Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE
25 June 2012 at 10.30am

Membership

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

District Members
Trevor Locke – Ashfield District Council
A Paul Henshaw – Mansfield District Council
Tony Roberts – Newark and Sherwood District Council
Vacancy – Bassetlaw District Council

Officers
Martin Gately - Scrutiny Co-ordinator
Ruth Rimmington - Governance Officer

Also in attendance
Councillor Mel Shepherd
Nina Ennis – Project Manager Mansfield and Ashfield Clinical Commissioning Group
Phil Milligan – Chief Executive EMAS
David Winter – Assistant Director of Operations EMAS
Rhiannon Pepper - NHS Nottinghamshire County
Simon Smith - Nottinghamshire Healthcare NHS Trust

CHAIRMAN AND VICE-CHAIRMAN

The appointment by the County Council of Councillor Sue Saddington as Chairman and Wendy Quigley as Vice-Chairman was noted.

MEMBERSHIP

The membership of the committee as set out above was noted.

It was reported that Councillor June Stendall had been appointed to the Committee in place of Councillor Les Ward for this meeting only.

APOLOGIES FOR ABSENCE

No apologies submitted.

DECLARATIONS OF INTEREST

Councillor Sue Saddington declared a personal interest in agenda item 6 – East Midlands Ambulance Service Change Programme and 7 – Proposed Changes – Ashfield Health Village; due to her husband being a volunteer ambulance driver and daughter being employed by the NHS.

TERMS OF REFERENCE

The report was noted.

EAST MIDLANDS AMBULANCE SERVICE CHANGE PROGRAMME

The Chair welcomed the Chief Executive of EMAS Mr Phil Milligan to the committee and introduced the report before members on the change programme - Being the Best being undertaken by the East Midlands Ambulance Service. The service was currently developing models for change that would go out to consultation in late July. Being the Best was intended to ensure the right patient services, within the funds available for the long term.

Mr Milligan explained how the service had made public its ideas in March this year to gain what anxieties, strengths and support was out there. It was intended to present its ideas and findings to the Trust Board in July. The formal public consultation elements of the review would be reported back to this committee and include detail about specific plans for each ambulance station. He assured members that there was a good knowledge of the pressures within the system and opportunities to address anxieties and improve its work with community hospitals.

Mr Milligan said that the changes were clinically focussed to allow better use of clinician skills, to deliver on performance targets and quality standards, improve patient outcomes and offer more care closer to their home. If the proposals were approved by the Trust Board at its meeting in July it planned to launch a full consultation in September to allow staff and local communities to share their views. The findings would feed into the final plan to be presented to the EMAS Trust Board in January 2013.

EMAS currently operated 65 ambulance stations across the East Midlands, North and North East Lincolnshire regions. The service was a busy one and one of the largest geographically. In recent years there had been a significant increase in the number of emergency calls it received which had resulted in most 999 calls being responded to by ambulance crews already out on the road. For the majority of the day the stations were empty. In light of this it was looking at having fewer ambulance stations but better facilities to ensure that ambulances were clean, well maintained and fully equipped at the start of each shift.

The change would see more investment in the Emergency Care Practioner (ECP) role allowing them to treat and refer patients to the most appropriate

service, or treat them in their own home and avoid unnecessary journeys to A&E departments leaving the ambulance crews to concentrate on patients with most life threatening conditions.

He also spoke about the improvements made to the Board structure and responsibilities with a proposal to move from the current 5 divisions to three business units.

In terms of its performance across Nottinghamshire, he reported that the ambulance service had been the only division to have exceeded national standards. In terms of investment, the service was recruiting Emergency Care Assistants (ECAs) on a fixed contract for the Newark Urgent Care Pilot as well as permanent relief ECAs. The ring back service was proving to be successful. Further investment was needed in Newark with its urgent care tier.

Mr Milligan explained that all provider organisations were expected to become Foundation Trust by 2014. Services would still remain part of the NHS and free at the point of care but there would be more local accountability. Local people would be able to influence the design of a service. It was anticipated that over the next three to five years all NHS trusts would become foundation trusts.

During discussion the following additional information was provided in response to questions:-

Ring back was usually within 10 minutes, where the doctor knew a patient there was dialogue with community services who also knew the patient to try and avoid hospital and being taken from their home. Just over 60% were taken to the hospital and 40% were treated at home.

A location map showing the hub locations would be provided for the committee. Maps would be published and include information on standby points to demonstrate how there would be no reduction in the service.

It was disappointing to note that the consultation was being done at a time when people would be on holiday. How did it plan to convince people that closure of their ambulance station was the right thing to do? A lot of money was tied up in its buildings. People were treated in ambulances; hubs would act as standby points. The proposals had been driven by the quality of services to patients.

How would the service operate in Nottinghamshire? It was intended to provide the committee with half yearly information based on postcode response times.

How would complaints be managed? There would be a quarterly review of complaints. Where the service was once failing in this area it was now able to deal with 99% of its complaints within 20 days.

What were the plans to have vehicles ready for the start of a shift? It was the duty of the staff going off a shift to ensure that the ambulance was fit for purpose for its new shift. The proposals looked to have teams in place to deal with this since this was not felt to be a good use of a clinician's skills.

Why were there patient delays in being seen after being taken to A&E by ambulance? The problem had been acknowledged and was being addressed between all parties involved. There were occasions when

there had been delays of over 2 hours. Key to this was the development of good community services which were important on discharge from hospital as well as avoiding hospital in the first place.

Clinical Commissioning Groups (CCGs) local clinicians were able to contribute in detail to the design of the urgent care model. Local urgent care networks got together to design local services.

The service did not use the scoot system that allowed for emergency services to change traffic light signals. It was able to make contact with traffic centres and access the "green wave" a system where all lights were put on green. It intended to invest more on technology in the future to work together to add benefit all round.

Members were mindful that communities often had a strong connection to their local ambulance station and felt strongly that EMAS explained its proposals fully as part of their consultation process. It was also important that people had the facts and that those hard to reach groups were made aware of the changes that could affect them. Mr Milligan confirmed that he would be happy to attend public meetings.

The Chair also expressed concern over past miscommunication with other health related proposals for change that had caused panic and hoped that this would be avoided.

Following discussion it was agreed that:-

1. EMAS would contact those towns affected by the closure of ambulance stations to offer a public meeting in order to be able to ensure that the public are aware of the facts behind the closure and understand the benefits arising from this.

2. Mr Milligan would update the committee on the consultation process in September and provide further detailed information on its plans.

PROPOSED CHANGES TO THE ASHFIELD HEALTH VILLAGE

Nina Ennis Project Manager, Rhiannon Pepper NHS Nottinghamshire County and Simon Smith, Nottinghamshire Healthcare NHS Trust, came to talk to the committee about its plans to shape a healthier vision for Ashfield that included the bringing together of a wider range of services to Ashfield Health Village to meet the changing health needs of local people.

It was acknowledged that the services faced a real challenge over the coming years due to an ageing population, a growing bill for drugs and increase in diseases such as diabetes, heart failure alongside high levels of obesity, smoking and alcohol use. NHS Nottinghamshire County (the Primary Care Trust) was operating in difficult times and needed to save £90 million by 2015.

The document that provided information on the plans to improve was attached as an appendix to the report.

The PCT was co-ordinating the consultation on behalf of the NHS partners that commenced on 6 June and would run until 9 September with information being provided in a variety of formats. Work was also being undertaken with the voluntary sector and health interest groups.

The proposals included:-

- Existing services for older people and develop a “one stop service” approach to care
- Services for people with dementia
- Services for people with long term conditions – especially diabetes
- Health and wellbeing including primary care services (family doctors, nurses etc).

The committee heard that the Ashfield Health Village had not been well utilised and having ruled out its sale, now had a vision to use it as a 12 hour site. In order to use it more productively to secure its future the public’s views were being sought. There were strong clinical reasons for moving 3 of the 4 wards to other sites; that included the stroke rehabilitation ward to the Kings Mill Hospital right next to the acute ward, the service for people with dementia who demonstrated challenging behaviours to Highbury, Bulwell. These were difficult to look after and tended to stay in care a long time and required highly specialist staff to look after them.

Plans also included:-

- A modern vision of what keeps people out of hospital
- How to address increasing health problems such as dementia, diabetes and obesity by reviewing local primary care services and
- The development of a centre for health and well being.

It was hoped to improve co-ordination and provide a more holistic approach so that patients had a care plan following an assessment provided by third tier care.
Evidence gathered had shown that fewer than 30% of patients using the Ashfield Community Hospital beds lived in Ashfield and that during 2011-2012 there had been 157 patients.

Officers responded to members’ questions and comments.

- Concerns regarding the additional travel time for Newark residents and why wasn’t its service being utilised ?
  All wards in Ashfield were specialist and available to the whole of Nottinghamshire. There had been joint work carried out as part of the national dementia strategy to look at clinical support and locations. It was found that high quality assessments and better longer term care at home. This had been followed as a pilot in Newark ¾ years ago. It had proved too costly to equip a building of that nature with specialist skills for community support.

- Was the move one to make money?
  The national dementia strategy recommends that wards caring for people with dementia are located wherever possible with other mental health wards in specialist units. Stand-alone mental health wards in a community hospital are at risk of becoming isolated. In principle the Shelley Ward dealt with assessment needs and the patient was sent home afterwards. The Bronte ward was for people with more challenging needs and a longer period of admission. Whilst it acknowledged that the move to Bulwell was quite considerable it would bring benefits to the

service as a whole including the recruitment of highly skilled staff within the field of challenging behaviour.

- Members were concerned that local people could see this as a money saving exercise and were keen for the message that this was not the case was got across to patients and the public.

- Councillor Quigley was pleased to note the support for families with dementia that enable them to stay in their own home.

The local member for Ashfield asked that he had an input into the consultation.

The Chair informed the Committee of impending visits set up to visit the Ashfield Health Village and Kings Mill Hospital on either 9th or 11th July and asked members to let her know their availability.

Following discussion it was agreed:-

1. That the visit to the Ashfield Health Village would take place on Monday, 9 July at 11am, followed by a visit to the King's Mill Hospital that afternoon.

2. That the committee would receive an update on the ongoing consultation on the proposed changes at its next meeting in September.

WORK PROGRAMME

The Scrutiny Co-ordinator indicated that the focus of the draft work programme was on examining new health service changes rather than revisiting reviews previously undertaken by the Social Care and Health Scrutiny Committee. Addressing new changes was likely to take up a substantial amount of the new Health Scrutiny Committee's time.

Consideration was given to the draft work programme. Following discussion, it was agreed that the committee would receive a briefing on the Sherwood Hospitals Trust.

It was further decided to arrange a visit for members of both Health Committees to the EMAS Headquarters. As the Chair of the Joint Health Committee was in attendance it was suggested that the invite be extended to the Joint Health Committee members.

The revisions to the work programme were noted.

The meeting concluded at 13:03pm.

CHAIR