NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 23 July 2015 from 13.30 - 15.39

Membership

Present	Absent
Councillor Ginny Klein (Chair)	Councillor Merlita Bryan
Councillor Anne Peach (Vice Chair)	Councillor Corall Jenkins
Councillor Jim Armstrong	
Councillor Ilyas Aziz	
Councillor Neghat Nawaz Khan	
Councillor Dave Liversidge	
Councillor Chris Tansley	

Colleagues, partners and others in attendance:

Stephanie Cook	-	Senior Commissioning Manager, NHS England
Martin Gawith	-	Healthwatch Nottingham
Lynne McNiven	-	Public Health
Peter Morley	-	Care Act Implementation Manager
Ruth Rigby	-	Healthwatch Nottingham
Clare Routledge	-	Senior Governance Officer
Linda Sellars	-	Director for Adult Social Care Quality and Change
Zena West	-	Governance Officer

16 APOLOGIES FOR ABSENCE

Councillor Merlita Bryan

17 DECLARATIONS OF INTEREST

Councillor Dave Liversidge declared an interest in item 8 on the agenda, GP Practice Merger in Sneinton, as he is a patient at one of the surgeries. Councillor Neghat Khan also declared an interest in item 8 on the agenda, as she is a patient at one of the surgeries. Neither interest was sufficient to preclude either Councillor from speaking or voting on the item.

18 MINUTES

The minutes of the meeting held on 18 June 2015 were confirmed and signed by the Chair.

19 PROGRESS IN THE IMPLEMENTATION OF THE CARE ACT 2014

Peter Morley, Care Act Implementation Manager, and Linda Sellars, Director for Adult Social Care Quality and Change, gave a presentation on the progress of the implementation of the Care Act 2014, highlighting the following points:

(a) the Act passed into law in May 2014. Part 1 final regulations and statutory guidance were published at the end of October 2014, with implementation by April 2015;

(b) an announcement was made on 17 July that the proposed cap on care costs is to be delayed until 2020;

(c) the Care Act Programme Board is in place, with programme leads in key areas – Overseeing audit of compliance with part 1 and further development work;

(d) there are new duties around wellbeing and prevention, with wellbeing principle built into training, contracts and practice. A redesign has taken place of assessment and support planning documentation, to demonstrate consideration of wellbeing and prevention approach, and frontline staff have attended mandatory cultural change workshops;

(e) work is ongoing with partners to upskill and empower frontline staff to consider whole household wellbeing issues at every contact. Frontline staff are being supported with more skills to support citizens in making positive lifestyle choices, and implementing preventative interventions;

(f) a factsheet has been developed and published on the Adult Social Care website. Information and advice services are being commissioned for a range of issues, including debt management, welfare benefits, and housing, with a multi-agency strategy for citywide information and advice currently in development. Commissioning is also underway to replace the Choose my Support directory;

(g) contacts are in place with the Care Quality Commission, and market position statements have been reviewed. A provider failure protocol is in place, with an early intervention pilot designed to identify and support struggling providers;

(h) eligibility for care is now identified using a national framework, with an audit of this due in August 2015. Carers are now being assessed in line with the requirements of the Care Act by the Carers Federation, which has resulted in the removal of carer responsibilities from 7 young carers since April 2015;

(i) workshops are being delivered to practitioners on care and support planning, and POhWER have been commissioned to deliver independent advocacy;

(j) a Local Government Association tool has determined that policies and procedures surrounding charging and financial assessment are compliant. A deferred payments policy is in place, but there has been very little citizen interest;

(k) care and support planning and personal budget procedures have been reviewed, and new forms rolled out to frontline staff. Detailed information is available to citizens regarding Direct Payments and care and support planning, with a Care and Support policy recently published. A workforce culture change programme has also been delivered, with further training to be delivered until 2016;

(l) the transition process for children (and carers) likely to have needs when they turn 18 has been checked and agreed as compliant, with a transition strategy currently in development;

(m) the Council must promote integration with the aim of joining up services. This is currently in progress through the work of the Health and Wellbeing Board and the partnership work with the Nottingham City Clinical Commissioning Group;

(n) a Safeguarding Board has been established, as has a training programme designed to embed the principle of making safeguarding personal. The Safeguarding Care Act Working Group meets to monitor safeguarding progress;

(o) current practices and process for ensuring continuity of care when moving between areas have been checked and confirmed as compliant. The Association of Directors of Adult Social Services have developed a regional cross-border carers protocol, and consideration is being given to how this can be adopted by Nottingham City Council;

(p) links have been established with HMP Nottingham, approved prison premises, and bail accommodation providers, and NHS England is providing social care assessments for prisoners. Work is underway at a regional level to understand is assumptions about prison social care were sound. HMP Nottingham is a remand prison, and it was anticipated that demand for social care would be low. However, Nottingham and other areas with remand prisons have a higher need than expected for social care provision. This may be due to the robust assessment process in place.

The following points were raised during discussion:

(q) personal budgets have been around for many years as part of the personalisation agenda. National indicators have recently been submitted, and everyone who is eligible to receive them currently is;

(r) There is a legal duty to monitor direct payments, and citizens submit invoices for checking every 3 months. A card account has recently been introduced, so that citizens won't have to submit returns, as the account can be checked directly by Nottingham City Council to ensure that the money has been used correctly. 28 citizens are currently using the new card account;

(s) a Senior Community Care Officer and a Social Worker are dedicated to the monitoring of direct payments, and there are procedures in pace to transfer citizens from direct payments on to a commissioned service in cases of misuse;

(t) citizens who employ a personal assistant now have to offer them the option of opting into a pension. Nottingham City Council has taken the decision to support citizens with the complicated process of setting up a pension, and citizens have been notified of their obligations. Some external providers offer

direct payment citizens employment support, to ensure that they are good employers of their personal assistants;

(u) the Care Act is clear that there is a statutory responsibility to ensure that nobody under 18 is carrying out inappropriate care of an adult. All 7 young carers who had their carer responsibilities removed were under 18. Action for Young Carers, which is part of the Carers Federation, is working in partnership with Nottingham City Council;

(v) the Provider Failure Protocol will be provided to members of the Committee. It is very detailed. It is an ever-evolving document, with new information and learning added with each closure. The process is moving towards early intervention, to help struggling providers prior to closure becoming necessary and avoiding provider failure where possible;

(w) the entire 2nd part of the Act has been deferred until 2020, so there is no immediate work to do on any of the requirements of part 2. More detailed information on the implications of part 2 will be received in 2019;

(x) Healthwatch Nottingham representatives reported they are keen to use the “enter and view” function into care homes.

RESOLVED to:

(1) thank Peter Morley and Linda Sellars for the presentation;

(2) ask that details relating to young carers be provided to committee members;

(3) ask that details of the Provider Failure Protocol be provided to committee members.

20 UPDATE ON THE PROGRESS ON THE TRANSFER OF THE HEALTH VISITORS AND FAMILY NURSE PARTNERSHIP COMMISSIONING RESPONSIBILITIES FROM NHS ENGLAND TO NOTTINGHAM CITY COUNCIL - 1ST OCTOBER 2015

Lynne McNiven, Consultant in Public Health, and Stephanie Cook, Senior Commissioning Manager NHS England, presented a report on the progress of the transfer of Health Visitor and Family Nurse Partnership Commissioning Responsibilities from NHS England to Nottingham City Council on 1 October 2015, highlighting the following points:

(a) as of 31 March 2015 there were 126 full time equivalent Health Visitors in post. This is more than doubled the original starting number, and is an immense achievement. The target is 154 Health Visitors, so it is in everyone’s interest to get as close to that number as possible;

(b) service specifications have been agreed nationally. The funding allocation has been agreed in year, from October 2015 to 31 March 2016. Nottingham City

Council is still awaiting clarification from the Department of Health and Local Government Association on the funding formula and allocation for 16/17;

(c) historically health visitors and family nurse practitioners have been commissioned on a registered basis but nationally this will be changing to resident population. Whilst this may sound simple, it is complicated when working with vulnerable families. Nottingham City Council have raised concerns over last 9-10 months, and high level guidance and principles are expected on the matter;

(d) there is a lot of work to do to ensure data (i.e. new-born blood spot, vaccines etc.) is not jeopardised and tightened up before April;

(e) communication plans are in place to ensure colleagues and the public are informed that there is a change in contracts ownership, not the actual services;

(f) vitamin D supplement provision is part of the universal service offered to women and this policy is expected to continue;

(g) the public health team have developed profiles for 0-5 years olds, based on children's centres geographies. The profiles give health and social outcomes for all 0-5 year olds across city, enabling services to be targeted on evidence base;

(h) The exchange of contract has been signed and approved by NHS England. The West Midlands are a couple of months ahead in the process, which is useful for learning about any issues that may arise with the process.

The following points were raised during discussion:

(i) there is currently a health visitor staffing shortfall, but there are no penalties in place for missing the targets. Funding and support has been made available to providers for them to continue to recruit. There is some over-supply in other areas, so public health has been connecting people in different areas to enable appointments. Primary Care Trusts didn't previously view health visitors as a key area for investment. It takes 12 months to train a health visitor and they must be qualified nurses prior to entering the training, so increases in staffing levels take time;

(j) the Department of Health set the health visitor target of 154 in 2011 and this target has not yet been reviewed, but Nottingham City Council will review it at a later date. The staffing shortfall is being managed at the moment, but most nurses are over 50, which will bring more issues when they reach retirement age. Citycare health visitors are mostly keeping to their key performance indicators for service provision, achieving about 90% of targets;

(k) health visitors have a crucial role in working more closely with diverse communities in the city. The public health remit for training health visitors is based around equity of access and evidence base. Although the workload of health visitors is huge it is important that health visitors use the skill mix of support staff around them;

(l) the health visitor service is the only universal service that has the privilege to see every child born and identify early vulnerabilities. It is the bedrock of prevention and early intervention;

(m) Small Steps, Big Changes will potentially come under public health with 2016/17 funding being ring fenced into the public health budget but the amount has not yet been confirmed. The funding formula was sent out for comment in February 2015, and extensive comments were sent back, but there has been no update since then. There is a mandate regarding health visitors is in place, and an expectation of continuation of funding for at least the 18 month settling in period;

(n) health visitors within Citycare receive very robust training, intensive 1-2-1 support, and supervision. The mentorship relationship is maintained throughout a new Health Visitors 1st year in post;

(o) the service was congratulated and the importance of promoting the public health agenda for long term gains was reiterated.

RESOLVED to thank Lynne McNiven and Stephanie Cook for the update on the transfer of Health Visitor and Family Nurse Partnership Commissioning Responsibilities.

21 UPDATE ON THE IMPLEMENTATION OF NOTTINGHAM'S NEW NEEDS-LED SCHOOL NURSING SERVICE

Lynne McNiven, Consultant in Public Health, presented an update to the committee on the implementation of Nottingham's new needs-led school nursing service, highlighting the following points:

(a) school nursing is incredibly important, and is often the only independent access that children and young people have to health and social care. Nurses work with young people to ensure physical and emotional health, and health and education outcomes are often very strongly connected;

(b) the new needs led model commenced in September 2014. Previously there was a bit of a scattergun approach, with nurses working in isolation. Most senior nurses worked exclusively in secondary schools, when there was just as big a need in primary schools. Public Health has worked with providers to develop teams for school nursing, 33 whole time equivalents across the city. There is a skill mix, from band 6 right down to nursery nurses. The teams now work with groups of schools organised within Clinical Commissioning Groups delivery areas, trying to integrate and mix school nursing with education and Clinical Commissioning Groups. There is a coordinated effort to deliver service;

(c) existing data has been examined, and developed into a profile which anyone can use. The data is currently being refreshed. It is very important to examine the data and target services according to need. Readiness for school is an important time in a child's life. If a child has an identified physical health need,

the transfer goes quite well. However, if a child is just missing targets, that information often doesn't get passed on to the school nurse or early year's teachers;

(d) traditionally there has been a school entrance questionnaire. This has been changed to be much more holistic, much more useful to schools, and much more useful to school nurses;

(e) (e) there are 3 health improvement facilitators in post. These are non-clinical staff, with experience in health promotion. They support campaigns and get information back to families. Their specialities are sexual health relationships, healthy weight, and the rest of the agenda (mainly mental and emotional health and wellbeing);

(f) Public Health is working with schools and the Healthy Schools team to try to build capacity within schools. 3 stakeholder events have been held over the last 18 months. The stakeholder events have focussed on sex and relationship education, child sexual exploitation and female genital mutilation;

(g) historically, vaccinations and immunisations have been provided by the school nursing team, and commissioned by NHS England. There is now a dedicated vaccinations and immunisations team for schools starting in September 2015, which will free up additional school nursing time to address other health issues;

(h) the school health agenda is growing. There are still high levels of teenage pregnancy, emotional and wellbeing issues and ongoing problems with healthy weight.

The following points were raised during discussion:

(i) whilst there has been some opposition to sex education by parents, with some choosing to have their children opt-out, all sex and relationship education in the city is completely age appropriate. If children and young people are not taught what is normal, they won't know what's abnormal (i.e. abuse, exploitation, female genital mutilation) and will potentially be susceptible. Some populations may attempt to label sex and relationship education as a cultural issue, but there are options for overcoming these barriers, including mother and daughter sessions, gender separated sessions, and involving parents to let them know what valuable life skills are being taught;

(j) the cost of the school nurses programme is £1.6 million;

(k) a full review of the service and stakeholders was held 18 months ago, which highlighted problems with the school nursing service from both sides, including:
- visibility of school nurses as some schools did not know they even had a school nurse;
- issues with lack of facilities for school nurses - no private room, no parking, no Wi-Fi
- issues with inappropriate facilities – storage rooms being used as nurse consultation rooms;

stakeholder meetings have been useful for addressing these issues. Public Health can work with the schools on quality assurance and sharing good practice;

(l) a personalised health plan is being introduced for all children and young people. At reception age aa health questionnaire is completed, which picks out areas of work and key points As there are 47,000 5 – 16 year olds in the city Resources are not available to maintain plans for those children who do not have identified needs, except in the case of looked after children, where there is a legal requirement. Children are monitored as they come into primary and secondary school, and school nurses work closely with schools to pick up any developing issues or needs;

(m) each nurse covers around 4 schools, with Monday to Friday coverage. Providers are expected to be flexible to meet demand and visits can be carried out of school term if required. The guide to school nursing in Nottingham did not appear to show contact points for nurses in Radford and Park, this will investigated and reported back to the Committee;

(n) school nurses do not carry out blood tests for children as it is good practice for phlebotomists to do this. GP practices with phlebotomists are now open more frequently in the evenings, so children who require regular blood tests may not necessarily have to be taken out of school for them to be done;

(o) school nursing profiles are available on Nottingham Insight.

RESOLVED to:

(1) thank Lynne McNiven for the update on the school nurses programme;

(2) further scrutinise uptake of advertised services;

(3) request further information on school nursing contact points in Radford and Park.

22 HEALTHWATCH NOTTINGHAM ANNUAL REPORT 2014/15

Martin Gawith and Ruth Rigby from Healthwatch Nottingham, gave a presentation on its annual report for 2014/15 and future plans for Healthwatch Nottingham, highlighting the following points:

(a) Healthwatch Nottingham is a local consumer champion for health and social care and has matured over the last year. It represents the voice of Nottingham citizens, gathers the experiences of service users, and uses this information to provide a fuller picture of people’s experiences for commissioners, providers, and regulatory bodies;

(b) 845 separate experiences were gathered to inform service and system development, with around half of those from “seldom heard” individuals. The Healthwatch website has been redeveloped to make engagement easier, and pop-up “Talk to Us” information points were developed. The information

gathered was fed back to every care home and GP practice, and is continuously rolled out;

(c) targeted work has taken place to ensure the views of various groups have been accounted for, including:
- older people;
- people in care homes;
- people with mental health issues;
- younger people;
- asylum seekers and refugees;
- recovering alcohol or drug users;
- carers;
- citizens from minority ethnic groups;
- LGBT (lesbian, gay, bisexual and transgender) citizens;

(d) Healthwatch Nottingham also has the power to see how health services are working, to enter and view services and collect the views of service users, carers and staff, and to observe service delivery. This is not an inspection; it is instead an opportunity for lay people to engage with service users and their families. This methodology was used to assess Nottingham City Council's implementation of the Care Act, and development for 2015/16 includes care homes and learning disabilities;

(e) Healthwatch Nottingham raised concerns with Nottingham City Council regrading information issued prior to the implementation of the Care Act, and enabled citizens to be part of the procurement process of the urgent care centre services developments; as well as contributing to the Joint Strategic Needs Assessment and quality surveillance groups. Healthwatch Nottingham delivers recommendations to various partners and meetings, including:
- Health and Wellbeing Board;
- Nottingham City Council regarding Care Act implementation;
- Clinical Commissioning Groups;

(f) Healthwatch Nottingham aims to put people at the heart of service improvement, by feeding information to commissioners, providers and regulators. They also aim to involve people in strategy development and commissioning, such as South Notts Transformation, Urgent Care Centre procurement, and upskilling volunteers to work in other areas;

(g) In 2015/16, ongoing priorities include care homes, young people and mental health, ME (myalgic encephalomyelitisthe – chronic fatigue syndrome), and the impact of the Immigration Act 2014. A local profile with the public, information systems, and involvement of local people in decision making will all continue to be developed. Other areas to be looked at sustainably include engagement work, increased use of mystery shoppers, and using research evidence and insight.

The following points were raised during discussion:

(h) Healthwatch Nottingham currently receives £160,000 in funding each year from Nottingham City Council up to March 2016, and are required to report how it is spent. £130,000 is spent on staffing, leaving a very small amount to

feed into the service, and for other costs such as publicity. It is not a large organisation, but they use resources efficiently and provide a good service with what little they have. There is a target of 40 volunteers, and there are currently 38, with volunteer recruitment ongoing. Some core funding is necessary to maintain the independence of the service;

(i) providers are able to add the Healthwatch Nottingham feedback widget to their website for citizens to provide feedback more easily. The new website went live in November 2014 and some aspects are still being rolled out. Information and feedback is also fed in from other areas, such as Patients Opinion, and NHS Choices. Healthwatch Nottingham focuses on those who perhaps won't comment elsewhere, for example because they don't have internet access. They collate all information gathered from all arenas into a standard format. There is a dedicated researcher post within the team for 2 days per week;

(j) some training sessions, such as safeguarding, have to be run regularly. Specific training on mystery shopping will be launched shortly. There is a relatively small pot of volunteers to call from, and they are not necessarily representative of the whole population of the City, so Healthwatch Nottingham are keen to get a wider demographic of volunteers.

RESOLVED to thank Martin and Ruth for the update on Healthwatch Nottingham's activities.

23 GP PRACTICE MERGER IN SNEINTON

RESOLVED to note the information provided in the report.

24 HEALTH SCRUTINY COMMITTEE 2015/16 WORK PROGRAMME

Clare Routledge, Senior Governance Officer, presented a report on the work programme for the Health Scrutiny Committee for 2015/16. The following points were raised during discussion of the item:

(a) the work programme reflects previous discussions. The September 2015 meeting will consider sex and relationship education in schools and a strategic response to reducing health inequality in the city;

(b) Councillors Neghat Khan, Chris Tansley, Ilyas Aziz, Corall Jenkins and Ginny Klein agreed to be members of the study group. Councillor Jim Armstrong also expressed an interest, but will not be available for November.

RESOLVED to note the work programme for the Health Scrutiny Committee for 2015/16.