**NOTTINGHAM CITY COUNCIL**

**JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE**

**MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 13 May 2014 from 10.17 - 12.40**

| | | |
|---|---|---|
| ✓ | Councillor Ginny Klein (Chair) | |
| | Councillor Pauline Allan | |
| ✓ | Councillor Mohammad Aslam | (minutes 82 – 85) |
| ✓ | Councillor Richard Butler | |
| | Councillor Azad Choudhry | |
| | Councillor John Clarke | |
| ✓ | Councillor Kay Cutts | (substitute for Councillor Handley) |
| ✓ | Councillor John Doddy | (minutes 79 – 84) |
| ✓ | Councillor Kate Foale | (minutes 79 – 84) |
| | Councillor John Handley | |
| ✓ | Councillor Carole-Ann Jones | |
| ✓ | Councillor Thulani Molife | |
| | Councillor Eileen Morley | |
| ✓ | Councillor Brian Parbutt | |
| ✓ | Councillor Parry Tsimbiridis (Vice-Chair) | |
| ✓ | Councillor Jacky Williams | |

✓ indicates present at meeting

**Colleagues, partners and others in attendance:**

| | | |
|---|---|---|
| Tracy Madge | - | Assistant Director Clinical Strategy, NHS England Area Team, Derbyshire and Nottinghamshire |
| Dr Ian Matthews | - | Deputy Medical Director, NHS England Area Team, Derbyshire and Nottinghamshire |
| Ceri Charles | - | Deputy Programme Director for Better for You |
| Mohamed Rahman | - | Assistant Head of Pharmacy |
| Donna Clarke | - | Healthwatch Nottingham and Nottinghamshire |
| Jane Garrard | - | Overview and Scrutiny Coordinator, Nottingham City Council |
| Martin Gately | - | Democratic Services Officer, Nottinghamshire County Council |
| Angelika Kaufhold | - | Overview and Scrutiny Coordinator, Nottingham City Council |

## 79 APOLOGIES FOR ABSENCE

Councillor Pauline Allan – taken ill at the meeting

Councillor Azad Choudhry
Councillor John Handley

## 80 DECLARATIONS FOR INTEREST

None.

## 81 MINUTES

The minutes of the last meeting held on 11 March 2014 were confirmed and signed by the Chair.

## 82 OUTCOME OF SUBMISSION TO CHALLENGE FUND TO IMPROVE ACCESS TO PRIMARY CARE

The Committee considered a report of the Head of Democratic Services and a joint presentation by Tracy Madge, Assistant Director Clinical Strategy, NHS England Area Team, Derbyshire and Nottinghamshire and Dr Ian Matthews, Deputy Medical Director, NHS England Area Team, Derbyshire and Nottinghamshire, relating to the Outcome of submission to Challenge Fund to improve access to Primary Care. The key points from the presentation included:

(a) The context and reasons:
- Pressures include 50% increase in GP consultations;
- 35% increase in emergency care admissions;
- 65% increase in secondary care episodes for >75;

(b) There is a lot of evidence to support the following factors:
- Demographic changes;
- Poorly joined up services between primary, secondary and social care;
- Technical advances
- Economic pressures;
- Workforce pressures including increasing challenges in recruiting new GPs whose working day is becoming increasingly pressurised seeing on average 60 patients per day.

(c) The aim is to deliver high quality care and to achieve this through:
- Better access to primary care (GPs) for all, 7 days per week with extended hours (8am – 8pm);
- Patients with long-term/complex conditions being able to spend more time at their appointments with their GP;
- The introduction of personalised health plans for patient/carers;
- More joint education and training programmes for all staff;
- Appraisals and workforce plans for all staff;
- Improved and shared use of technology such as Skype or Facetime;
- Greater collaboration across providers, GPs, Pharmacy, Dental and Optometry as well as sharing good practice and ideas;
- Conducting independent checks and reviews of all providers for example the Fit to Practice revalidation of GPs;
- Services delivered in well equipped buildings;

- A payments system that rewards better patient outcomes.

(d) The Challenge Fund was launched by the Prime Minister:
- £50 million to help improve access and stimulate innovation by testing new ways of working;
- 250 expressions of interest were received in January 2014;
- 20 pilot projects across England were announced in April 2014 including the successful Derbyshire and Nottinghamshire "collaborative" bid for £5.2 million). This is a 12 month project consistent with the local 5 year strategy.

(e) This project aims to improve the quality of service for 1.2 million patients locally from 85 general practices across Derbyshire and 71 general practices from across Nottinghamshire, by:

- Increasing the number of appointments available by offering 7 day services Saturday and/or Sunday through locality hubs for up to 537,000 patients by March 2015;
- Implementing new ways of communication through email/Skype for 328,300 patients by March 2015;
- Increasing choice by enabling patients to access services from other GP sites;
- Introducing and roll out of telecare services so patients can help manage their own care;
- Providing joined up services between the GP and the hospital with GPs responding to avoid unnecessary increases in Accident and Emergency and hospital admissions.

(f) The implementation, monitoring and governance arrangements for the pilot include:
- The Area Team is supporting the implementation of the pilot and communication and reporting arrangements with patient involvement groups;
- The Clinical Commissioning Groups (CCGs) are strengthening their project management to ensure delivery of these plans at the general practice level;
- Independent monitoring and evaluation of the pilot and plans will take place;
- The Challenge Fund scenario model:
    - Includes the assumed benefits;
    - Assumes that the cost of the scheme against breaks even from reduction in acute provider costs;
    - Is free to the NHS and Social Care;
    - Can be expanded to include all other providers and metrics from the system plans;

(g) The wished for outcomes are:
- Patients will have personal health plans for improving outcomes;
- Workforce plans to meet needs;

- Finding different ways of working through transformation of services and delivery of services;
- Premises will be aligned to meet the needs of the population;
- Payments will be targeted to reward improved outcomes for patients which provide better value for money.

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

(h) Part of the requirement for the pilot was to show how sustainable it is once funding from the Challenge Fund has ceased. This hopefully will be achieved by reducing the number of patients going to secondary care (hospitals and Accident and Emergency). This is part of the evaluation process for the pilot and a massive challenge, especially if the numbers attending secondary care do not reduce.

(i) Home visits should be available for frail/elderly patients or those with long-term chronic conditions who are unable to attend GP practices but the preference is for patients to go to medical centres as they are fully equipped and provide better facilities for doctors to access patient files and equipment etc.

(j) Funding the additional workforce needed to deliver the pilot is only available for one year and the bid had to show how this will be sustainable in the longer term. The level of funding is £5.2 million which in context of the annual budget for the NHS is very low.

(k) In relation to the preference for GP practices to open on Saturdays rather than Sundays, this was identified through consultation and generally it was more about convenience, for example for patients who work during the work it can be more difficult to get time off work. However, it would be impossible to require early to late or 7 day a week opening on all practices due to the funding implications but also the recruitment and retention of new GPs. The Out of Hours and urgent care services will still be available for people to access.

(l) Nottingham is already at the forefront of developing and using Apps (for mobile phones, tablets and laptop devices etc) to support patients to manage their own healthcare for long-term and chronic conditions such as diabetes etc and the feedback from patients has been very positive so far.

(m) The funding for the pilot has been split according to the size of CCGs and the populations they support. There is significant variation in the number of patients, and number of GP practices within the CCG area. For example, Nottingham City has a high number of small single handed practices whilst Derbyshire tends to have larger practices.

(n) The bid was developed as a result of individual CCGs suggesting what schemes might add value and would be willing to support in their area. This has resulted in variation in the pilot schemes being trialled across the area, but learning is being shared across the region. All the proposed schemes were tested against the criteria as part of the bidding process.

(o) It is essential that all the pilot activities are evaluated by the Team as a whole to identify what does and does not work, sustainability, and ultimately what will add value and improve access. Learning from successful pilots will be rolled out across the region.

(p) The workforce plan includes all practitioners involved with GP practices such as nurse practitioners and community matrons and existing good practice should be shared by all.

(q) It is hoped that through better education of patients it will become clearer to them whether they need to see a GP, nurse practitioner or pharmacist to deal with medical issues and this should improve access for those who do need to see a GP.

(r) The Challenge Fund is about improving access to primary care services and the project criteria is firmly focuses on this so whilst other professionals such as community matrons etc are not specifically involved their contribution to the overall work and sharing of good practice at a local level is very valued.

(s) There are 45 measures that the pilot will be evaluated against. The evaluation will be carried out by two researchers against the existing baselines, and will include looking at:

- Qualitative and quantitive research;
- Satisfaction surveys;
- Impact on Out of hours service;
- Impact on ambulance services;
- Focus groups with patients and staff surveys before and after the pilot to measure the impact;
- The number of A&E attendances.

This data can also be compared with statistics from GP practices which fall outside of the pilot.

A view was expressed that some of the proposals were difficult to implement due to GP capacity, for example extending patient appointments may increase the number of delayed appointments and reduce the number of patients that a GP can see in each day. It was also suggested that if practices were required to open longer hours, 7 days per week the number of doctors willing to become GPs may reduce as historically the more family-friendly hours have been an attraction of the job. The demand for GP appointments has risen substantially and there is a need to manage patient expectations and educate them more about when it is appropriate to visit a GP for minor ailments such as sore throats and headaches. There is a risk that by increasing the availability and access to GPs it could actually increase demand rather than meet existing requirements.

A representative from the local Royal College of Nursing (Maria Hannah) commended the paper 'Harnessing the Potential' to the Committee and speakers and offered to work in partnership locally on the pilots which was welcomed by Tracy Madge and Dr Ian Matthews.

**RESOLVED to**

**(1) add to the work programme,**

**(a) progress on developing 24 hour services;**

**(b) the outcomes of the evaluation of Challenge Fund pilot projects in Nottinghamshire/Derbyshire;**

**(2) note the contents of the report and the presentation and thank Tracy Madge and Dr Ian Matthews for their contribution and information supplied at the meeting.**

## 83 NOTTINGHAM UNIVERSITY HOSPITALS PHARMACY DELAY

The Committee considered a report of the Head of Democratic Services and joint presentation by Ceri Charles, Deputy Programme Director for Better for You and Mohamed Rahman, Assistant Head of Pharmacy relating to improving the pathway for patients leaving hospital and delays waiting for medicine from hospital pharmacies. The key points raised in the presentation included:

(a) The context is that during 2013/14 10% of Nottingham University Hospitals (NUH) complaints were discharge-related which was a reduction from 13% in 2012/13. The main reason cited for delays was 'waiting for tablets' but this captured a variety of different issues and reasons for delay. Previously there was no robust way of capturing and measuring waiting times and no single lead practitioner responsible for the discharge process which passed through a number of different staff at different times. A project was set up to review the systems and processes, culture and communication with patients and identify areas for improvement.

(b) The priority 'fewer waits' which includes delays for drugs and medicines is a quality priority for NUH in its Quality Account 2014/15.

(c) The NUH target for outpatient's pharmacy is a waiting time of less than 30 minutes. During April 2014 there were 5,704 outpatients seen at the pharmacy with 18,000 medications dispensed. The average wait during this period was 26 minutes and 99% of prescriptions were dispensed within 60 minutes by the Queens Medical Centre and 93% by the City Hospital pharmacies.

(d) There can be many reasons for wait in dispensing prescriptions including the pharmacist having to check that the drug dosage, frequency and duration are correct and that the instructions are clear. Occasionally the pharmacists have to check with the prescribing doctor because the instructions are unclear or there are questions about dosages and allergies etc. Errors and omissions by doctors identified by pharmacists affect approximately 5% of prescriptions.

(e) Some prescriptions may also not be 'off the shelf' and have to be made up by pharmacy which can also create further delays

(f) There are also unexpected periods of high demand for example clinics closing at the same time etc and issues such IT system failures which cause delays. The service has halved the average time delays for issues within its control since May 2012.

(g) The process for discharging or patients and providing their prescriptions was explained as follows:

- Patient is deemed medically stable and ready for discharge and informed they can go home
- The 'ToTakeOut' (TTO) prescription is written and checked by pharmacy and if no rework is needed then prepared
- The prescription is delivered to the ward and has to be signed off by the nurse which can create delays if the ward is very busy
- The patient is given the TTOs and leaves

(h) This process should take about 1 to 2 hours for 'simple' discharges but there have been reports of patients being told in the morning they are going to be discharged and then waiting up to 5 hours for the prescription before they can leave. There are many reasons that this could happen include having to check the accuracy of prescriptions and bespoke medication etc. One of the issues is that the doctor may tell the patient that they can be discharged but it is not until the end of the ward round (which may be another couple of hours) that s/he starts the process for discharging the patient. This means there can be a difference between when the patient views the discharge process as starting and when the process actually commences and can give a mis-leading impression to the patient about the expected time until discharge.

(i) Simple transfer and discharge can take place quickly and are usually when patients do not have complex needs (ie social care arrangements have to be in place prior to leaving hospital etc) or bespoke prescriptions which need making up. Supported Transfer refers to those with more complex needs which include co-ordinating with other services such as social services.

(j) As part of the review, a new E-prescribing system is being explored and procurement of this should take about two years.

(k) Another option is for pharmacists to accompany doctors on their ward rounds and if patients are informed that they are going to be discharged the prescription system starts at that point rather than waiting for the rounds to finish with doctors writing up prescriptions at that point.

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

(l) Pharmacists accompanying doctors on ward rounds visits have not started yet. There will be a 20 ward pilot scheme and staffing resources are currently being sought to implement this proposal.

(m) The pharmacy tells outpatients how long they may have to wait for their prescription as soon as it is handed in and there are television monitors which

show the progress of each prescription and waiting times. The outpatient pharmacy waiting area at QMC is currently being refurbished and this will provide a more pleasant area to wait in.

(n) This project is still in its early stages (6 months) and the team receive feedback from patient groups as to discharge processes and waiting times, staff are also continually ward walking to identify issues which create delays and difficulties in the discharge process. It is a major project and improvements and changes in culture and systems will not happen overnight.

(o) It was suggested that a significant number of patients take their prescriptions to their GP surgery rather than waiting for it to be dispensed at the hospital pharmacy. NUH does not have any data on the number of prescriptions not taken to its pharmacy but would be interested in this information. It was suggested this issue needed to be explored.

(p) Views were expressed that although there was a lot of work going on to reduce delayed discharges and the impact that pharmacy waiting times had on this, there were issues with waiting times and delays in the outpatient pharmacy that also needed to be addressed.

In response to some of the issues raised Ceri Charles confirmed that the focus of the review to date had been primarily on in-patient discharge pathways, however given the clear concerns raised at this meeting about outpatients waiting times for prescriptions this issue would be taken back to the project team for exploration. Some of the issues should hopefully be resolved when the refurbished waiting area opens.

The Committee felt better informed about the discharge process and the impact that dispensing of prescriptions has on the process. There was a feeling that patients could be better informed about the process and the likely timescales so that expectations could be more realistic.

**RESOLVED to**

**(1) note the evidence provided for the pharmacy waits review;**

**(2) gather data from GPs about the number of prescriptions from Nottingham University Hospitals Trust that they deal with.**

## 84 QUALITY ACCOUNTS 2013/14

The Committee considered a report of the Head of Democratic Services outlining the process for the drafting and submission of comments for inclusion in the Quality Accounts 2013/14 for Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare Trust, Circle – Nottingham Treatment Centre and the East Midlands Ambulance NHS Trust.

Study groups were taking place to review the draft Quality Accounts from the key providers (except East Midlands Ambulance NHS Trust) and following these meetings comments will be drafted and will be emailed to all members of this Joint

Committee with the final approval for submission being delegated to the Chair or Vice-chair and in their absence the Chair of the relevant Study Group.

**RESOLVED that delegated authority be given to the Chair or Vice-Chair of this Committee, or in their absence the Chair of the relent Study Group to approve comments to be submitted in to the following Quality Accounts 2013/14:**

- **Nottinghamshire University Hospitals NHS Trust**
- **Nottinghamshire Healthcare NHS Trust**
- **Circle – Nottingham Treatment Centre**
- **East Midlands Ambulance Service NHS Trust**

## 85 WORK PROGRAMME

The Committee considered a report of the Head of Democratic Services including the provisional draft work programme for the Committee during 2014/15 in Appendix 2.

A concern about the ability of people to engage with new technology to support access to/provision of healthcare was raised as a possible topic for future scrutiny.

The Committee noted that from June meetings of the Committee during 2014/15 would take place at County Hall, West Bridgford.

**RESOLVED to add the following items into the work programme 2014/15:**

**(1) progress in development of 24 hour services;**

**(2) the outcomes of the evaluation of the Challenge Fund to Improve Access to Primary Care pilot.**

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