



NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY PANEL

Date: Wednesday, 25 March 2015

Time: 1.30 pm

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

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

Acting Corporate Director for Resources

Governance Officer: Clare Routledge Direct Dial: 0115 8763514

AGENDA

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

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NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES of the meeting held at LB31 - Loxley House, Station Street, Nottingham, NG2 3NG on 28 January 2015 from 13.33 - 16.13

Membership

Present

Councillor Ginny Klein (Chair)
Councillor Thulani Molife (Vice Chair)
Councillor Brian Parbutt
Councillor Anne Peach
Councillor Emma Dewinton

Absent

Councillor Mohammad Aslam
Councillor Merlita Bryan
Councillor Azad Choudhry
Councillor Eileen Morley
Councillor Timothy Spencer

Colleagues, partners and others in attendance:

Rosemary Galbraith, Nottingham CityCare Partnership
Courtney Nangle, Nottingham City Health Watch
Ruth Rigby, Nottingham City Health Watch
Lucy Davidson, NHS Nottingham City CCG
Deborah Hooton, NHS Nottingham City CCG
Dave Miles, NHS Nottingham City CCG
Rachel Towler, Nottinghamshire Healthcare Trust
Ann Wright, Nottinghamshire Healthcare Trust
Laura Catchpole, Nottingham City Council
Sarah Gibbons, Nottingham City Council
Tajinder Madahar, Nottingham City Council
Anna Masding, Nottingham City Council
Linda Sellars, Nottingham City Council

Barbara Venes, Patient Representative

Kim Pocock, Nottingham City Council
Clare Routledge, Nottingham City Council
James Welbourn, Nottingham City Council

40 APOLOGIES FOR ABSENCE

Cllr Eileen Morley – medical appointment
Cllr Merlita Bryan – Non-Council business

Cllr Thulani Molife joined the meeting at 13.47
Cllr Brian Parbutt joined the meeting at 14.12

41 DECLARATIONS OF INTERESTS

None

42 MINUTES

The Panel confirmed the minutes of the meeting held on 26 November 2014 as a correct record and they were signed by the Chair.

43 NOTTINGHAM CITYCARE PARTNERSHIP QUALITY ACCOUNT 2014/15

The Panel considered a report of the Head of Democratic Services detailing Nottingham CityCare Partnership's progress against its quality improvement priorities for 2014/15; and proposals for their Quality Account 2015/16, including plans for public engagement in developing the Quality Account.

Rosemary Galbraith, Assistant Director of Quality & Safety and Deputy Director of Nursing at Nottingham CityCare Partnership advised the Panel of the progress and, during discussion, stated the following;

- (a) Phlebotomy services are now being offered in a wider range of locations, with fewer complaints and shorter waiting times. More information will be available in the annual quality account. Rosemary will provide further written information from a provider perspective;
- (b) Healthwatch voiced concern that offering a choose and book service for blood tests is confusing for patients who are used to going straight to the phlebotomist in their own Health Centre following a GP referral
- (c) Members of the panel were also aware of concerns about the new phlebotomy arrangements and may consider further scrutiny in the future;
- (d) A mixture of practical and Admiral Nurses (dementia specialists) are employed to tackle the growing concern over Dementia. Admiral Nurses have more all-round awareness of the condition. Rosemary assured the Panel that collective work will continue to address the issue of Dementia;
- (d) Connect House, a care home run by an arms-length subsidiary of Nottingham CityCare Partnership (CityCare Connect Ltd), will impact on hospital discharge rates by providing an extension to the core care offer;
- (e) An evaluation of instances of falls in care homes will be carried out. Early assessment and providing an appropriate high quality response will be a priority in the quality account, and will include case studies of how hospital admission can be prevented;
- (f) The following are coming year priorities for 2015/16:
 - (i) Pressure ulcers – a national and regional priority.
 - (ii) Duty of Candour (ie the duty to ensure that providers are open and transparent with people who use services and receive care and treatment, and specifically when things go wrong with care and treatment) – has now been published and will be applied;

- (iii) Development of wider scrutiny – the needs of the patient can be met by public patient involvement.
- (iv) Carer support – signposting of carers to be improved for patients and families, by providing early information on initiatives and new projects;
- (g) A new DVD has been launched in care homes, and this contains information on how to prevent pressure ulcers. In addition to this, the Tissue Viability Scheme provides more information on what pressure ulcers are, and how they can be recognised;
- (h) New priorities have been decided after a range of consultations with the NHS and patients, as well as other factors such as quality indicators, and feedback from last year's priorities. Patients provide a large proportion of feedback, through their complaints and praise, and also through their needs;
- (i) Ruth Rigby from Healthwatch voiced concerns over CityCare's identity. In some cases, the public do not know whether or not they are using a CityCare service. The information that Healthwatch currently have on CityCare is fairly low, although a recent invite from CityCare to Healthwatch was welcomed, and provided useful insight.
- (j) Branding and logos for CityCare were distributed in April 2014. Work to raise awareness of CityCare is still ongoing, and still has a way to go. Members at the Panel were concerned that a low level of complaints for CityCare could be attributed to its low public profile.

RESOLVED to

- (1) thank Rosemary Galbraith and Nottingham CityCare Partnership for the information provided; and**
- (2) request from Rosemary Galbraith written information on the phlebotomy service from a provider perspective; the project paper for Connect House to provide more information on the role of the arm's length organisation and the service provided; and more details on the policy for pressure ulcer prevention and SKIN (pressure sore care).**

44 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

The Panel considered a report of the Head of Democratic Services detailing the findings of recent commissioner and provider reviews of Child and Adolescent Mental Health Services in Nottingham, and how changes being made as a result will impact on service users.

Lucy Davidson, Assistant Director of Commissioning at NHS Nottingham City CCG, Deborah Hooton, Head of Joint Commissioning at NHS Nottingham City CCG, Rachel Towler, Assistant General Manager at Nottinghamshire Healthcare Trust CAMHS (Child and Adolescent Mental Health Services), Tajinder Madahar, Acting Head of Service, Extensive and Specialist Services at Nottingham City Council, Anna Masding, Service Manager CAMHS Tier 2 at Nottingham City Council, and Ann

Wright, General Manager, Specialist Services at Nottinghamshire Healthcare NHS Trust advised the Panel of their findings and, during discussion, stated the following;

Pathway

- (a) The review was necessary to identify young people that are at high risk. Many of these young people have emotional and mental health needs; in addition to this, the number of 'looked after children' is increasing year on year. It is clear that the demand for Child and Adolescent Mental Health Services (CAMHS) services is increasing, and some of the mental health issues are more complex;
- (b) Work commenced on the CAMHS pathway prior to review, as it was anticipated that the review would back this work up. The Pathway itself has been approved for children and young people, and it can be seen online by any parent, carer or guardian. A key part of the pathway is early intervention and prevention of escalation to specialist services such as paediatricians, Tier 2, 3 and 4 CAMHS and in care placements;
- (d) Emergencies are dealt with by the emergency pathway. This would either be escalated to Tier 4, or reintegrated into the universal pathway;
- (e) The Pathway is also being contributed to by Family Support Workers and Paediatricians to make sure that children are receiving the best possible care;
- (f) The next steps in the process include:
 - (ii) Further learning – this scheme is still a pilot
 - (iii) Performance management
 - (iv) Further work with organisations such as Healthwatch
 - (v) Continue to gain feedback; so far it has been positive;

CAMHS Tier 2

- (g) Nottinghamshire Healthcare Trust has been working in partnership with Tier 2 colleagues to ensure that there is collaborative working. It is imperative that existing relationships are built on;
- (h) Young people who have received services, and want to contribute to the system can apply for a Peer Support Worker post. One area that has specifically been identified for peer support is transition from CAMHS to Adult Services;

Following questions and comments from the Panel, additional information was provided:

- (i) Healthwatch are doing a piece of work on young people and mental health from the perspective of a critical friend providing a positive challenge. They have recently had a helpful meeting with Nottingham City CCG and will be

meeting with all partners. Once completed, this information will be shared with the Health Scrutiny Panel.

Healthwatch also provided feedback on the Behavioural, Emotional or Mental Health Needs website (www.bemhnottingham.co.uk). The length of the name could be a barrier to access and the design could be improved;

- (j) The Pathway is already on the website (www.bemhnottingham.co.uk). The easiest way to use the Pathway would be to go directly to the website, but GPs can use the 'choose and book' system, or alternatively, a telephone referral;
- (k) Referrals through the Single Point of Access are screened within 24 hours, with an outcome in 48 hours, and a referral within 7 days. The period of time expected for an assessment is dependent on what section of the pathway a patient entered at. For Tier 2 assessments, this is likely to be 3-4 weeks, and for Tier 3, this increases to 6-8 weeks. Alternatively, if the clinical need is high, duty slots are offered on a daily basis. Overall, there has been an improvement on waiting times, with more practitioners available through CityCare;
- (l) Training and support for parents and carers is available in the form of Parenting Programmes. The programme is due to start in February, and has already been commissioned with a capacity for 10 people;
- (m) Peer Support Workers will be trained and supported by the Recovery College (run by Nottinghamshire Healthcare Trust to help people develop skills, identify goals, build confidence and access opportunities);
- (n) A range of different approaches were used when undertaking this review, including:
 - (i) User and family feedback
 - (ii) Workshops
 - (iii) Performance data
- (o) Plans for transition from CAMHS (0-19, to 24 for people with learning disabilities) to Adult Services should start before the age of 17, and should be a staged approach with joint working between both services;
- (p) The Self Harm Awareness and Resource Project (SHARP) has been visiting, training and supporting staff in Nottingham City. Guidance has been produced for secondary schools (for staff), as a result of work with other secondary schools. The Early Intervention aspect of SHARP in particular has been a success, and partners are looking at setting up a support group for parents on self-harm;
- (q) Workforce planning for the future, and earmarking potential staff is taking place as part of service development planning. By reviewing referrals and recurring patterns, appropriate training can be delivered to nurses, health visitors and school nurses to provide additional skills;

- (r) Locally, there has been an increase in self-harm presentations. However, the increase in the need for CAMHS services has been a national trend. Previously, the stigma surrounding mental health issues is likely to have been a barrier, but recently there has been an increase in take-up of assistance now that more individuals know that there are accessible services. An online counselling service is open at suitable times for young people, which could mean that young people's issues are identified at an earlier stage, rather than say in 12-18 months' time from onset;
- (s) The problem of self-harm online is being looked into on an ongoing basis. Publicity and information sharing is a tricky area to tackle through social media. CAMHS is considering the suitability of a Facebook page;

RESOLVED to thank colleagues from Nottingham City CCG, Nottinghamshire Healthcare Trust and Nottingham City Council for the information provided; and to request that they provide an update on the impact of the new approach to the Panel in 12 months.

45 ADULT INTEGRATED CARE PROGRAMME

The Panel considered a report of the Head of Democratic Services detailing proposals on the Adult Integrated Care programme. Dave Miles, Assistive Technology Project Manager of Nottingham CCG advised the Panel of the proposals and, during discussion, stated the following;

- (a) The Adult Integrated Care Programme will be delivered through the Nottingham Better Care Fund Plan. Nottingham was one of only six authorities in the whole country that required no amendments following submission of its Better Care Fund Plan to NHS England. Nottingham has also received a nomination as an 'Integrated Pioneer Site';
- (b) The Office for Public Management (OPM) was commissioned to carry out an evaluation on key areas of Adult Integrated Care, which included:
 - (i) Have key pathways been implemented?
 - (ii) What lessons have been learnt?
 - (iii) How is successful information influenced by context?
- (c) The report revealed that 74% of the workforce felt that patients had to repeat themselves a lot of the time. It also suggested that the majority of the workforce agreed that services were now joined up, and that 52% of users thought that services are inaccessible. Positive responses were received in relation to Telecare, with 95% of service users feeling safer, and 75% of carers feeling less stressed;
- (d) One area of improvement being considered is for calls to the service to be answered straightaway, rather than being given five options by an automated service;
- (e) Financial savings for patients will be looked at in the next wave of reviews;

- (f) The 'You said, we did' approach is used to communicate changes made in response to feedback;
- (g) Exploring the reality or real-life situation of a patient could be introduced. These patient outcomes could work alongside existing DVD communications;
- (h) Evidence gathered on what is working well so far has come from care-co-ordinators. More feedback and evidence is required from patients themselves. New care-co-ordinators are getting people into Social Care quicker;
- (i) Multi-disciplinary team meetings offer the opportunity for joined up care plans. People who require social care can receive this care quicker if their holistic needs are discussed at a single meeting, rather than a GP having to be consulted first. This is working well from a provider perspective, but patient views have yet to be evaluated;
- (j) Three areas that are impinging on the workforce (technology, cultural change, workforce development) cannot be tackled independently; they must be tackled together;
- (k) Telecare is currently provided by Nottingham City Council, and Telehealth is provided by Nottingham CityCare Partnership. There are plans to consider more joined up working of these two services;
- (l) Tracking the patient and the carer experience can be done through a series of evaluations. There needs to be a concentration on giving the public the right service at the right time. For example, 100 participants will be tracked pre-Telecare/health, and then after Telecare/health has been introduced, the results can be monitored to discover the patient experience;
- (m) Further evaluation reports are due in September 2015, and in March 2016. Reports containing information on patient stories, and economic information should form part of this. In addition, there is an ongoing self-evaluation within Nottingham City Council, Nottingham CityCare Partnership and Nottingham CCG;
- (n) The Programme is being integrated into the Better Care Fund. A steering group will report to the Health and Wellbeing Board;
- (o) It is important that the work of the Panel and the work of the Health and Wellbeing Board are not duplicated in scrutinising the Better Care Fund

RESOLVED to

- (1) thank Dave Miles for the information provided;**
- (2) request further written information from Dave Miles on specific arrangements for tracking patient/ carer experiences and on Telecare/ Telehealth; and**

- (3) request that Dave Miles provides an update on implementation of the Better Care Fund to the Panel at its meeting in October 2015.**

46 PROGRESS IN IMPLEMENTATION OF THE CARE ACT

The Panel considered a report of the Head of Democratic Services detailing the Council's progress in responding to requirements of the Care Act 2014 to ensure that it meets statutory deadlines for implementation.

Linda Sellars, Chief Social Worker, Sarah Gibbons, Senior Social Work Practitioner, and Laura Catchpole, Policy Officer advised the Panel of progress to date and, during discussion, the following points were raised;

- (a) Part 2 of the Care Act (related to funding reform and the care cap) is due to be implemented by April 2016. Currently, no guidance has been received, but a draft is expected in February 2015. Final guidance is due in October 2015. This will include consultation over fairer charging;
- (b) A proposal to jointly manage citizens' joint budgets has been put forward. Some citizens are funded by health and social care, and the need for clarification on direct payments under the Care Act could arise, now that the personal health budget pilot has come to an end. Ultimately, whatever is best for the citizen will prevail;
- (c) Contributors assured the Panel that Nottingham City Council will be compliant with Part 1 of the Care Act by April 1st 2015. There is further work to be carried out, but compliance is of primary importance
- (d) The Care Act involves some significant cultural changes; there will be a cultural programme next year focusing on embedding the Care Act;
- (e) The fact that Nottingham City Council adopted the personalisation agenda at a very early stage contributes to helping with the required cultural change. There is less of a cultural shift needed at Nottingham City Council than there has been at other Local Authorities because of existing experience of personalisation;
- (g) Colleagues are engaged with national discussions on the cap on care costs and associated risks, for example the potential impact on private providers who may want to withdraw services if they can't set charges for self-funders. The need to prepare for the risk of market failures is being addressed;
- (h) All of the work carried out so far has been done by using existing resources at Nottingham City Council. Some additional money has been allocated for carers and self-funders, and there has been some expense to cover the cost of the new duty to cover people in prisons, and the cost of training;
- (i) Carers can also be employers, and can potentially be funded from two sources (health and social care). Currently, these individuals are assessed by Nottingham City Council for social care funding, and are supported by account

providers. In the future, there is the potential to have an internal team that can provide this service for both health and social care funding;

- (j) Service users will not see a huge amount of difference when Part 1 of the Care Act is implemented in April 2015. The main differences will be for carers, as their level of eligibility may change, and carers may see more support from April 2016, when Part 2 is implemented;
- (k) Nottingham City Council has always been very proactive over both early intervention and reablement;

RESOLVED to thank colleagues from Nottingham City Council for the information and request that they provide an update to the Panel on implementation of Part 1 of the Care Act and progress with preparing to implement Part 2 of the Care Act in the summer 2015.

47 WORK PROGRAMME

The Panel considered a report of the Head of Democratic Services relating to the work programme for the Health Scrutiny Panel for 2014/15.

RESOLVED to note the work programme.

48 AMENDED TIME OF MEETING - 27 MAY 2015

The time of the meeting for May 27 2015 has been brought forward to 10am, with a pre-meeting for members of the panel at 9:30am;

RESOLVED to note the change in time.

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HEALTH SCRUTINY PANEL
25 MARCH 2015
URGENT CARE SERVICES
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

- 1.1 To update the Panel on the preferred provider for urgent care services, more detail on plans for the future service, timescales and intentions regarding service provision in the interim before the new service commencement date.

2. Action required

- 2.1 The Panel is asked to use the information provided to inform scrutiny of the development of Urgent Care Services; and decide if further scrutiny is required.

3. Background information

- 3.1 In March 2014, the Panel heard from NHS Nottingham City Clinical Commissioning Group (CCG) about proposals to remodel the current Walk In Centre provision in the City and develop an Urgent Care Centre when the current Walk In Centre contracts come to a natural end in April 2015. At that meeting it was agreed that this change constituted a 'substantial development' in service and as such the Panel had a statutory responsibility to consider:
- Whether, as a statutory body, the Panel has been properly consulted within the consultation process;
 - Whether, in developing the proposals for service change, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and
 - Whether the proposal for change is in the interests of the local health service.
- 3.2 In May 2014 the Panel received information on the outcomes of consultation that had taken place and plans for further consultation with specific groups and communities for example people not registered with a GP.
- 3.3 In July 2014 the Panel was updated on the remodelling of Walk In Centre provision/ development of an Urgent Care Centre including consultation and engagement that had taken place since May and how this influenced the development of the service specification. The minutes of this meeting are attached at Appendix 1 for information.
- 3.4 Representatives of Nottingham City Clinical Commissioning Group will attend today's meeting to provide a further update on the preferred provider for urgent care services, more detail on plans for the future service, timescales and intentions regarding service provision in the interim before the new service commencement date.

- 3.5 Nottinghamshire County Council health scrutiny function has been advised that this item is being considered at this meeting so that councillors representing wards where residents might be affected by the changes can be made aware and able to attend this meeting if they wish to do so.

4. List of attached information

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

Appendix 1 – Extract from the minutes of the meeting of the Health Scrutiny Panel, 30 July 2014

Appendix 2 – Nottingham City Clinical Commissioning Group - Urgent Care Centre Procurement Report, March 2015.

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

None

6. Published documents referred to in compiling this report

Report to and minutes of meetings of the Health Scrutiny Panel on 26 March, 28 May 2014 and 30 July 2014.

7. Wards affected

All

8. Contact information

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**EXTRACT FROM THE MINUTES OF THE MEETING OF THE HEALTH
SCRUTINY PANEL, 30 JULY 2014**

22 WALK IN CENTRES/ URGENT CARE CENTRE

The Panel considered a report updating it on the progress of the development of an Urgent Care Centre in Nottingham. A presentation was made by Naomi Robinson, Primary Care Development and Service Integration Manager, NHS Nottingham City Clinical Commissioning Group. The key points of the presentation included:

- (a) the contracts for the London Road and Upper Parliament Street walk-in centres end in March 2015. EU procurement regulations require that the service is recommissioned which gives an opportunity to review and revise, the walk-in centre services in the City;
- (b) the Nottingham City Clinical Commissioning Group has been canvassing opinion from various organisations including the People's Council, Clinical Congress, Overview and Scrutiny Committee and local Area Team. There have been engagement events for clinicians and providers, patient events, roadshows and an on-line survey;
- (c) there has been a good response rate to broad patient engagement with 60% being of working age. However, demographic monitoring of respondents indicates a limited response rate from key equality groups:
- (d) respondents were supportive of a merge and re-commission of an enhanced service with a view to:
 - reducing confusion and duplication between services;
 - recognising that current specifications cover a standard Primary Care response;
 - being able to 'see and treat' in one visit;
 - including diagnostics, including x-ray;
 - having a City Centre location giving equity of access;
 - keeping the service as a 'walk-in' service i.e. no appointment needed;
 - having consistent opening hours;

- (e) the Procurement Delivery Group has approved the draft specification, which outlines the minimum clinical governance and quality standards. The invitation to tender (ITT) includes:

Clinical/ Patient Feedback	Specification/ ITT inclusion
Consistency of opening times	7 days a week, 365 days a year, same times each day
Open outside of GP provision	7am until 9 pm
Assessment within 15-20 mins	Assessment within 15-30 mins (15 mins for children)
Extended diagnostics and clinical provision	X-ray facilities as a minimum Provide a tier of care between GP and emergency services.
'See and treat' in the same visit	This will be a core objective of the new service
Mental Health Support	Require an integrated response for vulnerable patients and those who have mental health, alcohol and substance misuse issues.
An accessible, city centre location (public transport and parking)	The UCC will in a City Centre location and providers will be required to demonstrate accessibility
'Walk-in appointments'	The UCC will continue this approach
Patients are unsure about the name Urgent Care Centre	National guidance to use the name Urgent Care Centre but we are looking to include a strap line of 'Walk-in' Patients will be involved in the publicity of the new service

- (f) the draft specification has been released to potential providers and the PQQ stage has commenced. The Patient Procurement Panel will also be able to influence the scoring criteria for bidders. The Panel will continue to meet during the implementation and publicity stages;
- (g) the proposed timeline involves local clinicians and the public continuing to shape the final service with engagement on the draft service specification and input into the ITT documents in July and August with the ITT documents being approved in September. ITT stage and scoring will take place in the latter part of 2014 with the new service being publicised in January-March 2015 and the New Urgent Care Centre being launched in April 2015;

During discussion the following comments were made:

- (a) Ruth Rigby of Healthwatch Nottingham confirmed that, despite initial concerns about consultation responses, she had found the consultation process to be a positive experience. Phase two of the consultation didn't identify any significantly different issues so the major of issues had probably been captured. Ruth Rigby identified that there had been low engagement by those not registered with a GP but she was of the view that the proposed model did not disadvantage them;

- (b) the Panel agreed that the current services on offer are quite complex and not easy for citizens to understand. There will need to be a huge communication exercise to get across the new facilities to citizens

RESOLVED

- (1) to thank Naomi Robinson for the update;**
- (2) to request that a further update be brought to this Panel at a later date.**

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**March 2015 Health Scrutiny Committee
Urgent Care Centre Procurement**

SUMMARY

This report updates on the progress of the walk-in services re-modelling and the outcome of the Urgent Care Centre procurement. Following review of current walk-in services, plans were agreed to combine resources from the current contracts to fund an enhanced 'Urgent Care Centre' from a single city-centre location, to include additional benefits such as diagnostic x-ray for suspected breaks and sprains. The new model will offer patients a real alternative to attending the Emergency Department for non-emergency health problems by better supporting the treatment of urgent but non-life threatening conditions outside of the hospital. The paper reports that following a robust procurement process, CityCare Partnership CIC have been successful in their bid to provide the Urgent Care Centre from the location of the existing Walk-in Centre on London Road. The report explains how clinical and patient feedback were incorporated during the specification development and tender evaluation to offer assurance that the project is being developed to meet the needs of the local population and that links will continue to be made with appropriate committees during the implementation stage.

REPORT

BACKGROUND

In 2013, Sir Bruce Keogh published his report 'Transforming Urgent and Emergency Care Services in England'¹, which suggests the need to reduce the level of duplication and confusion caused by the range of current services by setting out the vision that services will be streamlined so that patients with urgent but non-life threatening needs are able to access effective services outside of hospital in coordinated Urgent Care Centres.

Nottingham has two 'walk-in centre' services, the 'Walk-in Centre' on London Road (including the satellite clinic; Clifton Nurse Access Point) and the '8-8 Health Centre' on Upper Parliament Street. Both services offer walk-in provision of face-to-face consultation for minor illness and injury and provide self-care advice, information and signposting services that are highly rated by patients. NHS Nottingham City CCG undertook a review of both contracts ahead of their scheduled end dates in 2015. The review of activity data and surveys found that patients were using the services as an extension to primary care for conditions that could be assessed by their GP or a Pharmacist and there was concern about duplication in the use of resources.

The findings of the review were presented to the CCG clinical commissioners, who were in favour of continuation of the 'walk-in' element of the service and committing the same level of funding but remodelling to include additional provision to treat an extended range of urgent, immediate health needs. Following agreement of this approach, we began a period of intensive clinical and public engagement in early 2014 with the support of the CCG Patient Engagement Team and by following the guidance of Healthwatch Nottingham and recommendations set out by Monitor², we have aimed to ensure that we engage broadly, meaningfully and purposefully with the public and ensured that the views of all patient groups are heard.

Reason for the work/ programme

The views of providers, clinicians and patients have helped to shape the new service from the outset, beginning with a survey of public views, which attracted over 600 responses. The findings were presented at both a Clinical/Provider and a Patient Engagement Event; both events enabled open discussion about the future service, highlighted issues and generated solutions with an interactive focus. A report on the 'Phase 1' patient engagement highlighted key themes, many of which mirrored the

¹ <http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>

² Monitor. Walk-in Centre Review Final Report and Recommendations. Feb 2014.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283778/WalkInCentreFinalReportFeb14.pdf

feedback received from clinicians, including support for a city centre location, short waiting times, increased diagnostic ability (particularly x-ray), co-location or links to urgent dental services and the ability to see and treat the majority of patients within the same visit.

The success of Walk-in centres in removing barriers and improving access to healthcare for the most vulnerable people in society is valued locally and is recognised in both Sir Bruce Keogh's report and the Monitor recommendations³. It was therefore important for a second phase of patient engagement to involve a more targeted focus on communities and patient groups who are 'seldom heard', including homelessness, drug and alcohol services, LGBT and minority ethnic groups. Meetings with patient groups gave the opportunity to raise concerns or question the proposal and enabled more in depth discussion of patient pathways, allowing people to talk through their experiences of current services and to consider how this may be improved by the proposed changes.

A total of 18 focus groups took place with minority and vulnerable patient groups, enabling over 200 attendees to feedback. Patient views included echoes of the key themes from phase 1 engagement but with some additional comments including, value placed on provision of a welcoming and non-judgemental attitude of staff (praise was given for existing services), appreciation of close work between walk-in services and substance misuse services and mental health crisis response teams. In addition, a number of cross-cutting themes emerged such as difficulty in accessing mainstream primary care services and access to repeat prescriptions. In contrast to feedback from general engagement, vulnerable patients valued the ability to access assessment and repeat prescriptions at short notice. There was some nervousness about the plans as attendees expressed the value of current services and their concern about losing current benefits.

The findings of all patient and clinical engagement was included in the development of the Urgent Care Centre service model and in June 2014, the model, along with plans to undertake a robust procurement process was presented to key committees (including Clinical Congress, Clinical Council, People's Council and the Health Scrutiny Committee); all were supportive of the approach. Approval was granted by the NHS Nottingham City, Rushcliffe, Nottingham West and Nottingham North East CCG Governing Bodies to proceed with re-commissioning of the existing 'Walk-in Centre' and '8-8 Health Centre' service in order to undertake procurement of a single Urgent Care Centre service. The Governing Bodies agreed to delegate appropriate authority to a project team or Procurement Delivery Group (PDG), who would agree the specification, set fair and robust evaluation criteria, address specific challenges and mitigate risk, particularly in relation to conflict of interest. The Procurement Delivery Group included representatives from all stakeholder CCGs, clinical governance, finance and GPs. The PDG co-opted or sought advice from individuals with specialist knowledge as required and Healthwatch Nottingham were invited to attend meetings in an advisory capacity.

It was decided that GEM commissioning Support Unit would be contracted to lead and advise the commissioners on the procurement process and ensure it adhered to procurement regulations. All members of the Procurement Delivery Group were required to sign and agree to the Declaration of Conflict of Interest and Confidentiality prior to their involvement. The role of the PDG would be to make the following decisions on behalf of the CCGs:

1. Finalising the service model and service specification
2. Finalising tender documentation including evaluation criteria
3. Assessing and scoring bids
4. Contract award on the basis of scoring

Patient Procurement Panel

³ Monitor. Walk-in Centre Review Final Report and Recommendations. Feb 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283778/WalkInCentreFinalReportFeb14.pdf. NHS England. Transforming urgent and emergency care services in England. <http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>. Nov 2013

The Procurement Delivery Group agreed to create a separate Patient Procurement Panel to enable patients with an interest in the development of the Urgent Care Centre to continue to be involved throughout the procurement process. The Panel was setup to enable patients to share their views about the content of the specification and provide input into the evaluation criteria. Whilst the Patient Panel would provide feedback into the scoring process, the PDG agreed that members of the Patient Panel would not score bids directly due to the difficulty in one or several members of the Panel being able to represent a wide public view and also to minimise risk in terms of confidentiality and potential or perceived conflict of interest. The Patient Panel helped to set the evaluation criteria by creating scenario-based questions, which were developed through a combination of Panel members' experience and the findings of engagement reports. The questions required bidders to demonstrate their understanding of the key quality and safety aspects of the patient journey (e.g. presentation of a homeless young person with a long term condition). In addition, the Patient Panel reviewed all draft evaluation questions and provided views about what would constitute a 'good' or 'poor' answer. Their comments were collated and shared with the Procurement Delivery Group prior to the scoring process.

The fourth meeting of the Patient Procurement Panel meeting is being arranged for April 2015 and will provide a detailed debrief of the rationale behind the scoring and moderation of bids. Plans are in place for the CCG to work with Healthwatch Nottingham to capture feedback from Panel members about their involvement and whether they felt their participation added value to the procurement process. The aim will be to share learning with commissioning colleagues and inform patient involvement in future large-scale procurement processes.

The key stages of the procurement process are outlined below, providing further detail of where patient and clinical engagement continued as far as possible as we developed the final service specification and prepared evaluation criteria for procurement.

'Pre-qualification Stage' - Shortlisting Bidders

The Urgent Care Centre 'Pre-qualification stage' was launched on 21st July 2014, with 13 organisations expressing an interest and of those 5 submitted a completed pre-qualification questionnaire for consideration. The 5 Providers were shortlisted against key, high level assessment criteria and all were passed, which enabled them to progress to take part in the ITT stage and submit a full tender application.

Market Engagement Event or 'Bidder Event'

The CCGs hosted a Bidder Event on 26th September 2014, which was formed of three discussion rooms, 'Premises', 'Urgent Care Network Stakeholders' and the 'Patient Procurement Panel'. The aim of the event was to offer the 5 PQQ shortlisted organisations the opportunity to discuss possible premises solutions with commissioners and query areas of uncertainty in relation to requirements and location boundaries, meet key stakeholders (including NUH and EMAS) and to answer patient pathway scenario questions from the Patient Procurement Panel. The key outcomes for the Procurement Delivery Group was to verify the assumptions made in costing the financial envelope for the Urgent Care Centre and to understand the main areas for clarification to be included in the ITT supporting documentation, particularly in relation to premises.

A number of points of clarification were raised during the event including the potential cost of providing X Ray equipment and the viability of the implementation period. As a result, commissioners reviewed the accuracy of their estimated costs for X Ray provision and agreed to extend procurement process, postponing the commencement of the Service to 1st October 2015. As a result the CCG has extended current walk-in centre contracts beyond the end of March 2015 to coincide with the opening of the Urgent Care Centre, which will support a smooth transition and clear communication plan.

Continued engagement and ITT development

Following release of the PQQ documentation and draft specification to potential providers, we were able to continue engagement activities and presented the draft service specification to a number of key groups for discussion. Clarification questions were captured and presented at the Procurement Delivery

Group meetings, where a response was agreed or appropriate action taken. The Invitation to Tender (ITT) required potential providers to respond to a range of questions with associated evaluation criteria relating to the key deliverables within the Service Specification. The ITT stage allowed continued scope for clinicians, subject experts (e.g. Medicines Management) and patients to influence the final Urgent Care Centre service by having direct input into the evaluation questions. A full outline of ITT stage feedback and outcomes is included in Appendix 1.

The finalised Urgent Care Centre Service Specification and ITT evaluation criteria was released to bidders on 31st October 2014 with a closing date of 11th December 2014. A total of 3 organisations submitted a tender submission for consideration by the CCGs. The Procurement Delivery Group nominated the ITT evaluation team with representatives from a range of cross functional areas, including specialists in Clinical Governance, Information Governance, Equality & Diversity and Medicines Management. ITT scores were discussed in a moderation meeting in January 2015, which ensured evaluators comments were considered and agreed final scores. The meeting also confirmed any areas of uncertainty and questions to be clarified prior to contract award.

Contract Award and Implementation

CityCare Partnership CIC was announced as the successful bidder on 18th February 2015 and work is underway to agree the contract award. The first Implementation meeting is planned take place in April 2015 and will agree the key areas of focus to monitor deliver of the new Service. It is anticipated that members of the Procurement Delivery Group will form the Implementation Group, which will offer continuity to the project and ensure development of the Urgent Care Centre is on track and meeting the objectives set out in the Service Specification.

Alongside implementation of the new Urgent Care Centre, there will be close working with the Providers of the 8-8 Health Centre and the Clifton Nurse Access Point to minimise the impact of and to ensure that the closures are well planned. Patients have highlighted the need for clear communication and signposting to alternative services to prevent unnecessary concern. Commissioners plan to meet with existing services to establish a joint transition plan and to discuss the approach to communication.

Discussion will take place with CityCare Partnership about plans to continue to engagement patient groups during the implementation phase of the Urgent Care Centre, with a view to developing a joint publicity and engagement plan.

Timeline and Next steps

- February 2015- CityCare CIC announced as the successful bidder to provide the new Urgent Care Centre
- March 2015- Contract Negotiation and Agreement
- April 2015- Implementation Group established
- April 2015- Patient Procurement Panel debrief and feedback sessions
- July-September 2015- continued Public and Clinical engagement
- August/ September 2015- Urgent Care Centre public publicity in collaboration with Provider
- 1st October 2015- Urgent Care Centre commences

EXPECTED OUTCOME

** what are the expected changes, when will this happen and how will it be evidenced*

- Urgent Care Centre to open on 1st October 2015 to provide high quality assessment, diagnosis and treatment of urgent health conditions
- Increase in the number of patients who are treated for immediate but non-life threatening health conditions outside of hospital
- Open 365 days a year between the hours of 7am to 9pm
- Provision of urgent diagnostic x-ray without the need to attend the Emergency Department
- Short waiting times for initial assessment (20 minutes or 15 for children) and treatment (within 2

hours or 4 hours if diagnostics are required)

- Reduction in patient uncertainty around what service to access of urgent health needs
- Reduction in minor illness presentations and provision of patient information and support to access the right service for their health needs
- Continued support for vulnerable patients groups with close links to specialist services
- Continue to work with Healthwatch Nottingham as a 'critical friend' to learn from previous engagement activities and plan future public involvement in the development of the Urgent Care Centre

Outcomes will be evidenced through contract monitoring of the Urgent Care Centre, with key performance indicators to monitor waiting times, patient satisfaction, diagnostic decision making and number of patients who are referred to other services. Activity monitoring will determine whether patients are accessing the Service appropriately and that Urgent Care Centre is creating collaborative links and effective joint working across the urgent care system.

Appendix 1 Feedback into ITT Development

(March 2015 Health Scrutiny Panel- Urgent Care Centre Procurement)

Group/ Committee	Feedback received	Action
Health Scrutiny Panel (July 2014)	<p>Important to capture the views of patients from vulnerable or 'seldom heard' communities</p> <p>Keep the current close working between the '8-8', 'Walk-in Centre' and services for vulnerable patients (including homeless and patients with substance misuse problems)</p>	<p>A Phase 2 Patient Engagement Report will include focussed work with vulnerable patient groups. Patient engagement reports were published and to bidders at ITT stage.</p> <p>The Urgent Care Centre specification includes a section about 'Focused support for Vulnerable Patients' and specific ITT questions addressed this.</p>
Clinical Congress (cross-CCG representatives)	<p>Concerns about a city-centre location and a suggestion that the service is provided on the QMC site.</p> <p>Comments that there need to be a clear aim in relation to a reduction in Emergency Department attendance.</p>	<p>Highlighted that engagement to date has shown preference to provide a city centre based service. Also, confirmed that location on the hospital site is not currently an option.</p> <p>Reduction in unnecessary ED attendance is listed as an outcome and will be linked to provision of urgent x-ray.</p>
CCG GP Practice Members (Cluster Boards and Clinical Council)	<p>Important for GP clinical systems to be interoperable with the new Service systems</p> <p>Queries about the follow up for X-ray and how the UCC will link with existing fracture services.</p> <p>Clarification requested about whether a multi-site solution would be considered and if the Clifton Nurse Access Point contract will end</p> <p>Important to reduce current minor illness activity that duplicates primary care and avoiding overall demand generation and strong communication about the e term 'urgent'</p> <p>Consistency of staffing to enable links to 111</p>	<p>Specification includes reference to NHS compliant IT systems and advice sought from CCG IT Lead to ratify specification wording.</p> <p>ITT stage will require bidders to detail their plans to deliver x-ray, including any collaborative working with stakeholders.</p> <p>It was confirmed that a multi-site solution was not required by the Specification.</p> <p>Activity modelling has been based on existing minor injury activity. An objective of the specification and a question within the tender documents will be about avoiding duplication with primary care services and working collaboratively with the local health system to ensure that patients use the new service appropriately.</p> <p>Specification and ITT criteria require a consistent level of clinical expertise throughout opening times and that the Service will link to 111 and other urgent care stakeholders.</p>

	<p>Discussion about monitoring activity by CCG to understand long term financial implications</p>	<p>The PDG agreed the timeframes for a period of review to determine activity levels for each CCG.</p>
<p>Patient Procurement Panel</p>	<p>Commented that bidders should clearly link to the Patient Engagement Report to explain the benefits of their premises solution</p> <p>Important to have consistent staffing to ensure that the same quality service is provided to all patients, particularly important in relation to paediatrics.</p> <p>Comments that both clinical and non-clinical staff should be trained to recognise symptoms requiring expedited assessment.</p> <p>The service should be responsive to the needs of diverse communities and knowledgeable about migrant and vulnerable patient groups.</p> <p>Access to interpretation (such as language line) was seen as crucial.</p> <p>The service should be responsive to the needs of mental health patients, with appropriately trained staff to assess and deal with presentations from patients in crisis.</p> <p>How will we be assured that the service is affordable and value for money?</p> <p>Assurance needed that patients who present and require emergency medical assistance are recognised and transferred to ED quickly and safely</p>	<p>Engagement report was included in the ITT and bidders were asked to outline how their premises and service model delivered the key findings. The premises compliance document included a definition of what is considered to be good accessibility.</p> <p>The workforce section of the specification contains reference to the need for consistent staffing to meet the needs of all patients who present (i.e. paediatric or mental health specialism)</p> <p>Question included in Bidder event panel and required in ITT submission</p> <p>Included in specification and ITT questions to ensure that current links are maintained</p> <p>A requirement in the specification and ITT</p> <p>Asked as a question at bidder event and included in ITT questions.</p> <p>High level CCG financial representation at PDG meetings to develop and ratify financial ITT template. The financial template for bidders will require detail about proposed staffing, shift patterns and building/ equipment costs.</p> <p>The specification and ITT required bidders to detail how they would work with other urgent and emergency care providers to provide safe and efficient transfer of care</p>

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HEALTH SCRUTINY PANEL
25 MARCH 2015
ACCESS TO SERVICES FOR PEOPLE WITH ME (MYALGIC ENCEPHALOPATHY/ ENCEPHALOMYELITIS)
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. **Purpose**

- 1.1 To receive a briefing and a range of views on access to services for people with ME, to help identify whether further scrutiny is required

2. **Action required**

- 2.1 The Panel is asked to use the information provided to decide whether further scrutiny could add value and influence any of the issues raised.

3. **Background information**

- 3.1 The UK ME Association notes that there are a number of different names for what is an illness of uncertain cause affecting many thousands of people. The Association estimates that approximately 250,000 people in Britain are affected by this illness, which affects people at all ages. Severe and debilitating fatigue, painful muscles and joints, disordered sleep, gastric disturbances, poor memory and concentration are commonplace. In many cases, onset is linked to a viral infection. Other triggers may include an operation or an accident, although some people experience a slow, insidious onset. Diagnosis may include the following:

- Myalgic Encephalopathy or 'ME' (a term which The ME Association feels is more appropriate than the original, Myalgic Encephalomyelitis)
- Chronic Fatigue Syndrome or 'CFS'
- Post-Viral Fatigue Syndrome or 'PVFS'
- Chronic Fatigue Immune Dysfunction Syndrome or 'CFIDS'

- 3.2 According to the Association, effects range from minimal to lives which are changed drastically: in the young, schooling and higher education can be severely disrupted; in the working population, employment becomes impossible for many. For all, social life and family life become restricted and in some cases severely strained. People may be housebound or confined to bed for months or years.

- 3.3 'The Rough Guide to ME/ CFS' is attached at Appendix 1. This is based on the publication 'Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: A Clinical Case Definition and Guidelines for Medical Practitioners. An Overview of the Canadian Consensus Document', Bruce M.Carruthers, Marjorie I.van de Sande 2005.

- 3.4 In November 2014, the Disability Involvement Group approached the Chair of the Health Scrutiny Panel to see whether it could provide assistance to improve

access to services for people who have severe ME. The main concerns raised were:

- Lack of clarity on what consultation has taken place with GPs on the options available to support people with severe ME and any outcomes from this;
- Concern that some GPs refuse to acknowledge ME and other conditions such as Fibromyalgia and Chronic Fatigue Syndrome as health conditions which need treatment/ support; (what guidance is provided if any?);
- Concern that some GPs don't make referrals to test for ME or other conditions such as Fibromyalgia and Chronic Fatigue Syndrome, which results in diagnoses not being made and, therefore, people are not able to access appropriate support;
- Concern about lack of service provision for people severely affected by ME; and
- The need for clarity regarding the commissioning process for integrated community services for ME and other conditions such as Fibromyalgia and Chronic Fatigue Syndrome.

3.5 The Panel has invited representatives of Nottingham City Clinical Commissioning Group (CCG), MESH (the ME Self Help Group), HWB3 (the Third Sector Health and Wellbeing forum) and Healthwatch to attend today's meeting to provide a range of information and views. This should enable members of the Panel to decide whether any further scrutiny is necessary.

4. List of attached information

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

Appendix 1 – Nottingham City Clinical Commissioning Group - ME/CFS Report, March 2015

Appendix 2 – Sarah Found M.E. Self Help Nottingham Report, March 2015

Appendix 3 – 'The Rough Guide to ME/ CFS', based on the publication 'Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: A Clinical Case Definition and Guidelines for Medical Practitioners. An Overview of the Canadian Consensus Document', Bruce M.Carruthers, Marjorie I.van de Sande 2005.

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

None

6. Published documents referred to in compiling this report

'The Rough Guide to ME/ CFS', based on the publication 'Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: A Clinical Case Definition and Guidelines for Medical Practitioners. An Overview of the Canadian Consensus Document', Bruce M.Carruthers, Marjorie I.van de Sande 2005.

<http://www.meassociation.org.uk/about/what-is-mecfs/>

7. **Wards affected**

All

8. **Contact information**

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ME/CFS

Health and Scrutiny Committee 25th March 2015

Chronic Fatigue Syndrome, also known as Myalgic Encephalomyelitis, (CFS/ME) is recognised by the Department of Health as a long-term debilitating disease which can cause profound, prolonged illness and disability, which has a significant impact on patients and their families.

Definition and Prevalence

NICE classifies CFS/ME into 3 groups:

Mild CSF/ME:

- Mobile, can care for themselves, light domestic tasks with difficulty.
- Majority working, but most will use weekend to rest in order to cope with the week

Moderate CSF/ME:

- Reduced mobility, restricted in all areas of daily living
- Peaks and troughs of ability, dependant on symptoms
- Usually stopped working
- Require rest periods, night time sleep poor and disturbed

Severe CSF/ME:

- Able to carry out minimal daily tasks only (face washing, cleaning teeth)
- Severe cognitive abilities
- Wheelchair dependant for mobility
- Often unable to leave the house (except on rare occasions, followed by prolonged after effects)

Very severe CSF/ME

- Unable to mobilise or do any tasks for self
- In bed for majority of time
- Often unable to tolerate any noise and generally extremely sensitive to light

Overall, evidence suggests a population prevalence of at least 0.2–0.4%. This means that Nottingham City, with a total population of 305,700, could have as many as 1,223 people with ME/CFS; half of these people will need input from specialist services.

The Department of Health estimates a diagnosed incidence of 0.04% in the UK (Department of Health 2002) with a higher incidence in urban populations. Evidence estimates that the number of people with severe CFS/ME varies between 10% and 25%, but the weight of clinicians' opinion supports the 10% figure. Applied to the Nottingham City population this equates to:

Incidence and prevalence estimates of CFS/ME England population aged 5 years or older	Percentage of patients	Number of patients	Number of patients with severe/ very severe symptoms
Incidence	0.0425%	130	13
Prevalence	0.3%	917	91

Guidance

The National Institute for Health and Clinical Excellence published NICE clinical guideline 53, Diagnosis and management of chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy) in adults and children. It states the following as Key priorities:

General principles of care

- ...Acknowledge the reality and impact of the condition and the symptoms.
- ...Provide information on the possible causes, nature and course of CFS/ME.

Diagnosis and initial management

- ...Advice on symptom management should not be delayed until a diagnosis is established. This advice should be tailored to the specific symptoms the person has and be aimed at minimising their impact on daily life and activities.
- ...A diagnosis should be made after other possible diagnoses have been excluded and the symptoms have persisted for:
 - 4 months in an adult
 - 3 months in a child or young person; the diagnosis should be made or confirmed by a paediatrician.

Specialist CFS/ME care

- Any decision to refer a person to specialist CFS/ME care should be based on their needs, the type, duration, complexity and severity of their symptoms, and the presence of comorbidities. The decision should be made jointly by the person with CFS/ME and the healthcare professional.
- An individualised, person-centred programme should be offered to people with CFS/ME. The objectives of the programme should be to:
 - sustain or gradually extend, if possible, the person's physical, emotional and cognitive capacity
 - manage the physical and emotional impact of their symptoms.

- Cognitive behavioural therapy and/or graded exercise therapy should be offered to people with mild or moderate CFS/ME and provided to those who choose these approaches, because currently these are the interventions for which there is the clearest research evidence of benefit.

Current Services

The Nottinghamshire Adult Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) Team is based in the Mobility Centre at the City Hospital.

The overall purpose of the CFS/ME service is to help those diagnosed with mild to moderate Chronic Fatigue Syndrome/ Myalgic Encephalomyelitis to develop appropriate strategies for managing their symptoms and to improve their quality of life.

The service offered is based on the principles of Cognitive Behavioural Therapy, graded exercise and activity management as recommended in the NICE guidelines 2007.

The subjects covered during the group or individual sessions include

- Pacing
- Activity management
- Quality rest and relaxation
- Sleep
- Diet
- Exercise
- Exploring thoughts and feelings
- Communication
- Managing stress
- Memory and concentration
- Managing setbacks

Each patient has a key worker who will be one of the members of staff at the group.

Referrals can be made by any GP within the Nottinghamshire area.

For patients with more severe ME/CFS there is an inpatient unit (8-10 beds) in Leeds which accepts out of area patients. This service offers a residential setting with intense rehab. Once the patient is deemed 'well' they are referred back to the local team.

Integrated Care

Management of CFS/ME is difficult and complex and healthcare professionals should recognise that specialist expertise is needed when planning and providing care. Diagnosis, investigations, management and follow-up care for people with CFS/ME should be supervised or supported by a specialist in CFS/ME.

People with CFS/ME may need to use community services at times. These services may include nursing, occupational therapy, dietetics, respite care, psychology and physiotherapy. The input of different professionals should be coordinated by a named professional.

Next Steps

NHS Nottingham City CCG is committed to meeting the needs of people with CFS/ME. Based on local circumstances we have identified two key development areas.

- training and education
- continuity of care and access to services

Training and education

The diagnosis and management of CFS/ME involves a variety of professionals from different backgrounds. It is important that they are all similarly educated about how to work with people with CFS/ME and understand the nature of the condition.

We will:

- Explore the offer of education and awareness raising to non-specialists (in particular, GPs, and occupational health) covering the symptoms, diagnosis and management of the condition.
- Work with local specialist services to make local clinicians, for example GPs aware of their service.
- Ensure specialist services consider providing awareness raising and education for non-healthcare professionals (such as social services, education providers, employers and disability services through Jobcentre Plus) and for doctors providing medical assessments for Disability Living Allowance.

Continuity of care and access to services

Good communication is essential to providing continuous care in a seamless service.

We will:

- Establish agreed pathways to ensure people with CFS/ME are diagnosed in a timely manner
- Consider local referral protocols to ensure that people are treated in the right setting.
- Ensure Protocols incorporate appropriate guidance so that people receive consistent care across services.
- Review provision of support for people with severe CFS/ME in line with our integrated care work programme.

Russell Pitchford
Commissioning Manager – Community Services and Integration
March 2015

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Contribution of Sarah Found on behalf of the M.E Self Help (MESH) Nottingham Group to be submitted to the Nottingham City Health Scrutiny Panel for consideration at the meeting on 25th March 2015

Summary

For the purpose of simplicity, I will be referring to and Myalgic Encephalomyelitis and Chronic Fatigue Syndrome as the same illness (ME/CFS). There is a lot of medical conflict over whether they are exactly the same; however that is how the National Institute of Clinical Excellence (NICE) Guidelines currently define them, so using this is the best way forward.

M.E. Self Help Nottingham has had extensive contact with NHS services since June 2011, in an attempt to improve ME/CFS services in Nottingham City. Unfortunately MESH Nottingham are still currently (March 2015) no further with obtaining an integrated service for people with ME and have therefore asked Health Scrutiny to engage to try and get a service commissioned.

MESH Nottingham believes that an integrated service for ME/CFS should at least include the following:

- Clear information, guidance and advice to GPs in referral pathways for testing and diagnosis of ME/CFS.
- Re-training for all GPs in Nottingham City about the condition to ensure that they are all following the NICE Guidelines on ME/CFS. If it turns out after this that there are GPs still refusing to deal with the illness appropriately, sanctions should be applied.
- A community service for patients with severe ME/CFS which might include (depending on suitability for the patient) support through personal assistants provided via a personal budget.
- Individually tailored activity management programmes which might draw on CBT.
- Home visits from a GP when patients are too ill to attend their doctor's surgery or health centre.

Further points of concern raised by MESH are listed below and will be further explored within the Health Scrutiny Panel:

- Lack of clarity on what consultation has taken place with GPs on the options available to support people with severe ME/CFS and any outcomes from this.
- Concern that some GPs refuse to acknowledge ME/CFS as health conditions which need treatment/ support.

- Concern that some GPs don't make referrals to test for ME/CFS, which results in diagnoses not being made and, therefore, people are not able to access appropriate support.
- Concern about lack of service provision for people severely affected by ME/CFS.
- The need for clarity regarding the commissioning process for integrated community services for ME/CFS.
- The allocation of services on supply and demand basis.
- Collaborative working to develop appropriate services.

The Rough Guide to ME/CFS

This booklet is designed to help those with ME/CFS to understand what it means and how it feels. It can also be used by carers, supporters and families to assist you.

This is a 'Rough Guide' only. ME/CFS is a unique experience to every individual. This booklet should not be used to make a diagnosis. It has been produced to help you understand and manage your condition with help from the Norfolk and Suffolk ME/CFS Service with your named practitioner.

The information contained is based on information taken from ME/CFS a Clinical Case Definition and Guidelines for Medical Practitioners, Bruce M. Carruthers, Marjorie I. van de Sande, An Overview of the Canadian Consensus Document.

How did I get ME/CFS?

It is often triggered by a viral infection that feels like you never got over it. It can follow a period of a lot of stress. Sometimes it is not clear what triggered it.

Can you do a test to show I have it?

Currently there is no test.

Your GP will have done a series of blood and other tests to RULE OUT other conditions.

So how do you know that I have ME/CFS?

Your doctor will already have looked for other causes. After this we look at your symptoms, for example ongoing exhaustion, muscle pain, new headaches, etc.

As you already have a diagnosis it means that your symptoms fit the criteria for a diagnosis.

Symptoms and what they mean

There are many symptoms of ME/CFS. The following is a list of symptoms and what they mean.

Sudden onset fatigue, exhaustion and unrefreshing sleep.

This means that you start to feel exhausted and no matter how much sleep you get you still feel exhausted. People vary and for some just doing a little activity can make you feel ill/exhausted immediately. For others the exhaustion may come in the next day or the day after. Even with lots of sleep you feel exhausted.

What causes exhaustion?

Energy for everything you do and feel comes in the form of something called ATP. Every cell in your body needs this.

Your oxygenated blood goes to each cell and the energy factories in the cell (Mitochondria) get to work to produce and store energy.

In ME/CFS the energy factories seem to struggle to recycle the energy or store it. So anything left over goes into the waste system and passes out of your body.

When you do activities with your mind and with your body – you will get to the stage where you simply don't have enough ATP. Your ATP suddenly falls – 'CRASH'.

It takes at least three days for you to build up the levels of ATP again for you to have a better day.

Why is my sleep unrefreshing?

We know that people with ME/CFS go through more frequent sleep cycles. So you get less deep sleep and in shallower sleep you have a very active mind! Vivid dreams and frequent waking are common – so you are using lots of ATP in your sleep!

Even in deep sleep your mind acts as if it is awake from time to time – so even more ATP!

In short, your sleep does not replenish you, physically or mentally.

Swollen glands, recurrent sore throats, ear infections etc feeling fluey.

Often people have repeated swollen glands, especially in the neck. You may have had lots of throat/ear infections. Also people often feel very ill and fluey. GP's often do tests to look for infections and they all come back as okay!

So I don't have an infection/virus. Why is my body acting like I have?

Because when you first became ill your immune system reacted to your illness and was 'activated'. Your immune system has not reset itself to 'normal' and will often act as if you have an infection/virus/flu/throat/ear infection – even when tests reveal this is not so.

Cognitive difficulties – What does this mean?

You may find that you can't concentrate for very long, read like you used to, cannot remember things very well, and struggle to finish sentences. Struggle to think of words, feel exhausted after concentration. Occasionally people feel they have time lapses – they are suddenly aware time has passed but can't remember it. People find these things scary and they make them feel anxious and panicky. **THE IMPORTANT THING IS THAT YOU ARE NOT GOING MAD OR LOSING IT!!**

Dizziness/Vertigo

Feeling dizzy, weak and shaky and overwhelmed is a problem for a lot of people. Sometimes it happens when standing up, standing still for a period of time, even lifting your head off a pillow. It can come and go or it can hang around just making you feel awful. Sometimes you have to lie down immediately.

What causes cognitive difficulties and dizziness?

It is all caused by the lack of good quality oxygenated blood reaching the parts of your brain it needs to. It is also to do with the volume of blood in your body. Women have 38% less blood volume than men anyway! ME/CFS studies have shown that it is common to have a lower blood volume – i.e. less blood is spread out to try and reach all areas. In some areas it's just not enough so the brain doesn't have the fuel it needs to remember all the time. It doesn't have the energy to put new information into the working memory or the long term memory.

Oh and Gravity.

Gravity affects everyone – it is a force that pulls things down. So it naturally acts on our blood, pulling on the blood supply to pull it down to our lower limbs. When we sit up or stand up our heart beats a bit faster and other systems kick in to push the blood around the body, especially to get blood up to the brain. In ME/CFS the heart can beat wildly and the other systems do not work as well, and this means we feel very dizzy. People often have this when they have been standing still. In ME/CFS the body can't create the energy to push the blood around the body.

Muscle and Joint Pain and Headaches

People can feel aching and painful muscles and joints. Sometimes this can be a severe type of pain.

People also describe that limbs feel heavy and that they just don't want to do what you tell them!

Joints can feel stiff. You may feel you struggle to hold things. Using your body can be painful. Headaches are a problem for many with ME/CFS. They can be migraines, pain 'behind' the eyes, pains to the front of the head etc.

On the whole these types of symptoms are caused by Neuropathic Pain. This means that pain comes from actions of your nerves and is not due to a physical cause. Aching to muscles is also caused by poor blood supply.

Okay – So why do my nerves cause these pains?

The area of your nervous system that sends news of pain signals has got its wiring system muddled! So the brain and the body send signals to each other that are incorrect – the result is that your brain and body produce a pain response.

What about my aching/heavy muscles?

Well, you are not getting enough oxygen and nutrients to your muscle cells. So after a while your muscles have to do work without as much oxygen – this causes a muscle ache or burning feeling.

You are like an athlete who has used up all their oxygenated blood in a race, and finishes the race by pushing through the pain barrier and their muscles burn and ache. Unlike our athlete – you are doing it every day – you are like the Marathon Man/Woman.

SO WHY CAN'T I GET TO SLEEP IF I AM SO EXHAUSTED?

Many people with ME/CFS actually find getting to sleep very difficult. They feel exhausted and ache from head to toe but they feel that their mind will just not 'shut up'! People can go for days hardly sleeping at all, and then they crash and can hardly stay awake.

The Stress Response – active minds and anxiety

When the brain detects a threat (a stress) it will react with a stress response. This response helps you deal with the immediate danger - Your muscles tense, your heart pounds, blood whooshes around the body, your brain is stimulated and your immune system is suppressed. Afterwards you will then feel anxious and shaky.

If you have lots of physical stress – like low levels of energy – and/or psychological stress your EMERGENCY STRESS RESPONSE will flick on most of the time and will be harder to shut off.

Through the day it will be triggered repeatedly – it loads your brain with more and more signals and chemicals to make your mind be active. At the end of the day there is so much of this stimulation in your brain that it really can't shut up – it's still whirring away whilst your body is exhausted.

The stress response can trigger a crash as it is 'on' too often for too long and eventually total physical exhaustion is overwhelming and you can hardly do anything!

Feeling hot and feeling cold

Sometimes people feel cold and cannot warm up. Often people feel hot and sweaty and cannot cool down.

This is due to mixed messages from the nerves making it difficult for the body to achieve the right temperature.

Sensory Overload – Noise, crowds and busy environments and conversations

Sometimes people feel they just cannot listen to what someone is saying. In a group people may find it difficult to focus on the thread of the conversation. Crowds and busy environments can make people feel unwell. Supermarkets and shops which are full of people, colourful items are often intolerable. This is called sensory overload.

So what causes Sensory Overload?

Before you became ill your brain did a very good job of sorting the important bits of everything you see and hear and ignoring the unimportant bits. In ME/CFS the brain is not very good at sorting things out. It does not tell you what is important or unimportant. So your brain works harder as it treats everything – each noise, movement, sound – with equal importance. It becomes overloaded with all this information – making you feel unwell and overwhelmed.

There is so much going on in my body – what can I do? Where do I start?!!

With Activity Management / Pacing

Every waking hour, as far as possible, you need to take 10-15 minutes rest. If you feel 45 minutes of activity is too much then decide how much activity you could do i.e. 30 minutes and then take a 15 minute rest.

What is activity?

It is anything you do when you are NOT sitting quietly, calming your mind. So activity is watching TV, going on a computer, flicking through a magazine etc.

What is rest?

Rest is minimal brain and body activity – so unless you are sitting calming your mind – everything else is activity – even sleep!

How do I calm my mind?

Many people find that they cannot sit for 15 minutes as they worry too much, feel anxiety or feel like their brain is racing. An overactive brain uses a lot of energy. So to get good quality rests you need to learn to calm it down.

Things people have found useful:

- Watching nature
- Listening to melodic, calming music. Three tracks of gentle songs = one rest break.
- Using applications and downloads off the computer – especially iTunes.
- Guided relaxation and medication CDs and downloads
- Listening to calming sound tracks e.g. waterfalls, the sea etc. Freely available on the internet.

- If you have a laptop search for all of these on YouTube and save them in favourites – most are ten minutes long.
- Many people find using an iPod, MP3 player or phone ideal – Download your tunes on to these and you can take your 15 minute rest anywhere – Sit down and close your eyes with your headphones in.

What does activity management do?

Minimal brain and body activity allows you to begin to produce sufficient ATP, not to use your energy so fast, and then to sustain it over time. As you calm your mind and get better at it you begin to control your stress response. You will also begin to sleep better.

But I sleep loads anyway and spend days doing nothing anyway

At this point in time your sleep is NOT restorative – good activity management is. On days you are doing nothing you still need to actively pace every hour as on these days your energy levels are extremely low.

So what are you saying?

Very simply:

*Activity/Rest/ Activity/Rest/ Activity/Rest/ Activity/Rest/ Activity/Rest/ Activity/Rest/
Activity/Rest/ Activity/Rest/ Activity/Rest/.* On good and bad days.

Can I do any activity I like?

Activity management is not about stopping activity – it is about taking frequent good quality rest breaks.

You will already know the things that really make you suffer and for the time being it is probably best not to do these things, or only for a very short period of time.

You should not be taking on new activities or increasing activity. You need to pace to find a baseline for your energy.

Remember using your brain will fatigue and exhaust you just as much as using your body – so don't be tempted to spend hours on computers, Xboxes or watching TV without regular rest breaks.

Always plan to do some of the activities that you really like in some way – even if you can't play your favourite sport at the moment – go as a spectator or help in some other way. Keep in contact with friends in ways that don't exhaust you!

Do I have to manage activity forever?

You need to manage activity till you reach a steady pattern of energy. So you no longer get very active days and very poor days – you are spreading your energy out evenly every day.

When this happens, with help and advice, you can start to introduce and increase activity and rest less frequently.

NB: For the first week or two of activity management you may be slightly worse. This is normal. You are allowing your body to feel as exhausted as it really is. This will pass and then you will be much more in control.

– LAST WORD –

At the moment your ME/CFS controls YOU. It makes you lose three or more days of your week.

Activity management is a way for you to manage IT. To get those days back and to help you achieve a GOOD QUALITY OF LIFE.

**ACTIVITY REST ACTIVITY REST
EVERY WAKING HOUR**

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HEALTH SCRUTINY PANEL
25 MARCH 2015
OSCAR NOTTINGHAM
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

- 1.1 To receive a brief overview of the work of OSCAR Nottingham, to help identify whether further scrutiny is required.

2. Action required

- 2.1 The Panel is asked to use the information provided to decide whether further scrutiny could add value and influence any of the issues raised.

3. Background information

- 3.1 OSCAR Nottingham was started by a group of concerned parents of young Sickle Cell sufferers who struggled to find information, overcome difficulties, and find people who could understand their needs. It became a Registered Charity in 1983 and currently it aims to support Sickle Cell and Thalassaemia sufferers of all ages, and their families, with their social, financial and welfare needs.
- 3.2 Sickle cell disease (SCD) is a serious inherited blood disorder where the red blood cells, which carry oxygen around the body, develop abnormally, and can change shape, ie they can become sickle shaped instead of the normal doughnut shape. This causes episodes of pain and other symptoms, including chest infections and anaemia. Crises (sickling) can cause long-term complications, including damage to organs and joints, and strokes. Certain conditions can trigger crises, for example cold, infection, dehydration or low oxygen. In the UK, about 12,500 people have SCD. It is more common in people whose family origins are African, African-Caribbean, Asian or Mediterranean. It is rare in people of North European origin. On average, 1 in 2,400 babies born in England have SCD, but rates are much higher in some urban areas.¹
- 3.3 Thalassaemia is a group of inherited blood disorders where the haemoglobin is abnormal. The affected red blood cells are unable to function normally, which leads to anaemia. Consequences can be mild to very serious, for example, requiring frequent blood transfusions and the risk of heart failure. Anyone may carry a thalassaemia gene. Alpha thalassaemia is a blood disorder that occurs worldwide. It's particularly common in Southeast Asia, and also affects people of Mediterranean, North African, Middle Eastern, Indian and Asian origin. In England, beta thalassaemia major is thought to affect around 1,000 people, with an estimated 214,000 carriers. It most commonly affects people of Cypriot, Indian, Pakistani, Bangladeshi and Chinese origin. In the UK, 8 out of 10 babies born with BTM have parents of Indian, Pakistani or Bangladeshi ancestry.²

¹ www.patient.co.uk

² www.nhs.uk

3.4 Craig Galpin, Education and Awareness Officer, Nottingham City Clinical Commissioning Group will provide an overview of the work of the charity OSCAR Nottingham, to provide members of the Panel with an insight to its work and to enable them to decide whether any further scrutiny is necessary.

4. List of attached information

4.1 **Appendix 1** – Sickle Cell Disorder and Thalassaemia Major Report, March 2015.

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

None

6. Published documents referred to in compiling this report

<http://oscarnottingham.org/Index.aspx>

www.patient.co.uk

www.nhs.uk

7. Wards affected

All

8. Contact information

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OSCAR Nottingham Sickle Cell Support Service

Sickle Cell Disorder and Thalassaemia Major

Sickle Cell Disorder and Thalassaemia Major are serious and dangerous inherited conditions that affect the red blood cells in people from areas where malaria is or was common. Therefore, they are most likely to occur in people with family backgrounds from:

- Africa
- The Caribbean
- Mediterranean countries
- The Middle East
- Parts of Asia

Children can inherit the conditions from their parents when both parents have Sickle Cell or Thalassaemia Trait, which developed as defences against malaria. The traits themselves are not illnesses nor can they develop into one. Frequently people can live their entire lives without knowing they have one.

It is possible for those with Sickle Cell Trait to sometimes exhibit symptoms but they tend to be less severe and a connection between Sickle Cell Trait and the symptoms is often not made by medical professionals.

Sickle Cell Disorder

Sufferers are most likely to have family backgrounds from Africa, the Caribbean, Middle East and India.

Ordinarily red blood cells are round or doughnut shaped and flexible. In those with Sickle Cell Disorder (also known as Sickle Cell Anaemia), red blood cells can collapse to become

sickle or crescent shaped and become rigid. This causes them to clump and become stuck in blood vessels. When they do so they cause enormously painful episodes known as a 'crisis'. These can last hours, days or even weeks and months.

Because during Sickle Cell Crises blood flow is restricted, tissue and internal organs are starved of oxygen, causing long term damage. Strokes are also very common, particularly in children.

"You can be in crisis for a day, two days, a week, a month. I've had crisis and its affected everything. I've had pneumonia in my liver, I've had gallstones, I've had blood clots in my brain and nearly died because of it.

I've had a baby and I've been through labour and I'm not lying to you when I say having a crisis is worse than being in labour. "

An OSCAR client

Crises can be triggered by:

- Dehydration
- Stress
- Extremes of temperature and damp conditions
- Altitude
- Extreme exertion

Trying to reduce the frequency and severity of crises is vital. The goals are to relieve pain, prevent infections and damage to organs. This is done by:

- Food supplements
- Keeping hydrated
- Antibiotics
- Pain medication
- Healthy lifestyle with welfare needs addressed

In addition to crises, other symptoms of Sickle Cell Disorder include:

- Fatigue due to reduced oxygen
- Anaemia
- Eye disease

- Acute chest syndrome (a common cause of death)
- Vulnerability to infections

Thalassaemia Major

Is found mostly in people with family backgrounds from India, Pakistan, other Asian countries and many Mediterranean, North African and Middle Eastern countries.

People with the condition cannot make red blood cells and those that are made contain very little haemoglobin (iron).

Symptoms of Thalassaemia Major include:

- Growth delay and poor feeding in babies
- Fatigue
- Weakness
- Shortness of Breath
- Jaundice

OSCAR Nottingham

OSCAR Nottingham was started by a group of concerned parents of young Sickle Cell sufferers, who struggled to find information, overcome their many difficulties, and find people who could understand their needs. It became a Registered Charity in 1983 and currently its aim is to provide non-medical support to those with Sickle Cell Disorder, Thalassaemia Major and their families.

From February 2014 OSCAR Nottingham has been running a pilot project running until 31st July 2015 funded by NHS Nottingham City Clinical Commissioning Group designed to:

- Help prevent recurrent hospital admission for Sickle Cell crisis by supporting people affected by Sickle Cell Disorder through social and welfare interventions that help minimise symptoms.

- Minimise the suffering that Sickle Cell and Thalassaemia have on their lives and those of their families and carers, therefore reducing further the demand on health provision.
- Raise awareness amongst those groups most affected of the hereditary aspect of Sickle Cell and Thalassaemia. People with sickle cell or Thalassaemia trait may show no symptoms, but there is a 25% chance of them becoming the parent of a child with Sickle Cell Disorder or Thalassaemia Major respectively if their partner also has the trait.
- Raise awareness of screening and the genetic counselling available amongst affected communities and to encourage increased participation from these groups in screening.

This project brings together support for individual's health issues and support for social and welfare issues. We know this is a significant project since research has shown that Sickle Cell is now one of the commonest reasons for admission to hospital and has the highest rate of multiple admissions for individual patients.¹

OSCAR also runs the Wellbeing and Health for You (WHY) project. This is open to everyone from the community and is free to users. Health activities are held periodically around the city in schools premises, community organisations and churches such as:

- Healthy eating
- Martial arts
- Belly Dancing
- Cancer awareness
- Food Intolerance
- Yoga
- Support to quit smoking

¹ S Lucas, D Mason, M Mason and D Weyman, *'A Sickle Crisis? A report of the National Confidential Enquiry into Patient Outcome and Death'*, NCEPOD, 2008, p. 7

HEALTH SCRUTINY PANEL
25 MARCH 2015
WORK PROGRAMME
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

- 1.1 To consider the provisionally scheduled items for the Panel's first meeting in 2015/16, based on areas of work identified by the Panel at previous meetings.

2. Action required

- 2.1 The Panel is asked to note the provisionally scheduled items for the meeting to be held on 27 May 2015.

3. Background information

- 3.1 The Health Scrutiny Panel is responsible for carrying out the overview and scrutiny role and responsibilities for health and social care matters and for exercising the Council's statutory role in scrutinising health services for the City.
- 3.2 The Panel is responsible for determining its own work programme to fulfil its terms of reference. The work programme 2014/15 is attached at Appendix 1.
- 3.3 The work programme is intended to be flexible so that issues which arise as the year progresses can be considered appropriately. This is likely to include consultations from health service providers about substantial variations and developments in health services that the Panel has statutory responsibilities in relation to.
- 3.4 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Panel.
- 3.5 Councillors are reminded of their statutory responsibilities as follows:

While a 'substantial variation or development' of health services is not defined in Regulations, a key feature is that there is a major change to services experienced by patients and future patients. Proposals may range from changes that affect a small group of people within a small

geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area.

This Panel has statutory responsibilities in relation to substantial variations and developments in health services set out in legislation and associated regulations and guidance. These are to consider the following matters in relation to any substantial variations or developments that impact upon those in receipt of services:

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

Councillors should bear these matters in mind when considering proposals.

- 3.6 Nottingham City and Nottinghamshire County Councils have established a Joint Health Scrutiny Committee which is responsible for scrutinising decisions made by NHS organisations, together with reviewing other health issues that impact on services accessed by both City and County residents.
- 3.7 Today's meeting is the last meeting of this municipal year and a new Panel/ Committee will be appointed for the 2015/16 municipal year. However, to ensure continuity of scrutiny work and allow the planning necessary prior to a scrutiny meeting, the Panel is asked to agree a provisional agenda for the meeting which will take place on 27 May 2015.

4. List of attached information

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

Appendix 1 – Health Scrutiny Panel 2014/15 Work Programme (for information) and items provisionally scheduled for the meeting on 27 May 2015.

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

None

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

None

7. **Wards affected**

All

8. **Contact information**

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Health Scrutiny Panel 2014/15 Work Programme

<p>28 May 2014</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">Page 60</p>	<ul style="list-style-type: none"> <p>• Nottingham CityCare Partnership Quality Account 2013/14 To consider the draft Quality Account 2013/14 and decide if the Panel wishes to submit a comment for inclusion in the Account <div style="text-align: right;">(Nottingham CityCare Partnership)</div> </p> <p>• Adult Integrated Care To review progress in the Adult Integrated Care Programme <div style="text-align: right;">(lead – Nottingham City CCG)</div> </p> <p>• Health Scrutiny, Healthwatch and Health and Wellbeing Board Working Agreement To agree a protocol guiding the relationship between health scrutiny, Healthwatch Nottingham and Nottingham City Health and Wellbeing Board</p> <p>• Walk In Centres To consider the outcomes of consultation and engagement carried out in relation to remodelling Walk-in Centres/ development of an Urgent Care Centre and next steps in development of the proposals <div style="text-align: right;">(Nottingham City CCG)</div> </p> <p>• GP Practice Change - The Practice Nirmala To consider proposals to close The Practice Nirmala <div style="text-align: right;">(NHS England Derbyshire and Nottinghamshire Area Team)</div> </p> <p>• GP Practice Change - Merger of Boulevard Medical Centre and Beechdale Surgery To consider proposals to merge Boulevard Practice and Beechdale Practice <div style="text-align: right;">(NHS England Derbyshire and Nottinghamshire Area Team)</div> </p>
<p>30 July 2014</p>	<ul style="list-style-type: none"> <p>• Discussion with Portfolio Holder for Adults and Health/ Chair of the Health and Wellbeing Board To consider the Portfolio Holder for Adults and Health's work over the last year and progress in delivery of</p>

	<p>objectives relating to health and adult social care; current areas of work; and priorities and plans for 2014/15. (Nottingham City Council)</p> <ul style="list-style-type: none"> • Healthwatch Nottingham Annual Report To receive, and give consideration to the Annual Report of Healthwatch Nottingham (Healthwatch Nottingham) • Integration of Public Health within Nottingham City Council One year on, to review the integration of public health within the Council, including how the Public Health Grant is used to address wider determinants of health. (Nottingham City Council) • Urgent Care Centre Specification To receive information about the draft specification for a new Urgent Care Centre (Nottingham City CCG) • Implications of Care Act for Nottingham City Council To consider the implications of the Care Act for Nottingham City Council and how the Council is responding (Nottingham City Council)
24 September 2014	<ul style="list-style-type: none"> • Strategic Review of the Care Home Sector – findings and next steps To consider the findings of the Strategic Review of the Care Home Sector and to scrutinise how these findings are being responded to (Nottingham City Council) • Transfer of children’s public health commissioning for 0-5 year olds to Nottingham City Council To review progress in preparing for the transfer children’s public health commissioning for 0-5 year olds to the local authority in 2015 (Nottingham City Council/ NHS England Derbyshire and Nottinghamshire Area Team) • School nursing

	<p>To consider outcomes from the review of school nursing and the new model for school nursing in the City (Nottingham City Council)</p> <ul style="list-style-type: none"> • Procurement of End of Life Services To consider proposals for procurement of End of Life Services as current contracts for Hospice at Home/ Day Care and Bereavement Services are due to end on 31 March 2015. (Nottingham City CCG) • GP Practice Change – Merger between Meadows Health Centre, Bridgeway Centre and Wilford Grove Surgery, 55 Wilford Grove [deferred from July 2014] To consider proposals to merge Meadows Health Centre and Wilford Grove Surgery (NHS England Derbyshire and Nottinghamshire Area Team) • GP Practice Change – Merger between St Albans Practice, Bulwell and The Practice Nirmala, Bestwood To consider proposals to merge St Albans Practice and The Practice Nirmala (NHS England Derbyshire and Nottinghamshire Area Team)
26 November 2014	<ul style="list-style-type: none"> • Bowel cancer screening uptake To receive information on the uptake on bowel cancer screening in the City and to scrutinise activity to improve uptake (NHS England Derbyshire and Nottinghamshire Area Team/ Nottingham City CCG) • NHS Health Check Programme To review performance of the NHS Health Check Programme and progress in access for individuals not registered with a GP (Nottingham City Council)
28 January 2015	<ul style="list-style-type: none"> • Nottingham CityCare Partnership Quality Account 2014/15 To consider performance against priorities for 2014/15 and development of priorities for 2015/16

	<p style="text-align: right;">(Nottingham CityCare Partnership)</p> <ul style="list-style-type: none"> • Adult Integrated Care Programme To consider the findings to date of the independent evaluation of the Adult Integrated Care Programme and how these findings are being used to improve/ further develop the Programme (lead – Nottingham City CCG) • Progress in implementation of the Care Act To scrutinise the progress of the Council in implementing requirements of the Care Act (Nottingham City Council) • Child and Adolescent Mental Health Services To consider the future provision of CAMHS in light of a recent review by commissioners and new provider strategy (Nottingham City CCG, Nottinghamshire Healthcare Trust)
25 March 2015	<ul style="list-style-type: none"> • Urgent Care Centre To consider the progress in commissioning of an Urgent Care Centre receive information about plans for commencement of the service (Nottingham City CCG/ provider) • Access to services for people with ME To receive a briefing on access to services for people with ME, to help identify whether a scrutiny review is required • Overview of the work of OSCAR Nottingham To hear about the work of OSCAR Nottingham (sickle cell charity) (OSCAR Nottingham)

27 May 2015

- **Flu Immunisation**

To consider the progress of the children's flu immunisation programme, targeting of flu immunisations to children and adults, the relationship between flu in adults and flu in children; and the benefits and potential disadvantages of vaccination in children.

(NHS England/ Public Health England/ NCC)

- **Nottingham CityCare Partnership Quality Account 2014/15**

To consider the draft Quality Account 2014/15 and decide if the Panel wishes to submit a comment for inclusion in the Account

(Nottingham CityCare Partnership)

- **Discussion with Portfolio Holder for Adults, Health and Commissioning/ Chair of the Health and Wellbeing Board**

To consider the Portfolio Holder for Adults, Health and Commissioning work over the last year and progress in delivery of objectives relating to health and adult social care; current areas of work; and priorities and plans for 2015/16.

- **Extended work programme planning session**

To agree a draft work programme for 2015/16 and agenda items for June and July meetings