JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

15 SEPTEMBER 2009

REPORT OF THE ACTING HEAD OF OVERVIEW AND SCRUTINY (NOTTINGHAM CITY COUNCIL)

WORK PROGRAMME 2009/10

1 SUMMARY

This report reminds the Committee of its work programme for 2009/10 and provides the opportunity to review and update the content.

2 MATTERS FOR CONSIDERATION

2.1 The Committee is asked to

a) consider the work programme attached at Appendix 1;
b) consider the information attached at Appendix 2 and agree whether to proceed with further work on any of the topics identified;
c) agree the work programme for the remainder of the Municipal Year; and
d) decide whether councillors would like to visit the NHS Treatment Centre on the Queen's Medical Centre campus.

3 BACKGROUND AND SUPPORTING INFORMATION

3.1 The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, together with other issues, which impact upon the conurbation of Greater Nottingham. Much of the Committee's work is focused on major projects being carried out by Trusts within the conurbation.

3.2 Several items of work have been carried forward for continuation from 2008/09 and councillors discussed other topics at their meeting of 14 July. The proposed work programme is attached at Appendix 1 for the Committee to consider, amend and agree.

3.3 The Committee requested further information on 4 topics, identified as potential areas for review in 2009/10, when there is space in the work programme:

- Dementia care in hospital
- GP appointment systems
- Cervical Screening
- Hospital food

3.4 The key issues in relation to these topics are attached at Appendix 2. A flow chart is attached at Appendix 3 to support the Committee in deciding which of these topics, if any, would benefit from more detailed scrutiny.

3.5 The Committee is scheduled to receive an update on progress in relation to the NHS Treatment Centre on the Queen's Medical Centre campus at its 13 October meeting. Councillors have been invited to visit the Centre and, if they would like

to do so, have been asked to agree whether they would prefer to visit before or after the October meeting.

3.6 The programme of work for the year is intended to be flexible so that issues which may arise as the year progresses can be addressed appropriately.

3.7 This committee has statutory responsibilities in relation to substantial variations and developments in health services in accordance with sections 7 and 8 of the Health and Social Care Act 2001 and associated regulations and guidance. These are to consider the following matters in relation to any substantial variations or developments that impact upon the city and will need to be responded to as they arise:

a) Whether, as a statutory body, the OSC has been properly consulted within the consultation process;
b) Whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation;
c) Whether a proposal for changes is in the interests of the local health service.

3.8 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning.

4 LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING EXEMPT OR CONFIDENTIAL INFORMATION

None.

5 PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

Report to and minutes of the Joint City and County Health Scrutiny Committee, 14 July 2009.

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26 August 2009

APPENDIX 1

Joint Health Scrutiny Committee
Work Programme 2009-10

12 May 2009	• **Renal Services** Consideration of proposals for service developments (Nottingham University Hospitals NHS Trust and the Specialised Commissioning Group) • **Nottinghamshire Healthcare NHS Trust - Foundation Trust Equivalence – Consultation** To consider the Trust's proposals (Nottinghamshire Healthcare NHS Trust) • **EMAS NHS Trust - Foundation Trust – Consultation** To consider the Trust's proposals (East Midlands Ambulance NHS Trust) • **Patient Transport Services** To consider the final report • **Consideration of Joint Health Committee Protocol**
June 2009	**No meeting**
14 July 2009	• **NUH NHS Trust - Foundation Trust Proposals** Outcomes of the consultation and details of the final submission (Nottingham University Hospitals NHS Trust) • **Nottinghamshire Healthcare NHS Trust - Foundation Trust Equivalence – Consultation** To consider consultation progress and early outcomes (Nottinghamshire Healthcare NHS Trust) • **EMAS NHS Trust - Foundation Trust – Consultation** To consider consultation progress and early outcomes (East Midlands Ambulance NHS Trust) • **Patient Transport Services** To consider and agree the final report and recommendations

Joint Health Scrutiny Committee
Work Programme 2009-10

15 September 2009	• **Nottinghamshire Healthcare NHS Trust - Foundation Trust Equivalence – Consultation** To consider consultation progress and early outcomes (Nottinghamshire Healthcare NHS Trust) • **EMAS NHS Trust - Foundation Trust – Consultation** Outcomes of the consultation and details of the final submission (East Midlands Ambulance NHS Trust) • **Patient Transport Services** To receive responses to recommendations (East Midlands Ambulance Service & Acute Trusts) • **Next Stage Review - Major Trauma Services in the East Midlands** To hear background to plans to reconfigure regional services (NHS East Midlands Major Trauma Programme) • **Work Programme Update** To consider the Committee's work programme and potential topics for review
13 October 2009	• **NHS Treatment Centre** Update on Progress and consideration of booking procedures (Nations Healthcare) • **NUH Emergency Department Discharge Policy** Update on steps taken by NUH to improve the experience of patients on discharge from the Emergency Department (Nottingham University Hospitals NHS Trust) o **NUH Integrated Business Plan (plus FT status update)** Progress update on the Business Plan and Strategic Intent Document (Nottingham University Hospitals NHS Trust)
10 November 2009	• **Specialised Commissioning** Outcomes from consultation on perinatal and eating disorder services **(**East Midlands Specialised Commissioning Group) • **Annual Health Check** Outcomes of the Annual Health Check Process (All NHS Trusts)

Joint Health Scrutiny Committee
Work Programme 2009-10

	• **Work Programme Update** To consider work programmes of City and County Council overview and scrutiny committees and LINks (tbc)
15 December 2009	• **Modernising Day Services for older people with mental health problems** Update on progress developing commissioning strategy and plans for a Variation of Service (PCTs & Adult Social Care)
12 January 2010	
9 February 2010	• **Patient Transport Services** To consider action plans to address recommendations (East Midlands Ambulance Service & Acute Trusts) • **Six Lives – meeting the needs of people with learning disabilities** **To** review the local response to Six Lives, the report of the Health Service Ombudsman and the Local Government Ombudsman (County and City Adult Social Care / NHS Nottinghamshire County / NHS Nottingham City)
9 March 2010	• **Annual Health Check** Commentary as part of the Annual Health Check Process (All NHS Trusts)
13 April 2010	
11 May 2010	• **Consideration of Joint Health Committee Protocol**

Potential Issues for Review
• Dementia care in hospital • GP appointment systems • Screening (cervical and breast cancer) • Hospital food

APPENDIX 2

JOINT HEALTH SCRUTINY COMMITTEE – POTENTIAL AREAS FOR REVIEW

1. DEMENTIA CARE IN HOSPTIAL

Dementia is a disease with devastating personal, social, physical and economic consequences. The National Dementia Strategy suggests that around 700,000 people in the UK have dementia, and this number is predicted to double to 1.4 million over the next 30 years (Department of Health, 2009). Although the majority of medical care takes place within primary care and psychiatry, the disease impacts heavily in hospitals where patients with dementia can occupy a significant proportion of medical hospital beds.

Admission to a general hospital ward is a time of high risk for people with dementia. It can lead to worsening of the condition and poor outcomes in general. These patients have longer hospital stays and can cause additional difficulties because of behavioural problems.

There are two aspects to be considered in relation to dementia care in the acute setting:

a) the quality of specific services offered for dementia patients; and
b) the quality of dementia care in hospitals on a general ward

Acute medical units have to manage patients with dementia and delirium, who often present in a distressed state and are frequently aggressive and challenging to deal with. However, patients with dementia are frequent users of all kinds of hospital services, so the issue of providing radically improved quality of care is not confined to staff working in elderly care settings. Increasingly staff who do not specialise in dementia care will be working with people with dementia.

One of the key recommendations of the new National Dementia Strategy (2009) is that people with dementia in hospital receive good quality care appropriate for their dementia as well as their medical health needs. It is also recommended that hospital professionals receive better training and support.

1	**Review focus** To establish how the needs of people suffering from dementia are met when accessing secondary care delivered by Nottingham University Hospitals NHS Trust.
2	**Objectives and purpose** To identify how Nottingham University Hospitals addresses the needs of a) people who access secondary care to treat their dementia and b) people who are suffering from dementia and who need to access other secondary health services
3	**Anticipated outcomes** Recommendations which will contribute towards achieving the 17 key objectives and associated outcomes of the National Dementia Strategy 2009.

4	**Information required** • Is dementia recognised when people are presenting to secondary care with other health problems? • How is dementia care managed on general wards? • What training is offered to staff who do not specialise in dementia care? • How are people with dementia supported to access the services that can support them best? • How are the carers of people with dementia supported? • How do healthcare professionals involve carers in decision making about the patient? • How are information and referrals shared across agencies eg with GPs / voluntary support agencies. • What has been identified as existing good practice and what areas have been identified for improvement in hospital wards? • What is done to find out the quality of the care experience from the point of view of the patient?
5	**Contributors** Nottingham University Hospitals NHS Trust
6	**Timescale** To be determined.

2. GP ACCESS / RECEPTIONIST TRIAGE

Triage (meaning to separate, sort, sift or select) is a process of prioritising patients based on the severity of their condition. This rations patient treatment when resources are insufficient for all to be treated immediately.

Triage, in its original form, was the battlefield surgeon's practice of quickly dividing the wounded into three groups: the ones who'd die even if they got medical attention, the ones who'd survive even if they didn't get any, and the ones for whom medical attention would make the difference between life and death.

Triage is used for prioritising patients arriving at emergency departments, or to prioritise patients seeking a GP appointment, or to offer a more speedy service through nursing triage over the telephone through NHS Direct.

The use of diagnostic software and the internet has also meant that an increasing number of non health professionals are able to triage treatment – the Swine flu line being a good example (with reports now arising of misdiagnosis and conflicting advice).

With limited time and resources, it makes sense to triage the most needy and prioritise care. The problems arise over who does the triage and, increasingly, the perception is that it falls to practice receptionists to make judgements, 'award' appointment and even to offer advice they are not clinically qualified or experienced to make – exposing the practice to possible future legal action if the advice is wrong. Receptionists' questions are often considered inappropriate and intrusive when patients have the right to decide who they disclose personal information to.

Triage systems should be open and transparent and carried out by properly trained staff. Could more be done to help receptionists to better perform their role? Currently, 3,500 GP practices using EMIS computer systems – covering of 23 million patients – which also provides triage software. Could / should this be rolled out to all GP practices to improve triaging systems?

Is triage being used to ease the pressure on GPs or sometimes to cover up archaic GP practices? Are receptionists being pressured into providing advice and sanctioning appointments, or are they assuming this role for themselves?

1	**Review focus** To establish to what extent triage by non-medically qualified GP practice staff assists or impedes access to GPs.
2	**Objectives and purpose** To gain knowledge of the prevalence of triage by non-medically qualified staff taking place in the City / County. To understand the principles along which it operates and the pressures that may have brought the situation about.
3	**Anticipated outcomes** Recommendations that will facilitate patients' access to appropriate care.
4	**Information required**

	A substantial body of quantitative and qualitative data to allow proper conclusions to be drawn about the issue of triage. For example a survey of patient experience including perceptions around ‘gatekeeping’ and invasion of privacy by receptionists, details of receptionist training, academic studies into this area, if available.
5	**Contributors** Representative sample of GP practices, the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR), National perspective from British Medical Association, LINk.
6	**Timescale** To be determined.

3. CERVICAL SCREENING

What is cervical screening?

Cervical cancer caused 949 deaths in the UK in 2006. Cervical screening is not a test for cancer but is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb). The first stage in cervical screening is taking a sample from the cervix for analysis. Regularly screening of all women at risk enables identification and treatment of conditions which might otherwise develop into invasive cancer. Whilst cervical screening cannot be 100 per cent effective, cervical screening programmes have been shown to reduce the incidence of cancer in a population of women. Early detection and treatment can prevent 75 per cent of cancers developing but like other screening tests, it is not perfect. It may not always detect early cell changes that could lead to cancer.

Who is screened?

All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years. The NHS Cervical Screening Programme now offers screening at different intervals depending on age. This means that women are provided with a more targeted and effective screening programme. The new intervals are:

Age group (years)	Frequency of screening
25	First invitation
25 - 49	3 yearly
50 - 64	5 yearly
65+	Only screen those who have not been screened since age 50 or have had recent abnormal tests

Why are women under 25 not invited?

This is because changes in the young cervix are normal. If they were thought to be abnormal this could lead to unnecessary treatment which could have consequences for women's childbearing.

Why are women over 65 not invited?

Women aged 65 and over who have had three consecutive negative results are taken out of the recall system. The natural history and progression of cervical cancer means it is highly unlikely that such women will go on to develop the disease. Women aged 65 and over who have never had a test are entitled to one.

How many women are screened?

The programme screens almost four million women in England each year. For clinical reasons some women have more than one test during the course of a year and nearly four and a half million samples are examined by pathology laboratories every year. The national target is that by 2010 all women should be informed of their results within two weeks.

The Local Picture

The most recent comparative data available (2007/08) shows NHS Nottingham City and NHS Nottinghamshire County as top performers in getting results back in under 4 weeks (86.2% and 84.7% respectively). This compares well with the East Midlands average of 72.9% and the England average of 48.5%.

Councillors were concerned that a backlog of tests had built up locally as more women were presenting for cervical screening in response to the publicity surrounding Jade Goody's death from cervical cancer in March 2009. This is confirmed by the data in the table below. However, it can be seen that the average waiting time has reduced since June and stood at 4.5 weeks at the beginning of August this year.

DATE	TOTAL BACKLOG	WAITING TIME (WKS)
13/04/2009	8187	7
20/04/2009	8886	8
27/04/2009	9267	9
05/05/2009	9369	9
11/05/2009	9333	9
18/05/2009	9073	9
26/05/2009	8835	9
01/06/2009	8264	10
08/06/2009	8178	10
15/06/2009	8160	10
22/06/2009	7536	9
29/06/2009	6325	8
06/07/2009	5535	7
13/07/2009	4106	6
20/07/2009	3789	6
27/07/2009	3090	5
03/08/2009	2528	4.5

1	**Review focus** tbc
2	**Objectives and purpose** tbc
3	**Anticipated outcomes** tbc
4	**Information required** tbc
5	**Contributors** tbc
6	**Timescale** tbc

4. HOSPITAL FOOD

Hospital food is considered by the Department of Health to be an essential part of patient care. Good food can encourage patients to eat well, giving them the nutrients they need to recover from surgery or illness.

The Better Hospital Food (BHF) programme - which ran until the summer 2006 - was introduced to ensure the consistent delivery of high quality food and food services to patients.

Funding previously allocated centrally is now made available to the NHS locally – allowing it to develop services as appropriate. The BHF programme reflected one of the aims of the NHS Plan – that dietitians would advise and check on nutritional values of food.

A PEAT (Patient Environment Action Team) audit by the **National Patient Safety Agency** (NPSA) - which leads and contributes to improved, safe patient care – rated patient food at **Nottingham's City Hospital** as 'excellent' (following 'good' ratings each year since 2004).

The **Queen's Medical Centre** was given a 'good' rating for its patient food (following 'good' or 'acceptable' ratings since 2004). Both hospitals are run by Nottingham University Hospitals NHS Trust (NUH).

In 2009 1,265 sites from 321 trusts took part in the PEAT assessment – 58% were excellent, 37% good, 5% acceptable.

In 2006 a Notts County Council **Health Select Committee** considered the delivery and provision of food in Notts hospitals (City,QMC, Sherwood Forest Hospitals Trust and Bassetlaw hospitals) and carried out a public consultation following concerns about quality, suitability and care and support with eating.

Of the 162 million main meals produced for patients in 2004, almost 11 per cent went untouched, up from 8.8 per cent in 2002. About 40 per cent of patients admitted to hospital had malnutrition. More than half lost weight or became undernourished while in care because of poor-quality food, a lack of appetite and difficulty feeding themselves.

The **Department of Health** claim that hospital meals have been gradually improving. A report from independent inspectors in 2002 found that just 17 per cent of hospitals offered good food. The latest set of figures suggest that this has risen to 44 per cent.

Officials have admitted that while quality and availability of food have increased gradually, there remains a real need to tackle undernourishment and its impact on clinical status.

Initiatives such as protected meal times - when hospital visitor numbers are restricted – have also helped to prioritise food and nutrition on wards.

Some facts:

- 300 million meals are produced for the NHS each year, of which 162 million are main meals

- £172m is spent on food provisions and £563m on catering annually. £2.50 is spent per patient per day
- A third of meals are purchased ready prepared - 37 per cent of food services are contracted out
- Higher-quality menus, protected mealtimes and ward housekeepers have been set up since 2000
- A deficiency of more than 10,000 calories is associated with a significant rise in death rates and increased need for antibiotics. Better food can help to deal with wound and urinary infections, pneumonia and pulmonary failure

Nottinghamshire County LINk (local involvement network) is considering doing some work on hospital food in the future.

1	**Review focus** tbc
2	**Objectives and purpose** tbc
3	**Anticipated outcomes** tbc
4	**Information required** tbc
5	**Contributors** tbc
6	**Timescale** tbc

APPENDIX 3

SCRUTINY WORK PROGRAMME PRIORITISATION