KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 20 March 2009.

PRESENT: Mr B R Cope (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A D Crowther, Mr D S Daley, Mr C G Findlay, Ms A Harrison, Mr W A Hayton (Substitute for Mr R Tolputt), Mrs S V Hohler, Mr M J Northey, Mr R J Parry, Ms B J Simpson, Dr T R Robinson, Mrs E D Rowbotham, Cllr Ms A Blackmore, Cllr R Davison (Substitute for Cllr Mrs M Peters) and Cllr M Lyons.

ALSO PRESENT: Mr R A Marsh, Cabinet Member for Public Health

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee) and Mr P D Wickenden (Overview, Scrutiny and Localism Manager)

UNRESTRICTED ITEMS

18. Minutes - 9 January and 6 February 2009
(Item 3)

RESOLVED that Minutes of the meetings held on 9 January 2009 and 6 February 2009 are correctly recorded and that they be signed by the Chairman.

19. Medway NHS Foundation Trust
(Item 4)

(Lois Howell, Company Secretary and Linda Dempster, Head of Infection Control were in attendance for this item)

(1) In response to a question about whether there was an issue around public perception of the Trust, particularly people in those areas most likely to use the Trust's services, the Trust acknowledged that getting the right message out to the public was a challenge but that the Trust did have a very good communications team.

(2) In response to a question about infection control, the response was that for infection control the team were working towards a level of zero tolerance. In recent years the issue of infection control and its profile had been substantially raised and the public's awareness of its importance recognised.

(3) The targets for infection control which had been put in place had really helped the Infection Control Team within the Medway NHS Trust, but there were also a number of other areas which needed to be addressed.

(4) In response to a question relating to the Trust declaring on the Health Care Commission Core Standards for 2007/08 that the Trust had not met the requirements for decontamination the response was that it was not an issue of patient safety but related to some of the facilities that the Trust had during that year which prevented the Trust from declaring that it was compliant with this standard.

(5) The area that was non-compliant was the cold sterilisation facility for endoscopes. A brand new unit had been established and so this year the Trust were able to declare in their self assessment that they were compliant.

(6) In answer to a question about infection control and MRSA, Mrs Dempster responded that MRSA screening took place for all admissions and screening of in-patients also took place every week. She informed the Committee that this was a credit to the Microbiology Unit at the Trust who had looked carefully at the way they worked and increased the number of tests that they conducted from 1,000 to 17,000.

(7) In answer to a question about the policy on 'bare arms below the elbow', Mrs Dempster answered that the Trust had a stringent performance management regime. It was Trust policy that staff were 'bare below the elbows'. This had strengthened the infection control policy. All staff from the cleaner to the Chief Executive were empowered, as were the public, to challenge anyone who was found not adhering to this policy. There had been no need to date to taken any formal disciplinary action against any member of staff not adhering to the policy.

(8) A question was asked about an item within the papers before the Committee which indicated that the Healthcare Commission had undertaken a review at the Trust in January 2009 and whether the outcome of that inspection had been received from the Healthcare Commission. In response, the Committee were advised that the official feedback had not been received but the initial feedback had been very positive.

(9) In answer to a question as to why silver was used in catheters or central lines, Mrs Dempster responded that this was proven to reduce infection for patients.

(10) Acknowledging that bacteria was everywhere, a question was asked about the cleaning of trolleys and whether the paper medical notes used by professionals were cleaned and what the risk was. In response, Mrs Dempster said bacteraemia was the real risk, but in all cases it was about assessing the real risk and how that risk could be reduced. Hand hygiene was key. Bacteria can be found on notes, door handles, anything that is touched. It was important that professionals washed their hands immediately before dealing with a patient. Mrs Dempster said while notes could be seen as a perceived risk, she did not consider that there was a real risk relating to the notes.

(11) In answer to a question about infection control, and control of the wards, the answer given was that Ward sisters have control of the ward, which means they had ownership and power of what happens in the ward in terms of performance management. There was a direct line of performance management up to the Director of Nursing and onwards to the Board. The Board looked at the policy safety for each of the wards, including looking at issues of uniform, policy, considering whether there were any problems of skill mix for each of the wards which would then be addressed.

(12) In answer to a Member's question, relating to infection control targets and how they are set, the response was that the targets are initially set by the Government, but then the South East Coast Strategic Health Authority issued a 'stretched target' to each Trust.

(13) This was demonstrated by the number of cases of MRSA that were expected across the health economy this year and the stretch target that the Strategic Health

Authority had imposed. The Trust would be expected to reduce the total of 63 cases in any one year by a further 10% this year based on outturn.

(14) The Committee were informed that following each case of infection, thorough investigation was undertaken to ensure that from the Medway NHS Trust's point of view, the risk was being reduced.

(15) Exploring this issue of zero tolerance further and stretch targets, the representatives of the Trust acknowledged that it would be harder and harder to achieve zero cases and percentages become less meaningful. The only appropriate response was to look at each incidence of infection on a case by case basis.

(16) In answer to a question about whether staff were screened for MRSA, Mrs Dempster answered that this would not be practical as staff could present for a shift and be totally clear of any MRSA, but on leaving that shift they could be positive or vice versa.

(17) She added that in terms of training, by the following week, i.e. the last week in March, 100% of the staff should have been trained.

(18) With regard to student nurses, Mrs Dempster said that part of the training took place in university and part within the hospital setting. Within the first week of being employed by the hospital, nurses were trained on the basic skills and they had to demonstrate that they had the competencies to undertake those basic tasks effectively. The Trust had gone back to basics in terms of hygiene and she said that there was now an ethos within the Trust of checking that people were competent in terms of changing beds, drips procedures etc. The danger had been over the last 30 years that once a student nurse had been trained, there was an assumption that they were competent. All staff were now assessed for their competency. In terms of infection control specifically, there was a necessity not only for clinical staff but also for non-clinical members of the Board and Executive Directors to take a refresher course each year.

(19) Mrs Dempster added that people would be suspended without pay if they had not undertaken this mandatory training. This is a new policy coming in from April 2009.

(20) In response to a question about whether the Trust used agency staff, Mrs Dempster said there had been some agency staff utilised recently in Accident and Emergency, but over and above that, they had their own bank of staff which were used.

(21) Asked about compliance with anti-bacterial prescribing, Mrs Dempster said that all prescribers of drugs had to go on training and all junior doctors were trained as part of their initial induction. The Trust had clear guidelines about prescribing, and how antibiotics were to be prescribed.

(22) The amounts of antibiotics on each ward were audited and regular reports were made to the Governors Risk Committee for assessment. If it was acknowledged that there was over-prescribing on a particular ward, this would be addressed. In addition, the Risk Committee would be given additional reports if there was an outbreak of, for example, C Difficile.

(23) The Committee noted that on display on each ward were statistics relating to the number of breaches of hand hygiene, bed sores, 'slip, trip and falls', unclean commodes

etc. This really focussed staff minds to ensure that all these basic issues were attended to and embarrassment avoided. This was also available for the public to see.

(24) Asked about whether the Committee would get to know what was going on within the Foundation Trust, as many of the meetings took place in private, the response was that Board papers were published on the website and Minutes were made available following those meetings.

20. Kent & Medway NHS & Social Care Partnership Trust
(Item 5)

(Erville Millar, Chief Executive and Donna Eldridge, Assistant Director of Nursing/Director of Infection and Prevention Control were in attendance for this item)

(1) Mr Millar informed the Committee that Donna Eldridge's role as Assistant Director of Nursing/Director of Infection and Prevention Control was a recent appointment to the Trust in the last year.

(2) In response to a question raised by a Member regarding the Annual Health Check results for 2007-08 Mr Millar explained that the Trust had 'not met' the standards for infection control because the Board did not begin receiving regular reports on the issue until August of that year and so were not compliant for the full year. Reports had been received by the Board prior to this, but not in the proper form.

(3) Ms Eldridge explained how a process was triggered around infection control, if a patient presented with diarrhoea and sickness. The assumption was always made that this was Norovirus and dealt with accordingly unless and until tests showed otherwise. A deep clean takes place 48 hours after the last symptom has presented itself. No cases of MRSA has been caused by the Trust but some patients colonised with MRSA had been transferred in. No cases of MRSA bacteraemia had even been transferred in either.

(3) In answer to a question from a Member about the process for reporting incidents to the Board, the response was it was a responsibility of the ward matron to report either in person or e-mail to the Infections Prevention and Control Team who would also report to the Board. Mr Millar added that when the Board received a report they would follow up the incident.

(4) In answer to a question about an incident which had occurred in one of the Trust's establishments in Thanet where an outbreak of infection had occurred, the answer was that there were always meetings to discuss with staff an outbreak of infection when it occurred. What had happened in this case in Thanet was not that the member of staff was refusing to wipe down an area, but a case of not having sufficient knowledge about what should be wiped down and how.

(5) Ms Eldridge displayed to the Committee a check list which all staff worked to regarding infection control. The Trust worked closely with the Primary Care Trusts, (the Commissioners) and Acute Hospital Trusts on infection control issues.

(6) Asked the question of how people's attention were focussed on infection control when the primary need for a patient for the Trust was mental health, the Trust representatives acknowledged that was extremely difficult especially in dealing with

older adults who were suffering from Dementia. However, the Committee were advised that frontline staff were all trained in hand hygiene.

(7) In answer to a question about whether the Trust employed agency staff, the answer was that the Trust did not tend to, and if they did require any such staff they were NHS Professionals which is an NHS agency that trains staff on infection control.

(8) Turning to another case study contained within the papers which had been presented to the Committee was a case of a patient who was infected with HIV who had a sexual relationship with another patient. A Member asking the initial question about this incident was concerned that other patients were unaware that this person was HIV positive because of issues of confidentiality and for this reason needed to be monitored. The member was concerned that the Trust could be open to criticism.

(9) There followed a lengthy debate on this one particular case, but within the current legislative framework, the Trust had dealt with the incident appropriately.

(10) Asked how long it took between a sample being taken from a patient and the results being known, the response was that in instances of vomiting and diarrhoea, the results would be returned from the laboratory within 48 hours.

(11) Asked about the reporting process for infection control, the response was that it was down to the modern matrons, and if there was a need for onward reporting to the Infection Control Team and ultimately to the Trust Board.

(12) In answer to a question about training for nurses, the Trust responded that they worked closely with the universities and they spoke about the importance of their 'bare below the elbow' policy, and keeping uniforms pristine clean. They totally agreed with the Member asking the question, but it was also about appropriate lifestyles and standards in terms of hygiene.

(13) Referring to two other cases in the pack that Members had before them, the Trust responded by explaining the standard procedure when an incident occurred and the extra measures that had been taken.

(14) Asked about the length of stay and the correlation with MRSA, the Trust responded that it did not keep those statistics.

21. South East Coast Ambulance Service NHS Trust
(Item 6)

(Mr A Cashman, Assistant Director of Service Development was in attendance for this item)

(1) Mr Cashman advised the Committee of the acronyms which had been used in the report.

(2) In response to a question about training Mr Cashman explained that the expectations on ambulance staff had increased over the years. They had moved to a Foundation Course which took up to three years. Year one in university and year two and three mixed between operational and classroom based training.

(3) Mr Cashman explained to the Committee the role of the patient transport staff and how their skills had also increased, for example in terms of first aid, administering oxygen, defibrillation etc.

(4) The South East Ambulance Service also worked closely with the voluntary agencies including the Red Cross and the St John's Ambulance.

(5) The South East Coast Ambulance provided facilities for accident and emergency as well as some patient transport services. There were however a whole raft of patient transport providers. The Ambulance Service worked closely with the Acute Trusts, Primary Care Trusts and the Mental Health Trusts.

(6) The Ambulance Service did support the Red Cross and St Johns Ambulance in dealing with some of their training, but questions specifically about their training would need to be addressed to those two organisations.

(7) In answer to a question about the challenges for staff in the Ambulance Service, Mr Cashman said that any change was challenging and the performance standards for the Ambulance Service were extremely rigorous. During the past Winter this had been very difficult. He added that the Chief Executive of the service believes that embedded in the culture of the service is a strong patient focus and he was adamant that operational staff delivered the service appropriate to the patients needs.

(8) In response to a question about the "Make Ready System", Mr Cashman responded that the existing estate was very old and not always appropriate so the Trust had been finding new sites and developing the "Make Ready System". There were sites in Hastings and Chertsey, Mr Crowther commended Members to visit one of these "Make Ready Systems" having recently visited the Hastings site, and seen a number of ambulances arriving and turning round as quickly as possible to then move onto a new call and patient having been thoroughly cleaned.

(9) Several Members of the Committee having had recent personal experience of the service commended the service.

(10) Questioned about the performance report and the difference of levels between for example, Kent and Hampshire, Mr Cashman responded that the figures relating to Hampshire were only a small part of that county, which the South East Coast Ambulance Service covered, i.e. the Blackwater Valley.

(11) Asked about how a person's entitlement to patient transport services was assessed, the answer was that this was based on need.

22. Local Involvement Network (LINk)
(Item 7)

Mr J Fletcher, Governor, Kent Local Involvement Network and Mr Graham Hill, Director, Kent and Medway Networks Limited were in attendance for this item)

(1) Mr Daley asked colleagues from the Local Involvement Network whether they would consider looking as part of their programme at the issue of pain clinics, bearing in mind the report of the Chief Medical Officer published on Monday, 16 March 2009.

Colleagues from the LINk acknowledged that they would take this message away to other involved with the LINk.

(2) In answer to a question about whether infection control was better in United States of America or in the United Kingdom, Mr Fletcher said that he was not sure whether that was the case.

(3) LINk representatives responded that they would be preparing third party commentaries to the 24 Health Care Commission Core Standards but this would be a "quick and dirty" process.

(4) The LINk were working closely with a number of voluntary organisations across the county who had expressed surprise that they had not been asked for such information before, but of course this was leading to much more anecdotal evidence.

(5) Colleagues of the LINk referred to the re-designing of the main entrance at Medway Hospital and a decision then took place about the use of hand gels and the number of entrances to acute hospital sites. This was of concern to the LINk.

(6) Responding to a question about how the LINk was being publicised, (with one Member identifying that on a recent visit to her GP's surgery, the information still available in the surgery related to the Patient and Public Forums which had now been abolished), the answer was that the LINk now had 443 members, including some very new members. There was a good spread of members across the county. The LINk did have a number of items of publicity material and they were looking at how the County Council could help them with distribution methods. The representatives of the LINk commented on the issues around the policy of disinfecting commodes and toilets and gave their view on how they can influence the Secretary of State for Health.

(7) The representatives also agreed with comments made relating to the cleanliness of magazines, toys, food being taken in hospital by visitors and the policy of being bare below the elbows.

(9) One Member commented that the acronym LINk was not very explicit and he advocated that the LINk needed to publish what their purpose was as swiftly as possible.

23. Health Care Commission Core Standards - "Third Party Commentaries"
(Item)

(1) The Committee had at the last three meetings been gathering evidence from each of the Trusts on the various aspects of compliance with the Hygiene Code to enable it to prepare third party commentaries to be submitted by the Trusts with the self declarations against the Department of Health Core Standards.

(2) The Committee noted that third party commentaries are valued by the Healthcare Commission for the additional information they provide about the performance of NHS Trusts and form part of the evidence that goes towards the Annual Health Check. Health Overview and Scrutiny Committees are one of the main sources of third party commentaries along with Strategic Health Authorities and Local Involvement Networks (LINkS). Third party commentaries that are submitted through a declaration made by a Trust are made publicly available.

(3) The evidence and background information received by the Committee at its last three meetings now needed to be digested quickly and third party commentaries prepared in accordance with the Healthcare Commission's timetable. Trusts must submit their declarations between 15 April 2009 and midday, 1 May 2009.

(4) The approval was therefore sought and given by the Committee to delegate authority to prepare these third party commentaries in consultation with the Chairman, Vice-Chairman and Liberal Democrat Spokesman of the Committee. The third party commentaries would be circulated to all Members of the Committee so that individual Members could contribute to this process.

Recommendation

(5) RESOLVED that delegated authority be given to the Overview, Scrutiny and Localism Manager in consultation with the Chairman, Vice-Chairman and Liberal Democrat Spokesman of the Committee, to agree the third party commentary for inclusion in each Health Trusts self assessment which they are submitting to the Health Care Commission by the end of April 2009.

24. Date of next programmed meeting – Friday 1 May 2009 at 10:00 am
(Item 8)

(1) The Committee noted that the next meeting of the Committee was scheduled for Friday, 1 May 2009. Suggestions for inclusion on the agenda at that meeting was a presentation on the First Responders Scheme operating in the rural parts of Dover in Aylesham and other surrounding villages, and for the Committee to be given in a presentation about the Stroke Care Pathways.

(2) The Committee agreed that the Chairman, Vice-Chairman and Liberal Democrats Spokesperson would consider suggestions for inclusion on the programme and make a decision on 24 March 2009 as to whether the meeting of 1 May was to go ahead.