OVERVIEW & SCRUTINY COMMITTEE

Minutes of the Extraordinary Meeting held on Thursday, 3rd November 2011 at Retford Town Hall

Present: Councillor G J Wynne (Chair)
Councillors: B Barker, K Bullivant, I J Campbell, A Mumby, J W Ogle, D Potts, J B Rickells, J Scott, J C Shephard and Mrs A Simpson.

Officers: G Blenkinsop, V Cookson and L Dore.

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
Ian Greenwood – Director of Strategic and Service Development, Bassetlaw Hospital
Wendy Hazard – East Midland Ambulance Service
Mr Trinath Kumar – Orthopaedic Consultant, Clinical Director,
Wendy Knight – Deputy Director of Strategic and Service Development
Phil Mettam – Chief Operating Officer, NHS Bassetlaw
Denise Nightingale – Clinical Advisor NHS Bassetlaw and NHS Doncaster
Ginny Snaith – Management lead for the development of the A T C
Dr Jon Train – Consultant Anaesthetist, Clinical Director of Anaesthetics
Wendy Hazard - Service Manager, East Midlands Ambulance Service
Glenn Kay - Ambulance Driver, East Midlands Ambulance Service

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

(The Chairman welcomed all to the meeting and read out the Fire Alarm/Evacuation Procedure.)

86. APOLOGIES FOR ABSENCE

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

87. DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

(a) Members

There were no declarations of interest by Members.

(b) Officers

There were no declarations of interest by officers.

SECTION A – ITEMS FOR DISCUSSION IN PUBLIC

Key Decisions

None

Other Decisions

88. THE FUTURE OF SERVICES AT BASSETLAW HOSPITAL

Questions by Members of the Overview and Scrutiny Committee

As the Orthopaedic Consultant had been delayed due to surgery commitments, the Chairman advised a change in the order of questions so that those relating to Accident and Emergency were asked first.

Accident and Emergency

From Councillor G Wynne:
Question 11

"We know that you have a throughput of patients in Accident and Emergency at Bassetlaw Hospital of approximately 45,000 patients annually",

"What percentage of this number are Bassetlaw residents?"

"Where do the remaining patients come from and why do they choose Bassetlaw?"

Reply by Phil Mettam:

Statistically, two thirds (67%) of throughput at Accident and Emergency are Bassetlaw residents. The other third come from the surrounding area, e.g. Mansfield and Ashfield, Rotherham, Doncaster and those visiting Clumber Park and Center Parcs. Why do they choose Bassetlaw? We can speculate that they choose Bassetlaw because we have a good reputation and parking can be a determining factor as it is relatively good compared to other hospitals. There has not been a special audit undertaken regarding the question of why patients make the decision to come to Bassetlaw.

From Councillor I J Cambell:
Question 12

"What is the profile of the patients coming through Accident and Emergency at Bassetlaw Hospital?"

"Are there any recurring types of illness/injuries?"

"Should all of these illness/injuries be treated at the Accident and Emergency Department?"

"Why are cases that should be treated elsewhere coming into Accident and Emergency?"

Reply by Dr Bolton:

There were around 45,000 patients who attended the Accident and Emergency department at Bassetlaw last year with almost equal numbers of male and female. Ages ranged from birth upwards with the average age of females being 40.5 years and males 36.5 years. A quarter of patients attending were paediatric cases aged between birth and 18 years.

There are always quite a range of illnesses and these vary across the age ranges. The 'Casualty' TV programme shows similar scenarios to those we deal with. Patients are divided into two categories, minors, e.g. stings, cuts, grazes and majors, e.g. fractures, abdominal conditions, respiratory, cardiac and other significant illnesses and how we manage them varies.

There are some patients that frequently attend perhaps because of convenience, others because they have a chronic illness, e.g. respiratory problems mean repeat visits or perhaps an acute one-off episode. There are no specific patterns.

For minor illnesses, many could be managed elsewhere. Where patients self-present, it is difficult to turn them away. Triage determines the priority a patient is given, the next step for their treatment and by whom. Doncaster and Bassetlaw Hospitals will see everyone but many minor categories could be treated elsewhere.

As to why patients come to the hospital over anywhere else it is probably convenience and easier than getting an appointment with their GP and also that they get good service.

From Councillor K Bullivant:
Question 13

"Operating a busy Accident and Emergency Department is a challenge. Are there any particular issues you have in running this department, e.g. alcohol fuelled incidents?"

Reply by Dr Bolton:

The nature of Accident and Emergency is mostly unpredictable but some days are predictable, e.g. Friday and Saturday evenings and major football matches. We cannot pull staff from elsewhere and cannot understaff so we have to consider a 'midway' staffing arrangement.

Across the country hospitals are seeing more problems relating to binge drinking and the change of culture is more noticeable in some parts of the country than others. Have Licensing laws made things more difficult? We don't know but we are seeing a rise in alcohol related problems – behavioural, drink abuse, anti-social behaviour. We try and balance staffing accordingly.

From Councillor B Barker:
Question 14

"Given the savings that need to be achieved through the Quality, Innovation, Productivity and Prevention Programme – how will the planned enhancements to Accident and Emergency be paid for?"

"What knock-on effect will this have on other services?"

Reply by Ian Greenwood:

The programme will be funded through surplus funds – we aim to generate a surplus – last year we were successful in funding in part the Accident and Emergency programme. Other funding comes from Capital as part of identified funding therefore there is no impact on other programmes.

(Councillor Ogle joined the meeting).

From Councillor K Bullivant:
Question 15

"How will the new approach within Accident and Emergency increase the quality of diagnosis and referral to appropriate services?"

"How will this reduce the number of Accident and Emergency cases that are re-admitted to hospital?"

Reply by Dr Bolton:

New outcomes of quality measures are expected from all Accident and Emergency Departments – some are difficult measures to meet with an increased intensity of work. 95% of patients are in and out within four hours. The new targets are more refined.

We have altered who sees who and when with triage on arrival and by working with Social Services to try not to send people into hospital. Any department depends on the whole organisation working well together. There is a lot of work to do at all levels to get people to the right place.

We are trying to increase the quality of diagnosis with the right tests available at the right time, e.g. the Pathology Laboratory for blood tests, access to x-rays and scans, access to clinicians. The new role of medical assessment is to avoid admission if possible.

The target is to reduce the number of re-attendances over seven days to 0.05% but sometimes patients we think we have diagnosed may return with the same issue. We have work to do on re-attendances within thirty days, e.g. where the problem is not sorted or the support is not put in place or not working. Some patients with chronic conditions will come back and we accept this.

There is not a simple answer but we hope that by everyone working together we will improve the situation.

From Councillor J B Rickells:
Question 16

"We have received a question from a retired GP regarding the quality of diagnosis with Accident and Emergency. Can you provide information on what safeguards are in place to prevent mis-diagnosis within Accident and Emergency?"

Reply by Ian Greenwood:

There are a number of different levels to describe safeguards. The clinical governance programme is overseen by one of the non-executive directors. Each individual clinician is responsible for his/her own actions - the Trust has policies and procedures regarding diagnostics, to ensure the right ones are in place. The Clinical Service unit has its own safeguards and policies in place and there is a lot of auditing for specific procedures and for performance monitoring. Any issues identified through the process, e.g. complaints, will be investigated. Safeguards look at job plans, education and training. Organisations such as the General Medical Council and other external bodies ensure robust professional accreditation and assist in ensuring that the right safeguards are in place.

(Mr Kumar joined the meeting).

The second part of Question 16 from Councillor J B Rickells

"Are the skills of the staff within Accident and Emergency identical at Bassetlaw Hospital and Doncaster Royal Infirmary? What are your views on some of the media reports regarding language barriers between doctors and patients which is affecting service delivery?"

Reply by Ian Greenwood

Skill levels cannot be identical between individuals but a certain level of skill is expected to that appointment. A junior doctor will have less than someone more experienced, e.g. a consultant. For a senior consultant, the level of skill changes during their career and improves with experience and training. Overall skills are not identical but they are safe and equivalent to the requirement of patients being seen.

With reference to language barriers, this is a tricky one to answer. We want people that can understand – especially medical issues, local dialects and terms used. Traditionally the NHS has relied upon overseas graduates and this has changed as Government rules have changed. Available trainees have included those from the middle-east, including the Indian sub-continent and the Far East. They had to have a language examination before being able to practice. The European Union regulations do not require this and in fact forbid testing. It is possible at appointment to be reassured that language skills are adequate, however, adequacy is difficult to assess. There have been issues mentioned in the media concerning competency and language skills. The Hospital is working hard to ensure the level of language skills are appropriate and that service delivery staff have competency in the language skills required.

For clarification: all trainee doctors are under the direction of the Deanery which is responsible for ensuring training is delivered and signed off as different grades are achieved.

From Councillor J Scott:
Question 17

"We know that there is a national requirement to see all patients attending Accident and Emergency within four hours. Can you supply the average waiting time for patients within all the categories of need (as determined by triage)?"

"Can you also provide details in respect of waiting times at different times of the day, weekdays and weekends?"

Reply by Dr Bolton:

We do not have a detailed breakdown of this information although the Department does track the different issues referred to. The overall performance required is for 95% of patients to be seen within four hours of arrival. In September 2011, Bassetlaw Hospital achieved 95.6%.

Some issues are quick and easy to deal with, e.g. a bee sting, but patients may have to wait for attention while staff deal with a major case. One of the frustrations is the question of whether everyone has to come to Accident and Emergency. Triage can determine whether issues are urgent or acute with the less vital having to wait longer. Some may have to wait longer within the four hours as resources are directed elsewhere.

Reply by Phil Mettam

All PCT's are required to monitor this and there is rigorous monitoring of cumulative evidence. Our results are better than those at the hospitals in Sheffield.

From Councillor Mrs A Simpson:
Question 18

"How does your performance in Accident and Emergency compare with other hospitals of a similar size/level?"

Reply by Ian Greenwood:

Depends on which site – 100% of minor incidents at Montague Hospital are dealt with within four hours.

Bassetlaw does very well as an organisation year on year.

(Change of question order with Question 20 asked before Question 19)

From Councillor K Bullivant:
Question 20

"How many times does the Accident and Emergency at Bassetlaw Hospital reach capacity and result in patients being transferred to other locations?"

"What are the reasons for this?"

Reply by Dr Bolton

Capacity is a difficult thing to judge. We do not divert patients away when full unless we cannot avoid it. We have an escalation policy to try and prevent over capacity which works in conjunction with the ambulance service. Some patients are already triaged to other centres because of their condition, e.g. heart patients to Sheffield, stroke patients to Doncaster.

On a busy Saturday night the unit deals with business as best as it can. If a patient needs admitting to a hospital, we may try and divert the ambulance before it arrives. We may need to move patients out as new ones move in. When we are extremely busy because something major has happened and there are no beds available then the unit is put on 'Purple Alert' and the matter is dealt with across the authority. We have never had to close. We do try to manage our own patients.

Reply from Ron Calvert:

The important point is that we never close Accident and Emergency. It is possible that we could become unsafe in the judgement of the lead consultant and need to discuss the situation with the ambulance service to take patients elsewhere. This has never happened.

From Councillor J Shephard:
Question 19

"Are more minor injuries/illnesses now being treated through the 'Walk-in Centre' at Manton and other GP out-of-hours services?"

"Has the additional provision had an impact on the service offered at Bassetlaw Hospital Accident and Emergency?"

Reply by Phil Mettam:

The idea for 'walk-in' centres was introduced by the Government three/four years ago to provide extended hours access. The new service in Manton is a contractual arrangement which provides more choice for patients and is open between 8am and 8pm. There are a number of slots that they should have available for 'walk-in' patients and a number of appointments that patients can have if preferred.

Patients can also 'walk-in' to Larwood Surgery which is available until 6pm – this was introduced in summer 2011. This policy has introduced additional choice for patients.

As less serious cases have used the 'walk-in' service, Accident and Emergency has seen a small reduction in the number of this type of case.

From Councillor J Shephard:
Question 21

"The expectation of the Walk-in Centre' was that it could be used out-of-hours without an appointment. This does not appear to be the case. Can you explain how the 'Walk-in Centre' is supposed to work in conjunction with the GP services at Accident and Emergency (Dukeries)?"

Reply by Phil Mettam:

I was unaware of this until the question was raised. The PCT will have a discussion with the contractual provider on this matter.

To clarify: The GP out-of-hours service is GP lead and is co-located in Accident and Emergency (Dukeries). Patients should have the option of the 'Walk-in' Centre or the GP out-of-hours service. They are available through different providers but both services are meant to work together to try and prioritise care and to work with Accident and Emergency when it is busy.

From Councillor B Barker
Question 22

"Patients become distressed having to provide their details several times as they move through the Hospital. How are you going to improve communication within the Hospital and also with other hospitals/service providers – so that all clinicians have access to the same up-to-date information on a patient?"

Reply by Ian Greenwood:

Often patients are asked more than once to provide basic information. It is recognised as a problem for some of them and we are trying to address this – the I.T. systems used in the NHS often cause difficulties. There was an attempt to sort this out across all organisations with the national NHS IT system but it was closed down. We have just started to look at a new patient administration system which will enable us to connect a number of PC systems together. We are trying hard to modernise out I.T. but recognise we need to do this more rapidly to reduce the inconvenience for patients.

From Councillor G J Wynne
Question 23

"Is there anything else that you would like to add about your plans for Accident and Emergency services, the quality and outcomes of the service and the long-term sustainability of the service?"

Reply by Ron Calvert:

For the long term sustainability of Accident and Emergency Services, there are wider issues nationally. The Accident and Emergency unit of the hospital is probably the defining feature of a hospital – it differentiates the NHS from the private sector. We are committed to offering Accident and Emergency services at both Bassetlaw and Doncaster. Running an Accident and Emergency unit is not without issues and it can be difficult to get right, for example, ambulances blocking the front parking area, getting the diagnostic process right, identifying and prioritising correctly, managing beds to ensure availability. It is a good indicator about the health of the whole hospital.

I am leading a piece of work looking at what we can do to improve the quality and outcome of care for patients at Accident and Emergency. We are preparing for when we are assessed at national level and we have got to get it right. I have written to everyone involved for help in conducting a review of the service including the College of Emergency Medicine and PCT with the aim of getting the best advice on what we need to do. We may have to change the model of what we offer and it may bring change for different staff groups. We are committed to improving quality and providing a beacon service.

Fractured Neck of Femur

From Councillor G J Wynne
Question 1

"We understand that the PCT Board made a decision in May 2011 to continue to procure Fractured Neck of Femur services from Bassetlaw Hospital and Doncaster Royal Infirmary. What was the basis for this decision?"

Reply by Phil Mettam:

The PCT Board and Bassetlaw Commissioning Organisation are committed to retaining and sustaining local services therefore it is our wish that Fractured Neck of Femur provision will also be retained locally. We have to look at trauma services in context to some of the answers: there are national minimum standards of care for minor trauma (at Trauma Units) and major trauma (at Trauma Centres) and the requirements for Fractured Neck of Femur are similar.

Yorkshire and Humberside Strategic Health Authority expect to complete a piece of work this year and they are working with the Trust to establish a viable sustainable Trauma Unit locally at Bassetlaw Hospital within Accident and Emergency.

Reply by Ron Calvert:

It is important to emphasise that trauma is more than broken bones, e.g. head injuries. I am slightly worried that the process of establishing a Trauma Centre or Unit carries certain risks for us and the people we serve. There is a lot of work but I am anxious to ensure that ambulance services do not take all patients to Trauma Centres.

Reply by Wendy Hazard:

It is a challenge. We require clear guidelines on what is acceptable at each Accident and Emergency Department. We are up-skilling the staff we currently have so that every ambulance has a paramedic.

From Councillor J C Shephard
Question 2

"We have identified some concerns in respect of Fractured Neck of Femur. In particular the speed at which patients receive bone medication treatment on admission and the average time it takes for patient to receive surgery. What are your views on these performance issues and the impact this could have on successful outcomes – particularly the risk of mortality?"

Reply by Ron Calvert:

There have been some performance issues that the Trust Board are looking at. When we started to measure performance and issues were recognised, there were massive strides in improvement. We are not quite where we want to be yet.

Reply by Trinath Kumar:

As we move towards winter there are always more cases from falls and osteoporosis. We need to work on preventing falls and strengthening bones. We are one of the busiest units in the region with numbers only just short of those found in London hospitals – two thirds are seen at Doncaster and one third at Bassetlaw. We are very busy with a limited number of theatre sessions and until last year we treated fractures on own merit.

The Department of Health have currently have a financial incentive scheme for hospitals meeting six criteria and this has meant an extra income of £300,000 this year and potentially for the next two/three years. It is in our interest to ensure that both hospitals perform to the same level to meet the best practice tariff criteria because if we lose on one element of criteria we fail all six.

We know we have a bottleneck on the time to theatre but through changing the work of the consultants and having two trauma lists, it is hoped this will pay off in the months to come.

The treatment for osteoporosis is a long term process. The figures for achieving 36 hours to surgery have improved. Some patients are not very well so have to be prepared for surgery. Hip fracture patients are dealt with very quickly. For any patient for whom surgery is delayed through other issues, we undertake a root cause analysis and they are then taken as a priority when they are well enough.

From Councillor D Potts
Question 3

"We understand you are aiming to provide a minimum standard of service for Fractured Neck of Femur. Why is this and what improvements are needed to exceed minimum standards?"

"What targets for the performance of the Fractured Neck of Femur service are you setting?

Reply by Ron Calvert:

We are not looking just to provide a minimum standard of service. The gold standard is set nationally and we receive a financial reward as a Trust. It pays to hit the minimum criteria to get the extra money.

We expect to reach the target and we want to hit the high level. There is a joint care role with the physicians working in partnership with bone specialists. We are aspiring to the best service possible.

From Councillor J B Rickells
Question 4

"Is Bassetlaw able to deal with all Fractured Neck of Femur cases – even the more complex cases?"

"Do you transfer any Fractured Neck of Femur cases to Doncaster Royal Infirmary?"

"What would be the reasons for transfer?"

Reply by Mr Kumar:

It is not usual to transfer patients to Doncaster Royal Infirmary – there may be the rare occasion in winter when one or two are transferred due to bed capacity or to get a patient operated on more quickly. It is nothing to do with the complexity of the case as every case can be managed in Bassetlaw.

From Councillor A Simpson
Question 5

"Can we be assured that patients will receive the same quality of service and achieve the same outcomes at Bassetlaw and Doncaster Royal Infirmary for the treatment of Fractured Neck of Femur?"

"If not, what will the differences be and why will the services differ?"

Reply by Ron Calvert:

There is no intention to operate different standards between hospital sites. There is a slight difference in mortality rates: Bassetlaw 6.7% and Doncaster 5.7% - we would obviously like both to be 0%. (The national figure is 7-8%). We are confident in meeting the requirements to provide the service and when we looked at the capacity at each site we found a difference but we are slowly addressing this.

Reply by Phil Mettam:

We want the best outcomes we can get for the residents of Bassetlaw at the highest of national standards.

Reply by Mr Kumar:

There is approximately 30% mortality within one year following a hip fracture for the over 80 age group. Other ailments affect outcomes but there is more care of the elderly than there used to be. Mortality for this age group is 8.2% average nationally – 30 per day. In the last six months our figures show 6.7% for Bassetlaw and 5.5% for Doncaster. There are month by

month changes so the figures are averaged over the year but we are better than the national average.

From Councillor D Potts
Question 6

"Can you explain the specialist Fractured Neck of Femur personnel that will be available at Bassetlaw Hospital and Doncaster Royal Infirmary, i.e. consultants, specialist nurses and physiotherapists?"

"Again, will both Hospitals offer the same level of expertise?"

Reply by Mr Kumar:

Both hospitals offer the same level of expertise for Fractured Neck of Femur. The same level of basic care is offered throughout the country. Middle grade doctors operate and specialist nurses follow patients from entry to discharge at both hospitals.

From Councillor I C Campbell
Question 7

"Are specialist centres for Hip Replacements impacting on the overall viability of Fractured Neck of Femur services at Bassetlaw?"

(We understand there has to be a critical mass of patients to make the service viable).

"Will Bassetlaw Hospital be left to deal with more complex hip operations, with the easier and cheaper surgery being undertaken in other places, e.g. Barlborough?"

Reply by Ron Calvert:

The question recognises both emergency and elective operations and it is important to differentiate. Only the NHS provides emergency treatment for Fractured Neck of Femur. For elective surgery, e.g. hip replacements, the private sector can set up in opposition.

In reality, people want choice and we have to rise to the challenge with shorter waiting times and excellent outcomes.

From Councillor D Potts
Question 8

"From the patients' feedback you receive, what are the strengths and weaknesses of the Fractured Neck of Femur service currently offered by Bassetlaw Hospital?"

"How are the concerns of patients addressed?"

Reply by Ian Greenwood:

We listen carefully to what patients tell us as discussed at a recent meeting of the Board.

Reply by Mr Kumar:

A patient questionnaire in August 2011 asked twenty questions and most of the responses were in the 75% to 80% range. Many said they were happy with the service they received and

in response to being treated with respect and dignity, 63% said 'often' and 38% said 'sometimes'. 88% said they would recommend the hospital to family and friends.

From Councillor A Mumby
Question 9

"Are ambulance crews briefed to bring all Bassetlaw Fractured Neck of Femur patients to Bassetlaw Hospital?"

"In what instances would patients be taken to other locations?"

Reply by Wendy Hazard:

Yes we are all briefed to take Bassetlaw residents to Bassetlaw hospital for Fractured Neck of Femur or suspected cases of. The exception is Harworth where residents are given a choice of Bassetlaw or Doncaster. In the event of the escalation policy being in force it would depend upon bed capacity.

From Councillor G J Wynne
Question 10

"Is there anything else that you would like to add about your plans for Fractured Neck of Femur services, the quality and outcomes of the service and the long-term sustainability of the service?"

Reply by Ron Calvert:

We are committed to continue to develop the service, to recruit an orthogeriatrician with cross cover and and to be part of the Trauma Review to work towards the best possible outcome for patients.

Reply by Denise Nightingale

The Trust and PCT are working jointly together and national standards are always increasing and ever more challenging. Cases can be complex because of a patient's age and other conditions – not just in geriatric cases but also in Accident and Emergency and on wards. GP's do try and prevent what for many patients can be a traumatic incident.

(The meeting was suspended for a fifteen minute comfort break).

(Councillors Mumby and Ogle left the meeting).

From Councillor J C Shephard
Further to Question 21

"There are concerns about people being turned away because they did not have an appointment at the Walk-in Centre."

Reply by Phil Mettam:

I am aware of a few situations where patients were asked to come back at a later time – we are following this up. I am not aware of an increasing trend of complaints but we will discuss this with the provider of the service.

We have anecdotal evidence from a Worksop resident that they had tried to access the 'Walk-in' service and could not see anyone immediately or by appointment. They were then unable to obtain an appointment at their GP practice either.

If Members have their own examples of residents being unable to access GP services at the Walk-in Centre, these can be forwarded to me via the Council's Corporate Development and Policy Manager and we will discuss with these issues with the contract holder.

Community Outreach Services

From Councillor G J Wynne
Question 24

"For the benefit of the Committee and members of the public can you define what services are classified as community outreach services?"

Reply by Phill Mettam:

Community outreach services are hospital based services provided in community locations such as local clinics or GP surgeries.

From Councillor Mrs A Simpson
Question 25

"A shortfall in the availability of community outreach services has been highlighted in the Paediatrics external report. How do you plan to invest in these services and monitor their quality and delivery?"

Reply by Phil Mettam:

The report highlighted the necessity to increase community provision as a standard integrated community pathway for patients, regardless of where the patient is from. We have not achieved this yet but need to do so without additional cost, i.e. within current resources.

From Councillor I C Campbell
Question 26

"What percentage of the budget is to be allocated to community outreach services? How does this compare with other hospitals of a similar size?"

Reply by Denise Nightingale:

At this stage we cannot answer this question, for example, there are sub-specialities, e.g. asthma, children with diabetes. The Trust is working out what is needed to support parents and how the medical workforce can be adjusted to provide paediatric services to support cross-cover for Doncaster and Bassetlaw. Once these pathways are established, (led by acute consultants), we can design speciality pathways.

It is also difficult to provide a comparison as different Trusts/areas provide community support in different ways and work with different organisations, e.g. different local authorities.

From Councillor B Barker
Question 27

"The success of community outreach services will depend on the inter-connectedness of your services with other providers, e.g. Social Services and WRVS Home to Hospital Service. At a time when budget restraints are threatening front-line services how will you manage this impact on your community outreach services?"

Reply by Ian Greenwood:

It is really important that all services connect and work together whether health, social or voluntary.

Reply by Denise Nightingale:

Once pathways are right and it is apparent what needs to be managed in which areas, we can work through trigger points more clearly. Even with budget restraints, we need to improve the quality of care and ensure better outcomes and can make savings through efficient pathways. There are differences between Doncaster and Bassetlaw because they each have different PCT's, local authorities and services. It is complex therefore very important to resolve the pathways first.

From Councillor G Wynne
Question 28

"Do you have any comments on the role of community outreach services and how will you measure the overall effectiveness and patient benefits of this service?"

Reply by Denise Nightingale:

Standards that ascertain whether patients are being managed well, e.g. children with diabetes, will be a measure of overall effectiveness. Established pathways will develop and improve standards.

Reply by Ron Calvert:

The role of community outreach services will be a move towards treatment for patients in their own homes. Earlier diagnosis, more services at home for an increasing population and working with reduced finances.

Assessment and Treatment Centre

From Councillor J Rickells
Question 29

"We know that work is well underway to establish an Assessment and Treatment Unit. Has the necessary capacity building to provide this new model of care taken place over the summer as previously planned/reported to the NHS Bassetlaw Board?"

Reply by Phil Mettam:

Dr Michael Ho sends his apologies as he was unable to attend today. (GP commissioning lead on emergency services and the development of the ATC).

We have work to do within established NHS policies and standards. After working together on a review of services last year it has been fantastic to establish an Assessment and Treatment Centre (ATC) at Bassetlaw. The treatment and outcomes will be better, will bring professional fulfilment and clinicians want to be part of it. It is supported by all local GP practices and Robin Bolton and the team at Bassetlaw but is still at the early stages.

Reply by Ginny Snaith:

The ATC came out of discussion last year and will provide the right care in the right place at the right time. It is a concept development for faster diagnosis and treatment, so that as many people as possible see the right person. An ATC can ensure reductions in the length of hospital stays are achieved and that care plans are started earlier. It can also ensure that patients do not go into hospital if they do not need to and will provide a better interaction between primary and secondary care through linked-together services.

The ATC will be a bedded unit where patients can stay overnight if they need to and will be open every day throughout the year. It will be based on the Bassetlaw site and can be referred in to by a GP or commissioning professional, e.g. community matron or a therapist from Accident and Emergency if a patient needs more care or complex care. Patients will undergo a multidisciplinary assessment lead by a medical consultant from the hospital. Therapists, community nurses etc. will work together to assess the patient in conjunction with senior decision makers. They will ensure specialist advice is available through protocols to get that advice. There will be access to diagnostic tests and imaging to ensure each patient has a medical care plan in place while in the ATC and on-going.

Treatment will start (and possibly finish) at the ATC to get the patient home as soon as possible. Patients will be discharged into the most appropriate setting or as a default the ATC will try and get them home where it can. A patient may be admitted to hospital or another care bed, e.g. a nursing home, but will not be moved to another waiting place.

There will be a breakdown of information of the right resources for patients, e.g. therapy or back home. Plans will be in place to support the patient where it is needed. There will be close links with GP's and community services who will share records between them. Community nurses will also be able to access these records and feed in information for others to see.

In summary, it will be the same patients receiving care in the same place but we will be rearranging the pathways which will be more efficient and much quicker.

Reply by Wendy Knight:

A new build was not planned for the ATC – it will be a designated hospital ward area developed within Bassetlaw Hospital working with Ginny Snaith's colleagues. There will be clinic space, treatment areas and also reclining chairs for patients who are waiting to be assessed but do not need a bed.

Reply by Ian Greenwood:

Senior clinicians will work close by to new patient arrivals. New staff have been employed this summer including acute consultant clinicians and their work is starting to make a difference already.

From Councillor J Rickells
Question 30

"What are the benefits to patients of this enhanced service?"

Reply by Wendy Knight:

The key benefit is that they will be seen quickly by a senior consultant and a multidisciplinary team including in-reach services, e.g. if the patient is known to a community matron a message will be sent and they will then work with staff to get the patient home more quickly. We have worked hard in improving communication based on Bassetlaw Hospital site development care plans, treatment, and working with local GP's to do this. With immediate access to tests and imaging we can treat patients more quickly.

From Councillor Mrs A Simpson
Question 31 and 32

"Where will the unit for patients requiring further therapy prior to discharge be provided?"

"How does this approach link to the Assessment and Treatment Centre?"

Reply by Ginny Snaith:

With therapy it depends on what other needs the patient has and whether they need treatment while as an inpatient or outpatient. Where they need the treatment from will be planned before they leave the Centre.

From Councillor B Barker
Supplementary question:

"A patient goes into the ATC and then has rehabilitation somewhere else. Being based within Bassetlaw Hospital, will there be an impact on other services as money is used to prioritise or is there a separate budget for it?"

Reply by Ginny Snaith:

It will be the same number of patients with the same care. At the ATC the diagnosis and treatment will be quicker followed by a package of care.

Reply by Phil Mettam:

The joint shared ambition is that this service will not be at an additional cost to the taxpayer.

From Councillor Mrs A Simpson
Supplementary question:

"The WRVS work closely with many patients as they return home. Will they still be involved?"

Reply by Wendy Knight:

We work closely with and want to continue to work closely with and involve the WRVS and other services to help patients at home and get them home quicker.

From Councillor G J Wynne
Question 33

“Is there anything you would like to add about the role of the Assessment and Treatment Centre and the benefits it will provide?”

Reply

No one had anything additional to add.

SECTION B - ITEMS FOR DISCUSSION IN PRIVATE

Key Decisions

None

Other Decisions

None

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