Nottinghamshire County Council Minutes

Meeting	JOINT CITY/COUNTY HEALTH SCRUTINY COMMITTEE
Date	Tuesday,10th October 2006 (commencing at 10.30 am)

membership
Persons absent are marked with `A'

COUNCILLORS

Nottingham City Councillors:-

A Saghir Akhtar
A Brent Charlesworth
Gill Haymes (Vice-Chair)
Eileen Heppell
Afzal Khan
David Liversidge
A Tim Spencer
A Carole Stapleton

Nottinghamshire County Councillors:-

Steve Carr
Mrs K Cutts
Pat Lally
Edward Llewellyn-Jones (Chair)

Co-opted Members:-

Councillor Simon Harris, Ashfield Borough Council
Councillor Jacky Williams, Broxtowe Borough Council
Vacant - Gedling Borough Council
Councillor Mrs M Males, Rushcliffe Borough Council

ALSO IN ATTENDANCE

Mrs B Cast)
Ms N Watson) Nottingham City Council

Mr M Garrard	)
Mr H C Holmes	) Nottinghamshire County Council
Mr M Gately	
Ms R Magnani	) Nottingham University Hospitals NHS Trust
Dr S Fowlie	)
Ms A Cresswell	) Nottinghamshire Healthcare Trust
Mr H Whitehurst	) Nottingham University Hospitals NHS Trust PPIF
Ms H Dury	) SPAN Training Centre Group
Dr J Thornton	)

Councillor V H Dobson

MINUTES

The minutes of the last meeting were agreed, subject to a change on page 2, under Declarations of Interest – delete "Nottingham University Medicine School" and insert "Nottingham University Medical School".

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Saghir Akhtar and Tim Spencer.

APPOINTMENT OF CO-OPTED MEMBER

The appointment of Councillor Stella Lane as a co-opted member of the Committee was agreed following her nomination by Gedling Borough Council.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

Councillor David Liversidge declared a personal interest in agenda item 5 – Nottinghamshire Healthcare Trust – Adult Mental Health Directorate as his brother worked for the Trust.

Councillor Jacky Williams declared a personal interest in agenda item 6 – as she has an honorary post at the Nottingham University Medical School.

Councillor Llewellyn-Jones declared a personal interest in agenda item 6 – Nottingham University Hospital Trust as a member of his family was employed there.

NOTTINGHAM HEALTHCARE TRUST: ADULT MENTAL HEALTH DIRECTORATE

Adele Cresswell, Associate Director: Adult Mental Health from the Nottinghamshire Healthcare Trust gave a presentation to the Joint Committee. She stated that the Trust had developed a plan but that they were open to changes. Elements were to be put out for public consultation and they were happy to engage in scrutiny. She indicated that it was the mid-point for the NHS Plan for England and Wales and that they were carrying out a process of tidying and streamlining across the NHS because of the effects of expansion. Some budgets had overshot. She indicated that 1.7% was needed to tackle residual issues picking up failed targets and planning for the effect of the new pay system. Agenda for change, the new pay system, had brought in incremental drift. She pointed out that in part the plans were financially driven.

She indicated that when the service had expanded they had introduced new services which had had an effect on the previous services. With regard to in-patient services they had 10 mental health beds in the north of the county, and having looked at the capacity it was felt these beds were not needed. It was not proposed to lose occupied beds. She explained that over the last five years they had introduced crisis control and patients were seen at home which had led to a 30% reduction in patient admissions. She indicated that the south Nottingham and city community teams needed to be reconfigured; the north Nottinghamshire team was already in place. The wellbeing and social inclusion services were a new service which would look at education, voluntary, sports and arts to combine into one. The evidence indicated that there was a need to provide the service in a main stream environment. The shift now was that main stream providers would provide the service and the Trust as a specialist service would provide the bridge. This meant looking at the future of separate services and a consultation to run until the end of January 2007. She explained that with the reconfiguration of the south Nottingham and city community teams they were doing the service design around how pathways will look but they felt there was benefit in greater liaison with GPs. With regard to the wellbeing and social inclusion service they were developing this which involved looking at the existing structure. There was full consultation on this. She pointed out that the Professor Schneider was a national expert in this area. She indicated that it was hoped that the new proposals would take effect from 1st April 2007. The Trust was consulting widely and it was also planned to have an involvement strategy working alongside the proposals.

Councillor Llewellyn-Jones pointed out that the proposals in relation to Millbrook were being considered by the County Council's Health Scrutiny Committee and that a meeting had been held yesterday to which no one had attended from the Trust although they had been invited. Adele Cresswell apologised for the Trust's non attendance. Councillor Llewellyn-Jones commented that it was interesting to hear that nothing was set in stone and that there was to be real consultation as some of the papers in the report suggested otherwise. Adele Cresswell responded by indicating that the Trust Board had approved the main changes to the team in the south of the county but that the wellbeing and social inclusion service proposals were out for consultation. Councillor Llewellyn-Jones thought that there was a sense that consultation had not taken place at the right time or place. It appeared that there had

been introduction of changes which had not come before the Committee. He had hoped that she would bring more detail as the papers that went to the Board were very confusing. He added that she had said that the proposals were financially driven and he added that what came through the proposals was that they were purely financially driven and that the wellbeing of the patient was being shaped to the financial driver. Adele Cresswell responded that a new community based service had been introduced into the north of the county about three or four years ago. She stressed that they were not losing patient beds or episodes in the proposals. With regard to the financial imperatives she was not trying to hide that they were trying to bring the service into financial balance. This related to the fact that the Trust could not go into deficit and also about running the service on business principles.

In response to a question, Adele Cresswell explained that one of the gains in respect of the community service was the need to operate one single service which was easy for people to follow. At present there was a fragmented system and the proposals were about providing a more effective pathway. She added that a GP sat with a patient in crisis and was not able to get the person into the service. She thought that the Primary Care liaison would help this. She added that service users would not see a change as there would be the same level of activities. They were wishing to ensure that services would be available in the community and that they would be more locally based with a centralised management. They had met the GP clusters and were looking at the simplest interface. She commented that in the city the clusters were emerging on interests whereas in the county some were crossing boundaries. With regard to the wellbeing service, the challenge was not to lose the benefits of the old system with the new. The gains should be that the service was in a mainstream environment. She agreed there was a need for a safe haven and transition for patients.

Councillor Mrs Cutts commented that it was not clear what happened now with regard to services and what was proposed to change and how this would affect carers. Adele Cresswell agreed to provide details which would clarify this.

In response to questions from Councillor Eileen Heppell, Adele Cresswell stated that no GP practice would be excluded. With regard to supported employment, assessment would be made.

In response to a question from Councillor Liversidge, Adele Cresswell stated that with regard to assertive outreach they worked with social services and relied on organisations like Framework.

Dr Thornton hoped that during the consultation it would be possible for the evidence for the proposals to be made public so people could question it. Adele Cresswell confirmed that that would be the case and suggested that Professor Schneider attended the next meeting. Helen Dury pointed out that they had been told that SPAN Training Centre was to close in December therefore it was difficult to believe in the consultation period. She pointed out that SPAN was on a valuable site. Councillor Llewellyn-Jones pointed out that the Committee had the power to refer matters to the

Secretary of State and that unless consultation was carried out in a meaningful way this power would be invoked. Adele Cresswell stated that she wanted proper dialogue to take place. She commented that SPAN provided very good services but there were lots of people who did not access it. She emphasised that no decision had been taken. Councillor Llewellyn-Jones pointed out that the detail would be considered at another meeting.

Councillor Jacky Williams felt uncomfortable at the stage the Committee had been brought into the proposals. She had a concern over the move to 24 beds. She wondered to what extent there had been user involvement in the design and redesign of the proposals. She asked whether there had been any carer involvement in the proposals and felt that the Trust was trying to do too much at once. She suggested that a letter be sent to the Board to remind them of their need to involve the Committee in proposals. Councillor Llewellyn-Jones accepted that the proposals had been postponed from the last meeting. Adele Cresswell agreed that due process had to come before implementation of the proposals. Councillor Llewellyn-Jones thought there was a difficulty in keeping to the Trust's timescale and there was a need to have further discussions.

Councillor Steve Carr worried about the consultation. He added that he had not heard that anything would get better but the acid test was what would be delivered.

It was agreed that the Trust be asked to provide the following at the next meeting:-

(1) Detailed information on the proposals and its implications for patients and the public,

(2) Diagrammatic evidence of the current patient pathways and how they are to be altered,

(3) Details of the consultation plan for these proposals.

UNIVERSITY HOSPITALS TRUST: LONG TERM VISION

Dr S Fowlie, the Medical Director at Nottingham University Hospitals Trust, gave a presentation to the Committee. He indicated that the vision for the Trust was to be the best acute teaching Trust in the UK by 2016 judged against outstanding patient care, teaching and research and highly effective partnerships. They were determined to go to extraordinary lengths to place the patient at the centre of everything they did. They wanted to develop innovative patient care in collaboration with partners and put great store on consultation. They wanted to join the two organisations, the Queens Medical Centre and the City Hospital and exploit the clinical synergies.

Dr Fowlie stated that in each assessment domain there were theoretical and often demonstrable advantages in separating elective and emergency processes (services). He explained that on the Queens Medical Centre campus there was a very busy

accident and emergency department whereas the City Hospital campus was highly specialised and predominantly scheduled care departments; eg. heart and cancer services. He pointed out that there was a campus divide and it was not that one would be a backwater. For patients there were advantages in that patients who had been scheduled did not get derailed by emergency care. It meant that they could better use staff, resources and equipment. He referred to the bed reconfigurations and reductions in phase one. There was a programme to reduce full-time equivalents by approximately 10%. The majority would be by natural wastage. There would be redundancies but some would be redeployed. He commented that the situation with specialist nurses had attracted attention. The Nottingham University Hospitals Trust had a large number of specialist services and had developed specialist nurses. In a national audit it had emerged that the Trust had more specialist nurses than similar organisations serving similar populations. When they had looked at this internally and looked at what the specialist nurses were doing it was clear that a substantial proportion of their time was not spent on specialised nursing tasks and what others expected but were carrying out administrative and management tasks. They had taken over roles that they were over qualified for. The background was that specialised services would be in the community rather than hospital based – this was the direction of travel. They had decided to reduce the number of specialised nurses and had been re-examining to check that the analysis was right and that Primary Care partnerships were in place. At the moment the proposals were to reduce specialist nurses from 330 across the hospitals to 230 although the numbers may change.

Dr Fowlie stated that they were looking at the stroke patient pathway and improving the older person's care pathway. Older people benefited from seeing a specialist geriatrician when they came to hospital. Older people were the biggest users of accident and emergency. It was proposed to consolidate older person's services at the Queens Medical Centre campus and consolidate stroke services at the city campus. He felt that by consolidating these services there would be big improvements in patient care.

In response to a question from Councillor Llewellyn-Jones, Dr Fowlie stated that the bed reductions may appear significant but they had areas of the hospital where bed occupancy was very high but other areas where this was not the case. He pointed out that they had reduced beds in the past and the demonstrable evidence was that services had improved. He indicated that the surgical beds were being reduced because they had relatively low occupancy at the moment. With women and children's beds these were least effectively used at the moment and it was recognised that occupancy rates could be improved. With acute medical beds there was some reconfiguration proposed and they would import the City Hospital's approach to the Queens Medical Centre and it was felt that some beds could be lost. The aim was to separate stroke care and elderly care which had advantages for patients. As a larger hospital they can group stroke patients together. Having stroke wards for stroke patients the evidence is that patients do better in the short and long term. There is a growing trend for intervention with strokes within the first three hours and it was easier to do this if there was one team. These services can be provided on the City Hospital site and he was confident that it would be better care both long and short term.

In response to a question from Councillor Llewellyn-Jones, Dr Fowlie stated that there was a difference between specialist nurses and nurses on a ward with specialist knowledge. Ward based staff now had specialist knowledge whereas previously this was only held by specialist nurses. Councillor Jacky Williams commented that specialists nurses passed on information to practice nurses. She feared there would be a loss of expertise to transfer information back to Primary Care. She sensed that morale within the hospitals was very low at the moment and that this impacted on patients. She felt the new configuration was interesting but wondered how this related to the treatment centre and LIFT centres. She commented that when Stapleford Health Centre was built there was an expectation that services would be moved out but there was no evidence that this was happening. Dr Fowlie explained that they were using specialist skills to deliver training both in hospitals and the community, they recognised that there was an issue of training. There was an increasing cohort of nurses getting training the same way as ward based staff. Specialist nurses can be trained in the community and can drive training in hospitals. Most services can be delivered in LIFT buildings the evidence based for a kind of shift was rather mixed, for example outcomes for patients. Patients like it better but there is not much evidence that the clinical outcomes are better and not much evidence that it is better value for money. There were also operational issues. He indicated that the Treatment Centre was for outpatient services the Trust had to plan their outpatients they had taken into account the services which were likely to move into the Treatment Centre and LIFT buildings.

Councillor Liversidge said that he had no objections to the proposed reconfigurations. He expressed concern about the pace of change which he thought was not sustainable. He felt that because of budgetary pressures they were increasing the pace. He thought that the amount of finance which had to be lost was too large. He did not feel that the Primary Care Trust was talking enough to reconfigure services across the conurbation. Dr Fowlie stated that there was a very significant, challenging financial situation. Some of what was being decided was a solution to some of the problems. There was a responsibility to carry out the changes at a pace which was reasonable which did not prolong uncertainty. He thought it was a well made point about Primary care which they had been trying to address. The two hospitals had merged and the Primary Care Trusts had merged and it was difficult to get people to buy into a strategy moving services around. He agreed that there now needed to be dialogue between the Chief Executives of the new organisations.

Councillor Llewellyn-Jones expressed concern at the implications for community services of reducing beds and higher throughput. He thought there was a danger of adding pressures onto social services. Councillor Mrs Cutts thought that the problems of getting back in for aftercare should not be minimised. She thought there was a need to think about outreach services and that services should not just be urban ones. Dr Fowlie stated that they had been working with social services and primary care to deliver services with our specialities. In response to a question from Councillor Mrs Males, Dr Fowlie stated that they were still working on options for maternity services which would be the subject of a future report to the Committee. He added that with

regard to agency nurses they did not expect to use more and anticipated using less than at the moment.

Councillor Gill Haymes commented that the Queens Medical Centre was difficult to access particularly for older people because of the different levels. She did not disagree with the general direction of the proposals but asked whether there was any possibility of the pace being slowed down. Dr Fowlie stated that external drivers were very significant and these would not change significantly. If the changes were slowed down the financial problems would become even larger. He commented that the Trust recognised that as an organisation they had to change and that their judgement was that there was a need to get on with it. Ms Magnami indicated that the staff wanted the Trust to move ahead with the proposals as slowing them down would only lengthen the uncertainty. Dr Fowlie added that the changes which had been described outlined what the future held for the staff and it was not a spiral of decline. With regard to the access issues they were constrained by the building but would site services more appropriately. Ms Magnani commented that redeployment would always be an issue but that there would be training packages for the new roles. In response to a question from Councillor Lally, Doctor Fowlie stated that the ways the Trust could account for their finances had changed and that this was one of the drivers for change. Councillor Lally wanted to see improved transport between the two hospital sites. Ms Magnami indicated that the buses had been increased and were now more frequent.

Mr Whitehurst from the Public and Patient Involvement Forum for the Nottingham University Hospitals Trust indicated that he had been involved for several months and was supportive of the proposals. He felt it was important to appreciate the long term vision of the Trust and public understanding was a pre-requisite. He agreed there would be access problems with the two sites and the Forum had flagged that up as an issue. He referred to patient choice which would be more difficult with this vision of the merged hospitals but he felt that patient choice could be built in in other ways. He pointed out that the Patient and Public Involvement Forum would be very proactive in engaging the wider community.

OLDER PEOPLE SERVICES

It was agreed that a copy of the Joint Committee's response to the proposals on "improving health services for older people across greater Nottingham" be sent to the Nottinghamshire County Teaching and Nottingham Primary Care Trusts.

WORK PROGRAMME 2006/07

Consideration was given to the capacity of the Joint Committee to consider the volume of issues which needed to be dealt with. It was suggested that there may be a need to consider more meetings or prioritise issues for detailed consideration.

It was agreed that future meetings of the Joint Committee should start at 10.00 am and that the meetings be programmed to last for three hours if necessary.

The meeting closed at 1.35 pm.

CHAIR

Ref: ctee/select ctees/jt health/2006/m_10 OCT 06