Nottingham City Council

NOTTINGHAM CITY COUNCIL
JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

Date: Tuesday, 14 July 2015

Time: 10.15 am

Place: Ground Floor Committee Room - 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 8763514

AGENDA **Pages**

8 JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE 2015/16 WORK PROGRAMME 117 - 122

Report of Head of Democratic Services (Nottingham City Council)

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

A PRE MEET FOR COUNCILLORS WILL COMMENCE AT 10.00 AM.

CITIZENS ATTENDING MEETINGS ARE ASKED TO ARRIVE AT LEAST 15 MINUTES BEFORE THE START OF THE MEETING TO BE ISSUED WITH VISITOR BADGES

CITIZENS ARE ADVISED THAT THIS MEETING MAY BE RECORDED BY MEMBERS OF THE PUBLIC. ANY RECORDING OR REPORTING ON THIS MEETING SHOULD TAKE PLACE IN ACCORDANCE WITH THE COUNCIL'S POLICY ON RECORDING AND REPORTING ON PUBLIC MEETINGS, WHICH IS AVAILABLE AT WWW.NOTTINGHAMCITY.GOV.UK. INDIVIDUALS INTENDING TO RECORD THE MEETING ARE ASKED TO NOTIFY THE GOVERNANCE OFFICER SHOWN ABOVE IN ADVANCE.

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Loxley House on 16 June 2015 from 10.15am - 12.19pm

Membership

Present	Absent
Councillor Ginny Klein (Chair)	Councillor Richard Butler
Councillor Parry Tsimbiridis (Vice Chair)	Councillor John Handley
Councillor Eunice Campbell	Councillor Merlita Bryan
Councillor Carole-Ann Jones	Councillor Corall Jenkins
Councillor Pauline Allan	Councillor Chris Tansley
Councillor John Clarke	
Councillor Colleen Harwood	
Councillor Jacky Williams	
Councillor Anne Peach	
Councillor Richard Jackson (as substitute)	
Councillor Kay Cutts MBE	
Councillor Martin Suthers OBE (as substitute)	

Colleagues, partners and others in attendance:

Vicky Bailey	-	NHS Rushcliffe CCG
Nicky Bird	-	Mansfield and Ashfield CCG
Hazel Buchanon	-	South Nottinghamshire Transformation Partnership
Trish Cargill	-	South Nottinghamshire Transformation Partnership
Debbie Dolan	-	Nottinghamshire Healthcare NHS Trust
Rachel Eddie	-	Nottingham University Hospitals NHS Trust
Dr Stephen Fowlie	-	Nottingham University Hospitals NHS Trust
John Gulliver	-	NHS England
Peter Homa	-	Nottingham University Hospitals NHS Trust
Dr Hazel Johnson	-	Nottinghamshire Healthcare NHS Trust
Rebecca Larder	-	South Nottinghamshire Transformation Partnership
Paul Manning	-	CircleNottingham
Dr Guy Mansford	-	NHS Nottingham West CCG
Colin Monckton	-	Nottingham City Council
Simon Smith	-	Nottinghamshire Healthcare Trust
Helen Tait	-	CircleNottingham
Nayna Zuzarte	-	Rushcliffe CCG
Clare Routledge	-	Senior Governance Officer
Phil Wye	-	Governance Officer

1 APOLOGIES FOR ABSENCE

Councillor Merlita Bryan
Councillor Richard Butler (sent substitute)
Councillor Chris Tansley
Councillor Corall Jenkins
Councillor John Handley (sent substitute)

2 DECLARATIONS OF INTEREST

None

3 MINUTES

The minutes of the meeting held on 21 April 2015 were confirmed and signed by the chair.

4 JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE TERMS OF REFERENCE AND PROTOCOL

RESOLVED to

1) note the Committee's terms of reference;

2) agree the Commitees's protocol for 2015/16.

5 PROPOSED TRANSITION CHANGES WITHIN ADULT MENTAL HEALTH SERVICES 2015/16

Simon Smith, Nottinghamshire Healthcare NHS Trust, presented the report of the Head of Democratic Services on the proposed service redesign and improvement initiatives within Adult Mental Health services during 2015/16. The following points were highlighted:

a) Adult Mental Health is proposing the planned closure of two in-patient rehabilitation units. This forms the final part of progressive change that has been occurring over the past 4 years. The proposals are in line with the national strategy in meeting the needs of the population;

b) resources will be reinvested in community rehabilitation teams which are more appropriate to the needs of citizens as demonstrated through experience in other areas.

The following answers were given in response to questions from the committee:

c) evidence gathered in other areas demonstrates that rehabilitation through the work of community teams aids recovery and independence and decreases sigma;

d) there will still be a range of rehabilitation options available, including in-patient care;

e) Adult Mental Health aim to improve the accessibility of mental health provision, for example the provision of a 24 hour contact service which is seen as a priority;

f) Adult Mental Health staff will be trained in family intervention to support carers as this has been identified as an area where more support is needed.

RESOLVED to

1) note progression of the Adult Mental Health Directorate Rehabilitation Strategy focussing on increased community provision and decrease of in-patient rehabilitation services;

2) note 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) agree for the Adult Mental Health Directorate to return in 6 months with a further update.

6 SOUTH NOTTS TRANSFORMATION PARTNERSHIP

Rebecca Larder, Director of Transformation, South Nottingham Transformation Partnership (SNTP), presented the report of the Head of Democratic Services on the work of the SNTP in reshaping the local health and social care system to ensure it can provide sustainable, high quality care for everyone. As a result the SNTP is focussing upon the development of accountable care systems and outcome based commissioning. The following points were highlighted:

a) the area that the SNTP will cover has a population of around 700,000 people. 10% of these require urgent care and account for around 40% of the costs. The SNTP has the potential to save £20 million, whilst also improving experience and outcomes for everybody;

b) there will be a 5% increase in the population by 2021 (with an 11% increase in the over 65s and the current model has a £140 million financial gap, so new ways of working are required;

c) the SNTP is made up of 12 partners (Commissioners and Providers). It aims to provide accessible quality and sustainable care, centred around individual people, close to home;

d) international evidence from similar initiatives in Europe, New Zealand and the USA has demonstrated improved health outcomes and improved staff satisfaction, as well as a reduction in emergency admissions and costly acute activity;

e) a Strategic Outline Case (SOC) is currently being drawn up, with active engagement from service users throughout the South Nottinghamshire Transformation Board area through the Citizens Advisory Group, the Engagement Group and service work-streams. The SNTP is aiming to have the SOC completed by the end of October 2015.

The following responses were given in answer to questions from the committee:

f) knowledge is also being gathered from other areas of the UK including core cities, the integrated care pioneer status sites and North-West London;

g) the SNTP will attempt to engage with hard to reach groups by identifying gaps in knowledge and using the voluntary sector and other community groups to reach them;

h) the establishment of the SNTP is a huge opportunity for South Nottinghamshire and a lot of work is going into it. Other transformation partnerships, such as mid-Nottinghamshire and southern Derbyshire, may seem further ahead but are not necessarily comparable models. However, all local transformation partnerships will learn and share best practice with each other;

i) workforce development is a challenge for the SNTP.

RESOLVED to

1) note the report and presentation;

2) agree future working and reporting arrangements of the South Nottingham Transformation Partnership to this Committee.

7 NOTTINGHAM UNIVERSITY HOSPITAL PHARMACY INFORMATION

Dr Stephen Fowlie, Medical Director, Nottingham University Hospitals NHS Trust, presented the report of the vice-chairman of Joint City and County Health Scrutiny Committee providing an update on the ongoing review of pharmacy delay and prescribing issues at Nottingham University Hospitals (NUH). The following points were highlighted:

a) hospital dispensing is better value for money than community dispensing. NUH drug expenditure is reducing due to better procurement, the reduction of waste and the use of the best value for money drugs;

b) there has been a 50% increase in dispensary workload at NUH over the past 3 years, and now there are around 50,000 transactions a month;

c) the target out-patient waiting time for drugs to be dispensed is 26 minutes at NUH. The average monthly waiting times have met this target, however some people still have to wait much longer as it can take time to check specialised drugs. It is extremely unusual for an NUH pharmacy to not have a hospital-prescribed drug available for dispensing;

d) in response tp feedback NUH now publish enhanced pharmacy opening times and the Area Prescribing Committee is reviewing the Pharmacy Policy;

e) waiting areas and consultation facilities have been recently refurbished to improve comfort and privacy;

f) the target for turnaround of TTO (to take out) medicines is 2 hours. This target is met in the majority of cases, however it can take longer. Attempts to reduce these cases further include the recruitment of more pharmacy staff and a review of prescribing policy;

g) plans are in place to introduce e-prescriptions by 2017. This would lead to fewer medication errors and drug-related incidents, better TTO turn-around times, and better control over prescribing.

The following answers were given in response to questions from the committee:

h) each CCG within the county provided information on how they attempt to reduce waste. This information is in the papers that were circulated prior to the meeting;

i) costs in Mansfield and Ashfield are proportionately higher than elsewhere due to health inequalities;

j) community pharmacists are encouraged to undertake 'medicines use reviews' to ensure all patients are taking their drugs correctly. However, pharmacists are increasingly busy with their workload and so may not always be doing this.

RESOLVED to note the presentation

8 INDEPENDENT PANEL REVIEW OF DERMATOLOGY SERVICES

Vicky Bailey, Chief Officer, NHS Rushcliffe CCG introduced the final report of the Independent Review of the Nottingham Dermatology Service, which was circulated to members prior to the meeting. The following points were highlighted:

(a) work has begun on developing an action plan and all 3 parties are meeting regularly. It is a challenge to recruit dermatologists to Nottingham;

(b) Helen Tait, General Manager of CircleNottingham said that Circle is aiming to recruit specialist dermatology nurses. Tele dermatology services have been launched and there is recognition that care and delivery need to be changed in order to be sustainable;

(c) Peter Homa, Chief Executive, Nottingham University Hospitals reported that there remains a significant shortage of dermatology expertise, so it is vital to develop a proposition that is highly attractive to staff. As well as making best use of technology there also needs to be a cohort of professionals to deliver the service. This will require changes in the commissioning and provision of dermatology services;

The following responses were given in response to questions from the Committee:

(d) the paediatric dermatology service is maintained and protected. One consultant is leaving the service in July and the other consultant works reduced hours due to research commitments. There is agreement to recruit to paediatric dermatology and other paediatric services. The relationship with GPs will be built on and their work will be overseen by consultants and non-consultant staff will continue to

support paediatric services;

(e) the transfer of patients to Leicester for in-patient care does not affect a large number of patients, and most patients can be moved safely between NUH and the treatment centre;

(f) the recommendations of the review have been accepted by all 3 parties, and an action plan is currently in development, once approved by NHS England it will be shared;

(g) there are wider lessons to be learned regarding workforce development which do not only affect dermatology but other departments too. Attention must be given to similar small specialties so that these expert staff are not lost;

(h) Rushcliffe CCG reported that discussions are taking place with Health Education East Midlands and at a national level regarding workforce development and training;

(i) Circle is working to reduce the numbers of locums employed and increase substantive appointments;

(j) NUH felt workforce was key and it is important to grow careers in Nottingham;

(k) Healthwatch will be consulted on details of the action plan. They are also invited to CircleNottingham's forum for service design.

RESOLVED to note the report

9 DRAFT JOINT HEALTH SCRUTINY COMMITTEE 2015/16 WORK PROGRAMME

The Committee considered the report of the Head of Democratic Services about the Committee's work programme for 2015/16.

RESOLVED to add the following items to the Committee's work programme:

(i) Workforce recruitment
(ii) Immunisation
(iii) Long-term conditions
(iv) End of life care

10 DATES OF FUTURE MEETINGS

RESOLVED to meet on the following Tuesdays at 10.15am:

2015 – 14 July, 15 September, 13 October, 10 November, 15 December
2016 – 12 January, 9 February, 15 March, 19 April, 10 May

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
14 JULY 2015
REVIEW OF ADULT MENTAL HEALTH AND MENTAL HEALTH SERVICES FOR OLDER PEOPLE SERVICES TRANSFORMATION 14/15
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

1. Purpose

To consider the service transformation that has taken place within Adult Mental Health Services and Mental Health Services for Older People (MHSOP) during 2014/15.

2. Action required

2.1 The Committee is asked to

a) consider and comment on the transformation of services to date; and
b) invite representatives to attend a future Committee meeting to report back on progress of addressing the challenges and next steps as outlined within the report

3. Background information

3.1 Adult Mental Health (AMH) transformation achievements include:

- Development of Enhanced Crisis Resolution and Home Treatment Teams serving Nottingham City and South Nottinghamshire in October 2014 allowing the closure of 42 acute in-patient beds at QMC;

- Development of a 6 bedded Crisis House serving Nottingham City and South Nottinghamshire;

- Development of Community Rehabilitation Team within Newark and Sherwood in September 2015 allowing the closure of 24 rehabilitation beds at Enright Close;

- A reduction in inpatient rehabilitation beds by achieving the closure of the Enright Close Rehabilitation Unit in Newark;

- Development of a pilot project for 111 mental health calls to be transferred to a mental health professionals minimising the risk of unnecessary attendance at A&E departments.

3.2 Mental Health Services for Older People (MHSOP) Transformation achievements include:

- Development of City Mental Health Intensive Recovery Services;
- Closure of Daybrook and Bestwood Wards;
- Additional staffing in Kingsley and Cherry Wards;
- All staff redeployed

3.3 Previously the Committee had been concerned about the level of public consultation that had taken place regarding the transformation plans, but acknowledged the changes were in the interest of the local health services. Nottinghamshire Healthcare Trust are working closely with patients, carers, staff, commissioners, Healthwatch Nottinghamshire and partner organisations regarding developments.

4. List of attached information

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

Appendix 1 - Review of Adult Mental Health and Mental Health Services for Older People Services Transformation 14/15 Report

Appendix 2 - Presentation – An Overview of changes made to Mental Health Services last year

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 meeting of the Joint Health Scrutiny Committee held on 7 October 2014

7. Wards affected

All

8. Contact information

Clare Routledge, Health Scrutiny Project Lead
Tel: 0115 8763514
Email: clare.routledge@nottinghamcity.gov.uk

LOCAL SERVICES DIVISION ADULT MENTAL HEALTH DIRECTORATE REVIEW OF ADULT MENTAL HEALTH AND MENTAL HEALTH SERVICES FOR OLDER PEOPLE SERVICE TRANSFORMATION 2014-2015

INTRODUCTION

This paper outlines progress made within Adult Mental Health and Mental Health Services for Older People following the closure of inpatient units and the re-investment into Community based services.

AMH SERVICE CHANGES

1. EXECUTIVE SUMMARY

This paper provides a review of the progression and impact of service transformation within the Adult Mental Health (AMH) Directorate in 2014/15. The paper will give feedback on service transformation undertaken across the city and county of Nottinghamshire.

The AMH directorates clinical Strategy was reflected in the development of the Transformation Programme for 2014/15, which included:

- The development of Enhanced Crisis Resolution and Home Treatment teams (ECRHT) serving the city and south county of Nottinghamshire
- The establishment of a 6 bedded Crisis house serving the same population
- A reduction in acute inpatient beds by achieving the closure of wards A42 and A43 at Queens Medical Centre
- The development of a Community Rehabilitation Team (CRT) serving the population of Newark and Sherwood
- A reduction in inpatient rehabilitation beds by achieving the Closure of Enright Close Rehabilitation unit in Newark
- The establishment of a pilot project for 111 callers with identified mental health needs to access expert mental health advice and avoid unnecessary emergency department attendance

This paper provides detail relating to the delivery of the Service Transformation Programme and the impact of the same.

2. SERVICE TRANSFORMATION ACHIEVEMENTS

2.1 DEVELOPMENT OF ENHANCED CRHT AND CLOSURE OF WARDS A42 AND A43

- Supported by our commissioning colleagues, the AMH Directorate was able to effectively manage the development of the enhanced Crisis teams while gradually reducing bed occupancy at the Queens medical Centre site due to decreased clinical need. This was achieved through the funding of both services during the

development of Enhanced Crisis Resolution and Home Treatment teams (ECRHT) by our commissioners to allow optimum clinical care to be delivered throughout the transition process

- AMH completed a wide ranging public engagement exercise relating to these proposals and were able to offer more detailed clinical assurance to service users, carers and other interested parties
- In partnership with commissioners AMH set stringent performance indicators relating to the new Enhanced Crisis Resolution and Home Treatment teams, these related to quality, reactivity and responsiveness, patient and carer satisfaction, and impact on partner agencies, particularly social care and emergency care of the reduction in inpatient beds
- Both wards A42 and A43 were able to be closed within the agreed timescale with the majority of service users discharged to appropriate community settings
- The Enhanced Crisis Resolution and Home Treatment team has been offering a 24 hour a day and seven day a week service to those in mental health crisis since September 2014 offering a true alternative to both admission to hospital and attendance at an emergency department for those experiencing a mental health crisis
- The Enhanced Crisis Resolution and Home Treatment team now provides a multidisciplinary service including consultant psychiatrist presence over seven days a week improving access to expert assessment and treatment, and offering wider access to expert clinical opinion than any other community service
- All staff affected by the closures of wards A42 and A43 were able to be offered appropriate alternative employment within Nottinghamshire healthcare with many choosing to work in the enhanced Crisis Resolution and Home Treatment teams
- Detailed training packages were developed for all staff working within the Enhanced Crisis Resolution and Home Treatment teams focusing on managing risk specifically for those in mental health crisis, and acknowledging the concerns of some carers with whom the Directorate engaged we have ensured that all staff are receiving specialist training with regard to working with families and carers
- Haven house a six bedded crisis house opened in January 2015 with support for commissioners and in partnership with framework offers a further alternative option for those experiencing a mental health crisis.
- Since the 01/09/2014 The Enhanced Crisis Resolution and Home Treatment teams serving City and County South have been able to support 2440 service users. Admission rates for those services users referred to the teams by our GP colleagues have been less than 5% when reviewed month on month.

2.2 DEVELOPMENT OF NEWARK CRT AND CLOSURE OF ENRIGHT CLOSE

- Enright close residents were all successfully supported to appropriate onward care packages by September 2014, most of these service users continue to receive rehabilitative care from the newly developed Community Rehabilitation Team
- AMH completed a wide ranging public engagement exercise relating to these proposals and were able to offer more detailed clinical assurance to service users, carers and other interested parties

- The Newark and Sherwood Community Rehabilitation Team has been fully operational since September 2014 offering intensive and specialist multi-disciplinary rehabilitation packages to a wider range of service users than ever before, the team currently has a caseload of 71 service users and has undertaken assessments of 86 service users since becoming operational offering a much wider range of service users access to this specialist service than ever before
- The Community Rehabilitation Team are also offering and in reach service to acute inpatients in order to support the facilitation of timely discharge for those services users who require a period of acute admission
- Continued close monitoring of developments in rehabilitation strategy and the impact of Community Rehabilitation Teams is a core part of the terms of reference for the Rehabilitation project work stream which benefits from service user and carer representation
- Service users who have spent many years in inpatient care living independently for the first time in many years
- Most staff affected by the closure of Enright Close were able to be offered appropriate alternative employment within Nottinghamshire healthcare many staff are using their expertise to support service users in the Community Rehabilitation Team

2.3 111 SERVICE

- Pilot Project, commenced in February 2015, running until March 2016 funded by NHS England for AMH to work in partnership
- Calls are transferred to expert Crisis Resolution and Home Treatment clinicians that historically would have been diverted either to emergency GP contact or the accident and emergency department with a 999 ambulance required in many cases
- 132 calls received since commencement of pilot, 98% have not required emergency department or GP attendance and the 2% that have has related to physical health concerns
- Service users are often signposted directly into secondary mental health care following this call offering a streamlined pathway and reducing pressure on GP capacity
- Advice given to service users on medication, coping strategies, accessing appropriate non-statutory support services where, and pathways into secondary mental health care
- All of these calls would have previously accessed the emergency department or an emergency GP historically

3. SERVICE USER AND STAFF FEEDBACK REGARDING SERVICE TRANSFORMATION

'***When I ring the crisis team they calm me down and help to ground me. They talk me through my coping strategies and make sure I am safe. If they weren't there in the night I am not sure I would still be alive. They have saved my life so many times. I wanted to thank them for their care and understanding'***

'I wanted to thank the County Crisis Team for their recent support I could not stay safe and calm without their support. I think I would struggle a lot, thank you'

'The support workers in Newark CRT have set up a number of groups in the community (walking group, coffee morning, etc) which are generally well attended and have been helpful in engaging people and promoting social inclusion. These groups have also attracted the attention of other teams who have referred clients to the team for these groups. The Team is currently in the process of setting up some psychologically informed therapeutic groups to run alongside these. The support workers in the team have often said that they enjoy working with people in the community as they feel that they are making a real difference to service users recovery'

'Didn't want to come when first suggested but I was desperate and now I don't want to go as I have been so impressed. I think it should be renamed Haven Retreat. I like that if I want to be alone I can be or if I want to have company I can. I have found it a very therapeutic experience.'

4. CHALLENGES AND NEXT STEPS

- AMH are now focusing on ways to more effectively achieve timely discharge from inpatient care to optimise recovery outcomes for service users working in close partnership with social care colleagues to meet the challenges of finding appropriate accommodation and placements for service users
- The AMH Directorate are working with service users and carers to Incorporate the 'Triangle of Care' into all clinical areas and to ensure this is implemented as best practice
- Continued delivery of the Rehabilitation strategy, moving toward increased community rehabilitation provision
- Review of all community services and improved access to non-crisis community care
- Continued work to deliver 24/7 crisis care in all areas of the county and focus on diversion from the emergency department/ emergency care when in mental health crisis.
- Continued focus on home treatment minimising the risk of hospital admission wherever possible

MHSOP REDESIGN AND REINVESTMENT PROGRAMME

1. WARD CLOSURES

Bestwood ward closed to admissions in July 2014 and closed permanently on 4th August 2014 all staff were redeployed to temporary posts within the Directorate until the completion of the staff consultation process.

Daybrook ward closed to admissions on 15th January 2015 when Cherry ward began accepting male admissions. Daybrook ward then permanently closed 23rd February 2015. All staff where successfully redeployed to their new roles and no staff were made redundant.

Building work on Kingsley ward began on 27th October 2014 to provide the required extra 5 functional beds within the Directorate, these opened on 16th February 2015.

The new model for inpatient provision across the Directorate is now 40 functional beds and 45 organic beds.

2. REINVESTMENT INTO THE WARDS

The skill mix on all the wards has been increased to facilitate a more robust admission, treatment and discharge process. It is acknowledged that the enhanced staffing levels are required on all the remaining wards due to admission of most complex patients and intensity of need. Extra registered staff have also been included to cover multidisciplinary team working (MDT) rounds and Electroconvulsive therapy (ECT)

Psychology input has been increased across inpatient services.

Increased psychiatry sessions have been provided to the remaining wards from the inpatient psychiatry establishment. This has supported both increased clinical complexity and reduced length of stay. The frequency of patient reviews has increased to accommodate increased clinical need.

3. REINVESTMENT TO COMMUNITY SERVICES FROM WARD CLOSURES

- Enhancing community services over 7 days a week to provide intervention from state registered staff at a weekend for both organic and functional patients who have increased risks
- Enhancing dementia outreach services to manage patients within the care homes to reduce organic admission to the wards
- In Rushcliffe, there has been an increase in Care Support Workers (CSW) hours and state registered staff within Intensive Recovery Intervention Service (IRIS), to allow seven day a week cover of state registered staff covering an early and late shift.
- In Nottingham West, an increase in Care Support Workers (CSW) hours and state registered staff in Intensive Recovery Intervention Service (IRIS) as well as Occupational Therapy and support worker hours in Dementia Outreach.
- Investment has enabled MHSOP to establish the City Mental Health Intensive Recovery team (MHIR) operating a flexible 7 days a week, between 7.00 am to 10.00 pm to meet client need.

4. MONITORING OF THE IMPACT OF THE MHSOP REDESIGN PROGRAMME

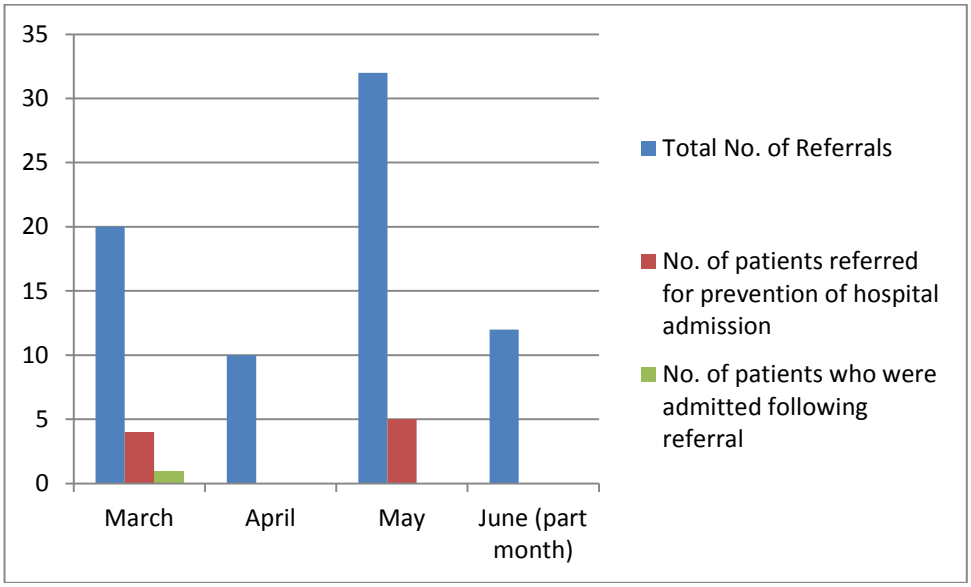
Patients have increased engagement in their own care; having more community services allows the patients to return home in a timelier manner with the support they require helping to maintain their recovery.

Since the closure of Daybrook and Bestwood wards the Directorate have had sufficient bed capacity and there have been no out of area placements.

The patient's length of stay has not increased with an average of 40.5 days for functional patients and 33.6 days for organic.

The increase of staffing and skill mix both on the wards and in the community has had a positive impact on both patients and carers; there has been a reduction in complaints and an increase in compliments received by all teams and especially Intensive Recovery Intervention Service (IRIS).

The table below describes the referrals and prevented admissions to the wards.



5. CHALLENGES AND NEXT STEPS

One of the big challenges for MHSOP is the recruitment of allied health professionals, through the workforce planning group the Directorate lead is looking at a more creative way of advertising the posts e.g. social media and recruitment days.

At times there is a slow transition into social care both from community and inpatient settings which can then lead to delayed transfers of care.

Having dedicated social workers within all the Intensive Recovery Intervention Service (IRIS) teams would be beneficial and help speed up the transition.

Having delayed transfers of care within the Intensive Recovery Intervention Service (IRIS) teams has an impact on the capacity and contacts that the teams are able to undertake.

6. CONCLUSION

AMH have achieved wide ranging service transformation during 2014/15 improving community crisis and rehabilitative care for service users and carers which has allowed a

reduction in inpatient beds in both Acute and Rehabilitative care. The Directorate continues to focus on the delivery of recovery focused service user centered care in all environments and evaluation and clinical development is a continued focus moving forward into 2015/16 and beyond.

MHSOP have achieved good patient outcomes from changes made to services, which have allowed more people to remain at home.

The Committee is asked to note the good progress made within services during the last 6-12 months.

This page is intentionally left blank

Nottinghamshire Healthcare NHS
NHS Foundation Trust

An Overview of changes made to Mental Health Services last year

Amanda Kemp – Deputy Director

AMH Service Transformation Achievements

- Development of Enhanced Crisis Resolution and Home Treatment Teams serving Nottingham City and County South in October 2014 allowing the closure of 42 acute inpatient beds at QMC

- Development of Community Rehabilitation Team for the Newark and Sherwood population in September 2015 allowing the Closure of 24 Rehabilitation beds at Enright Close

- Development of Haven House, a 6 bedded Crisis house serving the city and county south of Nottinghamshire

- Development of a pilot project for 111 mental health calls to be transferred to a mental health professional minimising the risk of unnecessary attendance at Emergency departments

Monitoring of Impact

- Monthly meetings with commissioners regarding enhanced crisis resolution and home treatment team. Set performance measures relating to reactivity of the service, service user outcomes, concerns and complaints, and any use of out of area or private beds as a consequence of acute bed reduction

- Monthly project meetings regarding delivery of rehabilitation strategy with particular focus on care delivery of community rehabilitation service and impact of rehabilitation bed reduction

- Monitoring of performance of Crisis 111 service monitoring service user satisfaction and decreased, Emergency Department attendances following contact with the service

Monitoring Continued

- Service user and carer feedback on new services
- Staff feedback on transformation process
- Supporting a review of care for people in mental health crisis to be led by Health Watch
- Full review of the clinical impact of transformation to be completed by the adult mental health directorate involving service users, carers, staff and partner agencies
- Joint meetings with key partner agencies, including the police and social care to monitor impact of changes on working partnerships

Positives

- Significant increase in service users successfully supported in a community setting and no longer requiring a period of Acute admission or inpatient rehabilitation admission
- Service users who have spent many years in inpatient care living independently for the first time in many years
- Service transformation has allowed rehabilitation and crisis care to be delivered to a larger number of people than ever before
- Truly 24/7 service provision for the first time
- Fidelity to the key aspirations of the Crisis care Concordat
- Significant success in diverting those in contact with the 111 service away from attendances at Emergency departments

Challenges and Next steps

- Focus on delayed transfers of care and ensuring timely and appropriate discharge from hospital including robust bed management
- Continuing to develop and enhance support structures for carers within our clinical services
- Focus on non-crisis community provision ensuring improved responsiveness for all
- Continuing to work in partnership to deliver the aspirations of the Crisis care concordat
- Work with service users to continue to move away from inappropriate use of Emergency departments

MHSOP Service Transformation Achievements

- Development of City Mental Health Intensive Recovery Service
- Closure of Daybrook and Bestwood Wards
- Additional staffing into Kingsley and Cherry Wards
- All staff redeployed

Monitoring of Impact

- Increased patient engagement in their own care
- There has not been an increase in suicides or serious untoward incidents
- The directorate has had adequate inpatient bed capacity since the ward closures
- No out of area placements
- There has been a reduction in complaints from patients and carers
- Very positive feed back and compliments from patients/carers about the new community services
- Increased staffing and skill mix on wards and in community teams
- Offers patients more choice about their care
- Length of stay has not increased since reduction in inpatient beds

Challenges and Next Steps

- Difficulty in recruitment of extra Allied Health Professional staff both to inpatient and community teams
- Delayed transition into social care from community teams, delays discharge from the teams
- Capacity reduced within the Intensive Recovery Intervention Service and Mental Health Intensive Recovery teams if delayed discharges are experienced
- No dedicated social worker for City Mental Health Intensive Recovery team

This page is intentionally left blank

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
14 JULY 2015
NOTTINGHAMSHIRE HEALTHCARE TRUST - 5 YEAR STRATEGY FOR CHILDREN, YOUNG PEOPLE AND FAMILIES
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

1. Purpose

To consider Nottinghamshire Healthcare Trust's proposals regarding services for children, young people and families.

2. Action required

2.1 The Committee is asked

(a) to consider if the proposals are a substantial variation or development of service;
(b) to consider and contribute their views to the consultation process of the proposal; and
(c) to invite representatives to attend a future meeting to discuss the outcomes of the Full Business Case that will be presented to the Nottinghamshire Healthcare Trust Board in September 2015.

3. Background information

3.1 Representatives of Nottinghamshire Healthcare Trust attended the Committee on 10th February 2015 and presented a series of options on the Trust's transformation plans for children, young people and families in relation to Child and Adolescent Mental Health Services (CAMHS) and Perinatal Services.

3.2 These developments are part of a wider implementation programme to improve services for children and young people with emotional and mental health needs.

3.3 Following a detailed options appraisal Nottinghamshire Healthcare Trust began a twelve week consultation on 15th June 2015 regarding the following proposals:

- Community CAMHS – new outpatient facilities for the City and South of the County with a Countywide single point of access
- Inpatient CAMHS – a new unit, with an increase in the number of beds from 13 to 24 and a new 8 bed Psychiatric Intensive Care Unit
- A purpose built Education Unit for CAMHS inpatients
- Perinatal Services – new Mother and Baby inpatient unit, with a small increase in the number of beds from 7 to 8 and a new outpatient facility for the City and South of the County.

3.4 It is proposed to bring the above four services together onto a new, single site at what was previously known as the Cedars Rehabilitation Unit on Mansfield Road, Nottingham. Resulting in the relocation of CAMHS from Thorneywood and Perinatal Services from the Queens Medical Centre site.

3.5 The Cedars site would provide green open space, thus improving the therapeutic and caring environment for children, young people and perinatal mothers and babies as well as having access to good transport links.

3.6 These proposals require significant financial investment so it is planned that a full Business Case will be taken to the Trust Board in September 2015 for consideration.

3.7 The benefits of the proposals include:

- more children and young people accessing specialist services closer to home
- improvement of the overall pathway of care and the development of high specialist CAMHS support for eating disorders and psychiatric intensive care
- improvement in the quality of care through modern fit for purpose facilities
- address the isolation of in-patient areas

3.8 Areas of risk currently being worked through include:

- securing sufficient income for the increase in bed occupancy
- financing the capital development
- gaining planning permission for the Cedars site

3.9 This Committee has statutory responsibilities in relation to substantial variations and developments in health services. While a 'substantial variation or development' of a health service is not defined in Regulations, a key feature is that there is a major change to services experienced by patients and future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area. The Committee's responsibilities are to consider the following matters in relation to any substantial variations or developments that impact upon those in receipt of services:

a) Whether, as a statutory body, the relevant Overview and Scrutiny Committee has been properly consulted within the consultation process;
b) Whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation;
c) Whether a proposal for change is in the interests of the local health service.

3.10 Councillors should bear the matters outlined in paragraph 3.9 in mind when considering the proposals and discussing them with Nottinghamshire Healthcare Trust.

4. List of attached information

Appendix 1 – Consultation on improving Child and Adolescent Mental Health Services and Perinatal Services

Appendix 2 – Consultation and Communication Plan Summary
Appendix 3 – Presentation Improving CAMHS and Perinatal Services

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

None

6. Published documents referred to in compiling this report

Joint Health Scrutiny Committee report and minutes of the meeting held on 10 February 2015.

7. Wards affected

All

8. Contact information

Clare Routledge, Health Scrutiny Project Lead Tel: 0115 8763514
Email: clare.routledge@nottinghamcity.gov.uk

This page is intentionally left blank

Our 5-Year Strategy for Children, Young People and Families

Joint Health Scrutiny Committee: 14 July 2015

Consultation on improving Child and Adolescent Mental Health Services and Perinatal Services

1. Introduction

Officers from Nottinghamshire Healthcare attended the Joint Health Scrutiny Committee in February 2015 to share details of work being undertaken to improve services the Trust provides for children, young people and families. At that point, the Trust was developing a series of options for consideration and wanted to share these with the Committee at the planning stages.

The particular focus is on:

- **Child and Adolescent Mental Health Services (CAMHS)** – inpatient and outpatient services currently provided by the Trust at the Thorneywood Unit (Porchester Road), Nottingham
- **Perinatal Psychiatric services**, for mothers and babies, currently provided at the Queen's Medical Centre (QMC), Nottingham.

Since February, the options appraisal has been completed and the Trust Board has considered an Outline Business Case. In developing the proposal we have:

- Listened to what people say about the services
- Reviewed national quality standards and requirements
- Looked at current and future need
- Assessed a number of options covering:
    - the type and number of inpatient beds
    - the range and type of community CAMHS
    - the site location.

The Trust Board has asked that a Full Business Case of the preferred option be presented at its meeting on 24 September 2015.

We want to hear the views of our stakeholders before the Full Business Case is presented to the Board and the Trust has therefore commenced a consultation on the proposal. The feedback received will be part of the presentation to the September Trust Board.

This paper summarises:

- The background and case for change
- Details of the proposal
- Benefits and risks
- Overview of the consultation process.

2. Background and Case for Change

The report to the Committee in February 2015 set out the context and case for change. In summary, the case for change is compelling and largely driven by:

- National priorities – with increasing national spotlight and pledges for additional funding
- For CAMHS, the new local integrated pathway – developed in response to commissioner-led reviews and in line with the recent National CAMHS Task Force report 'Future in Mind'
- Limitations of current built environments – inpatient areas are not suitable by modern standards and present clinical and operational challenges which jeopardise the achievement of national standards. Community and outpatient areas are similarly unsuitable
- Inpatient areas are isolated
- Lack of sufficient local CAMHS inpatient services, which leads to many local young people being placed out of area, often at time of great distress for them and their families
- No Psychiatric Intensive Care (PICU) provision or any specialised eating disorders units within the East Midlands.

3. The Proposal

Following the detailed options appraisal, our proposal is as follows:

The proposal is to develop a new campus-style health and wellbeing 'hub', bringing **services together onto a new, single site** at what has previously been known as the Cedars Rehab Unit, Mansfield Road, Nottingham. The 'hub' will provide:

- **Community CAMHS** – new facilities for the City and South County, with a Countywide single point of access and new professional base.

- **Inpatient CAMHS** – a new unit, with an increase in the number of beds from 13 to 24, and a new 8 bed PICU.

- A purpose built **Education Unit** for the CAMHS inpatients - working in partnership with education colleagues and Nottingham's Hospital and Home Education Learning Centre.

- **Perinatal Services** - a new Mother & Baby Unit, with a small increase in the number of beds from 7 to 8, and new outpatient facilities for the City and South County.

The Cedars site is owned by the Trust and has real potential to provide green open spaces to improve the therapeutic and caring environment for children, young people and perinatal mothers and babies needing our services. The site is also ideally located to serve both Nottinghamshire and Derbyshire, with good transport links.

If the Trust Board approves the Full Business Case, we will make an application for planning consent to the City Council. We have already begun informal dialogue with the City's Planning and Building Control team.

If approved, this will mean CAMHS moving from Thorneywood and Perinatal Services moving from QMC.

The CAMHS development is part of an exciting wider programme we are implementing to improve services for children and young people with emotional and mental health needs. This will include developing new and innovative ways of delivering care within localities and closer to home eg digital health solutions such as apps and improved working with schools etc.

4. Benefits and risks

There are very significant benefits to this proposal:

- more children and young people will be able to access specialist support closer to home - reducing the need for so many to be cared for out of area.
- we will improve the overall pathway of care and develop highly specialist local CAMHS support, eg for eating disorders and for psychiatric intensive care
- we will improve the quality of care through modern, fit-for-purpose facilities which are 'child and family friendly' and offer therapeutic and caring environments
- inpatient areas will be better supported, addressing isolation.

There are also some risks, which we are working through and which will be considered as part of the Full Business Case. These include:

- securing sufficient income for the increase in beds
- financing the capital development – the Trust Board will consider affordability
- gaining planning consent for the Cedars site.

5. Involving and consulting our key stakeholders

Meaningful involvement with our key stakeholders, particularly children, young people and their families and perinatal mothers is underpinning our transformation programme.

We have undertaken a range of service user feedback activities to ensure their views are reflected in all stages of development, including the early scoping and design stages and the development and assessment of options. This includes, for example, user group discussions with former and current patients and we have reviewed feedback from a range of sources.

Following on from that, the Trust has commenced a 12 week consultation process, which will run until 7 September 2015. We are ensuring there are a number of ways for people to have their say, including two public meetings and an online survey. A summary of the consultation and communication plan is attached at Appendix 1.

Our consultation questions are seeking feedback as follows:

Consultation questions

Are you supportive of proposal overall?

Is there any part that you are particularly supportive of?

Do you have any concerns about the proposal overall?

Is there any part that you are particularly concerned about?

How could we address any concerns you have?

If the services move to the Cedars site, what would you want us to consider?

If the proposal is approved by the Board, we will continue to work with the people who use the services, their families, our staff and partner organisations in developing the detailed designs.

6. Conclusion

Nottinghamshire Healthcare is committed to improving the care and support we provide. We have developed an ambitious proposal to significantly improve the quality of care and local access to highly specialist services.

Feedback from the public consultation will form part of the Full Business Case presented to the Trust Board in September 2015.

We welcome the opportunity to discuss the proposal with the Joint Health Scrutiny Committee and seek its advice and views.

Sharon Creber, Associate Director
Nottinghamshire Healthcare NHS Foundation Trust
sharon.creber@nottshc.nhs.uk

Appendix 1

positive about integrated healthcare

Nottinghamshire Healthcare NHS
NHS Foundation Trust

One Door MANY Pathways

Our 5-Year Strategy for Children, Young People and Families

Consultation and Communication Plan

Summary

June 2015

Purpose

The aim of this plan is to support communication and consultation regarding the service development proposals outlined in the Business Case for *One Door, Many Pathways*, the Trust's Strategy for Children, Young People and Families.

The specific aims of this plan are to:

- set out the key consultation and communication messages and narrative
- identify potential areas of concern relating to the service development proposals
- identify key stakeholders
- plan and coordinate a range of consultation activities
- ensure communication/consultation with stakeholders is timely and effective.

Communication with all stakeholders will be open and honest, two-way, timely, clear and consistent.

KEY MESSAGES

Our overall ambition

- We know that early help is the best way to make lasting improvements in people's lives. A key theme of our strategy is to respond early and quickly to the needs of children, young people and their families.
- We provide a comprehensive range of services and are in a unique position to make a real difference. Over £52 million of the Trust's annual income relates to CYP&F services - ranging from services such as health visiting that every child and family receives to some highly specialised services. Our services are there from before birth, during school years, through adolescence and into young adulthood.
- We are ambitious to achieve real and lasting improvements. We have identified a number of areas where we are committed to transform our services.
- The Trust has agreed *One Door, Many Pathway,* an exciting 5-year strategy to improve services for children, young people and families, with the overall aim *to improve the quality of life and life chances for children and young people.*

Key messages

The key messages relating to the proposal are:

- The need for change is compelling
- The challenge is how we respond to this in a way that is affordable and sustainable into the future
- We have developed an ambitious and exciting proposal that includes a significant increase in the number CAMHS inpatient beds and provides modern fit for purpose facilities, both inpatient and outpatient, for CAMHS and perinatal services
- For CAMHS, this is part of a much wider transformation programme
- We have listened to what our patients and their families say and reflected this in the early planning stages. We will continue to involve them at every stage
- Our Trust Board has not yet made a decision about this proposal. We want to hear the views of our stakeholders before we present the full business case to the Board.

Potential areas of concern

We would hope the proposal receives high levels of support. However, concerns may be raised relating to:

- Change of location
- Planning objections or other concerns of local residents
- Affordability and relative investment decisions

Our consultation questions

The main aims of the consultation are to:

- inform stakeholders about our proposal and the reasons for it
- seek support for the proposal
- understand any concerns about the proposal in order to respond to them.

Our consultation questions are therefore:

Consultation questions

1a.	Are you supportive of proposal overall?
1b.	Is there any part that you are particularly supportive of?
2a.	Do you have any concerns about the proposal overall?
2b.	Is there any part that you are particularly concerned about?
2c.	How could we address any concerns you have?
3.	If the services move to the Cedars site, what would you want us to consider?

External Stakeholders – Planned Consultation Activities

STAKEHOLDER	ACTION
All stakeholders	Information on Trust website, with access through social media ie Twitter and Facebook and online survey
	Press release
	Public meetings – 1 July and 28 July
	Annual General Meeting 24 July display and information
Current and former patients, and families	Posters in clinical reception areas
	Posters to patients on current and recent past caseloads
	Focus groups
NHSE Commissioners	Letter and briefing note
	Request for meeting
	Contract review meeting(s)
Local CCGs	Letter and briefing note
	Contract review meeting(s)
	Meetings/presentations as required
County CYP Integrated Commissioning Hub	Letter and briefing note
	Meetings/presentations as required

Joint Health Scrutiny Committee – Nottingham and Notts	Attended committee meeting on 10 Feb
	Provide briefing for Chair
	Attend committee on 14 July to present proposal and seek views
Healthwatch City & County	Initial meeting held on 22 April
	Invite to be involved in consultation process
Local MPs	Letter and briefing note
City Education Department	Several planning meetings held
	Briefing note
Hospital and Home Education Learning Centre	Several planning meetings held
	Letter and briefing note
	Meetings/presentations as required to governing body
Local residents – Cedars site	Letter to notify of consultation
City Planning Authority	Meetings with Planning & Building Control team
	Application for planning consent in due course
Community of Interest for Children and Young People	Link to website
Local acute providers – NUH & SFHT, B'law	Letter and briefing note
	Meetings with NUH as required re protocols with obstetrics
Local residents – Thorneywood site	Direct to Trust website
Relevant 3rd sector providers and organisations	Alert to consultation and link to Trust website
GPs	Article in primary care newsletter
City and County Councils	Letter and briefing note
Other East Midlands Mental Health	Letter and briefing note

Trusts	
Joint Health Scrutiny Committee – Derby and Derbys	Contact scrutiny officer for advice
National Quality Networks • Community CAMHS • Inpatient CAMHS • Perinatal	Letter and briefing note
	Seek advice and support in design stages
Regional clinical networks	Letter and briefing note
Police	Letter and briefing note
General public	Public meetings – two to be held
	Trust website
	Social media – Twitter etc
	Media coverage
Education – County	Link to City Education and HHELC dialogue
Deanery and nurse training bodies	Letter and briefing note

positive about integrated healthcare

Nottinghamshire Healthcare NHS
NHS Foundation Trust

One Door MANY Pathways

Improving Services for Children, Young People and Families

Improving CAMHS and perinatal services

Joint Health Scrutiny Committee: 14 July 2015

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Current position

Child and adolescent mental health services (CAMHS)

- Focus of consultation is on services provided at Thorneywood, Porchester Road, Nottingham
- Community services for City and South County
- Inpatient services - 13 specialist beds for Notts and Derbys

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Current position

Perinatal Mother and Baby Unit

- Focus of consultation is on services provided at Queen's Medical Centre, Nottingham
- Community services for City and South County
- Inpatient services - 7 specialist beds

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Case for change

CAMHS

- National and local priority to improve CAMHS
- New model to join up care and improve access
- Insufficient local inpatient services to meet need
- Limitations of the current facilities
- Inpatient unit is isolated

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Case for change

Perinatal services

- Inpatient unit is isolated
- Limitations of the current facilities
- Potential for increased demand

How we've arrived at this proposal

- Listened to what people say about the services
- Reviewed national quality standards and requirements
- Looked at current and future need
- Assessed a number of options covering:
  - the type and number of inpatient beds
  - the range and type of community CAMHS
  - the site location

Nottinghamshire Healthcare NHS
NHS Foundation Trust

The proposal

A new campus-style health and wellbeing 'hub' – located on the Cedars Unit, Mansfield Road, Nottingham, providing:

- ✓ **Community CAMHS** – new facilities for the City and South County, with a Countywide single point of access and new professional base
- ✓ **Inpatient CAMHS** – a new unit, increase in the number of beds to 24, and a new 8 bed Psychiatric Intensive Care Unit
- ✓ A purpose built **Education Unit** for the CAMHS inpatients
- ✓ **Perinatal** - a new Mother & Baby unit, a small increase in the number of beds to 8, and new outpatient facilities for the City and South County

Benefits of the proposal

- ✓ More children and young people will be able to access specialist support closer to home
- ✓ Improved overall pathway of care
- ✓ New local provision of highly specialist CAMHS support, eg for eating disorders and psychiatric intensive care
- ✓ Improved quality of care through modern, fit-for-purpose facilities which are 'child and family friendly' and offer better therapeutic and caring environments
- ✓ Inpatient areas will be better supported

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Consultation plan

Several ways for people to have their say, including:

Public meetings – 1 July and 28 July 2015

Visit www.nottinghamshirehealthcare.nhs.uk/haveyoursay

Complete the online survey at www.surveymonkey.com/ithinkCYPeri

Focus group discussions

Next steps

- Listen to what people think - closing date for comments 7 September 2015
- Business case to Trust Board on 24 September 2015 – will include consultation feedback
- If approved:
  - seek planning consent
  - continue involving children, young people, perinatal mothers, families and other stakeholders in the design

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

14 July 2015

Agenda Item: X

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

MAXIMISING THE USE OF OUR NHS RESOURCES (GLUTEN FREE PRESCRIBING)

Purpose of the Report

1. To introduce proposed changes in prescribing for coeliac disease sufferers.

Information and Advice

2. The symptoms of coeliac disease vary from person to person and can range from very mild to severe. Symptoms of consuming gluten (a protein composite found in wheat) include diarrhea, stomach pains and lethargy. The reaction is not the same as an allergic reaction and does not cause anaphylactic shock. The symptoms may last from a few hours to a few days. Coeliac disease is known as a 'multi-system' disorder' – symptoms can affect any area of the body.

3. For around 50 years, coeliac disease sufferers have been able obtain gluten free products on prescription. Now that gluten free products are commonly available in supermarkets, the cost of prescribing - £27 million a year in England - has attracted some considerable attention, especially since a small loaf might cost as much as £3 on prescription.

4. [In Nottingham City and Nottinghamshire County, plans are under consideration to end gluten free prescribing or to restrict prescribing to bread flour only, or even just flour.]

5. A presentation from Nottingham North and East Clinical Commissioning Group is attached as an appendix to this report. Hazel Buchanan, Director of Operations and Jonathan Bemrose, Director of Finance, Nottingham North and East CCG will attend to brief the committee and answer questions as necessary.]

6. Members will wish to particularly focus on how consultation with coeliac disease patients has been undertaken.

7. If Members consider that this change amounts to a substantial variation of service, the Joint Health Committee should determine if the change is in the interests of the local health service.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Consider and comment on the information provided
2) Determine if the change is in the interests of the local health service, if it is a substantial variation of service

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

NHS
Nottingham North and East
Clinical Commissioning Group

Maximising the use of our NHS resources

Context for Five Year Forward View

The NHS has dramatically improved over the past fifteen years:

- Cancer and cardiac outcomes are better and waits are shorter
- Patient satisfaction is much higher
- Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff

Context for Five Year Forward View

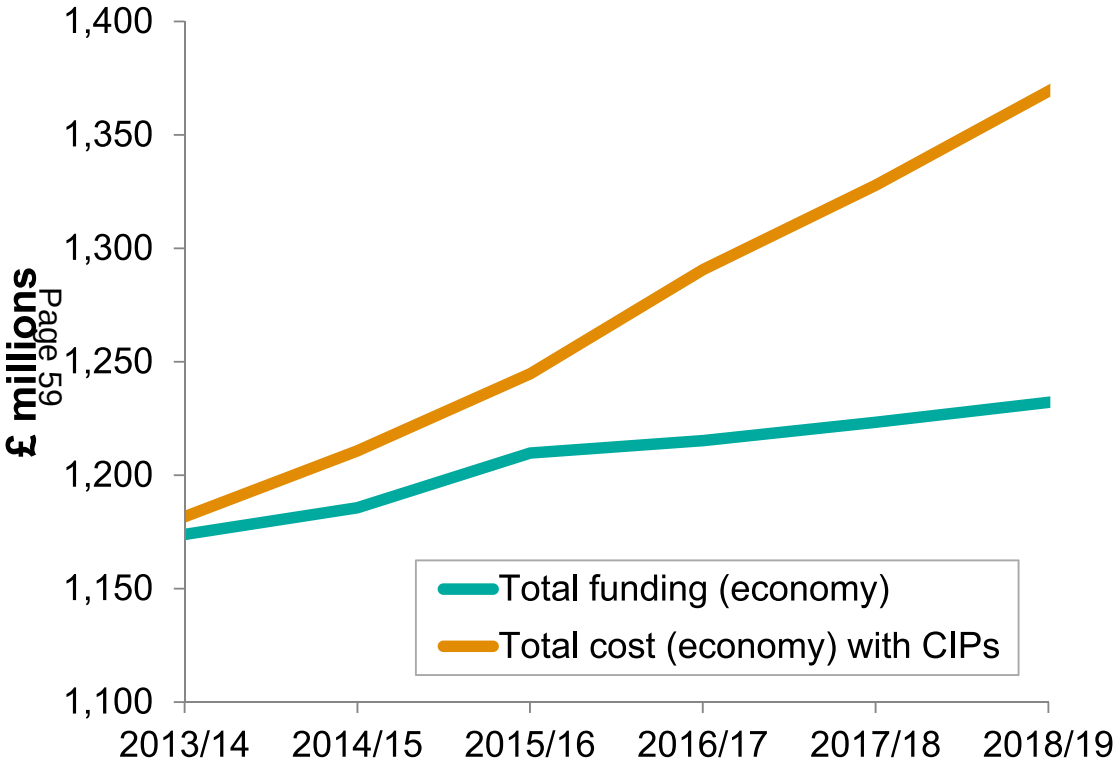
…but:

- Quality of care can be variable and preventable illness is widespread
- Health inequalities are deep-rooted
- Our patients' needs are changing
- New treatment options are emerging
- Challenges in areas such as mental health, cancer and support for frail older patients
- Service pressures are building

Scale of the challenge

	Allocation 2015-16	QIPP target	QIPP target as % of allocation
Nottingham North and East	£179.7m	£7.1m	4.0%
Nottingham West	£117.3m	£2.3m	2.0%
Rushcliffe	£136.5m	£4.5m	3.3%

Our resources



Gap between funding and costs of care if services continue to be delivered as they are now

CCG plans

- The South CCGs have plans to address the Quality, Innovation, Prevention and Productivity (QIPP) agenda. Top priorities include:
  - **Quality in primary care**
  - **Pathway redesign**
  - **Contracting**
  - **Medicines management**
- Focus on improving quality of care and value for money, ensuring that patients receive the right care at the right time in the right place
- Also an opportunity to be innovative around service redesign

Major challenges facing health services

All health services, everywhere, still face 5 major problems:

- **Unwarranted variation**
- **Failure to prevent disease & disability**, e.g. stroke and vascular dementia from AF
- **Waste of resources** through low value activity
- **Harm**, from overuse even when quality is high
- **Inequity** from underuse by groups in high need

NHS
Nottingham North and East
Clinical Commissioning Group

Major challenges facing health services

…and new, additional, challenges are developing:

- **Rising expectations**
- **Increasing need**
- **Financial constraints**
- **Climate change**

Quality in primary care

This focuses on:

- Reducing clinical variation between GP practices, where there can be wide differences in the approach to patient care
- Avoiding hospital admissions where possible, through proactive risk and case management
- Improving access to GP practices, e.g. phone triage, online appt. booking, weekend opening pilots, working towards extended opening
- Enhancing opportunities for sharing of records across primary, community and secondary care, out of hours services, and ambulance services, though the Medical Interoperability Gateway

Pathway redesign

This focuses on:

- Working with adult social care services to provide holistic patient centred care through aligning health and social care services
- Redesigning services that provide care closer to home e.g. ophthalmology, trauma and orthopaedics and gynaecology
- Testing the primary care management of patients attending ED
- Reviewing the requesting of diagnostic tests including using alternatives in primary care

Contracting

This focuses on:

- Working proactively with providers to identify areas of improved patient pathways
- Review of pricing models
- Review of thresholds to ensure that patients have the best outcomes possible e.g. encouraging conservative management of conditions prior to surgery

NHS
Nottingham North and East
Clinical Commissioning Group

Medicines management

This focuses on:

- Medicines optimisation
- Medicine safety
- Evidence based choice of medicines
- Patient experience

Patient and Public Involvement

- Build on existing feedback and intelligence
- Target different segments, including those who do not actively engage with health services
- Include a plan and spectrum of involvement from building on existing intelligence to co-production

NHS
Nottingham North and East
Clinical Commissioning Group

Coeliac Disease and Gluten Free Prescribing

- Coeliac disease is a common digestive condition – adverse effects are triggered by intolerance to the protein gluten found in bread and many processed foods.
- Locally South CCGs spend approx. £250k providing gluten free products on prescription for patients intolerant to gluten.
- Over 20 -30 years ago gluten free products were not easily available.
- Gluten free products are now readily available in supermarkets and many restaurants label gluten free meals.
- Patients can still eat a wide variety of foods including rice, potatoes, vegetables and fruit.

Committee is asked to :

1. Support the South CCGs with their plans to address the QIPP agenda. Top priorities include:

- **Quality in primary care**
- **Pathway redesign**
- **Contracting**
- **Medicines management**

2. Acknowledge and agree with engagement plans e.g. gluten free with all stakeholders and appreciate some decisions will not be favourable for all.

Coeliac Disease and Gluten Free Prescribing ctd.

- NHS does not provide food on prescription for patients with diabetes, lactose intolerance or other conditions where patients need to follow a restricted diet.
- NHS Nottingham North and East CCG restricted prescribing of gluten free products to bread and flour only in December 2014
- The South CCGs are now planning a 90 day consultation August – October with key stakeholders, patients and public.
- Three options for consultation are **stop all prescribing**, **restrict prescribing to bread and flour** (apply to Rushcliffe and Nottingham West) or **restrict prescribing to flour only**.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

14 July 2015

Agenda Item: X

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

HEALTHWATCH RENAL PATIENT TRANSPORT REVIEW

Purpose of the Report

1. To introduce Healthwatch Nottinghamshire's report on renal patient transport.

Information and Advice

2. Members will be aware that in March 2015 Healthwatch Nottinghamshire concluded their work on a report into renal patients' experience of the Patient Transport Service. The report is attached as an appendix to this covering report.

3. Claire Grainger, Chief Executive Nottinghamshire Healthwatch will attend to Joint Health Committee to present the report and the responses to its recommendations. [Representatives of the service provider, Arriva, will be in attendance to answer questions].

4. Members will wish to commend this thorough report by Healthwatch Nottinghamshire [and may also wish to schedule consideration of the responses to the two additional recommendations (page 49)].

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Consider and comment on the information provided
2) Schedule further consideration, if necessary

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

healthwatch Nottinghamshire

Insight

Renal patients' experience of the patient transport service

March 2015

Contents

1 Summary of evidence

1.1 Introduction

We wanted to understand renal patients' experience of the patient transport service going into and home from the Nottingham City Hospital renal dialysis units. To do this we did the following:

- spoke to 45 people who use the transport service, collecting over 12 hours of feedback;
- gathered diaries of journeys from 7 patients covering 50 journeys;
- collected 50 completed surveys from renal dialysis patients; and
- collected surveys from 17 members of the renal unit staff to get their experiences of the service.

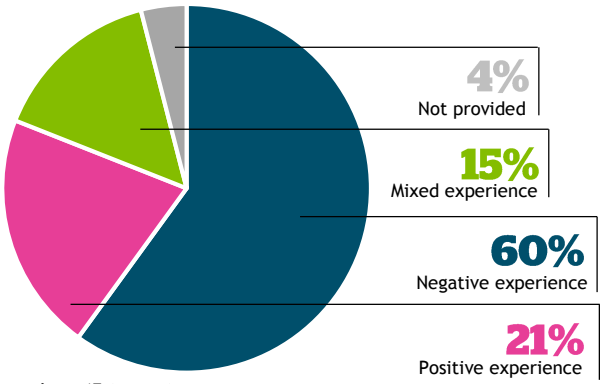
These activities were conducted and supported by a group of Healthwatch Nottinghamshire volunteers and staff. Every effort was made to encourage all patients to participate, but as this was voluntary it is possible that some patients not engaged in our project had different experiences of the patient transport service.

This section details the main findings across all of these sources of evidence.

1.2 Main findings

A recent improvement in experience has been acknowledged and praised by a small number of renal dialysis patients. For the majority of patients, their overall experience of the transport service has been and continues to be poor.

Figure 1 Overall summary of experience for all patients



Note: Based on 45 interviews

Most frequent overall rating provided by patients in survey
(Base = 25 patients)

Most frequent overall rating provided by renal unit staff
(Base = 17 staff members)

Patients needing special requirements for their transport and the time patients attend for dialysis makes a difference to their overall experience. Compared to 60% of all patients:

73% of patients with special requirements for transport had a negative experience	75% of patients having dialysis in the afternoon had a negative experience	50% of patients having dialysis in the evening had a negative experience

These experiences reported by patients were reinforced by renal staff, who suggested that wheelchair patients and those attending the afternoon sessions can be waiting for transport longer than others.

Poor experiences affected patients physically and emotionally.

Every patient who talked to us about waiting for transport into the renal dialysis units, identified that as a consequence of being late they have not had their full prescription of dialysis. Some patients identified that whole sessions had been missed, they told us that this was a choice they made based on previous poor experiences of the patient transport service.

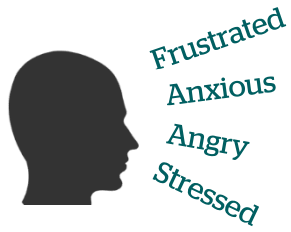
Patients and staff agreed that this is detrimental to patients' physical health.

> Patients sat on the unit doing nothing for 2-3 hours after their treatment they are missing out on sleep, food and possible medications which all contribute to overall health.
> Renal dialysis unit staff member

> Some don't do full time, that's when you start to impact on people's lives, it's going to get dangerous.
> Renal dialysis patient

Patients talked about raised blood pressure and nausea, and for those suffering other long term health conditions the long days and being late home impacted on their diet and nutrition.

Waiting for transport was a cause of distress for many renal dialysis patients.



These are the words used to describe emotional feelings across all sources of evidence.

These were not only significant in themselves but there was a feeling that these emotions exacerbated the impact on physical health.

The impact of a poor experience doesn't just affect that patient. Staff on the renal dialysis units, other patients attending after them and family and carers of relatives can all be affected.

Patients were quick to recognise that if they were late on machine it had an impact on patients attending the subsequent dialysis session. It was obvious that many were very conscious of this and felt anxious about it.

Renal dialysis unit staff confirmed the impact on other patients and identified that poor transport experiences impacted on them in two ways:

- Querying and re-arranging transport issues diverted their attention from nursing duties.
- Having to frequently deal with angry and frustrated patients.

Carers and relatives were affected in three identified ways:

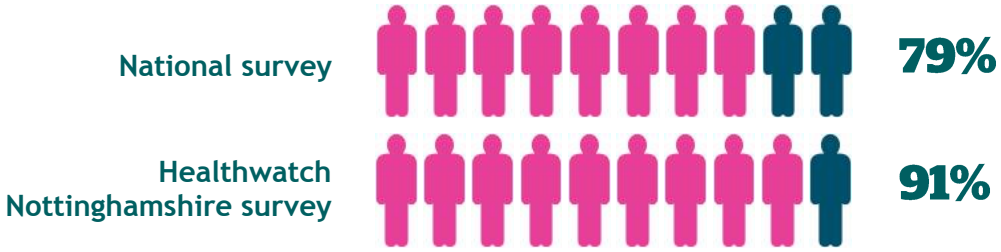
- When patients called on them for transport to and from the dialysis unit when the patient transport service did not arrive.
- When they were at home waiting anxiously for patients to return from dialysis.
- Living with the time commitments that their family member has to devote to cover the transport requirements in addition to their prescribed dialysis time.

The transport crews were universally praised, 84% of all patients we interviewed talked about their positive experience of transport drivers and attendants. Almost two thirds of survey respondents identified them as the 'best' part of the patient transport service.

The majority (76%) of patients who had a negative overall experience of the patient transport service still talked about the drivers and attendants in a positive way. They were quick to point out that the Arriva transport crews played no part in their negative assessment.

Patients clearly felt that the Arriva drivers cared for them, evidenced by frequent stories of drivers helping them in and out of vehicles and walking them to their doors. The drivers were seen as improving the patient experience of dialysis treatment, and some see them as part of their treatment.

Figure 2 % happy or very happy with friendliness of staff



Note: National survey is National Kidney Care Audit Patient Transport Survey 2010

We found that renal dialysis patients in Nottinghamshire are happier with their patient transport staff than other patients across the country. As illustrated in figure 2 91% of our survey respondents indicated that they were happy or very happy with the friendliness of their staff, compared to 79% of patients in the national kidney care audit patient transport survey 2010.

Experience of taxi drivers was less positive. Patients reported issues with the care and support they provided and gave examples of when they had turned away from their homes without them.

> They have come and they have actually gone away saying that I am not there...a neighbour tells me oh yes he was there for a few minutes but he did not get out the car.
> Renal dialysis patient

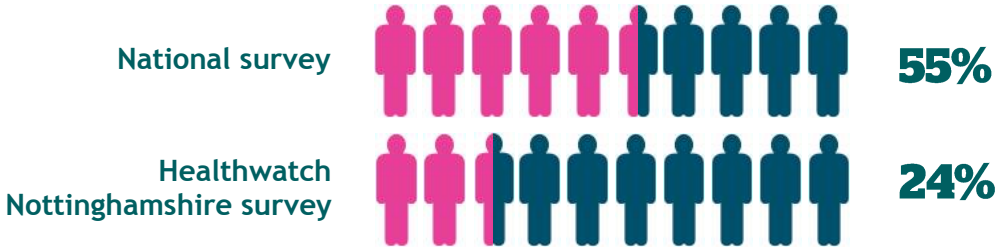
The punctuality of the service was the central issue contributing to negative experiences. 90% of patients talked at length about long waiting times after dialysis and 67% mentioned being picked up late before dialysis.

Figure 3 shows that renal dialysis patients in Nottinghamshire were much less happy with the punctuality of the patient transport service, when compared to the national survey. Patients used words such as 'very often' and 'most of the time' when asked whether they had been picked up more than 30 minutes after coming off the dialysis machine.

The long waits were a source of distress for many patients, they talked frequently about feeling angry, frustrated and stressed. This was also confirmed by staff. Such

feelings were exacerbated by poor communication as patients and staff had no information or had been given inaccurate estimations of collection times.

Figure 3 % happy or very happy with the punctuality of the service



Note: National survey is National Kidney Care Audit Patient Transport Survey 2010

For vulnerable patients particularly, the waiting had very concerning consequences. We heard examples of patients using public transport or walking to get home. For example:

> My daughter gets really mad with me, [she says] you keep ringing me to tell me you've wondered off... why don't you stop where you are. I said 'I don't know duck!' I'm sitting in that waiting room and there's only me in so I think oh no-one's coming to fetch me, so off I went.
> Renal dialysis patient

> Well, with me suffering from dementia, the hospital ask me to go by their transport but sometimes when I get so mad I end up walking to the bus stop. Sometimes, when I have to walk down there I forget which number bus. I end up walking from the forest to St Anns where I live. And it's really bad when I get home.
> Renal dialysis patient

Poor planning and co-ordination of journeys was perceived by patients and staff as being responsible for long waiting times and long journeys.

For many patients the inconsistency and unpredictability of the transport service doesn't match the routine of dialysis treatment. This was illustrated through the range of collection times reported in the patient journey diaries.

> They know what jobs they've got to do that day, they book it all the time so they know. I come four days a week, same time so why can't they come at the same time to fetch me?
> Renal dialysis patient

Patients gave examples of travelling on routes which crossed several areas of the county and city, which could be responsible for the longer travel times reported by patients using the transport service (when compared to those who make their own transport arrangements). This was also identified as one of the reasons why some patients had stopped using the transport service to get to their dialysis appointments.

Both patients and staff linked poor planning to the poor punctuality and perceptions of inefficiency, and most frequently recommended that this aspect of the service needed to be improved. Training and development for planning staff was suggested to improve their geographical knowledge of the local area.

Improving this aspect of the service for renal dialysis patients was identified by patients and staff as having the potential to improve experience of the service.

2 Conclusions and recommendations

Conclusion 1:

Renal dialysis is a treatment which places significant demands on a patient's quality of life and their experience of the transport service increases this demand.

> It takes so much of your time, for some people, this just becomes your life, just this, and it doesn't have to be, it's just a little part of your life, not the whole of your life. Transport doesn't help make it a little bit of your life."
> Renal dialysis patient

A recent improvement acknowledged by a small number of patients is encouraging and has impacted positively on their most recent experiences of the service. For the majority, the unreliable nature of the service and the unpredictable waiting times patient's experience, mean that a four hour dialysis prescription can frequently require up to the same amount of time for transport. This can then demand three full days of a patient's week, rather than the 12 hours of dialysis time prescribed.

Patients not receiving their full dialysis treatment and missing complete dialysis sessions could be serious implications of a poor service, which have the potential to negatively impact on the physical health of patients.

Recommendation 1:

Invest time and capacity into developing new systems and processes for communication between drivers, the call centre, the dialysis units and patients.

This would help to ensure that all were more informed about the transport arrangements in place and expected collection times. We believe that this would significantly reduce the feelings of frustration and stress felt by everyone involved, thereby improving their experience of the service.

Recommendation 2:

Allocate drivers and vehicles to provide transport primarily for renal dialysis patients.

The routine nature of dialysis lends itself to fixed arrangements which could improve punctuality. When combined with the frequency with which patients need their treatment, improved punctuality could help ensure that their renal dialysis treatment has a smaller impact on their life. This would reduce feelings of frustration that result in some patients choosing not to receive their full prescription of dialysis.

Conclusion 2:

Inequality of experience is evident, but all patients should experience a good quality service, particularly those patients managing other chronic health conditions.

When the service is good it's very good, illustrated by the positive ratings in many of the journey diaries. But our evidence across all sources indicates inequality in waiting times for those people needing special transport requirements; the level of care and support provided by taxi drivers; and the overall experience for patients attending morning and afternoon dialysis sessions compared to those attending evening sessions. These are frequently resulting in very poor experiences and are having potentially serious impacts on vulnerable patients, managing other chronic health conditions.

Recommendation 3:

Put in place some safeguards to ensure that the patients managing other chronic health conditions and who need special transport requirements are prioritised for journeys home after dialysis sessions.

The current service is placing these patients at a substantial disadvantage in relation to their experience of, and impact of the patient transport service in comparison with other patients. Prioritising these patients would help to reduce the potential impact of waiting times on physical health conditions and ensure that the service is carrying out its duty to make arrangements for these patients under the Equality Act 2010.

Recommendation 4:

Improving the quality of service provided by subcontracted taxi companies is necessary to ensure they provide a service comparable to Arriva transport crews.

This could be achieved through a programme of training and development to improve their knowledge of the routes into the City Hospital and their understanding of the dialysis process and how it impacts on patients. Consideration could be given to whether a set of quality standards could be written into their contracts, and processes developed through which this could be rigorously monitored and enforced. This is important given the rise in the use of taxis reported by ten patients we interviewed.

Conclusion 3:

The transport service for renal dialysis patients is inefficient.

> ...an elderly gentleman who lives near me... the transport came for him, and it was a car so four seats...They sent me a minibus...all the way from Worksop which arrived five minutes after with two crew...I said to these guys, can I ask why you're taking me, they said we've been asked to come all the way and take you home...That's a ridiculous waste of time, money and effort.
>
> Renal dialysis patient

Our evidence includes many examples provided by patients and renal unit staff, of poorly planned journeys and poor use of vehicles. This is creating inefficiency, which patients and staff felt was in some part responsible for the poor punctuality of the service. Staff and patients were both quick to suggest that planning and co-ordination of journeys could be improved and would reduce the frustration they both felt.

Recommendation 5:

Arriva transport crews are an asset to the service, and should be given more opportunity to use their initiative, and act on the observed real-time transport needs in the units. This could reduce the occasions when ambulances transport single patients, and journeys are duplicated. It could reduce waiting times for some patients and lessen the frustration experienced when drivers are unable to take some patients living near to, or on the route of others. This could also help to reduce the time renal unit staff are spending on the phone to the call centre being diverted from nursing duties.

Recommendation 6:

Further training for drivers and the staff who plan journeys, which includes an element of seeing first-hand renal dialysis patients experience of the transport service would be beneficial. This could help to improve their understanding of dialysis treatment, the impact of this on patients and the consequences of a poor transport experience. The improvement in service delivery that this could potentially achieve could impact directly on renal patients' experience of the service.

3 Introduction

At the end of December 2012 approximately 27,000 adults in the UK were undergoing some form of dialysis, with over 22,000 receiving this therapy in hospital (National Kidney Foundation, 2014). Dialysis is a form of treatment for patients suffering from kidney failure, which replicates many of the kidney's functions. Over 450 people were receiving dialysis (UK Renal Registry, 2013) at the Nottingham Renal Centre based at the Nottingham City Hospital (UK Renal Registry, 2013) at this time.

Many patients need to have dialysis on a long term basis, possibly for the rest of their lives, and those receiving Haemodialysis (the most known and used form of dialysis; UK Renal Registry, 2013) need to undertake three four-hour sessions every week (NHS Choices, 2013). Some people receiving dialysis are eligible for transport to and from hospital for this treatment, and the National Institute for Health and Care Excellence (NICE) has a quality standard for renal replacement therapy services, which states that this transport service must be effective and efficient. They acknowledge that poor transport can undermine good dialysis care and can have a major impact on a person's quality of life (NICE, 2014).

We started this project because we had received a number of comments about renal patients' experience of Patient Transport Service going into and out of the renal dialysis units at the Nottingham City Hospital. Our prioritisation panel (a group of volunteers who help us make decisions about where we focus our work) scored these comments as a high priority and asked us to undertake a project so that we could understand more about patients' experiences of this service. We want our findings to be used to identify if and how the service could be improved over the remaining term of the contract.

3.1 Our approach

We wanted to gain a deep understanding of patient's experiences and perceptions of how this experience impacts on their wider life. The main focus of our project was therefore on talking to patients face to face. Working with the renal dialysis unit staff we identified a week in November 2014 when we could go into the units and talk to the patients whilst they were receiving their dialysis treatment.

We planned our attendance on the two dialysis units to ensure that we covered as many dialysis sessions as possible, and had the opportunity to speak to all patients who used the service. We covered eight dialysis sessions in total, ensuring that we had morning, afternoon and evening sessions for patients who attended on a Monday/Wednesday/Friday pattern, and those who attended on a Tuesday/Thursday/Saturday pattern. Across these eight sessions we conducted 45 semi structured interviews with patients using the transport service provided by Arriva Transport Solutions Ltd. Participation in interviews was on a voluntary basis and patients were informed that they could withdraw from the interview at any point. Before interviews were conducted patients were fully informed about the project and gave consent for their interview to be recorded. Interviews were conducted by a Healthwatch Nottinghamshire volunteer or member of staff.

We also wanted to understand if patients' experience of dialysis treatment and care changed depending on how they travelled into the renal dialysis units. To gather this information we put together a survey for all patients on the renal dialysis units to complete. The survey focused on rating different aspects of the service and included

some questions which had been asked as part of the National Kidney Care Audit Patient Transport Survey in 2010; this was so that we could compare our findings with the national results. Patients were given the option of completing this survey whilst on the unit, or at home, returning it to us in a freepost envelope. A total of 50 completed surveys were returned, with an even distribution of patients who currently used the transport service and those who made their own transport arrangements. Participation in the survey was voluntary, and whilst we made every effort to encourage all patients to complete the survey, there is inevitably an element of nonresponse bias. It is possible that those who did not participate have different experiences of the patient transport service.

Staff working on the two renal dialysis units were given the opportunity to contribute to this project through a paper survey of open ended questions. These allowed staff to tell us what they thought about various aspects of the renal patient transport service. The surveys were left on the renal dialysis units, and staff were asked to put completed surveys into a sealed 'post box' which was collected from the units the following week. A total of 17 completed surveys were returned, but as with the patient survey, the voluntary nature of participation means it is possible that the staff who responded had more experiences of, and stronger feelings about, the transport experiences of renal dialysis patients.

Patients were also given the opportunity to complete some paper-based diaries to tell us about their journeys and how they're feeling during a normal week of dialysis. The diaries were requested by and sent out to 16 renal dialysis patients, they were asked to complete them in the two weeks after our interviews at the hospital. Seven patients returned diaries for 50 journeys. Self-selection bias was likely as patients identified themselves for participation in this element of the project.

Arriva Patient Transport Solutions were given the opportunity to participate in a survey of their attendant crews but this was declined.

3.2 Our team

The use of our Enter and View volunteer team was a key part in collecting individual stories of patients in the dialysis unit. Enter and View is a power laid down in law and given to local Healthwatch through the Health and Social Care Act 2012. It enables Authorised Representatives of local Healthwatch to go into health and social care premises to see and hear for themselves how services are provided, and collect the views of service users at the point of service delivery.

Within Healthwatch Nottinghamshire it was decided that Authorised Representatives would carry out Enter and View visits as an outcome of an issue being discussed at the Prioritisation Panel and would be planned into larger pieces of work about quality, where it would form part of the evidence gathering or add value to the work being done.

Recruitment for these Enter and View Authorised representatives was done through our usual networks: existing volunteers, newsletters, Voluntary and Community Sector (VCS) websites and social media. We also had a list of potential volunteers who had expressed an interest before we were ready to recruit. We went through a formal selection process, including the taking up of references, a Disclosure and Barring Service (DBS) check and an interview with a panel of Healthwatch Nottinghamshire staff and a representative from Nottinghamshire County Council's market development and care standards team.

We recruited seven people into the team. All received training over two days, which covered the role of an Enter and View Authorised Representative and how that would fit in with our Insight Projects, of which this project is one, confidentiality, safeguarding, equality and diversity and Dementia Friends awareness. The final part of the training was a practical task, which took the form of the Enter and View Team interviewing some fictional patients in a mock up renal dialysis unit. We wanted staff and volunteers to be as prepared as possible for what they were about to find, including dialysis machines and blood moving backwards and forwards from the patients arms. During the week we were onsite at the renal dialysis units, five volunteers took part in interviewing patients alongside three staff members.

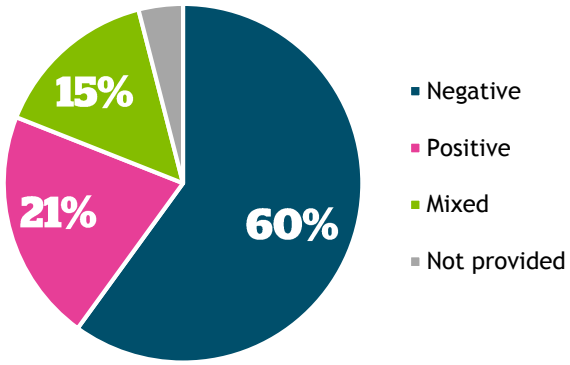
4 Findings from our patient interviews

During the week beginning the 3rd November 2014 our team of volunteers and staff attended both renal dialysis units at the Nottingham City Hospital to talk to renal patients about their experiences of the patient transport service. Only patients who used the service were interviewed. 45 interviews were conducted and transcribed, totalling over 12 hours' worth of feedback from patients. The transcripts were analysed and what follows are the key findings.

4.1 Overall experience

Patients were asked to summarise their overall experience of the patient transport service and figure 4 shows that almost two thirds (60%) provided a negative rating, almost three times more than the number of patients providing a positive assessment.

Figure 4 Overall experience of interview patients



Note: Based on 45 patient interviews

Table 1 Overall experience by patient group

Patient group	All	Special requirements*	Morning	Afternoon	Evening
Number of patients	45	11	17	16	12
Negative	60%	**73%**	59%	**75%**	50%
Mixed	15%	9%	12%	6%	17%
Positive	21%	18%	18%	12%	33%
Not provided	4%		12%	6%	

** relates to transport requirements*

Table 1 illustrates that there was some difference between patient groups:

- Patients needing special requirements for their transport, and patients attending dialysis in the afternoon sessions were more likely than any other patient group to identify their overall experience as being negative.
- Patients attending the evening dialysis sessions were less likely to identify their experience as being negative and more likely than any other group of patients to identify a positive experience

4.2 Waiting times after dialysis session

90% of all patients we spoke to talked about the waiting times for transport home after their dialysis session. It was the most talked about theme of people's experiences. However, it should also be noted that nine people acknowledged that there had been a recent improvement in waiting times after dialysis sessions.

All patients who identified that they needed special transport requirements talked about waiting times for transport home, as did all patients who attended the afternoon session of dialysis.

The longest waiting time identified was almost three and a half hours, but many people talked about waiting times of between one and a half hours and three hours, the following are some examples of this.

> We often wait over an hour. Week last Thursday I finished at 4.30pm and it was 9.00pm when we got home. We left here at 8pm. We kept ringing, they rang three times, and they kept saying a taxi was coming for us. Three times she rang, taxis on its way. It never turned up at all so we had to have an ambulance car in the end it was 7.55pm when they came for us.
>
> ...but sometimes it doesn't come until one hour or two hours after we come off the machine and I have known it to be three hours.
>
> As I say I mean waiting one and a half hours to two hours was nothing.

The majority of people used words such as *'often'*, *'very often'* and *'most of the time'* when asked whether they had ever been picked up more than 30mins after coming off the machine. These responses were typical:

> Oh yes, that happens quite often yes. Most of the time, more than half an hour.
>
> Yes, many times. Probably about 80% of the time.
>
> ...you sit there an hour, hour and three quarters is the most I've waited. It don't happen now and again it happens a lot.

Waiting for long periods of time after having dialysis was the cause of distress for many people, patients frequently talked about feeling frustrated, angry and stressed.

Poor communication characterised this situation. Negative feelings were made worse as patients had no information as to if and when transport would arrive, or were given inaccurate estimations. For example:

> Sometimes they ring and say taxi will be 10-15mins and it's an hour.
>
> But she can't tell me how long they're going to be, they just say they're on their way. Somebody is on the way. Not a clue how long it's going to be.

The time spent waiting for transport extended the time dialysis treatment requires from patients. For many who were in the later years of their life, this was a significant issue and one which not only affected themselves but also their family waiting for them at home.

> So I'm not finishing till say 12.45pm to 1pm and then I have to sit in there for about an hour or so. It's getting, well when you've been up since 4.50am in the morning, it's a long day.
>
> Well it really makes me feel quite ill actually, cos I've eaten at 5.30am to be ready then it comes to 1.45 – 2.15pm, it really is a long day. I mean particularly at 84.
>
> I know I'm going to wait out there and the family at home is beginning to expect that. On occasions, well not on occasions most of the time, I reach home at about 12am midnight. An hour and a half to wind down after this...I've asked them to go to bed, they usually do cos they have to go to work the next day but I disturb them when I get in.

The impact of waiting went beyond feelings and emotions. Patients described physical impacts on their health such as increased blood pressure and sickness or nausea. For those balancing other long term illness, being late home had potentially serious implications. For example:

> ...my blood pressure, when I'm thinking about what's going on, my blood pressure goes up.
>
> "Plus I'm diabetic...I've got to be having meals at certain times and if I got to be waiting two to two and a half hours out there I'm going over...me sugars are up.
>
> I have problems preparing meals and things at night, as I'm arriving home sometimes very late and by the time I've got in the house I'm just not wanting to face up to cooking and eating and consequently I'm not getting the quality of nutrition if you like.

There was also a feeling that the negative effects of waiting for transport 'undid' the good work of the dialysis:

> You sit and steam, all the good is gone by the time you get home.

When waiting times got too much for some people they made their own way home. For some, this meant calling on friends and family. For other patients their use of public transport or walking was a concern to their safety. For example:

> Well, with me suffering from dementia, the hospital ask me to go by their transport but sometimes when I get so mad I end up walking to the bus stop. Sometimes, when I have to walk down there I forget which number bus. I end up walking from the Forest to St Anns where I live. And it's really bad when I get home.
>
> I don't know really, I don't know I'm doing it. They know about it and the doctors. Me daughter gets really mad with me, [she says] you keep ringing me to tell me you've wondered off... why don't you stop where you are. I said I don't know duck! I'm sitting in that waiting room and there's only me in so I think oh no-ones coming to fetch me so off I went.

The combined effects of this experience and its impact also affect the way some people feel about their dialysis treatment. For example:

> I've often waited, the longest I've waited to get picked up from here is two and a half hours which really annoys a person, especially when you've had dialysis you want to go home and rest to wait out there for another two and a half hours is ridiculous, you do find the whole experience becomes quite unpleasant.
>
> If I could go home by bus I would, some days I can't, you know, I get tempted to say look you know what forget it...
>
> You just wish that you didn't have to have it.

4.3 Transport crews

84% of all patients we interviewed spoke about their positive experiences of the transport drivers and attendant crew.

The majority (76%) of patients who had a negative experience of the service overall, still talked about drivers and attendants in a positive way. They were quick to point out that they played no part in their negative assessment of the service. The following are typical examples of this:

> Yeah I've got no complaints with those.
>
> The drivers are marvellous, can't fault them at all, they're brilliant.
>
> I think they do a great job.

Patients clearly felt that the drivers cared for them, evidenced by stories of drivers helping them in and out of vehicles, walking them to their doors and ensuring they entered and exited their property safely.

> Sometimes, they have some people to help you to your door. They take them inside. Sometimes some of them help me well, unlock the door and see that I lock up proper so nobody can get in.
>
> Well, I mean, they often see you to the door when you're going home, make sure you're in the house, lights on and everything, that sort of thing. Help you in and out the ambulance if you need it so you can't fault them.

Drivers play an important role in patient's experience of dialysis treatment. They can improve the experience of the treatment and are seen by some people as being a part of their treatment. For example:

> They're important in having a good experience, if they're committed to being an attentive person that translates into the service you get from them.
>
> ...like I say some have got a great sense of humour, it picks you up when you're you know. Laughter is the best medicine, no matter what you get in here.
>
> Staff are extremely important, as you get to know people. You see them more than your own family. People are seeing these drivers eight times a week, six times a week. You get to know the people really well.
> It's part of the social part of treatment.

Arriva drivers and crew members were singled out for praise by over half (51%) of all patients. When compared with taxi drivers patients felt Arriva drivers:

- had a better understanding of their needs;
- had a more positive attitude towards them, which meant they were more friendly and talkative; and that
- they were more knowledgeable about the routes into and out of the Nottingham City Hospital.

There were a number of people who felt safer and more confident travelling with Arriva drivers and attendants than when travelling by taxi, as explained by these two patients:

> The ambulance is the best one, as you're with a guy who knows what's wrong. Let's be honest we're all ill people, very poorly people, if someone falls ill in a taxi what's he gonna do? I hope they understand that point, cos it's very major point, that is.
>
> They're all trained. But as I said, if you go with a taxi and feel bad or what, what are they going to do? They don't have a clue.

The positive relationships developed between Arriva drivers and some patients has a negative consequence for a small number of others. They felt some drivers had 'favourite' patients who they would wait for, despite other patients being ready and waiting for their own transport home.

> There are some who have their own favourites maybe they've know some patients for a longer period of time they prefer those routes perhaps.
>
> ...them drivers are always sitting waiting for them to come off the machine. I'm sitting there watching them waiting while they could take me home and be back in time for them.

Four patients questioned that the times they were made to wait for transport were a consequence of them making a complaint or only using them for journeys when necessary. This felt personal, like they were persecuted, and was not a nice feeling for patients to bear. For example:

> ...so they decided they weren't gonna take me no more all because I complain.
>
> Sometimes I wonder if it's because I'm not using them to go home that I have to wait longer. That's just me. It's not a nice thought.

There were negative comments about taxi drivers from over 40% of patients. Many people gave examples of when taxi drivers had not knocked on their door or did not offer any help support getting in and out of vehicles.

There was also a considerable number of people who stated that a taxi had turned away from their house without them, after not signalling to the patient that they were there or not waiting long enough for the patient to come out of their house. For example:

> ...when you get a taxi, it's just that sometimes they don't even ring your doorbell. Because I had experiences with drivers who come and they beep the horn and then if I don't come out within a certain time they just go.
>
> There have been occasions where they have come and they have actually gone away saying that I am not there – they have sat in the car, not come and knocked on the door and I cannot see they're there...A neighbour tells me oh yes he was there for a few minutes but he did not get out the car so I mean that's poor.

A number of patients didn't feel safe when travelling by taxi, this was as a result of poor driving standards and lack of consideration of patient needs. The following quotes explain this:

> Not so with the taxis. Because I live on a very busy road, sometimes, plenty of times, they put you on the other side of the road. And they don't wait to see that you cross over safely. It's dangerous it is.
>
> I went home in a taxi the other night, it was in a line of traffic, he hadn't got patience to wait so we overtook 12-14 cars butted in and joined the traffic again...its nerve wracking.
>
> Well I've had many a taxi driver who I'm not joking, have gone down the side streets and over the humps, I'm not joking, at about 20 miles per hour. They've not thought there's passengers the car, its vroom, vroom, you're bouncing about in the back of the cab...

Patients also gave examples of when taxi drivers had told them they did not want to pick them up as they received less payment for the hospital transport than they would earn from other jobs. This had a negative effect on how people felt about themselves and their treatment.

> Often when they pick me up they make a point that they're only going to get like £8 for my journey when the official price or price they would charge is closer to £12 or something.
>
> No it doesn't affect your treatment but it affects how you feel inside, which is sometimes not a nice feeling. You feel like you've been put on by someone else who doesn't understand.
>
> A lot of the drivers are saying they would rather not pick us up because it doesn't pay enough for them.

4.4 Waiting times for transport before dialysis

Two thirds of patients (67%) talked about the waiting times they experienced for their journey into the hospital. They were less frequently late being picked up than going home but many people still talked about this using words such as *'half the time'* and *'sometimes'*.

Patients feelings about this wait were similar to those reported when waiting for transport to take them home, but there was a recognition that being able to wait in the comfort of your own home made this wait easier to bear.

> But at least I'm sitting there in my own chair in comfort not here.
>
> Coming in to the hospital are easy, you're losing time because it isn't a punctual service, but you're actually doing your own thing at home so you're not losing so much on that journey.

Half of all patients who talked about waiting times before their dialysis session reported that transport was never sent to collect them and that they had been 'forgotten', for some this happened more than once:

> I've had at least four occasions when I've not been picked up.
>
> Sometimes they forget about you, you see.
>
> My name just didn't come up, and that was it, you know. Just missed it off, forgot me, for want of a better word.

Patients were sometimes forced to arrange their own transport into the dialysis unit which was an inconvenience for their family and friends, but patients most commonly identified that taxis were then dispatched to collect them.

A lack of consistency and unpredictability of the time patients would be picked up from their homes was very frustrating. Some patients claimed to never have been told an expected collection time whilst many more felt that having to be ready for collection from two hours before their dialysis appointment was too long. This was particularly the case for:

- patients attending dialysis in the morning, who were required to be ready for collection from 5am; and
- patients needing special transport requirements.

> So if we're on at 7am in the morning, we have to get up at 5am to be ready. And then they'll come and pick you up, other times they're late for you and that's just not fair.
>
> I've had them come at 5.15am one morning...if you're on at 7am that means you're up and ready for 5am, who's gonna get up at 4.30am just to hope they'll turn up.
>
> I have to be up at 5am to be ready for 6am, sometimes I am not picked up until 7.45am and then other times they will come at 6.10am...

The most frequently identified impact of this wait was being late onto their dialysis machine. Every patient who talked to us about waiting for transport to get them into hospital identified that as a consequence, they have not had their full prescription of dialysis. In many instances this decision was made by the patient born out of their frustration with the transport service. A small number of patients commented on how they have missed complete sessions, they told us that this was a choice they made based on previous poor experiences of the patient transport service.

> Sometimes if I'm frustrated I ask for a shorter time on dialysis.
>
> So like I say I've had times when Arriva have picked me up and I've been so frustrated when I've got home that I've refused, that next time I will not come in.

For patients attending the evening dialysis session this decision was often taken out of their hands and was a result of the water supply to the dialysis machines automatically shutting down before they had their full prescription.

The majority of patients felt that this did have a direct impact on their health:

> On Wednesday in particular I'm due to go the machine at 6.45pm. Arriva didn't pick me up until 7.30pm. Which meant I can't have my full complement, full hours so I have to reduce the amount of time that I'm on the machine. That's not good for me, it affects my health as you need your four hours dialysis.
>
> ...some don't do full time, that's when you start to impact on people's lives, it's going to get dangerous.
>
> When a patient's late at night it's a knock on to their health as they're not getting their prescribed dialysis, it's not acceptable.
>
> ...so you're not getting your proper treatment. That can have detrimental effects on your health, if that happens often, then it wouldn't be very good at all.

The impact of being late onto the dialysis machine was not confined to them, patients identified that staff on the renal unit also suffered and there was a knock on effect to other patients attending the following dialysis session. It was obvious that many patients felt anxious about this. For example:

> Of course, not only my treatment but the people who come after me as well because I do my four hours, four and a half hours, they have to change the equipment, clean the machines, wipe down all the chairs and get everything ready for the next person who comes in. If the next person comes in late, it means the person after that comes in late. It's an ongoing thing. It's not good at all.
>
> When you're having to wait on transport coming to you because it's late, then you're late coming in here and then, late in coming off, which has a knock on effect for the timeslots after, people are late. So it's unfair for everybody.

4.5 Planning and co-ordination of journeys

Almost two thirds of patients (62%) commented on how they felt the planning and co-ordination of journeys was negatively affecting their experience of the patient transport service. This was mostly due to spending long periods of time in vehicles travelling across the city and county:

> It's a tour of Nottingham before I get home.
>
> But I don't really understand why they have to send them such a long way away to take you home when you only live a stone's throw away.
>
> ...sometimes we go to Arnold to pick up a chap from there then come back to Sherwood to pick someone up from there, and then go over to Basford to pick someone up from there...it can be quite a long time.

The inconsistency and unpredictability of the transport journey doesn't match with the routine of dialysis treatment. Many patients gave examples of when they had not been collected, or who were no longer routinely collected with people who lived in their locality.

> They know what jobs they've got to do that day, they book it all the time so they know. I come four days a week, same time so why can't they come at the same time to fetch me?
>
> Its things like, how can you not be planned, we come three times a week every week. It annoys me when you phone up and say you're waiting. How they are not planned, why not? That's the one I can't understand. The terminology is that you're planned or not planned, surely you should be planned unless the hospital or someone else informs them you're an inpatient or passed away.
>
> The people I used to come with still come in via somewhere else. It's you know, there's no logic. I can give you an example Mr <X> and Mr <Y> live in the same area, same estate, same housing place. And they get two cars to pick them up...they live four doors from each other, the logic in that is tell me what? I aint got a clue.

The majority of patients felt that bad planning and co-ordination of journeys was also responsible for the waiting times they experienced for either their journey into dialysis, or their journey home again. Patients found it frustrating when transport would come to collect someone who either was not yet ready to be collected, or who lived near or on the route of other people who were being collected. For example:

> I think it's really the planning. Because a lot of the time, I know there are a couple of people who are on a route that can be used for all of us, four or five people, rather than take a taxi for each one, I mean that, those five people could fit in an Arriva ambulance and go home.
>
> What it is, they drop him off first they drop the old lady off after, and then me next. But they never do it like that they pick him up, her up and I'm still sitting there waiting, It's the same area why don't you just pick, the three of us came in this morning, why can't they do it like that.
>
> When it's time to go home they picked the other three people I usually travel with and leave me, it was another hour and half before they pick me up. The transport it like hit and miss.

Poor communication between drivers, the call centre and patients was adding to people's frustrations. Contacting the call centre was a negative experience for 17 of the 20 patients who had made contact with them directly. They talked about not being able to get through on the phone, being placed on hold for lengthy periods of time and being told conflicting information.

Patients believed that the poor planning of journeys was responsible for the widely held perception amongst patients that the service is not efficient. There were examples of poor communication which resulted in transport either not turning up, being sent to collect the same person twice or being sent to collect patients who have already told the call centre they do not need transport.

> On another occasion they picked me up at 6.30am and half an hour later they sent another car but of course I had gone then so that was a complete waste of money.
>
> ...my neighbour tells me 10mins later a driver came to pick me up.
>
> Arriva have even come to pick me up when I've not ordered transport on several occasions.

The lack of flexibility of the transport crew in being able to arrange journeys based on the observed need at the renal dialysis units was also a frustration. Five patients identified occasions when they had asked the driver to share transport home with someone who lived on or near their route but were refused.

> I mean I don't want to have any, what they call, privileges before anybody else, I'll take my turn obviously, but it just seems silly when they've only got one in the car going the same way but they're not allowed to pick you up and take you. I know they'd take me if they were allowed to. They often say sorry <name> I can't take you, they go and ask them but they come back saying they can't take me, someone else is coming to get me.
>
> I have sat in this waiting room at 11 o'clock at night, and this is the honest truth, this was Arriva, I've had a friend, an elderly gentleman who lives near me, and the transport came for him, and it was a car so four seats, they took him in and he said oh <name> lives near me, they said <name> wasn't on the list, fair enough. They sent me a minibus, alright, from Worksop, all the way from Worksop, which arrived five minutes after with two crew one driver and one in the back, all for me. I said to these guys, can I ask why you're taking me, they said we've been asked to come all the way and take you home. I said that man who's leaving now he lives a few doors from me, they said we'll ring and tell them so he rang and they said we've already got you there so you'll have to take him home. That's a ridiculous waste of time, money and effort.

4.6 Transport requirements and preferences

11 patients indicated that they needed some form of special transport requirement, the majority of which were related to mobility issues that impacted on their ability to get into and out of transport vehicles.

Eight of these 11 patients (73%) had experienced the wrong type of transport that did not match their requirements. Wheelchair patients had been sent cars that could not accommodate their chairs resulting in additional waiting times. Others felt that their needs were not being listened to resulting in poor experiences.

> I have to have a front seat. But they're not listening, so they'll put two front seat passengers in together, who gets the seat?
>
> I'm asthmatic, I don't smoke, and I kept coming with a lady who smokes so heavy I was having to use my inhaler, and I said don't put me with her again and they did. They're not listening. I'm not trying to be awkward.

When asked about preferred transport type, patients most frequently identified Arriva cars as providing a more comfortable and quicker journey.

Negative experiences of taxis was the most common reason for patients who indicated a preference for any type of Arriva vehicle.

A quarter (24%) of all patients stated that they didn't have a preferred transport type, they would be happy to use any vehicle available if it arrived on time or reduced the time they were waiting for transport.

> I don't mind as long as it turns up on time
> It doesn't bother me what type of transport, it's just if they're there.
> They pick me up on time.

4.7 Effective, efficient and reliable service?

At the end of the interviews patients were asked to summarise their experience and consider whether the renal patient transport service is an effective, efficient and reliable service.

> It brings me here and takes me home, you can't fault that side of it.
> They're good when they get here.

Opinion was equally divided as to whether the service was effective, 18 patients stated yes and 18 stated no. Where reasons were provided the positive evaluations were due to an acknowledgement that the service did fulfil its transport role, patients did get into hospital and did get back home.

Almost half of all patients (49%) we spoke to concluded that the service wasn't efficient. Where explanations were provided, people talked about the poor planning of journeys and inefficient use of transport vehicles. For example:

> If it's an ambulance with five seats they need to use those five seats to use it efficiently enough. Rather than send a taxi out for three of them and take an ambulance for two of them which is why it's costing so much.

62% of all patients felt that it wasn't a reliable service, and justified this response by identifying a lack of confidence in the service and examples of when transport had not arrived to collect them.

4.8 Improving the renal patient transport service

The patients we interviewed were asked how they think the renal patient transport service could be improved. Only five patients were unable to identify any improvements or felt that the service did not need to be improved.

4.8.1 Better planning of journeys

The most frequently identified improvement was the planning of journeys, suggested by 18 patients we interviewed (40%). When making this suggestion people talked about the current inefficiencies of the service and their evidence of journeys being poorly planned.

Seven of these patients suggested that staff who were planning the journeys needed further training and development, they questioned whether these members of staff had sufficient knowledge of the city and county, for example:

> Make sure that planners are trained and know the area.
>
> Retrain the people that are in charge of routing the transport, make sure they understand the geography of the county, of taking people to and from the unit.
>
> I used to do deliveries, colour code the map. Don't cross colours with patients. So like, Clifton would be yellow, and the Meadows would be yellow cos that's close. Colour code the map by patients.

One patient suggested that improving knowledge and understanding of the dialysis process and how the transport experiences impacts on patients would help.

> What needs to happen is that they need to see what the patients go through to understand, the times I've been picked up and asked how long are you dialysing for? Four hours. How long for? For life!

If the planning of journeys was improved patients believed that their experience of the service would improve as they would feel less stress and frustration.

4.8.2 Improved punctuality

When talking about the planning of journeys, 14 patients suggested that this would improve the punctuality of the service. The majority of these people (10; 71%) talked about it overall, whilst four specifically identified that this needed improving for their journeys after dialysis:

> When people finish dialysis you don't want to wait, you spend three to four hours sitting here. Punctuality is number one on my list.
>
> I genuinely feel, when we finish, we need transport.

The most frequently identified impact of this would be an improvement in renal dialysis patients' quality of life. The unpredictable waits for the transport service restricted patients' activities for the remainder of their dialysis day. This is something which particularly impacted on patients attending the morning dialysis session.

> If you are not worrying about transport it makes life so much more pleasant, if you have got to think when am I going to get home? I mean, it's a silly thing, well it's not a silly thing, to have an appointment for the doctors or the nurse at your own practice, you can't make one on a Monday, Wednesday or Friday afternoon because you have got no idea whether you are going to get home or not and that's a big thing because sometimes they can only give you an appointment on a Monday, Wednesday or Friday afternoon and then you are waiting weeks to get the appointment because you can't guarantee you getting home.
>
> A punctual service means I wouldn't be wasting half of my life.
>
> If I got home sooner definitely. If you don't get home till 7-8pm it's time to go to bed isn't it.

4.8.3 Further training and development for drivers

Eight patients recommended that drivers undertake some additional training to improve their understanding of renal dialysis and how this impacts on patients.

More than half of these patients specifically identified that taxi drivers needed further training to get them up to the standard of the Arriva drivers.

> I'm not so sure whether the taxi drivers are trained. What if something happens to you like you're bleeding, would they know what to do? An ambulance driver would know how to do those things if you're feeling faint or anything.
>
> Yeah. We need the taxi drivers to be better.

Simple improvements such as ensuring taxi drivers knock on patients' doors and greet patients with a friendly smile would make a big difference to some patients' experience of the service, and how they feel in themselves.

> A lot better, don't feel good when they don't say thank-you. Speak to everybody friendly...and everybody feel better.
>
> ...there's a lot more going on in dialysis than can be seen, and I'm sure they deal with all sorts of patients, I respect that, but the drivers can be worn down, worn down in a way that they don't feel this job, like doing it, and they have to rise above it, I respect that.

4.8.4 A dedicated renal dialysis transport service

Five patients specifically requested that there is a transport service dedicated to getting patients into and out of the renal dialysis units. The routine of the dialysis schedule was seen as enhancing the ability to co-ordinate these patients' journeys and subsequently improve their experience.

> ...the renal transport used to just do renal and if the driver came in and somebody was ready they used to take them without any hassle, now whether that would work now or not I have got no idea but they should be able to sort the renal out because people are coming in on the same days at the same time and they are going home at the same time so they should be able to sort that out without too much trouble I would have thought.
>
> Erm, just, if I was in charge I'd put all dialysis patients, we're all up in the same time each week, all have appointment times. If they put those people together, if they could do that it would be better really you know...

It is because of this routine, the effects of being late on their health, and the health and experience of other patients that they felt it important to give renal dialysis patients dedicated transport resources.

> ...don't pick anyone up who is going to a ward or clinic, just pick dialysis up together, it's important we get on because if we're late, the next one's late, the next one's late and some don't do full time, that's when you start to impact on people's lives, it's going to get dangerous.

5 Findings from our patient journey diaries

Patients were also given the opportunity to complete some paper-based diaries to tell us about their journeys and how they're feeling during a normal week of dialysis. The diaries were requested by and sent out to 16 renal dialysis patients, they were asked to complete them in the two weeks after our interviews at the hospital. Seven patients returned diaries for a total of 50 journeys, 25 journeys into the dialysis unit and 25 journeys home.

5.1 Journeys in to the renal dialysis units

Of the 25 journeys into the renal unit patients identified that they were late on four occasions (16%), with the longest delay being 30 minutes.

One patient reported that transport had not arrived to collect them from home and that they had to make their own transport arrangements in order to reduce the delay to them getting onto the dialysis machine.

79% of journeys into hospital were identified as being shared with others, most frequently through ambulances (58%). Patients were most likely to give these journeys a four star rating (when using a scale of one to five where one is the worst and five is the best).

Three quarters (76%) of journeys described were positive, with no problems or issues experienced. When this happened, journeys were rated very highly, with patients most frequently providing a four star rating (when using a five star scale, where one is the worst and five is the best).

Negative journeys resulted in very negative feelings, patients wrote about feeling anxious and upset.

5.2 Journeys out of the renal dialysis units

Of the 25 journeys out of the renal dialysis units patients identified that they were waiting longer than 30 minutes for the transport on seven occasions (28%).

The longest wait was 90 minutes, whilst the shortest wait was five minutes. Waiting times between patients were variable, one patient waited an average of 17 minutes compared to two other patients each waiting an average of 55 minutes.

Overall, the average rating for journeys home was 4.10 (when using a scale of one to five where five is the best and one is the worst), patients most frequently provided a five star rating.

Over half (57%) of all journeys home were shared with others, most frequently in ambulances. These shared journeys received an average rating of 4.17.

There was a particularly negative journey identified where a patient had a journey of just over three miles to get home, which took a journey time of 1 hour 15 minutes, after waiting 45 minutes to be collected from the hospital. During this waiting time the patient identified very negative feelings and frustration at having to see drivers waiting for other patients to come off their machine whilst he was ready and awaiting collection. The patient identified that this was a frequent occurrence.

6 Findings from our patient survey

During the fieldwork week patients visiting the renal dialysis units at City Hospital were asked to complete a patient survey regarding their experiences of travelling into the unit. Patients could either complete it during their dialysis session with the help of a volunteer or complete it at home and return it to us in a freepost envelope. 50 completed surveys were returned.

6.1 Profile of respondents

Just over half were from current users of the patient transport service, as identified in table 2.

Table 2 Profile of respondents

	Count	%
All respondents	**50**	**100**
Currently use the patient transport service	26	52
Not current users, but have been in the past	11	22
Not current users, never have been	12	24
Users needing special transport requirements	15	30

Note: one patient did not respond to this question

A third (30%) of all respondents needed special requirements for their transport to and from dialysis. The majority (60%) stated that needed a wheelchair, and others identified mobility issues which impacted on the type of vehicle they could travel in.

Patients travelled between one and 31 miles for a one way journey to or from the renal dialysis units, the average distance travelled was six miles. The postcodes of all respondents are shown in figure 5.

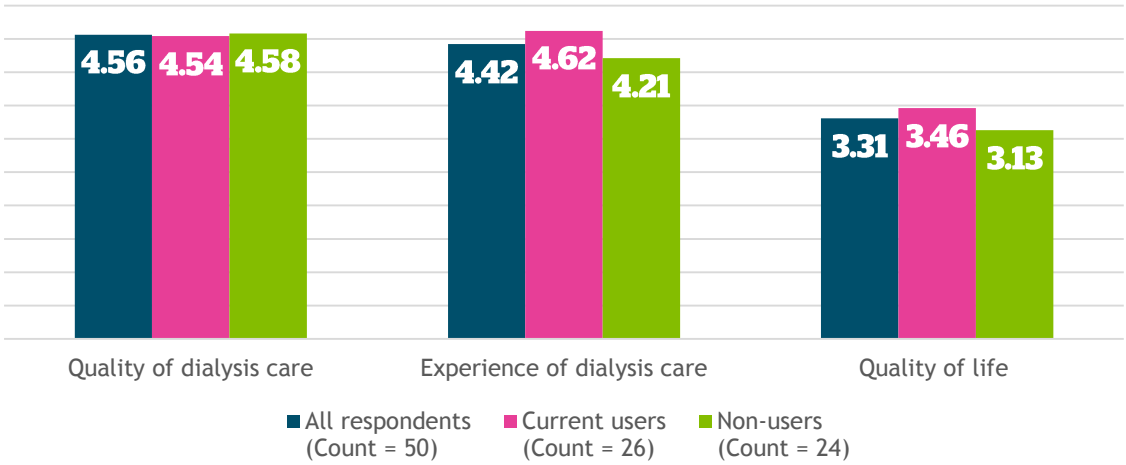
Figure 5 Map showing postcodes of survey respondents and Nottingham City Hospital

Source: Patient survey respondents. Base = 50
Green markers = Transport service users; Red markers = Patients arranging their own transport; Blue marker = Nottingham City Hospital.

6.2 Ratings of care and experience

As illustrated in figure 6, all responding patients rated the dialysis care they received very highly, most frequently rating both the quality and experience of this care as five star (when using a five star rating where one is the worst and five is the best).

Figure 6 Average* ratings of care and experience



** calculated from a scale of one to five where one is the worst and five is the best*
Source: Patient survey responses. Base = 50.

Patients rated their quality of life lower, most frequently giving a three star rating.

As shown in figure 6 there was no significant difference in ratings provided by patients using the transport service.

There was also no significant difference between the ratings given by those needing special requirements for their transport and those who didn't.

6.3 Travelling into and out of the renal dialysis units

Patients were asked to provide their postcode and the average and longest time it has taken for them to get into and home from the renal dialysis units at the City Hospital. A summary of this data is presented in table 3.

Table 3 Average distance and time travelling into the renal dialysis units

	Own transport arrangements	Transport service user
Average miles	5.44	6.53
Shortest miles	1.0	1.1
Furthest miles	22.6	31.2
Average usual minutes into hospital	19.79	35.68
Maximum usual minutes into hospital	60	140
Average usual minutes to get home	18.57	46.08
Maximum usual minutes to get home	50	145
Average longest minutes into hospital	34.47	83.96
Maximum longest minutes into hospital	120	210
Average longest minutes to get home	45.63	110.60
Maximum longest minutes to get home	180	300

Patients using the transport service travelled an average of one mile further to get to the dialysis unit than those patients who arranged their own transport.

The furthest distance travelled by a patient using the transport service was 31 miles, compared to 22 miles for patients who made their own travel arrangements.

Patients using the transport service took an average of 15 minutes longer to get into the hospital and 28 minutes longer to get home, compared to patients who made their own transport arrangements.

The longest journey times were 50 and 65 minutes longer for patients using the transport service than patients who arranged their own transport.

6.4 Ratings for the patient transport service

Patients using the transport service provided by Arriva Transport Solutions were asked to rate this service using a five star scale, where one is the worst and five is the best.

The average overall rating for the transport service was 2.44. Patients most frequently provided a one star rating.

Patients who need special requirements for their transport into the renal dialysis units were less positive than those who didn't. They most frequently provided a one star rating compared to a four star rating for those who didn't, as illustrated in table 4.

Table 4 Overall ratings of transport service by patients

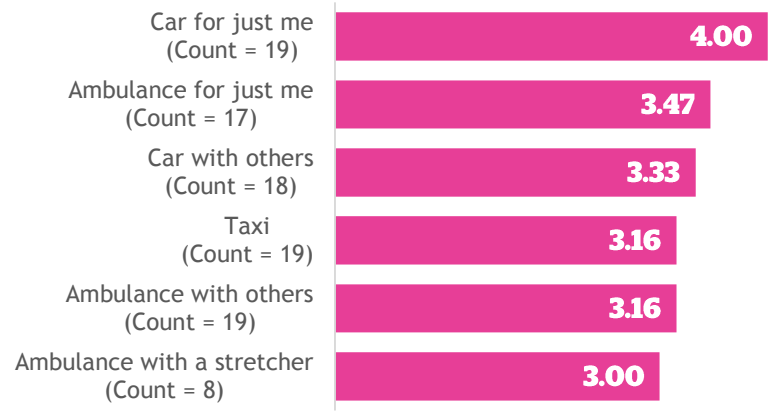
	Total	No. of ratings provided					Average* rating
		1-star	2-star	3-star	4-star	5-star	
All patients	25	10	3	4	7	1	2.44
Special requirement patients	10	6	0	3	0	1	2.00
Patients with no special requirements	15	4	3	1	7	0	2.73

** Calculated using a score of one to five where one is the worst and five is the best*

6.5 Types of vehicle

Patients using the patient transport service were also asked to provide ratings of the different types of vehicles they had experienced. This was using the five star rating where one is the worst and five is the best.

Figure 7 Average* ratings of transport type



** calculated when using a scale of one to five where one is the best and five is the worst*

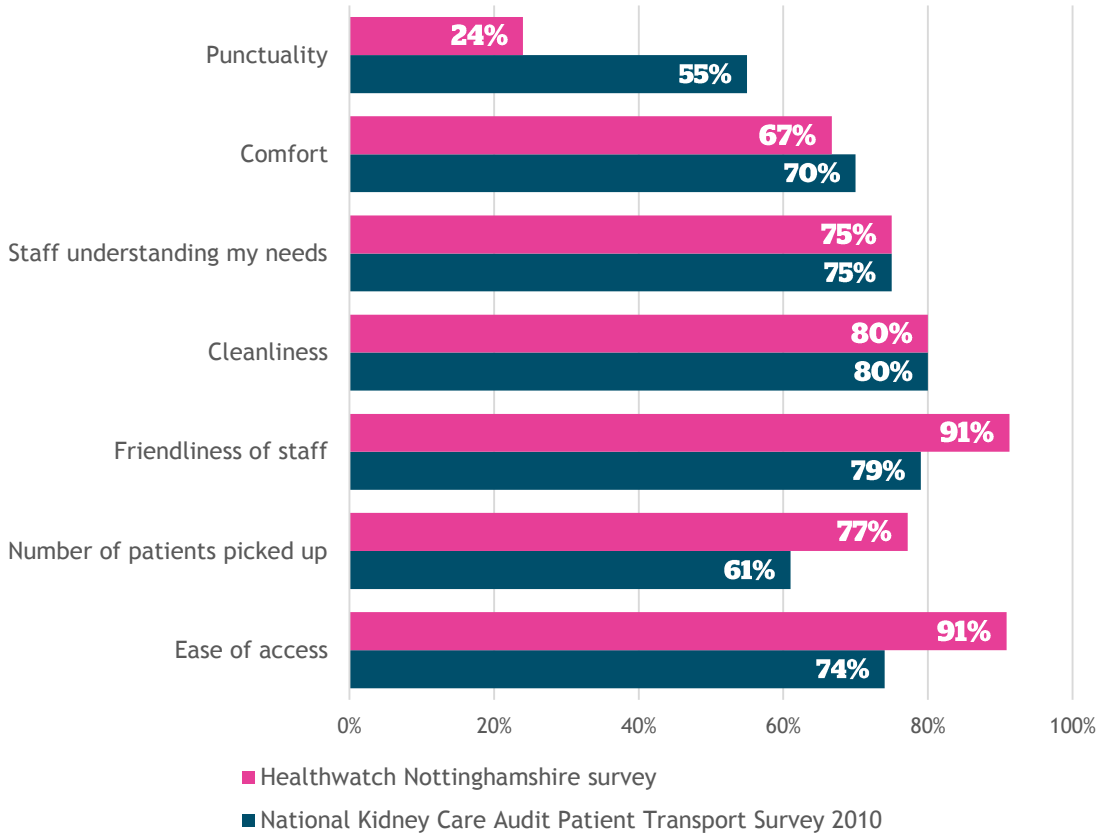
As illustrated in figure 7, individual cars were the most highly rated form of transport with the lowest rated being the two types of ambulances.

Patients were also asked to rate their satisfaction with aspects of the service that also featured in the National Kidney Care Audit Patient Transport Survey 2010.

Figure 8 shows that patients in our survey were more positive about the Arriva Patient Transport service than the national findings with regards to the number of patients picked up, ease of access and friendliness of staff.

Levels of satisfaction with the punctuality of the patient transport service were low in the national study, with only 55% of patients stating they were happy or very happy. In this project, the findings were worse, with just under a quarter (24%) being satisfied with this aspect of the service.

Figure 8 % happy or very happy with aspects of transport service



Note: When using a five point response scale from very happy through to very unhappy

When asked what are the best things about the patient transport service, the most frequently identified aspect was the drivers. Almost two thirds (63%) of respondents leaving comments wrote about the drivers and crew being friendly and helpful, for example:

> Drivers who are cheerful and doing a thankless job, can be pleasant and helpful.
>
> Reliable and friendly drivers.

The other consistently identified positive was that it got them into the hospital and home, and provided a service which they would otherwise have to source themselves if possible.

There were two main areas for improvement identified by respondents:

1. **Improved planning and co-ordination of journeys** – identified by 48% (10 out of 21) of respondents. This included training for staff who undertake this role.
2. **Improved punctuality** – identified by 48% (10 out of 21) respondents, four people specifically identifying reduced waiting times following their dialysis session.

6.6 Reasons for not using the service

Patients who identified that they had stopped using the transport service were asked to identify why. Of the 11 patients leaving comments all but two referenced that they had made this decision because of a poor experience of the service.

Waiting times were the most frequently identified specific reason, with patients writing about the two hour wait before being picked up or the wait for transport home after their dialysis session.

Long journeys caused by indirect routes and picking up or dropping off other patients were also identified by multiple patients who had stopped using the service.

These issues were identified as causing stress and anxiety, resulted in meals being missed and patients were, on occasion, travelling very late into the night.

7 Findings from our renal unit staff survey

Administrative and clinical staff working on both renal dialysis units at Nottingham City Hospital were invited to participate in a paper survey to provide their feedback on the Arriva Patient Transport Service. Surveys were available at a central location and completed surveys were collected in a box which was available during the week after the patient interviews were conducted. 17 completed surveys were provided.

7.1 Overall service ratings

Staff were asked to provide an overall rating of the patient transport service for renal dialysis patients using the same five star rating scale as patients, where one is the worst and five is the best. Staff were also asked to provide a rating of the Arriva Transport Call Centre.

Staff most frequently provided a two star rating for the service overall, and a slightly higher rating of three stars for the call centre.

When asked to explain their ratings half (52%) of staff commented on a poor experience of contacting Arriva on behalf of patients. The time taken to get through to speak to someone or being **placed on hold for long periods** of time characterised this poor experience. For example:

> It takes up time to chase up and rebook transport for patients on Arriva's contact number. Much of this time is spent on hold.
>
> ...it takes such a long time to get through to Arriva on the phone.
>
> Sometimes you are put on hold for far too long.

When writing about poor experiences, staff also commented on poor communication between the Arriva call centre and their drivers, which resulted inaccurate estimations of waiting times.

> Each time they say a different story then the drivers say something else.
>
> But most of the time I am kept waiting on the phone and the responses are unhelpful, i.e. saying a car is allocated when we know this is not the case because one hour later they still haven't been picked up...and it doesn't seem that the office/admin staff at Arriva can get in touch with the drivers to find out their exact location.
>
> If we ring the office they are helpful but I find they exaggerate how long we will be waiting for drivers to arrive.

7.2 Impact on the role of staff on the unit

All but one member of staff completing a survey stated that calling the Arriva call centre does impact their role on the unit. There were two main effects identified:

1. **Diverting time and attention from nursing duties**; identified by six members of staff. This was due to the time required to query existing transport or make new transport arrangements on behalf of patients.

2. **Dealing with angry and frustrated patients**; three staff members specifically identified that patients can be very angry and upset when arriving on the unit late and that they can, *'…take it out on staff'*.

Only one of the responding staff on the renal dialysis units identified that they had not called Arriva transport office themselves.

When asked to indicate the frequency with which they had to call, almost two thirds (63%) stated that this was either '*most*' or '*every day*' or '*every shift*' they worked.

Over half (59%) of responding staff identified that transport issues were most likely during the afternoon and evening sessions.

> …once we get to lunch time and evening time there are very long waits…
>
> Afternoon and evening.

Three members of staff specifically identified that wheelchair patients frequently experienced delays with their transport home following dialysis sessions.

> …normally wheelchair patients wait for long periods.
>
> …particularly wheelchair patients lunchtimes and evenings.

7.3 Impact on patients

15 out of the 17 responding members of staff specifically identified that a poor experience of the patient transport service does impact on patients' renal dialysis treatment. The two main reasons for this were patients:

- either **reducing the time** the patients have on the dialysis machine; or
- **missing** complete dialysis sessions.

The decision to reduce the dialysis time was taken by the staff on the dialysis unit when:

- the delay would impact on patients in the following session; or
- when the unit was due to close and the water supply to the unit (required for the dialysis process) would be automatically shut down.

> Sometimes they have to do less time on the machine to enable other patients to get their treatment.
>
> …if they are late in, they can't have full dialysis.
>
> The evening patients have to be off by 23.30 as the purified water for the machines switches off.

Staff identified that patients were also making this decision to reduce their dialysis time for themselves. Patients were anxious that being late off the machine would mean they would miss their pre-booked transport home, resulting in a very long wait until another driver and vehicle was able to collect them. For example:

> They often ask to have less treatment time as they are afraid of missing their transport home, that it will not wait or that they will have to wait for a rebooking.
>
> They feel that they will be left waiting for two hours to go home so they ask for their time to reduce.

Many staff specifically identified that not getting the full dialysis session or missing sessions completely was detrimental to their physical health, as explained by this member of staff:

> If patients sat on the unit doing nothing for two to three hours after their treatment they are missing out on sleep, food and possible medications which all contribute to overall health.

Staff also talked about the impact of dialysis on their patients' quality of life, when delays result in additional time being added to that which they already give up for their treatment. Some patients felt that the impact was too much on their lifestyle and family commitments. Staff felt that this resulted in some patients wanting to reduce or stop this treatment:

> The quality of life impact is huge as prevents keeping employment, affects family life puts a huge strain on relationships and has made patients want to stop dialysis.
>
> These patients already spend around four hours three times per week at the dialysis unit... This is a considerable commitment of their time which must affect other commitments such as jobs and families.

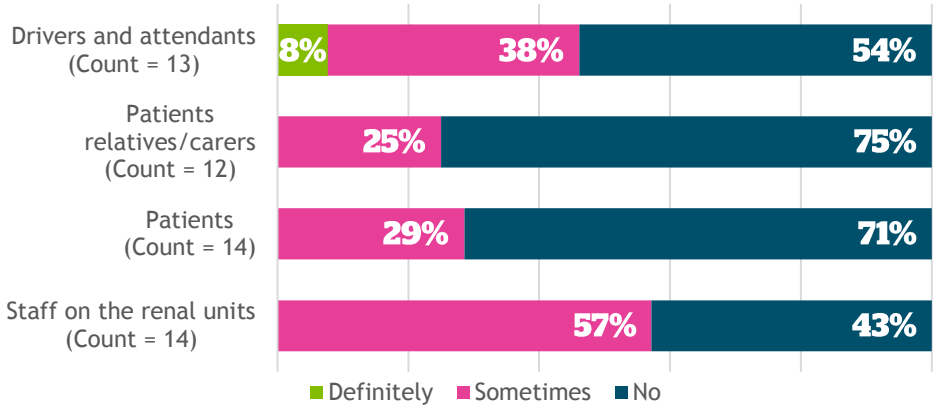
7.4 Improving the experience

Staff were most likely to indicate that they didn't feel Arriva listened to people in order to make improvements to their service, as illustrated in figure 9. They felt that other staff were more likely to be listened to, rather than patients or their relatives/carers.

Comments provided as explanation for ratings most frequently identified that they felt the problem lay with the planning of journeys and not the drivers themselves.

Some staff specifically identified that complaints and issues were listened to, but that no actions were taken which many found frustrating. There was a perception from some that this was due to a lack of capacity.

Figure 9 Perceptions of how much Arriva listen to others to improve their service



Note: 'I don't know' responses removed

All but one responding member of staff provided suggestions as to how the transport service could be improved for people attending renal dialysis. The most frequently identified suggestion was improving punctuality, 69% made reference to reducing the time patients were waiting for transport. The following are examples of this:

> Better timekeeping, less waiting to get patients in on time.
>
> Less waiting time.

Improved punctuality was typically talked about for both the journeys but there were slightly more specific references to the journey into the renal dialysis unit than the journey home after their dialysis session.

For a number of these respondents (four; 36%) improving punctuality was linked to improving the planning of journeys, for example:

> Plan they journeys better. Send patients in vehicles that are going in the same direction.
>
> Patients in same area need to have the same transport.

It was felt that this would reduce the time spent by patients in vehicles as journeys would be more direct.

Six members of staff (38%) identified a need for more drivers and vehicles operating for patients waiting times to be reduced:

> More staff/cars would resolve the length of time patients wait to go home.
>
> More cars and drivers.

Having a dedicated or allocated dialysis transport service was suggested by five staff (31%) as something that would improve the patient experience of the service.

Staff identified that this would benefit both the patients and the driving staff who would get to know each other and frustrations arising from long journeys and waiting times would be reduced.

> Dedicated drivers who know patients. This would make a massive improvement in patients' experience.
>
> ...it would make drivers lives easier and it would help to lessen patients' frustration.

Improving the communication between all involved, i.e. patients, renal unit staff and Arriva drivers and call centre was requested by four members of staff. An increase in the flow of information and an improvement in the accuracy of estimated collection times were identified. For the latter, one member of staff suggested a digital timing system similar to that seen at bus stops.

8 What next?

8.1 Official responses

This report has been sent to:

- Arriva Transport Solutions Ltd who currently run the patient transport service.
- Nottingham University Hospitals NHS Trust who run the Nottingham City Hospital.
- Mansfield and Ashfield Clinical Commissioning Group who oversee the contract for the Patient Transport Service in Nottingham and Nottinghamshire.
- The Greater East Midlands Commissioning Support Unit, who support the commissioning process for the contracting of the Patient Transport Service.

Responses to our report are included below.

8.1.1 Arriva Transport Solutions Ltd (Current providers of the patient transport service in Nottinghamshire)

We welcome this report from Healthwatch Nottinghamshire looking at renal patient experiences and renal unit staff experiences when using the patient transport service. It provides in-depth insight from both perspectives. As a UK wide provider of patient transport services we fully understand the impact that transport can have on the lives of renal patients who regularly travel to and from hospital for haemodialysis and as such have already put in a number of measures over the last 6-8 months that focuses on improving patient experience for this group of patients. This includes, daily, weekly and monthly meeting with renal units to discuss issues arising with transport - this includes discussions around any patients whose dialysis has been shortened as a result of transport. We understand that on the occasional occurrences of shortened treatment time, a full clinical assessment will take place to ensure this is appropriate under the circumstances. As part of our most recent improvement plans we will be conducting an observation day in conjunction with the Nottingham renal unit to analyse each section of the patient's journey to determine what factors cause delays and how these can be mitigated. We have invested in additional staff in our control and planning centre and extra vehicles. We have made a concerted effort to reduce our reliance on taxi providers and endeavour to undertake more journeys with our own staff.

This report now gives us additional insight into the specific areas that really cause concern for patients and will enable us to focus on areas that will specifically improve patient experience further. We are aware that patients who travel home in the afternoon can be impacted by other patient journeys taking place more than any other time of the day and this report confirms that. This is an area of work that we are working in partnership with our NHS colleagues to try to reduce the amount of on the day journeys that are booked elsewhere in the system as the more we can plan the journeys in advance, the better service we can deliver for all.

We are very pleased to see the comments about the excellent quality of care delivered by our staff. This is testament to their hard work and commitment and reflective of the patient centred business ethos that we operate.

There are useful recommendations made about better communications with patients and NHS staff and we have just developed new patient literature to help with this process and we would be happy to work with Healthwatch on further ideas regarding this. The other recommendations focus on improved planning and dedicated vehicles which we will consider fully alongside our NHS commissioners of the service. We regularly survey our patients on the areas of comfort, communication and care as well

as gathering feedback on patient experience through our concerns, compliments and complaints team. We will use the information in the report alongside the feedback we gain directly to focus on areas that matter most to our patients.

8.1.2 Nottingham University Hospitals (NUH) NHS Trust (providers of Nottingham City Hospital)

Alison Kinchin, Renal Dialysis Unit Manager, Nottingham City Hospital, said:

We welcome the work that has been undertaken by Healthwatch to seek the views of renal dialysis patients who use the transport service to get to and from our hospital. The findings provide a powerful account from patients of the impact of late and often unpredictable transport on their overall experience and the wellbeing on them and their families and carers. It is clear that renal dialysis patients require very specific transport arrangements, recognising the frequency of their treatment and individual needs of these patients. We have carefully considered Healthwatch's report and recommendations. We will work ever closely with our partners at Arriva during the remaining course of the existing contract and beyond to improve the experience of our patients, their families and carers.

Recommendation one response:

Staff in our renal unit will work with partners to introduce changes to how we do things that improve communication for the benefit of patient and staff experience. We would specifically encourage transport providers to consider introducing the use of innovative technology (such as text messaging reminders) to keep patients better informed about their transport arrangements. The introduction of such technology has proved successful in other clinical areas across NUH from which we can learn.

Recommendation two response:

We are concerned to learn that each of the patients who took part in this important work described how transport delays too often lead to a poor experience and a reduction in treatment time for patients. This is frustrating for patients and can, if it occurs frequently, could have an adverse impact on the health of patients (dialysis treatment time has been directly linked to outcomes in haemodialysis patients). We strongly support this recommendation which mirrors the commissioning model that exists in other parts of the country. Such an improvement would improve the health and wellbeing of our patients.

Recommendation three response:

We acknowledge the difficulties for Arriva when it comes to providing non-emergency transport for such a large organisation such as NUH and the competing priorities colleagues face when it comes to providing transport. This includes substantial numbers of requests for transport daily for renal dialysis patients, inpatients (from ward discharges) and return journeys home after outpatient appointments. Nevertheless, renal dialysis patients remain the largest user of this patient transport and do have very specific and individual patient needs which require this group of patients to be prioritised for home journeys after their treatment. Given the national commissioning intention to promote more home dialysis, it is highly likely that patients attending hospital dialysis units will continue to increase in dependency. This does need to be factored into both commissioning and provision of renal patient transport services. We agree that renal dialysis patients are not presently getting the transport service, nor experience, they deserve. We would be fully supportive of any work undertaken to progress this recommendation.

Recommendation four response:

Staff on our renal unit fully understand the complexity of renal dialysis patients. They are therefore well-placed to assist in any training which would raise awareness (to taxi companies) so that colleagues better understand the detrimental impact their service can have on the overall experience of our patients.

Recommendation five response:

We concur that the drivers and attendants are the biggest asset of the patient transport service. They are extremely caring towards our patients and this is demonstrated by this Report. The renal unit wholly supports any recommendation which allows nurses more time to care for patients and reduces the considerable amount of time that is currently spent dealing with patient concerns about transport and getting in touch with Arriva staff to enquire about transport.

Recommendation six response:

Putting yourself in patients' shoes is often the best way to understand their experience. Staff on the renal unit are willing to help with any training that would help our partners to better understand the impact of a poor and often unpredictable patient transport service on the impact of our patients.

8.1.3 Mansfield and Ashfield Clinical Commissioning Group (Lead commissioner for the non-emergency patient transport service in Nottinghamshire)

Mansfield and Ashfield Clinical Commissioning Group (CCG) is the lead commissioner for non-emergency patient transport services for patients registered with Nottingham and Nottinghamshire (including Bassetlaw) GP's. The service we commission from Arriva Transport Solutions Ltd for patients travelling to and from dialysis appointments includes a number of key performance indicators (KPI's). These KPI's include arrival times, travel time and pick up times following treatment. The service levels commissioned are not being achieved. The CCG's are working with Arriva on a revised service improvement plan.

We value this report, which is comprehensive and has used a variety of methods to illicit the important views of both patients and staff in relation to their experience of patient transport services. It draws out a number of concerns which need addressing with the provider. We note that overall the report indicates that patient and staff experience of the current service is unsatisfactory. The principal cause of the concern seems to be punctuality and the timeliness of the current transport service. We also note that drivers and attendants are highly valued by patients. The report highlights that the experience of those patients with special requirements is particularly poor, with service being particularly problematic in the afternoon and evenings. We feel the report outlines the physical and emotional impact that this has on patients and also staff who are working in the renal service.

The CCG's will consider the recommendations contained within the report and will discuss these with Arriva to identify how the service and KPI levels could be improved over the remaining term of the contract.

8.2 Additional recommendations

Following on from the responses provided by the organisations involved we have identified two further recommendations.

Recommendation 7:

Data needs to be collected to identify when patients do not receive their full prescription of dialysis or miss complete dialysis sessions.

This will also need patients to communicate with staff on the dialysis unit when making decisions at home about their dialysis treatment as a result of their patient transport service experiences. Collecting and routinely monitoring this data will allow medical staff to act upon the impact this could or is having the health of renal dialysis patients.

Recommendation 8:

Dialysis patients waiting for transport home after their dialysis treatment need to be provided with a level of care during this time to ensure their safety.

This would mean that all patients, particularly those managing other chronic health conditions, do not experience unnecessary and preventable negative impacts to their physical health. Their overall experience of dialysis treatment would be improved and carers/relatives would be less concerned about the physical and mental state of their loved one when returning from hospital. There needs to be a greater level of communication between all parties, patients, renal dialysis unit staff and the transport service for this happen.

8.3 Future actions

We will ensure that our report is circulated as widely as possible in addition to publishing the report on our website. Patients involved in the project who requested a copy of the report will sent a hard copy in the post, and reports will be sent to both renal dialysis units.

This report isn't the end of our work.

We are currently in the process of setting up meetings to discuss the actions identified in the official responses to our findings and the implementation of these new recommendations and those identified in section 2.

We will return to the renal dialysis unit in the coming months to identify whether improvements reported to us in November have been sustained and identify any impact of actions taken since the publication of this report. We remain committed to ensuring that change happens and patient experience of the service improves.

Acknowledgements

We would like to take the opportunity to thank everyone involved in this project.

To all patients, thank you for giving up your time to talk to us.

To the staff on the renal dialysis units, thank you for looking after us during our week on the dialysis units and for your feedback through the surveys.

To our volunteers, thank you for also giving up your time to prepare and undertake the interviews with patients.

Who are Healthwatch Nottinghamshire?

Healthwatch Nottinghamshire is an independent organisation that helps people get the best from local health and social care services. We want to hear about your experiences, whether they are good or bad.

We use this information to bring about changes in how services are designed and delivered, to make them better for everyone.

Why is it important?

You are the expert on the services you use, so you know what is done well and what could be improved.

Your comments allow us to create an overall picture of the quality of local services. We then work with the people who design and deliver health and social care services to help improve them.

How do I get involved?

1. Have your say

We want to hear your comments about services such as GPs, home care, hospitals, children and young people's services, pharmacies and care homes.

You can have your say by:

- ☎ 0115 963 5179
- www.healthwatchnottinghamshire.co.uk
- @HWNotts
- Facebook.com/HWNottinghamshire
- Freepost RTES-TCEC-JTBR, Healthwatch Nottinghamshire, Unit 2-3 Byron Business Centre,Duke Street, Hucknall, Nottingham NG15 7HP

2. Join our mailing list

We produce regular newsletters that feature important national health and social care news, as well as updates on local services, consultations and events.
You can sign up to our mailing list by contacting the office by phone, email or by visiting www.healthwatchnottinghamshire.co.uk

3. Become a Healthwatch volunteer

We need enthusiastic volunteers from around the county to promote the Healthwatch message, to feed information to and from groups, and help us collect people's experiences. We also need insight volunteers to help us to assess services through Enter and View and other projects like this.

Interested? Get in touch and we'll let you know what roles are currently available and what to do next.

healthwatch Nottinghamshire

Unit 2 Byron Business Centre
Duke Street
Hucknall
Nottinghamshire
NG15 7HP

Phone: 0115 963 5179
Web: www.healthwatchnottinghamshire.co.uk
Twitter: @HWNotts

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
14 JULY 2015
WORK PROGRAMME
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

Purpose

1.1 To consider the Committee's 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 currently planned for municipal year 2015/16 and make amendments to this plan 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.

3.4 The 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 Com 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, 21 April 2015 and 16 June 2015..

7. Wards affected

All

8. Contact information

Clare Routledge, Health Scrutiny Project Lead
Tel: 0115 8763514
Email: clare.routledge@nottinghamcity.gov.uk

APPENDIX 1

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
14 July 2015	• **Transformation Plans for Children and Young People** To receive an update on the preferred site (Nottinghamshire Healthcare Trust) • **Public Consultation regarding Gluten free Prescribing** (Rushcliffe CCG)

	• **Changes in Adult Mental Health Care Provision in Nottingham City and County** To receive the latest update on the changes (Nottinghamshire Healthcare Trust) • **Healthwatch – Renal Patient Transport Review** To receive an update on addressing the findings of the Report produced in March 2015 (Healthwatch Nottinghamshire and Arriva Transport Solutions) • **Work Programme** To consider the 2015/16 Work Programme
15 September 2015	• **Outcomes of the Primary Care Access Challenge Fund Pilots** Evaluation of Results (South Nottinghamshire CCGs and Area Team) • **Patient Transport Service – Performance Update** (Arriva /CCG lead) • **NHS 111 Performance Update** (Nottingham City CCG) • **East Midlands Ambulance Service – New Strategies Update** Update on the implementation of new Strategies (EMAS)

13 October 2015	• **Urgent Care Resilience Programme 2015/16** To receive an update on the preparation and planning for Winter 2015/16 (Nottingham City CCG and NUH) • **Rampton Secure Hospital Variations of Service** To receive an update on treatment and care of people with personality disorders (NHS England and Nottinghamshire Healthcare Trust) • **South Notts Transformation Partnership** To receive an update on the SNTP developments (South Notts Transformation Partnership)
10 November 2015	• **NUH Environment and Waste Update** To receive the latest update (NUH) • **Long Term NUH Strategy (5 years and beyond)** To receive a presentation (NUH) • **East Midlands Senate Briefing**
15 December 2015	• **Royal College of Nursing** Further briefing on the issues faced by nurses (RCN) • **Long Term Conditions (including Neurology)**

	• **Update on Transitional Changes Within Nottinghamshire Healthcare Trust Adult Mental Health Service For 2015/16** To receive the latest update (Nottinghamshire Healthcare Trust)
12 January 2016	• **Child Immunisation** To receive information relating to performance and impact of Child Immunisation (Public Health) • **NHS and Adult Social Care Workforce Challenges**
9 February 2016	
15 March 2016	
19 April 2016	

To schedule:

NHS England Area Team and Quality Surveillance Groups
End of Life Care
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
Quality Surveillance Group (QSG)

Visits:
Urgent and Emergency Care Services
Rampton Secure Hospital

Study groups
Quality Accounts