MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
7 October 2014 at 10.15am

Nottinghamshire County Councillors

Councillor P Tsimbiridis (Chair)
A Councillor P Allan
Councillor Chris Barnfather
Councillor R Butler
Councillor J Clarke
Councillor C Harwood
Councillor P Owen
Councillor J Williams

Nottingham City Councillors

Councillor G Klein (Vice- Chair)
A Councillor M Aslam
A Councillor A Choudhry
Councillor E Campbell
Councillor C Jones
Councillor T Molife
A Councillor E Morley
Councillor B Parbutt

Also In Attendance

Councillor T Roberts - Member for Newark West
Councillor D Staples - Newark and Sherwood District Council
Pete Barker - Nottinghamshire County Council
Teresa Cope - Programme Director, Urgent Care – Nottingham City CCG
Alan Davis - HVSU Nurse, NUH
Demas Esberger - Clinical Director of Acute Medicine, NUH
Jane Garrard - Nottingham City Council
Martin Gately - Nottinghamshire County Council
Claire Grainger - Healthwatch Nottinghamshire
Dr Hazel Johnson - Notts Healthcare Trust
Dr Ola Junaid - Notts Healthcare Trust
Amanda Kemp - Notts Healthcare Trust
Nikki Pownall - Deputy Director of Operations, NUH
Sally Seeley - Director of Quality and Delivery, Nottingham City CCG

Other Attendees

Ian Hewitt - Keep Our NHS Public (KONP

MINUTES

The minutes of the last meeting held on 9th September 2014, having been circulated to all Members, were taken as read and were confirmed, subject to the following amendment, and were signed by the Chair:-

The date of the previous meeting should read 15th July 2014.

Disappointment was expressed that no member of the NCC communications team was present as previously requested.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor P Allan (other County Council business), and Councillors P Aslam, A Choudhry and E Morley (other City Council business)

DECLARATIONS OF INTERESTS

None

NOTTINGHAMSHIRE HEALTHCARE NHS TRUST AND NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP OUTCOMES OF CONSULTATIONS AND ENGAGEMENT:

PROPOSED CHANGES TO PROVISION OF ADULT MENTAL HEALTH SERVICES IN NOTTINGHAM AND NOTTINGHAMSHIRE

In July 2014 Nottingham City Clinical Commissioning Group and Nottinghamshire Healthcare NHS Trust advised the Committee of proposed changes to the provision of adult mental health services. Amanda Kemp, Deputy Director, Local Services, NHCT and Sally Seeley, Deputy Director of Quality and Delivery, Nottingham City CCG gave a presentation on the proposed changes which form part of a wider transformation programme focused on reducing inpatient beds and improving community based provision.

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

- The 206 inpatient beds were distributed between Highbury Hospital, Millbrook Mental Health Unit at Kings Mill Hospital and Bassetlaw Hospital.

- The Crisis House was located on MacMillan Close, Porchester Road, Nottingham. It was due to open in December 2014 and would have 6 beds. It would be staffed with Third Sector employees and by visiting NHS staff. It would support those who do not require hospital admission and other models suggested that the average stay would be for no more than 5 days. It was situated in the City/south of the County as the impact of the closing of the QMC wards would affect this area. Not aware of problems elsewhere in the County but there was the possibility of opening another Crisis House further north.

- Internal procedures had been tightened to ensure only those who need crisis support receive it with more people supported to move into mainstream services. This had created capacity within the Crisis Team. Additional ward rounds had been implemented and the discharge process had been revised. The demand for beds had declined and on Monday there were only 6 patients on Ward A at the QMC.

- Hospitalisation for some patients who had requested a bed was not necessarily the right course of action. Often a better overall care package was available which involved the patient remaining at home.

- Substantial reinvestment had been made in the crisis teams and a wider skill set was now found within the teams to enable them to support families and an increase in full time equivalent staff. Skills included family therapy, other intervention skills and clinical support. There would always be beds for those that needed them and there would be the Crisis House for those who needed support but not a hospital admission. In response to feedback about issues arising at evenings and weekends, the Crisis Team would be available 24 hours a day 365 days a year, which had not previously been the case.

- Approximately 30% of patients were admitted informally rather than sectioned.

- An annual benchmarking exercise was undertaken by the NHS and the trend over the last few years was that the demand for acute mental health beds continued to decline. It was expected that this trend would continue. The best way to ensure that future need was met was to provide sufficient support to enable people to stay in their own homes.

- In the last year 2 patients had been admitted out of area (plus any Trust staff who are also treated elsewhere for confidentiality reasons).

- There were now no patients at Enright Close although it had not formally been closed yet, and Dovecote Lane and MacMillan Close had both closed. In Newark there was a Community Rehabilitation Team for those requiring intense support for longer term needs. The review of long term bed use had found that demand had decreased substantially. Clinicians had been surprised and pleased at the subsequent positive outcomes for patients at Dovecote Lane and MacMillan Close. This had been achieved through giving patients more choice eg on budgets and treating them in a more appropriate setting.

- Street Triage had also been operating successfully for 6 months. A Community Psychiatric Nurse accompanied police officers until 2am. The numbers being referred to hospital or taken to a police station had declined substantially as a result. The Police appear to be satisfied at how well the scheme is working and it was not anticipated that they would withdraw.

- Though treatment at home may well be the best option there was a risk that patients could become isolated. The Community Rehabilitation Team did provide intensive support including support to patients' own networks. The Peer Support Workers comprise people who had been seriously ill previously or who had used the community services and they were able to give a valuable insight

into what kept people well through means other than clinical. The Prism Team was also able to signpost patients to available voluntary services and physical and mental health care options.

- Concern was expressed that despite the holding of 14 events not everyone had been aware of the consultation period regarding the proposed changes. The Trust was really confident that it had carried out a thorough piece of consultation and been open and transparent in reporting on the feedback. There was a long list of consultees including voluntary and third sector groups and some smaller groups that were sometimes neglected in consultation exercises e.g. the travelling community. A special effort had been made to contact those who could not attend an event. Attendance was highest in those areas where the changes had been identified and engagement was better than for previous similar consultation exercises carried out by the Trust.

- Users' views would continue to be sought and their challenges and feedback would influence the development of the plans. There was an awareness that the help users required needed to be available when they need it and not at some point in the future. Models would be refined as a result of any concerns subsequently raised and Committee would be kept informed as to what was working well and what was not.

- Healthwatch and Keep Our NHS Public (KONP) shared others' concerns about the comprehensiveness of the consultation process. A meeting between the Trust and Healthwatch was scheduled for the following day where those concerns would be discussed.

- Patient safety was taken very seriously and risk assessments were carried out and updated monthly.

The Committee considered that it had been properly consulted and that the proposed changes were in the interests of the local health service. There were some concerns about the public consultation carried out and although there was no intention to delay the implementation of the proposals it was felt that lessons learned needed to be incorporated into any future consultations. The Committee requested that a written paper on the learning identified from the consultation process, including outcomes from discussions about this with Healthwatch, be provided to the Committee.

Councillor Clarke abstained.

NOTTINGHAMSHIRE HEALTHCARE NHS TRUST AND NOTTINGHAM CITY CLINICAL COMMISSIONING GROUP OUTCOMES OF CONSULTATIONS AND ENGAGEMENT:

PROPOSED CHANGES TO PROVISION OF MENTAL HEALTH SERVICES FOR OLDER PEOPLE IN NOTTINGHAM AND NOTTINGHAMSHIRE

In July 2014 Nottingham City Clinical Commissioning Group and Nottinghamshire Healthcare NHS Trust advised the Committee of proposed changes to the provision of mental health services for older people. Amanda Kemp, Deputy Director, Local

Services, NHCT gave a presentation on the proposed changes which formed part of a wider transformation programme focused on reducing inpatient beds and improving community based provision.

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

- A reduction in mental health care budgets together with an ageing population meant that change was unavoidable. The CQC had rated the directorate as 'outstanding' in care and there was a commitment to maintain that standard.

- The Trust's Quality and Risk Committee was looking at all paperwork and assessment tools supporting the delivery of mental health services for older people and considering how they could be improved.

- Liaison between different teams did occur to ensure that not everyone visited a patient at the same time. The IRIS team was an integrated multi-agency service including social care. The aim was integration not duplication. The length of visits would vary over the 6 week period depending on patient need. Councillors expressed their support for this approach.

- Older people presenting in crisis after 10pm was extremely rare.

- Commissioners had a role overseeing the quality of service delivered by all providers and it did monitor and challenge performance. The Trust also considered that it had a duty of care to not ignore bad practice, and report it appropriately.

- As for consultation about changes to adult mental health services, concern was expressed that despite the holding of 14 events not everyone had been aware of the consultation period regarding the proposed changes. The Trust was really confident that it had carried out a thorough piece of consultation and been open and transparent in reporting on the feedback. There was a long list of consultees including voluntary and third sector groups and some smaller groups that were sometimes neglected in consultation exercises e.g. the travelling community. A special effort had been made to contact those who could not attend an event. Attendance was highest in those areas where the changes had been identified and engagement was better than for previous similar consultation exercises carried out by the Trust.

- Healthwatch and Keep Our NHS Public (KONP) shared others' concerns about the comprehensiveness of the consultation process. A meeting between the Trust and Healthwatch was scheduled for the following day where those concerns would be discussed.

The Committee considered that it had been properly consulted and that the proposed changes were in the interests of the local health service. There were some concerns about the public consultation carried out and although there was no intention to delay the implementation of the proposals it was felt that lessons learned needed to be incorporated into any future consultations. The Committee requested that a written paper on the learning identified from the

consultation process, including outcomes from discussions about this with Healthwatch, be provided to the Committee.

Committee requested that a progress report be brought to Committee 6 months after the implementation of the changes in both the provision of adult mental health services and the provision of mental health services for older people to provide an opportunity for the Committee to review implementation of the changes and to consider the initial impact of the changes for service users and carers.

INTOXICATED PATIENTS REVIEW – RESPONSE TO RECOMMENDATIONS

Demas Esberger, Clinical Director of Acute Medicine, NUH and Alan Davis, HVSU Nurse, NUH introduced a report which examined the impact of intoxicated patients on the Emergency Department at NUH.

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

- The differing levels of service provision available in the City and County areas were a source of frustration.

- Cannot assume that drink was the cause of all problems. Information gathering could be more sophisticated, for example alcohol levels are not measured. The figures were likely to be an under estimation as those recorded only included those whose sole attributable reason for referral was alcohol.

- NUH staff very good at isolating patients likely to soil the general area in A&E. Those able to were encouraged to clear up their own mess.

- It had not been possible to begin the study into the perception of the problems caused by intoxicated patients on others as currently going through a period of transition. Other studies would be looked at and methodologies compared.

- There was an awareness of the work of the street pastors. All were volunteers, a ‘drunk tank’ was provided but patients were sent to A&E if this was required. Their premises, which were located in a pub, were being refurbished at the moment. There was the possibility that the pastors’ roles would expand from their current ‘Samaritans’ type service into one that also provided medical care.

- Mr Davies’ post was unique in the country as it was a full-time post. A&E departments in Derby and Leicester both wanted to introduce a similar post in their establishments.

The committee requested that Mr Esberger and Mr Davis return to Committee once their work had been completed.

RESPONDING TO PRESSURES ON THE URGENT CARE SYSTEM

Teresa Cope, Programme Director, Urgent Care, Nottingham City CCG and Nikki Pownall, Deputy Director of Operations, NUH gave a presentation on the work taking

place to address current pressures on the urgent care system, including the preparation for dealing with winter pressures.

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

- The main difference this year (an election year) was that the level of funding for dealing with winter pressures was notified in June rather than in November as previously. This had allowed a level of planning and consequently a quality of service that had not been possible in the past. Councillors felt that it was important that the significance of this was fed back to national decision makers.

- In the last week an additional 70 beds had opened at NUH, including for respiratory patients and an older persons ward. In two weeks time additional oncology beds would be made available. Changes were being made to the Emergency Department to create an additional 12 cubicles from the end of November and arrangements were in place to be able to fully staff those additional cubicles. From December there would be additional trauma beds and in January additional respiratory and surgical beds would be available. Overall there would be 108 additional beds available to cover the winter period, with 48 beds remaining open beyond April through recurrent funding.

- There was the possibility of staff at risk losing their jobs in the Mental Health Trust due to the proposed changes to adult mental health services. There were however, other job opportunities available within the NUH.

- Recruitment difficulties presented the biggest obstacle to proceeding with the plans to open more beds and all other aspects of the plans were on track. There was a shortage of Band 5 nurses of approx 20-22 to meet requirements for planned bed increases. All other staffing requirements had been recruited to. There was a national shortage of GPs with the East Midlands suffering disproportionately. The inner city was a challenging area in which to work, also the nature of the work may discourage some ie the requirement to be on call.

- It was unclear whether the local authorities could address the recruitment problem and it might be an issue that the Health and Wellbeing Board might wish to consider.

The Committee expressed its reassurance regarding the plans that are in place to manage 2014/15 winter pressures.

WORK PROGRAMME

The contents of the Work Programme were noted.

The meeting closed at 1.10pm.

Chairman