Health Scrutiny Committee

Minutes of the meeting held on 23 May 2013

Present:
Councillor E Newman – In the Chair
Councillors Cooper, Ellison, Fisher, Fletcher-Hackwood, Lyons, O'Neil, Paul, Siddiqi, Swannick, and Watson

Councillor Andrews, Executive Member for Adult Services

Nick Gomm, Head of Corporate Services - North, Central and South Manchester Clinical Commissioning Groups
Dr Richard Deacon, GP and Board lead for Quality, North Manchester Clinical Commissioning Group
Helen Curtis, Governance Director, Pennine Acute Trust
Dr Ivan Bennett, Clinical Lead for Quality, Central Manchester Clinical Commissioning Group
Deborah Carter, Deputy Director of Nursing, Quality and Patient Experience, Central Manchester Foundation Trust
Sarah Corcoran, Associate Director of Clinical Effectiveness, Central Manchester Foundation Trust
Kate Lord, Quality Lead, Central and South Manchester Clinical Commissioning Group’s
Dr Naresh Kanumilli, Clinical Lead for Quality and Performance, South Manchester Clinical Commissioning Group
Kath Hingley, Head of Patient Safety and Quality, University Hospital of South Manchester Foundation Trust
Dr Helen Hosker, Clinical Lead, Public Health Manchester
Carol Harris- Manchester Mental Health and Social Care Trust

Apologies:
Councillors A Ahmed, Cox and Judge

HSC/13/17 Urgent Business

The Chair welcomed the new members to the Committee which included Councillors Fletcher-Hackwood and Paul who were present and Councillors Cox, Reid and Judge who were not. The Chair also welcomed the new Executive Member.

The Chair advised that Quality Accounts would be considered as an item of urgent business. Draft statements had been prepared in advance of Committee and had been circulated to members and Trust representatives for comment. Members would be asked to provide any amendments and agree these at today’s meeting in order that the Health Scrutiny Committee Statement could be submitted prior to the deadline.

The Chair expressed dismay that a report had been submitted to Neighbourhood’s Scrutiny Committee earlier that week on 20mph zones, which was being funded through the Public Health Budget. He supported 20mph zones, but felt it was wrong
that the Health Scrutiny Committee had not been consulted or informed of this. The Executive Member for Adults advised that this funding was the result of a separate bid to Government related to reducing road deaths and would not affect the general allocation of public health funding.

**Decision:**

To accept an item of Urgent Business on Quality Accounts

**HSC/13/18 Quality Accounts**

Members commented that it was difficult to compare and contrast the Quality Accounts when different Trusts used different indices to measure mortality ratios. Representatives advised they would explain this as part of the response to the Francis Report.

The lead nurse for Manchester Mental Health and Social Care Trust (MMHSCT) updated members on the Care Quality Commission (CQC) Outcome 10. The CQC had confirmed that MMHSCT were now compliant with this as of 31st March 2013.

**Decision:**

1. Members agreed all of the draft statements for the Quality Accounts.

2. The Committee Support Officer to submit the statements as a final version to each of the Trusts

**HSC/13/19 Minutes**

**Decision**

1. To approve the minutes of the Health Scrutiny Committee meeting on 7th March

2. To approve the minutes of the Health Scrutiny Committee meeting on 13th March

**HSC/13/20 The Mid Staffordshire NHS Foundation Trust Public Inquiry - Response from the Clinical Commissioning Groups**

The Committee welcomed representatives from the North, South and Central Clinical Commissioning Groups, Central Manchester Foundation Trust, Pennine Acute Trust, and University Hospital of South Manchester NHS Foundation Trust. The representatives had been invited to deliver their response to the Mid Staffordshire NHS Foundation Trust Public Inquiry (known as the Francis Report). Representatives delivered a presentation to the Committee.

The Clinical Lead for Quality, CMCCG explained the Central Manchester response. He advised that patient safety was their first priority and they scrutinised Central Manchester Foundation Trust (CMFT) in a number of ways including quarterly meetings to scrutinise the Quality Accounts, attending board meetings of CMFT,
mystery shopper exercises, and CQUIN (Commissioning for Quality and Innovation payment framework) quality indicators which were developed each year.

Representatives advised they submitted a board paper in December on this, and their 3 priorities as outlined in their Quality Account are Patient Safety, Clinical Effectiveness and Patient Experience. It was explained that when measuring mortality rates different indicators were available for Trusts to use and they measured mortality rates in different ways. These were known as HMSR, MARI, and SHMI. At CMFT they had mixed results dependent on which indicator was used. Coding and quality improvement work was ongoing in order to understand the indicators better and to ensure they were an accurate reflection of current practice. She advised that CMFT had experienced 8 ‘never events’ (an event which should not have happened or could have been prevented) not 7 as was stated in the report. They were very disappointed by this as they had experienced none in the previous year. All of these events related to surgical procedures, although not within the surgery arena. She assured members these had not resulted in significant harm to patients and the events were analysed and results shared. The Deputy Director of Nursing explained that she had been working with nurses and midwives who had devised their own values framework in order to challenge behaviour in a constructive way. They were interested in what motivates people to provide excellent care—and want to be perceived as a high provider of excellent care, be held to account, focus on the basics and decrease incidents to the lowest level. Clinical staff were helping to drive improvements in quality and progress would be reported in their next Quality Account.

The Clinical Lead for Quality and Performance, South Manchester Clinical Commissioning Group (SMCCG) introduced himself and echoed NMCCG’s comments in respect of the quality strategy. He explained that South Manchester has its own Quality Strategy and holds quarterly quality meetings where the QA’s are discussed and the patient and public advisory group was very active. The group gathered soft intelligence from walkabouts, collaborated with the trust and other CCG’s, and had an integrated governance group which shared best practice. The Head of Patient Safety and Quality explained that the first Francis Report in 2010 had kick started changes. The ‘Patient Safety Quality and Experience’ programme was founded on the outcomes of this. One initiative filmed patients and families and was used with clinical teams and junior doctors as feedback/training. In respect of mortality rates she explained that they had a mortality review process for the past 3 years and were supplying a paper to the board next week to request more resources for this. The intention being to review every death within 1 week by a multi-disciplinary team of senior doctors and nurses. This related to the CQUIN indicators as better management of sepsis and pneumonia should help prevent unnecessary deaths.

The Governance Director for Pennine Acute Trust explained that they did not yet have Foundation Trust status but had aspirations for this. The 1st Francis Report had resulted in changes to the application process which included the need for Quality Indicators which trusts now had to provide evidence This included a long term quality plan, and evidence to support how they were working together in terms of the healthier together agenda and strategic planning. The GP and Board lead for Quality emphasized the importance of collaborative working.
Members emphasised the importance of encouraging and protecting whistleblowers. They were concerned that the role of patients was not underestimated as they were often the first to notice when things were going wrong. They felt that culture change was vital within the NHS but commented that they had already noticed a shift to increased transparency and openness. They queried whether the collection of ‘real time information’ meant that incidents would be responded to quicker. Members were pleased with the explanation of attempts to standardise mortality data, felt the role of Monitor and relationships with the Care Quality Commission (CQC) were significant. Members felt standardisations of mortality data needed to be taken up with national bodies due to increased autonomy of NHS bodies.

The Chair highlighted the difficulties of effectively scrutinising North Manchester General Hospital as it is part of the Pennine Acute Trust which covers four local authority areas which is scrutinised by a specific joint health scrutiny committee. However this Committee was still concerned by what happens at North Manchester General Hospital. A member highlighted the concerns around Tameside hospital which was being inspected today regarding high mortality rates, although it didn’t come under the remit of the Health Scrutiny Committee it impacted on residents in East Manchester as users of this service.

Members empathised with representatives present and healthcare staff generally who had to deal with such failings as had happened at Mid Staffordshire and commented on the difficulties of assessing human life in business terms. Members welcomed the ‘Patients must come first’ agenda and queried whether any significant findings had arisen via complaints, changes in approach and the introduction of non legal remedies and litigation.

Representatives advised they felt ‘whistleblowers’ was a negative term and referred to different initiatives they had established such as ‘Ask’ and ‘Speak up’. They felt the initiatives helped to encourage the ‘Duty of Candour’ in a more constructive and positive way. They highlighted how Senior Managers had been getting involved at all levels including doing ward rounds, using complaints and tracking devices to gather intelligence, rating all wards, assessing performance, and developing bespoke solutions. CMFT was one of the highest reporting trusts for incidents in the NHS but they felt this was partly attributable to incident reporting being encouraged. The Quality Lead advised her role was to provide information to external regulators including liaising with Monitor and CQC. Indications were that relationships would continue to improve. Monitor had moved to a more quality based role using numerical indicators, and the CQC had recently held a road-show where they acknowledged the need to work differently. Representatives acknowledged the importance of apologising to patients where things had gone wrong, and the visibility of the board and the executive team in driving culture change within the NHS.

The Governance Director of the Pennine Acute Trust advised she wanted to address the Chairs concerns re the scrutiny of them; and explained the different nature of the complaints they were receiving and how they were consulting with staff and patients. A key concern was communication and they now had 700 staff that were ‘Dignity Champions’ from across a number of disciplines. The Chair advised the concern was around the structure of NHS organisations and services, and that the Committee
would wish to examine the impact on North Manchester General Hospital of the Healthier Together proposals due to be published in the next few months.

Members stressed the fact that patients in hospital were often those that were most vulnerable and asked representatives not to under-estimate the difficulties for patients and staff to challenge more senior staff with their concerns. Members also stressed the importance that both patients, and their families and friends, re-gained confidence in the NHS following the negative publicity around the Mid Staffordshire inquiry. Members noted that whilst all the CCG’s were taking action in line with government time-lines, some had made more progress than others. Members expressed interest in the response of the regulators and noted they would be interested to find out what this was.

**Decision:**

1. The Committee Support Officer will invite representatives from CQC and Monitor to a future meeting of the Committee

2. The Committee would like to re-visit this issue in about 6 months time when the government timelines had been reached for response.

**HSC/13/21  Falls in Older People**

The Clinical Lead for Public Health Manchester introduced the report. She explained the Joint Strategic Needs Assessment had identified falls as a priority and there was a need to develop further understanding on this. Lots of organisations were involved in falls and a multi-agency approach was needed based on evidence. She outlined some of the key points of the report and explained her role had recently changed so she now supported the CCG’s one day a week.

A member noted an initiative that had been run previously in North Manchester where Aids and Adaptations Teams had visited all residents over 70 to assess them for Aids and Adaptations and that this had resulted in reduced hip injuries over the subsequent 12 months. The Clinical Lead advised that although this sounded like a good initiative it was difficult to prove that the decrease in hip injuries was a direct result of the initiative. She emphasized that a falls risk assessment covered more than aids and adaptations alone, they needed to be evidence based and holistic. The Community Falls Service were more in-depth than those provided in hospital. They were not just related to falls but fractures also and many included bone health assessments.

Members were pleased by developments in this area and that the report stated that patients came first. A member highlighted the statistics on falls that we have four times as many falls as the national average and the North-West as a region has double the national average. Members were concerned that patients admitted to hospital because of a fall could find their health then declines because of other reasons. The Clinical Lead explained that many reasons contributed to falls and there may be underlying socio-demographic reasons contributing to this. She also highlighted some of the ways this was being addressed such as information sharing and better use of ICT.
Decision:

1. The Committee thanked the Clinical Lead for her commitment, enthusiasm, and co-ordinating the collaboration of different agencies

2. The Committee would like to consider this item again at a future meeting to see what progress has been made

HSC/13/21 Health and Wellbeing Update: Part One

The Committee considered the monthly Health and Wellbeing Update report, which provided members with an overview of developments across the NHS and social care. The Strategic Director for Families, Health and Wellbeing introduced the first part of the report which included information on Universal Credit, the role of Local Authorities in Health, and Quality Standard. The Strategic Director explained there had been lots going on over recent months and the pace of change had increased. The Health and Social Care Bill was now at secondary legislation stage and a national eligibility criteria for adult social care was being developed. Legislation for adult social care was being consolidated and how social care was funded was being re-assessed. It was felt that the formula was not beneficial to Manchester residents and was based on the Shire Counties where residents had increased equity and capital. Manchester’s Treasurer was on the national group developing the formula and the Strategic Director was contributing to this via the Core Cities group. Manchester Council were testing the national eligibility criteria assessment and getting involved at the outset.

Members commented that Universal Credit would have a negative impact on vulnerable people and noted that Economy Scrutiny was leading on the impact of these changes. The Chair noted that at the next meeting they would be considering the outcomes of public consultations for Community Alarms, Drug and Alcohol Services, and Supporting People. Members noted they were aware of many issues through their casework and publicity surrounding the reforms. The Director commented that the changes had resulted in increased legislative burdens but no extra resources to help address this. The pace of change was very fast at present and challenging.

Decision:

To note the report and welcome the proposals

HSC/13/22 Health and Wellbeing Update: Part Two

The Committee considered the monthly Health and Wellbeing Update report, which provided members with an overview of developments across the NHS and social care. The Head of Corporate Services - North, Central and South Manchester Clinical Commissioning Groups introduced the second part of the report. He advised that he would continue to provide regular updates on the 111 service. A member queried the locality updates and how the priorities for Whalley Range, Chorlton, and
Fallowfield had been identified. The Head responded that the report had been drafted from the minutes of local meetings which could be supplied to Committee if required.

Decision:

The Head of Corporate Services to provide the local meeting minutes for each of the four localities across the city

HSC/13/23 Health Scrutiny Committee- Governance and Constitutional Issues

The Committee were presented with a report of the Governance and Scrutiny Support Unit which the Chair explained the rationale for. New regulations had removed the legal obligation for a local authority to establish a specific Health Scrutiny Committee and the Council now had greater flexibility to decide how to delegate these powers. Other aspects of the new regulations had been incorporated into the new Member’s Guide which had been re-issued to all members at the meeting. Members advised they had read the report and were happy with current arrangements.

Decision:

1. The Committee requests that the Constitutional and Nomination Committee recommend to Council that the Council retains the existing structure for the discharge of the Council’s Health Scrutiny functions, namely that they are discharged by the Health Scrutiny Committee

2. The Committee requests that the following local authority powers are delegated to the Health Scrutiny Committee:
   a) REVIEW ANY MATTER RELATING TO THE PLANNING, PROVISION AND OPERATION OF HEALTH SERVICES IN THEIR AREA;
   b) REQUEST INFORMATION FROM NHS BODIES AND RELEVANT HEALTH SERVICE PROVIDERS;
   c) REQUIRE ATTENDANCE OF NHS STAFF AND MEMBERS OF RELEVANT HEALTH SERVICE PROVIDERS AT SCRUTINY MEETINGS;
   d) MAKE REPORTS AND RECOMMENDATIONS TO NHS BODIES, RELEVANT HEALTH SERVICE PROVIDERS AND THE LOCAL AUTHORITY, AND EXPECT A RESPONSE WHERE ONE IS REQUESTED WITHIN 28 DAYS;
   e) RESPOND TO CONSULTATIONS BY NHS BODIES AND RELEVANT HEALTH SERVICE PROVIDERS ON MATTERS OF SUBSTANTIAL VARIATIONS OR DEVELOPMENTS TO HEALTH SERVICES. THEY MUST PUBLISH TIMESCALES FOR MAKING SUCH RESPONSES;
   f) REFER CONTESTED SERVICE CHANGES TO SECRETARY OF STATE ON SPECIFIC GROUNDS. THEY MUST PROVIDE ROBUST EVIDENCE IN SUPPORT OF THIS AND PUBLISH CLEAR TIMESCALES WITHIN WHICH THE REFERRAL WILL BE MADE,
   g) CO-OPT REPRESENTATIVES ONTO THEIR HEALTH SCRUTINY ARRANGEMENTS;

3. The Committee noted that the regulations contain further provisions in respect of procedures and protocols in respect of Healthwatch and NHS service change which are included in the updated members guide which they have received
HSC/13/19  Overview report

A report of the Governance and Scrutiny Support Unit was submitted. The overview report contained key decisions within the committee’s remit, responses to previous recommendations made by the committee and the committee’s work programme. The Committee was asked to amend or approve the work programme.

The Chair noted there were a number of outstanding recommendations which would be resolved via the agenda setting process. It had also been agreed in the pre-meeting not to hold a work programming session after the meeting as it was not required at this time. Members were encouraged to contribute items at any time, in particular during the section of the Committee where the Overview Report was discussed.

Members noted that they had requested that the Committee invite representatives from both the Care Quality Commission (CQC) and Monitor to a future meeting. It was also requested to add an item to the work programme on ‘Living longer, Living better- the Blueprint for Integrated Care’

Decision:

1. To agree the Committee’s work programme

2. The Committee Support Officer to update the work programme with the above amendments