**NOTTINGHAM CITY COUNCIL**

**HEALTH SCRUTINY COMMITTEE**

**MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 12 September 2019 from 10.07 am - 12.46 pm**

**Membership**

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

**Colleagues, partners and others in attendance:**

| | | |
|---|---|---|
| Nancy Barnard | - | Governance and Electoral Services Manager |
| Hazel Buchanan | - | Director of Operations, NHS Nottingham North & East CCG |
| Sarah Collis | - | Self Help Nottingham |
| Lucy Dadge | - | Director of Commissioning, Nottingham City Clinical Commissioning Group |
| Helene Denness | - | Public Health Consultant |
| Marie Cann-Livingstone | - | Teenage Pregnancy and Early Intervention Specialist |
| Kate Morris | - | Governance Officer |

## 17 APOLOGIES FOR ABSENCE

Councillor Merlita Bryan
Councillor Sam Gardiner

## 18 DECLARATIONS OF INTEREST

None

## 19 MINUTES

The minutes of the meeting held on 11 July 2019 were confirmed as a true record and signed by the Chair.

## 20 LOCAL IMPLICATIONS OF THE LONG TERM PLAN

Lewis Etoria, Head of Communications and Engagement for Nottingham and Nottinghamshire Integrated Care System (ICS) presented a report to the Committee on the Local Implications of the NHS Long Term Plan. He highlighted the following points:

(a) The NHS Long Term Plan sets out the NHS priorities in England over the next 10 years. Local areas must develop their own plan establishing how they will implement the national strategy;

(b) Nottingham and Nottinghamshire ICS in partnership with Healthwatch Nottingham and Nottinghamshire designed and delivered a programme of engagement to establish what is important about health care to local people. Information gathered will go towards informing the Local Plan;

(c) There were three main methods of engagement:
- Public engagement by the ICS through face to face consultation and online surveys;
- Public engagement by Healthwatch through face to face interaction; and
- Focus groups with staff and members of the public facilitated by Attitudes and Understanding Research.

(d) The different approaches and focuses of the three methods ensured a wide spectrum of society was engaged, including, through Healthwatch, some of the harder to reach groups;

(e) Throughout the engagement there were over 1000 reponses to the survey, 50 community events, over 50 in-depth interviews/focus group participants, 3,200 visitors to the website and social media reach of over 70,000 people;

(f) Overwhelmingly the consultation established that the most valued aspect of the NHS is that it is free at the point of need. Frontline staff and accessibility of services were also valued highly by respondents;

(g) There was widespread public support for urgent and emergency care along with mental health care, both of which are priorities within the National Long-Term plan.

(h) Prevention was also an important priority with some public reservations, as were finances and efficiency, but these were not as significantly supported as other areas;

(i) There were mixed views on personalisation and choice of care as there was with digital innovation in healthcare. It is possible that these less supportive views are a result of a lack of understanding around how these aspects work within the NHS. This learning point is to be taken forward to raise awareness of how digital innovation is already working within the NHS and how it can benefit patients going forward;

(j) The final key insight from the engagement is that staff are concerned about reduction in resources and an increase in demand for services;

(k) Following this engagement, the next step for the ICS is to draft a plan outlining priorities for the next 5 years. This plan is currently being written. Close work with Healthwatch continues to ensure learning points form the engagement work are integrated into the local system plan;

Following questions and comments from the Committee the following points were made:

(l) Although the response rate, just over 1000 responses, was not large, these were in depth and represented a wide range of communities. The demographics of respondents was increased by the partnership working with Healthwatch;

(m) Further work to promote the use of digital innovation needs to take place. It is clear that the public as a whole are not as aware of the established use of digital technology within the NHS as they could be and this has led to limited enthusiasm for focus on this area;

(n) Healthwatch tailored the questions used throughout the engagement process to Nottingham and Nottinghamshire citizens. This enabled the engagement process to be far more focused and relevant to the local area;

(o) It is not thought that the key points highlighted from the engagement in Nottingham differed significantly to those points across raised at a local level across the country, although it is still early in the process and headlines are only recently beginning to be shared;

(p) Health inequalities continue to be a focus for the ICS and the engagement highlighted that accessibility of NHS services was one of the most important aspects of the service;

(q) Funding for priorities is set out in the NHS Long Term Plan. Local results of engagement closely mirror the priorities of the Long Term Plan including a focus on Urgent and emergency care and Mental Health;

(r) Investments in preventative care are carefully balanced against ensuring later stage care receives sufficient funding. A great deal of prevention work and care is being carried out by organisations within the Voluntary and Community Sector. It will be essential that the way this work feeds into the Local Plan is mapped carefully;

In conclusion, the Committee noted the content of the report and presentation and thanked Lewis Etoria for his attendance. They requested a written update to a future meeting on the Local Plan once it has been published.

## 21 UPDATE ON PROGRESS OF GP FORWARD VIEW

Lynette Dawes, Head of Primary Care – Nottingham Clinical Commissioning Group and Dr Manik Arora introduced the report updating the committee on the progress of the delivery of the GP Forward View (GPFV) focusing on improvement of access and quality of services within Nottingham City. They highlighted the following points:

(a) Following the publication of the GPFV in 2016 there has been a commitment to improve general practice services across Nottingham. There have been a number of projects implemented in partnership with the CCG's across Nottinghamshire to achieve this aim;

(b) Since it was first commissioned in March 2018 a service known as GP+ has provided an additional 182 hours of primary care services per week including evening and weekends. This service is across the primary care services including appointments with GP's, Nurse Practitioners and Clinical pharmacists and is currently offered from a city centre location;

(c) The workflow optimisation initiative was launched in 2017/18 and works to train administrators to deal with clinical correspondence in a safe and confidential way. 45 out of the 50 GP practices in Nottingham participate in this programme and it is estimated that 40 minutes of GP time, per GP per day have been released. In late 2018 an evaluation took place that found that over 1,000 GP hours were released in a year;

(d) Active signposting training was delivered to GP reception staff, which allows them to signpost patients to the right service first time. This works alongside a web based directory of services and self-care information that was developed by the Nottingham City GP Alliance;

(e) Funding was made available to practices specifically for schemes that developed sustainability and resilience. This scheme also allowed practice managers to develop further providing training and change management. This led to the establishment of the Practice Managers' Forum;

(f) Recruitment and retention of international staff has been a challenge that is being addressed at a national level. Coordination of recruitment of clinical staff sits with the ICS;

(g) The 8 Primary Care networks (PCN's) have now been configured across the ICS which aim to deliver localised care. Each PCN has a Clinical Director in place and all but one has a Deputy Clinical Director appointed;

Members of the committee asked a number of questions and raised various points. The following information was highlighted during discussion:

(h) There is still work to do to raise awareness of the GP+ scheme. The GP Alliance continue to provide training and education with receptionists as part of the signposting work programme to ensure that where appropriate the public is referred to the GP+ scheme;

(i) There are a number of pockets of good practice around referral to GP+. Now that PCNs are established and being embedded there is the opportunity to more easily share good practice and standardise the referrals;

(j) There are a number of work streams looking at making GP practices resilient and with the newly formed PCN in place there will be the opportunity to look at a model which can provide increased support where needed;

(k) Practices are increasingly using telephone triage to signpost patients to the correct care. This does however require training for the reception staff and more awareness from the public along with strict clinical governance.

(l) The introduction of the PCN's will allow the groups of practices within the same area a degree of autonomy to commission services that are suitable for their specific population and allow more choice to patients;

The committee thanked Lynette and Dr Arora for the updated and noted the information provided.

## 22 THE NATIONAL REHABILITATION CENTRE

Amanda Sullivan, Accountable Officer for Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) together with a number of colleagues, gave a presentation informing the Committee about plans for the National Rehabilitation Centre. She highlighted the following information:

(a) Planning permission has been granted on land donated to the NHS for a regional rehabilitation clinical facility and national research and innovation hub. It is proposed that the facility consist of 63 single and multi-bed rooms to act as a regional clinical service;

(b) NHS patients would have access to the state of the art Ministry of Defence facilities which is located next to the site of the proposed regional centre;

(c) The 6 CCG's within Nottingham have been working alongside Nottingham University Hospitals Trust in the review to develop plans, working towards establishing services and considering how they will link with local services and fit with local populations;

(d) This development will give the opportunity to deliver more capacity to services and strengthen the overarching national strategy for rehabilitation;

(e) The facility will link with the regional trauma unit at Queens Medical Centre and provide services where there is currently a gap. It will provide targeted and intensive rehabilitation which will not only improve patient outcomes but will reduce the amount of time patients are in hospital;

(f) The current rehabilitation service is based at Linden Lodge at Nottingham City Hospital and consists of 24 rehabilitation beds. There are additional secondary facilities that provide other aspects of rehabilitation but these are based across a number of different sites. The rehabilitation centre will ensure that services are based at one site;

(g) Referral criteria are yet to be confirmed but will rely on the need for patients to be able to cope with, and benefit from, the intensive rehabilitation that will be offered at the centre;

(h) Referral will take place through a single point and will be reviewed by experts through the East Midlands Trauma Network. Programmes of rehabilitation will be tailored to suit each individual patient;

(i) The centre will aim to deliver a net increase of 39 specialist beds across the East Midlands Region, and it is estimated that the centre will treat up to 800 patients a year. Individual stays at the centre will not be time limited;

(j) The aim is for the centre to be cost neutral for commissioning and to provide services within the current budgets, achieved by system wide reviews of currently commissioned services and transfer of current services/activities. It is projected that this will lead to a reduction in the cost of ongoing care, release acute trauma beds more quickly, and will attract central funding;

(k) Following a review by the Clinical Senate there have been a number of recommendations. The referral criteria will need to ensure equality across patient groups and conditions, there needs to be consideration of workforce planning, discharge planning process must be considered and interface with the community ensured. There needs to be more consideration of the cost/benefit relative to potential capacity gap in the system;

(l) Following engagement with patient groups the following points were raised:
- Quality of care is important, as is access to care all in one place
- Concerns were raised about losing access to personal connections
- Most people were willing to increase travel time to reach better services;

(m) There will also be a focus on mental health rehabilitation for patients built into the physical rehabilitation programmes. This supports the NHS Long Term Plan;

(n) An impact analysis has been conducted. It found that travel would be impacted significantly. On average, patients would need to travel further and travel time would increase from 20 minutes to 39 minutes. Those using public transport would be greatest impacted with an average regional travel time of 2 hours;

(o) Key benefits would include improved patient outcomes, minimised waiting times, access to state of the art equipment, vocational rehabilitation, longer term savings in community and social care and research opportunities including integration with military education and training;

The Committee asked a number of questions and the following discussion points were made:

(p) Concerns were raised about the significant impact on travel time for Nottingham City patients. Travel time to the new facility will impact everyone, but especially those using public transport. This will impact out-patients as well as families visiting in-patients, both in terms of travel time and cost. Consideration is being given to whether it is possible to subsidise travel in any way;

(q) There are early stage discussions with local transport companies looking the possibility of adding new routes to the infrastructure to help with transport times and accessibility of the site. The number one bus already serves the site from Nottingham city centre;

(r) The site of the facility has been predetermined by the donation of land to the NHS. It is beneficial to be sited close to the MoD rehabilitation centre as it allows access to the state of the art facilities not currently available to NHS patients. It also allows better education, training and research;

(s) The commissioning of the services will be subject to all of the proper processes and will be open competition. Nottingham University Hospitals Trusts will have to bid alongside other trusts if they wish to deliver the service;

(t) A centralised, regional facility combined with a National Research centre will allow for the opportunity to increase bed count, offer the opportunity for efficiency savings, as well as help to shape the national strategy for rehabilitation which are not things that could occur if the local services were retained;

(u) There is a need for further engagement with patient groups, service users and the public. Healthwatch can facilitate with this engagement to feed into the business case;

The committee thanked everyone for their attendance, noted the content of the presentation, and indicated that they would be interested in hearing future developments on this project. Colleagues agreed to take back the Committee's comments on the accessibility of the site, links with local services and the impact of transition from current services to new services.

## 23 REDUCING TEENAGE PREGNANCY

Helene Denness, Public Health Consultant and Marie Cann-Livingstone, Teenage Pregnancy Specialist gave a presentation on work taking place to reduce unplanned teenage pregnancies. They highlighted the following points:

(a) Teenage pregnancies are considered to be those pregnancies in under 18's that result in a live birth;

(b) Since the baseline figure was taken there has been a significant reduction in teenage pregnancies in Nottingham;

(c) Since 2012 however there has been no significant statistical reduction and numbers have fluctuated year on year;

(d) 20% of teenage pregnancies in Nottingham are in young women aged under 16 years old;

(e) Nottingham City currently has the third highest teenage pregnancy rate within the Core Cities cohort, with Manchester and Liverpool having higher rates. Bristol has the lowest teenage pregnancy rate out of the Core Cities and Teenage Pregnancy workers have been liaising with Bristol colleagues to establish what, if anything, different is happening in Bristol;

(f) Early intervention and primary prevention are the main points to the approach for reducing Nottingham's teenage pregnancy rates along with sex and relationship education in and out of school, contraception and sexual health services that are young person friendly and targeted support for those most at risk of teenage pregnancy;

(g) Following analysis of the most recently available data two areas of Nottingham, Berridge and Hyson Green, have a higher than average teenage pregnancy rate and so resources are being targeted in those areas;

(h) There has been sustained targeted work in the last 12 months following a review of services by this Scrutiny Committee. Work has taken place to target resources at reducing conceptions in the high-rate wards, and to reduce conceptions in the under 16 age group;

(i) Youth workers in high rate wards have all received specific C-Card training and workers within schools in high rate wards have also received this training;

The Committee discussed the presentation and asked a number of questions. The following further information was given:

(j) There is more work to be done around raising aspirations of young people to encourage them to think beyond teenage parenthood. There are a number of programmes within schools targeting at risk young people;

(k) Teenage pregnancy rates across the city have been mapped against sexual health care services and access to contraception. This mapping has allowed resources to be targeted in areas of greatest need and demand;

(l) Nottingham City Council has a good relationship with faith schools. There is a multi-faith committee that meets including Councillors and discussion around sex education has been productive;

(m) A significant proportion of teenage mothers go on to have a second teenage pregnancy. Targeted work and education is ongoing to review this.

In summary, the Committee thanked both Helene and Marie for their attendance and their work on reducing teenage pregnancy in Nottingham. They noted the information contained within the presentation and invited them to return in a year's time to provide a further update.

## 24 HEALTH SCRUTINY COMMITTEE WORK PROGRAMME

Nancy Barnard, Governance and Electoral Services Manager, introduced the Health Scrutiny Committee Work Programme report, detailing the proposed work programme. There was discussion around the proposed agenda timetables and reports, and the committee agreed that the timetable should be altered to balance out workload in the upcoming months.

The following amendments to the work programme were agreed:

- Emergency Pathways Transformation and Planning for Winter Pressures will come to the October meeting as one item;
- Gluten Free Prescribing and Over the Counter Medicines to be deferred from October to December;
- The Portfolio Holder for Health, HR and Equalities will be attending in October to discuss her Portfolio;
- Suicide Prevention Plan to be scheduled for the January meeting alongside the item on Young People's Mental Health and Wellbeing.

The remainder of the work programme to be discussed by the Chair and the Senior Governance Officer and brought back to the Committee for approval.