KENT COUNTY COUNCIL

NHS OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the NHS Overview and Scrutiny Committee held in the Council Chamber at Sessions House, County Hall, Maidstone on Friday 8 June 2007.

PRESENT: Mr A R Chell (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr M J Angell, Mr A D Crowther, Mr D Daley, Mr D A Hirst, Mr G A Horne, MBE, Mr I T N Jones (substituting for Ms A Harrison), Mr J London (substituting for Ms B Simpson), Mr W Newman (substituting for Mrs E Rowbotham), Mr M Northey (substituting for Mr R Tolputt).

OTHER MEMBERS PRESENT: Mr G Gibbens, Mr P Lake.

OBSERVERS: Mr R Appadoo (West Kent Primary Care PPIF), Ms C Swann (Kent and Medway Mental Health and Social Care PPIF), Mr D Easton (East Kent Hospitals PPIF) and Mr J A Ogden DL (Chairman of KCC Standards Committee).

IN ATTENDANCE: Dr D Turner, Research Officer to the NHS Overview and Scrutiny Committee, and Ms D Fitch, Assistant Democratic Services Manager (Policy Overview).

UNRESTRICTED ITEMS

28. Membership

It was noted that Mr J A Davis had replaced Mr C Hibberd, and Ms B J Simpson had replaced Mrs P A V Stockell as Members of the Committee.

29. Minutes

RESOLVED that the Minutes of the meeting held on 11 May 2007 were correctly recorded and that they be signed by the Chairman.

30. Matters arising relating to the Minutes

1. Business Plan for the Private Finance Initiative (PFI) – Pembury (Minute No. 25 of 11 May 2007)

(i) Mr Crowther stated that there was a chapel on this site that had served the hospital for many years. It was proposed to demolish this and use the space for car parking. English Heritage had now listed the building and he believed that the Committee should express its support for the retention and protection of this building. The Chairman said that clarification would be sought from the Trust and fed back to Members.

2. Maidstone and Tunbridge Wells PPI Forum

(ii) Mr Fittock mentioned a letter from the Maidstone and Tunbridge Wells PPI Forum relating to the meeting on 11 May 2007 and asked how the Committee would be dealing with it. Mr Chell stated that he had not seen the letter but that he would talk to Mr Fittock outside of the meeting about this.

3. Local Involvement Networks (LINks)

(iii) Mrs Angell stated that it was important for the Committee to be kept informed about developments regarding the introduction of LINks.

(iv) Mr Chell confirmed that there would be a full report on LINks on the agenda of the July meeting.

4. Community hospitals in west Kent

(v) Mrs Angell expressed regret that a stakeholder meeting in relation to the review of community hospitals in west Kent had been held on the afternoon of the County Council meeting on 17 May and, therefore, it had been difficult for Members to attend. Mr Chell stated that the community hospitals review would be on the agenda for the next meeting of the Committee. The good news arising from the review was that it was planned to retain all the community hospitals in west Kent.

31. Urgent Business

The Chairman stated that he was of the opinion that the committee should receive representations about the renaming of the Minor Injuries Unit at Edenbridge and District War Memorial Hospital as a matter of urgency, as this change had already been made and, therefore, it was not appropriate to leave this item until the next meeting.

32. StourCare Out-of-Hours service

(Peter Robinson, Eastern and Coastal Kent Primary Care PPIF, Jayne MacDonald, Head of Primary Care and Community Contracts, and Lynne Selman, Director of Citizen Engagement and Communications, Eastern and Coastal Kent PCT, were in attendance for this item)

(1) Mr Robinson set out the background to the StourCare Out-of-Hours service and the change to the contract, which had been the subject of a recent review after six months of operation. He stated that joint working between the Forum and the NHS Overview and Scrutiny Committee had led to a satisfactory outcome. He made the Committee aware that there would be a full review of the Out-of-Hours Service in late 2007 or early 2008 for the PCT area and the existing contract had, therefore, been extended to the end of May 2008. He stated that he believed the PPIF and the NHS Overview and Scrutiny Committee should be involved in this review at an early stage.

(2) Ms Jones stated that, as a result of the work of the PPIF, there had been a renegotiation of the contract between the PCT and StourCare and a satisfactory result for the public in the area had been achieved. She highlighted the fact that the PCT was part

of the national pilot for the Urgent Care Review programme. Work on this had started and the PPIF had a representative on the Project Board.

(3) In relation to engaging with the public and organisations, Ms Selman stated that the PCT was setting up a "virtual panel" across the PCT area to use for consultation for the Urgent Care pilot. This was a key part of their ongoing work.

(4) The Chairman expressed the Committee's thanks to Mr Robinson for the detailed piece of work that the PPIF had undertaken and stated that this was a good example of PPIFs being the "eyes and ears" of the NHS Overview and Scrutiny Committee.

(5) RESOLVED that the update on StourCare Out-of-Hours Service be welcomed and noted.

33. Renaming of the Minor Injuries Unit at Edenbridge and District War Memorial Hospital

(Dr A Russell, Chairman of the League of Friends of Edenbridge and District War Memorial Hospital, and Julian Ross, Director of Public Engagement and Sharon Jones, Director of Community Services, West Kent PCT, were in attendance for this item)

(1) A petition from the League of Friends of Edenbridge and District War Memorial Hospital regarding the Minor Injuries Unit at the hospital (attached as Appendix 1 to these Minutes) was tabled, along with information supplied by West Kent PCT (attached as Appendix 2). The Chairman welcomed Dr Andrew Russell to the meeting and invited him to address the Committee. Dr Russell made the following points:-

- The Minor Injuries Unit at Edenbridge had been a nurse-led unit for the past nine years and had worked satisfactorily.

- On 24 May the West Kent PCT at their Board meeting had decided, on safety grounds, that the unit should be renamed a "Treatment Clinic" with immediate effect.

- A consultation period on the future of the Clinic was due to run from 2 July for three months and he expressed concern that the name change had occurred one month before the official consultation period had started.

- The PCT had given the reason for the renaming as the low throughput of patients, which did not give staff adequate exposure to all types of case for the safety of patients.

- He made the point that there had never been any question of poor safety; the unit had a 100% safety record, with no complaints.

- He highlighted the important support given to the unit by Dr Julian Webb, the A&E consultant who covered this unit and others in the area. He audited the unit's work regularly and visited the unit weekly to discuss the work with nurses; in the view of Dr Webb, the unit was safe.

- The nurses at the unit rotated with colleagues at the Sevenoaks Hospital Minor Injuries Unit and, therefore, saw the same case-mix.

(2) In conclusion, Dr Russell stated that he believed that the name change at this time, before a consultation on possible closure of the Unit, would lead people to believe that the Minor Injuries Unit had already ceased to exist. This would prejudice the consultation that was about to take place and, therefore, was unfair. He suggested that the question of the final closure of the Unit might be a subject for further consideration by the NHS Overview and Scrutiny Committee.

(3) Ms J Ross was invited to speak and stated how disappointed she was that the good news in relation to community hospitals had been overshadowed by more minor issues. She made the following points in relation to the Minor Injuries Unit at Edenbridge:-

- The PCT had taken legal advice and they had the right to change the name of the unit.

- Out of the 11 patients a day that were seen in the unit, 50% were sent by GPs for re-dressings or Electrocardiograms (ECGs). ECGs had actually already been paid for in the General Medical Services contract and did not need to be provided in a Minor Injuries Unit.

- The issue was not the safety of the current service. Rather, there was a risk in retaining the name “Minor Injuries Unit” that, if a patient were to present with a serious injury, the service would not be able to cope, given that it was not used to such cases. The name “Treatment Clinic” was a more accurate reflection of the service actually being provided.

- The PCT would be going out to consultation on the future of the renamed Treatment Clinic.

- The PCT had data from 2004 and the numbers using the unit had not changed. Although it had the support of the local community, it was not a well-used facility.

- It should be noted that the outcome of the review of community hospitals was: to keep all six hospitals; to re-open those beds that had been closed in recent years; and to bid for national capital funding. This new investment would include modernising the x-ray facilities at Edenbridge.

- Another contentious issue that had arisen was the matter of possibly transferring the Renal Dialysis Unit to Tonbridge Cottage Hospital. This would be going out to consultation. On the whole, the outcome of the community hospitals review was very good news – and the controversy around the small changes at Edenbridge and Tonbridge should not be allowed to obscure this.

(4) Ms S Jones stated that she had a clinical background and a passion for community hospitals. She corrected the statement made by Dr Russell regarding Dr Webb, the A&E consultant. Dr Webb was not clinically in charge of the Minor Injuries Unit at Edenbridge:

he only audited clinical notes, not the actual work of the unit. Only 9–11 patients a day used the unit, and 50% of them attended to have their dressings changed; this was not a proper workload for qualified nurses. There was not the throughput of patients at Edenbridge to consolidate training and there were problems getting nurses to work there. She said, from a personal point of view, that if she were a Nurse Practitioner she would not stay in that unit. There was actually only one member of staff who rotated between Edenbridge and Sevenoaks Hospital. She stated that there was no one definition of a Minor injuries Unit. When the Healthcare Commission and PriceWaterhouseCooper had audited emergency units, they had broken them down into three types. Type 1 was a full A&E unit; Type 2 saw at least 20,000 patients a year; and Type 3 saw at least 10,000 patients a year. Edenbridge was seeing just 3,000 patients a year and, as such, did not even count as a Type 3 facility. In changing the name of the unit at Edenbridge, the PCT was merely calling it what it really was – which was a Treatment Clinic.

(5) The Chairman stated that he welcomed the result of the community hospitals review overall. Members made a number of points in response to what they had heard and Ms Ross responded.

(6) RESOLVED that

(i) the presentations and discussions be noted;

(ii) the next meeting of the NHS Overview and Scrutiny Committee would consider West Kent PCT's community hospitals review in its totality.

34. Vice-Chairman in the Chair

Mr Fittock, Vice-Chairman, took the Chair for the remainder of the meeting, as the Chairman had to leave early, for which he apologised.

35. General Pharmaceutical Services

(Mike Keen, Chief Executive of the Kent Local Pharmaceutical Committee, Professor John Butler, the Chairman of Kent and Medway Pharmaceutical Regulations Committee, Julia Ross, Director of Civic Engagement, West Kent PCT, Jayne Macdonald, Head of Primary Care and Community Contracts, Eastern and Coastal Kent PCT and Anne Bretherton, Chief Pharmacist, West Kent PCT, were in attendance for this item)

(1) The Chairman welcomed Mr Keen to the meeting and invited him to give his presentation. Mr Keen's presentation (attached as Appendix 3) covered the following:-

- What is a Local Pharmaceutical Committee?
- Where does it draw its powers from?
- How does pharmacy help to improve services to patients?
- How does pharmacy help public health?
- What is control of entry?

(2) Professor Butler from the Kent and Medway Pharmaceutical Regulations Committee, the body responsible for awarding contracts to applicants for pharmacies,

explained that the number of pharmacies in Kent and Medway over the past 15 years had remained approximately the same. However, the location of the pharmacies had changed; and large pharmacy companies had taken an increased share of the market. There was a tendency to have more pharmacies in supermarkets and also to move pharmacies out of high streets and to co-locate with doctors' surgeries, which ran in parallel with the increase in the redevelopment/relocating of doctors' surgeries. Professor Butler explained that in rural areas under regulations it had been possible since 1982, with consent, for doctors to dispense, as often in these areas it was not commercially viable for pharmacists to operate.

(3) Ms Bretherton stated that in Kent the PCTs were looking at formally setting in place a Clinical Governance Framework based on the national programme. East Kent PCT had the responsibility to carry out the performance monitoring visit. In West Kent every pharmacy had a visit and pharmacist would go on the visit with a lay Member. This visit would be pre-arranged and anything arising from it would form part of an action plan. PCTs gave pharmacies help and support so that they could address any issues identified as requiring action. In relation to a question on counterfeit drugs, she stated that the PCT had no influence as this was a national problem. In relation to unused drugs, Ms MacDonald and Ms Bretherton stated that they headed teams of Prescribing Advisors who visited GP practices and supported GPs. Members asked a number of questions, and received responses, regarding the following points:-

- As regards the regulation of pharmacists, it was explained that they had a professional code of ethics and that their professional body, the Royal Pharmaceutical Society of Great Britain, played a regulatory role (although the regulatory and representative functions of the Society were to be separated under planned reforms to the regulation of healthcare professionals).

- All pharmacies had to agree their opening hours with the contracting PCT. New pharmacies had to specify their total opening hours and their core contract hours, which had to be at least 40 hours per week. When the Pharmaceutical Regulations Committee received an application, the applicant usually offered to open in excess of 40 hours, but contractors were able to withdraw from any commitment to provide additional hours (with three months' notice). The Committee could only accept the hours that were being offered – if the pharmacy did not offer to open on Saturdays or Sundays, or in the evening, then they could not be forced to do so. Given a choice of applicants in the same area, the Committee would choose the one offering the greater coverage, other things being equal.

- One of the problems with the regulatory system was that it was reactive. Pharmacists chose where they wished to provide services and there was no direct means of directing provision at underserved areas. PCTs worked to try and develop local pharmacy services where there were gaps. There were certain areas where pharmacists would not find it attractive to open up a pharmacy; on the other hand there were others areas that were "over-pharmacied" – for example, Westwood Cross Retail Park in Thanet, which did not necessarily need the four pharmacies that it had.

- The Galbraith Inquiry, which was looking at the NHS pharmacy "control of entry", was due to report before the end of June (although the report itself might not actually be published). This could lead to further reforms in the "control of entry" mechanism.

- The provision of "advanced" and "enhanced" services by community pharmacists was a cost-effective way of providing medical help and advice in the community.

- PCT prescribing advisors went round to every GP practice, to provide unbiased evidence on drugs, thereby acting as a counterweight to the targeting of GPs by pharmaceutical companies. GPs valued this advice.

(4) The Chairman thanked the presenters and representatives from the PCTs for attending the meeting and giving Members an interesting overview. He stated that the NHS Overview and Scrutiny Committee hoped to be able to contribute to the discussion about the future of the "control of entry" regulations following the Galbraith Inquiry.

(5) RESOLVED that the presentations and discussions be noted.

36. Infection Control

(Rose Gibb, Chief Executive, Amy Page, Service Improvement Director, Maidstone and Tunbridge Wells PCT, James Nash, Director of Infection Prevention and Control, East Kent Hospitals NHS Trust, Mark Devlin, Chief Executive and Iris Smith, Director of Infection Control, Dartford and Gravesham NHS Trust and Helen Goodwin, Head of Governance and Risk with Kath Hughes, Modern Matron for Infection Control, Medway NHS Trust were in attendance for this item)

(1) The Committee received presentations from each of the Acute Hospital Trusts across Kent and Medway regarding the processes and procedures that they had put in place concerning infection control and the incidence of hospital-acquired infection within each Trust (attached as Appendix 4). Members' questions were answered by PCT colleagues.

(2) In response to a question from a Member, Ms Hughes undertook to provide Members with data showing the numbers of patients that had contracted *Clostridium difficile* and MRSA, expressed as a proportion of the total number of patients treated.

(3) RESOLVED that health colleagues be thanked for their informative presentations.

37. Public Health Strategy for Kent

(Meradin Peachey, Director of Public Health, and Mark Lemon, Policy Manager, KCC Department of Public Health were in attendance for this item)

(1) Mr Gibbens introduced the latest draft of the Public Health Strategy for Kent, which had been circulated to key stakeholders for comment and discussion before being taken to a meeting of the full County Council on 24 July 2007. Ms Peachey stated that she was pleased the Committee were looking at this. It was an opportunity for the PCTs and KCC to clarify what they meant by public health. The strategy set out six key outcomes for all partners to focus on. Some of the targets were already part of the Local Area Agreement

for Kent. Mr Lemon emphasised that the document was work in progress and, even when agreed, it would still be work in progress, as the strategy would continue to evolve and develop. After the County Council meeting on 24 July 2007 the document would go out to public consultation.

(2) Members made the following comments on the document:-

- It would be helpful to have more discussion in the document on food – for example, the importance of adequate information being shown on food packaging, so that informed choices could be made; and also the need for information about how to find healthy, local food.

- In relation to obesity, the "pleasure principle" was important: a healthy diet and lifestyle needed to be presented as enjoyable.

- It was noted that KCC's Environment and Regeneration Directorate had set a good example of encouraging staff to take exercise in an enjoyable way.

- The Healthy Schools programme was acknowledged as another good example of promoting healthy lifestyles.

- The Alcohol Abuse Select Committee's recommendations would feed into the next version of the Strategy, which was due to be published in October 2008.

- Members were pleased to see that mental health was included in the document.

- It was noted that a lot of work had been done to reduce teenage conception rates.

- Members who sat on Local Strategic Partnership Boards would find it helpful to have advice about how to challenge other organisations to ensure that they were working along the lines set out in the strategy. It was noted that once the document had been agreed, there would be discussions with the Local Strategic Partnerships and district authorities.

- The challenges around health inequalities were starkly illustrated by the different life-expectancy rates found in geographically adjacent wards in some parts of the county.

- It would be useful to have a map of the county illustrating the different indices, so that the various aspects of health inequalities could be visually presented.

- It was noted that Environmental Health, which was a district council function, was key to public health – but it was important to look at major public health issues where all local authorities could make a big difference to a large number of people. One of the main issues that district councils wanted action on was air-quality improvement.

- It was noted that the County Council was a major player in relation to public health and had the opportunity to have a very powerful lobbying voice but it was important to be very careful about which issues were selected for lobbying.

- It was suggested that establishing "excellence in public health" awards for organisations could be considered.

(3) An undertaking was given that as part of the consultation on this document, it would go to PPIFs.

(4) RESOLVED that the latest draft of the Public Health Strategy for Kent, and comments made by Members of the Committee, be noted.

38. Fit for the Future - Update

(1) Tabled at the meeting was a paper from Ms J Ross, Director of Civic Engagement for West Kent PCT, which set out the current situation regarding Fit for the Future (attached as Appendix 5). Work on Fit for the Future was continuing, with the health economy across Kent and Medway on track to deliver a formal update for all stakeholders in July. At an extraordinary County Council meeting on 24 July 2007, the PCTs would have an opportunity to share more detail about next steps regarding Fit for the Future and there would be an opportunity for Members to speak to a range of clinicians and staff about the service improvements that were planned. Once the public document was published, there would the opportunity for a full discussion with the Committee and to discuss in detail about what would happen next in west Kent.

(2) RESOLVED that the report be noted.

39. Date of Next Programme Meeting

It was noted that the next programmed meeting of the Committee would be held on Friday 20 July 2007 at 10.00 am, with the venue to be confirmed.

Appendix 1

Petition to the NHS Overview and Scrutiny Committee of Kent County Council by the League of Friends of Edenbridge and District War Memorial Hospital

Subject of the Petition

1. On May 24 the West Kent Primary Care Trust Board announced that the Minor Injury Unit (MIU) at Edenbridge Hospital should be renamed as a treatment clinic with immediate effect for safety reasons;
2. The PCT should consult on the closure of the Treatment Clinic, currently the MIU
3. The PCT should provide a redressing clinic for 1 to 2 days a week for existing patients until such time as current patients are discharged when it should cease; and
4. That new redressing patients are redirected to other services.

In subsequent discussion with the PCT it is confirmed that the proposed new Treatment Clinic will continue to function as the present Minor Injuries Unit during the consultation period commencing July 2nd.

Thus the only substantive change during the consultation period is one of name but not of function. This change is recommended by the PCT Board on grounds of the alleged safety of the patients.

The patients are alleged to be at risk because the number of patients seen is deemed to be too low to maintain the competence of the Emergency Nurse Practitioners who staff the unit.

The grounds for objection to the name change before the consultation period

1. If the unit continues to function as previously during the consultation period there is no reason to change the name.
2. The present Minor Injury Unit has a 100% safety record and has been running as a nurse led unit since 1998. There has never been a complaint from the public.
3. The Consultant Surgeon in clinical charge is very supportive of the unit, visits weekly to see patients and staff and carries out a regular audit of the work.
4. No arguments of substance have been advanced to justify the renaming of the unit without due consultation.
5. The inevitable consequence of a change of name without consultation will lead members of the public to believe that the Minor Injury Unit has ceased to exist. This could adversely affect the availability and operation of the unit during the consultation period.
6. A proper consultation can only take place in relation to the entirety of the Board's decisions and not part only.
7. The name should not be changed prior to consultation taking place.

Dr Andrew Russell, Chairman, League of Friends

June 5 2007

Summary for NHS Overview and Scrutiny Committee 8 June 2007

Edenbridge Minor Injuries Unit

1. Definition of a Minor Injury Unit

There is no one definition of a Minor Injuries Unit. The Health Care Commission, working with Price Waterhouse Coopers, undertook reviews of all A&E units during 2004/5. These were mandatory audits carried out in acute trusts and PCTs that delivered significant levels of A&E services. This included nurse led Minor Injury units and walk in centres. They defined them as type 1, 2 and 3. Types 1 are those units with access to a full range of specialist departments, such as eye departments and children's A&E departments. Type 2 included Gravesham Community Hospital as it treats 20,000 patients a year whilst type 3 included those minor injuries units departments where the level of attendances were more than 10,000 patients per year. Whilst Gravesham and Sevenoaks MIUs were included in these audits the Edenbridge Minor Injuries Unit was excluded by the auditors as its attendances were deemed too low. Therefore, in this context, it can be argued that Edenbridge MIU was not regarded as an MIU.

The PCT has also assessed the access criteria and key characteristics of both minor injuries units and walk in centres across England. The following seem to be common features in all minor injury units and are also reflected in a Kings Fund Document on Walk in Centres.[1]

- *Initial Point of Contact*. Patients attend with new unforeseen health problems to the unit as the first point of contact. They are not referred to the unit by another service;
- *Immediate Access*. Patients require neither appointment nor referral;
- *No or limited follow-up care*. Treatment or advice is given for the presenting problem. If further care is needed patients are advised and redirected to attend the appropriate services;
- *No substitution of care*. Minor Injuries Units are not substitutes for care that is provided elsewhere.

2. Observations

It appears that the Edenbridge Minor Injuries Unit is working outside these criteria as patients are often referred to the unit, there are high levels of follow up care given and a primary care treatment/redressing service makes up a significant part of its activity. In all these aspects it is an outlier when compared to the other units. Therefore it is the PCT's view that this service is not serving its primary function of a MIU and should be renamed as a treatment/redressing service. This is not changing the service that it provides, but giving it a name that more accurately describes the service offered. Legal advice was taken prior to this action being instigated.

[1] Mountford L, Rosen R (2001) '*NHS Walk-in Centres in London An initial assessment'*, Kings Fund

3. Activity Levels

To provide care safely, health care professionals need to treat a critical mass of patients to be able maintain their skills. This argument would apply even in a health system with unlimited resources. The strategic review looked at the statistics for average attendances at a range of MIUs and took note of the Healthcare Commission report previously mentioned. On the basis of this and the professional judgement of the members of the management team responsible for clinical governance an MIU would need to see a minimum of 20-30 appropriate patients per day to be clinically viable. Edenbridge falls far short of these levels.

On average Edenbridge MIU sees between 9 – 11 patients a day. It has recently increased up to 14 patients a day but often a service under scrutiny will gain a temporary increase in activity. Up to 50% of these are for redressings that could be undertaken in a clinic or GP practice environment. These also do not require to be undertaken by an Emergency Nurse Practitioner. A local GP practice also sends patients to the unit for ECGs whereas it is more usual (and we would argue better for the patient) for these to be undertaken at the practice.

There has been concern that the opening hours limit the number of patients attending the unit. Modelling the peak activity times against the other three units the PCT manages (Sevenoaks, Gravesend and the Urgent Care Centre at Darent Valley Hospital) it is clear that mornings (9 – 12) and early evenings (4 – 7) are the busiest times. However looking at the data opening the unit for longer hours would only mean an increase of 3 – 5 patients a day and would require a disproportionate increase in staffing costs. Also as up to 50% of attendees at Edenbridge MIU are for redressings, only 1 to 3 of these patients would be true MIU attendees.

It has been suggested to the review team that the Minor Injuries Unit should provide leg ulcer care on behalf of a local practice. However, it is not normal practice for a minor injuries unit to provide this service and is outside the key characteristics of an MIU as described above. Redressings and leg ulcer care also do not require an emergency nurse practitioner. The Minor Injuries Unit would not be functioning appropriately.

Another issue that has been raised is that the unit is not effectively advertised and so unknown by the local population. This is incorrect. The unit is advertised on websites, in directories, and in neighbouring cottage hospitals. Also we had 140 people attending a stakeholder workshop in April who were all aware of the unit. The unit has come under scrutiny in 2002 and 2004 and on these occasions up to 4,000 people have expressed their views on the unit. Therefore it is well known locally.

Concerns had been expressed that the threat to the MIU was as a result of financial considerations. While it is the PCT's duty to ensure that it obtains value for money, as we have shown the reason for these recommendations are clinically based.

COMMUNITY HOSPITAL MIU ATTENDANCES

COMMUNITY HOSPITALS	ATTEND per DAY	ATTEND per MONTH	ATTEND per YEAR
Cromer Hospital	25	173	>9,000
Weymouth Hospital	43	1,333	16,000
St Albans Hospital	27	834	10,000
Orsett Hospital (Thurrock)	36	1108	13,300
North Cambridgeshire Hospital	33	1000	12,000
Royal Victoria Infirmary Newcastle	19	583	7,000
Trafford Hospital	27	808	9,700
Uckfield Hospital	33	1000	12,000
Crowborough Hospital	11	333	4,000
Chippenham Hospital	79	2416	29,000
Withernsea Hospital	16	475	5,700
Southmead Hospital (Bristol)	55	1666	20,000
Stratford (Warwicks) Hospital	23	691	8,300
Mendip Hospitals	26	800	9,600
Panteg Hospital (Gwent)	27	833	10,000
St Mary's Hospital (Portsmouth) [includes Walk-in Centre)	137	4166	50,000
Grinden Lane Primary Care Centre (Sunderland)	55	1666	20,000
Average (minus highest and lowest)	**35**	**1026**	**12773**

Figures assume opening 365 days per year.

8 June 2007

West Kent Community Hospital Review

Conclusions & Recommendations

1. Introduction

This document brings to the PCT Board the recommendations of the review team looking into the future of our Community Hospitals.

The purpose of this report is to provide a summary for the PCT Board concerning:

- THE OUTCOME OF THE REVIEW OF THE COMMUNITY HOSPITALS;
- TO OUTLINE THE STRATEGIC REVIEW DOCUMENT;
- The key recommendations of the review;
- TO SEEK APPROVAL OF THE RECOMMENDATIONS OF THE REVIEW.

The review has taken a long time to complete and it is recognized that this has been an unsettling period for stakeholders – particularly for staff who have been concerned about their futures. The executive management team is grateful for the contributions made by stakeholders and appreciative of the patience shown. There are some significant findings arising which would probably not have come to light without such a comprehensive exercise.

If the recommendations are supported, public consultation will be needed regarding:

- the closure of the Minor Injuries Unit at Edenbridge and District Memorial Hospital
- The reprovision of the Livingstone Hospital.

2. Summary of Key Proposals

- There is a significant degree of variation in practice throughout the 6 community hospitals. By adopting best practice consistently in all of them, particularly with a focus on active rehabilitation, we expect to make major improvements to the quality of care provided while at the same time improving efficiency and cost effectiveness.
- Based on an exercise to model the need for community hospital beds, the current open bed base would be sufficient were all community hospitals currently operating in the optimum way. However, since they are not, it will be necessary to reopen 18 beds in the short term to meet demand.
- As services evolve over the next 3-5 years, it will be necessary to reopen all the existing closed beds. While these will not all be required in the short term, we propose to open them in advance of need just as soon as the revised models of service are put in place and staff recruited.
- Not surprisingly, there is strong and widespread support within the area for our community hospitals. This is shared by our executive team as we see community hospitals as being a key component of our strategy to provide more care for people more locally.
- There is a need for all the hospitals in the south of the area to remain in place and continue to provide the majority of services as at present, though many of these

services will need to be modernized. We plan to make a number of investments in these to augment service.

- The fabric of the Livingstone Hospital in Dartford no longer meets modern requirements. A cost benefit analysis of refurbishment, reprovision or rebuilding will need to be done. The working assumption, subject to the cost benefit analysis and a full business case, is that reprovision may be the most likely option. However, the model of care provided at the Livingstone is excellent despite the challenging physical environment and will be retained in whatever the physical manifestation of the successor building.
- The MIU at Edenbridge Hospital is not clinically viable and should be closed.

3. Background & Context

The former PCTs in South West Kent and Maidstone Weald commissioned a review of their community hospitals in August 2006. The scope of the review originally focused on the four community hospitals in the south of the PCT area. However the formation of West Kent PCT on 1st October 2006 resulted in 2 more community hospitals being part of the PCT and so the scope was expanded. Originally, the review had an emphasis on the financial aspects of the community hospitals. However the brief was made more extensive and comprehensive to ensure that it was patient focused, considered quality, efficiency, effectiveness and sustainability of the services. These areas were placed at the heart of the review.

Most of the PCT's community hospitals pre-date the NHS and were established and/or have benefited from local benefactors. One was built with local donations as a war memorial. The PCT recognizes that its community hospitals have a civic importance for communities and that there is a strong sense of local ownership. However, the current locations reflect history rather than an overall plan. To some extent the services currently provided in community hospitals also reflect history as much as strategic planning.

4. Principles

THE FOLLOWING PRINCIPLES SET THE CONTEXT FOR THE REVIEW:

- West Kent PCT has a challenging financial position. The community hospital review is set within this context. Affordability and sustainability are key to the future of the community hospitals.
- However it was equally important to ensure that the following were also core to the review:

    - Safety & Governance
    - Quality
    - Efficiency
    - Quality of environment
    - Equity

Considerations of privacy and dignity, infection prevention and control were intrinsic to the Safety & Governance and Quality of environment.

5. Findings

5.1 Patients in community hospitals need high quality care that gets them well as quickly as possible to enable them to return home and to families. There are real dangers for patients remaining in hospital beds for longer than necessary. There are unnecessary variations in the average length of stay in the community hospitals. There is also potential to improve the efficiency in the use of community hospital beds by improving the average stay to 18 days. This requires an active rehabilitation focus which will be necessary if the PCT is to deliver the service modernisation required by our aspiration for many more people to be cared for in local settings. The current range varies from 26 to 18 days once long stay patients, such as continuing care patients, are excluded. Therefore the community hospitals need to improve efficiency and the throughput of patients to allow an increase in capacity. The PCT has a range of adult community health services that can provide care in the patient's home to allow this to happen. The PCT is also about to commence a review of adult community health services to ensure that it is well placed to support the improvement in the average length of stay in the community hospitals.

Not all of the hospitals were able to demonstrate that they have written and agreed admission and referral criteria, operational policies and a modern set of service standards. It is essential that each hospital has these written and agreed as well as a service level agreement against which they are performance managed.

Further work can also be undertaken to use the day centres more effectively and efficiently. This would mean that some patients could be offered day care to provide for their health needs rather than being admitted to a community hospital bed. This is particularly the case for those who need rehabilitative care.

5.2 The PCT needs to ensure that all the community hospitals implement the best practices as advised by the Department of Health and the Chief Nursing Officer of England. These include The Essence of Care and the Chief Nursing Officer's 10 Key Roles for Nurses and 10 Key Roles for Allied Health Professionals. 'The Essence of Care' has been designed to support the measures to improve quality set out in 'A First Class Service' and is an important part of implementing clinical governance at a local level. The benchmarking process outlined in 'The Essence of Care' helps practitioners to take a structured approach to sharing and comparing practice, and enables them to identify best practice and to develop action plans to remedy poor practice. The 10 key roles empower nurses and allied health professionals to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs. At present the implementation of both of these has not been systematic or even (in the case of the Essence of Care) implemented at all in some of the community hospitals. Implementation of these would help to ensure that the effectiveness and efficiency of the services is consistent across the PCT area. They would also be used as the tools that would ensure that the National Service Frameworks for Older People and Long Term Conditions are consistently implemented and evidenced in all the community hospitals. This would include the following:

- Performance data on activity, length of stay, skill mix levels, costs and standards of care;
- An agreed number of clinical and documentation audits;
- The clinical audits focussed upon evidence based care;
- A programme for the Essence of Care will be implemented and monitored;
- Yearly benchmarking exercises.

Each hospital should have its own governance framework based on the models that have already been put in place within the PCT. Each hospital should have its own governance group with terms of reference that covers:

- Patient care issues such as complaints, falls, infections;
- Essence of Care and other benchmarks
- Sharing lessons learnt from incidents elsewhere in the PCT;
- Checking that clinical supervision is in place and is being effective;
- Organization and delivery of care is evidenced based.

5.3 The 6 community hospitals have 177 beds of which 115 are currently open. The modelling has shown that if we were more efficient we currently have the correct number of beds open for the current and future population growth. Our future plans for services closer to local communities will allow for the prospect of the PCT making greater use of community hospital beds and facilities – providing the care is up to date, the standards are high and the costs are economic. Whilst we still have work to do to agree the balance between inpatient beds and other services it is clear that we need to provide these beds more efficiently. The modelling we have done is based on improving our average length of stay to 18 days. The current range varies from 26 to 18 days once long stay patients, such as continuing care patients, are excluded. Whilst the current model of care is not as efficient as it could be, it is clear that there is enthusiasm, vision, expertise and commitment by the staff in the care and expertise that they provide.

5.4 The PCT needs to make its services affordable and it appears that there are variations in the costs of running the community hospitals. This seems mainly to be a variation in skill mix with some hospitals having a high level of registered nurses and a low level of band 2 and 3 nurses i.e. support staff or “health care/rehabilitation assistants”. There are also apparent differences in the cost of hotel services and in particularly catering costs. It is planned that further work will be undertaken once the Head of Facilities management is in post to understand this across the three current providers within the PCT area.

5.5 Edenbridge Minor Injuries Unit

5.5.1 Definition

There is no one definition of a Minor Injuries Unit. The Health Care Commission, working with Price Waterhouse Coopers, undertook reviews of all A&E units during 2004/5. These were mandatory audits carried out in acute trusts and PCTs that delivered significant levels of A&E services. This included nurse led Minor Injury units and walk in centres. They defined them as type 1, 2 and 3. Types 1 are those units with access to a full range of specialist

departments, such as eye departments and children's A&E departments. Type 2 included Gravesham Community Hospital as it treats 20,000 patients a year whilst type 3 included those minor injuries units departments where the level of attendances were more than 10,000 patients per year. Therefore, whilst Gravesham and Sevenoaks MIUs were included in these audits the Edenbridge Minor Injuries Unit was excluded by the auditors as its attendances were deemed too low.

During this process the PCT has assessed the access criteria and key characteristics of both minor injuries units and walk in centres across England. The following seem to be common features in all minor injury units and are also reflected in a Kings Fund Document on Walk in Centres.[2]

- *Initial Point of Contact***.** Patients attend with new unforeseen health problems to the unit as the first point of contact. They are not referred to the unit by another service;
- *Immediate Access***.** Patients require neither appointment nor referral;
- *No or limited follow-up care*. Treatment or advice is given for the presenting problem. If further care is needed patients are advised and redirected to attend the appropriate services;
- *No substitution of care***.** Minor Injuries Units are not substitutes for care that is provided elsewhere.

5.5.2 Observations

It appears that the Edenbridge Minor Injuries Unit is working outside these criteria as patients are often referred to the unit, there are high levels of follow up care given and a primary care treatment/redressing service makes up a significant part of its activity. In all these aspects it is an outlier when compared to the other units. Therefore it is the PCT's view that this service is not serving its primary function of a MIU and should be renamed as a treatment/redressing service.

5.5.3 Activity Levels

To provide care safely, health care professionals need to treat a critical mass of patients to be able maintain their skills. This argument would apply even in a health system with unlimited resources.

The strategic review looked at the statistics for average attendances at a range of MIUs and took note of the Healthcare Commission report previously mentioned. On the basis of this and the professional judgement of the members of the management team responsible for clinical governance an MIU would need to see a minimum of 20-30 appropriate patients per day to be clinically viable. Edenbridge falls far short of these levels.

On average Edenbridge MIU sees between 9 - 11 patients a day. It has recently increased up to 14 patients a day but often a service under scrutiny will gain a

[2] Mountford L, Rosen R (2001) '*NHS Walk-in Centres in London An initial assessment'*, Kings Fund

temporary increase in activity. Up to 50% of these are for redressings that could be undertaken in a clinic or GP practice environment. These also do not require to be undertaken by an Emergency Nurse Practitioner. A local GP practice also sends patients to the unit for ECGs whereas it is possible that these could be undertaken at the practice.
There has been concern that the opening hours limit the number of patients attending the unit. Modelling the peak activity times against the other three units the PCT manages (Sevenoaks, Gravesend and the Urgent Care Centre at Darent Valley Hospital) it is clear that mornings (9 – 12) and early evenings (4 – 7) are the busiest times. However looking at the data opening the unit for longer hours would only mean an increase of 3 – 5 patients a day and would require a disproportionate increase in staffing costs.

It has been suggested to the review team that the Minor Injuries Unit should provide leg ulcer care on behalf of a local practice. However, it is not normal practice for a minor injuries unit to provide this service and is outside the key characteristics of an MIU as described above. Redressings and leg ulcer care also do not require an emergency nurse practitioner. The Minor Injuries Unit would not be functioning appropriately.

Concerns had been expressed that the threat to the MIU was as a result of financial considerations. While it is the PCT's duty to ensure that it obtains value for money, as we have shown the reason for these recommendations are clinically based. The Edenbridge service is not expensive to run and its unit costs are within the expected range.

5.6 There is an opportunity to provide a new service at Tonbridge Cottage Hospital for renal dialysis patients. This arises from the desire of Guys & St Thomas's NHS Trust to relocate from the Pembury site. Work has been ongoing to confirm the viability of this proposal, which also envisages an increase in provision from 14 to 20 units.

5.7 Edenbridge Hospital: The current x-ray facility is close to the end of its useful life and is in serious need of upgrading if the facility is to meet the challenge of expansion envisaged in this paper.

5.8 Livingstone Hospital: The service model in place at the hospital is modern and up -to-date and has been commended by the NHS National Director for Older People.

The main estates problems are concentrated at the Livingstone Hospital where inpatient facilities are based in the original hospital building. Although it is notionally a 38 bedded inpatient unit on the ground floor layout restricts the practical use to 30 beds and has done for some time. The inpatient unit was extended in 2002 but still provides cramped working and unacceptable patient care conditions. The beds are too close together and breach infection control guidelines. At present this risk is minimised by not using all the beds but even this measure is inadequate.

5.9 The NHS run day centres should be remodelled so that they maximise their potential. Any patient not requiring clinical care should be discharged. The current provision is focussed on social activities rather than healthcare.

5.10 Quality of the Environment

Despite the age of 5 of the 6 community hospitals, the problems associated with the current buildings are perhaps not as significant as may be expected. The overall backlog maintenance figure of £500k is relatively low. The bed pan washers in all of the community hospitals need to be replaced immediately. This is an urgent infection prevention and control measure.

Sevenoaks Hospital: The biggest cost will be the refurbishment of the kitchen at Sevenoaks. It is recommended that a decision as to whether to refurbish this or not will depend on the outcome of the review of the hotel services. A capital bid will be developed for 2007 to further develop and improve the infra structure of Sevenoaks Hospital.

6. Detailed Recommendations

6.1 The PCT should implement modern service models, appropriate to individual need across all sites.

6.2 All sites should develop a range of operational, clinical, professional and managerial policies consistent with national and local best practice.

6.3 Current beds should be reopened in a phased manner once new service models are in place and recruitment is completed. There are other dependent factors, for example, if we are successful in a capital bid for Sevenoaks Hospital we will need to keep some or all of the ward space available for decanting.

6.4 The PCT should aim to open the all the beds at Edenbridge and Hawkhurst Hospitals within three to six months. Seven beds at Sevenoaks will also be opened within the same timescale. The timetable for the remaining beds at Sevenoaks will be subject to the outcome of the capital bid (see below) as if that is successful it will be used as decanting space and in any event are not currently essential.

6.5 Further work should be undertaken within the next twelve weeks with Guys and St Thomas's NHS Trust on the development of the potential renal dialysis unit at Tonbridge Cottage Hospital. The trust is looking to relocate the unit currently at Pembury and increase the dialysis units from 14 to 20 for the local population.

6.6 A capital bid should be made in 2007 for Sevenoaks Hospital. The bid should aim for improvements in:

- outpatients
- ward areas
- rehabilitation facilities
- MIU

6.7 Edenbridge MIU:

- The MIU service should be renamed as a treatment clinic with immediate effect for safety reasons
- The PCT should consult on the closure of the treatment service, currently the MIU
- The PCT should provide a redressing clinic for 1 to 2 days a week for existing patients until such time as current patients are discharged when it should cease
- That new redressing patients are redirected to other services

6.8 Edenbridge X-Ray

A capital bid should be made to replace and upgrade the current x-ray facility.

6.9 Livingstone Hospital

Although the hospital has a successful model of care in place the building no longer meets modern requirements. A cost benefit analysis of refurbishment, reprovision or rebuilding should be commissioned.

The working assumption, subject to the cost benefit analysis and a full business case is that reprovision may be the most likely option with a dedicated 'Livingstone Unit' run and managed by PCT staff on the Darent Valley or Gravesham Hospital sites.

6.10 The PCT should work with local voluntary groups to reprovide current day centre activity.

6.11 The PCT should do further work to assess the value for money of the hotel services. The PCT has three providers and a significant variance in the costs of the service.

6.12 There is a mixed model of medical cover across the hospitals and the PCT should work with GPs and practice based commissioners on this service.

Appendix 3

Providing NHS Pharmacy Services in Kent

Michael Keen,
Chief Executive Kent Local Pharmacy Committee

Local Pharmacy Committees

Topics I intend to cover today:

- What is a Local Pharmaceutical Committee?
- Where does it draw its powers from?
- How does pharmacy help to improve services to patients?
- How does pharmacy help public health?
- What is "Control of Entry?"

How Does Pharmacy Help Improve Services to Patients?

- Working with PCTs, providing commissioned services
- Ensuring equitable access to services
- The role of providers and types of pharmacy providers

Pharmacy and Public health?

- Providing a minimum standard of quality and monitoring through the national pharmacy contract
- NHS and Local Authorities working together – where does pharmacy fit?
- The Commissioning Framework for Health and Wellbeing
- The range of skills and services available

What is “Control of Entry?”

- How did we get to where we are?
- Possible reforms
- What does the public want?

Conclusion

We have today covered:

- Local Pharmaceutical Committees
- Pharmacy’s role in improving services to patients
- Pharmacy and public health
- Control of entry

This is a very brief summary of where we are. Where do we go from here!

Appendix 4

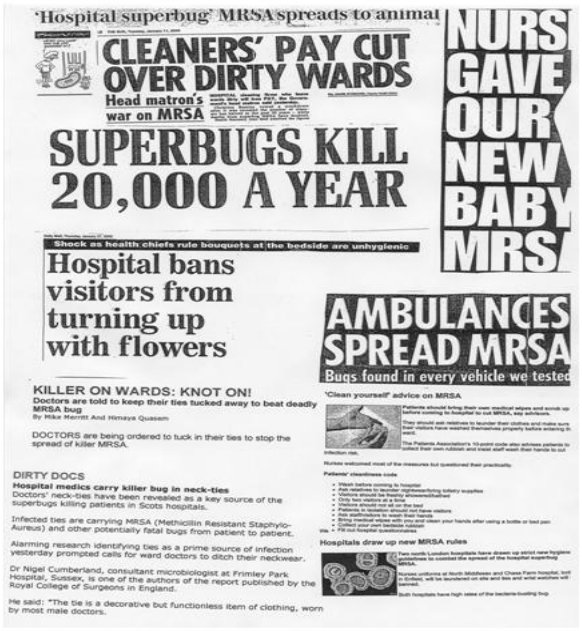
"There remains the question whether at some future date the control of hospital cross-infection will have reached such a level of effectiveness that there will no longer be a place for an Infection Control Sister in General hospitals.

A similar argument that bacteriologists would become unnecessary in hospitals because of the advent of antibiotics was a familiar one about 1945 but is rarely heard today.

The future of hospital cross-infection is impossible to predict, but its present toll of misery is such that it would seem wiser to contemplate any measure that might reduce its incidence than to worry unduly about the possibility of an unemployed ICS at some future time."

Moore. B. Control of Infection (1961)
The *employment of a Senior Member of the Nursing Staff as a member of the Infection Control Team in General Hospitals.*

45 years later


'Hospital superbug' MRSA spreads to animal

CLEANERS' PAY CUT OVER DIRTY WARDS

Head matron's war on MRSA

SUPERBUGS KILL 20,000 A YEAR

NURS GAVE OUR NEW BABY MRS

Shock as health chiefs rule bouquets at the bedside are unhygienic

Hospital bans visitors from turning up with flowers

AMBULANCES SPREAD MRSA

Bugs found in every vehicle we tested

KILLER ON WARDS: KNOT ON!

Doctors are told to keep their ties tucked away to beat deadly MRSA bug

By Mike Merritt And Himaya Quasem

DOCTORS are being ordered to tuck in their ties to stop the spread of killer MRSA.

DIRTY DOCS

Hospital medics carry killer bug in neck-ties

Doctors' neck-ties have been revealed as a key source of the superbugs killing patients in Scots hospitals.

Infected ties are carrying MRSA (Methicillin Resistant Staphylo-Aureus) and other potentially fatal bugs from patient to patient.

Alarming research identifying ties as a prime source of infection yesterday prompted calls for ward doctors to ditch their neckwear.

Dr Nigel Cumberland, consultant microbiologist at Frimley Park Hospital, Sussex, is one of the authors of the report published by the Royal College of Surgeons in England.

He said: "The tie is a decorative but functionless item of clothing, worn by most male doctors.

'Clean yourself' advice on MRSA

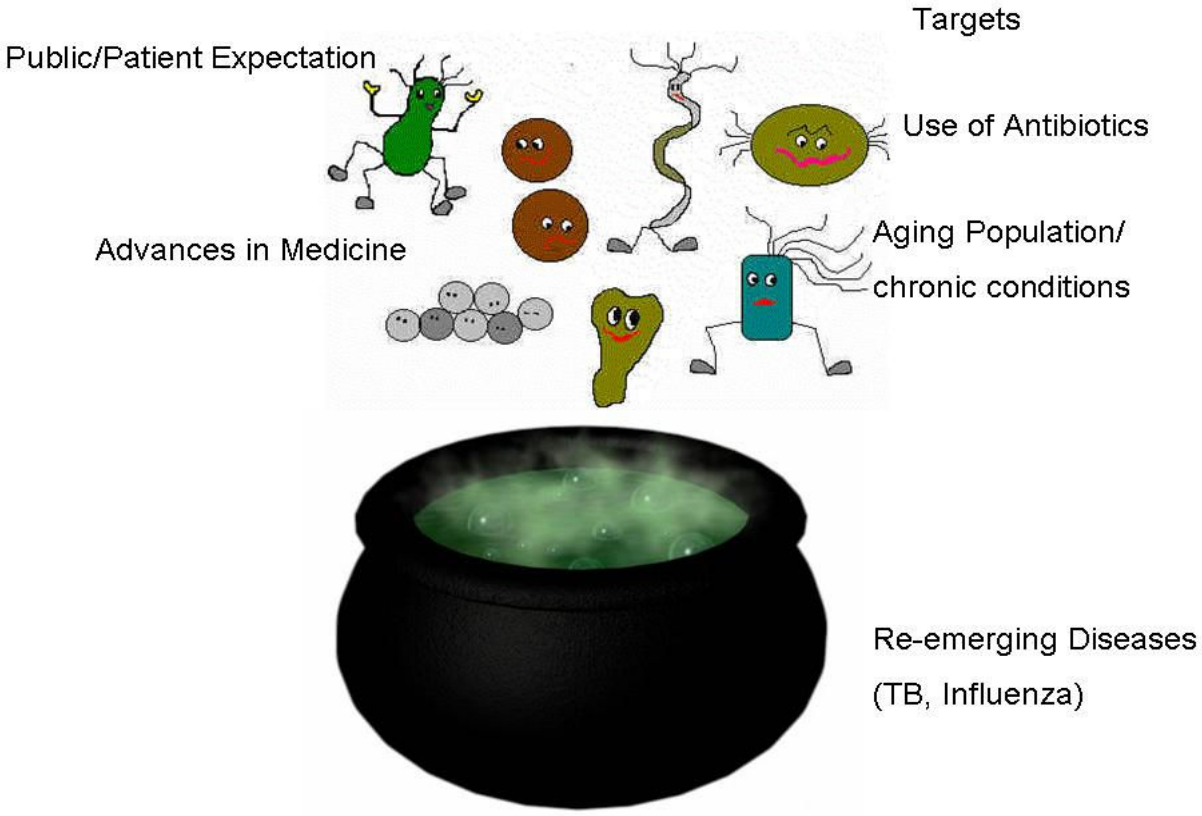
Hospitals draw up new MRSA rules

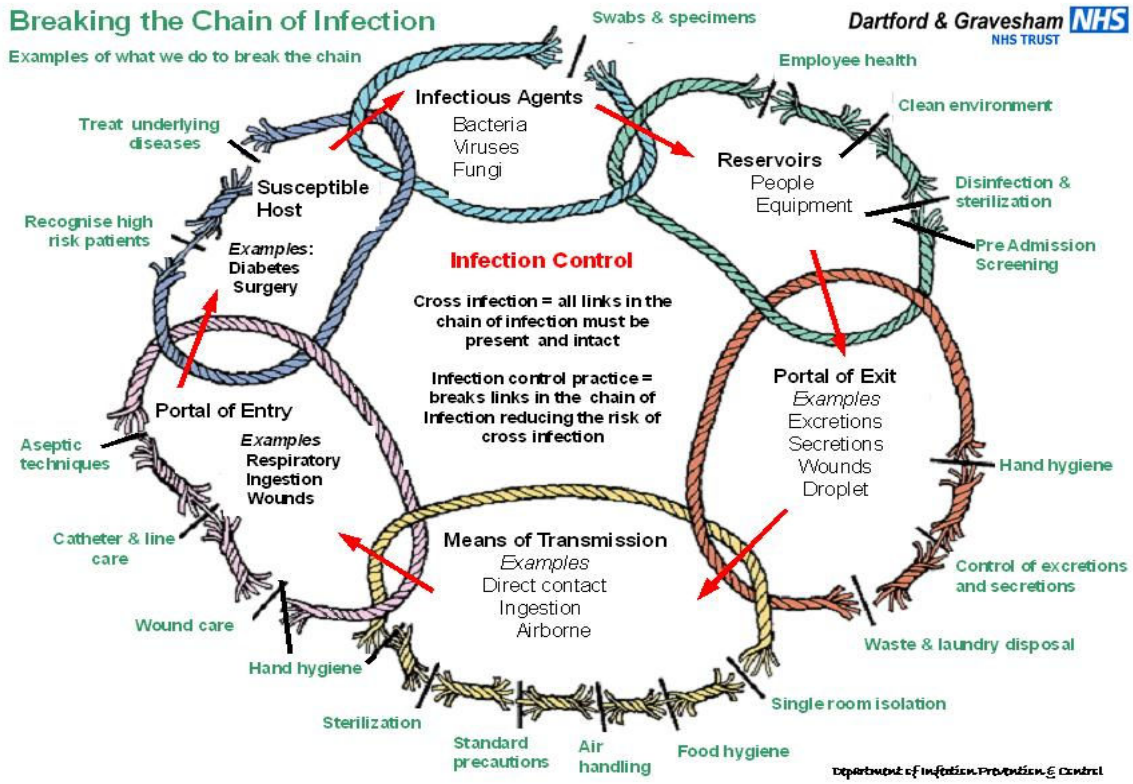

NEW NHS SUPERBUG IS WORSE THAN MRSA

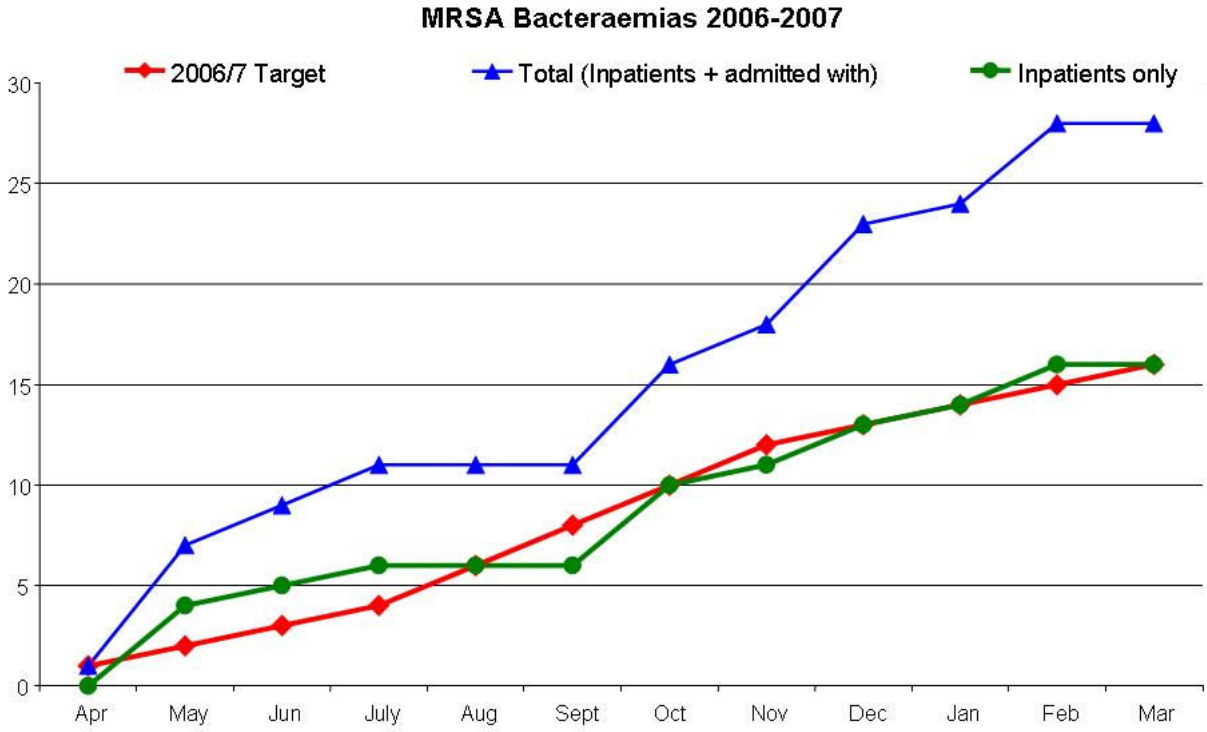
12 KILLED BY A NEW HOSPITAL SUPERBUG

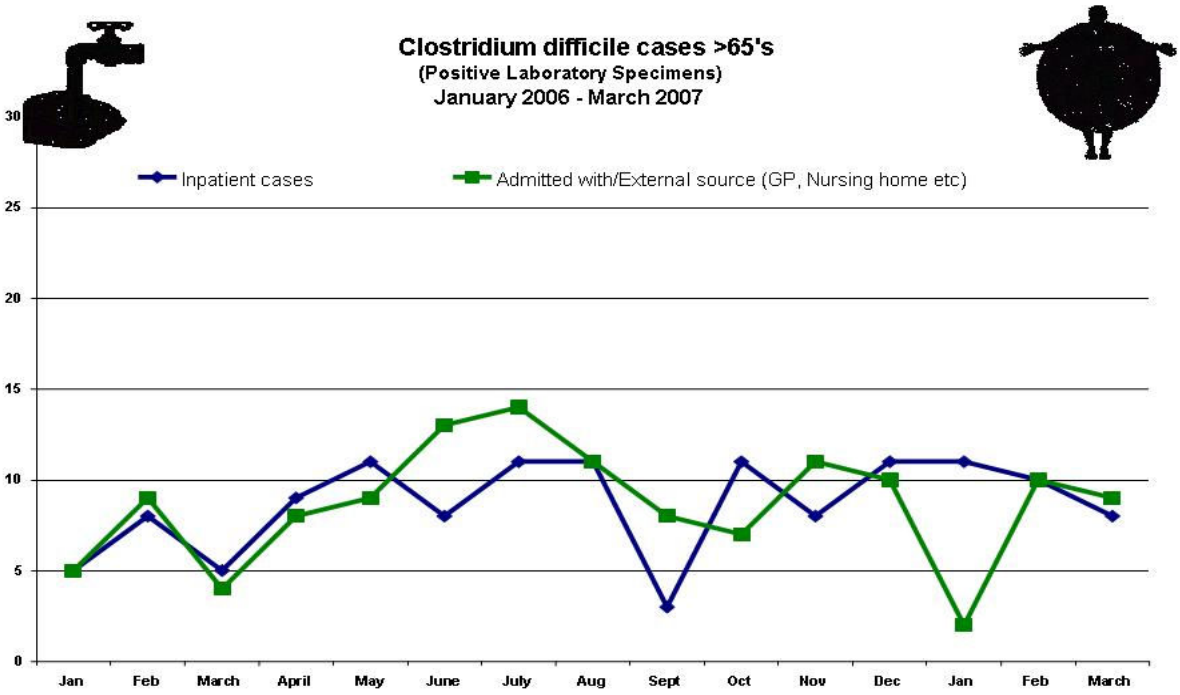
12 DIE IN JUST ONE NHS HOSPITAL

The deadly new bug stalking our wards

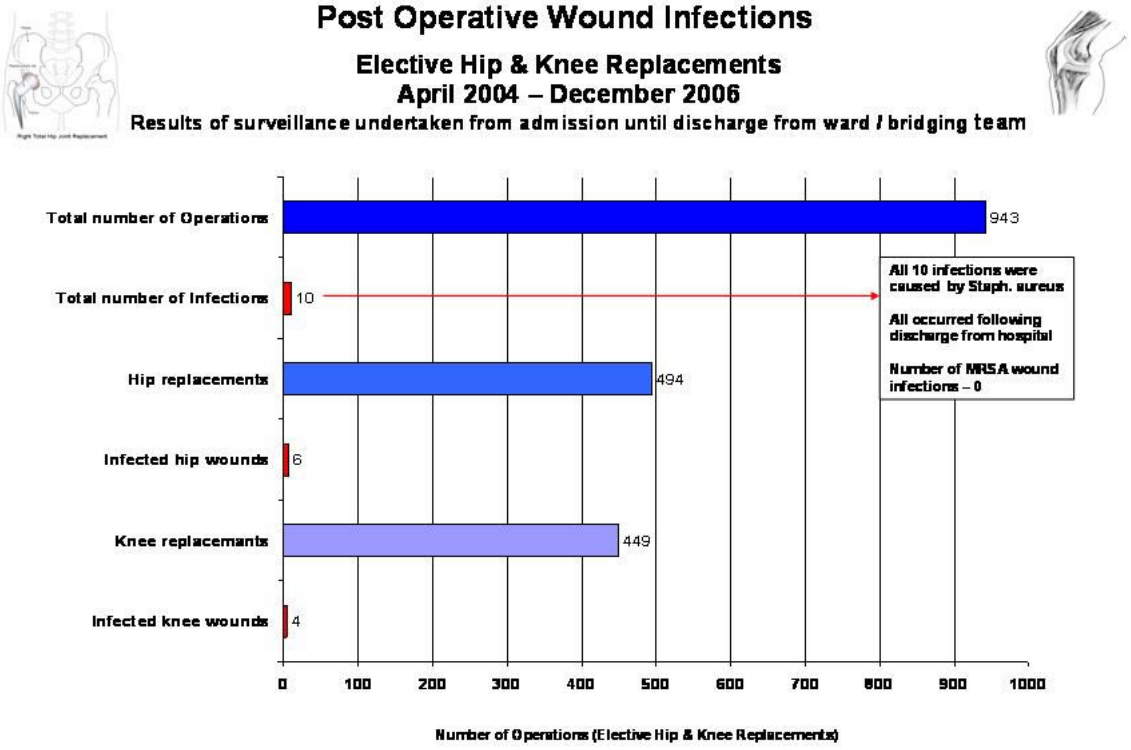



Breaking the Chain of Infection
Examples of what we do to break the chain
Dartford & Gravesham NHS
NHS TRUST
Swabs & specimens
Employee health
Clean environment
Disinfection & sterilization
Pre Admission Screening
Hand hygiene
Control of excretions and secretions
Waste & laundry disposal
Single room isolation
Food hygiene
Air handling
Standard precautions
Sterilization
Hand hygiene
Wound care
Catheter & line care
Aseptic techniques
Recognise high risk patients
Treat underlying diseases
Infectious Agents
Bacteria
Viruses
Fungi
Reservoirs
People
Equipment
Susceptible Host
Examples:
Diabetes
Surgery
Infection Control
Cross infection = all links in the chain of infection must be present and intact
Infection control practice = breaks links in the chain of infection reducing the risk of cross infection
Portal of Exit
Examples
Excretions
Secretions
Wounds
Droplet
Portal of Entry
Examples
Respiratory
Ingestion
Wounds
Means of Transmission
Examples
Direct contact
Ingestion
Airborne


MRSA Bacteraemias 2006-2007
2006/7 Target
Total (Inpatients + admitted with)
Inpatients only
30
25
20
15
10
5
0
Apr
May
Jun
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar



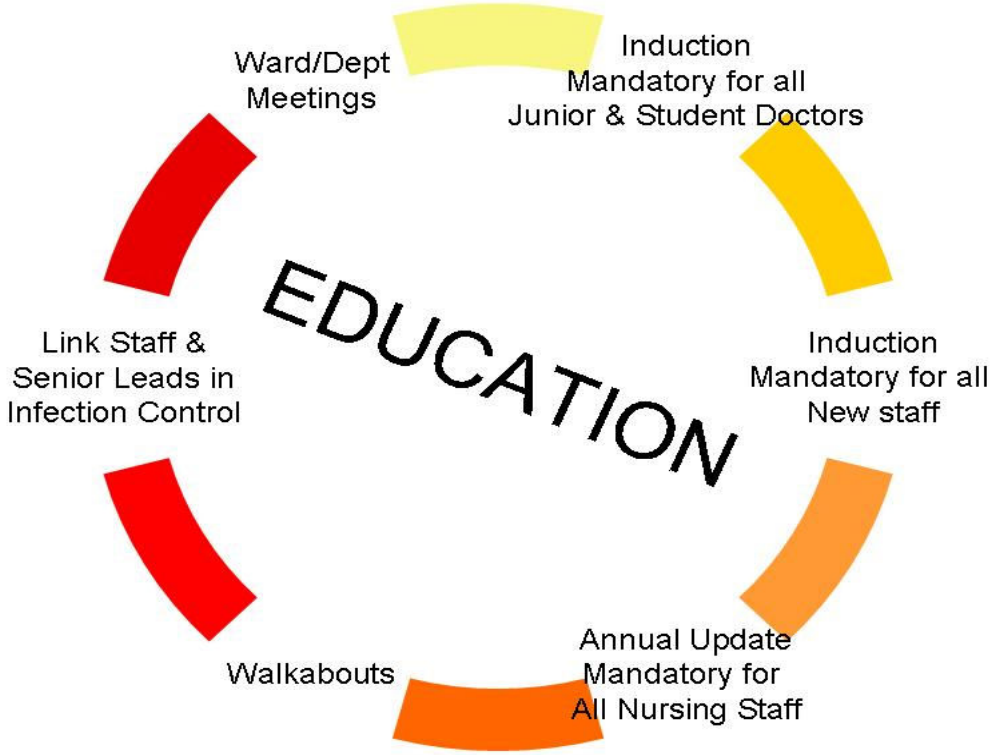
Notes: We have not had any identified cases of type 027 (Hypervirulent strain of Clostridium difficile)
From April 2007 we will be reporting all positive laboratory specimens irrespective of age 2



Results of the Third Prevalence Survey of Healthcare Associated Infections in Acute Hospitals 2006
Published February 2007

Prevalence Rate	National	Darent Valley Hospital
	8.19%	5.2%

Infection type	National Rate	Darent Valley Hospital Rate
MRSA	1.28%	0.3%
Clostridium difficile	1.98%	1.5%
Norovirus	0.74%	0.0%
Surgical site	1.27%	0.9%
Urinary tract	1.80%	0.6%
Pneumonia	1.27%	1.8%
Gastrointestinal	2.02%	0.9%
Lower respiratory tract	0.55%	0.6%
Primary bloodstream	0.62%	0.3%



What are we doing about MRSA and other infections?

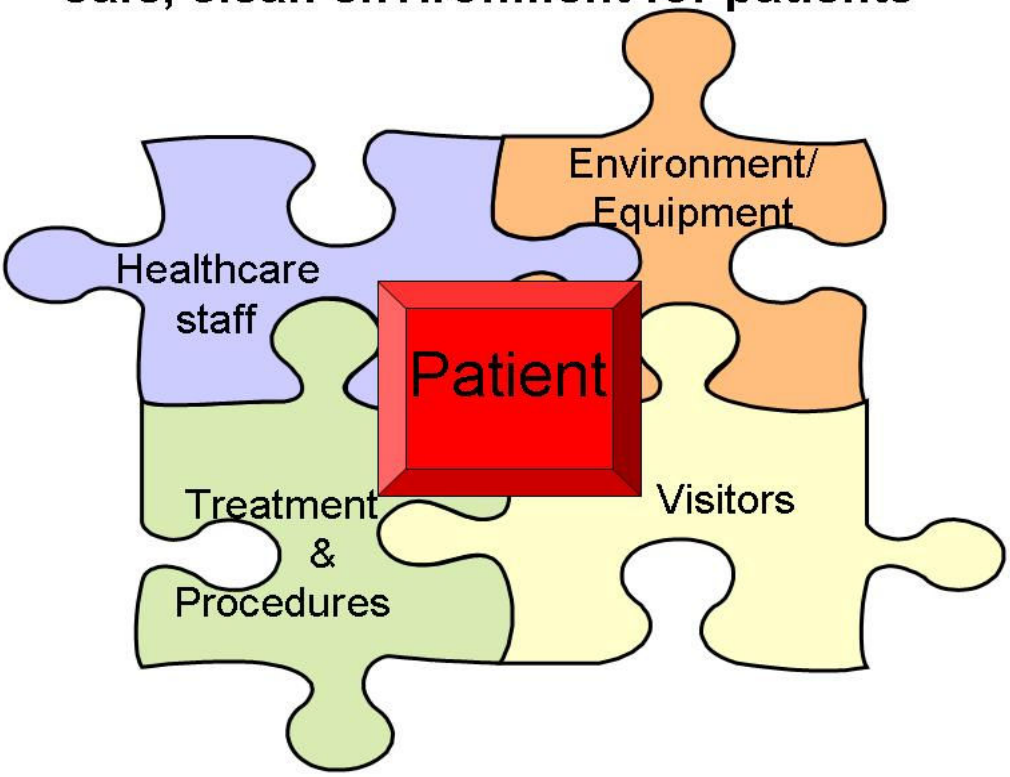
Hand hygiene (Staff, Patients and Visitors)



Clean environment & equipment


Prudent use of antibiotics

Working as a TEAM to provide a safe, clean environment for patients



East Kent NHS Trust
Infection Control

end of year report
April - 2006-07

James Nash
Director Infection Prevention and Control
Sue Roberts
Deputy Director Infection Prevention Control

Topics for discussion

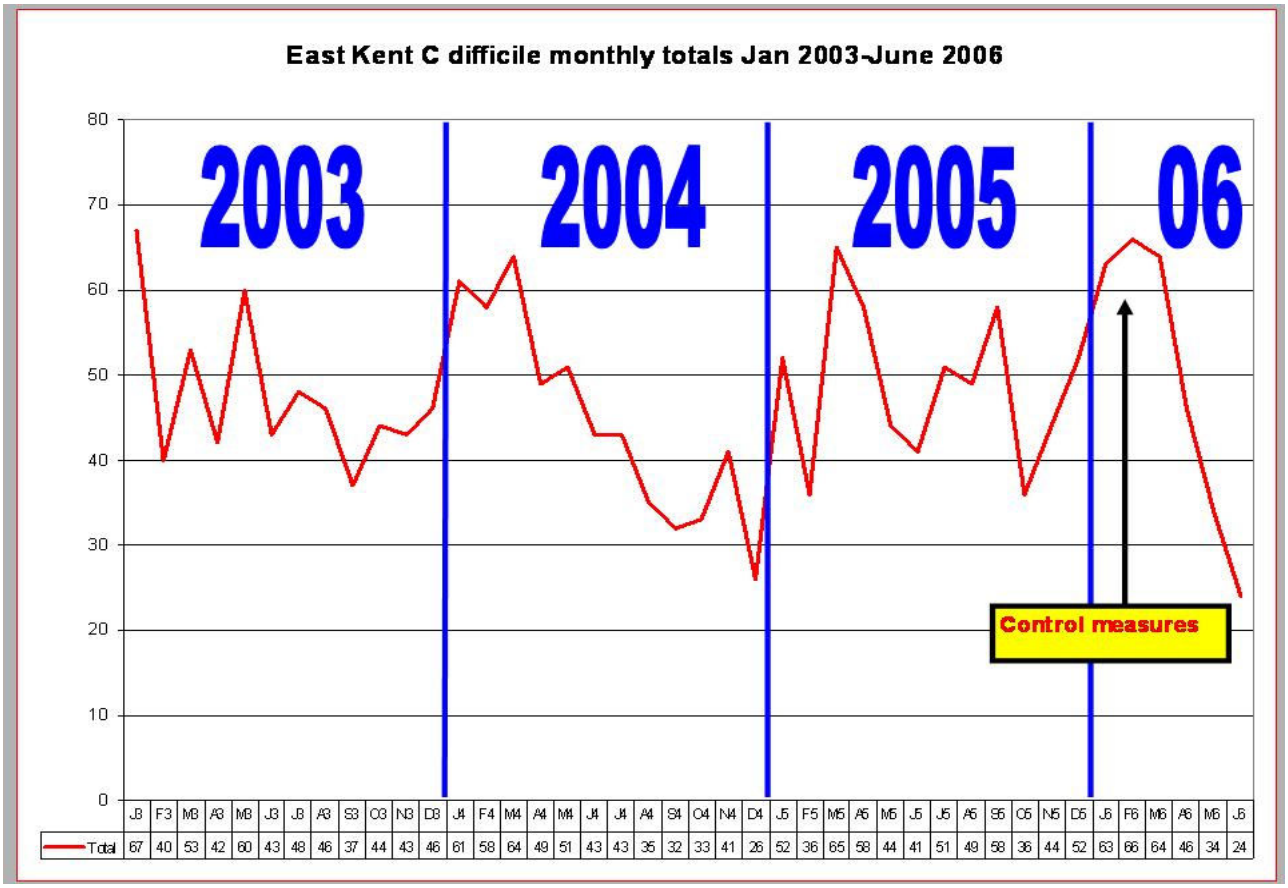
- Restructuring Infection Control
- Clostridium difficile
- MRSA bacteraemia (DH targets)

Clostridium difficile

- Important cause of diarrhoea and colitis
- Mainly in patients receiving antibiotic therapy
- Elderly hospital patients vulnerable
- The new hypervirulent strain (O27)

Clostridium difficile
EKHT Annual report of 2005-06

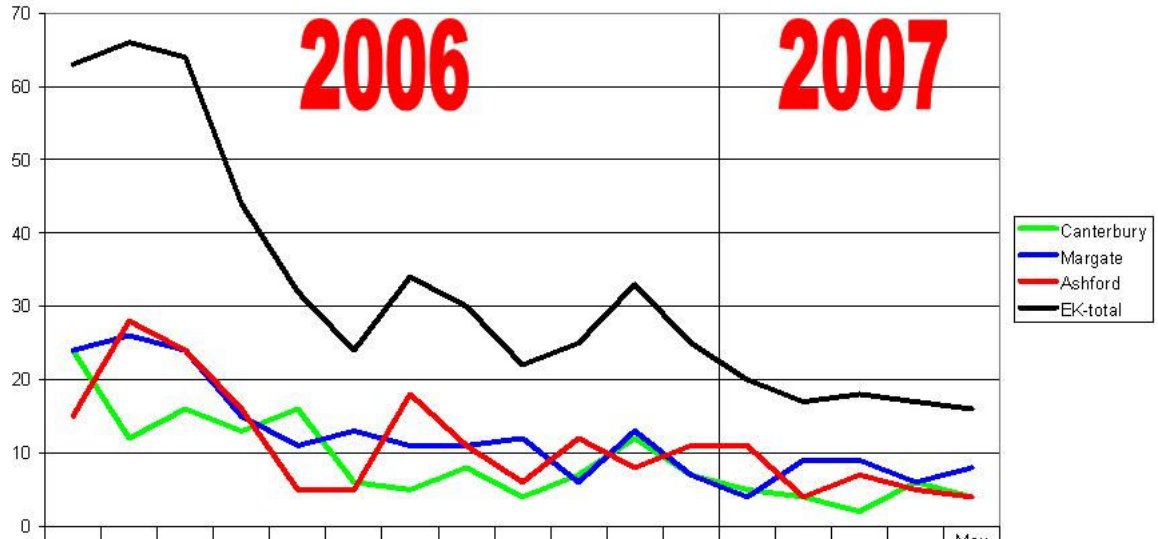
- Increased rate of C difficile Jan-Feb 2006
- O27 strain reported locally
- New infection control measures required
- Objectives for 06-07
  - Establish control over prescribing
  - Reduce rates of C difficile to < 15 cases/month/site


East Kent C difficile monthly totals Jan 2003-June 2006
2003
2004
2005
06
Control measures
80
70
60
50
40
30
20
10
0
J3 F3 M3 A3 M3 J3 J3 A3 S3 O3 N3 D3 J4 F4 M4 A4 M4 J4 J4 A4 S4 O4 N4 D4 J5 F5 M5 A5 M5 J5 J5 A5 S5 O5 N5 D5 J6 F6 M6 A6 M6 J6
Total 67 40 53 42 60 43 48 46 37 44 43 46 61 58 64 49 51 43 43 35 32 33 41 26 52 36 65 58 44 41 51 49 58 36 44 52 63 66 64 46 34 24

Sustained fall in 2007:

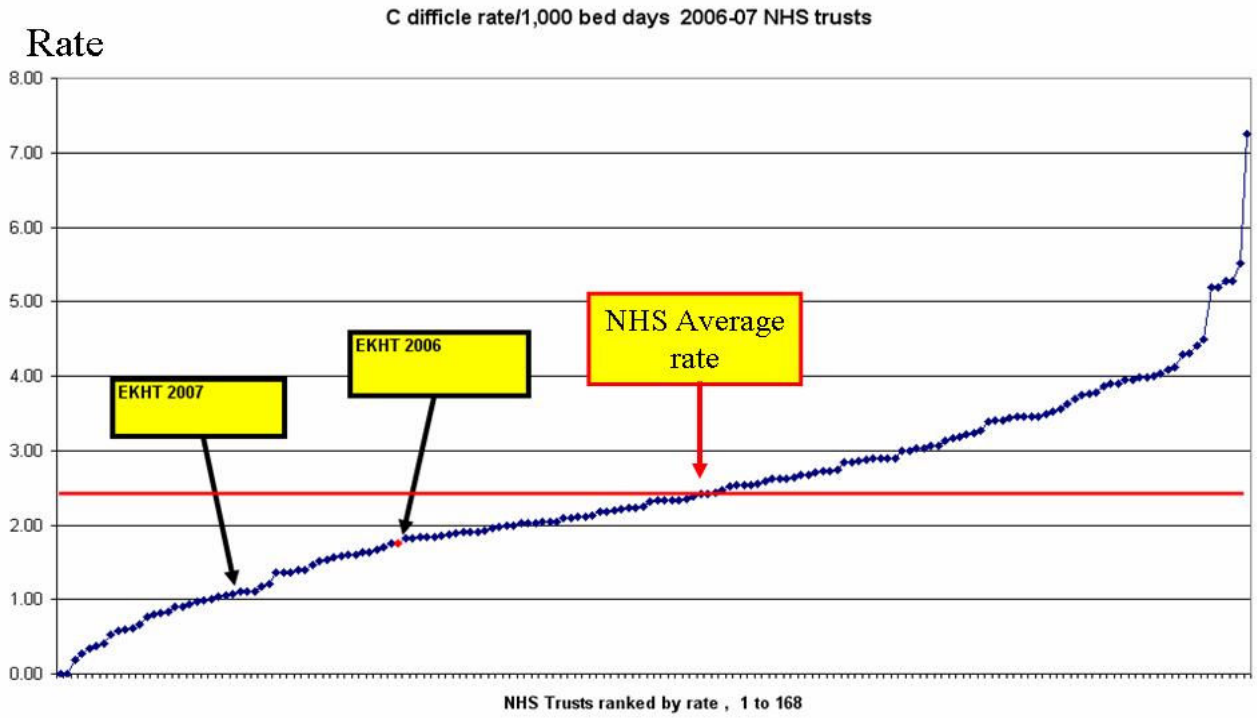
C difficile rate < 1.3 /1,000 bed days (NHS Average 2.4)

EKHT C difficile by hospital New cases by month and site May 2007



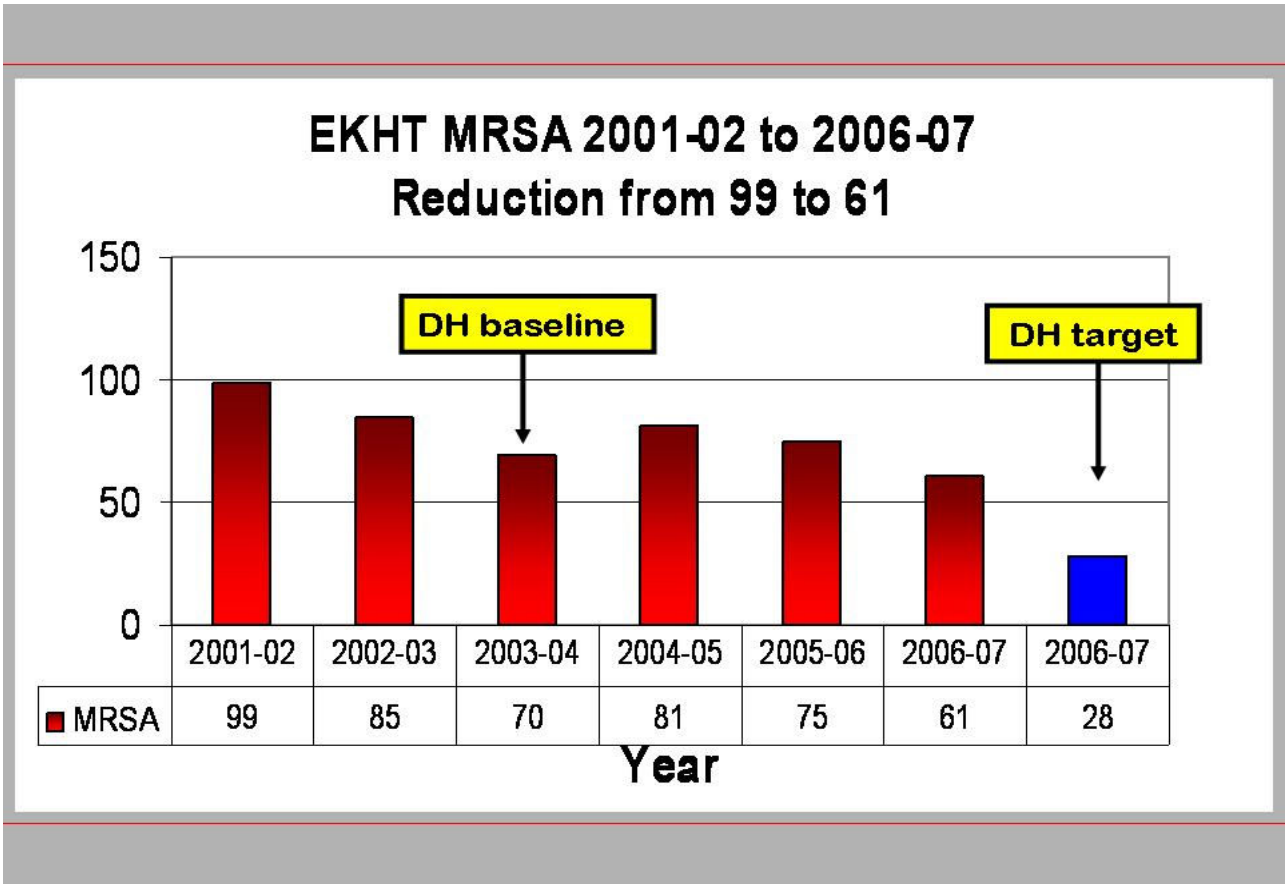
	6M1	6M2	6M3	6M4	6M5	6M6	6M7	6M8	6M9	6M10	6M11	6M12	7M1	7M2	7M3	7M4	May 07
Canterbury	24	12	16	13	16	6	5	8	4	7	12	7	5	4	2	6	4
Margate	24	26	24	15	11	13	11	11	12	6	13	7	4	9	9	6	8
Ashford	15	28	24	16	5	5	18	11	6	12	8	11	11	4	7	5	4
EK-total	63	66	64	44	32	24	34	30	22	25	33	25	20	17	18	17	16

EKHT C difficile rates were below the NHS average during 2006 and have fallen further during 2007



MRSA blood stream infections

- DH target is 60% reduction on figure for 2003-04



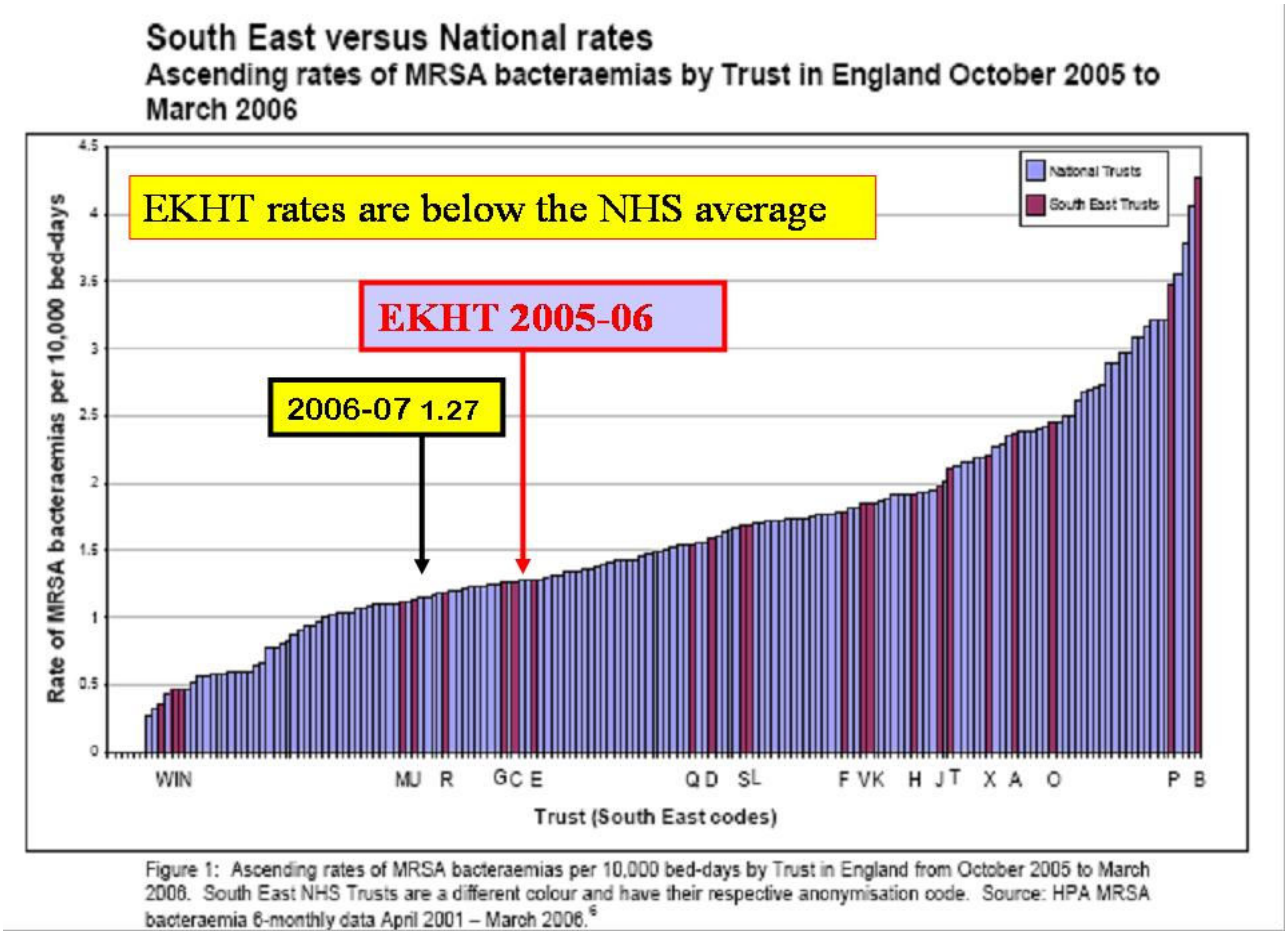


Figure 1: Ascending rates of MRSA bacteraemias per 10,000 bed-days by Trust in England from October 2005 to March 2006. South East NHS Trusts are a different colour and have their respective anonymisation code. Source: HPA MRSA bacteraemia 6-monthly data April 2001 – March 2006.[6]

MRSA EKHT

- MRSA rate is below average and falling
- But needs to fall further ....

MRSA control
lessons from Root Cause Analysis Jan-March

- Improved IV line care required
  - standardised IV line policies to be re-launched
  - improved training of junior hospital doctors
- MRSA screening lapses
  - Screening compliance to be performance managed at ward level
- False +ve results due to contamination
  - Blood culture collection protocols to be revised + improved training for staff

Summary

- Infection control has been restructured
  - "ownership" now at a ward level
  - Clinical infection control leads in place
  - Root Cause Analysis being used to identify why infections occur
- C difficile and MRSA rates below national average and continuing to fall

The Medway NHS
NHS Trust

Infection Control Update
June 2007

Kath Hughes
Infection Control Matron
Medway NHS Trust

MRSA Target

- The Trust has breached this target for 2006-7 we had 43 bacteraemias -Target was 29
- The target for 2007- 8 is **19**
- There is a comprehensive plan to achieve this for the coming year, as this includes patients admitted with infections this requires close collaboration with the PCT.

Key Actions to Reduce Infections include

- Compliance with hand Hygiene
- Infection Control training for all staff
- Compliance with the MRSA policy, including screening, isolation and treatment.
- Review of the management of all invasive devices and removal of IV,CVP urinary catheters ASAP
- Compliance with Antimicrobial guidelines
- Use of Central and peripheral line insertion packs to maintain asepsis and appropriate skin disinfection.
- Saving Lives High Impact Interventions to be applied to all relevant patients.

The Medway NHS
NHS Trust

Number of MRSA Bacteraemia Infections

2005/06 Trajectory												2005/06
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2	2	3	2	4	4	2	3	5	5	3	3	38

2005/06 Actual Data												2005/06
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
4	3	4	1	0	2	7	2	2	2	2	5	34

2006/07 Trajectory												2006/07
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1	2	2	2	3	3	1	2	4	4	2	2	28

2006/07 Actual Data												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
4	2	4	6	8	4	2	5	2	3	1	2	43

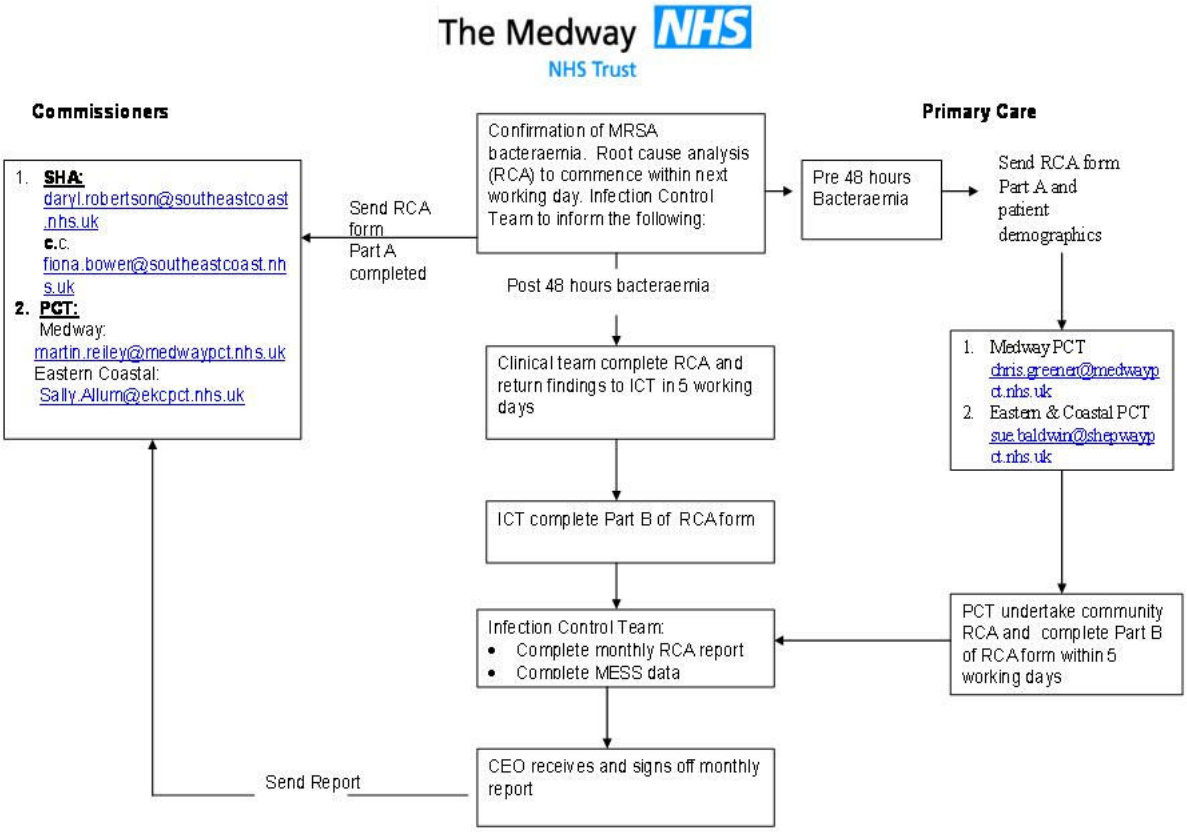
2007/08 Trajectory												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1	1	1	1	1	1	2	2	3	2	2	2	19

2007/08 Actual Data												2007/08
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2	2											

Root Cause Analysis (RCA)

- Investigation is undertaken for all MRSA bacteramias. This is lead by the clinical team. Lessons learned are then reported.

- The PCT undertake the RCA for those samples taken within 48 hours of admission if there has been no previous admission the past month.



Clostridium difficile Toxin (CDT) Target

- New target set for CDT.
- Current rate of CDT for mandatory reporting is 1.99 per 1000 bed days.
- New target 1.75 per 1000 bed days
- This mandatory reporting includes people 65 years and over from all samples received in microbiology. Hence this includes GP and Community specimens.

The Medway NHS
NHS Trust

Mandatory Reporting of *Clostridium difficile* Toxin Diarrhoea Cases (Hospital and Community)

Year	2005/06												2005/06
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period	30	23	18	18	15	12	14	22	16	18	23	28	237 (2.20)

Year	2006/07												2006/07
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period	14	15	20	15	15	20	25	17	15	22	14	23	215 (1.99) to date

Year	2007/08 Trajectory												2007/08
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period - Trust	12	10	10	8	8	10	11	11	12	12	11	10	125
A&E and Community	6	6	4	4	4	6	5	5	6	6	5	6	63
Total	18	16	14	12	12	16	16	16	18	18	16	16	Overall Total = 188 (1.75)

Year	2007/08 Actual Figures												2007/08
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of *Clostridium difficile* in period - Trust	10	14											
A&E and Community	6	10											
Total	16	24											Overall Total =

Actual Data 2005/07 — Projected Data 2007/08 — Actual Data 2007/08

Medway NHS Trust rate of 1000 bed days:		
	January – December 2004	2.29
	January – December 2005	2.33
	January – December 2006	1.92

N.B. This is the same figure as the HPA mandatory reporting all patients 65 years and over, this is all samples sent to Microbiology including all community samples repeat samples on patients are counted again after 28 days. The rate is based upon 1,000 bed days using activity figure of 107,564 for 2004 (as per HPA).
February 2007

CDT Action Plan

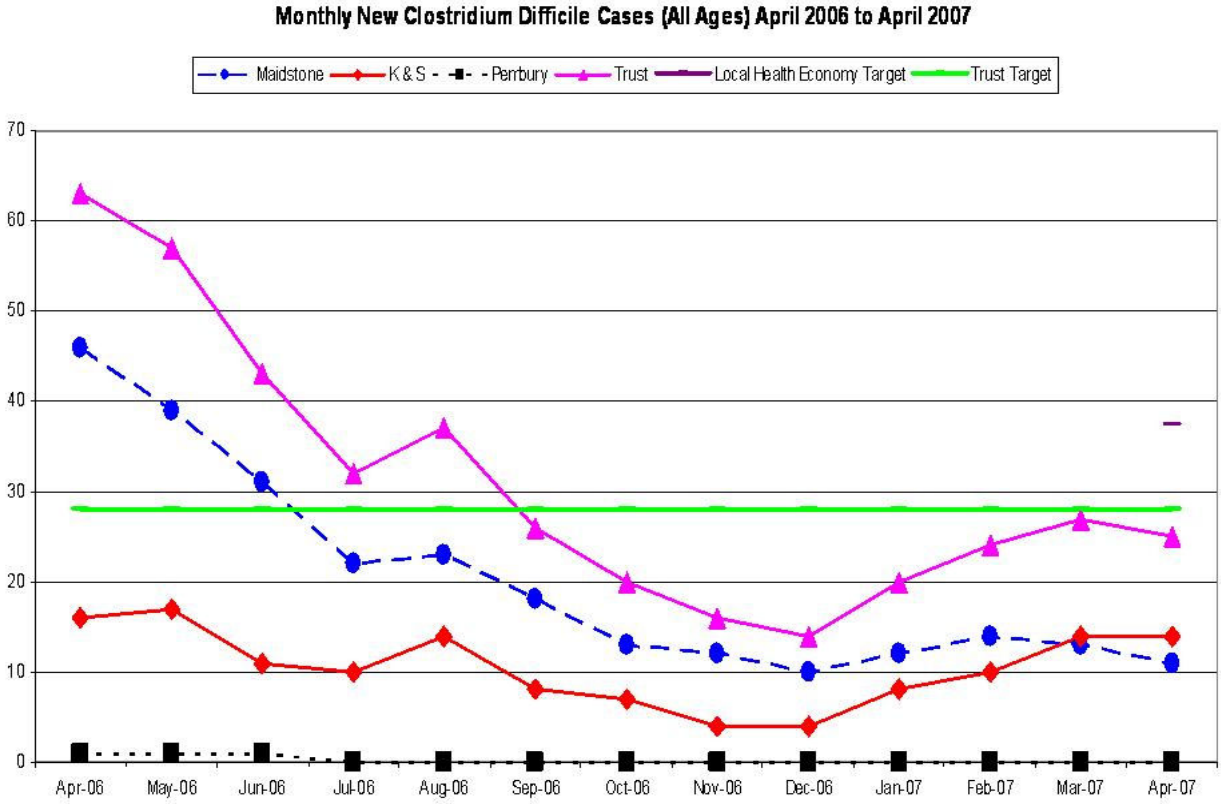
- Prudent antimicrobial prescribing
- Updated antimicrobial guidelines /restricted antibiotics
- Excellent hand hygiene Using soap and water for CDT patients NOT Alcohol hand rubs.
- Isolation of all cases in single rooms and adherence to IC precautions
- Treatment of cases with Metronidazole as first line treatment.
- Environmental cleaning and equipment cleaning to a high standard using Chlorine based product

Infection Control Progress within Maidstone & Tunbridge Wells NHS Trust

Gail Locock
Acting Director for Infection Prevention and Control

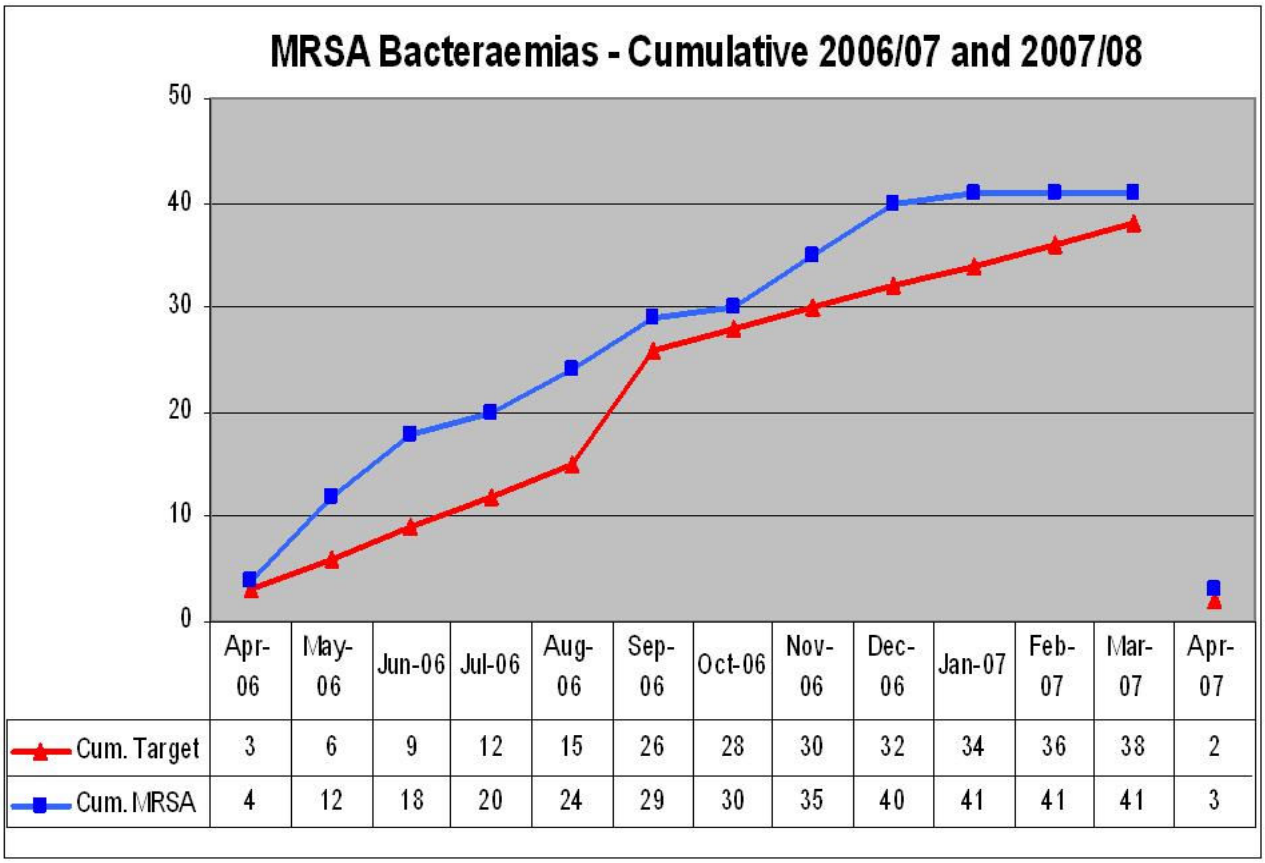
Outline of Presentation

- *Clostridium difficile* statistics
- MRSA Bacteraemia statistics
- Saving Lives Programme
- Clean Your Hands Campaign
- The Role of the Infection Control Link Nurse



MRSA Bacteraemia vs Projected Rates (06/07)

	Total Blood Cultures Processed	Total Positive Blood Cultures (All organisms)	Total MRSA Positive Blood Cultures	Hospital Acquired	Community Acquired	Projected MRSA Positive Blood Cultures
Apr	787	112	4	3	1	3
May	857	157	8	4	4	3
June	940	149	6	3	3	3
July	943	171	2	1	1	3
Aug	842	166	4	3	1	3
Sep	863	162	5	4	1	2
Oct	976	172	1	0	1	2
Nov	907	162	5	4	1	2
Dec	951	162	5	4	1	2
Jan	1038	202	1	1	0	2
Feb	938	170	0	0	0	2
Mar	920	155	0	0	0	2
Totals	10962	1940	41	27	14	38



	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07
Cum. Target	3	6	9	12	15	26	28	30	32	34	36	38	2
Cum. MRSA	4	12	18	20	24	29	30	35	40	41	41	41	3

Saving Lives 'A Delivery Programme to Reduce Healthcare Associated Infections, including MRSA'

Self Assessment:
"Balanced Score Card"

High Impact Interventions:

No 1. Preventing the risk of microbial contamination
No 2. Central venous catheter care
No 2b. Peripheral line care
No 2c. Renal dialysis bundle
No 3. Preventing surgical site infection
No 4. Care of ventilated patients
No 5. Urinary catheter care
No 6. Reducing the risk of infection from and the presence of *Clostridium difficile*

Clean Your Hands Campaign

- Instigation of Clinical Champions
- Increasing awareness with all staff and the general public
- Hand hygiene audits (observational and facilities) undertaken at ward level
- Floor and wall signage
- Use of light box for technique training
- Increased resources to improve facilities
- Will review Hand Hygiene Leaflet


STOP
CLEAN
YOUR HANDS


ATTENTION
Visitors
Please disinfect your hands prior to entering and before leaving this ward/department.
HELP US TO PREVENT INFECTIONS.
Pour Softalind® into the hollow of your dry hands.
Use the simple 6 step routine to rub the product thoroughly around your hands and wrists for 30 seconds.
Please supervise your children.
B BRAUN
CLEAN
YOUR HANDS


Staff Office
ATTENTION
Visitors
Please disinfect your hands prior to entering and before leaving this ward/department.
HELP US TO PREVENT INFECTIONS.
Pour Softalind® into the hollow of your dry hands. Use the simple 6 step routine to rub the product thoroughly around your hands and wrists for 30 seconds.
Please supervise your children.
B. BRAUN

Improving Link Nurse Role

- Joined up working
- Increasing their contribution
- Training
- Auditing
- Cascade information
- Two-way process

Thank You for Listening

Appendix 5

Fit for the Future
Update for Health Overview & Scrutiny Committee
8 June 2007

Work on Fit for the Future continues, with the health economy across Kent & Medway on track to deliver a formal update for all stakeholders in July. The public document will describe the work that has been going on within and across health economies over the last year, including:

- Outcomes and key messages from the MORI social research and deliberative event
- Outcomes of local consultation with the public and partners
- Outcomes of the demographic and financial modelling that has been carried out to 2015/16 and the assumptions that we've built into our planning
- Why and what we'll be working on under the Fit for the Future banner both across Kent & Medway and within local health economies, including specific initiatives and next steps

The public document will describe an evolutionary process of modernisation and improvement for the local NHS, providing clarity about the areas we will be focusing on over the next year or so.

For West Kent key initiatives will include:

- Urgent Care – we'll be putting in place 'Urgent Care Centres' where primary care staff can provide a service for non-emergency attendances at A&E. We'll also be considering what more can be done in primary care settings (e.g. GP surgeries and high street pharmacies)
- Planned Care – we'll be looking at key areas where people can be diagnosed and treated in community settings closer to home and reviewing our adult community services to support this
- Maidstone & Tunbridge Wells NHS Trust – subject to the response of the Secretary of State we will be working with MTW to implement the outcomes of the recent Surgical & Orthopaedic Consultation
- Community Hospitals – following the recent review we will be re-vitalising all our community hospitals, including re-opening many of the closed beds, establishing the most modern models of care across all the hospitals and applying for capital funds to upgrade Sevenoaks Hospital and X Ray facilities at Edenbridge. We will also consult on the future of the service provided in the Minor Injuries Unit at Edenbridge, the potential to provide renal dialysis at Tonbridge and the refurbishment, re-building or reprovision of the Livingstone Unit in Dartford
- Children's Services – continuing implementation of the Health Visitors' Review and improving services for children and adolescents with mental health needs (CAMHS) in partnership with the Children's Trust
- Mental Health – we'll be redesigning the adult mental health pathway and improving services for older aged adults with dementia
- End of Life Care – we'll be reviewing the care that's available and working to provide more choice for people at the end of their life

Through all of this we will be continuing on-going discussions with the public and other stakeholders, and are in the process of setting up a Patient Advisory Group to work with us on reviewing and re-designing services. Any substantial variations in service will be subject to full and formal Section 7 consultation as deemed appropriate or necessary in discussion with the HOSC.

Across Kent & Medway we will be focusing on a number of high-level specialty areas (for example vascular and stroke services and trauma services). A major clinical event to support this work is scheduled to take place in July when the National Clinical Advisory Team will be coming to Kent to work with our most senior clinicians across the County. Again, outcomes of this work maybe subject to formal consultation.

At the Extraordinary Council meeting on 24th July in the afternoon we will be sharing more detail about Fit for the Future Next Steps and give councillors the opportunity to speak to a range of clinicians and staff about the service improvements we're planning.

I would value the opportunity for a full discussion with the HOSC, perhaps in September once the public document is published, to talk in more detail about what happens next in West Kent.

Julia Ross
Director of Civic Engagement
8 June 2007