HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 9 March 2011.

PRESENT: Councillor Dryden (Chair); Councillors Junier and Lancaster.

OFFICERS: J Bennington, J Ord, T Parkinson, M Robinson and K Warnock.

****PRESENT BY INVITATION:** Councillor Brunton, Chair of Overview and Scrutiny Board
Councillor Elder

South Tees Hospitals NHS Foundation Trust:
Tricia Hart, Deputy Chief Executive Officer and Director of Nursing and Patient Safety
Alison Peevor, Deputy Director of Infection Prevention and Control

Cleveland Local Medical Committee:
Dr Vaishali Nanda, Middlesbrough Practice Based Commissioning
Janice Foster, Development Manager

NHS Middlesbrough:
Jenny Eggett, Commissioning Manager, Middlesbrough GPs
Martin Phillips, Director of Health Systems Development.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Carter, Cole and P Rogers.

**** DECLARATIONS OF INTEREST**

Name of Member	Type of Interest	Item / Nature of Interest
Councillor Elder	Personal/Non Prejudicial	Any matters arising relating to the South Tees Hospitals NHS Foundation Trust – a Member of the Trust

****MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 18 February 2011 were submitted and approved as a correct record.

HEALTHCARE ASSOCIATED INFECTIONS – SOUTH TEES HOSPITALS NHS FOUNDATION TRUST

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from South Tees Hospitals NHS Foundation Trust to provide a briefing on current performance relating to Healthcare Associated Infections (HCAIs).

The Chair welcomed representatives from the South Tees Hospitals NHS Foundation Trust who provided an update on the main areas of infection prevention and control in accordance with legislative requirements and national guidance the key areas of which were outlined.

It was confirmed that the MRSA bacteraemia target was seven for the current financial year and that from April 2010 to date there had been five attributed Trust cases. It was pointed out that the number of MRSA cases had significantly reduced from 120 in 2001 to the current rate. Given the overall number of patients and complexity of the cases dealt with at James Cook University Hospital it was acknowledged that it was a difficult target to achieve. A chart displayed at the meeting demonstrated the differences in the levels of MRSA bacteraemia which was shown to have fluctuated and had vastly decreased since 2004 to date in respect of JCUH and reflected a lower, steady rate throughout at the Friarage Hospital, a smaller District Hospital. Such results had been the result of a number of activities as previously reported to the Panel and of ongoing work.

In terms of MSSA bacteraemia it was reported that the target was approximately 40 and that from April 2010 to date there had been 20 cases. It was noted that the Health Protection Agency was monitoring cases more closely as reported to the Department of Health. It was noted that there were many different organisms one of which was particularly resilient and difficult to treat.

The Panel's attention was drawn to the level of C difficile cases which had recently been the subject of high profile media attention. The number of such cases had been monitored for the past four years.

The target for C. difficile, which was considered to be extremely difficult to achieve, was reported as 116 cases in-patients for more than 48 hours and over two years old. From April 2010 to date the latest figure was reported as 118 cases which in comparison with 2009/2010 of 141 reflected an 18% reduction to date. It was noted that given an increasing number of very complex cases being dealt with at JCUH there was a higher number of cases of under 65 year olds involved. An assurance was given that a vast amount of work continued to be undertaken with regard to C. difficile which included more refined laboratory tests.

In response to clarification sought from Members it was confirmed that there were a number of national and local targets where fines could be attributed should certain targets not be achieved. It was confirmed that the Trust had not received any fines in this regard.

The Panel was advised of ongoing work with regard to infection prevention and control activity in respect of the following:

(a) Cleanyourhands campaign in its fifth year which included focussing at the patient bedside;

(b) Saving lives delivery programme in its fourth year which continued to be embedded into everyday practice;

(c) MRSA and C. difficile pathway and VIP score compliance had continued to improve;

(d) Antibiotic prescribing audits by Antibiotic Pharmacist;

(e) Individual patient follow-up on a regular and at least a weekly basis;

(f) Additional Training

(g) Environmental audits completed;

(h) Surveillance both mandatory and identifying what else could be undertaken;

(i) Outbreak control.

In commenting on the individual needs of patients an assurance was given by the Trust representatives of the need for continued vigilance to review training to cope with the care for the elderly, vulnerable adults and patients with learning disabilities.

In terms of the next steps confirmation was given that HCAI reduction continued to be of the highest priority in the Trust involving:-

(i) closer working with the community;

(ii) raising the profile at every opportunity;

(iii) increasing the knowledge of frontline staff;

(iv) working closely with the Strategic Health Authority, Department of Health and partnership organisations.

During discussions regarding the Trust's new impending responsibilities with regard to Community Services with effect from 1 April 2011 the representatives indicated that from an infection and nursing perspective there would have to be an equality of provision across all areas with the same policies and procedures which currently operated adopted throughout.

The Panel discussed a number of campaigns and policies which had involved a gradual change of culture and was now seen to be common practice. Such areas included ensuring that patients felt comfortable in being able to complete patient surveys and to ask questions of clinical staff on hand cleansing; bare arms below elbows directive; and for staff uniforms only to be worn inside hospitals.

Although it involved significant costs it was noted that the level of screening had increased to all patients. A Member referred to personal knowledge and welcomed the steps taken and support given to a patient with learning difficulties in terms of the time taken to explain what was happening during the screening process. As part of the objective to ensure quality and continue to make improvements details were provided of patient experiences at every meeting of the Board.

The Panel supported the need for constant vigilance in relation to HCAIs and agreed that they should continue to be appraised and receive regular updates in this regard.

AGREED as follows: -

1. That the representatives be thanked for the information provided which was noted.

2. That the Panel continues to receive regular updates on Healthcare Associated Infections.

HEALTH AND SOCIAL CARE REFORMS

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from Middlesbrough Council, NHS Middlesbrough and General Practice to discuss progress in responding to the impending significant reforms for the health and social care economy.

Since the meeting of the Panel held on 15 December 2010 when such matters had previously been discussed the Health and Social Care Bill had been published. Whilst the consultation process had resulted in some aspects of the proposals being amended, major components such as GP Commissioning Consortia, Local Health and Wellbeing Boards and the abolition of Primary Care Trusts remained central to the reforms.

In order to assist with the Panel's deliberations a series of questions had previously been forwarded to the representatives.

The attention of the Panel was first drawn to GP Commissioning Consortia which although had to be operational by 1 April 2013 it was still considered that there were a number of areas which required further Government clarification. From the PCT's perspective an assurance was given that arrangements were in place to ensure a smooth, safe and secure transition as GP Consortium emerged.

The first wave of GP Commissioner Pathfinders had been announced in December 2010 with the second wave covering approximately half of the population of England and Wales being announced in January 2011. As previously reported Redcar and Cleveland had been selected as one of the first groups of GPs in the North East to take on commissioning responsibilities. As part of the third wave of GP Commissioner Pathfinders an application from Middlesbrough would be submitted to the PCT on 10 March which would be subject to assessment by the Regional Panel by 1 April.

As previously indicated the representatives from the Cleveland Local Medical Committee confirmed that they working closely with the existing Practice Based Commissioning Group, PCT, Pathfinders to ensure that appropriate measures were in place during the transition period and a GP Consortia was established by April 2012 and operative from 2013.

Local representatives together with Council Officers acknowledged the importance that current links continued to be strengthened as the different roles developed and the various workstreams established.

Current guidance had made the links clearer between Health and Wellbeing Boards and the Joint Strategic Needs Assessment and GP Consortia. The Panel was advised of work which was being developed with the aim of establishing a Shadow Health and Wellbeing Board by July/August 2011.

In terms of the composition of Health and Wellbeing Boards the Panel discussed the current statutory requirements and potential conflicts of interest which may arise. Given the crucial role of developing a joint needs assessment and health and wellbeing strategy it was considered important to have sufficient Elected Members on Health and Wellbeing Boards. It was noted that whilst current guidance provided a requirement for a GP Consortia to be represented on Health and Wellbeing Boards it didn't necessitate GPs to be involved. It was considered beneficial if GPs attended Health and Wellbeing Boards in order to ensure that GPs were also engaged in the wider determinants of health and wellbeing issues of the Town.

In commenting on the performance monitoring aspects it was suggested that whilst the a Health and Wellbeing Board would be responsible for overseeing a health and wellbeing strategy there was likely to be a number of working groups to ensure its delivery.

As previously acknowledged there inevitably would be a number of GPs who did not wish to play a leading role in the GP Commissioning Consortia but would have the opportunity to be involved in the various workstreams.

The Panel was advised of the links being developed and work progressing to ensure that the Council was in a position to assume its Public Health roles and responsibilities.

AGREED that all representatives be thanked for the information provided and that a further update on progress be reported to the Panel in three months time.

ANY OTHER BUSINESS – SPINAL PAIN

The Chair referred to the meeting of the Panel held on 25 January 2011 when Professor Greenough from James Cook University Hospital together with a Specialist Nurse Practitioner had provided evidence on the current model of service to deal with back pain.

The Panel received a detailed account of the personal circumstances of a number of Members regarding their back related problems from the first visit to their GP and through Primary Care and ultimately Secondary Care and the time frames involved during such periods.

Such evidence supported the claims that in order to improve the overall service there was an overriding need for the early triage for back pain and swift access to specialist care for non-specialised surgery.

The Panel had previously heard of the need for a seamless interface between primary and secondary care which included the creation of Triage and Treat Practitioners in Primary Care and a Functional Restoration Programme as reflected in the 2009 NICE guidelines.

AGREED that the Members be thanked for the information provided.