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Nottingham City Council

NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY COMMITTEE

Date: Thursday, 23 March 2017

Time: 1.30 pm (pre-meeting for all Committee members at 1pm)

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Corporate Director for Strategy and Resources

Senior Governance Officer: Jane Garrard **Direct Dial:** 0115 8764315

1	**APOLOGIES FOR ABSENCE**	
2	**DECLARATIONS OF INTEREST**	
3	**MINUTES** To confirm the minutes of the last meeting held on 23 February 2017	3 - 8
4	**REDUCING UNPLANNED TEENAGE PREGNANCIES**	9 - 22
5	**MATERNAL HEALTH**	23 - 38
6	**HEALTH SCRUTINY COMMITTEE WORK PROGRAMME**	39 - 46

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NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at LB 41 - Loxley House, Station Street, Nottingham, NG2 3NG on 23 February 2017 from 13.31 - 14.33

Membership

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

Colleagues, partners and others in attendance:

Jane Garrard - Senior Governance Officer
Kate Morris - Governance Officer
Jo Powell - Communications, Nottingham CityCare Partnership
Tracey Tyrrell - Director of Nursing and Allied Health Professionals, Nottingham CityCare Partnership

37 APOLOGIES FOR ABSENCE

Councillor Jim Armstrong - Personal
Councillor Corall Jenkins - Personal
Councillor Dave Liversidge - Personal
Councillor Chris Tansley - Personal

38 DECLARATIONS OF INTEREST

None.

39 MINUTES

The minutes of the meeting held on 19 January 2017 were confirmed as a correct record and signed by the Chair.

40 NOTTINGHAM CITYCARE PARTNERSHIP QUALITY ACCOUNT 2016/17

Tracey Tyrrell, Director of Nursing and Allied Health Professionals, Nottingham CityCare Partnership, gave a presentation introducing Nottingham CityCare Partnership's Quality Account 2016/17. She highlighted the following points:

(a) The information is currently in draft form and in the early stages of going to partner agencies for comment on proposed priorities for 2017/18. The final report is due to be published in June 2017 when it will contain a far more detailed account from 2016/17 and more detail on the agreed priorities for

2017/18. The final report is due to be brought before the Committee at the May 2017 meeting for detailed comment;

(b) Quality Accounts allow local providers of NHS services to report on quality and demonstrate improvements in their services to stakeholders and local communities;

(c) Service quality is measured by patient safety, effectiveness of treatments and patient feedback and engagement about care provided;

(d) Nottingham CityCare Partnership was inspected by the Care Quality Commission (CQC) in late November 2016. The final report and recommendations have not yet been published but the final version of the Quality Account 2016/17 will reflect any recommendations or comments made by the CQC;

(e) Work that has taken place in relation to priorities for 2016/17 has included:

- Care and Support of Staff – looking after the most important asset of the partnership:
    - staff survey – results of which are embargoed until the end of February,
    - "We said, We Did" engagement events with specific events planned following the release of the staff survey at the end of February,
    - workforce strategy plans,
    - development of a Workforce Well-being Group and improvements to the Employee Assistance Programme,
    - development and implementation of restorative and clinical supervision,
- Mental Health knowledge – recognising the importance of having good background knowledge to be able to signpost to services, whilst not being a provider of mental health care:
    - ensuring that specialist training is introduced,
    - recruitment of Specialist Practitioners who are working in the Neighbourhood teams and Children's Services,
- Self-management – promotion of self-care and reducing avoidable harm:
    - additional training to support staff,
    - social needs of patients are identified and patients are signposted to the appropriate service,
    - ensuring that clinicians or social care workers are able to recognise the need for a social prescription,
- Integration with partnership organisations:
    - Duty of Candour embedded across all services,
    - Quality Strategy and Sign up to Safety action plans,
    - Introduction of patient safety walkabouts,
    - Patient safety focused work groups asking patients what being "safe" means to them;

(f) Proposed priorities for 2017/18 are:

- Promoting prevention:

    - Improving mental health and wellbeing,
    - Better signposting to key services,
    - Ensuring that every contact counts,
    - Further promotion of self-care,
- Further integration of services:
    - Focusing on specific services for Children and Young people, and Adults,
- Reducing Avoidable Harm:
    - Learning from incidents,
    - Recognition of deteriorating sick adult or child – staff are more often seeing acutely unwell patients in the community and it is essential that staff are skilled up further to cater for their needs,
    - Focus on Safeguarding for both children and adults.

(g) Through these three priorities a central theme will be equality and diversity which came through at a patient feedback event as an important feature for many patients.

Following questions and comments from the Committee the following information was highlighted:

(h) The patient safety walkabouts have been developed using the same principles as a CQC inspection. Using this toolkit allows teams to ensure safety and assess responsiveness of staff, prevention of infection, and staff engagement with patients;

(i) Consultation on the priorities for 2017/18 has taken place with the Equality and Diversity Group which then feeds into the Board and its detailed Work Plan. Consultation is also taking place with the Patient Experience Group (PEG), but by its nature it is not representative of all groups. Groups consulted so far include:

- Patient Experience Group
- Clinical Commissioning Groups
- HealthWatch groups
- Local community groups;

(j) Citycare Partnership will forward a full list of groups who have been consulted/ are due to be consulted on these priorities to the Committee, and if there are gaps, or if councillors feel that there are groups in the community that should be consulted then this will be fed back;

(k) CityCare work with partners to offer a range of services as commissioned. The range of services provided is changing and some services, such as podiatry, are no longer provided by CityCare because the organisation was unsuccessful in winning the contract. The priority for CityCare is to ensure that the services that it does provide are safe and effective;

(l) Co-location has been successful and it is anticipated that the CQC will endorse this in their inspection report. CityCare is currently on track to achieve its targets around joint staff training and streamlining the service for patients;

(m) Patient satisfaction is high, numbers of complaints remain stable and year on year upheld complaints remain low as do those upheld by the Ombudsman. The level of harm caused remains low. On receipt of the final CQC report it will allow CityCare to compare their statistics to the national averages and these findings can be bought back to the meeting in May;

(n) Pressure sores remain an important focus and will be a major thread within the "reducing avoidable harm" workstream although it isn't currently proposed to be a specific priority. The detail of this will be available for May, however at present the number of grade 3 and grade 4 ulcers has been reduced, but the level of grade 2 ulcers is up. The reason for this increase in grade 2 pressure ulcers is better recognition by clinical staff;

(o) Recruitment of additional district nurses to meet with demand is going well. Although District Nursing is not traditionally a role taken on by newly qualified nurses the partnership are working hard to make it more accessible. They have recently entered into a training rotation with NHS trusts and recruited 16 nurses who will all spend time in the community, in acute medicine and a mental health setting. This training has been enabled by Health Education East Midlands;

(p) Once the Quality Account is completed and signed off it will be published on the website and in paper format. The Partnership will also write out to all stakeholders with a copy and a summary document;

RESOLVED to

(1) thank Tracey Tyrell for her attendance;

(2) invite Nottingham CityCare Partnership back to the meeting in May with the final version of the Quality Account 2016/17 document for comment; and

(3) request that Nottingham CityCare Partnership provide a list of all stakeholders that CityCare have/ will be consulting on its proposed priorities for 2017/18 to enable the Committee to identify if there are any groups that it feels are missing and should be included.

41 FEEDBACK FROM VISIT TO NOTTINGHAM CITYCARE PARTNERSHIP CLINIC AT BOOTS, VICTORIA CENTRE

The Committee provided feedback from its visit to Nottingham CityCare Partnership Clinic at Boots, Victoria Centre on 30 January 2017. Tracey Tyrrell, Director of Nursing and Allied Health Professionals, Nottingham CityCare Partnership, listened to and commented on the feedback. The following points were highlighted during discussion:

(a) the clinic environment was pleasant and spacious but did not seem very busy. It appeared that there was capacity to increase the number of clinics provided at this location;

(b) It was confirmed that bringing in additional services was being considered by Nottingham CityCare and although they are not permitted, under the terms of the lease agreement, to sublet space they are looking at entering into partnership agreements with other service providers to offer services not currently commissioned from CityCare;

(c) Access to the clinic was a little difficult on the Monday afternoon that the Committee visited. The lift was out of order and signage to reach the clinic via stairs was difficult to see and to follow. Councillors felt that there was nothing in the main Boots store to promote the clinic or the services it provides. Improved signage would help those attending the clinic and also make potential patients aware that it could be an option available to them;

(d) There are restrictions on the lease conditions governing what signage CityCare Partnership are allowed to display, but if improvements can be made to the signage then this will be put forward;

(e) General impressions of the clinic were positive, including the location and opening hours (there were later clinics on some days).

RESOLVED to

(1) request that Nottingham CityCare Partnership consider the feedback provided by the Committee and provide a response to the issues raised: and

(2) rearrange the cancelled site visit to Connect House.

42 HEALTH SCRUTINY COMMITTEE WORK PROGRAMME

Jane Garrard, Senior Governance Officer outlined the Committee's future work programme. She reported that the item on improving access to services for people with ME, which had been expected on the agenda for today's meeting, had not been included because Nottingham City Clinical Commissioning Group did not have progress to report on the two areas identified for development: training and education; and continuity of care and access to services. In addition, the current service provided by Nottingham University Hospitals is due to be decommissioned in July 2017 and a new service recommissioned. The Joint Health Scrutiny Committee is leading on scrutiny of a range of services being recommissioned, including the service for people with Chronic Fatigue Syndrome/ ME and therefore it was felt that it would be duplication for the Health Scrutiny Committee to explore the issues further at this time.

Councillors suggested that the Committee consider including the following issues on its work programme for 2017/18:

(a) Social prescriptions – progress in the roll out of social prescribing; and the impact of reducing availability of activities and groups in local communities

(b) Self-management of conditions – the extent to which approaches to self-management are taking into account the needs of specific local communities

RESOLVED to note the work programme.

HEALTH SCRUTINY COMMITTEE
23 MARCH 2017
REDUCING UNPLANNED TEENAGE PREGNANCIES
REPORT OF CORPORATE DIRECTOR FOR STRATEGY AND RESOURCES

1 Purpose

1.1 To review whether the focus and investment in reducing unplanned teenage pregnancies in Nottingham over the last 16 years is resulting in a sustainable reduction in teenage pregnancy rates.

2 Action required

2.1 The Committee is asked to identify whether any further scrutiny is required.

3 Background information

3.1 Teenage pregnancy is a health inequalities issues. Teenage mothers, and children born to teenage mothers are at greater risk of experiencing a range of poorer health and wellbeing outcomes.

3.2 In line with the national Teenage Pregnancy Strategy, published in 1999, reducing unplanned teenage pregnancies has been a priority in Nottingham for a number of years, with focused activity to reduce teenage pregnancy rates.

3.3 Over that time there has been a reduction in the teenage pregnancy rate nationally and locally. In Nottingham the target to halve teenage pregnancy by 2020 was met by 2014, but the England under-18 conception rate remains higher than other Western European countries and the rate in Nottingham is still above the national average.

3.4 The Council Plan 2015-2019 includes a target to reduce teenage pregnancy by a further third.

3.5 The Teenage Pregnancy Taskforce is currently chaired by Councillor Alex Norris, Portfolio Holder for Adults and Health. The role of this Taskforce is to lead and co-ordinate activity locally to reduce teenage pregnancy, improve health outcomes and support teenage parents, including through delivery of the Teenage Pregnancy Plan.

3.6 A paper on work to reduce unplanned teenage pregnancies in Nottingham is attached. The latest data on teenage pregnancy rates is due to be published on 22 March and will be provided at the meeting.

4 List of attached information

4.1 Report on reducing unplanned teenage pregnancy in Nottingham

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Joint Strategic Needs Assessment chapter: Reducing unplanned teenage pregnancy and supporting teenage parents (December 2016)

7 Wards affected

7.1 All

8 Contact information

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jane.garrard@nottinghamcity.gov.uk

9 March 2017

Reducing unplanned teenage pregnancy in Nottingham – a report for the Health Scrutiny Committee

1 Introduction

The term teenage pregnancy includes under-18 conceptions that lead to a legal termination of pregnancy or birth. Teenage pregnancy is an issue of inequality and having children at a young age can negatively influence the health and wellbeing of young women and their children, who are then more likely to become teenage parents themselves.

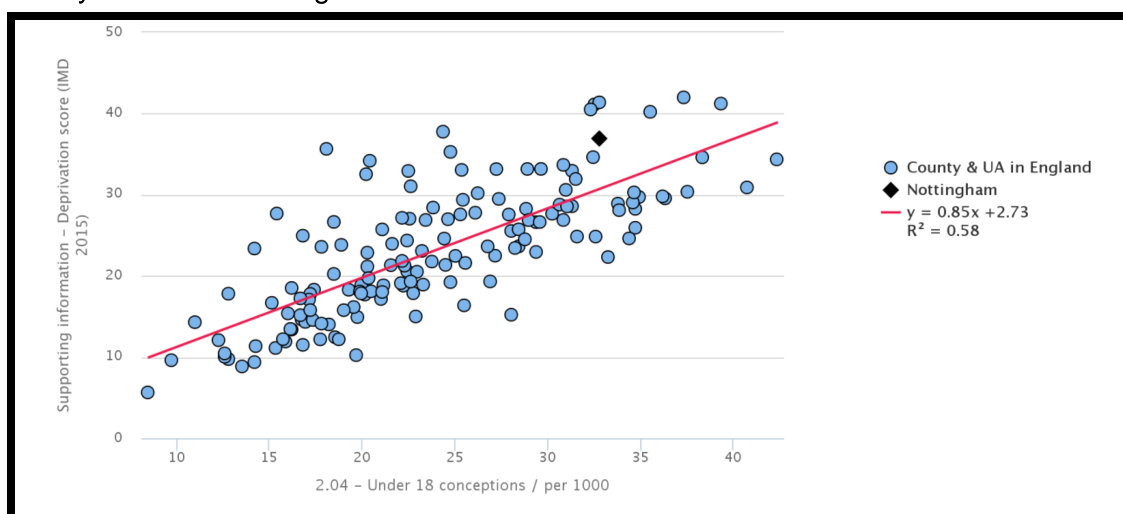
2 National and international evidence

National and international evidence suggests that the majority of girls who conceive under-16 and under-18 do not have specific risk factors. Therefore it is important that we do not concentrate on high risk groups alone. However, some young people are at more risk of teenage pregnancy and will need great support. These risk factors include:

- Pupils eligible for free school meals are twice as likely to conceive by the end of year 11 as those who are not.
- Pupils living in 'deprived' areas are more likely to conceive at age 17 and below; half of all under-18 conceptions occur in the most 20% deprived wards and teenage pregnancy rates are four times higher in the most deprived 10% of wards than in the 10% least deprived. Figure 1 shows the relationship between deprivation and teenage pregnancy in unitary local authority areas across England.
- Pupils who are persistently absent in year 9 are over three times as likely to conceive by the end of year 11 as good attenders.
- Pupils who make slower than expected progress between Key Stage 3 and Key Stage 4 are significantly more likely to conceive and more likely to continue with the pregnancy after conception.
- Girls who attend higher performing schools are less likely to conceive and more likely to have a termination if they do conceive.
- Low maternal aspirations of mothers for their daughters at age 10.
- Young mothers and fathers are twice as likely to have been sexually abused in childhood as the general population.
- Having a previous pregnancy.

It is very important that these risk factors are not seen as causal as a range of confounding factors present may also have an impact on under-18 conception rates. However, communities in Nottingham are subjected to many of these risk factors which could explain the higher than average teenage pregnancy rates in the City.

Figure 1: Relationship between Deprivation and Teenage Pregnancy Rate for County and Unitary Authorities in England



Source: PHOF, Teenage Conception Rate (2014), Public Health England

2.1 Impact on young people and their children

For teenage conceptions that end in a birth, the outcomes are often poorer for mother and child:

- Teenage mothers are twice as likely to smoke before and during pregnancy and three times more likely to smoke throughout the whole of their pregnancy.
- Teenage mothers are a third less likely to initiate breast feeding and half as likely to be breastfeeding at six to eight weeks.
- Babies of teenage mothers have a 56% higher risk of infant death as compared to mothers of all ages.
- Babies of teenage mothers are three times more likely to die from Sudden Unexplained Death in infancy. The reasons for this are complex and include lifestyle factors and late booking for maternity services.
- Children of teenage mothers are twice as likely to be hospitalised for gastroenteritis or accidental injury.
- At age five, children of teenage mothers are four months behind on spatial ability, seven months behind on non-verbal ability and 11 months behind on verbal ability.
- Teenage mothers are three times more likely to experience postnatal depression and have higher rates of poor mental health for up to three years after birth. This is distressing for the young parent, undermines their ability to parent positively and is the most prevalent risk factor for poor child development outcomes.
- Parenting is the biggest single factor affecting children's wellbeing and development. Two in three teenage mothers experience relationship breakdown in pregnancy or in the three years after birth; compared to one in 10 older mothers.
- Children born to teenage mothers have a 63% higher risk of living in poverty.
- One in five girls aged 16-18 not in education, employment or training are teenage mothers.

- Women who were teenage mothers are 22% more likely to be living in poverty at age 30.

3 Teenage Pregnancy in Nottingham

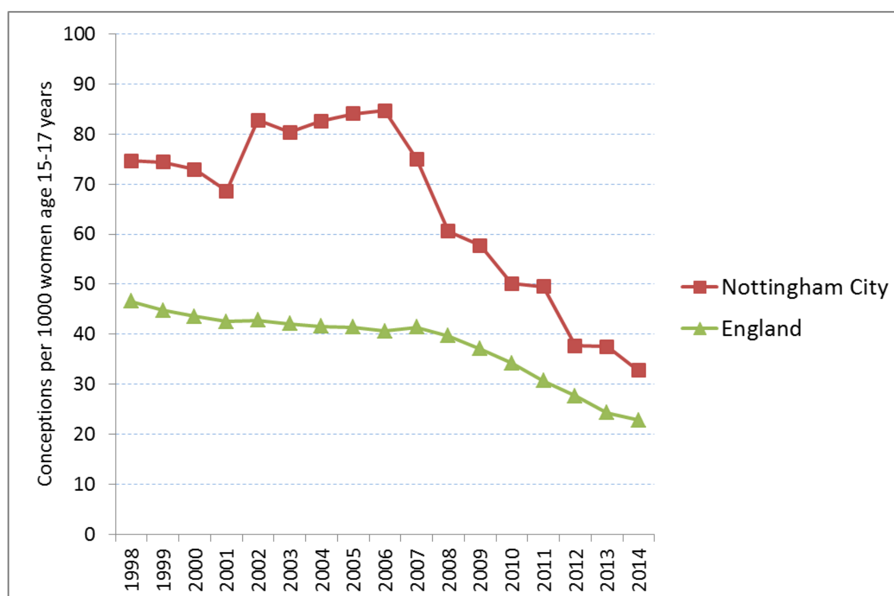
In Nottingham in 2014, the most recently available annual conception data, there was a decrease of 21 conceptions from 181 in 2013 to 160 in 2014 in the under-18 (15-17) year old age group. This represents a rate reduction from 37.5 conceptions per 1000 girls aged 15-17 in 2013 to 32.7 in 2014.

The rate reduction was significant from 2004, when it was 82.6 conceptions per 1000 girls aged 15-17 to 2014 when it was 32.7. Figure 2 shows this rate reduction of 60.4% over the 10 year period.

However, Nottingham's under-18 conception rate is still higher than the England rate of 22.8 conceptions per 1000 girls aged 15-17 in 2014 and the Core Cities average rate of 29.5 per 1000. The England average remains higher than other Western European countries. Nationally, 80% of teenage conceptions are to 16 and 17 year olds and around 20% are to under-16s.

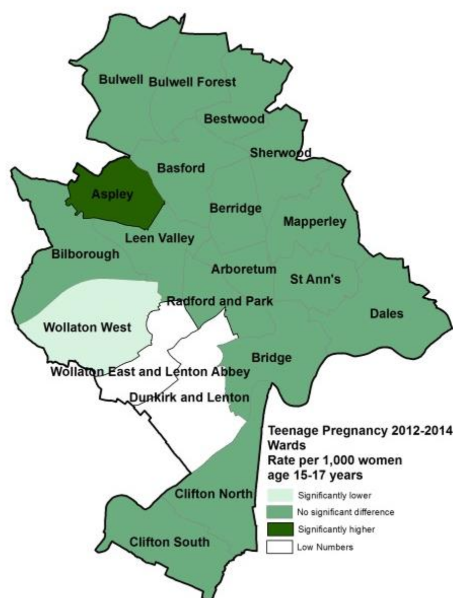
Figure 3 illustrates that the ward with the highest three-year aggregated rates of teenage conceptions, over 2012-14, was Aspley whilst Wollaton West had the lowest published rates.

Figure 2: Teenage Conception Rate trends, 1998 - 2014



Source: Office for National Statistics (2016) [Dataset of conception statistics, England and Wales 2014]

Figure 3: Nottingham ward conception rates 2012 – 2014



Source: Office for National Statistics (2015) Ward conception rates 2009-11, 2010-12, 2011-13 and 2012-14 confidential data.

Please note: the 2015 data will be released on the 22 March 2017; therefore a summary of the latest data will be brought to the committee meeting.

4 What works to reduce teenage pregnancy?

National and international evidence suggests that reducing teenage conceptions is best achieved by:

- Providing comprehensive sex and relationships education in and out of school.
- Providing easy access to, and uptake of, young people friendly contraception and sexual health services.
- Targeting support to those most at risk of teenage pregnancy (please see risk factors in section 3).

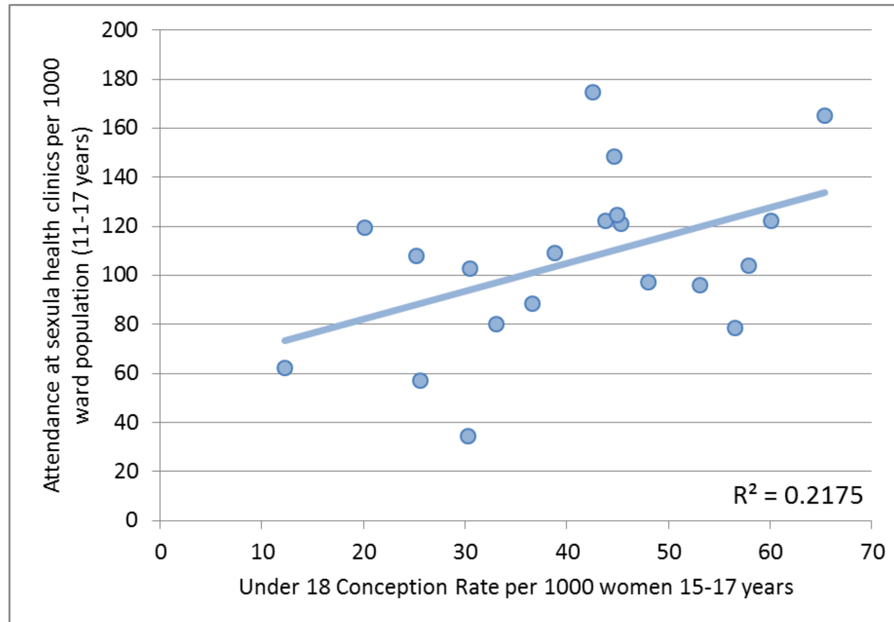
Work to tackle unplanned teenage pregnancy in Nottingham is delivered through universal services for children, young people and families (such as sexual health services) as well as through targeted support for those most at risk (such as the Family Nurse Partnership). Early intervention and primary prevention is central to our approach in Nottingham.

4.1 Primary prevention services

Nottingham City's Sexual Health Services for young people seek to deliver accessible and integrated sexual health services within the community (eg schools and health centres etc) offering advice and support with the full range of

contraceptive services. Figure 4 shows the relationship between attendance at sexual health clinics and teenage conceptions for wards across the City; there was a weak positive correlation between high service uptake and the teenage pregnancy rate.

Figure 4: Relationship between attendance at sexual health clinics and teenage conceptions for Nottingham Wards.



Source: Nottingham City Council service monitoring data.

The **C-Card scheme** provides free condoms to young people aged between 13 and 24 at 37 registration points and a further 50 pick-up points across the City.

General Practitioners provide information and contraception, including Long Acting Reversible Contraception (LARC).

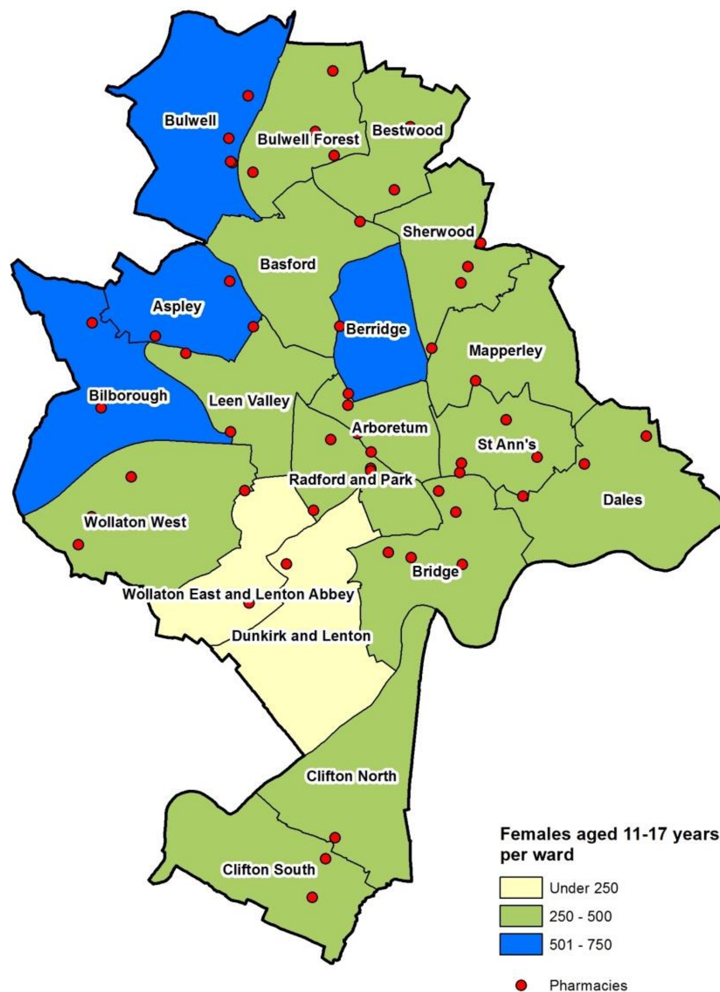
Pharmacies across Nottingham provide a range of services including emergency contraception and pregnancy testing; Figure 5 shows the location of pharmacies offering Emergency Hormonal Contraception in relation to the number of girls aged 11-17 in each ward.

The **Public Health Nursing for school-age children and young people service (formerly known as the School Nursing Service)** provides information and practical support through the delivery of ‘clinic in a bag’.

The delivery of effective **Sex and Relationships Education (SRE)** is encouraged in all schools as an evidence-based approach to reducing teenage pregnancy rates Nottingham City Council. All schools are encouraged to sign up to Nottingham’s SRE Charter to pledge their commitment to effective SRE for all children and young people.

Family and Community Teams have staff trained to deliver sexual health, contraceptive and positive relationships advice for young people aged 13-25.

Figure 5: An illustration of the number of girls living in Nottingham Wards in relation to pharmacies offering Emergency Hormonal Contraception.



Source: Nottingham City Council.

4.2 Early intervention and support

Termination of pregnancy services include counselling and support whilst making a decision and after the decision has been made.

Accommodation services for vulnerable teenage parents and their children have recently been re-commissioned to include sixteen units of self-contained hostel accommodation for teenage mothers and their babies as well as a further four units (at no extra cost) for teenage fathers and / or more confident young women requiring semi-independent accommodation.

The **Family Nurse Partnership** programme provides support and guidance for up to 200 pregnant girls and mothers each year. It is an intensive health visiting programme that visits the teenager from early on in her pregnancy until the child is two years old. The programme aims to enable teenagers to have a healthy pregnancy, improve their child's health and development as well as plan their own futures and aspirations.

The **Education Officer for Teenage Pregnancy** provides one-to-one support for pregnant teenagers and teenage parents to engage in education. The officer monitors the participation and attainment of all pregnant teenagers and school-age parents assisting them to overcome barriers.

The **Teenage Pregnancy Midwifery Service** is available to support all pregnant under-18s offering flexible one-to-one care for teenage parents to increase self-esteem, promote a sense of self-worth and boost their confidence as parents.

5 Current challenges

A 'needs analysis' carried out during the production of teenage pregnancy JSNA chapter identified the following challenges:

- Not all young people have access to comprehensive SRE. Whilst the proportion of schools signing-up to the SRE Charter is encouraging some schools appear reluctant to sign-up; some of these schools are in areas of high teenage conceptions.
- Pupils at Nottingham schools don't have equitable access to sexual health services such as Emergency Hormonal Contraception (EHC) and pregnancy testing on the school site. This is due in part to whether schools find this provision acceptable but also to whether there are sufficient public health nurses to deliver the provision.
- Whilst the majority of the school-age pregnancies are from a White British background as Nottingham becomes an increasingly diverse city there are more conceptions in pupils from BME communities. Current services may need to adapt to meet their needs.
- There is insufficient data to assess the needs of migrants from Central and Eastern Europe who are increasingly featuring in Nottingham's under-16 conception statistics. This is particularly true of Roma families who do not identify themselves as a single, homogenous community.
- With the 14-month time delay in reporting teenage conceptions, it is important to collect more timely local data to accurately inform commissioning decisions. Current systems do not enable the collection of real time data on the number of live births and terminations by ethnicity, age etc. This information would be useful when commissioning services as it would help ensure that services are responsive to need.
- Nottingham's high rate of teenage pregnancy is commensurate with Nottingham's over-representation of structural, demographic and psychosocial risk factors within the population. Long-term strategies are needed to increase the proportion of citizens in employment thus reducing the number of families living in poverty.
- Local intelligence suggests that the needs of teenage fathers are not always recognised. Changes in service delivery are required to better support the engagement of teenage fathers.
- Under-16 year old conceptions are not reducing as rapidly as the 15-17 year olds, the reasons for this are not clear.
- Research suggests that, nationally, teenage conceptions may be reducing due to a fall in traditionally risky behaviours such as drinking and drug taking

(Paton 2016). It is unclear whether this reduction in risky behaviours is reflected in Nottingham.

- More information is needed about the girls for whom their pregnancy does not end in a live birth, including both terminations and miscarriages, as these girls are at more risk of going on and having further pregnancies. This information will enable schools and other providers to put services in place such as intensive SRE, sexual health services and ensure that, where they are statutory school age, the education support officer works intensively with them.
- Further information is needed about the barriers to girls not using, or not effectively using contraception, following a termination. This will enable sexual health services and others to support girls to choose and use contraception that is right for them.
- Sexually transmitted infection rates are high in Nottingham. It is unclear whether the increased use of long-acting reversible contraception is associated with a reduction in condom use in young people aged under-18.
- It is not clear why many teenage parents choose not to return to education, training and/or employment. A better understanding of these reasons would enable schools and colleges to plan effectively to maximise the chances of this cohort of young people.
- It is unclear why fewer girls who become pregnant as a teenager choose to have a termination. It is important that girls have the information that they need in order to make informed choices regarding termination.

6 Addressing the challenges

For each of the unmet needs and gaps identified, recommendations for action were created:

- Encourage every school in Nottingham to sign-up to the SRE Charter; particularly those schools in areas of high teenage conceptions. This work will be strengthened by the Government's announcement to put Relationships and Sex Education on a statutory footing so that every child has access to age appropriate provision in a consistent way from September 2019.
- Encourage all secondary schools to provide access to sexual health services such as EHC and pregnancy testing on the school site in addition to signposting pupils to other sexual health provision in the community.
- Ensure that all services working with children and young people adapt to meet the needs of an increasingly diverse city.
- Encourage services to collect data to assess the needs of migrants from different European communities who increasingly feature in Nottingham's under-16 conception statistics.
- Devise ways of collecting more timely local data to accurately inform commissioning decisions, including real time data on the number of live births and terminations by ethnicity, age etc.
- Increase the number of pregnant teenagers and teenage parents who continue to take part in education, employment or training.
- Encourage services working with pregnant teenagers and teenage parents to support the engagement of teenage fathers.

- Investigate the reasons why under-16 year old conceptions are not reducing as rapidly as those in the 15-17 year old age-group.
- Find out if teenage conceptions in Nottingham, as research suggests at a national level, are reducing due to a fall in traditionally risky behaviours such as drinking and drug taking.
- Find out more information about the girls for whom their pregnancy does not end in a live birth, including both terminations and miscarriages, as these girls are at more risk of going on and having further pregnancies. This information should be used to enable schools and other providers to put services in place.
- Investigate what the barriers are to girls not using, or not using effectively using contraception, following a termination. This will enable sexual health services and others to support girls to choose and use contraception that is right for them.
- Carry out research to establish if the increased use of long-acting reversible contraception is associated with a reduction in condom use in young people aged under-18.
- Establish the reasons why many teenage parents choose not to return to education, training and/or employment to enable schools and colleges to plan effectively to maximise the chances of this cohort of young people.
- Establish why, in Nottingham, fewer girls who become pregnant as a teenager choose to have a termination.

7 Equality and diversity

Several specific pieces of work have been initiated over the last two years to address inequalities in our communities with regard to teenage pregnancy.

In 2015 Professor Yamamoto from the University of Osaka in Japan and Marie Cann-Livingstone carried out focus groups in secondary schools in order to find out about attitudes to sexual risk taking. Firstly, pupils at a school in the West Area of Nottingham raised the issue that they did not know where to go to get sexual health advice and contraception. Further research and scoping took place and Nottingham City Council worked with our sexual health services provider to set up a new clinic in the area; this is now operational and can be seen in Figure 6 along with the other clinic locations across the City.

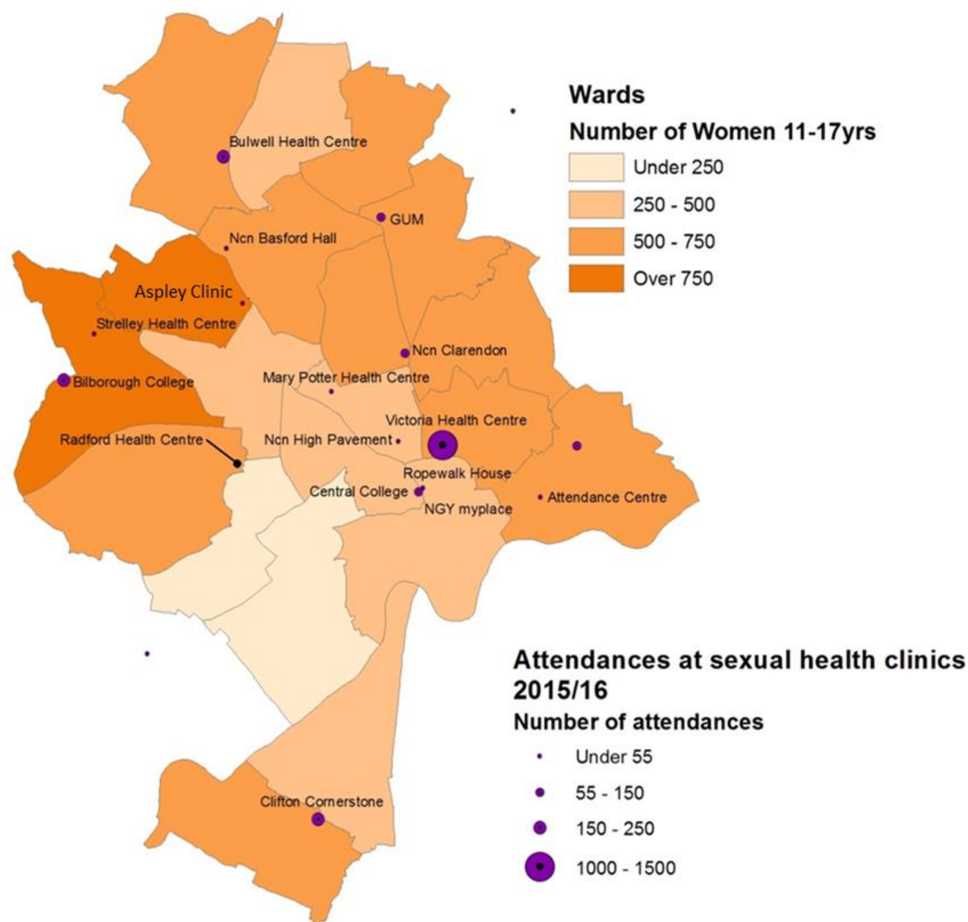
Secondly, two years ago, professionals across the City expressed concern about the increasing number of under-16, Roma pregnancies in the City. The Teenage Pregnancy Taskforce set up a sub-group of professionals to investigate the reasons for this sudden increase and establish what could be done to support these communities. Although numbers are small, and conclusions should be drawn with caution, the number of under-16 pregnancies within these communities appears to be declining.

Over the past year, Nottingham City Council's SRE Consultant has been working to encourage schools to commit to effective SRE through signing the local SRE charter. When schools commit they will need to engage parents and carers to ensure that different faith perspectives are acknowledged and taken into consideration when they are planning and delivering SRE. The SRE consultant is looking into different

ways that she can engage faith groups across the City and is currently working with the Primary Schools Religious Education Adviser from the Catholic Diocese of Nottingham to look at how best to support Catholic primary schools in the City with relationships and sex education.

The University of Nottingham is currently undertaking a piece of research to investigate interventions that improve maternity care for immigrant women in the United Kingdom. The research will be shared with relevant stakeholder in order to increase knowledge and create recommendations for influencing future policy and practice.

Figure 6: Attendances at health clinics across Nottingham's wards.



Source: Nottingham City Council service monitoring data.

8 Summary

Although we have seen a sustained reduction in teenage pregnancy rates in Nottingham over the past 10 years, there is no room for complacency and all organisations and partners must continue to work together to achieve the Council Plan target of a reduction of a further third in Nottingham's teenage pregnancy rate by 2020. The newly released Teenage Pregnancy JSNA chapter and the refresh of the Teenage Pregnancy Plan are central to ensuring that we continue to achieve a sustained rate reduction year-on-year.

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HEALTH SCRUTINY COMMITTEE
23 MARCH 2017
MATERNAL HEALTH
REPORT OF CORPORATE DIRECTOR FOR STRATEGY AND RESOURCES

1 Purpose

1.1 To develop an understanding of the health needs of pregnant women in Nottingham and review the local approach to improving maternal health.

2 Action required

2.1 The Committee is asked to identify whether any further scrutiny is required.

3 Background information

3.1 Pregnant women have particular health needs that need to be met both for their own health and wellbeing and for their health and wellbeing of their future child. Issues associated with maternal health often come up in the course of the Committee's work, for example uptake of seasonal flu vaccinations, perinatal mental health, FGM, levels of smoking in pregnancy; and therefore the Committee decided to make this population group a focus to develop a better understanding of their specific health needs and the extent to which these are being met.

3.2 A paper updating on maternal health in Nottingham is attached and colleagues will be attending the meeting to outline how partners are working together to improve the health and wellbeing of mothers and babies.

4 List of attached information

4.1 Report on maternal health in Nottingham

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 As set out in the attached paper

7 Wards affected

7.1 All

8 Contact information

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HEALTH SCRUTINY COMMITTEE
DATE OF MEETING 23.03.17
TITLE OF AGENDA ITEM Maternal Health in Nottingham City

1 Purpose

The purpose of this report is to provide the Healthy Scrutiny Committee with an update on maternal health in Nottingham City. An integral part of this is to update on the national report '*Better Births, Improving outcomes of maternity services in England: A Five Year Forward View for maternity care'* which was published in 2016[1] and associated action in Nottingham City.

2 Action required

The Committee is asked to scrutinize the local strategic approach to maternal health in Nottingham City and consider actions to improve the health and wellbeing of mothers and babies.

The Consultant in Public Health and colleagues will outline how partners are working together across Nottingham City to improve the health and wellbeing of mothers and babies in order to inform discussion.

3 Background information

3.1 Introduction

Better Births: Improving Outcomes of Maternity Services in England (2016)

Baroness Cumberlege, chaired a review of maternity services in England which culminated in the publication of this report. She acknowledged that the quality and outcomes of maternity care have improved significantly in the 20 years since she oversaw the publication of *Changing Childbirth*. For example, there has been a 20% fall in stillbirth and neonatal mortality rates despite the increasing complexity of many women's health needs.

However the review also found evidence of opportunities for improvement in the safety and quality of maternity services across England and has made the following recommendations that must be delivered by 2020, in line with the *Five Year Forward View* timescale.

[1] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

1. **Personalised Care,** centred on the women, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.

2. **Continuity of Carer**, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.

3. **Safer Care,** with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong**.**

4. **Better postnatal and perinatal mental health care**, to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.

5. **Multi-professional working**, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.

6. **Working across boundaries**, to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

7. **A payment system** that fairly and adequately compensates providers for delivering high quality care to all women efficiently, while supporting commissioners to commission for personalisation, safety and choice.

3.2 Progress in Nottingham and Transformation Programme Structure

In order to implement the recommendations outlined in *Better Births* a local Maternity Transformation Steering Group was established in 2016. The Steering Group has evolved to cover Nottingham City and Nottinghamshire County in order to be co-terminus with the Sustainability and Transformation Plan (STP) and develop a Local Maternity System (LMS), covering a population of 500,000 to 1.5 million, as recommended by the national guidance. Members include CCGs, providers of maternity services and public health.

In Nottingham City, a local maternity review was undertaken in 2013-14 and some progress toward the priorities outlined in *Better Births* has already been made. For example:

Personalised Care

- The launch of two birthing units in 2015 has increased choice for a midwifery-led birth.

- 'Pocket Midwife' app developed by NUH has improved access to locally targeted and free pregnancy information in a digital format.

- Close collaboration between Nottingham University Hospitals NHS Trust and East Midlands' Regional Clinical Network to develop care pathways for high risk pregnancy and foetal medicine.

- 'Partnership in Maternity' (our Maternity Service Liaison Committee) actively engages women across Nottinghamshire through quarterly surveys to capture women's experiences and of specific aspects of maternity care to support service development. The group takes into account the views of service users, in the commissioning and delivery of maternity services. The group draws upon their diverse skills and experiences to influence the development of services for pregnancy, labour, birth and the care of the family up to the end of the postnatal period. The ultimate aim is to improve services for the benefit of users.

Continuity of Carer

- The St Ann's Community Midwifery team undertook a pilot implementing a continuity of carer model which evaluated positively. Satisfaction was high among pregnant women who had antenatal appointments with the same midwife, or a midwife from the same midwifery team. Staff also evaluated the pilot positively. This pilot is being rolled out, with continuous evaluation, across more teams.

Safer Care

- Large numbers of women in Nottingham City are assessed by maternity services as having 'complex social factors', which carries an uplift payment in tariff for antenatal care. In 2016[2] an audit found that 1,605 pregnant women in Nottingham City (out of approximately 4200 births annually) were on complex social factors caseloads and required additional support in pregnancy. This

[2] 2015/16 case file audit undertaken by Public Health, Nottinghamshire County Council (August 2016)

includes pregnant teenagers, refugee/asylum seekers, women identified with substance misuse and those with mental health problems. Fewer women with a complex social factors access maternity services by 12 weeks and 6 days. The learning is being used to improve pathways and services; and will require a multi-professional, multi-agency approach to address improving early access to maternity services for these women.

- Regularly monitoring access to maternity services by 12 weeks 6 days, as per NICE guidelines, in the contract performance. The reasons for late access are subject to ongoing review, including by audit.

- Glucose Tolerance testing is offered in the community for women at risk of gestational diabetes.

Better Postnatal and Perinatal mental healthcare

- A steering group was established in 2016 in order to implement an improved pathway across Nottingham and Nottinghamshire, with clinical, provider and commissioning representation.

- The pathway will provide support for all women from preconception care (targeting women of child bearing age and women having mental health medication), antenatal care from a midwife and up to 1 year post-birth.

- Developing screening algorithm and tool for mental health to facilitate direct referral from midwives and health visitors to Improving Access to Psychological Therapies (IAPT).

- Improving information sharing to ensure women can be supported and treated in the right place, and all health professionals can escalate quickly to perinatal psychiatry and the Mother and Baby unit where required.

Multi-professional working and working across boundaries

- Developed pathways into maternity services for women with high risk pregnancy and foetal medicine.

- Developing improved pathways into perinatal mental health support and care pathways for women with complex social factors, including promoting earlier access, as described above.

- Women can access maternity services directly by telephoning the local midwifery team to increase access to a booking appointment by 12 weeks and 6 days.

3.3 Integrated Assessment Framework

The Improvement and Assessment Framework (IAF) in 2016/17 included four indicators for maternity services. Performance in Nottingham City CCG on stillbirths and neonatal deaths and for smoking in pregnancy are not at the expected standards and are an area of focus (data for stillbirths relates to 2014/15). Performance in the Care Quality Commission Survey of women's experience and choice is on par with rates nationally, and is regarded as 'good'.

3.4 Actions being taken to improve performance

Perinatal deaths (stillbirths and deaths within 28 days of birth)

The Secretary of State announced a national ambition to halve rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030, with a 20% reduction seen by 2020.

In-conjunction with the CCG and Nottingham University Hospitals NHS Trust Nottingham City Public Health Team is undertaking a review of perinatal deaths, including stillbirths, to identify any themes and consider any actions that need to be taken to reduce the number of perinatal deaths. The review will report in April 2017.

In addition to this, providers have been asked to review their systems and processes against the recommendations outlined in *Saving Babies Lives* (2016). This was the 'care bundle' to prevent stillbirth and neonatal deaths published by the National Review team, which recommends best practice to be implemented in health surveillance, care and support to reduce the modifiable risk factors associated with still birth and neonatal deaths e.g. undetected poor foetal growth and smoking in pregnancy. This will be reviewed in May 2017.

Smoking at Time of Delivery

In Nottingham City in 2015/16 18.7% of mothers were smokers at the time of delivery which, as figure 1 illustrates, is higher than the regional and England average. In addition, local intelligence suggests that rates of maternal smoking vary significantly across the city with more mothers smoking in Bulwell and less in Wollaton.

2.03 - Smoking status at time of delivery 2015/16 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	67,195	10.6*	10.6	10.7
East Midlands region	↓	5,833	13.7*	13.3	14.0
Derby	→	445	14.2	13.0	15.5
Derbyshire	↓	1,065	14.2	13.5	15.1
Leicester	→	583	11.4	10.6	12.3
Leicestershire	↓	705	10.0*	9.3	10.7
Lincolnshire	–	-	*	-	-
Northamptonshire	↓	1,168	13.9	13.1	14.6
Nottingham	–	800	18.7	17.5	19.9
Nottinghamshire	–	1,177	14.5	13.8	15.3
Rutland	–	-	*	-	-

Source: Calculated by KIT East from the Health and Social Care Information Centre's return on Smoking Status At Time of delivery (SSATOD)

Figure 1: Proportion of mothers smoking at the time of delivery
Source: Public Health Outcomes Framework

Nottingham City CCG has received £75,000 from NHS England to support local plans to address the high maternal smoking rates. This funding will be used to support the purchase of carbon monoxide monitors, health promotion resources and training for midwives both in the use of equipment and in engaging with women who may be smoking in pregnancy. Implementation of the agreed actions will be monitored by a sub-group of the Local Maternity System Meeting which meets bi-monthly, with representation from Public Health, the CCGs and providers.

Smoking in Pregnancy by Ethnicity[3]

Medway maternity data[4], 2014-15, shows that 53% of all the 4,203 live births were to 'any BME' identifying mothers (including White Other). 45% of live births were to White British mothers; 27% of these births were to British mothers who smoked. The largest BME pregnant smoker group were women who identified as Mixed Race accounting for 16.5% of the total pregnant smoker population.

As figure 2 illustrates, information on the smoking status at time of delivery by ethnicity is not well recorded. Further investigation would provide a more accurate representation of what proportion of pregnant smokers are from White British or BME groups and enable the targeting of interventions towards these groups.

[3] This information is taken from a Health Equity Audit undertaken in 2016
[4] Nottingham University Hospital's maternity data recording system

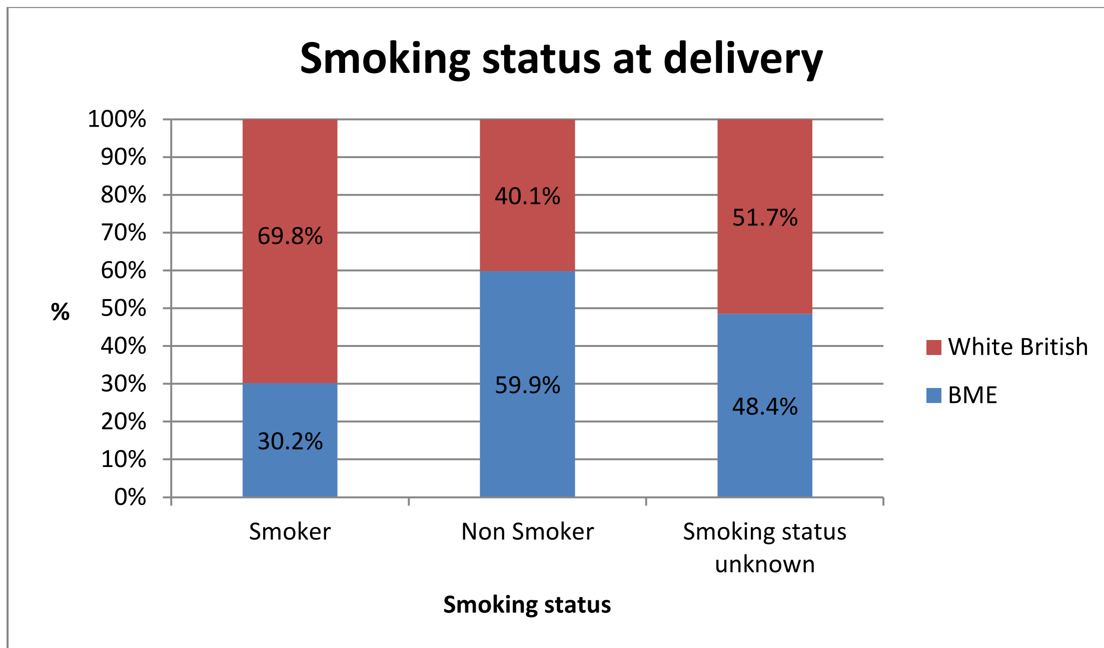

Figure 2: *Proportion of white British and BME pregnant women within Nottingham CCG, smoking status recorded at delivery.*
Source: Medway Maternity April 2014 - March 2015.

An analysis of the ethnicity data from both New Leaf stop smoking service and Medway maternity data from NUH shows that of all the pregnant women referred to the New Leaf programme, the uptake from White British mothers has been the least successful. 68% of mothers who were smokers at the time of delivery were White British but a lower proportion of pregnant smokers (63%) were accessing New Leaf compared to the non-pregnant female population (76%). This evidence suggests more work need to be carried out to further engage white British pregnant smokers with the New Leaf smoking cessation programme.

Equity of Access/Vulnerable women with complex social factors

Women with complex social factors are far less likely to seek antenatal care early in pregnancy or to stay in contact with maternity services. Delays in accessing maternity care often results in worse outcomes for both mother and baby. The four key groups (Table 1) highlighted in the recent Confidential Enquiry into Maternal and Child Health (1) reports as having poorer pregnancy outcomes were:

1) *Women who misuse substances (alcohol and/or drugs)* - maternal misuse of drugs during pregnancy increases the risk of low birth weight, premature delivery, perinatal mortality and Sudden Infant Death (SIDs) (1).Structural damage to the foetus is most likely during 4-12 weeks of gestation; drugs taken later can affect growth or cause intoxication or withdrawal syndromes (1). Alcohol is classed as a Teratogen which causes harm to the foetus by interrupting the correct coding of

amino acids which leads to the development of abnormal proteins and ultimately damages the frontal lobe of the brain. The function of the frontal lobe of the brain is executive function for example development of sensory processes and the development of fine motor skills.

A number of risks are associated with drinking alcohol during pregnancy, including:

- Increased risk of miscarriage.

- Risk of Foetal Alcohol Syndrome (FAS) whose features include: growth deficiency for height and weight, a distinct pattern of facial features and physical characteristics and central nervous system dysfunction.

- Risk of Foetal Alcohol Spectrum Disorders (FASD), Alcohol Related Birth Defects (ARBD) and Alcohol Related Neurodevelopment Disorder (ARND) – which do not show the full characteristics of FAS and develop at lower levels of drinking.

- Increased risk of learning disability (without either of the above conditions).

It is estimated that approximately 1% of deliveries are to women with drug misuse problems (2) and a similar number to problem alcohol users. A recent cross sectional study found a quarter of women reported drinking alcohol despite being aware they are pregnant report.

2) *Women who experience domestic abuse* - A number of studies suggest there can be an increased incidence of domestic violence during or shortly following pregnancy.

3) *Women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English*- Black African women including asylum seekers and newly arrived refugees have a maternal mortality rate nearly six times higher than white women (1). In addition, it has been found that the proportion of infant deaths is disproportionately higher than amongst other ethnicities. It is estimated that births to African-Caribbean, non-EU and Asian (Pakistani, Indian, Bangladeshi) born women total around 10.2% of total births (1).

4) *Young women aged under 20* - Teenage mothers are at increased risk due to late presentation and the mother's lifestyle and diet. The proportion of births to women under-20 years in England was 5.2% during 2013.

Table 1 gives estimates the number/proportion of live births for the four main exemplar groups of women considered in the guideline on ‘Pregnancy and complex social factors’ (NICE clinical guideline 110).

Group	Percentage (estimate)	Number of births
Women who misuse substances (alcohol and/or drugs)	4.5%	30,200
Women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English	10.2%	68,400
Young women aged under 20	6.1%	40,900
Women who experience domestic abuse	7.0%	47,000

Table 1: Breakdown of births in England by exemplar group
Source: NICE, 2010. Costing statement: Pregnancy and complex social factors (2)

It should be recognised that vulnerable women may experience a number of complex social factors at the same time.

In addition to the above, the national maternity pathway payment system also identifies that pregnant women with a learning disability, who are homeless and where there are safeguarding concerns will also require increased support.

Complex social factors in Nottingham City

Table 2 shows the number and percentage of pregnancies to women in Nottingham with complex social factors during 2014/15.

Complex social factor	**Number (%) of births** *(Number of births = 4886)*
Aged under 20 years	313 (6.4%)
Recent migrants, asylum seekers or refugees, or those who have difficulty reading or speaking English	319 (6.5%)
Experiencing domestic abuse	Data not available
Misuse substances (drugs or alcohol)	113 (2.3%)
Learning disability	35 (0.7%)
Homeless	Data not available
Mental health issues	864 (17.7%)

Table 2: Number (and percentage) of pregnancies to women with complex social factors (2014/15)
Source: NUH Medway Maternity data

The rise in fertility rates as in part, been due to increased migration. Ten countries joined the European Union in 2004, and another two in 2007. In 2013, 32.7% of Nottingham's births were to mothers born outside of the UK, a slight increase from 2012 (31.8%), and more than double the percentage in 2001 (14.5%)[x].

The Office for National Statistics (ONS) estimated that the City gained 5,190 people due to international migration in 2013/4 alone. The number arriving from the EU Accession countries was 2,690. The majority of these were from Poland (1,750) but there was a notable increase in migrant workers from Romania (320 - up from 83 the previous year). However, migration flows from Eastern Europe have slowed down in recent years (1) . Migrants from EU Accession countries were predominantly aged less than 35 years old.

In October 2014, there were 779 asylum seekers residing in Nottingham city who have been assessed as destitute and are in receipt of housing or financial support from UK Visas and Immigration (UKVI) (Formerly UKBA). This figure excludes asylum seekers who are not assessed as destitute, refugees, failed asylum seekers and unaccompanied minors. This data provided by the Home Office provides a point prevalence of the number of asylum seekers receiving support at any one time, and does not show the number of asylum seekers arriving in an area, or the number ceasing to receive support due to either positive or negative asylum decisions. This number has increased steadily over the last year. Numbers are expected to continue to rise: the Home Office anticipates a 10-15% rise over the course of 2015 in the number of asylum seekers requiring support. More detail is given in the Asylum seekers, refugee and migrant health (2015) chapter of the JSNA.

Women accessing maternity services from a BME heritage

There were 4203 births between April 2015 and March 2015. Table 3 shows the number of births from BME women and overall percentage of deliveries to women from BME communities. 8.9% of births were from women with a Pakistani heritage followed by 6.4% from White and Black Caribbean and 6% African heritage.

Mothers Ethnic Category	Values	Percentage of total deliveries
Pakistani	377	8.9%
White and Black Caribbean	273	6.4%
African	253	6.01%
Any other ethnic group	165	3.9%
Any other mixed background	161	3.83%
Any other Asian background	136	3.2%

Indian	111	2.6%
White and Asian	71	1.69%
Caribbean	69	1.64%
White and Black African	54	1.2%
Any other Black background	48	1.14%
Chinese	35	0.83%
Bangladeshi	17	0.4%

Table 3: Number and percentage of births from BME women in Nottingham City
Source: NUH Medway maternity data

The University of Nottingham is currently undertaking a piece of research to investigate 'interventions that improve maternity care for immigrant women in the United Kingdom (UK)'. A narrative synthesis systematic review is being undertaken that will effectively generate better understandings and recommendations for influencing policy and practice. The findings will be shared with relevant stakeholders to maximise transfer of the knowledge into practice. Public health and the CCG are both represented on the expert reference panel for this research.

4 List of attached information

None

5 Background papers, other than published works or those disclosing exempt or confidential information

None

6 Published documents referred to in compiling this report

Better Births https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

Public Health Outcomes Framework http://www.phoutcomes.info/public-health-outcomes-framework

Nottingham City Pregnancy JSNA Chapter
http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottingham-JSNA/Adults/Pregnancy.aspx

7 Wards affected

All

8 Contact information

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References

1. **Council, Nottingham City.** *Pregnancy Joint Strategic Needs Assessment.* Nottingham : Nottingham City Council, 2015.
2. **National Institute of Health and Care Excellence.** *CG110: Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors.* London : NICE, 2010.

HEALTH SCRUTINY COMMITTEE
23 MARCH 2017
WORK PROGRAMME 2016/17
REPORT OF CORPORATE DIRECTOR OF STRATEGY AND RESOURCES

1. Purpose

1.1 To consider the Committee's work programme for the remainder of 2016/17 based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

2. Action required

2.1 The Committee is asked to note the work that is currently planned for the municipal year 2016/17 and make amendments to this programme as appropriate.

3. Background information

3.1 The Health Scrutiny Committee is responsible for carrying out the overview and scrutiny role and responsibilities for health and social care matters and for exercising the Council's statutory role in scrutinising health services for the City.

3.2 The Committee is responsible for setting and managing its own work programme to fulfil this role.

3.3 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately. This is likely to include consultations from health service commissioners and providers about substantial variations and developments in health services that the Committee has statutory responsibilities in relation to.

3.4 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.5 The work programme for the remainder of the municipal year is attached at Appendix 1.

3.6 In April 2017 the Committee will be considering the development of its work programme for 2017/18 so councillors are asked to start thinking about the key issues and priorities for the Committee to focus on for the forthcoming year.

3.7 Nottingham City and Nottinghamshire County Councils have established a Joint Health Scrutiny Committee which is responsible for scrutinising the

commissioning and delivery of local health services accessed by both City and County residents.

4. List of attached information

4.1 Appendix 1 – Health Scrutiny Committee 2016/17 Work Programme

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 Reports to and minutes of the Health Scrutiny Committee during 2016/17

7. Wards affected

7.1 All

8. Contact information

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Health Scrutiny Committee 2016/17 Work Programme

Date	Items
19 May 2016	• **Nottingham CityCare Partnership Quality Account 2015/16** To consider the draft Quality Account 2015/16 and decide if the Committee wishes to submit a comment for inclusion in the Account (Nottingham CityCare Partnership) • **Homecare Quality** To review the performance and contract management for home care services by the Council's Contract and Procurement Team (Nottingham City Council) • **Response to recommendations of the End of Life/ Palliative Care Review** To receive responses to recommendations of the End of Life/ Palliative Care Review and determine timescales for review of implementation • **Work Programme 2016/17**
30 June 2016	• **Urgent Care Centre** To review operation of the Urgent Care Centre, with a focus on usage; access to the Centre; patient experience and feedback; impact on primary care and emergency care services; and future developments. (Nottingham City CCG, Nottingham CityCare) • **Development of Health and Wellbeing Strategy** To respond to consultation on development of the Health and Wellbeing Strategy (Health and Wellbeing Board) • **Work Programme 2016/17**

Date	Items
21 July 2016	• **Scrutiny of Portfolio Holder for Adults and Health** To scrutinise the performance of the Portfolio Holder for Adults and Health against relevant Council Plan priorities (Nottingham City Council) • **Healthwatch Nottingham Annual Report** To receive and give consideration to the Healthwatch Nottingham Annual Report (Healthwatch Nottingham) • **Work Programme 2016/17**
22 September 2016	• **Adult Integrated Care Programme** To review progress in delivery of the Adult Integrated Care Programme and the impact for service users; and to look at the Equality Impact Assessment for Assistive Technology (Nottingham City CCG) • **Work Programme 2016/17**
20 October 2016	• **Seasonal flu vaccination programme** To review the uptake of the seasonal flu vaccination programme during 2015/16; and how effective action to improve uptake has been (NHS England, NCC Public Health) • **Homecare Quality – Adult social care and safeguarding perspective** To review the role of adult social care and safeguarding teams in ensuring the quality of homecare services meets the needs of service users (Nottingham City Council) • **Work Programme 2016/17**

Date	Items
24 November 2016	• **End of Life/ Palliative Care Review – Implementation of Recommendations** To scrutinise implementation of agreed recommendations • **Nottingham Homecare Market** To consider how the Council is responding in the immediate and longer term to pressures in the homecare market to minimise the impact on citizens. (Nottingham City Council) • **Work Programme 2016/17**
22 December 2016 **CANCELLED**	
19 January 2017	• **GP Services in Nottingham** To review work taking place to ensure that all residents have access to good quality GP services now and in the future. a) Update on GP service provision from NHS Nottingham City Clinical Commissioning Group b) Report from Healthwatch Nottingham on GP services • **Feedback from regional health scrutiny chairs meeting** (Chair) • **Work Programme 2016/17**
23 February 2017	• **Nottingham CityCare Partnership Quality Account 2016/17** To consider performance against priorities for 2016/17 and development of priorities for 2017/18

Date	Items
	(Nottingham CityCare Partnership) • **Feedback from visits to Nottingham CityCare Partnership services – Connect House and Partnership Clinic at Boots, Victoria Centre** • **Work Programme 2016/17**
23 March 2017	• **Health needs of pregnant women** To develop an understanding of the health needs of pregnant women in Nottingham and review how services are being commissioned to meet those needs, with a focus on reducing health inequalities (Public Health Nottingham City Council/ Nottingham City CCG) • **Teenage pregnancy rates** To review whether the focus and investment in reducing teenage pregnancy over the last 10 years has resulted in a sustainable reduction in teenage pregnancy rates (Public Health Nottingham City Council) • **Work Programme 2016/17**
20 April 2017	• **Next Phase Integrated Care** To hear about the next stages in implementing integrated care (following the Integrated Care Programme) including commissioning of a Multispecialty Community Provider (Nottingham City CCG) • **Work Programme 2017/18** To develop the Committee's work programme for 2017/18

To schedule

- **Diagnosis of terminal and/or life altering conditions**
  To identify what follow up and support is provided to people diagnosed with terminal and/or life altering conditions and their carers; and how this can be improved.
- **Current and future capacity within the care home sector**
- **Cardio-vascular disease/ stroke**
  To review how effective work to reduce levels of CVD/ stroke is in the City

Visits
- Urgent Care Centre – prior to Urgent Care Centre item at June Committee meeting. 15 June
- Connect House – postponed and being rescheduled
- CityCare Partnership Clinic, Boots Victoria Centre 30 January

Items scheduled for 2017/18

May 2017
- **Seasonal Flu Immunisation Programme 2016/17**
  To review the performance of the seasonal flu vaccination programme 2016/17 and the effectiveness of work to improve uptake rates
- **Nottingham Homecare Market**
  To review the effectiveness of work that has taken place since November 2015 in response to pressures in the homecare market; and the development of longer term plans to address pressures in the homecare market.
- **End of Life/ Palliative Care Review – Implementation of Recommendations**
  To receive update from NUH on progress in implementing agreed recommendation
- **Nottingham CityCare Partnership Quality Account 2015/16**

June 2017
- **Self Harm and Suicide Prevention**
  To review approaches to preventing self harm and suicide in the City, in the context of the Wellness in Mind Strategy, Suicide Prevention Strategy and the Joint Health and Wellbeing Strategy
- **Urgent Care Centre**
  To review performance of the Urgent Care Centre against expected outcomes
- **Scrutiny of Portfolio Holder for Adults and Health**
  To scrutinise the performance of the Portfolio Holder for Adults and Health against relevant Council Plan priorities

July 2017

- **Healthwatch Nottingham Annual Report 2016/17**
- **Improving access to assistive technology**
  To review progress in improving access to assistive technology, with a particular focus on equality groups and how access can be improved for groups that are currently under represented amongst service users

October 2017

- **Access to dental care**
  To review whether access to, take up and quality of NHS dental services has improved since scrutiny's review of dental care in 2009
- **Carer Support Services**
  To speak with commissioners and providers (Carers Federation and Carers Trust) about new carer support services and review plans to ensure that carers' needs are met.

January 2018

- **GP Services in Nottingham City**
  To review current provision and quality of GP services in the City