Nottinghamshire County Council Minutes

Meeting	JOINT CITY/COUNTY HEALTH SCRUTINY COMMITTEE
Date	Tuesday,12th September 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)
A Eileen Heppell
Afzal Khan
David Liversidge
A Tim Spencer
A Carole Stapleton

Nottinghamshire County Councillors:-

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

Co-opted Members:-

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

ALSO IN ATTENDANCE

Mrs B Cast)
Ms N Watson) Nottingham City Council

Mr M Garrard)
Mr C Gilbert)
Mr H C Holmes) Nottinghamshire County Council

Dr P Homa) Nottingham University Hospitals NHS Trust
Ms R Magnani)
Dr R Morris)
Ms D Good)
Ms S Bowler)

Ms S Creber) Rushcliffe PCT

Ms B Venes) Patient and Public Involvement Forum
Councillor P Henshaw

MINUTES

The minutes of the last meeting were agreed, subject to a change on page 4, paragraph 3, 1st line – delete "his" and insert "her".

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Brent Charlesworth, Eileen Heppell, Tim Spencer, Steve Carr, Pat Lally, Simon Harris and Mrs M Males.

DECLARATIONS OF INTEREST

Councillor Jacky Williams declared a personal interest in item 4 – Nottingham University Hospital Groups as she has an honorary post at the Nottingham University Medicine School.

Councillor David Liversidge declared a personal interest in item 6 – Nottinghamshire Healthcare Trust – developments – as his brother worked for the Trust.

NOTTINGHAM UNIVERSITY HOSPITALS TRUST

Dr Homa, the Chief Executive and Ms. S. Bowler, Deputy Director of Operations from the Nottingham University Hospitals Trust, gave a presentation to the Joint Committee. A copy of the slides from the presentation is attached as an appendix. They outlined their vision for the Trust which was:-

- We will strive to give our patients the same care and attention that we would wish to give members of our own family.

- To work to become by 2016 the best acute teaching Trust in the country based on outstanding patient care, teaching, research and effective partnership. We believe that our patients deserve nothing less.

As part of the work plan they were to develop selected specialities where the Trust was or could be seen as a national and international leader. An example of this was the new PET scanner at the City Hospital which was the only one outside London. This would serve 1,200 patients in the first year. It was necessary to ensure that the Trust had a strong financial foundation and became a successful, innovative, responsive Foundation Trust giving benefit to patients, carers, partners and staff. The objective of strong financial foundation was a means to an end and not the end in itself.

Ms. Bowler stated that they were looking at efficiencies across the organisation to improve services. They were improving the quality of services through service re-design by spreading current good practice and introducing new ideas which released resources. New ways of working were being introduced which ensured shorter hospital stays prior to surgery and gave greater certainty and less time in the operating theatres. Example given was theatre scheduling and pre-ops. A patient would go to a pre-op facility to start tests immediately after seeing the consultant. This would be a one-stop facility when an operation date would also be discussed. Theatre operation lists would be maximised to avoid gaps and over-runs. This was already happening in urology and breast clinics and would be rolled out to other specialities. With regard to delivering efficient patient care, there were improving medical cover out of hours at weekends and night. All medical staff and nurses were pooled and allocated according to patient need and the skills and competency of the team. This would lead to making savings on out of hours banding. The management for medicines was being expanded by the using generic drugs and increasing the role of pharmacy to challenge the use of drugs. Administration was being made more efficient. With regard to secretaries, medical secretaries and administration, they were looking at what the patient requires. They were looking at the use of a typing pool so that medical secretaries could become case managers.

Ms. Bowler explained that services were being modernised through bed re-configuration. They were planning reductions of 56 beds from health care of the elderly/stroke (out of 255); 34 surgery beds (out of 360); 38 beds women and children (out of 431); and 10 beds for acute medicine (out of 234). It was explained that the surgical assessment unit would be closed as patients could go direct to the ward and would be seen as soon as they were admitted. There would be a nurse-led service for gynaecology and the four points of access at the moment would be combined for maternity patients. The length of stay would be reduced as they were developing community midwives so that patients could go home earlier. They were working with community matrons so that patients could be treated at home, for example given antibiotics.

Work was being undertaken on improving the older person's care pathway which took account of valuing the patient's time and delivering efficient patient care. At the

moment Parkinson Disease cases were dealt with on both campuses and it was proposed to merge and enhance the service to deliver a better one. They were trying to reduce the ring road transfer by ambulance from one hospital to another. They were proposing to develop “one-stop” community assessments so that as much as possible was done in one visit by the patient so that repeat visits were not needed. There was an assessment ward for older people at the City Hospital and the plan was to increase this facility which speeded up the assessment process.

Pro-active discharge planning would reduce the time patients stayed in hospitals. The ward team would start planning a discharge when a patient was admitted. Problems over patients waiting for tablets when they were discharged would be reduced. Longer opening times within the admission assessment clinic would lead to less admissions to hospital. It was proposed to expand the hours into the evening and weekends so that patients did not end up needing a hospital bed. It was proposed to provide support in the community for patients having shoulder operations. At the moment patients are in hospital for up to 11 days whereas elsewhere they had gone home the next day or after two or three days using a different anaesthetic and with the provision of support in the home. It was explained that the impact of all these changes would be measured by looking at re-admission rates, day case rates, length of stay and theatre/diagnostic utilisation. They would also be looking at infection rates and mortality and morbidity rates.

Ms. Magnani from the Trust explained about the consultation arrangements concerning their plans. She explained that the plans were developed by services with input from patients, the public and primary care. Some active patient groups had been involved, for example, stroke and gastroenterology. The plans had been shared widely with staff and staff-side organisations. All stakeholders were involved throughout the process in the planning, consideration of proposed changes and decision making. There was also wider stakeholder involvement with patients and public, PPI Forum, staff and staff-side bodies, other NHS organisations, voluntary sector, social services and local authorities, MPs and the media. The key milestones and timelines were set out. The children’s hospital consultation would run from mid-September to December 2006. The first tranche of workforce reductions would be from September 2006 to March 2007. Phase 1 reconfiguration options would be agreed by the Trust Board in November 2006 with public consultation running from December 2006 to February 2007. Implementation of Phase 1 would happen onwards from April 2007 for which capital approval would be needed.

In response to a question from Councillor Llewellyn-Jones seeking clarification about the workforce reductions, Dr Homa explained that this referred to posts being taken from the hospitals and that most would be dealt with through redeployment. This related to bed reduction and needing fewer staff to service. The primary effort was to redeploy but it was clear that they would not be able to deal with all through this process. They were seeking ways of being more efficient. It was pointed out that the June meeting had received details of potential staff reductions. Dr Morris explained that they were moving the venue of care and that people may lose one job and find it with another which enabled the level of skill to be maintained in wider organisations.

In response to a question from Councillor Jacky Williams Ms Bowler referred to the hospital at night and explained that a lot of supporting patient's requirements could be done by medical staff which did not matter what speciality they covered. She added that if a patient was unwell and needed a specialist they would come and attend. She gave as an example of general work which would be providing pain relief drugs. She added that this system would enhance the training of junior doctors.

In response to a question from Councillor Mrs Cutts, Dr Homa explained that patients had to go to London for a PET scanner. He added that the scanner was used for cancer patients but could do other scans. He explained that the advantage with the PET scan was that changes in growth could be measured more finely compared with MRI scans.

Councillor Mrs Cutts expressed concern that patients were to be out of hospital sooner and asked who would pick up the care in the community as some would require this. Dr Morris referred to Department of Health guidance about developing intermediate care which was between hospital and home. He added that they were developing and supporting more robustly so that this could be developed. The thrust was to have people in the venue of care to deliver care and to make sure people were in the right venue. Ms Bowler gave an example of specialist nurses who went out to patients 2 or 3 times a day following shoulder surgery.

Councillor Mrs Cutts expressed concern about the proposed typing pool. Dr Homa stated that they were putting in all safeguards around supervision and the contract would require training. He added that this approach had been used in other hospitals.

Councillor Mrs Cutts asked how patients would be told about the changes and who would hold patients notes. Dr Homa commented that sometimes patients held the notes themselves. He also referred to the electronic records which were being introduced. Ms Good referred to the use the hospitals were making of a leaflet produced by the Stroke Association. Councillor Llewellyn-Jones commented that patients tended not to discover information until after an illness had occurred and he thought there was a need for information beforehand. Dr Homa indicated that he would look at information issues.

Councillor Liversidge thought that it would be useful to have a complete list of the proposed hospital wide projects rather than just examples. Dr Homa agreed to provide this.

Councillor Gill Haymes felt that the bed reductions looked large. She asked whether non hospital bedcare would be provided by the hospital and not transferred to others. She asked how this linked in with the Lings Bar bed reduction. Dr Homa stated that the hospital were not cutting services but were delivering them in another way based on healthcare in other hospitals. He added that the hospital were putting these changes in place and that if care was needed in other places they saw this as their responsibility. He added that if there was a need to share with other colleagues they

would discuss these well in advance. Ms Bowler stated that with some of the bed reductions for example coronary and children there were empty beds at the moment so they were using them better. They were looking at patient pathways and there was a need to ensure these were in place before bed reductions took place. Dr Morris referred to the elderly beds reduction. He added that the assessment team which was front loaded had made a difference and there were fewer delays in the delivery of care.

Councillor Gill Haymes referred to the proposed changes in the use of medical secretaries and worried if these were sent overseas which would lead to language problems and misunderstandings. She added that patients were irritated when the notes were not there and that appointments needed to be reconfigured. Dr Homa stated that any system would be designed to avoid these risks. He added that they were piloting a range of options and that they did want a high quality service. He added that the objective was to give the patient the best service.

In response to a question from Councillor Gill Haymes, Dr Homa stated that they wanted a range of services which they knew were the best they could do. He added that the hospitals had a long history of patient involvement which they would built on and be open and transparent. Councillor Llewellyn-Jones stated that the Committee would be interested in the way consultation was taking place and knowing in more detail the Patient and Public Involvement Forum views.

OLDER PEOPLE'S SERVICES

A briefing note was circulated from David Pearson, Strategic Director, Adult Social Care and Health on behalf of the City and County Councils Adult Social Care Services. In addition a note of the key themes identified by Rushcliffe PCT from the consultation process and the proposed response of the PCT was circulated.

Ms Creber stated that the Board of Rushcliffe PCT had considered the proposals together with the consultation responses at their July meeting. They had approved all the recommendations and so had approved the direction of travel. They had recommended that all the other PCTs across Greater Nottingham should approve the proposals. More details were needed for the implementation plan so it would now pass to the new Nottinghamshire County Teaching Primary Care Trust. She added that discussions had taken place with the Chief Executive of the new Primary Care Trust.

Councillor Llewellyn-Jones stated that the Committee had been concerned that there was a lot of work which still needed to be done. He added that there appeared to be merit in the scheme but that there had not been enough detail for the Committee to commend it. He was happy that the new Primary Care Trust was taking the matter forward.

In response to a question from Councillor Gill Haymes, Ms Creber stated that they recognised that transport was not a problem for patients as the Trust had transport. They were looking at transport issues from the point of view of carers.

Ms Venes reported that the Healthcare Trust Board welcomed the changes. She stated that some of the wards would be used for earlier diagnosis of dementia.

In response to a question from Councillor Jacky Williams, Ms Creber explained that with regard to the PFI contracts the PCT had underwritten any potential costs of changes. They had signalled formally that they may change the use but no firm decisions had been taken yet. She added that they had held meetings with Nottingham University Hospitals to ensure there was synergy in the proposals.

NOTTINGHAMSHIRE HEALTHCARE TRUST

It was noted that the Nottinghamshire Healthcare Trust will be presenting its service and finance strategy to the October meeting. It was noted that there were plans to rationalise bed numbers at the Millbrook site and that one of the County Council's scrutiny Select Committees would be looking at this as it was a county issue.

It was agreed that the strategy be considered at the October meeting.

WORK PROGRAMME 2006/07

Clarification was sought about what the University Hospitals Trust would be bringing to the next meeting. It was suggested that the Committee should meet the new Chief Executive of the Greater Nottingham Primary Care Trust. It was also suggested that the Committee should look into the Air Ambulance.

The meeting concluded at 1.00pm

CHAIR

Ref: ctee/select ctees/jt health/2006/m_12 sept 06