Joint City / County Health Scrutiny Committee

Tuesday, 11 December 2012 at 10:15

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

AGENDA

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:-

(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 Sara Allmond (Tel. 0115 977 3794) 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.

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
13 November 2012 at 10.15am

Nottinghamshire County Councillors

Councillor M Shepherd (Chair)
Councillor G Clarke
Councillor V Dobson
Councillor Rev. T. Irvine
Councillor E Kerry
Councillor P Tsimbiridis
Councillor C Winterton
Councillor B Wombwell

Nottingham City Councillors

Councillor G Klein (Vice- Chair)
Councillor M Aslam
A Councillor E Campbell
A Councillor A Choudhry
Councillor E Dewinton
Councillor C Jones
Councillor T Molife
A Councillor T Spencer

Also In Attendance

County Councillor Sue Saddington – Member of Health Scrutiny Committee (first item only)
County Councillor June Stendall – Member of Health Scrutiny Committee (first item only)
County Councillor Stuart Wallace – Member of Health Scrutiny Committee (first item only)
Phil Milligan – Chief Executive, East Midlands Ambulance Service
Tracey Adams – Assistance Director – Operations, East Midlands Ambulance Service
Dave Winter – Business Delivery Manager (Nottinghamshire) East Midlands Ambulance Service
Simon P Smith – Executive Director for Local Services, Nottinghamshire Healthcare NHS Trust
Julie Grant – Nottinghamshire Healthcare NHS Trust
Dr Sheila Marriott – Regional Director, East Midlands, Royal College of Nursing
Marie Hannah – Regional Officer, Nottinghamshire, Royal College of Nursing
Tim Baggs – Royal College of Nursing
Gill Cort – Royal College of Nursing
Tom Turner – Nottinghamshire County LINKs
Barbara Venes - Nottingham City LINks
Michelle Welsh – Nottinghamshire County Council
Anna Vincent – Nottinghamshire County Council

Martin Gately - Nottinghamshire County Council
Sara Allmond – Nottinghamshire County Council

MINUTES

The minutes of the meeting held on 9 October 2012 were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor E Campbell and Councillor T Spencer

DECLARATIONS OF INTERESTS

None

EAST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST CONSULTATION – CHANGE PROGRAMME JOINT REVIEW

Mr Phil Milligan, Chief Executive of the East Midlands Ambulance Service (EMAS) gave a presentation to the Committee regarding the formal consultation process EMAS was undertaking in relation to proposed changes to how the ambulance service was delivered in the East Midlands.

Mr Milligan assured Members that a genuine consultation process was taking place and changes would be made to the plans following the completion of the consultation.

Members were advised that there was a growth in calls to the service every year and there was a need to make changes to continue to meet demand. EMAS currently provided '999' emergency care, 'Hear and Treat', 'See and Treat' and 'See and Convey' services. EMAS also provided patient transport services in parts of Lincolnshire, but no longer provided this service in Nottinghamshire meaning there was now over capacity within the ambulance stations where the patient transport vehicles were previously kept. When a '999' call was received there was now the option, where appropriate, for advice to be given over the telephone via the 'Hear and Treat' service, and this area of work was expected to grow in the future. The service was provided by trained health care professionals. 'See and Treat' referred to when an ambulance attended a call and was able to treat the patient on site, such as suturing a cut, without the need to transport the patient to a hospital and 'See and Convey' was where a patient was taken to a hospital.

In relation to the national performance targets, EMAS were on target for A8 (8 minute response to a minimum of 75% of 999 calls) with a performance level of 75.2%, whilst they were slightly under target for A19 (19 minute response to a minimum of 95% of 999 calls – patient carrying capability) with a performance level of 94.5%.

EMAS were looking at where they could locate the standby points including sharing with other services. Changes to shift patterns would ensure that there was appropriate staff cover over the full 24 hour period. Paramedics currently checked their vehicles including carrying out vehicle maintenance at the start of each shift.

In selecting suitable standby points, they would need to have the right facilities. If necessary these could be portacabins set up in laybys, however, this was the last option, only to be used if no alternative location could be found.

The Hubs would have a minimum of 170 staff and the vehicles would be cleaned, fully fuelled and prepared ready to go by staff at the Hub. The Hubs would also have a team leader or supervisor who would be available to the paramedics at the end of their shifts to provide support as required.

EMAS had already received hundreds of responses, held 77 meetings and had received a lot of media coverage. The issue of providing services in rural areas was being considered very carefully to ensure the model would work in both rural and urban areas.

Members raised concerns regarding the consultation meetings which had taken place in relation to how they had been run. It was felt that debate had been stifled and the EMAS staff taking part where the meetings involved round table discussions did not have the knowledge needed to be able to answer the concerns raised. Particular concern was expressed regarding the plans for Newark and the impact the changes would have on the service received by rural communities. Mr Milligan advised that the consultation process had included a variety of different types of consultation. The round table discussion had been found to be particularly useful in generating responses. In relation to Newark, Mr Milligan informed Members that modelling showed that a hub in Mansfield would serve the Newark area well. It was important to ensure that the rural communities continued to be properly served for example a vehicle would return to its own zone after a drop off at the Queen's Medical Centre, rather than being diverted to a call in the city. Newark Hospital and Newark Police Station were suggested as possible standby locations for Newark and would be considered. In response to a suggestion Mr Milligan agreed to meet with Sherwood Forest Hospital Trust to discuss ways to work together to serve the local community.

Concern was raised regarding whether ambulances would be restocked during a shift and whether two hubs across the whole of the county were enough to service and maintain the whole fleet. It was commented that a pilot scheme would have been useful, to determine whether this approach would work in Nottinghamshire. Mr Milligan informed Members that the demands of the service had changed and EMAS had not changed to keep up with this demand. The proposal regarding the preparation of vehicles followed the model used by West Midlands Ambulance Service, one of the best ambulance services in the country, and it was working well there. The ambulances would be fully stocked, cleaned and fuelled, which would be enough for the whole shift.

Members were concerned that local Members had not been informed of when the consultation meetings were taking place in their areas. This had been raised at another Committee, yet this information was still not being passed to Members. Mr Milligan apologised that information was not being provided and agreed to the information being provided to the local members. Members questioned the lack of detailed information in the consultation document regarding where the standby points and hubs would be located and asked for further information. Members were informed that the first stage would be to identify the geographical points where the standby points needed to be, then identify specific sites and begin negotiations with the relevant landlords. It was not intended that there would be a further consultation

on the specific locations, but information regarding the locations would be published. The modelling of the locations would be based on where calls came from.

The Joint Health Committee:-

1. **noted the briefing on the change programme**

2. **agreed that the Committee would commence a review of the change programme by way of a sub-committee (including interested Members from the Health Scrutiny Committee, subject to the restrictions of political proportionality) and report back to the next meeting.**

NOTTINGHAMSHRE HEALTHCARE TRUST – FOUNDATION TRUST APPLICATION

Mr Simon Smith, Executive Director for Local Services - Nottinghamshire Healthcare Trust gave a presentation on the Trust's proposal to apply for Foundation Trust status. The Trust was consulting on the proposal and the Committee was asked to give its views.

The presentation set out what being a Foundation Trust would mean and the benefits of being one. The Trust and the care it provided would be accountable to the public rather than just the Government. The proposal included a list of strategic objectives which were also being consulted on.

The Trust had obtained 'Foundation Trust Equivalent' status on 1st November 2010, but had been unable to become a Foundation as statutory restrictions were in place to prevent Trusts who provided high secure services, such as provided at Rampton Hospital, from achieving full Foundation Trust Status. The Health Care Trust Act 2012 amended this legislation and compelled all trusts to apply for NHS Foundation Trust status since they could not remain as NHS Trusts. The process of assessment to become a Foundation Trust would take a year and a number of opening visits had already taken place.

In response to questions, Members were advised that Foundation Trust status would allow the Trust more freedom to do things such as generating capital for building improvements. The Trust would continue to provide care, but Foundation Trust status would enable the Trust to change how they worked with partners. The Trust already provided services outside Nottinghamshire, so their footprint was quite large.

In response to a question regarding their budget, Mr Smith informed Members that he had worked at the Trust for six years and during that time the Trust had never been outside its budget. The Trust had a surplus of £6m in 2011/12.

The following comments were made by Members in relation to the consultation:-

- It was suggested that the Board of Governors should include carers as whilst they were not service users they would be directly affected if treatment was stopped. Other representatives could include Housing Associations and parents of patients.

- It was commented that there was still work to be done to address diversity issues.

- It was commented that it was important to ensure that there was a proper complaints mechanism in place.

- The Committee were generally in support of the proposal.

The Joint Health Committee:-

agreed that a response to the Consultation be prepared and approved by the Chairman and Vice-Chairman of the Committee before submission.

ROYAL COLLEGE OF NURSING PRESENTATION

Dr Sheila Marriot gave a presentation on the work of the Royal College of Nursing (RCN), giving a brief overview of what the organisation did, possible work for the future and their concerns and challenges within Nottinghamshire.

Members were informed that RCN was founded in 1916 as a professional organisation for trained nurses with their trade union work starting in the 1970s. It developed to become a successful combination of professional union and professional body with more than 400,000 members across the UK. RCN was acknowledged as the voice of nursing by both the Government and the public and it represented almost 8,000 nurses, health care assistants and student nurses in Nottingham and Nottinghamshire.

RCN were running a campaign called 'this is nursing' in response to concerns raised in the media regarding poor care. The majority of healthcare professionals were very good, but some of the concerns raised in the media were valid. RCN were looking at the training of nurses and had developed the 'Principles of Nursing Practice'.

Marie Hannah provided Members with a local perspective, explaining that since she had taken up her post a year ago she had been meeting the people involved with the 'Transforming Community Services' programme. This had highlighted how quickly new processes could become fragmented as they were implemented within different areas and concerns regarding the 'transition gap' between acute and community health care had also been raised. Nurses were keen for their views to be considered when services were developed, as they felt they had an important holistic view of health care as they were involved in both acute and community care.

There had been a reduction in the number of nurses in Nottinghamshire but this reduction was less than the national average. There had been a higher reduction in higher skilled nurses.

There was the requirement for more care to be delivered in the home in future and nurses needed the facilities and skills if they were to provide the service.

RCN were keen to work with the Committee, to provide an insight into what was happening on the frontline, professional expert knowledge, advice and guidance and

an independent perspective and picture of what was happening across the UK and asked the Committee to consider how they could participate in the work of the Committee in the future.

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

- RCN was working with its Members to look at best practice and guidance to ensure standards of care were excellent and there was respect for patients. RCN also worked closely with the Care Quality Commission (CQC). It was not the role of the RCN to enforce standards but to promote the use of good standards and best practice.

- There was concern that nursing numbers were going down, whilst they were being expected to take on work previously carried out by junior doctors. This related to work load, not capability.

- There was now a wider range of service providers many of whom RCN did not have a recognition agreement with, making it harder for RCN to influence them.

- RCN promoted clinical leadership programmes which provided nurses with the skills and competencies to fulfil the roles previously thought of as the traditional matron role, such as good leadership skills, and setting clear expectations of good nursing from their teams.

- RCN would fight against any proposal to change or remove the national pay and conditions as they felt that this would be very damaging to the NHS.

- The savings being made were meaning that staff were so busy they were struggling to carry out their regular duties. There was concern that patients were only being treated for the symptoms they presented with rather than providing holistic care. Some managers were refusing to cut nursing staff any further, but this was resulting in budgets not being met.

- RCN would publish examples of good nursing care early in 2013 as it was important to recognise good work.

Following discussion:-

1. the Joint Committee noted the presentation

2. it was agreed that the Chairman and Vice-Chairman would consider how the RCN could be involved in the work of the Committee in the future and advise them accordingly.

WORK PROGRAMME

In addition to the items listed within the work programme, the Committee would receive a report back on the outcome of the EMAS Change Programme Review at its next meeting.

The meeting closed at 1.10pm.

Chairman

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
11 DECEMBER 2012
DEVELOPMENT OF SERVICES AT LINGS BAR HOSPITAL - UPDATE
REPORT OF THE HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL) **ITEM 4**

1. Purpose

1.1 To keep the Committee informed of service developments at Lings Bar Hospital, pending the outcome of NHS restructuring and commissioning decisions in early 2013.

2. Action required

2.1 The Committee is asked to note the latest service developments at Lings Bar Hospital.

3. Background information

3.1 Local NHS Trusts have a statutory duty to consult the relevant local authority overview and scrutiny committee when proposing changes to local health services.

3.2 The Committee received reports on the reconfiguration of services offered at Lings Bar Hospital, Gamston, at its meetings in September 2011 and April 2012. The changes were designed to accelerate discharge of less complex patients, develop integrated pathways between Adult Social Care and Health and Community services, redirect resources through avoiding admission to Lings Bar (City-based pilot) and providing early supported discharge from Lings Bar (County-based pilot) and explore expanding the service offer at Lings Bar, with a focus on haemodialysis and stroke rehabilitation services.

3.3 The Committee was reassured that the changes undertaken had resulted in improved efficiencies and patient experience, freeing up resource to provide enhanced community services, including haemodialysis. It requested further information on pilot evaluation and subsequent commissioning decisions – this was tentatively scheduled in the work programme for December 2012. However, NHS colleagues have advised that, due to the transfer to the new NHS structure, and the need for clinicians to evaluate fully the options available, decisions on the way forward for services at Lings Bar Hospital were unlikely until early 2013.

3.4 In the meantime, and with Chair's approval, it has been agreed to receive for information a progress report at the Committee's December 2012 meeting, with full consideration of the issue scheduled to take place in March 2013. NHS colleagues have provided the report at Appendix 1, but will not be available to take questions on the day. Substantive consideration of the item has been rescheduled for the Committee's March 2013 meeting.

4. List of attached information

Appendix 1 – Letter from NHS Nottingham City and Nottinghamshire County dated 30 November 2012.

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

None.

6. Published documents referred to in compiling this report

Report, presentation and minutes arising from Joint Health Scrutiny Committee meetings on 13 September 2011 and 17 April 2012.

7. Wards affected

All

8. Contact information

Contact Colleague

Noel McMenamin
Overview and Scrutiny Co-ordinator
noel.mcmenamin@nottinghamcity.gov.uk
0115 8764304

30 November 2012

APPENDIX 1

Nottingham City and
Nottinghamshire County

Birch House
RansomWoodBusinessPark
Southwell Road West
Mansfield
Nottinghamshire
NG21 0HJ
Tel: 01623673128
Fax: 01623 673001
Web: www.nottspct.nhs.uk

30 November 2012

Dear Councillors

Development of services at Ling's Bar Hospital
Following our meeting with you in April 2012, I'm pleased to update you on the development of services at Ling's Bar Hospital since that time.

By way of background; following an independent utilisation review of community hospitals in Nottinghamshire County, the results demonstrated that nearly half of the patients treated at Ling's Bar Hospital (LBH) did not need to be there or would be better cared for in the community. A working group of clinicians have been looking at ways to develop sustainable and appropriate care for patients in the community whilst re-utilising LBH as a valuable health facility.

Update:

- In May 2012 Nottingham University Hospitals NHS Trust (NUH) opened the Haemodialysis Unit at LBH. This has improved access to haemodialysis services for patients in the South of Nottinghamshire.

- The accelerated discharge scheme at LBH, which is ensuring patients are returned to more appropriate care at the right time, is now fully embedded in working practices across the whole hospital.

- Since October 2011, 128 patients have been through an early supported discharge scheme (Enhanced Community Support Service) in Rushcliffe where appropriate and individualised packages of care have enabled earlier discharge of patients from LBH into their home with the majority of patients being in the new service for less than 14 days.

  The scheme has also now been extended to patients in Nottingham West and Nottingham North and East Clinical Commissioning Groups (CCG). The evaluation of the pilot has been completed by the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) in Nottinghamshire. This report together with provider and patient feedback will be used to inform future commissioning decisions regarding this work from April 2013.

Patient feedback from the new service remains overwhelmingly positive, with all patients extremely happy with the care they have received. Feedback includes:

- "I preferred being at home and this service was better for me"
- "The care (I received) helped me survive"
- "I have got nothing but positives to say (about the service)"

- Additional funding has been requested to extend the capacity of the Enhanced Community Support Service in Rushcliffe from 5 places to 10 places as it has been identified that there is the demand to fill the places.

- The Nottingham City Enhanced Community Support pilot ended in April 2012. The evaluation undertaken by the University of Nottingham indicated that although this was a suitable pathway for patient care, a number of processes between the acute hospital and community services needed to be improved. The learning from this work has gone on to inform the development of intermediate care services in the City. The City CCG is also continuing to provide in-reach to LBH building on the success of the County Pilot.

- Increased efficiency with the level of admission activity for the hospital's three wards remains comparable to the previous number of admissions when the hospital had four wards in operation. This year it is forecast to increase the number of admissions.

- Work has started to investigate whether an alternative, more appropriate care setting can be provided for medically stable non-weight bearing patients who currently stay at Lings Bar Hospital.

The next steps

- To agree the future of the Enhanced Community Support Services and commission the service from April 2013
- To continue to work with the both Nottingham University Hospital and Lings Bar Hospital to ensure that LBH is used in the most appropriate and effective way
- To complete a further service review using a recognised care tool to ensure patients are seen in the most appropriate setting and that the issues highlighted by the utilisation review have been addressed by the work that has been done.
- To develop an overarching strategy as to the future use of Lings Bar Hospital and the appropriate use of the facility for patients in the South of the County.

We will happily provide further developments in our report to you in March 2013.

We look forward to meeting again in March to update you further on progress. In the meantime, if you require any further information, please do not hesitate to contact me.

Best wishes,
Yours sincerely

Samantha Walters
Chief Officer Designate, Nottingham North and East Clinical Commissioning Group
On behalf of NHSNottinghamCity and NottinghamshireCounty

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
11 DECEMBER 2012
NOTTINGHAM UNIVERSITY HOSPITALS TRUST – CANCELLATION OF NON-URGENT ELECTIVE OPERATIONS – PROGRESS REPORT
REPORT OF THE HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL) **ITEM 5**

1. Purpose

1.1 Representatives of the Nottingham University Hospitals Trust (NUH) have been invited to today's meeting to set out further measures taken and resulting outcomes to date in respect addressing the unacceptable levels of cancellations of non-urgent elective operations at the Queen's Medical Centre (QMC) and City Hospital earlier in 2012.

1.2 This is the second of three quarterly progress reports requested by the Committee following its meeting in May 2012. A written report from NUH is attached.

2. Action required

2.1 The Committee is asked to consider the information presented at the meeting and determine whether it is satisfied with progress to date.

3. Background information

3.1 At its May 2012 meeting, and as a matter of urgency, the Committee considered in detail the issue of the cancellation of nearly 600 non-urgent elective operations at the QMC and City Hospitals in January to April 2012. The Trust explained that had experienced unprecedented pressures on both Emergency Department and on critical care capacity during this period, that these could not have been forecast, and that a raft of measures were being taken to minimise cancellations and to achieve the 'national standard' level of service for Nottingham patients.

3.2 In response, the Committee requested quarterly updates until March 2013 to ensure a quick resolution to the upsurge in cancellations, to make sure there was no repeat upsurge, especially in advance of Winter 2012/13, and to monitor the Trust's progress against the National Standard, it having been an 'outlier' in performance terms for some time.

3.3 At its September 2012 meeting, the NUH Chief Executive was able to report significant progress, reassuring the Committee that this remained an ongoing, key priority for the Trust. The Committee

welcomed the initiative taken by the Trust to tackle the issue of operations cancelled earlier than 'on the day', but noted that, despite the improved situation, the Trust remained an 'outlier' nationally in respect of 'on the day' cancellation performance.

3.4 The Chief Executive also reported that the external review of emergency and elective pathways, and NUH action plan would be published at the Trust's September Board. The Executive Summary is included in the Trust's report.

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

Minutes from Joint Committee meeting held on 15 May 2012

7. Wards affected

All

8. Contact information

Contact Colleague

Noel McMenamin
Overview and Scrutiny Co-ordinator
noel.mcmenamin@nottinghamcity.gov.uk
0115 8764304

30 November 2012

APPENDIX 1

Nottingham University Hospitals NHS
NHS Trust

Trust Headquarters
City Hospital campus
Hucknall Road
Nottingham
NG5 1PB

Please ask for: Chief Executive's Personal Assistant

Tel: 0115 969 1169 ext 76007
Email: Peter.Homa@nuh.nhs.uk
www.nuh.nhs.uk

Thursday 29 November 2012

Councillor G Klein
Constitutional Services
L H Box 28
Loxley House
Station Street
Nottingham
NG2 3NG

Dear Councillor Klein,

Further to the Committee meeting I attended in September 2012, I am pleased to provide our second quarterly update which describes our improving cancelled operations performance.

In this update I include:

- A summary of the findings of the Mott MacDonald Report (the external review of cancelled operations, published in September 12). The report and our associated commentary was shared with the Committee ahead of publication
- An update on our performance for cancelled operations July-September 12

QUARTERLY UPDATE: 2

Please find below our second quarterly update for the Joint Health Scrutiny Committee, covering each area in turn where information has previously been requested by the Committee.

1. **An update on the progress, and outcomes, of the external review commissioned by the Trust into the upsurge in cancellations**

The report (external review), published in September 12, concluded that there was no single reason for the cancellations. Rather the increased pressure in

our emergency (and then) elective pathways was caused by the unforeseen and complex interaction of inter-related organisational and service changes.

In February 2011 we reduced our capacity at Nottingham City Hospital by 96 beds. We were able to do so safely by reducing internal waits and hence length of stay. The external report describes that the bed reductions did not cause the increase in cancellations. Several months passed between the bed closures and the marked rise in cancelled operations. But the bed closures did reduce the resilience of our system to changes in patient flows.

In April 2011 we changed the flow of patients to our Nottingham City Hospital and Queen's Medical Centre (QMC) campuses. In line with our strategy to develop QMC as our unselected emergency care centre and City Hospital as the focus for planned care and treatment (including emergency treatment) of long-term diagnoses, we directed patients with known illnesses to City Hospital and those with unknown diagnoses/conditions to QMC. Emergency general surgery (and elective gastroenterology) moved to QMC, patients with long-term illnesses were directed to City Hospital.

The report supports our safety and quality reasons for making these changes to the configuration of services across our campuses. It describes that, notwithstanding the significant number of cancellations and the pressure experienced by our hospitals and staff, our clinical outcomes remained among the finest in the country.

However, the report describes that our planned changes in patient flow were in a system which was already stressed. Although it was not immediately apparent in the number of cancellations or in any of the other numbers we track, the swing (daily and weekly) in the number of patients entering and leaving our hospitals had increased. The anticipated move of elective orthopaedics from QMC to City Hospital in April was delayed by staff concerns. Although bed numbers remained the same at QMC in the run up to winter 2011/12, the types of bed changed. Fewer elective beds were readily available for emergency use when there were peaks in demand.

The overall impact was that our system was less able to cope with extreme day-to-day variations in demand, and we took much longer to recover from very busy days, than in previous years.

In the first weeks of January QMC became overfull with emergency patients and we had no reasonable alternative than to cancel planned many operations. Even then it was several weeks until the system re-established an equilibrium and we were able to reduce cancellations.

Like other NHS hospitals we routinely tracked the number of operations cancelled on-the-day of planned surgery, but not all cancellations (including those before-the-day). Because we avoided on-the-day cancellations if at all possible they did not increase until our systems were very stressed, by which time there had already been a very significant increase in before-the-day

cancellations. We were unaware of this huge number of increased cancellations for several weeks.

The report describes that in future we can and should improve our planning to better take account of day-to-day variation in flow in and out of our hospitals. We should not rely on average numbers.

The full report and related action plan are available on our website at www.nuh.nhs.uk. The executive summary is attached as an appendix (Appendix 1).

2. Levels of last minute ('on the day') & prior to the day non-clinical cancelled operations

Mindful of the significant impact of the cancellations on our patients and their families, we have focused our efforts on reducing cancellations for all reasons. We can report that we have largely sustained our significantly improved position since the end of April 2012. Our Chief Executive's Team is sighted and reviews all cancellations weekly and our Trust Board on a monthly basis. This information is published monthly (as in Table 1).

January-October 2012 we cancelled 3,161 operations prior to the day and 977 operations 'on the day' (a total of 4,138 operations). In the same period we performed a total of 106,152 operations at NUH.

Notably, the prior to the day cancellation figures have reduced from 1,894 in Quarter 4 11/12 (Jan-March 12) to 704 in quarter 1 12/13 (April -June 12) and more recently to 443 in quarter 2 for 12/13 (July-September 12).

Please refer to Table 1 (below) for monthly figures for NUH (for 'on the day' and 'total' cancellations) for all reasons January-October 2012 and Table 2 (also below) for the percentage of cancellations (vs total admissions) for the same period.

The total cancellation rate January-March 2012 was 10%, compared to 2.7% for July-September 2012.

DEFINITIONS

- **'On the day' (or 'last minute')** means on or after the day the patient was due to be admitted for their operation (usually on the planned day of the surgery). For example: if a patient is admitted on a Monday for an operation on Tuesday and we cancel the operation on Monday or Tuesday, this would count as an 'on the day' cancellation.
- **'Prior to the day'** means before the day the patient was due to be admitted for their operation (this can range from one day before to several weeks before the scheduled surgery).

Table 1

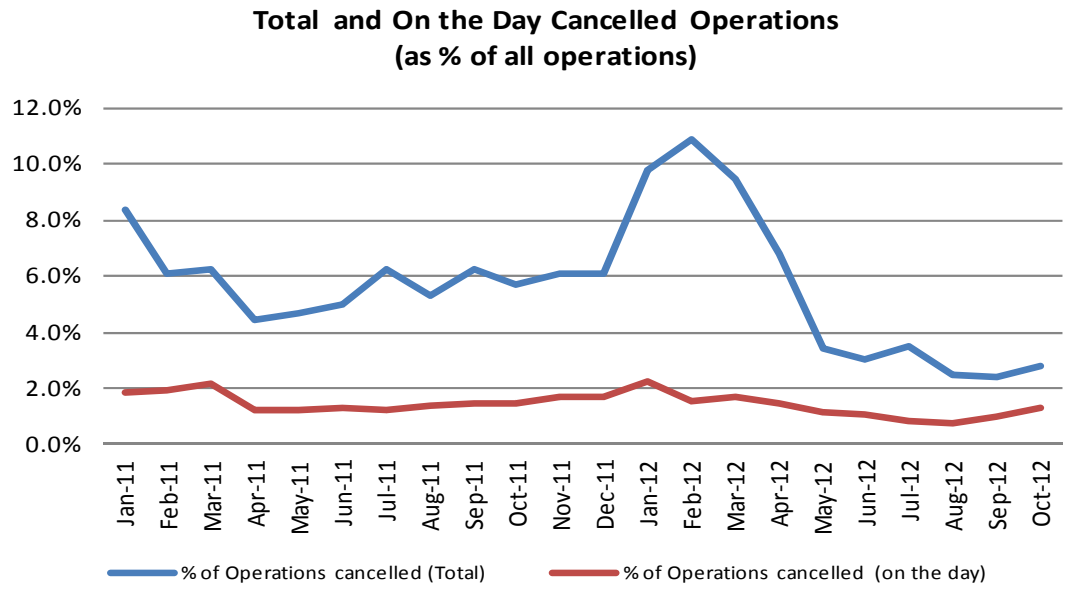
Reason	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12
Ward Bed Unavailable	417	463	348	156	20	13	21	2	5	24
ICU/HDU Bed Unavailable	21	17	41	42	31	9	13	9	6	11
Clinical Priority	110	105	152	117	89	89	86	92	80	102
Staffing	62	98	83	59	73	44	70	34	29	55
Theatre Time	64	29	41	37	59	11	15	14	14	11
Administrative Error	29	29	31	14	4	9	11	13	11	15
Equipment	10	9	11	12	11	40	57	21	17	9
Other	38	53	52	30	0	1	6	1	1	
Total Cancelled Operations	751	803	759	467	287	216	279	186	163	227
% of Operations cancelled (Total)	9.82%	10.90%	9.44%	6.79%	3.40%	3.04%	3.46%	2.51%	2.36%	2.80%
Cancelled twice for the same procedure					12	19	32	12	10	24
Cancelled 3 times for the same procedure					1	8	16	6	2	3
Cancelled 4 times or more for the same procedure					1	0	5	1	0	0
On the day Cancelled Operations	169	115	135	98	95	73	64	55	66	107
% of Operations cancelled (on the day)	2.21%	1.56%	1.68%	1.43%	1.12%	1.03%	0.79%	0.74%	0.95%	1.32%
Cancelled twice for the same procedure	13	11	11	12	6	2	5	3	1	6
Cancelled 3 times for the same procedure	1	3	5	0	1	0	1	0	0	1
Cancelled 4 times or more for the same procedure	0	0	0	0	1	0	0	0	0	0

A total of 227 operations were cancelled in October (including 107 'on the day'). This was higher than the previous months and is the first time since April we have seen an increase in cancellations. This increase was mainly due to 'on the day' cancellations due to ward and critical care bed capacity and clinical priority of other patients in theatre.

As at Monday 26 November (at the time of writing this paper), the latest figures for November for total cancellations was 172. This compares to 227 in October, 163 in September, 186 in August, 279 in July, 216 in June and 287 in May.

We have reviewed all reasons for cancellations. We have made significant improvements in relation to cancellations due to bed unavailability. The main reason for cancellation is in relation to patients being rescheduled to accommodate more clinically-urgent patients. We are progressing further work with clinical colleagues to understand how we further reduce these cancellations while also retaining appropriate access for clinically-urgent cases.

Table 2



3. Comparator information from similar major trusts in the region

The Department of Health publishes comparative information for all NHS Trusts on a quarterly basis. This allows NUH to see how we compare with our peer organisations (and other Trusts around the region) for 'on the day' cancellations. The recently- published Department of Health figures for Quarter 2 'on the day' cancellations demonstrate that NUH's position compared to peer hospitals has improved markedly since quarter 1.

The comparative data for Quarter 2 (July-September 2012) was published in November 2012 (see Appendix 1). NUH had 193 'on the day' cancellations for Quarter 2, compared to 286 in quarter 1 (April-June 12) and 454 'on the day' cancellations the previous quarter (December 2011-March 2012), as previously shared with the Committee.

215: Sheffield
204: Cambridge
202: Leicester
193: NUH
188: Leeds
159: Birmingham
135: Bristol

We are confident that the Quarter 3 figures for 2012/13 will show a sustained improvement in our performance as a result of the ongoing actions we are taking to reduce cancellations (as described on page 2).

4. **Benchmarking performance against the national standard, where available**

See response to question 3. The Department of Health comparative data (which is published quarterly) is only available for 'on the day' cancellations. We believe we are first trust in the country to report 'total' cancellations. As these numbers are not routinely collected or made available, as such no comparative data is currently available.

An assessment of the knock-on effect of the upsurge in cancellations on waiting times for non-urgent elective operations, the Committee being concerned that patients suffering cancellations could potentially face ever-longer waiting times for rescheduled operations

We continue to prioritise patients who have operations cancelled when booking operations, to ensure patients have their operations as soon as possible. We have increased the number of patients who we readmit within the 28 day national standard compared to earlier this year. Since April, 81 out of 583 who had their operations cancelled on the day (13.8%) were not readmitted for their operation within the 28 day standard. The national target is 5%.

We have more work to do to improve our performance Vs the 28 day readmission percentage although there are signs that our performance is improving. April 12 – 25 patients (were not readmitted within 28 days), May 12 – 15 patients, June 12 – 11, July 12 – 6, August 12 – 7, September 12 – 9 and October 12 – 8.

There are a very small number of cases each month where either the complexity of the treatment and the resources required to deliver it or the prioritisation of more clinically-urgent patients means it is not possible to offer earlier dates without compromising patient safety or subjecting another patient to cancellation.

If there is any further information that I can provide in advance of the Committee meeting on 11 December please do not hesitate to contact me. I look forward to seeing you at next month's meeting.

Yours sincerely,

Peter Homa, Chief Executive
Appendix 1 – Executive Summary – Mott MacDonald Report (external review)

Executive Summary

Overview

1. This report has been commissioned to identify the main reasons for the high level of elective cancellations at Nottingham University Hospitals NHS Trust (NUH) in the winter of 2011/12. Its findings and recommendations will be used to improve resilience and performance in the future.

2. The path which led to the unacceptably high level of cancellations was complex, and there was no single cause of failure.

3. The trust has maintained its position as one of the best in the country in terms of clinical outcomes. To have sustained this while navigating through the significant disruption of last year is a considerable achievement.

4. The relative contribution of individual factors to the cancellations is difficult to assess, as there were multiple interdependencies and a cumulative impact. We consider the most important single contributor was loss of synchronicity in a planned reconfiguration of services across the Trust's two main campuses. This reconfiguration, moving emergency surgery and undifferentiated medical emergencies to the QMC campus and elective activity to the City campus was undertaken for valid patient safety, clinical quality and workforce sustainability reasons. During the process of reconfiguration the planned revised flow of emergency and elective patients to the two campuses became un-synchronised. This led to a loss of resilience and unpredictable changes in the system when controls were applied in an effort to meet demand and maintain both emergency and elective services.

5. Reporting systems were not sensitive enough to changes in processes (in emergency and elective services) and did not pick up early warnings that resilience had been lost and that consequently (1) elective cancellations were higher than should be expected and (2) there was an increasing underlying number of emergency patients placed on non-core-specialty wards (outliers).

6. If individual services had considered more fully the impact of local changes on the overall capacity of the system, and had this been more visible to the leadership team, the Trust could have managed the loss of synchronicity (and hence resilience) more effectively.

7. The removal of 96 beds from the City Hospital campus in February 2011 did not itself cause the increase in cancellations, though it was one of the many elements increasing stress on the system.

8. A number of other internal and external factors relating to patient volumes and case-mix have been investigated as possible contributory factors to the rise in cancellations. These include: an increased number of emergency admissions, an increase in the acuity of ED attendances and subsequent admissions, an increasing age of emergency admissions, and a longer length of stay of emergency admissions. The report finds that these played a relatively minor part in the system deterioration and increased cancellations.

Key Findings

KF1: Changes made to the organisation of services across the two campuses resulted in a loss of resilience in the system : it was unable to cope with the combination of peak demands for emergency admissions and continuing elective demand, and to recover from the destabilisation caused by the emergency peaks. The changes caused the system to behave in an unexpected manner, rendering forecasts and planning assumptions invalid. This was a novel situation that could not have been predicted from previous experience.

KF2: Disparate information systems and flows made collation of a clear and unified picture challenging. Information provided to all levels of Trust management no longer represented the whole system, due to multiple planned and tactical changes (both local and corporate).

KF3: The growing problem was not visible early. In retrospect the system had probably changed (become unstable and unpredictable) by September 2011. Indeed there is some evidence that there had been a change in the system (to a different but relatively steady state) at least a year earlier (before the closure of beds in February 2010 and before the service reconfigurations through 2011/12). But the Trust's routine reports (supporting decision-making) did not signal the growing system failure until December 2012.

KF4: A multitude of local and corporate process workarounds were enacted to cope with a system that was becoming unstable and not reacting as it had previously to changes in demand or to control measures. Rather than reasserting control, in the absence of an understanding of the fundamental system-wide issues, these workarounds amplified the instability.

Conclusion

9. There was no single cause of the increased cancellations in winter 11/12. Three factors were pre-eminent:

a. Although most individual decisions about the emergency and elective pathways over the period were reasonable, they were based on incomplete data and forecast models which over-relied on average previous numbers (rather than 'worst case' numbers and variation).

b. Service moves between QMC and City (reconfiguration) did not happen with the anticipated choreography. This led to a loss of flexibility of bed use at QMC; notably the number of beds readily available for emergencies (the potential outlier "buffer") at QMC was reduced. The availability of beds for elective operations (at QMC and City) became more difficult to predict. This inefficiency in bed use coincided with a period in which emergency and elective volumes were unsteady because of Christmas and bank holidays. To maintain capacity for emergencies the Trust cancelled an increasing number of electives. In an effort to maintain elective activity the Trust rescheduled elective operations as soon as there seemed to be some capacity. This led to an increased swing in the pattern of flow into and out of the hospital beds. The day-to-day and week-to-week fluctuation in availability of beds for operations increased dramatically. Such a system is unstable, difficult to control, and lacks resilience if faced with short-term (days or even hours) increases in demand.

c. There was limited awareness of this instability and loss of resilience, the swinging day-by-day flow, and the number of cancellations, because information on prior-to-the-day cancellations was not routinely collated across the trust, or escalated through its performance management mechanisms. On-the-day cancellations, which the Trust did track, are a much less sensitive indicator of system deterioration. This in turn meant that the corporate response, integrated across all directorates, was later than it might have been. By the time of this corporate escalation and response there had been many hundreds of additional prior-to-the-day cancellations.

10. The combination of a severe loss of resilience, inadequate information flows and an inability to fully coordinate cancellations led to an increasingly unstable system, running with a high background level of cancellations (to which the 2010 system change may have contributed earlier). In this circumstance a relatively minor seasonal increase in demand over the winter of 2011/12 had a disproportionate impact because the system could no longer cope with any further variation (or increase) in demand. The planned responses to cope with even short-term (hours or days) changes in demand were no longer sufficient, and the Trust found itself in uncharted waters, requiring wholesale cancellation of operations – a situation that had not been modelled, so decisions could not be based on any reliable projections.

11. Focus should now be brought to aligning the resources on the two sites with the demand on them. This needs to be supported by an accurate and timely picture of the status of the trust's emergency and elective systems, which will require unification of its information systems to enable effective decision-making.

Appendix 2 – Benchmarking figures published by the Department of Health

The number of last minute cancelled elective operations in the quarter for non-clinical reasons, NHS provider organisations in England for Quarter 2 (July-September 2012)

SHA Code	Organisation Code	Organisation Name	Number of last minute elective operations cancelled for non clinical reasons	Number of patients not treated within 28 days of last minute elective cancellation
-	-	**England (Excluding Independent Sector)**	**13,122**	**577**
-	-	**England (Including Independent Sector)**	**13,154**	**590**

Q30	RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	28	0
Q30	RLN	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	82	1
Q30	RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	15	0
Q30	RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	130	0
Q30	RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	61	0
Q30	RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	100	7
Q30	RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	36	0
Q30	RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	80	1
Q31	NT497	BMI GISBURNE PARK HOSPITAL	0	0
Q31	RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	74	12
Q31	RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	90	0
Q31	RBQ	LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	5	0
Q31	RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	5	0
Q31	RBT	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	89	10
Q31	RBV	THE CHRISTIE NHS FOUNDATION TRUST	2	0
Q31	REM	AINTREE UNIVERSITY HOSPITAL NHS	82	9

		FOUNDATION TRUST		
Q31	REP	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	27	1
Q31	RET	THE WALTON CENTRE NHS FOUNDATION TRUST	47	3
Q31	RJN	EAST CHESHIRE NHS TRUST	22	0
Q31	RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	55	0
Q31	RM2	UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	144	1
Q31	RM3	SALFORD ROYAL NHS FOUNDATION TRUST	54	0
Q31	RMC	BOLTON NHS FOUNDATION TRUST	94	1
Q31	RMP	TAMESIDE HOSPITAL NHS FOUNDATION TRUST	35	0
Q31	RNL	NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	73	4
Q31	RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	55	1
Q31	RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	130	3
Q31	RTX	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	168	22
Q31	RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	63	3
Q31	RW3	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	92	2
Q31	RW6	PENNINE ACUTE HOSPITALS NHS TRUST	141	0
Q31	RWJ	STOCKPORT NHS FOUNDATION TRUST	97	3
Q31	RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	119	3
Q31	RXL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	54	0
Q31	RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	128	5
Q31	RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	103	5
Q32	NTP23	ECCLESHILL NHS TREATMENT CENTRE	29	13
Q32	RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	143	0
Q32	RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	151	1
Q32	RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	35	0
Q32	RCF	AIREDALE NHS FOUNDATION TRUST	31	0
Q32	RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	15	0
Q32	RFF	BARNSLEY HOSPITAL NHS FOUNDATION TRUST	51	0
Q32	RFR	THE ROTHERHAM NHS FOUNDATION TRUST	72	0
Q32	RHQ	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	215	2
Q32	RJL	NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS FOUNDATION TRUST	75	0
Q32	RP5	DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	83	0
Q32	RR8	LEEDS TEACHING HOSPITALS NHS TRUST	188	7

Q32	RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	163	0
Q32	RWY	CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	75	0
Q32	RXF	MID YORKSHIRE HOSPITALS NHS TRUST	86	0
Q33	RFS	CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	63	2
Q33	RK5	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	59	1
Q33	RNQ	KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	75	1
Q33	RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	126	0
Q33	RTG	DERBY HOSPITALS NHS FOUNDATION TRUST	61	0
Q33	RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	190	68
Q33	RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	202	15
Q33	RX1	NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	193	22
Q33	RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	18	0
Q34	R1D	SHROPSHIRE COMMUNITY HEALTH NHS TRUST	0	0
Q34	RBK	WALSALL HEALTHCARE NHS TRUST	42	0
Q34	RJC	SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	11	0
Q34	RJD	MID STAFFORDSHIRE NHS FOUNDATION TRUST	80	4
Q34	RJE	UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST	229	3
Q34	RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	50	0
Q34	RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	94	2
Q34	RL1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	18	0
Q34	RL4	THE ROYAL WOLVERHAMPTON NHS TRUST	72	0
Q34	RLQ	WYE VALLEY NHS TRUST	17	0
Q34	RLT	GEORGE ELIOT HOSPITAL NHS TRUST	37	1
Q34	RLU	BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST	4	0
Q34	RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	40	0
Q34	RQ3	BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	107	6
Q34	RR1	HEART OF ENGLAND NHS FOUNDATION TRUST	150	0
Q34	RRJ	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	8	0
Q34	RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	159	0
Q34	RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS	90	1

		TRUST		
Q34	RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	85	1
Q34	RXW	SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	207	45
Q34	RYW	BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST	0	0
Q35	5PT	SUFFOLK PCT	2	0
Q35	NNQ01	BRAINTREE COMMUNITY HOSPITAL	2	0
Q35	RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	140	6
Q35	RC1	BEDFORD HOSPITAL NHS TRUST	34	4
Q35	RC9	LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST	30	1
Q35	RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	99	15
Q35	RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	70	4
Q35	RDE	COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	25	0
Q35	RGM	PAPWORTH HOSPITAL NHS FOUNDATION TRUST	96	3
Q35	RGN	PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	101	11
Q35	RGP	JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	53	2
Q35	RGQ	IPSWICH HOSPITAL NHS TRUST	56	0
Q35	RGR	WEST SUFFOLK NHS FOUNDATION TRUST	39	0
Q35	RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	204	7
Q35	RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	226	37
Q35	RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	186	6
Q35	RQQ	HINCHINGBROOKE HEALTH CARE NHS TRUST	45	2
Q35	RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	62	10
Q35	RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	103	6
Q35	RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	23	0
Q35	RYV	CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	2	0
Q36	R1H	BARTS HEALTH NHS TRUST	243	0
Q36	RAL	ROYAL FREE LONDON NHS FOUNDATION TRUST	102	0
Q36	RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	28	0
Q36	RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	14	0
Q36	RAS	THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	29	3
Q36	RAX	KINGSTON HOSPITAL NHS TRUST	18	1
Q36	RC3	EALING HOSPITAL NHS TRUST	25	0

Q36	RF4	BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	83	2
Q36	RFW	WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	12	0
Q36	RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	94	1
Q36	RJ2	LEWISHAM HEALTHCARE NHS TRUST	50	7
Q36	RJ6	CROYDON HEALTH SERVICES NHS TRUST	61	0
Q36	RJ7	ST GEORGE'S HEALTHCARE NHS TRUST	78	2
Q36	RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	118	12
Q36	RKE	THE WHITTINGTON HOSPITAL NHS TRUST	20	0
Q36	RP4	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	36	0
Q36	RP6	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	39	0
Q36	RPY	THE ROYAL MARSDEN NHS FOUNDATION TRUST	7	0
Q36	RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	19	2
Q36	RQX	HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	6	0
Q36	RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	152	14
Q36	RT3	ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	92	0
Q36	RV8	NORTH WEST LONDON HOSPITALS NHS TRUST	112	1
Q36	RVL	BARNET AND CHASE FARM HOSPITALS NHS TRUST	88	0
Q36	RVR	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	74	0
Q36	RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	190	6
Q36	RYQ	SOUTH LONDON HEALTHCARE NHS TRUST	372	17
Q37	NTP16	WILL ADAMS NHS TREATMENT CENTRE	1	0
Q37	RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	68	2
Q37	RDU	FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	40	0
Q37	RN7	DARTFORD AND GRAVESHAM NHS TRUST	44	2
Q37	RPA	MEDWAY NHS FOUNDATION TRUST	80	0
Q37	RPC	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	8	0
Q37	RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	12	0
Q37	RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	35	2
Q37	RVV	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	103	8
Q37	RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	39	0
Q37	RXC	EAST SUSSEX HEALTHCARE NHS TRUST	53	1
Q37	RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	96	0

Q37	RYR	WESTERN SUSSEX HOSPITALS NHS TRUST	115	3
Q38	R1F	ISLE OF WIGHT NHS TRUST	34	6
Q38	RD7	HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST	175	18
Q38	RD8	MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST	70	0
Q38	RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	92	6
Q38	RHU	PORTSMOUTH HOSPITALS NHS TRUST	82	1
Q38	RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	67	5
Q38	RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	29	0
Q38	RTH	OXFORD UNIVERSITY HOSPITALS NHS TRUST	Data not returned	Data not returned
Q38	RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	15	0
Q38	RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	60	2
Q39	5QH	GLOUCESTERSHIRE PCT	0	0
Q39	RA3	WESTON AREA HEALTH NHS TRUST	2	0
Q39	RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	43	0
Q39	RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	135	11
Q39	RA9	SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	92	10
Q39	RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	97	0
Q39	RBD	DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	64	0
Q39	RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	41	0
Q39	RD1	ROYAL UNITED HOSPITAL BATH NHS TRUST	131	0
Q39	RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	77	1
Q39	RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	0
Q39	RDZ	THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	65	1
Q39	REF	ROYAL CORNWALL HOSPITALS NHS TRUST	99	1
Q39	RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	0	0
Q39	RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	131	6
Q39	RK9	PLYMOUTH HOSPITALS NHS TRUST	199	5
Q39	RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	56	0
Q39	RNZ	SALISBURY NHS FOUNDATION TRUST	83	4
Q39	RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	200	4
Q39	RVJ	NORTH BRISTOL NHS TRUST	82	17

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

11 December 2012

Agenda Item: 6

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

EAST MIDLANDS AMBULANCE SERVICE CHANGE PROGRAMME – CONSULTATION RESPONSE

Purpose of the Report

1. To allow Members the opportunity to amend and agree the consultation response relating to the East Midlands Ambulance Service (EMAS) Change Programme.

Information and Advice

2. At the last meeting on 13 November, the Joint Health Committee agreed to form a sub-committee, which included representation from the County Council's Health Scrutiny Committee, in order to gather evidence and develop a response to the East Midlands Ambulance Service Change Programme consultation.

3. The sub-committee met for a single session of evidence gathering on 29 November when they heard from West Midlands Ambulance Service (via secondee to EMAS Tracey Adams), UNISON, the GMB, Sherwood Forest Hospitals Trust and Nottingham University Hospitals via a written submission.

4. Following the evidence gathering Members of the sub-committee identified various areas for recommendation and these are set out in the attached appendix which takes the form of a draft letter to the Chief Executive of EMAS, Mr Phil Milligan.

5. Members are requested to amend the draft letter as necessary and agree the final form for onward transmission to EMAS.

6. EMAS representatives will attend the 12 February meeting of the Joint Health Committee to provide a response to the committee's recommendations.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee amend and agree the response in relation to the EMAS change programme as necessary.

Councillor Mel Shepherd
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

This matter is being dealt with by:
Martin Gately
Reference: S/JH/CP/EMAS
T 0115 977 2826
E martin.gately@nottscc.gov.uk
W nottinghamshire.gov.uk

Nottinghamshire County Council

Mr Phil Milligan
Chief Executive
East Midlands Ambulance Service
1 Horizon Place
Nottingham Business Park
Nottinghamshire
NG8 6PY

11th December 2012

Dear Mr Milligan

Thank you for your attendance at the Joint Nottingham City and Nottinghamshire County Health Scrutiny on 13th November. Further to that meeting, you will be aware that the Joint Health Committee set up a sub-committee to undertake an evidence gathering session and develop draft recommendations in relation to the change programme proposals. At today's meeting the Joint Health Committee ratified the recommendations developed by the sub-committee. The Joint Health Committee is broadly in agreement with the hub and spoke model that is the basis of the change programme, but has some concerns about the impact of the proposals on the rural areas. In addition, Members were concerned to have heard from local councillors who were not aware of EMAS Change Programme consultation events which were taking place within their electoral divisions. It is greatly in the interests of EMAS to ensure that local councillors are made aware of local consultation, since doing so will serve to both maximise attendance and further develop good relations with elected Members. The recommendations are set out below:

- There should be another hub in the North of the County – to cover the Bassetlaw and Newark areas
- There should be proper provision of maintenance resources (i.e. mechanics) once the changes have been implemented across all areas
- EMAS should carefully review all existing arrangements and protocols for cross-boundary working to ensure that the greatest possible benefits are secured for people in the North of Nottinghamshire.
- All issues relating to ambulance stocking governance and accountability should be carefully reviewed – practitioners picking up vehicles should not be held accountable for equipment and medication that is missing
- The facility to transport patients should be available all through the night
- The fines levied against Ambulance Trusts for not meeting targets are unfair and counter to the interests of the local people and health service – Members recommend that EMAS campaigns hard to have the regime of fines lifted. In addition, the Chairman of the Joint Health Committee will write to the Secretary of State for Health regarding this issue

Representatives of EMAS are invited to attend the meeting of the Joint Health Committee on 12th February 2013 to provide a response to the recommendations above and to indicate how the responses to the change programme consultation have shaped the current iteration of the proposals.

The Joint Health Committee would like to take this opportunity to thank all of the EMAS staff who attended either the main committee or the sub-committee in order to furnish information.

Yours sincerely,

Councillor Mel Shepherd MBE
Chairman of the Joint Health Scrutiny Committee

Nottinghamshire County Council, County Hall, West Bridgford, Nottingham NG2 7QP

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

11 December 2012

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 – specifically, those located within the City and in the Southern part of the County.

3. The East Midlands Regional Stroke Review was due to feature on the agenda for this meeting but proposals are not yet sufficiently advanced. This item will be rescheduled for February or March 2013.

4. The work programme is attached at Appendix 1 for the Committee to consider, amend and agree.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee agree the content of the draft work programme.

Councillor Mel Shepherd
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

15 May 2012	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 (new)** To consider the reasons for the recent spate of cancelled operations, to find out what actions are being taken to address the situation, and to agree any follow-up action by the Committee (Nottingham University Hospitals Trust) • **Quality Accounts** To consider Trust's Quality Accounts 2010/11 and whether to make a statement for inclusion (Nottinghamshire Healthcare Trust / Nottingham University Hospitals Trust / East Midlands Ambulance Service/NHS Treatment Centre/Nottinghamshire Hospice - new) • **East Midlands Ambulance Service (EMAS) NHS Foundation Trust consultation (new)** To consider review of EMAS Service Delivery Model and Operating Strategy as part of formal consultation. (EMAS)	
12 June 2012 (revert to County)	• **Review of Specialist Palliative Care Services across Nottinghamshire - update** To consider proposals and the consultation process for changes to improve access to day care for people with life limiting diagnoses (NHS Nottingham City / Nottingham University Hospitals Trust) • **Integrated Health and Social Care Discharge Project - update** To consider how to partners are working together to deliver more efficient services on discharge from hospital (Nottingham University Hospitals Trust and partners – to be identified)	
10 July 2012	• **Out of Hours Services** To consider an update on the procurement exercise being planned for Out of Hours Services in Nottinghamshire (NHS Nottingham City / NHS Nottinghamshire County) • **Mental Health Utilisation Review** To receive the findings of the review undertaken by NHS Nottingham City CCG and NHS Nottinghamshire County CCG in conjunction with the local authorities	

	(NHS Nottingham City/NHS Nottinghamshire County)	
11 September 2012	• **Psychological Therapies Service Changes – update** To consider how the changes to the Service have been delivered, and their impact on service users (Nottinghamshire Healthcare NHS Trust) • **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 - update** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust)	
9 October 2012	• ***Care Quality Commission (CQC)*** *To consider the work of the CQC in the City and County and the implications for scrutiny (CQC)* • **Contraceptive and Sexual Health Services** (from June 2012) To consider findings informing the new service model (NHS Nottingham City / NHS Nottinghamshire County / Nottingham University Hospitals Trust)	
13 November 2012	• **East Midlands Ambulance Service (EMAS) NHS Foundation Trust consultation – Change Programme (new)** To consider the EMAS Change Programme as part of formal consultation ▪ **Royal College of Nursing – Presentation** To consider an introductory presentation on the work of the RCN ▪ **Healthcare Trust Foundation Status** To consider the Healthcare Trust's application for Foundation Status	

11 December 2012	▪ **Lings Bar Update** (NHS Nottinghamshire City/Nottinghamshire County**)** • **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 – progress report** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust) ▪ **East Midlands Ambulance Service Change Response**	
15 January 2013	• **Patient Transport Service (PTS)** Update on performance of Arriva Group following takeover of PTS contract from EMAS (NHS Nottinghamshire County / NHS Nottingham City) • **Quality Accounts** Preliminary consideration of priorities for Trusts' Quality Accounts 2012/13 (Nottinghamshire Healthcare Trust/Nottingham University Hospitals Trust/NHS Nottingham Treatment Centre/Nottinghamshire Hospice) ▪ **Eating Disorders – feedback on review recommendations** To consider responses to the study group recommendations (Department for Education , Department of Health, others to be confirmed) TBC	
12 February 2013	• **Dementia Care (ongoing Scrutiny)** Annual update on dementia issues, including national audit on dementia (Nottingham University Hospitals Trust) • **Out of Hours Services (ongoing Scrutiny)** To consider an update on the procurement exercise being planned for Out of Hours Services in Nottinghamshire (NHS Nottingham City / NHS Nottinghamshire County) • **Mental Health Utilisation Review (ongoing Scrutiny)** To receive an implementation update undertaken by NHS Nottingham City CCG and NHS Nottinghamshire County CCG in conjunction with the local authorities ▪ **EMAS Change Programme – response to recommendations**	

	(East Midlands Ambulance Service)	
12 March 2013	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 – progress report** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust)	
16 April 2013		
May 2013	▪ **Consideration of Quality Accounts**	

To schedule:

Review of Specialist Palliative Care Services across Nottinghamshire – further update (June 2013)
Integrated Health and Social Care Discharge Project – further update (June 2013)
Children's Cardiac Services
Psychological therapies update
Care Quality Commission (postponed from October 2012)
East Midlands Stroke Review

EMAS control centre visit

Date in May 2013 –as part of consideration of dates in June 2012