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 11 March 2021 from 10.00 am - 12.18 pm

Membership

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

Colleagues, partners and others in attendance:

Dr Margaret Abbott	-	Nottingham City GP working with Nottingham and Nottinghamshire CCG
Alex Ball	-	Director of Communications & Engagement, Nottingham and Nottinghamshire ICS and CCG
Ajanta Biswas	-	Vice-Chair, Healthwatch Nottingham and Nottinghamshire
Alison Challenger	-	Director of Public Health
Nicole Chavaudra	-	Nottinghamshire Covid Vaccination PMO lead, Nottingham and Nottinghamshire CCG
Lucy Dadge	-	Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group
Lewis Etoria	-	Head of Insights and Engagement, Nottingham and Nottinghamshire Clinical Commissioning Group
Esther Gaskill	-	ICS Vaccination Quality Lead
Joe Lunn	-	Associate Director of Primary Care, Nottingham and Nottinghamshire ICS and Clinical Commissioning Group
Amanda Sullivan	-	Chief Operating Officer, Nottingham and Nottinghamshire CCG
Michelle Tilling	-	Nottingham City Locality Director, CCG
Dr Ian Trimble	-	Former Nottingham City GP working with Nottingham and Nottinghamshire CCG
Kim Pocock	-	Scrutiny Officer

52 Committee Membership

The Committee noted the resignation of Councillor Lauren O'Grady and thanked her for her work.

53 Apologies for absence

Councillor Anne Peach (medical appointment).

54 Declarations of interest

None.

55 Minutes

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

56 Commissioning of Services at Platform One Practice - Lessons Learnt

Lucy Dadge, Chief Commissioning Officer and Joe Lunn Associate Director of Primary Care, attended the meeting on behalf of Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) to present to the Committee the lessons learnt from the commissioning process to secure a new provider for current Platform One services and provide an update on staffing arrangements going forward.

The CCG highlighted the following information:

Lessons Learnt

(a) The CCG has considered the commissioning steps taken and the processes it used to secure the new provider for the practice population currently served by NEMS at Platform One and is committed to ensuring that its commissioning process going forward address the specific scrutiny requirement of this Committee more effectively.

(b) The CCG recognised the Committee's concerns that patient engagement has not been as thorough as best practice determines and also acknowledged that it took an overly cautious approach to sharing information on procurement activities. It is clear that sharing the thinking as the EQIA (Equality Impact Assessment) was being developed would have provided insight and knowledge to inform the transition between the current provider and the new provider. Whilst the CCG sought to optimise opportunities for local GPs it did not have strong enough plans in place for the widest possible stakeholder engagement in the transition and mobilisation process. The CCG acknowledged that the Health Scrutiny Committee's (HSC) work to address these issues will lead to a much better process and patient experience for those patients affected by the change of provider.

(c) The CCG identified the following key learning points:

i. The CCG recognised the HSC concerns that procurement of new city centre practice, together with dispersal of patients, could be seen as a significant service change. The original contract with NEMS was let in 2009 and continued to 2016, at which point the CCG was legally bound to reprocure the contract. The CCG agreed that it should have made the Committee aware of the need to recommission a provider even though the same core primary care services as those currently provided by NEMS will be provided to the current registered population by the new provider, Nottingham City GP Alliance (NCGPA), or by their local GP practice.

ii. Funding for GP services contracts is determined nationally by National Health Service England (NHSE) and the CCG works alongside NHSE to ensure it provides appropriate local services. The new contract for services to be delivered by the new provider (NCGPA) will receive more funding that the basic NHSE budget. The CCG is committed to funding all GP services to match local need. Where additional need is identified then the CCG will commit additional funding to meet that additional need. An example of the way the CCG uses funding to meet identified need through its local discretion is its response to the Committee's concerns for patients with severe multiple disadvantage (SMD). The newly created service to address this need will be accessible to patients of any GP practice, ie including the new Parliament Street practice, the other practices which receive patients dispersed from Platform One and all other GP practices in the city. The service will not be restricted by cost, but based on need.

iii. While funding is nationally determined there is always scope for planning to match this locally. The CCG is keen to work with the Committee to understand local requirements, plan services and match resources to local needs.

iv. While CCGs cannot access data about individual patients, they are required to liaise with providers to establish and meet local need. The CCG will constantly review population health needs to ensure it uses its resources to address health inequalities and improve outcomes. Consequently, the CCG must engage with stakeholders. This is particularly important for those patients with complex needs and those who cannot engage with services in traditional ways. The CCG values the input of the Committee in this process.

v. The CCG will not restrict sharing EQIAs or other relevant documents going forwards.

vi. The CCG acknowledged the need to engage all stakeholders and if these are not immediately easy to identify or locate, then it will find out by being transparent and open, in order to support stakeholders to come forward and enable them to engage.

vii. The CCG will communicate clearly to the Committee on what is determined by policy and what can be determined and shaped locally and will work with all partners on local arrangements where this is possible.

viii. It is possible that the CCG's capacity to look outwards was restricted by viewing the reprocurement of Platform One services simply as the culmination of five years of ongoing work and concluding that work at the early stages of the Covid-19 pandemic. The CCG stressed that this was context and has acknowledged that it could have worked in a more communicative and inclusive way.

ix. The recent Health White Paper on Integrated Care makes is clear that it is imperative that health commissioners/ providers and partners work together and the CCG is committed to doing this. CCG colleagues reiterated their view of the positive input of this Committee.

<u>Transfer of Undertakings Protection Employment (TUPE)</u>

(d) Successful bidders for the reprocurement of services currently provided by Platform One were required to develop a staffing model to meet the service specification and the needs of the patient population they will be serving.

(e) As the successful bidder NCGPA is working with NEMS to agree relevant staffing transfers and TUPE arrangements. TUPE regulations are to ensure protection for employee rights when transferring to new employer and apply to a role (rather than an individual) which will transfer from the old to the new provider. Confidential discussions have started with eligible staff in accordance with TUPE regulations.

(f) This is a confidential process – however there will be consideration of employee rights, liabilities at transfer and the employment terms and conditions for those staff moving over.

(g) The CCG will support NEMS and NCGPA to retain knowledge and expertise and to build on the experience already within the GPA.

Amanda Sullivan, Chief Operating Officer, Nottingham City and Nottinghamshire CCG also attended the meeting. She highlighted the following:

(h) The CCG takes its role and relationship with the Committee very seriously and wants to be transparent and upfront to ensure that the Committee is content with how the CCG engages to meet the shared objective of getting the best possible care for people within resources, particularly for the most vulnerable.

(i) Reprocurement of the Platform One service has been a lengthy process and the CCG was very focused on securing a new provider rather than engagement and has learnt from this. The new service to be delivered by the new provider has great potential and the enhanced service will help deliver to those who need wraparound services.

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

(j) TUPE discussions are at a very early stage and discussions are guided by the requirements of the core PMS (Personal Medical Services) contract (a national requirement). Services outside this core requirement, eg the new SMD service, fall outside the TUPE arrangements.

(k) Discussion about the new SMD service is taking place between NCGPA and NEMS and all other practices who will receive patients. The service has been designed to be accessible to any GP who needs to access it for patients they are supporting and the CCG is committed to funding whatever is applied for by GPs. It is recognised that there will be a concentrated number of these patients in the patients who will move from the Platform One practice.

(l) There has been wide consultation, including with the SMD Group and a range of providers (not just primary care), on the new SMD locally enhanced service. The service aims to facilitate access for this client group to primary care itself, provide a regular review of their physical and mental health and social wellbeing and includes working with a range of joint services. The new service will be approved and offered across Nottinghamshire within the next few weeks.

(m) There is a strong commitment to making sure wraparound care is available to this group of patients with a focus on distributing funds to meet needs where they arise, rather than to one particular practice / provider in a single location.

(n) While the Committee has concluded that the reprocurement of the Platform One service is a substantial service change, the CCG does not consider it so, but rather that it is commissioning the same service from a new provider. However, both the Committee and

the CCG agree that there should be clear communication, transparency and openness when there is service change which will have a significant impact.

(o) The CCG works within a range of publicly available commissioning policies, including the NHSE Policy Handbook and the Primary Care Policy Manual. The CCG agreed to share links to these documents with members of the Committee.

(p) In relation to EQIA and involvement of stakeholders, the CGG may not have followed its own guidance as carefully as it should have. It agreed to share its EQIA guidance with members of the Committee and to consider how future learning from this can be embedded in that guidance.

(q) There was a legal duty to undertake the re-procurement. However; the CCG acknowledged that it should have looked at all of the transition issues earlier and not just the transfer of PMS contract. The EQIA could have been used more appropriately at an earlier stage to manage the impact of the proposed changes, ie earlier stakeholder engagement could have informed the EQIA. This learning will now be embedded as part of the CCG's EQIA process going forwards.

(r) In future monitoring of stakeholder engagement and the impact of the reprocurement on the patients affected, the Chair noted that it would be helpful to reflect on the EQIA to check that issues raised have been addressed effectively.

(s) The CCG acknowledged that their focus with Platform One had been on securing an ongoing service after several years of working towards reprocurement and that, as a consequence engagement was not approached as it should have been, for which the CCG has apologised. The CCG is committed to working with the Committee in the future to ensure that there are no unwelcome surprises in the development of services. Regular informal meetings have already been set up with the Chair and the Vice Chair of the Committee to this end.

The Chair thanked the CCG for attending and urged it to continue to work closely with Healthwatch. The Committee will continue to request regular reporting on this item, including attendance at the Committee's April meeting to discuss needs assessment processes and support to access services for patients who will be moving to the new provider or to their local GP practice.

57 Covid 19 Vaccination Programme

Nicole Chavaudra, Nottinghamshire Covid Vaccination Lead, Michelle Tilling, Nottingham City Locality Director and Alex Ball, Director of Communications and Engagement, attended on behalf of Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) to provide an update on the progress of the Covid-19 vaccination programme in the city.

The CCG highlighted the following information:

(a) The Covid-19 vaccination programme is the largest vaccination programme in NHS history. The programme is currently focused on meeting the timescales to deliver the first phase of the vaccine to cohorts 1-9 as defined by the Joint Committee on Vaccination and Immunisation (JVCI):

- residents in a care home for older adults and their carers
- all those 80 years of age and over and frontline health and social care workers
- all those 75 years of age and over
- all those 70 years of age and over and clinically extremely vulnerable individuals

- all those 65 years of age and over
- all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
- all those 60 years of age and over
- all those 55 years of age and over
- all those 50 years of age and over

(b) The vaccination programme for Nottingham and Nottinghamshire has taken a whole system approach, led locally as a Local Resilience Forum (LFR), making use of all local resources across the NHS, local government, public services and the voluntary sector. The work is overseen by the Covid Oversight Board and delivered by an Operational Delivery Team.

(c) A Strategic Inequalities Cell and a Programme Inequalities Task and Finish Group looks on a weekly basis at data and intelligence being gathered from local communities about any inequalities in the access to and take up of the vaccination. These are then addressed with a rapid response, delivered through the three Integrated Care Partnerships [ICPs], working with community leaders so that actions are locally informed and sensitive.

(d) More than 340,000 people have been vaccinated across Nottingham and Nottinghamshire as of last week. Significant improvement has been seen in the take up of vaccination by those in Black BAME (Black, Asian Minority Ethnic) groups, supported by local councillors and community leaders. The Nottingham approach to adults with learning disabilities has been applauded at a national level by Mencap. Use of the transport service provided to support access to vaccination centres has been highest in the city where car ownership is lowest, rather than in rural areas.

(e) The gap in take up between the city and the rest of the county is closing, but there is still more to do, especially to tackle inequality challenges. Overall, as you go down the age groups, vaccination take up has been lower by BAME groups, those in the most deprived areas and those who are extremely clinically vulnerable.

(f) There are a number of different sites for vaccination delivery, including hospital hubs controlled through local booking, the mass vaccination centre in Mansfield accessed through the national booking service, local vaccination services (for example The Forest), pop ups (eg primary care sites, community pharmacies and other community locations), a roving service to care homes and housebound individuals and a vaccination bus which will start touring in the next two weeks.

(g) The model used is that the majority of people are vaccinated on a vaccination site and primary care is used to target at risk groups or where take up is low. The model allows primary care services to continue to offer its usual services to patients, rather than focus being largely on vaccination.

(h) Contact with residents as their cohort becomes eligible is by letter and text messages, available in a number of languages, including braille. Each time a cohort goes live it is publicised across local media and posted on local websites in English and the most common other languages used in the city. After receiving an invite, it is possible to book online or by phone (8am to 8pm). Residents can choose which site they wish to go to for their vaccination. The service is working closely with GPs to check if their residents have received their letters and through outreach work with community leaders.

(i) Cohort 8 (55 years plus) is now live and receiving vaccinations. 95% aged 80 and over have been vaccinated, virtually everyone in the 75-79 age group, 95% in the 70-74 age

group and 87% in the 65-69 age cohort. These are unprecedented levels of vaccination uptake and far higher than the flu vaccine, which has been available for many years. Take up is slightly lower in the city; however, this is common with other similar areas and is being addressed by targeted work to increase take up.

(j) To target activity to encourage take up, National Immunisation Management System (NIMS) data is used to monitor progress within wards and shows lower uptake in most deprived areas and within ethnic minority communities, particularly by Black men.

(k) Examples of intelligence led approaches include those already mentioned, ie primary care pop ups in communities with lower take up, community pharmacy sites in areas furthest from vaccination sites, a roving service and a new bus to provide mobile vaccination services.

(l) Cohort 6 (all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality) is one of the largest and most complex cohorts. Within this group homeless people are being offered walk in clinics, without the need for appointment, led by GP practices (eg the Windmill Practice). Unpaid carers are identified through GP records, DWP records, social care assessments or are able to self-identify to ensure that they are not missed. A range of communications is used to target different groups as well as making reasonable adjustments to meet specific needs, for example quiet times have been arranged to support those who have sensory sensitivities (eg those with learning difficulties) to be able to take up the vaccination.

(m) Nottingham has tailored approaches through the Integrated Care Partnership and its Primary Care Networks. These include setting up pop up clinics in two mosques in the city, following work alongside community leaders to listen to their advice and feedback on how best to overcome the lack of take up and design an approach together that works, given some lack of confidence about the vaccine within the Muslim community. Local community leaders, GPs and the Council's Community Cohesion team have worked with NHS colleagues to connect with members of the community, which involves a wide range of communication methods, including radio and Twitter. A similar approach is being applied to other areas of the city and to other communities where there is low vaccine take up, eg Black African and Caribbean communities.

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

(n) The Committee acknowledged the excellent work that has been done so far in the vaccination roll out.

(o) The vaccine programme has the capacity to administer second doses of the vaccine (between the end of the 11th and start of the 12th week from the date of the first vaccination) whilst still providing first vaccines. All vaccination sites will be running at full capacity and more local pharmacies and pop ups will be administering the vaccine. Logistically it will be challenging as people have to have the same type of second vaccine as the first, but plans are in place to manage this. Capacity and supply will gradually be reduced over time to match need. 56-58,000 vaccinations per week are being delivered and the plan is to build to a capacity of 80,000 per week to meet the profile of upcoming cohorts.

(p) The first vaccination sites in the city opened slightly later than other parts of Nottinghamshire for multiple reasons. The challenge was identifying suitable sites to be signed off by NHSE and the need to add appropriate facilities on The Forest site created

a small delay. There were some issues with equipment in the early stages, for example some supplies did not arrive on time, but this has since been resolved. The gap in numbers of vaccinations administered has started to close now and the learning from this experience will be used to shape any future needs / responses.

(q) The take up by GP practices of the vaccination programme is locally determined, not nationally. By focusing on sites other than GP practices and using a whole system approach, Nottingham has been able to protect general practice. GPs are able to participate if they choose to do so, depending on their staffing and local circumstances, and funding is available for this. It is a particularly busy time for GP practices, responding to questions about Covid infections and effect of Covid, for example, on mental health.

(r) There have been some supply issues which have impacted on getting appointments, particularly for older and vulnerable people. The Military has been providing a rapid response to complement existing services to support the roving service to those who are housebound, and at all centres in a supporting capacity.

(s) The roving service has been an issue across the country and it is acknowledged that currently the service is not working exactly as it should do. However, there is work taking place to improve this. GP systems flag those patients who are housebound, but there is no complete record or list of every resident who is housebound. The CCG acknowledged that there is still more to learn about addressing the struggle to get through to the telephone service to book a vaccine.

(t) Top Valley was highlighted as an area of concern as it has no vaccination hub at the moment, despite having one of highest levels of deprivation and disadvantage, as well as very low car ownership, in the city. The CCG agreed that Top Valley and Bestwood stand out as areas which require attention and will discuss this further with primary care colleagues. In addition, it will look at how the bus could be deployed in these areas as well as monitor the data to see if some GP pop ups are required.

(u) There is some confusion around communications to individuals which provide two different links to vaccination centres. One of these is to the local centre booking system (eg The Forest) and the other links to national centres (eg the Mansfield Centre). It is further confusing that community pharmacy sites are also booked through the national booking system. This is not within the control of the CCG, so people will continue to receive two letters.

(v) The list detailing the extremely clinically vulnerable cohort is confusing, eg it states ‘some neurological conditions’, but it is not clear what that means or how this group is defined. Some conditions for example Chronic Fatigue Syndrome are not specifically listed. This issue has been escalated today to NHSE for more detailed guidance on who is included in the clinically vulnerable cohort.

(w) Citizens will be notified of the bus vaccine service mainly through GPs who will contact individuals to let them know where the bus will be and when the service will be available. This will be supplemented through community groups and the media. It is planned that this service will start small and will be built it up as what works in practice is established.

The chair thanked the CCG for attending and noted that the Committee is likely to request an update on vaccination progress in the near future, particularly in relation to the roll out of second vaccines.

58 Work Programme

(a) An informal work programme meeting has been scheduled for Committee members to discuss the priorities for the Committee's work in 2021/22 in detail.

(b) The agenda for the meeting to be held on 15 April 2021 will include:

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