Nottingham City Council

Health Scrutiny Committee

Minutes of the meeting held remotely via Zoom and livestreamed on the Council's YouTube Channel - https://www.youtube.com/user/NottCityCouncil on 19 November 2020 from 10.05 am - 1.06 pm

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 Angela Kandola	
Councillor Dave Liversidge	
Councillor Lauren O`Grady	
Councillor Anne Peach	

Colleagues, partners and others in attendance:

Ajanta Biswas	-	Healthwatch Nottingham and Nottinghamshire
Alex Ball	-	Director of Communications and Engagement, Nottingham and Nottinghamshire Clinical Commissioning Group
Jane Bethea	-	Consultant in Public Health, Nottingham City Council and Nottinghamshire Healthcare Trust Foundation Trust
Lucy Dadge	-	Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group
Joe Lunn	-	Assistant Director responsible for primary care, Nottingham and Nottinghamshire Clinical Commissioning Group
Jane Laughton	-	Healthwatch Nottingham and Nottinghamshire
Lynn Lapere	-	Deputy Chief Executive, NEMS
Dr Ian Trimble	-	Former City GP
Dr Jane Turrill	-	Former Lead GP, NEMS
Dr Stephen Willott	-	Clinical Lead for Alcohol and Drug Misuse, Public Health Nottingham City Council and GP at Windmill Practice, Sneinton
Jane Garrard	-	Senior Governance Officer

27 Apologies for absence

None

28 Declarations of interest

None

29 Platform One Practice

The Chair informed the Committee that this meeting was being held because of concern about the impact of changes being made by Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) to the contract for the Platform One Practice on the many vulnerable service users with complex needs who currently receive services at that Practice. The Chair informed the Committee that the CCG had been asked to provide a copy of the Equality Impact Assessment (EIA) relating to this decision but it had stated that it was unable to provide it due to the current procurement process.

Lucy Dadge, Chief Commissioning Officer, supported by Joe Lunn, Assistant Director responsible for primary care, and Alex Ball, Director of Communications and Engagement, all from Nottingham and Nottinghamshire Clinical Commissioning Group and Dr Ian Trimble, a former City GP, spoke to the Committee and answered questions about changes to the contract for Platform One Practice. The following information was highlighted:

a) The CCG recognises the importance of ensuring the highest quality general medical services to City populations and the need to give due regard to the needs of vulnerable groups.

b) The Equality Impact Assessment had not been provided to the Committee due to a belief that sharing the information during the active procurement process to secure a new provider could result in releasing commercially sensitive information but this now isn't considered to be the case and the CCG will share information that is available either at the meeting or at the earliest opportunity.

c) In 2008 the then City Primary Care Trust awarded a contract to meet the needs of this population. NHS England guidance is that such contracts should be awarded for a maximum of five years. The initial contract with NEMS ran from 2009 to 2014 and there was permission granted to extend the contract for a year and then another further year to 2016. Work took place to explore extending the contract with NEMS for a longer term, but this was not supported by NHS England.

d) Since 2016 commissioners have undertaken three procurement exercises to identify a longer term provider. NHS England has agreed that the provider identified can have a contract of ten years, plus potentially a further five years, to ensure sustainability.

e) The most recent procurement exercise was carried out in early 2020 and there were no bids. Therefore, NEMS' contract has continued to be extended since 2016. NEMS has indicated that it does not wish to provide the service going forward but has said that it will be willing to extend the contract until June 2021 to enable the CCG to secure a new provider and support a smooth transition.

f) The current contract with NEMS concludes in March 2021 and therefore a new provider needs to be identified by the end of the December to ensure a smooth transition.

g) Following the failed procurement exercises, the Primary Care Commissioning Committee agreed to review how to secure a new provider. The options considered included repeating an external competitive procurement; dispersal of the whole patient list; and a partial patient list dispersal.

h) During the summer a Strategic Needs Review was undertaken which looked at the characteristics of the practice and the service needs to ensure a new provider could be found. Details of this Review can be shared with the Committee. The Review concluded that a partial list dispersal with retention of a smaller City practice was the option most likely to meet population health need and secure a new local practice able to provide the core general practice services.

i) Therefore, in accordance with feedback about the importance of offering opportunity to local providers, local practices are being offered the opportunity to bid for the contract to provide these services at a city centre location, and alongside this work is taking place with practices on registering patients who will no longer be within the practice boundary to ensure continuity of care.

j) A detailed EIA has been carried out in reaching the decision. It is a live document and should have been available for review by the Committee and will be made available.

k) The CCG is aware that many of the current patients have complex mental health needs. This isn't explicitly part of the contract but the CCG will commit to looking at whether it needs to commission an additional service for these patients, that could be accessed by other patients in the area as well. In addition, some patients have substance misuse issues, are asylum seekers and/ or have significant requirements for translation services. Therefore, in addition to core general practice services there will be an opportunity to provide enhanced services to meet these additional needs offered to the new provider.

l) Existing skilled NEMS staff will be offered employment through TUPE arrangements.

m) Based on this proposal for core general practice and enhanced services for additional needs and potentially a separate mental health service, the CCG has received bids to run the service in a city centre location. It is hoped that the contract award will be made in the next week.

n) The financial envelope for the new service recognises the nature of the patients and finance has not been a driver. It is funded 17.5% in excess of national global sum calculated on a weighted cost per patient for the first four years. To ensure equity with other practices, after four years the funding for this practice will be reviewed. Bids have been received from practices on this basis.

o) Going forward the issues will be management of patients on an individual basis, ensuring continuity of care and a holistic approach for those with complex needs; supporting other practices who will be receiving patients; and ensuring that all staff who are willing to do so are supported to transfer to the new provider.

In response to questions from Committee the following responses were made:

p) The driver for this is that the existing contract has come to an end and a procurement process has to be followed to secure a new contract to provide services.

q) The financial envelope for this local solution is the same as when the CCG went out to the market previously, and is greater than the national global sum and higher than for the majority of practices. However, the CCG has to operate within national boundaries on funding for general medical practice. Discussions have previously taken place with NHS England about continuing with the contract at previous financial allocations and this was not possible. Higher levels of funding for this contract also risks inequity with other practices who also manage patients with complex needs. In determining the financial envelope, the CCG considers that it has taken due account of the needs of patients. The CCG does not recognise all the numbers quoted in a recent article by the British Medical Association about the changes.

r) The contract will be awarded on the same terms as the current contract to provide core general medical services with the availability of local enhanced services. Therefore, the same range of services will be available to patients. The number of patients registered with the practice will be reduced due to the partial list dispersal.

s) The majority of patients being dispersed are not be considered to be vulnerable and most of the vulnerable patients will remain with the new practice located in the city centre.

t) Patients being dispersed have been plotted according to geographic location and will be dispersed across 96 practices. There will be core general medical services in all of these practices and they will all also be able to engage in wrap around local enhanced services as well as other additional services. If an additional mental health service is commissioned it will be available to all patients whether they are registered with the new practice or not. Some Committee members raised concerns as to whether there is sufficient skill and expertise within all of these practices to effectively support patients with multiple and complex needs and whether they would be able to replicate the ‘one stop shop’ that currently exists at Platform One Practice. The CCG stated that this is why there will be additional wrap around services that all patients can access.

u) The current practice originally had a very small patient list and was established to meet the needs of patients with multiple needs and has been successful. Needs have grown as the practice list size has grown.

v) Access to translation services will be on the same basis as currently.

w) Unlike Platform One Practice currently, the new practice will have a patient boundary. The CCG considers that this will enable it to secure a sustainable provider. Some Committee members raised concerns about the impact that this could have on people with transient lifestyles who may need to move GP practice frequently compared with remaining registered with a practice without a patient

boundary regardless of where they live or how often they move. The CCG stated that it will work with the new provider to accommodate temporary accommodation moves.

x) The majority of homeless patients will remain within the inner city boundary of the new practice and work is taking place to look at continuity of care for those just outside the inner city boundary. Support for homeless people is covered in the EIA.

y) A series of engagement events have been held with primary care networks (PCN) and practices about the changes and there have also been meetings with individual PCNs and practices about the specific implications for them e.g. numbers of patients being dispersed to each PCN and practice. Patients have been mapped to their geographically closest practice but mapping has also looked at the second and third closest practice to identify options if a practice flags that it will struggle to take the dispersed patients. No PCNs have said that they will be unable to manage across their network. 1 practice has said that it may not be able to take the entirety of the patients that would be dispersed to it, but another practice in their PCN has said that they will be able to take those patients instead. Some concerns were raised in PCN East about capacity to take on patients with substance misuse issues and within the PCN it has been decided that all patients with substance misuse issues will go to a specific practice that has the most expertise to support them.

z) A number of related services operate out of the Platform One Practice and have close working relationships with the Practice, such as substance misuse services, support for those with multiple complex needs, housing support. A Committee member cited that currently 35 Platform One patients are Clean Slate users, 117 are Nottingham Recovery Network Patients and 44 are Shared Care patients. Platform One Practice currently provides drug treatment for 44 patients. Some Committee members were concerned that Nottingham Recovery Network does not have capacity to take on these additional patients. The CCG confirmed that so far conversations have been held with the lead commissioners at the Crime and Drugs Partnership who commission Clean Slate, Nottingham Recovery Network and Shared Care. The next steps will be to engage with individual providers. The CCG reported that 21 Nottingham Recovery Network patients are likely to be dispersed. Shared Care clients are currently spread across 5 practices in the City and there is interest from PCNs on providing a replacement service from an inner city location.

aa) In response to comments made, the CCG stated that more could be done on working with non-health providers to understand and manage the impacts of change. A Committee member cited the example of probation hostels being primarily located outside the city centre and probably not within the new practice boundary.

bb) If patients receiving services from their Local Mental Health Team are dispersed to a practice linked with a different Local Mental Health Team they may experience a discontinuity of mental health professional, but there will not be a discontinuity of service. This will only affect a small number of individuals and

work will take place with Nottinghamshire Healthcare NHS Trust on this transition.

cc) The 3000 patients to be dispersed have not been dispersed yet. It is intended to write to patients again in January with the intention of them moving practice at the end of March.

dd) The CCG will continue to work with commissioners and providers to identify the needs of each patient and how best to support them. There is detail about this in the EIA. NEMS are also engaged with this to ensure that there are care plans in place for the handover.

The Chair informed the Committee that two written submissions had been submitted for the Committee's consideration and that a range of individuals and organisations had requested to address the Committee on this issue. The Chair invited these individuals and organisations to address the Committee in turn.

Jane Bethea, Nottingham City Council Consultant in Public Health responsible for drugs and alcohol and who works closely with commissioners of those services, and Nottinghamshire Healthcare NHS Foundation Trust leading for Nottingham City Integrated Care Partnership (ICP) on severe multiple disadvantage, addressed the Committee on behalf of the ICP Group supporting severe multiple disadvantage work. She highlighted the following information:

ee) The Group would like to know the number of individuals with severe multiple disadvantage affected by the change and how that number was determined, and would have liked to have seen the EIA and needs assessment.

ff) The Group has concerns around consultation. Clean Slate and Nottingham Recovery Network have not been consulted and, as commissioners of Drug and Alcohol Services, the only contact has been to ask which services are providing which services. Engagement has not taken place with commissioners of those services.

gg) Primary care is the bedrock of care for the most vulnerable citizens and it is important for the Group to have assurance about the plans for these citizens and how the transition will be managed.

hh) The main concern is the ability of providers to meet the needs of these individuals, who can face big challenges and barriers and involves a lot of complexity. This is a concern of the Group which includes all statutory and voluntary organisations in the City working with people who face severe multiple disadvantage and also service user representation. Service users have raised significant concerns about the changes proposed.

ii) A key issue for users and providers is the existence of good relationships to support stable progress and recovery. There is also a need for services to be flexible. Flexibility e.g. the ability to hold drop in sessions and the central location have been key at the Platform One Practice and the Group would like assurance that this will continue with the new provider.

jj) The staff at Platform One Practice are committed and highly skilled and they understand the complexity of patients with severe multiple disadvantage. There is concern about what will happen to these staff and their skill set at a time when the ICP is trying to be as responsive as possible to people with severe multiple disadvantage and there is a known gap in the ability to meet needs.

kk) Over 100 Platform One patients currently receive care from the City Local Mental Health Team and it is likely that they will be dispersed to other practices. This will impact on continuity of care for the individual and could impact on service provision.

ll) Flexible skilled primary care is the most important thing to support clients' recovery and healthcare and the Group would like reassurance that the needs of this client group have been fully understood and taken into account.

Dr Stephen Willott, Clinical Lead for Alcohol and Drug Misuse Public Health Nottingham City Council and GP at Windmill Practice in Sneinton and for homeless people based at the Friary addressed the Committee, highlighting the following information:

mm) It is paramount to focus on the needs of patients, both those being dispersed and those remaining with the new practice, and who is best to continue looking after them. Severe multiple disadvantage refers to homelessness, mental health, substance misuse and an offending history. Of the 11,000 current Platform One patients it is likely that a significant proportion of them have at least some of these problems. They make up a significant proportion of Clean Slate patients, patients at the Nottingham Recovery Network and at Shared Care. There is often a good reason why they are registered at Platform One Practice, perhaps they have been unable to get care anywhere else.

nn) While efforts have been made, consultation has been too little too late. An example of this is that suddenly, without warning, 25 patients living at the Mercure Hotel received a letter saying that they were being reregistered. A lot of work took place to get these patients registered in the first place. Even if care does continue elsewhere there has already been a destabilising effect of the change to consider. Primary Care Networks will do their best to ensure provision and continuity for this group of patients but that is not to say that the change is welcome.

Dr Jane Turrill, former lead GP, and Lynn Lapere, Deputy Chief Executive, both from NEMS, addressed the Committee highlighting the following information:

oo) The Practice was set up to meet the needs of patients with complex needs.

pp) NEMS is interested in continuing to provide services for these patients but cannot provide services under the current framework and financial model. Over the last seven years there has been a lot of engagement with the CCG about the costs of delivery, and NEMS recognises that the direction of travel set by NHS England is for a level playing field. However, the cost of delivering these services is higher than the general medical service contract value. The work done by staff to enable vulnerable patients to have the same access to care as

everyone else and to stabilise patients and provide reactive, proactive and wrap around care in a flexible way costs more. Delivering the same services under the new contract would result in NEMS losing more than £400,000 per year and this is not sustainable as it would put other services at risk.

qq) Flexibility and the huge importance of not having a boundary have been key to the Practice's ability to reach people. Of the 3000 patients being dispersed who stayed with Platform One Practice when they moved or didn't reregister this is often because either they have been unable to access care where they live, have been removed from a patient list where they live or have been advised to register with Platform One as it is best place to meet their needs. It is likely that such patients are over-represented rather than under-represented in the 3000 patients being dispersed.

rr) NEMS is very proud of its staff. It was suggested by the CCG that all staff would be transferred to the new provider to provide expertise. Under the new contract NEMS calculated that it would have to make 40% of its current staff redundant and therefore it does not consider that the transfer of all staff will be financially possible under the new model.

ss) Investment to support these patients ensures stability and helps the whole healthcare system by reducing the need for patients to access other services, putting pressure on other partners of the healthcare system.

Jane Laughton, Chief Executive Healthwatch Nottingham and Nottinghamshire, addressed the Committee highlighting the following information:

tt) This particular group of patients will be likely to find it more difficult to understand information communicated to them than others, may have life circumstances that make it difficult to respond to options and may be reluctant to access services without active support. It is important to recognise their needs, both in how they are communicated with, the ways in which they are consulted and how they access services.

uu) The concerns raised by others are echoed, but a particular concern of Healthwatch is whether the patients affected have a good understanding of what is happening, that they have been communicated with in a way that they understand and whether they are in a position to exercise an element of choice, if that is available to them.

vv) Healthwatch is part of the Integrated Care Partnership and understands that the strategic direction is for partners to work more effectively together in a multi-agency way, to reduce health inequalities and ensure services are more effectively based on needs. This procurement feels as though it is happening in a different context. Unless they are mitigated, concerns raised today are that the changes will result in a negative impact on other services which is against this direction of travel.

ww) Healthwatch would like reassurance about aspects of the procurement process, including whether the assessment of patient need was included in the service specification so that patient characteristics were clearly set out and

understood by potential bidders; the EIA; and what patients think and whether they were consulted in a meaningful way.

Based on the submissions received, the Committee asked additional questions of representatives of Nottingham and Nottinghamshire Clinical Commissioning Group. In the responses to these questions and the subsequent discussion the following points were made:

xx) The CCG has to work within the required financial and procurement regimes. The decision to open the opportunity to bid for the contract to local providers this time reflects feedback about the importance of supporting local providers to provide local services. No decision has yet been made.

yy) The CCG recognises the quality of service currently provided by NEMS at Platform One Practice but as the contract to provide those services has come to a natural end, the CCG is required to carry out a procurement process that is open to a range of providers. Even if the financial envelope for the contract could be increased (and to such a level that NEMS consider acceptable) there would be no guarantee that, following the completion of the procurement process, there would be no change of provider. The Committee accepted that a procurement process had to be carried out and this could, in any event, result in a change of provider, however some Committee members raised concerns that the financial envelope for the contract was not sufficient to enable the current high quality of care to be maintained by whoever the new provider is.

zz) Committee members raised concerns about the risks of adverse impacts on other public services, both health and non-health, if vulnerable patients and particularly those with severe multiple disadvantage do not have appropriate access to good quality primary care. For example, lack of access to primary care could result in an increase in attendance at the Emergency Department. Therefore, where good services exist, such as at Platform One Practice, it is important for them to be retained. The representative of Healthwatch Nottingham and Nottinghamshire raised the importance for this patient cohort of having high quality primary care but also the importance of it for other public services, both health and non-health, who are at risk of additional pressures and associated costs if patients do not have appropriate access to primary care. If the outcomes are not successful then this would be detrimental to patients, services and the rest of the health system. They suggested that it would be helpful to see the assessment of risks and associated mitigation plans.

aaa) Committee members raised concerns about the consultation that had taken place, referring to issues raised in the submissions to the Committee. It was confirmed that the 3000 patients due to be dispersed were sent a letter approximately 6 weeks previously to let them know about the change and informing them that they would receive a further letter in January with the next steps, details of their allocated practice and that patient choice about which practice to attend, within their geographical boundary, applies. The letter included a link to Frequently Asked Questions on the CCG's website and details of how to contact the CCG's Patient Experience Team about the changes. Out of the 3000 patients sent a letter, 15 comments were received

by the Patient Experience Team. The CCG did not have details of the comments received available to share at the meeting. NEMS have also been involved with communications and leaflets have been placed in the practice. Committee members questioned whether communicating with this particular patient group by letter, leaflet or directing them to a website, when many do not have stable accommodation let alone internet access and given literacy rates due to the disadvantage that they experience, is the best approach and suggested that more could be done to support meaningful consultation. The representative from Healthwatch Nottingham and Nottinghamshire commented that only receiving 15 comments back from 3000 letters highlights how difficult it is, that consultation needs to be tailored to the particular population's ability to engage with that consultation and there are risks with relying on patients' initiative to engage.

bbb) Committee members questioned whether the letters were informing people about the change or consulting them on the change. The CCG informed the Committee that engagement had taken place with patients at the practice prior to the third formal procurement exercise early in 2020, including what was happening, the need to go out to procurement, why this was happening and options including that there may been a need to move to new premises. Committee members expressed interest in the questions asked and whether it was made clear that there could be a practice boundary introduced that may result in some patients having to move to a new practice.

ccc) The CCG has not yet written to the 7,800 patients who will remain with the practice as the only change for them will be that the practice is run by a new provider. They will be written to in late December/ early January once the new provider is confirmed to explain who the provider is and where in the city centre the practice will be located.

ddd) It was raised that while the 7,800 patients remaining with the practice run by a new provider may not be significantly affected by the changes now, if they move to new accommodation in the future, and many individuals with severe multiple disadvantage have transitory lifestyles, they will then be affected by the existence of a practice boundary and have to move to a new practice at that point. In addition, the introduction of a practice boundary will also affect future patients who may have otherwise been able to register at the practice.

eee) Citing the evidence heard in the submissions, Committee members raised concerns about the lack of consultation to date with other providers, such as Clean Slate and Nottingham Recovery Network, who work directly with patients affected and have a good understanding of patient needs and the impact of change on related services.

fff) It was acknowledged that, given the current Covid-19 pandemic, the timing of this is not ideal but it is driven by the need to carry out a procurement process to ensure continuity of service as the current contract is coming to its natural end.

ggg) Committee members asked about the continuity of care for patients being dispersed who access additional services, for example services provided by

Local Mental Health Teams who are linked to GP practices. The Chair informed the Committee that she had previously raised this issue with the CCG and received the following response: "We are working closely with mental health commissioners to ensure patients will have continuity of care. The patient record will automatically transfer to the new allocated practice, there will be no requirement to re-refer patients to services they are currently accessing. Mental health services are all provided by Nottinghamshire Healthcare Trust across the whole of Nottingham and Nottinghamshire and there will be no change in service provision and there will be no change in staff managing those patients." The CCG confirmed that this statement stands apart from that registering with a new practice could result in a patient being under the care of a different professional. There would not be a discontinuity of service but could be a discontinuity of professional within that service. The CCG will review the number of individuals potentially affected by this and it will be picked up as part of the mobilisation plans. If patients do need to change care professional this will be managed with sensitivity recognising the importance of individual relationships with mental health professionals.

hhh) A number of the issues raised in the meeting will be covered in the detailed mobilisation plans supporting the transition process. The CCG is happy to share these plans with the Committee when they are available.

Having considered the information available to it, including from the CCG and submissions from other stakeholders, the Committee concluded that it had significant concerns about the decision. The Committee was concerned about whether the CCG's current trajectory was based on adequate evidence and understanding of patient need of a particularly complex cohort of service users, and how best to meet those needs; the potential impact that this may have for service users - present and future - and their outcomes; the knock on effect the potential absence of a comprehensive, and long term wrap around support package may have on other NHS and partner services should the proposed changes go ahead; and that the approach seemed out of line with the Integrated Care Partnership's focus on patients who experience disadvantage. The Committee felt that the absence of provision of the Equality Impact Assessment and Strategic Needs Review to inform the Committee's consideration at the meeting made it harder for the Committee to get assurance about these issues.

Resolved to:

1) **request that the Equality Impact Assessment, Strategic Needs Review and any other relevant documents are made available to the Committee and key partners, and made publicly available as soon as possible;**

2) **request additional information relating to:**
   i. **anonymised feedback received from the 15 patients who contacted the Patient Experience Team in response to the letter sent about the changes;**
   ii. **proportion of the patients being dispersed to other practices with severe multiple disadvantage and disadvantage;**
   iii. **details of consultation carried out with current patients in January 2020 and feedback received from that consultation;**

iv. numbers of patients currently registered with the City South Local Mental Health Team who may be dispersed to other practices covered by a different Local Mental Health Team;

3) recommend that Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) work with NEMS to agree a short extension to its current contract enabling the CCG to pause its procurement process and review the approach being taken based on the issues that have been raised at the Health Scrutiny Committee meeting on 19 November, also allowing the CCG to carry out meaningful engagement and consultation with service users and other relevant stakeholders. The Committee also asks that the CCG report back to the Committee on the outcomes of this review to provide assurance that the option being progressed is in the best interests of service users - current and future, and local health services and other supporting agencies, and if not, its proposals to amend the approach. The review should include a) the process carried out, approach to engagement and consultation and understanding of patient need; b) the financial aspects in the context of the wider health system;

4) recommend that Nottingham and Nottinghamshire Clinical Commissioing Group works with organisations who are already engaged with service users potentially affected, and who have experience of supporting service users on how best to consult and engage with service users as part of the consultation process. The Committee notes the need for particular consideration to be given to the barriers that this group of service users may face as part of a standard consultation process given the additional and complex needs represented. The necessity of a pro-active approach to support and encourage service users to be able to fully participate in a meaningful consultation cannot be understated;

5) recommend that Nottingham and Nottinghamshire Clinical Commissioning Group works proactively to engage with non-health commissioners and providers to understand any knock on effect and potential impacts any changes may have, and how they may be mitigated to ensure the best possible outcome both for service users and for health and other public services; and

6) request that Nottingham and Nottinghamshire Clinical Commissioning Group keep the Committee and key partners regularly updated on the progress of commissioning and mobilisation processes; including provision of the mobilisation plans at the earliest opportunity.