



AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 27th November, 2007, at 10.00 am Ask for: Paul Wickenden
Council Chamber, Sessions House Telephone 01622 694486
County Hall, Maidstone

Tea/Coffee will be available from 9:45 am

Membership (17)

- Conservative (12): Lord Bruce-Lockhart (Chairman), Mr A R Chell, Mr B R Cope,
Mr A D Crowther, Mr J Curwood, Mr J A Davies, Mr D A Hirst,
Mrs S V Hohler, Mr G A Horne MBE, Dr T R Robinson, Mr R Tolputt
and Mrs E M Tweed
- Labour (4): Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and
Mrs E D Rowbotham
- Liberal Democrat (1): Mr D S Daley

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

- | Item No | | Timings |
|---|---|-------------------|
| 1. | Substitutes | |
| 2. | Declarations of Interests by Members in items on the Agenda for this meeting. | |
| Infection Prevention and Control | | |
| 3. | South East Coast Strategic Health Authority (Pages 1 - 10)
<i>Deborah Stubberfield, Nurse Advisor and Sumona Chatterjee, Head of Performance will be in attendance for this item.</i> | 10:10-11:00
am |
| 4. | West Kent Primary Care Trust (Pages 11 - 22)
<i>Barrie Collins, Director of Infection Prevention & Control/Director of Nursing and Julia Ross, Director of Civic Engagement will be in attendance for this item.</i> | 11:00-11:45
am |
| Break 11:45 am-12:00 noon | | |
| 5. | Eastern & Coastal Kent Primary Care Trust (Pages 23 - 26)
<i>Ann Sutton, Chief Executive, Sarah Andrews, Director of Nursing, Sally Allum, Assistant Director of Clinical Performance, Philip Greenhill, Director of Operations, Sue Baldwin, Assistant Director of Intermediate Care Services, Phil Edbrook, Assistant Director of Organisational</i> | 12:00-12:45
pm |

Development and Governance and Carol Cassam, District Nurse Sister will be in attendance for this item.

Lunch break 12:45-1:30 pm

6. Medway Primary Care Trust (Pages 27 - 32) 1:30-2:15 pm

Martin Riley, Director of Provider Development and Barbara Edwards, Infection Control Adviser will be in attendance for this item.

7. Patient & Public Involvement Fora (Pages 33 - 36) 2:15-3:30 pm

Mr David Herbert, Chair, Maidstone & Tunbridge Wells PPIF and colleagues will be in attendance for this item.

Break 3:30-3:45 pm

8. Conclusions and recommendations 3:45-4:30 pm

9. Date of next programmed meeting – Friday 14 December 2008

The meeting will take place in the Council Chamber commencing at 10:00 am. Items on the agenda will include Audiology and Dentistry.

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Stuart Ballard
Head of Democratic Services
(01622) 694002

19 November 2007

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

November 5, 2007

Paul Wickenden
Legal and Democratic Services
Kent County Council
Sessions House
County Hall
Maidstone, Kent ME14 1XQ



Dear Paul,

I am writing in response to your request for written evidence to the County Council's NHS Overview and Scrutiny Committee in the wake of the Healthcare Commission's report on two outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust and the trust's performance ratings by the Healthcare Commission.

I understand the Committee's desire to strengthen its oversight role in the interests of improving the services offered to patients and the public of Kent.

The issues identified by the Healthcare Commission report raise pressing challenges for the NHS both nationally and locally. I also believe they present an opportunity for Kent County Council, NHS South East Coast and the local NHS to work together to restore public confidence in the safety and quality of healthcare in the Maidstone area.

NHS South East Coast has drawn up a comprehensive improvement plan in conjunction with the trust and we are working closely with the leadership to address each issue in light of the Healthcare Commission's recommendations and in line with our remit to performance manage the trust. These include:

- supporting the trust in its review of leadership
- working closely with management and through multi-agency task forces to improve systems for preventing and controlling infections
- regularly monitoring performance against a range of measures – infection control and prevention being crucial ones
- ensuring reporting systems are robust and capture every infectious disease outbreak and
- funding a range of activities to improve cleaning programmes in the trust

The attached note sets out our written evidence to the Committee. Could you explain whether the Committee will also be seeking oral evidence from either the SHA or West Kent Primary Care Trust or both and if not, whether this represents a new approach by the Committee and the rationale behind it.

In any event, I would appreciate feedback from the committee on this particular session and look forward to our meeting in December where we can share our thoughts about how Kent County Council, the local NHS and NHS South East Coast can work together to rebuild public trust in services in Kent.

Regards

Candy Morris

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The Role of the Strategic Health Authority in the Performance Management of Healthcare Associated Infections (HCAIs)

The role of NHS South East Coast Strategic Health Authority (the SHA) is:

- To provide strategic leadership to the NHS in the South East
- To ensure the appropriate development of local NHS organisations and their workforce
- To ensure the effective delivery of, and improvement in, NHS services

In discharging these functions, the SHA:

- Must work in partnership with local NHS services and regional organisations, particularly the Government Office for the South East
- Must hold local NHS services to account for their performance
- Will be held to account by the Department of Health for ensuring its local health systems operate effectively and in line with Government policy.

SHA Board level leadership on healthcare associated infections

- The Strategic Health Authority (SHA) has a Board-level lead for healthcare associated infections (Director of Clinical and Workforce Development).
- The SHA has a performance improvement team which reports directly to the Director of Clinical and Workforce Development on matters of infection control and prevention. The team comprises:
 - a doctor
 - a nurse advisor
 - a pharmacist
 - a public health information analyst
 - a programme manager
- The team monitors a wide range of data pertaining to HCAIs. Its role is to review and analyse the data and report monthly to:
 - The SHA Programme Management Board
 - The SHA Board
- The team also undertake site visits to organisations where an issue such as low compliance with hand-washing or recurring outbreaks of infection has been identified.

Performance management by the SHA

- The SHA has a signed annual performance agreement with all Chief Executive Officers (CEOs) within NHS South East Coast and the reduction of HCAIs is a key indicator in all of them.
- The SHA undertakes monthly performance reviews with all primary care trusts and acute trusts. HCAIs is a core agenda item at each meeting.

- The SHA has a patch director structure in place. Each Director has responsibility for overall performance in each patch (Kent, Surrey and Sussex). A crucial part of the Patch Director's role is to meet regularly with each CEO in their patch. HCAI performance forms a key agenda item at each meeting.
- All trusts within NHS South East Coast are obliged to have HCAI improvement and delivery plans against which they are performance managed.
- In addition to monthly performance meetings, the SHA also holds 'challenge' sessions with organisations. These are focused on improving the management of HCAIs. CEOs and Directors of Infection Prevention and Control (DIPCs) present progress to date, highlighting specific issues and identifying good practice going forward.

Directors of Nursing

Nationally, Directors of Nursing have a leadership role in improving the management and prevention of HCAIs. In NHS South East Coast the Directors of Nursing network has identified the reduction of HCAIs as a key deliverable.

Multi-agency review group

- The SHA is in the process of setting up a multi-agency review group. This comprises members of the SHA Performance Improvement Team together with:
 - Kent, Surrey & Sussex HPUs
 - A PCT Director of public Health
 - An acute trust DIPC
- Terms of reference are currently being developed. This group will be looking at areas of improvement, discussing evidence-based practice to ensure good practice is shared and there is a consistency of approach across the region.

Serious Untoward Incidents (SUIs)

- As part of the SHA SUI policy, all NHS organisations are required to report any MRSA bacteraemia or *C. difficile* outbreak to the SHA as a Serious Untoward Incident.

Primary Care Trust role

- The SHA have worked with primary care trusts to develop their local health community plans to reduce rates of HCAIs. These plans focus on infection that originates in the community such as in nursing homes and residential homes.
- Primary care trusts have the lead role in performance managing local health community plans and there are many examples of local health community groups engaging with local care homes and also NHS community hospitals and social services to reduce potential infections originating in the community.

Key external partners

- The SHA works closely with the Department of Health (DH). In particular, it collaborates with the Department's Intensive Support Team. There is a designated member of the Department's Intensive Support Team who links with each SHA and works with the performance improvement team.
- The Healthcare Commission, in its regulatory role, works with NHS South East Coast through the Commission's regional arrangements. There are regional meetings where they review each organisation's compliance with standards.

Managing poor performance

- Existing arrangements allow us to monitor closely evidence of compliance with agreed standards of good practice and current policy at all trusts. However, where the SHA judges it is necessary to refer, we have the power to refer matters to the Healthcare Commission for review and investigation.

The role of the SHA in performance managing the public health system including Directors of Public Health and working with the Health Protection Agency

Public health comprises three core functions:

- Health improvement (which encompasses reduction in inequalities, performance for health and the delivery of Local Area Agreements)
- Health protection (which encompasses infection surveillance and control; the delivery of services by the Health Protection Agency and internal arrangements within primary care trusts, which are not part of the Health Protection Agency functions as well as aspects of emergency planning as they relate to chemical, biological or radiological incidents)
- Health services oversight (which includes the effectiveness and safety of services, and equitable access to effective care)

Strategic Health Authorities host public health directorates

Since 2006, the strategic health authorities host public health directorates headed by the Regional Director of Public Health & Medical Director of the SHA.

The role of the Regional Director of Public Health

The Regional Director of Public Health is head of the public health system and coordinates a comprehensive perspective across the NHS and the wider dimensions of public health. The latter includes a direct relationship with the Health Protection Agency through a Memorandum of Understanding, which is agreed annually.

Emergency planning

The emergency planning function is held within the SHA directorate of public health. This includes the substantial preparation for pandemic influenza. The function links with, and supports local resilience forums across Kent, Surrey and Sussex. The Directorate of Public Health also heads up the clinical governance function (but it is not universal). Finally, the Medical Director component of the Regional Director of Public Health

function opens the door to develop supportive relationships with Medical Directors of provider trusts, and, according to the capacity of the Regional Director, with other key clinical leaders on the patch. In the South East Coast, these senior relationships are seen by the Regional Director as important and they include the foundation trusts.

Accountability

The Regional Director of Public Health is jointly accountable to the SHA Chief Executive, the Regional Director of the Government Office, and the Chief Medical Officer. As such the span of relationships is very broad.

Appointment of Directors of Public Health

As head of the public health system in a geographical area, the Regional Directors of Public Health since 2006 have appointed all new Directors of Public Health in their areas; and usually provide professional appraisal of the primary care trust Directors of Public Health. The new Directors of Public Health are all joint appointments with local government in the southeast – as is the case in the majority of England.

Leadership group

Regional Directors of Public Health usually chair a leadership group, the core of which is the Primary Care Trust Directors of Public Health and the Health Protection Units locally. A primary care trust chief executive sits on the South East group. Our leadership group addresses performance for health and health protection as a monthly standing item. The group accounts to the Management Board of Primary Care Trust Chief Executives and the SHA.

Performance for health is backed up by a small performance team jointly drawn from the Regional Public Health Group at the Government Office and the SHA public health directorate. This team addresses health targets, capacity for delivery and the quality of Local Area Agreements. The Group may discuss aspects of the quality of care in provider trusts as it relates to the role of the Director of Public Health. The input of the local public health system to support provider trusts varies across England and may change again as foundation trusts evolve. The accountability for performance for health is to the SHA Chief Executive and Board, which reviews selected performance indicators weekly (at the Executive) and monthly (at the Board).

The relationship between the SHA, the Regional Director of Public Health and the Health Protection Agency

The SHA relates to the Health Protection Agency via the Regional Director of Public Health at two levels: (a) at regional level and (b) via regular contact with the local Health Protection Units. The Regional Epidemiologist is a senior public health appointment and the Regional Director of Public Health and Regional Epidemiologist meet regularly. They also provide mutual support to cover the regional resilience function. The regional Health Protection Agency provides surveillance of infection and support to the two local Health Protection Units (in Kent and Surrey/Sussex). Although the SHA has close relationships with the local Health Protection Units, the day to day relationships of those units are with primary care trusts. Each primary care trust is required to have a Director of Infection Prevention and Control. This may or may not be the Director of Public

Health. It is important that the Director of Public Health and the Director of Infection Prevention and Control link closely.

The Health Protection Agency and its units will become involved in infection outbreaks and control at the request of local agencies including hospitals and primary care trusts. The units deal with outbreaks within their area. If an incident escalates, the regional Health Protection Agency, in coordination with the Regional Director of Public Health, will require other units to become involved. This may include regional and national support from the Health Protection Agency.

Accountability in a health protection incident is jointly held by the Health Protection Agency (for the work of its units) and the Chief Executive (of the location where the incident commenced). Outbreaks engender a complex set of interdependencies. The SHA will hold the whole NHS system to account for the appropriate coordination of a response to an outbreak. However it is important to re-emphasise that the Health Protection Agency is a national agency and is accountable directly to its Chief Executive.

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5th November 2007

SENT VIA EMAIL

Paul Wickenden
Overview and Scrutiny Manager
Kent County Council
Sessions House
County Hall
Maidstone ME14 1XQ

Dear Paul

Health Overview and Scrutiny Committee – 9 November 2007 – EVIDENCE

Thank you for the opportunity to submit written evidence for the above meeting. You asked for evidence covering four topics. I have not included all of the papers to support these statements, which would be a considerable amount and some of which are not available electronically. They are available if Members would like them, and confirm the statements made below:

(1) As commissioners how do you quality assure the care the Primary Care Trust are purchasing on behalf of the patient?

We have a contract, which is based on a national NHS contract for Acute Trusts. This contract has a section that relates to Clinical Key Performance Indicators (KPI)

We monitor performance at a number of levels:-

- (a) formal meetings between our contracting team and the Trusts at Director and senior manager level – monthly;
- (b) formal monitoring meetings between the PCT, Trusts and the Strategic Health Authority (SHA) - monthly at CEO and Director level;
- (c) where we get patient and representative complaints/concerns, we fully investigate and seek improvement from the organisations involved;
- (d) ad hoc visits from PCT Directors as well as the CEO. For example the Director of Infection Prevention and Control (DIPC) is the PCT Director of Nursing and he visits the wards in our local hospitals regularly to observe care delivery and talk to the Directors of Nursing, Matrons, and ward staff;
- (e) review of regulatory reports such as the Patient Environment Action Team, the Healthcare Commission Annual Health Check;

- (f) regular meetings between the PCT and Acute Trust Directors of Nursing;
- (g) regular meetings between the PCT and Acute Trust Infection Control nursing teams;
- (h) Monthly meeting of the West Kent Infection Prevention and Control Committee, chaired by the PCT DIPC. This has DIPC representation from all the NHS providers in West Kent;
- (i) Ad hoc reports such as the recent one on *clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust;
- (j) Untoward Incidents are reported to the SHA and PCT, with subsequent root cause analysis and action plans as necessary;
- (k) The Board receives a report at every public meeting on performance against KPI;
- (l) The Executive Team are considering proposals to provide additional evidence of the quality of clinical services in all healthcare providers commissioned by West Kent PCT. More details of this will be released when further work is done.

(2) As a provider of services how are you as a PCT ensuring that you are observing good practice in Infection Control?

The Assistant Director for Adult Services with the Director and Deputy Director for Community Services have been working closely with community staff across all services to ensure that managing the risk of infection is high on everyone's agenda.

Meetings have been held with a representative from West Kent Shared Services Environment team, to ensure that our internal performance systems are independently audited and scrutinised regularly. The community hospitals have regular PEAT (Patient Environment Action Team) assessments carried out.

Copies of last years overall PEAT scores for each community hospital and the quarterly audit results as covered in the SLA with WKSS* (see below) are shown.

PEAT visits 2007

PEAT assessments were carried out during February and March this year. These are led by the Head of Environment Services for WKSS and supported by the Modern Matron of the site and a senior manager.

The results are available in detail, however below is a summary of the findings:

Hospital	Date	Overall score	Action plan comments
Tonbridge	March	Good	Attention to detail e.g. walls, doors, electrical equipment.
Sevenoaks	Feb	Good	Some areas requiring attention e.g. electrical

			equipment, flooring
Livingstone	Feb	Good	Attention to detail e.g. small equipment
Gravesham	Feb	Very Good	
Edenbridge	Feb	Very Good	
Hawkhurst	March	Very Good	

Quarterly cleaning audit report

The last quarterly cleaning audit was carried out in September 2007. Again this is carried out by the Head of Environment Services for WKSS to provide external scrutiny of our service standards.

The audit is set against the National Specification for Cleanliness in Hospitals. The pass rate being 85%.

Audit results

Livingstone: 83%*

Gravesham: 91%

Hawkhurst: 91%

*The Modern Matron and the Locality Manager responsible for the Livingstone Hospital have implemented a programme of work with WKSS to ensure that the next audit result is brought up to the standard required to reach at least 85%.

The current SLA with WKSS means that the following Hospitals are excluded from the external audit process.

Tonbridge Cottage

Edenbridge

Sevenoaks

Internal audits are carried out but these are not benchmarked in the same way as the WKSS audit. The current situation with these 3 community hospitals is being reviewed and discussion is ongoing with WKSS to evaluate the additional cost to the PCT to include quarterly audits for these sites in the SLA for 2008/09.

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The chart below shows all the community hospitals and the appropriateness of the bed spacing and hand washing facilities to manage the control of infection.

Hospital	Open beds	Bed spacing	Closed beds	Bed spacing	Single rooms	Bathrooms/hand washing facilities	Other actions
Gravesham Community (Sapphire Wing)	12	All single rooms	10	All single rooms	All single rooms	One ensuite in each room plus 2 additional bathrooms	Hand gel at entrance to ward area. Hand gel at the foot of each bed All staff carry small hand gel containers
Livingstone	30	Meets requirement	0 (8 beds decommisioned due to bed spacing issues)	Meets requirement	0	1 full wash basin within each of the 8 bays. 1 ensuite within the 2 bedded bay. 2 bathrooms. 2 shower rooms 5 toilets with full wash basin facilities.	Hand gel at entrance to ward area Hand gel at the foot of each bed All staff carry small hand gel containers
**Hawkhurst	19	Meets Requirement except one ward area see below	4	Meets requirement	See below	See below	Hand gel at some entrances but not all See below
Edenbridge	10	Meets requirement	7	Meets requirement	7	1 en suite in each single room. 2 additional bathrooms 4 shower rooms 6 toilets with full wash basin facilities.	Hand gel at all entrances. All staff carry small hand gel containers.

***Sevenoaks	24	18 beds do meet requirement. ***6 beds do not meet requirement	23	Meets requirement	4	5 bathrooms 4 shower rooms 4 Toilets with full wash basin facilities. 28 wash basins.	Hand gel at all entrances. Hand gel at the foot of every bed. On trolleys, nursing station and sluice.
***Tonbridge Cottage	15	***Does not meet requirement	15	Ward area not set up therefore no data available at this time.	3	4 bathrooms 4 shower rooms 16 toilets with full wash basin facilities 36 wash basins across the site (including those in closed ward areas)	Hand gel at all ward entrances. All staff carry small hand gel containers.

** Hawkhurst: a Clinical Governance audit was carried out in September by 2 locality managers and the locality facilities coordinator. The action plan from that audit was reviewed October 30th. The written report following that review will be available in mid November. The action plan included hand gel to be provided at every entrance and at the foot of each bed, bed spacing in one area of the ward to be reviewed as well as privacy and dignity issues.

*** The bed spacing is under review at Tonbridge Cottage Hospital and at Sevenoaks Hospital, as it appears that some of the bed spacing does not currently meet the recommended 3200mm. The AD for Adult Services is aware of this and is being supported to resolve the issue. (See below)

Bed Spacing

During the Community Hospital review, work was done, with WKSS to prepare CAD plans of each community hospital inpatient area and to demonstrate optimal bed spacing within each ward (3200 mm) whilst maintaining bed numbers.

The plans are available for viewing.

This highlighted areas where the bed spacing would be compliant with the recommendations and where it would not. Actual bed spacing is being reviewed as a matter of urgency within each community hospital by the senior nursing staff and is shown in the chart above. Any non compliance is being addressed to ensure optimal spacing is in place throughout. If this leads to the need to reduce bed numbers in the interim, this will be highlighted as a matter of urgency. (See ***Tonbridge Cottage Hospital and Sevenoaks Hospital above). The compliance with optimal bed spacing is now in place.

In addition the issues around nightingale wards have been addressed and there are bays identified in each ward area allowing for no more than 6 beds in any one bay. The Assistant Director for Adult Services is working closely with the Community Hospital Modern Matrons and the Locality Managers to ensure all recommendations relating to cleaner hospitals is being implemented, reviewed and audited.

All cases of MRSA and C. Diff. are reported as required.

Current Action Plans

Current plans in place include:

- A review of the square footage of each community hospital and benchmarking against national cleaner hospitals data to ensure the appropriate number of cleaning hours are in place for each hospital site.
Completion: end November 2007.
- Review of the job specification for the housekeeper role prior to developing this role across each community hospital site.
Completion: end of November 2007.
- Unannounced PEAT visits have been set up for November and December 2007, carried out by the Head of Environment services for WKSS, accompanied by the AD for Adult Services. These are as follows:
 1. Hawkhurst Hospital 21st November
 2. Edenbridge Hospital 22nd November
 3. Tonbridge Cottage Hospital 28th November
 4. Sevenoaks Hospital 3rd December
 5. Livingstone Hospital and Sapphire unit 4th December.

Results available end December 2007.

- Application for deep clean money for each community hospital. This includes confirmation of square footage for each area and total costs to undertake deep clean.
 1. Livingstone Hospital-WKSS
 2. Gravesham Sapphire Wing-GFM
 3. Hawkhurst Hospital-internal
 4. Edenbridge-internal
 5. Sevenoaks Hospital-internal
 6. Tonbridge Cottage Hospital-internal
- *Review of the SLA with WKSS as not all sites within the PCT are included in the SLA and are therefore not included in the external auditing and bench marking process. This requires discussion with the Finance Director as the SLA currently sits with him.

In the community, where staff work in people's homes, they have well-established systems to ensure that standards of clinical practice are maintained, and all nurses carry alcohol gel with them and ensure appropriate levels of cleanliness whilst providing care for patients. Dressings are disposed of appropriately, and equipment is either disposable or is returned for sterilisation and decontamination via systems that are compliant with statutory requirements.

(3) *How are the PCT dealing with healthcare associated infections as a public health issue?*

Monitoring and surveillance is the way we identify changes in patterns of infection rates. It is now a statutory requirement to monitor MRSA and C Difficile. All cases are reported to the Health Protection Agency (HPA). The Primary Care Trusts get a copy. All trusts have a responsibility to notify the HPA of any outbreaks or infections. This is a way of identifying emerging diseases.

The West Kent Infection Prevention and Control Committee discusses and analyses surveillance data, in part via an expert subcommittee as relevant, on a monthly basis. The Board receives the surveillance information, including trends, at each public Board meeting.

Implementing the national standards is the responsibility of individual providers. The west kent infection patient safety committee monitor audits of practice and share good practice to ensure compliance with standards.

New guidelines and protocols for Kent and Medway are developed by the Kent and Medway Directors of Infection Control Committee which is led by the clinical director of the Health protection agency.

I understand that the committee already has a copy of the memorandum of understanding with the HPA and the terms of reference for the infection control committee.

(4) What work are you doing as a PCT working with GPs to reassure the public that the acute hospitals and community hospitals are safe?

The Medical Director (also a local GP) has written to MTW offering to meet senior clinical and managerial staff, in conjunction with the Local Medical Committee if appropriate, to discuss how General Practitioners might best advise their patients about the current situation at the Trust with regard to clinical safety.

Whilst there have been frequent anecdotal reports of patients expressing concern to their GP about potential treatment at MTW, the commissioning team reports that there appears to be no current evidence of patients cancelling previously booked procedures to a greater extent than before the crisis broke, nor is there any convincing current evidence of a decrease in fresh referrals to MTW for elective care. It nevertheless remains our view that it is possible that a trend towards patients being referred further afield for treatment will ultimately emerge.

I hope that this information is helpful. If you require anything further please don't hesitate to contact me.

Yours sincerely,



Barrie Collins
Director of Nursing/Director of Infection Prevention and Control

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1) As commissioners how do you quality assure the care the Primary Care Trust are purchasing on behalf of the patient?

As commissioners the PCT adopts a zero tolerance to all avoidable infections.

Eastern and Coastal Kent PCT appointed a Director of Nursing who is responsible for infection control across the PCT area and who works with the PCT and other providers to minimise the risk of health care acquired infections. All providers must adhere to and comply with the 2006 Hygiene Code. The code sets out eleven duties and sub duties all of which are monitored using a performance monitoring tool. An assessment is currently being undertaken by all providers and this will provide assurance of performance and actions taken to address how shortfalls or deficits will be managed with timescales.

A Provider Assessment Document is used to assess willing Providers against a series of quality metrics.

Key Performance Indicator benchmarking documents have been devised to set standards across the local health economy. Provider performance and development is reported into and discussed at the monthly Infection Prevention and Control Committee (IPCC). Provider's performance is measured against Standards for Better Health, which is reported to the SHA and in turn to the PCT Board.

Issues raised within the Infection Prevention and Control Committee are discussed and actions formulated with defined timescales.

Breaches in targets for MRSA and Clostridium Difficile achievement are scrutinised within the IPCC. Providers are asked to submit a detailed action plan and decisions are then made within the commissioning team to address this.

2) As a provider of services how are you as a PCT ensuring that you are good practice in infection control?

All providers work to achieve both the Standards for Better Health and the Hygiene Code requirements. Performance is measured against the PCT local health economy performance tool.

The PCT (provider arm) has appointed an Infection Prevention and Control development coordinator to lead on the delivery of the PCT Health Care Associated Infection Plan and monitor progress and development within the PCT provider arm.

Infection prevention and control is included in induction programmes for all staff within the PCT. Best practice is shared across the local health economy and disseminated through the IPCC.

Root cause analysis are undertaken for all MRSA bacteraemias to ascertain causative factors. Such cases are reported to and discussed within the local health economy Infection Prevention and Control Committee. Learning is then shared across the health economy.

Local community hospitals, Primary Care, and the home visiting services including intermediate care are taking the hand hygiene campaign very seriously.

3) How are the PCT dealing with healthcare associated infections as a public health issue?

There is now statutory reporting of MRSA and Clostridium Difficile to the Health Protection Agency and public health reports this to the local health economy wide Infection prevention and Control Committee.

There are specific targets for both MRSA and C. Difficile for all acute trusts. Any rise in infections the Health Protection Agency visit to advise. If changes are not made then the health commission are asked to investigate.

Any outbreaks are reported to the public through press releases.

The PCT support all providers of services across the local health economy to meet their trajectories for both MRSA and Clostridium difficile.

Acute Trusts must demonstrate a reduction in the numbers of Clostridium difficile by 25% for 2007 and by 30% for 2008 and an overall 50% reduction for MRSA.

South East Coast Strategic Health Authority injected extra funding for developments in infection prevention and control, part of which is being used to develop projects that address public health issues.

The PCT is to undertake a hand hygiene campaign for the community and community hospitals. We are currently looking to developing communication systems to increase public understanding and confidence within local health care systems. The PCT is leading on the making of a hand hygiene video to reinforce our commitment to promoting safe practice and indeed for empowering the public to challenge practices within healthcare organisation. The PCT will work in close collaboration with Trusts, Kent County Council and the National Patient Safety Agency to achieve this.

4) What work are you doing as a PCT with the GPs to reassure the public that the acute hospitals and community hospitals are safe?

GP services are currently being assessed using Standards for Better Health and the Quality and Outcomes Framework.

A key priority is to work with General Practice, PCT teams and the acute Trusts to develop an antibiotic benchmarking policy, together with a performance monitoring tool to ensure treatment is both appropriate and safe.

The PCT is sending out a letter to all GP Practices to remind them about appropriate prescribing of antibiotics and their role in the prevention of infection that could be acquired in both community and district hospitals.

There is GP representation at the local health economy Infection Prevention and Control Committee to support some of the work across patient care pathways.

Briefing note: November 2007

Continuing to reduce the risk of infection in eastern and coastal Kent

Eastern and Coastal Kent PCT is determined to achieve excellence in the care of all patients in our care and in the practice of infection control. In order to provide the best standards of privacy and dignity and to minimise any chance of infection spreading should such an infection occur, we have decided to increase the space between beds in three of our community hospitals.

The Community Hospital Managers have undertaken a bed audit and risk assessment based on guidance from NHS Estates which recommends that in ideal circumstances 3.6 metres space should be available between the middle of one bed and the middle of the next. Three of our community hospitals do not currently meet this recommendation and as a result the PCT will be reducing the number of beds in Faversham, Deal and at Whitstable and Tankerton. Over time, as we are able to so when they become empty, we have decided to remove four beds in Faversham, 10 beds in Deal and one bed in Whitstable and Tankerton. In Herne Bay, Sittingbourne and Sheppey we already achieve the best practice standard for space between the beds. At the same time as removing these beds, we will be opening more beds at Herne Bay and at Sheppey Hospital so that overall the same number of beds will be available to our patients.

We will of course strive to ensure that when people are admitted to a community hospital it will be as close to home as possible. However, if travelling were to cause hardship due to this action, we will look for alternative accommodation within a local residential or nursing home.

“The more space we can provide between beds in our hospitals the better care we can provide for our patients” says Sarah Andrews, Director of Nursing for the PCT.

“Space is essential if we are to provide the best possible care and if we are to ensure scrupulous conditions of hygiene. Our community hospitals are a valuable resource for our community services that already achieve high standards. We are now taking this a step further so that the very best of modern care can be delivered.”

This action is happening alongside a range of others to further reduce the likelihood of infection, including a comprehensive hand hygiene campaign, advice for staff and hospital visitors about their responsibilities towards reducing the risk of spreading infection, a revised uniform policy and exploring more effective methods of deep cleaning.

For more information or answers to any questions you may have can be obtained from Communications via email communications.team@shepwaypct.nhs.uk or on 01227 791165.

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7-8 Ambley Green
Bailey Drive
Gillingham Business Park
Gillingham
Kent ME8 ONJ

21 November 2007

Mr Paul Wickenden
Legal & Democratic Services
Kent County Council
Sessions House
County Hall
Maidstone
ME14 1XQ

Dear Paul

Thank you for your letter of 14 November to Medway PCT asking for written evidence on the questions that you forwarded to us on 15 November. We hope that the answers will be useful to the committee and can confirm that Martin Riley, Director of Provider Development and Barbara Edwards, Infection Control Adviser for the PCT will be available to answer questions on the 27th November.

(i) As commissioners how do you quality assure the care the Primary Care Trust are purchasing on behalf of the patient?

The PCT is working with a number of providers on assuring quality.

- The PCT has a contract in place with Medway Maritime Hospital based on an NHS contract for Acute Trusts. The contract has a section that relates to clinical key performance indicators. The PCT are able to monitor performance of the trust in a number of ways.
- The PCT has set up a Health Economy Infection Control Committee which meets monthly (Terms of Reference attached). This committee includes PCT commissioners who are able to identify any issues arising from the committee that need to be linked to wider commissioning issues for the PCT.
 - The committee reviews and monitors compliance with the NHS Code of Practice / Hygiene Code 2006. Reviews Healthcare Associated Infections (HCAI) data identifying trends and actions and ensure compliance with the actions.

- The committee will also review results of the Patient Environment Action Team (PEAT) systems.
 - The Committee specifically monitors MRSA Bacteraemia and C difficile numbers against targets in addition to monitoring of the Saving Lives programme audit analysis, reviewing infection control policies across the range of providers.
- The PCT has formal *monthly Performance Management meetings* between the Trusts CE/Director, the PCT CE/Director and the SHA and infection control is a standing item on the agenda at this meeting.
 - Any complaints that we are informed of or issues raised through the Patients Forum, we investigated and actions sought from the provider.
 - The Acute Trust has recently undertaken a Department of Health MRSA Improvement Review and developed an action plan. This is being performance managed by the PCT.
 - The PCT is also working with the Acute Trusts and its PCT provider services to review antibiotic prescribing to ensure compliance with antimicrobial guidance.
 - Provider performance is measured against Standards For Better Health guidance for compliance against the safety domain which includes infection control.
 - The PCT has put in place working with Commission for Social Care Inspectorate (CSCI), Medway Council and the Healthcare Protection Unit a formalised notification advice and audit systems for Independent Care Homes for infections.
 - The Director of Infection Prevention and Control is reporting quarterly to the PCT Trust Board on Medway compliance with infection control.
- (ii) **As a provider of services how are you as a PCT ensuring that you are observing good practice in Infection Control.**
- The PCT Provider Services are setting up an internal Infection Control Operational Group to review infection control standards within provider services. This will report to the PCT Clinical Governance Committee and provide evidence to the Health Economy Infection Control Committee.
 - The PCT is signing up to the Essential Steps Department of Health Framework to ensure that good practice with infection control is implemented and audited. Infection control advice is provided by the PCT Infection Control Adviser and supported by the Kent HPU.
 - Infection Control is identified as mandatory for training of all staff and the Link Practitioners are working in all service areas with the Infection Control Adviser.

Infection Prevention and Control is included in the induction programme for all staff within the PCT.

- Provider Services have reviewed their in patient antibiotic policy to bring it in line with Medway Maritime Hospital to ensure consistency of antibiotic prescribing between Medway Maritime Hospital and the PCT.
- Hand hygiene audits are undertaken by provider services
- Any incidents involving infection control are monitored and followed up through the IRIS reporting process.
- Gateway Department of Health funding is being used to recruit an additional Infection Control Nurse who will support the PCT Infection Control Adviser in ensuring ongoing effective delivery of infection control within Provider Services in addition to provider support to external providers such as Care Homes.
- Cleaning audits are undertaken of all provider premises. The results are reported to the Trust Board through the DIPC.
- All in patient units for Provider Services have to undertake PEAT inspections.

(iii) How are the PCT dealing with healthcare associated infections as a public health issue?

- The PCT has a Memorandum of Understanding with the Health Protection Agency.
- The Medway Health Economy Infection Control Committee receives reports on outbreak numbers and actions reported by the Health Protection Agency. This would include where appropriate information shared with GPs and the public.
- Mandatory reporting is in place for all notifiable diseases. The Health Economy Infection Control Committee considers progress against C Diff and MRSA trajectories across the Health Economy.
- Outbreaks are reported to the SHA and Health Protection Agency.

(iv) What work are you doing as a PCT working with GPs to reassure the public that the acute hospitals and community hospitals are safe?

- The PCT are reviewing the antimicrobial prescribing patterns of GPs within the PCT. This is considered as part of a training package for practices locally. In addition the PCT is planning to undertake a wider training programme on infection control with all practices in the new year.
- The PCT monitors the achievements by GPs against the Quality and Outcome Framework (QOF).

- The PCT and the Acute Trust are providing information to the local press on progress and developments with infection control. A joint Infection Prevention and Control campaign is being planned on an ongoing basis.
- The PCT Director of Infection Prevention and Control and the Infection Control Adviser have met with the Chair of the PCT Patient Forum to update him on progress with infection control within Medway and to ask if there is any further information the Patients Forum would like.

Yours sincerely

A handwritten signature in black ink that reads "Marion Dinwoodie". The signature is written in a cursive style with a long, sweeping underline that extends to the right.

Marion Dinwoodie
Chief Executive

Medway PCT
Infection Control and Decontamination Committee

Terms of Reference

Aims

To commission and provide health care services which can demonstrate compliance with the Code of Practice and reduce Health Care Associated Infections (HCAI) to the lowest possible rate across the local health economy.

To identify trends, monitor progress against action plan and make appropriate recommendations to reduce the level of HCAI across the local health economy.

- 1) Performance monitor the implementation of the Improvement Plan for HCAI across the local health economy.
- 2) Review action plan ensuring that all HCAI policy development is incorporated.
- 3) Scrutinise and challenge commissioned services Annual Infection Control Programme and performance manage against this.
- 4) Set and manage local performance standards and those set within the Code of Practice and Standards for Better Health.
- 5) Receive reports on audits, surveillance, root cause analysis trends, training, education, and outbreaks to inform the commissioning decisions.
- 6) To monitor and act upon reports from the Immunisation and Vaccination sub committee.
- 7) Provide leadership in reducing HCAI across the local health economy in the development best practice.
- 8) To receive reports on standards for decontamination compliance, across all provider services, from the decontamination sub group.
- 9) Report to the Clinical Governance sub committee
- 10) Review terms of reference in 6 months

Frequency of meetings

Monthly

Membership

Executive Nurse Medway PCT/DIPC - Chair – Pippa Barber

Director of Provider Development Medway PCT - Martin Riley

Senior Specialist Nurse/Manager, Kent Health Protection Unit – Rita Simmons

Acting Director Public Health, Medway PCT – Sally Ann Ironmonger

Professional and Clinical Lead, Medway PCT – Val Clarke

Lead for Infection Control, Medway PCT – Barbara Edwards

Director of Nursing Medway Maritime Hospital – Jacqueline McKenna

Lead for Infection Control Medway Maritime Hospital – Linda Dempster

Asst Director of Commissioning Medway PCT – Alison Burchell

Social Care Commissioning & Voluntary Sector Manager, Medway Council – Genette Laws

Infection Control Manager, South East Coast Ambulance Service – Brian Pullen

Kent & Medway Partnership Trust, Infection Control Lead – Nicola Dawber

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Maidstone and Tunbridge Wells Hospitals

Patient Public Involvement Forum



Maidstone & Tunbridge Wells NHS Trust PPI Forum Comments on Annual Health Check

We wish to preface our comments on specific standards with some general observations.

Firstly, we are encouraged by and supportive of the steps taken by the Trust to engage clinicians more closely in issues facing the Trust, in particular, through the new Governance and Risk Committee. This is an important and significant development.

Secondly, we fully recognise the financial pressures and constraints under which the Trust is operating. In these circumstances it is difficult, and a matter of judgement, what cost savings can be made without impairing patient care.

Thirdly, we believe Trust Management is aware of the issues that confront the Trust and the steps needed to address those issues. The challenge for the Trust is to implement and embed the changes required quickly, something it has been unable to do in the past.

Finally, there have been a number of occasions during the year when the Trust omitted to inform the Forum, in a timely manner, of changes or new initiatives which might impact patient care. We would welcome the opportunity to be consulted in advance.

We have the following comments on specific standards:-

1. Core Standard C4

The outbreaks of C.Diff and the incidence of MRSA call into question the adequacy of the Trust's safety systems.

The Forum has pressed repeatedly for improved hand hygiene and enforcement of procedures with disciplinary measures if necessary. In addition the Forum has

All correspondence should be addressed via our Forum Support Organisation:

Kent & Medway Networks Ltd
Office Hours: Monday - Friday 8.30 am - 4.30 pm
Unit 24, Folkestone Enterprise Centre, Dealway Road, Folkestone, Kent, CT19 4RH
Tel No: 01303 297050 Fax No: 01303 297069 Email: janine@kmn-ltd.co.uk

questioned the under-spend on nursing budget in the context of the need for more nurses to relieve pressure on existing staff. We are heartened that the Trust at last appears to have taken steps to address these concerns.

2. Core Standard C6 and D2c

We question whether the level of collaboration between the Trust and the PCTs – West Kent PCT in particular – is sufficient to achieve the best outcomes for users. We see this as primarily an issue for the PCT which we expect to show strategic leadership.

It appears that the Trust's financial problems are exacerbated because levels of service commissioned by the PCTs fall short of what is required and that effective management of demand for certain services is lacking. Instances which evidence this include the number of operations cancelled due to emergency admissions, apparently substantially higher than at other trusts, and waiting times for radiotherapy. It is our understanding that the Trust has been unable to provide radiotherapy within nationally agreed timescales because of insufficient commissioning by PCTs.

We would welcome evidence that the PCTs and the Trust recognise these as problems for which they jointly share responsibility.

3. Core Standards C14c and C17 and Development Standards D8 and D11

The Picker Annual Inpatient Survey based on responses from 478 patients shows the Trust to be significantly worse than Average on 40 out of 79 questions. It also shows the Trust to be significantly worse compared with the results of the previous year on 5 questions and significantly better on only 1 question. An area of particular concern identified by the surveys is that of communication between doctors and patients, nurses and patients and doctors and nurses.

We question whether the Trust has made sufficient efforts to address issues raised by past surveys. In particular, we are unclear how widely the results were disseminated and considered within the Trust.

4. Core Standard C21

The Trust's hospitals are not well-designed or easy to maintain given the age and fabric of some of the buildings.

We do not believe the Trust satisfies the National Specifications on Cleanliness. The Trust employs a Quality Monitoring Officer to monitor adherence to National Standards. Over the period under review, her reports have noted consistently a failure to meet required standards in various areas at Kent & Sussex and Pembury hospitals, including Very High Risk and High Risk areas. There are no reports for Maidstone since there is no Quality Monitoring Officer for that site.

It appears that the Trust may have placed reliance on PEAT inspections for monitoring cleanliness. It is our understanding that PEAT has different criteria and does not have the frequency, range or depth required by the National Specifications and is, therefore, inadequate.

We are aware that, due to concerns over the existing process and revised National Specifications, a new and more robust process was agreed on the 9 February which is intended also to cover Maidstone hospital. However, as of 31 March, we understand that this had still not been introduced.

David Herbert
Chair – Maidstone and Tunbridge Wells PPIF
April 2007

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