NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 20 October 2016 from 13.30 - 15.25

Membership

Present	Absent
Councillor Anne Peach (Chair)	Councillor Ilyas Aziz
Councillor Merlita Bryan (Vice Chair)	Councillor Carole-Ann Jones
Councillor Jim Armstrong	Councillor Chris Tansley
Councillor Patience Uloma Ifediora	
Councillor Corall Jenkins	
Councillor Ginny Klein	
Councillor Dave Liversidge	

Colleagues, partners and others in attendance:

Councillor Wendy Smith	-	Councillor
Agnes Belencsak	-	Screening and Immunisation Lead, NHS England North Midlands
Helene Denness	-	Public Health Consultant, Nottingham City Council
Sarah Mayfield	-	Screening and Immunisation Manager, NHS England North Midlands
Julie Sanderson	-	Head of Adult Safeguarding and Quality Assurance
Jane Garrard	-	Senior Governance Officer

20 APOLOGIES FOR ABSENCE

Councillor Carole Jones – personal
Councillor Chris Tansley - personal

21 DECLARATIONS OF INTEREST

None

22 MINUTES

The minutes of the meeting held on 22 September 2016 were approved as an accurate record and signed by the Chair.

23 SEASONAL FLU IMMUNISATION PROGRAMME 2015/16

Sarah Mayfield, Screening and Immunisation Manager NHS England North Midlands, introduced the report setting out performance of the seasonal flu immunisation

programme in Nottingham City and work to improve performance, including uptake rates during 2016/17. She highlighted the following information:

a) NHS England is responsible for commissioning all national immunisation programmes. Nottingham City falls within the footprint of NHS England North Midlands. As part of the commissioning process NHS England engages with a range of stakeholders including clinical commissioning groups, local authorities, GPs, school age immunisation providers and pharmacies.

b) Provision of the vaccination by pharmacies is a nationally commissioned service.

c) There is evidence to show that the flu immunisation programme reduces pressure on health services, for example by reducing hospital admissions for flu and complications of flu; and avoidable flu-related deaths.

d) The seasonal flu immunisation programme is focused on groups that are most vulnerable to flu: children aged 2-8 years; children and adults in an 'at risk' category; pregnant women; and over 65's.

e) During 2015/16 more people were vaccinated in Nottingham City than in previous years but because there had been an increase in the number of eligible people this was not reflected in uptake figures.

f) For adults aged 65 years and older, Nottingham City uptake decreased in 2015/16 and was lower than the national average and target.

g) For individuals aged 6 months to 65 years (excluding pregnant women) in 'at risk' categories Nottingham City uptake decreased in 2015/16 and was lower than the national average and target.

h) For pregnant women Nottingham City uptake decreased in 2015/16 and was lower than the national average and target. In a correction to the published report, it was reported that an additional 808 pregnant women would require vaccination in order to reach the 55% target.

i) For children aged 2-4 years Nottingham City uptake was lower than the national average and target.

j) Nottingham City has a lower proportion of the population vaccinated than other Core Cities.

In response to questions, Sarah Mayfield, Agnes Belencsak, Screening and Immunisation Lead NHS England North Midlands, and Helene Denness, Public Health Consultant Nottingham City Council, provided the following additional information:

k) Following a procurement exercise, Nottinghamshire Healthcare Trust holds the contract to deliver vaccinations to school-aged children. However the Trust did not have a previous relationship with Nottingham City schools and it has taken a while to establish working relationships. There has been no opposition from schools regarding this new contract and provider.

l) The pharmacy programme aims to make it easier for people to access flu vaccinations, for example the ability to access a pharmacy near where they work and at a more convenient time for those who work during the day. Initial feedback is that uptake is higher than at the same point last year. This is particularly positive because these are likely to be people who wouldn't otherwise present for a vaccination.

m) NHS England, working with stakeholders, is exploring different ways in which the vaccination programme can be provided to improve accessibility and uptake, for example providing vaccinations at walk-in centres while people are there for other reasons. There are challenges, such as governance and data sharing issues, to overcome when looking at alternative options. The vaccine also needs to be kept refrigerated prior to use.

n) There is sufficient quantity of the vaccine for full delivery of the 2016/17 immunisation programme.

o) It is difficult to provide vaccinations for those not registered with a GP because their details aren't known. NHS England encourages stakeholders to help get such individuals registered. NHS England and Public Health undertook to speak with the homeless health team about vaccinations for homeless people.

RESOLVED to request that NHS England North Midlands and Public Health, Nottingham City Council provide information to the Committee at its meeting in May 2017 on performance of the seasonal flu immunisation programme during 2016/17 with an analysis of the effectiveness of work that has taken place to increase uptake.

24 HOMECARE, SAFEGUARDING AND QUALITY ASSURANCE

Julie Sanderson, Head of Adult Safeguarding and Quality Assurance, presented the report outlining how citizens in receipt of homecare services are responded to when they have concerns about the quality of care or there are safeguarding concerns. She highlighted the following information:

a) The Adult Safeguarding Quality Assurance Team was established in 2012 and oversees Regulated Provider investigations. These are complex investigations with the potential to identify systemic problems. Providers are held to account and the Team monitors work to address identified issues until there is evidence of sustained improvement.

b) Investigations into care provided by Regulated Providers are different to those for safeguarding concerns between, for example, two relatives because Regulated Providers are contractually obliged to deliver a good quality service.

c) A Provider Investigation Procedure has been in place since 2012. A multi-faceted approach to evidence gathering is required and good information sharing is crucial. Following the Provider Investigation Procedure monitoring officers check if improvements have been made, for example improvements to care plans.

d) A pilot is taking place under which citizens receiving care by a particular provider are identified for review, to look at both the care package they receive and the quality of care and whether there are any safeguarding issues. This early intervention approach helps to identify themes. Work then takes place with the relevant provider to address concerns with escalation as appropriate.

e) There are challenges in getting information and evidence from individuals receiving care because they may be reluctant to raise concerns due to the relationship they have with a care provider, or a lack of a social network to support them in making a complaint or raising a concern.

f) Most care providers take safeguarding issues very seriously.

Councillor Wendy Smith attended the meeting and gave an example of the homecare service received by her mother. While Councillor Smith commended the Council's reablement service she highlighted a number of failings with the homecare services that her mother received and her contact with homecare providers. Julie Sanderson commented that the communication problems raised, for example unreturned calls and missed appointments were common issues with many homecare providers, and that the example highlighted why the Safeguarding Team try to be proactive in identifying issues and ensuring providers address them.

In response to comments and questions, Julie Sanderson provided the following additional information:

g) Service quality can deteriorate quite quickly even within a usually good performing provider with a change of manager and/or staff.

h) While experience of the Council's reablement service is generally positive it is important that quality of care is sustained afterwards.

i) Monitoring improvements following an investigation is resource intensive and there are financial pressures on the ability to carry out effective monitoring.

j) NHS Nottingham City Clinical Commissioning Group offers some clinical training e.g. on tissue viability for homecare providers, but generally speaking homecare providers are responsible for training their own staff.

k) It is very difficult to monitor and investigate homecare provision. It is easier to inspect care homes because inspectors can more easily walk into the site and talk to staff and service users.

l) There is a reluctance within the independent sector to provide care for people with complex care needs. It may be necessary for the Council to provide care for such individuals in the future.

m) An in-house Council homecare service would have an incentive to support individuals to get better (and this would help to achieve financial savings) but there is no such incentive for the independent sector to do this because it reduces demand for their services.

n) There is a hidden cost of maintaining the independent sector, for example the cost of carrying out safeguarding investigations and monitoring performance.

o) Service users and their families have differing expectations about the type and quality of care they should be receive. Some safeguarding concerns relate to citizens being coerced into accepting poor care through the development of a co-dependency relationship between carer and service user and the exertion of control by the carer. It can be a closed world unless the service user has family or friends for support or visits from another professional e.g. district nurse.

p) Most safeguarding referrals are made by relatives or health care workers.

RESOLVED to

(1) schedule an item for a future Committee meeting about the current pressures on the homecare market and development of in-house homecare service; and

(2) request data on the length of visits to service users by homecare providers.

25 HEALTH SCRUTINY COMMITTEE WORK PROGRAMME

Jane Garrard, Senior Governance Officer outlined the Committee's future work programme.

RESOLVED to cancel the Health Scrutiny Committee meeting scheduled for 22 December 2016 1:30pm.