

NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES of the meeting held at LB31-32 - Loxley House, Station Street, Nottingham, NG2 3NG on 25 March 2015 from 1.30pm – 3.31pm

Membership

Present

Councillor Ginny Klein (Chair)
Councillor Thulani Molife (Vice Chair)
Councillor Merlita Bryan
Councillor Azad Choudhry
Councillor Brian Parbutt
Councillor Anne Peach

Absent

Councillor Mohammad Aslam
Councillor Eileen Morley
Councillor Timothy Spencer
Councillor Emma Dewinton

Colleagues, partners and others in attendance:

Voluntary and Community Sector

Jenny Billings - MESH Nottingham
Anne Darby - Disability Involvement Group
Craig Galpin - OSCAR Nottingham
Maxine Robinson - Support for Survivors
Barbara Venes - Patient representative
Chrissie Wells - OSCAR Nottingham

Nottingham City Clinical Commissioning Group

Dr Manik Arora
Russell Pitchford
Naomi Robinson
Hazel Wigginton

Nottingham City Council

Noel McMenamin - Governance Officer
Annette Molyneux - Project Officer, Equalities and Community Relations
Louise Noon - Public Health Manager
Kim Pocock - Constitutional Services Manager
Clare Routledge - Senior Governance Officer

49 APOLOGIES FOR ABSENCE

Councillor Emma Dewinton (other Council business)
Councillor Eileen Morley (leave)

50 DECLARATION OF INTERESTS

Councillor Merlita Bryan declared a personal interest in agenda item 6 (minute 54 below) – ‘Overview of the work of OSCAR Nottingham’ – as a patron of the organisation, which did not preclude her from speaking or voting.

51 MINUTES

The Panel confirmed the minutes of the meeting held on 27 January 2015 as a true record and they were signed by the Chair.

52 URGENT CARE SERVICES

Naomi Robinson, Commissioning Manager – Primary Care, Nottingham City Clinical Commissioning Group, introduced a report and presentation, updating the Panel on the preferred provider for urgent care services, providing further detail on plans for interim and future service provision.

Ms Robinson made the following points in her presentation:

- (a) a review of both walk-in service contracts had previously taken place. While a service data and patient survey review in 2011/12 indicated a duplication of services and variances in delivery between both services. Patient feedback indicated high levels of satisfaction with the services, but also highlighted problems in accessing primary care. GP commissioners used these findings to inform a remodelling of walk-in services committing the same level of funding but develop a service model that treats an extended range of urgent health problem; the remodelling approach presented to key stakeholders in 2013/14 was broadly welcomed. There was specific support for a more seamless ‘see and treat’ approach, for greater clarity between the roles of walk-in and primary care services, and for greater equity of access through having a city centre location;
- (b) there followed intensive clinical and patient engagement, involving the Patient Engagement Team and Healthwatch Nottingham and including ‘roadshows’ and 2 significant engagement events. The engagement findings confirmed support for a city centre location, increased diagnostics (particularly x-Ray), co-location with urgent dental services, consistent 7-day opening times and public transport and parking access;
- (c) a further period of engagement focused on ‘seldom heard’ groups. Feedback included the need for a welcoming and non-judgmental approach, maintaining current links between services and substance misuse and homelessness organisations and access to repeat prescriptions;
- (d) the key features of the final urgent care specification included high quality assessment, diagnosis and treatment of urgent health conditions, urgent diagnostic x-Ray without attending Accident and Emergency, year-round opening hours of 7am-9pm, short waiting times for initial assessment and treatment and continued access for vulnerable patient groups with close links to specialist services;
- (e) the procurement process attracted 13 expressions of interest, and, following a market management-bidder event in September 2014, 3 organisations submitted a bid. The procurement process was supported by a Patient Procurement Panel, providing a ‘patient voice’ throughout;

- (f) Nottingham CityCare Partnership was announced as the preferred bidder in February 2015, and an Implementation Group is to be established to oversee the development of the Urgent Care Centre;
- (g) The Centre is to be sited at Seaton House, London Road and the CityCare Partnership is working to a commencement date of 1 October 2015. There will be a managed transition of the Urgent Care Centre and the closure of the 8-8 Health Centre and Clifton Nurse Access Point; .

The Panel commended the process for its high levels of transparency and stakeholder engagement. During discussion, the following points were made:

- (h) Ms Robinson confirmed that there will be consistent ongoing communication with citizens and GP practices on transition arrangements. While it would be for the preferred bidder to clarify what was meant by 'urgent' care, communications leads from all relevant organisations involved in interim arrangements needed to liaise to ensure a seamless transition;
- (i) Ms Rigby confirmed that Healthwatch's close involvement with the Urgent Care Services development was as a direct result of the Health Scrutiny Panel commencing the scrutinising of the remodelling process in March 2014;
- (j) Ms Robinson confirmed that TUPE arrangements will apply for affected staff and a programme of upskilling staff will take place. A Provider Event and Roadshow Events for staff had also taken place.
- (k) There was consensus that Seaton House on London Road, while not ideal, was the best available option, being relatively central, on an arterial route and having parking available;
- (l) A Panel member suggested that a 'Hopper' bus service would make the Centre more accessible;
- (m) Ms Robinson welcomed a Healthwatch suggestion to locate a Healthwatch 'Talk to Us' information and feedback point at Seaton House;
- (n) The Panel welcomed the Urgent Care Centre alleviating pressure on the A&E Department and shorter waiting times for patients;
- (o) The Panel requested an update once the Seaton House facility was fully established, and welcomed the opportunity to visit the Seaton House site in the future.

RESOLVED to

- (1) thank Ms Robinson for her informative presentation;**
- (2) consider a further update once the Seaton House Walk-In Centre was fully operational, and to organise a Panel visit to the Centre.**

53 ACCESS TO SERVICES FOR PEOPLE WITH ME (MYALGIC ENCEPHALOPATHY/ENCEPHALOMYELITIS)

The Chair introduced a report of the Head of Democratic Services on the services provided for and issues faced by people with Myalgic Encephalopathy (ME) and related diagnoses, to determine whether further scrutiny is required. The issue had been brought to the Panel's attention by members of the public, and public concerns had been expressed about gaps in and consistency of service provision.

The Panel received a presentation by Russell Pitchford, Commissioning Manager – Community Services and Integration at NHS Nottingham City Clinical Commissioning Group (CCG), who highlighted the following points:

- (a) ME and related conditions, including Chronic Fatigue Syndrome (CFS), Post-Viral Fatigue Syndrome (PVFS) and Chronic Fatigue Immune Dysfunction Syndrome (CFIDS) were prevalent in 0.2 to 0.4% of the population. The National Institute for Clinical Excellence classifies ME/CFS into 3 categories: mild, moderate and severe, but definitive figures for each category are not known;
- (b) It is acknowledged that there is a considerable variation in current practice by service providers;
- (c) Diagnosis is by exclusion of other possible diagnoses, with symptoms persisting for 4 months in adults and 3 months in children and young people, and may present with other conditions, making diagnosis complex;
- (d) It is acknowledged that the conditions have a significant impact on patients and families;
- (e) There is a specialist Nottinghamshire Adult CFS/ME Clinic based at the City Hospital, providing services to those with mild to moderate diagnoses. The programme offered seeks to sustain and/or extend the person's physical, emotional and cognitive capacity, to manage the physical and emotional impact of their symptoms and to provide cognitive behaviour therapy and/or graded exercise therapy;
- (f) The nearest facility for treating severe ME is in Leeds, but there are no current patients from Nottingham referred to the facility;
- (g) Services should be needs-based and delivered under local integrated services, with support from specialist services;
- (h) The CCG has identified training and education and continuity of care and access to services as the key development areas going forward. The CCG will look to offer education and awareness raising among non-specialists on the symptoms, diagnosis and management of the ME, will look to make local clinicians aware of the specialist services available, and seek to ensure that specialist services consider providing education and awareness training to non-health professionals;
- (i) The CCG will also establish agreed pathways to ensure timely diagnosis, consider local referral protocols so people are treated in the right setting, include guidance in protocols so that care is consistent across services.

The Chair then invited Jenny Billings of the ME Self Help Nottingham Group (MESH) to address the Panel, who made a number of points, summarised below:

- (j) sufferers of ME/CSF in Nottingham City have experienced delays in diagnosis, have been misdiagnosed and have not been taken seriously by GPs when presenting with ME/CSF symptoms. Sufferers of Fibromyalgia have had similar experiences;
- (k) there is a need for a training refresh for GPs in Nottingham to address attitudes to ME/CSF, and to ensure consistency of diagnosis and treatment. In particular, there has been inconsistency in carrying out blood tests and in referring patients to specialists to rule out other illnesses at an early stage;
- (l) it is regrettable that Nottingham City CCG did not circulate to GPs for information a report produced by Carruthers and Van de Sande on ME/CSF, as

- it purportedly failed to meet NICE Guidelines. This was at odds with NHS Services elsewhere in England, which have based information given to patients on this report;
- (m) it is unacceptable that the nearest service for those with severe ME/CSF is in Leeds, while patients with moderate ME/CSF find it difficult to access the service at the City Hospital because of its remote location;
 - (n) MESH Nottingham has experienced poor levels of communication and consultation with Nottingham City CCG, particularly about progression and outcomes of a personalised health budget pilot, and proposed service provision for those with severe ME/CSF. Better working relations between MESH Nottingham and Nottingham City CCG are needed to achieve better outcomes for Nottingham citizens;
 - (o) It is unacceptable to have local diagnosis figures based on national percentages rather than on local NHS medical records, and this is down to a failure to diagnose and refer appropriately;
 - (p) There is a sense that there has been little positive action to improve the situation for patients 'on the ground'. Without the CCG being held to account through a timetable for action this situation is likely to continue, and MESH Nottingham wanted the Panel's help in continuing to monitor the service provided to ME/CSF sufferers in Nottingham;
 - (q) A service user endorsed Ms Billings' comments about diagnosis difficulties, and advised that a majority of survivors of child sexual exploitation suffered from CFS;
 - (r) In response to points (j) to (p) above, Mr Pitchford advised that patient feedback for the ME/CSF clinic for mild to moderate sufferers was very positive. He acknowledged that there were gaps in provision for those with severe ME/CSF, but that commissioning a service was difficult given low numbers, and options for a joint Nottingham/Derby service were being explored.

Dr Manik Arora of Nottingham City CCG provided a GP/clinician perspective, making the following points:

- (s) GPs need to diagnose by exclusion and, while frustrating for both patients and clinicians, taking time to eliminate non-ME/CSF conditions such as anaemia and Multiple Sclerosis is vital if very serious alternative conditions are to be identified and treated. An added complication was that diagnosing other conditions did not mean that ME/CSF was not also present;
- (t) Clinicians are happy to take on board learning but are also frustrated by the conflicting guidance, advice and evidence available;
- (u) Accurately recording numbers is challenging and this makes the task of commissioning a service very difficult. Addressing the lack of information through the Joint Strategic Needs Assessment (JSNA) would be helpful;
- (v) Fragmented commissioning is an issue, but can only be improved through all stakeholders working together non-confrontationally. Ultimately, clinicians want to address patient needs.

Ruth Rigby, Managing Director, Healthwatch Nottingham, appealed to all stakeholders, but especially to patients groups, to share information with Healthwatch. This will build an evidence base to help inform the Joint Strategic Needs Assessment (JSNA) and commissioning decisions going forward. As an

independent body, Healthwatch Nottingham is in a position to help facilitate information-sharing among stakeholders.

RESOLVED to note the presentations and very valuable, open discussion and to endorse Healthwatch Nottingham's offer to facilitate information gathering and exchange.

54 OVERVIEW OF THE WORK OF OSCAR NOTTINGHAM

Craig Galpin and Chrissie Wells of OSCAR Nottingham (Organisation for Sickle Cell Anaemia Relief) gave a presentation on the disorder and the organisation's work in Nottingham, addressing the following points:

- (a) Both Sickle Cell Disorder (SCD) and Thalassaemia Major (TM) are related inherited blood conditions affecting red blood cells, primarily affecting people with family backgrounds in areas where malaria is or was prevalent;
- (b) It is estimated that there are 250,000 SCD carriers and 214,000 TM carriers in the UK. There is no current information on prevalence in the East Midlands, but in 2009 there were 320 SCD and 35 TM sufferers diagnosed in the region;
- (c) In Nottingham, OSCAR provides non-medical support to SCD and MT sufferers and their families. It also runs the WHY (Health and Wellbeing for You) Project to help address wider Black and Minority Ethnic health inequalities, and engages in education and awareness raising activities;
- (d) OSCAR has trained 120 Police custody officers from across Nottinghamshire on the care of people with SCD and TM, and it is hoped this service will be rolled out nationally. It also works closely with health and housing partners to improve outcomes and opportunities for sufferers;
- (e) The organisation gave a presentation to the All Party Parliamentary Group for Sickle Cell and Thalassaemia, informing it of a pilot screening project commissioned by Nottingham Clinical Commissioning Group Norcomm Cluster Group;
- (f) OSCAR Nottingham's main challenges going forward include helping secure sustainable social and welfare support for people with blood disorders, and to identify further funding streams and efficiencies for general health and wellbeing through bringing together health and social care.

The Panel thanked Mr Galpin and Ms Wells for their informative presentation, and made the following points:

- (g) In response to a Panel member's query, Ms Wells explained that the symptoms include chronic pain, fatigue, dehydration, shortness of breath and palpitations. Because symptoms can be episodic, it can be difficult to maintain jobs or education opportunities, or find appropriate housing that does not exacerbate symptoms;
- (h) It was suggested that OSCAR Nottingham should inform the review of Nottingham's Joint Strategic Needs Assessment to help identify prevalence and gaps in provision;
- (i) It was suggested that GPs sometimes misdiagnose the conditions. While babies and pregnant women are screened, being diagnosed as a carrier of the conditions is not considered a major medical issue by some doctors. Ruth Rigby

of Healthwatch Nottingham advised that issues about specific GPs should be referred to them to help ensure a consistent approach;

- (j) The Chair advised that there is a specialist team of NHS nurses doing outreach work in Nottingham to address blood disorders, including SCD and TM;
- (k) OSCAR Nottingham is involved with the social element of a medical research project on SCD and TM being conducted by De Montfort University;
- (l) A Panel member undertook to raise awareness of the conditions' symptoms among Trade Union colleagues;
- (m) City Council actions to license the private rental housing sector will help improve housing conditions in Nottingham, alleviating SCD and TM sufferers' symptoms.

RESOLVED to note the presentation and Panel members' comments.

55 WORK PROGRAMME

The Panel considered a report of the Head of Democratic Services relating to the work programme for the Health Scrutiny Panel's first meeting in 2015/16. The Panel noted that there will be an extended work programme planning session at the May 2015 meeting.

RESOLVED to note the Panel's work programme.