NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 19 April 2018 from 1.32pm - 3.38pm

Membership

Present	Absent
Councillor Anne Peach (Chair)	Councillor Merlita Bryan
Councillor Patience Uloma Ifediora	Councillor Jim Armstrong
Councillor Chris Tansley	Councillor Ilyas Aziz
Councillor Carole-Ann Jones	Councillor Jackie Morris
Councillor Adele Williams	Councillor Ginny Klein
Councillor Eunice Campbell	
Councillor Brian Parbutt	
Councillor Georgia Power	

Colleagues, partners and others in attendance:

David Pearson - Lead for Nottinghamshire STP) Sustainability and Transformation
Dr Stephen Shortt - Clinical Lead) Partnership (STP) and Greater
Rebecca Larder - Director of Transformation) Nottingham Integrated Care
Steve Thorne - Communications and Marketing) System (ACS)
Councillor Nick McDonald - Portfolio Holder for Adults and Health
Alison Challenger - Director of Public Health
Jane Garrard - Senior Governance Officer
Catherine Ziane-Pryor - Governance Officer

71 APOLOGIES FOR ABSENCE

Councillor Ginny Klein)
Councillor Jim Armstrong) Personal
Councillor Jackie Morris)

72 DECLARATIONS OF INTEREST

None.

73 MINUTES

Subject to including Caroline Shaw's comment 'there wasn't enough spare capacity in the system to cut beds' within minute 68, 'Response to Pressures on Urgent and Emergency Care Services in the Post-Christmas Period', the minutes of the meeting held on 22 March 2018 were confirmed as a true record and signed by the Chair.

74 SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP AND GREATER NOTTINGHAM ACCOUNTABLE CARE SYSTEM

David Pearson, Lead for Nottinghamshire Sustainability and Transformation Partnership (STP), Dr Stephen Shortt, Clinical Lead for STP and Greater Nottingham Integrated Care

System (ICS), Rebecca Larder, Director of Transformation STP/ ICS, and Steve Thorne, STP Communications and Marketing, were in attendance to update the Committee following their last attendance at the 23 November 2017 Committee meeting.

A presentation was delivered and is circulated with the initial publication of the minutes. The following points were made and questions from the Committee responded to:

(a) The Sustainability and Transformation Partnership includes the aligned Greater Nottingham Clinical Commissioning Groups Nottingham North and East Clinical Commissioning Group (CCG), Nottingham West CCG, Nottingham City CCG and Rushcliffe CCG. As funding for health services is reduced, (with a funding gap of £314m projected by 2020/21) but the population rising and patients' needs are changing and increasing, savings need to be found. It is proposed that this can be achieved by developing better integrated care systems and services, streamlining patient flow, simplified commissioning and applying a 'Right Care at the Right Time and in the Right Way' approach;

(b) The STP is still at an early stage of development but progress to date has been achieved by considering the broader patient pathway, reviewing practices and streamlining care procedures. However, the STP is mindful that no statutory authority can concede its responsibility to another organisation;

(c) Governance arrangements across the STP have been examined and are subject to more thorough scrutiny and the positive engagement of patient and advice groups. The STP needs to work together to address the challenges of health and wellbeing, care quality, affordability and culture. Further details can be found in the presentation and it is noted that the STP refers to organisations which have been benchmarked as providing 'a well-managed and joined up system' with the aim of providing 'best practice care' and creating the 'optimum business structure';

(d) Evaluation of positive achievement is considered by outcomes and system level metrics. It's important to ensure that appropriate and compatible IT systems are in place across the Partnership to enable the required level of detailed information to be captured and inform further changes;

(e) The integrated framework (further detail is provided in the presentation) focuses on the three headings of 'best practice care, optimal infrastructure and operating /governance model' which are reliant on workforce and cultural change;

(f) New approaches to commissioning are also being considered and the STP is involved in a National Pilot of Independent Individual Commissioning for children and adults which started with 89 engagements but now involves more than 2,000 individuals;

(g) Professionals from different specialisms have been brought together to work to benefit those most vulnerable to admission to hospital, not only to benefit potential patients, but also to save money on high cost hospital care and reduce the financial strain on social care budgets. More effective and co-ordinated hospital discharge procedures and admission prevention measures of providing the right support at the right time, has reduced admission and re-admission to hospital. In Rushcliffe alone, where the Advanced Care Care-Home model is operating (having been initiated in the City) there was a 49.5% reduction in admittance to hospital for the most vulnerable patients. This

system is now being rolled out across Mid-Nottinghamshire and Sherwood, and has already achieved a 26.1% reduction in hospital admissions;

(h) Some scheduled stakeholder information and engagement events to which councillors had been invited have been cancelled due to the evolving governance structures. However, if it can be determined that the meetings are useful, then there may be capacity for them to be re-established but it should be noted that other stakeholder events are taking place so the opportunity to inform and engage still exists, just in a slightly different format;

(i) Councillor's comments that the City Council, and possibly other Councils, will not be in a financial position to contribute to the transformation programme, including for Social Care due to budget cuts, are noted. All partners will remain responsible for maintaining their statutory duties, but the intention is that all partners work together in a joined-up approach to support the redesign of systems and improve overall efficiency and ensure that services are as cost efficient as possible. In March 2017 the Lancet reported that due to a rising population and increasing demand, a further 25% of funding/resources would be necessary to maintain services by 2025. This figure can be reduced but funding and sustainability is and remains a major topic. The Government is due to issue a Green Paper on Social Care this summer which will be interesting, but at this point there are currently no guarantees with regard to future funding. It is vital that all partners work together to identify and apply the best possible model of care, both financially and for the health care of the population;

(j) The STP sets a coherent direction of travel for community and NHS commissioned services which is given priority when commissioning services. A consistent approach to commissioning is necessary but with consideration to balancing budgets and following the direction of travel;

(k) Significant cuts to Public Health's early intervention services were found to be necessary but there must be evidence of success before there is any potential consideration of re-establishing any early interventions, to ensure that funding provides the best possible value;

(l) It is difficult to establish a single point of contact across the whole system when organisations work differently with their own systems and procedures. Ideally a single new system across all partners and organisations would re-align communication paths and resolve disjointed practices. Hospital integrated discharge has been a success in the partnership as information is in one place and patients follow a specific pathway. However, there is much work to be done to streamline primary care communications and systems whilst being risk aware;

(m) There had been a proposal to reduce the number of beds at QMC by 200 but nothing will be done until there are satisfactory alternative community services available. The Trust's Annual Report provides information on what it plans to achieve with examples of implications and benefits. NHS England has issued interim guidance that beds cannot be withdrawn until alternative provision is in place. At the moment beds are definitely required so there are no immediate proposals to 'close' any;

(n) The length of patient's hospital stay has been reduced which in turn has helped improve the performance of A&E. During the winter period all beds were in use which illustrates the level of flexibility needed;

(o) Resources is a national debate which is likely to be on-going for quite some time, but everyone needs to ensure that the resources available are used as effectively as possible for the best outcomes;

(p) The new systems thinking approach was applied to primary care during the busiest period of the winter crisis, when GP appointments were available in the evenings and at weekends. Pro-active multi-discipline models of care are essential going forward.

Members of the Committee welcomed the update but expressed concern that whilst saving NHS funding, some money saving alterations to NHS health systems could result in significant financial implications to the Public Health and Social Care budgets for which additional funds were not available. Added to which funding is not available from the City Council to support the transformation process.

RESOLVED

(1) to note the update and thank contributors for their attendance;

(2) for a further update to be provided to the 18 October 2018 meeting, or earlier if any significant issues occur.

75 SCRUTINY OF PORTFOLIO HOLDER FOR ADULTS AND HEALTH

Councillor Nick McDonald, Portfolio Holder for Adults and Health, was in attendance to summarise to the Committee the work that had been undertaken within the Portfolio during the past year and what is intended for the forthcoming year.
Alison Challenger, Director of Public Health, was also in attendance and assisted in delivering a presentation which will be included in the initial publication of the minutes.

The following points were highlighted and responses given to the Committee's questions:

(a) Some tough decisions have been made in the past year and whilst it's interesting to hear the discussion on the Sustainability and Transformation Partnership (STP), the achievement of some of the objectives should be considered with scepticism as progress has been slow. Public Health and the Health Scrutiny Committee need to remain involved in the STP and be clear about what they require from the STP;

(b) At the start of the financial year, there was a funding gap of £10.5m due to mis-communications regarding the STP, but as a result of the significant action taken in relation to Public Health services, next year's budget is robust and there is confidence at the projections for future years;

(c) The challenge for Local Authorities is not just regional and the decisions requiring service cuts have been difficult but it is necessary to set a sustainable budget for social care services, independently of any potential savings or costs connected to the STP. As it's unknown what level of savings may be created through the STP, there is no guarantee that Public Health will receive any funding for preventative work, even though investing in prevention provides the best value for money;

(d) Social Care services cannot be delivered in the same way as previously and significant changes will have to be made, including modernising services. There is still

much work to do but new pathways will need to be established and different models of service delivery introduced;

(e) The 3 year Adult Social Care Strategy 'Better Lives, Better Outcomes' needs to be progressive and take control of the agenda with the Transformation Programme for 2018/19 delivering the strategy. The STP focuses on challenges elsewhere and does not directly seek to address Social Care challenges;

(f) Since its transfer to Local Authority responsibility, difficult decisions about public health have been required to ensure services can be maintained. Reconsideration of the treatment and approach to Public Health is required both within the City and the Council in that Public Health needs to be fundamental and a priority to all City Council services with health and wellbeing principles and interventions embedded across the Council;

(g) Upscaling of prevention work is required with NHS partners who will need to contribute resources and/or financially as although it's acknowledged that they too are subject to reducing budgets, preventative work will save them money in the long term. Finance from acute services could be transferred to early intervention and preventative work which in the longer term would be far more effective financially and for citizens;

(h) Community assets need to be used to the best effect by 'sign-posting' citizens to raise awareness of available services;

(i) Privatisation of services, including within the NHS must be avoided as creating successful systems has been achieved elsewhere;

(j) Fluoridisation of the City's water is a controversial topic with anti-fluoride groups being very vocal in opposition to any suggestions. However, given the significance of the poor dental health in the City and the resulting negative health implications, in the opinion of the Portfolio Holder, fluoridisation would be undeniably beneficial to dental health in the City;

(k) The change in policy for Adult Social Care transport relates to those service users who are capable of travelling on public transport being expected to do so following training and initial support. It is not sustainable to provide taxi travel as a default position for the whole of someone's life; it's not good for the service and does not promote independence for service users. Each case will be considered individually and where it's not appropriate for the service user to use public transport, a taxi will be provided;

(l) The lines of communication need to be improved between partners of the Health and Wellbeing Board. Very difficult decisions had to be made with regard to drug and alcohol and smoking cessation services and although sought, there was no way found to mitigate the action finally taken. Public Health are in discussions with the CCG and partners as how they may be able to support these areas;

(m) Some difficult decisions have been made with regard to traditional services as priority must be given to statutory responsibilities. This been a lot of work on re-profiling the public health grant which has resulted in a different approach to that of the NHS and a greater emphasis on prevention across society which links into employment and health, housing and health and air quality and health;

(n) As smoking contributes to broader health issues, Public Health is working with commissioners to locally source smoking cessation services but with a better understanding of the context of who smokes and who wants to quit. It is anticipated that any new service will operate a different model to the recently decommissioned 'New Leaf' service with a more detailed understanding of where patients come from, and what they are returning home to;

(o) The 'Clean Air Zone' which will come into effect in the City will have broader implications than just on buses and diesel engines. Although on the agenda for some time, there will be a push to change the culture of communities and what we can achieve as individuals. Public consultation will start during the summer to gain a better understanding of what this means to citizens and how they believe they will be impacted and contribute. GPs will also be asked about what they advise patients with asthma;

(p) With regard to the lack of NHS occupational health or well-being services available to employers in Nottingham, this can be raised with the Health and Well-Being Board. Many employers are realising the value of providing preventative and health support to staff in the form of occupational health type services;

(q) Promoting and enabling independence with care of patients in the community is cheaper and more beneficial for patients. It will be difficult to develop as citizen's needs continue to increase and more patients are becoming sicker than before with more complex needs. A holistic streamlined approach with a review of pathways is required. Prevention is vital as is finding issues before they escalate to serious health conditions. This must be built into all pathways and systems, not just as an add-on the service.

A member of the Committee commented in regard to employment and health, that large local employers often provide their own occupational health services, which whilst previously provided by the third sector, are now generally commissioned from the NHS at a local level. It is a concern that there were no NHS occupational health providers in Nottingham and therefore their organisation's employees are expected to travel to Leicester where the service is available. This often results in employees often not taking advantage of a service which employers pay for, which in turn may impact on the health and well-being of employees and citizens. This is an obvious gap and weakness in services so maybe it could be suggested to NHS partners that here is a business opportunity for Nottingham based services which could also benefit citizens at no cost to the NHS?

RESOLVED to note the update and schedule further discussion with the Portfolio Holder for Adults and Health about progress within their Portfolio at the 18 October 2018 meeting.

76 HEALTH SCRUTINY COMMITTEE WORK PROGRAMME

Jane Garrard, Senior Governance Officer, presented the work programme schedule for 2018/19 and requested the Committee's comments and suggestions.

In addition to scheduling an update on the STP and ICS and the Portfolio Holder responsible for Health to attend the 18 October 2018 meeting, the following topics were suggested for scrutiny:

Waiting times and access to Nottinghamshire Healthcare Trust Services

Workforce challenges and work to address this, including the STP Workforce work-stream. The Chair suggested that as workforce issues are a broader regional issue, it could be suggested for regional level scrutiny at a Regional Scrutiny Chairs meeting.

Further to the Committee's resolution (minute 45 regarding 14/12/17) to ensure that a co-ordinated approach is taken to scrutiny of University Hospitals of Leicester NHS Trust's provision of Level 1 congenital heart disease services, the Chair informed the Committee that the Joint Committee of Leicestershire County Council, Leicester City Council and Rutland Council Health Scrutiny Committee had confirmed that they will be undertaking this work to ensure that the NHS England standards are met. The Chair believed that contributing the work to retain congenital heart disease services in the region was one of this year's achievements by the Committee for citizens.

RESOLVED to note the Committee's proposed work programme for 2018/19.

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Greater Nottingham: Work to date & progress in last 6 months

19 April 2018

STP The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Nottingham City Council

Nottinghamshire County Council

NHS

Greater Nottingham

- 730,000 diverse population
- Nottingham City and South of Nottinghamshire County
- £1.3 billion annual health and social care budget
- Complex health and social care landscape
- Part of wider Nottingham and Nottinghamshire Integrated Care System

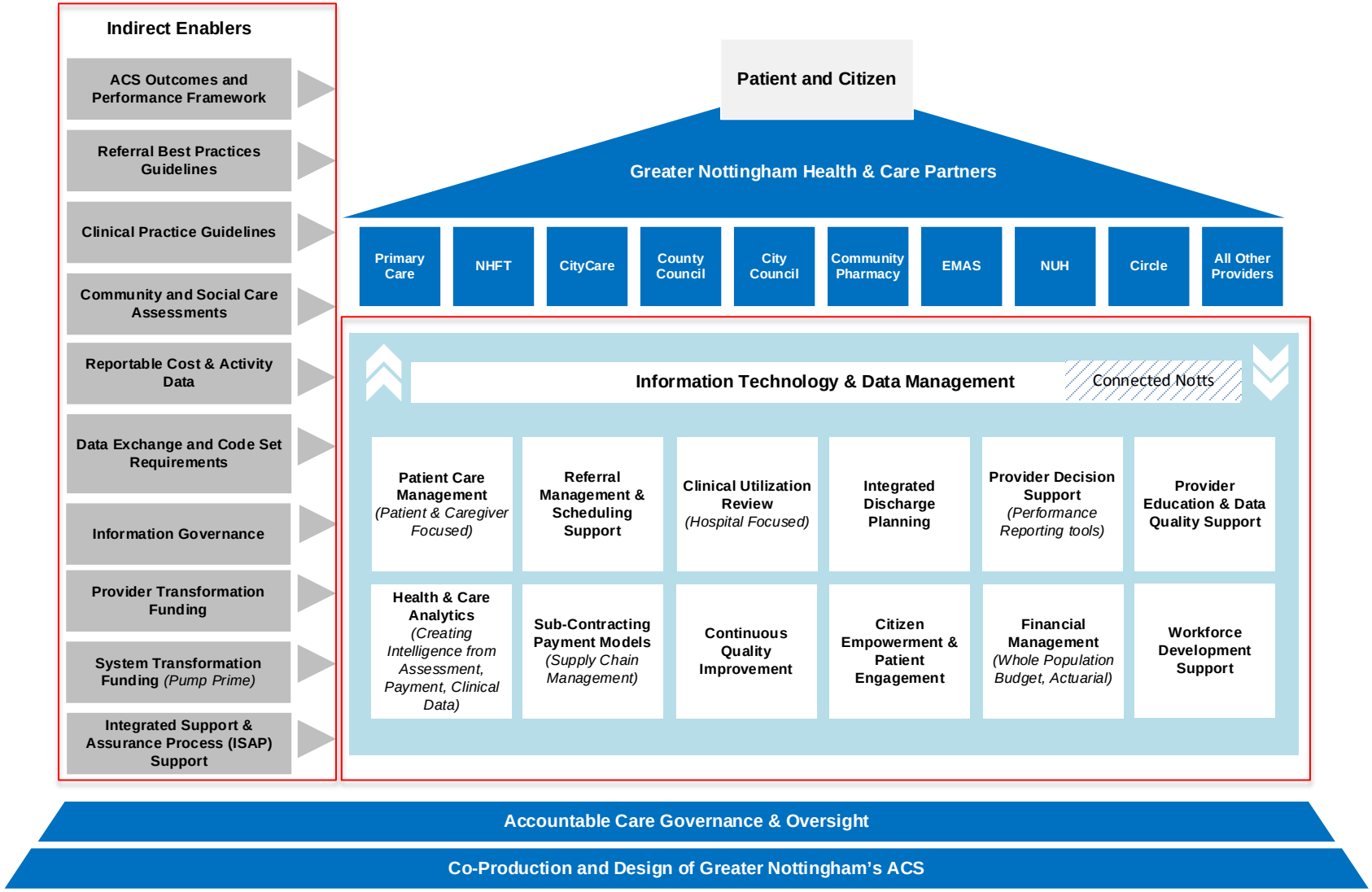
Our challenges

- **Health and wellbeing:** Local healthy life expectancy is too low
- **Care and quality:**
  - High mortality rates for patients with long-term conditions
  - elderly and frail spend too much time in hospital
  - urgent care pathway doesn't achieve national standards
  - Health problems are diagnosed late – often in crisis – leading to avoidable hospital care and worse outcomes
- **Affordability:** Current funding gap projected to grow to £314m by 2020/21 unless we make radical changes
- **Culture:** limited track record of delivering major whole system transformational change

Phase 1 : value opportunity 2016

- Greater Nottingham organisations collectively completed an actuarial analysis
- Provided the opportunity to understand where user activity & costs are in the system with the identification of the opportunities to move to person and population-centred care (i.e. reshaping the care system, with a specific focus of tailoring services to the user groups with the biggest value opportunity)
- This analysis provided a starting point that would enable decisions to be informed by patient / population and system value, rather than organisational benefit

Phase 2 : Designing an integration framework late 2016 to mid 2017



Phase 3: progressing the framework: 2017/18

Best practice care (inc.)	Optimal infrastructure (inc.)	Operating / Governance model
• Population health management • Standardised pathways • Patient flow (levels of care) • New models of cross organisational care (e.g. Integrated Discharge)	• IMT and data management • Reportable quality, activity and cost data • Financial management on whole population basis	• Integrated, strategic commissioning • Provider partnership • System integration i.e. ongoing management of a set of integration functions and activities

Workforce and Cultural Change

Best practice care (inc.)	Optimal infrastructure (inc.)	Operating / Governance model
• Population health management • Standardised pathways • Patient flow (levels of care) • New models of cross organisational care (e.g. Integrated Discharge)	• IMT and data management • Reportable quality, activity and cost data • Financial management on whole population basis	• Integrated, strategic commissioning • Provider partnership • System integration i.e. ongoing management of a set of integration functions and activities

Best practice care

Early success: Integrated discharge

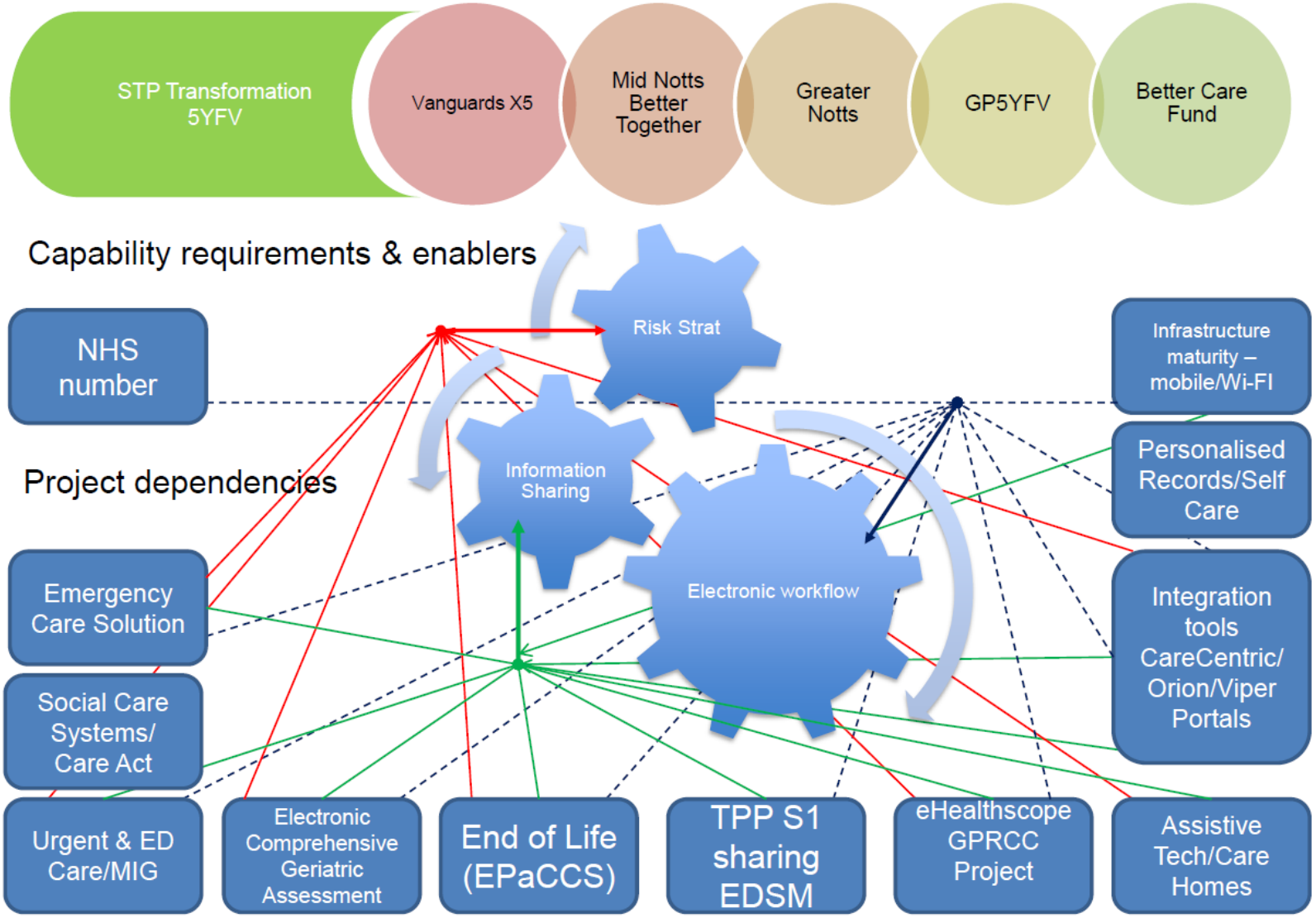
- Integrated Discharge work-stream looks at the way people go home from hospital (with a ‘Home First’ priority):
  - No one stays in hospital more than 24 hours of being identified as medically safe to go home
  - Long-term care needs assessed at home rather than in hospital (unless best interests are to remain in hospital)
  - Patients and carers involved in all discussions
- Work included:
  - Single point of access and for health and social care
  - Care plan in place within 14 hours of admission to hospital
  - 44 referral forms for hospital reduced to just one form
- **Results:** Target of 180 supported discharges per week – now reaching 240 (week before Christmas 2017 saw 362 supported discharges, compared to 182 same week in 2016)

Best practice care (inc.)	Optimal infrastructure (inc.)	Operating / Governance model
• Population health management • Standardised pathways • Patient flow (levels of care) • New models of cross organisational care (e.g. Integrated Discharge)	• IMT and data management • Reportable quality, activity and cost data • Financial management on whole population basis	• Integrated, strategic commissioning • Provider partnership • System integration i.e. ongoing management of a set of integration functions and activities

Optimal Infrastructure

Analytics and Information Systems: Infrastructure

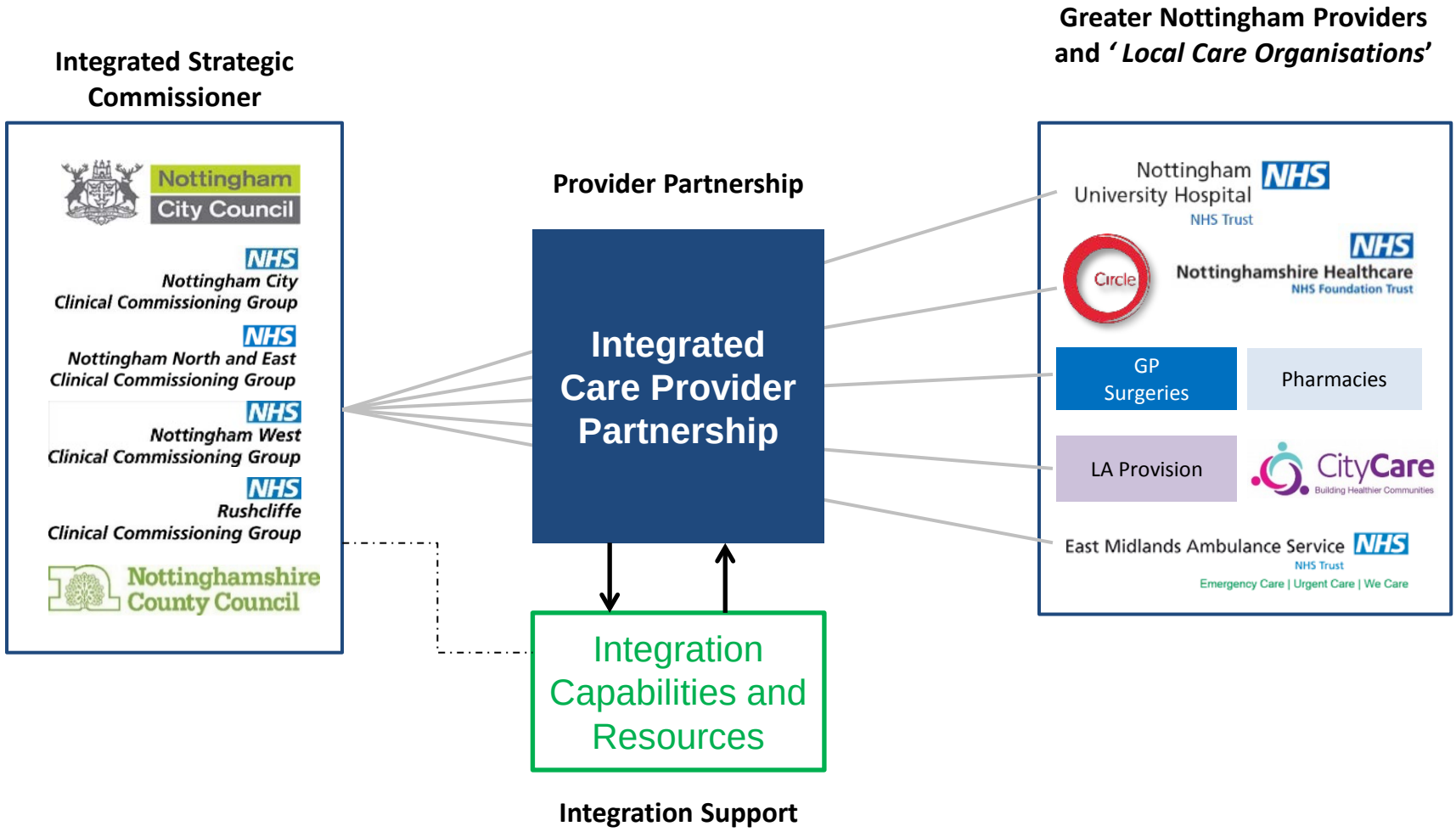
Work building on our ‘Connected Notts’ IMT programme



Clinical service model (inc.)	Optimal infrastructure (inc.)	Operating / Governance model
• Population health management • Standardised pathways • Patient flow (levels of care) • New models of cross organisational care (e.g. Integrated Discharge)	• IMT and data management • Reportable quality, activity and cost data • Financial management on whole population basis	• Integrated, strategic commissioning • Provider partnership • System integration i.e. ongoing management of a set of integration functions and activities

Operating / Governance model

Developing Operating Model



Communications and engagement

- Lay and elected member oversight
- Greater Nottingham Transformation Board
  - Lay representation and HealthWatch
- Greater Nottingham Citizens Advisory Group and STP-level non-exec group
- As part of communications work we have started regular public meetings led by the four Greater Nottingham CCG clinical leads
- First was at Albert Hall, and then Radcliffe. Over 100 attendees at each – lots of helpful feedback and input which has been fed into the workstreams
- Next is in Beeston on 10 May, 1-4pm

Work continues on…

- Implementing best practice aligned to our ICS work-streams
- Developing optimised system infrastructure inc. IT
- Exploring the route to new commissioning arrangements and provider partnerships in line with national guidance
- Determining the integration capabilities and resources needed to support these new models are best achieved
- Strengthening leadership & governance for each stage of the transformation journey
- Continue to engage citizens to help define and steer these changes

City Health Scrutiny Committee

- In due course, seek advice on the level and timing of engagement / consultation activities as plans are developed in more detail
- Request the opportunity to share the emerging case for change and options later in the year

Questions

stp@nottscc.gov.uk
0115 9773577

www.greaternottinghamtransformation.co.uk

Health Scrutiny - 19th April 2018

Councillor Nick McDonald, Adults & Health

Adults – Review of 2017/18

1. New Transformation Programme: Better Lives, Better Outcomes in place.

2. New Pathways established for citizens: older people, long-term, learning disability, mental health.

3. Community Led Support approach underway: pilot site in Aspley “Community Together Surgery”.

4. Move to Whole Life Disability Approach and aligned services by April 2018.

5. Waiting times for citizens have reduced.

Adults – What's coming in 2018/19

1. Portfolio Holder 3 year strategy for Adult Social Care to include: values, "Better Lives, Better Outcomes", our Contact with citizens and Community Led Support, a focus on the quality of services.

2. Transformation Programme for 18/19 to deliver strategy is in place.

Adults - Challenges

- Financial, demand and transformation pressures in Health - costs transferring from health to social care.

    e.g. Transforming care, speedier discharge from acute hospital, mental health services under pressure due to waits for psychiatric beds / ambulances.
- Demand is increasing both in terms numbers and complexity of need and therefore cost.
- Pace of change needed to deliver savings is unprecedented.
- Reductions in front-line staffing.
- Additional Better Care Fund from Spring budget 17 (£7.2m) helped with budget gap but did not stretch to fund increased demand.

Public Health – Review of 2017/18

1. Commissioned new integrated service for 0-19's
2. Successfully applied to be regional Time to Change Hub
3. Health & Wellbeing Board partners committed to tobacco control and physical activity & nutrition declarations
4. Increased take up of flu vaccination amongst vulnerable groups
5. Identification and implementation of targeted intervention savings – contributing to Councils budget

Public Health – What's coming in 2018/19

1. Develop a Public Health strategy for the Council which will inform the remodeling of services to ensure they meet demand / positive outcomes whilst being affordable
2. Take a health in all policies approach across the council – maximizing opportunities to positively impact health and wellbeing across the full breadth of council services
3. Integrated Care System – focused on work on prevention
4. Continued development work with the Health and Wellbeing Board
5. Focus on key areas:
    - Alcohol
    - Air quality
    - Childhood Obesity
    - Mental Health

Public Health – Challenges

- Embedding health and wellbeing principles and interventions across the Council will require significant work
- Upscaling prevention in the system – working alongside our NHS partners (including the Integrated Care System and Health & Wellbeing Board
- Develop approaches that build on existing community assets
- Remaining outcomes focused to maximize impact of available budget

ICS Challenges

Significant investment made locally in understanding the necessary functions required to integrate the system, and the evidence to support a whole population based health and care system

Challenges to our Integrated Care Partnership development:

- Ensuring integration works
- Avoiding ‘privatisation’
- **Whole** system not just health system
- Transitioning resources from acute to community
- Restructures and governance
- Embedding an early intervention and prevention ethos