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NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 30 July 2014 from 1.30 pm - 4.07 pm

Membership

Present	Absent
Councillor Ginny Klein (Chair)	Councillor Eileen Morley
Councillor Thulani Molife (Vice Chair)	Councillor Timothy Spencer
Councillor Mohammad Aslam	
Councillor Merlita Bryan	
Councillor Azad Choudhry	
Councillor Anne Peach	
Councillor Emma Dewinton	

Colleagues, partners and others in attendance:

Councillor Parry Tsimbiridis	Nottinghamshire County Council
Ruth Rigby	Healthwatch Nottingham
Naomi Robinson	NHS Nottingham City Clinical Commissioning Group
Laura Catchpole	Policy Officer
Jane Garrard	Overview and Scrutiny Coordinator
Carol Jackson	Constitutional Services Officer
Chris Kenny	Director of Public Health
Alex Norris	Portfolio Holder for Adults, Commissioning and Health
Linda Sellars	Chief Social worker

15 APOLOGIES FOR ABSENCE

Councillor Eileen Morley
Councillor Timothy Spencer

16 DECLARATIONS OF INTERESTS

None

17 MINUTES

The minutes of the last meeting held on 28 May 2014 were confirmed and signed by the Chair.

18 INTEGRATION OF PUBLIC HEALTH WITHIN NOTTINGHAM CITY COUNCIL ONE YEAR ON

The Panel considered a report of the Head of Democratic Services reviewing how well the public health function has integrated into the Council since its transfer on 1 April 2013. Chris Kenny, Director of Public Health summarised the progress made by the new Public Health (PH) function across the City and updated the Panel on the key issues for the PH function;

(a) to ensure a robust assessment of population health need. This is an ongoing process but the key health needs for Nottingham City are; the fact that the health of people in Nottingham is generally worse than the England average; deprivation is higher than average; life expectancy for both men and women is lower than the England average; child health; obesity levels; alcohol abuse; levels of teenage pregnancy, GCSE attainment; breastfeeding and smoking at time of delivery are all worse than the England average and rates of sexually transmitted infections, people killed and seriously injured on roads and tuberculosis are worse than average;

(b) the transition of staff into the local authority. This occurred on 1 April 2013. Work to develop the PH workforce is ongoing. A number of key elements of this process include reducing duplication wherever possible in responsibilities between Consultants in the County and City, ensuring the senior PH teams across both organisations act as strategic leaders for all the different PH areas and ensuring that elected members receive timely and professional advice about use of the PH ring fenced grant, including developing plans to ensure the grant is spent in ways which maximise the opportunities for investment to promote the health and wellbeing of the population;

(c) to ensure continued understanding of the PH function by elected members and officers within the Council and to emphasise the integration of the PH Consultants across the different directorates of the organisation to act as key link staff members;

(d) the development and implementation of the PH business plan from April 2014 and integration of it into the Council's strategic plans. This work includes developing more radical proposals in relation to tobacco and obesity;

(e) to lead the process of identifying efficiencies within the PH budget in 2015/16,2016/17 and 2017/18, and the realignment of this resource within the overall City Council's expenditure plans;

(f) to continue to ensure a strong PH function within the Clinical Commissioning Group and review the Memorandum of Understanding to continue from March 2014. This review has been done with any changes being implemented from now onwards;

(g) to continue to support and develop the Health and Wellbeing Board to ensure they are robust and fit for purpose by a PH paper presented to each meeting whenever possible. A particular focus needs to be the translation of the strategic plans into action plans, as part of the routine Council business;

(h) to ensure the safe transfer of the Commissioning responsibility for Health visiting and the Family Nurse partnership, from NHS England to the local authority from October 2015. This will enable a greater degree of flexibility in the use of overall resources for children and young people, including resources for school nursing, health schools and children's centres.

During the discussion the following additional information was provided:

(a) ensuring the safe transfer of the Commissioning responsibility for health visiting and the Family Nurse partnership, from NHS England to the local authority from October 2015 is proving challenging due to the need to integrate the service with other services for children as part of an overall package. There is, however, over a year to go until this has to be implemented;

(b) there is no current intention to produce an annual report for public health as there will be bi-monthly progress reports to the Health and Wellbeing Board on various public health issues and objectives. Targets are linked to the National Public Health Outcomes Framework and are contained within the Business Plan;

(c) the Chair welcomed the publication of health profiles for individual Wards.

RESOLVED to note the progress made to date on the integration of the public health function into the Council and to thank Chris Kenny for his update

19 DISCUSSION WITH PORTFOLIO HOLDER FOR ADULTS, COMMISSIONING AND HEALTH

The Panel considered the report of the Head of Democratic Services on the remit of the Portfolio for Adults, Commissioning and Health.

Councillor Alex Norris, Portfolio Holder for Adults, Commissioning and Health outlined his current areas of work, progress in delivering the objectives relating to health and adult social care and the key challenges ahead. Councillor Norris updated the Panel on his key priorities as follows:

(a) driving delivery on the priorities of the Joint Health and Wellbeing Strategy is largely complete;

(b) the transition of Public Health (PH) into the City Council has gone smoothly thanks to the hard work and professionalism of the PH staff;

(c) creating stability during a period of significant change in the NHS remains a key priority;

(d) supporting the continued existence of the Council as a direct provider of care, helping to drive up standards in the sector;

(e) ensuring that personalisation is appropriately applied and supported;

The challenges for the next year are:

(a) further work on the Health and Wellbeing Strategy integrating health and social care across health partners;

- the integration of health and social care. This is challenging as the goal posts are being changed in the Better Care Fund which exists to ensure a transformation in integrated health and social care. The provision of more integrated health and social care services that will ensure a better experience of care is offered to older people and those with long term conditions;

- the prevention of alcohol misuse to reduce the number of citizens who develop alcohol-related diseases;

- earlier intervention to increase the number of citizens with good mental health;

- the support of priority families into work, improving school attendance and reducing levels of anti-social behaviour and youth offending;

(b) new responsibilities under the Care Act 2014;

(c) looking after each other- empowering communities to look out for one another and greater use of the voluntary sector.

During the discussion the following additional information was provided:

(a) a number of self -funders use the care provided by the Council. For this to continue to be sustainable there is a need to ensure that care is delivered by staff earning a living wage but at the same time ensuring that costs are competitive with those of the private sector providers;

(b) scrutiny can assist the process by looking at what is going on and responding and by being informed of how things are done elsewhere and feeding back

The Panel noted the update on progress of the Portfolio of Adults, Commissioning and Health and thanked Councillor Norris for his attendance.

20 IMPLICATIONS OF THE CARE ACT 2014 FOR NOTTINGHAM CITY COUNCIL

The Panel considered a report of the Head of Democratic Services relating to the implications of the Care Act 2014 (the Act) for the City Council. Linda Sellars, Chief Social Worker, gave a presentation which highlighted the following points:

(a) the Act became law in May 2014 and draft regulations and statutory guidance were published in June for consultation (closing on 15 August). The majority of the Act comes into force in April 2015, with the exception of the cap on care costs which comes into effect in April 2016;

(b) the Care Act Programme Board is in place, with programme leads in key areas. Corporate risks have been set relating to how the Act affects the wider adult social care system;

(c) the general duties of the Council under the Act will be:

- wellbeing: local authorities must promote wellbeing and actively seek improvements when carrying out any of their care and support functions in respect of a person. The definition of 'wellbeing' is very broad, implying that it should be embedded Council wide;

- prevention: local authorities must also provide or arrange services, facilities or resources that prevent, delay or reduce the development of needs for care and support. This reflects the Council's commitment to effective prevention and early intervention;

- a duty to provide a comprehensive information and advice service, including signposting to independent financial advice. 'Choose my Support' will go some way to deliver this but further development work is required to ensure that citizens receive information about signposting services including independent financial advice and universal services;

- market shaping and provider failure: local authorities responsibilities have been strengthened, including a new duty to ensure local authorities provide a continuity of care, should a care provider fail. This expands the Council's current market role but a better understanding of relationship with the Care Quality commission is required;

- all citizens are entitled to receive a care and support assessment and, if relevant, a care plan. Citizens can also ask the local authorities to arrange care, irrespective of who is funding care. This will increase the number of assessments for care accounts and increase the requirement to provide independent advocacy;

- eligibility: assessments must use the new national framework;

- a duty to complete carers assessments and meet their eligible needs. Modelling work is being undertaken to estimate the number of assessments required;

(d) Other key provisions of the Act include;

- deferred payment - people will not have to sell their home to pay for residential care whilst they are still alive. This will increase the administrative burden and may mean that there are more empty properties;

- a cap on care costs (from April 2016). The cap limits how much people will pay towards their care costs, with the local authority paying the full cost thereafter (minus daily living costs). Citizens in residential care are expected to contribute £12,000 annually to daily living costs The cap will be set depending on the age of the eligible persons needs e.g. £72,000 for state pension age,

£0 for those aged 18 LA managed 'care accounts' will track contributions to the cap. This will add to the administration and may mean an increase in citizens which have to be funded over the longer term;

- a duty on local authorities to provide a care and support plan and development of the plan must involve the citizen and be reviewed. Citizens/carers can have a joint care and support plan;

- using the information from the personal budget, the person has a legal entitlement to request a direct payment and local authorities must provide them to citizens who meet the conditions in the regulations;

- integration: local authorities must promote integration with the aim of joining up services particularly between the NHS, care services, and wider determinants of health such as housing;

- local authorities and partners must cooperate in the case of specific individuals;

- children (and carers) likely to have needs when they turns 18, must be assessed, regardless of whether they currently receive any services;

- local authorities must establish Safeguarding Adults Boards with local partners, with public plans, annual reporting and clear processes for investigating suspected abuse or neglect;

- moving between areas – there will be a new process to ensure continuity of care, widening the responsibilities of the local authority to include supported living and shared lives schemes. A clear policy will need to be developed and possible changes to IT systems may be required to allow easier transfer of information to other local authorities;

(e) duties under the Act will increase the Councils adult social care costs significantly, with potentially high levels of set up costs in terms of:

  - IT systems;
  - increased number of assessments;
  - increased administrative burden;
  - workforce skills and training;
  - greater funding responsibility when people reach the cap;

  Detailed financial modelling is currently taking place to enable the financial risks going forward to be understood;

(f) the focus will be on managing and reducing demand through early intervention and preventative approaches at a time when many local authorities feel under pressure to cut preventative service due to government cuts.

During discussion the following additional information was provided in response to questions:

(a) a key aim of the Council is to keep people independent for as long as possible. This involves linking citizens in with their local communities and trying to ensure that they have active social lives;

(b) the tight timescales set by the Government for implementing the provisions of the Act will be challenging;

(c) via East Midlands Association of Directors of Adult Social Care there was a Programme Lead to avoid duplication in work by local authorities and share learning, for example in determining the definition of eligibility.

(d) the Chief Social Worker was confident that the Council would be in a position to meet the new duties upon it by April 2015, but this would require an escalation of the IT review currently underway across the Children and Adults Department;

(e) services users and carers aren't currently involved in developing the new services and ways of working. Ruth Rigby, Healthwatch Nottingham suggested that this could be a missed opportunity and offered to provide support in engaging users and carers.

RESOLVED

(1) to note the likely impact on the Council of the Care Act 2014;

(2) to request that an update on progress with regard to the implementation of the Act be submitted to this Panel early in 2015;

21 HEALTHWATCH NOTTINGHAM ANNUAL REPORT 2013/14

The Panel considered a report of the Head of Democratic Services relating to the Healthwatch Nottingham Annual Report 2013/14. Ruth Rigby, Managing Director Healthwatch Nottingham, presented the first annual report of Healthwatch Nottingham, highlighting the following points:

(a) the role of Healthwatch Nottingham is one of a local consumer champion for health and social care, representing the voice of Nottingham citizens, gathering the experiences of people who use services, using this information to provide a fuller picture of people's experiences for commissioners, providers and regulatory bodies;

(b) Healthwatch Nottingham Interim Board has been set up and a Chair and Vice Chair identified. Healthwatch has a seat on Health and Wellbeing Board and reports to each meeting. A protocol has been developed between Healthwatch Nottingham, Health Scrutiny and Health and Wellbeing Board;

(c) key work areas during 2013/14 include:

- the development of organisation's structures, information systems and relationships with stakeholder organisations ;

- improvements to information if care homes close;
- as a provider of Quality information, passing on specific concerns raised by the public in relation to local services/organisations to providers, commissioners, Care Quality Commission etc;
- scrutinising engagement and consultation arrangements e.g. South Nottingham Transformation Board;
- communications – developing public messages and responses to media;

(d) a reflective audit survey has been undertaken, looking at how Healthwatch is performing with a view to focusing plans to improve the service and make a difference. It was sent to around 800 people; commissioners, providers, third sector and public (members and info line users) The key findings were:

- there is a need to do more to ensure that all local people know who Healthwatch is and what it does. This was unanimously agreed by the vast majority of respondents irrespective of whether they had a professional or service user role:
- there is more that can be done to gather and share the experiences of seldom heard groups. Only 50% of providers and commissioners agreed that Healthwatch identify and represent the needs of seldom heard groups;
- some good strong relationships have been built with decision makers in the City. The vast majority of professionals have had a positive experience of working. There is a need to build on this to remain independent and provide confirmation and challenge where necessary to deliver the best outcomes for local people;

(e) the current focus is on increasing the profile of Healthwatch, continuing to develop relationships and making sure that seldom heard groups are represented.

During the discussion the following additional information was provided:

(a) Healthwatch are about to pilot ‘Talk to Us’ points in two Joint Service Centres the City. These access points will provide an opportunity for direct dialogue with the public across the City, to be used for both general feedback and for specific campaigns. Evaluation of the ‘Talk to Us’ points will include the extent to which ‘participants’ matched the demographics of the population and the ‘reach’ into seldom heard communities;

(b) it is hoped to launch a new website by the end of September and to publicise its launch with a view to attracting more users, especially those from minority groups.

RESOLVED

(1) to note the first annual report of Healthwatch Nottingham;

(2) to thank Ruth Rigby for her update.

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:

(f)

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

(g) 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;

(h) 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.

23 GP PRACTICE CHANGE - MERGER OF MEADOWS HEALTH CENTRE (DR RAO AND PARTNER) AND WILFORD GROVE SURGERY

This item was withdrawn from the agenda by the Chair.

24 WORK PROGRAMME 2014/15

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 amend the work programme to include the following items:

- **the outcomes from the school nursing review and new delivery model to be included in the September meeting agenda;**
- **the transfer of commissioning of public health services for children aged 0-5 to be included in the September meeting agenda;**
- **the findings and next steps from the strategic review of the care home sector to be included in the September meeting agenda;**
- **NHS Health Check Programme would now be included in the November agenda.**

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