NORTHUMBERLAND COUNTY COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

At a meeting of the **Health and Wellbeing Overview and Scrutiny Committee** held in Committee Room 1, County Hall, Morpeth on Wednesday, 5 March 2019 at 1.00pm

PRESENT

Councillor Watson, J.
(Chair, in the Chair)

COUNCILLORS

Cessford, T.	Nisbet, K. (part)
Dungworth, S.	Rickerby, L.
Moore, R.	Seymour, C.

COUNCILLORS ALSO PRESENT

Dodd, R. (part)	Jones, V.

OFFICERS

M. Bird	Senior Democratic Services Officer
C. McEvoy-Carr	Executive Director of Adult Social Care and Children's Services

ALSO IN ATTENDANCE

L. Harris	Newcastle upon Tyne Hospitals NHS Foundation Trust
D. Nugent	Healthwatch Northumberland
A. O'Brien	Newcastle upon Tyne Hospitals NHS Foundation Trust
A. Pike	Newcastle upon Tyne Hospitals NHS Foundation Trust
J. Rushmer	Northumbria NHS Foundation Trust
C. Riley	Northumbria NHS Foundation Trust
S. Young	NHS Northumberland Clinical Commissioning Group

13 members of the public and one member of the press were also in attendance.

62. MEMBERSHIP

It was noted that Councillor Armstrong had replaced Councillor Horncastle on the committee.

63. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Armstrong and Simpson.

64. MINUTES

RESOLVED that:

(a) the minutes of the Health and Wellbeing OSC held on 8 January 2019, as circulated, be approved as a correct record and signed by the Chair; and
(b) the minutes of the Health and Wellbeing OSC held on 23 January 2019, as circulated, be approved as a correct record and signed by the Chair, subject to being amended to record that Councillors Oliver and Wearmouth had also been present at the meeting.

65. FORWARD PLAN OF KEY DECISIONS

Members received the latest Forward Plan of key decisions (enclosed with the official minutes as Appendix A). No items listed were due for pre-scrutiny by this committee.

RESOLVED that the information be noted.

66. HEALTH AND WELLBEING BOARD - MINUTES

Minutes of recent Health and Wellbeing Board meetings were presented for the scrutiny of any issues discussed there (enclosed with the official minutes as Appendix B).

RESOLVED that the information be noted.

REPORTS FOR CONSIDERATION BY SCRUTINY

67. QUALITY ACCOUNTS

Members were reminded that a Quality Account was a report about the quality of services offered by an NHS health care provider. Northumberland's practice in recent years had been for Health Overview and Scrutiny Committee to receive presentations at its March meeting annually on the Quality Accounts/Future Priorities of local NHS Foundation Trusts. This year, representatives of Northumbria NHS Foundation Trust and Newcastle Hospitals NHS Foundation Trust were presenting to this meeting, and representatives of North East Ambulance Foundation Trust and the Northumberland, Tyne and Wear NHS Foundation Trust would be presenting at the committee's next meeting on 26 March.

The committee was requested to receive and comment on the presentations from

each Trust and also agree to submit a formal response to each Trust following the meeting based on members' views.

(a) Northumbria NHS Foundation Trust Annual Plan and Quality Account 2017/18

A presentation was provided by Jeremy Rushmer, Executive Medical Director, Northumbria Healthcare NHS Foundation Trust. (Copy of presentation enclosed with the official minutes of the meeting.)

Key headlines and details of the presentation included:

- the Trust's vision, mission, core business and non-core business
- the vision to be the leader in providing high quality, safe and caring health and care services and to lead collectively, with partners, to deliver system wide healthcare
- their annual planning process
- safety and quality objectives for 2018/19
- quality account 2018/19
- details of performance on their priorities for 2018/19 - sepsis, falls, frailty, flow and staff experience
- their quality improvement formula
- safety and quality objectives for 2019/20
- quality account - ready by mid April 2019 and circulated for stakeholders for formal opinion late April, and final version to be submitted to NHS Improvements and Parliament by the end of May.

Detailed discussion followed of which the key details of questions from members and answers from Dr Rushmer follow.

'Stranded patients' were defined as people who could not be moved on elsewhere due to any issues with their treatment. Work continued to take place to review and address any blockages in the system to avoid this happening.

The 30% achievement of the sepsis target contrasted to the 65% target; didn't targets need to be realistic as well as challenging, so what target was thus planned for the following year? Members were advised that it had been an ambitious target; a clinical lead officer for sepsis was in post and there was a good evidence base for the six interventions. However it was very complicated to keep achieving the six tests required within the one hour target. The target would be maintained as the clinical lead wished it it to remain ambitious. There would be a focus on meeting the bundle compliance requirements. It was proposed that the sepsis lead officer could attend this committee in future to provide an overview specifically about sepsis; members welcomed this proposal. An update about progress made towards meeting the target during the next year would also be welcomed. It was further noted that the Trust were involved in regional collaborative work on sepsis.

It was confirmed that beds in the frailty ward were not used as assessment beds; if there was a surge in admissions then the area was used as necessary, as people would not be treated in corridors. The increase in patients during winter and longer stays required by some patients were key challenges. When the beds were needed, no other services could be provided in that area.

Members welcomed an invite to visit the new frailty ward at a time to be arranged.

The numbers of cancer referrals were reported monthly and quarterly and publicly available. Details were not available to hand at this meeting but could be provided for members afterwards, perhaps as a formal committee update about overall performance on cancer. Cancer targets were extremely challenging, partly due to the lowering of the threshold at which people entered the cancer treatment system.

Members had agreed for further scrutiny to be arranged about end of life care. A report was proposed for a forthcoming meeting, at which point progress made on actions recommended from the previous scrutiny review would be considered. A decision would then be taken about whether any further themed scrutiny work was required.

Sepsis continued to be a big problem. Nationally, death rates were not increasing, but sepsis was a difficult condition to label and define. Giving the appropriate antibiotics at the right time following a diagnosis was the intervention that made the most impact.

The achievement for the four hour accident and emergency waiting time target at the Northumbria Specialist Emergency Care Hospital (NSECH) at Cramlington was below the 95% overall achievement for the Trust. Northumberland was in the top ten performing Trusts nationally for its accident and emergency rate. This was despite the challenge of operating over multiple sites, whereas other Trusts might only have one. Members asked if additional information could be provided in due course about the waiting times at NSECH.

Readmissions from frailty problems could depend on several factors. For example as the length of stay was reduced, some readmissions could go up, but increasingly more people stayed at home. The safety net arrangements ensured that patients could be readmitted if needed. Readmission rates were also measured.

The pilot for the Medical Examiner Role applied to anybody who died within the care of the organisation; a senior independent doctor spoke to and sought feedback from relative then advised on the next steps. It was very important for the Trust to benefit from any learning or feedback received from this process.

As concerns existed about the rise in resistance to antibiotics the right diagnosis for sepsis was essential, so how was this being addressed? Members were advised that there was not a test to immediately diagnose sepsis; for example on occasions it might initially be diagnosed as pneumonia. It was important to treat symptoms early and de-escalate any cases the following day if they were subsequently confirmed as not being sepsis. It could take 24-48 hours to diagnose, and other symptoms could appear similar to those for sepsis. Sepsis was however measured differently in other countries; Australia's rate was double the UK's for this reason.

Regarding the staff survey, the Trust had created a tool to record staff experiences in real time which helped them to intervene quicker and treat people better.

In response to a query members were advised and reassured that the Trust did not

consider that there was any negative impact upon non-priority services through having to focus on priority services. The detail in this presentation represented a small amount of the Trust's services.

Reference was made to a number of attendees from the Berwick Hospital Campaign Group being in attendance. Director of Communications and Corporate Affairs Claire Riley had spoken to them before the meeting and would be writing to the group's co-ordinator with a further update in due course. The Trust were currently at an early stage of the process for developing new proposals. Further discussions would take place after which information would be shared regarding how this was proposed to be taken forward. Feedback received from the campaign group and local councillors had been helpful and used in their discussions. The Chair added that this issue would be considered by this committee in due course once there was detail available to scrutinise.

A member referred to a case in which a family member whose treatment for one condition had been split between three different hospitals; the inter-hospital communication had been poor - blood tests had not been shared nor had the respective consultants communicated with each other. Members were advised that progress had since been made; all results could now be shared between hospitals and a business case was being submitted for a medical intraoperative gateway. Thanks were expressed from Northumbria Trust to Newcastle Trust as whenever they asked for information it was then received straightaway. Efforts continued to be made to keep improve joined up working.

Mr Rushmer and Ms Riley were thanked for their attendance.

(b) Newcastle upon Tyne NHS Foundation Trust Annual Plan and Quality Account 2017/18

A presentation was provided by Angela O'Brien, Director of Quality & Effectiveness, Andy Pike, Head of Quality Assurance & Clinical Effectiveness, and Liz Harris, Deputy Director of Nursing & Patient Services, all from Newcastle upon Tyne NHS Foundation Trust. (Copy of presentation enclosed with the official minutes of the meeting.) Key headlines and details of the presentation included details of progress made on priorities:

Patient Safety:
- Priority 1 - to reduce all forms of healthcare associated infection (HCAI)
- Priority 2 - to reduce inpatient acquired Pressure Ulcers (PU)
- Priority 3 - management of abnormal results
- Priority 4 - local safety standards for invasive procedures (LocSSIPs)
- Priority 5 - Human factors training

Clinical Effectiveness:
- Priority 6 - digital enhancements to care
- Priority 7 - closing the loop

Patient Experience:
- Priority 8 - deciding right
- Priority 9 - enhancing patient and public involvement in quality improvement
- Priority 10 - improving the experience of vulnerable patients.

2019/20 proposed quality priorities:

- patient safety: reducing infection; pressure ulcer reduction; management of abnormal results
- clinical effectiveness: alignment of quality and clinical effectiveness - SAMM (systems for action management and monitoring); enhancing capability in quality improvement
- patient experience: deciding right; implementation of 'treat as one'; ensure reasonable adjustments are made for patients with suspected or known learning disabilities.

Detailed discussion followed of which the key details of questions from members and answers from Ms Harris, Ms O'Brien and Mr Pike were:

Regarding differences between the two Trusts' presentations as for example accident and emergency services had not featured in Newcastle's, members were advised that this was because it was spread across many of their priority areas. Emergency department work included identifying people with pressure ulcers and sepsis. The priorities all reflected the importance of emergency department work. The four hour accident and emergency targets were not being currently met in light of winter pressures faced, but the priorities did not include areas considered business as usual.

Regarding the management, frequency and outcomes of abnormal results, members were advised that they were occasionally experienced. Two incidents were referred to of which one case concerned a lesion not being picked up earlier which did not affect the patient's life expectancy but could have enabled more palliative care support to have been organised.

Mr Young of the CCG acknowledged that it was important that the Trust was identifying areas for improvement and if it was successful in local initiatives that addressed national problems it was important to share them with other local Trusts. It was noted that the Healthcare Safety and Investigation Branch picked up examples of good practice; the Trust worked closely with them.

It was explained that infections could kill or contribute to death if undetected, although it could depend on the health of the individual patient. Members welcomed an offer to provide statistics about healthcare acquired infections after the meeting.

In response to why the referral of any abnormal results to another consultant could not be quicker than three to five days, members were reassured that there needed to be a cut off point and if it bounced quicker, it could lose the link to the original consultant for them to act. The timescale had been agreed on the basis of risk, and this was not expected to occur very often, as it had been introduced to anticipate any results not being picked up in the event of any consultants' absence from work.

In connection with any risk of any initial data entries of people's being incorrect, members were advised that it was machines rather than people who recorded blood pressure and temperature, and blood results were then analysed in the lab.

Replying to a question about reducing infections from catheters by 5% and what caused the infections, work took place to educate staff, patients and families about safer catheter use and support. The nurse consultant oversaw both equipment and

education provision; staff observed patients and ensured that catheters were safely put in and taken out as soon as reasonably possible.

Regarding the sharing of other best practice, networks existed including regional collaborative programmes and regular meetings between groups of equivalent directors; members welcomed this.

Reference was made to the challenge of mental health conditions as they could be less visible; how was work undertaken and was there any lower age limit for services to be provided? Members were advised about arrangements for identifying people with a learning disability, including work of the Learning Disability Liaison Team. The learning disability passport service, which was not age specific, helped to recognise the behaviour of people in particular scenarios, for example they might respond differently to certain symptoms than other patients. The service provided access to screening and advice. Learning disability death reviews were also carried out as people with learning disabilities were more likely to die younger, and assessed what communication the carers and/or family received.

Regarding what services were provided for people with learning disabilities or mental health problems before they needed to enter the hospital setting, members were advised that proactive work took place with community groups, including Deaf Link, to ask them for details of their experiences.

In reply to a question about other work not included within the priorities detailed, this presentation had provided a brief summary; full details of all services provided by the Trust would be included in their complete Quality Account report.

In connection with concerns about MRSA infections, members were advised that there was more than one type of MRSA and infections in the blood were more serious. The procedure for discharging patients with MRSA/C-difficile would depend on the condition of the individual patient.

A member welcomed the digital observation system but warned of the impact of any other factors such as power supply, plus also enabling the removal of human error from some situations; members were very pleased to hear that the Trust had a strong no-blame culture as it was the best way to learn from experiences including mistakes.

Regarding consultation undertaken with people and groups outside of Newcastle who used the Trust's services, members were advised of consultation work with representatives of Northumbria Trusts, Northumberland County Council and work to seek patients' views using a range of engagement exercises. Their chief executive embraced a culture of working together, for example the development of an Integrated Care System. Patient and public involvement continued to be priority piece of work, but the foundations had been laid for taking it forward when it had previously been one of the Trust's priorities. The Trust were held to account on delivering their Quality Account aims and continued their patient and public involvement.

Ms Harris, Ms O'Brien and Mr Pike were thanked for their attendance and very good presentation and level of information provided. Following this it was:

RESOLVED that written responses be sent to Northumbria NHS Foundation Trust and Newcastle upon Tyne Hospitals NHS Foundation Trust about the committee's views on their quality accounts and future priorities.

68. REPORT OF THE SENIOR DEMOCRATIC SERVICES OFFICER

Health and Wellbeing OSC Work Programme

Members considered the latest version of the committee's work programme. (Work programme enclosed with the official minutes as Appendix C.)

Members were advised that details of the committee's decisions to date for 2018/19 were included in the work programme. A developing work programme for the forthcoming 2019/20 council year would be presented to the committee's next meeting which would include a number of annual or regular updates. Members could suggest possible agenda items to the Chair or Senior Democratic Services Officer.

The next meeting on 26 March would include Quality Account presentations from the North East Ambulance Services and Northumberland, Tyne and Wear NHS Foundation Trusts. An update would also be provided on the Whalton Unit regarding the Trust's early findings and how the temporary move had went.

Possible additional items for the 30 April meeting included the next six monthly update from Healthwatch and an invite had been made for a repeat of a presentation given recently to the Northumberland, Tyne and Wear and North Durham Joint Sustainable Transformation Plan Committee.

Further reference was made to the proposed themed scrutiny on end of life care; a report was provisionally scheduled for the committee in June 2019 to receive an update on the latest position. Members could then consider whether any further themed scrutiny would also be necessary.

An item would also be scheduled in due course to scrutinise any proposals for Berwick hospital once sufficient information became available.

RESOLVED that the updated work programme be noted.

69. INFORMATION REPORTS

(a) Letters to Secretary of State for Health

Members had received copies of the letters sent to the Secretary of State for Health about Rothbury Hospital from both this committee and Northumberland Clinical Commissioning Group (enclosed with the official minutes at Appendix D).

RESOLVED that the information be noted.

(b) Committee Meetings 2019/20

Dates for future meetings had recently been decided, all on Tuesdays at 1.00pm:

- 26 March 2019
- 30 April 2019
- 4 June 2019
- 2 July 2019
- 3 September 2019
- 1 October 2019
- 5 November 2019
- 3 December 2019
- 7 January 2020
- 4 February 2020
- 3 March 2020
- 31 March 2020
- 5 May 2020

The Chair explained that the meeting frequency had increased to provide more flexibility and diarise more meeting slots so no additional meeting dates needed to be organised during the council year, as that had been required in the current year. If any dates were not deemed to be necessary the right would be reserved to remove them from the diary in due course.

RESOLVED that the information be noted.

(c) Policy Digest

The report gave details of the latest policy briefings, government announcements and ministerial speeches which might be of interest to members. It was available on the service finder element of County Council's website at www.northumberland.gov.uk.

CHAIR _____

DATE _____