Nottingham City Council

Health Scrutiny Committee

Minutes of the meeting held at remotely via Zoom on 16 July 2020 from 10.01 am - 12.08 pm

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Samuel Gardiner
Councillor Cate Woodward (Vice Chair)	
Councillor Phil Jackson	
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:

Ajanta Biswas	-	Healthwatch Nottingham and Nottinghamshire
Hazel Buchanan	-	Associate Director for Special Projects, CCG
Alison Challenger	-	Director of Public Health, Nottingham City Council
Lucy Dadge	-	Chief Commissioning Officer, CCG
Lewis Etoria	-	Head of Insights and Engagement, CCG
Amanda Sullivan	-	Accountable Officer, CCG
Laura Wilson	-	Senior Governance Officer, Nottingham City Council

1 Apologies for absence

Councillor Sam Gardiner – work
Councillor Lauren O'Grady – lateness

2 Declarations of interest

None.

3 Minutes

The minutes of the meeting held on 12 March 2020 were confirmed as a true record and signed by the Chair.

4 Covid-19 Pandemic

a The impact on Nottingham

Alison Challenger, Director of Public Health, Nottingham City Council, was in attendance to provide the Committee with information on the impact of Covid-19 on Nottingham.

In addition to the report that had been provided, a presentation was delivered which highlighted the following points:

(a) Covid-19 is an infectious disease caused by a newly discovered coronavirus;

(b) the World Health Organisation declared a Covid-19 pandemic on 11 March 2020;

(c) most people are either asymptomatic or have mild symptoms;

(d) those at risk of serious illness include older people, and those with underlying health conditions such as cardiovascular disease, cancer, diabetes, and chronic respiratory disease;

(e) by 8 July 2020 there were 1172 lab-confirmed cases of Covid-19 in Nottingham, which equates to 354 positive cases per 100,000 citizens. This is lower than the England average of 439.1, and the second lowest of the Core Cities;

(f) there have been 231 Covid-19 deaths in Nottingham (up to 26 June 2020);

(g) cases and deaths have declined since the mid-April peak;

(h) Covid-19 has worsened pre-existing health inequalities;

(i) older age is the biggest pre-determinant of poor outcome from Covid-19, particularly for those aged over 85;

(j) risk and poor outcomes are also greater for Black, Asian and other minority ethnic groups, possibly due to:
- deprivation and occupation;
- public transport use;
- household composition and condition of housing;
- population density;
- pre-existing conditions;

(k) Nottingham and Nottinghamshire's Local Resilience Forum has worked throughout the pandemic to:
- ensure that the local need for personal protective equipment is met in a timely way;
- ensure that sufficient testing capacity exists for key workers and the wider community;
- provide support for care and support workers;
- provide accommodation for rough sleepers in hotels to enable them to socially distance and self-isolate;
- establish the Customer Service Hub enabling local citizens to log requests for help;

(l) the national NHS Test and Trace Programme is being introduced;

(m) Nottingham City Council has published an Outbreak Control Plan, which includes:

- mitigating the risks of further outbreaks of Covid-19;
- managing further outbreaks of Covid-19;
- analysing key data indicators and soft intelligence;
- mobilising the Incident Management Plans for high-risk settings should the need arise;

(n) local Outbreak Control Engagement Boards are working with local communities;

(o) the pandemic has had significant impacts that go beyond the health of those affected by the disease and the families and friends of those who have sadly died as a result of Covid-19. These include:
- mental health;
- economic impact;
- education as a result of school closures;

(p) work to reduce health inequalities is crucial to recovery planning and the strong partnerships that are in place in Nottingham means that the city is well placed to do this.

During the discussion that followed the following points were raised:

(q) the city has 44,000 students across the two universities, so there was a working group looking at the potential impact of them returning to the city, and how to manage any outbreaks;

(r) a lot of data is available in relation to infection rates, and all relevant data is published on the Council's website;

(s) postcode data is provided weekly, but a request has been made for it to be provided daily so that any potential spikes can be identified quickly;

(t) the BAME community is diverse and work to understand disproportionate impact of Covid-19 is being carried out;

(u) it is important to ensure that the Council works in partnership with the CCG to ensure that mental health support is readily available;

(v) Nottingham has complied what with has been asked for nationally, and is looking at what measures are required locally.

The Committee thanked Alison for the presentation.

Resolved to have an informal meeting of the Committee to decide on areas for future scrutiny.

b Changes to NHS Services

Amanda Sullivan, Accountable Officer, CCG, and Lucy Dadge, Chief Commissioning Officer, CCG, were in attendance to provide the Committee with information on the NHS service changes in response to Covid-19.

In addition to the report that had been provided, a presentation was delivered which highlighted the following points:

(a) on 30 January 2020 the first phase of the NHS's preparation and response to Covid-19 was triggered with the declaration of a Level 4 National Incident;

(b) on 17 March 2020 NHS England sent a letter asking every part of the NHS to redirect staff and resources, building on actions already in progress locally;

(c) the first local case was confirmed on 21 February 2020;

(d) the peak of the local incident took place in April 2020;

(e) on 29 April 2020 NHS England sent a letter signalling that whilst a Level 4 National Incident remained, with all the action to manage this, the NHS should start to move into the restoration phase. The restoration should focus on standing up services for urgent and essential services, and 'lock in' beneficial changes that were made during phase 1. Initially restoration was to cover the period up to 16 June, but is now recognised as a more fluid timetable;

(f) a further letter from NHS England is currently awaited regarding phase 3 of the incident, which will have requirements for the remainder of 2020/21, which will signal the recovery phase;

(g) local service changes have been made to help manage the impact of Covid-19 so that the increased demand on hospitals can be managed;

(h) some of the changes made have been mandated nationally, eg reducing face to face appointments and postponing the provision of some non-urgent services;

(i) other changes have been made by the local system in response to locally specific circumstances, eg local staffing pressures;

(j) most changes have been made by providers to manage workforce and operational pressures and to maintain patient safety;

(k) work is now being done to identify which service changes to immediately reverse and which to consider as a longer term change;

(l) all changes have been made to support a number of principles for care:
- ensuring adequate hospital and intensive care capacity for patients who need acute care as a result of Covid-19;
- keeping staff and patients safe in healthcare environments (including cohorting of infected patients, infection prevention and control, and workforce deployment);
- reducing face to face contacts where services can safely be delivered via alternative methods;
- supporting the most vulnerable members of the population;

(m) in relation to phase 1 – incident response:
- changes to activity included:

  - Primary Care consultations reduced with most consultations taking place virtually;
  - a significant reduction in Emergency Department attendances;
  - a significant reduction in non-elective admissions;
  - reduced two week wait and routine referrals;
  - outpatient activity has reduced, with a significant shift to non face to face contacts;
  - mental health admissions showed a small decrease, but patients had higher acuity, and there was a growth in self referrals to crisis centres;
- service changes included:
  - a rapid increase in the use of technology across all care settings;
  - a single discharge pathway was developed;
  - a reduction in ambulance conveyance to A&E rates;
  - a package of support to care homes – infection prevention and control, personal protective equipment, training, etc;
  - self-care support was enhanced across services, eg use of information and advice where face to face contact wasn't possible;
  - new interventions and targeted support – support for vulnerable groups, 24/7 crisis line, joint support for people who are homeless, etc;

(n) in relation to phase 2 – restoration principles, the system has agreed that prior to re-starting services:
- assurance is required that safe, effective and compassionate care can be delivered in all settings so that both staff and the public re-build any confidence in local services that may have been lost;
- environmental issues must be addressed to ensure that across the whole system, including the Primary Care estate, patients can receive treatment in settings that comply with infection prevention and control requirements;
- assurance is required that there is adequate capacity (beds, testing, supplies, and workforce) to manage those patients who contract Covid-19, the expected increase in non-elective admissions for non-Covid-19 conditions, and to maintain flow through the system;
- there is consistency across the system regarding service restoration so that essential but scarce supplies are targeted for patients with the greatest clinical need;
- capacity plans must be realistic for the 'new normal' working environment, taking into account requirements for social distancing, infection prevention and control practices, testing, etc;
- plans need to be able to flexibly respond to possible further Covid-19 peaks;

(o) in relation to phase 2 – restoration priorities, the system's priorities for restoration are ensuring:
- patients have confidence that it is safe to access services when they need to;
- the positive changes that have been seen in the way patients and clinicians have responded and behaved are maintained;
- there is sufficient capacity for the predicted increase in non-elective admissions (Covid and non-Covid);
- patients have continued access to urgent services, using the Royal College of Surgeons framework for prioritising services as a guide;
- routine services are resumed in a phased process safely;

- staff continue to be alert to safeguarding issues both for adults and children, particularly as lockdown is lifted;

(p) the current focus includes:
- ensuring cancer and urgent patients receive treatment, with a gradual increase of routine work;
- non-Covid activity is increasing – Primary Care consultations are nearing pre-Covid levels, and non-elective admissions are increasing 1% per day since mid-April;
- despite increased emergency admissions, there remains relatively low levels of occupancy in acute beds as the number of discharges in matching admissions, which is critical to maintaining capacity in acute care;
- planning work for restoration of services is based on clinical prioritisation;
- the biggest risk to restoring services in all care settings is the consistent availability of personal protective equipment;
- plans remain in place for a potential second wave of Covid;

(q) a log of all service changes made in response to Covid has been developed and can be categorised as:
- changes not viable to maintain that should be reversed when it is safe to do so;
- changes that should be reversed, but in line with transformation programmes;
- changes that should be considered to be maintained as they provide long-term solutions to improve health outcomes and are aligned to the NHS Long Term Plan. These include neuro rehab, centralisation of hyper acute stroke services, future urgent care pathways.

During the discussion that followed the following points were raised:

(r) moving away from face to face appointments does have advantages, but isn't suitable for everyone which needs to be considered when appointments are offered. Guidance is being developed as learning takes place and the impact is being monitored;

(s) discharge pathways have always been difficult to manage. They have improved during Covid because of extra funding, so work is being done to try to make the extra funding permanent;

(t) regular contact is being maintained with those patients who have had procedures and appointments postponed;

(u) the care home situation has been difficult nationally and lessons have been learned, which has resulted in extra support being put in place;

(v) it is important to maximise the number of people accessing the flu jab in order to minimise the winter pressures;

(w) lack of dentistry services has had a major impact, and the community dentistry service remains closed which means the most vulnerable people are being left without treatment;

(x) non-essential services are steeping back up rapidly to address the backlog, and additional resources are being investigated to help ease pressure;

(y) work is being done to look at how mental health services can meet demand moving forward, eg virtual appointments, etc;

(z) consultation will take place on any proposed permanent changes.

The Committee thanked Amanda and Lucy for their presentation.

Resolved to have an informal meeting of the Committee to decide on areas for future scrutiny.

5 National Rehabilitation Centre - Updated Consultation Plan

Lewis Etoria, Head of Insights and Engagement, CCG, and Hazel Buchanan, Associate Director for Special Projects, CCG, were in attendance at the meeting to present the updated public consultation plan in relation to the National Rehabilitation Centre, and notified the Committee of their intention to hold the public consultation on the proposals, for a period of 8 weeks, from 27 July 2020.

Resolved to note the consultation dates.