Central Bedfordshire Council
Priory House
Monks Walk
Chicksands,
Shefford SG17 5TQ

This meeting may be filmed.*

please ask for Paula Everitt
direct line 0300 300 4196
date 19 May 2016

NOTICE OF MEETING

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

Date & Time
Tuesday, 31 May 2016 10.00 a.m.

Venue at
Committee Room 1, Watling House, Dunstable

Richard Carr
Chief Executive

To: The Chairman and Members of the SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE:

To be confirmed at the Annual General Meeting on 19 May 2016

[Named Substitutes:

To be confirmed at the Annual General Meeting on 19 May 2016

All other Members of the Council - on request

MEMBERS OF THE PRESS AND PUBLIC ARE WELCOME TO ATTEND THIS MEETING

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AGENDA

1. **Apologies for Absence**

   Apologies for absence and notification of substitute members

2. **Minutes**

   To approve as a correct record the Minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 21 March 2016 and to note actions taken since that meeting.

3. **Members' Interests**

   To receive from Members any declarations of interest and of any political whip in relation to any agenda item.

4. **Chairman's Announcements and Communications**

   To receive any announcements from the Chairman and any matters of communication.

5. **Petitions**

   To receive petitions from members of the public in accordance with the Public Participation Procedure as set out in Annex 2 of Part A4 of the Constitution.

6. **Questions, Statements or Deputations**

   To receive any questions, statements or deputations from members of the public in accordance with the Public Participation Procedure as set out in Annex 1 of part A4 of the Constitution.

7. **Call-In**

   To consider any decision of the Executive referred to this Committee for review in accordance with Procedure Rule 10.10 of Part D2.

8. **Requested Items**

   To consider any items referred to the Committee at the request of a Member under Procedure Rule 3.1 of Part D2 of the Constitution.

9. **Executive Members' Update**

   To receive a brief verbal update from the Executive Members for:-
   - Social Care and Housing and
   - Health

Part A: External & NHS matters

To review and scrutinise any matters relating to the planning, provision and operation of health services in Central Bedfordshire commissioned by the NHS or external organisations (such as the Clinical Commissioning Group).

Reports

Item	Subject		Page Nos.
10	**Hospital and Care Providers' Quality Accounts 2015/16**	*	13 - 26

The Committee is asked to consider the Quality Accounts provided by:-

1. Bedford Hospital Trust
2. SEPT
3. East and North Herts Hospital Trust (The Lister Hospital)
4. The Luton and Dunstable Hospital and
5. East London Foundation Trust (ELFT)

Comments on the Quality Account are voluntary, the Committee is not obliged to comment if it does not feel it necessary. Any statements agreed by the Committee will be sent to each Hospital and Care Provider in order to include the statement in their final document. A dashboard summary is attached and the full Quality Account for each provider is available from this link:- http://centralbeds.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=644

CENTRAL BEDFORDSHIRE COUNCIL

At a meeting of the **SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE** held in Council Chamber, Priory House, Monks Walk, Shefford on Monday, 21 March 2016.

PRESENT

Cllr P Hollick (Chairman)

Cllrs	N B Costin P A Duckett	Cllrs	C C Gomm Mrs S A Goodchild

Apologies for Absence: Cllrs R D Berry, P Downing, Mrs D B Gurney, G Perham

Substitutes: Cllrs Mrs A Barker, Mrs T Stock

Members in Attendance:		
Cllrs	C Hegley	Executive Member for Social Care and Housing
	J G Jamieson	Leader of the Council and Chairman of the Executive
	M R Jones	Deputy Leader and Executive Member for Health
	M A G Versallion	Executive Member for Education and Skills

Officers in Attendance:		
Mrs P Everitt	–	Scrutiny Policy Adviser
Mr N Murley	–	Assistant Director Resources
Mrs C Shohet	–	Assistant Director of Public Health
Mrs N Sinden	–	Public Health Co-ordinator

Others in Attendance		
Mr A Cook		
Mr C Goodson		Senior Locality Manager
Mr C Hartley		East of England Ambulance Service
Dr H Jopling		Public Health Registrar
Mr A Moore		Chief Operating Officer, Bedfordshire Clinical Commissioning Group
Mr R Smith		Chairman Central Bedfordshire Healthwatch

SCHH/15/76. **Minutes**

RESOLVED that the Minutes of the meeting of the Social Care Health and Housing Overview and Scrutiny Committee held on 25 January 2016 be confirmed and signed by the Chairman as a correct record.

SCHH/15/77. **Members' Interests**

There were no Members' Interests declared for the meeting. However, although not a member of the Committee Mrs C Shohet registered an interest at item 12 because of a medical condition.

SCHH/15/78. **Chairman's Announcements and Communications**

The Chairman advised the Committee of his attendance at the opening of the Rosewood Court Care Home in Dunstable. The Chairman and Cllr Goodchild also attended an event hosted by the Centre for Public Scrutiny in Peterborough that had focussed on Health inequality, the reconfiguration of Health services, Health and Wellbeing Boards and integration of CCGs and GPs.

The Chairman informed the Committee of a collaborative approach to setting the work programme for next year, agreed at a meeting of the Chairs and Vice-chairs of Overview and Scrutiny. Focusing on the 5-Year Plan, the process would allow Members, co-optees and a range of partners to meet and determine items in the coming year.

The Chairman requested the BCCG to include details on the affect on hospitals of the recent junior doctors' strike in their Winter Resilience report to be considered by the Committee in June.

SCHH/15/79. **Petitions**

None.

SCHH/15/80. **Questions, Statements or Deputations**

None.

SCHH/15/81. **Call-In**

None.

SCHH/15/82. **Requested Items**

None.

SCHH/15/83. **Report by the Local Government Ombudsman**

The Director of Social Care Health and Housing introduced a report that outlined the Local Government Ombudsman (LGO) findings into a complaint made by Ms J. The Council had accepted all recommendations in the LGO's ruling and actions had been put in place that included the development of a more robust record keeping system that included every interaction with a client. Staff would be trained on this case along with key partners to ensure that lessons learnt were embedded into good working practices.

The LGO found that Ms J had made complaints over a number of years to different areas of the Directorate and the Council had not followed its complaints procedure. Going forward a chronology of complaints would be recorded in one place. The Director had apologised to Ms J, arranged the compensation payment recommended by the LGO and arranged for an independent social worker to review her case.

The Council had not managed Ms J's direct payment arrangements properly and the service would explore a move to a payment card system. This would enable the monitoring of payments on a regular basis and issues would be picked up and dealt with sooner. A new direct payment leaflet for customers had also been produced. The Director had also increased the number of colleagues working in the direct payments team.

In light of the report, Members of the Committee raised the following concerns:-

- Whether Mrs J was happy with the outcome and support plan. The Director advised that Mrs J was satisfied and had declined the support of an independent advocate.
- How this would have been managed in the case of a client in receipt of a direct payment and subsequently taken into hospital. The Head of Integrated Services advised the team would review the care plan and discuss any changes to the direct payments with the person, family members and significant others. However, the onus was on the customer to advise the Council of changes. Those customers with high balances would be contacted as part of the regular monitoring of direct payments.

In conclusion the Committee supported the idea of pre-payment cards and agreed that the new arrangements put in place by the Director would have a good impact for our customers.

RECOMMENDED:-

1. **That the importance of our professional staff giving clear and precise explanations to clients and to ensuring records are kept of each and every interaction with clients be stressed;**
2. **That an assessment be made as to whether any training, or any further training is required, which, if so, be formulated and implemented.**
3. **That it be noted the recommendations of the Local Government Ombudsman have been accepted and acted upon and that the Directorate confirm it has taken action within three months of the date of the report.**

SCHH/15/84. **Executive Members Update**

The Executive Member for Social Care and Housing advised the Committee of a regional meeting on the Syrian refugee position. Many councils including Central Bedfordshire were ready to receive Syrian families, however, few had arrived in the region. The Committee were also informed a small housing development had been opened at Creasy Park in Dunstable and Priory View was on track to open to residents on 18 April 2016.

The Executive Member for Health advised that the contract for the 0-5 children's services would be extended for a further 2 years. During this time

officers would work along side the BCCG to improve the Community Services Contract. The work would culminate in a revised contact for 0-19 Children's Services.

SCHH/15/85. **East of England Ambulance Trust Performance Report**

The Head of Communications at the East of England Ambulance Trust introduced a performance report that highlighted there continued to be a pressure on the ambulance service, along with increased handover delays, and more patients with more serious conditions. A new recruitment plan had been put in place, although the full benefit would not be realised just yet; especially as the 750 student paramedics recruited over the last 18 months are still completing their training and education.

A new Chief Executive, Robert Morton, had started to build a new leadership team and strategy. The Trust was moving towards a mix of skills within the workforce that included clinical support by GPs in the control room, in order that a patient can be assessed and put on the right care pathway.

In light of the update, Members raised the following issues:-

- Whether it was feasible to merge Fire and Ambulance stations in close proximity to each other. In response the Senior Locality Manager advised that in many cases it was not possible to merge as space was often fully utilised.
- Whether defibrillators available in the community had made a difference to the service. The Senior Locality Manager advised there had been some good results following the distribution of over 200 defibrillators in the area. The first responders' initiative had also proved successful.

In response to questions from Members the Director of Communications advised the targets shown were national, however, the EEAST hoped to improve targets in remote areas with the community first responders and fire fighters trial.

RECOMMENDED:

1. **That the Committee noted the service had moved forward and was striving to meet the needs of the public.**
2. **That the Committee welcomed the stability in the management team and a successful recruitment process in the north of Bedfordshire.**
3. **That the Committee noted the pressures on the service but emphasised the need to set and strive to achieve realistic targets in conjunction with partners.**
4. **That the Committee would welcome future comment on potential blue light collaboration.**

SCHH/15/86. **BCCG Value Based Elective Commissioning**

The Chief Operating Officer, Bedfordshire Clinical Commissioning Group (BCCG) introduced a report that outlined service changes being considered by the BCCG during a period of pre-engagement. Feedback gathered would be reported to the BCCG Board in April 2016 on whether to withdraw investment

in specialist fertility treatment, gluten free food and over the counter medication prescriptions and to recommend the commencement of a public consultation.

A Member requested that consideration be given to the high cost of gluten free food in supermarkets that make some products unaffordable for some low income families.

The Executive Member for Social Care and Housing suggested that the BCCG share information with the public regarding back office cuts as well as the proposed service cuts and where reinvestment would take place in services. The BCCG was urged to consider those financially disadvantaged and that safeguards be put in place for patients.

RECOMMENDED:-

1. **That the Committee emphasised the importance of clear explanations to the public on the proposals going forward.**
2. **That there should be consultation on limiting or ceasing funding in respect of specialist fertility services, the prescription of gluten-free foods and over-the-counter medicines which are prescribed for short, self-limiting illnesses.**
3. **That BCCG emphasise the need to further educate the public on the advice available from pharmacists, not least of all in respect of using lower cost, over-the-counter medication.**
4. **That the Committee expresses its wish that account is taken of the cost implications for low income families.**

SCHH/15/87. **BCCG Primary Care Strategy**

The Locality Business Manager, BCCG introduced a report that advised of the formal joint commissioning of Primary Care services by NHS England and Clinical Commissioning Groups from April 2016.

Proposals were focussed on two main areas to sustain and support practices and to offer stabilised high quality services.

The new models of care formed part of the Health Care Review and work was underway in Dunstable and Biggleswade to provide a care hub and feasibility studies were being developed.

In light of the report Members raised the following concerns:-

- Whilst the Committee supported the principle of hubs and the proposal to share back office functions, there was a concern at the speed at which the changes would happen. In response the Chief Accountable Officer advised that GP's would hear from a Birmingham GP brand that had successfully opened 20 GP practices in 2 years.
- The steps that could be taken to support GP's in the interim. The Locality Manager advised that work behind the scenes to support GP Practices and premises would continue.

The BCCG officers present were requested to report back on the progress made to imbed the strategy.

RECOMMENDED That the Committee recognised an ambitious programme to develop a primary health care strategy and the work being carried out around GP Hubs.

1. **That a report be presented to the Committee within nine months showing constructive progress especially in relation to the development of a first Hub.**
2. **That the Committee recognised a strategy being put forward by the BCCG as well as one being put forward by the Council to the Executive and looks to some common working.**

(Meeting adjourned at 11.50am and reconvened at 12 noon)

SCHH/15/88. **Excess Weight Services Strategy and Contract**

The Executive Member for Health introduced the Excess Weight Services Strategy that outlined a partnership approach to tackle the high levels of excess weight. The Assistant Director Public Health advised that 70% of adults weighted more than was healthy and excess weight affected emotional wellbeing too.

The Strategy's action plans would be measured quarterly and aimed to achieve a 1% reduction year on year to bring down the average in Central Bedfordshire. The National Strategy was yet to be published, however, the Council's Strategy would be updated in line with any new advice.

A Member asked how Town and Parish Councils could be made aware of the Strategy. In response the Executive Member for Health would look to include an item at the Town and Parish Conference event.

Members also queried whether there should be healthy eating events to teach children and parents the importance of eating healthily to steer them away from takeaway outlets. The Assistant Director advised that school nurses would reinforce the healthy eating message and also support those children under eating, and other associated problems. School Governors would also be asked to relay in schools the message on healthy eating and exercise. Restricted opening times were also imposed on take away outlets near schools.

The Executive Member for Education and Skills advised the Committee that food technology had been reinstated on the schools curriculum and gave some opportunity for schools to teach healthy eating.

RECOMMENDED:-

1. **That the Committee recognised it is the responsibility of all (including parents in respect of their children) to ensure a good diet and exercise are the foundations for a healthy life.**
2. **That the Executive Member encourages schools to be even more proactive in tackling excess weight through the curriculum and sport.**
3. **That a further report be submitted in 12 months in relation whether the Council has achieved success**
4. **That the Strategy be shared with the BCCG.**
5. **That Town and Parish Councils be informed about this work.**

SCHH/15/89. **Q3 Budget Monitoring Reports**

The Assistant Director Resources introduced the Q3 budget monitoring report that drew attention to the current forecast revenue outturn for Social Care Health and Housing which was overspent by £0.468m, an improvement on the previous quarter. Care packages for older people continued to dominate the overspend positon. However, with the BCCG's support, continuing health care was having a positive impact.

In light of the update, a Member raised concern regarding the number of people not receiving care at home. The Assistant Director advised there was a number of causes and would provide the Committee with additional information.

RECOMMENDED:-

1. **That the pressures on the revenue budget and the steps taken to mitigate such be noted.**
2. **That the Committee was pleased to note that the forecast spend on Priory View remains on budget albeit noting a loss of income from its delayed opening.**
3. **That the balanced budget in Public Health be noted.**

SCHH/15/90. **Work Programme 2015/16 and Executive Forward Plan**

The committee considered the current work programme and agreed that the following items be included:-

- Primarily care strategy
- Hubs
- Blue light collaboration
- Weight strategy

The Members discussed proposals for a briefing on the Housing Strategy and the need for more affordable housing.

The Executive Member for Social Care and Housing would ensure an Affordable Housing briefing was arranged.

RECOMMENDED that subject to the addition of those items noted in the minutes, the work programme be approved.

(Note: The meeting commenced at 10.00 a.m. and concluded at 1.30 p.m.)

Chairman……..

Dated……..

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Central Bedfordshire Council

SOCIAL CARE, HEALTH & HOUSING OVERVIEW & SCRUTINY COMMITTEE

Tuesday, 31 May 2016

Quality Accounts

Advising Officers: Tracey Brigstock Bedford Hospital Trust, Jacqui Evans East and North Herts Hospital Trust, John Wilkins ELFT, Helen Smart and Rachel West SEPT, Victoria Parson Luton and Dunstable Hospital Trust.

Contact Officer: Paula Everitt, Scrutiny Policy Adviser, paula.everitt@centralbedfordshire.gov.uk

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Purpose of this report

1. The Committee is asked to consider the Quality Accounts from the Local Hospitals and NHS Care providers in Central Bedfordshire and provide any comments as they feel appropriate. Comment on the Quality Accounts are voluntary, the Committee is not obliged to comment if it does not feel it necessary.

RECOMMENDATIONS

The Committee is asked to comment and agree a statement, if so minded, on the Quality Accounts submitted by Bedford Hospital, SEPT The ENH Hospital (Lister Hospital), The Luton and Dunstable Hospital Trust and ELFT.

Issues

2. All providers of NHS healthcare services in England are required to publish a quality account that represents the quality of the healthcare services delivery over the previous year. Trusts are required to share their quality accounts with Healthwatch and appropriate Overview and Scrutiny Committee with responsibility for health matters who are offered the opportunity to comment on the draft document on a voluntary basis. The quality accounts are produced annually and made available to the public.

3. The Department of Heath (DoH) have produced guidance on Quality Accounts titled “Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs)”. The DoH guidance states that “Quality Accounts aim to enhance accountability to the public and engage the leaders of

an organisation in their quality improvement agenda. If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention."

4. The Department of Health Guidance "Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs)" suggests that OSCs might consider the following:-
   - Do the priorities identified by the provider contained in the Quality Account match those of the public?
   - Has the provider omitted any major issues from the Quality Account?
   - Has the provider demonstrated they have involved patients and the public in the production of the Quality Account?

Corporate Implications

The review of services contained in the draft Quality Accounts are for NHS agencies and not the Council itself. The services referred in the Quality Accounts will however support the Council Priorities by protecting the vulnerable; improving wellbeing.

Conclusion and next Steps

5. Any statements agreed by the Committee will be sent to the provider to allow them time to prepare their final Quality Account, which will include the statement, for publication

Attachments
Bedford Hospital Priorities Dashboard
SEPT Priorities Dashboard
ENH Hospial Priorities Dashboard
Luton and Dunstable Hospital Priorities Dashboard

The full Quality Accounts are provided on the Committee's web page:

6. Bedford Hospital Quality Account
7. SEPT Quality Account
8. East and North Herts Hospital Quality Account
9. The Luton and Dunstable Hospital Quality Account
10. East London Foundation Trust Quality Account

Background Papers The following background papers, open to the public

Quality Accounts: a guide for Overview and Scrutiny Committees

Quality Accounts Data Sets – Bedford Hospital NHS Trust

Quality Account 2015/16		
Priority	**Targets**	**RAG**
Patient Safety Priority: continued reduction of the incidence of avoidable harm experienced by our patients whilst receiving care and treatment at the trust	Zero MRSA blood infections	One MRSA blood infection reported in April 2015
	Less than ten hospital-apportioned *Clostridium difficile* infections	23 cases hospital-apportioned *Clostridium difficile* infections
	Less than 17 hospital acquired avoidable grade 2 pressure ulcers and nine hospital acquired grade 3 pressure ulcers	10 hospital acquired avoidable grade 2 pressure ulcers 6 hospital acquired grade 3 pressure ulcers
	95 percent venous thromboembolism (VTE) assessment rate	95.16%
Patient experience priority: improve the information the trust provides to patients and their relatives when they leave hospital.	Implement the 'Helping You Plan to Leave Hospital' information booklet for all inpatients.	The trust has partially achieved this target. All patients on elderly frail wards receive the booklet with a covering letter explaining how the discharge team can help patients and their families. The trust discharge planning team is responsible for ensuring patients on the elderly frail wards receive the booklet and appropriate support. This is monitored by the trust's lead matron for discharge. The trust plans to roll out the use of the booklet to all wards in 2016/17.
	Implement a discharge information pack (the Place of Discharge Toolkit) tailored to meet the needs of patients with more complex discharge requirements will be implemented across the Trust.	The trust provide patients and their carers and relatives with an information pack that guides them through the complex process of finding new nursing and residential homes. This pack is due to be updated in 2106/17 to be compliant with the new requirements of the Care Act 2015 and new social care charges. We also include a leaflet for the Bedford Hospital carers lounge which provides free and independent support and advice.
Clinical Effectiveness Priority: introduce the Hospital at Home service to help reduce the length of stay of patients who do not need to be in hospital to receive their care and treatment.	Recruit two whole time equivalent (WTE) band 6 nurses to the Hospital at Home Service	The trust were unable to achieve the additional funding required for the posts in 2015/16, however we were able to flex the service based on patient demand and we were often able to increase the virtual ward to 10 or more beds. The trust has introduced a 'patient tracker' system for patients under the complex discharge team. This allows the team to support patients as they move through the hospital until discharge. The system also provides greater transparency for our partners as this provides a daily picture of patients who are fit for discharge yet remain in hospital.

Quality Accounts Data Sets – Bedford Hospital NHS Trust

Quality Account 2016/17		
Priority	**Targets**	**Measurement**
Patient Safety Priority: Improve learning following never events, incidents and complaints to prevent avoidable harm	Develop and implement the trust's learning framework and demonstrate improved learning from incidents, never events and complaints across all staff groups	This improvement priority links directly with a CQC requirement notice. Progress against the detailed action plan will monitored by the Governance work stream and reported to the trust's Quality Board on a monthly basis.
Patient Experience Priority: Build on good practice in maintaining privacy and respecting outpatient areas and to further improve the range of patient information in languages other than English.	To ensure patients have their outpatients and emergency consultation provided with privacy and respect by ensuring that measures are taken to ensure private conversations are not overheard.	The trust will develop a performance metric (e.g. percentage of information leaflets available in translation) and report quarterly via established quality monitoring framework to the Quality Board.
	To further extend access to patient information that meets their language needs.	The trust will develop a performance metric (e.g. percentage of information leaflets available in translation) and report quarterly via established quality monitoring framework to the Quality Board.
Clinical Effectiveness Priority: Benchmark clinical outcomes of care to drive improvement for patients	For all national audits where patient outcomes are below average, the trust will develop and implement action plans to improve patient outcomes	Each division will receive a monthly report (contained with the Clinical Quality Portfolio) detailing annual reports received, due date for action plans, clinical lead and progress in implementing actions Divisions will report upwards to the trust's Quality Board

Quality Report / Account 2015/16 Dashboard – South Essex Partnership NHS Foundation Trust

(summarises Trust-wide performance against quality priorities 2015/16 and quality priorities for 2016/17)

Quality Accounts Data Set – SEPT 2015/16		
Priority 1: **Effectiveness** **Restrictive practices** To reduce the number of restrictive practices undertaken across the Trust.	**Target areas** We will have less prone restraints in 2015/16 compared to 2014/15.	**RAG** **GREEN** 266 prone restraints in 2015/16 compared to 312 in 2014/15
Priority 2: **Safety** **Pressure ulcers** To further reduce the number of avoidable category 3 and 4 pressure ulcers acquired in our care.	**Target areas** We will have less avoidable grade 3 and 4 pressure ulcers acquired in our care in 2015/16 compared to 2014/15.	**RAG** **GREEN** 16 avoidable grade 3 and 4 pressure ulcers acquired in our care identified for 2015/16 (some Root Cause Analyses still in progress) compared to 23 in 2014/15
Priority 3: **Safety** **Falls** To reduce the number of avoidable falls that result in moderate or severe harm within inpatient areas.	**Target areas** We will have less avoidable falls that result in moderate or severe harm in 2015/16 compared to 2014/15.	**RAG** **GREEN** 2 avoidable falls resulting in moderate or severe harm identified for 2015/16 compared to 5 in 2014/15.
Priority 4: **Experience** **Early detection of the deteriorating patient** To embed system of early detection of deteriorating patients and preventative actions.	**Target areas** We will establish a baseline for improvement in Modified Early Warning System (MEWS) scores recorded.	**RAG** **GREEN** Baseline of 70% established for MEWS scores recorded for Older People and Adult Wards
Priority 5: **Experience** **Unexpected deaths** To reduce the number of unexpected deaths (suicides).	**Target areas** We will achieve a year on year reduction in the number of suicides across clinical services in 2015/16 compared to 2014/15.	**RAG** **RED** There have been a total of 29 unexpected deaths (suicides) in 2015/16 compared to 16 in 2014/15. Significant work is in progress to continue to address this priority.

Priority 6: Safety **Medication omissions** To reduce the number of medication omissions across the Trust and reduce the number of medication omissions where no reason code is annotated.	**Target areas**	**RAG**
	We will reduce the number of omitted doses in Mental Health Services in 2015/16 compared to 2014/15.	**AMBER** 1.2% of doses were omitted without a valid clinical reason in 2015/16 (audit in January 2016) compared to 3.7% in the baseline audit in 2014/15
	We will improve the reporting of omitted doses within Community Health Services so that a clear baseline can be established.	**AMBER** Reporting rates increased from 61 in 2014/15 to 94 in 2015/16. A baseline has been established for omitted doses as a result of an audit undertaken in January 2016.

Quality Report / Account 2015/16 Dashboard – South Essex Partnership NHS Foundation Trust

(summarises Trust-wide performance against quality priorities 2015/16 and quality priorities for 2016/17)

Quality Accounts Data Set – SEPT QUALITY PRIORITIES 2016/17		
Priority 1: **Effectiveness** **Restrictive practice** To further reduce the number of restrictive practices undertaken across the Trust.	**Target areas**	**Measurement**
	We will have less prone restraints in 2016/17 compared to 2015/16.	Number of prone restraints.
Priority 2: **Safety** **Pressure ulcers** To further reduce the number of avoidable grade 3 and 4 pressure ulcers acquired in our care.	**Target areas**	**Measurement**
	We will have less avoidable grade 3 and 4 pressure ulcers acquired in our care in 2016/17 compared to 2015/16.	Number of avoidable grade 3 and 4 pressure ulcers acquired in our care.
Priority 3: **Safety** **Falls** To further reduce the number of avoidable falls that result in moderate or severe harm within inpatients areas.	**Target areas**	**Measurement**
	We will have less avoidable falls that result in moderate or severe harm in 2016/17 compared to 2015/16.	Number of avoidable falls resulting in moderate or severe harm.
	We will have a reduction in the number of patients who experience more than one fall in 2016/17 compared to 2015/16.	Number of patients who experience more than one fall.
Priority 4: **Experience** **Earlier detection of deteriorating patient** To further embed a system of early detection of deteriorating patient and preventative actions.	**Target areas**	**Measurement**
	We will increase the % of Modified Early Warning System (MEWS) scores recorded during 2016/17 from the baseline established in 2015/16.	Number and percentage of MEWS scores recorded in records, taken from a regular schedule of audit of a sample of mental health in-patient records.
	We will increase the % of patients with a MEWS score greater than 4 (or a single score of 3) that are escalated appropriately.	Number of patients with a MEWS score greater than 4 (or a single score of 3) that are escalated appropriately, taken from a regular schedule of audit of a sample of mental health in-patient records.

Priority 5: **Experience** **Reduction in unexpected deaths** To further develop the suicide prevention culture across all services in order to achieve the Trusts strategic ambition of no avoidable suicides of patients known to services.	**Target areas**	**Measurement**
	We will implement a bespoke training package for suicide intervention and train 50% of relevant mental health front line staff during 2016/17.	Implementation of training package. Number of relevant mental health front line staff trained.
Priority 6: **Safety** **Reduction in medication omissions** To further reduce the number of omitted doses and the number of omitted doses where no reason code is annotated.	**Target areas**	**Measurement**
	We will further reduce the number of omitted doses within services in 2016/17 compared to 2015/16.	Number of omitted doses.

East & North Hertfordshire NHS Trust Quality Account 2015/16

Please find below a summary of achievement against the targets. Specific data, with historic figures where available, is given in appendix 1.

Priority	Targets	RAG	Comment
Patient Safety Priority: Improve safety thermometer scores	• Safety thermometer score for falls, pressure ulcers, UTI and VTE	2.5%	This data is collected and is published on the national reporting system.
	• Number of inpatient falls	861	Aim < 888. The National Audit of Inpatient Falls shows the Trust as reporting 3.23 falls per 1000 bed days compared with a national average of 6.63 and places the Trust in the top 10% of best performing Trusts.
	• Number of falls resulting in serious harm	11	Aim < 24. All serious harm falls are thoroughly investigated with learning identified and shared. There were 11 severe harm falls leading to fractured hip and 1 fall resulting in a head injury. This represents a small improvement on the previous year where there were 14 such incidents.
	• Number of pressure ulcers (hospital acquired)	26	Aim < 36.
Patient Safety Priority: Improve medication management	Survey results (medication purpose & side effects)		The national In-Patient Survey results will not be released until 8th June.
	• Incident reporting re medication		Final end of year data is awaited although indications to date suggest that the medication incidents leading to harm has reduced and that the number of medication errors being reported has remained stable.
	• Medication omission audit		December 2015 audit of omitted or delayed critical medication showed: 92.67% doses correctly given (89.16% in January 2015) 5.31% doses omitted (10.33% in January 2015) 2.02% doses delayed (0.51% in January 2015)
	• Implement Medicines Optimisation Strategy objectives for year		The milestones of the strategy have been met. This includes the introduction of the medication safety thermometer.
	• Results of medication thermometer		This is a measure of medication errors on one day from a review of all medication charts from 13 wards. The tool assesses compliance with allergy status, omissions of critical medication and briefing sessions. The results are currently variable and individual ward feedback reports are starting to be prepared to generate improved ownership.
Clinical Effectiveness Priority: Continue to reduce mortality	• HSMR (Hospital Standardised Mortality ratio)	94.8	This measure of mortality remains better than the England average (100). Please note there is a time lag as this information is reported approx 3 months in arrears. The figure will be updated before final publication of the report.

Priority	Targets	RAG	Comment
	• SHMI (Summary Hospital Mortality Indicator)	110.3	This measure of mortality remains worse than the England average (100). Please note the time lag is approx 7 months. The reasons for this are largely around the Trust having a hospice where people are expected to die (these deaths are included in the SHMI figure) and around deaths in the community within 30 days of discharge. It is noteworthy that the Trust treats a significantly higher proportion of end-stage respiratory and cardiac disease patients who are admitted to die than the England norm. Significant actions, working with community partners, have taken place to better manage chest conditions, urinary infections and acute kidney injury.
	• SHMI data adjusted for palliative care	98.69	This measure of mortality removes the impact that having a hospice. Whilst better than the England average it does not meet the trust aim of <96%
	• Unexpected admissions to critical care audit		The results of this audit are being finalised.
	• Cardiac arrest calls		The data is currently being finalised although April – September 2015 data shows that 0.15% of patients admitted have a cardiac arrest which is an improvement compared with 2014/15. National data confirms performance better than national averages with 25% of patients having had an arrest being discharged home compared with 18% nationally.
	• Observation Compliance		Audits of observation compliance, undertaken on a monthly basis, indicates that on average 93.61% (of 7278 sets of notes audited) are completed properly. There is no pre-determined aim for this although the expectation should be that 100% are completed properly.
	• Mortality review		A review of the notes of 546 patients who died within the Trust was undertaken. A formal review process identifies any areas of concern which are then discussed during the learning forums within the clinical teams. The clinical governance strategy committee oversees the findings and will make further recommendations where necessary.
Clinical Effectiveness Priority: Continue to improve stroke standards	• 3 hr thrombolysis		Final end of year data is awaited, but year to date is 7.32% against a target of >=12%
	• 4 hrs to stroke unit		Final end of year data is awaited, but year to date is 61.88% against a target of >=90%. This is better than 2014/15 but has been impacted by the high emergency demand and the closure of the hyper-acute stroke services in Harlow.
	• 90% time on stroke unit		Final end of year data is awaited, but year to date is 82.57% against a target of >=80%.
	• 60 minute to scan		Final end of year data is awaited, but year to date is 89.47% against a target of >=50%
Patient Experiences Priority: Improve communication	• Improvement in survey results (involved in decisions, consistent info, providing understandable answers, name of contact)		The national In-Patient Survey results will not be released until 8th June
	• Monitoring ward staffing levels		Staffing levels are routinely monitored each shift with results reported monthly. The percentage of 'red shifts' range from 1.85% (June 2015) to 7.1% (February 2016). The latter figure is largely linked with vacancies and the payment restrictions for agency staff.

Priority	Targets	RAG	Comment
	• Reduction in complaints & PALS concerns (rate)		End of year data is awaited. However the position so far indicates an increase in the rate of complaints relating to communication (approx 0.3% of discharges compared with 0.2% in 2014/15) and PALS concerns (approx 0.57% of discharges compared with 0.48% in 2014/15).
	• GP Survey		The GP survey was undertaken, although the number of responses was very low. The results indicated a lack of awareness by GPs of some of the electronic and fast-track means of gaining advice which the Trust is working to promote.
Patient Experiences Priority: Reduce delays	• Reduction in complaints & PALS concerns (rate)		End of year data is awaited. However the position so far indicates an increase in the rate of complaints relating to delays (approx 0.32% of discharges compared with 0.33% in 2014/15) and PALS concerns (approx 1.07% of discharges compared with 0.96% in 2014/15). Improvements are noted in quarter 3 though which indicate an overall improving trend.
	• Improvements in survey results (waiting list, waiting for bed, OPD waiting time)		The national In-Patient Survey results will not be released until 8th June.

The priorities for 2016/17 will largely remain the same as in 2015/16 to continue the improvements in these important areas. The safety thermometer scores and complaints / PALS concerns relating to delays are being retired from the QA. These will continue to be routinely monitored as part of the Director of Nursing reports to the Risk and Quality Committee. The introduction of Human Factors and the improvement in nutrition and hydration standards have been introduced. These align with the national travel on safety and the implementation of the Trusts Food and Drink Strategy.

Appendix 1

	PATIENT SAFETY	12/13	13/14	14/15	15/16 YTD	Aim for 15/16	Met
1.1a	Safety thermometer score for falls, pressure ulcers, UTI and VTE (no of harms)	N/A	6.4%	4.9%	2.5%	Collect	✓
1.1b	Number of inpatient falls	1244	988	919	861	<876	✓
1.1c	Number of in-patient falls resulting in serious harm	14	16	14	11	<=24	✓
1.1d	Number of preventable hospital acquired pressure ulcers	113	45	54	23	<=36	✓
2.1	Survey results: - medication purpose - side effects	8.4 5	8.2 4.4	8.4 4.8	Awaited	Improve	✓
2.2	Medication incidents - rate per 100 discharges - % leading to harm	1175 N/A N/A	987 1.24 11.96	799 0.91 11.76	Awaiting full year	N/A >1.24 <11.96	N/A
2.3	Undertake medication omission audit					Undertake	✓

2.4	Implement Medicines Optimisation Strategy objectives for year	Implement	✓
2.5	Medication safety thermometer	Introduce	✓

	CLINICAL EFFECTIVENESS	12/13	13/14	14/15	15/16 YTD	Aim for 15/16	Met
3.1	HSMR (3 month arrears)	97	88.96	92.31	**94.8**	<=95.3	✓
3.2	SHMI	111.39	111.76	112.9	**110.3**	<=110	✗
3.3	SHMI (adj palliative care)	102.04	100.43	100.51	**98.69**	<=96	✗
3.4	Unexpected admissions to critical care	N/A	Audit completed	Completed	**Underway**	Complete audit	✓
3.5	Cardiac Arrests	219	174	203	**Awaiting**	<174	✗
3.6	Observation compliance	96.02	95.88	95.49	**93.61%**	N/A	-
3.7	Mortality review	N/A	N/A	N/A	Undertaken	Undertake	✓
4.1	3 hour thrombolysis for stroke	8.1%	10.08%	7.36%	**7.32%**	>=12%	✗
4.2	Admission to stroke unit within 4 hours of arrival	46.5%	66.25%	51.89%	**61.88%**	>=90%	✗
4.3	90% time in dedicated stroke unit	79.8%	72.71%	73.87%	**82.57%**	>=80%	✓
4.4	60 minute to scan				**89.47%**	>=50%	✓

	PATIENT EXPERIENCES	12/13	13/14	14/15	15/16	Aim for 15/16	Met
5.1	Improvement in survey results (involved in decisions, consistent info, providing understandable answers, name of contact)	See results below			Awaited	N/A	-
5.2	Monitoring ward staffing levels	N/A		Introduce	Monitored	Monitor	✓
5.3	Communication - reduction in complaints & PALS concerns (rate)	See results below			Awaiting year end data	Reduce	
5.4	GP Survey	N/A		Completed	Completed	Complete	✓
6.1	Delays - reduction in complaints & PALS concerns (rate)	See results below			Awaiting year end data	N/A	
6.2	Improvements in national surveys (waiting list, waiting for bed, OPD waiting time)	See results below			Awaited	N/A	-

Quality Accounts Data Set – Luton & Dunstable (2015/16)		
Priority	**Target areas**	**What we achieved and RAG Rating**
Priority 1: Clinical Outcomes	Implement earlier recognition of Acute kidney injury (AKI) illness severity and earlier senior clinical involvement	More than 90% of our junior doctors have completed the AKI eLearning training module, increasing the likelihood that patients with AKI will get the treatment necessary to maximise their recovery. An AKI discharge template has been developed and the discharge letter is started when a patient develops stage 2 or 3 AKI. The template prompts the doctor writing the discharge letter to complete the necessary information regarding medication changes and recommended blood tests for monitoring renal function. In Quarter 4, compliance at the time of reporting has been excellent with more than 90% of AKI patient discharged with full information.
	Implement a new model of integrated care for older people	The Cluster alignment has been completed in Luton and the MDTs are in the process of being standardised. The Cluster 1 Pilot was able to demonstrate that a new model of care that will provide continuity of care for patients and allow more collaborative work with Primary Care is possible. There were a number of qualitative benefits for patients and GPs identified through the pilot. This was especially the case with patients living in Care Homes and immobile patients in their own home. GPs benefited from the easy access to a specialist opinion and the pilot was also able to identify changes that need to be put in place within the current medical model to enable the full roll out of integrated care. A programme has been launched to introduce a Needs Based Care approach which will be the vehicle used to introduce integrated care to all medical specialties.
	Implement processes for screening patients for sepsis and ensuring that intravenous antibiotics are initiated within 1 hour of presentation for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock	Audit has shown that compliance with sepsis screening is now above 90% and 71% of patients presenting with severe sepsis or septic shock now receive antibiotics within one hour.
Priority 2: Patient safety	Ensure that we have the appropriate level of clinical expertise available to deliver consistent inpatient care irrespective of the day of the week	7 day working is embedded in a number of services within the Trust and working patterns and rotas are already designed with this in mind. Significant progress has been made in imaging and work is planned for delivering the on-going consultant review standard. The Trust has participated in the national 7 Day Services progress survey in April 2016 with results expected to be made available by the end of May 2016.
	Ongoing development of Safety Thermometer, improving performance year on year	• We consistently achieved 98% harm free care. • We continued to reduce the overall incidence of category two and three hospital acquired avoidable pressure ulcers. This was achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process. • We have maintained a falls rate of 4.32 per 1,000 bed days which is below the national average with continued challenges from an ageing and more frail population with complex health needs.

Quality Accounts Data Set – Luton & Dunstable (2015/16)		
Priority	**Target areas**	**What we achieved and RAG Rating**
		• We have achieved the 95% or greater target compliance of all VTE assessments.
	Improve the management of the deteriorating patient	• The delivery of the improvement programme to safely and effectively manage the deteriorating patient has made notable improvements right across the deteriorating patient pathway. There has been a reduction of 42% in the inpatient cardiac arrest rate. Further work needs to be undertaken over the next year to ensure that the Trust devises strategies to sustain this improvement.
	Reduce Avoidable Harm by ensuring patient's current medicines are correctly identified, communicated and prescribed at admission	• More than 85% of patients identified, using the risk prioritisation tool as at high risk of medication related adverse events, received a pharmacy- led medicines reconciliation at some point within their inpatient stay.
Priority 3: Patient Experience	Implement patient focussed booking systems including self check-in and partial booking of outpatient clinics	• We have seen substantial reductions in DNA rates achieved, with follow up DNA rates from April 2015 to the present across those specialties that have gone live with partial booking showing an overall reduction of 1.6%. The target is to achieve an overall Trust follow up DNA rate reduction of 2% in 2016/17 with full implementation of partial booking.
	Improve the experience and care of patients at the end of life and the experience for their families.	• **Strengthened resource and communication** Investment in the Palliative Care Team has been strengthened to include a team leader who will focus on clinical leadership supported by two band 7 Clinical Nurse Specialists. • **Improved the recognition of End of Life** The Palliative Care team and the Resuscitation team have worked with Consultants to improve the way we use our 'Personal Resuscitation Plans' (PRPs) more effectively. **Improved care planning** Collaborative working with the Emergency Department (ED) has enabled the introduction of the End of Life Care pathway for the department. ED are also monitoring palliative patients who have been inappropriately referred to ED and following investigation have shared the lessons that can be learned to prevent patients from dying in the ED.
	Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with dementia and delirium	• The Trust was compliant with over 95% of screening taking place each quarter; 90% compliance with onwards referrals and recommendations for patients with cognitive dysfunction in line with local pathways. • A robust training plan has been implemented and all 4000 staff were given a dementia awareness booklet in February 2016. Feedback is being collected and is generally positive. • Feedback is on-going and evidence of the impact of training will be evaluated using patient and carer feedback, complaints, compliments and incidents. Staff comments and feedback on the impact training is being gathered. • Feedback has been received from the carers survey which refers to aspects of care in hospital and the wider health economy. This information is being used to inform local commissioners of any areas of improvement recommended by the carers of people with dementia. Each organisation has evaluated its findings and discussed themes to report.

Quality Accounts Data Set – Luton & Dunstable (2016/17)		
Priority	**Target areas**	**How it will be measured**
Priority 1: Clinical Outcomes	**Improve the management of patients with acute kidney injury (AKI)**	• Continued and improved use of AKI Alerting system • Implementation of the standards for recognition and treatment of AKI. • Monitor compliance with AKI standards • Provision of a plan of care to monitor patients identified with AKI whilst in hospital after discharge • Establish a baseline for accuracy of fluid charts.
	Improve the management of patients with severe sepsis	• Compliance with appropriate sepsis screening (audit) for emergencies and ward –based patients. • Timely compliance with antibiotic delivery for patients presenting with severe sepsis and septic shock (audit) for emergencies and ward – based patients.
	Improve our approach to mortality surveillance, identifying and reducing avoidable deaths	• Improving HSMR • On-going review by the Mortality Board
	Reduce our antibiotic consumption	• A baseline of antibiotic consumption (audit) • Implementation of a process for antibiotic reviews within 72hrs.
Priority 2: Patient safety	**Ongoing development of Safety Thermometer, improving performance year on year**	• Further reduce incidence of grade 2 pressure ulcers. • Maintain the current position in providing 98% or above in new harm free care (95% in 2013/14, 97% in 2014/15 98% in 2015/16)) • Maintain the current prevalence of patients who experience a fall and incur harm • Aim that no more that 16% of all inpatients will have a urinary catheter • Maintain 95% (minimum) patients to have had a VTE risk assessment and those that are identified as at risk of developing a thrombosis are provided with appropriate prophylaxis
	Improve the management of the deteriorating patient	• Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline. • To continue to sustain improvements all along the deteriorating patient pathway ensuring: 1. Timely and appropriate observations 2. Timely escalation of concerns to medical staff 3. Timely medical response times, 4. Improvement in timely and appropriate decision making by medical staff.
	Further development of stroke services	• Improved compliance with the Sentinel Stroke Audit (SSNAP)
Priority 3: Patient Experience	**Improve the experience and care of patients at the end of life and the experience for their families**	• Improved performance in the national 'Care of the Dying' audit • Improved performance in the further local audits of the EOL Individualised Care Plan • A reduction in incidents and complaints through the End of Life Steering Group • Continued improved feedback from patients and carers
	Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with Dementia and Delirium	• Reduction in the number of falls for a patient with Dementia • Maintain and increase the number of staff with appropriate knowledge and skills training • Reduced number of emergency re-admissions within 30 days • Maintain good feedback on overall quality and experience from carer/ patient survey
	Completing the Roll Out of Partial Booking across the Trust	• Reduce the volume of missed appointments to 8%.