NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 18 October 2018 from 1.30pm to 4.21pm

Membership

Present	Absent
Councillor Anne Peach (Chair)	Councillor Ilyas Aziz
Councillor Merlita Bryan (Vice Chair) (minutes 34 -42 inclusive)	Councillor Chris Tansley
Councillor Eunice Campbell-Clark (minutes 36-43 inclusive)	Councillor Brian Parbutt
Councillor Ginny Klein	Councillor Andrew Rule,
Councillor Georgia Power	Councillor Mohammed Saghir
Councillor Adele Williams (minutes 36-43 inclusive)	
Councillor Cate Woodward	
Councillor Jim Armstrong	

Colleagues, partners and others in attendance:

Councillor Sam Webster - Portfolio Holder for Adult Social Care and Health

Michelle Malone	- Interim General Manager Adult Mental Health	) Nottinghamshire Trust) Healthcare NHS
Luba Hayes	- Head of Performance	) Foundation
Cheryl Gresham	) Associate Chief Pharmacists in	) Greater Nottingham
Beth Carney	) Medicines Management	) Clinical Commissioning
Hazel Buchanan	- Director of Strategy and Partnerships	) Partnership
David Pearson	- STP Lead	) Sustainability and
Rebecca Larder	- South Nottinghamshire Director	) Transformation Partnership
Caroline Shaw	- Chief Operating Officer	) Nottingham University Hospitals
Julie Pomeroy	- Non-Executive Director of NUH Board	)
Nicky Powell	- Program Director of Urgent Care	- Greater Nottingham Clinical Commissioning Partnership
Sarah Collis	- Chair	- Nottingham and Nottinghamshire Healthwatch
Zena West	- Senior Governance Officer	
Cath Ziane-Pryor	- Governance Officer	

34 APOLOGIES FOR ABSENCE

Councillor Chris Tansey - personal
Councillor Saghir - other Council business
Councillor Andrew Rule - personal

35 DECLARATIONS OF INTEREST

None.

36 MINUTES

The minutes of the meeting held on 20 September 2018 were confirmed as a true record and signed by the Chair.

37 NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST WAITING TIMES

Michelle Malone, Interim General Manager for Adult Mental Health, and Luba Hayes, Head of Performance, were in attendance to update the Committee on the current position regarding waiting lists for Mental Health Services as a response to the Healthcare Trust's priority 'to reduce waiting times in services where delays in access could potentially cause harm, and to improve the experience whilst waiting'.

Whilst the report provides an outline view and statistical information, the following points were highlighted:

(a) The data provided in the report relates to patients referred to services between April and August 2018;

(b) Complaints by service users and careers regarding waiting times have fallen from 280 in 2016/17 to 210 in 2017/18, with the service quality rating remaining consistent at 91.3% for 2017/18 and the first year quarter of 2018/19;

(c) The target for referral to treatment of patients is 26 weeks but locally the target is set at 18 weeks, and of the 3,202 patients referred during April to August 2018, 97.07% were assessed within18 weeks, 2.93% were assessed within 19-26 weeks, and 1.40% were assessed after 26 weeks. By August 1,269 patients were still waiting to be assessed;

(d) There is a 2 week target for Early Intervention Psychosis, which is met for 53% of patients;

(e) For Improving Access Psychological Therapies (IAPT) the 6 week access target of 75% is exceeded at 82%;

(f) There are 4 Local Mental Health Teams which deal with referrals from GPs having first received primary care but needing further help. There is a small number of referrals which are not seen within 26 weeks but this can be for a variety of reasons including that patients want to see a specific gender doctor, elective waiting, and lack of appointment availability;

(g) It is proving very difficult to recruit Consultant Psychiatrists but as a result of vacant posts (particularly in 'Step 4') locums and non-medical prescribers have been appointed. It is predicted that once the newly appointed consultants are in post during late October, waiting lists will be a significantly reduced within the next 6 months;

(h) If a patient is still waiting at 18 weeks, they are contacted and a telephone triage takes place to determine the current needs of the patient and confirm if treatment is still wanted. If wanting to remain on the waiting list patents are contacted at regular intervals;

(i) There are between 8,550 - 9,000 adult mental health patients in the City at any one time but as there is a lot of movement the total receiving treatment during the year is significantly higher;

(j) The Trust provides a wide range of services but some are commissioned so not directly provided. Some services produce assessments based on needs but as the needs of the patient may change, the way in which the services operate needs to change;

The following responses were provided to the Committee's questions:

(k) Some patients may feel that they are being moved from one service to another without help, but it's important that the treatment is right for that person and to acknowledge that their needs may change. For access to Step 4 services, the patient must be motivated to access and fully engage with the treatment which is why a questionnaire is sent out and is required to be returned before treatment can commence. If the patient isn't motivated to engage and respond with the questionnaire, then it is wholly unlikely that treatment will be beneficial. If the questionnaire is not returned there is an initial follow-up to ensure that there are no literacy or language issues, but if still not engaging the patient is removed from the waiting list and another treatment route sought;

(l) The Healthcare Trust needs to identify the needs of society and the proportions of which services are needed by citizens along with the broader issues relating to poor mental health. Some people are willing to feedback on these issues, but it is believed that the current data is not a true reflection of the reasons why people seek mental health care, and this needs to be known to ensure that services are appropriately shaped;

(m) It is very difficult to gauge the success level of treatment as services deal with a range of conditions and presentations. Early Intervention Psychosis has clear national standards around timescales to treatments but it can take several years for some people to successfully complete treatments. Guidance does exist for some other services and whilst the needs of each person are different, holistic assessments can take place and a collaborative approach taken;

(n) Patients are referred to the Local Mental Health Teams by GPs so it's important that close relationships are maintained with GPs invited to the monthly meetings where information and ideas for service development are shared.

Comments from the Committee included:

(o) Assessment and the access to services need to have a person centred approach;

(p) The Healthcare Trust needs to have a better understanding of the work that charities are doing in 'mopping up' where citizens approach charities as they don't know where else to go. Some charities are not equipped to support people but it's not clear as to where people should be directed. The Healthcare Trust needs to provide more information, better communications and consider liaising more closely with the voluntary sector to get a broader understanding of the wider issues.

The Chair thanked Michelle Malone and Luba Hayes for their attendance and presentation.

RESOLVED

(1) to note the update and activity to address waiting times for adult mental health services;

(2) for a written update to be provided to the Committee in January / February 2019, from which a decision will be made if the Committee requires further formal consideration of waiting times for Adult Mental Health Services.

38 PROPOSALS FOR GLUTEN FREE FOOD PRESCRIBING

Cheryl Gresham and Beth Carney, both Associate Chief Pharmacists in Medicines Management, and Hazel Buchanan, Director of Strategy and Partnerships, all from Greater Nottingham Clinical Commissioning Partnership, were in attendance to discuss the future of gluten free food prescribing, highlighting the following points:

(a) The document submitted from the Commissioning Partnership outlines what coeliac disease is, that it requires a gluten free diet, and what alternative foods can be eaten;

(b) With an estimated annual cost of £156,528 for prescribing gluten free foods, the Clinical Commissioning Partnership has undertaken consultation on several options for the future of gluten free food prescribing including not to change the current arrangements, to stop prescribing gluten free food, and to limit gluten free prescribing to bread and flour mixes;

(c) The overall result of the public consultation was 49% in favour of continuing prescribing at some level, and 47% in favour of stopping prescribing. 86% of responders with coeliac disease favoured some level of gluten free food being available on prescription;

(d) The Commissioning Partnership is recommending that gluten free food prescribing is stopped for all for all patients within the Greater Nottingham Area. The Committee is asked to consider if the recommendation to stop prescribing gluten free foods is a substantial variation to services;

(e) A representation against the recommendation has been received from the Coeliac UK and is published and circulated as a supplement to the agenda.

The following responses were provided to the Committee's questions:

(f) Although non prescribing of gluten free food will be advised to GPs across the whole Partnership area, as of December a very limited number of gluten free food will remain on the prescribing list so GPs will be still have the ability to prescribe bread and flour mixes to patients who they may feel are particularly vulnerable;

(g) The Partnership is not promoting prescribing on a social basis and is asking GPs to support its decision. The NHS is supporting patients to choose alternative healthier diets and foods. Dietary advice is readily available and referral to dieticians can be provided where necessary;

(h) The impact of the prescribing change on pregnant women is included within the Equalities Impact Assessment;

(i) GPs supporting patients with dietary advice is already an accepted element of the role so should not be considered as an extra/additional element. GPs are comfortable with the decision and some are already having conversations with patients in advance withdrawal. It

should be noted that although a GP representative was unable to attend the meeting, GP executives and representatives have been involved in discussions at every stage;

(j) There will be an evaluation of the impact of withdrawing prescribing of gluten free foods in twelve months' time. However, the evaluation by other CCGs in the county which have withdrawn gluten free food prescribing, has not provided any clear evidence that there has been a negative impact on gluten free diets.

Comments from the Committee included:

(k) The cost of gluten free products in the supermarket is prohibitive for anyone on a low income and gluten free foods, such as bread, are rarely available in food banks;

(l) It's important for young people with coeliac disease to feel normal so access to bread on prescription would be beneficial and would prevent the introduction of social barriers;

(m) The consultation, though extensive, appears not to have taken into account the views of consultees;

(n) Where the impact assessment identifies negative impact, such as pregnant women, it is concerning that there's no specific evidence of how this will be addressed.

RESOLVED

(1) to note the report form the and submission from Coeliac UK;

(2) that the recommendation to stop prescribing gluten free foods is accepted as a substantial variation to services, but that it can proceed;

(3) for the Greater Nottingham Clinical Commissioning Partnership to submit the findings of the twelve month review to the Committee, with a GP representative in attendance to respond to the Committee's questions.

39 PRESCRIBING OF OVER THE COUNTER MEDICINES

Beth Carney, Associate Chief Pharmacist in Medicines Management, Greater Nottingham Clinical Commissioning Partnership, presented the report which outlines proposals, consultation, and recommendations on prescribing over-the-counter medicines, in line with NHS England guidance.

It is noted that some clinical commissioning groups within the county have already implemented the restriction and it is intended that a standard approach is adopted throughout the Greater Nottingham area. It is proposed that with the exception of vulnerable groups and those with long-term disabilities, medication is not prescribed for self-limiting conditions or minor illness, or where there is no clinical evidence of efficacy (such as vitamins, minerals or probiotics).

The report details the minor illnesses for which prescriptions will no longer be available, and identifies patients who are considered exceptions and exceptional circumstances. However, ultimately the decision to prescribe remains with the GP. The following points were highlighted and committee members' questions responded to:

(a) The CCG will work with GPs to try and ensure the new approach is implemented to the same level across the area but where guidelines are not met, the CCG will discuss issues with GPs;

(b) Patients' individual circumstances can be considered, but if it is found that there is a wider issue in that GPs are not comfortable following the guidelines, then further examination by the CCG will take place;

(c) Self-care will be will be promoted and support put in place;

(d) National guidance states that there is evidence only in a limited number of situations that vitamins are of benefit, so these are included in the exceptions;

(e) An advisory form/leaflet with tick boxes is available for GPs to use for non-prescription medication and the CCG is asking pharmacists to accept and support the recommendations of GPs;

(f) The GP is expected to consider the vulnerability of the patient and their long-term conditions when deciding if medications which are available to buy should be prescribed. There is no limitation on treatment, however there are some medications which patients need to buy themselves;

(g) With regard to some medications, including treatments for vaginal thrush, it is cheaper to buy them over the counter than pay the prescription charge.

Comments from the Committee included:

(h) It is a concern that if medicines are only advised by the doctor and not prescribed, patients may not take them seriously and not consider them as necessary;

(i) Advising and supporting self-help needs to be very carefully considered, including preventative self-help such as taking vitamin D.

RESOLVED

(1) to note the report, the consultation process and proposals for implementing the national guidance on withdrawing the prescribing of over the counter medications;

(2) for the Greater Nottingham Clinical Commissioning Partnership to provide the Committee with an update on progress in implementing the guidance to a future meeting.

40 SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP AND GREATER NOTTINGHAM INTEGRATED CARE SYSTEM

David Pearson, Sustainability and Transformation Partnership (STP) Lead, Rebecca Larder, South Nottinghamshire Director of Transformation and Councillor Sam Webster, Portfolio Holder for Adult Social Care and Health, were in attendance to update the Committee on the Partnership's activity and progress in improving outcomes for the people of Nottingham and Nottinghamshire.

David Pearson delivered a presentation, a copy of which is circulated with the initial publication of the minutes. The following points were highlighted and responses given to committee members' questions:

(a) The partnership is taking a collaborative approach to focusing on what is required to meet the needs of the population;

(b) There is an ageing population with a longer life expectancy but with more complex conditions. This also includes citizens with disabilities, for instance in the 1980s the average life expectancy for someone with Down Syndrome was 23 years of age, in 2018 the life expectancy is 60 years of age but with 40% of Down Syndrome patients over the age of 50 experiencing some level of dementia;

(c) With increasing demand and the challenging financial position, it is vital that changes take place to current, often disjointed, services to ensure sustainability. This includes ensuring that services and treatments can provide improved and joined up care as part of an integrated care system;

(d) In addition to ensuring integrated care, preventative work is vital in ensuring that citizens remain healthy and do not experience avoidable conditions and complications, such as strokes. As a result of a trial of proactive diagnosis and treatment of atrial fibrillation (an irregular heartbeat) approximately 44 strokes and 12 deaths are being prevented each year in the borough of Rushcliffe alone, with the preventative scheme now rolled out across the county;

(e) Previously, it has been accepted that approximately 27% of patients requiring end-of-life care will receive that care in an emergency department hospital environment. However, with better co-ordination and integration of services it is anticipated that admissions to hospital at end of life can be reduced by 10%, which will provide savings in the region of £450,000 and provide an improved experience for patients, their families and carers;

(f) Integrated personal care commissioning is helping people to better coordinate and take control to meet their specific needs;

(g) A study in December 2017 by Nottingham Trent University and Peopletoo (service design and implementation practitioners) showed that Integrated Health and Care Teams deliver better outcomes for service users who have a combination of health and care needs, than staff working in separate teams to support people;

(h) Further work is required to integrate services, including development of a new integrated care model where multiple care co-ordinators are not required;

(i) Many current services may be considered fragmented but a more coherent approach and shared vision which is sensitive to local needs, including revised care strategies, is providing significant savings, improving efficiency and patient experience;

(j) Ensuring that mental health and physical health services are co-ordinated will also provide improved outcomes for patients;

(k) With regard to care packages, where further assistance is required Nottingham City Council implements the Better Care Fund and is the highest provider of the fund in England;

(l) The Partnership is looking at healthcare services across the county and whilst there are some which will require a longer-term approach, improvements by integration are achievable and will provide saving and improve patient experience;

(m) Prevention will require investment but this approach will achieve significant savings in treatment and care. At the moment there isn't enough focus on and investment in prevention so the funding gap appears substantial. The city and county are working together to prevent alcohol issues which impact on both health and wellbeing. Collaborative working is taking place and ambitious with regard to prevention but it's a big agenda;

(n) The STP works with external partners to try and support people to stay independent for longer. However, some aspects of the system are fragmented and whilst there is change, embedding the practice to seek earlier diagnosis and therefore often prevent hospital admission, is likely to take several years;

(o) Historically the drive for early intervention has been lacking nationally so there is a lot of work to be done to realise the longer-term investment, which may not become apparent for several years. However this must be addressed and the barriers preventing early intervention broken down.

Committee members welcomed the update.

RESOLVED for a further update to be submitted to the Committee in 6 months' time.

41 PLANNING FOR WINTER PRESSURES

Caroline Shaw, Chief Operating Officer of Nottingham University Hospitals (NUH), Nicky Powell now Program Director of Urgent Care Greater Nottingham Clinical Commissioning Partnership, and Julie Pomeroy, Non-Executive Director of NUH Board, were in attendance to inform the committee of the actions taken and planned in preparation for the predicted winter pressures on health services. Hazel Buchanan also contributed during the item.

Julie Pomeroy delivered a detailed presentation, a copy of which is included in the agenda, and highlighted the following points and responded to the Committee's questions:

(a) Planning for the known winter pressures started in March 2018 for winter 2018;

(b) Last winter was particularly harsh and a lot has been learnt following the excessive demand on services;

(c) Safety and quality remain top priorities regardless of the level of pressure. Although there is a national requirement for at least 95% of Emergency Department patients to pass through the department within 4 hours, the flow of patients through all services is important so good discharge co-ordination is vital;

(d) Not only did services have to cope with the primary condition for which patients were admitted to hospital last winter, but 25-30% of mental health issues were unknown prior to presenting at the Emergency Department, and the hospital was the patient's first point of contact with a medical professional;

(e) The A&E Board meet weekly to prepare all providers for winter. The Board membership includes NUH Executive Leaders, NEMS, ARIVA, CityCare and other partners;

(f) A new process has been established of 'discharge to assess' where patients are well enough to be discharged, they are discharged home and then assessed for further care. This has proved very successful in releasing hospital beds at times of extreme pressure;

(g) For winter 2018 an additional 116 acute beds are planned which equates to an extra ward, additional community based (care home) beds and 48 community run beds are prepared;

(h) The QMC 'front door' will be redesigned with regard to emergency and urgent care pathways;

(i) Flu prevention and staying well will be promoted across the NHS and focus on 'home first' and 'help us help you' campaigns;

(j) The workforce is being asked how the hospital can help them to prepare for the demands of winter, including a staff flu immunisation programme (with incentives) for which take-up has been 50% in the first 2 weeks;

(k) Further physical space and capacity is required at QMC for the demand on services. A national grant of £4.5m is enabling Floor A of the hospital to be modernised and expanded, including 30 additional cubicles, from 2020. Further development will be considered as part of the system wide clinical services strategy within the Sustainability and Transformation Plan;

(l) There have initially been some issues with the availability of the flu vaccine, but this is only a temporary issue and vulnerable groups will be prioritised to receive the jab;

(m) With regard to recruitment and retention of the workforce, more regular recruitment is taking place across the system. There are approximately 40,000 nursing vacancies across the country at the moment but NUH is doing everything possible to mitigate the impact on its services;

(n) As a training hospital, NUH tries to ensure that when nursing students undertake placements, the experience is as positive as possible and a good relationship is established to encourage them to apply to the hospital on qualification;

(o) An exit interview is held for staff leaving and asks the reason for leaving NUH. The most common reason is to join another organisation as there is so much choice available. Younger members of staff tend to move around quite a lot, seemingly to gather experience;

(p) There is a lot of promotion of the '111' phone number (as a pre-front door facility to NUH) for citizens to seek medical advice (from NEMS) prior to considering presenting at hospital. NEMS act as care organiser and in addition to offering appointments with a doctor can refer to pharmacists, dentists and mental health services, including for emergency treatments;

(q) Back-door services support patients post-treatment and discharge and can be based in community hubs, but further work needs to be done in this area;

(r) NUH is taking part in the 'Building Better Health' scheme with officers enthusiastic to attend steering group meetings, as it provides an exciting opportunity to better understand the possibilities and work more closely with the voluntary sector.

RESOLVED to note the planning and preparations in place, including preventative, to cope with the anticipated rise in patient admissions during winter.

42 GYNAECOLOGY SERVICES

The Greater Nottingham Clinical Commissioning Group submitted a written report which outlines changes to gynaecology services. Following a successful pilot scheme, it is more appropriate for some conditions (listed in the report) to be treated within primary rather than secondary care.

RESOLVED to note the report.

43 HEALTH SCRUTINY COMMITTEE WORK PROGRAMME

Zena West, Senior Governance Officer, presented the proposed work programme for the remainder of the municipal year and a list of topics yet to be scheduled.

RESOLVED to note the work programme.

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Improving Outcomes for the People of Nottingham & Nottinghamshire

David Pearson

Integrated Care System Lead

A History of Collaboration

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

- Our health and care organisations have a history of collaborative working, in the pursuit of improved outcomes for the local population
- In 2016, a new collaboration was formed to develop a sustainability and transformation plan
- No organisation can achieve quality and sustainable care working alone:
  - Healthy life expectancy is too low and shows huge variation
  - High mortality rates for patients with long-term conditions
  - Elderly and frail spend too much time in hospital
  - Flow issues in our urgent care pathway
  - Variable cancer outcomes
  - Significant financial challenge

An Integrated Care System

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

- Over the last two-years, we have progressed from collective planning to a Partnership and now to a new integrated system of care – one of just ten in the country and cited as a leading example (eg, King's Fund Sept. 18).
- The partners are committed to the objectives of our Integrated Care System
  - Sustainably and consistently achieving the best outcomes – making best overall use of existing resources
  - Ensuring coherent decisions and processes to plan and deliver care across the system – local people tell us that this is not evident
  - Giving primacy to the needs of individuals or population groups – not organisations, transactions or sectors / professional interests
  - Alignment of objectives and incentives for better collective decisions, based around population needs

Population Health & Wellbeing Management

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

- The what:
  - Identifying and supporting citizens and populations who are in greatest need
  - Preventing the progression of disease
  - Promoting wellness to the wider population
- The how:
  - Having information on citizen, patient and population groups
  - Engaging and empowering people with their health and wellbeing
  - Targeting interventions tailored to individual needs
  - Having multi-disciplinary working across health, social care and, at times, the wider public and voluntary sector

Improved Outcomes (1)

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Preventing Strokes in Greater Nottingham

- Project to promote wellness for the 'at risk' of stroke population, which was initiated in Rushcliffe
- Through proactive diagnosis and treatment of a condition called atrial fibrillation (an irregular heartbeat) approx. 44 strokes and 12 deaths are being prevented each year in the borough
- Benefits to the population; benefits for the NHS and Care system
- Project is being rolled out across the patch

Improved Outcomes (2)

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

End of Life Care in Mid Notts

- 27% patients currently attend ED
- Lack of coordination in services between specialist and generalist
- New, integrated service aims to reduce admissions to hospital at end of life (10% reduction in this cohort, £450k savings)
- Achieved through education and training of all health and care sectors
- Improved use of Electronic Palliative Care Co-ordination Systems
- Much improved patient and family experience
- Reduction of 150 citizens on fast track services (£1.35m savings overall)

Improved Outcomes (3)

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

- **Integrated Personal Commissioning:**

- Encourages people to take a more active role in their health and wellbeing by offering personalised support plans and health budgets, where appropriate
- National evaluation shows this results in improved outcomes and an average saving of 17% for people with Continuing Healthcare funding

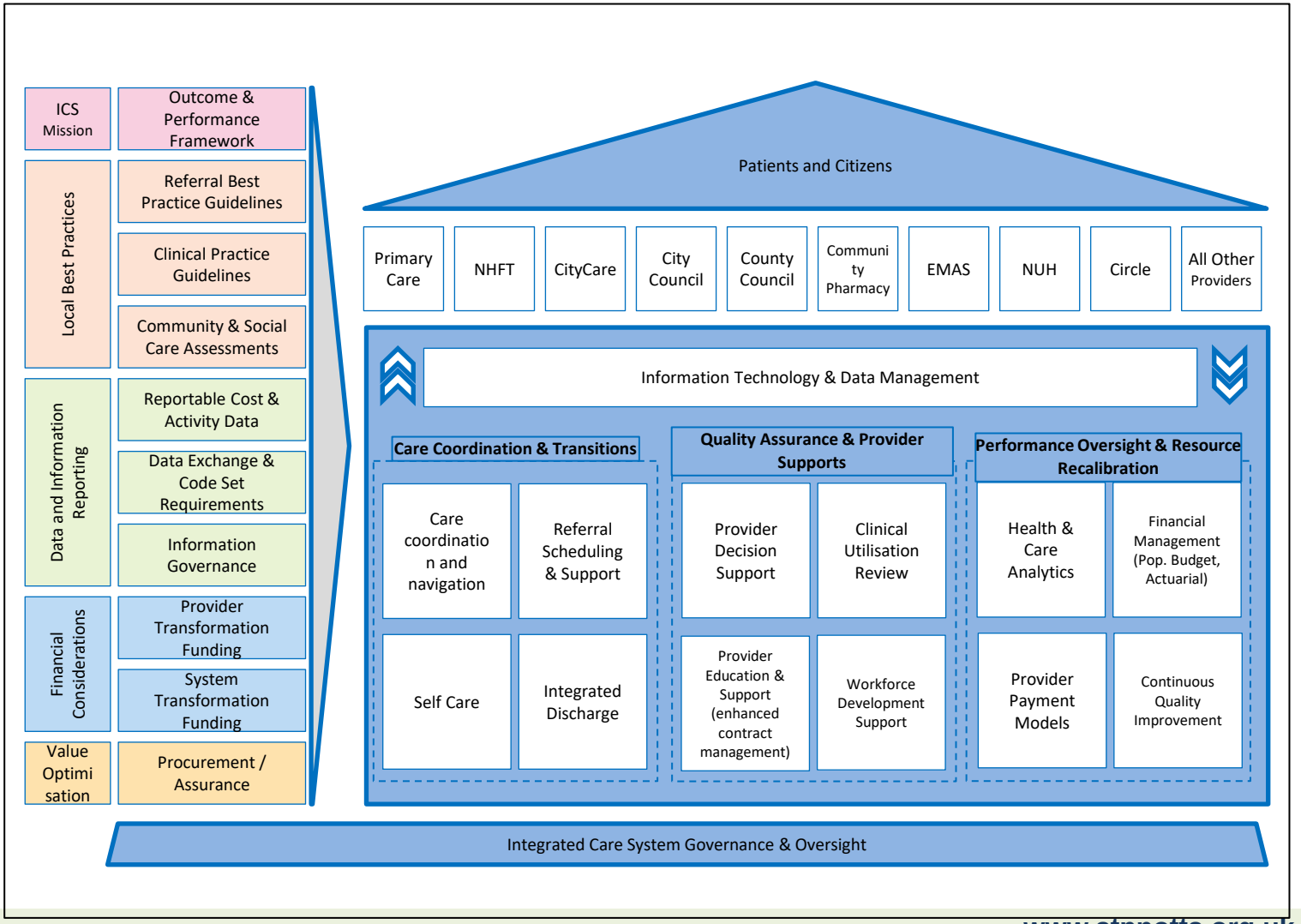
- **Integrated Care Teams**

- Evaluation by Nottingham Trent University and Peopletoo (December 2017) showed Integrated Health and Care Teams deliver better outcomes for service users who have a combination of health and care needs, than staff working in separate teams to support people

The Integration Framework

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

- Best Practice Care
- Optimal Infra-structure



Improvements Planned

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

- A new model of Care Co-ordination preventing people having up to 13 care co-ordinators!
- Consistent standards of care tailored to need, e.g. one evidence based diabetes pathway rather than multiple
- Smooth transitions of care for individuals including improvements to Referral and Discharge processes
- Better information and support for professionals to be able to consistently provide joined up evidence based care
- The right care, in the right place, at the right time because of the system rather than despite the system

A Change in Financial Management

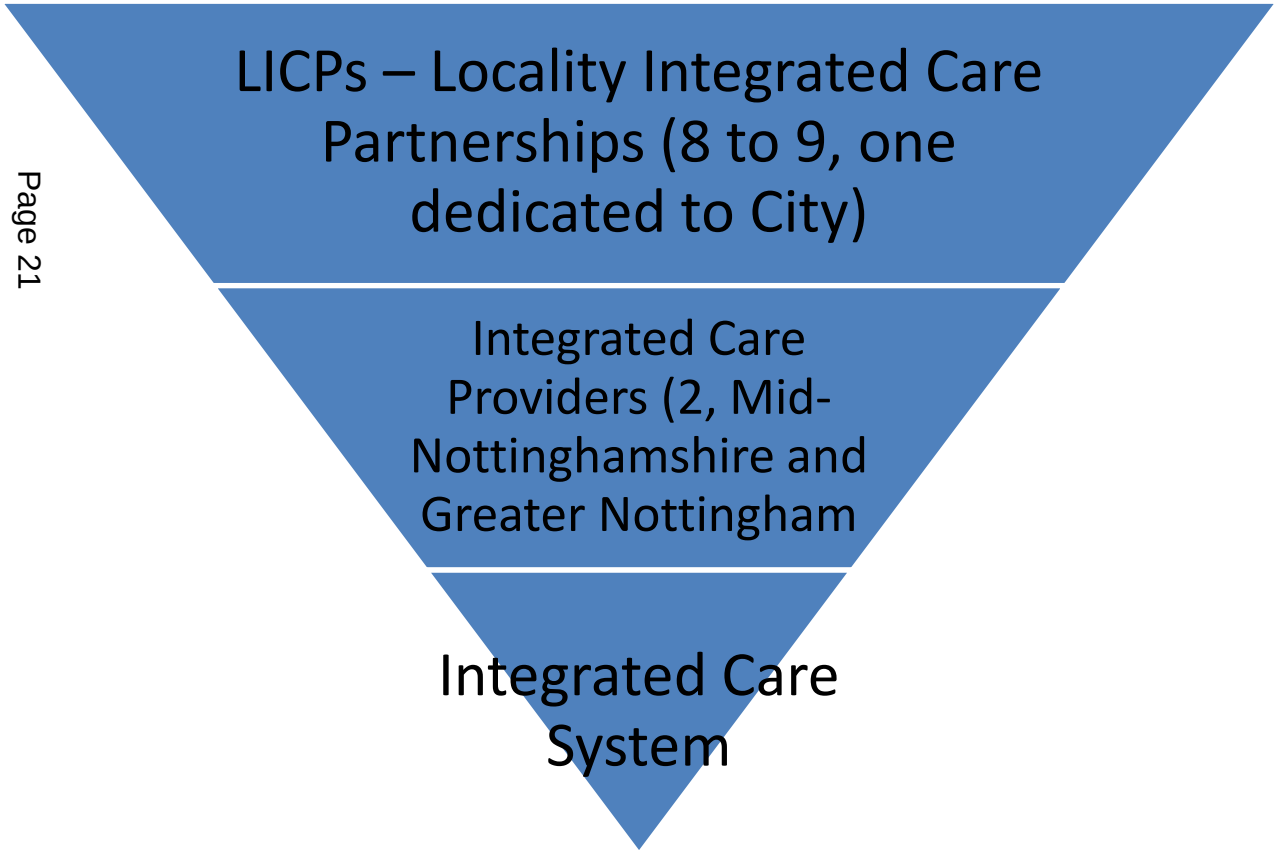
The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

- System Control Total (across health)
  - Shared commitment to deliver the overall financial goals
  - Mechanism for the system to deploy local flexibility in support of transformation
  - Approach facilitates shared financial risk management (across health economies)
  - An enabler of joined up oversight of a system
  - Supports the prioritisation of areas of greatest need

The Architecture

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Integrated Care System by 2020



Deliver care in communities and neighbourhoods

Integrated provision and delivery of outcomes

Strategic planning, commissioning and oversight

Engagement & Governance

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

- Proposal for a Integrated Care System Board with nominated Councillor representation
- Chairs and Elected Members Group established under the Chair of Eric Morton
- Role for Health and Wellbeing Boards being considered
- Workshop for NHS Chairs and Non-Executives and Local Authority Elected Members on 7th November 2018
- Series of Public Engagement events, which have been designed and facilitated by the Greater Nottingham Citizen Advisory Group

The Nottingham and Nottinghamshire
Sustainability and Transformation Partnership

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Thank You

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