KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 19 July 2013.

PRESENT: Mr R E Brookbank (Chairman), Mr M J Angell (Vice-Chairman), Mrs A D Allen, Mr N J D Chard, Mr D S Daley, Dr M R Eddy, Mr J Elenor, Ms A Harrison, Mr A J King, MBE, Mr R A Latchford, OBE, Mr G Lymer, Mrs Z Wiltshire (Substitute for Mr L Burgess), Cllr M Lyons and Cllr R Davison (Substitute for Cllr Chris Woodward)

ALSO PRESENT: Cllr Mrs A Blackmore

IN ATTENDANCE: Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

1. Introduction/Webcasting

(Item 1)

2. Declarations of Interest

(a) Mr Nick Chard declared a personal interest in the Agenda as a Non-Executive Director of Health Watch Kent.

(b) Councillor Michael Lyons declared a personal interest in the Agenda as a Governor of East Kent Hospitals University NHS Foundation Trust.

3. Minutes

(Item 4)

(a) Following up one the issues discussed at the previous meeting, the question was put to the Chairman as to the possibility of having a look at outpatient services at Deal Hospital. The Chairman responded positively and said it would be found a place on the Forward Work Programme.

(b) RESOLVED that the Minutes of the meeting of 7 June 2013 are correctly recorded and that they be signed by the Chairman.

4. The Francis Report: Update

(Item 5)

Sally Allum (Director of Nursing and Quality (Kent and Medway), NHS England), and Dr Steve Beaumont (Chief Nurse, NHS West Kent CCG) were in attendance for this item.

(a) The Chairman welcomed the Committee's guests and they introduced themselves and provided an overview of the topic with the aid of a PowerPoint

which was shown in the meeting and also made available in advance of the meeting and contained in the Agenda pack Members had before them.

(b) Dr Beaumont explained that in his previous career in the military, he had sent staff to Mid-Staffordshire Hospital and feedback mirrored the comments in the Francis Report about the hospital's 'unhealthy, dangerous culture'. However, it was also stressed that underneath there was still good nursing care provided. He went on to explain that along with the other Chief Nurses at Clinical Commissioning Groups (CCGs) across Kent, his priority was to address issues around quality of care. The Francis Report contained 290 recommendations and promoted a 'board to ward' approach to implementation. In the new NHS landscape, this was the equivalent to saying 'CCG to provider'. Dr Beaumont explained that he would be visiting all providers, starting with the main Acute Trust in his CCG area (NHS West Kent CCG), Maidstone and Tunbridge Wells NHS Trust, and moving on to all others, including independent providers.

(c) His CCG held their board meetings in public and there were PPGs (Patient Participation Groups), lay member involvement and patient satisfaction data on which to draw. There was a new complaints system in the NHS and information was available direct from providers as well as that which went direct to CCGs. In addition, the NHS Constitution underpinned everything which was done in the NHS. This covered actions by staff and patients as it was in effect a concordat. The NHS had to deliver safe care, but patients had a responsibility to turn up to appointments.

(d) One particular area of data was highlighted, that around serious incidents and 'Never Events.' Members asked for some examples of what came under these terms and it was explained that the context defined what or was not a serious incident. An example was given of an incident where the patient was satisfied with the outcome of the treatment received, but which was still reported and classified as a serious incident. In this particular case a simple change was possible, reducing the chance of it recurring. The key aim was to get people to regard serious incidents as an opportunity for learning rather than to pinpoint somebody to blame. In places where there has been a defensive culture, events might be downgraded to avoid reporting. This was something which needed to change. Staff involved in a serious incident were debriefed. The other side of this was the importance of spreading best practice. These points were relevant to health and social care, with each sector able to learn from the other. The outcomes of the Berwick review were awaited and were expected later in July. Professor Don Berwick was an international safety expert, and had particular experience of the USA, which had a different culture in its health services and which would mean the results of the report would need careful consideration.

(e) In response to a specific question it was explained that attitudes to whistle-blowing were changing and becoming more positive. It was suggested that the defence ombudsman model could be something the NHS could consider. In addition, each CCG had a Chef Nurse who was outside of the chain of command and they were all a source of support for nursing staff.

(f) Tackling issues of safety and quality of care involved looking at the education and training of staff. NHS representatives brought the Cavendish Report to the attention of the Committee. This looked at the training received by Health Care Assistants (HCAs). The report found this to be variable, with some training consisting of nothing more than the viewing of a DVD. This had an impact as registered nurses were still responsible for the quality of any care delegated to a HCA. It was unclear how this worked in the community setting. Against this variability, there was a need for a clear career progression for HCAs. The debate on whether there was a need to register HCAs was also raised. Although no definitive answer on one side or the other was given by NHS representatives, the point was made that it was currently perhaps too easy for a HCA who had been sacked in one area to move to another and find a new job.

(g) There were also wider issues around recruitment and training to consider. The importance of recruiting people with the right values was discussed. This included medics and values based assessment was being introduced across the NHS. Members brought up the suggestion that the idea of nursing being a vocation had been lost when nursing became a graduate career. It was explained that this had been introduced in part to ensure nurses had parity of esteem with other professions within the NHS. However, work was currently ongoing locally with Canterbury Christ Church and Greenwich University to make nurses education more practical. Work was also being done to address the fact that there were minimum standards for midwifery and intensive care nursing, but not for nursing on general wards. The Chief Nursing Officer for England introduced the 6 Cs last year and these were being relaunched with the idea of covering all caring staff, including those in social care. These 6 Cs are Care, Compassion, Competence, Communication, Courage and Commitment.

(h) At the national level, Health Education England was a new organisation charged with providing leadership for the new education and training system. The improvement of training around end of life care was a priority. More broadly it was recognised that there was a need to avoid a system where a trainee's energy and enthusiasm was reduced.

(i) Members also raised concerns about the barriers to putting quality at the heart of care due to the apparent tendency for NHS organisations to work in silos, both within an organisation and between organisations. NHS representatives replied that there was a genuine opportunity to make positive changes in this area now. There had been a series of major reports which required a response. Locally, there was the Keogh report into Medway Hospital, and this report raised questions for all hospitals to consider, not just Medway. The point was also raised as to why it needed a major report to be published before action was taken. It was acknowledged that there was a need to tap into knowledge of local issues and react before this stage. CCGs were visiting local providers and leading clinicians in CCGs were working shifts at local providers to see the situation at the ground level and data was being used to identify the key areas to investigate further. NHS representatives also pointed out that the experiences of students needed to be tapped into as they saw a range of places and services and were in a good position to make comparisons between good and bad practice.

(j) Part of the issue was the difficulty in defining quality and there was a need to get beneath a service being simply labelled as 'green' or 'red'. This was where the Quality Surveillance Groups (QSG), hosted by NHS England local teams, were so valuable. For the first time there was a formal way to bring soft and hard intelligence on the quality of health and care provision together. Commissioners, local authorities, regulators and Health Watch were all represented on the local QSG. There was a QSG for Kent and Medway. In the transition from Primary Care Trusts to CCGs, there had been a quality handover as well of the kinds of information which would be of value to the new commissioners. The question was asked about the role of the public on the QSG. It was explained that there was a need to ensure public access to the relevant records. It was suggested the role of Health Watch might also need to be strengthened.

(k) There were also changes to the regulatory system reported to the Committee. There was a Burdens review underway with the aim of reducing regulations and paperwork by a third. There were acknowledged issues at the CQC and this was one area where the system was being simplified. This would include ratings for providers and a 'well run' test. The current system was too complex to enable members of the public to properly judge the quality of a service. Separate Chief Inspectors for hospitals, social care and primary care had either been already appointed, or would be appointed. Opinions on these were split between seeing them as a positive way forward or an additional layer of bureaucracy. It was explained that the Chief Inspector of hospitals would be available to go into hospitals which had been placed in special measures. More broadly there was an accountability review looking at three levels – individual, organisational, and system failure.

(l) The 'friends and family' test was being rolled out across a number of health sectors, including for prisoners. This would provide a useful source of data and information.

(m) The hope was expressed that the measures being taken would improve public confidence in the NHS. Members of the Committee and NHS representatives discussed the difficulty in getting good practice and success stories a higher profile in the media, who were more interested in negative stories. NHS representatives explained that the media reaction to stories also differed across the sector with the Keogh report into Medway getting a higher profile in the local papers than on the radio. The point was also made in discussion that public confidence was more than just a matter of reporting in the media, with nursing and other staff travelling to and from work in uniforms given an example of the negative impression which could be given.

(n) The impact of the Francis Report was also discussed. A Member indicated that there were 290 recommendations, which was a large number to consider. Some of the recommendations dealt directly with scrutiny. One of them was for the need for health scrutiny to have the appropriate support and this meant that Members needed to know enough to be able to ask the right questions when presentations were delivered at HOSC. NHS representatives explained that they were more than happy to have more involvement by HOSC Members in the day to day business of the health sector, including taking part in visits or

shadowing. On the number of recommendations, it was indicated that it would not be possible to come up with a response to all 290 locally and there was a need to be aware of and link into work being led nationally by the Department of Health and others. The request was made that a paper be prepared on how HOSC, the Health and Wellbeing Board, and Health Watch all fitted together.

(o) A series of questions on specific services were asked during the meeting. It was explained that the Deputy Chief Nurse had a special interest in working with the police on mental health issues and work was being done with Kent and Medway NHS and Social Care Partnership Trust around custody suites and that this should show some benefits. On the levels on attendance at accident and emergency departments, it was explained that there were 17,000 care home beds across Kent and Medway and it was necessary to ensure better care was being delivered here to reduce attendance at accident and emergency departments. More broadly, there a need to ensure appropriate community health services were in place. For example, the current model of district nursing needed to be considered to see if it was the best way of delivering services, particularly as many district nurses were nearing the age of retirement.

(p) The Chairman proposed the following recommendation:

- That the Committee thanks its guests for their attendance and contributions today, asks that they take on board the comments made by Members during the meeting and looks forward to receiving a further update in November, in particular in relation to quality surveillance aspects.

(q) AGREED that the Committee thanks its guests for their attendance and contributions today, asks that they take on board the comments made by Members during the meeting and looks forward to receiving a further update in November, in particular in relation to quality surveillance aspects.

5. Chairman's Update

(a) The Chairman explained that, through the South East Health Scrutiny Network, he had taken part in a visit to the 111 call centre in Dorking along with the Researcher to the Committee. This had been an interesting and informative day and had also provided the opportunity to hear from South East Coast Ambulance Service NHS Foundation Trust about their future plans more broadly. Members responded positively to the suggestion that a similar site visit be arranged for them to the 111 call centre in Ashford.

(b) The Chairman proceeded to then explain that a Forward Work Programme for the Committee was being developed and asked for suggestions as to what could be included. The specific request to consider outpatient and post-operative care in Deal was raised again. The request was also made as to whether it might be possible for the Committee to meet in Deal to consider the commissioning plans of the Thanet CCG. In response the Chairman and Researcher to the Committee explained that there had been correspondence between the Chairman and the Chairman of the Overview and Scrutiny Panel at Thanet District Council as to the ability locally to look at these plans. It was also stated that it was already the intention to consider the commissioning

plans of CCGs as part of the regular work of the Committee and this would commence in September.

(c) The need for Members to be better informed and trained on issues around the Francis Report was also raised as this was one area where the Committee needed to be on top of the subject. The Chairman said this was something which would be looked at.

6. Date of next programmed meeting – Friday 6 September 2013 @ 10:00 am
(Item 6)