Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 17th June 2015

Present: Councillor S Kerrison (in the Chair)
Councillors P Adams, E FitzGerald, J Grimshaw, S Haroon, K Hussain, J Mallon, S. Smith and R Walker

Also in attendance: Councillor Andrea Simpson, Cabinet Member Health and Wellbeing
Stuart North, Chief Officer at Bury CCG
Linda Jackson, Assistant Director, Operations, Bury MBC
Joanne Moore, Divisional Director for Medicine, Pennine Acute NHS Trust
Dr Anton Sinniah, Acting Medical Director, Pennine Acute NHS Trust
Nadine Armitage, Head of Partnerships, Pennine Acute NHS Trust
Julie Gallagher, Democratic Services Officer

Public Attendance: 2 members of the public were present at the meeting.

Apologies for Absence: L Fitzwalter, R Skillen and T Pickstone

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HSC.94 DECLARATIONS OF INTEREST

Councillor Joan Grimshaw declared a personal interest in all matters under consideration as a Member of the Patient's Cabinet.

HSC.95 PUBLIC QUESTION TIME

There were no questions from Members of the public present at the meeting.

HSC.96 MINUTES OF THE LAST MEETING

It was agreed:

That the Minutes of the last meeting held on 19th March 2015 be approved as a correct record and signed by the Chair.

HSC.97 MATTERS ARISING

In response to a question from Councillor Mallon, the Assistant Director of Operations for Adult Care reported that the re-tendered Drug and Alcohol services provided in Bury provides a recovery model of care.

It was agreed:

Performance data in relation to the recently re-tendered Drug and Alcohol Service will be considered at a future meeting of the Health Overview and Scrutiny Committee.

HSC.98 PENNINE ACUTE NHS TRUST MATERNITY SERVICES UPDATE

Members of the Committee considered a verbal presentation from Dr Anton Sinniah, Pennine Acute NHS Trust, in relation to the recently conducted external review of maternity services within the Trust. The presentation contained the following information:

Following the appointment of the new Chief Executive a system was introduced whereby all serious untoward incidents were notified to the Chief Executive and Executive Directors within 24hours and discussed at senior management team on a weekly basis.

The report highlighted several incidents within maternity services. The incidents were reviewed through the Trusts own root cause analysis. The Trust commissioned an external review of nine incidents which had occurred in maternity services six neonatal and 3 maternal deaths.

In summary, the findings of the external review were:

- The population of women cared for at Pennine Acute Trust is diverse and challenging and includes a significant number of high risk and vulnerable women.
- There are clearly areas of good practice which are appropriately noted and acknowledged and which should be widely shared.
- The three maternal deaths did not appear to be the result of deficiencies in care.
- The serious incidents were thoroughly and comprehensively reviewed by the Trust and there was a clear, honest and open approach to identifying failings.

There were twelve recommendations made as a result of the review and a comprehensive improvement plan has been drawn up to address the issues raised.

Dr Sinniah explained the sequence of events around the media coverage of the maternity review. A member of staff had approached the MEN prior to the review being shared with the families. Whilst families had previously been involved with some of the root cause analyses (not all had wished to be), a learning point for the trust was that it should have informed the families of the review at an earlier stage.

Those present were given the opportunity to ask questions and make comments and the following points were raised:

Dr Sinniah reported that there have been a number of changes to senior management at the Trust since the commencement of the external review; the appointment of a new Chief Nurse as well as a new Deputy Chief Nurse, the appointment of a new Director of Governance and an Acting Medical Director.

In response to a Member's question Dr Sinniah acknowledged that when the external review commenced, the Trust should have informed those families directly affected.

The external review highlighted 4 key areas for improvement: risk management, escalation, clinical leadership & management of obesity. There were neonatal cases where the outcomes could have been different, but the maternal deaths were not felt to be preventable. The trust was never the less keen to point out that there was still learning & improvement for the teams in the maternal cases.

Dr Sinniah confirmed that any death that occurs up to 365 days after giving birth is recorded as a Maternal death.

Following the decision to conduct an external review, the Trust informed the local CCGs as well as the Trust Development Authority. An incident management group has been established which is co-chaired by Gill Harris, Pennine Acute's Chief Nurse and Stuart North, Bury's CCG Chief Operating Officer.

In response to a Member's question, Dr Sinniah reported that there has been some ongoing media interest in the Trust's maternity services. As part of a communication and media plan, Gill Harris (Chief Nurse) & Dr Sinniah met with a MEN journalist to give more clinical background to the reporter and to show him around the maternity unit at the Royal Oldham Hospital.

In response to a Member's question, Dr Sinniah reported that in response to the concerns raised about clinical leadership the Trust must ensure that there is clarity in relation to individuals' roles and responsibilities and that information is disseminated.

Dr Sinniah reported that both sites provided 134 hours of consultant cover which is significantly higher than some other comparable units in the region.

In response to concerns raised by Members, Dr Sinniah reported that in individual cases, a failure of staff to escalate concerns did lead to poor outcomes. The Trust has subsequently twinned with Newcastle Hospital NHS Foundation Trust to share best practice.

In response to a Member's question, Dr Sinniah reported that the external review did not highlight concerns in relation to a shortage of midwives but rather a shortage of health care assistants.

Stuart North, Chief Operating Officer Bury CCG reported that the CCG have been involved in overseeing the process and there will be issues for the CCG as well as the Trust to take forward.

It was agreed:

That the Health Overview and Scrutiny Committee would receive an update in relation to the Pennine Acute Maternity Services improvement plan at a future committee meeting.

HSC.99 DELAYED DISCHARGE

Joanne Moore, Divisional Director for Medicine Pennine Acute NHS Trust attended the meeting to provide members of the Committee with an update in relation to concerns raised with regards to delayed discharge. An accompanying report had been circulated to Members which provided information in relation to; the current

process to manage delayed discharges the reasons for delays and the current actions that are being taken to address the issues.

The Divisional Director for Medicine reported that there are two measurable types of delayed discharge. The first group are the Delayed Transfers of Care (these are externally monitored) DTC and the second group are those that are defined as Medically Fit for Discharge (MFFD).

Members considered the types of delays; the proportion of patients delayed across all hospital sites, the number of MFFD by site and the distribution of medical MFFD and DTC by local authority area and hospital site.

The Divisional Director reported that the reason for the delays are multi-factorial and community and Local Authority partner organisations are working with the Trust to develop and implement solutions.

In response to a Member's question the Divisional Director reported that at North Manchester General Hospital all staff are involved in the discharge process form acute, community and local authority as they work as an integrated team based on the same site and are line-managed on a daily basis by one Trust Manager.

The Divisional Director reported that it is the Trust's and partner organisations aspiration to have single discharge process on the sites, a northeast sector discharge group meets regularly to discuss these issues and monitor progress.

In response to a Member's question the Divisional Director reported that the Trust's performs very well in respect of readmission rates and within the Northwest are in the top quartile.

In response to a question from the Chair the Divisional Director reported that the Trust are currently conducting a 'Perfect Week' exercise which is a focussed piece of work which involves senior staff spending time at each hospital site observing and logging issues.

It was agreed:

That a follow up report from the Trust wide discharge planning group will be considered at a future meeting of the Health Overview and Scrutiny Committee.

HSC.100 CHANGES TO BARDOC (BURY AND ROCHDALE DOCTORS ON CALL)

Stuart North, Chief Operating Officer Bury CCG provided members with a verbal briefing in respect of the proposal to transfer the BARDOC treatment rooms to Fairfield General Hospital.

BARDOC will be situated at the outpatients department, Foulds Suite. The BARDOC clinical team have audited referrals received to their GPs from the Bury Urgent Treatment Centre and BARDOC believes there is no clinical risk in moving the Out of Hours GPs from the Moorgate site.

In response to concerns raised by Members, the Chief Operating Officer reported that there will be no difference in the service provided to patients.

It was agreed:

The proposed changes to Bury and Rochdale Doctors on Call be noted.

HSC.101 HEALTHIER TOGETHER

Stuart North, Chief Operating Officer Bury CCG reported that a meeting of the Healthier Together Committees in Common took place earlier today (17.07.2015). The Committee confirmed that there would be four specialist sites the details of which will be confirmed on 15th July 2015.

It was agreed:

Stuart North, Chief Operating Officer Bury CCG would provide the Health Overview and Scrutiny Committee with a further briefing in relation to Healthier Together at the next meeting of the Health Overview and Scrutiny Committee.

HSC.102 WORK PROGRAMME DISCUSSION

Julie Gallagher, Democratic Services Officer, submitted a report setting out the terms of reference for the Committee along with a Work Programme discussion report to assist members in the development of a Work Programme for 2015/2016.

The report also highlighted a number of issues/topics carried over from last years programme.

It was agreed:

1. In addition to the items highlighted within the work programme report that the following items be included part of this Committee's Work Programme for 2015/16:
   - Healthier Radcliffe update report
   - Access to Primary Care – do members of the public know where to go? How is this information communicated?
   - I Will If You Will update
   - How is Social Care delivered in Bury and levels of satisfaction with the services provided.
   - Devolution Greater Manchester

2. Julie Gallagher, Democratic Services Officer will meet with Linda Jackson, Assistant Director, Operations, Adult care to discuss the development of the work programme prior to the next Health Overview and Scrutiny meeting.

HSC.103 URGENT BUSINESS

There was no urgent business reported.

COUNCILLOR SARAH KERRISON
Chair

(Note: The meeting started at 7pm and ended at 8.55pm)