Nottingham City Council

Health Scrutiny Committee

Minutes of the meeting held remotely via Zoom on 15 April 2021 from 10.00 am - 1.15 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 Dave Liversidge	
Councillor Anne Peach	

Colleagues, partners and others in attendance:

Kate Burley	-	Deputy Head of Mental Health Commissioning, Nottingham and Nottinghamshire CCG
Sarah Bustard	-	Student Services Manager, Nottingham Trent University
Lucy Dadge	-	Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group
Detective Inspector Pamela Dowson	-	Nottinghamshire Police
Katie Freeman	-	Service Manager, Harmless
Caroline Keenan	-	Senior Public Health Manager
Sarah Kessling	-	Service Manager, Harmless
Rachel Lees	-	Trustwide Clinical Lead for Suicide Prevention, Nottinghamshire Healthcare NHS Foundation Trust
Joe Lunn	-	Associate Director of Primary Care, Nottingham and Nottinghamshire ICS and Clinical Commissioning Group
Dr Hussein Mawji	-	GP Director, Nottingham City GP Alliance
Duane McLean	-	Deputy Chief Operating Officer, Nottingham University Hospitals NHS Trust
Caroline Nolan	-	Systems Delivery Director, Urgent Care, Nottingham and Nottinghamshire CCG
Gemma Poulter	-	Head of Integration, Adult Social Care
Sara Storey	-	Director for Adult Social Care
Amanda Sullivan	-	Accountable Officer, Nottingham and Nottinghamshire CCG
Michelle Tilling	-	Nottingham City Locality Director, Nottingham and Nottinghamshire CCG
Dr Ian Trimble	-	Former Nottingham City GP working with Nottingham and Nottinghamshire CCG
Councillor Adele Williams	-	Portfolio Holder for Adult Care and Local Transport
Ajanta Biswas	-	Healthwatch
Kim Pocock	-	Scrutiny Officer

59 Apologies for absence

None.

60 Declarations of interest

None.

61 Minutes

The Committee confirmed the minutes of the meeting held on 11 March 2021 as an accurate record and they were signed by the Chair.

62 Implementation of the Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023

Caroline Keenan, Senior Public Health Manager introduced colleagues, who are working in partnership on suicide prevention, from the following organisations – Nottinghamshire Healthcare NHS Foundation Trust (Rachel Lees); Harmless (Sarah Kessing and Katie Freeman); Nottinghamshire Police (Pamela Dowson); Nottingham and Nottinghamshire Clinical Commissioning Group (Kate Burley); and Sarah Bustard (Nottingham Trent University).

Each partner contributed towards the presentation, highlighting the following information:

(a) Suicide is an important public health issue in England, with approximately one person dying every two hours as a result of suicide. It has a significant, lasting and often devastating impact on individuals, families, communities and wider society. Some studies have predicted an increase in suicide rates associated with the Covid 19 pandemic - particular emphasis has been placed on young people, due to evidence that their mental health has been affected disproportionately.

(b) Suicide rates tend to vary over time with a historical low in 2010 before increasing in the years to 2013 and reducing thereafter. Nottingham city has had a higher rate of suicide than the England average. In recent years the rates in the city have fluctuated significantly, and the most recent figures available from NHS Digital are above the national average rate.

(c) 31 suicides were recorded in 2019. Over the last three years, 38% of deaths occurred in people aged 23-39 and 38% occurred in people aged 40-59. In previous years, deaths have followed a social gradient with fewer deaths in people in the least deprived quintiles. Numbers are too low to assess the statistical significance of differences. Local ethnicity data is not currently available for the city.

(d) Real-time surveillance in Nottingham city and Nottinghamshire county has identified a potential slight increase in suspected suicides in young people,

although numbers are too low to assess statistical significance. Communications to students have been increased and all services are available in spite of the pandemic. The relationship with the universities is strong.

(e) Two partnership meetings have taken place to assess the approach to suicide prevention and determine additional activity, including skills sharing, communications and support for substance misuse.

(f) A joint city and county application has secured transformation funding of £627,483 over three years from NHS England and NHS Improvement, to expand the Suicide Prevention Programme. Areas for action include: competency, compassion, knowledge and skills; communication and public awareness; prevention support for higher-risk groups; and a real-time surveillance data system. A project manager will be recruited for this programme in the near future.

(g) CCG commissioning priorities will focus on:

(i) suicide reduction and enhancing bereavement support;
(ii) mental health crisis care and liaison, including open access referral, 24/7 triage and sign posting, and increasing the capacity of the Turning Point helpline for lower level support;
(iii) development of crisis alternatives, including the recent launch of crisis sanctuaries; safe spaces for anyone who needs them, available 6pm – midnight for out of hours' support, set up in response to stakeholder engagement;
(iv) a review of the all age self-harm pathway;
(v) adult severe mental illness (SMI) community transformation, wrapping services around primary care networks, further developing pathways to join up historical gaps where people fall between primary and secondary care and strengthening the offer to those who don't traditionally access crisis support; and
(vi) rough sleeping mental health support.

(h) Nottinghamshire Healthcare NHS Foundation Trust (Nottinghamshire Healthcare) launched its suicide prevention strategy 'Towards Zero Suicide' in May 2020, to provide compassionate, person-centred care. At the core of delivering the strategy is a strategy group and a lived experience panel, working in partnership with other organisations and local communities to support people with a whole range of issues which influence suicide.

(i) Work is in place to ensure best practice in developing clinical pathways which make sense and are accessible, even during the pandemic, by being flexible about how interventions and support are delivered. Support is provided to practice areas to make sure that the learning and the recommendations of the National Confidential Inquiry into Suicide and Safety in Mental Health project are applied. These cover a range of actions to ensure appropriate support from initial contact to discharge from services.

(j) The Trust's strategy promotes the development of a blame free just culture within which good care is provided and the needs of both staff and patients are met.

Those who provide care are at a higher risk of suicide, so staff wellbeing is key, as is staff training to ensure and support clinical competence.

(k) Nottinghamshire Healthcare priorities within these key areas are to:

(i) promote networks and partnership working;
(ii) monitor self-harm and suicide data;
(iii) promote good practice;
(iv) take a strategic approach to inpatient areas:
(v) develop appropriate resources and communication tools;
(vi) embed principles of a just and restorative culture to promote learning form incidents, a culture of safety and speaking up;
(vii) review training and implement a new training model; and
(viii) promote staff support and access to specialist support and advice.

(l) Harmless is a self-help and suicide prevention service shaped by service users to promote hope and recovery. The service is delivered via a number of pathways, which all run alongside each other:

(i) Self-harm pathway – 50% of those who die by suicide have previously self-harmed. The service offers two pathways for those who self-harm or are at risk of self-harm, funded by the CCG; the stabilisation tier and the psychotherapeutic tier. The stabilisation tier offers emotional support, (such as space to talk and safety planning) and practical support (such as liaising with other professionals involved in care, housing/ debt/ employment support and social support). The psychotherapeutic tier is a specialist therapy service taking a person-centered approach, focusing on managing distress and moving towards self-defined recovery.

(ii) Suicide bereavement pathway – offers support (via The Tomorrow Project) to anyone of any age and for any reason bereaved by suicide. This may include passers-by and professionals, as well as friends and family members. The service is funded by Nottinghamshire County Council to the end of March 2022, with the hope that funding will be picked up by the CCG in the future. Users can self-refer or are automatically referred by the Police (see (o) below). The service aims to provide a timely response to assess need and immediate support on a short-term or long-term basis to meet need. Referral and signposting to other services and an anniversary follow up are also part of the service.

(iii) Suicide crisis pathway – delivered by The Tomorrow Project, this service responds to referrals within one working day to offer emotional, practical and stabilising support for up to 12 weeks. Referral and signposting to other services is also available. The Project also offers a suicide crisis text support service (developed during the pandemic) to anyone living in Nottinghamshire, providing emotional and practical support, signposting, and referrals if necessary.

(m)Harmless also provides mental health crisis sanctuaries (referred to in (g) above) across Nottinghamshire in partnership with Mind, Framework, Turning Point and Notts Healthcare and the 'Let's Talk Training' CPD credited e-learning platform (offering a range of resources and training packages). 3,000 delegates were trained last year with a website reach of approximately 20,000 people.

(n) Harmless has received a 200% increase in referrals during the pandemic.

(o) Since the last presentation to the Committee on suicide prevention (January 2020), Nottinghamshire Police has developed a simple automated referral to the suicide bereavement pathway delivered by Harmless. As part of completing the coroner's report after a suicide, a button on the report form can be clicked to make an automatic referral to The Tomorrow Project bereavement service. Referrals are typically for 1-9 people and can include anyone affected (including Police officers) and has proved to be very successful. 164 referrals have been made in the last month. Nottinghamshire was the first force to introduce this system, which has now also been adopted by Derbyshire Police.

(p) The Police has a Suicide Prevention Policy for Suspects, whereby officers conduct an enhanced welfare assessment for suspects in custody and those interviewed voluntarily. This will often be where there have been offenses or child abuse, domestic violence, rape etc, where there is known to be high risk of suicide. Appropriate interventions are put in place, including referrals to support services. Individuals are revisited or contacted again after 24 hours and reassessed at trigger points in the investigation. The Force carries out approximately 10-15 welfare assessment per week and there has been a measurable reduction in deaths by suicide.

(q) The Police provides real-time surveillance data to partners on a weekly basis. The data does not refer to individuals but provides information to help identify triggers, mental health issues etc. While the Police has not seen an increase in suicide during the pandemic, there has definitely been an increase in the need for mental health support.

(r) Nottingham Trent University(NTU) has seen students struggling more. This has not been in terms of more students, but rather in terms of self-harm and thoughts of suicide. Anecdotally, it would appear that suicide of students has grown during the pandemic. NTU is currently developing a suicide safer strategy as part of its overarching institutional mental health strategy. This is based on prevention activity, eg enhanced campaigns, 'let's talk' sessions for students and 'let's talk about suicide' training for staff. Two additional posts have been added to the Mental Health Support Team in order to expand the support offered in response to student need. Appropriate support is being developed in the light of case reviews, learning from involvement with the Coroner (sharing good practice), including bereavement support. NTU continues to work in partnership with other organisations to support students.

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

(s) Several members of the Committee were concerned that, while services sound good on paper, patient experience of services is not always positive and sometimes patients are unable to access services, don't reach out to services, lose confidence in services because of their experiences or are unaware that such services exist.

(t) Service providers noted that they are working to address such gaps to provide accessible effective service by working better together to join up services. Services are regularly reviewed so that they can meet the needs of the individual. Partners are having these conversations and engaging with patient groups. It was recognised that patients do sometimes feel that they are assessed over and over again and aren't clear about pathways. Transformation plans are being discussed by partners to work on addressing gaps and wrapping services around the individual.

(u) While there have been improvements, there can still be systemic issues with access to service (to some extent bound by some national infrastructure), particularly whereby thresholds can mean that mental health support is not available at an early enough stage and situations can therefore worsen when they may well have been averted or minimised. Working effectively in partnership is supporting this to improve.

(v) People with poor mental health may not be in a position to provide feedback, eg through complaining about their experience of treatment, or lack of treatment, because they don't have the energy to do so while trying to manage their mental health.

(w) Further work needs to be done to look at what support can be provided to patients who are waiting for a diagnosis.

(x) Colleagues are working closely with schools in the city, including as part of the Government's scheme to support wellbeing as children and young people return to education from home during the pandemic. Child and Adolescent Mental Health Services (CAMHS) also works with pupils and staff in schools to raise awareness of self-harm and services are available for support through the SHARP (Self-Harm Awareness and Resource Project).

(y) Improving understanding and an ability to recognise the signs of self-harm/ suicidal thoughts and respond to individuals is essential. As part of transformation proposals there are plans for formal workforce training with those who are likely to come into contact with individuals who may be at risk of self-harm/ suicide so that they can be signposted to appropriate support.

(z) Members of the Committee noted that pathways often appear complex and confusing to the individual. Commissioners recognise this complexity. The 24/7 crisis line, introduced last year, acts as a single point of contact for crisis. Onward pathways need to be further developed. Services used to be structured via a single point of contact model but local mental health teams were introduced a few years ago. The aspiration of the transformation programme is that people will not feel bounced around the system but that all partners will work to bring together voluntary and statutory services to provide a single access hub with sign posting

to the most appropriate service(s). This is initially being tested in mid Nottinghamshire with a view to being rolled out to the city and across the whole county.

(aa) Harmless ensures that service users are flexibly referred to all relevant pathways within their service, ie if they begin on one particular pathway but they could benefit from other support they will be able to link seamlessly into another pathway if needed.

(bb) Listening to service users' experiences to shape services is essential to ensure that they are appropriate and accessible. There is a co-production group which works to help shape mental health services. Specific issues in relation to suicide for Black, Asian and Minority Ethnic (BAME) communities are being picked up through this co-production group which is looking at how to proactively engage communities so that services are designed around their needs. Continuing to work with service users to develop services through co-production and to refine the way patient feedback data is collected will form part of the three-year transformation plan.

(cc) Caroline Keenan agreed to provide a written briefing on any issues which were raised at the January 2020 Committee meeting, which had not been addressed in today's meeting. Sarah Kessing agreed to provide data in terms of service user feedback at Harmless.

(dd) The Chair of the Committee urged any members of the public to contact services should they need support and noted that the services offered by Harmless, including The Tomorrow Project are to be recommended.

63 Management of Winter Pressures

Amanda Sullivan, Accountable Officer, Nottingham and Nottinghamshire Clinical Commissioning Group (CCG), Michelle Tilling, Locality Director Nottingham City, CCG, Caroline Nolan, System Delivery Director, Urgent Care, CCG and Duane Mclean, Deputy Chief Operating Officer, Nottingham University Hospitals NHS Trust (NUH) attended the meeting to provide an update on how winter pressures have been managed this year, particularly in the light of the additional pressures of responding to Covid 19.

Colleagues highlighted the following information:

<u>Adult Social Care</u>

(a) The service entered the winter period with robust plans and increased capacity in reablement to mitigate the risks in the external homecare market. While there was significant pressure on the social care provider market due to the pandemic, the service felt well-prepared with strength-based practice firmly embedded across the department and the Adult Social Care Winter Plan in place.

(b) In delivering the Plan the service extensively engaged with partners to work effectively as a system to establish the right type/ volume of community services to enable reduced use of beds and support more at home. With a strong focus on

reablement and promoting independence, the service has worked closely with health colleagues and has continued to deliver enhanced support to external providers. It has also focused on supporting the resilience, health and wellbeing of its workforce.

(c) During the pandemic, additional non-recurrent funding has enabled capacity in social care reablement from January 2021-May 2021. Outcomes to date have been good, including reduced delays and increased capacity for citizens requiring reablement to be discharged home from hospital or to maintain their independence at home.

(d) Testing prior to discharge is standard practice and isolation on admission to care homes for 14 days is facilitated to further reduce the risk of infection. A setting was designated for Covid positive discharges, which was used by patients from across the county and out of area until funding and the service ceased on 31 March 2021.

(e) The workforce has been a significant risk across all health and social care organisations during the pandemic which has resulted in a reduction in the overall usual level of capacity, eg due to Covid absence, isolation absence and other illnesses. Having to do things differently to keep settings and services Covid compliant and secure has resulted in a reduction in the efficiency of staff. This was combined with an increase in demand. The roll-out of the vaccination programme is expected to reduce staff absences and support health and wellbeing of carers and those they care for.

(f) Pressure on demand has resulted from responding to the pandemic as well as continuing business as usual, the redeployment of staff to increase capacity for hospital discharge, the backlog across planned care and support, seasonal pressures and an increase in the acuity and complexity for health and care in lockdown.

(g) There have, however, been achievements, including increasing the number of citizens who have received the reablement service to maximise independence, delivering all duties under the Care Act, working with developers to operate supported living projects and working collaboratively with partners to develop joint plans to manage the impact of the pandemic.

<u>Health</u>

(h) Covid added a complexity to the winter, for example segregation of pathways and social distancing. This has required a flexible approach, which has included flexing resources to ensure that there has been a good flow of patients and that they have been safe. Wave 2 demands have resulted in significant pressure on intensive care units and on beds, while aiming to keep time-critical elective services operating, delivering a vaccination programme on a scale previously unchartered, the impact of prolonged lockdown on demand and other health issues, and staff absence due to sickness, shielding and the impact of doing high intensity, stressful jobs.

(i) Nottingham University Hospitals NHS Trust (NUH) winter goals have been dominated by Covid, focusing particularly on acute care needs, reducing the spread of Covid and how to best manage safe staffing levels to deliver appropriate care as well as the wellbeing of the workforce.

(j) The Emergency Department (ED) has historically been a point of congestion so reducing the number of patients in ED has been key to delivery goals. This has been achieved by diverting to other appropriate care, eg minor injury redirection to the Urgent Care Centre, primary care redirection to NEMS and direct referral pathways to specialties. Appropriate social distancing has been maintained in ED and throughout the patient stay.

(k) To reduce the pressure on beds for both Covid and non-Covid patients, same day emergency care (SDEC) provision has been increased to help reduce pressure on the acute bed base. In addition, emergency admission capacity has been created (which also reduces the exposure to Covid); pathways have been segregated to reduce risk and some enabling capital works have taken place to provide additional beds.

(l) As a result of putting into place such complex arrangements, caring of the critically unwell has been maintained. Additional investment in diagnostics (eg MRI) has provided additional resilience, the independent sector has been used to support time-critical surgeries and focused discharge planning has supported flow through and out of hospital.

(m) NHS 111 First has worked successfully as a first port of call, alongside GPs, for anything urgent. Advice has been provided to patients without the need for them to leave home and signposting or ambulance care provided where needed. An increase has been seen in the use of 111 online by the under 40s population.

(n) The rate of ambulance conveyance reduced from June 2020 through to February 2021. This is believed to be as a result of the pandemic whereby fewer people chose to go into hospital and paramedics were able to manage more treatment at home.

(o) Where possible people have been treated at home using national Covid funding to improve flow from NUH to care at home. Work is ongoing to improve rates of medically safe discharge as soon as possible.

(p) Work has been carried out jointly with Adult Social Care colleagues to deliver support to care homes and care at home, for example testing for Covid and flu, vaccination, training for staff to spot deterioration in residents and increased support for care at home.

(q) In terms of mental health, there has been enhanced support for mental ill health in the Emergency Department and clear signposting to the crisis helpline, crisis sanctuaries and mental health helpline.

(r) Telephone triage has been introduced as the first point of contact for primary care with video, telephone and on line consultations available. The Clinical Management Centre on Upper Parliament Street has been available for those

who are Covid positive or have suspected symptoms. It is now a priority to focus on long-term conditions and a learning disability physical health review. Work has been ongoing on both the flu and Covid vaccination programmes.

Due to time constraints, it was agreed to defer the update on the flu vaccination programme (scheduled as part of the winter pressures item) to a future meeting.

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

(s) There has been additional pressure on staff as a result of Covid. Adult Social Care staff across all systems (private providers, home support services, day services, care homes etc) have been working very hard. While staff work hard at all times, the emotional impact and anxiety and the additional requirements of Covid have added to pressure. Staff wellbeing is of great concern as significant demands on health and social care services continue. Staff have been able to feedback to supervisors/ managers on their needs, which has influenced, and will continue to influence, the design of support available, for example through occupational health, ensuring staff take proper and active breaks during their working day (whether at home or at work locations) and take their annual leave.

(t) Adult Social Care does not currently have a long-term sustainable funding plan, so it is difficult to plan for next winter, although it is clear that the need for resources and capacity to address flu, and now Covid, can be anticipated. Colleagues have been able to access one-off pots of funding during the pandemic, but as well as insecure long-term funding making it difficult to plan, it is difficult to attract staff without an offer of ongoing work and permanent contracts. Colleagues would welcome the ability to be able to plan a sustained level of resources year-round rather than having to respond to crises at specific times of the year.

(u) The experience has been very similar in health services, where there has also been a focus on gaining feedback from staff to ensure appropriate support in the light of flu and pandemic pressures. The NHS takes a range of measures to try and prevent the annual pressures, for example the flu vaccination programme and managing long-term conditions, but does need to plan to make sure that there is additional capacity across all services so that it can respond to increases in demand.

(v) This year, General Practice has been brought into the overall system of reporting on service pressures so that GP and locality services can be supported at the operational level to respond to demand. The CCG has also worked with General Practice on reducing bureaucracy, supported by some national approaches, and are increasing the workforce which supports primary care more generally through the Primary Care Networks.

64 Platform One - Patient Needs Assessment Policy and Process

Lucy Dadge, Chief Commissioning Officer, CCG, Joe Lunn, Associate Director of Primary Care, CCG and Dr Ian Trimble, former city GP working with the CCG

attended the meeting to discuss the approach being taken to individual needs assessment policy and practice for the transfer of patients from the Platform One practice.
Colleagues highlighted the following information:

(a) The CCG expressed its gratitude for the input from the Stakeholder Task and Finish Group as the process towards transition from Platform One proceeds and reassured the Committee that its Primary Care Team is very experienced at handling practice closures and dispersions.

(b) Due to the pandemic the CCG has proactively matched each patient who needs to be dispersed out of the city centre practice area to another practice, so that no patient slips through the net.

(c) The CCG and Nottingham City GP Alliance (GPA) are working with NEMS on dispersal of all patients. Of the 3,007 patients who will be allocated to another practice there are 40 patients who could be considered to meet the definition of living with Severe Multiple Disadvantage (SMD) having at least two of the following; mental health diagnosis read code (NHS clinical code used on a patient's clinical record), known to be homeless, known offender or known substance misuser. 27 of these patients live in a residential centre and will be transferred to a single practice. The remaining 13 patients have been allocated to 11 practices based on where they live. No single practice will be allocated more than two SMD patients.

(d) None of the homeless population registered at Platform One will be dispersed out of area as they either reside in Nottingham centre hotels or Platform One is their registered address. Therefore, they will transfer directly to the new Parliament Street practice. Where homeless patients receive primary medical services from other GP practices through the legacy Homeless Local Enhanced Service (LES). There will be no change to this cohort of patients in accessing services under the widened SMD LES.

(e) Patients known as 'sofa surfers', ie those who change address frequently, are difficult to identify. Where they are in touch with Platform One they will be supported with the change. Those who are not known will need to register with a new practice when they next need to access primary care services if they are not living in the Parliament Street practice boundary. As far as possible the CCG is linking with organisations who may be in contact with such patients through the Stakeholder Task and Finish Group.

(f) The CCG identifies offenders through the two probation hostel postcodes. Both of these hostels remain in the new practice boundary so there will be no transfer of these patients to other practices. The CCG is working with the Probation Service on communications and conversations with this group of patients. The CCG is also engaging with NHS England and NHS Improvement Specialised Commissioning colleagues and the National Probation Service to ensure that patients currently in custody also remain informed.

(g) The biggest cohort within the 3,000 patients to be dispersed is those who have a coded mental health diagnosis in their medical records, including past, active and

mild mental health conditions. Based on current registrations these patients will be allocated to 86 practices as follows:

Number of practices receiving between 1 and 9 patients	42
Number of practices receiving between 10 and 19 patients	32
Number of practices receiving between 20 and 29 patients	12

(h) All Nottingham and Nottinghamshire GP practices have the skills and competencies to manage mental health conditions and ensure patients have access to specialist services. The CCG has confirmed with Nottinghamshire Healthcare that patients currently accessing mental health services will initially remain with their current Local Mental Health Team until it is safe for their care to be handed over.

(i) Of the 92 patients identified as having a substance misuse code, 67 live in a residential centre and have been allocated to one practice. 15 are on the substance misuse shared care pathway and will be allocated to 13 practices. The new Parliament Street practice has indicated a commitment to sign up to the substance misuse shared care pathway service. There are 10 patients where additional work is needed to establish which are already linked into the shared care pathway.

(j) Platform One has a high number of families from overseas with a proportion of their patient list recorded as non-English speaking. This is typical for the practice location. There are a number of asylum seeker and refugee patients accessing primary care services from other practices in Nottingham city through the Asylum Seekers and Refugee Local Enhanced Service. The Nottingham and Nottinghamshire Refugee Forum (NNRF) is part of the Stakeholder Task and Finish Group. Work continues to communicate with and support asylum seeker and refugee patients with the transfers.

(k) The Stakeholder Task and Finish Group has met twice and work has already started on a number of actions, including producing wallet sized information cards and workforce briefings to all organisations.

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

(l) It was confirmed that homeless people in hotels will be within the Parliament Street practice boundary so will transfer from Platform One.

(m)The CCG confirmed that those patients who do not have a registered address (sofa surfers) will transfer to the Parliament Street practice. They are not included in the 3,000 patients who are moving from Platform One to a practice in their locality. However, if they find a permanent address and want to register with a GP with this address, then they will need to register with a practice in their locality if it is not within the Parliament Street practice boundary unless there are individual circumstances which the practice and patient will discuss.

(n) Transient tenants, ie those with a registered address, but one which changes frequently for a range of reasons, who want to register with their new address when they move, would have to register with a practice local to their registered

address if their current practice does not take out of boundary patients. This is true for all patients across the city and not specific to the Parliament Street practice. However, it is unusual for such patients to declare their new address and they often continue to receive care from the original practice.

(o) It is not possible to monitor or track such patients who will have transferred from Platform One to Parliament Street if they move in the future, as current systems do not enable this to be done on an individual level. If, for example, six months on from transfer they move and inform the practice of this, they would not normally be kept on by Parliament Street if that new address is outside the Parliament Street boundary, but this would be discussed on a case by case basis to ensure that the best support is available for the individual patient. The CCG will work through such scenarios (with information from partners from the Stakeholder Task and Finish Group and Healthwatch) with the GP Alliance to ensure that the individual circumstances are appropriately addressed.

(p) The CCG will report back to the Committee in future meetings on any issues arising from this as the transfer takes place and embeds.

65 Work Programme

(a) The Committee agreed the topics for its work programme 2021/22. These will be scheduled and presented to the next meeting.

(b) The Committee agreed to follow the process used in previous years for the consideration of Quality Accounts. An informal meeting will be held between the relevant provider trust and three members of the Committee. Any health scrutiny comments submitted to be included in the Quality Account will be reported back to the full Committee for noting.