D R A F T

OVERVIEW & SCRUTINY COMMITTEE

Minutes of the Extraordinary Meeting held on Wednesday, 23rd November 2011 at Worksop Town Hall

Present: Councillor G J Wynne (Chair)
Councillors: B A Bowles, I J Campbell, D Challinor, G Freeman, A Mumby, J W Ogle, D Potts, J Potts, Mrs W Quigley and Mrs A Simpson.

Officers: G Blenkinsop, V Cookson, L Dore and R Theakstone.

Standards Committee Members: None

Others present: Councillor G A N Oxby

Managers and clinicians present:

Dr Robin Bolton – Medical Director, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Ron Calvert – Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Barry Clark – Patient Representative
Ian Greenwood – Director of Strategic and Service Development, Bassetlaw Hospital
Dr Mike Ho – GP, East Bassetlaw
Dr Stephen Kell – Chairman, Bassetlaw Commissioning Organisation
Mr Mohammed Alloub – Consultant Gynaecologist/Obstetrician, Clinical Director, Women's and Maternity Services
Phil Mettam – Chief Operating Officer, NHS Bassetlaw
Dr Henry Mulenga - Paediatrician
Alan Portwood – Community Car Scheme
Robin Riley – Nottinghamshire County Council
Paul Smeeton – Chief Operating Executive, Nottinghamshire Health Care NHS Trust
Dr C P Stanley – GP, West Bassetlaw
Dr Peter Taylor – Deputy Postgraduate Dean, Yorkshire and the Humber Postgraduate Deanery
Lynn Tupling – Chief Executive, Bassetlaw Action Centre
Julie Walker – Rehabilitation & Integrated Services Manager, Bassetlaw Health Partnership

Also present: Hazel Brand – Communications Manager, Doncaster and Bassetlaw Hospitals NHS Foundation Trust

(The Chairman welcomed all to the meeting and thanked everyone for attending. He read out the Fire Alarm/Evacuation Procedure).

108. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors J Anderton, R B Carrington-Wilde, I Jones, T Rafferty, J Scott, J C Shephard and C Wanless.

109. DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

(a) Members

Councillors I J Campbell and D Challinor declared personal interests in Agenda Item No 3 – The Future of Services at Bassetlaw Hospital, as their GP's were present as witnesses at the meeting. They remained in the meeting.

(b) Officers

There were no declarations of interest by officers.

SECTION A – ITEMS FOR DISCUSSION IN PUBLIC

Key Decisions

None

Other Decisions

110. THE FUTURE OF SERVICES AT BASSETLAW HOSPITAL

Questions by Members of the Overview and Scrutiny Committee

G P Commissioning and Referrals

From Councillor Wynne
Question 1

"What do you believe are the risks and benefits of the proposed NHS reforms – for patients, service providers and commissioners?"

Reply by Phil Mettam:

Bassetlaw Commissioning Organisation (BCO) is the local Clinical Commissioning Group which has made good progress and is recognised nationally as being at an advanced stage with enthusiastic GP's working well together. Other benefits will follow. The PCT and BCO are integrated as a business organisation and are the first to do this in this area – others are following. The benefit to this is that the leadership has direct involvement with clinicians and we can reassure that through the governance we will have in place there is a co-ordinated approach to risk management which will continue through to when the new organisation is formed in 2013.

Reply from Dr Kell:

The appropriate work has been done. Clinicians engaging with Bassetlaw GP's have worked very well. Risks and benefits – there have been difficult times financially. The benefits are improved joint working, changing the way we work together on a clinical level. Patient engagement is to be improved. BCO needs to ensure that as the PCT relinquishes responsibility, the Clinical Commissioning Group is ready to step up. We need to stay focussed on quality for patients – the risk is that during the transition, quality needs to be a priority.

Reply from Ron Calvert:

Risk – there is some uncertainty as people change roles and relationships but this is a chance to start again. We have lost some structures and processes and do not know what will be in the Bill when it passes through the Houses of Commons/Lords. Benefits: power to commission - and a lever for significant change. This will depend on how the acute sector responds to it. It is a period of uncertainty but there can be big gains.

Reply by Dr Bolton:

De-stability and change is never an easy time. The benefits – if we join up well then patient involvement brings benefits to patients. GP's commissioning in smaller groups could create a postcode lottery and with different commissioning groups we do not quite know how it will work out. A local commissioner can manage things in primary care without referral to secondary. Another area is training – across the board there will be new regulations to revamp how it is delivered. Localised group training has not been fully worked through yet; it is a threat but also an opportunity for primary, secondary and community care.

From Councillor Mrs Quigley
Question 2

"Can you explain the respective responsibilities of the Bassetlaw Commissioning Organisation and NHS Bassetlaw during this transition phase?"

Reply by Phil Mettam:

NHS Bassetlaw and BCO are part of the South Yorkshire and Bassetlaw cluster. The cluster includes other PCT's - Doncaster Sheffield, Barnsley and Rotherham. The Bassetlaw PCT Board stood down. Each of the five stakeholders has two seats on the new Cluster Board. BCO has received a letter of delegation for £140m services including acute, community and mental health services. NHS Bassetlaw's budget is £200m. The other £60m is managed by the PCT and includes primary care specialist care (e.g. burns) and prison healthcare.

In autumn the single cluster Board was established, with BCO operating as a Committee. Of that, BCO has a number of sub-committees to manage risk. These include quality and patient safety, finance audit and risk, and issues specific to Nottinghamshire.

The BCO Executive is made up from Dr Kell (Chair) and six other GP's. Also two lay members (one of these is the Vice-Chair) who were previously non-executive directors to the PCT. Additionally the Executive includes the Chief Operating Officer and the Chief Finance Officer.

Reply by Dr Kell

In terms of governance it is not just a group of GP's working alone in isolation. Managers, lay members and the Cluster Board will be working alongside GP's providing the checks and balances. There will be local priorities and national priorities to consider. Local priorities will consider things like paediatrics, maternity, e.g. care near to home, efficient use of resources and new services such as thrombosis and dermatology. National priorities will include alcoholism and dementia - we will find out more about the national priorities tomorrow. There will be more real patient engagement in decisions.

Additional question from Councillor Campbell

"The name of the vice chair?"

Reply by Dr Kell

Melvyn Morris – previously Non-Executive Director for Bassetlaw PCT – appointed through national process.

Additional Question from Councillor Wynne

"Severe cuts – to what extent does price influence the commissioning process?"

Reply by Dr Kell:

Price will have some influence on commissioning decisions – we are also conscious of keeping services local, with new and improved services but it is important we stay within budget. GP responsibility will bring new local services and improvements and we have to ensure value for money and reduce waste. It is very important to GP's – they want the commissioning group to work, they are passionate about it and will be judged on it. It is most important that quality improves through the changes made but we have to be realistic about the need to manage finances responsibly.

Reply by Phil Mettam:

David Nicholson, Chief Executive of the NHS, is driving forward an efficiency programme of £20 billion across the nation. For 2011/12 Bassetlaw PCT/CCG has to achieve an efficiency target of £5.7m from an allocation of £200m. The PCT does not provide services it commissions them therefore the challenge will be to ensure the focus is on quality and the securing of local services. Next year there will be a further efficiency programme with different issues to consider and we will be trying to manage this in a difficult climate**.**

From Councillor D Potts
Question 3

"Please can you explain the incentive scheme for GP practices and why the Bassetlaw Commissioning Organisation designed this type of scheme?"

Reply by Dr Kell:

The incentive scheme has been in place for approximately 15/18 months. It was first implemented by the PCT with the support of GP's who recognised the need to change the way we worked, a smarter way of working and changed primary care so that patients see the right person, in the right place, at the right time and avoid unnecessary trips to hospital. It does not stop GP referrals – there are no rules on what we can and cannot refer. We have improved the way we work within the Practices utilising GP's different skills and levels of training. As a GP I have experience of dermatology and can see a patient rapidly therefore saving a hospital appointment and providing quicker patient access. We have set up new services within existing Practices. It is based upon old money using PCT enhanced services money and we need to see that it works. We have to deal with demand management as hospitals are an expensive place for patients to be seen. We have made a significant difference but have not blocked referrals. There is no referral management centre locally and we are keen for decisions to be made in the consulting room between patients and their GP's. Any patients needing a referral are referred and we want this to continue.

Reply by Phil Mettam:

We did not know whether this approach would work but are pleased with the way it is going. Feedback from GP's is positive. Some parts of the country are introducing controls with referral management. We prefer working this way so local GP's can decide with their patient what steps to take and whether care could be provided outside of hospital. Next year we will have the discussion with Ron and his colleagues regarding the impact this is having on the Hospital.

Additional Question from Councillor D Potts

"I live at Everton and have access to surgeries at Larwood and Harworth. How are those people in rural areas affected?"

Reply by Dr Kell:

These will have no effect on these services.

Additional question from Councillor Mrs Quigley

"Will this mean that each surgery is working against each other?"

Reply by Dr Kell:

We do not set up to compete but offer different services. Other GP's offer different services. The patient chooses the GP that they want the service from, including which specialities they offer.

Additional question from Councillor Campbell

"Is offering a specialist service a direct financial benefit to GP's?"

Reply by Dr Kell:

It will bring extra money into the Practice – but not much. Every Practice is committed to doing extra work and the income will be necessary recognition of the extra work being done to improve services.

From Councillor Bowles
Question 4

"Can the Hospital give their opinion on the merits of the incentive scheme?"

"What would the impact on Bassetlaw Hospital be if other NHS Trusts and Clinical Commissioning Groups in our region adopt the Incentive Scheme?"

Reply by Ian Greenwood:

Looking at all the work going into hospital, population growth, increasing age population, our consultant colleagues know it is important to support GP's so that people get to see the right person and this can be in primary care. For example The Breast Cancer service offer less follow-up appointments, this is a benefit. Speciality/outpatient work - it is fair to say there is concern where there is less work. In a previous meeting we indicated there were fewer patients seeing specific services. We have to work differently and what we are good at is adapting. We are working with colleagues in commissioning about how we make some of

these changes. Work coming into hospital is growing – more emergency patients less outpatient work.

Reply by Doctor Kell:

Breast cancer follow-ups are not part of the incentive scheme, they are flagged as part of the cancer network before the scheme began**.** I do not have information about the number of follow up appointments

From Councillor Freeman
Question 5

"How would you define an inappropriate referral?"

Reply by Dr Stanley:

I object to the term 'inappropriate referral' – a more sensible term to use would be 'avoidable referral'. Patients could be dealt with in better way. The incentive scheme has seen useful improvements but is not a perfect scheme. It does not tell the whole story - it is much more complex than 'I will get money for not referring'. When, how and who to refer has to be determined by factors of experience, training, career path and system investigation. With a different system involved a patient may not need referral. Skills within Practice – own or others – can be quicker, better for patients. We are not going to stop a referral if this is what the patient wishes. GP's group meetings consider levels of referral and meetings stimulate discussion regarding options. Could we have dealt with differently? It is positive learning.

Reply by Dr Ho:

Half of referrals are inappropriate. Currently if a patient requires expertise out of the remit of the GP's Practice – a referral is obviously needed. We will always refer when there is a clinical need/requirement.

Reply by Dr Kell:

We are determined to keep the patient central so much goes into decisions on their treatment.

Reply by Ron Calvert:

I think there is inappropriate referral. Patients can self-refer in some cases What is best for the patient/tax payer? Could the patient have been dealt with more efficiently in a place other than an expensive hospital environment? Patients' may say they could not get a GP appointment – but did they try? They do not know there are alternatives. The Hospital is working GP's alongside in Accident and Emergency to access primary care.

From Councillor Ogle
Question 6

"What are the reasons for the drop in first patient referrals to Bassetlaw Hospital and what impact is this having on the Hospital?

Reply from Ron Calvert:

The reason for the drop in patient referrals was covered in previous meetings – there are better ways to see the patient that can cost less and is better and more convenient utilisation of GP skills. The impact on the Hospital is a 6% drop. Due to GP's working more efficiently

our offer of inconvenient services and unpopular services may mean patients are being sent elsewhere. The trick is being more responsive to services that are required given the aging population and their increase in demand. We need to deal with by discussion and agreements with GP's so that there is the right quality and efficiency.

Reply from Dr Ho

In our own Practice there are three reasons why referrals are decreasing: 1) Colleagues understand GP's clinical responsibility and financial responsibility; if there is no discipline in clinical/financial matters our patients will suffer. GP's have to understand financial budgets. 2) The change in the way we work. The incentive scheme in the last year or two has meant remarkable change – we meet regularly to discuss clinic pathways, uniformity, best practice, the patients and how they are best managed. We are using the skills of different clinicians within the Practice and talking a lot more as more second opinions are sought. The patient is treated in primary care where possible but referred if required. 3) Training, peer review, supporting each other, assessment of where more skill/training is needed through clinical meetings. There has been a major change in how the Practice operates resulting in increased quality and an energised Practice.

Reply by from Dr Stanley:

Systems have changed in my Practice utilising expertise across the team. Pathways and the education process improve quality.

Reply from Dr Kell:

There are implications for secondary care - pressures on the workforce, capacity in clinics and financial issues. It is not the best use of a consultant if people do not need to see them but, for example, freeing up their time can improve emergency care capacity. Capacity is less about the number of specialist clinics. With regular appointments a patient can be seen locally quicker.

Reply from Ron Calvert:

There have been fewer patients seen this year. In short – if this continues, the Hospital would have to adapt – we would have to change to improve and make the offer more attractive. If we cannot, we have to reduce costs and consolidate but this would add risks – people do not want to travel and may not go elsewhere. There are risks for the future but if it is the right thing to do we will co-operate.

From Councillor Challinor
Question 7

"If GP's are making less referrals to secondary care – where else are they referring patients to?"

"Is Bassetlaw Hospital the hospital of choice for Bassetlaw GP's when referring Bassetlaw residents into secondary care?"

Reply by Dr Kell:

In-house services or community based services. Most patients choose to go to Bassetlaw Hospital wherever possible unless a specialist hospital is required.

Reply by Dr Ho:

The GP is now more responsible for investigating and for the outcomes of a patient. We will refer appropriately. The choice is for the patient. 92-93% go to Bassetlaw Hospital with others going to Doncaster or Sheffield.

Reply by Ian Greenwood:

Bassetlaw Hospital is the choice for residents of Bassetlaw GP's. 30% come from outside because they want Bassetlaw Hospital services.

Reply by Dr Stanley:

Dermatology and gynaecology – we are particularly experienced in these areas in our GP Practice. If referred, the choice is for patients. People choose Rotherham if they live nearer to the hospital there. Harworth residents often choose Doncaster. The vast majority choose Bassetlaw unless ultra specialist treatment is required, e.g. neurology or cancer then Sheffield is the preferred choice.

From Councillor Mrs Quigley
Question 8

"You have stated several times in previous sessions that the relationships between NHS Bassetlaw, Bassetlaw Commissioning Organisation and the Hospital are very positive. How does this relationship work in practice and what mechanisms are in place for this working relationship to continue to be developed?"

Reply by Ian Greenwood:

Negotiations regarding money and contracts have been positive but the contracting process is always difficult. Mature relationships, communications – we spend a lot of time together. We have become better at reconnecting consultants and GP's – working together on specific patient pathways, quality groups, focus groups. We have re-established forums, communications between GP's and clinicians, reconnection of relationships. Mechanisms are in place for contracts, performance indicators and meetings. In contrast with other places it feels very positive. Signing contracts early has illustrated working relationships are productive.

Reply from Dr Kell:

There have been difficult times and issues – it has been important working together. In terms of health economics, it is not in the interest of either the GP or hospital to go bust. It is not about contracts but about quality relationships.

From Councillor Mumby
Question 9

"Are all GP's in Bassetlaw engaged in the Bassetlaw Commissioning Organisation and supportive of its aims and objectives?"

"Where are the differences of opinion – how are these resolved?"

Reply by Dr Kell:

Eleven out of twelve GP Practices are engaged. We are to have a meeting with the Walk-in Centre in December and are hoping that they will join.

Reply by Dr Stanley:

Across the spectrum, people are enthusiastic and positive although some are battle weary and some young GP's are not fully aware. At the first meeting there were collective decisions – in the months prior there had been splintering. There is now a common view given reforms, financial situations and a solidarity around Bassetlaw for one community organisation which we are signed up to. Aims and objectives – there are some controversial issues so we see what happens when specific proposals are made clear. I see a positive atmosphere and support.

Reply by Dr Ho:

There are differences of opinion – yes, a few times, but GP's are really talking the same language in terms of safety, quality and a sense of engagement. GP's are thinking about their work. They understand the aims and objectives. The forums meet and the service development groups are active – there is good clinical discussion happening which is patient focussed. There is the most exciting clinical engagement in Bassetlaw.

Additional question from Councillor Campbell

"What is the decision process for each practice within the BCO?"

Reply from Dr Ho:

Decisions are made at monthly meetings. The service development group meeting discusses clinical topics. The Leads bring back ideas etc. to Practices. GP's are involved if there is a major decision to be made and it requires clinical focus. With financial matters there is often a difference of opinion but not much discussion as it is centred on how a patient can be best managed.

Reply from Dr Stanley:

The members' forum is something that all GP's may attend to enable engagement between individual GP's and BCO and specialists out of BCO to discuss at individual Practice. Opinions, pros/cons are fed back. For a specific change of service at the Practice meeting, we come to a majority view.

From Councillor Wynne
Question 10

"Is there anything you would like to add further about GP Commissioning and plans for the future?"

Reply by Ron Calvert:

I am new to the system and made assessment of the organisation before joining. Why here? There is a perception of threats to Bassetlaw Hospital. There is no doubt the level of beds could cause concern and the Hospital be under threat. Relationships are important and there is the commitment on the part of GP's that Bassetlaw stays as a fully fledged hospital.

Community Services

From Councillor Mrs Quigley
Question 11

"Can you confirm the community services you now provide under contract to NHS Bassetlaw and the length of this contract?"

Reply by Paul Smeeton:

Thank you for the invitation to come here today. We already provided the mental health care services in Bassetlaw so we were tremendously proud to be offered Community services. A lot of work and investment has gone in to improving services. We were impressed by the clinical leadership in the area. It is worth noting the level of involvement of GP's in the commissioning and delivery of Community services. This has helped services to be tailored to local needs, a more integrated, joined up working - Bassetlaw is focussed. Nottinghamshire County Healthcare is also commissioned to provide Community Services in the rest of Nottinghamshire and is focussed on retaining separate geographical areas with the same staff. The contract is for three years.

Reply from Julie Walker:

We provide a comprehensive range of services in three areas: Children's Services, Adult services and Rehabilitation Services. Some are provided in partnership with Nottinghamshire County Council (Adult Social Care) and Acute services. We also have a number of service level agreements with Doncaster and Bassetlaw Hospitals Trust.

From Councillor B Bowles
Question 12

"In your opinion what are the implications, if any, of these new management arrangements?"

Reply by Dr Stanley:

A large number of local community services are staying within the NHS – it is a large and successful organisation known for good governance as a good employer which is reassuring. Notts Healthcare entered into the relationship from the beginning with enthusiasm to involve and engage GP's and Practices which was refreshing. They put energy into finding out our views and wanting to engage the Practice.

Reply by Dr Ho:

The implications were important as good care in the community is critical. To be a success in community services requires strong clear clinical leadership, patient focus, coherent vision for partnership between social services, GP's and secondary care, well trained locally accountable valued staff and these were inherited. They had a vision of working with primary care, an integrated approach to provide primary services. Regarding the Tender – these were the only ones that came to talk to us about the contract.

Reply by Paul Smeeton:

Primary care know what the issues are and we tailor to what is needed.

Reply by Julie Walker:

A test is how staff feel. There was no cause for concern during the first three weeks. Staff feel very comfortable with the arrangement. Even at this early stage, Bassetlaw Health Partnership is already seeing delivery in some of the areas Notts Healthcare promised to support us with, such as staff training and leadership development.

From Councillor Ogle
Question13

"What are the performance measures contained within your contract with NHS Bassetlaw?"

Reply by Paul Smeeton:

There are a lot! There are general quality targets and the Commissioning for Quality and Innovation (CQUIN) scheme. Performance measures are discussed with commissioners.

Reply by Julie Walker:

There are a range of measures – some are nationally mandated measures with which we have to comply and others are local quality measures to ensure quality and value for money. Monthly performance reports showing activity and quality are provided for NHS Bassetlaw such as response times, minimum caseloads, saved hospital admissions and measures that improve patient care. They are monitored by a traffic light system – red/amber/green – to show progress towards the target. We also have to demonstrate that mechanisms are in place to address any issues, but there are very few of these locally.

The CQUINS are quality improvement indicators; these are incentivised targets to drive up the quality of patient care and are monitored monthly and quarterly depending on the indicator.

Reply by Phil Mettam:

Prior to transfer the contract team had most of targets on plan. Service standards have been maintained and we are confident that they will continue to do so.

From Councillor J Potts
Question 14

"Have the levels of investment in community services remained the same – or has there been any uplift in investment – if so please specify?"

Reply by Phil Mettam:

The transfer of services has seen broadly the same investment. We have invested a lot in community services and are proud of them. There is good interim care from community matrons and there has been investment in community equipment. Many of the services provided are of the highest quality.

Reply by Paul Smeeton:

The level of investment in Bassetlaw has been very significant. Bassetlaw is in a good place.

(As some witnesses were leaving at this point, the Chairman thanked everyone for coming to the meetings and commented that it had been an interesting process with a free exchange of information and views).

Walk-in Centre

From Councillor Campbell
Question 15

"Is the Manton Walk-in Centre still classed as a walk-in centre and what is the procedure for getting an appointment?"

Reply by Phil Mettam:

The Manton walk-in centre/Westwood GP Practice evolved from a national initiative where all PCT's were required to find access to a GP for all patients with out-of-hours provision. The PCT holds a contract with them – it provides a regular GP service where a patient can register with the Practice and this is (1400 approximately) on plan. It is approximately half way through the contract. The walk-in terms are for 10 walk-ins per day. These are the structured arrangements and there is discussion on how the contract is going on a quarterly basis. The 10 walk-ins a day are required to be to be seen within 30 minutes as part of a key performance indicator. In practice, the 10 walk-ins are seen fairly early in the day therefore those arriving later in the day may not receive the same service.

At the last review meeting with the team, after seeing 10 walk-ins, anyone else has been sent to Accident and Emergency and we have asked that the Centre be more flexible and stage the 10 throughout day or alternately see more. We have found that the demand on the walk-in requirement is greater than the contract that is let. So what should we do? More investment would not be favoured but we need to find a way for the system to work more together. At present we are finding that those who present at Accident and Emergency or Westwood have not always tried to get an appointment at their own practice. We need to work together to be more effective.

Additional question from Councillor Campbell

"How much longer has the contract to run?"

Reply by Phil Mettam:

A further two to three years.

Question 16

"How long should it take for a patient to be seen by a doctor at the walk-in centre?"

Answered as part of question 15.

Question 17

"You mentioned last time that you would meet with the service contractors to discuss problems if any are reported"

"How many times have you met with contractors since the walk-in centre opened?"

"Has the issue of not being able to see a GP without an appointment been resolved?"

Answered as part of question 15

(The Chairman agreed a change of order to questions at this point so that question 36 was asked next as Mr Calvert had to leave the meeting early).

From Councillor Bowles
Question 36

"Nationally there seems to be a trend for centralising hospital services – in larger units".

"Looking ahead how can Bassetlaw Hospital resist this trend and remain a sustainable hospital offering a wide range of safe, high quality services in Bassetlaw?"

Reply by Ron Calvert:

We do not want to resist the trend. There are a lot of services, e.g. burns, cardiac, spinal injuries etc. where a large number of patients are required to warrant these services e.g. Burns Unit. We would not want to resist change. It does not have to be super specialist, an example is: stroke patients go from Bassetlaw to Doncaster for the acute phase then return to Bassetlaw for continued treatment. It has much to do with guidelines.

We do want to remain a sustainable hospital. We have encouraged general commissioning to Bassetlaw as a district general hospital for a number of months. There is an advantage in pursuing Doncaster Royal Infirmary as a bigger unit as it can attract and recruit anaesthetists and physicians and retain experienced staff to rotate across the two sites. We can do this because we are part of a larger hospital. If there is a shared commitment between commissioners and hospital, there will be opportunities in the final Health Bill to negotiate special prices for special situations, including in rural areas. Tariffs need to be appropriate to particular circumstance, e.g. geographically isolated services. There are no guarantees – it is a critical message to commissioning in the future.

From Councillor Mrs Simpson
Question 18

"In a rural District access to services is always a concern."

"What arrangements are in place to make access easier for patients and their families to key hospital and GP services – particularly out of hours and where treatment is accessed out of the District?"

Reply by Alan Portwood:

The car scheme is operated by volunteer drivers: 35 transfer Bassetlaw residents door to door where people are unable to get to places by other means. Sometimes the journey is by community minibus. Journeys by car cost 47p per mile with a £2.50 booking fee. Last year 2700 journeys were undertaken using community transport. These people are not able to access public transport therefore would not get there. We also cater for other social journeys but mostly GP appointments, day rehabilitation, inpatient/outpatient appointments, visiting hospital. We have drivers in both Retford and Worksop and also rural areas.

Reply by Julie Walker:

We use the volunteer car service for community services, in particular day rehabilitation and pulmonary rehabilitation. The majority of these people are unable to access public transport due to their health problems.

Patients journey times are considerably reduced using the volunteer car service compared with the ambulance service and it is more cost effective.

In the Out of Hours service provided by Bassetlaw Health Partnership, where a patient is unable to provide their own transport to get to the GP appointment at Bassetlaw Hospital in an evening or weekend, transport is provided, free of charge to the patient, by a taxi company (R Cars). The company will take the patient to the primary care centre at Bassetlaw Hospital and return them home. Given the rural nature of the district, it was not deemed appropriate to transport patients after 11pm therefore we operate a visiting service by Specialist Support Practitioners.

Reply by Alan Portwood:

The Bassetlaw community minibus is also used for PCT day rehabilitation. As there are more people, it helps cut down on costs.

Reply by Robin Riley:

I am pleased to be here. There is a good partnership between the volunteer and health sector. We received a Beacon authority award two years ago for partnership working. For the transport to health service, patients ring if they require access to health services in the District. We work with other partners such as Stagecoach who now have bus services to the Retford primary care centre. The Council re-launched transport accessible to all and the web service enables people to find out what services are available, e.g. volunteer provision, cars etc. Where transport may not be suitable due to particular mobility concerns, that person needs to register so that we can take things forward to assess and to deliver services.

Reply by Lynn Tupling:

Shuttle buses operate between Bassetlaw and Doncaster Hospitals. GP's have relocated at Retford and patient feedback has revealed there are no issues for patient parking.

Additional question from Councillor D Potts

"Is there a cost to patients for the use of RCars?"

Reply from Alan Portwood:

There is no cost whether in or out of hours as it is considered part of the delivery of treatment. The 47p per mile and the £2.50 booking fee is paid for by the PCT so there is no cost implication for the patient.

Junior Doctors

From Councillor Mrs Simpson
Question 19

"How does the Deanery decide on the number of Junior Doctors to be sent to each Hospital or Trust?"

Reply by Dr Taylor:

Thank you for the invitation to attend today. The number of doctors is historic: contract funding flows are based on the number of doctors in the organisation previously. There are significant national constraints specifically prohibiting expansion and doctors are funded

centrally to ensure the right doctors and the right numbers needed in future are in place in each hospital.

From Councillor Mrs Simpson
Question 20

"Is the Deanery planning to reduce the number of junior doctors to be sent to Bassetlaw Hospital?"

Reply by Dr Taylor:

There is significant national workforce planning and consequently in Yorkshire and Humberside we are looking at reducing trainees in certain specialities. There is a mismatch, e.g. surgical trainees who are never going to be surgeons and we have to redress this through a review of trainees and training placements. In Bassetlaw there are no immediate plans to withdraw any trainees but we will redress concerns.

Reply by Dr Bolton:

We are aware of training issues. From the Deanery quality review we are aware of issues of mismatch regarding trainees/seniors. We are internally addressing this and are looking to rotate throughout the region to find the right level of support for junior doctors, middle registrars, senior consultants. We lack middle doctors so junior doctors are more vulnerable as they do not have them to refer to. Discussions are ongoing as part of wider clinical service review. Junior doctors are good value – we need to find the balance between training and providing a service. We are looking to see how can do this within constraints.

(Councillor Mrs Simpson left the meeting at this point).

From Councillor D Potts
Question 21

"What improvements to training would the Deanery like to see at Bassetlaw Hospital?"

Reply by Dr Taylor:

There have been some improvements with new appointments by the Trust since the last Deanery visit in June 2011. The supervision of junior doctors, (anyone from one week to those within one to three years of qualifying), we found that in Bassetlaw they are managing acute admissions and referring to consultant staff at home as middle grade doctors are not available for rotas. There are issues of patient safety and for the environment they are working in. With the challenge of the issues raised, many have been addressed but supervision is still to be resolved regarding the availability of middles to work due to rota hours.

From Councillor Mrs Quigley
Question 22

"How does the Deanery ensure that the appropriate quality of training is delivered so that each hospital is attractive and useful in training hospital doctors?"

Reply by Dr Taylor:

The way we ensure that the appropriate quality of training is delivered is by visiting the hospital, talking to doctors and the Trust and looking at the standards they need to achieve.

From Councillor Wynne
Question 23

"Concerns about Hospital services have been the subject of wide-scale media attention. As the Leader of the Council we know that you have received many representations from elected Members and the public about their concerns for the future of services at Bassetlaw Hospital."

"Based on what you have heard throughout this review do you feel that these concerns have been addressed?"

"If the answer is no – what areas do you think remain unresolved?"

Reply by Councillor Oxby – Leader of the Council:

I would like to praise the administration and conduct of the review. Members have asked questions in a courteous and consistent manner. Everyone has been professional, open and transparent. The decision to circulate questions in advance was the correct decision.

My answers to these questions represent my personal views and opinions. It is important to understand my role over the last 12 months given my involvement with the protest group, media coverage and the issues being a focal point for the concerns of residents.

One year ago, there was widespread concern regarding the future of services at Bassetlaw, Mexborough and Doncaster Hospitals. I accept that some of it was rumour and conjecture. It was difficult to determine what rumour was and what was accurate information. Minutes of meetings acquired from the PCT through a Freedom of Information Request raised concerns over the Accident and Emergency Service, Paediatrics and Maternity. These minutes from December 2009 showed that proposals were in place for several services to be transferred. The Health Panel should also note that these minutes contained proposals to withdraw/transfer services from Bassetlaw Hospital and also stated that this should not happen until after the General Election. The Save Our Services (SOS) Group was accused of scaremongering that 1000 nurses would be lost. This was not said – as there are not even 1,000 nurses employed at Bassetlaw Hospital. However, I firmly believe that without the protest group we would not be discussing such a bright future for Bassetlaw Hospital today. Back in 2009 there was also concern that half of the Hospital's accommodation could be used by GP's. It therefore begs the question that if the Hospital had that level of accommodation available which services would have been transferred to free up this space?

The protest group was not a group of left wing militants. It comprised nurses, school governors, councillors from both Labour and Conservative groups. Through the protest group concerns were addressed and relationships with hospital managers and commissioners were established. We have all learnt lessons.

I still have concerns about GP commissioning but this is a Central Government led initiative and they will decide if it is right or wrong. My personal concern is the dual role of GP's in the NHS who offer good services, but may also be Directors of private medical companies.

There is also the issue of trauma services. The proposed changes by Government will see more serious trauma cases being dealt with outside Bassetlaw. This mirrors the American model where they have "super A&E" departments.

We have all learnt from this difficult period over the last twelve months but I would not change my role in any part of the process or do anything differently.

From Councillor Wynne
Question 24

"Senior Managers and clinicians from NHS Bassetlaw and Bassetlaw Hospital have asked that the Council assist them to communicate more effectively with Bassetlaw people"

"In your role as Leader of the Council would you be prepared to help to facilitate better communication between health colleagues and the public in future?"

"What mechanisms would you want to see set up to help make this happen?"

Reply by Councillor Oxby – Leader of the Council:

Yes – several months ago we met at the Hospital and PCT with Dr Kell, Mr Mettam, the Chief Executive of Bassetlaw District Council and it was a fruitful discussion. It has been difficult to get back together to meet again but on a quarterly basis it would be helpful to discuss other issues like communication.

From Councillor Mumby
Question 25

"Elected Members involved in the Health Review have expressed a wish to continue to meet with health colleagues in the future, e.g. through an annual event."

"Would you be prepared to support this request if health partners were in favour of this proposal?"

Reply by Councillor Oxby – Leader of the Council:

There is no reason why I would not want to. Only good could come from such a proposal.

(Councillor Freeman left the meeting at this point).

(The Chairman advised a short comfort break).

Maternity Services

From Councillor Bowles
Question 26

"Birth rates are reported to be rising".

"How confident are you that the current model of Maternity Services can meet the projected increase in demand?"

"Is the service future proofed?"

Reply by Mr Alloub:

The anticipated increase on demand is one to two percent year on year for the next few years. It varies considerably from day to day. We are looking at pathways to ensure a patient is seen in the right environment. We are future proof for five years then we should review again. We look at the birth rate every six months or so to ensure appropriate staffing is in the right place looking after women one to one.

Reply by Dr Bolton:

As discussed in previous meetings the maternity unit is consultant led and organised to look at resources. Bed capacity is managed by moving people around. On staffing matters there is discussion on affordability which is taken forward. As Ron Calvert has stated "Babies continue to be born at Bassetlaw" but the recommendation of the recent review, which we rejected, suggested that in the future we might have to move to a midwife-delivered system and more community based midwives.

Future proofing is difficult – the organisation NICE has just advised today that in future ladies can choose a caesarean section irrespective of medical need. We do not know what is around the corner but will future-proof as far as we can.

From Councillor Ogle
Question 27

"What are the cost and staffing implications of dividing up the shared Gynaecology, Obstetric and Paediatric rota?"

Reply by Ian Greenwood:

We are looking to see how we can address the situation in discussion with Dr Taylor to define roles – solutions are not straightforward. By separating different sections, costs will increase but this forms part of a conversation with the commissioners as to how to move forward.

From Councillor Mumby
Question 28

"Are women who have a miscarriage or abort babies now accommodated on the Maternity Ward with new mothers and babies?"

"If so why has this happened and what is the ward now being used for?"

Reply by Mr Alloub:

Due to a problem with capacity on the surgical ward we lost eight beds. For women with pregnancy problems that we do not have beds for they go to the Maternity Ward. This is not a long-term solution and we are in discussion with the surgical ward. There are three single rooms on B6/B7 where we can take a patient into for assessment: they can come and go home and come back following day. These patients are not put with delivered mothers or those about to deliver - they are away from main ward area.

Additional question from Councillor Mumby:

"Ward B7 used to accommodate women with pregnancy problems. Why has facility been taken away?"

Reply from Mr Alloub:

I cannot answer that question – it is now used for women's surgical admissions. We are pushing for our own facility.

Reply by Ian Greenwood:

I do not know the specific answer – it was changed three/four years ago. We have not got things right on the surgical floor but are looking to ensure the right bed is in the right place. We are hoping to conclude work quickly to provide more single accommodation etc. We recognise we have issues to sort out with the aim of developing a surgical floor so it is fit for purpose.

Additional question from Councillor Mumby

"The situation regarding the beds for women with pregnancy problems has not been going on for four years – it has only happened recently. Why has this facility been taken away?"

Reply by Ian Greenwood:

I will have to come back to you later with a more precise answer. We recognise there are more than general issues.

Children's Services

From Councillor Mrs Quigley
Question 29

"We understand that there is very little engagement by GP's with Children's Centres"

"The Centres provide a forum to develop the skills and confidence of expectant mothers and mothers and fathers of young children".

"Why has this opportunity not been taken up?"

Reply by Dr Kell:

The GP is focused on the medical side with health visitors, parents, paediatricians. In terrns of development skills and confidence, this discussion takes place with the health visitor. As part of the new service, the BCO is being linked in through the Health and Wellbeing Board where a strong part of the strategy is to look at child issues, poverty etc. As GP's we are working on it as there is lots to get involved in.

From Councillor Bowles
Question 30

"We have been told that children come into Accident and Emergency in hours because there were no appointments within surgeries available. Is this the case and if so how is this being addressed?"

Reply by Dr Bolton:

Regarding the number of appointments available, I am not able to answer. Regarding Accident and Emergency, we are back to the debate of appropriate place of referral. One of the concerns when we see children on arrival at Accident and Emergency is that some could have been managed elsewhere. But it is also down to patient choice. Accident and Emergency is not the most appropriate place for many children but facilities are being enhanced. It is difficult for a parent as they may need for a child to be seen e.g. children with longer term problems such as chronic disorders. The community paediatric service could offer a more joined up service and this should be part of the investment in community paediatrics.

Reply by Dr Kell:

This is back to the patient being seen by the right person at the right place. Many problems are not Accident and Emergency problems and a GP is more experienced to deal with these problems than a junior doctor in Accident and Emergency. Many children need to be in their own bed rather than a hospital bed. There is some work to do on communications as we try to increase access in primary care, for example, Larwood Surgery has walk-in access and a patient can be seen within twenty minutes. Here is the opportunity and a plea to work together.

Reply from Phil Mettam:

BCO are committed to finding a way of communicating with the public and to using new technical platforms for feedback such as 'Facebook' and 'Twitter'. We are working with commissioners to make communication more efficient – why should a patient go to Accident and Emergency when they do not need to? At the annual event mentioned by Councillor Oxby we can take stock and consider how we can engage with the public more effectively. We are looking forward to receiving the report following this review and to working with anyone who wants to engage with us.

(The Chairman advised the report regarding the review of the future of services at Bassetlaw Hospital would be ready to share in January 2012).

From Councillor Mumby
Question 31

"What are the strengths/weaknesses if the current Children's Service at Bassetlaw Hospital?"

Reply by Dr Mulenga:

We see ourselves as a small department which is very proactive. We work in partnership with obstetrics and work closely with Mr Alloub with whom we have in-depth discussions about how to improve services. We work closely with Accident and Emergency. We have a good network and most patients can come to us directly through GP's or consultants and can be seen the same day. We do not operate a waiting list and dedicate a lot of time to our patients. With regard to post-graduate education, Dr Taylor will confirm we have no middle grade doctors so we include three research fellows from the Children's Hospital as part of our rota. We have two junior doctors and would like to increase the number to five.

Our strengths: the training in our department is always commended and we address any issues as soon as possible. Another strength is our community focus - mothers are proud to stand up for the department vindicating everything we do in Bassetlaw. Our outpatient patients do not wait more than six weeks. As part of our internal processes we have strong audit controls. The team are professional and really want to work together with management.

Our weakness is those that do not know what we do and we need to change their perception. The department is costly to run and we are dedicated to reducing those costs without affecting how quickly patients are seen.

From Councillor Mumby
Question 32

"What would you like to see changed/improved in Children's Services?"

Reply by Dr Mulenga:

Doctors are competitive – we need to set the service on conversations of shared value. We need to increase the better utilisation of services at Bassetlaw and Doncaster Hospitals; we need to strengthen conversations with parents and children when they come as part of the care relationship. Doctors need to be engaged in performance management and to be aware of the real difficulties faced in measuring how to reduce waste and create value.

From Councillor Mumby
Question 33

"Do you think the future of the Children's Service is sustainable? What steps could be taken, in your opinion to make it more sustainable?"

Reply by Dr Mulenga :

The process must change. In America, children must have access to services 24/7, 365 days per year, be within walking distance or be able to utilise public transport to obtain inpatient access to family centre care. The change has now come where there should be no waste. For Bassetlaw Hospital to be sustainable we need to look towards this same family centre care.

From Councillor Mrs Quigley
Question 34

"As a user of Bassetlaw Hospital services, what has your experience been?"

"Is there anything you would like to comment on about current services or future services?"

Reply by Barry Clark:

I have MS so avail myself of quite a few services. I am generally very satisfied with the use of the neurological service and the MS nurse service – they are efficient and friendly as is the vascular service. I had trouble with the orthotics service – at the time I was trying to resolve a problem with a bag of bits and pieces which were wasted as they could not be recycled other than by posting to the USA which would have cost postage.

I cannot fault the out of hours patient and paramedic service. I need the use of a wheelchair full time and a stand aid to get in and out of bed. My leg folded and I fell to the floor. The ambulance crew were fantastic.

Service at the Newgate Street Surgery is always very good. As a wheelchair user it can be difficult to access some surgeries. The car parking at Bassetlaw Hospital was difficult in the past but has improved recently.

At Doncaster Hospital I suffered adverse bowel screening and a one and a half day stay developed into a nine day stay. Some aspects of patient care were less than perfect and I was left in bed for several days during preparation.

With MS I feel there is a lack of communication. The MS specialist nurse is steering the committee to try and create a patient pack which will detail a patient's needs, to take into hospital.

(Councillor Mumby left the meeting).

From Councillor Ogle
Question 35

"In previous sessions there has been an acknowledgement that direct communications with the public from Bassetlaw Hospital and NHS Bassetlaw has been limited. As we move forward how you do plan to make sure that communities know what they can expect from Health Service providers in our area?"

Reply by Phil Mettam:

Refer to my response to question 30.

Question 36 had been discussed earlier on the agenda.

SECTION B - ITEMS FOR DISCUSSION IN PRIVATE

Key Decisions

None

Other Decisions

None

The Chairman thanked everyone remaining for their participation and closed the meeting.