

## **Joint City / County Health Scrutiny Committee**

**Tuesday, 21 April 2015 at 10:15**

**County Hall, County Hall, West Bridgford, Nottingham, NG2 7QP**

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### **AGENDA**

- |   |  |         |
|---|--|---------|
| 1 | Minutes of the meeting held on 10th March 2015   | 3 - 8   |
| 2 | Apologies for Absence  |         |
| 3 | Declarations of Interests by Members and Officers:- (see note below)<br>(a) Disclosable Pecuniary Interests<br>(b) Private Interests (pecuniary and non-pecuniary) |         |
| 4 | NUH Pharmacy Information - GP Survey and Electronic Prescribing  | 9 - 22  |
| 5 | Rampton Hospital Variations of Service   | 23 - 30 |
| 6 | Urgent Care Winter Pressures - Future Planning   | 31 - 48 |
| 7 | Work Programme   | 49 - 56 |

### **Notes**

- (1) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

- (2) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Julie Brailsford (Tel. 0115 977 4694) or a colleague in Democratic Services prior to the meeting.

- (3) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.
- (4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.
- (5) This agenda and its associated reports are available to view online via an online calendar - <http://www.nottinghamshire.gov.uk/dms/Meetings.aspx>

## **MINUTES**

**JOINT HEALTH SCRUTINY COMMITTEE**  
**10<sup>th</sup> March 2015 at 10.15am**

### **Nottinghamshire County Councillors**

Councillor P Tsimbiridis (Chair)  
Councillor P Allan  
Councillor R Butler  
Councillor J Clarke  
A Councillor Dr J Doddy  
Councillor C Harwood  
Councillor J Handley  
Councillor J Williams

### **Nottingham City Councillors**

Councillor G Klein (Vice- Chair)  
Councillor E Campbell  
Councillor C Jones  
Councillor T Molife  
A Councillor E Morley  
Councillor T Neal  
Councillor B Parbutt  
Councillor A Peach

### **Other Members in Attendance**

Councillor Mrs K Cutts MBE

### **Officers**

Julie Brailsford - Nottinghamshire County Council  
Alison Fawley - Nottinghamshire County Council  
Martin Gately - Nottinghamshire County Council  
Claire Routledge - Nottingham City Council

### **Also In Attendance**

Vicky Bailey - Rushcliffe CCG  
Donna Clarke - Healthwatch Nottinghamshire  
Councillor K Cutts - Nottinghamshire County Council  
Dr Fowlie - Nottingham University Hospitals  
Martin Gawith - Healthwatch Nottingham.  
Claire Grainger - Healthwatch Nottinghamshire

Pauline Hand	- NHS 111
Dr Manning	- Nottingham University Hospitals
Guy Mansford	- Nottingham West CCG
Joathan May	- Arriva
Neil Moore	- Arriva
Stewart Newman	- NHS 111
Jane Ravenscroft	- Consultant Dermatologist
Amanda Roberts	- Dermatology Patient
Helen Tait	- Treatment Centre
Paul Willetts	- Arriva

## **MEMBERSHIP CHANGE**

It was reported that Councillor Toby Neale and Councillor Anne Peach had been permanently appointed to the committee in place of Councillor Mohammad Aslam and Councillor Azad Choudhry.

## **MINUTES**

The minutes of the last meeting held on 10<sup>th</sup> February 2015, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair except for the following:

Councillor C A Jones had sent apologies for the meeting.

## **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor E Morley and Councillor Dr J Doddy.

## **DECLARATIONS OF INTERESTS**

There were no declarations of interest.

## **DERMATOLOGY CONTRACT**

Vicky Bailey, Chief Officer of NHS Rushcliffe Clinical Commissioning Group (CCG) (and lead officer for dermatology commissioning) and Guy Mansford, Clinical Lead Nottingham West CCG, gave a presentation on the operation of the Dermatology Contract at Nottingham University Hospitals NHS Trust (NUH) and other associated issues.

(During the committee meeting, members of the committee received a letter emailed directly to them from the British Association of Dermatologists in response to the 'Nottingham Dermatology Service Crisis'; this letter was shared with the CCG representatives).

The Treatment Centre contract covered core and non-core services, including dermatology; this was broadly replicated in terms to what was currently in place and then commissioned. The Terms and Conditions were decided 7 to 8 years ago by the Department of Health. Following the TUPE of staff to Circle a letter dated 11th March

2013 made the CCG aware of the Dermatologists concerns over transferring their employment.

Helen Tait, General Manager of the Treatment Centre, stated that a dermatology service had been successfully provided for six and a half years. An offer had been made to forego the sole provider contract terms in an effort to secure the service.

Lessons had been learnt, there was a flawed split of adults and paediatrics and this had been a 'novel' experience in terms of procurement resulting in valued colleagues leaving. In 2013 there had been 11 dermatology consultants but from May 2015 there would be 3. With over 200 dermatology vacancies nationally this was not an easy situation to resolve.

Following the briefing the following comments and additional information was provided in response to questions:-

- The CCG had commissioned an independent review of dermatology starting in April 2015.
- Concern was expressed regarding the commissioning body only discovering the views of the dermatologists when it was too late, suggesting a lack of proper consultation.
- This was a commercial contract under European legislation and the awarding of a contract could only be based on the criteria set down. During the procurement period the commissioners' role was not to undermine the procurement process. Notice had been given on the current contract as they did not have the consultants to provide the service.
- The publicity surrounding the situation had not helped with recruitment of new dermatologists.
- Dr Manning stated that the use of locums was fully integrated into the structure and training sessions for all staff within the Treatment Centre. There was a high demand nationally for locums.
- Dr Fowlie, Medical Director NUH stated that the Service Model they currently had was not sustainable. In addition, the Employment Model (recruitment and retention) offered was not attractive to those who had left or who may come to work here. These two areas had been fractured and needed changing and rebuilding to attract consultants back to work in Nottingham/Nottinghamshire.
- The Dermatologists who had remained would prefer to have NHS type contracts.
- Circle did not know the feelings of the Dermatology Consultants when they took the contract on and not all of the current situation could have been foreseen. Dermatology was part of the overall contract and the majority of staff had been happy to TUPE to Circle. No risk assessment had been done on whether staff would be willing to TUPE.

- There was concern that Circle did not have access to the NUH teaching and research facilities.

Jane Ravenscroft, one of the remaining Consultant Dermatologists spoke to the committee about her concerns and points of view. The TUPE was not accepted by some and there was no obligation to provide an out of hour's service for patients. The lack of acceptance of TUPE to Circle was nothing to do with a private company, acute dermatology and children's dermatology had not been commissioned to Circle. The Service Model was flawed and needed to be remodelled for a sustainable service. The service could not be sustained without any colleagues. Most locums were not qualified to be a permanent dermatologist under the NUH.

Amanda Roberts, a dermatology patient spoke to the committee about her concerns and points of view. Amanda, an eczema patient, told the committee that the treatment for dermatology patients was 'world class' prior to commissioning, since then the department had declined and it was the patients who were having to live with the consequences from this. It was important for patients living with a chronic illness to have a long term relationship with consultants to gain understanding. There was a concern that locums were not fully qualified dermatologists. Patients did not have a choice and had to accept what was offered, even if the service provided was unsuitable. Tele dermatology was good for patients with moles and skin cancers but not for eczema. Amanda requested that a dermatology patient be included on the review team so that the needs of the patients were not forgotten

The committee requested an update on the Dermatology Service in 3 months.

### **HEALTHWATCH – RENAL PATIENT TRANSPORT REVIEW**

Claire Grainger and Donna Clarke from Healthwatch Nottinghamshire gave a presentation to the committee on the findings from the review of 'Renal Patients' Experience of the Patient Transport Service'. The information had been compiled by a panel of volunteers who had looked at the comments, diaries and experiences of renal patients. This was the first time that the findings had been made public.

Paul Willets, Director of Governance & Quality, Arriva transport solutions, responded on behalf of Arriva.

Following the briefing the additional information was provided in response to questions:-

- Voluntary drivers had not been included in the survey.
- This was a draft report and Arriva had until the 23<sup>rd</sup> March 2015 to address the issues raised in it. Healthwatch would be helping Arriva with the actions recommended in the report.
- Safeguards were put in place and they tried to use the same driver for patients so that a relationship could be formed.

- Arriva monitored Service Level Agreements and would be challenging some of the findings in the report.

The committee requested that Healthwatch and Arriva returned to the committee in 4 months' time with an updated report.

### **PATIENT TRANSPORT SERVICE – PERFORMANCE UPDATE**

Neil Moore, Director of Procurement and Market Development, Mansfield & Ashfield CCG and Jonathan May, UK Managing Director, Arriva, gave a presentation on Non-Emergency Patient Transport Service. The presentation showed that as of January 2015 the Key Performance Indicators (KPI's) were still not being met and some parts of the plan had not been as effective as they should have been.

Following the briefing the additional information was provided in response to questions:-

- Communication was made with wards if a pre-arranged time slot was not going to be met. Wards were being asked to give prior notice of patients being discharged as part of the discharge pathway.
- All staff had been issued with a Personal Digital Assistant (PDA) to assist with the eight and a half thousand journeys planned every day in Nottingham and Nottinghamshire. Pressure was put on the system with 'same day' bookings.
- There was assurance that patients being returned to Care Homes were not being left until later in the day for convenience reasons.
- There were more wheelchair users than had originally been planned for.
- There would be investment in more vehicles, staff training and an 'on line booking system'.
- The committee, whilst acknowledging that the patient experience was important, were not happy that the KPI's were still not being met.

The committee requested that Arriva returned in 6 months' time with an updated performance report.

### **NHS 111 PERFORMANCE UPDATE**

Stewart Newman, Head of Urgent Care and Pauline Hand, NHS 111 Programme and Operations Director (Derbyshire Health United) gave a presentation on the NHS 111 performance. December 2014 had been a difficult month with a 35% increase in the number of calls compared to December 2013 resulting in an increase in the number of abandoned calls for that month.

Following the briefing the additional information was provided in response to questions:-

- The 'Triage System' used by 111 was agreed with every service provider who were also invited to attend 111 meetings. There was a form for health professionals to feedback when patients had been advised incorrectly by 111 and a 'data warehouse' was being built to monitor if 111 were sending people to the correct service/place.
- The average call back time to patients was 30-40minutes over the past two months. All calls were monitored for an appropriate call back time; this could take up to 72 hours.
- Staff recruitment would commence in June, with a 3 to 4 month training period to prepare them for the peak time. It was difficult to predict when the flu season would start.
- A HR advisor was helping to tackle staff absences and deal with them appropriately.

The committee requested that NHS 111 returned in 6 months' time for an update.

### **WORK PROGRAMME**

The contents of the Work Programme were noted.

The meeting closed at 13.35pm.

Chairman



21 April 2015

Agenda Item: 4

## **REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE**

### **NUH PHARMACY INFORMATION – GP SURVEY AND ELECTRONIC PRESCRIBING**

#### **Purpose of the Report**

1. To provide information relating to the committee's ongoing review of pharmacy delay and prescribing issues.

#### **Information and Advice**

2. Members will recall their longstanding concerns in relation to delays in filling outpatient prescriptions at Nottingham University Hospitals (NUH), resulting in hospital prescriptions being taken to GPs to be filled.
3. The results of a survey requested by the Joint Health Committee and carried out by Nicky Bird, the senior prescribing and interface officer for Mansfield and Ashfield CCG (Prescribing Lead for Nottinghamshire) are attached as an appendix to this report.
4. In addition, a briefing from the Electronic Prescribing Project Lead Michelle Peet is also attached as an appendix to this report. It is anticipated that the advent of electronic prescribing may mean that it will be possible for hospital prescriptions to be filled by high street pharmacists, which is central to this issue.
5. The Joint Health Committee will be considering further information on pharmacy issues in June when Mo Rahman, NUH Chief Pharmacist will be providing information on a recent piece of work by NUH on medicine supply as well as responding to the results of the survey.
6. RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

- 1) Receive the briefing and ask questions as necessary in relation to this substantial change
- 2) Schedule further consideration.

**Councillor Parry Tsimbiridis**

**Chairman of Joint City and County Health Scrutiny Committee**

**For any enquiries about this report please contact: Martin Gately – 0115 9772826**

**Background Papers**

Nil

**Electoral Division(s) and Member(s) Affected**

All

## **Dealing with Hospital Outpatient Prescriptions in Primary Care**

The Nottinghamshire County Council Joint Health Scrutiny Committee for Nottingham City and Nottinghamshire looks at health matters which impact on both City and County residents. The committee has a longstanding interest in pharmacy issues and earlier this year looked into delays dispensing medication at Nottingham University Hospitals (NUH) Pharmacy.

Some anecdotal evidence heard by the committee suggested that a large number of hospital prescriptions are taken to GPs to be rewritten due to delays at the pharmacy.

A survey monkey questionnaire was designed using the following questions and sent to all GP practices within NHS Mansfield & Ashfield CCG, NHS Newark & Sherwood CCG, NHS Nottingham North & East CCG, NHS Nottingham West CCG, NHS Rushcliffe CCG and NHS Nottingham City CCG. The survey was open from 2<sup>nd</sup> March to 3<sup>rd</sup> April 2015.

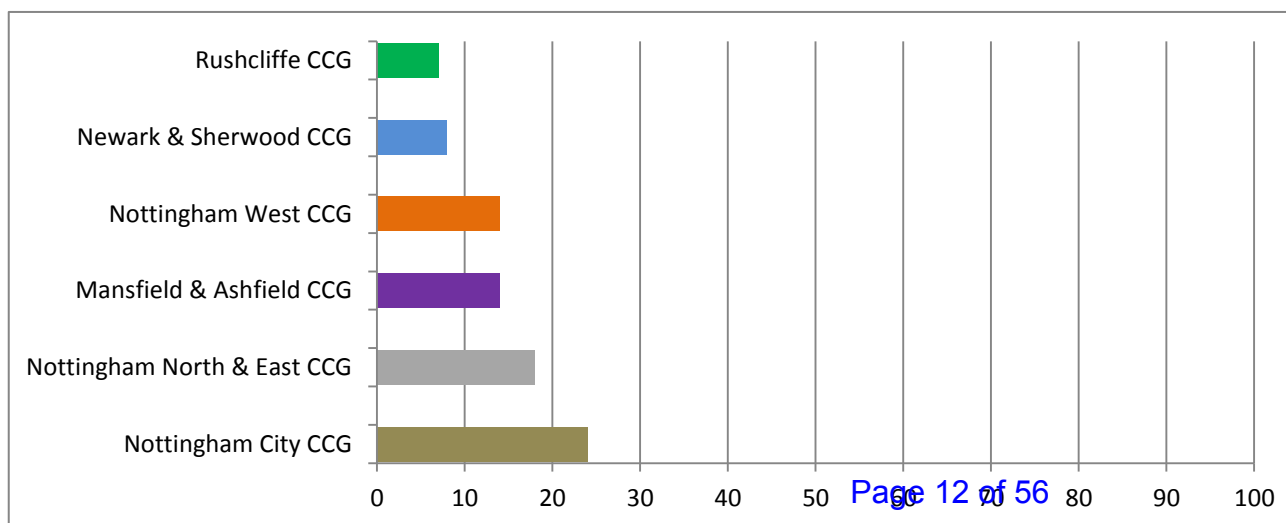
### **Executive summary**

- 85 survey responses were received the majority of responses being from GPs.
- Over 90% of responses stated that 0-10 patients per week presented at their surgery requesting a hospital prescription is transcribed onto an FP10 prescription.
- These requests came predominantly from patients who had attended Nottingham University Hospital NHS Trust but was not confined solely to NHS Service Providers
- The most common reason given was 'the wait at the hospital pharmacy was too long'.
- Comments also indicated that hospital staff had advised the patients to take the hospital prescription to their GP or the patient themselves did not realise that the prescription should be dispensed by the hospital pharmacy.
- Issues faced by GP practices when dealing with patients requesting FP10s included managing patient expectations for when their FP10 prescription would be ready, counseling patients on their use of their new medication, dealing with patients whose supply from the hospital runs out early.
- Suggested solutions included the use of the electronic prescription service and putting notices up within the practice highlighting to patients the issues raised when they present with a hospital prescription.

Nicky Bird  
Senior Prescribing Advisor  
On behalf of the Nottinghamshire County CCGs

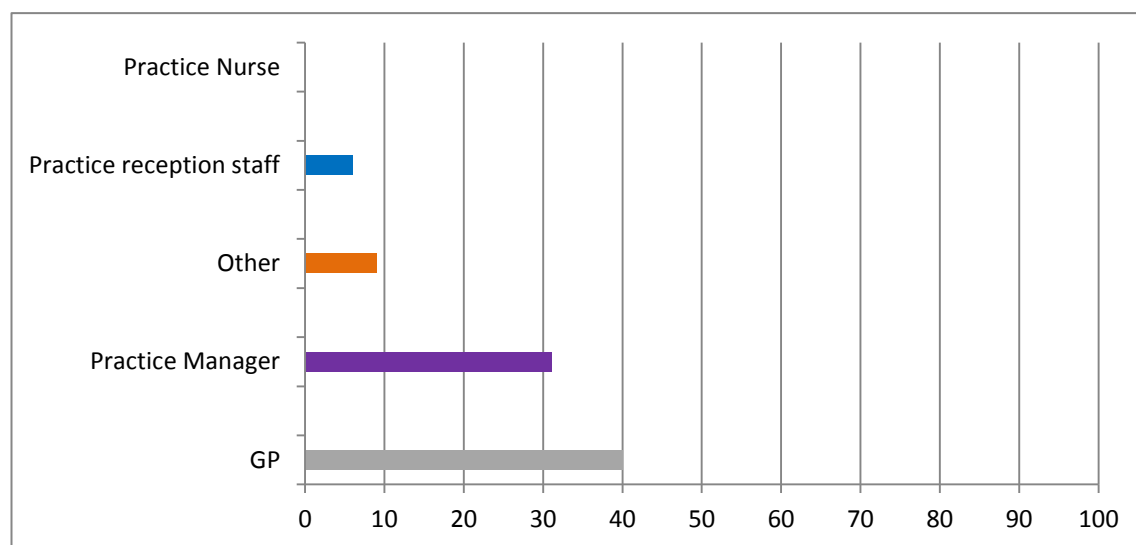
**Q1. Please select which Clinical Commissioning Group (CCG) your practice is**

Answer Choice	Responses	
Nottingham City CCG	28.24%	24
Nottingham North & East CCG	21.18%	18
Mansfield & Ashfield CCG	16.47%	14
Nottingham West CCG	16.47%	14
Newark & Sherwood CCG	9.41%	8
Rushcliffe CCG	8.24%	7
Total		85



## Q2. Please select your role within the practice

Answer Choice	Responses	
GP	46.51%	40
Practice Manager	36.05%	31
Other	10.47%	9
Practice reception staff	6.98%	6
Practice Nurse	0.00%	0
Total		86



### Comments:

Assistant Practice manager

CCG Staff

Clinical Administration Lead

Practice Pharmacist

Prescribing Advisor

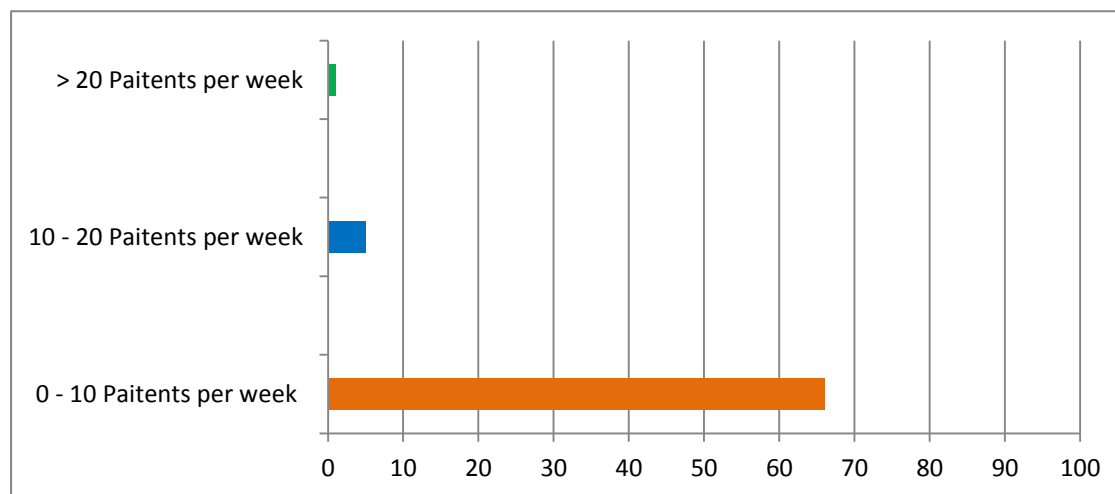
Prescribing Facilitator

Practice Pharmacist (directly employed)

Assistant PM

**Q3. On average how many patients request hospital prescriptions to be rewritten on FP10 prescriptions each week?**  
**Please select**

Answer Choice	Responses	
0 - 10 Patients per week	91.67%	66
10 - 20 Patients per week	6.94%	5
> 20 Patients per week	1.39%	1
Total		72



**Comments:**

Not even 1

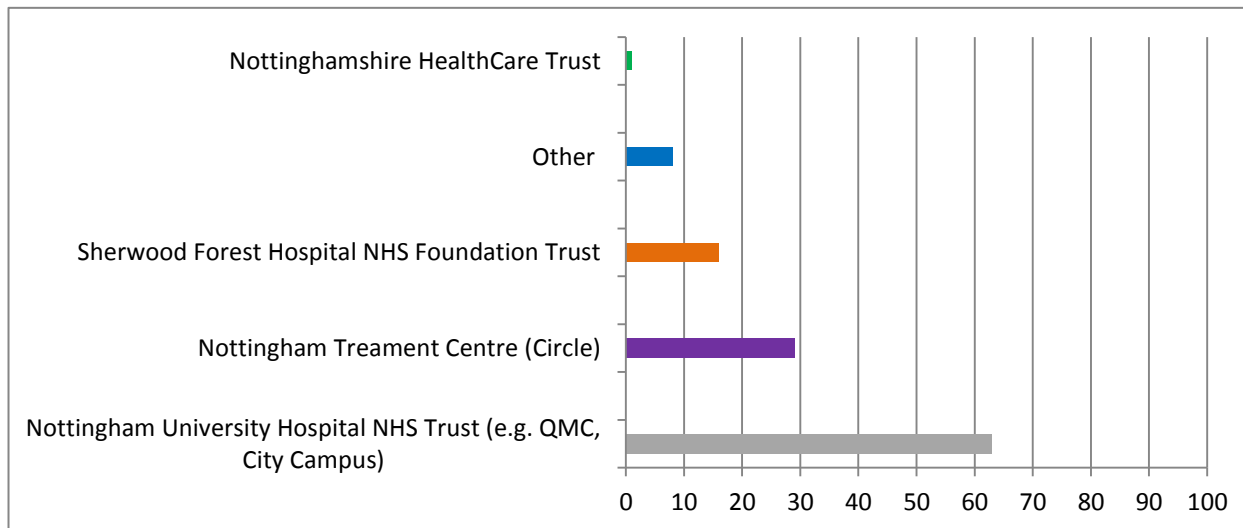
1-4 per week, 10 including private prescriptions

10-15 per month roughly

#### Q4. Which hospital trust are these generally from?

5

Answer Choice	Responses	
Nottingham University Hospital NHS Trust (e.g. QMC, City Campus)	87.50%	63
Nottingham Treatment Centre (Circle)	40.28%	29
Sherwood Forest Hospital NHS Foundation Trust	22.22%	16
Other	11.11%	8
Nottinghamshire HealthCare Trust	1.39%	1
Total		72

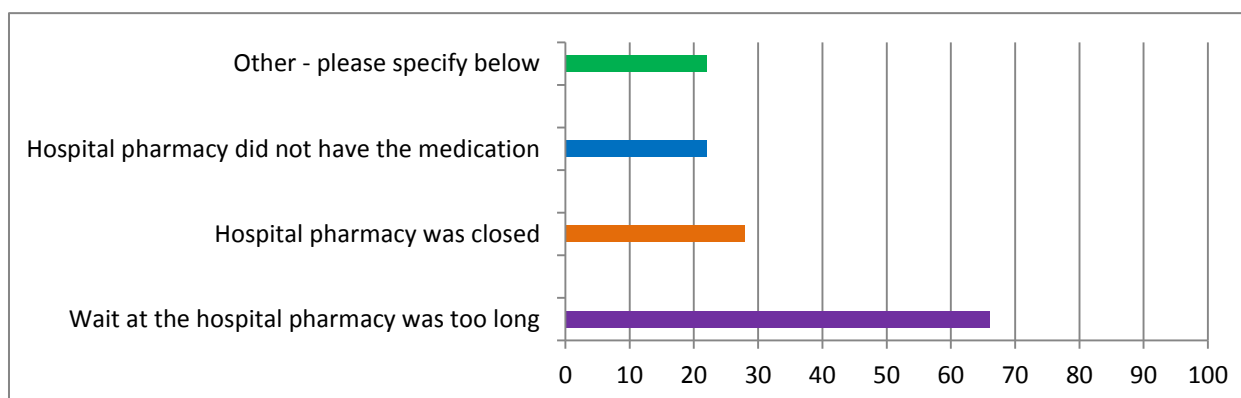


#### Comments:

Woodthorpe hospital, Rope Walk, Community paediatrics  
DRI  
Woodthorpe hospital  
The Park - when patients have been sent NHS  
Woodthorpe  
Private consultants and various hospitals  
The Park, Woodthorpe  
Derby hospitals  
NCH

### Q5. What do patients say are the main reasons for doing this?

Answer Choice	Responses	
Wait at the hospital pharmacy was too long	89.19%	66
Hospital pharmacy was closed	37.84%	28
Hospital pharmacy did not have the medication	29.73%	22
Other - please specify below	29.73%	22
Total		74



See comments on page 6



<b>Comments:</b>			
<b>1.</b> Healthcare trust patients do not have access to a pharmacy, bring handwritten notes from psychiatrist to ask to prescribe same day. At NUH the wait at the pharmacy is too long	<b>10.</b> Doctors/Nurses say to PT, easier to get script from own GP, this problem is much worse from locum consultants	<b>19.</b> Also consultants have advised them to	<b>28.</b> I was told my GP would do the script
<b>2.</b> Unwilling to travel back to Nottingham to collect	<b>11.</b> Doctor told them to collect from GP	<b>20.</b> Most of the patients have said "take this to your GP and they will issue you a prescription" most patients don't realise the paper form they have is a prescription	<b>29.</b> Told to bring to GP rather than wait at hospital
<b>3.</b> Patients have been instructed by hospital Doctor to go to GP as they will do rather than waiting at hospital pharmacy	<b>12.</b> Patient claimed that she was unaware the medication was supposed to be obtained at the hospital - thought the prescription was supposed to be prescribed by GP	<b>21.</b> Advised by consultant to take to GP	<b>30.</b> Advised to take this prescription to GP to convert
<b>4.</b> Secondary care clinician has told them to take RX to surgery	<b>13.</b> Patients consistently run out of dexamethasone eye drops post cataract operation, It would be helpful if they had enough from the outset	<b>22.</b> Patient informed to get it from GP	
<b>5.</b> Hospital pharmacist suggested to seeing own GP	<b>14.</b> Hospital did not make it clear it was only for use at hospital pharmacy	<b>23.</b> Told to bring here for conversion (but no letter)	
<b>6.</b> Just been told to GP	<b>15.</b> Patient preference	<b>24.</b> Did not want to wait	
<b>7.</b> Often just want it checking and do not understand what has happened advice given ect.	<b>16.</b> Was told by consultant/nurse at clinic to get the GP to change the prescription	<b>25.</b> Didn't know needed to take it to hospital pharmacy	
<b>8.</b> Not instructed to go to hospital pharmacy	<b>17.</b> A lot of the time they don't realise they can't use it outside the hospital pharmacy	<b>26.</b> The hospital told them to bring it to GP	
<b>9.</b> Hospital pharmacy did not have item in stock	<b>18.</b> Patient advised by hospital staff to come to GP	<b>27.</b> PT convenience (though obviously they have not seen the implications of asking GP to do the RX)	

### Q7. Any further comments?

<p><b>1.</b> I think this needs improvement in pharmacy performance - requesting GPs to prescribe meds via FP10 under these circumstances is unsafe and lacks proper governance</p>	<p><b>4.</b> This is an interesting problem. We are having to do some of this work by default and as a GP I would like to see ourselves properly remunerated for undertaking such but we would need the letters from clinic to be sent with the prescription request in some circumstances. I do not think KMH has the same delays as NUH so maybe not such an issue.</p>	<p><b>7.</b> Consistent offenders are patients who have had cataract operations but run out of dexamethasone drops</p>	<p><b>10.</b> Thanks for your interest in this area</p>
<p><b>2.</b> Happy to challenge behaviour and have discussed directly with hospital doctors who state they are told to send patients to GP to save hospital budgets re prescribing/ they feel it is better than having to wait. Personally feel significant education programmes need to be initiated</p>	<p><b>5.</b> More commonly get a letter for us to prescribe something that it would have been better to start in the clinic. We then have to contact the patient and make sure they understand how to take it etc. Wasteful of GPs/patients time and a problem if we can't get hold of them. In my opinion NOT ENOUGH hospital scripts are issued. Why don't they use scripts that can be used at a community pharmacy as well or electronic scripts</p>	<p><b>8.</b> The other issue is that patients are told that GPs will issue the same day This is usually the case but they should be advised it will be done in 48hrs [as per GP requests] as if it's not done practices are then unfairly in trouble!</p>	<p><b>11.</b> Patients expect instant prescriptions to be generated and cause problems when we can't oblige</p>
<p><b>3.</b> Patients get very frustrated that their Rx cannot be changed over immediately - don't understand that to the surgery this is not an acute Rx and if it is should have waited to be dispensed at hospital. Patients have to wait an unreasonably long time for Rx to be dispensed</p>	<p><b>6.</b> I think hospital discharge medications were in the past for 28 days now seem to have reverted to couple weeks when not needed creates patient anxiety/ extra GP work - patients often say long wait hospital pharmacy - but this creates extra significant work and GP risk and patients always demand them as urgent!</p>	<p><b>9.</b> We have recently looked into this problem at our surgery: Action was: Find Out QMC &amp; TC pharmacy opening hours QMC 9-midnight 7 days a week Treatment Centre is open 8.30-6.00 Mon-Fri with the provision of a drop box if patient are seen after the pharmacy is closed, the pharmacist will then contact patient the next day to advise them their medication is ready for collection. Treatment centre staff to advise patients of this when pharmacy closed Completed With the above facts we no longer issue hospital prescriptions and have put a poster in the waiting area to advice patients</p>	

## Electronic Prescription Service

In 2007 Nottinghamshire were selected to be part of the initial Electronic Prescription Service (EPS) pilot by the National Programme for IT (NPFIT). From 2007 to 2009, as part of the technical framework, EPS Release 1 (EPS R1) was tested with bar code functionality.

In 2010, the East Leake GP Practice went live with EPS Release 2 (EPS R2) followed by Hama Medical Centre, Kimberley in 2011. The pilot was conducted over a two year period. Initially the software was not fit for purpose and CfH and the SystmOne supplier, TPP continued to test the software, which was eventually validated by CfH.

Across the county over 50% of practices are now live with EPS. There are 69 practices live (shown below) for all CCG's. 78 left to deploy of which 17 have go live dates booked.

The current software does not support dispensing practices so these are out of scope.

CCG	GP Practices	Practice	Location
R	Kelly AT (C84005)	East Leake	East Leake
NW	Hama TM (C84624)	Hama Medical Centre	Kimberley
C	Carolan U (C84043)	Leen View Surgery	Bulwell
NS	Pollard VA (C84059)	Clipstone Health Centre	Clipstone
C	Riverlyn Medical Centre (C84717)	Riverlyn Medical Centre	Bulwell
MA	Primorac D (C84036)	Rosemary Street Health Centre	Mansfield
C	Atiomo T (C84695)	Alice Street Med Centre	Bestwood
NNE	Ransford (C84667)	Giltbrook Practice	Giltbrook
MA	Sheikh RR (C84051)	Orchard Med Practice	Mansfield
MA	Patel KR (C84057)	Pleasley Surgery	Pleasley
MA	Steiner ES (C84069)	Roundwood Surgery	Mansfield
NS	Glazier (C84113)	Major Oak Medical Practice	Edwinstowe
NNE	Westdale Lane Surgery (C84033)	Westdale Lane Surgery	Carlton
C	Churchfields Med Pract (C84034)	Churchfields Medical Practice	Basford
NS	Dalton MJ (C84037)	Blidworth & Ravenshead Surgeries	Blidworth/Ravenshead
MA	Dale J (C84106)	Millview Medical Practice	Mansfield
MA	Allen SM (C84658)	Meden Vale Surgery	Meden Vale
C	Henry Rif (C84619)	Tudor House Med Practice	Sherwood
MA	Lovelock Hilary (C84077)	Brierley Park Med Cent	Huthwaite
C	Rivergreen Med Cent (C84060)	Rivergreen Medical Centre	Clifton
C	Sood NC (C84018)	Carlton Road	Carlton
NNE	Plains View Surgery (C84115)	Plains View	Mapperley
C	Balendran S (C84151)	Zulu Road	Basford
NS	Kharkongor SK (C84648)	Balderton PCC	Balderton
NNE	Gallagher GM (C84066)	Daybrook Med Practice	Daybrook
NNE	Ndirika A (C84124)	Whyburn Med Practice	Hucknall
C	St Albans Practice (C84004)	St Albans Practice	Bulwell
NNE	Sparrow NJ (C84131)	Newthorpe Medical Practice	Eastwood
NNE	Campbell IW (C84709)	Park House	Carlton
C	Lavelle P (C84081)	John Ryle Med Practice	Clifton
MA	Harwood Close Surgery	Harwood Close	Sutton-in-Ashfield

	(C84061)		
NS	De Gay NR (C84009)	Barnby Gate	Newark
C	Taylor H (C84046)	Clifton Medical Practice	Clifton
NS	Head S (C84021)	Middleton Lodge	Ollerton
NNE	Cockburn A (C84026)	Stenhouse	Arnold
C	Khalique A (C84688)	Bilborough Medical Centre	Bilborough
MA	Oza NJ (C84629)	Health Care Complex	KiA
NW	O'Neil M (C84042)	Saxon Cross	Stapleford
NS	Hormis P (C84123)	Bilsthorpe Surgery	Bilsthorpe
NS	Jairam IC (C84656)	Hillview	Rainworth
C	Wright SR (C84091)	Aspley Medical Centre	Aspley
NW	Doddy JA (C84705)	Hickings Lane	Stapleford
NS	Corbyn CN (C84087)	Rainworth Health Centre	Rainworth
NS	Selwyn JE (C84019)	Fountain Med Centre	Newark
C	Amin (C84136)	St Lukes Health Centre	Radford
NNE	Marsh AJ (C84010)	Forester St	Netherfield
C	Rao D (C84092)	Meadows Health Centre	Meadows
C	Southglade Health Centre (Y03363)	Southglade Road	Nottingham
C	Welbeck Surgery (C84664)	Mansfield Rd	Sherwood
R	West Bridgford Med Ctre (C84621)	Musters Road	West Bridgford
C	Sharma OP (C84104)	Greenfields	Hyson Green
MA	Ward SJ (C84020)	Churchside Med Practice	Mansfield
NNE	Nyatsuro S (C84612)	Willows	Carlton
NW	Browne NC (C84065)	Abbey Medical Centre	Beeston
MA	Kirkby Health Centre (C84076)	Lowmoor Rd	Kirkby-in-Ashfield
NNE	Highcroft Surgery (C84055)	Arnold Health Centre	Arnold
C	Larner JR (C84144)	Bridgeway Centre	Meadows
C	Kagzi (C84103)	Forest Practice	Hyson Green
C	Rudrashetty S (C84105)	Fairfields Practice	Hyson Green
MA	Macdougall PW (C84067)	Forest Rd	Annesley Woodhouse
C	Chahal PS (C84672)	Dale Surgery	Sneinton
NS	Porter JD (C84678)	Old Surgery	Farnsfield
C	Abbott MD (C84683)	Windmill Practice	Sneinton
NW	Gavrilovic Anica (C84120)	Valley Surgery (+ Branch) (40 Staff)	Chilwell
NNE	Myers D (C84095)	Oakenhall Medical Practice	Hucknall
MA	Riverbank Med Services (C84127)	Church Street	Warsop
C	McLachlan AN (C84078)	Hucknall Rd Med Centre	Sherwood
NNE	Khan A (C84150)	Unity Surgery (318 Westdale Lane)	Mapperley
C	Silcock NA (C84122)	Wollaton Park Medical Centre	Wollaton
NS	Wathen (C84029)	Lombard Street	Newark
C	Sherwood Rise Med Pract(C84628)	Sherwood Rise Medical Practice - EMIS WEB	Sherwood

The main benefits of using EPS R2 are as follows:

- Full traceability of prescriptions for GP Practices and Pharmacies from GP signature to collection by patient
- A reduction in the GP Practice workload by patients not collecting repeat prescriptions
- A reduction for GP Practices in printing prescriptions (repeats)
- GP's able to sign electronic prescriptions at a time convenient to them

- GP's able to bulk sign repeat prescriptions
- Time savings for GP's with repeat dispensing

**Michelle Peet, Project & Business Change Manager**  
**Nottinghamshire Health Informatics Service (NHIS)**  
**April 2015**



21 April 2015

Agenda Item: 5

## **REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE**

### **RAMPTON HOSPITAL VARIATIONS OF SERVICE**

#### **Purpose of the Report**

1. To provide the information on a variation to service within Rampton Secure Hospital.

#### **Information and Advice**

2. NHS England anticipates undertaking a variation of service in relation to the treatment and care of people with personality disorders at Rampton Secure Hospital.
3. A briefing from NHS England is attached as an appendix to this report.
4. Ms Ruth Sargent, Head of Specialised Mental Health and Learning Disabilities POC and High Secure Lead will attend to brief the Committee and answer questions as necessary.
5. RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

- 1) Receive the briefing and ask questions as necessary in relation to this substantial change
- 2) Schedule further consideration.

**Councillor Parry Tsimbiridis**  
**Chairman of Joint City and County Health Scrutiny Committee**

**For any enquiries about this report please contact: Martin Gately – 0115 9772826**

#### **Background Papers**

Nil

#### **Electoral Division(s) and Member(s) Affected**

All





Report for the April Meeting of the HOSC

**The Decommissioning of the DSPD service at Rampton Hospital**

**Executive Summary**

- The new Offender Personality Disorder (OPD) strategy was approved by Ministers in 2011.
- In terms of services for high risk Personality Disorder Offenders, the OPD Strategy proposed that the default position for the majority of Offenders was that management and treatment should be provided within the Prison Estate. There would continue, however, to be the need for specialist medium and high secure hospital services for those prisoners/patients who required detention under the MHA and treatment in a hospital environment.
- There have been significant developments in the services available for PD Offenders in prisons, including the development of PIPEs (Psychologically Informed Planned Environments) and specialist treatment units. These developments have also been combined with educational programmes to enhance the Prison Officers awareness of the needs of PD Offenders.
- The OPD strategy proposed that the pilot DSPD hospital services (the two High Secure and three Medium secure services) should be decommissioned and the released funds recycled into other parts of the OPD pathway.
- The High Secure DSPD service (in the Paddocks building) at Broadmoor hospital was decommissioned in 2012 and at that time, it was agreed that the Rampton hospital High Secure DSPD service (in the Peaks building) would continue on a transitional basis. The three DSPD Medium secure units (two in London and one in the North East) continue to provide services.
- In July 2014, Nottinghamshire Trust was served with formal notice of the intention to decommission the DSPD service at Rampton hospital. A Task group was established to oversee the process and it had its inaugural meeting on 18<sup>th</sup> July 2014.
- The Task group has met regularly since this date and has agreed/noted that:
  - The Peaks unit will continue to admit PD patients (who meet the standard criteria for admission to a High Secure Hospital) but that after the 18<sup>th</sup> July 2014, all subsequent admissions (other than an identified cohort of 'DSPD' patients who were already in the unit, on the waiting list, or on trial leave) would be categorised as standard PD patients.
  - The Peaks unit would be utilised by the standard PD service at Rampton hospital because it already was the sole admission route for all PD patients, was a purpose built unit, and had more appropriately sized wards in comparison to the three standard PD wards at the hospital.
  - An additional Case Manager would be appointed to attend CPA meetings where discussions about individual DSPD patient progress, risk, and care pathway needs would take place.
  - Approximately 50% of the DSPD patients in the unit are on hospital orders and will require a healthcare route as the next stage in their pathway (High secure or Medium secure hospital PD service) and none of the remaining patients on prison transfer orders were not considered by their RCs to meet the MHA criteria for remission to prison.
  - The most recent occupancy modelling exercise has indicated that the hospital may be able to close a 17 bed PD ward in 2017/18.
  - Nottinghamshire Trust has received legal advice about the consultation process that raises potential issues that may need to be resolved.

- Subject to the outcome of discussions concerning the need to increase the bed capacity of the Men's PD service at Rampton hospital, the decommissioning of the DSPD service could have a significant impact on the standard PD service at Rampton and Medium secure PD services.
- Financial modelling has taken place with regard to the implications of the Occupancy profile modelling forecast.
- The DSPD service at Rampton hospital has 60 beds in the Peaks building and an agreed target occupancy of 52 patients. The Peaks currently has 50 in-patients, with an additional one patient on the waiting list for admission, and ten referrals being processed.
- There is a need to resolve the future High Secure PD capacity at Rampton, the additional financial implications of using the Peaks building for standard PD patients, and the future funding needs for the developing OPD prison services.

## 1. Background

1.1 In 2011 the Department of Health and Ministry of Justice held a public consultation on the future shape of services for offenders with personality disorder. It described an ambition to reshape these services by developing new services mainly in prisons. The consultation at the time included individuals and organisations in the NHS and criminal justice system, the voluntary sector, the independent sector, professional associations, and prisoner/patient groups.

1.2 The proposed new OPD pathway, subsequently endorsed by Ministers, decided that the money invested by the NHS in England in DSPD hospital services (the two high secure services at Broadmoor and Rampton hospitals, and the three Medium secure services) could be used more effectively to improve the management and treatment of offenders with severe personality disorder. The intention of the new OPD strategy was to:

- reduce spending in NHS secure psychiatric hospitals' DSPD units and increase the number of treatment places in prisons as well as improved case management services
- invest in early identification of offenders who present a high risk of serious harm to others and who are likely to have a severe personality disorder
- improve risk assessment and case management of offenders with personality disorder who are in the community
- improve the nationally commissioned treatment services in high security prisons
- provide new intervention and treatment services in secure and community environments
- create specially designed environments within prison and probation trusts for offenders who have completed treatment or been released from prison
- build the wider workforce (NHS, social care, criminal justice and independent and voluntary sector) by developing staff knowledge, understanding and competencies

1.3 Implementation of the new OPD strategy is overseen by a joint programme board that is co-chaired by NHS England and the Ministry of Justice. On the NHS side, the programme board makes recommendations to NHS England's Specialised Commissioning Oversight Group, which has operational oversight of specialised commissioning and has delegated authority to make decisions on behalf of the Board of NHS England.

1.4 The Offender Personality Disorder Pathway is based on a 'whole systems' community-to-community pathway approach. Offenders who enter the pathway are managed by the criminal justice system,

either in prisons or in the community via probation services (for individuals who are not held in custody), but with access to secure specialist hospitals for individuals/prisoners assessed as requiring detention under the MHA and treatment in a hospital setting. The pathway enshrines the concept of 'joint operations' whereby responsibility for an offender's pathway is shared between the NHS and the criminal justice system.

1.5 The DSPD service (The Paddocks) at Broadmoor hospital was decommissioned in 2012 and it was agreed that the DSPD service at Rampton would continue as a transitional arrangement to support the development of the new pathway. The three DSPD Medium secure services continue to provide services to the pathway.

1.6 Since 2012, the Offender Personality Disorder pathway has increased the volume and range of offender services considerably. The current portfolio comprises over 100 separate projects, including:

- early identification, case formulation and consultation services via a NHS – probation service partnership
- 2 re-specified personality disorder services for 135 men in high security prisons
- 1 re-specified personality disorder service for 12 women in prison
- 6 new personality disorder treatment services for men providing 248 places in prisons, plus 3 new therapeutic community based treatment services for men with learning difficulties providing 52 places
- 18 prison and approved premises providing 600 Psychologically Informed Placement Environment places for men
- 3 new personality disorder treatment services for women providing 60 places in prisons and 6 new Psychologically Informed Placement Environment places
- A major national workforce development programme
- Plans are underway to develop a specialist 18 bed PD PIPE service at HMP Long Lartin.
- Plus numerous prison and community projects supporting key elements of the pathway

1.7 In July 2014, Nottinghamshire Trust was served with a formal notice to de-commission the DSPD service, and a Task group was established to oversee the process. The Task Group is chaired by David Sharp, Leicestershire and Lincolnshire LAT, and has full members from NOMs, NHSE Finance, Commissioners, and with representatives from Nottinghamshire Trust in an Advisory capacity.

1.8 This paper reports on the developments since the Task Group was established and the current outlook.

## **2. Progress to date**

### **2.1 Consultation**

The Task group has met regularly since July 2014 and initially agreed the terms of reference and process to be followed. An initial issue concerned the need to ensure that the rights of the patients currently in the DSPD service were respected. The Trust obtained legal advice on the process and this raised concerns about the applicability of the OPD Consultation process to the present situation and patients. This issue, however, was managed by ensuring that the pathways for patients currently in the service would continue to be determined by their clinical teams and the respective Responsible Clinician, and at a time that was appropriate to their needs. As all the patients in the unit are detained

under the MHA, the Responsible Clinician is in charge of their treatment and identifying, with the clinical team, their pathway needs.

## **2.2 Communications**

The Trust has ensured that Patients have been kept informed of the process and reassured that their needs would be paramount. This has involved meetings directly with patients by the Modern Matron, General Manager, and Clinical Director. In addition, to this regular communiqués/updates have been circulated to patients. Similar processes have been followed for other stakeholders such as staff and Carers. Initially, patients (and their Carers) were concerned about the implications of the decommissioning of the DSPD service for their personal care/pathway; and this was reflected in complaints, the involvement of advocacy, contact with their lawyers and MP, and threats of the need for a Judicial Review. Fortunately, the Trust has been able to reassure patients that their needs were paramount and that the decommissioning process would not adversely impact on their care pathway.

## **2.3 Admissions**

As the Peaks unit was already being used to process all PD admissions to Rampton hospital (because the three larger standard PD wards were too large to take direct admissions), it was agreed that it would continue to admit patients (who meet the standard criteria for admission to a High Secure Hospital) but that after the 18<sup>th</sup> July 2014, all subsequent admissions (other than an identified cohort of 'DSPD' patients who were already in the unit, on the waiting list, or on trial leave) would be categorised as standard PD patients.

## **2.4 Post decommissioning use of the Peaks building**

It was also agreed that the Peaks unit would be utilised by the standard PD service at Rampton hospital because it already was the sole admission route for all PD patients, was a purpose built unit, and had more appropriately sized wards in comparison to the three standard PD wards at the hospital.

## **2.5 Case Manager Reviews**

In terms of reviewing the needs of patients, it was agreed that an additional Case Manager would be appointed to attend CPA meetings where discussions about individual DSPD patient's progress, risk, and care pathway needs would take place. The person appointed is an experienced Case Manager and familiar with Rampton hospital and the review process.

## **2.6 Peaks population profile updates**

A number of updates concerning the profile of the patients in the Peaks and these indicated that approximately 50% of the DSPD patients in the unit are on hospital orders and will require a healthcare route as the next stage in their pathway (High secure or Medium secure hospital PD service) and none of the remaining patients on prison transfer orders were not considered by their Responsible Clinicians (RCs) to meet the MHA criteria for remission to prison. The latest update indicated only a small number of the current 'DSPD' patients were from outside the Rampton hospital catchment area, and that the RCs considered that there may be seven patients who could be discharged/transferred out of the Peaks in the next 12 months.

## **2.7 Workshops on PD Prison services**

Colleagues from the specialist PD services in the prison estate have attended the hospital on two occasions to update and inform senior clinicians within the Peaks about the PD services that were now available in specific prisons.

## **2.8 Future Occupancy Modelling Exercises**

The Trust was asked to produce modelling exercises to forecast the future occupancy profile of the service and the associated PD service. These forecasts have been based on historical data about admission and discharge rates, and more recently assumptions about the impact of the developments in the Prison services. The most recent occupancy modelling exercise has indicated that the hospital may be able to close a 17 bed PD ward in 2017/18.

## **2.9 Financial Modelling**

The outcome of the occupancy modelling exercise has been used to generate financial forecasts about the impact of occupancy profile changes in the service. This also includes the financial implications of the PD service using the smaller but more clinically appropriate wards in the Peaks. Work is in progress exploring patient variable costs, and the 'step changes' in occupancy that might release overhead monies.

Commissioners have agreed to the full funding of the Peaks in 2015/16 and future funding will be decided in due course.

## **2.10 Impact of Decommissioning the DSPD service on other clinical services**

It was noted that subject to the outcome of discussions concerning the need to increase the bed capacity of the Men's PD service at Rampton hospital, the decommissioning of the DSPD service could have a significant impact on the standard PD service at Rampton and Medium secure PD services. The current PD service at Rampton is based in three wards of 17, 18 and 20 beds and has significantly less capacity than the other two High Secure PD hospital services.

## **2.11 Current Occupancy in the Peaks**

The DSPD service at Rampton hospital has 60 beds in the Peaks building and an agreed target occupancy of 52 patients. The Peaks currently has 50 in-patients, with an additional one patient on the waiting list for admission, and ten referrals being processed. Of the 50 in patients, 46 are part of the original DSPD cohort.

## **2.12 Engagement**

- NHS England is committed to discharging its legal duties around engagement with - and involvement of - individuals in decisions that are made about them. In this particular case the individuals' status as detainees of the criminal justice system, or requiring detention for the purposes of treatment under the MHA, raises obvious challenges in terms of engagement, and NHS England and the Trust share responsibility for ensuring that appropriate engagement has and does take place.
- As previously mentioned, the Trust has already engaged in extensive engagement exercises with patients, staff and carers, and has met with colleagues from NHSE and NOMs in March to discuss any further actions that may be required. It was agreed that further work will be undertaken on developing User friendly descriptions of the components of the OPD care pathway.

### **2.13 Equality Considerations**

NHS England is committed to actively meeting its legal duties as described in the Equality Act 2010 and the associated Public Sector Equality Duties (PSED). These specify that through the delivery of their functions, public bodies must evidence that they have paid due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not.

The Trust has provided a breakdown of these characteristics amongst the current DSPD population to the Task group.

### **3. Next Steps**

The future occupancy modelling and associated financial forecasts will continue to be refined. Fundamental to this exercise, however, is the need to resolve the future High Secure PD capacity requirements at Rampton, the additional financial implications of using the Peaks building for standard PD patients, and the future funding needs for the developing OPD prison services.

<b>JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE</b>	
<b>21 APRIL 2015</b>	
<b>URGENT CARE WINTER PRESSURES – FUTURE PLANNING</b>	
<b>REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)</b>	<b>Agenda Item: 6</b>

# **1. Purpose**

To consider the lessons learnt from pressures on the Urgent Care System during Winter 2014/15 and the planning already underway for Winter 2015/16.

# **2. Action required**

- 2.1 The Committee is asked to use the information provided to scrutinise action taken across the urgent and emergency care system to minimise the impact of pressures on the system on service users during 2014/15 and support 2015/16 Winter planning.

# **3. Background information**

- 3.1 There are well-documented pressures on the urgent care system nationally and locally, and the Committee has been interested in action being taken to address these pressures locally and minimise the impact on service users.
- 3.2 At previous meetings the Committee has heard about the establishment of the Greater Nottingham System Resilience Group and from Nottingham University Hospitals NHS Trust about the challenges in meeting the four hour Emergency Department waiting time target.

Collectively Clinical Commissioning Groups in South Nottinghamshire have been allocated £4.2 million recurrent funding in their baselines to address System Resilience. During quarter 4 of 2014/15 a “Confirm and Challenge” stock take exercise has taken place to fully assess the impact of schemes that have been put in place during winter 2014/15 and agree with system resilience partner organisations which schemes should be funded during 2015/16.

- 3.3 Colleagues working to improve the urgent care system in South Nottinghamshire will be attending the meeting to give a presentation and answer questions on how the local urgent care system responded to the demands of the 2014/15 winter pressures and preparation for 15/16.

4. **List of attached information**

None

5. **Background papers, other than published works or those disclosing exempt or confidential information**

None

6. **Published documents referred to in compiling this report**

Reports to and minutes of meetings of the Joint Health Scrutiny Committee held on 10 September 2013, 11 February 2014 15 July and 7 October 2014.

7. **Wards affected**

All

8. **Contact information**

Clare Routledge, Overview and Scrutiny Review Co-ordinator  
Tel: 0115 8763514  
Email: [clare.routledge@nottinghamicity.gov.uk](mailto:clare.routledge@nottinghamicity.gov.uk)



# Improving emergency patient flow in our health and social care community

**Dr Stephen Fowlie**  
**NUH Medical Director & Deputy Chief Executive**

**April 2015**

# Agenda

- NUH performance 14/15
- The singular features of winter
- Future key actions and challenges

# Our performance 14/15

86.2% in less than 4 hours

- vs 95% national standard
- vs 93.3% in 13/14

## Demand in 14/15

3% increase in ED attendances

5.2% increase in emergency admissions

In >65 years

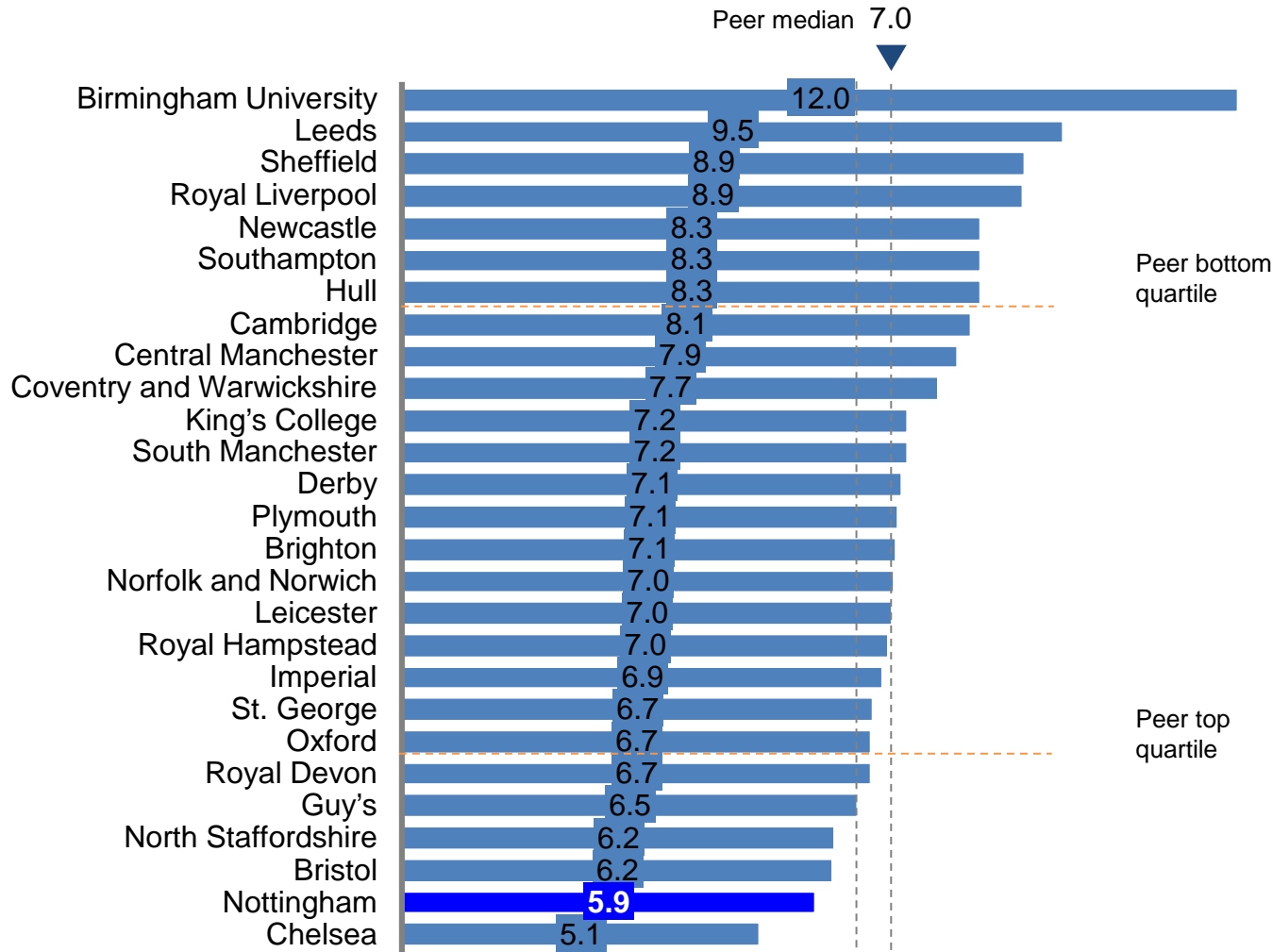
9.3% increase in emergency admissions

Mean LoS = 8.5 days

## National picture: 4 hour performance by Trust (23-29 March 2015)



# NUH's non-elective length of stay remains among shortest in country

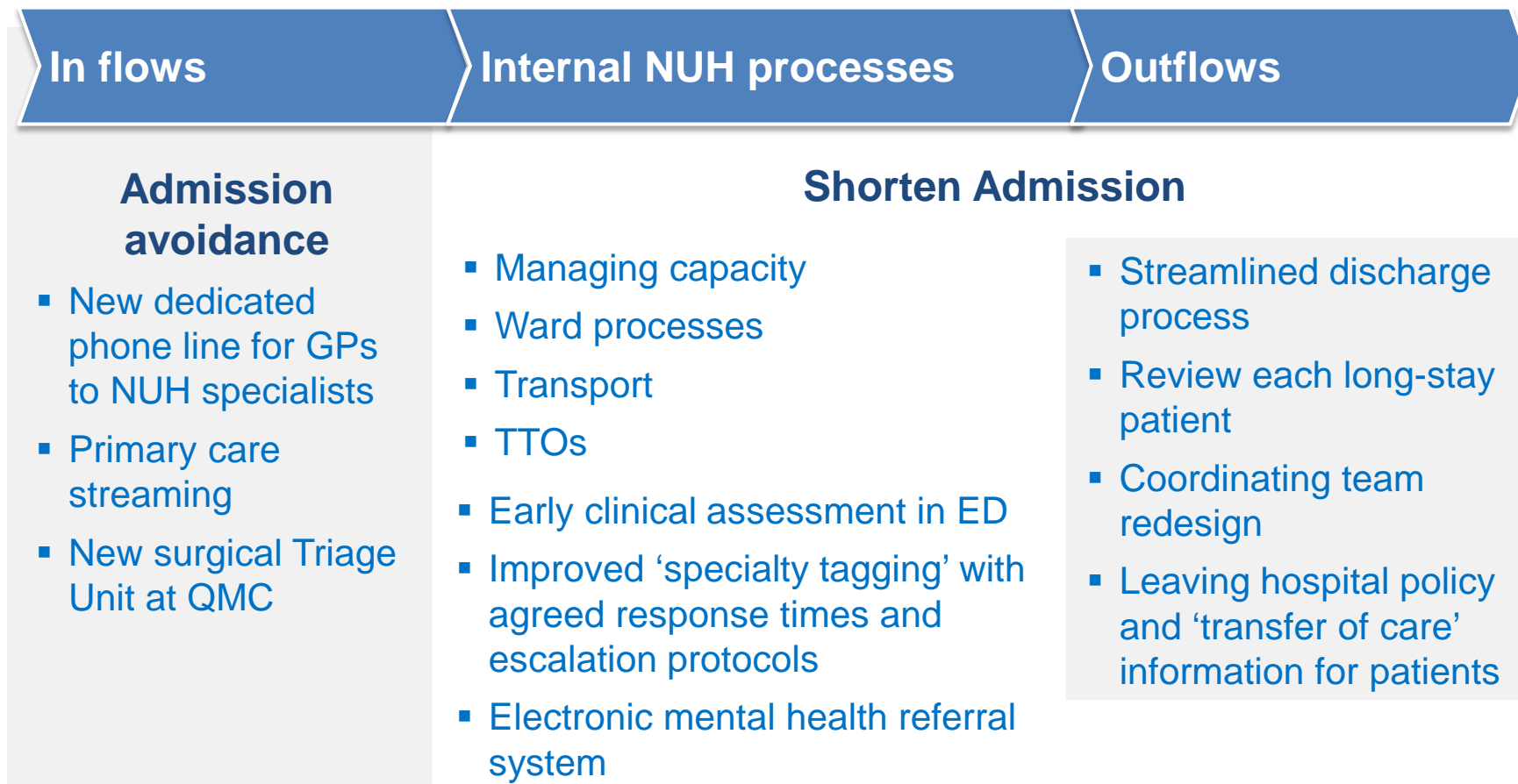


# Preparing for last winter

- £10m + for the Nottinghamshire health and social care system
- 70 extra beds: NUH
- 48 extra beds: community
- 12 additional Emergency Department cubicles

All extra capacity was opened on time

# Key initiatives have been developed along all parts of the Emergency Pathway



NOTE: not an exhaustive list of all initiatives



# 14/15 was busiest winter on record

## 16 day period Dec-Jan

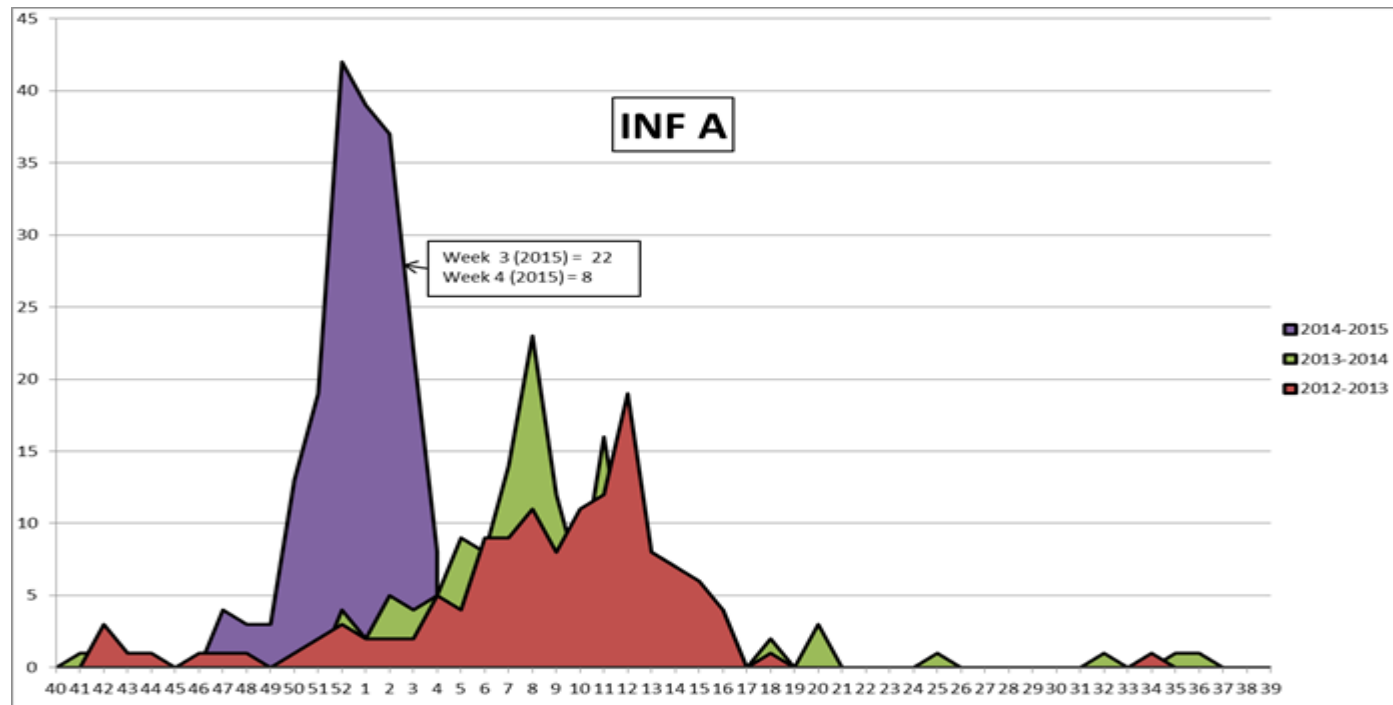
- ED attendances + 13%
- ED attendances >65yrs + 23%
- Increase in emergencies + 3%

higher in >65yrs  
sick  
respiratory

- Bed-days for emergencies + 11%

# Early flu & Norovirus

- Flu started earlier 14/15 and peaked over Christmas (NUH and beyond)



# Early flu & Norovirus

- Norovirus started Nov / Dec (vs Jan/Feb in most previous years)
- Surge in ward closures and staff sickness

# Our health system's response

- **NUH 'internal Incident' on 6th January 2015**

Cancellation of a few additional elective patients  
(no cancer patients & our interval between referral and treatment remains among shortest in country)

Corporate nurses supplemented patient care in ED

Community colleagues in NUH to support weekend discharges

- **52 twelve-hour breaches**

RCA and safety review of each

# Continuing challenges

- **ED Workforce**

Nurses 124 WTE

18 vacancies (40 vacancies August 2014)

Consultants 19 WTE

3 vacancies

- **Other NUH workforce**

- **Other system-part workforce (home-care packages)**

# Continuing challenges

- Increasing demand for admission
- Pressure on length of hospital stay
- High bed occupancy levels (hospital & 'community' beds)
- Capacity in rehabilitation / re-enablement
- Availability of complex care packages
- System transformation when demand exceeds capacity

# Our focus

1. Improved operational management & accountability
2. Focus on weekend internal flow
3. More effective use of beds ('specialty tagging')
4. Increase weekend discharges
5. Breaking the Cycle x 2

# Questions

Thank you



21 April 2015

Agenda Item: 7

## **REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE**

### **WORK PROGRAMME**

#### **Purpose of the Report**

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

#### **Information and Advice**

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents.
3. The work programme for 2014-15 is attached as an appendix for information.
4. The independent review of Nottingham Dermatology Services by Dr. Chris Clough is expected to produce its final report in June or July. The report will be brought to Joint Health Committee as soon as feasible and this may result in changes to the draft work programme.
5. Dates for the future meetings of Joint Health Committee are as follows: 16 June, 14 July, 15 September, 13 October, 10 November, 15 December, 12 January 2016, 9 February 2016, 15 March 2016, 19 April 2016 – all meetings commence at 10:15 a.m. with a pre-meeting at 9:45 a.m. The venue for these meetings is the City Council Offices, Loxley House, Station Street NG2 3NG.
6. At the meeting on Tuesday 14 June 2016 the chairmanship and administration of the Joint Health Committee will revert to the County Council and the venue will again be County Hall.

### **RECOMMENDATION**

- 1) That the Joint City and County Health Scrutiny Committee note the content of the work programme for 2014-15 and dates for future meetings.

**Councillor Parry Tsimbiridis**  
**Chairman of Joint City and County Health Scrutiny Committee**

**For any enquiries about this report please contact: Martin Gately – 0115 9772826**

**Background Papers**

Nil

**Electoral Division(s) and Member(s) Affected**

All

## Joint Health Scrutiny Committee 2014/15 Work Programme

<b>10 June 2014</b>	<ul style="list-style-type: none"> <li>• <b>Intoxicated Patients Study Group</b> To consider the report and recommendations of the Intoxicated Patients Study Group</li> <li>• <b>Terms of Reference and Joint Protocol</b></li> </ul>
<b>15 July 2014</b>	<ul style="list-style-type: none"> <li>• <b>Developments in Adult Mental Health Services</b> To receive information about developments in adult mental health services (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust)</li> <li>• <b>NUH Performance Against Four Hour Emergency Department Waiting Time Targets</b> To receive the latest performance information (NUH)</li> <li>• <b>New Health Scrutiny Guidance</b> To receive briefing on the new Department of Health guidance on Health Scrutiny</li> </ul>
<b>9 September 2014</b>	<ul style="list-style-type: none"> <li>• <b>Greater Nottingham Urgent Care Board</b> To consider the progress of the Greater Nottingham Urgent Care Board (Nottingham City CCG lead)</li> <li>• <b>Patient Transport Service</b> To consider performance in delivery of Patient Transport Services (Arriva/ CCG lead)</li> <li>• <b>NUH Pharmacy Information</b> Information received as part of ongoing review (Nottingham University Hospitals/CCG)</li> <li>• <b>NHS 111 Performance</b> To receive the latest update on workforce change implementation (Nottingham City/Nottinghamshire County CCG)</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>New Health Scrutiny Guidance – Key Messages</b> Further discussion</li> </ul>
<b>7 October 2014</b>	<ul style="list-style-type: none"> <li>• <b>Intoxicated Patients Review</b> To consider the response to the recommendations of this review (NUH)</li> <li>• <b>Developments in Adult Mental Health Services</b> To receive information in relation to the consultation response (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust)</li> <li>• <b>Mental Health Services for Older People</b> To receive information in relation to the consultation response (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust)</li> <li>• <b>Response to Pressures in the Urgent Care System</b> To consider immediate and medium-longer term planning to address pressures and demands in the urgent care system (TBC)</li> </ul>
<b>11 November 2014 CANCELLED</b>	<ul style="list-style-type: none"> <li>• <b>Out of Hours Dental Services</b> An initial briefing following concerns raised at the 9 September committee (Nottingham City CCG, others TBC)</li> <li>• <b>Royal College of Nursing</b> Further briefing on the issues faced by nurses (RCN)</li> </ul>
<b>9 December 2014</b>	<ul style="list-style-type: none"> <li>• <b>Out of Hours Dental Services</b> An Initial briefing following the concerns raised at the 9 September committee (NHS England)</li> <li>• <b>Daybrook Dental Practice – Apparent Breach of Infection Control Procedures</b> (NHS England)</li> <li>• <b>Royal College of Nursing</b> Further briefing on the issues faced by nurses (RCN)</li> </ul>

<b>13 January 2015</b>	<ul style="list-style-type: none"> <li> <b>NUH Environment &amp; Waste</b>  Initial Briefing    (Nottingham University Hospitals) </li> <li> <b>Primary Care Access Challenge Fund Pilots</b>  Pilot outcomes and next steps    (South Nottinghamshire CCGs and Area Team) </li> <li> <b>East Midlands Ambulance Service - New Strategies</b>  Initial briefing    (EMAS) </li> </ul>
<b>10 February 2015</b>	<ul style="list-style-type: none"> <li> <b>Eye Casualty</b>    (NUH) </li> <li> <b>Third Sector Organisations briefing</b>    (HWB3) </li> <li> <b>Transformation Plans: Children, Young People and Families</b>    (Notts Healthcare Trust) </li> </ul>
<b>10 March 2015</b>	<ul style="list-style-type: none"> <li> <b>Patient Transport Service</b>  To consider performance in delivery of Patient Transport Services    (Arriva/ CCG lead) </li> <li> <b>Healthwatch – Renal Patient Transport Review</b>    (Healthwatch Nottingham and Nottinghamshire) </li> <li> <b>NHS 111 Performance</b>  To receive the latest update on workforce change implementation    (Nottingham City/Nottinghamshire County CCG) </li> <li> <b>Dermatology Contract</b>  To receive information on issues relating to the operation of the dermatology contract    (Rushcliffe CCG, Circle and NUH) </li> </ul>

<p><b>21 April 2015</b></p>	<ul style="list-style-type: none"> <li> <b>Urgent Care Winter Pressures – Future Planning</b>  To receive the latest update on lessons learned from winter 2014/15  (Nottingham University Hospitals) </li> <li> <b>Rampton Hospital – Variations of Service</b>  (NHS England) </li> <li> <b>NUH Pharmacy Information</b>  Information received as part of ongoing review  (Nottingham University Hospitals/CCG) </li> </ul>
<p><b>16 June 2015</b>  <b>(New Municipal Year – draft work programme for rest of the year will be attached to the June committee papers)</b></p>	<ul style="list-style-type: none"> <li> <b>NUH Pharmacy Information</b>  Information received as part of ongoing review  (Nottingham University Hospitals/CCG) </li> <li> <b>South Notts Transformation Partnership</b>  To receive information relating to the establishment, remit and work plan of the Partnership  (South Notts Transformation Partnership) </li> <li> <b>Changes in Adult Mental Health Care Provision in Nottingham City and County</b>  To receive the latest update on the changes  (Nottinghamshire Healthcare Trust) </li> <li> <b>Proposed Service Redesign projects within Adult Mental Health Services in 2015/16</b>  TBC </li> </ul>

To schedule:

Transformation Plans for Children, Young People and Families (Nottinghamshire Healthcare Trust – Sharon Creber, Dr Lucy Allsop)

NHS 111 – to consider outcomes of GP pilot and performance following workforce changes

Nottingham University Hospital Maternity and Bereavement Unit

24 Hour Services

Outcomes of primary care access challenge fund pilots

Impact of changes to adult mental health services and mental health services for older people (early summer 2015)

Responses to Pressures in the Urgent Care System (Teresa Cope and Nikki Pownall) - April

Autumn 2015 -

East Midlands Ambulance Service – Update on New Strategies

Nottingham University Hospitals – Environment and Waste

Visits:

EMAS

Urgent and Emergency Care Services (various dates)

Study groups:

Quality Accounts

Waiting times for pharmacy at Nottingham University Hospitals NHS Trust (review now taking place as part of the committee meeting rather than via study group sessions)

