Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Tuesday 13 February 2018 at 10.30am

Membership

Councillors

Keith Girling (Chair)
Richard Butler
Dr John Doddy
Kevin Greaves
David Martin
Errol Henry JP
Liz Plant
Kevin Rostance
Steve Vickers
Muriel Weisz
Martin Wright

Officers

Keith Ford Nottinghamshire County Council

Also in attendance

Michelle Livingston Healthwatch Nottinghamshire

MINUTES

The minutes of the last meeting held on 9 January 2018, having been circulated to all Members, were taken as read and were signed by the Chair.

APOLOGIES

Councillor Henry replaced Councillor Payne for this meeting only.

DECLARATIONS OF INTEREST

None

SHERWOOD FOREST HOSPITALS AND NOTTINGHAM UNIVERSITY HOSPITALS PARTNERSHIP

Tracy Taylor, Chief Executive and Dr Keith Girling, Medical Director of Nottingham University Hospitals (NUH) and Richard Mitchell, Chief Executive, and Andy Haynes, Medical Director of Sherwood Forest Hospitals (SFH) attended the meeting. They gave a joint presentation highlighting progress in the first year of this strategic partnership, including:-

- the steps taken to improve patient care, including agreed business cases around neurology and urology and the development of a business case for vascular services;

- the existing close working relationships between the two organisations prior to this formal partnership which was being increased through a developing culture of collaboration;

- the benefits gained from the Getting It Right First Time review of the Urology process;

- the lessons learnt and challenges faced;

- the next steps and priorities for 2018/19 which underlined the commitment to work together and embed the partnership approach.

During discussions, the following issues were raised:-

- it was clarified that services within both Trusts worked within the STP footprint and across a wider footprint, as well as within localised areas. This enabled the standardisation of care pathways across the City and County whilst retaining some flexibility so that specific local needs could still be met;

- the partnership had not delivered significant financial savings this year, although the expectation was that savings would be made in future. The greater benefits in this first year had been in terms of service improvements. The reduced spend by Sherwood Forests Hospitals on agency neurology consultants, a resource now provided by NUH, was one example of an area of work in which savings were being achieved;

- with regard to the potential impact on health inequalities, one of the objectives of collaborative working was to provide consistent services and access, rather than the previously fragmented provision seen around issues such as cancer care. The partnership was also seen as a real opportunity to address health inequalities through a consistent and more innovative approach to prevention;

- Members expressed concerns about the lack of visible integrated pathways for services other than Neurology and Urology. They asked whether any obstacles that had prevented the overall merger continued to impact. The degree of merged services was also queried with reference to the Integrated Care System (ICS) and single controlled total budgets. In response it was felt that a formal merger would have meant resources and efforts would have been diverted towards issues such as governance whereas the transformational change approach had meant that the focus was primarily on clinical work (developed initially during the discussion stage of the merger). It was underlined that a single Board was not needed to provide the necessary ownership and leadership for clinicians to work more closely in partnership. The Chief Executives of both Trusts were committed to meet regularly to develop this closer working and to consider areas for future collaboration. It was also felt that the STP and ICS would encourage joint working with both organisations therefore having to take responsibility for the budget in not only their service delivery areas but also in areas such as social care and primary care. It was

underlined that the proposal for a merger had been one of the findings of the Care Quality Commission to address concerns about performance within Sherwood Forest Hospitals but that the Trust was now within the Top 20 trusts for those relevant issues and was now ranked in the Top 3 of trusts for dealing with issues such as Sepsis;

- Members sought assurances that communication between the Trusts was at the optimum level in areas such as follow-up clinics to prevent any negative impacts on patients. In response it was stated that communication was on a continual basis with relationships developing, enabled by background work to get appropriate communications and systems in place. Care pathways had been changed to address patients' needs – for example, in Urology, patients no longer needed to travel to Derby for secondary care and in Neurology, consultants from NUH were now providing care at SFH to reduce the amount of patient travel;

- Members recognised that the success of the collaboration was dependent upon the staff involved. They queried whether the formal merger had been more worrying to staff than increased collaboration and how the new ways of working (such as increased travel) were impacting upon staff. They also queried whether recruitment and retention had been affected. In response, the Trusts felt that it had been welcomed positively by staff, with teams from 31 specialisms having come together, as part of the proposed merger discussion, to look at building specialisms together rather than offering competing services. There had been a lot of discussions in the last few months about how staff perceived the Integrated Care System and it was recognised that the approach with this could only be sustained with real staff engagement. SFH's Urology department had previously struggled with recruitment and retention but the shared service had seen this improve significantly with the previous vacancy rate of 30% now reduced to 8-9%. SFH's proportion of staffing costs spent on agency staff had also been reduced from 15% to 7.5%;

- Healthwatch Nottinghamshire welcomed the partnership approach in terms of benefits for patients. With reference to the NHS England Planning Guidance 2018, Healthwatch was keen to see an increase in pace, although the difficulties in trying to achieve that over the next year were recognised. In response it was acknowledged that the last year had been difficult and the next year would also be challenging with the increase in demand seen in recent years likely to continue. The current progress needed to develop further, with due consideration given to the future hospital clinical model and what level of investment was needed in primary care in respect of access to services, the prevention agenda and addressing people's lifestyle choices to ensure a sustainable and appropriate offer. Part of the Clinical Services Strategy would involve ensuring an integrated approach with more significant work to consider how and where people access health care. There was a new willingness to take ownership of the whole health agenda, with the acute trusts taking responsibility for out of hospital care as well. The need to build a shared purpose and vision with Nottingham Health Care and Healthwatch and other relevant groups was understood;

- Members queried whether finances were the real reason for the merger not going ahead, with reference to the financial deficit which SFH was facing at the time of inspection. In response it was underlined that although money had been one of the issues considered, there were wider reasons for not pursuing the

merger, including the need to improve quality and the potential negative impact on patient care from a merger (with the level of risk changing during the life of the merger discussions). It was also underlined that wider NHS financial issues were less clear at the point when a potential merger was first being considered;

- with regard to out of hospital care and the reduction in the number of District Nurses and Health Visitors, Members queried how the challenge in funding such community services could be addressed. In response it was stated that the STP was committed to developing the right models of care in all services, both in and out of hospital. Concerns about reductions in these services were recognised and the overall expectation is that people should be cared for closer to home or at home. A pilot scheme was running in South Notts. & Rushcliffe and Mid-Notts areas whereby six nurses were working with nine care homes. This had already had a drastic impact on ambulances and other services and had saved 900 nursing hours as a result. The challenge would be to implement this as quickly as possible across the piece.

The Chairman thanked Tracy Taylor, Dr Keith Girling, Richard Mitchell and Andy Haynes for their attendance.

EAST MIDLANDS AMBULANCE SERVICE

Annette McFarlane, Service Delivery Manager, Keith Underwood, Ambulance Operations Manager and Emily Dunn, Communications Officer, attended the meeting.

Annette McFarlane outlined the key points from the briefing for Members, including contrasting the usual levels of demand with the increases seen over December and January.

Keith Underwood highlighted various issues relating to addressing seasonal pressures, including:-

- the planning stages, which commenced in late Summer;

- the use of a triage vehicle in Mansfield Town Centre;

- the utilisation of a triage unit in Nottingham City Centre on key dates such as New Year's Eve;

- the use of alternative staff (including a mini preparatory team to deal with the vehicles at the hospitals);

- the use of a Clinical Assessment Team (CAT) car;

- the identification of specific managers to respond to delays with handovers;

- the changed response to patients who did not have life-threatening injuries, ensuring each patient received the most appropriate response. The NHS recognised that a period of readjustment was required and therefore the service was not being measured against the time standards in that respect currently;

- the Trust Board's belief that funding levels were not sufficient to address demand.

During discussions the following issues were raised:-

- in terms of comparisons with regional neighbours, it was clarified that the level of calls was comparable with Leicestershire;

- with reference to the 500 hours lost due to handovers in hospital, Members queried the usual handover time on a typical Saturday night. The officers agreed to provide comparison figures to the Members on that issue. Members queried what further steps could be taken to address this issue. In response it was highlighted that meetings were taking place with relevant colleagues in the hospitals to see what could be done to improve the flow;

- with regard to the 20-30% of calls not included in the overall breakdown of calls, it was explained that these would relate to face to face incidents, calls from the CAT team seeking advice and duplicate calls (it was possible to receive numerous calls about the same incident);

- in relation to the previously mentioned funding gap, Members queried what level of additional funding was required for the service to operate at optimum levels. In response, it was explained that there was an ongoing capacity and demand review to consider existing resources (staff, skills and vehicles) and current demand. It was underlined that the gap had now changed as a result of the national response programme and work was underway to clarify the extent of the funding gap via an independent report. Officers agreed to share this report with Members when finalised;

- Members queried what work was being done to manage expectations and demand. The 'Make the Right Call' initiative aimed to educate people against ringing for an ambulance in cases that were not emergencies. The local media and social media helped to promote this message, focussing on real life examples of inappropriate calls. Members offered to help promote this initiative and asked for details to be shared with them. Members also felt that the message needed to focus on the fact that ambulances contained increasingly sophisticated equipment that could help to administer life-saving care. It was hoped that these sorts of messages message may help dispel the notion of ambulances being seen primarily as a transport service;

- Members recognised that a paramedic's role was difficult and felt that morale within the service was suffering as a result of the demand pressures and a 'crisis of confidence' in the service. Members requested an action plan to come back to the Committee to highlight what was being done to address the demand pressures and develop new approaches. It was clarified that an Improvement Plan had been developed at a regional level;

- Members requested further information about the number of calls that were alcohol-related (in terms of all year round rather than just in the Winter months). They also referred to specific incidents they had experienced involving incidents in the street and lengthy delays in an ambulance arriving and queried how many such delays may have contributed to deaths. Comparisons with other areas within the Region and neighbouring areas such as South Yorkshire were also

requested. In response it was underlined that ambulance crews were paramedics who do care strongly about the service they provide and the patients they serve, and who do not want to keep patients waiting. The difficulties in serving rural areas was underlined and a call-out to a rural area could result in a knock-on delay for the subsequent call whilst the vehicle returned. It was acknowledged that EMAS compared well in some areas pf practice but not in others. It was particularly successful on the Clinical Assessment Team front and managing demand in that way. With regard to accidents in the street it was recognised that such incidents were emotive to the public and the service and whilst data was reviewed to forecast activity there was a finite amount of resources available. Consultation was currently being undertaken on a new rota system which would be in place by 9 April 2018. In terms of responding to emergencies, EMAS was developing a new level of response termed Urgent Care Transport which could send trained professionals in non-blue light vehicles to deal with incidents that were urgent but not life-threatening. This was an example of the Service thinking differently to try and provide the best possible care for patients. The officers agreed to share a fact sheet about this with Members;

- Healthwatch Nottinghamshire recognised the pressures which the Service was under but would welcome more detailed breakdowns of data, to help clarify which issues were specific to Nottinghamshire and which ones were broader issues affecting the region. By receiving a more detailed breakdown, Healthwatch would be able to be of greater use in helping the service to improve. Healthwatch also sought assurances that the families of patients who had passed away after not getting to hospital on time received an appropriately dignified and respectful response from the Service. In response it was clarified that a dedicated team dealt with the 'patient experience' process and such cases were obviously very difficult. Responses could range from explaining how the prioritisation systems worked to offering a formal apology depending on the circumstances. It was underlined that more compliments were received than complaints;

- In response to a query as to what support was in place for Community First Responders (CFR), it was clarified that the Service meets with CFR Managers to provide feedback on particular jobs. They were also invited to join ambulance crews as observers to help them better understand the process.

The Chairman thanked Annette McFarlane, Keith Underwood and Emily Dunn for attending the meeting and Members underlined their gratitude for the difficult jobs being undertaken.

The Chairman stated that it would be helpful to hear from Trust Board Executives and for the Improvement Plan to be shared as part of the next update to the Committee.

NEURO-REHABILITATION UPDATE (CHATSWORTH WARD)

The Chairman of the Committee agreed that Councillor Diana Meale could attend the meeting and speak on this matter which affected her electoral division.

Lucy Dadge, Chief Commissioning Officer, Mansfield & Ashfield Clinical Commissioning Group (CCG) / Newark & Sherwood CCG, Peter Wosencroft, Sherwood Forest Hospitals and Nigel Marshall, GP Clinician attended the meeting

and gave a presentation on progress with the redesigned provision which included engagement with staff and the public and the decision-making processes. The next steps in this process included a further public engagement session in April 2018.

A meeting had taken place with staff yesterday which had been well-attended and offered some useful insights. The headline messages from that meeting were:-

- there was overall support for a Level 3 non-specialist service to be commissioned from Chatsworth Ward;

- staff were very keen that patients were not moved without good reason;

- there was a strong desire to ensure that when local patients were ready to step down from a Level 2 service then they should be able to come to Chatsworth Ward to be dealt with in their own community;

- staff were interested to know the number of beds to be commissioned;

- staff were keen to recognise community services currently being offered;

- staff requested that outcomes be patient-centred. They were interested to know what impact it would have on current team configuration and wanted to be fully involved in the design of the service and new roles. They asked for assurance that the change would enable a better tie-in with the Sustainable Transformation Partnership;

- staff reiterated that there had been uncertainty about the changes since July 2017 which had not been helpful. Work was ongoing to finalise the specification with the providers over the next month.

During discussions, the following points were made:-

- Members felt that the feedback from the staff meeting echoed their own understanding from having visited the Ward. With regard to the number of places and any plans to use other beds for complementary means, it was clarified that 8 of the 16 current patients had neurological needs. Although the final number of beds had yet to be agreed it would be less than 16 in future. Retrospective analysis had been undertaken to clarify demand and ensure viability of the Ward. The development of a community based service would ensure some demand for beds, along with the earlier 'stepping down' of people. With regard to the rest of the beds, Chatsworth would remain as a service for this care cohort but there was a desire to use the faculty as flexibly and as appropriately as possible. Other service offers, aside from the provision of beds, would be explored, and staff were keen to offer therapies such as neurological rehabilitation. The actual bed requirement would be clearer once the service was embedded and it was too early to work out the entire reconfiguration at this point. Members welcomed the proposed diversification of the service offer (as a means of protection against fluctuation of demand), the redefining of the name of the service and retraining of staff as appropriate;

- Healthwatch Nottinghamshire underlined the need for a range of treatments and sought assurances that community recovery services would be able to deliver from the most appropriate place. The CCG and Trust were keen to ensure

greater consistency of pathways and to ensure patients were cared for in the right place at the right time, without 'bouncing' between service provision. Staff had highlighted the existence of community services which GPs were not necessarily referring patients to and better alignment of provision was needed. The biggest challenge at the moment was to capture the community services offer succinctly;

- Councillor Meale highlighted the concerns amongst staff and the local community, welcomed the time and attention taken to review this issue and underlined the need for a clear message to be developed by the time of the next Health Scrutiny meeting (27 March 2018) so that this could be shared with staff and local people. In response, it was clarified that the next steps would involve clearly defining the service, seeking Governing Body approval and undertaking further engagement with staff and the public.

It was agreed that the finalised implementation plan should be submitted to the next meeting of Health Scrutiny Committee.

The Chairman thanked Lucy Dadge, Peter Wosencroft, and Nigel Marshall for attending the meeting and for considering the views of the Committee in the development of these proposals.

WORK PROGRAMME

The Chairman introduced the report. As part of his introduction, he highlighted his regular meetings with the Chairman of the Nottingham City Council Health Scrutiny Committee to consider any issues across boundaries that both Committees needed to be considering. He underlined that he would welcome any suggestion of such cross-boundary issues from Committee Members. He was arranging for the dates and agendas of the City Committee meetings to be shared with the County Health Scrutiny Committee's Members and underlined that these were public meetings which the County's Members were welcome to attend (with permission to speak a possibility if requested).

In response, Members suggested that the issue of Integrated Care Services would be an appropriate topic to consider in a joint Health Scrutiny, involving both the City and County Members. The Chairman agreed to give that suggestion further consideration.

Members also requested that the Chief Executives of the three Care Commissioning Groups be requested to attend a future meeting to discuss their financial strategies (as previously discussed at the Committee). It was agreed that this issue be added to the work programme.

The current work programme was noted

The meeting closed at 12.56 pm

CHAIRMAN