Nottinghamshire County Council Minutes

Meeting	JOINT CITY/COUNTY HEALTH SCRUTINY COMMITTEE
Date	Tuesday, 8th July 2008 (commencing at 10.00 am)

membership

Persons absent are marked with `A'

COUNCILLORS

Nottingham City Councillors:-

Emma Dewinton
A Michael Edwards
A Penny Griggs
A Eileen Heppell
A Ginny Klein (Vice-Chair)
Tony Marshall
A Andrew Price
A Mick Wildgust

Nottinghamshire County Councillors:-

Reg Adair
Mrs K Cutts
Pat Lally
Ellie Lodziak
Sue Saddington
A Parry Tsimbiridis
Chris Winterton (Chair)
Brian Wombwell

Also in attendance

County Councillor Edward Llewellyn-Jones

MINUTES

The minutes of the last meeting held on 24th June 2008 were agreed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Penny Griggs, Eileen Heppell, Ginny Klein and Parry Tsimbiridis (on other County Council business).

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

Councillor Edward Llewellyn-Jones declared a personal interest in agenda item 4 – Nottingham University Hospital, Emergency Department Discharge Policy – as his son was employed at the hospital.

Later in the meeting Councillor Sue Saddington declared a personal interest in agenda item 4 – Nottingham University Hospital, Emergency Department Discharge Policy – as her daughter was employed at the hospital.

NOTTINGHAM UNIVERSITY HOSPITALS EMERGENCY DEPARTMENT DISCHARGE POLICY

Jackie Hickling, Director of Strategy from the Nottingham University Hospitals spoke to the Select Committee about the emergency department's discharge policy. She indicated that in addition to the emergency department at the Queen's Medical Centre, patients had access to emergency treatment at walk-in centres and through GPs. She commented that nationally 40% of patients who came in to accident and emergency departments could go elsewhere for treatment.

At the emergency department patients were assessed by a nurse or doctor. How quickly this was depended on age, how busy they were or how ill the patient was. Patients had to wait to be seen and resources were always directed at emergencies first i.e. those with life-threatening conditions. The process was the same whether the patient came in by ambulance or by walking into the centre. Those patients who needed a dual diagnosis were seen by the relevant professionals and if a psychiatrist said a person should be admitted – they were. If a patient was drunk they were kept until they had sobered up. Often relatives came to pick patients up, but sometimes decisions were made that they provide transport rather than keep a patient in. If the patient was not admitted they would be advised to contact their GP and a letter would be sent to the GP by the hospital. She reported that the daily levels of physical and verbal abuse were quite high. The emergency department saw 1,062,000 patients last year and there were 1,700 complaints.

In response to a question from Councillor Winterton, Dr. Dove stated that the emergency department had access to outpatients and they were probably as well connected as anyone in the health service.

Councillor Llewellyn-Jones expressed concern at the picture which had been outlined of where patients could go for emergency treatment. He pointed out that patients did not have access to a GP and some had to wait days and weeks for an appointment and therefore would go to accident and emergency as it provided easy access to doctors. He felt that people were using the health service in ways which were not

intended and that the different parts of the health service were not communicating with each other. He referred to the proposed walk-in centre and asked how this would work, together with the emergency department. He felt that the out-of-hours GP service worked well. Dr. Dove stated that they recognised that some patients in A & E may be seen elsewhere. He explained that it had to be an open access service and that from the patients viewpoint they were ill and needed help and casualty was where you went.

Councillor Emma Dewinton related her experiences of being discharged without transport to get home, as a patient in the emergency department. She asked about guidance for staff treating a patient as an individual as it appeared to be about processes with no one's task to think about the patient. She wondered whether work with people with alcohol problems was being prioritised. She understood that there was one alcohol worker and there was a need to see patients when they were not drunk. She also asked about how elderly patients attending the emergency department in relation to falls were dealt with when discharged. In response to her questions, Dr. Dove stated that there was the Front Door Assessment and Care Team (FACT team) which assessed elderly patients. There was a falls clinic run by them. Psychiatric patients could be difficult to handle and disruptive and were seen and assessed by the Healthcare Trust. With regard to alcohol services, there were discussions about increasing the service. There were links to the alcohol liaison service which was in outpatients. He commented that people who were drunk were difficult to help and the priority was to identify and arrange an appointment. He pointed out that only 5 – 10% attended the subsequent outpatient's appointment. He stressed that chronic alcoholics only went for treatment when they wanted to. He commented that the FACT team operated from 9 – 5, outside that a nurse carried out an assessment and if there was a doubt the patient would be admitted and referred to the FACT team the following day.

Councillor Emma Dewinton asked what happened when a person suffering from alcohol problems did not keep their appointment? She felt that a better system was needed eg provision of services in communities. Dr. Dove stated that this was a society problem and it was difficult to make progress unless the patient thought they needed help.

At this point Councillor Sue Saddington declared a personal interest in the item as her daughter was employed at the Queen's Medical Centre.

In response to a question from Councillor Sue Saddington, Dr. Dove stated that the government target was that 98% of patients would be treated within four hours. He pointed out that walk-in centres were different organisations.

Councillor Mrs. Cutts pointed out that if 40% of people attending emergency departments should go elsewhere, it was in their interests to address this problem. She thought there was a real problem with GPs only working 9 – 5, Monday to Friday. She commented that people relied on neighbours or ambulances to transfer them home. If they were referred to the falls clinic they would not have any transport. She thought that there was a need for dialogue with other parts of the health service.

Councillor Reg Adair asked about discharges and what arrangements were in place. He referred to people who had been sent home in a taxi with no follow up. Dr. Dove explained that continuing care was the responsibility of primary care. He added that they relied on what the patient told them, made assessments and involved the front door team. If there was a doubt about a patient's safety, they would be admitted. They ensured that the GP was notified. He explained that they would provide taxis as a last resort for people on low incomes. With regard to patients with mental health needs they had access to the acute sector at all hours.

Reference was made to the waiting time for discharge. The representatives from the Nottingham University Hospitals indicated that they would find out what the statistics were. They pointed out that they provided transport for very few people. Councillor Mrs. Cutts thought there was a need to think about discharge arrangements and that there was a need for an area to wait and have a drink at all times.

Councilor Winterton indicated that the Select Committee would like more information on the treatment of alcoholics; arrangements for out of hours discharge; arrangements for making clear that the services are joined up; consideration of where people wait for their transport home after treatment at the emergency department; further data on the total waiting times for patients who are dependant on patient transport services ie the time they have waited in the emergency department plus the time they then wait for transport home; and information about the complaints process to ensure it is working satisfactory.

ACCESS TO URGENT AND EMERGENCY CARE

Tony Madge and Alison Treadgold from Nottingham City Primary Care Trust and Tony Madge from Nottinghamshire County Teaching Primary Care Trust respectively, gave a presentation to the Committee on Nottingham's emergency medical services and out-of-hours services. They outlined the options before accident and emergency. This involved self-care through having a well stocked medicine cabinet which was able to deal with common illnesses with over the counter medicines. Pharmacies can do more than just dispense and can advise on minor ailments and signpost to further services if required. NHS Direct was a nurse led service which was available 24 hours, 365 days. This provided information and advice about health, illness and health services to enable patients to make decisions about their health care and that of their families. This was provided by direct telephone, on-line or digital TV.

Tony Madge explained that the Nottingham walk-in centre was a free nurse-led service offering advice and some treatments for minor illnesses or injuries. The opening times were 8.00 am to 8.00 pm 7days per week. No appointments were necessary. There were no doctors at the walk-in centre and no x-ray facilities. There were nurse advisors and health information advisors. The walk-in centre saw 1,200 patients per week. The Stapleford walk-in centre provided a nurse led treatment of minor injury and illness. This saw 400 patients per week and operated 7 days per week (8.00 am – 6.00 pm weekdays and 8.00 am – 4.00 pm weekends). No appointment was necessary. He indicated that the GP surgery had an important role to play and that practices carried slots for emergencies. Home visits could also be made. The out-of-hours services were provided via Nottingham Emergency Medical

Services (NEMS) which provided urgent care via automatic transfer of telephone call from the practice to NEMS.

Urgent medical care was defined as “care that cannot safely wait until the GPs surgery is next opened”. NEMS operated Monday to Friday, 6.30 pm – 8.00 am and 24 hours on Saturdays, Sundays and Bank Holidays. They provided advice over the telephone – in partnership with staff at NHS Direct in Nottingham; an appointment at the NEMS centre – not a walk-in service; or a home visit – usually for bed-bound or terminally ill patients. It was not a walk-in service and patients must be assessed first. In a normal week 1,200 patients were seen per week. Half of these received advice over the telephone in partnership with NHS Direct. The Derby Road centre had 480 attendees and 120 received a home visit from a NEMS Doctor. Communications was the key to getting patients to understand the options and there was a leaflet which explained this. The range of services needed a re-focus and the Lord Darzi Review would stimulate this. Experience was that people who were not satisfied with the answer they received from one part then tried another part of the service. They felt that when accident and emergency and NEMS were co-located in 2009 this would enable closer working.

Councillor Sue Saddington felt that it was incorrect to say that patients can always access GPs. She asked how patients were equipped to make choices about different routes for treatment. Tony Madge indicated that the Primary Care Trust tried hard to publicise this. He added that GP practices made slots available but these were well used. He indicated that they were always open to advice about how communication could be improved. He felt that the situation with regard to access to GPs was better than it was, although it was not perfect. He added that Saturday services were starting to come back.

In response to Councillor Reg Adair, Tony Madge felt that the co-location of NEMS and the emergency department in 2009 would be a significant step. He pointed out that people wanted local services. Councillor Lally thought that the establishment of NHS Direct was to divert patients away from doctors. He asked whether this had made accident and emergencies less busy. Alison Treadgold stated that accident and emergency was seeing patients faster. She added that they access services in different ways. Tony Madge stated that there was an element of people going to walk-in centres because they were there.

Councillor Emma Dewinton thought there was a need to consider whether it was clear what services were provided at the walk-in centres. She felt that there was a need for clarity and that by calling it an NHS nurse walk-in centre would make this clearer. She thought that there was a need to know the details of the numbers attending GP services. She pointed out that patients wanted local access. She thought that there were problems with the out-of-hours service because of public transport. She felt it would be useful to know the impact on GPs.

Councillor Mrs. Cutts thought that the 1200 using the Nottingham walk-in centre was not a great number and that there was a need to have a closer look. She pointed out that people expected a 24 hour service. She was not surprised that patients inundated accident and emergency.

Councillor Winterton thought that it was clear that walk-in centres were necessary. He felt that the services were better than they were and that there were alternatives. He thought there was a need for information so that patients accessed the right service and that the health service needed to look at this.

Councillor Sue Saddington asked why GPs in Newark had to close for training on Wednesday afternoons which would increase the numbers of people going to accident and emergency. Tony Madge pointed out that ongoing professional training was important but would look into this and respond.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (NICE)

Val Moore from the National Institute for Health and Clinical Excellence (NICE) gave a presentation to the Committee. She indicated that NICE was an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. They were established in 1999 and had two bases, one in London and Manchester. The core principles of all NICE guidance was comprehensive evidence base, expert input, patient and carer involvement, independent advisory committees, genuine consultation and contestability, regular review; and an open and transparent process. There was an opportunity for appeal by manufacturers for technology appraisal guidance.

NICE provided guidance on the clinical and cost effectiveness of specific new or existing medicines and treatments leading to recommendations on the appropriate use of the technology within the NHS. They also provided guidance on the appropriate treatment and care of people with specific diseases and conditions based on the evidence of clinical and cost effectiveness. In addition they provided guidance as to whether interventional procedures used for diagnosis or treatment were safe enough and worked well enough for routine use in the NHS. NICE also provided public health guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public, private and voluntary sector. She gave details of the model used to assess cost effectiveness which measured the cost per qaly (quality of life years).

Val Moore stated that the NHS most usually make funding and resources available within three months of the issue of NICE technology appraisal guidance. For other guidance – local health organisations should review their management of clinical conditions against the NICE guidelines. She added that the Health Care Commission would inspect to see whether account was being taken of new guidelines. She gave details of the public health guidance which had been issued by NICE and those under development. She outlined questions which had been jointly branded by the Centre for Public Scrutiny and NICE on scrutinising how physical activity can be promoted through planning, transport, and the physical environment.

Councillor Emma Dewinton commented that NICE was a medical organisation which was producing guidelines about what was effective in the community. She expressed concerns about the health service giving guidance about what worked in the community. In response, Val Moore stated that NICE was looking at dropping some of the NHS branding to challenge the perception that it was linked soley to the NHS. She

pointed out that anyone could suggest topics for NICE to look at which would be considered by a panel. She added that they were receiving topic suggestions about complimentary medicine, but it was not currently in the NICE remit to take them on.

In response to a question from Councillor Reg Adair, Val Moore explained that the Department of Health was the sponsor of NICE and its budget was £33 million provided by them. NICE were independent in methodology and process. She added that if NICE said yes doctors were able to prescribe drugs. They did not put post codes on certain treatments and local health organisations (PCTs) had to agree local policy.

Councillor Mrs. Cutts expressed concern at attempts to measure the quality of life. She did not think that NICE should look at public health. Val Moore commented that there was a need to work on preventative strategies because if we did not improve determinants of health and lifestyles the pressure on the NHS would become impossible to manage.

In response to a question from Councilor Winterton, Val Moore explained that with dementia drugs, guidance had originally seen some value. Over the next four years further research was available which had showed differential effects and NICE limited the treatment for those groups who would not benefit. The revised recommendations had caused controversy and one particular issue was being reviewed by the House of Lords.

Councillor Emma Dewinton expressed concern about the medicalisation of the health guidance. She commented that often a person needed support and pointed out that the guidance on teenage sexual health did not say explicitly there was a need to talk to a person about confidence levels and self esteem.

WORK PROGRAMME 2008/09

The work programme for 2008/09 was noted. It was agreed that the emergency department be asked to circulate the information requested at the meeting and if necessary be invited back to a future meeting.

The meeting closed at 12.35 pm

CHAIR