Nottingham City Council

Health Scrutiny Committee

Minutes of the meeting held remotely via Zoom on 11 February 2021 from 10.00 am - 11.49 am

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Phil Jackson
Councillor Cate Woodward (Vice Chair)	
Councillor Samuel Gardiner	
Councillor Maria Joannou	
Councillor Kirsty Jones	
Councillor Dave Liversidge	
Councillor Lauren O`Grady	
Councillor Anne Peach	

Colleagues, partners and others in attendance:

Dr Ajanta Biswas	-	Vice-Chair, Healthwatch Nottingham and Nottinghamshire
Lucy Dadge	-	Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group
Lewis Etoria	-	Head of Insights and Engagement, Nottingham and Nottinghamshire Clinical Commissioning Group
	-	Nottingham City GP Alliance
Dr Jonathan Harte	-	Associate Director of Primary Care, Nottingham and
Joe Lunn		Nottinghamshire Clinical Commissioning Group
Dr Husein Mawji	-	Nottingham City GP Alliance
Dr Paul Scotting	-	Chair, Nottingham Homelessness Voluntary Sector Form
Dr Ian Trimble	-	Former Nottingham City GP
Kim Pocock	-	Scrutiny Officer

46 Committee Membership

The Committee noted the resignation of Councillor Angela Kandola. The Chair thanked Councillor Kandola for her significant contribution to the Committee.

47 Apologies for absence

Councillor Phil Jackson (unwell).

48 Declarations of interest

None.

49 Minutes

The minutes of the meeting held on 14 January 2021 were approved as an accurate record and signed by the Chair.

50 Transition, Engagement and Mobilisation Approach for the Registered Population of the Platform One Practice

Lucy Dadge, Chief Commissioning Officer, Lewis Etoria, Head of Insights and Engagement, Joe Lunn, Associate Director of Primary Care and Dr Ian Trimble, former city GP, attended the meeting on behalf of the Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) to provide an update on the transition, engagement and mobilisation plans for the registered population of the Platform One Practice.

The CCG highlighted the following information:

a) The CCG remains committed to communicating with and working with the Health Scrutiny Committee on this matter.

b) To ensure a smooth transition the NEMS contract for Platform One has been extended from 31 March 2021 to 30 June 2021. This will allow more time for the transfer to the new provider and for supporting patients who are being dispersed to other practices.

c) The CCG has written to all patients currently registered with Platform One. It is aware that this is not the only method of communication which should be used and will explore different means of communication and engagement with key stakeholders and partners. This is particularly important for vulnerable cohorts. It is clear that some patients will need multiple messages and in some cases patients will not react immediately.

d) Conversations have restarted with Primary Care Networks (PCNs) on the dispersal of patients and meetings are taking place with all relevant commissioners and providers to input into the mobilisation plan.

e) Conversations are also ongoing with local mental health teams to ensure that the needs of patients with severe mental illness(SMI) and/ or severe multiple disadvantage (SMD) are taken into account.

Dr Jonathan Harte, GP, and Dr Husein Mawji, GP, attended on behalf of the Nottingham City GP Alliance (NCGPA) to provide information having been commissioned to take on the services currently delivered by Platform One to residents who live within the newly defined boundary. They highlighted the following points:

f) NGPA’s purpose is to promote general practice resilience and to support locally owned and led, list-based general practice providing sustainable health care.

g) Dr Jonathan Harte is a GP Director and Chair of NCGPA. He is a partner at Aspley Medical Centre and member of BACHS Primary Care Network. NCGPA has been providing care, particularly extended access to services, since 2017.

h) Dr Husein Mawji is also a Director of NCGPA, which comprises 44 of the city's 48 GP practices and covers approximately 336,000 patients. Dr Mawji has been in a city practice for 16 years and his current practice boundary heavily overlaps with Platform One, giving him a good knowledge of health inequalities of the population currently registered with Platform One. Dr Mawji is also one of two deputy clinical leads for the Nottingham City Integrated Care Partnership (ICP).

i) Both Dr Harte and Dr Mawji have strong links with partners through the ICP. NCGPA's board includes 70 partners and practice managers, many of them working in areas where deprivation is significant and with many decades of experience between them. One of the ICP priorities is to work with those who experience severe multiple deprivation and the NCGPA is committed to working with such patients.

j) NCGPA has held caretaker contracts for two practices experiencing significant difficulty in areas of high deprivation and has built these up to the point of receiving 'good' ratings from the Care Quality Commission (CQC). As such, NCGPA has a good track record of being able to tailor services to match patient need.

k) NCGPA also has a contract to deliver smoking cessation services (partly resourced by Public Health), which specifically requires them to target those with mental health and substance misuse problems.

l) NCGPA also provides the extended access service, and has done so for the last three years. This offers appointments at weekends and outside usual core hours and which is delivered by GPs, nurses and a range of other clinicians and health workers. Platform One is one of the largest referrers to the service.

m) Discussions have begun with NEMS about mobilisation of patients and staff, including those with experience of working with extremely vulnerable patients with the aim of achieving smooth transition to the new practice. It is hoped that the transition of known staff will help with the transition for those patients who will be registered with the new practice.

n) NCGPA is involved in collaborative working with the CCG in relation to patients with severe multiple disadvantage (SMD), to ensure access to necessary services and to reduce inappropriate attendance at Accident and Emergency. This applies across all NCGPA practices, not just the new practice. NCGPA does not underestimate the challenges of providing care to vulnerable citizens.

o) Dr Harte and Dr Mawji's roles with the ICP, NCGPA and as members of Primary Care Networks were acknowledged as potential conflicts of interest, which will need to be managed throughout the process.

p) At the December 2020 meeting of this Committee the CCG agreed to put together a Stakeholder Group to guide engagement in the process of transition. Time has been taken to get the membership of that group right. Healthwatch has agreed to chair the group. Membership includes commissioners, service providers, NCGPA and service users. The draft terms of reference are being updated as new

members are added to the group. The terms of reference will be signed off at the first meeting of the group to be held in March (and monthly thereafter). Communications and engagement are still being planned so that service users, ie those who are the experts, are consulted.

The Chair noted that the Committee had received two reports from the voluntary sector (both available publicly on Nottingham City Council's website in the papers for this meeting) and invited representatives to address the meeting.

q) Dr Ajanta Biswas, Vice-Chair, Healthwatch Nottingham and Nottinghamshire noted that while a lot of progress has been made, the process has failed to engage those patients most in need, particularly vulnerable patients. This has led to some scepticism amongst patients, which Healthwatch hopes will be addressed by the CCG and NCGPA.

r) Healthwatch has worked with Platform One since the commissioning process started. Concerns from patients affected about the proposals have been communicated to Healthwatch and have been reported to the CCG and the Health Scrutiny Committee. Healthwatch has focused a lot of time on ensuring that vulnerable patients do not fall through the gap and that the transition to new services is as smooth as possible.

s) Engagement with patients needs to be improved, for example the letter sent out by the CCG does not highlight the patient's right to choose.

t) The Equality Impact Assessment (EQIA) is a live document and has gone through a number of iterations. While wishing that this had happened at an earlier stage, Dr Biswas thanked the CCG for the progress that has been made. More detail on specific actions to mitigate risk, with a clear timeline for implementing these, would be welcomed.

u) Healthwatch would like to see the patient needs assessment tool being used to ensure access to appropriate services and that dispersal to other GP practices and services will not affect inequalities.

v) Dr Paul Scotting, Chair, Nottingham Homelessness Voluntary Sector Form (representing 18 organisations) noted that the Forum communicated its concerns about the closure of Platform One following the presentations from the CCG to the Health Scrutiny Committee meetings in November and December. The Forum's concerns reflected those of the Committee. Subsequently Dr Scotting has been in discussion with the CCG and the Forum will be a member of the new Stakeholder Group.

w) Engagement with individual patients is key to ensure that the needs of vulnerable patient cohorts are met. Dr Scotting welcomed the reassurance provided at this meeting by the new provider.

x) The Forum is keen that NCGPA takes the welcoming, open approach to registration that has been taken by Platform One. It would like to see a flexible model in relation to the new boundary, so that the needs of vulnerable patients

are met, particularly where there is unstable residence, so that patients do not have to change GP as they move in and out of areas.

y) Vulnerable patients are not limited to those with severe multiple deprivation (SMD) but also include those who have no recourse to public funds and those without identification documents (eg refused asylum seekers). No homeless person should be turned away from any GP practice.

z) The expertise of NCGPA is appreciated and it is hoped that it will reflect the expertise of Platform One, for example in offering services to homeless people, asylum seekers, those with specific mental health problems, post-traumatic stress syndrome and language barriers.

aa) The Forum is concerned that communications are all one-way, ie from the CCG to patients. It is hoped that the new Stakeholder Group will be a means for two-way communication. The terms of reference for the Group need to include the ability to influence how services are delivered (eg, boundaries, access and expertise) not just how changes are communicated to patients. The Forum does not want to be part of something which legitimises a poor process, but wants to have an effect on the outcomes for their client groups.

In response to questions from the Committee and in the subsequent discussion the following points were made:

bb) NCGPA is currently in discussion with Platform One about TUPE (transfer of undertakings [protection of employment]) of staff to the new practice. The Alliance wants to retain as much expertise, experience and resource as possible.

cc) NCGPA has a great deal of experience of providing services to patients with severe multiple deprivation (SMD) across the city and can reflect the current expertise at Platform One. The aim is to provide care tailored to meet individual patient need.

dd) NCGPA would welcome discussions and support from the voluntary sector, including the Homelessness Voluntary Sector Forum, as it recognises the benefits of collaborative and collegiate working. As part of the Stakeholder Group NCGPA will want to fully participate in communications and engagement, not just for the city centre practice, but across the city to other practices and services.

ee) The CCG is confident that the five-month period provides enough time to carry out the necessary work for the new provider to operate and the dispersal of patients to other practices to have taken place by 1 July. However, should it appear that more time is needed the CCG believes that NEMS (the current Platform One providers) and NCGPA would be flexible with this date and will keep the Committee informed of progress on a regular basis.

ff) The CCG is committed to making consultation and engagement as meaningful as possible during this period and to using the expertise of those on the Stakeholder Group will be key in achieving this. There will be some areas where contractual obligations will mean that changes cannot be made and it is important to ensure that expectations of patients and other stakeholders are not raised unrealistically.

The work of the Stakeholder Group will continue beyond 1 July as the changes are embedded.

gg) A local enhanced service (LES) is an extension to the core contract which GP practices hold. The CCG is developing a LES for patients who experience SMD in wide consultation with a whole range of stakeholder providers and groups. An EQIA will be carried out in relation to this service (to be approved by March) to ensure that no patients are impacted adversely. The service will launch on 1 May and will be offered to all practices across the city and the county.

hh) Committee members expressed continuing concern for the 3,000 patients who are being dispersed to their local practice, particularly for those who are vulnerable and have complex / high needs.

ii) The majority of the 3,000 patients to be dispersed are not vulnerable patients. Where the patient is not vulnerable there will be automatic transfer to the new practice. The patient will not need to do anything themselves. Each patient has been matched to the nearest three practices, but there is choice to go wider than this.

jj) The receiving practice will review each new patient; their needs will be assessed and understood and appropriate wraparound services provided. The services currently provided as patients registered with Platform One will still be available to them from their new practice. The core services required of general practices are all exactly the same, regardless of what needs a patient presents with.

kk) NCGPA has a track record of and experience in rapid or planned closures and service changes and has communicated with and supported patients through previous GP practice transfers.

ll) Discussions with Platform One are ongoing to see whether there are any patients who may need to be referred to a particular practice for a specific need, rather than simply being referred to their nearest geographical practice. It is part of the mobilisation process to ensure that care plans are in place and handed over to the most appropriate practice in their geographical patch. All city GP practices are used to providing support and services to patients with a range of/ multiple needs.

mm) The CCG does not have access to patient records, but recognised the Committees concerns that the patients to be dispersed are considered at an individual level. Patients currently fall into three broad categories – those who are vulnerable and transient who need to be identified and supported, often with a high level of service; those who are vulnerable, who, for a range of reasons, have chosen to seek care at Platform One but whose family may be registered outside the new catchment area – in such cases the family will need to be considered as it may or may not be appropriate for them to be registered at the same local practice as their family; and the greatest number of patients who have chosen to register with Platform One because they work in the city and who will be migrated to their local area within patient choice. Further work is now needed to break down the mapping of these cohorts.

nn) Committee members were concerned that those who are transient are at risk as they are not strictly categorised as homeless and may fall through a gap as they move from one area to another.

oo) In addition, it may be that those who work in the city have chosen to register at Platform One because they have conditions which require regular GP appointments. It could impact their ability to work (post Covid) if they are registered at a practice in their local area, which they have to travel to for frequent GP appointments.

pp) The CCG noted that very few services are not offered by all practices. The one (locally enhanced) service which is not universally available is substance abuse services and patients will be referred to the appropriate providers of that service.

qq) In terms of those who work in town, the pandemic will change the way services are delivered. Virtual consultations are likely to continue and, combined with extended access hours, may be more convenient to patients who work away from their local area.

rr) Not all patients find virtual consultations helpful. Healthwatch has received a lot of feedback on this during Covid. While interpretation services may be available at all practices, for some patients having an extra person in the consultation may be intimidating and they may be more comfortable at a practice where existing members of staff speak their language.

ss) Using interpreters requires a degree of training, as does being able to respond to the needs of certain cohorts of patients, for example asylum seekers, many of whom have mental health issues and post-traumatic stress disorder (PTSD). Their needs are best supported by those with a good understanding of the asylum process. This can't be guaranteed in every local GP practice. There will be several voluntary sector organisations willing to support and facilitate the best match for such patients.

tt) This experience of dispersal is likely to damage trust in health services for some vulnerable patients, which could influence their willingness to engage with a new GP practice

uu) The CCG acknowledged that more work is needed on the needs assessment at the individual level to be able to provide a full response to the concerns of the Committee and to provide the reassurance requested.

vv) The CCG respected the concerns expressed about asylum seekers and the need to be able to swiftly access trauma therapy when required. The CCG will focus effort to where there is greatest need and acknowledged that there will be lack of trust if need is not recognised and specific attention paid to it.

ww) While there is not a formal appeals process for patients no longer eligible to register with the new city centre practice, the individual circumstances of patients will be discussed further if the allocation of a local practice is not a good fit. This is the current practice when a patient is unhappy with their local practice. To avoid delays in resolving issues for individual patients, Lucy Dadge agreed to be the key

CCG contact for Healthwatch and advocates when patients raise concerns and to keep the Committee informed on the outcomes of this.

The Committee welcomed the attendance of the CCG and representatives of the new provider, NCGPA, at the meeting. Members appreciate the extended timescale for mobilisation and the fact that this can be flexible if needed, given the range of vulnerable need to support, especially in the time of a pandemic.

However, having considered the information provided, the Committee still has a number of concerns and supports and agrees with the need for a more flexible approach to the registration of vulnerable patients facing dispersal, as expressed by Healthwatch and the Homelessness Voluntary Sector Forum.

Resolved to:

1) **request that patients without a stable address, who face the possibility of being moved from practice to practice or falling through the gap, are closely monitored and the Committee is updated on progress;**

2) **recommend that the CCG considers working closely with Healthwatch and the Voluntary Sector Homelessness Forum to address the specific needs of those patients who may struggle to engage with a new provider, particularly those who have experienced trauma, such as refugees and asylum seekers;**

3) **request clarification on the transfer of staff expertise from NEMS to NCGPA, what expertise is missing and what plans are in place to address this;**

4) **request further detail on what options extremely vulnerable patients, who are moved to new practices, will have to access services they currently rely on (in the short and long term) if they need to;**

5) **recommend that the updated terms of reference of the Stakeholder Group make it clear that that members of the Group are able to properly represent their stakeholders through two-way communication and the ability to influence the mobilisation plan and process (where this does not relate to contractual obligations);**

6) **request that the updated terms of reference of the Stakeholder Group are reported to the Committee's March meeting (where the CCG is due to report on lessons learnt from the process to change the Platform One contract); and**

7) **requests continued regular reporting on this item from the CCG, including attendance at the Committee's April meeting to discuss the different cohorts of patients and the individual needs assessment policy and process, particularly in relation to dispersal of vulnerable patients to new practices and services.**

51 Work Programme

a) A training session is being arranged for Committee members on the roles and responsibilities of a health scrutiny committee. Ajanta Biswas, as the Healthwatch representative will also be invited to this session.

b) In addition, an informal work programme meeting is being scheduled to consider priorities for the Committee's work in 2021/22.

c) It was agreed that items for the remainder of 2020/21 would be scheduled as follows:

11 March

- The Covid Vaccination Programme
- Platform One – lessons learnt, updated stakeholder group terms of reference, TUPE and transfer of skills arrangements

15 April

- Platform One - patient needs assessments
- Suicide Prevention Strategy
- Update on Winter Pressures