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 Tuesday, 27 November 2007.

PRESENT: Mr M J Fittock (Vice-Chairman), Mr A R Chell, Mr B R Cope, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Dr M R Eddy (Substitute for Ms A Harrison), Mr D A Hirst, Mrs S V Hohler, Mr G A Horne MBE, Mr M J Northey (Substitute for Mr J A Davies), Mr W V Newman, DL (Substitute for Mrs C Angell), Dr T R Robinson, Mrs E D Rowbotham, Mrs P A V Stockell (Substitute for Lord Bruce-Lockhart), Mr R Tolputt and Mrs E M Tweed

OTHER MEMBERS PRESENT: Mr G K Gibbens, Cabinet Member for Public Health.

OBSERVERS: Mr D Herbert, Mrs A Loveday, Mr R Kenworthy, Mr J Cunningham, Mr R Hansell, Mr J Fletcher and Mrs F Witherden from the Patient and Public Involvement Fora; Mrs R Gunstone, Medway Council.

IN ATTENDANCE: Dr D Turner, HOSC Research Officer and Mr P D Wickenden, Overview, Scrutiny and Localism Manager.

UNRESTRICTED ITEMS

66. Lord Bruce-Lockhart

The Vice-Chairman informed the Committee that he had spoken to Lord Bruce-Lockhart; he was out of hospital and making good progress, and was due to start further treatment in the middle of December.

RESOLVED that the Committee's best wishes for a speedy recovery be sent to Lord Bruce-Lockhart.

67. Letter from Roger Gale, MP

The Overview and Scrutiny Manager tabled the letter which he had summarised to the Committee on 9 November 2007 from Roger Gale MP, as he had subsequently received a further letter from Mr Gale expressing disappointment that his letter had not been made available to the Committee.

Infection Prevention and Control

(*Note: Mr A D Crowther declared an interest as a Member of Medway NHS Trust)*

68. South East Coast Strategic Health Authority

(Debbie Stubberfield and Sumona Chatterjee of the South East Coast Strategic Health Authority were in attendance for this item.)

(1) The Committee asked a range of questions which covered the following:-

(a) What extra funding the Strategic Health Authority had given to local health economies for developments in infection prevention and control, and how this money was being spent.

(b) How the SHA performance-managed infection prevention and control by acute hospital Trusts and Primary Care Trusts and ensured that best practice was shared.

(c) How the Strategic Health Authority collaborated with the Department of Health, the Healthcare Commission and key stakeholders in dealing with under-performance

(d) The role of the Regional Director of Public Health in performance-managing the health protection role; the Strategic Health Authority's relationship through an annual memorandum of understanding with the Health Protection Agency and the local Health Protection Unit in respect of healthcare-associated infections.

(e) How ambulances were cleaned and how often this took place.

(f) Visiting times, numbers of visitors, and patients and visitors being able to bring in their own food into hospital.

(g) At what point the Strategic Health Authority became involved in outbreaks of infection through invoking its escalation procedures.

(h) Mr Daley referred to the letter from Mr Gale MP which had been summarised by the Overview and Scrutiny Manager at the Committee's previous meeting on 9 November, and tabled and circulated at today's meeting. Mr Daley referred in particular to Mr Gale's questioning the role of the Strategic Health Authority. The Committee acknowledged that it was unfair for the representatives from the Strategic Health Authority to respond to this in the absence of not seeing the letter. The Overview and Scrutiny Manager informed the Committee that this was an issue that would be raised by the Health Overview and Scrutiny Committee Vice-Chairman with the Chief Executive of the South East Coast Strategic Health Authority Candy Morris when they met with her on 6 December 2007.

69. Primary Care Trusts across Kent and Medway

(Items 4, 5 and 6)

(Mr B Collins Director of Infection Prevention and Control/Director of Nursing, West Kent PCT, Ms A Sutton, Chief Executive, Ms S Andrews, Director of Nursing, Ms S Allum, Assistant Director of Clinical Performance, Mr P Greenhill, Director of Operations, Ms S Baldwin, Assistant Director of Intermediate Care Services, Mr P Edbrook, Assistant Director of Organisational Development and Governance and Ms C Cassam, District Nurse Sister, Eastern & Coastal Kent PCT, Mr M Riley and Ms B Edwards, Medway Primary Care Trust were in attendance for this item.)

(1) The Committee asked a series of questions of the Primary Care Trusts, each in turn, covering the following:

(a) How the Primary Care Trusts' public health responsibilities in respect of healthcare-associated infections were being discharged under the terms of their Memoranda of Understanding with the Health Protection Agency.

(b) How the Primary Care Trusts monitored and performance-managed the prevention and control of infection in the acute Trusts from which they commissioned services.

(c) How PCTs were meeting the requirement in the 2007/2008 NHS Operating Framework for Primary Care Trusts to "engage with clinicians and agree local targets" for a significant reduction in Clostridium difficile-associated disease occurring in their local acute Trusts.

(d) How PCTs were working to implement the Department of Health National Action Plan on Hospital Acquired Infections (Winning Ways 2003) and other relevant national policy, including the 2006 Hygiene Code.

(e) What PCT policies were in respect of infection prevention and control in their own premises and those of independent primary care practitioners (GPs, Pharmacists, Dentists and Optometrists) from whom they commissioned services.

(f) What their policies were on the decontamination of medical devices in PCT premises and those of independent primary-care practitioners from whom they commissioned services, with reference to the emerging Kent Decontamination Strategy.

(g) How PCTs monitored antimicrobial prescribing practices by clinicians employed by the PCTs and by independent primary-care practitioners from whom they commissioned services; and what they did to promote good prescribing practice through means such as the development of a community antibiotic formulary.

(h) What they did to ensure that all the premises they managed complied with the National Standards for Infection Control and Food Hygiene and what plans they had made with their local health communities (including social care colleagues) to reduce rates of healthcare-associated infections originating in the community, including settings such as nursing homes and residential homes.

(i) The issue of hand-washing and cleanliness (there were many notices relating to the use of hand gel, but this was not effective against Clostridium difficile).

(j) The regime of deep cleaning throughout the Acute Hospital Trusts and the cleaning materials used, and whether they were effective in killing Clostridium difficile.

70. Patient and Public Involvement Fora

(Item 7)

(Mr J Cunningham, Mr J Fletcher, Mr R Hansell, Mr D Herbert, Mrs A Loveday, Mrs F Witherden, PPIF Members, were in attendance for this item.)

(1) The Committee then took the opportunity of asking the Patient and Public Involvement Forum representatives some questions. In particular they were keen to hear from Patient and Public Involvement Forum representatives for the Maidstone and Tunbridge Wells NHS Trust.

(2) The Committee had specific questions they wished to ask the Patient and Public Involvement Forum Members including:

(a) Whether there was a shared work programme for Patient and Public Involvement Fora across Kent and Medway.

(b) How the Patient and Public Involvement Fora decided what their priorities were for inclusion in their work programme.

(c) What arrangements there were for Patient and Public Involvement Fora to pick up things that emerged from complaints made through the Patient Advice and Liaison Services, and Independent Complaints Advocacy Services.

(d) Whether the Patient and Public Involvement Fora regarded it as core business each year to produce third-party commentaries on NHS bodies' performance against Core Standards as part of the Health Care Commission's Annual Health Check process.

(3) Asked for his comments on the Healthcare Commission Report on Maidstone and Tunbridge Wells Trust, Mr Herbert responded that overall it was helpful. However, the media coverage had focussed on management failings, which he felt was unfortunate as it had distracted attention from other reasons for what had occurred. He acknowledged that funding was a huge issue for Maidstone and Tunbridge Wells NHS Trust; a deficit had led to underspending on the nursing budget, for which criticism was due.

(4) He felt that if relationships between the PCT and the acute hospital Trust had been better, and if the Strategic Health Authority had undertaken its performance management role more effectively, then there would not have been the need for the Healthcare Commission Report.

(5) He felt that some senior clinicians and nurses were culpable for the provision of poor care, but this had been glossed over. He acknowledged the difficulty that management had had in implementing changes, which he attributed to the lack of support from some senior clinicians.

(6) He felt that the non-executive directors of the Trust also needed to consider their role and responsibilities.

(7) Mr Herbert referred to a PPIF press release, which had been made available to the Committee on 9 November, recounting the actions that they had taken following the initial BBC South East television news report on hospital cleanliness in 2004. He commented that nobody had picked up on some of the issues which the PPIF had referred to in their third-party commentaries for the Healthcare Commission Annual Health Check.

(8) Mrs Loveday raised concerns that, with the abolition of Patient and Public Involvement Fora, there would be a potential loss of continuity and competence, as had happened with the abolition of Community Health Councils.

(9) Mr Herbert said that Maidstone and Tunbridge Wells NHS Trust Patient and Public Involvement Forum would be producing a final report for the new Local Involvement Network. Asked what they felt about the HOSC, there was general agreement among Patient and Public Involvement Forum colleagues that there was now better preparation for meetings and that the Committee's new way of working was a step in the right direction.

(10) The HOSC needed to prioritise and stick to those priorities to ensure that impetus was not lost.

(11) One member said that he was impressed by the range of topics that had been covered by the HOSC and how well they were researched. The Overview and Scrutiny Manager said that the Patient and Public Involvement Forum colleagues were a significant foundation stone for the HOSC's work. Kent was struggling, as were a number of local authorities, with exactly how the Local Involvement Network would operate; but Kent was keen to ensure that the Local Involvement Network was placed in a position where it added value to the patients and public of the county. He indicated that the County Council might have to ensure that there were transitional arrangements put in place for a period, as it was possible that the Local Involvement Network for Kent would not be operational by 1 April 2008.

It had been evident in gathering written evidence on healthcare-associated infection prevention and control that the Patient and Public Involvement Fora, the Health Overview and Scrutiny Community, the Patient Advice and Liaison Service etc., had not been communicating and coordinating their work as well as they should have done.

The Overview and Scrutiny Manager said he felt it would be useful to have a mutual understanding of what should be achieved and hopefully a well-developed complementary work programme.

71. Conclusions

(1) The Committee concluded as follows from the meetings held on 9 and 27 November:-

a) To note that part of the Director of Public Health's role is to proactively monitor infection prevention and control across the Kent and Medway Health economy;

b) To ensure that the Strategic Health Authority and Primary Care Trusts share best practice by individual Trusts, so that there is a consistent approach across the Kent and Medway health economy;

c) To seek clarity on the respective roles of Primary Care Trusts, the acute hospital Trusts and the Strategic Health Authority;

d) To seek clarity about how the Primary Care Trusts are dealing with the issue of antibiotic prescribing;

e) To consider what methods are being used by health organisations to inform patients and the public about how they can help avoid infection risks;

f) To welcome the opportunity to receive an action plan from the Maidstone and Tunbridge Wells NHS Trust on how they are responding to the Healthcare Commission report, having heard that bed occupancy within the Maidstone and Tunbridge Wells NHS Trust was currently at 95% instead of the recommended level of 85%;

g) At a future meeting, to understand how adult social care, health and other stakeholders are responding to the issue of step-down facilities and delayed discharge;

h) To understand from the Strategic Health Authority how the money recently allocated by the Government for deep cleaning is to be allocated to Trusts across the Kent and Medway Health Economy;

i) To welcome the offer of the Healthcare Commission to provide some training for Members of the Committee on what makes a good third-party dialogue contribution to the Annual Health Check;

j) To welcome the Healthcare Commission's offer for Members to accompany them on some visits to health organisations, so that Members may see at first hand how the Committee can contribute to the Healthcare Commission's Annual Health Check;

k) To state that the cleaning of health establishments should include the non-clinical areas, especially above head height;

l) To state that deaths that might be related to adverse effects of medical treatment or to poor standards of care, or where there has been any complaint about healthcare services, should be referred to the relevant Coroner as a matter of routine;

m) To write to the Government responding to the draft regulations for Local Involvement Networks;

n) To ensure that relevant information is sent to the Healthcare Commission and, if appropriate, the minutes of each Health Overview and Scrutiny Committee meeting;

o) To encourage Members of the Health Overview and Scrutiny Committee to attend meeting of local health organisations' Boards;

p) To build into the Committee's work programme as core business the matter of compliance with the Healthcare Commission's Core Standards;

q) To have a dialogue with the existing Patient and Public Involvement Fora,

the Local Involvement Network (when established), Patient Advice and Liaison Services, Independent Complaints Advocacy Services, local Members of Parliament and local councillors; to listen to patients' concerns; and to utilise more effectively information that is provided and act on concerns that are expressed;

r) To ensure that the good work going on in various local level Patient and Public Involvement Fora feeds into the Health Overview and Scrutiny Committee to enable it to provide an evidence-based strategic view across the county;

s) To analyse whether, if the Committee had operated in the style that it does now when it asked colleagues from Kent and Medway health economy to address the Committee on infection control in October 2004, July 2006 and June 2007, the public would have been better served;

t) To consider whether it has helped for the Committee to seek written evidence in advance of each meeting, agree a work programme (up to two years ahead) and link this to the training of Members for service on the Committee;

u) To consider the role of senior clinicians in changing the leadership and culture of NHS organisations;

v) To support measures to ensure that a correct balance of food is eaten by patients in hospitals, having due regard to the patients' clinical needs;

w) To consider whether spot checks of hospital food suppliers should be undertaken by Environmental Health and Trading Standards;

x) To investigate what training adult social care and health providers undertake to ensure that infections in the community are not brought into hospitals;

y) To consider how the County Council can help with a campaign to advise the public on taking steps to help avoid infection in hospitals and elsewhere.

z) To seek the views of microbiologists on the effectiveness of different cleaning products against Clostridium difficile;

aa) To examine the role of non-executive directors on the Boards of NHS bodies;

bb) To look at possible inequalities in the funding of health services and the impact of this on ratios of nurses and healthcare assistants;

cc) To understand how Trusts spend their budgets;

dd) To undertake a review of arrangements regarding hospital visitors.

Recommendations

The Vice Chairman, and the Conservative and Liberal Democrat spokesmen would like to suggest the following recommendations to the Committee, having heard and considered the conclusions of the evidence taken by the Committee at its meetings on 9 and 27 November:

a) At the heart of the Health Overview and Scrutiny Committee's work programme should be the Healthcare Commission Core Standards.

b) Evidence should be recorded from the Health Overview and Scrutiny Committee's work programme electronically, so that when the Health Overview and Scrutiny Committee is asked to make third-party submissions for the Annual Health Check the evidence for this is already available.

c) There should be greater collaboration between the Patient Advice and Liaison Services, the Independent Complaints Advocacy Services, the Patient and Public Involvement Fora / the Local Involvement Network, Members of Parliament and local authority councillors, in order to listen to patient concerns and utilise more effectively the information they provide to assist in formulating the Health Overview and Scrutiny Committee's work programme.

d) The Overview and Scrutiny Manager should, together with colleagues from health organisations, explore and arrange an ongoing programme of training and activities to address the knowledge deficit for all stakeholders involved in scrutinising the health economy.

e) Recognising that the patient and public view is paramount, the Health Overview and Scrutiny Committee and the County Council should respond to the draft regulations for Local Involvement Networks to ensure that there is an adequate right to inspect premises where healthcare is provided. This will make for robust scrutiny, helping to bring about health improvements and reduce health inequalities – which are the fundamental principles of Health Overview and Scrutiny.