Nottinghamshire County Council Minutes

Nottingham City Council

Meeting	JOINT CITY/COUNTY HEALTH SCRUTINY COMMITTEE
Date	Tuesday, 10 March 2009 (commencing at 10.15 am)

membership
Persons absent are marked with `A'

COUNCILLORS

Nottingham City Councillors:-

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

Nottinghamshire County Councillors:-

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

MINUTES

The minutes of the last meeting held on 10 February 2009 were agreed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Griggs, Price, Adair, Mrs Cutts and Lodziak.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

There were no declarations of interest.

PATIENT TRANSPORT SERVICE

Pete Ripley, George Gray and Louise Bettany from East Midlands Ambulance Service (EMAS) attended the meeting in connection with this item. Also present were representatives of the trusts which commissioned the Patient Transport Service (PTS) and Mr K Chidlow from NHS Procurement. Ms Bettany gave a presentation outlining the service, key performance indicators, the challenges in meeting those indicators, and current and future developments. Councillor Winterton invited the commissioners to give their views. He asked whether they had looked at the service's performance, and asked whether there were penalties. Mr K Chidlow replied that the existing service level agreements had no financial penalties for failing to achieve key performance indicators. The PTS was now in the last year of a three year contract. Councillor Winterton believed that members had been told that there were penalties. Mr Chidlow replied that all the commissioners could do was adjust tolerance levels.

Councillor Winterton asked whether the booking system was adequate. Mr Gray replied that a sophisticated software package, used nationally, was also used by EMAS. The software was being developed so it could be used for planning the allocation of vehicles and resources. He said there were no staffing problems. Mr Ripley stated that EMAS had as many staff as the contract would allow. However with more resources, the service could meet standards better. He believed that the new booking system would greatly improve efficiency. In the mean time, there was a need to tackle matters such as abortive journeys and booking on the day.

Councillor Wombwell expressed concern about poor performance on arrival times. He pointed out that the target was that 50% of patients should arrive within 15 minutes of their appointment and even this was being missed. He referred to the stress for patients and the disruption to hospital staff. He believed that the target should be raised, and EMAS should make significant progress to meet it. The service was failing to meet the standards which the public could expect of it. Mr Ripley pointed out that the target could be missed by patients arriving more than 15 minutes early for their appointment. Mr Gray gave as an example of the difficulty presented by 5 patients travelling from Newark to the Queen's Medical Centre, each with a different appointment time, but within an hour of each other. Logistically, the service would prefer to carry all the patients together. He added that EMAS only transported a small percentage of outpatients, and that they had asked the acute trusts to make appointment times closer together.

Councillor Edwards asked whether EMAS felt it could meet the targets with the resources available, what kind of improvement might be made with the new planning system, whether the service sought to learn from others' experience, whether they were meeting the targets set by any of their commissioners and whether ambulance trusts elsewhere were meeting their targets. Mr Ripley replied that EMAS had set up a PTS Programme Board and brought in consultants, with a view to making EMAS a more effective business. The new software would enable the planning of the following

day's journeys, currently carried out manually. A pilot exercise had shown this to be more efficient. The software would cover the whole region, whereas the current manual system was more local. The service was not asking for more resources. Councillor Edwards asked further questions: which PTS showed best practice, what improvement did EMAS anticipate and would they meet their targets. Mr Gray replied that most ambulance services were in a similar position and that there were no national KPI's. Mr Ripley added that meeting targets depended on the money available. However they might be able to meet targets if abortive journeys could be stopped. In response to further comments about the poor service, Mr Ripley expressed disappointment that people felt this way. He observed that many patients were happy with the service, and that EMAS was striving to improve.

Councillor Heppell commented that the briefing had been the same as the committee had received in the past. She was surprised there was no good example of joined up working with clinics and wards. She felt that patients came low down on the list of consultees, and emphasised that EMAS should listen to their views. She asked whether EMAS had looked at examples of good practice in patient transport as they had said a year ago that they would. She asked what result EMAS expected from PriceWaterhouseCoopers (PWC) and expressed surprise that there were no penalties. Mr Ripley replied that relationships with commissioners were better; that there was a public and patient involvement forum, and patient satisfaction surveys due in the next few months and in the autumn; that commissioners should be asked why there were no penalties in the contract; and that PWC would be looking at professional accountability and whether to endorse what the Programme Board decided to do. Mr Gray added that PWC had a good deal of logistical expertise.

Councillor Winterton pointed out that patients became anxious when they were late for appointments rather than early. He wondered whether the key performance indicator should be changed. He referred also to the waiting time for patients to be taken home. Mr M Rhodes, Doncaster and Bassetlaw Hospitals NHS Foundations Trust, pointed out that they had tried to change the KPI about arrival times, but understood that EMAS wanted the KPIs to be regional. Ms Tomlinson, Nottingham University Hospitals Trust (NUHT), stated that they tried to allay patients' fears about transport by for example making a clinic aware that a patient was coming by PTS. If a patient rang to say that the pick up was late, they would inform the clinic. Ms A Gray, Sherwood Forest Hospitals Trust, said that they operated a similar procedure. Mr R Tyson, Doncaster and Bassetlaw Hospitals Trust, referred to the tension arising from Choose and Book which allowed a patient to choose the appointment time which suits them, and EMAS's requirement for efficient routing and loading. Councillor Winterton gave the example of a taxi picking a patient up two hours after the appointment time. He wondered if the new software would help. Councillor Klein referred to the stress for a patient waiting to go home. She also referred to the poor performance for patients at Nottingham University Hospitals. Mr Chidlow reminded the Committee that the current contract expired in 2010, and the new contract was in preparation. It was however a lengthy process involving the whole region. He pointed out that acute trusts had similar targets, and that the KPIs were a core part of the contract. Very few companies could provide the Patient Transport Service, so the contract with EMAS was not one to be terminated lightly. He added that a national contract for PTS was being devised to be used as a model for all new contracts.

Councillor Dewinton asked when patients could expect the service for Nottingham University Hospitals to match others. Councillor Winterton referred to renal dialysis patients who were not able to choose an appointment and who, after their treatment, would want to return home as soon as possible. Their journeys were predictable but were still handled poorly. He asked whether the commissioners were happy with the Patient Transport Service. Mr P Edge, Nottingham University Hospitals Trust, indicated that his trust was happy with the service and that on the whole, EMAS provided a very good service. Ms Tomlinson, NUHT, disagreed with this view, believing that while the day to day service was adequate, there were logistical issues to resolve. In reply to Councillor Dewinton, she was unable to give a timescale for improvements, and indicated that there was no action plan.

Councillor Winterton summed up the discussion by observing that the Committee would reflect on the responses given at the meeting. He accepted that this was a complex service, and hoped that the new contract would be more effective especially for patients with regular appointments. He had understood that the amalgamation of ambulance services would give rise to economies of scale and improvements in service. He believed that penalties could be devised to deal with the circumstance of EMAS being a sole provider. He referred to the need to drive up performance.

The Committee agreed to receive a further report on the impact of the new contracts and software at a future meeting.

SPECIALISED SERVICE COMMISSIONERS

(a) Perinatal Mental Health Services

Doctor J Brewin and Ms Kath Murphy gave a presentation on the Perinatal Mental Health Services commissioned by the East Midlands Specialised Commissioning Group. The presentation arose from discussion at the Committee in December 2008. Inpatient services were provided in Nottingham, Derby and Leicester, and community services in Nottinghamshire and South Derbyshire. It was intended to extend this model to the whole region.

In reply to Councillor Heppell, Dr Brewin explained that the Nottingham unit was in a separate ward adjacent to the adult psychiatric ward. Kate Caston, Director of the Specialised Services Commissioning Group, referred to the wish to create an appropriate environment for new mothers and their babies. Councillor Dewinton commented that there had been only one patient when she had visited the Nottingham unit. Ms Caston said that on an epidemiological basis, they could expect 101 patients across the region to be admitted, compared with the actual figure of 50, leading them to believe that another 50 patients were being admitted to acute psychiatric wards without their baby. She questioned whether services were asking the right questions before admission. She referred also to peaks and troughs which could mean a high level of vacancies at a particular time. Dr Brewin referred to the need for the mother to be admitted with her baby. Ms Caston emphasised that perinatal mental illness was the most common cause of perinatal deaths, making it important to raise the quality of the service across the region, as well as the quality of the environment for

patients. In reply to Councillor Heppell, Dr Brewin stated that they tried not to categorise patients by age. The service was designed for adults, and might not be appropriate for younger mothers. He believed there might be a need to reflect on how the service dealt with the transition of younger patients into adulthood. In reply to Councillor Klein, Dr Brewin stated that Nottingham would take patients from Lincolnshire, where there was a poor community service. Ms Caston concluded the discussion by observing that Nottingham had an exemplary service model, and that now perinatal mental illness was a regional priority, good progress was anticipated.

(b) Eating Disorders Services

Doctor Brewin gave a second presentation on the Eating Disorder Services in the region, which operated on the basis of 15 inpatient beds in Leicester and specialist outpatient services in all the counties. He pointed out that patients with severe eating disorders could have a high mortality rate. Nottingham patients went either to the Leicester facility or to the independent sector. Councillor Klein asked whether there were plans to extend the inpatient service beyond Leicester and how East Midlands compared with other regions. Ms Caston replied that the service was only provided in Leicester but not all patients or Primary Care Trusts used it. The Specialised Commissioning Group wished to understand why, in order to produce the right specification. East Midlands provided a similar service to other regions. Ms Caston commented that they would like the service to have closer contact with children and adolescent mental health services. Dr Brewin observed that patients might have physical and mental health problems requiring input from different specialisms.

Councillor Wombwell expressed concern that there was nowhere in Nottinghamshire for young people with eating disorders. He wondered whether a family style setting was better than a hospital environment. Dr Brewin commented that each county generated the need for only 3-4 beds and would not produce a critical mass of expertise. Ms Caston emphasised that as much work as possible was conducted in the community local to the patient. She indicated that there were many outside providers in this market, and the commissioners could use their contract to specify the service they required. Councillor Dewinton was pleased to see the involvement of the voluntary and not-for-profit sector. She referred to the apparent increase in numbers of young people suffering from eating disorders and expressed the wish to see connections with work with parents and with young people suffering other types of stress in order to prevent eating disorders developing. She asked for information on outcomes and on current developments. Ms Caston replied that services should be incorporated into an overall service model, and work was required to achieve this. She offered to present a progress report to the Committee in six months time.

The Committee recognised commissioners' efforts to create smooth and effective patient pathways. The Committee believed that the key was a focus on involving patients and carers in the development of new models. It might be possible for the Committee to be involved in that work. It was agreed to ask the Specialised Commissioning Group to return in six months time to report on the outcomes of work to involve patients and carers and in the development of the two services.

NOTTINGHAM UNIVERSITY HOSPITALS TRUST – STRATEGIC INTENT DOCUMENT

Julia Hickling and Rebecca Larder from Nottingham University Hospitals Trust (NUHT) attended in connection with this item. Referring to the trust's reluctance to release the Strategic Intent Document to the Committee, Councillor Winterton emphasised that the Select Committee was a public meeting which had to follow nationally set rules on the availability of documents to the public. He would have found it helpful for the Committee to have seen the document in advance. Ms Hickling apologised that the trust's timescales did not tie in with the Select Committee's. She said there would be an opportunity to comment on a detailed draft and there had been no intention to compromise the Committee. Ms Larder gave a presentation to outline the background and content of the strategy.

Opening the discussion, Councillor Edwards observed that while the presentation gave a sense of the trust's aspirations across the range of its services, he wondered whether a strategy should focus on the services which the trust believed it could transform. He wondered how the trust distinguished quality from service improvements and expressed surprise that there was no focus on excellence or reputation. Ms Hickling replied that they were giving the fullest picture possible to illustrate the detail underpinning the strategy. There were six strategic aims, which were the result of two years of internal consultation. Councillor Tsimbiridis asked how the trust proposed to alleviate inequalities. Ms Larder gave the example of the trust's practice of carrying out a health and equality impact assessment every time a service was reviewed. Ms Hickling added that the trust should play its part in health promotion, and gave anti-smoking campaigns as an example. Councillor Tsimbiridis believed there was a need to address differences in life expectancy. In reply to the observation that there was a need for improvement on the basics (for example health care for the elderly, single sex wards or cleanliness), Ms Hickling agreed, pointing out that the strategy was a seven year plan with many action points. Councillor Wombwell believed that the strategy was a comprehensive assessment of activity across a large organisation. He believed that health inequalities could best be tackled in the community. Ms Larder observed that this was a priority for the Nottingham City PCT, in particular, and NUHT would be working with them.

Councillor Edwards referred to the need for a focus on the individual service user, and asked how that focus could be demonstrated. Ms Hickling was confident that such a focus was fundamental to the way that care was delivered and would be demonstrated over the next 5-7 years. In reply to a further question Ms Hickling said that the trust would manage its reputation through the choice agenda and by representations from members and patients. Ms Larder indicated that they would work closely with Nottinghamshire Community Healthcare Trust on dementia, with Ms Hickling adding that a dementia centre was under consideration.

Ms Larder pointed out that the Strategic Intent Document would be a large document. While the trust wished to make it user friendly, there was a risk of missing some details.

It was agreed that the Select Committee would scrutinise the Strategic Intent Document and its implementation at future meetings.

NHS ANNUAL HEALTH CHECKS – COMMENTARY 2008-9

It was agreed to postpone this item to the Select Committee meeting on 31 March 2009.

WORK PROGRAMME 2008/9

The work programme was agreed, subject to the above amendment

The meeting closed at 1.25pm.

CHAIR