Nottingham City Council

Health Scrutiny Committee

Minutes of the meeting held remotely via Zoom and livestreamed on to the Council's YouTube Channel - https://www.youtube.com/user/NottCityCouncil on 17 December 2020 from 10.05 am - 1.00 pm

Membership

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

Colleagues, partners and others in attendance:

Lucy Anderson	-	Head of Mental Health Commissioning, Contracting and Performance, Nottingham and Nottinghamshire Clinical Commissioning Group
Chris Ashwell	-	Associate Director of Mental Health, Nottinghamshire Healthcare NHS Foundation Trust
Rich Brady	-	Programme Director, Nottingham City Integrated Care Partnership
Lucy Dadge	-	Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group
Kazia Foster	-	Head of Transformation, Nottinghamshire Healthcare NHS Foundation Trust
Amy Goulden	-	Community Relations Manager, Nottingham City Council
David Johns	-	Consultant in Public Health, Nottingham City Council
Helen Johnston	-	Public Health Registrar, Nottingham City Council
Joe Lunn	-	Associate Director with responsibility for primary care, Nottingham and Nottinghamshire Clinical Commissioning Group
Dr Ian Trimble	-	Former City GP

30 Apologies for absence

Councillor Angela Kandola - unwell

31 Declarations of interest

None

32 Minutes of the meeting held on 12 November 2020

The minutes of the meeting held on 12 November 2020 were approved as an accurate record and signed by the Chair.

33 Minutes of the meeting held on 19 November 2020

The minutes of the meeting held on 19 November 2020 were approved as an accurate record and signed by the Chair.

34 Platform One Practice

Lucy Dadge, Chief Commissioning Officer, supported by Joe Lunn, Assistant Director responsible for primary care both from Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) and Dr Ian Trimble, a former City GP, spoke to the Committee about the CCG's response to the Committee's comments and recommendations in relation to changes to the contract for the Platform One Practice. The following information was highlighted:

a) The CCG has taken account of the views of the Committee and other stakeholders and is committed to working with all stakeholders, including commissioners of non-health services who support vulnerable patients.

b) The CCG is also committed to working with patients so they are engaged with what the transition will mean for them and other service providers e.g. Nottinghamshire Healthcare NHS Foundation Trust.

c) The Equality Impact Assessment and Strategic Needs Assessment documents have now been shared, which show how the CCG identified options, assessed their impact and decided upon the final arrangements that the CCG believes will provide a sustainable solution for a local practice to support patients.

d) The intention is for the new practice to be part of the Nottingham City East Primary Care Network, so it will be part of the wider health system and work alongside other practices.

e) The CCG has considered in detail the extent to which current commissioning activities support patients with severe multiple disadvantage, currently registered with Platform One and other practices in the City and County. As commissioners, the CCG cannot access individual patient data but is mapping information about those who receive care and support in relation to one or more of four areas of severe and multiple disadvantage and where they live. The CCG intends to commission a new Primary Care Local Enhanced Service for Severe Multiple Disadvantage that this and all other practices can access. Additional funding has been identified for this. The investment will not be bound by budget but by the GP practices accessing it. The CCG will work with stakeholders, including City Integrated Care Partnership (ICP) partners, on designing the Local Enhanced Service that supports general practice in properly supporting patients.

f) Expressions of Interest to run the new practice have now closed and the Primary Care Commissioning Committee, in confidence, approved the appointment of a

new provider. As required by Regulations, there will be a 10 day standstill period to enable any bidders to make representations and following that period the CCG will announce the new provider publicly.

g) The CCG will work with the current and new providers to ensure a successful transition to the new arrangements.

The Chair noted that the CCG has taken the decision not to pause the procurement process and review the approach being taken as recommended by the Committee at its meeting on 19 November 2020. Despite the opposing positions on this and the Committee's concerns, the Committee does want to work constructively with the CCG on this issue.

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

h) The CCG is not able to continue with the APMS contract as it was originally set up and NHS England has provided clear guidance on this. Therefore, the CCG is seeking to replicate those arrangements the best it can. The context has changed over time and the new provider will be part of the broader primary care network arrangements and the CCG will work with all practices to support their vulnerable populations. The CCG is open to further scrutiny on achieving this.

i) The CCG has identified a provider for the new practice which it believes will provide a sustainable service. Alongside this, detailed consideration has been given to the needs of people with severe multiple disadvantage and the need for investment has been recognised. The ability to support patients with severe multiple disadvantage is an issue for GP practices across the City, and it is important that the new Local Enhanced Service is available to all practices and that there is an equitable service to all patients in the City. The CCG is confident that GP practices will be in a stronger position to support patients as a result.

j) Following feedback at the previous meeting, the CCG is exploring improvements to communication methods and deliverables in relation to Platform One patients, and to do this is working with Healthwatch and the Integrated Care Partnership Severe Multiple Disadvantage Group, who have patient experts as part of the Group. The CCG will be working with other commissioners and providers to use every appropriate method and model to improve the information provided and ensure patients have a good understanding going forward.

k) Committee members raised concern about the top-down approach to the process and the engagement and consultation carried out. As requested by the Committee on 19 November, the CCG had provided details of the 15 responses to the 3000 letters sent out. Committee members noted that the responses reflected patients' distress, concern and anxiety, and reiterated that good communication and reassurance is important. The representative of Healthwatch Nottingham and Nottinghamshire supported this view. The information showed that the CCG considered the contacts to be 'resolved' but the Committee questioned whether it was really a satisfactory resolution for the patient. The CCG stated that future communications will build on that already undertaken, and the same consideration will be given to patients being dispersed as for those

remaining with the practice. There has been contact by some patients since then about which practice they will be transferred to and whether they have a choice about that.

l) The CCG is continuing to engaging with GP practices who will be receiving dispersed patients. There are 96 practices across Nottingham and Nottinghamshire who will receive one or more patients from the patient list. Individual patient engagement will take place with individual practices and they will be encouraged to take up the new Local Enhanced Service.

m) Patients who are registered to live outside the new practice boundary will not be able to choose to register with the new practice but will have choice about which of their local practices they register with. However, practices cannot refuse to register someone because they are homeless so the CCG is confident there will be no patients who cannot register with a GP in the City. The CCG will work with the new provider on this.

n) There is an Asylum Seekers Local Enhanced Service and in responding to a significant influx of asylum seekers into the City over the last six months the CCG has been able to identify a suitable GP practice that was not Platform One to accept those individuals. Committee members expressed concern about the impact of frequent accommodation moves by those without settled status given that there will no longer be a practice that they can register with without a practice boundary and therefore remain with regardless of where they are moved to.

o) The CCG confirmed that any staff with specialist skills currently working at Platform One will be eligible to be TUPED to the new practice, and reiterated the importance of having professionals with expertise in substance misuse, homelessness etc in primary care across the City.

p) Concerns were raised about the implications of the practice boundary and, while acknowledging that the CCG has stated that it will support patients in moving to a new practice, commented that people with transitory lifestyles are likely to move multiple times and therefore need support on subsequent changes of GP practice as they change accommodation because there will be no practice to stay registered at regardless of where they live.

q) Detailed conversations at a patient level will start once the new provider is able to access that patient list, and the CCG will be working with both the current and new providers on the detailed mobilisation plans. The CCG is happy to discuss this planning with the Committee at a future meeting.

r) Some Committee members expressed the view that they would like the appointment of a new provider to be delayed to fully address concerns that have been raised in relation to this substantial change to services, such as about the consultation and engagement.

s) The representative of Healthwatch Nottingham and Nottinghamshire commented that the Equality Impact Assessment indicated that patient engagement should have happened earlier and this represented a failure in the initial stages of the

procurement process. They suggested that instead of addressing this failure the CCG continued with the process 'railroading' patients into accepting the position.

t) The CCG stated that it recognised that the process hadn't been perfect and accepted that it could have done more to engage with service users earlier about the changes and that deeper engagement with the Committee would have been the right thing and recognised that this didn't happen. Some Committee members suggested that this raised concerns about the CCG's processes, and the CCG said that it was happy to follow up on the issues raised and look at lessons to be learnt from its perspective.

Having considered the CCG's response and further information provided at the meeting, the Committee concluded that it still had major concerns about the new arrangements, particularly in relation to the implications of the practice boundary. However, given the stage in the process, the Committee noted that the change was happening and the Chair stated that the Committee would undertake close scrutiny both of the mobilisation plans and further into the future to assess the implications for both patients and wider services, for example the impact on Emergency Department attendance and drug and alcohol services. The Committee expressed the view that consultation on the changes had been minimal and it would not want to see this repeated in relation to other service changes; and because of the minimal consultation and engagement that initially took place with patients, it was important that their views were represented in the development of mobilisation plans and considered that the CCG should engage with all interested stakeholders, and particularly those who work closely with people with severe multiple disadvantage, in the development of those plans. The Committee welcomed the work underway to improve communication and engagement with affected service users.

Resolved to:

1) **recommend that Nottingham and Nottinghamshire Clinical Commissioning Group review lessons that can be learnt from this process and discuss it with the Committee at a future meeting;**

2) **recommend that Nottingham and Nottinghamshire Clinical Commissioning Group work with all relevant stakeholders to ensure the interests of patients and service users are reflected in mobilisation plans to ensure the best outcomes for individuals and the wider system; and**

3) **request that Nottingham and Nottinghamshire Clinical Commissioning Group and the new provider of the practice come to the Committee's meeting in February 2021 to discuss the detailed mobilisation plans and the communication and engagement taking place with service users.**

35 Support for people in mental health crisis

Lucy Anderson, Head of Mental Health Commissioning, Contracting and Performance Nottingham and Nottinghamshire Clinical Commissioning Group, and Kazia Foster, Head of Transformation and Chris Ashwell, Associate Director of Mental Health, both from Nottinghamshire Healthcare NHS Foundation Trust spoke

to the Committee about the services and support available for people experiencing mental health crisis. They highlighted the following information:

a) There are a range of services available, both traditional services and alternatives, including those provided by other providers. The services include Crisis Resolution and Home Treatment Teams, Mental Health Liaison Services, Children and Young People Mental Health Service, 24/7 Crisis Line, Mental Health helpline, Crisis House, Street triage and Harmless, alongside services funded nationally or by charities.

b) There is a Crisis Line available 24 hours a day seven days a week with open access to people of all ages.

c) Implementation of the Mental Health Crisis Sanctuaries has been delayed by the Covid pandemic but it is intended that there will be a pilot in early 2021.

d) There is work to increase capacity by recruiting additional staff into urgent care pathways.

e) There is an awareness that health inequalities exist and data is being used to improve service delivery.

f) As part of the NHS Long Term Plan there is an ambition to grow services for people in mental health crisis, and Nottinghamshire Healthcare Trust has already made significant investment in this. However, as a provider the Trust cannot do it all on its own and there needs to be a whole system response.

During subsequent discussion and in response to questions from Committee members, the following points were raised:

g) There needs to be preventative support and services in place to try and prevent people from reaching a position of crisis. A Committee member cited evidence that the Committee had previously heard about people struggling to access lower level mental health support and ending up in a more serious situation. A representative of the Trust acknowledged that it is important for services to recognise that a crisis is a crisis for that person, regardless of how it is defined by the service. Work is taking place to try and address this, for example the Crisis Helpline with Turning Point is intended to support people with issues ranging from lower level health and wellbeing issues up to escalating them to other services if necessary.

h) A Committee member raised concern about the capacity of secondary care services to accept all those who need those services and the gap between primary and secondary services. The Committee was advised that not all referrals to secondary care are appropriate and the reason for this is a combination of inappropriate referrals by GPs and a lack of appropriate services available. If a patient is not accepted for secondary care it is important that they are not just passed back to primary care without support on the next steps for them. The Improving Access to Psychological Therapies (IAPT) services sometimes fill this gap but sometimes an individual does not just need therapy,

but also support on other issues as well. It is hoped that the new hubs will help to address and reduce the number of inappropriate referrals.

i) The Long Term Plan is a national plan that comes with significant investment, which reflects local and national recognition of previous under-funding. There was £9.9million of funding for this year which is ringfenced, which is unusual for NHS funding.

j) It is currently Year 2 of the Five Year Plan. Some crisis investment took place last year and there are plans for implementation in crisis and community services this year and next year. The detail of plans for future years is being developed.

k) Although Nottinghamshire Healthcare Trust already has 300 more staff than December 2019, recruitment is a challenge. There are limited numbers of suitability qualified people in the region. Recruitment plans are in place, including trying to attract people by offering opportunity for growth and promotion in clinical roles. Recruitment to posts in the Early Intervention in Psychosis Service is underway and should be achieved by the first quarter of 2021/22.

l) As part of the transformation plans, it is intended to increase access so that there is no 'wrong door', with evidence-based therapy available at different levels.

m) Crisis investment through the Long Term Plan focuses on crisis alternatives to try and prevent people reaching the level that they need crisis intervention, for example investment in personality disorder pathways. Work is also taking place with GPs and Primary Care Networks to try and prevent crisis before it happens. The language used is shifting from 'crisis access' to 'crisis alternatives'.

n) One of the downsides of the Long Term Plan is that it is health-based and there needs to be engagement with other sectors to address all needs. For example, the sanctuaries will need to demonstrate that they are working in their localities and neighbourhoods and are sensitive to local cultural needs, which will vary from place to place. This is part of a wider move away from traditional models that have not always been successful, to co-location with other services so that support is not just health-based, and working with smaller providers in that locality. The pilot, taking place with Mind, Harmless, Turning Point and Framework, will start in January 2021. It will initially be a roaming sanctuary due to the restrictions related to Covid-19 and learning is being taken from other areas across the country.

o) There will be a media campaign over Christmas and the winter period about the services available to people.

p) A Committee member commented on the relatively high rates of suicide currently and anecdotal evidence of people who have committed suicide having previously unsuccessfully tried to access mental health services. It is important for services to understand the impact on an individual of being rejected from accessing a service. The Trust informed the Committee that it is recruiting more people with lived experience of services as Peer Support Workers.

The Committee welcomed the investment in mental health services and decided to look in more detail at the effectiveness of work taking place through the Long Term Plan to improve access to mental health services. In particular, the Committee agreed to review the effectiveness of the mental health hubs, once they are established and in operation.

36 Health inequalities related to Covid-19

David Johns, Consultant in Public Health, Helen Johnston, Public Health Registrar, and Amy Goulden, Community Relations Manager all from Nottingham City Council spoke to the Committee about work to understand and address inequalities across Nottingham's diverse communities during the Covid response. They highlighted the following information:

a) There has been a lot of focus nationally and locally on inequalities relating to ethnic minority communities, but there are a range of other inequalities affecting citizens. As requested, the information provided to the Committee focuses on inequalities facing ethnic minorities in relation to Covid-19.

b) There are also inequalities between ethnic minority communities. Office of National Statistics data shows that the risks of dying with Covid-19 are not equal between Black, Asian and Minority Ethnic (BAME) communities and the increased scale of risk varies.

c) The reasons for the inequalities faced by BAME communities are complex and include social, domestic and economic issues. These issues were present pre-Covid but the high profile of the Covid-19 pandemic has highlighted them. Existing health inequalities meant that everyone did not start the pandemic in the same position.

d) There have been some changes at a national level in relation to data collection and assessing risk, for example in workplaces.

e) At a local level it is difficult to replicate the data about the prevalence and impact of Covid-19 that is available at a national level, due to the relatively low numbers but it is known that during the first wave the majority of Covid-19 cases were amongst the older population and those in care homes. The White British population was over-represented at this time. However, there was little community testing and therefore that picture may be incomplete. Between June and August there were lower rates of infection and they mainly occurred in small outbreaks/ hotspots. The second wave in early October primarily affected the younger population aged 18-22 years and those living in Houses of Multiple Occupation. There was some over-representation amongst Black and Asian populations, but the overall number of cases was relatively low. Cases have been broadly representative of the ethnic makeup of the City, but this may reflect issues with recording ethnicity accurately.

f) When looking at prevalence amongst ethnic minority communities by age, for the 0-17 age group there are some variations between communities but relatively low rates overall; for the 18-24 age group the greatest prevalence is amongst white and 'other' populations; for the 25-59 age group there is a slightly higher

prevalence amongst Black and Asian communities and for those aged 60 years there is little variation. There may be data issues with relatively large numbers in the 'other' category and this needs further consideration.

g) Socio-economic disadvantage is associated with higher rates of death, both for all deaths and for specific causes of death e.g. from Covid-19 which follows a similar pattern to other causes of death. Evidence shows that other factors include chronic disease and structural racial inequalities.

h) The Council is working to develop a place-based approach to reducing health inequalities that aligns to the work of the Integrated Care Partnership, and will be presenting a proposed framework for doing this to Executive Board in due course. This work includes looking at a range of evidence bases and national work, and listening to local communities about ways to address inequalities that are appropriate to those communities. This approach has informed the response to Covid-19. The framework will include ways of working and areas for prioritising change. An example of the approach to addressing health inequalities is the reintroduction of the NHS Healthcheck Programme, which will now be prioritising BAME populations. The framework will also include policy considerations and tools for ensuring equity in decision making.

i) In responding to the Covid-19 pandemic, the civic mobilisation has recognised that different communities have been affected differently and they need to be supported appropriately. This has been supported by community cohesion work to support communities and bring communities together. For example, there has been specific work with the Roma community to see how they feel and what support they need. The response has been to increase door to door interaction due to relatively low levels of literacy and trust. There has also been engagement with faith leaders on addressing concerns about Covid-19 and communicating health messages.

j) The Nottingham Together Board was established to provide 'check and challenge'. It currently meets monthly and has provided input into the Covid response and recovery plans and work of the Integrated Care Partnership on tackling inequalities.

Rich Brady, Programme Director for the Nottingham City Integrated Care Partnership, spoke to the Committee about the work of the Integrated Care Partnership (ICP) in tackling health inequalities. He highlighted the following information:

k) One of the priorities for the ICP since before the Covid-19 pandemic has been reducing inequalities in health outcomes in BAME communities. The original scope for this was to look at how providers can better engage and communicate with different groups to improve access.

l) In response to the Covid-19 pandemic and Black Lives Matter, this priority has been reviewed with input from different community groups. This has included input from the Nottingham Together Board on designing the future programme of work.

m) There has been feedback about the need to look at structural issues, specifically in relation to commissioning and whether there are aspects of commissioning that actually widen inequalities.

n) Work is taking place to better understand the value and offer of smaller voluntary sector organisations, especially those that can contribute to a culturally sensitive approach to meeting needs.

o) One of the aims is to transform engagement and communications to improve access and patient experience.

During the subsequent discussion, and in response to questions from Committee members the following points were raised:

p) The challenges are national and there are no 'quick fixes' and therefore the Council's approach is to set out underlying principles to influence and direct decision making rather than a detailed action plan with deadlines attached.

q) Covid-19 has highlighted existing health inequalities, including those faced by BAME communities, which has created an opportunity to focus on addressing the issues. The development of the Integrated Care System (ICS), which has its own health inequalities strategy, and the ICP provide opportunities to do this.

r) It is important to look beyond health because health needs are just one aspect of a person's experience. Wider determinants, such as socio-economic factors, need to be included. There are different levels on which work can happen: from ward to ICS level.

s) The issues will take time to address but the Programme Director for the ICP suggested that for the first time there is agreement on the areas of focus with organisational leaders within the ICP all supporting the same activity.

t) The ICP has recognised that representation on its decision making bodies is not as diverse as it could be and work is taking place to improve this. It is also acknowledged that specific work in relation to BAME communities should be led by those communities, and these should be paid roles and not expected to be done voluntarily.

u) Death certificates have to follow a nationally agreed template. Local data on deaths is obtained from hospitals, but data on community deaths lags behind. It is understood that the Government has committed to reviewing this.

v) The circulation of 'fake news' about specific communities is concerning. This happened pre-Covid and has also been happening during the pandemic. Tools and resources are used to try and counter messages quickly. Informal ways of myth-busting can often be the most useful.

The Committee welcomed the work taking place to address inequalities in relation to Covid-19 but also in relation to health more generally, and requested a further update on progress in addressing health inequalities locally in due course.

37 Work Programme

The Committee noted its current work programme for 2020/21, including the following issues identified for inclusion earlier in the meeting:

a) Platform One Practice – to review mobilisation plans with Nottingham and Nottinghamshire Clinical Commissioning Group and the new provider, including work taking place on engaging with affected service users;

b) Lessons learnt from the commissioning of services at the Platform One Practice; and

c) Effectiveness of work taking place through the Long Term Plan to improve access to mental health services, including the introduction of mental health hubs.

The Committee also noted that an item had been added to the agenda for the meeting in January about the recent Care Quality Commission inspection of maternity services at Nottingham University Hospitals NHS Trust.