



**NOTTINGHAM CITY COUNCIL**  
**JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE**

**Date:** Tuesday, 16 June 2015

**Time:** 10.15 am

**Place:** LB31-32 - Loxley House, Station Street, Nottingham, NG2 3NG

**Councillors are requested to attend the above meeting to transact the following business**

**Acting Corporate Director for Resources**

**Governance Officer:** Clare Routledge **Direct Dial:** 0115 8764315

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ALL MEDIA ENQUIRIES RELATING TO THE INDEPENDENT REVIEW OF DERMATOLOGY SERVICES ARE TO BE DIRECTED TO LUKE BARRETT, COMMUNICATIONS MANAGERS (NOTTS). EMAIL: [luke.barrett@ardengemcsu.nhs.uk](mailto:luke.barrett@ardengemcsu.nhs.uk) MOBILE: 07775546987.

IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE GOVERNANCE OFFICER SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

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## MINUTES

JOINT HEALTH SCRUTINY COMMITTEE  
21<sup>st</sup> April 2015 at 10.15am

### Nottinghamshire County Councillors

Councillor P Tsimbiridis (Chair)  
Councillor P Allan  
Councillor J Clarke  
Councillor Mrs K Cutts MBE  
Councillor C Harwood  
A Councillor J Handley  
Councillor J Williams  
Councillor S Wallace

### Nottingham City Councillors

Councillor G Klein (Vice- Chair)  
Councillor E Campbell  
Councillor C Jones  
A Councillor T Molife  
Councillor E Morley  
A Councillor T Neal  
A Councillor B Parbutt  
Councillor A Peach

### Officers

Julie Brailsford - Nottinghamshire County Council  
Martin Gately - Nottinghamshire County Council  
Claire Routledge - Nottingham City Council

### Also In Attendance

Nicky Bird - Mansfield & Ashfield CCG  
Dr Stephen Fowlie- NUH Medical Director & Deputy Chief Executive  
Claire Grainger - Healthwatch Nottinghamshire  
Dr Julie Hall - NHS Foundation Trust  
Michelle Peet - Project Lead on Electronic Prescribing  
Ruth Sargent - Head of Specialised Mental Health & Learning Disabilities  
Sarah Skett - NHS England  
Dawn Smith - Nottingham City Clinical Group  
John Wallace - NHS Foundation Trust

## **MEMBERSHIP CHANGE**

It was reported that Councillor Mrs K Cutts MBE had been permanently appointed to the committee in place of Councillor Dr J Doddy.

It was also reported that Councillor S Wallace had been appointed in place of Councillor R Butler for this meeting only.

## **MINUTES**

The minutes of the last meeting held on 10<sup>th</sup> March 2015, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

## **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor B Parbutt and Councillor T Neal.

## **DECLARATIONS OF INTERESTS**

There were no declarations of interest.

## **NUH PHARMACY INFORMATION – GP SURVEY & ELECTRONIC PRESCRIBING**

Nicky Bird, Senior Prescribing and Interface Officer for Mansfield and Ashfield Clinical Commissioning Group (CCG) (on behalf of Nottinghamshire County CCG's) and Michelle Peet, the Project Lead on Electronic Prescribing gave a presentation on the results of a survey of hospital outpatient prescriptions and the Electronic Prescription Service. The survey had previously been requested by the committee. The survey was sent to 160 CCG's and 85 had responded resulting in a 50% response rate. The survey showed that up to 10 patients a week were taking prescriptions, mainly from NUH City and QMC, to Doctor's surgeries, the main reason being due to the long wait at NUH pharmacy.

Michelle Peet explained that there were currently two electronic prescribing systems. The first was a system used within the hospital for Doctor's to send prescriptions electronically to the hospital pharmacy. The second was where patients nominated a preferred dispenser in their community and the local GP sent the prescription directly to them for dispensing.

Following the presentation the following comments and additional information was provided in response to questions:-

- The survey had only included outpatients as inpatients should be discharged with a supply of medication.
- A 48 hour window is required by GP's to transcribe and dispense hospital prescriptions.
- The transfer of the cost from the hospital to the GP depended on the drug prescribed. There had been a trial when the hospital completed a form regarding medication required for the patient to take to their GP for prescribing. The information was often incomplete and the trial had ceased.

- Not all GP's were signed up to the electronic prescribing service. It had been trialled for 2 years and currently 50% of practices were signed up to it and looking to increase this to 60 to 70% in the next financial year. It was not mandatory for GP's to join this service; they had to plan when it was financially appropriate for their practice to migrate their systems.
- Medication returned to pharmacies could not be reused as it was not known if they had been stored correctly.
- Technology and software issues meant that it was difficult to find one prescribing system that sat comfortably with all parties.
- The electronic prescribing system used by Doctors within hospitals also generated an electronic patient discharge sheet; this included lots of patient information and reduced the problems associated with poor handwriting.
- Printing the cost of drugs on prescriptions whilst deterring some from ordering unnecessarily, had resulted in some patients stopping necessary medication due to the cost.
- The Area Prescribing Committee looked at the effectiveness, cost and systems used within Nottingham and Nottinghamshire.

The committee were informed that Mo Rahman, Head of Pharmacy at NU H would be attending the June meeting to provide more information regarding NUH pharmacy delays.

### **RAMPTON HOSPITAL VARIATIONS OF SERVICE**

Ruth Sargent, Head of Commissioning, Sarah Scott, NHS England, John Wallace, Clinical Director at Rampton and Dr Julie Hall, Forensic Healthcare gave a briefing on the Rampton Hospital Variations of Service. The new Offender Personality Disorder (OPD) strategy was approved by Ministers in 2011. It was explained that they currently did not know the speed of the impact of new services. The current predictions were that the first ward at Rampton could close in 2016. Staff and patients had been consulted on a regular basis, patients had been assured that they would not be moved until clinically appropriate and it was not anticipated that there would be any significant changes in staffing.

Following the presentation the following comments and additional information was provided in response to questions:-

- The trust had been notified of the changes in June 2014 and this raised criticism from the committee regarding the length of time it had taken for them to be informed.
- It was hoped that there would be a reduction of prisoners being admitted to hospital as the default position for offenders with personality disorders was that they should be managed within the prison. There would be investment in to prisons and probation services to help them manage prisoners with OPD.

Treatment environments were running in several long stay prisons and the pathway started in probation as soon as prisoners were convicted.

- There were other pathways for juvenile offenders. It was preferred not to label people with a personality disorder but it was recognised that they had needs.
- Lessons had been learnt from the closure of Broadmoor hospital and these would help with the change in service at Rampton.
- It was anticipated that more personality disorder beds would be required at Rampton hospital.
- There was assurance that the variation of service would not pose a risk to the community.
- There were currently 44 admissions of OPD patients per year and the average length of stay was for 7 years.

The committee requested that an update was provided in 6 months.

### **URGENT WINTER CARE PRESSURES – FUTURE PLANNING**

Dr Stephen Fowlie, NUH Medical Director & Deputy Chief Executive and Dawn Smith, Chief Operating Officer, Nottingham City Clinical Group, gave a presentation on Improving Emergency Patient Flow In Our Health and Social Care Community, focusing on future planning for urgent winter care pressures. 2014/2015 was the busiest winter on record, the flu season had started early along with nor virus and there had also been significant staff sickness absences during this period.

There had been 52 patients who had breached the twelve hour response time. A review had been undertaken of all of these patients and no significant safety issues were found.

Following the presentation the following comments and additional information was provided in response to questions:-

- The surgical assessment unit (triage) had significantly reduced the amount of time that patients had to stay in hospital and also improved the flow from the Emergency Department (ED) to other services.
- The ED was less reliant on agency staff than other hospitals and tried to use bank staff where possible.
- Planning for the Easter holiday had included four GP's working at the front doors of the ED, Triage nurses could not send patients away in the same way that a GP could, the impact of this was still being assessed.
- There was a national advertising campaign to advise patients to phone the 111 service rather than going straight to the ED.

- Through the Better Care Fund it was anticipated that early intervention for patients in Care Homes would have a positive impact before they were admitted in to hospital. However, it was difficult to assess the success of any early intervention due to the speed with which many elderly people deteriorated.
- There had been significant improvements in the discharge pathway from hospital and work with partner organisations had helped this. It was difficult to discuss discharge arrangements with patients and relatives when the patient was still not well.

## **WORK PROGRAMME**

The contents of the Work Programme were noted.

The committee were informed that the next meeting on 16<sup>th</sup> June 2015 would be held at Loxley House, Nottingham City Council.

The meeting closed at 12.40pm.

Chairman

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<b>JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE</b>
<b>16 JUNE 2015</b>
<b>JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE TERMS OF REFERENCE AND PROTOCOL</b>
<b>REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)</b>

**1. Purpose**

- 1.1 To note the terms of reference for the Joint City and County Health Scrutiny Committee. There is an agreed protocol in place governing the operation of the Committee.

**2. Action required**

- 2.1 The Committee is asked to:
- a) note the Committee's terms of reference
  - b) agree the Committee's protocol for 2015/16

**3. Background information**

- 3.1 Nottingham City and Nottinghamshire County Councils have established a joint committee for scrutinising health matters which affect the Greater Nottingham area. The terms of reference is attached at Appendix 1 and were agreed at Nottingham City Council's Full Council meeting on 18<sup>th</sup> May 2015.
- 3.2 There is a protocol governing the operation of this committee. The protocol was last amended in May 2014 and is attached at Appendix 2.

**4. List of attached information**

- 4.1 The following information can be found in the appendices to this report:

**Appendix 1** – Joint City and County Health Scrutiny Committee Terms of Reference

**Appendix 2** – Joint City and County Health Scrutiny Committee Protocol

5. **Background papers, other than published works or those disclosing exempt or confidential information**

None

6. **Published documents referred to in compiling this report**

Report to and minutes of Joint Health Scrutiny Committee meeting held on 10 June 2014.

7. **Wards affected**

All

8. **Contact information**

Clare Routledge. Senior Governance Officer, (Health Scrutiny)

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**Joint City and County Health Scrutiny Committee**

**Terms of Reference**

- (a) To scrutinise health matters which impact on both the areas covered by Nottingham City Council and Nottinghamshire County Council, including the statutory health scrutiny role.
- (b) the Joint Committee is accountable to Council, has 8 City Councillors (who cannot be members of the Executive Board) and 8 County Councillors.
- (c) the Chair and Vice-Chair will be appointed in alternate years by each authority. The Vice-Chair will always be appointed by the authority not holding the Chair.

**Meetings:**

- (d) The Joint Committee will meet at least 2 times per year and usually has 11 meetings per year;
- (e) notice of meetings, circulation of papers, conduct of business at meetings and voting arrangements will follow the Standing Orders of the authority which holds the Chair, or such Standing Orders which may be approved by the parent authorities. Meetings will be open to citizens;
- (f) the secretariat of the Joint Committee will alternate annually between the two authorities with the Chair. The costs of operating the Joint Committee will be met by the Council providing the secretariat services.

### **PROTOCOL FOR THE OPERATION OF A JOINT COMMITTEE ON THE OVERVIEW AND SCRUTINY OF HEALTH IN GREATER NOTTINGHAM**

1. Nottinghamshire County Council and Nottingham City Council established a Joint Committee between the two Authorities in 2003 to scrutinise health matters which impact upon the Greater Nottingham area.
2. The role and operation of the Joint Committee will be kept under review, with a further complete review of its responsibilities and workings to be carried out on an annual basis from the adoption of this protocol.

#### **Role**

3. The role of the Joint Committee is
  - To scrutinise health matters which impact both on the areas covered by Nottingham City Council and Nottinghamshire County Council.
4. A list of stakeholders is attached to this protocol.

#### **Responsibilities**

5. The Joint Committee will scrutinise significant health developments that cover the Greater Nottingham area. This means that a decision will impact on both Nottingham City and Nottinghamshire County residents.
6. The main focus will be on issues relating to public health with particular regard to health inequalities and access to services.
7. The agenda will be determined by the Chair and Vice-Chair, and the lead officers for both councils.

#### **Purposes of Joint Health Scrutiny**

8. Issues for potential scrutiny include:
  - Major capital projects;
  - Proposals to close services such as hospital wards and GP surgeries;
  - Issues that impact on health inequalities;
  - Issues that affect access to services such as the ending of a service or its relocation to an alternative site, including the availability of appropriate public transport;
  - Performance issues – but only those not already monitored by other bodies;

- Issues that impact widely on public health;
- Issues that impact significantly on the local economy.

### **Definition of Significant Variation/Development of Health Services**

9. There is no national definition. Local authorities are requested to arrive at a local definition following consultation with bodies such as Healthwatch.
10. National guidance states that in considering whether a proposal is substantial, health service organisations, committees and stakeholders should consider generally the impact of the change upon patients, carers and the public who use or have the potential to use a service. More specifically they should take into account:
  - Changes in accessibility of services, for example both reductions and increases on a particular site or changes in opening times for a particular clinic. Communities attach considerable importance to the local provision of services, and local accessibility can be a key factor in improving population health, especially for disadvantaged and minority groups. At the same time, development in medical practice and in the effective organisation of health care services may call for reorganisation including relocation of services. Thus there should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location.
  - Impact of proposal on the wider community, and other services including economic impact, transport, regeneration;
  - Patients affected, changes may affect the whole population (such as changes to accident and emergency), or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial;
  - Methods of service delivery, altering the way a service is delivered may be a substantial change – for example moving a particular service into community settings rather than being entirely hospital-based. The views of patients and patient’s forums will be essential in such cases.

### **Notification of Potential Scrutiny Items**

11. In line with the national Guidance on Overview and Scrutiny of Health, health bodies will need to notify the lead officer of the Joint Committee secretariat of relevant issues for potential scrutiny. Commissioners and

providers should agree on potential joint health scrutiny items to notify to the joint Committee, and they should also become a standing item on executive level management meetings. Similarly Healthwatch will need to inform the secretariat of any issues they wish to raise. The secretariat will inform the Chair and Vice-Chair of issues raised, so that they can decide on the best way of responding.

### **Chair and Vice Chair**

12. The Chair and Vice Chair from each Social Services authority will be appointed in alternate years from each council. The Vice Chair will always be appointed from the authority not holding the Chair.

### **Size of Committee**

13. It is proposed that the Joint Committee will comprise 8 non-executive members of the City Council and 8 members of the County Council. The County Council should look to include members who represent electoral divisions in the Broxtowe, Gedling, Hucknall and Rushcliffe areas.
14. Allocation of seats will be determined by the two Social Services authorities involved.

### **Co-opted Members**

15. The power of health scrutiny lies with local authorities with responsibility for Social Services i.e. the City Council and County Council for Nottinghamshire. However non-executive district council members can be co-opted to Health Scrutiny Committees on an indefinite basis or for a time-limited period. Similarly Health Scrutiny Committees have the power to co-opt other people, regardless of background, as long as it is felt that they add value to the Committee. The Joint Committee can determine any co-options.

### **Frequency of Meetings**

16. The Joint Committee will usually meet monthly, but must hold a minimum of two meetings per year.

### **Organisation and Conduct of Meetings**

17. Notice of meetings, circulation of papers, conduct of business at meetings and voting arrangements will follow the Standing Orders of the authority which holds the Chair, or such Standing Orders which may be approved by the parent authorities. Meetings will be open to members of the public.

## **Officer Support**

18. The secretariat for the Joint Committee will alternate annually between the two authorities with the Chair. The costs of operating the Joint Committee will be met by the Council providing the secretariat services.

## **Reports from the Joint Committee**

19. When the Joint Committee has completed a scrutiny review, it should produce one report on behalf of the committee. The report should reflect the views of both the City Council and County Council and so the aim should be for consensus whenever possible.
20. The health service organisation(s) receiving the report must respond in writing to any requests for responses to the report or recommendations, within 28 days of receipt of the request.

## Joint Health Scrutiny Protocol

Adopted      May 2005

Reviewed     July 2006  
                  June 2007  
                  April 2008  
                  May 2010  
                  June 2011  
                  May 2012  
                  June 2015

Amended     July 2006  
                  April 2008  
                  May 2010  
                  May 2014

## **KEY STAKEHOLDERS IN GREATER NOTTINGHAM**

### **Nottinghamshire Social Services Authorities (who comprise the Joint Health Committee)**

Nottingham City Council (eight Members)  
Nottinghamshire County Council (eight Members)

### **District Councils**

Ashfield District Council (Hucknall area)  
Broxtowe Borough Council  
Gedling Borough Council  
Rushcliffe Borough Council

### **NHS Trusts**

Nottingham University Hospitals NHS Trust  
East Midlands Ambulance NHS Trust  
Nottinghamshire Healthcare NHS Trust

### **Clinical Commissioning Groups**

Nottingham City Clinical Commissioning Group  
Nottingham West Clinical Commissioning Group  
Nottingham North and East Clinical Commissioning Group  
Rushcliffe Clinical Commissioning Group

### **NHS England Local Area Team**

### **Health and Wellbeing Boards**

Nottingham Health and Wellbeing Board  
Nottinghamshire Health and Wellbeing Board

### **Healthwatch**

Healthwatch Nottingham  
Healthwatch Nottinghamshire



<b>JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE</b>
<b>16 JUNE 2015</b>
<b>PROPOSED TRANSITIONAL CHANGES WITHIN NOTTINGHAMSHIRE HEALTHCARE TRUST ADULT MENTAL HEALTH SERVICE FOR 2015/16</b>
<b>REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)</b>

**1. Purpose**

- 1.1 To consider the proposed service redesign and improvement initiatives within Adult Mental Health services during 2015/16.

**2. Action required**

The Committee is asked to consider two proposals:

- Progression of the Adult Mental Health Directorate Rehabilitation Strategy focussing on increased community provision and decrease of in-patient rehabilitation services
- A review of the delivery of community mental health services for adults across the city and county of Nottingham and the implementation of proposed changes

**3. Background information**

- 3.1 Nottinghamshire Healthcare Trust Adult Mental Health have completed several service transitions over the past 4 years, as well as closing several in-patient facilities and reinvesting in community based services.
- 3.2 In line with national directives and guidance Adult Mental Health are proposing the closure of two open rehabilitation units:
- Heather Close - an 18 bedded open rehabilitation unit with resources reinvested in the development of the Community Rehabilitation Team (CRT) in the Mansfield and Ashfield area;
  - Broomfield House - a 12 bedded open rehabilitation unit serving the city and south of the county and the continued development of other Community Rehabilitation Teams in existence across the city and county of Nottingham.
- 3.3 The Adult Mental Health Directorate has recognised the need to focus on

the development of non-crisis community mental health services. The Community Review will enable Adult Mental Health and stakeholders to identify the most effective and efficient way for citizens to access the services. Ensuring the provision of responsive, reactive and evidence based interventions.

3.4 Extensive engagement and consultation on both these proposals will be undertaken.

5. **Background papers, other than published works or those disclosing exempt or confidential information**

None

6. **Published documents referred to in compiling this report**

None

7. **Wards affected**

All

8. **Contact information**

Clare Routledge. Senior Governance Officer, (Health Scrutiny)

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## LOCAL SERVICES DIVISION

### ADULT MENTAL HEALTH DIRECTORATE

#### COMMUNITY SERVICES STRATEGY

## EXECUTIVE SUMMARY

The Adult Mental Health Clinical Strategy details the development of a service re-design / transformation Programme for 2014-2016 which includes the closure of acute admission wards to facilitate the development of enhanced crisis resolution and home treatment services; the closure of in-patient rehabilitation units to facilitate the development of community rehabilitation services; a focus on early intervention; the development of psychological therapies across community services and the development of family intervention services

This paper describes the second stage of the service re-design programme which requires a review of all existing community mental health services across the adult mental health directorate to ensure service models and pathways are meeting the needs of the population and service and commissioning requirements.

The JOSC are asked to support the Trust in its wish to engage and consult on changes.

## STRATEGIC DRIVERS FOR REVIEW

### SERVICE REVIEW: CLINICAL PATHWAYS

Working towards Mental Health National Tariff (PbR) has been mandated since April 2011. The trust has introduced clustering and has been developing cluster pathways for the last two years. The redesign of community services needs to ensure that all services can deliver the required national tariff care pathways.

### ISSUES IN CURRENT SERVICE DELIVERY

There are a number of issues in the current service delivery model which need to be addressed, namely:

- **Waiting times:** Ideally all services would aim to see patients within 2 weeks of referral
- **Over complication of services:** multiple service teams can appear complicated and confusing for referrers and patients.
- **Repetition of assessment:** patients are often assessed by numerous services before a service is offered. This means that patients have to tell their story several times and leads to feelings of hopelessness, e.g. no-one can help me. It leads to the patient being seen as a problem rather than the service being able to meet their need

- **Debates between teams:** time and energy can be taken up debating which team the patient fits into. This is frustrating and can result in poor relationships between teams.
- **Duplication of service:** a number of service teams share common cluster groups which can lead to lack of clarity regarding pathways
- **Lack of equity of service:** Young people with psychosis receive an intensive service from EIP. This is not equitable for older patients who present with psychosis.
- **Outpatients:** medical time taken up with large out-patient clinics. Teams work more effectively with consultants embedded within the leadership of the team. A full review of medical Out-patient clinics needs to be undertaken
- **Pathway of discharge to Primary Care:** There is not a clear pathway for referral back to primary care
- **Size of County South CMHTs:** the county south CMHTs have very small numbers of community staff and this makes service delivery difficult

Any service redesign will aim to identify solutions to the issues identified.

## FINANCIAL CONSIDERATIONS

Whilst this redesign scheme does not identify any immediate cost savings, the Trust must ensure that services are clinically and cost effective and that service changes are sustainable in a competitive market.

## THE COMMUNITY SERVICES RE-DESIGN PROGRAMME

The Community Service Re-design Programme is being managed in two parts. The first part focuses on the development of the enhanced models for provision of community crisis resolution and home treatment services. This approach has been implemented with the closure of the acute admission wards at the QMC.

The second part is a review of all existing community mental health services in Nottingham City and Nottinghamshire County South and North. The AMH Community Mental Health services have been delivered along traditional models for many years, for example, Community Mental Health Team's and NSF (National Service Framework) services, Early Intervention in Psychosis and Assertive Outreach.

New service models for the delivery of community mental health care and treatment (such as the FACT model which is being delivered in Newark) have been introduced in recent years. This review will consider the benefits and disadvantages of the existing community teams, examine any problems with systems and structures within the teams that may impact on service delivery.

**Expected outcomes of the review:** The implementation of this review will deliver improved efficiencies in service delivery, and new ways of working (e.g. new ways of working for medical staff and increased use of non-medical prescribers and nurse led clinics).

## COMMUNITY SERVICES REVIEW: CITY AND COUNTY AMH

### COMMUNITY SERVICES REVIEW:

The AMH community services for Nottingham City, Nottinghamshire County South and Nottinghamshire County North have been established for many years. Some teams have retained traditional models of service delivery such as locality Community Mental Health Teams and services that were developed out of the National Service Framework policy implementation guidance such as Early Intervention in Psychosis, Assertive Outreach and Crisis Resolution and Home Treatment.

Over the last 3-5 years a significant number of changes have been made to services as a result of health and social care strategic drivers, policy and economic requirements. Although many traditional services have been retained these are operating to different models and pathways across the city and county areas in part due to the needs of the local population and following previous organisational change processes. This has led to a complex range of services and system of service delivery.

### SERVICE REVIEW: TERMS OF REFERENCE

A project work-stream has overseen the second stage of the community services review. This has coordinated a series of focus groups, consulted different professional groups across the community mental health services and reviewed the following information and issues:

- Team Caseload's
- Individual care co-ordination caseloads
- Caseload management: productivity/activity review
- Patterns of Referrals to teams
- National Tariff Cluster patterns
- National Tariff Cluster Pathways
- Patient Pathways through services
- Patterns of community activity
- Team Functions
- Operational protocols and policies
- Staffing structures across teams
- Multi-disciplinary working
  - Roles of professionals
- Structure and Delivery of services
  - Medical out-patient services
  - Nurse led clinics
  - Non-medical prescribing
- Delivery of evidence based practices
- Interfaces between teams/services
- Training needs and Core competencies of staff
- Estates suitability

## SERVICES REVIEW: EXPECTED OUTCOMES

Expected outcomes of the community services review:

- Review the current community mental health structures and models of delivery.
- Review the staffing structures and professional grades of staff required in community services.
- Review the training and professional development required within community mental health services to deliver new ways of working.
- Examine the most up to date evidence based practices for the effective delivery of Community Mental Health care.
- Ensure the pathways of care developed in community mental health services support the service re-design programme for the closure of acute mental health and in-patient rehabilitation beds and the development of enhanced crisis resolution and home treatment services.
- Consider the developments and interventions required to enable new ways of working in community services
  - Early intervention
  - Nurse led clinics
  - Non-medical prescriber roles
  - Evidenced based psychological interventions
  - Multi-disciplinary Team working
- Identify the models of delivery and pathways of care required across Community Mental Health Services in Nottingham City and Nottinghamshire County south and north areas
- Make recommendations for any changes required to teams and services to ensure the most effective and efficient delivery of care and treatment to service users
- Detail the routes of access for initial referrals from Primary Care Services.
- Ensure value for money within the financial budget identified for community services

## OPTION APPRAISAL

An option appraisal for configuration of existing community teams was communicated to teams and services city, county south and county north areas.

## NOTTINGHAM CITY COMMUNITY SERVICES

Secondary mental health services for Nottingham City are accessed through referral to the Single Point of Access team at Highbury Hospital and cover the Nottingham city CCG catchment area. Referrals are processed at allocation meetings which operate twice weekly. The Front line services such as CATS, Recovery, Early Intervention in Psychosis and Deaf Services are accessed via this process. Other services; Assertive Outreach and Community Rehabilitation are tertiary and are accessed via internal referral. City Community Services are located at the Stonebridge Centre; Highbury Hospital and Marlow House.

## NOTTINGHAM COUNTY COMMUNITY SERVICES

### **County South Community Services**

Secondary mental health services for Nottinghamshire County South are accessed through referral to the Single Point of Access for each of the following areas/teams. The Front line services such as Community Mental Health Teams, Early Intervention in Psychosis and Deaf Services are accessed via this process. All other services are tertiary; Assertive Outreach and Community Rehabilitation are accessed via internal referral. County South Community Services are located at Manor Road (Gedling); the Hope Centre Beeston (Broxtowe and Hucknall); Musters road West Bridgford Rushcliffe); Highbury Hospital (county south EIP).

### **County North Community Services**

Secondary mental health services for Nottinghamshire County North are accessed through referral to the Single Point of Access for each of the following areas/teams. The Front line services such as Community Mental Health Teams, Early Intervention in Psychosis and Deaf Services are accessed via this process. All other services are tertiary services and are accessed via internal referral. The County North teams are located at Northgate Newark; Millfields Mansfield; Bassetlaw District Hospital.

## ADDITIONAL COMMUNITY SERVICES

### **Social inclusion and Well-being**

This service covers Nottingham city and county south areas and provides specialist occupational therapy; employment and volunteering specialists working to an IPS model (individual placement support).

### **Deaf Services**

This service provides specialist community mental health services to Nottingham city and Nottinghamshire county north and south patients who are deaf or deafened.

### **Carer Support Service**

This service provides support services to carers' of patients receiving services from Nottingham city community services.

### **Psychological Services service**

- Step 4 Psychological Health (city)
- Psychotherapy
- Specialist Depression Service
- Mindfulness Service
- Bipolar disorder service
- DBT



## CURRENT SERVICES / MODELS OF DELIVERY

### **CATS**

The City CATs service was created at the request of the City CCG to provide a single point of access to all city services. The service provides assessment and treatment to patients with high levels of non-psychotic illness and disability. The service was originally created as an integrated health and social care team. The service receives a high volume of referrals and undertakes a screening/triage function of all referrals from city GP's. The service requires some adjustment to ensure that patients are seen in a timely manner and have time limited interventions. The services has seen an increasing caseload of people referred with ADHD; these client are managed by medical staff within the team whilst waiting for ADHD specialist diagnostic assessment which is currently up to a year, this is due to prescribing of controlled medication.

### **Early Intervention in Psychosis**

The Nottingham City and Nottinghamshire County South Early Intervention teams are managed as one service by one team manager. The city team works to a North and South geographical model to serve the two Nottingham Universities. The City and south county teams are city focused to fit with a student population who use city based services.

The EIP service is focused on shortening the course and decreasing the severity of the initial episode, thereby minimising the many complications that can arise from untreated psychosis. This is essentially;

- The early detection and treatment of psychosis within a bio psychosocial framework.
- The provision of treatment, and psychological intervention during the 'critical' early phase focussing on strengths, hope and recovery.

The service works to the broad parameters of the National Service framework EIP policy implementation guidance.

The target group for early intervention is 14 – 35 years of age.

- The Adult Mental Health (AMH) EIP teams work with 18 – 35 year olds.
- This is Cluster 10 within HoNOS PbR.
- Head 2 Head, Child and Adolescent Mental Health Services (CAMHS) provide care for the 14 – 18 year olds.

The Directorate has EIP teams across the city of Nottingham and Nottinghamshire county south and north patches. There is strong evidence base for retaining Early Intervention in Psychosis services in the city. These teams have been able to respond quickly and effectively to patients presenting with high levels of risk and distress. Nottingham City has the highest proportion of patients referred for an EIP service. This is in the main due to the two local universities and a large number of further education colleges in the City. The city EIP service has seen a large increase in referrals over the three years. There is evidence of high rates of early onset psychosis in Nottingham city.



However, the current EIP service does not operate to full National policy implementation guidance and requires amendment. For example; patients over 35 do not have access to specialist EIP services as per NICE guidance. Capacity pressures across services have also led to difficulty with clients transitioning to other services resulting in clients staying in the service the recommended three years.

### **City Recovery**

The City Recovery team was created in 2010 from existing three city CMHT teams. The Recovery Service is a secondary care mental health service. The team provides assessment, treatment and recovery based interventions for service users with mental health diagnosis, who require longer term contact with services. Longer term is defined as more than one year. This multi-disciplinary service is committed to providing an appropriate range of treatments and interventions, for a range of cluster pathways which promote mental health and social inclusion and reduce discrimination for people with severe and persistent mental health problems. There is also a collaborative working approach with statutory services, voluntary services and the private sector. The underpinning philosophy of the service is recovery orientated, to promote independence, autonomy and choice for service users. Emphasis is placed on community based assessment and care, working in partnership to promote social inclusion.

The team takes referrals for any new clients of age 18-64 with severe and complex mental health problems across a range of PBR cluster groups. The team will continue to work with existing clients who are 65 plus who continue to experience mental health difficulties and the service is able to meet their needs. Clients under the care of the City Recovery Service will be supported either under the Care Programme Approach (CPA) care pathway or the care pathway process. Clients on either pathway will have a care coordinator who is responsible for coordinating appropriate assessment, care planning and reviews. Care -coordinators will be a member of the multi-disciplinary team. The Recovery team receives referrals from all other city services and therefore has a large caseload.

### **Assertive Outreach City**

Assertive Outreach Services aim to provide a comprehensive and flexible client centred service for people and their families experiencing severe and enduring mental health problems who historically have struggled to engage with mental health services.

The service provides an intensive multi-disciplinary community based approach to the delivery of care for people with severe and enduring mental health problems. In both City and County teams social care staff and social care services will be delivered outside of the immediate team. In seeking to maximize the value of a whole team approach, all staff take a shared responsibility for the care of all service users and service users are viewed as active participants in the direction of their care.

Successful outcomes for Assertive Outreach Teams are based upon the establishment of collaborative partnerships which support the development of trust and the opportunity for therapeutic risk taking. Assertive Outreach teams should offer a wide range of evidence-based interventions including practical support as well as frequently reviewed access to medication. Service users who take a positive decision to manage their mental health will be

supported to explore how they may be able to achieve their goals in a planned way whilst continuing to utilise the support the team can provide in enhancing their social circumstances. Target group:

- Adults identified as suffering from a severe and enduring mental illness who have a primary diagnosis of psychosis or bi-polar disorder and are aged between 18 and 65 years at the point of referral.
- Receiving services or in need of services equivalent to the CPA Care Pathway of the Care Programme Approach (CPA).
- Evidence of difficulty in maintaining lasting and consenting contact with traditional statutory services, and lack of meaningful engagement with services.
- Service users will typically have multiple complex needs, including a number of the following:
  - Posing significant risks to self or others including self-neglect.
  - Poor response to previous treatment.
  - Dual diagnosis of substance misuse and serious mental illness.
  - Unstable accommodation or homelessness.
  - Non-concordance with treatment/care plan.
  - Must meet criteria for Clusters 16 or 17.

The City Assertive Outreach service operates as two city teams. It does not meet full policy implementation guidance. It currently operates seven day working. As above pathways are not clear into and out of this team and it requires change.

### **Community Rehabilitation**

The service is for people who fit the criteria for intensive community rehabilitation from the psychosis clusters 12 and 13. The expected duration of treatment/intervention will be a maximum of 2 years with the aim to try to move people through the system within 12-18 months. Clients may live independently, communally, with carers', some will be supported in community based rehabilitation units or 24-hour supported accommodation, with additional support provided by SDS packages and or personal health budgets.

The service will provide in-reach to inpatient acute admission wards for early identification of clients appropriate for a community rehabilitation pathway to support effective and timely discharge and pathways through inpatient services. The service will provide in-reach to the inpatient rehabilitation units in Nottinghamshire, including locked rehabilitation to ensure discharge packages are proactive and a continuity of therapeutic relationship is provided, promoting timely discharge and transition through services.

The service will offer an alternative to an inpatient rehabilitation admission via a community rehabilitation package with the emphasis on maintaining people in the community as a first priority. Exit from the service will follow a successful period of rehabilitation moving towards discharge to primary care or if assessed as requiring social care support, service users will be referred to social care or other community mental health services and third sector agencies.

The Community Rehabilitation service was created in 2013 from the closure of in-patient rehabilitation units. Their remit is to provide community rehabilitation and as an alternative to an in-patient rehabilitation placement.

### **Community Mental Health Teams (County South and County North)**

No service specification exists for the traditional community mental health services. These have been in place in Nottingham city and Nottinghamshire county areas for over thirty years and have developed different models across south and north areas. The community mental health teams are multi-disciplinary community based working in partnership with other agencies providing specialist assessment and treatment, risk assessment and risk management of patients with moderate to severe mental health problems. Community mental health teams have developed a range of evidence based interventions supporting clients across the broad range of national tariff cluster groups.

### **Newark FACT**

The creation of the Fact model for Newark and Sherwood merged the existing individual teams (Assertive Outreach, Early Intervention in Psychosis, Community Mental Health Team, Crisis Resolution and Home Treatment Team and Medical Outpatients) into one Flexible Assertive Community Treatment (FACT) Team, which will offer interventions based on cluster led Care Pathways.

These Pathways are offered to Service Users whose needs are assessed and identified to be best met by the identified pathway, outcome measures inform both the Service User and clinician when their objectives have been achieved or another Pathway of care becomes appropriate.

All staff work across Pathways and a Service User can receive interventions from more than one Pathway at any given time. The Service actively seeks to match Service User need against staff skills.

## **DEVELOPMENT OF EVIDENCE BASED INTERVENTIONS**

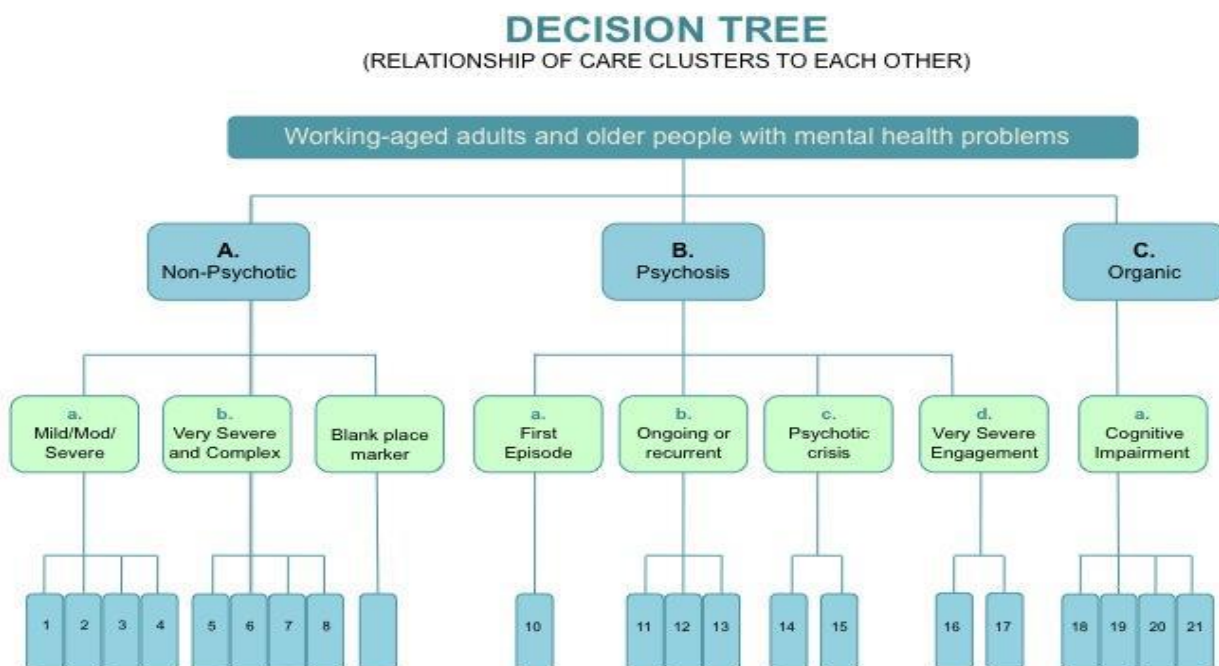
The adult mental health clinical strategy details the strategic intentions of the directorate in the development of evidenced based interventions as follows:

- Development of Cluster 1-3 care pathways, within IAPT and primary care, contact with secondary care advisory only.
- Development of cluster 4 care pathway, jointly with IAPT/primary care. Ensure cluster 4 within secondary care have access to appropriate psychological interventions.
- Development of care pathways for clusters 5-7, ensuring provision of intensive CBT as recommended by NICE, ensuring access to specialised prescribing in line with NICE and Maudsley guidelines. Development of rTMS service and support research in this area.
- For cluster 6, includes development of specialised depression service to provide second opinions, local specialist expertise and influence prescribing. In addition to

attract external funding through tertiary referrals for consideration of specialised treatments not routinely available, including rMTS, psychosurgery.

- For development of cluster 7, joint working with primary care and social care to ensure appropriate social care package and monitoring in place, and SDS. Thereby reducing contact with secondary care, freeing up resource to provide psychological and prescribing interventions.
- Provision of a community care pathway, including DBT, for cluster 8 service users, to reduce acute inpatient bed use and readmissions.
- Care pathway development for clusters 10-17. Includes development of specialised bipolar service, to enable specialised psychological interventions. Ensure financial and clinical benefits of EIP, AO are preserved, but design services to meet geographical need as efficiently as possible, this includes development of FACT teams for geographically dispersed areas.
- Joint working with primary care to develop cluster 11 pathway, reduce use of routine follow up in secondary care, but enabling prompt, easy access to secondary care for those in relapse/transitioning to clusters 13, 14, 15.
- Development of nursing clinics for psychosocial intervention in clusters 7, 11 and 12, when secondary care input is still required.
- Community re-provision for some long term users of residential inpatient care, but maintaining some provision in this area.
- Change in threshold for transition from acute inpatient care to residential rehabilitation wards, to enable acute bed reduction and enable those requiring a longer period of inpatient care to receive it in a therapeutically appropriate environment.
- Development of crisis house to support acute in-patient bed reduction.
- Development of enhanced community crisis and home treatment service as an alternative to inpatient care, to enable the reduction of inpatient bed numbers

National Tariff Cluster Pathways



The strategic outcomes expected from the implementation of the clinical strategy are:

- Improved clinical outcomes as evidenced by greater cluster transition probabilities.
- Improved access to effective interventions
- Better service user experience of working in partnership with services to achieve personal goals
- Reduced need for inpatient care

Over the last two years the directorate has developed a range of specialist evidence based treatments which have been delivered in community mental health teams, in specialist clinics, nurse led clinics, seeing individuals and groups for;

- Distress tolerance
- Specialist Depression Treatment
- Specialist Bipolar Disorder Treatment
- Dialectic Behavioral Therapy
- Cognitive Behavioral Therapy
- Mindfulness
- Interpersonal Therapy
- Recovery focused groups

## OTHER PROFESSIONAL INTERVENTIONS

### **Occupational Therapy provision**

Occupational therapy is a profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying their environment to better support participation.

The aims and philosophy of occupational therapy (OT) are:

- To maximise occupational participation.
- To assess and treat individuals, using purposeful and meaningful activities to maximise their level of function and independence in everyday life.
- To assess and treat individuals to enable occupational participation, performance and skills in the areas of self-care, domestic tasks, work/education & leisure.
- To endeavor to utilise service user's strengths and values when working towards a joint treatment plan
- Motivation, confidence, interests, roles, routines, communication skills, problem-solving, motor skills, social and physical environment are the main parts of OT assessments.

OT is highly valued across the directorate and is reflected in the numbers of referrals. Referrals to OT have increased since the introduction of social care self-directed support packages have been introduced as clients require functional assessments of need.



## **Psychology provision**

The role of the Psychologist may be broken down into five key areas:

- Direct clinical work
- Indirect clinical work / working with the whole team
- Research and evaluation
- Training and supervision
- Organisational

## **PROPOSALS FOR SERVICE CHANGE**

### **WHAT WILL THE SERVICE CHANGE DELIVER**

The scale of the transformational change programme in adult mental health with the closure of a number of in-patient admission beds and the development of an enhanced crisis resolution and home treatment services has the potential for high levels of risk. The review and development of the non-crisis related community services aims to mitigate potential risks within this service change through ensuring community services remain robust and of benefit. In addition to this objective, these proposals will have the following benefits:

- Improve accessibility to the services from the point of referral
- Improve timeliness of assessment to treatment waiting
- Minimise transitions between different services for the service user
- Simplify structures for referrers and service users to minimise confusion and improve clarity of roles and options
- Offer more fully multidisciplinary services
- Reduce team size improving cohesiveness consistency and cross service relationships
- Improve discharge pathways to primary care and the ability to re-enter services should this be necessary

### **OPTION APPRAISAL**

An option appraisal for configuration of exiting community teams has been undertaken seeking the views of teams across Nottingham city, county south and county north areas.

#### **Evidence for Change:**

There is strong evidence base regarding EIP although there is currently debate regarding the delivery of this from a specialised team versus a pathway model, e.g. FACT. Reviews of other city based services external to Nottingham have shown that when specialised EIP services are not available there can be an impact on early recognition and diagnosis of psychosis. The guiding principles of EIP – prompt assessment and treatment, intensive support when required, services which relate to age and interests, access to psychology, support to undertake education and employment, embodying hope for the future, invest now to save later – apply to all patient groups and therefore should be embedded in all teams.

Michael West et al (2012) researched what makes a good team work and concluded that the following principles make a good and effective team:

- Clear goals for the team
- Clear leadership
- Clarity of roles within the team
- Appropriately trained staff with positive values and attitudes
- Time for reflection
- Effective team meetings, including development time
- Medical staff embedded in the team as part of clinical leadership
- Good relationships with other teams

These principles align with the principles of Early Intervention in Psychosis and if applied to all teams would assist teams to be more effective.

Following a review by the Directorate management teams three options are being considered as follows:

#### **Model One: Locality based Generic Community Mental Health Team Model**

- **City:** Locality Based Mental Health Team (incorporating the specialty functions of EIP, AO, City Recovery and CRT pathways) provided by 4 teams across the City offering services on a geographical basis. Separate assessment service maintained
- **County South:** Service for CRT and EIP to be separated from the existing City services and repatriated to local management structures, creating 3 locality based MHT for county south (incorporating EIP, AO, CRT and CMHT) covering Broxtowe and Hucknall, Gedling, and Rushcliffe
- **County North:** 3 Locality based MHT for County North (incorporating EIP, AO, CRT if in existence, and CMHT) covering Mansfield and Ashfield, Bassetlaw, and Newark and Sherwood. (Newark and Sherwood incorporating CRHT also as FACT Model)

#### **Model Two: Enhanced Community Rehabilitation Team/Early Intervention in Psychosis model with generic Community Mental Health Teams**

- **City:** CRT AND EIP to merge, providing a focused service for first onset psychosis and those within cluster 13. Age barrier for referral to service removed (EIP age limit currently 35) and time limit for involvement with service increased (current time limit for involvement with EIP 3 years) 3 teams covering the City offering the service to specified localities. In addition 3 locality based MHT (including AO and City Recovery) for other cluster groups. Separate assessment service maintained
- **County South:** CRT and EIP to merge, providing a focused service for first onset psychosis and those within cluster 13. Age barrier for referral to service removed

- (EIP age limit currently 35) and time limit for involvement with service increased (current time limit for involvement with EIP 3 years). One service for county south. In addition 3 locality based MHT (including AO and CMHT) for other cluster groups. 1 in Broxtowe and Hucknall, 1 in Gedling, and 1 in Rushcliffe. Assessments will be undertaken by the mental health teams
- **County North:** CRT and EIP to merge, providing a focused service for first onset psychosis and those within cluster 13 Age barrier for referral to service removed (EIP age limit currently 35) and time limit for involvement with service increased (current time limit for involvement with EIP 3 years). One service covering Mansfield, Ashfield and Bassetlaw. Newark to remain separate as current FACT model only just in place and funded. In addition separate locality based community MHT for Mansfield and Ashfield, and Bassetlaw. Newark to retain FACT service. Assessments will be undertaken by the mental health teams. Assessments will be undertaken by the mental health teams

### Model Three: Cluster Pathways Model

- Pathways based services split along psychosis/ non-psychosis cluster pathways
- **City:** Split between psychosis and non-psychosis by identified cluster. Retain separate assessment Service. The team structure would incorporate AO, CRT, EIP and Recovery. Staffing for each team dependent on needs identified and cluster distribution staffing model to allow staff to be based in teams in which skills and experience could be best utilized
- **County South:** Pathways based services, split between psychosis and non-psychosis by identified cluster. The team structure would incorporate AO, CRT, EIP and CMHT. Staffing for each team dependent on needs identified and cluster distribution. Staffing model to allow staff to be based in teams in which skills and experience could be best utilised. Continued locality based services for Rushcliffe, Gedling, and Broxtowe and Hucknall.
- **County North:** Pathways based services. Split between psychosis and non-psychosis by identified cluster. Referrals would be via SPA Services incorporated into this model would be AO, EIP, CMHT, and Group services. Staffing for each team would be dependent on needs identified and cluster distribution staffing model to allow staff to be based in teams in which skills and experience could be best utilized. Continued locality based services. Services to continue to be locality facing in Bassetlaw and Mansfield and Ashfield. No change to Newark services

### NEXT STEPS

The next steps arising from this proposal are as follows:

#### Engagement of Stakeholders



The Directorate will be co-ordinating a range of engagement events with stakeholders across the geographical areas of Nottingham City, Nottinghamshire South County and Nottinghamshire North County to seek views on the current provision and possible re-design of community mental health services to secondary care clients.

- Service user and carers - using existing service user and carer groups and meetings and undertaking focus groups.
- Public engagement events.
- Engagement of protected characteristic groups and other groups who have not traditionally engaged in consultation processes.
- Statutory Partner agencies, such as social care, the police, primary care.
- Non statutory partner agencies
- Staff groups within Adult Mental Health
- Key staff groups within the trust

## RECOMMENDATIONS

The Committee is asked to support the following recommendations:

- A programme of engagement events with service users and other stakeholders in relation to a review of existing community services provided by Nottinghamshire Healthcare NHS Foundation Trust Adult Mental Health services.
- The re-design of community mental health services across Nottingham City and Nottinghamshire County South and County North areas.

Adult Mental Health Directorate  
May 2015

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## LOCAL SERVICES DIVISION

### ADULT MENTAL HEALTH DIRECTORATE

# PROPOSAL TO ESTABLISH AND DEVELOP COMMUNITY REHABILITATION SERVICES IN MANSFIELD AND ASHFIELD AND CITY AND COUNTY SOUTH TO ENABLE THE CLOSURE OF RESIDENTIAL BEDS AT HEATHER CLOSE IN MANSFIELD AND BROOMHILL HOUSE IN GEDLING

## 1 EXECUTIVE SUMMARY

This paper is the second in a series detailing the proposals for the component parts of the Adult Mental Health (AMH) Directorate's Transformation Programme for 2015/16. It builds on changes already consulted on and delivered across the city and county.

A key element of the AMH Directorate's Clinical Strategy is to "reduce inpatient bed provision through improved community services, a focus on early intervention across the diagnostic spectrum, and specialisation within community rehabilitation. This is in line with the programme of rehabilitation re-provision that has been delivered over the last 4 years.

The Clinical Strategy has been reflected in developing the Transformation Programme for 2015/16, which includes:

- The closure of inpatient rehabilitation beds at Heather Close, Mansfield in October 2015
- The establishment of a Community Rehabilitation Scheme for Mansfield and Ashfield in September 2015
- The Closure of inpatient rehabilitation beds at Broomhill House in Gedling in October 2015
- The continued development of the Community rehabilitation team already established in the City and county south
- Continued provision of Open inpatient Rehabilitation at 145 Thorneywood Mount
- Continued Provision of Locked Inpatient rehabilitation at Bracken House

***This paper details proposals for how this Transformation Programme can be achieved during 2015/16.***

- The potential financial implication of this proposal should it be approved, would be***
- ***Reinvestment in the Mansfield and Ashfield Community Rehabilitation Team of £218,807 in 2015/16 and £437,615 recurrently from 2016/2017***
  - ***Potential savings of £286,452 in 2015/16, with potential recurrent savings of £286,452 from 2016/17 relating to the reduction of beds at Heather Close***

- **All clients from the city and county south currently resident at Broomhill House with ongoing rehabilitation needs will be supported by the existing Community Rehabilitation Team, with additional investment of £80,000**
- **Potential savings of £416,761 in 2015/2016 with potential recurrent savings of £416,761 from 2016/2017 relating to the reduction of beds at Broomhill House**

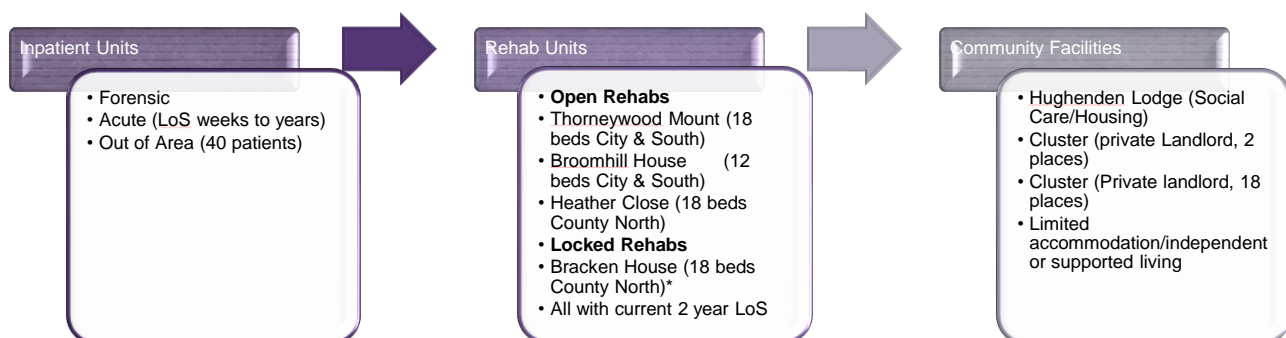
## 2 CONTEXT FOR SERVICE CHANGE

The key reasons for developing community rehabilitation services across Adult Mental Health Services in Mansfield and Ashfield and City and County South are:

- To implement the recommendations of the Mental Health Utilisation Review which in summary propose the redesign of service models changing focus for rehabilitation provision from in-patient to community, are a shared focus of both commissioner and provider
- To contribute to the overall development of the redesigned care pathway for community mental health services.
- To improve recovery outcomes for service users and carers who have long term and complex rehabilitation needs.
- To ensure the most effective use of available resources
- To ensure clear pathways of care across inpatient acute, rehabilitation and community services.

## 3 CURRENT COMMUNITY SERVICES CONFIGURATION

The diagram below shows the existing service model of referral to in-patient rehabilitation for city of Nottingham and North and South Nottinghamshire and highlights the current in-patient rehab provision across Nottinghamshire:



Over the last 3-5 years a significant number of changes have been made to services as a result of health and social care strategic drivers, policy and economic requirements. Nottingham City and County areas have retained National Service Framework-created services such as Early Intervention in Psychosis, Assertive Outreach, Crisis Resolution and

Home Treatment and Community Mental Health Teams, but these are operating in different models across the county reflecting the needs of the local population and are subject to review through the community services redesign process during 2015-16.

Within the Mansfield and Ashfield CCG area, there is currently no specific community based rehabilitation service provided by the Trust. Historically there has been recognised inappropriate use of beds highlighted by the Mental Health Utilisation Review including service users who have experienced hospital as their home for many years and Service users whose needs could be better met in the community setting should an appropriate service exist .

In the Newark and Sherwood area, a similarly modelled Community Rehabilitation Service was established in August 2014. Evidence shows that there has been a significant increase in the number of people that have accessed this service (from 24 service users to 81 referrals since the 01/08/2014). The team attends the inpatient acute ward and facilitates the identification of service users who would benefit from rehabilitation, providing in reach and accompanied leave home to support early discharge. The team can visit numerous times per week if required. In the first 9 months since the close of the inpatient rehabilitation unit, on average one inpatient bed has been used by a Newark and Sherwood resident for rehabilitation. All other needs have been met by the community rehabilitation team. There have been only 2 readmissions to acute inpatient care of any service user taken on by the Newark and Sherwood Community Rehabilitation Team.

This successful model is proposed to be used as a template for Community Rehabilitation developments in Mansfield & Ashfield.

Within Nottingham City and County South CCG's area a successful community rehabilitation team has been established since December 2014. The development of this service has allowed the successful closure of rehabilitation beds at Dovecote Lane and Macmillan close rehabilitation units. The development of the Community Rehabilitation Team has offered an community rehabilitation service which has allowed the delivery of intensive rehabilitation to a far expanded client group in a community setting improving outcomes for a number of service user for whom inpatient rehabilitation was not an appropriate option.

All previous residents of Dovecote Lane and Macmillan close are appropriately placed in other supported and independent living options and some of these service users are in the process of being discharged back to primary care, a significant achievement for those who have accessed secondary care provision for much of their adult lives.

## 4 CURRENT SERVICE PROVISION AT HEATHER CLOSE AND BROOMHILL HOUSE

### Heather Close

Heather Close is one of 2 rehabilitation units covering North Nottinghamshire. It is an 18-bedded open rehabilitation unit situated on the Mansfield Community Hospital Site, close to Mansfield Town Centre. It provides in-patient rehabilitation to service users 18 to 65 years from across Nottinghamshire.

Heather Close currently has an inpatient population of 17 clients, 12 male and 5 female. 4 service users are currently detained on a section of the mental health act, but all are improving and these will not be in place in the medium to long term.

Many of the current service users are from the Mansfield & Ashfield area; ***one of the significant benefits of this proposal for the Mansfield and Ashfield population is that a locally based Community Rehabilitation Team will be created which will provide a focused service for the population, offering them an alternative to inpatient care which is not currently available.***

Referrals to Heather close include service users stepping down from acute wards, out of area repatriation of service users, transfers from medium and low secure environments, and referrals from community and other residential services.

Heather close accepts service users who are detained under the Mental Health Act as well as those under Home Office restrictions.

Occupancy rates for Heather close for 14/15 were 84.8 %. However, this has included some service users whose needs are continuing care in nature who are about to be rehoused. The clinically appropriate relocation of service users will reduce occupancy levels even further in the coming months.

The unit is staffed on a 24 hours, 7-day per week basis by qualified nurses and healthcare assistants.

The service provides intensive rehabilitation on a strengths based model providing the following:

- Assessment and delivery of mental health care and treatment including risk assessment and management
- Education and development of daily living skills and personal functioning,
- Management of mental health symptoms and treatment
- Assessment and management of physical health
- Medication management
- Social and community engagement, employment, education

The Medical cover at Heather Close currently includes one session of Consultant time plus an extra session of Senior Psychiatric Registrar when available to the rota.

### **Broomhill House**

Broomhill House is one of two Rehabilitation units serving the City and South County of Nottingham/shire. It is situated in the Borough of Gedling Nottinghamshire, it provides inpatient rehabilitation to service users 18 to 65 years old from across Nottinghamshire.

Broomhill House currently has an inpatient population of 11 service users, 6 female and 5 male. 8 service users are currently detained under the mental health act, all are improving and many of these will not be in place in the short to medium term future.

Almost all of the current service users are from the City of Nottingham or from the South of the county allowing the smooth transition of care to the already established and successful community rehabilitation team covering these areas.

Referrals to Broomhill House include service users stepping down from acute wards, out of area repatriation of service users, transfers from medium and low secure environments, and referrals from community and other residential services.

Broomhill House also offers an outreach service for previous users of the service a role which it is envisaged the Community Rehabilitation team will continue to facilitate.

Broomhill House accepts service users who are detained under the Mental Health Act as well as those under Home Office restrictions.

Occupancy rates for Broomhill House for 14/15 were 92.0%. However, this has included some service users whose needs are continuing care in nature who are about to be rehoused. The clinically appropriate relocation of service users will reduce occupancy levels even further in the coming months.

The unit is staffed on a 24 hours, 7-day per week basis by qualified nurses and healthcare assistants.

The service provides intensive rehabilitation on a strengths based model providing the following:

- Assessment and delivery of mental health care and treatment including risk assessment and management
- Education and development of daily living skills and personal functioning,
- Management of mental health symptoms and treatment
- Assessment and management of physical health
- Medication management
- Social and community engagement, employment, education
- An outreach service to service users previously resident at Broomhill house

The Medical cover at Broomhill House currently includes one session of Consultant time plus an extra session of Senior Psychiatric Registrar when available to the rota.

#### 4.1 CURRENT FINANCIAL MODEL FOR HEATHER CLOSE

Heather Close has the following staffing structure operating on a 7 day / 24 hours staffing rota. The table shows the direct costs associated with the current service provision.

	Posts (wte)	Total cost (£)
<b>Staffing Costs</b>	25.56	835,000
<b>Drugs</b>		21,149
<b>Other Non-Pay Costs</b>		154,101
<b>TOTAL</b>	<b>25.56</b>	<b>1,010,250</b>

#### 4.2 CURENT FINANCIAL MODEL FOR BROOMHILL HOUSE

Broomhill House has the following staffing structure operating on a 7 day / 24 hours staffing rota. The table shows the direct costs associated with the current service provision.

	Posts (wte)	Total cost (£)
Staffing Costs	21.21	689,232
Drugs		32,984
Other Non-Pay Costs		111,305
<b>TOTAL</b>	<b>21.21</b>	<b>833,522</b>

## 5 PROPOSAL TO DEVELOP COMMUNITY REHABILITATION SERVICES IN MANSFIELD AND ASHFIELD

### 5.1 NEW COMMUNITY REHABILITATION SERVICE MODEL FOR MANSFIELD AND ASHFIELD

It is proposed that the number of inpatient rehab beds should reduce through the closure of Heather Close inpatient rehabilitation unit – 18 beds.

***It is recommended this unit is replaced by the development of community rehabilitation and recovery services across Mansfield and Ashfield, to work alongside the existing Community mental health services and the acute care pathway.***

Following the recommendations of the Mental Health Utilisation Review, which focuses on moving from inpatient provision to community provision for rehabilitation, different models for Community Rehabilitation have been developed according to local need, but all retain the same key characteristics:

- To enable service users to live meaningful lives they wish to by introducing access to roles, relationships, facilities and opportunities for all.
- To enhance the existing Community services pathways.
- Create new pathways of care for in-patient mental health recovery and rehabilitation services as part of a local pathway of health and social care mental health services for people with long term mental illness and complex needs living in Mansfield and Ashfield.
- Provide a flexibility which improves the Service User and carer experience by offering earlier medical and nursing interventions in the community to people when they require it, for the period of time that is needed. This would reduce admissions and length of stay and outpatient clinic numbers.
- To provide full Multi-Disciplinary Teams overview and intervention including OT and Psychology provision
- Develop and implement care pathways in line with PbR mental health clusters.
- Develop specific interventions in line with PbR cluster pathways such as nurse prescribing clinics and nurse led recovery clinics.
- Develop services to deliver interventions including family interventions in line with NICE guidelines
- Improve staff satisfaction levels by focusing on what they should be providing, so improving the quality of the interventions.



- Create a sustainable service within the resources available that links clearly with key partners including social care.
- To improve recovery outcomes for service users and carers
- To ensure the most effective use of available resources; accounting for the Trust needing to deliver services with a year on year tariff deflator of 1.8%, re-provision in the community is how this would inevitably be achieved.

## 5.2 OPERATIONAL MODEL

The community rehabilitation team (CRT) would aim to provide a comprehensive, multi-disciplinary flexible recovery focused and client-centred service for people and their families experiencing serious and enduring mental health problems that require a period of rehabilitation.

The multi-disciplinary team would deliver intensive time-limited rehabilitation support for people with severe and enduring mental health problems in a community setting. All staff would have a shared responsibility for the care of all service users and service users would be viewed as active participants in the implementation of their care package.

***The proposed new service has been designed to be closely aligned to the existing Community mental health services, including the already established community rehabilitation teams in other geographical areas. The aim is for the new Community Rehabilitation Team service to work predominantly with those in clusters 12-13. It will also be providing focused in-reach to all acute inpatients whatever their cluster. The Community Rehabilitation Team will also become involved with those in cluster 10 and 14 working alongside the Crisis Resolution Home Treatment and Early Intervention Teams to maintain these service users at times of increased need in the least restrictive environment possible thus minimising risks of acute admission. In order for this team to effectively achieve these objectives, we suggest that the CRT should stand as a separate service to the other community mental health teams with management and operational structures that focus strongly on promoting and supporting recovery in this wide-ranging group.***

## 5.3 CRITERIA FOR ENTRY AND EXIT

- The service would be for people who fit the criteria for intensive community rehabilitation which will mainly be people in the psychotic care clusters 12 & 13 as per the care pathways. Though all service users identified with complex rehabilitation need will be considered. This Mirrors the successful model in the Newark and Sherwood area
- Expected duration of treatment/intervention would be a maximum of 2 years with the aim to try to move people through the system within 12-18 months.
- Community rehabilitation would be considered as an alternative to an inpatient rehabilitation admission.
- Exit from the service following a successful period of rehabilitation moving towards discharge to primary care or if assessed as requiring social care support discharged to social care or into other community mental health services

## 5.4 REFERRAL PROCESS

Referrals would be taken from;

- The other community mental health teams
- Inpatient acute admission wards.
- Inpatient rehabilitation units

## 5.5 DISCHARGE PROCESS

Discharge planning would start from entry into the community team through the development of an agreed plan with the service user.

Discharges from the CRT could be to:

- Other appropriate community mental health teams, if a longer period of intervention with secondary mental health services is required
- Social care
- Primary Care/GP
- Specialist inpatient services if the service user has a higher level of need.

## 5.6 FOCUS OF CARE/INTERVENTIONS

The care pathway for Community Rehabilitation would focus on service users being active participants in their care, involved in developing a recovery focused plan of care aiming towards discharge from the service.

Service users would be supported to engage in recovery-focused interventions:

- practical assessment of activities of daily living and tenancy support needs,
- family education and interventions,
- psycho-social education and training
- symptom management and treatment
- medication education and management
- developing wellness recovery plans with peer support workers
- community engagement
- Assessment of occupational functioning, for employment, education or volunteering opportunities.

## 5.7 REMIT OF SERVICE

The proposed service would provide in-reach to inpatient acute admission wards for early identification of service users appropriate for a community rehabilitation pathway to support effective and timely discharge and pathways through inpatient services.

The service would provide in-reach to the inpatient rehabilitation units in Nottinghamshire, including locked rehabilitation to ensure discharge packages are proactive and a continuity of therapeutic relationship is provided, promoting timely discharge and transition through services.

Service users would have, if required, an OT assessment identifying social functioning, availability and opportunity for occupational, education, employment and or volunteering opportunities as an integral part of service delivery.

The Mansfield and Ashfield CRT would act as the direct interface with social care and housing, building relationships with partner organisations and developing local packages of care. Service users would be referred for social care self-directed support assessment, to identify additional social care support needs, such as tenancy support in advance of discharge.

The service would offer an alternative to an inpatient rehabilitation admission via a community rehabilitation package with the emphasis on maintaining people in the community as a first priority.

The service would liaise appropriately with those clients in Out of Area placements to support effective and appropriate return to Nottinghamshire services as and when appropriate as part of their care pathway.

## 5.8 STAFFING MODEL FOR THE PROPOSED MANSFIELD AND ASHFIELD COMMUNITY REHABILITATION TEAM

The proposed Staffing Model for the Mansfield and Ashfield Community Rehabilitation Team is based on a Monday to Friday service, operating from 9am until 6pm with no enhancements:

	Posts (wte)	Total Cost (£)
<b>Total - Pay (Clinical)</b>	10.4	£364,588
<b>Total - Non Pay</b>		£48,027
<b>Total - Drugs Expenditure</b>		£25,000
<b>TOTAL</b>	<b>10.80</b>	<b>£437,615</b>

The following table shows the staffing profile for the new service in comparison to the staffing for Heather Close. Of particular importance is the move to create a more multi-disciplinary approach to community rehabilitation involving psychology and occupational therapy.

	Existing – Heather Close	Proposed – Mansfield & Ashfield CRT
<b>Medical Staffing</b>	0.2	0.2
<b>Clinical Psychologist</b>	0	0.40
<b>Occupational Therapy</b>	0.7	1.00
<b>Team Leader</b>	1.00	1.00
<b>Nursing (qualified)</b>	10.86	5.00
<b>Healthcare Assistants</b>	14.0	3.00
<b>TOTAL</b>	<b>25.56</b>	<b>10.40</b>

## 5.9 RATIONALE FOR THIS SERVICE CHANGE

There are a number of important drivers that form a part of the rationale for this proposed service change

### 5.9.1 ACTIVITY MODELLING:

The implication on activity for the CRT would be as follows:

Service	Current Activity	Proposed Activity
Heather Close inpatient rehabilitation	6570 occupied bed days	0
Mansfield and Ashfield Community mental health services	26,576	26,576
Mansfield and Ashfield Community Rehabilitation Team	0	7728

There are currently 144 Mansfield and Ashfield patients in Clusters 12 and 13 who are recorded on the RIO system:

- 9 of these are current inpatients
- 28 in medical outpatients and
- 109 are being managed by Community mental health services.

The AMH referrals report has identified an overall increase in referrals to community teams in the Mansfield and Ashfield area in the last 6 months of 5%. Both the early intervention in psychosis (106%) and the assertive outreach team (120%) are currently exceeding caseload targets. Several new supported living options have recently opened or are due to open in the Mansfield and Ashfield area in the near future, all of which will potentially increase referral rates into the secondary care mental health services.

Two key commissioning documents, The Joint Commissioning Panel for MH-guidance for rehabilitation services, 2013 and Royal College of Psychiatrists –complex psychosis services, the role of community mental health rehabilitation teams, 2012 suggest the need for a community rehabilitation service that is distinct from a more general Adult Mental Health service. The latter interestingly identifies the group of service users who are often held in outpatients as they engage with services and are not presenting with immediate risks but have high levels of need which negatively impacts on their lives. It suggests that this group would benefit from active rehabilitation to improve recovery and quality of life. Therefore, with the staffing levels for care coordinators identified in this paper for the Mansfield and Ashfield CRT, this would support the management of caseloads for clusters 12 and 13. The caseload levels would be similar to those put in place at the closure of Macmillan Close (i.e. approx. 15 per care coordinator).

### 5.9.2 GEOGRAPHICAL MAKE-UP OF THE CURRENT INPATIENT POPULATION

The geographical make-up of the service users who are currently inpatients at Heather Close is shown in the following table

Original Locality	Number of service users
Newark & Sherwood	1
Mansfield & Ashfield	9
Bassetlaw	4
Notts City	2
Nottinghamshire County South	1

This relates to the original home location of the patient. Once they have registered with a local GP, some of these patients will now show on RIO as being from Mansfield and Ashfield as opposed to their original place of residence.

### 5.9.3 POTENTIAL FUTURE ACCOMMODATION/PLACEMENT FOR THE EXISTING INPATIENT POPULATION AT HEATHER CLOSE

An analysis has been undertaken of current plans for the future accommodation or placement of current residents at Heather Close in relation to the potential closure in October 2015. This shows that;

- 5 have supported living placements identified and dates set for discharge in or prior to September 2015
- 3 will require supported living placements, all have had completed community care assessments and Health and social care colleagues are actively involved in allocated placements. All have discharge dates set for September 2015
- 5 of the current residents have tenancies to return to/ or will return to live with relatives. All no longer have inpatient rehabilitation needs and their needs will be met by the newly established CRT in Mansfield and Ashfield
- 2 Will require continuing care packages, both have had community care assessments and have been clearly identified as no longer having ongoing rehabilitation needs. Placements are being sought and discharge dates have been set for September
- 2 of the current residents may require further open rehabilitation which will be facilitated by Adult mental health should this be the case. 1 of these cases relates to complex social needs and an ongoing court of protection application which may delay onward referral. The 2<sup>nd</sup> may be able to be supported in the community but this is dependent on the success of the current inpatient rehabilitation prior to October 2015

### 5.9.4 EXPERIENCES IN BASSETLAW

In 2012 a similar Community Rehabilitation Team was established in Bassetlaw. Covering a similar population, in an arguably more challenging area, the success of the CRT in Bassetlaw has produced a template that we are looking to replicated in Newark and Sherwood and are Looking to replicate in Mansfield and Ashfield.

Feedback from one service user and her family is that they have benefited by being able to vent their feelings and not feel a burden to the team. Anxiety management, relaxation techniques and behavioural family interventions were identified as most useful and the

family could not have managed without the team. This service user stated that prior to the team's involvement her husband felt overwhelmed and close to suicide but is now able to cope. Another service user has stated that it has been helpful to have regular visits at home at convenient times. He feels the team has been flexible in meeting his needs, involved in the care plan and listened to. He says help with practical tasks of daily life and help to contact friends has been the most supportive element.

The provision of a similar service model in the Mansfield and Ashfield area alongside existing community mental health services will offer a real positive alternative to service users and carers when delivering intensive rehabilitation.

### 5.9.5 PROVISION OF IN-REACH TO MILLBROOK

One of the difficulties faced by current community mental health teams is providing consistent in reach to the inpatient acute wards thus facilitating timely discharge. Under the revised model, this responsibility would be passed to the CRT, who would visit the inpatient wards at Millbrook each day, and be the primary point of coordination for those service users who are on the inpatient wards and open to secondary mental health teams. This will free up the Community teams resource, and thus provide significant benefit across the entirety of the care pathway. Close liaison will be established with RRLP and CRHT, and work undertaken to reduce acute inpatient admissions by facilitating packages of home treatment wherever possible. This will include close liaison with primary care, GP's, and Social care colleagues.

### 5.10 COMPARISON OF FINANCIAL MODELS (HEATHER CLOSE V CRT)

The comparison of the direct costs between the two

	Heather Close		CRT	
	£	wte	£	wte
<b>Staffing Costs</b>	£835,000	25.56	£364,588	10.40
<b>Drugs Expenditure</b>	21,419		£25,000	
<b>Provisions Expenditure</b>	91,138			
<b>Other Non-Pay Costs</b>	62,963		£48,027	
<b>Total Direct Costs</b>	<b>£1,010,520</b>	<b>25.56</b>	<b>£437,615</b>	<b>10.40</b>

The level of reinvestment required to achieve the proposed CRT model would be £437,615(full year effect).

## 6 PROPOSALS FOR SUPPORT OF SERVICE USERS CURRENTLY RESIDENT AT BROOMHILL HOUSE

### 6.1 CURRENT COMMUNITY REHABILITATION TEAM PROVISION AND COMMUNITY SERVICES REVIEW

The City of Nottingham and Nottinghamshire County South have a successfully developed community rehabilitation which was developed in December 2013 as an integral part of Adult Mental Health Services Rehabilitation Strategy focusing on increasing the provision of intensive rehabilitation in the community setting.

The development of this team allowed the successful reduction of inpatient rehabilitation beds at the Macmillan close and Dovecote Lane sites.

The Community Rehabilitation team for City and county South now has a caseload of 134 clients, all from Clusters 12 and 13, and is providing intensive and complex rehabilitation packages to this groups of service users whom historically often limited engagement with rehabilitation services leading to them being unable to optimize their recovery and often to admissions to inpatient care.

Alongside the successful development of the community rehabilitation team, Adult Mental health services are undertaking a wide review of Community mental health provision and are keen to focus on responsiveness, evidence based treatment and care clear and simplified pathways for service users carers and referrers, value for money and services that will stand the test of time.

Adult mental health feel confident that the current residents at Broomhill House can be effectively supported by appropriate existing community mental health services, particularly the Community Rehabilitation team, with a small re-investment of 2 additional staff members.

## 6.2 STAFFING MODEL FOR THE EXISTING CITY AND COUNTY SOUTH COMMUNITY REHABILITATION TEAM

The table below shows the multidisciplinary staffing provision for the existing Community rehabilitation team serving the population of Nottingham city and Nottinghamshire County South. It is proposed that a further £80,000 is invested into this team.

	Current City and County South CRT	Proposed Additions
<b>Medical Staffing</b>	0.2	0.2
<b>Occupational Therapy</b>	2.00	2.00
<b>Team Leader</b>	1.00	1.00
<b>Nursing (qualified)</b>	8.60	10.60
<b>Healthcare Assistants</b>	9.43	9.43
<b>TOTAL</b>	21.03	22.03

## 6.3 RATIONALE FOR SERVICE CHANGE

There are a number of important drivers that form a part of the rationale for this proposed service change.

### 6.3.1 ACTIVITY MODELLING

The implication on activity (measured in contacts) for the CRT and Other Community teams would be as follows:

Service	Current Activity	Proposed Activity
<b>Broomhill House inpatient rehabilitation</b>	4029	0



<b>Broomhill Outreach</b>	4223	0
<b>Community Rehabilitation Team</b>	8724	TBD
<b>City Community services</b>	77174	TDB
<b>County South Community Services</b>	37938	TBD

Changes to activity for existing community teams relating to the reduction in inpatient beds at Broomhill House will be determined as part of the community services review and negotiated with relevant CCG's.

There are currently 1112 City and County South patients in Clusters 12 and 13 who are recorded on the RIO system, 9 of the current residents of Broomhill House are in these clusters and would be appropriately placed with the community rehabilitation team.

Two key commissioning documents, The Joint Commissioning Panel for MH-guidance for rehabilitation services, 2013 and Royal College of Psychiatrists –complex psychosis services, the role of community mental health rehabilitation teams 2012 suggest the need for a community rehab service that is distinct from a more general Adult Mental Health service. The latter interestingly identifies the group of service users who are often held in outpatients as they engage with services and are not presenting with immediate risks but have high levels of need which negatively impacts on their lives. It suggests that this group would benefit from active rehabilitation to improve recovery and quality of life.

The development of the Community rehabilitation has had a demonstrable positive impact on the above identified client group.

### **6.3.2 GEOGRAPHICAL MAKE-UP OF THE CURRENT INPATIENT POPULATION**

The geographical make-up of the service users who are currently inpatients at Broomhill House is shown in the following table;

<b>Original Locality</b>	<b>Number of service users</b>
<b>Newark &amp; Sherwood</b>	1
<b>Mansfield &amp; Ashfield</b>	0
<b>Bassetlaw</b>	0
<b>Notts City</b>	4
<b>Nottinghamshire County South</b>	6

### **6.3.3 POTENTIAL FUTURE ACCOMMODATION/PLACEMENT FOR THE EXISTING INPATIENT POPULATION AT BROOMHILL HOUSE**

An analysis has been undertaken of current plans for the future accommodation or placement of current residents at Broomhill House in relation to the potential closure in October 2015. This shows that:

- 1 is being transferred to acute inpatient care
- 6 will return to own homes with community intervention from health and social care prior to proposed closure date
- 1 will require a supported living placement which will be facilitated prior to proposed closure date



- 3 may require transfer to other inpatient open rehabilitation settings which can be facilitated by the Adult Mental Health Directorate.

## 6.4 COMPARISON OF FINANCIAL MODELS

The reduction of inpatient beds at Broomhill House does not require significant further investment in the CRT in existence as it is proposed that services for the current residents will be provided by the existing teams with a small additional investment as indicated;

Heather Close		
	£	wte
<b>Staffing Costs</b>	£769,232	23.21
<b>Drugs Expenditure</b>	32,984	
<b>Provisions Expenditure</b>	68,547	
<b>Other Non-Pay Costs</b>	42,758	
<b>Total Direct Costs</b>	<b>£913,521</b>	<b>23.21</b>

## 7 OUTCOMES AND BENEFITS

Key outcomes arising from this proposal are as follows:

### Service User Benefits:

- The provision of support and care in the person's own home where appropriate as opposed to a more restrictive hospital environment
- Increase in ability to provide intensive intervention at home in a more responsive way to meet service user need.
- Increase family and carer support through the provision of family interventions including behavioural family interventions, psycho-education and information about treatments and services.
- Provision of further NICE based therapeutic interventions
- Access to an extended range of professional and support staff
- A more responsive and preventative approach to care.
- More positive experience for service users and carers of secondary mental health care.

### Organisational Outcomes:

- This service redesign is an important component of the implementation of the Adult Mental Health Directorate Clinical Strategy.
- The establishment of a Community Rehabilitation Team for Mansfield and Ashfield providing equitable service provision across all geographies.

### Performance & quality outcomes that would be measured include:

- Positive Service user feedback and satisfaction with services
- Positive Carer/family feedback and satisfaction with services
- Positive Service user recovery outcomes measures:
- All services users to have a recovery focused care plan, crisis and contingency plans in place
- Provision of relapse prevention support and plans
- Reduced length of stay in inpatient rehabilitation units
- Reduced re-admissions to inpatient rehabilitation

- Reduced re-admission to acute care
- Length of stay in community rehabilitation to be maximum 2 years (potential to decrease over years)
- Number of service users supported through the CRT who would have had an admission if service not available.

## 8 NEXT STEPS & RECOMMENDATION

### 8.1 NEXT STEPS

The next actions which are suggested as a consequence of this paper are:

- Engagement with staff, service users, carers and the public with regard to outlined plans for a 6 week period.
- There has been previous discussion with commissioners about the potential to establish a Crisis House facility in the North of the county along similar lines to that recently opened serving city and county south (possibly with a third sector provider). We believe this would provide an excellent support mechanism on the closure of Heather Close, providing the opportunity for locally based respite, without requiring inpatient admission. We would welcome further discussions on this topic.

### 8.2 RECOMMENDATIONS

The Committee is asked to support the Trust to engage and consult on the following plans for a 6 week period:

- The closure of inpatient rehabilitation beds at Heather Close, Mansfield and Broomhill House Gedling from October 2015.
- The establishment of a Community Rehabilitation Team in Mansfield and Ashfield from October 2015 and additional investment to the City Community Rehabilitation Team.

Adult Mental Health Directorate May 2015.

# Proposed Transitional Changes for 2015/6

## Consultation



# Adult Mental Health (AMH)

- AMH have successfully completed several service transitions over the past 4 years and have ensured that service users continue to receive a needs led service that is effective, efficient, recovery focused and person centred.
- AMH have successfully closed several inpatient areas and reinvested in community based services allowing us to offer care in the least restrictive environment possible while maintaining good access to inpatient care should this be required.



## Next Stage

- Following on from the successful reinvestment and development of crisis services in the community, AMH propose to continue to provide Mental Health Care in the least restrictive and most recovery focused way possible.
- AMH Propose the closure of 2 open rehabilitation units and a wide ranging review of all community based treatment with the intention to provide treatment and support to service users in the community wherever possible.
- These proposals are in line with National Drivers, such as the Five Year Plan, No Force First (least restrictive intervention), No Health without Mental Health, Outcomes Framework and Nice Guidance.



# Proposed changes

## **Closure of Heather Close.**

This is an 18 bedded open rehabilitation unit. AMH propose to close this unit and invest in the development of a community rehabilitation team (CRT) in the Mansfield and Ashfield area to support service users to meet their rehabilitation needs in a community setting

## **Closure of Broomhill house**

This 12 Bedded open rehabilitation unit serving the City and South county. AMH propose the closure of this unit and the continued development of the already successful community rehabilitation team serving the City and south county of Nottingham



# Proposed changes

- Review of the all community teams across AMH to identify the most effective and efficient way for service users to access the service.
- The review will incorporate feedback from service users and GP's regarding their experiences of contact with AMH and GP's for referrals.
- Service user feedback has been positive and outcomes have evidence of a significant increase in rehabilitation in the community.
- GP's have expressed concerns relating to the challenges of navigating AMH services to make appropriate referrals



# Proposal

## **The Community Review**

This will allow AMH and stakeholders to select a preferred option for change. AMH have conducted an internal option appraisal and have identified 3 possible models;

- 1. Locality based Mental Health Teams
- 2. Enhanced CRT and EIP with Generic Mental Health Teams
- 3. Super Cluster Pathway

AMH are keen to hear the views of those using the service on how to improve service provision and potential other options for future service delivery

## **Closure of Heather Close and Broomhill House Rehabilitation Units**

This proposal will allow AMH to focus on the delivery of rehabilitation in a community setting offering services in the least restrictive environment which are needs led and recovery focused.



<b>JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE</b>
<b>16 JUNE 2015</b>
<b>SOUTH NOTTINGHAMSHIRE TRANSFORMATION PARTNERSHIP</b>
<b>REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)</b>

**1. Purpose**

- 1.1 To consider the work of the South Nottinghamshire Transformation Partnership (SNTP) in reshaping the local health and social care system to ensure it can provide sustainable, high quality care for everyone.

**2. Action required**

- 2.1 The Committee is asked to:
- a) receive this report and presentation;
  - b) agree future working and reporting arrangements of the South Nottinghamshire Transformation Partnership to this Committee; and
  - c) advise on future public engagement and consultation exercises.

**3. Background information**

- 3.1 Nationally and internationally it is acknowledged that health and social care services are not meeting the needs of those using the services.
- 3.2 The South Nottinghamshire Transformation Partnership is made up of twelve partner organisations (commissioners and providers of health and social care) who are working with local citizens to improve the health and wellbeing of those who access the health and social care system. Over 3,000 local people alongside health and social care staff and other stakeholders have worked to determine the ambition of the system of care.
- 3.3 Partners agreed a five year strategy in September 2014 and work is currently underway to develop a Strategic Outline Case (SOC) which will underpin all future business cases and plans in South Nottinghamshire.
- 3.4 Separate commissioning and provider groups have been established. Whilst patients, carers and citizens have formed the Citizen's Advisory Group which will be integral to the development of the Strategy, a

Clinical Leaders Forum is working to ensure the Strategy and other decisions are clinically led, and based on evidence and best practice.

- 3.5 A Transformation Board, comprising of a senior executive lead from each partnership organisation, is chaired by a lay representative and includes citizens' involvement.
- 3.6 Each partner organisation has committed to a Partnership Compact which outlines the context for change, joint working and governance arrangements and tracking of joint success, which in turn will regularly be reported to each partner's Board or equivalent.
- 3.7 Work- streams include:
  - Services work-streams,
  - Enabling work -streams
  - Cross cutting work-streams.
- 3.8 The South Nottinghamshire Transformation Partnership has already presented to both the city and county Health and Wellbeing Boards and has been given their approval to develop accountable care systems and outcomes based commissioning.

#### **4. List of attached information**

- 4.1 The following information can be found in the appendices to this report:

**Appendix 1** – Transforming Health and Social Care in South Nottinghamshire Report

**Appendix 2** – South Nottinghamshire Transformation Partnership presentation to be submitted 2/6

#### **5. Background papers, other than published works or those disclosing exempt or confidential information**

None

#### **6. Published documents referred to in compiling this report**

None

#### **7. Wards affected**

All

**8. Contact information**

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## REPORT OF THE SOUTH NOTTINGHAMSHIRE TRANSFORMATION PARTNERSHIP TO THE JOINT HEALTH SCRUTINY COMMITTEE

### TRANSFORMING HEALTH AND SOCIAL CARE IN SOUTH NOTTINGHAMSHIRE

16<sup>th</sup> JUNE 2015

#### CONTEXT

Health and social care services need to continually develop to remain responsive in an ever changing global context. Within South Nottinghamshire the health and social care system needs to be fundamentally reshaped if it is going to continue to provide sustainable, high quality care for the local population going forward.

#### THE AMBITION

Twelve partner organisations, commissioners and providers from health and social care, have come together with local citizens in the South Nottinghamshire Transformation Partnership (SNTP). The aim of the Partnership is to improve the health and wellbeing of the people served through the development of a sustainable, high quality health and social care system for everyone.

Over 3,000 local people together with health and care staff and other key stakeholders have been engaged in determining the ambition for the system of care, with confirmation that this should be focused on:

- Care centred around the needs of individuals not institutions
- Teams working together across organisational boundaries
- Resources shifted to preventive, proactive care based closer to people's homes
- Hospitals and care homes only for people who need to be in these care settings
- High quality, accessible, sustainable services based on the real needs of the population.

A high level five year Strategy was agreed by the partner organisations in September 2014.

Work is now commencing on the development of the detailed service strategy which will take the form of a Strategic Outline Case (SOC). Patients, carers and the local population will be actively engaged in the development of this strategy. The SNTP's Citizens Advisory Group, which comprises a patient/service user from each of the partner organisations, will oversee meaningful engagement ensuring patients / services users are placed at the heart of this strategy.

#### THE SOUTH NOTTINGHAMSHIRE TRANSFORMATION PARTNERSHIP

The SNTP has an established Transformation Board comprising a senior executive lead from each partner organisation. The Board, which is chaired by a lay representative with citizen involvement, provides the overarching, strategic governing group for the work of the Partnership.

Each partner organisation has signed up to a Partnership Compact which outlines the context for change, the principles for working together, the responsibilities of the Partnership, the governance arrangements and the programme of joint work. As part of the commitment to collaborative working for a sustainable, high quality system, the Partnership is identifying the measures that it will use to track joint success. These measures will form the basis of a public commitment to action and will be presented, on a regular basis, in a common report to each partner's board or equivalent.

The Partnership Compact has also been presented to, and endorsed by, both the Nottingham City and Nottinghamshire County Health and Wellbeing Boards.

### WORK TO DATE

Work has been undertaken to understand the characteristics, and transformation journeys, of internationally renowned health and social care systems that are further ahead in securing quality and sustainable systems of care. These systems have all focused on cultural, operational (including infrastructure), financial and contractual change. Taking this into account, a number of work-streams and groups have been initiated locally.

The work-streams include:

- **Service work-streams** for example: urgent care. The service work-streams are supporting the development of the detailed service strategy and enabling service developments where early impact can be gained in securing system quality and sustainability. For example the urgent care work-stream is, in part, focusing on the bringing together of primary care clinicians with community health and social care professionals into locality based multi-disciplinary teams to provide joined up care to people with frailty and complex needs, supporting them to stay well wherever possible as well as intervening early to prevent admissions and/or enable early discharge from hospital where required.
- **Enabling work-streams** currently focused on communications and engagement, workforce, and information technology.
- **Cross cutting work-streams** currently focused on finance, system development together with governance and assurance.

A number of groups have also been established including a Citizen's Advisory Group, as confirmed above, and a Clinical Leaders Forum to ensure that service strategy and developments are clinically led, based on evidence and best practice.

Separate Provider and Commissioning Groups are also in operation. The Commissioning Group has been reviewing the current model of commissioning, including payment and contractual mechanisms, and has made a case for change for new mechanisms which best enable the service developments needed. This case for change has been signed off by both of the Chairs of the Health and Wellbeing Boards.

### NEXT STEPS

The next steps for the SNTP are to:

1. Build upon the South Notts five year Strategy by developing a Strategic Outline Case (SOC) for the future system of care. The purpose of the SOC is to:
  - Confirm the strategic context and case for change;
  - Identify and undertake an initial review of a wide range of options for the future;
  - Provide early analysis of the shortlisted options; and
  - Provide stakeholders with an early indication of the preferred way forward.

The SOC will be developed with the twelve partner organisations and will underpin all future business cases and plans in South Notts. An engagement process will be required from the outset seeking advice from the SNTP Citizen's Advisory Group about the best approach to involving the public at this stage.

2. Seek Joint Health Scrutiny Committee advice on the level and timing of engagement / consultation activities as plans are developed in more detail. A project plan will be agreed by July 2015 which will propose timescales for:
  - Completion of the SOC by the end of October 2015; and
  - Review and approval by partner Boards, or equivalent, in November / December.

The scope of the proposals is uncertain at this stage, but it would be much appreciated if the Joint Health Scrutiny Committee could receive an update on the emerging case for change and options prior to consideration by the partner boards. This would provide the opportunity to consider what level of engagement / consultation would be required at the next stage and plan for pre-consultation discussions as required.

3. Progress the implementation of early impact service developments – throughout 2015/16 and beyond.

### RECOMMENDATIONS

The Joint Health Scrutiny Committee is asked to:

- Receive this report and a presentation, with further information, at its meeting on 16th June 2015
- Advise on working and reporting arrangements as well as approach to preparing for any future public consultation.

Rebecca Larder  
Director of Transformation, South Nottinghamshire  
May 2015

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South Nottinghamshire  
Transformation Partnership

# Transforming Care in South Nottinghamshire



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*Rebecca Larder*  
*Director of Transformation*



# Context

- An unsustainable system of care
- People with frailty and complex needs:
  - 10% of urgent care service users
  - 40% of costs
  - Sub-optimal and fragmented care
  - Opportunity to improve experience and outcomes
  - Opportunity to save approximately £20 million



# Case for change



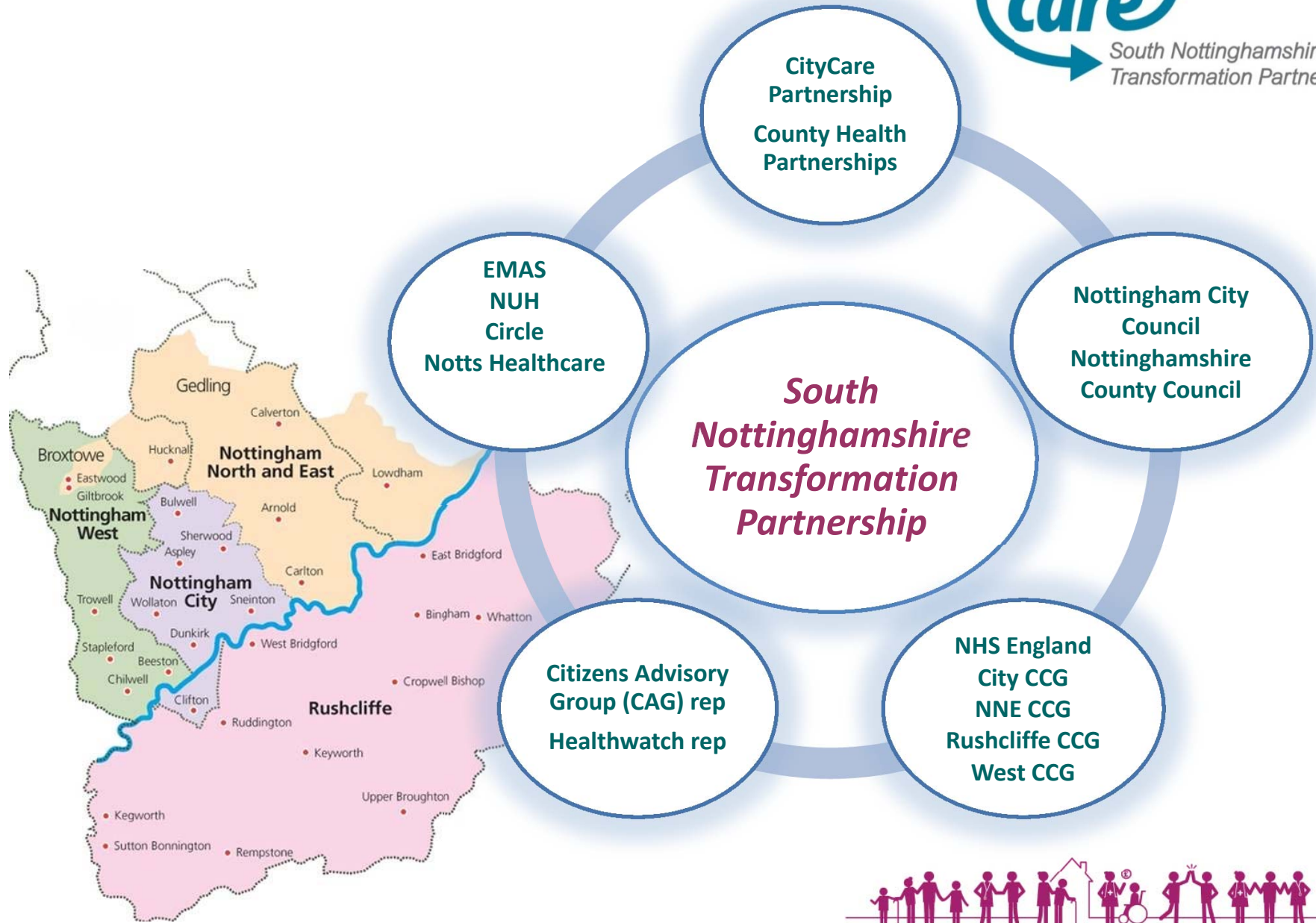
- Local people want:
  - Support to stay well and independent
  - Involvement in decisions about their care
  - More care provided closer to home
  - More joined-up services
- Demographic changes:
  - 5% increase in population by 2021
  - 11% increase in over 65s by 2021
- Advances in medicine and technology
- Economic context
  - £140 million financial gap



# South Nottinghamshire

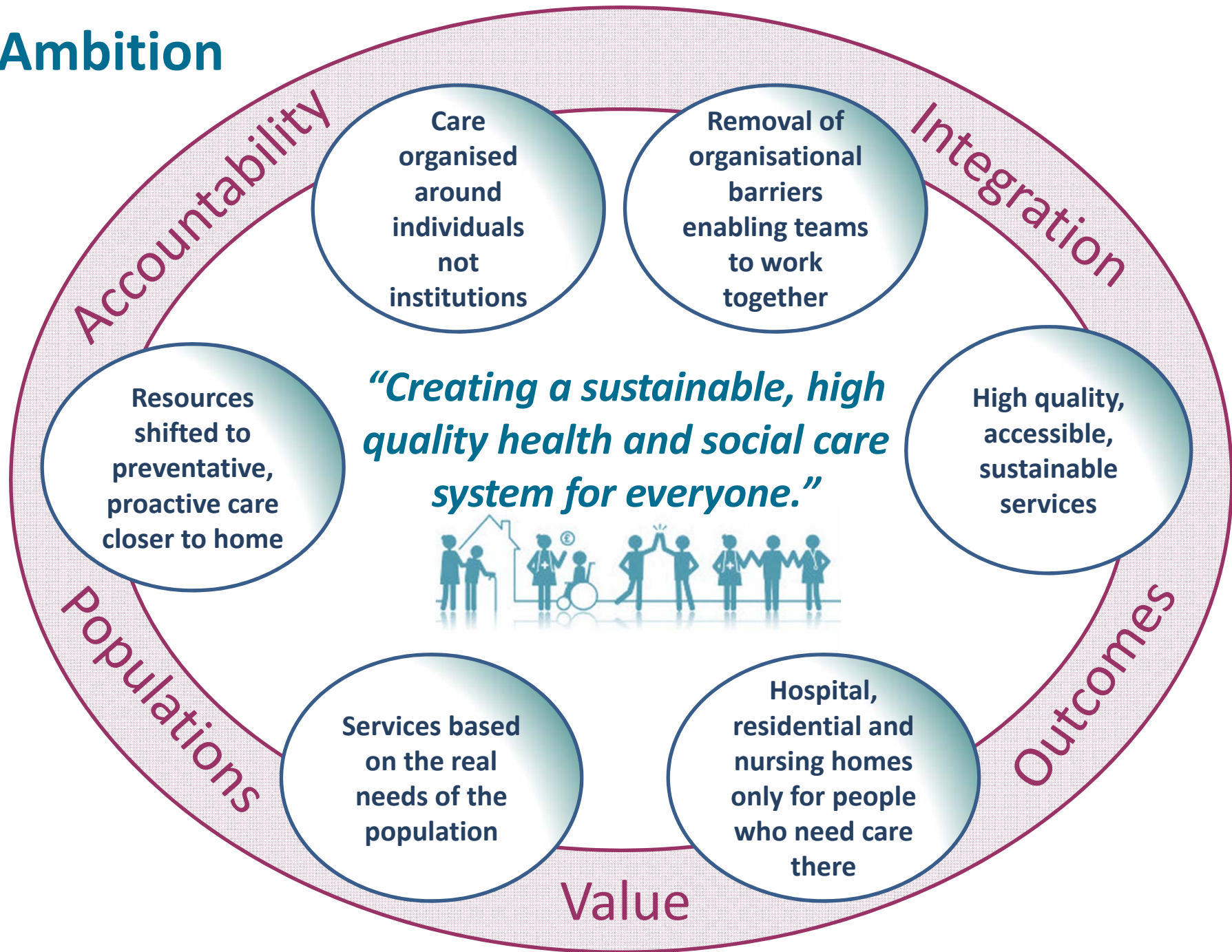


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# Ambition



# Leading edge mind-sets



**Outcomes:** From process measures and targets to improving outcomes that matter to the population

**Populations:** From institutional care (primary, secondary) to a focus on whole pathways for defined population groups

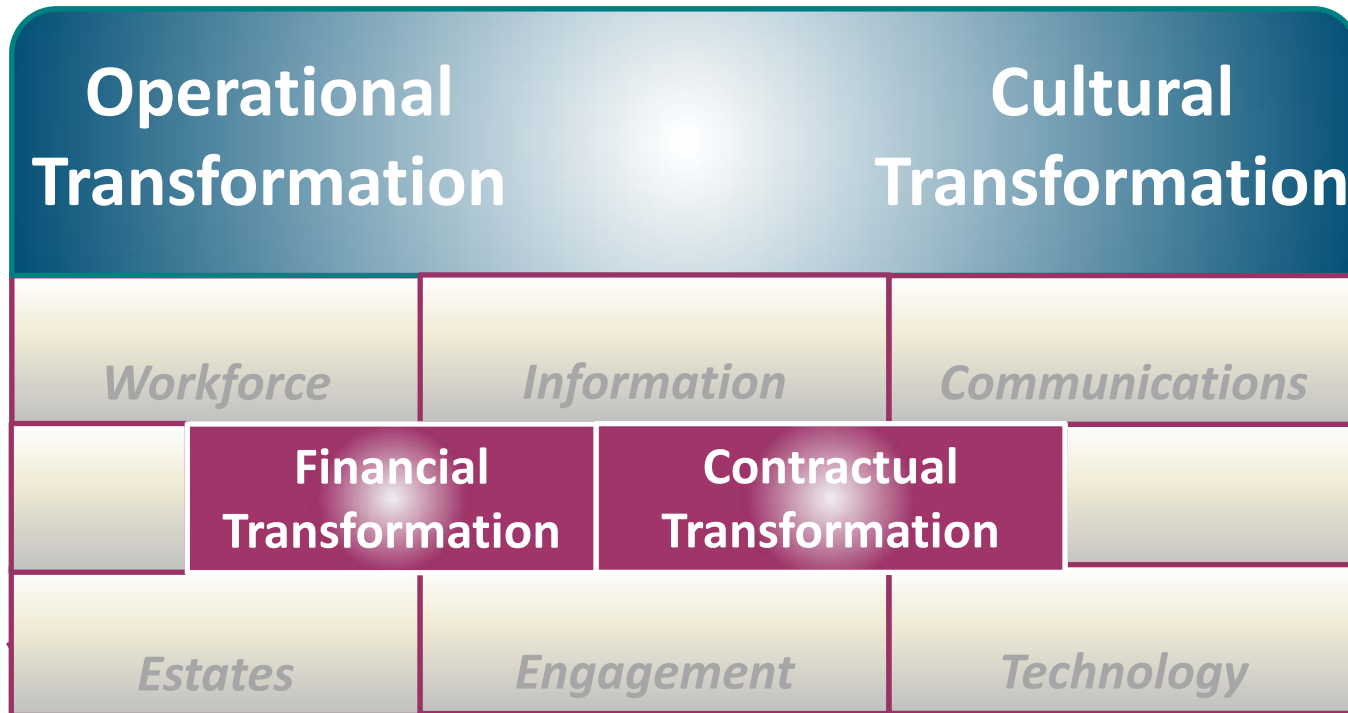
**Value:** From volume to value with a focus on prevention and proactive care

**Integration:** From fragmented care organised around professional groups and organisations to joined up services around the needs of service users

**Accountability:** To service users/citizens, to each other and to the success of the system



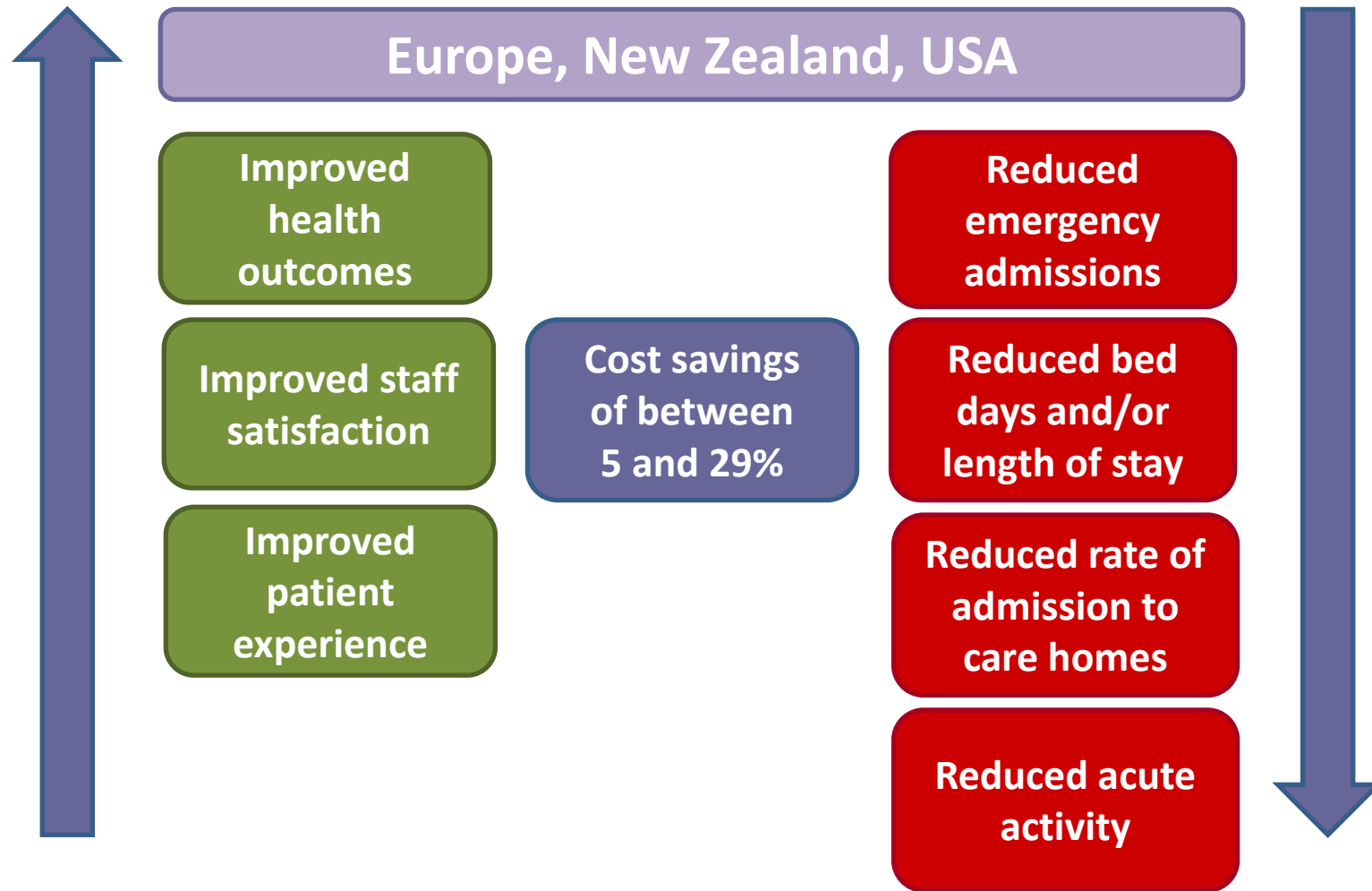
# Transformational change



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# International evidence





# Developing our plans



- Strategic outline case (SOC) for a new system of care
- Confirm case for change / strategic context
- Consider wide range of options
- Appraisal and analysis of short-listed options
- Provide an early indication of the preferred way forward subject to further engagement / consultation
- Patients, services users and carers actively engaged in developing and appraising the options
- Potential need for future consultation



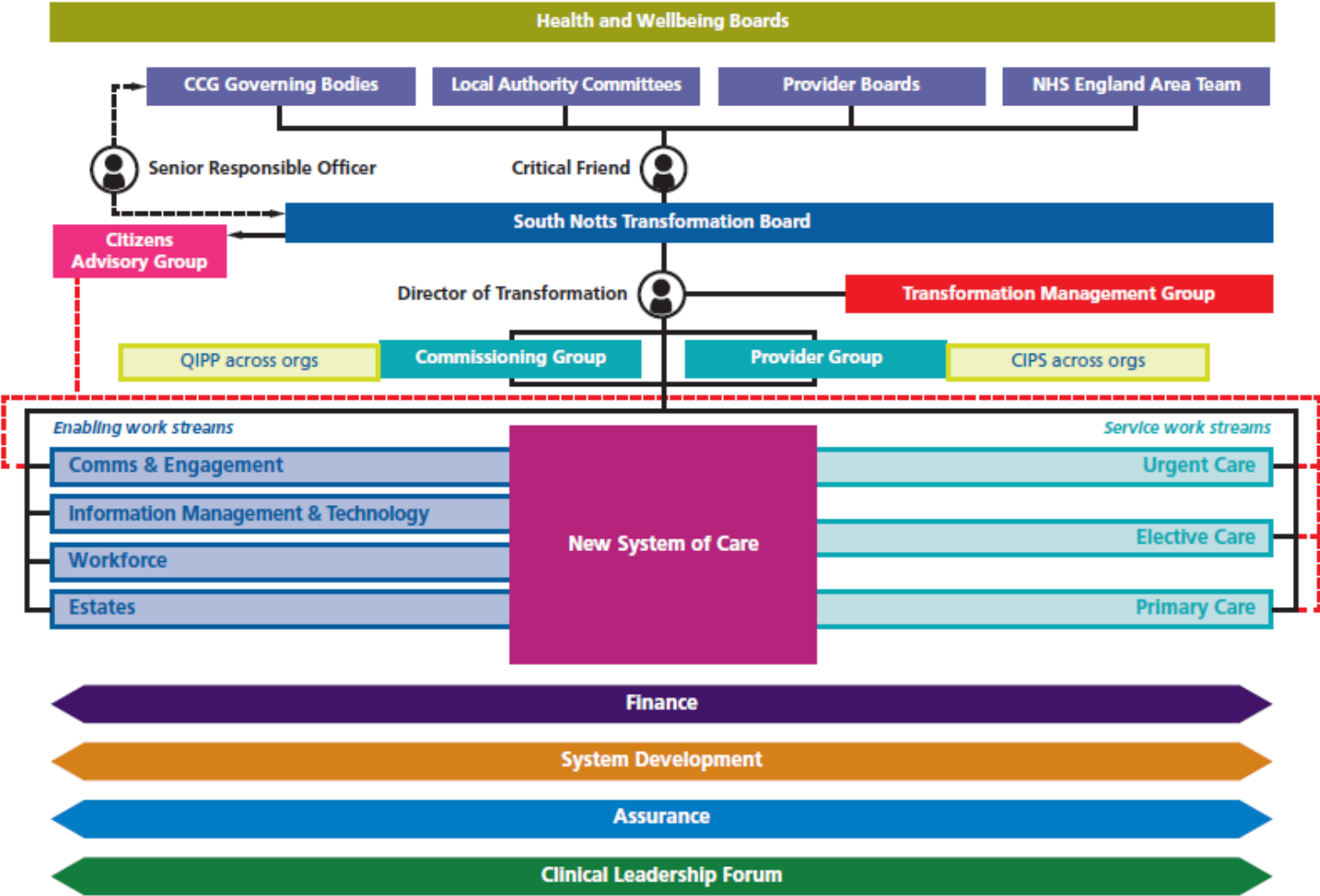
# Citizen engagement



- South Nottinghamshire Transformation Board
  - Lay Chair, citizen representative and Healthwatch
- Citizens Advisory Group
  - Citizen representative from each partner organisation and Healthwatch
- Engagement Group
  - Engagement leads from partner organisations
- Service work-streams
  - Citizen leaders



# Governance arrangements



# Today



- Share the work of the South Nottinghamshire Transformation Partnership
- Seek advice on the level and timing of engagement / consultation activities as plans are developed in more detail
- Request the opportunity to share the emerging case for change and options prior to consideration by the partner boards (or equivalent).





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16 June 2015

Agenda Item:

**REPORT OF THE VICE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH  
SCRUTINY COMMITTEE**

**NUH PHARMACY INFORMATION**

**Purpose of the Report**

1. To provide information relating to the committee's ongoing review of pharmacy delay and prescribing issues.

**Information and Advice**

2. Members will recall their longstanding concerns in relation to delays in filling outpatient prescriptions at Nottingham University Hospitals (NUH), resulting in hospital prescriptions being taken to GPs to be filled.
3. Following the results of the survey of GPs relating to prescribing issues presented to the committee in April, Dr Stephen Fowlie, NUH Medical Director will attend the committee to brief on the latest position and respond to the results of the survey.
4. In addition, Nicky Bird, Senior Prescribing Officer Mansfield and Ashfield CCG [or other appropriate officer] will attend the committee to brief on wider prescribing issues, such as cost, waste and stockpiling of medicines by patients.
5. The Joint Health Committee may wish to schedule further consideration of these issues or determine that the development of final recommendations would be appropriate.
6. RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

- 1) Receive the briefing and ask questions as necessary in relation to this substantial change
- 2) Schedule further consideration or development of final recommendations.

**Councillor Parry Tsimbiridis  
Vice Chairman of Joint City and County Health Scrutiny Committee**

**For any enquiries about this report please contact: Martin Gately – 0115 9772826**

**Background Papers**

Nil

**Electoral Division(s) and Member(s) Affected**

All



# Pharmacy Services @ NUH

**Dr Stephen Fowlie**  
**Medical Director, NUH**

**JHSC May 2015**

# Agenda

1. Prescriptions, dispensing, reimbursement
2. Waiting times: outpatients & TTOs
3. E-prescribing: coming soon
4. Medicines safety

# NHS Prescription types

1. **Community (outpatient) prescription (FP10)**
2. **Hospital prescription (cannot be dispensed by community pharmacists)**

# Prescription in OP clinics

**Prescription of drugs for outpatients is governed by agreement between NUH and commissioners**

**Area Prescribing Committee for CCGs**

**GPs carry responsibility for oversight of medicines management in their patients, secondary care role is advisory / supportive**

**Local arrangements are consonant with NHS practice**

# In clinics: treatment recommendations to the GP, who prescribes (FP10) .... unless

1. urgent (2 weeks)
2. only available from Hospital Pharmacy
3. only prescribable by hospital doctor (specialist)

# Hospital vs Community Dispensing (1)

Hospital pharmacists have easier access to

1. patient information (eg clinical notes, blood tests)
2. complete medication list (optimisation)
3. the prescribers (for response to queries/errors)

? SAFER

## Hospital vs Community Dispensing (2)

**Hospital pharmacists can more readily enforce formulary**

- 1. safer**
- 2. best value for money**

# Dispensing Value for Money (examples)

Medicine	Price per pack on FP10 (list price)	Price per pack in hospital (contract price)	Discount (%)
A	£0.99	£0.16	84
B	£4.90	£1.81	63
C	£1.29	£0.29	78
D	£30.00	£8.00	73
E	£3,100.00	£1,860.00	40



# NUH expenditure on drugs

Circa £100m per year

Value for money – procurement savings

Financial Year	2012/13	2013/14	2014/15
Medicines Savings	£4.02 m	£5.96 m	£4.81 m

# NUH Pharmacy Activity

**80% is hospital prescriptions**

**50% increase in dispensary workload in 3 years**

**now circa 50,000 transactions each MONTH**

# NUH Pharmacy Access

## 1. QMC Pharmacy 365 days

9am – midnight weekdays

10am – midnight weekends

## 2. City Pharmacy 9am – 5pm weekdays

# Waiting times for OP prescription

**Target: waiting time of < 26 minutes**

**High proportion of unlicensed, off-label, individually-manufactured, anti-cancer, high cost & highly-specialised medicines**

# Waiting times for OP prescription

Outpatient waiting time (minutes)	QMC	City Hospital
January 2015	21	25
February 2015	22	24
March 2015	22	31
April 2015	19	27

# NUH Pharmacy Stock

**Very unusual for NUH pharmacy not to have a hospital-prescribed drug for OP dispensing**

**Very unusual to suggest 'go to GP' because no NUH pharmacy stock**

**Doing further work after spring 2015 survey of GPs (and practice staff)  
'*Dealing with Hospital Outpatient Prescriptions in Primary Care*'  
[not a patient survey]**

# Pharmacy response to feedback

- 1. Improved processes: 23 mins vs 32 mins one year ago (Q1)**
- 2. Refurbished waiting areas to improve comfort & privacy (more private consultation facilities)**

# Discharge delays due to TTOs

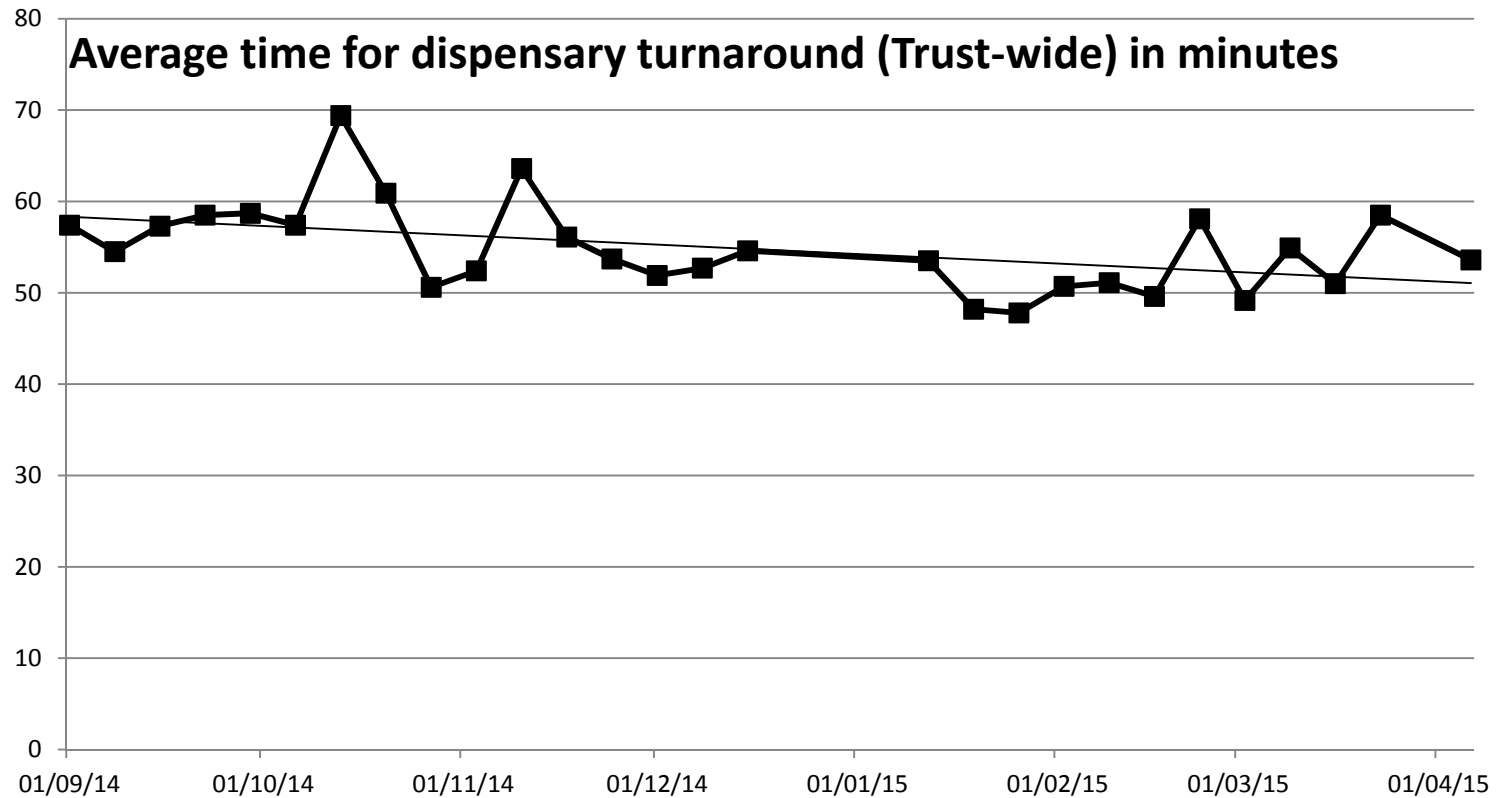
- **Concerns and complaints**
- **Slows patient flow**  
**(4 hour emergency access standard)**



# TTO Turnaround Time (1)

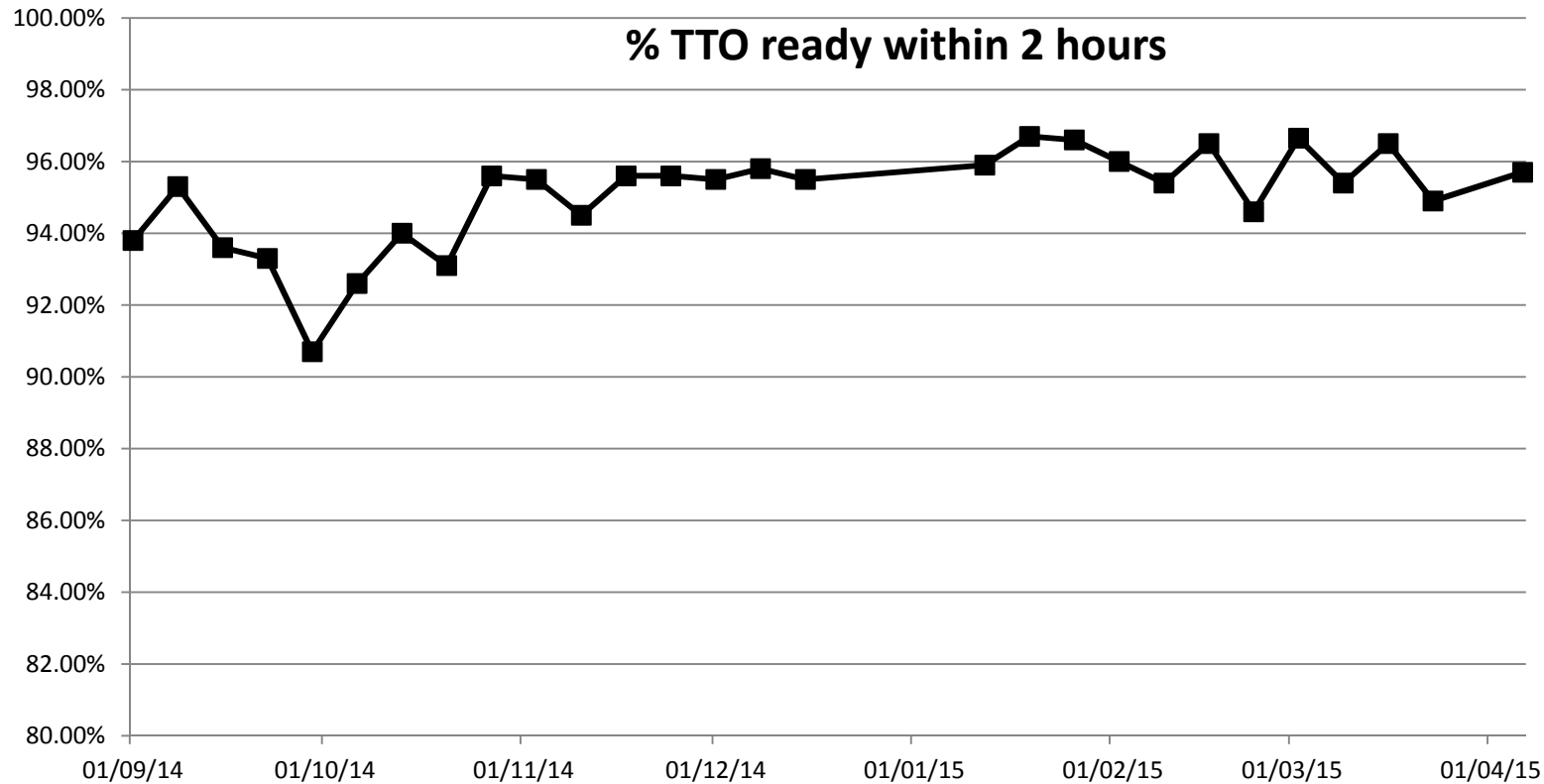
- **Interval between receipt of a correct TTO by pharmacy and readiness for collection/sending**
- **Target: < 2 hours**

# TTO Turnaround Time (2)



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# TTO Turnaround Time (3)



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Pharmacy update

*We are here for you*

# Discharge delays due to TTOs

## Shortening TTO turnaround time further:

- Increasing proportion of TTOs pharmacist-written (right first time)
- 14/15 invested £348,000 in pharmacy staff (9 extra pharmacists for QMC wards (but national shortage))
- Continuing focus of ward teams [SAFER in breaking the cycle week]

# Five **SAFER** actions for patient flow

<b>S</b> Senior review	<b>A</b> Anticipate	<b>F</b> Flow	<b>E</b> Early discharges (@ QMC use the lounge)	<b>R</b> React to delays & waits
Consultant & nurse-in-charge	All doctors & nurses	Nurse-in-charge	Nurse-in-charge	All doctors & nurses
<ul style="list-style-type: none"> <li>Board round by 9.30am:                             <ol style="list-style-type: none"> <li>Follow SHOP</li> <li>Daily updated PDMST</li> </ol> </li> <li>Submit Assessment &amp; Discharge Notices early in the morning wherever practicable</li> </ul> <p>(go to <b>R</b>)</p>	<ul style="list-style-type: none"> <li>Inform patient, relatives/ carers of their PDMST (use Welcome Card)</li> <li>Review PDMST at handovers</li> </ul> <p>(go to <b>R</b>)</p> <ul style="list-style-type: none"> <li>TTOs for tomorrow</li> <li>Book transport for tomorrow's discharges</li> </ul>	<ul style="list-style-type: none"> <li>Be ready to accept your first transfer by 9am</li> <li>Keep Horizon updated</li> <li>Contact ED/admissions wards for patients                             <ul style="list-style-type: none"> <li>– B3 65929</li> <li>– D57 67488</li> <li>– SRU 57495</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Maximise transfers from your ward before noon (every hour matters)</li> <li>QMC's Discharge Lounge - 69044</li> </ul>	<ul style="list-style-type: none"> <li>Work to resolve all internal waits and external delays early</li> <li>Then escalate to your Bronze on-call followed by your DMT, Site Matron/Silver</li> <li>Review long-stay patients (&gt;7 days)</li> <li>Escalate those past their confirmed PDMST to TAG meetings</li> </ul>

# Response to feedback

- **Address GP concerns through new communication updates/newsletter**
- **Better publicise our extended opening hours**
- **Review the Prescribing Policy at the Area Prescribing Committee**

# E-prescribing: coming early 2017

## New interactive e-prescribing & medicines administration system

- Fewer medication errors & drug-related incidents
- Improve TTO turnaround times
- E-drug history, supporting patients' future hospital visits
- Better control of prescribing (eg antibiotics)
- Fewer complications, allergic reactions & interactions

# Reducing medicines waste

- Improve reliability of 'Medicines go too' when patient transfers wards
- Increased use of patients' own medicines on admission
- Review of ward stock lists and improved stock management (ward level) – piloting the introduction of a stock optimisation assistant technical officer post
- Increasing recycling of medicines returns in hospital
- Most patients receive ongoing supplies of regular medicines via GP prescription. When prescribed by the hospital such drugs are often dispensed/delivered via a third-party homecare provider (more convenient for patients). NUH is leading the way nationally in its work to reduce medicines wastage through this supply route



# Improving medicines safety

15/16 quality priorities include reductions in:

- omissions of critical drugs
- preventable respiratory side effects from opioid drugs – incorrect dose, incorrect dosing interval, duplication of therapy
- preventable adverse drug reactions due to incorrect drugs or incorrect doses of drugs prescribed on admission and during inpatient stays

# Thank you

# Questions ?

## The GP practice prescribing budget

Every year, the Clinical Commissioning Groups (CCGs) set the prescribing budget for each GP practice by agreeing % uplift on outturn i.e what was spent on medicines last year. A number of different factors are also taken into consideration such as practice list size and population demographics such as deprivation, number of care home patients.

Each practice is reviewed regularly by the CCG's medicines management team using the database of prescription information provided by the NHS Business Services Authority (BSA), known as ePACT.

The CCG medicines management teams set a review programme for key target areas within current prescribing for practices to help manage their budgets. This might include measuring adherence to local drug formularies, drug switches of groups of patients to cost-effective generic alternatives, implementation of software such as *Scriptswitch* to improve clinical and cost effective prescribing.

The CCG medicines management teams also provide support and expertise to the practices in many other ways to support the safe prescribing of medication to patients. This might include Pharmacist-led disease specific clinics, medication review clinics, reviews of medication of patients in Care Homes.

### Spend for the Nottinghamshire CCGs for 14/15

CCG	Spend on medicines
NHS Mansfield & Ashfield CCG	£27million
NHS Newark & Sherwood CCG	£19million
NHS Nottingham North & East CCG	£20million
NHS Nottingham West CCG	£12million
NHS Rushcliffe CCG	£14million
NHS Nottingham City CCG	£40million
<b>TOTAL</b>	<b>£132million</b>

It should be noted that prescribing spend increases year on year for a number of reasons such as an aging population with more comorbidities, new technologies, recommendations from NICE etc which are unavoidable. Hence efforts are focused in controlling the degree of the growth and forecasting the likely impact of this will have to budgets.

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## **Reducing Medication Waste - Nottinghamshire CCGs 2015 - 16**

### **NHS Newark & Sherwood CCG**

- Practices have option to look at their repeat prescribing policies as the area of the 15-16 Engagement Scheme
- Support to practices to review quantities on prescriptions, checking dressing order forms for large quantities, quantities of insulin etc, etc
- Investment in the CCG Medicine Management team to provide increased pharmacist support to GP practices including medication reviews.
- Consideration of a Community Pharmacy 'Not Dispensed' scheme in collaboration with local community pharmacies and the Area Team.
- Talk of another waste reduction initiative with practices later in the year
- Previous collaboration with the Stakeholder reference group around getting messages out to patients about only ordering what you need etc

### **NHS Nottingham West CCG**

- In NW CCG we have employed a pharmacy technician where one of her roles, amongst others is to look at repeat prescribing issues to reduce waste.
- This is a one year project working with the practices, based on the work that Walsall CCG did / have done / are doing;

<https://www.nice.org.uk/savingsAndProductivityAndLocalPracticeResource?ci=http%3a%2f%2farmevidence.nhs.uk%2fresources%2fQIPP%2f1040169%3fniceorg%3dtrue>

### **NHS Mansfield & Ashfield CCG**

- GP practices are encouraged to prescribe 28 days' worth of medication and undertake reviews of medicines placed on repeat i.e medicines that have been discontinued are removed from the patient's list of medicines on repeat to prevent the medication being ordered in error.
- CCG Medicine Management team is focussing on medication reviews especially in care homes, identifying whether appropriate medication policies are implemented in care homes, making suggestions where necessary to reduce waste.
- Intention to review repeat prescribing systems in GP practices later in the year to ensure efficient /safe systems and processes are in place e.g. is each medicine prescribed for the same duration.

### **NHS Nottingham North & East**

- We have employed a pharmacy technician who is supporting the practices in various projects, which will hopefully reduce waste. She has also been working with the primary care pharmacists to look at the repeat prescribing – and particularly requests for repeat prescriptions being generated through community pharmacists – to try and address issues of over ordering which lead to waste.

### **NHS Rushcliffe CCG**

- Similar to Nottingham West CCG we have a technician who will be helping practices with their repeat prescribing processes.
- We have recently recruited a pharmacist to undertake medication reviews of patients in care homes and advise the homes on issues around over ordering and avoiding waste.

### **NHS Nottingham City CCG**

- Have had a Not Dispensed Scheme running in Nottingham City through all the 65 community pharmacies since 2008 which saves approximately £30k annually on medicines.
- Are currently looking at repeat dispensing on EPS to ensure this is rolled out across the City. Increases in patients using repeat dispensing should correlate with less waste through ensuring that community pharmacists check with patients which medicines they need each time a repeat instalment is dispensed.
- Actively promote the New Medicines Service and Medicines Use Reviews available in community pharmacies.
- Working with colleagues at NUH to improve information shared on discharge regarding medicines.
- Working with colleagues across the interface – primary, secondary and community care – to promote the message that patient's should bring their medicines with them into hospital and that the medicines should be kept with the patient throughout their time in the hospital.
- Annual medication review audits take place within the care homes to ensure systems are in place.
- Work is being undertaken to look at medicines stock within care homes and develop procedures to prevent stockpiling of medicines.

16 June 2015

Agenda Item: 4

**REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH  
SCRUTINY COMMITTEE**

**INDEPENDENT REVIEW OF NOTTINGHAM DERMATOLOGY CONTRACT**

**Purpose of the Report**

1. To introduce the final report of the Independent Review of the Nottingham Dermatology Service.

**Information and Advice**

2. In April 2015, NHS Rushcliffe Clinical Commissioning Group (CCG) commissioned an independent review of the dermatology service in Nottingham on behalf of all NHS commissioners.
3. The review was conducted by a group of distinguished clinicians: Dr. Stephen Jones, Consultant Dermatologist, Dr. David Colin-Thome, previously the National Clinical Director for primary care and Dr. Ian Bowns, independent public health consultant. The review was led by Dr. Chris Clough, consultant neurologist and Chair of the National Clinical Advisory Team.
4. The final report of the review panel is attached as an appendix to this report.
5. The Chair and Vice-Chair the Joint Health Committee, accompanied by Councillor Jacky Williams, Chair of the Nottingham University Hospitals (NUH) and Circle Quality Account Study Groups met with the Independent Review Panel on Wednesday 22 April to share their experience of scrutinising dermatology issues in Nottinghamshire.
6. The following people will be attending the Joint Health Committee to introduce the panel's report and recommendations :  
Dr Guy Mansford, Clinical Lead, NHS Nottingham West Commissioning Group (CCG)  
Vicky Bailey, Chief Officer, NHS Rushcliffe CCG  
Peter Homa, Chief Executive, NUH  
Dr Stephen Fowlie, Medical Director, NUH  
Rachel Eddie, Deputy Director of Operations, NUH  
Helen Tait, General Manager, CircleNottingham  
Paul Manning, Clinical Chairman, CircleNottingham

7. The Joint Health Committee may wish to undertake the monitoring of the implementation of the panel's recommendations.

## **RECOMMENDATION**

That the Joint City and County Health Scrutiny Committee:

- 1) Consider and comment on the independent review panel's final report
- 2) Agree to undertake monitoring of the implementation of the review panel's recommendations.

**Councillor Parry Tsimbiridis**  
**Chairman of Joint City and County Health Scrutiny Committee**

**For any enquiries about this report please contact: Martin Gately – 0115 9772826**

### **Background Papers**

Nil

### **Electoral Division(s) and Member(s) Affected**

All



**FINAL REPORT**

**INDEPENDENT REVIEW OF**

**NOTTINGHAM DERMATOLOGY**

**SERVICES**

**4 JUNE 2015**

**LEAD AUTHOR:**

**Dr Chris Clough, Independent Panel Chair, Consultant  
Neurologist, King's College Hospital, London**

**INFORMATION READER BOX**

<b>Commissioning Organisation</b>	NHS Rushcliffe Clinical Commissioning Group
<b>Document Purpose</b>	Independent Review
<b>Document Name</b>	Independent Review of Dermatology Services, Nottingham
<b>Author</b>	Dr Chris Clough
<b>Publication Date</b>	4 June 2015
<b>Target Audience</b>	NHS commissioners, NHS providers, Joint Overview and Scrutiny Committee, Patients and Public groups
<b>Additional Circulation List</b>	NHS England Midlands and East, North Midlands sub-region
<b>Superseded Docs</b>	None
<b>Action Required</b>	See recommendations
<b>Timing/Deadlines</b>	See recommendations
<b>Contact Details for further information</b>	Vicky Bailey, Chief Operating Officer, NHS Rushcliffe CCG <a href="mailto:vicky.bailey@rushcliffeccg.nhs.uk">vicky.bailey@rushcliffeccg.nhs.uk</a>
<b>Document Status</b>	
<b>Final</b>	

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## 1 Executive summary

Date of visit: 22 April 2015  
Venue: NHS Rushcliffe CCG  
Easthorpe House  
165 Loughborough Road  
Ruddington,  
Nottingham NG11 6LQ

### Panel Members

Dr Chris Clough	Chair of the panel, former Chair National Clinical Advisory Team
Dr Ian Bowns	Independent Public Health Consultant
Dr David Colin Thome	former National Clinical Director for Primary Care
Dr Stephen Jones	former President – British Association of Dermatologists

### 1.1 Summary of findings

The near collapse of acute and paediatric dermatology services in Nottingham was triggered by the incomplete transfer of consultant dermatologists from Nottingham University Hospital NHS Trust to Circle Nottingham employment, following Circle winning the bid to run the Nottingham Treatment Centre which includes dermatology services. This led to a cascade of problems, mostly concerning recruitment and retention of consultant dermatologists.

Whilst this could not have been predicted at the time of the procurement and contract award, and was an unintended consequence of the procurement, the slow response of commissioners and the main providers to acknowledge the problem and start to work together to solve it has aggravated matters. We believe that there is now a willingness and consensus to move forward and start to rebuild the service on the basis of collaboration between the main stakeholders and to build trust between these organisations.

We have suggested immediate actions that must take place to address urgent problems, and a more long term strategic review of dermatology services to develop the service in the long term for the benefit of all the citizens of Nottingham

## 2 Introduction

This independent service review of dermatology was initiated by NHS Rushcliffe Clinical Commissioning Group, which is the co-ordinating commissioner for Circle Nottingham services on behalf of the four Nottinghamshire CCGs. Dr Chris Clough was approached by Vicky Bailey, Chief Officer and Senior Responsible Officer, Rushcliffe CCG and asked to chair the review. The panel was selected to ensure independent representation from Primary Care, the British Association of Dermatologists and Public Health (see **appendix 1** for brief biographies of panel members). Dr Jonathan Corne from Health Education England East Midlands was also invited to be an observer and provide an educational perspective. Information was collected from multiple sources including key stakeholders, the CCG and the British Association of Dermatologists, and analysed prior to the visit. The visit was planned via teleconference in the weeks preceding the visit; terms of reference were agreed (**Appendix 2**); the project manager was Tracy Madge. **Appendix 3** is the programme for the day and list of attendees. **Appendix 4** lists the information received.

## 3 Background to the review

In 2007 the National Independent Sector Treatment Centre (ISTC) programme instigated the building of the Nottingham Treatment Centre (NTC). Nations, subsequently Circle Nottingham, were to provide services under a 5 year contract and they commenced service delivery in a phased manner from 28 July 2008. With the NHS reorganisation and the creation of Clinical Commissioning Groups in 2011, co-ordination of the procurement of services for the NTC was handed over from the PCT to the CCG with Rushcliffe CCG taking the lead on behalf of the Nottinghamshire CCGs, commissioning services for a population base of about 750,000.

For many years dermatology services at specialist level had been provided by Nottingham University Hospitals Trust (NUH). The department had developed into a centre of excellence with nationally regarded experts in a number of sub-specialties of dermatology. It was also renowned for its academic research. The various components of its service included general dermatology services (predominantly outpatient based), paediatric dermatology, dermatological surgery, dermatologic oncology (including multidisciplinary team and connections to plastic surgery and other cognate disciplines), an inpatient service and an acute dermatology service providing opinions for other specialties and ward referrals, available 24/7. It was also one of the main centres in the East Midlands for training of dermatology specialty training registrars and an academic centre for clinically based research.

With the advent of the NTC run by a private organisation, Circle, outpatient services were transferred to the NTC in July 2008. These included all general dermatology services, dermatology surgery, dermatology oncology with supportive nursing services and treatments, eg phototherapy. NUH consultants continued to provide much of the outpatient service through a staff supply agreement between NUH and Circle in addition to consultants directly employed by Circle and other clinicians (nurses, therapists).

In 2012 the CCG commenced a procurement process based on its own specification. This procurement was for a number of services, including dermatology. Bids in response to the tender were received from four different organisations including NUH and Circle. Circle were successful in the bidding process; as part of their bid it was expected that all staff from NUH involved in providing the dermatology outpatient service would TUPE (Transfer of Undertakings under Present Employment) to Circle employment, to enable them to continue the service. Following the award of the contract, the consultant dermatologists wrote to the CCG explaining that they wished to remain employed by the NHS, and outlining the likely consequences of TUPE enforcement. In the event, out of the 11 consultants, only 3 initially accepted TUPE, of whom 2 have now left. Four more that were eligible, declined TUPE and were unable to stay at NUH on NHS contracts so have chosen to take NHS contracts elsewhere. One has retired and has come back to work part time for Circle. For the remaining 4, TUPE did not apply due to commitments in paediatric dermatology and/or other trusts. One has left to return overseas, and another is leaving for another NHS trust. TUPE did not apply to two paediatric dermatologists because paediatric dermatology services fell outside the CCG procurement. The decision of most NUH consultants not to TUPE to Circle (and to ultimately seek employment elsewhere) led to a shortfall in the consultant workforce required to deliver the workload.

Dermatology consultant posts nationwide are currently difficult to fill with an estimated shortfall of approximately 200 posts in the UK vacant or occupied by locums (approximately 1 in 5 posts) [British Association of Dermatology figures].

In order to try to sustain the workforce at NUH, in 2014 the Trust set up a separate "repatriation service", provided from City Hospital. This was subject to a legal challenge and eventually, in view of this, was compelled to be withdrawn. Two years on, contractual and service issues have meant that many of the consultants who did not transfer to Circle have opted to leave for posts elsewhere.

Circle now have 4 directly employed consultants (3.8 Whole Time Equivalent) and have 6 long-term locums in place. A number of the locums are European graduates and so do not have automatic entry to the General Medical Council Specialist Register for dermatology to enable them to apply for substantive posts in the UK. Despite that, they are able to work at the level of a consultant. The cost of employing locum consultants is nearly £300,000 per annum per post, greatly in excess of that of a standard NHS consultant salary, and has led to financial pressures on the Circle service.

As a result teaching and training on the NUH/Circle sites has greatly diminished with withdrawal of trainees in keeping with the number of consultants available to teach. Medical students have been transferred to the Royal Derby Hospital.

In January 2015 it became clear that an acute dermatology service providing specialist in-patient care for dermatological emergencies was no longer possible and this is now being provided from the Leicester Royal Infirmary site. The imminent departure of another NUH consultant will leave only 2 full time consultants engaged in paediatric dermatology and ward referral services to support the acute service at NUH will be no longer viable from 18 May 2015. There is now a serious possibility that the two remaining consultants at NUH providing

the specialist paediatric services will leave by the end of the year with the likelihood of a failure to recruit to their posts to replace them.

Hence in spring 2015 the dermatology services in Nottingham are in crisis due to the inability to recruit to substantive posts and the on-going reliance on locum posts at Circle. There is very limited postgraduate training (because this is restricted to clinical supervisors who are on the specialist register), and clinical research has greatly contracted. The emergency dermatological inpatient service has had to be transferred with the imminent demise of any service to provide on call dermatological advice for emergency admissions or acute dermatological problems in patients in any of the other tertiary services (eg acute oncology or haematology). Paediatric dermatology services (for which Nottingham is one of the few tertiary centres) are also under immediate threat.

## 4 Comments made by stakeholders on the day of the visit

### 4.1 NUH consultants

- We were a very successful dermatology service at NUH before the attempt to TUPE consultants out to Circle.
- We were not aware of the possibility of TUPE and had not been involved greatly with the bidding process for outpatient services. It was a great shock when we found we may be required to work for Circle, and that the NUH bid had been unsuccessful
- We were a very close department. When we heard we were going to be removed from the NHS and transferred to the private sector we felt we had been sold down the river.
- We were the only service that was affected. At one point transfer of the rheumatology service was a consideration.
- After the contract was awarded to Circle we informed the commissioners and Trust that we would refuse to be TUPEd. We were told by Circle management if we did not come over we would be replaced.
- We did our best to try and protect training and were keen that the Trust set up a repatriation service to enable all services at NUH to continue.
- When we told the commissioners of our concerns, one of them told us they were not there to pander to the emotional needs of consultant dermatologists.
- Our colleagues who have left to go to Bath and Liverpool were involved in this repatriation service, but when it fell through they opted to move to hospitals where they feel able to provide a more clinically appropriate service.
- We are concerned that some of the consultants at Circle are not on the specialist register and cannot train dermatology StRs, and that those who are on the register have declined to organise a training programme for the SHOs.
- We felt we were being very cooperative and worked at the Circle site until last November (one consultant).
- Patients presenting to NUH A&E requiring acute dermatological admission since February 2015 are now transferred to Leicester.

## 4.2 NUH Management

- As an NHS Trust we feel that our number one priority is to maintain paediatric dermatology, which will be extremely difficult in the future.
- We were unable to provide an adult repatriation service following the legal challenge by the CCGs, mainly because we had not achieved a contract with another commissioner which would have allowed us do this under the Choose and Book system
- CCG and Circle need to agree to a shared model

## 4.3 Clinical Commissioning Groups and Lead GPs

- When we went to procurement of this service we did not think there was an alternative, or even considered one, to the single provider as the service had worked for the previous five years. Perhaps in retrospect that was a mistake.
- We felt that these consultants, by refusing to TUPE, were being selfish and that largely this was a bereavement response.
- We do not recognise there are necessarily any problems in the service provided by Circle and that they do appear to be committed to research and training.
- Patient experience at the NTC is good.
- At this point, following all the difficulties, we feel there are three options:
  - Firstly, no change but this is not acceptable
  - Secondly, move to an Any Qualified Provider, multiple provider provision
  - Lastly, and our preferred option, is a collaborative one.
- As commissioners, we are happy to make any solution that is feasible happen, but we think the health of the citizens of Nottingham has been improved by the provision of the Circle services.

## 4.4 Circle Management

- At Circle we rely on a number of fixed long term locums (6) and 4 directly employed consultants, one of whom was previously TUPEd. We do have a UK graduate working as a locum, but she is very worried how she is perceived by the profession, in particular by the British Association of Dermatologists.
- We have suggested that our European graduates, who are working as locums, go through the CESR process to enter directly on the Specialist Register.
- When we lost the trainees at Circle this did mean we lost 25% of the activity they provided but we are very keen that Circle is recognised as a provider of good training.
- Under the present arrangements with the cost of locums it is likely that our service is not financially sustainable.
- We are keen to develop the service in many other ways, for instance using telecommunications and advanced nurse practitioners.
- Generally our service is getting busier; we now operate a telephone hot-line for emergency referrals in hours. Out of hours the calls are left on the answer phone and picked up the following day.
- We are tired of being seen as the bad guys in all this as we feel we deliver a good service and would like to provide training and research.



- We would accept consultants being appointed to NUH and have a staff supply contract as previously
- Our recent CQC visit said our services as a whole were outstanding, and patients have said they are delighted with our service

#### **4.5 Circle Consultants**

- When I heard we might be TUPEd to Circle I had a similar emotional response to my colleagues. However I realised that there were excellent facilities where I could deliver my services at Circle. In actual fact, being TUPEd made no difference to patient care. The most difficult thing for me is that I have lost my colleagues and previous friends, and it can be very lonely. I have had to take on more responsibility now they are no longer there to do some of the administrative tasks.
- We could do more research and training, as we did in the previous 5 years, and have only lost this capability because people have left.
- For us to work together, a lot of the negativity that exists about Circle needs to go.
- At Circle I feel I have more freedom to change things and there have been enhancements in services, for instance the skin cancer team which now has a consultant nurse and an advanced nurse practitioner.
- We meet regularly with the Circle managers, 2-3 times per week, and I can't remember this ever happening when I was employed at NUH.
- We do have very good locums and I would be very happy to work alongside consultant colleagues who are employed by any other employer.
- I wish all this negativity would evaporate and that all would be allowed to provide services.
- We would be happy to take part in supporting an acute rota.

#### **4.6 British Association of Dermatologists (BAD)**

- The BAD is very concerned about the decline of services in Nottingham from a centre of excellence to somewhere now unable to offer expert dermatology, dermatological care for patients with acute dermatological problems and now its failure to deliver teaching to trainees and medical students.
- The BAD is dismayed that this has been allowed to happen despite the issues being highlighted on many occasions
- The BAD has concerns about governance arrangements.
- The BAD can contribute to the solutions. We have published documents on support for commissioning of dermatology services and a Clinical Services Unit, which specialises in supporting commissioners in developing quality/sustainable services.
- The BAD has a raft of information to aid commissioners to procure a quality/sustainable service and a 'Lessons Learnt' document outlining some of the pitfalls experienced in commissioning around the UK to help prevent the reinvention of 'broken wheels'.

## 4.7 Managers and lead clinicians of other local providers of Dermatology services

(University of Hospitals of Leicester NHS Trust, Derby Teaching Hospitals NHS Foundation Trust and Sherwood Forest Hospitals NHS Foundation Trust)

- We now need to acknowledge that mistakes have been made at Nottingham.
- Formerly across East Midlands we worked well together.
- Presently Leicester doesn't have the bodies to provide services at Nottingham, but we are very happy to support services in other ways. We wondered whether an in-reach service at Queen's Medical Centre could be provided by a clinical nurse specialist.
- We greatly valued a number of the specialty services that Nottingham offered and are fearful we will lose paediatric dermatology services, which are not presently provided anywhere else in the region.
- At Derby we offer acute dermatology services, we do not offer on call out of hours (17:00 – 09:00 service). If patients require admission with dermatology problems we co-care with acute medicine, providing an opinion to the medicine team on a daily basis.
- We are greatly concerned about the number of ward referrals at a specialist centre like Nottingham, which must be upwards of 6-8 per day, and these will need to be catered for in the very near future.
- Leicester could envisage working in partnership with Nottingham to provide services at Leicester and Nottingham

## 4.8 Healthwatch and patient involvement manager

- We have not heard a lot of noise about dermatology services but now as part of this review we have specifically asked patients we have managed to get opinions from about 20 who have been treated at the TC. This isn't a large response but there appears to be some consistency in this. It breaks down into those with acute problems and those with long term conditions. Whilst there is little problem for the former, the latter noticed that things now appear rushed and that since the services changed over to Circle there has been a loss of continuity as new doctors will often start from scratch when they meet for the first time (a major issue for someone with a severe chronic disease who has had much input into their care over time). Patients are very anxious about when other people retire (dermatologists).
- We have had one complaint about staff attitude but otherwise staff behaviours have been good.
- Some patients were worried it takes weeks to get a diagnosis
- Some doctors are difficult to understand because English isn't their first language.
- Appointments now appear more rigid, only lasting 10 minutes, and this has meant that sometimes whole body checks for skin lesions have not been performed.

- For some reason the pharmacy service seems to continue to be provided at NUH and patients do wait a long time there.
- Circle's complaints procedures are not very visible and easy to access
- Patients generally think that, out of all this, lessons need to be learned so that it doesn't happen again, and that it will be crucial in any subsequent planning of services that there is substantial patient and public involvement.
- **Appendix 6** shows collated responses and feedback

## 4.9 Clinical Senate

- The role of the Clinical Senate is to try and act as an independent honest broker. When approached about the dermatology services we were interested to hear whether there is a plan for future services. As there was nothing at that stage, there was nothing we could review. However we are very happy to look at any emerging proposals.

## 4.10 Joint Overview and Scrutiny Committee

- It is important that we learn lessons about the tendering processes and fragility of services.
- It strikes us that everybody had their head in the sand about what happened to dermatology services.
- We are worried that what has happened to dermatology may affect other services provided by Circle
- We hear that other clinical staff are leaving, not just doctors.
- We would be very keen for the locum doctors to become substantive, and don't know why this doesn't happen.

## 5 Discussion and Opinion

Skin disorders are extremely common. As indicated by the BAD documents up to 50% of the population have a problem with their skin each year. Many of these are dealt with by patients themselves, often with over the counter remedies and advice of pharmacists. However about 24% of the general population do present every year to their general practitioner with skin problems. General practitioners and their teams manage the majority of these but 5% do need specialist opinion, often for diagnostic purposes but also when common problems such as eczema, psoriasis and acne become difficult to treat, for severe inflammatory skin disease requiring specialist treatment and for cancer. Overall these referrals form 4.6% of hospital outpatient activity. Skin disorders are important having a major impact on quality of life. In addition, they can have serious consequences as regards morbidity and mortality relating to cancers such as malignant melanoma and other severe dermatological conditions such as toxic epidermal necrolysis (which can be fatal) and immunobullous diseases such as pemphigus which cause a blistering condition requiring sophisticated medical and dermatological support.

When looking at the provision of dermatology services it is important to consider many different levels from prevention of skin conditions (protection from UV radiation, smoking cessation) patient self-care and ensuring effective general practice primary care services as

this is where approximately 90% of skin disease is managed. Whilst we heard that GPs in the Nottingham region were strongly committed to the provision of primary care services for dermatology, we did not hear that there were many GPs with a special interest (GPwSI) in dermatology or other specialist clinicians at primary care level.

The BAD strategic documents describe a useful model of dermatology which is essentially a pyramid, recognising the importance of self-diagnosis, Primary Care management, Intermediate Care provided by GPwSIs or hospital outreach services, Secondary Care based services for specialist diagnosis and treatment (provided in most DGH hospitals) and lastly Specialist Dermatology services for small groups of patients which have existed within regional centres and teaching hospitals.

Historically Nottingham, through NUH, provided the full range of dermatology services at secondary care level in addition to many of the more specialist dermatology services such as paediatric dermatology. They also had a national and indeed international reputation for provision of training of consultant dermatologists, and of clinically based research. We heard from the consultants themselves that they regarded themselves as a finely honed machine providing a cost efficient service.

Into this mix came a national initiative to set up independent sector treatment centres, provided by private, non-NHS organisations. The Nottingham Treatment Centre was built in the grounds of the then Queens Medical Centre campus, since 2006 part of the Nottingham University Hospitals NHS Trust, which was fortunate and enabled it to more easily access NUH staff. In the usual way of things it provided a mixture of different services and an important component, around a fifth, was the dermatology services. The preferred provider, Circle, regarded dermatology as an important service which made a substantial financial contribution to the running of the NTC.

The service was set up in 2008 and ran successfully, initially on a staff support contract with those consultants who previously provided the outpatient service at NUH now providing the same service within the new facilities of the NTC. For five years everybody was happy with this arrangement. Income flowed to Circle for the provision of the service and there was reimbursement to NUH for the staff support from their consultants. Because of the close proximity of the unit, the dermatology team was able to maintain its closeness and working relationships, hence continued to provide other services within NUH such as the ward referral service and the acute service. There was also a separately commissioned paediatric dermatology service.

With the demise of the Primary Care Trust, in 2012 the task of the re-procurement of the services provided by the NTC (several specialties including dermatology) was passed over to the newly created Clinical Commissioning Group. It is clear that this procurement process was entirely above board, and was performed fairly and by independent observers according to standard assessments. . The Circle bid was successful probably partly because of its emphasis on provision of community services, which the CCG wished to see and because of the apparent successful delivery of services in the previous 5 years. The bid from NUH was the reserve bid.

Once Circle had been awarded the contract it became evident that a significant proportion of the NUH consultant workforce, previously seconded to Circle, were not minded to TUPE to Circle's employment. There was no evidence that the CCG were told prior to procurement that dermatology consultants might leave if the contract was awarded to Circle. The consultants told us they were not aware TUPE could be enforced. When this became apparent all the consultants immediately wrote a letter to the commissioners (March 2013, widely circulated) explaining the risks; for example consultants employed by NUH might seek employment elsewhere. It would be relatively easy to find alternative posts due to the national shortage of consultant dermatologists

It is at this stage that the problems really start to emerge for the overall dermatology services. The NUH consultants told us of their upset in their comments to us; the feeling of rejection after years of being an NHS employee and despatched to a private provider; and a provider who had been in the press for their difficulties over provision of services elsewhere. They had a lot of concerns about transfer of their contracts over to an uncertain model at Circle, when Circle had no involvement in the highly specialist aspect of their work or in providing emergency dermatology care. They felt that this would inevitably lead to a downscaling of their ability to deliver effective training and research. They also thought that the commercial approach of Circle inevitably would lead to a poorer service, even though effectively the service was going to stay the same as had pertained in the previous 5 years. There was obviously a break down in trust. Despite this, some consultants did agree to TUPE, albeit with reservations. However one who has continued to be employed by Circle has no regrets, regarding them as a good employer.

From the point of view of Circle, and the CCG, this response was totally unexpected. We did not detect any Machiavellian attempt here to shed these consultants or change the service. Indeed all concerned would have been delighted for the consultants to TUPE. They had not envisaged that it would cause this upset or be a problem.

We feel that the analysis by the CCG, that the issue was one of employment, not service change, is entirely the correct one. Subsequent events have borne this out, as there was no attempt to change the service design at the point of re procurement, or downplay the commitment to research and training. However whilst it might be viewed that the consultants response to being TUPEd was largely an emotional one, the panel feel that this was a valid concern which would be felt by many consultants finding themselves in this position. The strength of feeling was perhaps not fully recognised and accepted by Circle in particular, who thought that, even if a problem, the consultants could easily be replaced; not true, as they have subsequently discovered, or a bereavement response which in some way might settle as some within the CCG thought. People join the NHS for a number of reasons, and for some it is the commitment to public service which attracts them, and why they are willing to go the extra mile by working long hours, with a strong commitment to patient care. Transferring these clinicians (and other workers) to a private organisation with possibly a different value system (perhaps the profit motive) can be very difficult for them. They presumably had dedicated their lives to patient care and may not be able to understand how a private company is motivated to do this as well. This aspect of why people work for an organisation needs to be handled sensitively in any transfer of workforce

The lack of response at this time to the consultants concerns has led to the ongoing problems and difficulties that Circle has had in recruitment, and their reliance now on locums, and the situation whereby Nottingham is now faced with a service on a knife edge, with the imminent loss of a further consultant rendering the acute rota unworkable and the possibility that, if any of the remaining consultants leave, the demise of the tertiary paediatric subspecialty service which is not provided elsewhere in the region. It has been an unmitigated disaster.

Whilst numerous meetings have been held, we think there has been a lack of acceptance of the consultants' fears, which are seen in several quarters as irrational. Nevertheless they do exist, and the panel does have some sympathy with them. Whilst this decision by the consultants was not inevitable, it might have been anticipated as a risk and managed accordingly. There has been a lack of flexibility about how this service could be provided, and how TUPE was used. Whilst it is easy to say this in retrospect, there are lessons to be learnt here about how further service changes/procurements may occur, particularly those requiring TUPE arrangements. All in all this has led to an adversarial situation between providers and the CCG. Unfortunately things have been said, leading to a breakdown in relationships with the NUH consultants.

There was further loss of Trust between NUH and the CCGs and Circle when NUH set up a short-lived separate dermatology service, incorrectly judging that its on-going specialist contact with NHS England permitted it to do so.

Despite all this, Circle has managed to provide a good elective adult dermatology service, which is exactly what they were required to do. Patient feedback is excellent, local general practitioners are very pleased with the services, and the recent CQC report on services as a whole is also very encouraging. Healthwatch Nottinghamshire's assessment from the patients who attended the pre-review discussion would be that the service is highly valued by patients but that some people have poor recent experience, particularly patients with long term conditions. **Appendix 6** shows the collated responses from the Healthwatch Nottinghamshire sources. The consultants and nurse who we have heard from were also very content with their move to Circle. They feel they have been managed appropriately, and that far from being a bad employer, they value their relationship with Circle management. They have been able to achieve a lot of new things with the support of Circle. They would encourage their NUH colleagues to change their minds about Circle

Our overall conclusion is that no one person or organisation is to blame for what happened to Nottingham dermatology. This is a service that fell to pieces when the majority of relevant NUH consultants declined to TUPE, and over time resigned from NUH.

It could be said that that CCG should have predicted, and taken more account of, the possible responses to TUPE of the NUH consultants; this should at least have been part of their risk assessment. It could be said that Circle had their head in the sand about what might happen when the consultants failed to TUPE, and that they failed to heed the consultants' warnings.

NUH should have informed the CCGs more effectively of their proposal to set up a limited outpatient dermatology service (in addition to their informing NHS England).

Professional bodies such as BAD were put in a difficult situation when they saw what was happening to their members, both in NUH and those that had transferred to Circle. They were extremely concerned that a previously excellent, nationally renowned service was crumbling and the impact it was going to have on the provision of dermatology services for the people of Nottingham. As a result, when they saw that nothing was being done at a local level to resolve the situation they felt impelled to publicise things for the sake of Nottingham residents. Whilst some feel that some of their actions (eg briefing the OSC without prior sharing the document with the CCG and others) were unacceptable, the OSC felt that their briefing paper was the most helpful document they received. We hope that the spirit of collaboration that is emerging in Nottingham will enable the BAD to make a healthy contribution to the emerging service and begin to support the new beginning we envisage now happening in Nottingham.

## 6 Lessons to be learnt

- 1 Service providers, when entering bids for contested contracts, need to take the process seriously, understand what the commissioners are expecting and should involve their clinicians
- 2 Transfers of service involving TUPE should be considered carefully and the consequences fully understood as to what would ensue if staff does not wish to transfer and how that might impact on the continuity of service provision. This should be part of the risk assessment process.
- 3 Providers who are putting in bids dependent on TUPE for additional or existing staff also need to be aware of the potential pitfalls and carry out appropriate risk assessment. Where there is a healthy market for provision of consultant services the situation is much easier but where, as in this case, consultant services are much in demand, they need to be aware of the potential for consultants to move elsewhere rather than be TUPEd to their services
- 4 Staff need to be appropriately informed if commissioning changes are likely to result in a requirement for TUPE. They need to be counselled through the process so they fully understand that TUPE may not require them to change their jobs in any significant way, but it can be enforced. Clarity and transparency is required throughout the process
- 5 It is likely that, with the future direction of health service provision in England, there will be many opportunities for private companies to bid for established NHS services. Staff and medical staff in particular, need to be aware of this emerging world and the changes it may require in their attitude to risk, but also the opportunities it can create for them.

## 7 Next steps and Action Plan

Primarily, we have been charged to provide action steps which may lead to a resolution of some of the problems that Nottingham is now facing, firstly in the immediate/short term and secondly in the moderate to long term. Certainly, as can be seen from above, there are problems that need addressing immediately if paediatric dermatology in particular is to survive at Nottingham and if patients with acute dermatological problems are going to receive appropriate care.

Secondly we recognise that there is an opportunity with the procurement round occurring 3 years hence to spend some time developing plans which will affect the changes required, to create a high quality service in Nottingham.

Lastly, all we spoke to, and we are of a like mind, support the fact that a high quality and comprehensive dermatology service is required in Nottingham. It is not acceptable to consider provision from elsewhere; whilst this might happen by default, all providers and commissioners working together should do their best to prevent this from happening. This is not just an issue of access for patients in Nottingham, but also the support of established centres of excellence, of which Nottingham Dermatology services need to play their part.

Whilst carrying out this visit, we made it clear to all those we interviewed that our prime concern was not to dwell on the past but to move on to ensure a safe service can be secured as soon as possible. Everybody we spoke to was in agreement with this aim. Whilst difficult to achieve, there are a number of options. We believe that a collaborative approach would be the best way forward.

- 1 To do nothing at this stage is not an acceptable option. To allow the service to collapse and for other providers to emerge presents a huge risk in terms of safety, quality of the service and eventually cost of the service.
- 2 The second option we considered was whether permitting other providers, in particular NUH, to set up a service on Choose and Book would enable this service to develop. This might risk an unstructured and uncoordinated service with a risk of over provision and the likelihood of increased costs for the CCG. It does not address the immediate issues of lack of trust in Nottingham providers, leading to the recruitment and retention problems of consultant staff we have witnessed.
- 3 A collaborative approach (accepting there are continued market forces at play) is most likely to result in a solution which is acceptable not only to all providers but which remains affordable for the CCG and is most likely to fulfil the needs of the patients – the population of Nottingham – providing a high quality service with all elements of specialist and generalist dermatology. We have encouraged all we spoke to, to consider this as the best possible way forward

Thus the following steps should be considered as part of immediate plans to save what remains of the dermatology service at NUH, and start to turn around the outside view, particularly amongst professionals, that the service providers and commissioners in Nottingham are “toxic” and unlikely to be good employers. It is most important that Nottingham is seen as a good place to work and train if they are to recruit dermatologists in a highly competitive market.



We believe that, as a matter of some urgency, all the main stakeholders need to sign up to this approach so it is clear that they have shared objectives; that is the creation and preservation of high quality dermatology services. This is the minimum prerequisite for trust to be engendered with the dermatology staff. There is a need to focus on the present workforce, to prevent them from leaving. Managerial support is important, but bringing consultants and other clinical staff across providers together, so that they can talk, and begin to work out how they can ensure continuity of the service from here on is paramount.

From our discussions with managers at NUH, Circle and elsewhere it seems that all are prepared to make concessions and go the extra mile to make things work collaboratively going forward and it may be, therefore, that as a first step a meeting of the relevant clinicians (perhaps first in Nottingham and then possibly involving those elsewhere) with a view to discussing clinically appropriate solutions which managers might then support is facilitated. Additionally it is vitally important that patients and the public, who are now very concerned about the service, are brought in at an early stage to any discussions about the plans for dermatology. We could imagine that, in due course, an event is organised including all stakeholders; that is providers, patients and the public, specialist societies and commissioners, facilitated by an external professional around common themes such as what needs to happen now for dermatology services, and what needs to happen in the future.

The pressing problem of ward referrals at NUH cannot be ignored. NUH is a significant provider of specialist services for a large population and requires support from dermatology. Whilst acute dermatological admissions can be managed at Leicester at present, there are the needs of those presenting with acute dermatology problems in other specialities. The substantive Circle consultants expressed a willingness to become involved with this and discussions should ensue with a matter of urgency; an in reach service is possible. In the longer term other options may need to be considered, bringing in nearby providers to see in what way they can help. Whilst presently they feel they have little capacity, perhaps if they saw themselves as part of the solution their opinions may change and a larger workforce, all considered together, may find there are ways of cross cover across sites that may be helpful to all. Presently these other providers did not feel they were part of the solution. Indeed our meeting with them was the first time they had been able to contribute. All seemed very enthusiastic that they would support the Nottingham services, and some were beginning to think of ways how they could collaborate much more effectively. For instance, Leicester expressed interest in exploring a wider solution that brings together their services with Nottingham, providing a genuine two-city service this across both sites.

## **7.1 Medium and longer term solutions**

It is not acceptable in the medium and longer term for acutely ill dermatology patients to be transferred immediately to Leicester for acute care. Whilst the numbers are small, the present arrangement should be seen as temporary. The main requirement for care of these patients is acute medical and intensive care, utilising high dependency units or occasionally intensive care units with the direction of dermatology consultants providing assessment and advice. This is the model that that works well at Derby and could be replicated at NUH if

appropriate dermatology opinion was available through an on-call system (this could be phone advice out of hours supplemented by same day or next day consultant review).

Medium and long term solutions give an opportunity to think about new ways of working and service provision. There is an opportunity with the contract up for renewal in 3 years' time to take a more considered approach. Certainly an event staged as above might produce a number of themes. Overall we think it important that this is not just a focus on present secondary providers, but the overall service from self-care and prevention through to what happens in primary care on to more specialist services and highly specialised services. Such an approach should lead to a more complete development of primary care services so that much more is done within GP practices, and other clinicians are brought in to assist with the service, for instance pharmacists and nurses. Please see **Appendix 5** for analysis of service models and benchmarking.

We would like to see much more shared working between primary and secondary care providers, ie in the main between GPs and specialists. Fully understanding patient pathways may lead to a more effective way of attributing work, ensuring appropriate referrals through to specialist services, and producing better outcomes for patients. We support a population model, with specialist leaders who advise on patient pathways and can support those in primary care with diagnosis and provide advice, and ensure appropriate triage of referrals throughout the system. Designing services around single common diseases or problems can be very helpful in promoting this approach; for instance, services for people with eczema, psoriasis, acne and pigmented lesions. Often this can lead to new and novel ways of service provision with the involvement of other trained clinicians such as clinical nurse specialists, GPwSIs and pharmacists. Single disease services are notable for promoting an all-inclusive population approach with ease of access. BAD (see <http://www.bad.org.uk/healthcare-professionals/clinical-services>), and others, offer substantial guidance on the establishment of such services, and we understand the Kings Fund are about to publish further relevant work. Appropriate governance systems and data collection, including patient related and clinical outcomes, should be put in place to better inform commissioning.

Additionally for super-specialist services, wider geographical areas may well need to be considered. All commissioners within the East Midlands should get together to consider whether a strategic clinical network in dermatology is justified (it could be time limited). It would have the benefits in identifying and concentrating services on fewer sites of super-specialist services. The advantage of that is that these services could be of higher quality, with a more sustainable workforce, working more efficiently. Units such as this, driving through higher activity, often have better outcomes because clinicians are more used to dealing with these complex cases. This applies in particular to paediatric dermatology, but also to acute inpatient dermatology where presently there are variable services throughout the region. Whilst there is a limited evidence base to support any one particular model, one would expect a model which has specialist support from all clinicians, would produce better outcomes not only in terms of clinical outcome but service related outcomes such as length of stay, cost per episode etc. Certainly this is seen in other specialties. For instance there may only need to be one or two units across a larger region that provide acute inpatient dermatology, numbers of admissions are small, and the resource required would need to be well used. The BAD has the expertise and knowledge to inform the debate about the planning of an appropriate, comprehensive dermatology service and has produced guidance

on the requirements for effective commissioning of high quality/sustainable services. It can also advise on the size of population needed to sustain high quality super-specialist services. The BAD Clinical Services Unit should be involved in these discussions. A clinical network would ensure that access was equitable for all within the network, and that there were appropriate referral routes. Appropriate protocols would need to be in place to ensure the right patient is seen by the right person in the right service at the right time.

Much of what happened in Nottingham was compounded by the fact that currently there is a significant shortfall in the number of consultant dermatologists in the UK and the lack of training opportunities for potential dermatologists in the UK has led to this problem. Workforce planning for a small specialty such as dermatology is fraught with difficulty, with the risk of under and over provision in the marketplace. We note that the BAD has been alerting NHS Education England (and its predecessors) to its concerns about the mismatch between trainee numbers and numbers of consultant posts for several years. The problem is compounded by the differences in recognition of training between the UK and Europe. Trainees in Europe embark on training in Dermatology and Venereology and do not train in general medicine; hence their European training certification is not recognised by the GMC for direct entry onto the dermatology specialist register. This means that European graduates can only be appointed to locum posts and only apply for substantive consultant posts once they have demonstrated to the GMC that they have achieved all the competencies required for equivalence via the CESR route. As it is unlikely that the GMC will change the rules to enable more European graduates to be directly appointed, we think the best way to create more available doctors able to be consultants in the UK is to expand the trainee numbers. Although scarcity is often the mother of invention, in this case the opposite is true. Whilst there continues to be a demand for dermatologists it will prove difficult for commissioners and providers to change the way dermatology services are provided. The BAD has supported the increase in number of trainees and we would urge Health Education England to consider this request.

In future technology will be increasingly useful. Simple computer based technologies such as having available patient pathways (the BAD Clinical Services unit can supply examples) could be developed for all primary care providers to enable them to route patients through the system and find the appropriate referral route if needed, or management plan. Telemedicine has a potential role in the provision of a comprehensive dermatology service but is most effectively used as one aspect of an integrated service. Telemedicine may not be a cheaper option, but does enhance patient quality by ensuring that patients stay within the GP practice, or indeed their homes.

## 8 Recommendations

All stakeholders should consider this report and take action in line with its conclusions and recommendations.

### 8.1 To be done urgently

- 1 Rushcliffe CCG to initiate meetings with other key stakeholders to formulate a memorandum of understanding. This should be at a high level between chief executives of the organisations involved. We would suggest at a minimum that this involves Rushcliffe CCG, Circle and NUH. With a fair wind this could be achieved within weeks.
- 2 Agreement of common objectives, the core of which is the preservation of dermatology services within Nottingham and a commitment to develop those services. This would enable all the organisations involved to organise an event involving all providers, stakeholders and patients and the public. This should be independently facilitated and should be charged with the task of trying to answer key questions regarding the immediate sustainability of the services, what is required, and the long term vision for the dermatology service.
- 3 Investment should be made in supporting and developing consultants and other clinical staff, bringing together key players within the organisation to foster relationships. The consultants should work as a single body/team across both provider organisations. We believe that there are the beginnings of an understanding of how commissioners and the providers can build a relationship of trust and sustain the service. In particular it may be easier to appoint new consultants to NUH contracts who subsequently do a large part of their work within the Circle service. Appropriate job plans would need to be developed, with attention to training and research opportunities. Circle and NUH should continue to recruit, and do this together coordinating the job plans to maximise the chance of recruiting the best possible candidate and ensuring that workload and workforce are matched across the wider service.
- 4 The commissioners should invite BAD representatives to planned events and for Circle to show them the good work done within the NTC. The situation has led to unfavourable news coverage and the bringing together and closer cooperation between the parties involved will allow for a much more favourable and positive reporting of the situation in Nottingham in the dermatological and medical media, and a greater chance of future recruitment of dermatologists to the area.

### 8.2 Medium to long term

- 1 Rushcliffe CCG should take the initiative to invite other CCGs to consider the requirements for a strategic clinical network, with the aim of looking at the larger geographical provision of specialist services and how they could be more efficiently provided.
- 2 Bring together a dermatology action group with representation from local CCGs, present providers and patients and the public to consider the longer term strategy for dermatology
- 3 NHS Education England to urgently consider the need for expansion of dermatology training numbers.



## 9 Appendices

### 9.1 Appendix 1 – Panel Biographies

**Dr Chris Clough** is a consultant neurologist at King's College Hospital, London. He led the amalgamation of three services to form the Regional Neurosciences Centre, based at King's College Hospital, becoming the first regional Director of Neurosciences in August 1995. In 1998 Chris became Medical Director at King's College Hospital where he was joint lead for clinical governance and research and development director. Chris has held the posts of Chief Medical Advisor to the South East London SHA, Medical Director for the Joint Committee on Higher Medical Training, Federation of Royal Colleges and Clinical Advisor to the NHS Institute. Chris has led numerous independent reviews of NHS services across the country as Chair of the National Clinical Advisory Team for the Department of Health.

**Dr Stephen Jones** is a Consultant Dermatologist, from Wirral University Teaching Hospital, NHS Foundation Trust and honorary member and Past President of the British Association of Dermatologists, Fellow Royal Colleges of Physicians London & Edinburgh.

**Dr Ian Bowns** is a medically-qualified Public Health Consultant with over 20 years' experience in the NHS, academia and Public Sector Consultancy.

**Dr David Colin-Thomé** is the former national director for primary care at the Department of Health, with 36 years of experience as a GP. Before being appointed as national clinical director, David was director of primary care at the Department of Health's London regional office, senior medical officer at the Scottish Office and director of primary care North West region NHS Management Executive. He was also formerly a member of Halton Health Authority, Cheshire Family Health Services Authority and a local councillor. David is an honorary visiting professor at Manchester Business School, Manchester University and of the School of Health, University of Durham. He was awarded the OBE in 1997.

**Dr Jonathan Corne** will be observing the panel. Jonathan undertook pre-clinical training at Cambridge followed by clinical training at Kings College Hospital and undertook house officer and senior house officer posts at Kings College Hospital and Guys Hospital, London. Jonathan is currently Head of the East Midlands (North) Postgraduate Specialty School of Medicine.

## 9.2 Appendix 2 – Terms of Reference

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### Terms of Reference

Review of Dermatology Services in Nottinghamshire  
April 2015

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#### 1. Purpose

To undertake an independent clinical review of adult and children's dermatology services in Nottinghamshire. To propose short, medium and long term solutions to the problems of consultant recruitment and retention over the past 2 years, taking account of surrounding health systems, and looking to the future requirement of dermatology services and the workforce required to deliver these.

#### 2. Goals

To propose a sustainable dermatology service relevant to the population health needs of Nottinghamshire.

To assess the availability of the resources needed to deliver this in light of the national consultant shortage. (Comparison with similar health systems may provide alternate solutions)

To propose short, medium and long terms solutions to CCG and NHS England commissioners.

To suggest a service specification which will follow the proposed service model and should enable the CCG and NHS England to jointly commission the required service.

#### Scope of the review

- Staffing
  - Workforce planning
  - Access to education and training needs for all clinical staff (medical, nursing and AHPs)
  - Recruitment and retention of clinical staff
- Comparison of dermatology services with other similar providers/CCGs
  - Clinical outcomes
  - Patients experience
  - GP referral rates, , New: FU ratio, Standardised Admissions Rates (SARs)
- Pathways
  - Current treatments delivered within the service and their outcomes
  - Future research and development
  - Specialised and non-specialised commissioning responsibilities
  - Current services in line with national guidance
  - Comparison of services delivered by other health communities similar to Nottingham i.e. links to plastics, cancer services

- The evidence base for the services that need to be commissioned relevant to the population
- Models of delivery
  - Use of technology, e.g. telemedicine
  - Different contracting models
  - Other models of delivery in other health care systems

### **3. Tasks**

- Produce a report to advise CCGs and NHS England.
- Update stakeholders on the progress and outcome of the review
- Involve significant stakeholders in the review

### **4. Authority**

The project will be accountable to the CCGs with NHS Rushcliffe CCG acting as the co-ordinating commissioner for the review overall and for adult services and NHS England for children's services.

### **5. Reporting**

A project manager accountable to NHS Rushcliffe CCG will oversee and support the independent review team, and ensure the report is available to all the organisations involved with the dermatological review. The draft report will be delivered to the CCG by mid May 2015, and to all stakeholders for identification of any errors of fact. The final report will be delivered by 31 May 2015. The action points to be considered by the CCG at the first available executive meeting and a response delivered by the end of June 2015 to all stakeholders, with the report and response in the public domain as soon as possible.



## 9.3 Appendix 3 - Interview Timetable and Attendees

### Nottingham Dermatology Service: Independent Panel Review 22<sup>nd</sup> April 2015

#### Venue:

Easthorpe House, NHS Rushcliffe Clinical Commissioning Group

#### Interview Timetable and Attendees

Time	Organisation	
08:30	Panel pre-meet	Dr Chis Clough, Chair, Consultant Neurologist, Kings College Hospital, London Dr David Colin-Thome, Independent Healthcare Consultant GP Dr Stephen Jones, Consultant Dermatologist, Wirral University Teaching Hospital, NHS Foundation Trust I(NHS FT) Dr Ian Bowns, Public Health Consultant Dr Jonathan Corne, Panel Observer, Health Education East Midlands (HEEM)
09:00	Nottingham University Hospitals NHS Trust, Clinicians	Dr Jane Ravenscroft and Dr Ruth Murphy, Consultant Dermatologists
09:30	Nottingham University Hospitals NHS Trust, Managers	Stephen Fowle, Medical Director Rachel Eddie, Deputy Director of Operations Carol Greenfield, Deputy General Manager Keith Oliver, General Manager
10:00	Clinical Commissioning Groups GP leads and Chief Officers NHS England commissioners	Dr Hugh Porter, Clinical Lead, Nottingham City Dr Paul Oliver, Clinical Lead, Nottingham North and East Dr Guy Mansford, Clinical Lead, Nottingham West Kate Hunter, Head of Acute and Community Contracting, Mansfield and Ashfield and Newark and Sherwood Dr Stephen Shortt, Clinical Lead, Rushcliffe Vicky Bailey, Chief Officer, Rushcliffe Jon Gulliver, Specialised Commissioning, NHS England
<b>10:45</b>	<b>Break</b>	
11:00	Nottingham NHS Treatment Centre, Circle Nottingham, Managers	Helen Tait, General Manager Andy Addison, Operations Manager Paul Dawson, Patient and Public Engagement Representative
11:30	Nottingham NHS Treatment Centre, Circle Nottingham Circle Clinicians	Dr Anand Patel and Dr Sandeep Varma, Consultant Dermatologist Kate Blake, Lead Nurse
<b>12:30</b>	<b>Lunch</b>	
13:00	British Association of Dermatologists	Dr David Eedy, President, British Dermatology Society

<b>Time</b>	<b>Organisation</b>	
13:30	Clinical Directors/Leads, Derby, Leicester and Sherwood Forest hospitals  (teleconference facilities will be available)	Duncan Bedford Divisional Director and Dr Tanya Bleiker, Consultant Dermatologist, Derby Teaching Hospitals, NHS FT Theresa Joseph, Consultant Dermatologist, Sherwood Forest Hospitals, NHS FT Jane Edyvean, Head of Operations, Acute Medicine, University Hospitals of Leicester NHS Trust
14:00	Healthwatch Nottinghamshire and public/patients	Claire Grainger, Chief Executive Healthwatch Nottinghamshire, Nottinghamshire County Jane Kingswood, Community and Partnership Worker, Healthwatch Nottinghamshire, Nottinghamshire County
<b>15:00</b>	<b>Break</b>	
15:15	East Midlands Clinical Senate	Dr David J Rowbotham Co-Chair, East Midlands Clinical Senate
16:00	Overview and Scrutiny Committee	County Councillor Parry Tsimbiridis, Chairman City Councillor Ginny Klein, Vice-Chair  Jacky Williams (Chair of the Quality Account Study Groups for NUH and the Treatment Centre. Martin Gately, Lead Officer for Health Scrutiny at the County Council
16:45	Post panel meeting	Chis Clough Dr David Colin-Thome Dr Stephen Jones Dr Ian Bowns Dr Jonathan Corne
17:30	Panel debrief to Clinical Commissioning Groups and NHS England	Chis Clough Dr David Colin-Thome Dr Stephen Jones Dr Ian Bowns Dr Jonathan Corne Vicky Bailey Dr Guy Mansford Jon Gulliver
<b>18:15</b>	<b>Close</b>	

## 9.4 Appendix 4 – Information Pack Contents

### Nottingham Dermatology service review April 2015 INFORMATION PACK CONTENTS

Enclosure Number	Title
Enclosure 1	Dermatology review - final draft TORs - 13.3.2013
Enclosure 1a.	Timetable.
Enclosure 2	OSC Overview.
Enclosure 2a	MD and CEO NUH position statement25-02-15.
Enclosure 2b	Circle paper to OSC Feb 2015
Enclosure 2c	OSC Notes March 15
Enclosure 2d	BAD response to OSC Mar 15.
Enclosure 3	Specification General Dermatology.doc
Enclosure 4	Specialised Spec all ages 2013.
Enclosure 5	Spec for cancer-skin-adult.
Enclosure 6	. 01-05-14 Circle Benchmarking Report V1.1
Enclosure 7	17-02-15 SARS Report.
Enclosure 8	Circle CQC report.
Enclosure 8a	National Peer Review of Circle 2014
Enclosure 8b	2015 HEEM Workforce paper
Enclosure 8c	HEEM 2015 quality free text comments
Enclosure 9	11-03-13 Cons Dermatology Letter to CCG.
Enclosure 10	11-02-13 announcing preferred bidder
Enclosure 11	12-3-13 DH request post BAD and contract award.
Enclosure 12.	20-03-13 CCG Response letter to BAD
Enclosure 13	20-3-13 Letter to Consultants from CCG
Enclosure 14	22-03-13 BAD Letter to Nottingham CCG
Enclosure 15	03-04-14 Email trail re NUH offer on C&B
Enclosure 16	12-05-14 non-payment to NUH
Enclosure 16a	17-07-14 Legal letter to NUH re activity and non-payment.
Enclosure 17	11-08-14 CCG to NUH re non contract activity.doc
Enclosure 18	24-11-14 email NUH to CCG re review and urgency.
Enclosure 19	05-01-15. constituent letter to MP
Enclosure 19a	15-01-15 CCG response to MP letter
Enclosure 20	02-02-15 Email context for new service
Enclosure 20a	02-02-15 new service Arrangements
Enclosure 21	23-01-15 email for transfer of patients to Derby.
Enclosure 22	13-03-15 email from Circle giving up exclusivity
Enclosure 23	Summary Dermatology - FOI and PQs
Enclosure 24	2009 HNA on Skin
Enclosure 24a	Dermatology services transformation.

Enclosure Number	Title
Enclosure 25	PCC skin care guidance
Enclosure 26	BAD Comm Guide
Enclosure 26a	BAD Quality Standards
Enclosure 27	Dermatology Activity April 2013 to Feb 2015 South Notts CCGs
	Circle dermatology information
On day	NUH Evidence to the CCG April 2015
	Collated comments from users of the service – Dermatology review 22-4-15 collected by Nottingham Healthwatch Nottinghamshire
	Care Quality Commission Report on Circle Nottingham NHS Treatment date of inspection 28-1-15 (to be published May 2015)

## 9.5 Appendix 5 – Service Models and Benchmarking

### Service models

One of the commissioners' expressed intentions was to move appropriate dermatology services into community settings. There are already moves underway, but there is scope for greater use of more innovative service models. Most involve use of different staff (e.g. primary care staff) or expanding the roles of existing staff groups, particularly specialist nurses. Other innovations reaching the mainstream involve greater use of technology, particularly telemedicine. The various options are summarised in documents such as Skin Conditions in the UK: a Health Care Needs Assessment (particularly Chapters 4 and 5) document available at

<http://www.nottingham.ac.uk/research/groups/cebd/documents/hcnaskinconditionsuk2009.pdf>).

The Kings Fund/BAD Report entitled "How can dermatology services meet current and future patient needs while ensuring that quality of care is not compromised and that access is equitable across the UK?" (<http://www.bad.org.uk/shared/get-file.ashx?id=2347&itemtype=document>) gives additional and updated illustrations of service models and their potential impact. It is unlikely that it is sensible to commission every particular service described in these documents, but local commissioners need to consult with patients, public and professionals and then specify the most appropriate service "mix" for the wider Nottingham health economy.

### Benchmarking

The considerable limitations on the data available regarding specialist treatment undertaken in English hospitals have been noted by others (e.g. the 2009 HCNA). This reflects the importance given historically to any specialty that is predominantly out-patient based. There is, for example, no routine diagnostic data for first or follow-up out-patient attendances.

The benchmarking data available within the timescale of the review compared rates first attendances referred by GPs across the County, finding quite limited variation across the CCGs in the south of the County. The great majority of patients referred are seen within the relevant (18 week) target. The lead commissioner (Rushcliffe CCG) examined routinely available benchmarking data on the range of services provided by the Nottingham Circle Treatment Centre from sources such as the national PbR Benchmarking tool and Dr Foster. Based upon activity data for 2013, this suggested that attendance rates for Psoriasis (without any procedure being recorded) and surgery for known or suspected skin cancer are particularly high. Rates seem particularly high for the catchment area of the Circle service and for cases where no procedure has been recorded. These appear to be recorded as day cases, which carry a significantly higher tariff cost to the commissioner than the same cases treated in an out-patient or community setting. Consequently, these are areas for particular attention when considering alternative service models that might be more cost-effective and capable of delivery nearer to patients' homes. There are already examples of services that undertake some of these activities in community settings (e.g. Sunderland's Dermatology and Minor Surgery Service, see <http://www.kingsfund.org.uk/publications/specialists-out->

[hospital-settings/case-studies](#)). National comparisons have also suggested scope some reductions in follow-up appointment rates in a number of specialties, including dermatology. The latest available rates indicate that up to month 11 of 2014/15, Circle saw 7,811 new Outpatient (OP) first attendances and 17,629 follow-ups (FU). This would give a ratio of 2.25 FUs for every new patient seen. Although there are considerable difficulties in making simple comparisons, particularly for a combined secondary and tertiary service such as Nottingham, this is higher than many units have been achieving, suggesting scope for improvement. This would have the additional advantage of reducing pressure on the service.

## 9.6 Appendix 6 - Healthwatch Nottinghamshire Collated Responses

### Healthwatch Nottinghamshire

Evidence for Independent Review Panel of Dermatology Service in Nottingham

22<sup>nd</sup> April 2015

#### In summary

Some good care, but enough evidence to be concerned. Due to the short time scale of this process, we did not have time to do a large amount of engagement activity. Therefore we have collated as much evidence as possible from a public event, and other sources.

#### What will happen next?

- The report will be published? Patients were keen to see it.
- What follow up will happen?
- Seems to be a need for a PPI group of some kind to be established?
- We would like a response from the Panel which we can share with the patients.

#### Key Themes from patient feedback:

Several patients gave positive, or neutral feedback, a number have made negative comments, in some cases several comments by a single individual. With skin conditions, as a long term condition, often means very regular visits to the department. Therefore, even a seemingly minor issue, can become significant if repeated over time. Also with the potential seriousness of conditions, we are particularly concerned that regular checks for early intervention may have been lost.

<i>Theme</i>	<i>Examples</i>	<i>Quotes</i>
Staff Turnover, particularly Retirement of Staff	Lack of continuity. Mentioned by lots of patients, but particularly those with long term conditions.	“I think the constant turnover of doctors and the lack of any consultant lead is concerning both for local patients and for the future of the service.” “For Long Term Conditions continuity of treatment is really important. Seeing a new clinician each time is unhelpful.” [You have to explain your

<i>Theme</i>	<i>Examples</i>	<i>Quotes</i>
		<p>condition, and many years of history each time] [in comparison, LTC treatment in other departments is by the same Dr throughout]</p> <p>“...the consultant I was now seeing was a locum... it was clear he had not read my notes prior to my appointment. I had to go through all the same questions again and he could not locate the photos that had been taken by the hospital (I had to show the ones I had taken on my phone) which was very frustrating.”</p>
Staff Attitude	Helpful but busy. Rudeness.	<p>“saw a very rude and unhelpful doctor who I refused to see again”</p> <p>“saw a senior consultant in the department and was extremely impressed with the help she was able to give”</p>
Communication	Concerns about poor communication	<p>“A nice lady but couldn’t clearly understand her diction. Confusion between BCC and BBC”</p> <p>“just told "its skin cancer" bluntly”</p> <p>“Waiting for 6 weeks to receive a biopsy result, and due to this wait I went to the appointment assuming that it was all clear and I was completely unprepared for the news that I had cancer”</p> <p>“Recently had a Saturday appointment, so didn’t have to take time off work, then could not do blood test, or collect for pharmacy as they were both shut.”</p>
Quality of Care	Concern about mistakes, complaints made. Checks not done, which used to be.	<p>“Unclear complaints procedure and delayed response / there is not a complaints procedure listed on the Circle website”</p> <p>“...has not been fully checked over all skin since the switch. This used to happen at every appointment. With all over eczema it is important to check this regularly.” [PUVA treatment makes this more important.]</p>



<i>Theme</i>	<i>Examples</i>	<i>Quotes</i>
		<p>Concern that some clinicians don't have specific knowledge needed. When mentioned a treatment, the doctor went to look it up. This worried the patient that they didn't know what was needed.</p> <p>"Poor aftercare - I had severe nerve damage after surgery ... and this severely impacted upon my quality for life for nearly a year. I repeatedly told Circle staff at my appointments, but I was told these problems would settle down by themselves after 6 months it still had not, when I asked if I could be referred for physiotherapy I was told that this would not help me"</p>
Process - appointments and admin	Difficulty making appointment. Confusion about the system. Inability to book ahead.	<p>"lack of coherence of the system and the apparent randomness of receiving an appointment"</p> <p>"should get a phone call, but doesn't, so has to call to chase it"</p> <p>"no follow up, should have been phoned but wasn't, called to chase and was told the consultant "Mr .... is a very busy man"</p> <p>Appointment times "...used to be variable - from 5 to 40 minutes depending how long you needed this was really good for LTC management as needs vary"</p>
Pharmacy delays	Delays	<p>"The pharmacy is a joke that you have to wait 40 minutes"</p> <p>"separate section of pharmacy for Treatment Centre patients, which is always slow and seems disorganised"</p> <p>"You can wait here for about an hour to get your medicine which is too long"</p>

<i>Theme</i>	<i>Examples</i>	<i>Quotes</i>
Workload	Staff good but too busy	<p>“the nursing staff were really good but very, very busy.”</p> <p>“by the time it was due almost all the doctors in the clinic would be new so she didn’t know any of them....every time I go to the reception desk to make my next appointment it’s always extremely difficult for the staff to find an appointment slot as the clinic is so over subscribed for the medical staff and appointments available.”</p> <p>“ I used to have a nurse present at each consultation, who could translate the doctor’s language for patient, also would advocate for patient when needed”</p>

#### Questions raised by Patients and the Public:

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1. Concerned what will happen when my doctor retires?
2. Can I be reassured at least that the contract still requires the Dermatology team to fully participate in the training of new doctors and nurses?
3. I think the constant turnover of doctors and the lack of any consultant lead is concerning both for local patients and for the future of the service.
4. Are appointments now, ten minutes only, one size fits all? Seems like would make more sense to have short ones for a quick, one off check. And optional longer ones for people managing a long term condition.
5. Are locums not registered?
6. How do I make a complaint?
7. Will loss of local services mean patient have to travel out of area?  
Parent concern at having to take unwell children to Leicester.
8. Will lessons learnt be included in report?
9. Can the good reputation as a world renowned Dermatology Centre ever be re-established?
10. Lack of consultation in initial contract process.
11. Technology needs sorting out.
12. Pharmacy needs sorting out.
13. Staff time should be improved.
14. Care – can you bring back personalised care?
15. How would patients find out about new research and treatment? If it did develop?
16. ‘What on earth were those responsible for service contracts thinking of when letting Circle management change doctors and surgeons’

### Sources of Opinions:

1. Previously collected stories from Healthwatch Nottinghamshire (County residents).
2. Previously collected stories from Healthwatch Nottingham (City residents) at visit to Circle Treatment Centre
3. Opinions collected at Public Drop in event 16<sup>th</sup> April 2015
4. Comments submitted by those who could not attend the drop in event.



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<b>JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE</b>
<b>16 JUNE 2015</b>
<b>WORK PROGRAMME</b>
<b>REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)</b>

**1. Purpose**

- 1.1 To give initial consideration to the provisional draft work programme for 2015/16 based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

**2. Action required**

- 2.1 The Committee is asked to note the work that is provisionally planned for municipal year 2015/16 and make amendments to this programme if considered appropriate.

**3. Background information**

- 3.1 The Joint City and County Health Scrutiny Committee is responsible for setting and managing its own work programme to fulfil its role in relation to health services accessed by both City and County residents, including:
- scrutinising the commissioning and delivery of local health services
  - holding local decision makers to account
  - carrying out the statutory role in relation to proposals for substantial developments or variations in NHS funded services
  - responding to consultations from local health service commissioners and providers.

The detailed terms of reference for the Committee can be found in the respective Council Constitutions.

- 3.2 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities as outlined above. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately. This is likely to include consultations from health service commissioners and providers about substantial variations and developments in health services that the Committee has statutory responsibilities in relation to.
- 3.3 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. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

- 3.5 The provisional draft work programme for the coming municipal year is attached at Appendix 1, based on areas of work identified by the Committee at previous meetings and suggestions already put forward by Councillors. Councillors are asked to put forward any other possible suggestions of issues for scrutiny.

**4. List of attached information**

- 4.1 The following information can be found in the appendix to this report:

**Appendix 1 – Joint Health Scrutiny Committee Provisional Draft 2015/16 Work Programme**

**5. Background papers, other than published works or those disclosing exempt or confidential information**

None

**6. Published documents referred to in compiling this report**

Reports to and Minutes of Joint Health Scrutiny Committee meetings held on 10 June, 15 July, 9 September, 7 October, and 9 December 2014, 13 January, 10 February, 10 March and 21 April 2015.

**7. Wards affected**

All

**8. Contact information**

Clare Routledge, Senior Governance Officer (Health Scrutiny)  
Tel: 0115 8763514  
Email: [clare.routledge@nottinghamcity.gov.uk](mailto:clare.routledge@nottinghamcity.gov.uk)

**Joint Health Scrutiny Committee 2015/16 Provisional Work Programme****16 June 2015**

- **NUH Pharmacy Information**  
To receive information as part of an ongoing review  
(Nottingham University Hospitals)
- **South Notts Transformation Partnership**  
To receive information relating to the establishment, remit and work plan of the Partnership  
(South Notts Transformation Partnership)
- **Proposed Transitional Changes Within Nottinghamshire Healthcare Trust Adult Mental Health Service For 2015/16**  
(Nottinghamshire Healthcare Trust)
- **Independent Review of Nottingham Dermatology Services 2015**  
To receive the report following the independent review  
(Nottingham Dermatology Services Independent Review Team)
- **Work Programme**  
To consider the provisional 2015/16 Work Programme

<p><b>14 July 2015</b></p>	<ul style="list-style-type: none"> <li> <p>• <b>Transformation Plans for Children and Young People</b> To receive an update on the preferred site <span style="float: right;">(Nottinghamshire Healthcare Trust)</span></p> </li> <li> <p>• <b>Public Consultation regarding Gluten free Prescribing (tbc)</b> <span style="float: right;">(Rushcliffe CCG)</span></p> </li> <li> <p>• <b>Changes in Adult Mental Health Care Provision in Nottingham City and County</b> To receive the latest update on the changes <span style="float: right;">(Nottinghamshire Healthcare Trust)</span></p> </li> <li> <p>• <b>Healthwatch – Renal Patient Transport Review</b> To receive an update on addressing the findings of the Report produced in March 2015 <span style="float: right;">(Healthwatch Nottinghamshire and Arriva Transport Solutions)</span></p> </li> </ul>
<p><b>15 September 2015</b></p>	<ul style="list-style-type: none"> <li> <p>• <b>Outcomes of the Primary Care Access Challenge Fund Pilots</b> Evaluation of Results <span style="float: right;">(South Nottinghamshire CCGs and Area Team)</span></p> </li> <li> <p>• <b>Patient Transport Service – Performance Update</b> <span style="float: right;">(Arriva /CCG lead)</span></p> </li> <li> <p>• <b>NHS 111 Performance Update</b> <span style="float: right;">(Nottingham City CCG)</span></p> </li> <li> <p>• <b>East Midlands Ambulance Service – New Strategies Update</b> Update on the implementation of new Strategies <span style="float: right;">(EMAS)</span></p> </li> </ul>



<p><b>13 October 2015</b></p>	<ul style="list-style-type: none"> <li>• <b>Urgent Care Resilience Programme 2015/16</b> To receive an update on the preparation and planning for Winter 2015/16 (Nottingham City CCG and NUH)</li> <li>• <b>Rampton Secure Hospital Variations of Service</b> To receive an update on treatment and care of people with personality disorders (NHS England and Nottinghamshire Healthcare Trust)</li> </ul>
<p><b>10 November 2015</b></p>	<ul style="list-style-type: none"> <li>• <b>NUH Environment and Waste Update</b> To receive the latest update (NUH)</li> </ul>
<p><b>15 December 2015</b></p>	<ul style="list-style-type: none"> <li>• <b>Royal College of Nursing</b> Further briefing on the issues faced by nurses (RCN)</li> </ul>
<p><b>12 January 2016</b></p>	
<p><b>9 February 2016</b></p>	
<p><b>15 March 2016</b></p>	
<p><b>19 April 2016</b></p>	

**To schedule:**

Children's Immunisation uptake, performance and impact  
NHS England Area Team and Quality Surveillance Groups  
Nottingham University Hospital Maternity and Bereavement Services  
NHS Out of Hours Dental Services  
Daybrook Dental Services Report of findings and lessons learnt  
Progress on developing 24hour services  
East Midlands Senate  
Quality Surveillance Group (QSG)

**Visits:**

Urgent and Emergency Care Services  
Rampton Secure Hospital

**Study groups:**

Quality Accounts