NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held in the Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 11 July 2019 from 10:01am to 12:28pm

Membership

Present	Absent
Councillor Georgia Power (Chair)	Councillor Merlita Bryan
Councillor Cate Woodward (Vice Chair)	Councillor Angela Kandola
Councillor Samuel Gardiner	Councillor AJ Matsiko
Councillor Phil Jackson	
Councillor Maria Joannou	
Councillor Kirsty Jones	
Councillor Dave Liversidge	
Councillor Lauren O`Grady	
Councillor Anne Peach	

Colleagues, partners and others in attendance:

Andrew Chatten	-	Director of Estates and Facilities, Nottingham University Hospitals Trust
Esther Gaskill	-	Head of Quality for Primary Care, Nottingham City Clinical Commissioning Group
Duncan Hanslow	-	Programme Director, Nottingham and Nottinghamshire Integrated Care System
Adrian Mann	-	Governance Officer
Sarah Mayfield	-	Screening and Immunisation Manager, NHS England
Kate McCandlish	-	Assistant Locality Director, Nottingham City Clinical Commissioning Group
Dr Hugh Porter	-	Chair, Nottingham City Clinical Commissioning Group
Angela Potter	-	Programme Director, Nottingham and Nottinghamshire Integrated Care System
Professor Mandie Sunderland	-	Chief Nurse, Nottingham University Hospitals Trust
Zena West	-	Senior Governance Officer
Kerrie Woods	-	Head of Primary Care Contracting, NHS England

9 APOLOGIES FOR ABSENCE

Councillor Merlita Bryan	-	Council business
Councillor Angela Kandola	-	unspecified
Councillor AJ Matsiko	-	unwell

10 DECLARATIONS OF INTERESTS

None.

11 MINUTES

The minutes of the meeting held on 13 June 2019 were confirmed as a true record and signed by the Chair.

12 GP PROVISION IN NOTTINGHAM

Esther Gaskill, Head of Quality for Primary Care at Nottingham City Clinical Commissioning Group (CCG); Kate McCandlish, Assistant Locality Director at Nottingham City CCG; Dr Hugh Porter, Chair of Nottingham City CCG; and Kerrie Woods, Head of Primary Care Contracting at NHS England, gave a verbal report on the Care Quality Commission's (CQC) recent inspection and actions relating to the Beechdale Medical Group. The following points were discussed:

(a) in January, the Government published the NHS Long Term Plan, which includes a new contract for GPs and establishes the Primary Care Networks. These networks group GP practices together to cover a geographical catchment containing 30-50,000 people to encourage collaborative and integrated working between GPs, and to develop links between GPs and other care services over time. There are eight Networks covering the City. These seek to align with social care and community provision areas and match ward boundaries roughly, though not always exactly. There is a rising demand for GP services and, as practices in urban environments tend to be smaller and find it more difficult to recruit staff, investment is needed to create effective economies of scale;

(b) the Beechdale Medical Group contains four surgeries with their own individual contracts, but all four contracts are with the same provider. All of the surgeries were inspected by the CQC in March and three were rated 'good', with the Strelley surgery rated as 'requires improvement'. The CQC carried out a follow-up inspection of Strelley in early May and, following a further visit on 20 May, it identified serious concerns relating to the management of the surgery's triage process (which was not felt to provide robust enough assurances for patient safety), and to the GPs' available capacity and oversight procedures;

(c) within two days, the CQC submitted a letter identifying its concerns and requiring that corrective measures were taken. The practice agreed an action plan and implementation timetable with the CQC. However, when the CQC returned to the surgery on 4 June, it felt that the action plan had not been implemented within the agreed timetable, so patients were still at risk. Following further discussions with the surgery on 7 June, the CQC was not satisfied that the practice was able to address its serious safety concerns adequately, so it closed the surgery with immediate effect;

(d) the 4,600 patients on the surgery's register were contacted by text message and letter, and information was distributed by the other practices in the Group, local hospitals and through the media, so 2,900 of the patients are now registered at the next surgery most accessible and convenient for them, even if this is outside the Group. Emergency care, prescribing and district nursing provision is in place with other care providers and pharmacies, and the Nottingham City GPs' Alliance is able to access the surgery's clinical records system;

(e) due to the CQC's safety concerns, the triage system used at Strelley was discontinued at all practices within the Group. The CQC then re-inspected the other three practices and, on 28 June, raised serious patient safety concerns at the Boulevard surgery relating to its treatment facilities, clinical cover, leadership and infection control. Following discussions, the CQC did not close the surgery, but treatment delivery was stopped and transferred elsewhere as a temporary measure;

(f) the final CQC reports will be published shortly. Independent clinical reviews will be undertaken at the Strelley and Boulevard surgeries, with an assurance matrix developed to address the significant safety issues identified by the CQC. Consideration is being given to the merger of Boulevard with another practice. Work is being carried out with the Beechdale Medical Group and the local Medical Council to explore the issues and identify how service provision can be improved and made sustainable. The closure of any surgery is very disruptive to patients and does involve some risk to their safety, so steps are being taken to address the acute issues and then establish effective provision in the area for the future, in consultation with citizens, following the publication of the CQC reports.

RESOLVED to:

(1) note the information provided;

(2) request further information on the distribution of surgeries and Primary Care Networks within Nottingham (maps shared with the first publication of the minutes).

13 CLEANLINESS AT NUH TRUST HOSPITALS

Andrew Chatten, Director of Estates and Facilities at Nottingham University Hospitals Trust (NUH), and Professor Mandie Sunderland, Chief Nurse at NUH, presented a report on the current progress made by the Trust in improving standards of cleanliness at its hospital sites. The following points were discussed:

(a) the cleaning of NUH hospitals was brought in-house during 2017, with 420 full-time equivalent roles in place (up from 383 in 2017) and an annual budget of £250-300,000, which is intended to ensure that all cleaning staff have the right training and resources. Cleaning staff are salaried on the NHS wage structure and receive at least the living wage (as suggested by the Living Wage Foundation). Engagement has been carried out with front-line cleaning staff so that they form a consistent part of the ward teams. A vision for excellence is in place and the same cleaning methodology, with an associated audit process, is used across the Trust. Currently, it is intended to use in-house cleaning for the long-term;

(b) a two-part improvement plan is in place. For Part 1, further improvements will be carried out during 2019/20 within the existing budget, including a focus on training and the deployment of resources in high-risk facilities, with clear management responsibilities for defined areas. Part 2 will be implemented from 2020/21 and will focus on achieving compliance with the upcoming 2019 national standards and moving to a position where the total cleaning hours meet the needs of the hospital fully;

(c) following the changes since 2017, there have been fewer patient complaints in relation to hospital cleanliness, NHS Improvement (Regulatory) has given the Trust hospitals a 'green' rating, and the Patient Led Assessment of the Care Environment scores have improved. Patients, nurses and cleaners are also involved in the Cleaning Board;

(d) Clostridium difficile (C. diff) is an infection that can increase if a hospital environment is not kept clean and, following the improvements since 2017, infection rates are at their lowest on record, with 68 cases in 2018/19 (against a maximum target of 90). Only two cases of methicillin-resistant Staphylococcus aureus (MRSA) have been recorded in over 1 million patients, and only one of the patients acquired the infection while in the hospital. However, the rates of an infection known as Carbapenem-resistant Enterobacteriaceae (CRE) are increasing across the UK. CRE can often be picked up by people who have been in hospital in Asia or Eastern Europe and there is only one antibiotic currently available to combat the infection, so a screening programme has been put in place. There is a continued strong focus on environmental cleaning to mitigate the spread of infection and a programme of surveillance and audit is in place;

(e) the Ward Sisters have a responsibility for ensuring general cleanliness and are coordinating well with cleaning staff. A cleanliness manual has been produced to ensure that all staff are aware of their responsibilities. Information is communicated to visitors in a number of ways, including through the media and in-hospital posters, to raise awareness for the prevention of bringing infections into the hospital – and staff should be prepared to challenge visitors who are visibly unwell;

(f) the Care Quality Commission's 2019 inspection report did identify a need for a greater consistency of cleanliness levels in some areas, which can be a challenge due to the size of NUH's holdings and the age of some of the buildings. Scores are still lower than expected against the national standards, but there has been sustained improvement and every effort will be made to attain the new 2019 standards. Continual monitoring is in place through monthly Integrated Performance Reports to the NUH Board.

RESOLVED to note the positive progress made by the Nottingham University Hospitals Trust in improving standards of cleanliness at its hospital sites.

14 FLU IMMUNISATION PROGRAMME

Sarah Mayfield, Screening and Immunisation Manager at NHS England, presented a report on the performance of the 2018/19 seasonal flu immunisation programme and the effectiveness of the work undertaken to improve uptake rates. The following points were discussed:

(a) immunisation vaccination is one of the most effective interventions to mitigate harm from flu and reduce the pressures on health and social care. Increasing uptake in clinical risk groups is important because of the greater risk of flu leading to serious illness or death, while flu during pregnancy may be associated with perinatal mortality, prematurity, smaller neonatal size, lower birth weight and an

increased risk of complications for the mother. Nationally, approximately 600 people die from flu per year, including 16 children, and it is a contributory factor to 50,000 other winter deaths. Vaccination of health and social care workers is vital to protect them and reduce the risk of them spreading flu to their patients, service users, colleagues and family members;

(b) for 2018/19, the groups eligible for a free flu vaccination were all children aged 2-9 (who had received the live attenuated influenza vaccine (LAIV)), all primary school-aged children in former primary school pilot areas for LAIV, those aged six months to under 65 years in clinical risk groups, pregnant women, those aged 65 years and over, those in long-stay residential care homes, and carers;

(c) higher levels of flu activity were observed in 2018/19, particularly during November, December and January. The main impact of flu was seen in older adults (with a number admitted to hospital as a result), and a consistent pattern of outbreaks in care homes occurred. Vaccinations are provided through GPs, schools and pharmacies, and the impact on GPs was high during the months of November to January. Unfortunately, as vaccines are only provided by GPs to registered patients, they are not easily accessible to the homeless, so a new service is being developed to reach these vulnerable people;

(d) the flu vaccine uptake in 2018-19 in England was slightly lower than the 2017-18 season, with over 65 year-olds down from 72.9% to 72%, under 65 year-olds in a pre-defined clinical risk group down from 49.7% to 48% and pregnant women down from 47% to 45.2%. This decline may have been contributed to by a delay in some of the vaccines being distributed. However, uptake in the Childhood Flu Programmes increased slightly. In Nottingham, vaccination uptake is continuing to increase in level towards that of the national average and the targets required to achieve ‘herd immunity’;

(e) monthly flu planning meetings are underway, with local flu assurance plans in place and training packages for health care professionals available in the run-up to flu season 2019/20. Flu vaccine uptake data will be reviewed on a monthly basis at GP level and a pilot is underway to increase child uptake at practices. The School Age Immunisation Programme will continue to vaccinate in schools for reception to year 4, while information letters have been sent to parents of 2-3 year-olds. Flu messages will be promoted nationally by Public Health England and NHS England, and will be filtered to local communications teams. A nationally commissioned pharmacy flu service is in place and services continue to be commissioned at the Nottingham University Hospitals NHS Trust (NUH) for pregnant women and ‘at risk’ patients. NUH, Nottinghamshire Healthcare NHS Foundation Trust and Nottingham City Council are responsible for the vaccination of front-line staff;

(f) overall, the 2018/19 flu programme was successful, with more vaccines being delivered nationally and locally than in previous years. However, Nottingham City saw a decrease in flu vaccination uptake in most cohorts compared to last year, so NHS England and Nottingham City Council are working together and in conjunction with other stakeholders to bring about further improvement, including increasing the take-up amongst children.

RESOLVED to note the positive results of the 2018/19 flu vaccination programme and the work being carried out to improve uptake for 2019/20.

15 ICS CLINICAL SERVICES STRATEGY

Duncan Hanslow and Angela Potter, Programme Directors at Nottingham and Nottinghamshire Integrated Care System (ICS), presented a report on the proposed Clinical Services Strategy. The following points were discussed:

(a) nationally, there are 14 ICSs, which have collective responsibility for managing care resources, delivering NHS standards and improving the health of the population. Each ICS has been set up to make the best of existing resources to achieve good care outcomes sustainably and consistently, achieve the best outcomes, implement coherent decision-making and processes to plan and deliver care across the system, focus on the needs of individuals and population groups, and establish objectives and incentives for better collective decisions based around population needs;

(b) the developing Clinical Services Strategy recognises that the care system needs to change in its totality, rather than just in its individual elements, to achieve sustainability and viability at the right scale, sizing and estate, in the context of an ever-increasing demand on services. Long-term planning is required over a 5-10 year timeframe to justify and sustain capital investment and introduce a partnership strategy which integrates with other changes across the whole system;

(c) the Strategy intends to define a place-based model of care; establish the levels of standardisation or autonomy at different levels of the system; provide a long-term and sustainable healthcare model for Nottingham and Nottinghamshire; embed personalised care, prevention and early intervention; and provide a strategy in sufficient quality to enable a Pre-Consultation Business Case for any service change that emerges;

(d) the Strategy is underpinned by extensive engagement, including consideration of system engagement over the last 2-3 years, conversations and workshops with local patient groups (including engagement between patients and clinicians), 'confirm and challenge' sessions with staff on the high-level clinical model and future needs of the workforce, co-production of end-to-end care pathways in service reviews with systematic involvement of patients at every stage, involvement of the voluntary and community sector in service reviews, and engagement with system partners and stakeholders;

(e) the clinical model will be based on six core principles and will cover healthy living, living well, episodic crisis care, managing illness and end of life. Preventing ill health is a major priority and the commissioning processes need to ensure that the right resources are available to achieve effective results in this area. Some existing service locations are important care hubs, so future planning (through the service review process and engaging with patients and the public) will be carried out in the context of these fixed points, which include Kingsmill Hospital, Queen's Medical Centre Nottingham, Newark Hospital, Rampton Hospital and Wells Road Centre Nottingham. Measures are in place to secure the best value from existing

facilities under Local Improvement Finance Trust and Private Finance Initiative agreements for the remainder of the contract periods;

(f) there is no target to reduce the number of existing services or care professionals, as demand is projected to outstrip the available budget and a sustainable financial structure is needed. However, rationalisation work will be carried out to ensure that patients are not required to provide the same information each time they access a different service in the overall care system, and further links will be put in place between care professionals to improve communication regarding patients. The right balance must be struck between multi-disciplinary and specialist teams for addressing patients with complex care needs, so that the right care can be delivered in the right place. Budget concerns can sometimes drive service decision-making on care, so it is a key priority to see that the available resources are deployed effectively to an ethos of personalising care;

(g) a minimum of twenty service reviews have been identified in the context of the clinical model developed within this draft Strategy, and the priority reviews are underway for cardio-vascular disease, respiratory problems, frailty, children and young people, colorectal services, and maternity and neonates. The final Strategy will not be resolved until all of the reviews and consultations have been concluded, after the autumn. All of the ICSs are sharing knowledge in the creation of their Strategies, but there are particular local issues for which each ICS needs to develop tailored solutions;

(h) there is a separate work stream, strategy and review process for mental health, which has its own particular emphases. However, the mental health work stream will be connected back to the other areas to create the overall care strategy once the review and consultation work has been concluded.

RESOLVED to:

(1) note the current progress in developing a new Clinical Services Strategy by the Nottingham and Nottinghamshire Integrated Care System (ICS);

(2) request that updates are returned to the Committee by the ICS on the findings of the individual service reviews.

16 HEALTH SCRUTINY WORK PROGRAMME

Zena West, Senior Governance Officer, presented the proposed work programme for the 2019/20 municipal year, as per the agenda. The Nottingham and Nottinghamshire Integrated Care System has asked to give a presentation to the Committee on the local impact of the new NHS Long-Term Plan at a future meeting, which will be scheduled when possible.

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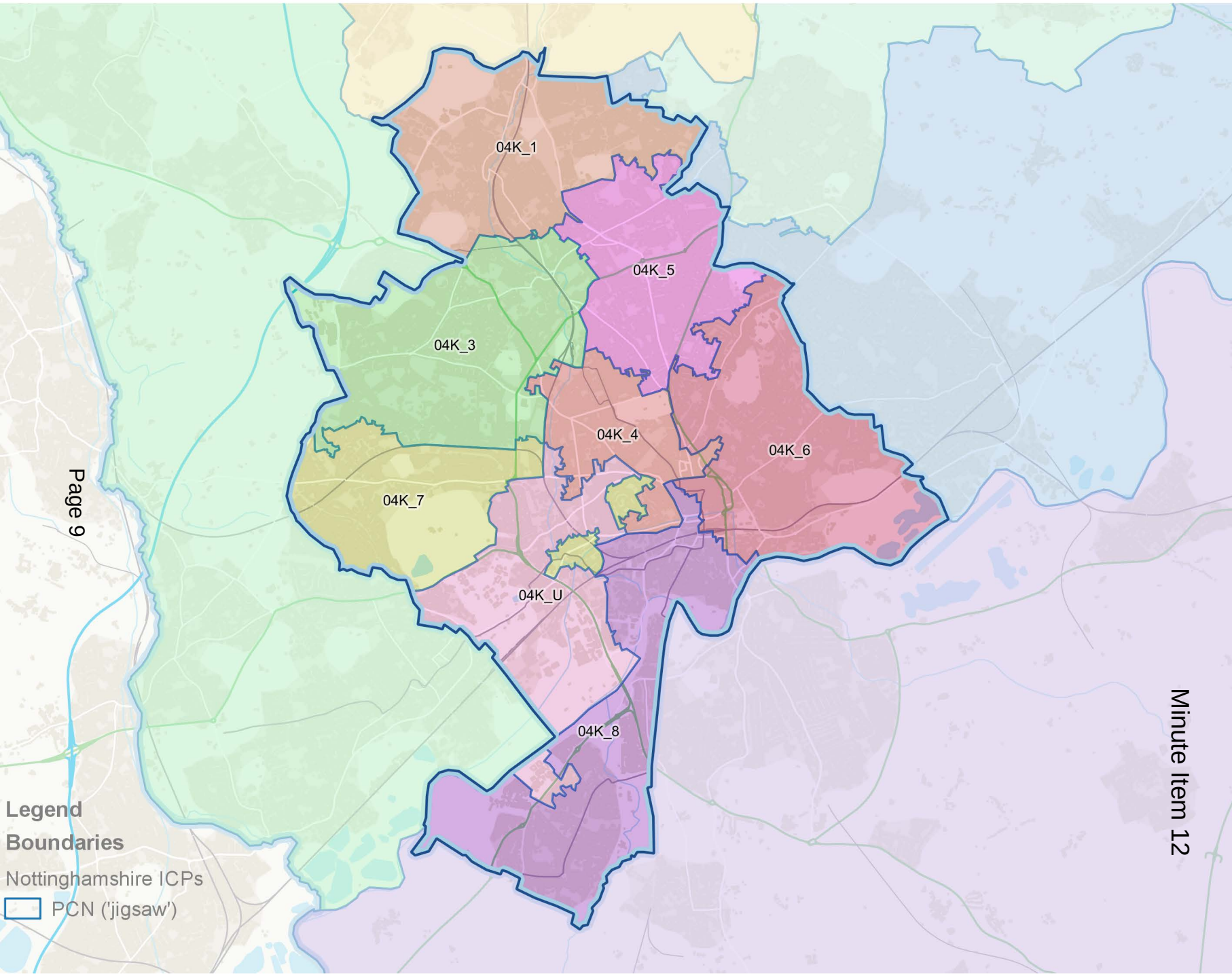
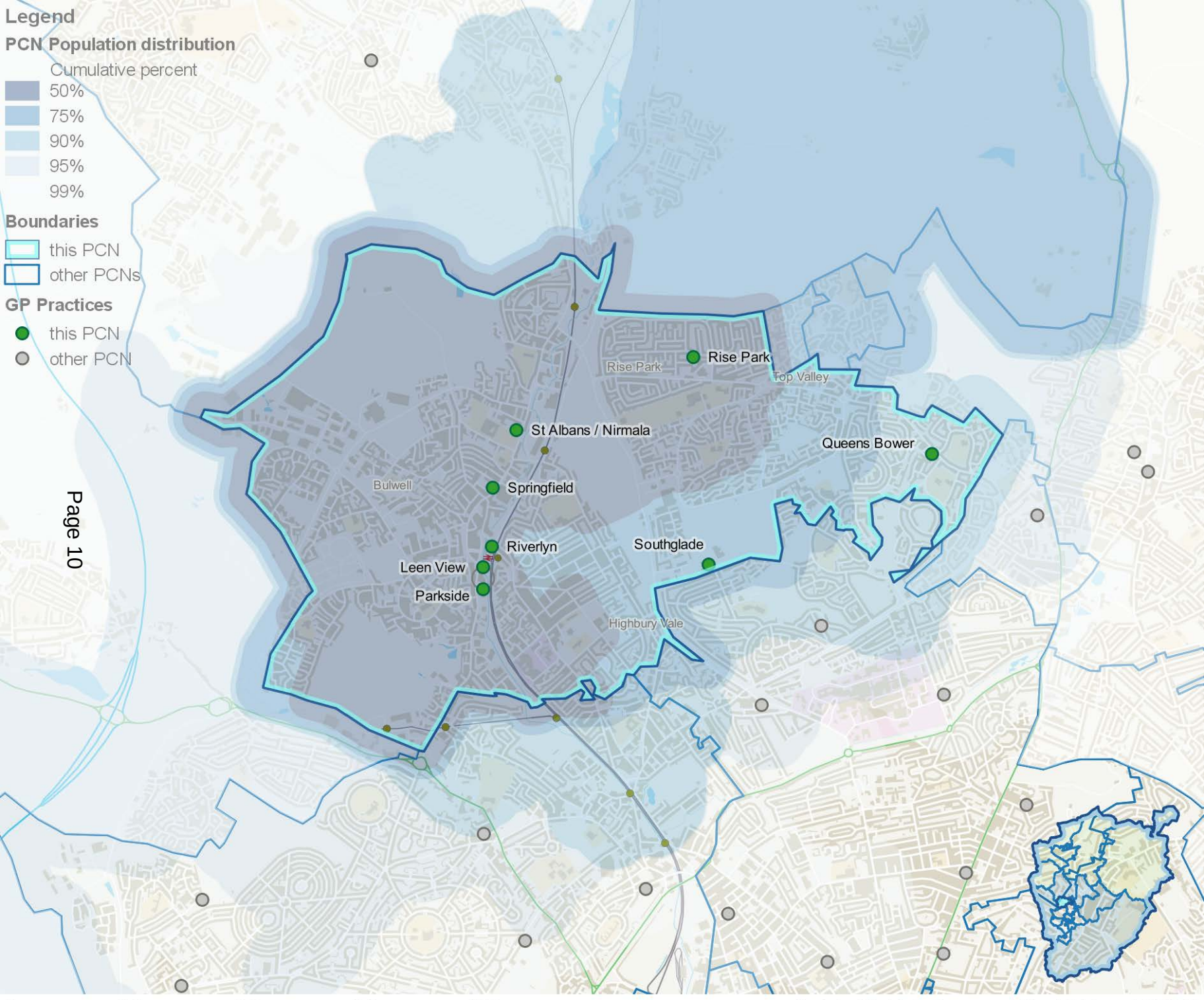
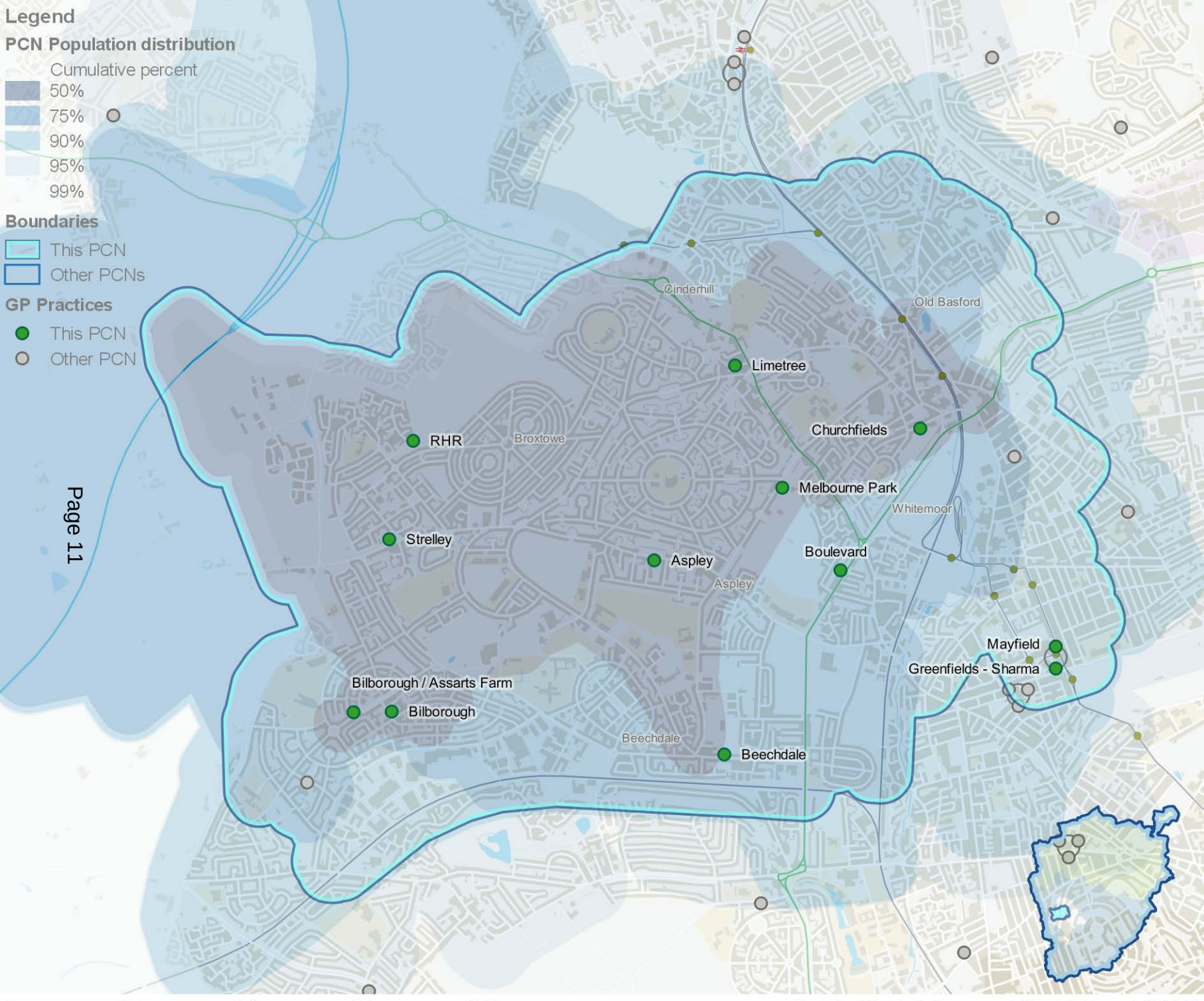
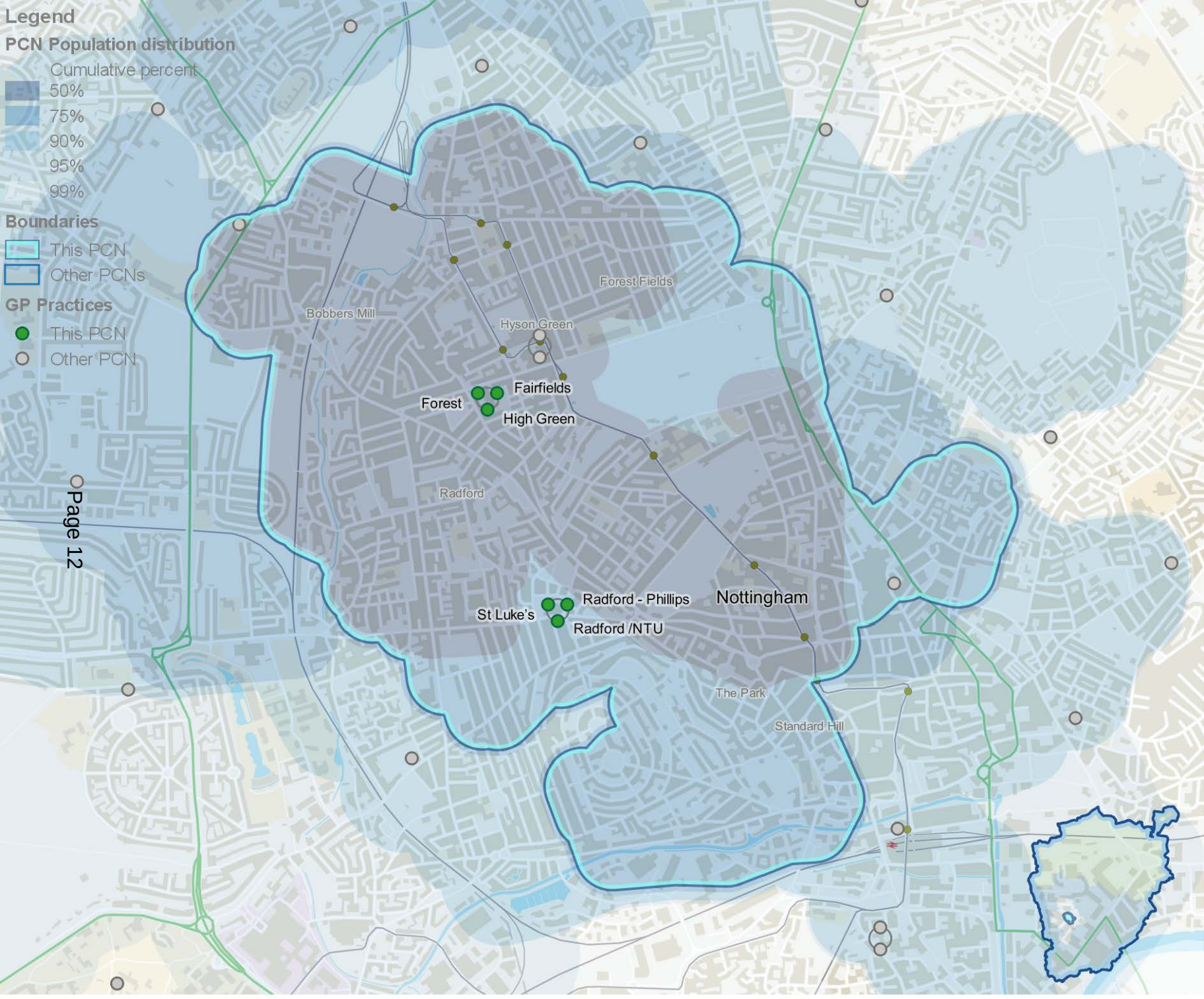
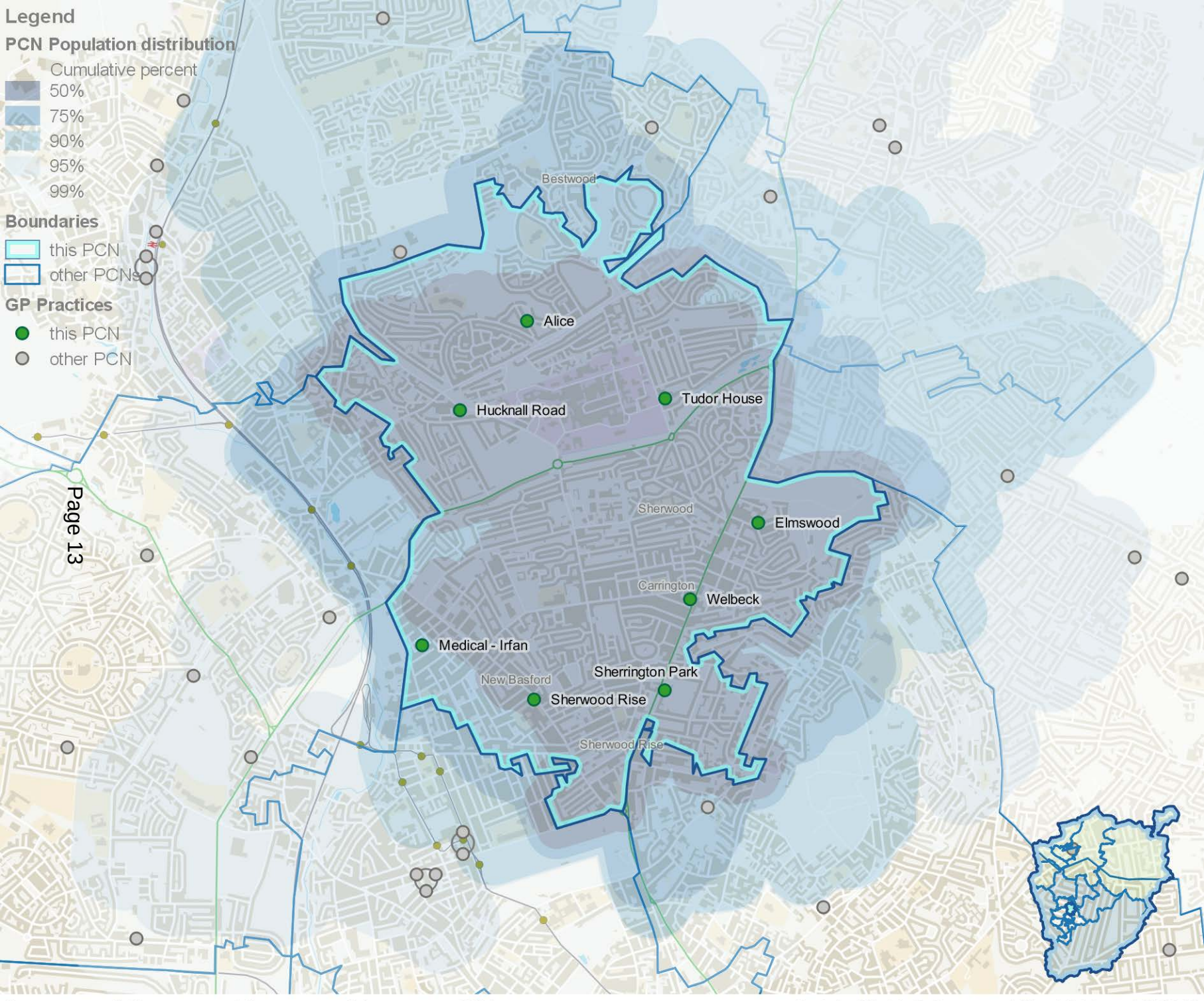
Nottinghamshire ICS: Nottm. City ICP

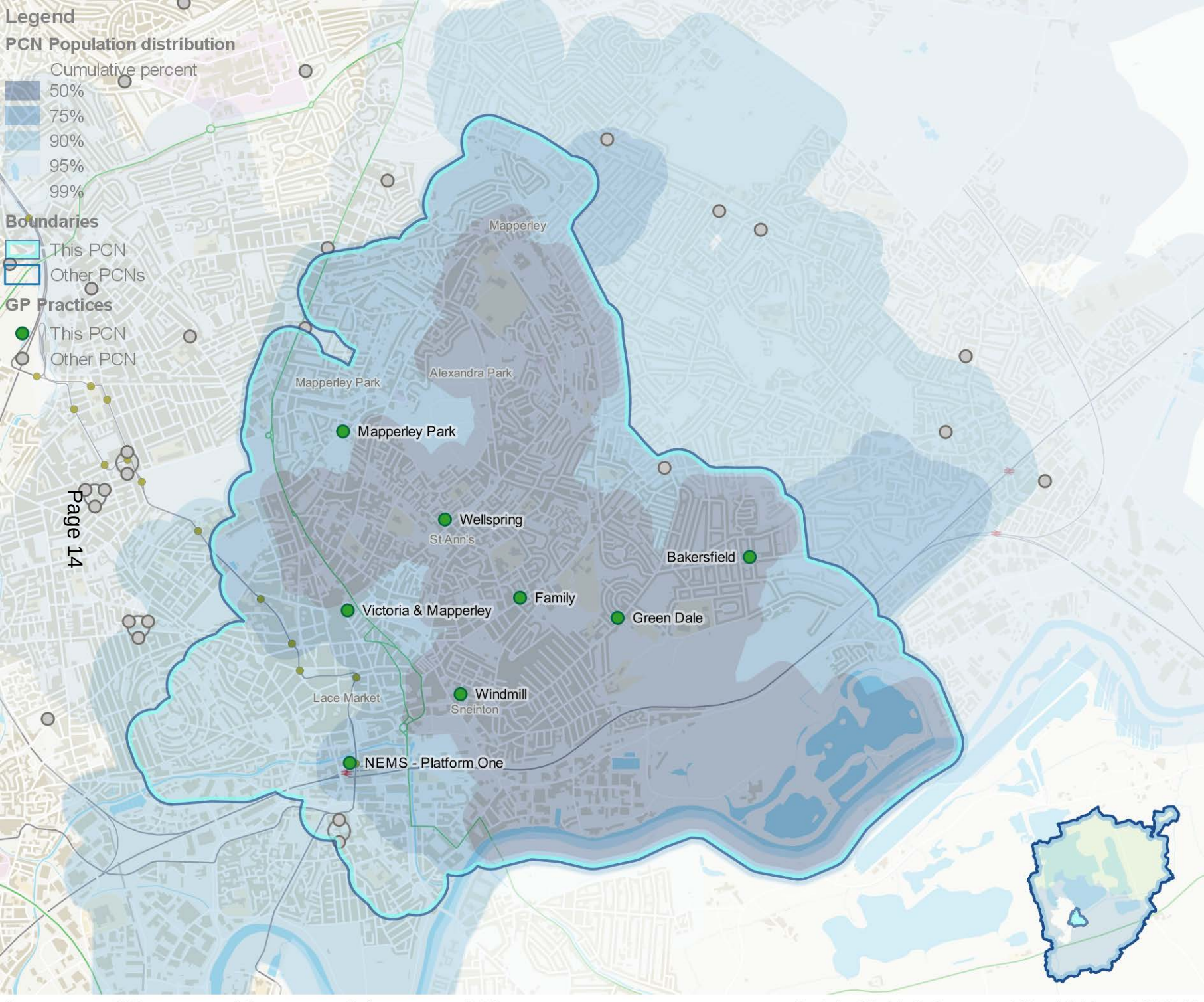


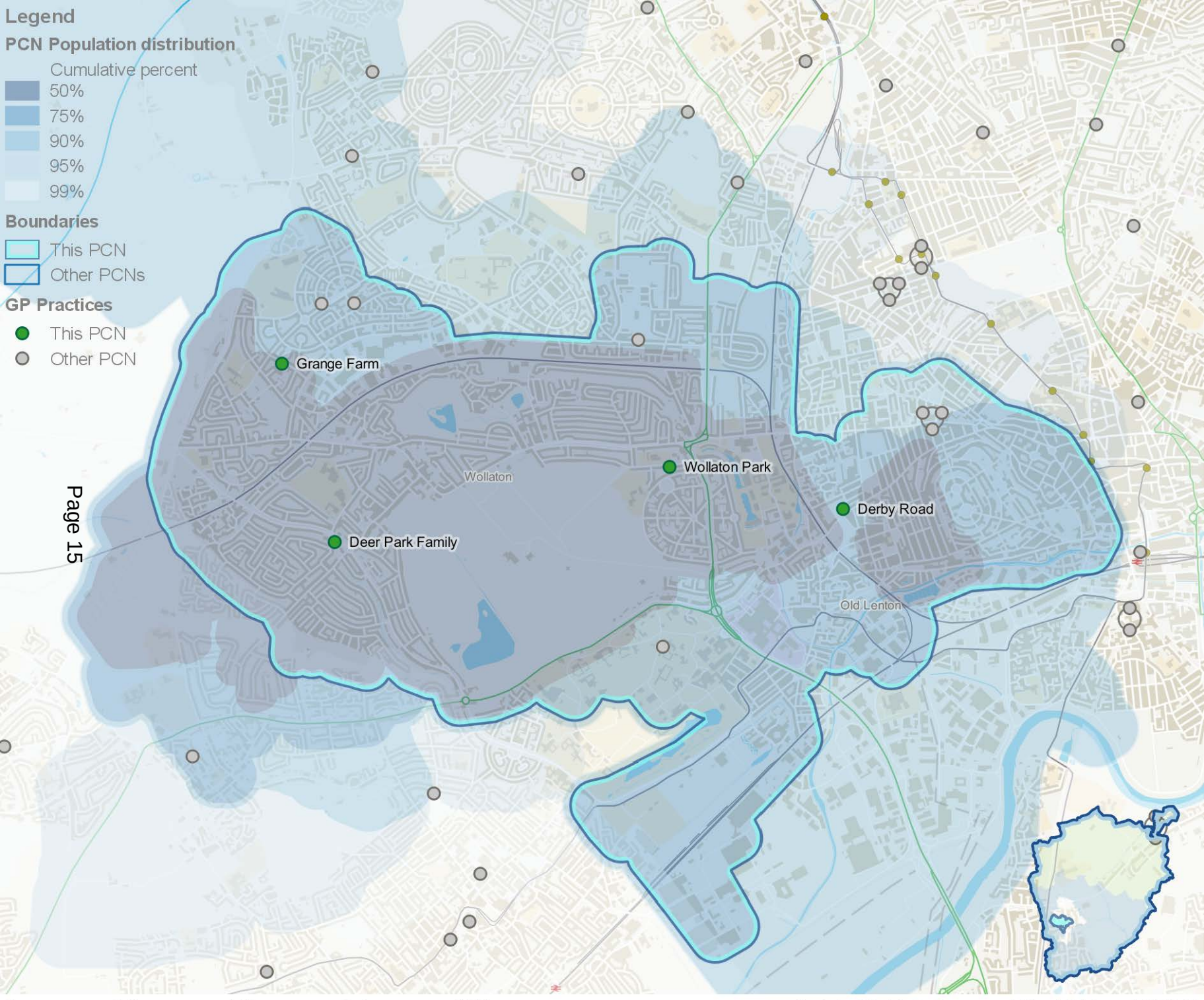


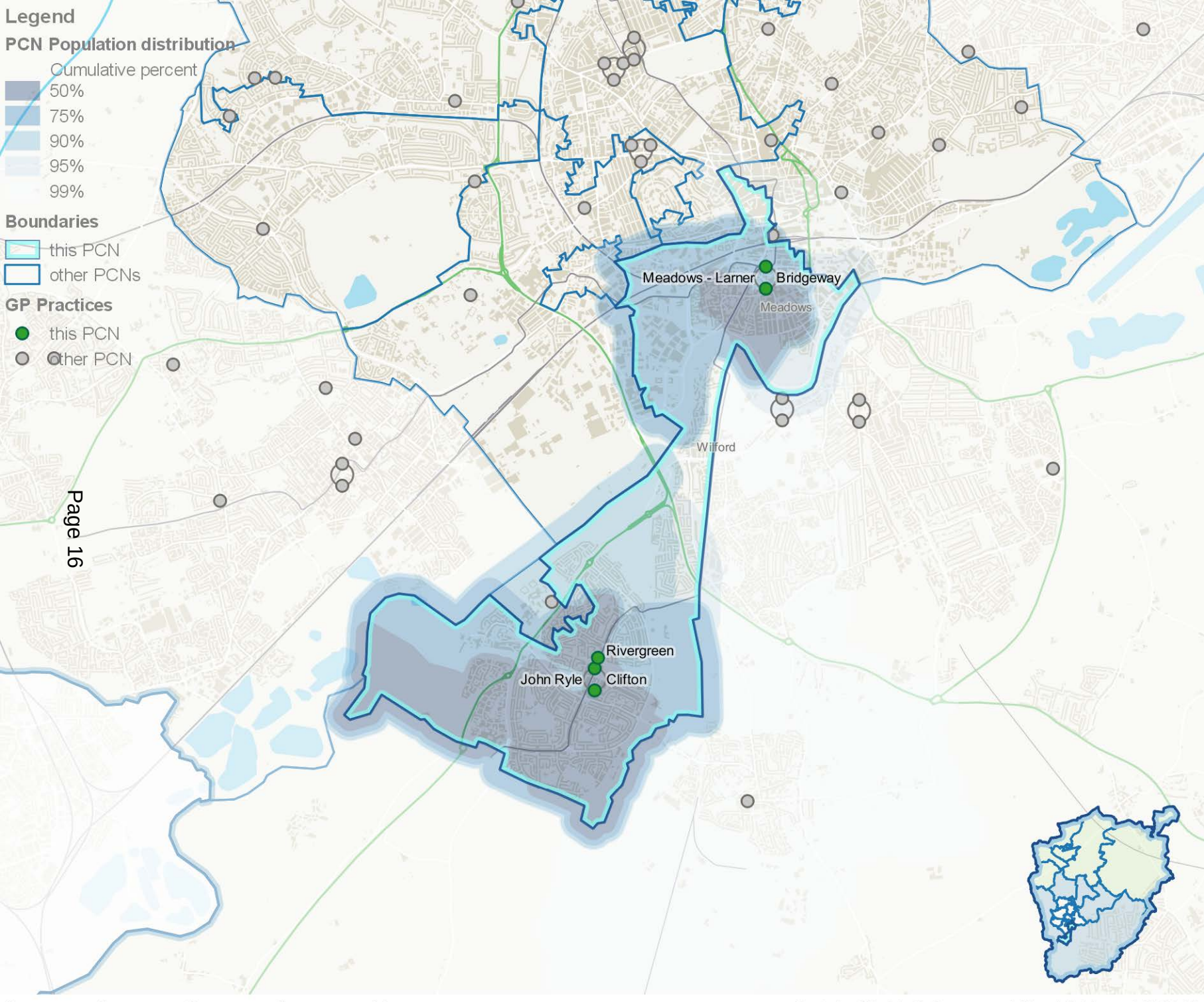


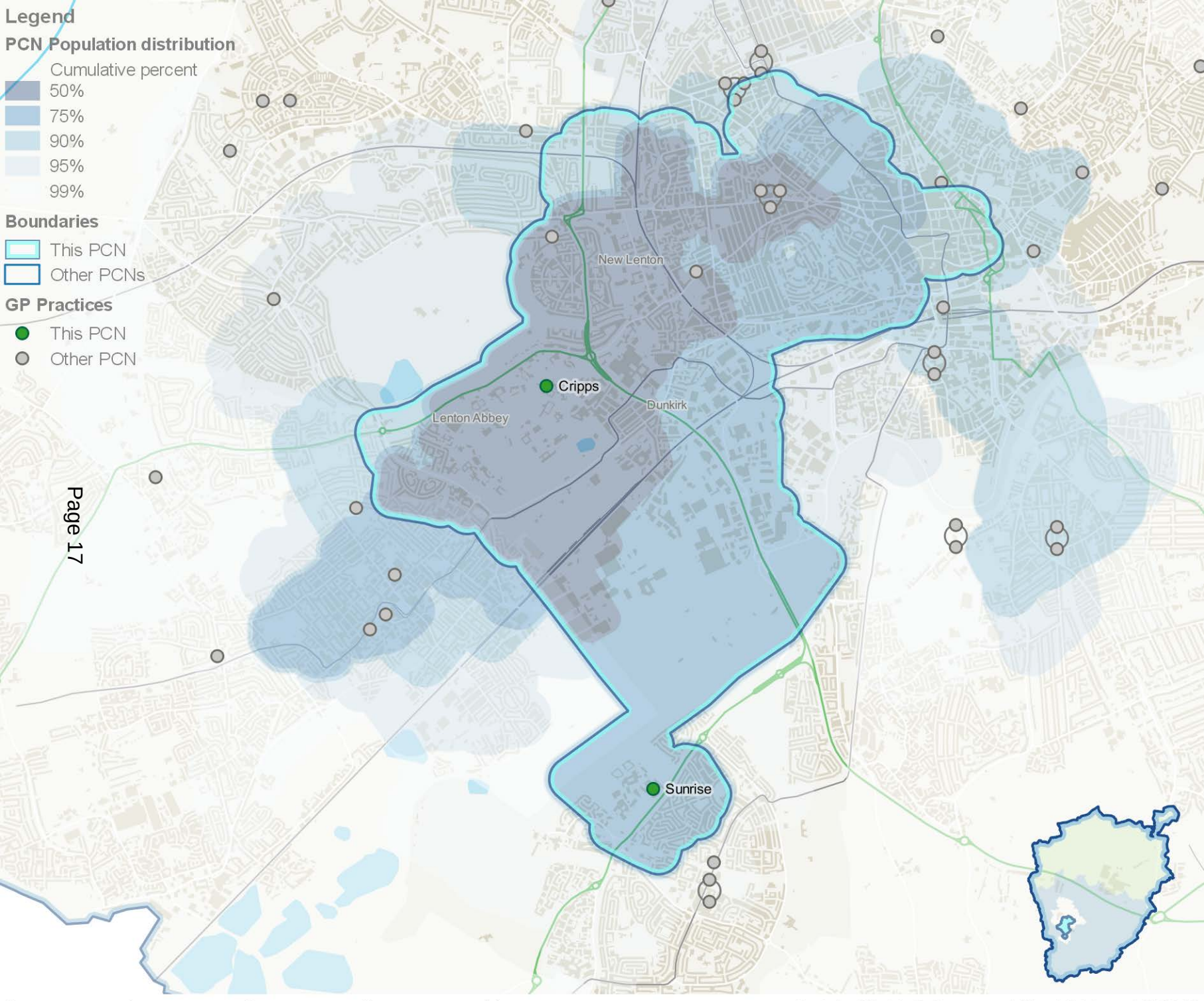












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