Nottingham City Council
Health and Adult Social Care Scrutiny Committee

Minutes of the meeting held in the Ground Floor Committee Room, Loxley House, Station Street, Nottingham, NG2 3NG on Thursday 14 July 2022 from 10:00am to 11:29am

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Eunice Campbell-Clark
Councillor Maria Joannou (Vice Chair)	
Councillor Michael Edwards	
Councillor Kirsty Jones	
Councillor Anne Peach	
Councillor Dave Trimble	
Councillor Sam Webster	
Councillor Cate Woodward	

Colleagues, partners and others in attendance:

Sarah Collis	-	Chair, Healthwatch Nottingham and Nottinghamshire
Dr Jonathan Evans	-	Head of Service for Neurology, Nottingham University Hospitals NHS Trust
Jane Garrard	-	Senior Governance Officer
Dr Keith Girling	-	Medical Director, Nottingham University Hospitals NHS Trust
Lucy Hubber	-	Director for Public Health
Adrian Mann	-	Governance Officer
Suzanne O'Neil	-	Deputy Director for Communications and Engagement, Nottingham University Hospitals NHS Trust
Dr Stephen Shortt	-	GP
Councillor Adele Williams	-	Portfolio Holder for Finance
Councillor Linda Woodings	-	Portfolio Holder for Adult Social Care and Health

16 Changes to Membership

The Committee noted that Councillor Eunice Campbell-Clark has replaced Councillor Nayab Patel.

17 Apologies for Absence

Councillor Eunice Campbell-Clark - Council business

18 Declarations of Interests

None.

19 Minutes

The Committee confirmed the minutes of the meeting held on 23 June 2022 as a correct record and they were signed by the Chair.

20 Neurology Services

Dr Keith Girling, Medical Director at Nottingham University Hospitals NHS Trust, Dr Jonathan Evans, Head of Service for Neurology at Nottingham University Hospitals NHS Trust, and Dr Stephen Shortt, GP, presented a report on access to Neurology Services. The following points were discussed:

(a) changes have been made to the Neurology Service with the aim of ensuring that specialist neurologists are able to offer the best value to the patients who would benefit most. There are 15 whole-time equivalent consultants covering the area of Nottinghamshire, Leicestershire, Derbyshire and Lincolnshire, focused in the larger population centres. This represents a reduction in capacity on previous years, and consultant numbers are relatively low for the size of the population served. Two new consultants have been appointed, but have not yet started in their roles;

(b) consideration is being given to expanding the number of consultants and a business case is being drawn up for submission in September, but it is difficult to secure the funding required for new positions. There is a need to increase Neurology support to acute medicine, with growing inpatient needs for its services, and funding is being sought to further develop a Neurology liaison role. A positive impact has been made in improving delivery in emergency patient pathways to date, and a great deal of work is underway to engage with inpatients at an early stage, to reduce their stay time in hospital;

(c) Neurology is primary an outpatient speciality, and the consultants see around 200 to 300 patients per month in outpatient clinics, with 3 to 4 clinics per week for each consultant. Appointments are needed for both new patients and patients with chronic conditions, with provision made for timely review appointments – while ensuring that outpatient appointment waiting times are relatively short. Now, when GPs refer patients to Neurology, the referrals are considered carefully to identify those with the greatest service need, those who are most appropriate for the Service and those who would benefit most from early treatment. Where patients with wider and complex needs enter the Service, the consultants will also refer them on to other provision that they might require;

(d) referred patients are triaged to ensure that they are offered the most appropriate kind of appointment, which can be either face-to-face, by phone or by video call. New patients are usually offered a face-to-face appointment. However, the use of video calls, where appropriate, has greatly reduced the number of missed appointments, and has been very helpful to patients who would otherwise need to travel some distance to access a clinic in person. There are a range of mechanisms available for the delivery of care, and it is aimed to use these in the most patient-responsive way possible;

(e) all of the proposed service changes have been audited, and there is confidence that patients that require it are being treated within Neurology, or are referred on to the service that they need. The total number of referrals to the Service have decreased, but the changes have resulted in more patients being referred back to the GP. A safety net process is in place to ensure that patients are not disadvantaged by the new system;

(f) in 57% of referrals returned to the GP, a bespoke letter is produced to provide detailed advice and guidance on the appropriate treatment pathway, and this is shared with the patient. In 20% of cases, advice is provided that the patient should be referred by the GP to another specialist service – however, in response to feedback, consideration is being given to whether Neurology could refer the patient on directly, to ensure that patients have access to the right clinics in a timely way;

(g) in other instances, the referral is returned because Neurology requires more information before an appropriate pathway for the patient can be determined. There are very few cases of a patient being referred back to the GP incorrectly. Although there is a workload associated with all patient contact, the new triage system should not have a substantive impact on GP workloads, even though more patients are being referred back to them;

(h) GPs have access to guidelines on when to refer patients to specialist Neurology services, and resources are in place to support GPs in supporting as many patients as effectively as possible in the primary care environment. GPs also have shared support in making sure that patients are sent to the right place for their needs. It is vital for Neurology to be involved as early as possible where its services are needed, particularly for complex cases – so GPs are able to request a same-day assessment where there is otherwise a risk of a patient requiring hospital admission;

(i) a great deal of work is underway to ensure the use of shared case models so that, instead of responsibility for a patient being transferred fully from the GP to a specialist service and then being transferred back again, services retain different degrees of responsibility for the patient at all points throughout their pathway;

(a) the Trust accepted that there probably had been insufficient engagement and consultation with GPs regarding the changes to how referrals are triaged and managed, and lessons will be learnt from this.

Resolved:

(1) to support the development of a new business case for Neurology Services as part of delivering the upcoming Integrated Care Partnership's strategy for Nottingham. However, the Committee queried whether a step-change in service provision should be considered, given the relatively low level of full-time equivalent Neurology consultants for the size of the population served;

(2) to recommended that GPs, primary care partners, patients and the Committee are consulted and engaged with closely as part of the development of any business case for future service re-design – particularly

as the current changes to service access do not seem to have been consulted upon widely before being introduced;

(3) to recommend that, within an Integrated Care System, all partners across the system should be supporting each other closely in managing service delivery and workloads effectively. The Committee noted that it is also vital for patients to be kept informed as to the boundaries of responsibility for their healthcare at any given point.

21 Proposed Change to Colorectal and Hepatobiliary Services

The Nottingham and Nottinghamshire Integrated Care Board submitted a report on proposals to transfer colorectal and hepatobiliary services provided by Nottingham University Hospitals NHS Trust from the Trust's Queens Medical Centre site to the City Hospital Campus.

Resolved to support the proposed transfer of the colorectal and hepatobiliary services provided by Nottingham University Hospitals NHS Trust from the Queens Medical Centre to the City Campus, and the proposed approach to patient engagement.

22 Integrated Care System Approach to Health Inequalities

Councillor Adele Williams, Portfolio Holder for Finance, and Lucy Hubber, Director for Public Health, presented a report on the approach being developed across the Integrated Care System (ICS) to address health inequality. The following points were discussed:

(a) Nottingham City and Nottinghamshire County Council are working closely with the ICS on developing and embedding an approach to achieving greater health equality and equity for citizens, within the context of the emerging new system for fully integrated care;

(b) unfortunately, the outcomes for Nottingham's population across most health areas are worse than elsewhere in the county, and the difference in the outcomes for the City area when compared to the wider national picture is statistically significant – including when compared to the position in the County. The average life expectancy is substantially shorter across all levels of deprivation, and the period of living in poor health is longer. The Coronavirus pandemic has also had a huge impact on mortality;

(c) many of the major causes of death within the City population are products of the lived environment, and so are preventable. As such, multiple approaches are required, including Levelling Up, developing health equity, addressing the wider determinants of health, growing strong anchor organisations, and enabling and supporting effective communications platforms;

(d) health equity recognises that more should be done differently for some people to provide them with the same chances as others to live a longer and healthier life. Work is being carried out to identify the groups that disease affects the most, and how the causes of disease can be addressed most effectively. A close focus is

required on addressing severe multiple disadvantage through the wider determinants of health, by working to ensure that everyone can access the same opportunities. Beyond growing equity, it is vital that work is carried out to remove as many of the barriers to good health a possible;

(e) going forward, it is important that the whole system works proactively to address people's needs, rather than aiming simply to meet demand. A clear focus is required on the unmet needs of communities that are not able to present easily, and structures must be built up around individuals, in order for them to receive the best health outcomes;

(f) the ICS Health Inequalities Plan is being produced for September, which will be an important foundation of the Integrated Care Partnership's (ICP) upcoming Strategy (being produced for December), to be delivered by the Integrated Care Board (ICB). Progress on the development of the ICP Strategy is scheduled to be reported to the meeting of the Nottingham City Health and Wellbeing Board in November;

(g) the concept and ambition for health equity is not a recent development. However, there is now a deeper understanding of the situation and a stronger appetite to bring about this change. Public Health approaches are being embedded into ICS structures, and services are being developed on the basis of information on need collected directly from communities. The cross-partnership ways of working being grown across the whole system represent an important shift in how services are provided, and there is a clear momentum for change. Community Health and Wellbeing Hubs are being established locally with the intention of reaching people with the greatest need much earlier. The need for equity is written into all ICB objectives, and the right steps are being taken;

(h) given the substantial difference in Nottingham's health figures to elsewhere, it is likely that reversing these trends will take a number of years. However, areas where change can be achieved more rapidly are being identified, and work is underway to ensure that resources are being targeted to the areas of greatest need. A full assurance processes is in place;

(i) there are four key priorities in the Council's Joint Health and Wellbeing Strategy. Financial wellbeing is one of the four priorities, as good employment and access to money represents a strong means of reducing health inequality. The key priorities all have clear, funded implementation plans, with defined and measurable outcome targets in place, which will be used to assess the level of change being delivered in people's lives.

Resolved:

(1) to recommend that there must be an extremely strong focus on addressing the wider determinants of health effectively, and in ensuring timely early intervention and prevention in an ongoing way;

(2) to recommend that very close engagement is carried out with individual communities in developing the Integrated Care System's and Integrated Care Partnership's strategic documents;

(3) to recommend that clear, effective measures are in place to assess the level of change being delivered;

(4) to request that an update on the development of the approach to addressing health inequality is submitted to the Committee in the New Year.

23 Work Programme

Jane Garrard, Senior Governance Officer, presented the Committee's current work programme for the 2022/23 municipal year.

The Committee noted the work programme.