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 20 February 2025 from 9:30am to 11:59am

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Sulcan Mahmood
Councillor Maria Joannou (Vice Chair)	Councillor Sajid Mohammed
Councillor Michael Edwards	
Councillor Kirsty Jones	
Councillor Eunice Regan	
Councillor Matt Shannon	

Colleagues, partners and others in attendance:

Dr Dave Briggs	-	Medical Director, NHS Nottingham and Nottinghamshire Integrated Care Board
Philip Broxholme	-	Strategic Lead for Community Safety
Caroline Goulding	-	Director of Primary Care, NHS Nottingham and Nottinghamshire Integrated Care Board
Councillor Corall Jenkins	-	Executive Member for Communities, Waste and Equality
Councillor Angela Kandola	-	Deputy Nottinghamshire Police and Crime Commissioner
Jane Lewis	-	Strategy and Commissioning Manager
Adrian Mann	-	Scrutiny and Audit Support Officer
Kate Morris	-	Scrutiny and Audit Support Officer
Colin Parr	-	Corporate Director for Community, Environment and Resident Services
Naomi Robinson	-	Deputy Head of Joint Commissioning, NHS Nottingham and Nottinghamshire Integrated Care Board
Sabrina Taylor	-	Chief Executive, Healthwatch Nottingham and Nottinghamshire
Nicola Wade	-	Commissioning Manager, Office of the Nottinghamshire Police and Crime Commissioner

47 Apologies for Absence

Councillor Sulcan Mahmood	-	personal reasons
Sarah Collis	-	Chair, Healthwatch Nottingham and Nottinghamshire

48 Declarations of Interests

None

49 Minutes

The Committee confirmed the Minutes of the meeting held on 23 January 2025 as a correct record and they were signed by the Chair.

50 Access to General Practice

Dr Dave Briggs and Caroline Goulding, Medical Director and Primary Care Director at the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), presented a report on access to primary care services across the city. The following points were raised:

a) There are 44 GP practices within the city, covering nine Primary Care Networks (PCNs). Since September 2023, one GP practice has closed and one has been re-procured, and one PCN has split into two new PCNs. There are a range of services that GPs deliver: a national contract for the core services; Enhanced Access, which provides a more cohesive service to patients across PCNs; and Local Enhanced Services, which provide an extended range of services that GPs can choose to deliver. There has been good sign-up to the Local Enhanced Services by GPs, which has allowed practices to provide care closer to home and targets care across the city. Services provided include taking blood, micro-surgery, heart tracing and anti-coagulation services, reducing the need for people to attend hospitals. There has also been increased enhanced safeguarding training in recognition that many areas of the city experience severe multiple disadvantage and deprivation.

b) There have been some challenges around primary care contract negotiations at a national level. Locally, the ICB has a responsibility to ensure that there is adequate access to primary care services, working with local stakeholders around the commissioning of additional Local Enhanced Services. The ICB also engages closely with the Council and Public Health colleagues to understand needs and demand, and consider how best to provide care taking account of infrastructure, the provider market and intended outcomes.

c) Performance and quality monitoring is overseen by the Performance Delivery Group, the Quality Group and the Support and Assurance Group, all focusing on slightly different metrics in order to triangulate information on performance. GP practices are assessed on a wide array of performance and quality indicators, but the ICB cannot have direct access to GPs' clinical records systems, due to patient confidentiality. The ICB visits GPs to learn what works well and how this can be adapted and adopted by other practices where additional support is needed, and has been working to improve engagement with all GPs to offer support where needed.

d) In May 2023, the Primary Care Access Recovery Plan was published by NHS England, recognising capacity challenges across the country. The ICB produced a local recovery plan including actions to increase self-referral routes, expand community pharmacy services (where Nottingham was part of a national pilot scheme), improve telephony services by moving over to digital telephony and technology and enhance training to provide better advice on care navigation.

e) However, there have been a number of challenges in recovering access to primary care. National collective action by GPs has impacted how practices engage with the ICB, with some practices stepping back from the Local Enhanced Services to focus on the delivery of the core contract. The relationship between GPs and the ICB has been different to that between the GPs and the previous Clinical Commissioning Groups, and this structural transition is still being embedded. Resilience continues to be a challenge, with impacts on the health and wellbeing of staff across the system. However, despite this, the metrics indicate that there are 5% more appointments available than the target set by the ICB, with improved access in place. Nevertheless, more work is still needed at a rapid pace to further improve access to primary care across the city.

The Committee raised the following points in discussion:

f) The Committee queried whether 10% of GPs not being signed up to the enhanced safeguarding training represented a concern to the ICB. It was explained that the national core contract ensures that a significant level of safeguarding training and practice is in place. This contractual responsibility on GPs is robust and requires practices to have clear levels of safeguarding processes in place. Where a practice choses not to engage in the further enhanced training, it will still meet all of the nationally required levels for safeguarding and is considered a safe practice.

g) The Committee queried whether the time required for GPs to submit detailed data for monitoring might impact on the time available to spend with patients. It was set out that monitoring the performance and quality of primary care services is fundamentally important, though the ICB has been working with GPs to ensure that the time commitment is not unnecessarily onerous – while still ensuring that patients are receiving good quality services. Much of the monitoring has been worked into GPs' day-to-day activities and is computer-generated, wherever possible.

h) The Committee asked whether Community Pharmacies were able to prescribe oral contraception without any input from a GP, and what percentage of people accessing oral contraception through the Community Pharmacy had to be referred through to GPs. It was explained that there are a number of brands of oral contraception the Community Pharmacies are able to prescribe without the need for the patient to see a GP, where the risks are low and there is no prior medical history. If there is any doubt about the suitability of prescribing a medication, the pharmacy is able to request access to the patient's medical records and, if necessary, refer the patient to see the GP. During the pilot of this programme, the rate of referrals to a GP was low. Going forward, all new pharmacists will be qualified as independent prescribers as part of their formal training, ensuring that qualified individuals are able to prescribe through the Community Pharmacy service.

i) The Committee asked what was being done to ensure that the physical space within Community Pharmacies was appropriate for prescribing conversations, and that the ICB had the right level of oversight in place. It was set out that all Community Pharmacies are required to provide a private consultation room. Many pharmacies have had to reengineer the space within their premises to achieve

this requirement, which has presented some challenges. This is a national issue and more support for the Community Pharmacy model is being explored at the national level. All Community Pharmacies are registered and are subject to the same level of oversight as GP practices, being required to work within a national framework that has clear boundaries, and they must report to the ICB on any issues in delivering their contracted opening hours.

j) The Committee asked how Physician Associates were used within primary care, and how their role was communicated to patients. It was reported that the role of Physician Associates is to work alongside GPs to treat a wide range of conditions. This role sits alongside a set of other clinical roles in practices designed to support the timely and safe delivery of primary care. Generally, Physician Associates can treat patients with acute and self-limiting conditions, and help to support on-the-day access to primary care services. Where there are elements of greater complexity, cases are referred to GPs. This relatively new role has been introduced nationally and it is essential that there is the right support to integrate them into GP practices effectively. There is an expectation that there will be senior oversight within the practice, with the the Physician Associates referring cases on to GPs where necessary. Monitoring and oversight is carried out by the individual GP practice, which communicate with patients about the different clinical roles provided and how they work together to offer a wide range of services.

k) The Committee asked how the ICB engaged with the Council around emerging need for primary care and supporting the expanding population. It was set out that the ICB has a good working relationship with the Council's Planning team and actively engages with them. Where a Planning application for a new housing development is approved, a Section 106 contribution will be set for the developer to grow capacity to ensure that GPs can manage the increase in the population for their area.

The Chair thanked the representatives from the ICB for attending the meeting to present the report and answer the Committee's questions.

Resolved:

1) **To request that further information is provided on the results of the pilot for the prescription of oral contraception by Community Pharmacies in terms of how many people reported that the medication prescribed in the first instance was unsuitable for them, and how this compares to prescriptions made by GPs.**

2) **To request that further information is provided on how the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) monitors the level of prescription of antibiotics made by Community Pharmacies, and how this compares to the numbers prescribed by GPs.**

3) **To request that a written update is provided on whether Community Pharmacies in Nottingham are achieving their contracted opening hours, and the current challenges being faced in ensuring that the required opening hours are delivered.**

4) **To request that further information is provided on how the ICB engages with the Council on planning the additional Primary Care infrastructure needed to meet the demand arising from new housing developments, and how the requirements for the increase in associated staffing are addressed.**

5) **To recommend that the ICB engages with GPs on the importance of information being easily available to explain the role that Physician Associates (and other medical staff who are not GPs) are carrying out at an individual Practice, so that patients can have confidence that the right services are being provided by the right people.**

6) **To recommend that the ICB considers how it can engage most effectively with patients around what their particular local needs are for the availability and flexibility of GP appointments.**

51 Sexual Violence Support Services

Angela Kandola and Nicola Wade, Deputy Police and Crime Commissioner and Head of Commissioning and Partnerships at the Office of the Nottinghamshire Police and Crime Commissioner (OPCC); Councillor Corall Jenkins, Colin Parr, Philip Broxholme and Jane Lewis, Executive Member for Communities, Waste and Equalites, Corporate Director for Community, Environment and Resident Services, Strategic Lead for Community Safety, and Strategy and Commissioning Manager at Nottingham City Council; and Naomi Robinson, Deputy Head of Joint Commissioning at the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), presented a report on how partnership work was being carried out through the Joint Sexual Violence Commissioning Group to recommission the Sexual Violence Support Service (SVSS). The following points were raised:

a) The key driver for the development of the SVSS arose from the findings of the Independent Inquiry into Child Sexual Abuse (IICSA) in Nottingham and Nottinghamshire, as a need arose for a specialist and non-medicalised service for survivors impacted by trauma. The OPCC became the lead commissioner in a partnership that also includes Nottingham City Council, Nottinghamshire County Council and the ICB. The SVSS model was developed with the input of survivors to create a single point of contact to eliminate the need for those accessing the services to retell their story multiple times, providing access to therapy and non-clinical support, with delivery commencing from 1 January 2021 to the end of December 2025. In June 2024, a needs assessment was undertaken around sexual violence service provision.

b) There are two main elements to SVSS – a single support hub and the specialist therapy provision. The hub is where referrals are received, and assessment and safeguarding actions are carried out. Survivors can access regular drop-in sessions and telephone support, and a seconded clinical Mental Health specialist offers stabilisation services. The specialist therapy provided is tiered and needs-led, including a number of different recognised methods over three stages: stabilisation, therapeutic processing and reintegration. Outcomes are measured through a Clinical Outcomes Routine Evaluation. Mental distress and anxiety are considered as part of a therapy service that aims to provide support and build resilience.

c) There has been a waiting list since the SVSS was launched, and this has grown throughout the life of the contract. In 2022, the SVSS received funding for additional support for those on the waiting list, including regular check-ins, group therapy sessions and mindfulness groups. From April 2025, there will also be recovery coaching sessions available alongside the stabilisation services. Increasing the availability of the stabilisation service at the early stage of engagement will reduce the need for as much intensive therapeutic input later in the process.

d) In terms of funding the SVSS, the OPCC element has come via the Ministry of Justice as part of a pilot scheme, with Nottingham being just one of five areas that co-commissions SVSS in this way. Additional money came in 2023 through the 'Pathfinder' funding from NHS England, which has enabled a specialist Mental Health worker to be embedded within the SVSS and the provision of the new recovery coaches. The commissioning partners have been meeting with other services accessing the Pathfinder funding to establish best practice.

e) To inform the future procurement of the SVSS to ensure efficient waiting list management, the latest needs assessment indicates that the three-tiered service methodology currently in use is effective, embedded Mental Health workers focusing on stabilisation early on reduces the need for extended therapeutic intervention, and that developing trust in services enables survivors to better benefit from therapeutic intervention. Looking forward, there is still a clear need for the SVSS and the current structure aligns well with established best practice, although work needs to be done to tackle the extended waiting lists as part of the recommissioning process.

The Committee raised the following points in discussion:

f) The Committee asked whether the limited funding available contributed to the current extended waiting times. It was explained that the need for the SVSS is significant and mostly hidden. Additional funding would always be beneficial, but the service has to be delivered within the wider context of a challenging financial landscape for all partners. There are actions both in place and planned to reduce the time people spend on waiting lists, including the implementation of additional stabilisation services, and the introduction recovery coaching posts. Nottingham City Council partners confirmed that they were committed to maintaining their current level of funding for the SVSS moving forward, acknowledging the incredibly impactful work done by the SVSS up to this point. There remains a strong partnership delivery approach to the SVSS, particularly in terms of tackling the waiting times for survivors.

g) The Committee asked if the SVSS had taken learning on specialist therapy models from other similar services, such as the Amara provision for children and young people or the National Society for the Prevention of Cruelty to Children's 'IICSA Changemakers' group. It was set out that although there were different recognised therapeutic techniques for children and adults, the SVSS is continually reviewing examples of best practice from across the country in order to offer the very best service to survivors. The SVSS is still relatively new, so part of the recommissioning process is to consider what worked well and work to improve the

service based on current best practice. The partnership can seek to engage with the 'IICSA Changemakers' group on developing the voice of survivors in service commissioning processes.

h) The Committee asked how survivors had been consulted when considering the structure of the SVSS. It was reported that, as part of the needs assessment, survivors were engaged with closely through focus groups. A reoccurring theme was how responses from some agencies had caused them to relive trauma, particularly the requirement to retell their story multiple times. Evidence-based clinical interventions have been developed in the context of the needs assessment, which highlighted the need for the stabilisation process prior to therapy to make it more effective and efficient. The introduction of the stabilisation process also benefited those people who did not need or want clinical intervention. Outside of the needs assessment, there is a continuous conversation with support groups, with a permanent Survivor's Voice role developed to attend groups and work with commissioners.

i) The Committee asked whether there were any specific bottlenecks in service assessment or delivery contributing to the significant time on waiting lists. It was explained that when the SVSS first started it inherited an existing waiting list, and referral rates have since increased. There is also an increased complexity of cases being referred and so therapy is required for longer periods of time, impacting on the waiting list. The introduction of the stabilisation service will help to reduce the overall time survivors need for therapy, which will positively impact on the waiting list, although the impact is likely to take around 6 months to a year to be visible.

j) The Committee asked how the transition from children's to adults' services was handled and whether young people making that transition would be placed on the adults' waiting lists. It was set out that young people's and adults' services work together to ensure that the transition from child-centred services to adult ones if effective and properly survivor-led, with a focus on ensuring continuity of service – so that over 18s can continue with Amara-based services if needed.

k) The Committee asked whether survivors across all Nottingham communities were properly represented within the SVSS, and how the service engaged with under-represented groups effectively. It was explained that, in 2024, the SVSS reviewed the ethnicity of people accessing the service, with the figures showing that Asian women were slightly underrepresented within it, but not significantly so from other city demographics. The representation of communities was in line with the current Census information. Engagement work has been undertaken with community groups and resources are available in a number of different languages commonly used across the city. The OPCC is also looking at why some people are less likely to report being a victim of sexual violence, and is working to improve trust and confidence amongst survivors to come forward.

The Chair thanked the representatives from the OPCC, the City Council and the ICB for attending the meeting to present the report and answer the Committee's questions.

Resolved:

1) **To request that further information is provided on how the commissioners have engaged directly with survivors of sexual violence and abuse (particularly those who are under-represented in the current service) and other partners, and how the arising learning has been used to plan the re-commissioning of a responsive service.**

2) **To recommend that the specialist sexual violence support service is re-commissioned (in close co-production with survivors), and to encourage all of the commissioning partners to confirm their commitment to continue to work together in its delivery and funding in the long term.**

3) **To recommend that consideration is given to what learning opportunities could be taken from the National Society for the Prevention of Cruelty to Children's 'IICSA Changemakers' group, and whether a similar group could be established locally.**

4) **To recommend that consideration is given to how further information could be made available online around how survivors can get involved in shaping the support service that is delivered.**

5) **To recommend that consideration is given to whether further mental health care provision could be provided within the sexual violence support service, to ensure as much continuity of care as possible for service users who also have clinical mental health needs.**

52 Responses to Recommendations

The Chair presented the latest responses received from the Council's Executive to recommendations made to it previously by the Committee.

The Committee noted the responses of the Executive to its recommendations.

53 Work Programme

The Chair presented the Committee's current Work Programme for the 2024/25 municipal year.

The Committee noted the Work Programme.