Public Document Pack

Nottingham City Council
Health Scrutiny Committee

Date: Thursday, 17 September 2020

Time: 10.00 am (pre-meeting for all Committee members at 9:30am)

Place: Meeting to be held remotely via Zoom - meeting participants will be provided with access details
Meeting will be livestreamed on the Council's YouTube Channel - https://www.youtube.com/user/NottCityCouncil

Councillors are requested to attend the above meeting to transact the following business

Director for Legal and Governance

Senior Governance Officer: Jane Garrard **Direct Dial:** 0115 876 4315

1 Apologies for absence

2 Declarations of interest

3 Minutes 3 - 10
To confirm the minutes of the meeting held on 16 July 2020

4 Changes to NHS services in response to Covid-19 11 - 22

5 Tomorrow's NUH (Nottingham University Hospitals) 23 - 26

6 Work Programme 27 - 34

7 Future meeting dates
To agree to meet on the following Thursdays at 10am:

- 15 October 2020
- 12 November 2020
- 17 December 2020
- 14 January 2021
- 11 February 2021
- 11 March 2021
- 15 April 2021

If you need any advice on declaring an interest in any item on the agenda, please contact the Governance Officer shown above, if possible before the day of the meeting

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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.

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Health Scrutiny Committee
17 September 2020

Changes to NHS services in response to Covid-19

Report of the Head of Legal and Governance

1 Purpose

1.1 To review progress in restoring services that changed in response to Covid-19.

2 Action required

2.1 The Committee is asked to:

a) where it is intended that services which changed in response to Covid-19 will return to pre-Covid models, scrutinise the progress in restoring those services; and

b) where it is intended to retain changes introduced in response to Covid-19, consider its engagement with the proposals to make these changes permanent.

3 Background information

3.1 At its meeting in July 2020, the Committee heard about changes that were made to services to manage the increased demand on some services and to ensure infection control procedures were in place as a result of the coronavirus pandemic. Some of these changes were mandated nationally and some were local decisions in response to local circumstances.

3.2 The Committee asked for an update on the current status of these services for this meeting to review the progress in restoring services to pre-Covid models or, where commissioners have identified a desire to retain the changes, to consider proposals for this. This is important because, due to the pace of response to the Covid-19 situation and the need to ensure patient safety, manage workforce issues and operational pressures at that time it was not always possible for the Committee to be notified in advance of changes made to services.

3.3 Attached is a briefing from Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) setting out which services have resumed as normal, which services are operating differently and which services are still not operational.

3.4 The CCG briefing also sets out initial proposals to retain service changes made in response to Covid-19 to urgent care pathways and stroke services. Going forward, the Committee will need to decide whether it considers the proposals for change to be substantial variations or developments of service and how it wishes to engage with the proposals as they develop.

4 List of attached information

4.1 Briefing from Nottingham and Nottinghamshire Clinical Commissioning Group

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Report to, and minutes of the meeting of the Health Scrutiny Committee held on 16 July 2020

7 Wards affected

7.1 All

8 Contact information

8.1 Jane Garrard, Senior Governance Officer
jane.garrard@nottinghamcity.gov.uk
0115 8764315

Changes to services to support the COVID -19 response
Update report for Health Overview and Scrutiny Committee

Dear Colleagues,

Further to the briefing paper issued to the Health Overview and Scrutiny Committee in June, this paper, together with supporting appendices, provides an update on the service changes included in the earlier brief.

As informed in June, as the commissioner of local health services, the CCG has been working closely with NHS Providers and other partners in our response to COVID-19. Part of this work involved making changes to local services to manage the increased demand on services, and to ensure the appropriate infection control procedures were in place. Some of these changes were mandated nationally, for example reducing face-to-face appointments and postponing the provision of some non-urgent services. Other changes were made by the local system in response to specific local circumstances.

At the time of the first brief to the Committee, the degree of pressure on the system and the rapid pace of response required to protect the safety and welfare of patients and staff meant that it was not always possible to notify the Local Authority in advance of changes being made to services. Service changes were made by providers to ensure patient safety, manage workforce and the operational pressures arising from the pandemic.

The June briefing contained a full list of all service changes that have been made in response to the COVID-19 pandemic. Appendix 1 includes an update on the current status of those services.

A number of services have now restored or partially restored and there is an on-going system Recovery Cell that is responsible for managing the return of services. Some services will restore to pre- COVID models of delivery and capacity, whilst others will operate differently where there has been positive transformation that they system wishes to retain. This includes changes that have been made that have made a positive impact on health outcomes and are aligned to the ambitions in the NHS Long Term Plan.

There are two areas (the urgent care pathway and reconfiguration of acute stroke services at Nottingham University Hospitals) where the service change during COVID-19 was based on clinical transformation work that was underway prior to the COVID pandemic. Work is continuing to confirm which aspects of delivery have demonstrated benefits and should therefore be retained. Details of these proposals are included within Appendix 2 and 3 of this report.

Proposals to retain any significant service changes will be subject to the usual procedures, including public consultation and consultation with the Local Authority.

For more information please contact;

Lucy Dadge

Chief Commissioning Officer

lucy.dadge@nhs.net

Appendix 1	**Restoration of Services**	
Normal services resumed	Services operating differently	Services still not operational
Children and Young People's Services		
Description of Change	**Update September 2020**	**Status**
Integrated Community Children and Young People's Healthcare Programme: Routine reviews of respiratory conditions delayed except for at risk patients; routine referrals delayed; therapy services delivered by video conferencing or phone.	All nursing and therapy services have been reinstated to all children and young people (routine and urgent). Face-to-face appointments are encouraged but choice of digital appointment is given to families.	
NUH out of hospital community paediatric services stopped except clinical priority services; child protection medicals; phone advice and urgent referrals.	**Community Paediatrics & Neurodisability Service** During the early stages of COVID, the service converted existing face to face clinics to virtual clinics and introduced twice weekly face to face rapid access clinics to see patients who could not be managed by telephone. A phased reinstatement of face to face provision is taking place, though this has been dependent on availability of accommodation in health centres, which have been utilised as COVID response centres. The safeguarding and SARC element retained its face to face service with additional safety measures in line with COVID guidance. **Children in Care Service** Face to face clinics resumed from 15.07.20. Due to restrictions prior to this, there is a backlog in children requiring the physical component of their Initial Health Assessment. A funding case has been developed to increase clinic capacity to ensure these are undertaken in a timely manner.	
Rainbows Children's Hospice: Respite Short Breaks suspended; family support services by video and phone; adult day care suspended.	**Respite and young adult day care**: These services will not be recommencing at Rainbows this year due to the continued requirement for social distancing and shielding of the extremely clinically vulnerable (see RCPCH guidance). **Family Support Services**: Family Support Services have continued virtually using e-mail, video conferencing & telephone. Rainbows report that they currently make up to 80 contacts per day with children, young people and families. **Further information**: Rainbows Hospice has been supporting the NHS with step down capacity to free up	

	acute Paediatric beds; this will continue throughout winter, as capacity allows. From May, an Emergency Support Services in the home for families most in need has been provided (ensuring compliance with PPE guidance); this service supports 21 families per week. From June, the organisation began to provide Emergency Stays in the Hospice for families that are in need of enhanced support or where the children and young people cannot be cared for in the home due to family illness.	

Mental Health Services		
Description of Change	**Update September 2020**	**Status**
Open access all age 24/7 crisis line set up.	The crisis line is continuing. Further capacity is provided by a mental health helpline provided by Turning Point.	
Reduction or suspension of face-to-face contact and increased use of phone and video consultations and online resources for the following: Crisis Teams; Local Mental Health teams; Community Mental Health Teams; CAMHS; Kooth; Sharp; Harmless project.	All commissioned services are continuing to provide phone and video consultations with face- to- face contact when required. A number of services have continued to provide a face- to- face service for example crisis resolution and home treatment teams.	
Temporary use of Haven House crisis house as a step down unit to support discharge (change now reversed).	Haven House is continuing to operate as a crisis house.	
Recovery College services suspended and staff deployed to other areas.	The Recovery College is providing services remotely.	
CAMHS support to schools via in-reach.	CAMHS are continuing to provide support to schools and a number of Mental Health Support Teams in Schools are going to be operational from September/October.	
Alexander House locked rehabilitation service designated as an isolation unit, with patients transferred to the Orion Unit at Highbury Hospital.	This change is no longer in place - Alexander House is operating as a locked rehabilitation service and the Orion Unit as an Assessment and Treatment Unit	
Planned Care		
Block Contracts established with Independent Sector (IS) providers to create additional bed capacity.	NHSE/I maintain the responsibility for the contracts with the independent sector, however these have moved on to allow the NHS to access capacity required but also to allow more routine services to restart. All NHS patients seen within the IS will still be	

	treated in clinical priority alongside the provision within the NHS Providers, however this next phase of the agreement in place will allow some of the services that were suspended to re-start. The IS will also be using some capacity to restore their own private services.	
Move from face-to-face to virtual clinics for outpatient services where appropriate.	The use of non-face to face is a desire within the NHS Long Term Plan and therefore work is ongoing with providers to establish the correct level of virtual appointments. The ambition will be to achieve as high a percentage of non face to face as possible whilst still seeing those patients that need to be seen or wish to be seen.	
Postponement of all non-urgent elective operations.	There is an increasing amount of routine elective work being undertaken. The guidance from NHSE/I is that providers should be planning to return to 90% of pre-Covid levels of elective activity by October and 100% of outpatient activity in the same period.	
Suspension of community non-obstetric ultrasound service.	All non-obstetric ultrasound service providers have self-assured that they meet the requirements for Infection Prevention and Control and that they have robust access to the required Personal Protective Equipment, and on this basis they have been instructed to re-start services.	
NUH suspended faecal sample testing.	All pathology services at NUH are now fully operational.	
Sherwood Forest Hospitals (SFH) suspension of termination of pregnancy service – service to recommence from 9 June (community service continued).	The service recommenced as intended.	
Temporary suspension of home births service by SFH and Nottingham University Hospitals (NUH) - NUH have since re-established a restricted home births service.	The temporary suspension was very short this option is now available should patients choose.	
Community Services		
Community Orthoptics service suspended all non-essential face-to-face services and increased use of video and phone consultation.	The Community Orthoptics service has now started to resume delivery of face to face clinics. Appropriate infection control measures have been put in place, but these will reduce the number of appointments available at each clinic. Virtual appointments continue where appropriate.	
Community diabetes nursing teams suspended clinics and education courses .	• Clinics have all been reinstated – virtual clinics and face to face clinics where clinically needed. • Consultant clinics also have recommenced at the beginning of September. • Virtual education courses have recommenced.	
Face-to-face community rehabilitation suspended, except for patients who have had recent elective surgery; fractures or	All redeployed staff returned to substantive roles. Face-to-face visits have recommenced.	

those with acute and complex needs.		
Neuro rehabilitation - Chatsworth Unit patients discharged to community provision and inpatient function temporarily closed to admissions.	The Chatsworth unit remains temporarily closed, with all patients being managed within the community neuro rehabilitation service. Any patients requiring access to the service (previously delivered within Chatsworth unit) will access the community service via the discharge to assess pathway.	
Community podiatry and podiatric surgery services suspended, except for high risk patients.	**Podiatry** - Community clinics being reinstated with social distancing measures. A phased approach has been taken due to access to estates. **Podiatric Surgery** – Service was due to recommence on 1 September 2020. There is currently an issue with the usual site of delivery, and alternative theatre space is being explored.	
Community services provided by Primary Integrated Community Services (PICS) suspended all non-essential face-to-face interventions.	• Clinics have restarted seeing urgent and longest waits. • Clinics are now split equally between face-to-face and telephone. This is now expected to be the new norm. • Within community gynaecology, the provider is working with NUH to identify consultant capacity to address backlog of routine patients.	
Community MSK groups suspended.	MSK groups recommenced virtually and plans to offer face to face being mobilised for patients unable to access virtual support.	
Community specialist nursing service suspended.	• Face to face appointments have recommenced following clinical prioritisation. • Alternatively virtual support being offered.	
Changes to community pain management services, including suspension of face-to-face consultations; greater use of video and phone consultations and suspension of steroid injections.	• Face to face appointments have recommenced following clinical prioritisation. • Alternatively virtual support being offered. • Steroid injections have recommenced.	

Appendix 2

Proposed retention of service changes implemented during Covid-19

Future urgent care pathways

1. Introduction

Nottingham and Nottinghamshire CCG remain committed to delivering the Long Term Plan for Urgent Care with Integrated Care System (ICS) partners. System partners have very recently joined together to produce a clinical services strategy for urgent care, which alongside emerging national guidance will help to shape the future of urgent care commissioning.

The current pandemic and the challenges it has provided health and social care services with has brought with it an opportunity (and the necessity) to look at the local urgent care pathway in a different way.

In order to ensure services can operate safely while social distancing remains in place and in the event of further pressures due to winter or second spikes in COVID-19, NHS England/Improvement are asking all commissioners and systems to implement the NHS 111 First initiative.

2. Alignment with Long Term Plan and Integrated Urgent Care pathway

In Nottingham and Nottinghamshire this new national drive aligns well with the local ICS plans for delivering the long term plan for urgent care, the outcome of the clinical services strategy review and the work that was already under way to transform the Integrated Urgent Care pathway. All of this work is being over seen by a new Right Place First Time Cell which is well attended by all stakeholders.

3. NHS 111 First

NHS 111 First aims to ensure patients receive the service they need first time by:

- Encouraging the use of NHS 111 or the local GP practice as the first places to go when experiencing a health issue that is not immediately life threatening
- A move away from going to a physical location as the first choice to access healthcare
- Embracing remote assessment and the technology which supports it
- Preventing hospital acquired infection by ensuring patients do not need to congregate in Emergency Department (ED) waiting rooms
- Allowing 111 to book patients directly into appointments or time slots in a service that is right for them

By the 1st December 2020 all areas have been asked to:

- Transfer 20% of unheralded (those that currently arrive at ED having not sought advice from another service) ED attendances to the 111 services
- Ensure an increased number of dispositions are available on the Directory of Services for 111 providers, with a focus on secondary care pathways including, Same Day Emergency Care, Assessment Units & Hot Clinics
- Provide a clear pathway for those patients that contact 111 and require an ED attendance to be booked into a time slot
- Develop a clear communication and engagement strategy
- Complete structured evaluation

A programme board for NHS 111 First has been set up and four key workstreams are now up and running which include;

- Capacity and demand
- Digital

- Clinical pathways
- Communications

The ICS is in the fortunate place of already having key components of the new urgent care pathway in place, including a clinical assessment service (CAS) which supports the 111 provider to ensure patients are seen by the right person first time.

3.1 Key deliverables

Key deliverables and changes to the current pathway locally which are being mobilised at pace include:

- 111 being able to access our local urgent response services (services that respond in under 2 hours)
- An increase in direct bookings (from 111 and the CAS) into the urgent treatment centres (UTCs) and primary care appointments
- Diverting more low acuity ambulance activity through the CAS and to alternative services
- Increasing the number of 111 ED dispositions that are reviewed by the CAS and diverted to alternative services
- Facilitating direct booking from 111/CAS into ED slots, same day emergency care appointments and speciality clinics at the acute hospitals
- Ensure unheralded patients attending ED are safely triaged/streamed to an alternative service including Same Day Emergency Care services, primary care and Urgent Treatment Centre(s)
- Developing a communications strategy aligned to the national messages in preparation for go live

3.2 Benefits

The key benefits of these changes include:

- A clear message to patients that 111 is their entry point to urgent care, which will reduce confusion
- Patients receive the care they need first time
- A reduction in the number of patients waiting in Emergency Departments which will reduce the associated risks to the public and allow the departments to operate more effectively
- Patients are seen at a time and location that is appropriate for their needs
- Appointment slots and transfer of patient information allows the Acute Trusts the opportunities to match demand to capacity more effectively
- Pathway developed to enable 111 to refer to community 2 hour urgent response services

The development of 111 First builds on the successful transition to digital and telephone based services that were well received and utilised by our citizens during the Covid pandemic. It provides incentives for the public to use 111 rather than walk in service as it provides access to a booked appointment with community services, GP, Urgent treatment centres and the emergency department.

3.3 Stakeholder Engagement

Commissioners are utilising the opportunities that COVID-19 has provided to engage with the public around how they have accessed urgent and emergency care services during the pandemic and their thoughts on accessing healthcare in the future. As part of this programme of work the public are being asked to feedback their thoughts on how and where they access services which will help to shape commissioning decisions that relate to the 111 First workstream and the integrated urgent care pathway as a whole. Early results from a survey of a representative sample of our population of over 2,000 people indicate that the public are supportive of remote

consultations with considerable acceptance of remote consultation for a number of possible scenarios including a “concern about a potential infection” (61%); “concern about minor physical illness or injury” (67%); “concern about your emotional wellbeing” (58%) and; “advice on an ongoing physical problem or condition” (64%). Further research is scheduled to explore access to emergency services and 111 in more depth.

The Nottinghamshire Health Inequalities Strategy recognises that deprivation and ethnicity are key determinants of health that influence 80% of health outcomes. Within the ICS, Nottingham City have more communities with high levels of deprivation and a higher proportion of the population from Black, Asian and Minority Ethnic communities. Recognising this, the urgent care commissioning team have met with the City Integrated Care Partnerships (ICP) members to update them on the plans for future urgent care pathways. This resulted in very useful feedback around the variety of hard to reach groups across the city which has helped to inform the communication and engagement plan associated with the programme. As a result, the team have made contact with the multiagency migrant forum as part of continuing stakeholder engagement.

4. Relocation of the primary care element of the Urgent Treatment Unit (UTU) at Queen’s Medical Centre (QMC) to Platform 1, Upper Parliament Street

4.1 Background and Context

As part of the response to the COVID-19 pandemic, the primary care element of the UTU delivered by NEMs was re-located from QMC to Platform 1, Upper Parliament Street in March 2020. The basis for this move was the requirement to introduce social distancing in the Emergency Department to minimise the risk of COVID infection spread in addition to the predicted increase in demand for acute services as a direct result of the rise in COVID cases.

4.2 Current Service Delivery

Since the relocation of the service, activity has significantly reduced from 80-90 patients seen per day to 20-30 patients seen per day. However, this is in the context of an overall reduction in patients using **face to face** urgent care services as demonstrated in the table below.

Table to show average daily number of patients using urgent care services pre and during COVID

Services	**Attends Pre Covid (Feb 2020)**	**Attends During Covid (July 2020)**
All A&E Activity; • NUH ED • SFH ED • London Road UTC • Newark UTC	Average 1184 attends per day.	Average 936 attends per day
NUH ED – Type 1 ED activity (all patients through the main NUH ED)	514	427
All A&E attendance in the Greater Nottingham area (Includes NUH ED, eye Casualty, UTC and NEMs in ED/Platform 1)	744	580

The UTU service continues to operate 24/7 and accept patients streamed from NUH ED. NUH and NEMs regularly review the patients streamed to ensure they are appropriate and streaming is done safely. To date, no significant incidents have been raised.

As a result of reduced demand for face to face services, NEMS have expanded their telephony based clinical assessment service (CAS) which offers remote consultations. To deliver this, NEMs have retrained staff and enabling home working in order to more effectively support the system during the pandemic. This is aligned to the direction of travel for 111 First which encourages the use of remote consultations and a move away from physical locations as a first choice to access healthcare.

The public are being encouraged to use ED for emergencies only and to access other urgent care services in primary care settings, community and urgent treatment centres. This means co-located primary care services over time will become less utilised as patients are offered advice and support by telephone or advised to attend alternatives, preserving emergency departments for those patients with conditions that need the level of service offered only by a hospital.

4.3 Future Intention for service delivery

As the COVID pandemic progresses, there is still the requirement for services to adhere to social distancing requirements to reduce nosocomial (hospital acquired) infection risk. This is the key ambition of the 111 First programme previously described which asks systems to triage or stream 'unheralded' (unknown to the system) patients to appropriate alternative services to reduce crowding in the department. We will continue to closely monitor attendances at all areas of the urgent care system and amend the service offers appropriately working with stakeholders.

Appendix 3

Reconfiguration of stroke services in Nottingham and Nottinghamshire

In July 2020 we informed you of a change to be implemented to reconfigure local acute stroke services so that we could manage the risk of Covid-19 infections among our patients and staff, as we progressed with restoring key NHS services.

To restore services safely, our providers needed to be able to treat patients with Covid-19 separately to those who are not infected. In Nottingham specifically, this meant creating additional capacity on Nottingham University Hospitals (NUH) NHS Trust City Campus site to create an additional admission assessment area. The only suitable area with direct access, which could be used as an additional assessment area, was the current Stroke Unit. The reconfiguration described in this briefing enabled this work to progress, while also being clinically beneficial for the treatment of stroke services and aligned to local, regional and national plans for stroke services.

Changes were made due to the urgency of local system restoration and recovery. The changes involved NUH centralising hyper acute stroke services at the Queens Medical Centre (QMC) site. This meant that the Hyper Acute Stroke Unit and the Acute Stroke Ward at the City Hospital campus moved to QMC. Stroke rehabilitation services at the City Hospital were enhanced and remain unaffected by these changes. Additional transport services for patients were made available between sites to facilitate the reconfiguration.

These changes mean that all urgent and immediate treatment for patients with a suspected stroke were centralised at QMC. This had two main benefits for the restoration and recovery of our services. Firstly, it enabled NUH to meet a national directive to reduce infection risk from Covid-19 by creating Covid and non-Covid admission assessment areas. Secondly, it created vital enhanced rehabilitation capacity on the City Hospital Campus for patients recovering from Covid-19 infection.

In addition to the impetus for these changes for the restoration and recovery of NHS services, there is a clear clinical case for the reconfiguration of stroke services and specifically for the centralisation of hyper acute stroke services. The change is aligned to regional and national stroke strategies and is a stated ambition of the local Clinical and Community Services Strategy review of stroke services. This review was underpinned by strong patient and public involvement with stroke survivors forming part of the work alongside staff and clinicians, and the Stroke Association supporting a number of patient engagement sessions.

Acute stroke services at NUH are currently a national outlier in two ways. Firstly, the hyper acute stroke service is not co-located with the emergency department. Currently 40% of strokes treated by NUH present at the Emergency Department at QMC and then require transfer to City Hospital. Secondly, it is not co-located with neurosurgical intervention and mechanical thrombectomy, which are required by a proportion of stroke patients.

Although aligned to national, regional and local plans for acute stroke services we informed you of this change as a temporary measure. There are plans to increase capacity at QMC for hyper acute stroke, which would enable this to become a permanent change.
However, that development would be subject to the usual procedures for service reconfigurations, including our requirement as the Commissioner to consult the Local Authority.

Health Scrutiny Committee
17 September 2020

Tomorrow's NUH (Nottingham University Hospitals)

Report of the Head of Legal and Governance

1 Purpose

1.1 To consider work taking place under the Tomorrow's NUH Programme.

2 Action required

2.1 The Committee is asked to note the briefing.

3 Background information

3.1 The Committee has previously heard about the Tomorrow's NUH Programme, a ten year transformation plan to plan for and deliver a future sustainable hospital that provides the right care in the right location for the population of Nottingham and Nottinghamshire and, for some services, to the wider region. The Committee has been aware of issues relating to poor clinical adjacencies, split site services, the condition of the current estate and the significant level of capital investment required to address these issues.

3.2 The Programme has been awarded seed money from the Department of Health and Social Care to develop detailed programme plans as part of the Government's announcement in 2019 of the intention to build 40 new hospitals.

3.3 The Chief Commissioning Officer from Nottingham and Nottinghamshire Clinical Commissioning Group, which is responsible for development of the pre-consultation business case, will be attending the meeting to provide the Committee with an initial briefing on the Programme.

3.4 It is anticipated that further reports will come to the Committee in due course as the Programme progresses.

4 List of attached information

4.1 Briefing from Nottingham and Nottinghamshire Clinical Commissioning Group

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Report to, and minutes of the meeting of the Health Scrutiny Committee on 21 September 2017

7 Wards affected

7.1 All

8 Contact information

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Tomorrow's NUH (Nottingham University Hosptials)

Briefing for Health Overview and Scrutiny Committee

Dear Colleagues

During the December 2019 General Election campaign, the Prime Minister announced the building of 40 new hospitals.

Tomorrow's NUH has been awarded seed money from the Department of Health Social Care's Health Infrastructure Plan 2 (HIP2) to develop detailed programme plans as part of that announcement. This includes:

- Developing proposals for clinical models that meet the needs of the population
- Understanding the impact that proposed changes will have on access to services for residents
- Ensuring alignment with the plans of the ICS and system partners
- Ensuring the affordability of future proposals.

The Tomorrow's NUH Programme has been established to plan for and deliver a future sustainable hospital that provides the right care in the right location for the population of Nottingham and Nottinghamshire, and, for some services, to the wider region.

Over the coming months, working with staff, partners, stakeholders and patients the programme will design a plan that will:

1. Enable the right care to be provided in the right location, transform clinical services and meet the commitments made in the NUH Strategy and Clinical Service Strategy, the NHS Long Term Plan and the vision for the Nottingham and Nottinghamshire Integrated Care System;
2. Address legacy issues that remain from merging two separate organisations, which impacts on the ability to deliver modern care because of services split across sites or duplicated, spreading staff and equipment across sites. It will also support clinical best practice and fulfil the hospital's role as a regional centre; and
3. Fix the parts of the ageing estate that have received little or no investment and do not meet the needs of services to deliver modern healthcare.

The CCG is responsible for the development of a Pre Consultation Business Case which seeks to build alignment between NHS commissioners and local authorities for the following areas:

- Providing a detailed case for change setting out how the proposal will benefit the population and the system
- Demonstrate that all options, benefits and impact on service users have been considered
- Demonstrate that the planned consultation will seek the views of patients and members of the public who may potentially be impacted by the proposals.

Over the coming months, the CCG and NUH will be presenting outputs of the programme to the Health Overview and Scrutiny Committee including initial proposals for the future clinical models, the public engagement that is being undertaken to support the development of proposals, and the engagement that is taking place across the system to ensure that partners in health and local authorities are working together to understand the impact of any changes.

The Pre Consultation Business Case is being developed for approval by the end of March 2021 in line with the timescales for the national HIP2 programme. A public consultation is currently planned to commence in July 2021.

Future reports will provide more detailed information about the emerging options for change to ensure that HOSC has an on-going oversight of the programme as it develops.

For more information on the changes described in this briefing, please contact:

Lucy Dadge

Chief Commissioning Officer

lucy.dadge@nhs.net

HEALTH SCRUTINY COMMITTEE
17 SEPTEMBER 2020
WORK PROGRAMME 2020/21
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1. Purpose

1.1 To consider the Committee's work programme for 2020/21 based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

2. Action required

2.1 The Committee is asked to note the work that is currently planned for the municipal year 2020/21 and make amendments to this programme as appropriate.

3. Background information

3.1 The purpose of the Health Scrutiny Committee is to act as a lever to improve the health of local people. The role includes:

- strengthening the voice of local people in decision making, through democratically elected councillors, to ensure that their needs and experiences are considered as part of the commissioning and delivery of health services;
- taking a strategic overview of the integration of health, including public health, and social care;
- proactively seeking information about the performance of local health services and challenging and testing information provided to it by health service commissioners and providers; and
- being part of the accountability of the whole health system and engaging with the commissioners and providers of health services and other relevant partners such as the Care Quality Commission and Healthwatch.

3.2 As well as the broad powers held by all overview and scrutiny committees, committees carrying out health scrutiny hold the following additional powers and rights:

- to review any matter relating to the planning, provision and operation of health services in the area;
- to require information from certain health bodies[1] about the planning, provision and operation of health services in the area;
- to require attendance at meetings from members and employees working in certain health bodies[1];

[1] This applies to clinical commissioning groups; NHS England; local authorities as commissioners and/or providers of NHS or public health services; GP practices and other providers of primary care including pharmacists, opticians and dentists; and private, voluntary sector and third sector bodies commissioned to provide NHS or public health services.

- to make reports and recommendations to clinical commissioning groups, NHS England and local authorities as commissioners of NHS and/or public health services about the planning, provision and operation of health services in the area, and expect a response within 28 days (they are not required to accept or implement recommendations);
- to be consulted by commissioners of NHS and public health services when there are proposals for substantial developments or variations to services, and to make comment on those proposals. (When providers are considering a substantial development or variation they need to inform commissioners so that they can comply with requirements to consult.)
- in certain circumstances, the power to refer decisions about substantial variations or developments in health services to the Secretary of State for Health.

3.3 While a 'substantial development or variation' of health services is not defined in legislation, a key feature is that there is a major change to services experienced by patients and/ or future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area. Health scrutiny committees have statutory responsibilities in relation to substantial developments and variations in health services. These are to consider the following matters in relation to any substantial development or variation that impacts on those in receipt of services:

- whether, as a statutory body, the relevant overview and scrutiny committee has been properly consulted within the consultation process;
- whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and
- whether the proposal for change is in the interests of the local health service.

Where there are concerns about proposals for substantial developments or variations in health services, scrutiny and the relevant health body should work together to try and resolve these locally if at all possible. Ultimately, if this is not possible and the committee concludes that consultation was not adequate or if it believes the proposals are not in the best interests of local health services then it can refer the decision to the Secretary of State for Health. This referral must be accompanied by an explanation of all steps taken locally to try and reach agreement in relation to the proposals.

3.4 The Committee is responsible for setting and managing its own work programme to fulfil this role.

3.5 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately.

3.6 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.7 The current work programme for the municipal year 2020/21 is attached at Appendix 1.

4. List of attached information

4.1 Appendix 1 – Health Scrutiny Committee 2020/21 Work Programme

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

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Health Scrutiny Committee 2020/21 Work Programme

Date	Items
16 July 2020	• **Covid-19 pandemic** To consider the impact of the Covid-19 pandemic on Nottingham and changes to NHS services. • **National Rehabilitation Centre – Updated Consultation Plan** To receive information on the updated plans for consultation in relation to the National Rehabilitation Centre
17 September 2020	• **NHS service changes in response to Covid-19** To review progress in restoring NHS services that changed in response to Covid-19. • **'Tomorrow's NUH'** To receive an initial briefing on the 'Tomorrow's NUH' Programme. • **Work Programme 2020/21**
15 October 2020	• **National Rehabilitation Centre** To consider the findings and outcomes of consultation on the National Rehabilitation Centre and how that is being used to inform decision making regarding the service. • **Managing winter pressures (tbc)** To scrutinise plans for managing winter pressures across primary care, secondary care and adult social care • **Work Programme 2020/21**
12 November 2020	• **'Tomorrow's NUH'**

Date	Items
	To receive an update on the 'Tomorrow's NUH' Programme. • **Work Programme 2020/21**
17 December 2020	• **Work Programme 2020/21**
14 January 2021	• **Work Programme 2020/21**
11 February 2021	• **Work Programme 2020/21**
11 March 2021	• **Work Programme 2020/21**
15 April 2021	• **Work Programme 2021/22**

Items to be scheduled

- **Flu immunisation programme**
  To review provision, and uptake of the flu immunisation programme, particularly for children
- **Scrutiny of Portfolio Holder for Adult Care and Local Transport**
  To review plans for delivery of aspects of the Council Plan 2019-2023 that fall within the Adult Care aspects of this Portfolio.
- **Nottingham Safeguarding Adults Annual Report 2019/20**
  To scrutinise work taking place in relation to work to safeguard adults in the City; and identify any issues or evidence relevant to the Committee's work programme
- **Child and Adolescent Mental Health Services (CAMHS)**
  To follow up on the Committee's previous work on CAMHS and consider the impact of Covid-19 on demand for, and access to CAMHS
- **Adult Mental Health Services**

To review access to crisis services, including the impact of Covid-19 on demand for, and access to services

- **Suicide Prevention Strategy**
  To review implementation of the Suicide Prevention Strategy, with a particular focus on the impact of Covid-19 on levels of suicide and demand for suicide prevention and bereavement services.
- **Access to dental services**
  To explore access to dental services in the City, including access during the coronavirus outbreak, restoration of services and impact of reduced access during pandemic
- **Scrutiny of Portfolio Holder for Health, HR and Equalities**
  To review plans for delivery of aspects of the Council Plan 2019-2023 that fall within the Public Health aspects of this Portfolio.
- **Health inequalities in relation to Covid-19**
  To consider the findings of work to explore impact of Covid-19 on Black, Asian and Minority Ethnic (BAME) communities and how this is being used to inform decision making on service provision
- **Homecare services model**
  To review changing approaches to the Council's model for homecare service provision

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