Paper 6

North West Anglia NHS Foundation Trust Draft Quality Account 2021-2022 Statement from Healthwatch Rutland

Healthwatch Rutland thanks North West Anglia NHS Foundation Trust (NWAFT) for sharing the draft 2021-2022 Quality Account.

Impact of COVID-19

We appreciate that this Quality Account spans a time of intense pressure across all NHS services due to the second year of the COVID-19 pandemic. We acknowledge, in particular, the tremendous pressures for existing staff members and the difficulties in staff recruitment and retention. Healthwatch Rutland therefore thanks all staff members for their hard work and dedication.

We also thank the authors for the candid and transparent presentation of progress against the priority areas identified for the last year.

Patient care

Whilst understanding the pressures across the whole NHS, we note some risks to patient care and safety identified in the Quality Account:

The care of patients with suspected sepsis

- The figures 2020-21 and 2021-22 show a marked drop in compliance with the 'Sepsis Six bundle of care' (Goal 3). The Quality Account informs that these figures seem worse than they might be as 'some delayed actions are being taken after initial observations'. Our understanding is that to be effective, treatment for sepsis should not be delayed.
- The CQC noted incomplete patient care records, including completion of the sepsis screening tool.
- Only 25.8% of doctors have achieved mandatory sepsis competency.
- Hinchingbrooke Hospital has an effective digital sepsis screening tool. Peterborough City Hospital will have this by March 2023 subject to effective recruitment. This slow roll out across all sites of the Sepsis Screening and Escalation model is of concern for patients from Rutland, many of whom attend Peterborough City Hospital.

Incidence of pressure ulcers

We agree that the incidence of pressure ulcers can be seen as a direct reflection of the quality of care, and are pleased note to a small decrease, indicating that incidence is moving in the right direction. Further to this we encourage the Trust to consider including the avoidance of pressure ulcers as an item for all care staff undertaking their annual mandatory training, rather than a voluntary attendance at sessions (which are poorly attended). Although record keeping is an essential part of pressure ulcer risk awareness, we hope that such training would also embed basic measures such as change of position,

adequate diet, encouragement to move and the appropriate use of pressure relieving equipment.

Clostridium Difficile

Referring to the goal of 'reduction of hospital acquired C. Diff infections', we note that although just within the overall target, there has been no significant fall in the total number of C. Diff cases. We will follow with interest how the Trust will embed improved monitoring, oversight of antibiotic prescribing, hygiene and stringent cleaning in the next year and hope to see a steady improvement.

The voices of patients, family, and friends

We see few patients', friends' or family voices in the draft account and would like to see more about how patient experience and the outcomes from the Patient and Public Voice Partnership and co-production group are being used to drive quality improvement forward in the Trust.

Research undertaken by Healthwatch Rutland, shared with NWAFT in 2021, highlighted families' distress about visiting restrictions and the poor provision by clinical staff of accurate and up-to-date information to families about inpatient relatives. Healthwatch Rutland respects the need to minimise the transmission of COVID-19 and acknowledges the positive benefits of 'letters to loved ones' & use of iPads but would like to stress the importance of family involvement in the patient care pathway as recently reinforced by the Chief Nurse for England.

Care Quality Commission (CQC)

Healthwatch Rutland welcomes the closer working partnership with the CQC but is disappointed to note that some recommendations from 2019 and 2020 remain outstanding.

We also note the verbal feedback provided to the Chief Executive following the CQC system wide inspection of Urgent and Emergency care in February 2022. While there are some positive comments, there are many areas to improve.

We note the CQC comments which suggest a workforce so stretched that patient care and safety is at risk. Staff being moved to unfamiliar work areas and understaffing seem to have created a poor workplace culture which has led to a lack of accurate completion of patient records, unsatisfactory oversight of vulnerable patients and gaps in safety checklists for equipment.

Such comments are reinforced by feedback received from Rutland patients which indicates poor patient experiences of the Emergency Department in terms of extended wait times and poor staff communication with waiting patients.

We do, though, welcome the use of volunteers to help support the wellbeing of waiting patients and look forward to a robust action plan from NWAFT to address recommendations in the report when published.

Healthwatch Rutland looks forward to strengthening collaborative working with the Trust both through Place-based partnerships such as the Rutland Health and Wellbeing Board and through closer working between Local Healthwatch and Trust management in all the counties served by the Trust.

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