Group NHS Foundation Trust and the West Midlands Ambulance Service NHS Foundation Trust.

The Dudley Group NHS Foundation Trust

Arising from the presentation of the report submitted Members asked questions, raised concerns and made suggestions and representatives from the Dudley Group NHS Foundation Trust responded as follows:-

- The issues raised following the Friends and Family Test in relation to the outpatient service referred to waiting times and in particular patients wanting information in relation to the length of time they would have to wait. It was noted that in order to resolve issues, boards were now in situ advising of waiting times and it was proposed to also introduce a LED screen system which would display waiting times.
- Further concerns had been raised regarding inadequate gowns and as a result these had been improved to produce more coverage.
- Issues in relation to the information contained in outpatient appointment letters had now been addressed with letters being re-worded and the signage around the hospital following the introduction of the new Urgent Care Centre had been updated.

Measures taken to improve services including consultations were outlined as follows:-

- Launching a project investigating the possibility of the introduction of telephone clinics and clinics outside the hospital environment, together with a consultation with parents and Governors of the Trust with regard to the possibility of introducing such clinics.

- Introduction of a “One Stop Clinic” which had resulted in patient times being reduced as patients received their results on the same day as their initial consultation.

- That consultations had taken place at the Annual General Meeting which was attended by approximately 40 to 50 members of the public, flyers were handed out and there had been a presentation on the Quality Account when ideas and suggestions were invited from members of the public and the Trust Governors met regularly to investigate any themes and trends in relation to patients complaints.

- That the inclusion of suggestions to improve services were included on the Questionnaire which could be completed on the Trust's website.

Regarding infection control, work had been conducted with multidisciplinary teams which had resulted in changes to normal practices, including assessing patients who were at greater risk, focusing on those who had a cannula fitted, with those patients being monitored with a view to removing the cannula as soon as practicably possible, in order to avoid exposure to the risk of infection and the new systems of monitoring as referred to above were being shared at learning events.

Details in relation to work to improve awareness regarding infections such as MRSA and Clostridium difficile including work through General Practices and community services were referred to.

In relation to in-hospital deaths and the specialist multidisciplinary review which would take place within a twelve week period following the death, details in relation to the review process were referred to including ascertaining whether any treatment was missed with all care providers being investigated in order to ascertain whether the care was adequate, better than adequate or optimal and if the death could have been preventable the review would be escalated to the Medical Director with a further review focusing on the changes that were required to address the issues raised.

Following a query raised regarding detailed figures in relation to responses received from the Friends and Family tests, D Eaves undertook to provide Members with response rates including percentages across all Departments.

In relation to pressure ulcers, it was noted that all patients were assessed once they were admitted and detailed figures would be available in the final Quality Account both in relation to the number of patients that developed pressure ulcers and the number of those that were avoidable and every pressure ulcer case underwent a root cause analysis process, which examined all care in order to establish whether care had been provided to the requisite standard and the Clinical Commissioning Group also conducted an independent review.

It was further noted that details of pressure ulcers would only be conveyed to a patient's next of kin should a patient not have mental capacity or specifically request that the information be shared.

The Chair requested that further information be included in the final Quality Account in relation to how may in-hospital deaths had been determined to be avoidable together with detailed reasons including a breakdown of the Root Cause Analysis.

In relation to nutrition and hydration auditing, the national tool used throughout the National Health Service was referred to, which was evidence based with many Trusts using the same tool which involved obtaining data in respect of ten patients from each Ward, as an indicator which provided a snapshot on a number of patients.

In relation to mortality issues and age groups it was noted that as part of the review following an in-house hospital death any patient trends would be reviewed and ultimately those trends would be reported in the final Quality Account.

Regarding the pressure ulcers review targets those had been set as no greater than the preceding year, given the increasing admission of frail elderly people and it was a great achievement to meet the target given the increase in admissions.

In relation to the two cases of MRSA, following the review both cases had occurred as a result of the removal of the patient's cannula sooner rather than later.

That looking ahead in relation to the targets for nutrition and hydration resulting in some areas that were not consistent with the future target of 93% in all Wards, this was in relation to replacement boards that had now been installed behind beds in order that nursing staff with could update dietary requirements for certain patients with special dietary requirements.

Following Members being invited to provide the Trust with suggestions in relation to prioritisation of quality priorities for 2016/17, the Chair suggested that pressure ulcers and infection control should be prioritised.

West Midlands Ambulance Service NHS Foundation Trust

Following further discussion A Sangian, Senior Policy Analyst was requested to collate Members comments and suggestions in relation to the Quality Accounts 2015-16 update and forward those to the West Midlands Ambulance Services NHS Foundation Trust.

It was noted that the final Quality Accounts would be considered at a future meeting of the Committee.

A Sangian, Senior Policy Analyst was requested to advise report authors of the requirement to provide a glossary of acronyms for each report submitted to future meetings.

Resolved

That the information contained in the reports, submitted on the Quality Account relating to the Dudley Group NHS Foundation Trust and the West Midlands Ambulance Service NHS Foundation Trust, be noted.

The meeting ended at 7.25 p.m.

Chair