HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 21 September 2011.

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

OFFICERS: J Bennington and J Ord.

**** PRESENT BY INVITATION:** South Tees Hospitals NHS Foundation Trust:

J Barlow, Lead Nurse, Infection Prevention and Control
Prof. P J Kane, Chief of Service, Neurosciences
J Moulton, Director of Planning
A Peevor, Assistant Director of Nursing /Deputy Director of Infection Prevention and Control
Dr G Young, Consultant Neurology.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Cole, Davison, Harvey and Mawston.

**** DECLARATIONS OF INTEREST**

There were no declarations of interest made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 24 August 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 the South Tees Hospitals NHS Foundation Trust (STHFT) to provide a further update on the current situation with regard to Healthcare Associated Infections (HCIAs) at James Cook University Hospital (JCUH).

The Chair welcomed representatives from the STHFT 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 in their presentation.

It was confirmed that the MRSA bacteraemia target had been seven in 2010/2011 and there had been six attributed Trust cases. The target for 2011/2012 was reported to be four and that from April 2011 there had been one attributed Trust case on trajectory.

Given the overall number of patients and complexity of the cases dealt with at JCUH 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 as outlined.

In 2010/2011 the target for C. difficile had been 116 cases in-patients for more than 48 hours. It was confirmed that although there had been 125 cases in 2010/2011 such a figure represented a 11% reduction compared to 2009/2010. The C. difficile target for 2011/2012 was reported as 112 cases including 7 in respect of community hospitals. The Panel was advised that as from April 2011 there had been 43 cases on trajectory. It was acknowledged that this was a difficult target to achieve especially given that the newly acquired community hospital beds had not yet been included in the denominator for setting the level of the target.

Whilst it was indicated that the Trust was doing well in meeting such targets the need to continue to disseminate the importance of CD management was acknowledged.

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 sixth year which included focussing at the patient bedside;
(b) saving lives delivery programme in its fifth year (doing the right thing every time) which continued to be embedded into everyday practice;
(c) policy compliance through audits and focus months;
(d) antibiotic prescribing audits by antibiotic pharmacist;
(e) daily IPC team patient follow-up;
(f) weekly multi-disciplinary ward rounds;
(g) training;
(h) environmental audits;
(i) increasing surveillance;
(j) outbreak control – no norovirus outbreaks at JCUH;
(k) external scrutiny;
(l) additional reporting of E.coli and Extended –Spectrum Beta-Lactamase bacteraemia.

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

(i) integration with community services which was seen as a real challenge;
(ii) raising the profile at every opportunity;
(iii) continuing to increase the knowledge of frontline staff;
(iv) continuing to work closely with the Strategic Health Authority, Department of Health and partnership organisations;
(v) monthly reports to the Board of Directors.

Members were keen to ascertain steps which were being pursued to empower patients to feel confident to ask about matters of cleanliness. In response reference was made to various measures
which had been undertaken including patient surveys and the use of publicity posters in each ward.

The Panel was mindful of the challenges facing the Trust in trying to sustain improvements given such difficult financial constraints. Other factors such as an ageing population with complex needs was seen as a major challenge for the Trust and also the affects of a severe winter period. In relation to other areas it was stated that the Trust was committed to providing support to Care Homes in terms of infection prevention and control.

In discussing the statistical information it was noted that there was only one comparable Trust which had slightly better figures based on the Trust's current number of cases.

AGREED as follows:-

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

2. That the Panel continues to receive a further update on Healthcare Associated Infections in six months time.

NEUROLOGICAL CONDITIONS – SOUTH TEES HOSPITALS NHS FOUNDATION TRUST

The Scrutiny Support Officer submitted a report the purpose of which was to introduce representation from the South Tees Hospitals NHS Foundation Trust to provide information on their perspective as a provider of many neurological services with regard to the Panel's current scrutiny topic on neurological conditions.

In order to provide background information and assist deliberations the Trust had provided information on the Neurological Secondary Care Services south of Tees as outlined in Appendices 1 and 2 of the report previously circulated.

In recent years the Department of Neurology had expanded significantly and embodied a number of specialised neurological services to a population of approximately 1.2 million. It was noted that Neurology services were commissioned as specialist services by the North East Specialised Commissioning Team.

It was confirmed that a large number of urgent (acute) and non-urgent (both short-term and long-term) conditions were seen within neurology, examples of which were listed in the report submitted and the Unit at JCUH had 21 beds two of which were specialised for complex assessment of patients with fits. It was confirmed that a viable Department of Neurology was pivotal to JCUH functioning as a Major Trauma Centre.

An indication was given of the model of care carried out at JCUH which was based on that widely practised elsewhere in the UK. The Panel was advised that current arrangements resulted in neurologists now spending a greater amount of time seeing 'worried well' in the outpatient clinic whilst patients with serious acute neurological disorders may not see a neurologist for some days following their presentation. In terms of the role of GPs the process of diagnosis in respect of neurological conditions which were often complex had seen a change of emphasis from that of consultation to more of a means of referral.

The Panel discussed issues around ensuring quality of access to services and whilst in general terms it was felt that patients who well informed might be in a better position to question GPs there was a concern regarding the more vulnerable patients. There was also a feeling that in many cases the prevailing culture largely resulted in potential vulnerable patients accessing services at a late stage. It was considered important that measures should be in place which made best use of a consultant's time.

It was stated that the demand for specialist input from patients together with the diminishing neurological skills of GPs had fuelled the increased provision of neurologists across the UK in the last 20 years. A significant proportion of out-patient neurology now involved seeing patients with complex symptoms. A case had been made for improving the provision of neurological expertise in primary care either by involving GPs with a specialist interest or else developing primary-care based specialist nurses. It was felt that if the majority of patients who did not have neurological conditions could be appropriately managed within primary care then the remainder would be able to be seen more quickly or more frequently by the specialist resulting in considerable pressure on review slots for patients with neurological disorders with no vacant slots in some clinics in excess of six months.

The need to develop a properly integrated neurological service with seamless boundaries between primary and secondary care was considered important and should ideally encompass the full range of services necessary to the management of patients with long-term conditions including in-hours and out-of-hours general practice, physiotherapy, occupational therapy, speech and language therapy, social services, wheelchair services and palliative care services.

Reference was made to the conditions covered at the general and specialist clinics. It was confirmed that it was not possible, without employing a very large number of consultants to have specialty clinics covering all of the neurological conditions. It was suggested however that there were important areas where the consultant specialty interests could be strengthened notably in the areas of movement disorders and neuroinflammatory conditions such as multiple sclerosis. In pursuance of this, two of the neurologists in the department had developed their expertise in MS and a movement disorder specialist had been identified for a currently vacant post.

In terms of rehabilitation it was reported that there were limited inpatient acute specialist rehabilitation facilities while community services were also limited and disease specific. It was confirmed that there were nine rehabilitation consultants working in five centres in the North East. It was noted that there were three disability services centres for prosthetic rehabilitation in the North East with one each in Newcastle, Middlesbrough and Carlisle. The regional spinal injuries rehabilitation centre was based at JCUH which was staffed by two consultants.

The report outlined the rehabilitation facilities and recent developments at JCUH.

The areas for further development included the need for dedicated neuro-psychology therapeutic input, local access to neuro-psychiatry services, provision of vocational rehabilitation and to improve therapy staffing levels for in-patient rehabilitation.

Neurorehabilitation at JUCH was currently not commissioned as a specialist service although it was providing services to category A patients but was commissioned separately by local primary care organisations. Members were advised that the Trust was working in collaboration with commissioner colleagues to review the current commissioning arrangements with a view to developing consistent arrangements across the North East. This was considered to be important as accessing facilities at Walkergate Park Hospital in Newcastle was considered difficult due to long waiting times and was impractical due to long distances and travelling times involved.

The Division of Neurosciences at JCUH was one of the two neurosciences centres in the North East providing services to a large catchment area extending from North Yorkshire in the south to Durham and Sunderland in the north. The neurorehabilitation department provided acute specialist in-patient rehabilitation services, outpatient services, prosthetic rehabilitation services and regional specialist wheelchair services. In-patient specialist rehabilitation was a level two facility which was providing service to patients with complex needs and as a result very few patients had been referred to Walkergate Park hospital in Newcastle-upon-Tyne in the last few years. Similarly, outpatient clinics had been developed including a specialist spasticity management clinic thereby providing services to patients close to their homes in accordance with the national service framework for long term conditions.

Owing to a large catchment area the neurorehabilitation department at JCUH relied on the local services/hospitals for the provision of outpatient/community therapy services. The areas for development included increasing the provision of dedicated rehabilitation beds in surrounding hospitals with medical leadership, increasing community provision and development of multidisciplinary teams.

The JCUH had been designated as one of the two major trauma centres in the North East along with Newcastle acting as a hub for trauma units in Stockton and Darlington. The key principle in the establishment of major trauma networks was the rapid delivery of patients to the facility with the specialised services needed to provide definitive care. The importance of rehabilitation services was recognised as a key component. Although it was acknowledged that the Trust had good rehabilitation facilities for neurological and spinal cord injuries, rehabilitation pathways for trauma centres would be developed so that in the future every patient had a rehabilitation plan with access to rehabilitation. It was acknowledged that there was much work to be undertaken regarding the development of co-ordinated specialist's rehabilitation services to support trauma.

The strengths of the current position were identified as follows:-

(a) a good skill mix had been developed in the neurology department with a group of like-minded neurologists and specialist nurses dedicated to providing and developing the service;

(b) from the patient's perspective the service provided a wide variety of general and specialist neurological services with excellent access to timely supporting investigations;

(c) availability of local general neurology clinics to patients from around the region;

(d) the majority of patients could have their illnesses diagnosed and managed close to home and tertiary referrals to centres in London/Newcastle were now rarely required;

(e) specialist nurses had significantly improved the accessibility of the department for patients with epilepsy, Parkinson's disease, MS and MND;

(f) some specialties were extremely well supported including development of acute stroke /TIA management, epilepsy services, and patients with cognitive disorders, sleep disorder, autonomic conditions, and Motor Neurone Disease Association Care Centre.

The Panel's attention was drawn to opportunities for possible development. Whilst still meeting national targets it was felt that improvements could be made to seeing newly referred patients at an earlier time.

It was considered that there were some specific areas of neurological practice where it was felt that there would be benefit from greater local expertise, notably the management of patients with movement disorders and multiple sclerosis.

Although there had been increase in specialist nurse roles over recent years it was felt that there was an opportunity for further development as well as seeking to increase therapeutic psychologist input.

In terms of the future it was reiterated that:-

(i) there was a need to develop services that were better integrated with primary care which may involved identifying and training GPwSIs or else developing and expanding the role of the specialist nurse practitioner;

(ii) there was a need to strengthen specialist support particularly for patients with MS and movement disorder;

(iii) there was a need to identify better ways to deliver neurological services to the patients in their own locality which was likely to involve investing in specialist nursing support with or without specialist GPs;

(iv) there was a need to find better solutions for patients with acute neurological disorders that would result in more timely access to specialist neurological opinions whatever the geographical location of the patient.

AGREED that the local NHS representatives be thanked for the information provided which would be incorporated into the overall review.

OVERVIEW AND SCRUTINY BOARD UPDATE

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from the meeting of the Overview and Scrutiny Board held on 23 August 2011.

NOTED