Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE
18 March 2013 at 10.30am

Membership

Councillors

Sue Saddington (Chairman)
Wendy Quigley (Vice-Chair)
Stuart Wallace
A June Stendall
Chris Winterton
A Brian Wombwell

District Members

A	Trevor Locke	-	Ashfield District Council
A	Paul Henshaw	-	Mansfield District Council
	Tony Roberts	-	Newark and Sherwood District Council
A	June Evans	-	Bassetlaw District Council

Officers

Martin Gately	-	Nottinghamshire County Council
Ruth Rimmington	-	Nottinghamshire County Council

Also in attendance

Dr Kate Jack	-	Newark and Sherwood CCG
Jan Balmer	-	Newark and Sherwood CCG
Dr Amanda Sullivan	-	Chief Executive Mansfield and Ashfield CCG
Dr Mark Jefford	-	Clinical Lead and Chair of NHS Newark and Sherwood Clinical Commissioning Group
Eric Moreton	-	Interim Chief Executive Sherwood Hospitals Foundation Trust
Cathy Quinn	-	Associate Director of Public Health

MINUTES

The minutes of the last meeting of the Health Scrutiny Committee held on 21 January 2013 were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Councillor June Evans
Councillor Paul Henshaw

Councillor June Stendall

DECLARATIONS OF INTEREST

Members declared private non pecuniary interests as follows:-

Councillor Sue Saddington - Item 6 – due to her daughter's medical profession.

Councillor Wendy Quigley - Item 4 – as member of the Bassetlaw Health Scrutiny Committee.

PUBLIC HEALTH AND THE HEALTH AND WELLBEING BOARD - PRESENTATION

Cathy Quinn introduced the report and gave a presentation on the Public Health transitions and Health and Wellbeing Boards. The Health and Social Care Act (2012) that would come into force on 1 April 2013 gave upper tier Local Authorities legal responsibilities to improve the health of the local population and establish Health and Wellbeing Boards to promote integrated health and care services and increased accountability.

Cathy and Dr Mark Jefford responded to questions and comments:-

- Plans for an extra £6m were currently being developed for consideration by the Public Health Sub-Committee.

- The Health and Wellbeing Board was the likely body to oversee collaborative working to avoid duplication and ensure value for money.

- It was important to push preventative measures and put out clear messages to influence the public. Local GP groups were involved in this and carried out horizon scanning of other areas and countries to facilitate it.

- The Board recognised the need to consider the relationship with the health scrutiny committees with discussions planned to take place over the coming months as the Board assumes its statutory role.

Following discussion the Chairman thanked Cathy and Dr Jefford for their presentation.

The Committee noted the report.

SHERWOOD HOSPITALS NHS FOUNDATION TRUST UPDATE

Eric Morton provided an update on the Sherwood Hospitals NHS Foundation Trust in relation to its status of in significant breach of Monitor, the Independent Regulator for NHS Foundation Trusts. In summary, there had been changes to its leadership, a review of Board and Quality Governance and the establishment of a committee of the Board to focus exclusively on clinical governance, quality and patient experience.

The Trust welcomed the review into the Quality of Care and Treatment led by Sir Bruce Keogh that included 14 Trusts, selected on the basis that they had been outliers for the last two consecutive years, on either Summary Hospital Standard Mortality Index (SHMI) or the Hospital Standardised Level Mortality ratio (HSMR). The review would determine whether there were sustained failings in the quality of care and treatment being provided to patients. The Trust was average on SHMI but an outlier on HSMR. One of the first actions after the Trust was put into "Significant Breach" by Monitor last October, was to commission a review of its mortality data, which had subsequently led to an action plan being monitored by the Trust's Clinical Governance Committee.

Actions already taken by the Trust had been publicly shared. Performance continued to be reviewed with the success of measures implemented at monthly Board meetings.

Mr Morton informed the committee on the findings under Monitor intervention that included the Trust had not had the best of relations with Monitor and recommendations had not been implemented. There had been a lack of ownership for leading the organisation and clinical staff had become disempowered. On a positive note the HQ had been relocated and was now part of the hospital. The Trust had good relations with the Care Quality Commission.

He responded to questions and comments:-

- There was a process in place to restore the Trust and the confidence of its Regulators through the agreement of an action plan and delivering on agreed objectives.

- A program was being implemented to empower the management and workforce to deliver on agreed objectives.

- Branding of the individual hospitals was important.

- The Trust needed to ensure that its assets were utilised effectively to support wider changes in future health care delivery and ensure effective return on Pfi investment, through providing increased value for money whilst ensuring provision of high quality care.

The Committee noted the briefing on the current position of Sherwood Forest Hospitals NHS Foundation Trust.

NEWARK HOSPITAL BRIEFING

Dr Amanda Sullivan and Dr Mark Jefford introduced the report and gave a presentation on the clinics at the Newark Hospital and its mortality rates; information attached as an appendix to the report.

Over one thousand people attended the hospital's outpatients per week across more than 20 specialities. Over 120 people were admitted to the hospital for a surgical procedure each week. The proportion of local people using the out-patient clinics and planned surgery had risen by 3% in 2012, with over 70% of

Newark residents attending the minor injuries unit for treatment, as opposed to other A&E departments, with 4% of these people transferred elsewhere. Rates of transfer had remained stable.

In terms of ambulance response times, performance was consistently above EMAS' average for Newark. Emergency care practitioners had been commissioned at the time of the Newark Review with a tier service now in place. To help with repatriation and frail elderly non-emergency response times two additional vehicles had been secured for the winter period which if proved successful would be left in place. An additional £500k had been secured for further investment for Newark and Sherwood over and above the existing contract.

They responded to questions and comments:-

- Critical illness was not feasible in Newark, since patients deteriorated quickly and required acute intervention in the right place at the right time. HSMRs would go up if took trauma to Newark.

- A lot of time and money had been invested in terms of ambulance response times in and around Newark.

- There was a lot of good non urgent work going on in the Newark hospital, hospitals commissioned better services now; EMAS were working closely with the Clinical Commissioning Group (CCG).

- It was important to reduce the length of time that people stay in hospital by improving support available at home.

- The CCG was working closely with Sherwood Forest Hospitals Foundation Trust to develop services at Newark hospital.

- The committee welcomed the GP out of hours service that provided access during evenings and weekends.

Work was continuing to make sure that the right plans were being made for the health needs of the people in Newark and Sherwood through the development of its GP practice services and progression of joined up care for people at home to avoid hospital admission in the first place.

The Chairman thanked the officers for their presentation.

The report and presentation were noted.

INTEGRATED CARE TEAM PROGRAMME UPDATE

The committee received an update on the implementation of PRISM in Newark and Sherwood from Jan Balmer and Dr Kate Jack. NHS Newark and Sherwood Clinical Commissioning Group had embarked on an innovative change programme designed to improve care for patients with long-term conditions including older people and those with cancer. Working with partners across the health and social care community, Macmillan Cancer Support and other third

sector organisations, PRISM aimed to deliver patient centred integrated care for people living in Newark and Sherwood.

The programme brings together three key elements of care - including those patients most at risk of being admitted to hospital; the development of fully integrated care teams and supporting patients to self-manage their conditions.

There were three localities within Newark and Sherwood; the North locality of the district was the first to be established with the final phase in Newark and Trent being rolled out by the end of March 2013. Each with a dedicated team to deliver integrated care for patients identified at the highest risk of admission to hospital. Teams included a Community Matron, District Nurses, Healthcare Assistants, Occupational Therapist and Physiotherapist.

The committee heard about risk profiling software available to all GPs that identified patients at high risk of going into crisis and requiring an unscheduled admission, which enabled the proactive management of patients through the use of multi-disciplinary team input to improve care. The programme aimed to divert resources from secondary care into the community services to ensure that patients were receiving the right care, in the right place.

During discussion, members' comments included:-

- In a short space of time the money saved from admissions would be reinvested for its patients in the future.

- The local population was risk profiled to determine how many community matrons were likely to be required. This was usually 2 per locality each taking up to 50-60 patients.

- Anecdotal evidence was only available at this stage. In time admissions data would allow the service to consider the cost benefit and reinvest into the health economy.

- There was support for reducing the number of hospital admissions. There were discussions with secondary care colleagues to consider ways to get people out of hospital.

Following discussion the Chairman thanked Jan Balmer and Dr Jack for their update on the Integrated Care Team programme.

The Committee noted the progress made to date.

WORK PROGRAMME

In light of the impending elections, it was decided that the work programme would be presented for consideration by the new committee formed under the new administration.

The meeting closed at 1.05pm.

CHAIR 18 March 13-Health Scrutiny