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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 28 May 2014 from 13.30 - 15.35

Membership

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

Colleagues, partners and others in attendance:

Martin Gawith) Healthwatch Nottingham
Ruth Rigby)

Maria Principe) NHS Nottingham City Clinical Commissioning Group
Naomi Robinson)
Jo Williams)

Rosemary Galbraith - Nottingham CityCare Partnership

Jane Garrard - Overview and Scrutiny Coordinator
Angelika Kaufhold - Overview and Scrutiny Coordinator

1 APPOINTMENT OF VICE-CHAIR

Councillor Thulani Molife was appointed Vice-Chair for this municipal year.

2 APPOINTMENT OF LEAD HEALTH SCRUTINY COUNCILLOR

Councillor Ginny Klein is appointed as Lead Health Scrutiny Councillor

3 APOLOGIES FOR ABSENCE

Councillor Emma Dewinton - Personal
Councillor Ginny Klein – Annual Leave
Councillor Brian Parbutt
Councillor Tim Spencer

4 DECLARATIONS OF INTERESTS

None

5 MINUTES

The minutes of the last meeting held on 12 February 2014 were confirmed and signed by the Chair.

6 HEALTH SCRUTINY PANEL TERMS OF REFERENCE

The Committee considered a report of the Head of Democratic Services regarding the Health Scrutiny Panel Terms of Reference for the Panel and the implications for its operation during the coming year which had been approved at Full Council on 12 May 2014.

RESOLVED to note the Terms of Reference.

7 WALK IN CENTRES

The Panel considered a report updating the progress of the re-modelling of the Walk-in Centres (WIC) in Nottingham and development of a new enhanced Urgent Care Centre from a single site. A joint presentation was made by Maria Principe, Director of Primary Care Development and Service Integration and Naomi Robinson, Primary Care Development and Service Integration Manager. The key points of the presentation included:

(a) A reminder that the reason for this consultation is the contracts for both the Walk in Centre on London Road and the 8-8 Service on Upper Parliament Street are due to end in 2014/15. Due to the complexity of the issues surrounding the two locations and clinical governance issues, it was decided that an open and transparent procurement method was appropriate.

(b) Since February 2014 a period of consultation has taken place including the Clinical Congress, Clinical Council, Councillor Norris as part of his remit of the Chair of the Health and Wellbeing Board, the People’s Council and the Health Scrutiny Panel on 26 March 2014. Other engagement activities with providers, patients and clinicians have been facilitated by the Patient Engagement and Communication teams to explore:

- What an Urgent Care Model should include?
- Define what is meant by good access and opening times
- What the new service could be called

(c) The Feedback received from clinicians, providers and the public through roadshow events. The online survey sent to all GP practices, 3rd Sector Organisations, patient groups and employers received almost 700 responses. The feedback from all the consultation included:

- It is important to assess and treat patients in one visit, reducing the need to refer to other services.
- The opening hours should be consistent.

- Having diagnostic facilities such as X-ray, a plaster room and eye casualty is essential to treat in a single visit and reduce the need to refer non-urgent cases elsewhere.
- The service should be open 7 days a week all year round from 7 or 8 am to 10 or 11 pm and the walk-in no appointment necessary philosophy is important. The idea of 24 hour care created resourcing issues in terms of costs etc.
- The location should be city centre, close to pharmacy provision with parking and public transport, as well as access for drop off/ambulance transfer being critical.
- A strong need for access to urgent dental appointments.
- Survey results showed that 33% of respondents had difficulty accessing primary care services which is why they chose to use the WIC.
- Over 50% of patients stated that assessment should be within 15 minutes to 1 hour, with treatment taking place within 2 hours. 27% recognised the importance of carrying out triage to assess the level of urgency.
- A strong mental health support was also identified by a patient group.

(d) The next steps are:

- To ensure publicity is clear, focused and clarifies the services provided by the new Urgent Care Centre and how this integrates with other healthcare provision services.

- Additional patient/public meetings (on request) for focused discussion and presentation of the urgent care model, especially for those who access emergency services frequently, regular users of walk-in centres and those who had difficulty accessing primary care (GP etc) services such as citizens who are not registered with a GP practice, homeless people and asylum seekers etc.

- The patient engagement report will be finalised and include feedback from surveys, road shows and patient engagement, and will be presented to the CCG governing body and published on the Clinical Commissioning Group website.

- A contract specification will be drafted including the clinical requirements, treatments and diagnostics required for the new service. In June 2014, a Procurement Delivery Group will be established with non-conflicted colleagues including Healthwatch and Patient Groups to review and finalise the specification, challenges and risks.

- The tendering process will start in June with shortlisting of potential providers taking place in July 2014. The procurement panel will include clinical and patient representatives.

- Patients will continue to be involved by:
    - The Procurement Delivery Group will include patient representatives;
    - Focused meetings to take place with patient groups as recommended by the Patient Engagement Report and through discussion with the CCG People’s Council and Healthwatch.

- o Engagement with help from Healthwatch, for patients not registered with GPs such as homeless, asylum seekers who currently represent 16 to 17% of WIC/8-8 attendees.
- o Publicity planning to communicate the changes with a tailored approach to key patient groups. A 'readership panel' will help guide the development of publicity.

During discussion the following additional information was provided:

(e) The majority of the patients accessing the WIC are registered with a GP however, the consultation has showed that a walk in service is still needed for hard to reach groups such as homeless people and asylum seekers etc to access medical care. Further consultation is being carried out with hard to reach groups and Healthwatch are linking in with the CCG to continue consultation for the next two to three weeks;

(f) The option of locating the WIC with the Emergency Department at the hospital was considered but from the consultation it is clear that a city centre location is preferred for accessibility.

(g) The proposal to review the existing contracts and services provided and to locate the current WIC and 8-8 service into a single site is to release funding to expand the services available including diagnostics and X-ray facilities etc. It is not a cost-cutting exercise. All the diagnostic services will be developed over a period of time once the contract has been awarded and staffing is in place.

(h) The new site will be dependent on accommodation availability and it will be a challenge to find a place which is easily accessible for clients using cars and public transport.

RESOLVED to request that a further update on progress, including the service specification for the new contract be submitted to this Panel once available.

8 NOTTINGHAM CITYCARE PARTNERSHIP QUALITY ACCOUNT 2013/14

The Panel considered a report of the Head of Democratic Services relating to the Nottingham Citycare Partnership Quality Account 2013/14. Rosemary Galbraith introduced the Quality Account and confirmed that feedback is welcome. This Quality Account had to be submitted to the Board mid June for sign off before publication on the internet.

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

(a) To increase the level of risk assessments and preventative action to reduce pressure sores, the National Pressure Sore Prevention Strategy is being implemented across all services. Care homes are also required to train staff to carry out risk assessments on residents for pressure sores.

(b) Not all the CQUIN targets have been met and some of these targets such as dementia care are considered to be very ambitious stretched targets. There can be many reasons why targets are missed which include competing priorities and the reasons for missing these will be explored as the year progresses. The CQUIN targets are agreed with commissioners and if missed the organisation will not receive the associated payment.

(c) In response to the Francis Report, the organisation has carried out whole workforce restructuring and provided training for front line staff to keep in line with national staffing guidance. The Board Assurance Framework and Risk Registers are uptodate and data on incident reporting is essential for training purposes, case conferences and serious case reviews.

(d) Part of the Francis Report recommendations is to encourage more open, transparent reporting of risks and incidents and the monitoring levels are low, severe and significant. There is an increase in the number of low level risks being reported and the learning from these is embedded into service development and staff training. One example is staff ensuring that insulin is given at the right time and that triggers are in place to ensure this happens. Serious Incident Reporting guides help staff through the grading and seriousness of events and how to report these.

(e) Complaints relating to waiting times for clinics need to be explored and could be the result of increased access choice, staff shortages or specialists. There has to be a flexible approach and appointments may need to be rearranged if patients arrive within ten minutes of a clinic closing.

(f) The review process to evaluate the CQUIN outcomes includes:

- Exploring action plans and early exception reports;
- Reflecting on what has worked well and sharing this information;
- Reviewing systems and data entry reports on performance and analysis;
- Holding regular meetings with service leads to review reports and progress on targets to ensure they are achievable;
- Share good practice at team and management events and training.

(g) Diet and nutrition are a large part of the Health and Wellbeing agenda and aids recovery when people are ill. Teams need to be vigilant to monitor eating and drinking by patients (including in the care home environment) and CityCare has a dedicated Dietician team to support this. Diet is included as part of patient assessment and has become more complex given the increasing number of allergies that patients present with. CityCare has embedded this into patient care programmes to ensure they receive the right care in terms of nutrition and fluid intake.

(h) Training on dementia care has started and is being rolled out to increase awareness amongst staff.

RESOLVED that Jane Garrard, Overview and Scrutiny Co-ordinator, draft a comment based on the issues identified for inclusion and circulate to the Panel by email for comment prior to final approval by the Chair.

9 ADULT INTEGRATED CARE PROGRAMME

The Panel considered a report of the Head of Democratic Services and joint presentation by Maria Principe, Director of Primary Care Development and Service Integration and Jo Williams, Adult Integrated Care Programme Manager relating to the progress of Adult Integrated Care Programme established in July 2012. In May 2013, the Panel heard that an integrated care model was being developed based around 8 Care Delivery Groups (CDGs) across the City comprising of GP Practices and multi-disciplinary neighbourhood teams of health and social care staff. This model took a new approach to assessment and re-ablement and use of assistive technology. The intention was for this model to be implemented by January 2014. This is a priority in the Joint Health and Wellbeing Strategy to 'improve the experience of and access to health and social care services for citizens who are elderly or who have long-term conditions'. Progress against this theme is due to be reported to the next meeting of the Health and Wellbeing Board in June 2014.

The structure for the integration of the Adult Care Programme is now in place and the next phase is to change the culture and practice. The developments in Phase 2 include:

- Review of specialist services;
- Joint assessment and care planning;
- Developing links with community and voluntary sector to support self care and on-going support.

The following additional information was provided in response to questions:

(a) As part of the project teams have visited other areas of the country to explore how other organisations are integrating these services as well as this project being part of the East of England Kings Fund Network which shares good practice. This project is quite advanced compared to other parts of the country and has involved developing a whole systems model including links and pathways to other services. The project team is receiving requests from other areas to come and see the model developed in Nottingham.

(b) Patients might see many different specialists or support workers at present providing a range of services. The proposal is to move away from having lots of 'specialists' carrying out very specific roles and move to having more 'generalists' who can be upskilled and provide core business such as carrying out assessments for falls when visiting clients. However, this project is in its very early stages and staff have to be engaged and encouraged to develop in this more 'generalist' holistic service delivery. The impact of asking staff to become more 'generalists' than specialists cannot be underestimated and will impact on culture and training. It is acknowledged that people will be proud of the specialisms they have built up and they will need to be supported in expanding their roles. Individuals have been trained as Change Champions

across Health and Social Care to support staff to adapt and this is proving to be a valuable resource.

(c) Feedback will be collected from focus groups of service users to evaluate their experiences of the new integrated service which will be available by the end of this year. An external evaluation of the project is also taking place.

(d) Evaluation of patients experience and satisfaction will be part on an ongoing monitoring process and included in contract management. An interim report by the evaluation team is expected in autumn 2014.

(e) A communication plan is in place with regular 'Connecting Care' newsletters informing stakeholders of developments and now plans are being made for an external communications campaign.

RESOLVED to request that findings of the initial evaluation of the Adult Integrated Care Programme be provided to the Panel when available.

10 NOTTINGHAM CITY HEALTH AND WELLBEING BOARD, HEALTHWATCH NOTTINGHAM AND HEALTH SCRUTINY WORKING AGREEMENT

The Panel considered a report of the Head of Democratic Services relating to a working agreement for the Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny.

RESOLVED

(1) to approve the Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny Working Agreement;

(2) that delegated authority is given to the Health Scrutiny Panel Chair to approve minor changes and updates to the Agreement.

11 GP PRACTICE CHANGE - THE PRACTICE, NIRMALA

The Panel considered a report of the Head of Democratic Services highlighting that NHS England Derbyshire and Nottinghamshire Team has advised of changes to a GP practice in Nottingham – The Practice Nirmala in Bulwell. A six month termination notice has been given to the Area Team by The Practice Nirmala stating they wish to terminate the contract. It had been decided to disperse the registered patient list to other practices when the contract expires following a full Stakeholder Engagement Plan to ensure all stakeholders are kept fully informed and patients supported in finding a new practice.

RESOLVED to

(1) note the information provided and that this information has been circulated to ward councillors in the areas affected; and

(2) inform the NHS England Derbyshire and Nottinghamshire Area Team of the correct names of the local MP and City Councillors.

12 GP PRACTICE CHANGE - MERGER OF BOULEVARD MEDICAL CENTRE AND BEECHDALE SURGERY

The Panel considered a report of the Head of Democratic Services highlighting that that NHS England Derbyshire and Nottinghamshire Area Team had advised of proposals for a merger between the Boulevard Medical Centre and Beechdale Surgery. The briefing provided by the Area Team included proposals for engaging with stakeholders about the proposed change.

RESOLVED to note the information provided and that the information had been circulated to ward councillors in the areas affected.

13 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:

- **Update on progress in developing an Urgent Care Centre including the service specification**
- **Findings of the initial evaluation of the Adult Integrated Care Programme**

14 FUTURE MEETING DATES

RESOLVED to meet on the following Wednesdays at 1.30 pm:

2014	**2015**
30 July	**28 January**
24 September	**25 March**
26 November	