Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 27 March 2018 at 10:30

County Hall, **West Bridgford, Nottingham, NG2 7QP**

AGENDA

1	Minutes of the last meeting held on 13 February 2018	3 - 10
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	Sustainability and Transformation Partnership Governance	11 - 18
5	GP Access Mansfield and Ashfield and Newark and Sherwood	19 - 26
6	Work Programme	27 - 34

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact David Ebbage (Tel. 0115 977 3141) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Tuesday 13 February 2018 at 10.30am

Membership

Councillors

Keith Girling (Chair)
Richard Butler
Dr John Doddy
Kevin Greaves
David Martin
Errol Henry JP
Liz Plant
Kevin Rostance
Steve Vickers
Muriel Weisz
Martin Wright

Officers

Keith Ford Nottinghamshire County Council

Also in attendance

Michelle Livingston Healthwatch Nottinghamshire

MINUTES

The minutes of the last meeting held on 9 January 2018, having been circulated to all Members, were taken as read and were signed by the Chair.

APOLOGIES

Councillor Henry replaced Councillor Payne for this meeting only.

DECLARATIONS OF INTEREST

None

SHERWOOD FOREST HOSPITALS AND NOTTINGHAM UNIVERSITY HOSPITALS PARTNERSHIP

Tracy Taylor, Chief Executive and Dr Keith Girling, Medical Director of Nottingham University Hospitals (NUH) and Richard Mitchell, Chief Executive, and Andy Haynes, Medical Director of Sherwood Forest Hospitals (SFH) attended the meeting. They gave a joint presentation highlighting progress in the first year of this strategic partnership, including:-

- the steps taken to improve patient care, including agreed business cases around neurology and urology and the development of a business case for vascular services;

- the existing close working relationships between the two organisations prior to this formal partnership which was being increased through a developing culture of collaboration;

- the benefits gained from the Getting It Right First Time review of the Urology process;

- the lessons learnt and challenges faced;

- the next steps and priorities for 2018/19 which underlined the commitment to work together and embed the partnership approach.

During discussions, the following issues were raised:-

- it was clarified that services within both Trusts worked within the STP footprint and across a wider footprint, as well as within localised areas. This enabled the standardisation of care pathways across the City and County whilst retaining some flexibility so that specific local needs could still be met;

- the partnership had not delivered significant financial savings this year, although the expectation was that savings would be made in future. The greater benefits in this first year had been in terms of service improvements. The reduced spend by Sherwood Forests Hospitals on agency neurology consultants, a resource now provided by NUH, was one example of an area of work in which savings were being achieved;

- with regard to the potential impact on health inequalities, one of the objectives of collaborative working was to provide consistent services and access, rather than the previously fragmented provision seen around issues such as cancer care. The partnership was also seen as a real opportunity to address health inequalities through a consistent and more innovative approach to prevention;

- Members expressed concerns about the lack of visible integrated pathways for services other than Neurology and Urology. They asked whether any obstacles that had prevented the overall merger continued to impact. The degree of merged services was also queried with reference to the Integrated Care System (ICS) and single controlled total budgets. In response it was felt that a formal merger would have meant resources and efforts would have been diverted towards issues such as governance whereas the transformational change approach had meant that the focus was primarily on clinical work (developed initially during the discussion stage of the merger). It was underlined that a single Board was not needed to provide the necessary ownership and leadership for clinicians to work more closely in partnership. The Chief Executives of both Trusts were committed to meet regularly to develop this closer working and to consider areas for future collaboration. It was also felt that the STP and ICS would encourage joint working with both organisations therefore having to take responsibility for the budget in not only their service delivery areas but also in areas such as social care and primary care. It was

underlined that the proposal for a merger had been one of the findings of the Care Quality Commission to address concerns about performance within Sherwood Forest Hospitals but that the Trust was now within the Top 20 trusts for those relevant issues and was now ranked in the Top 3 of trusts for dealing with issues such as Sepsis;

- Members sought assurances that communication between the Trusts was at the optimum level in areas such as follow-up clinics to prevent any negative impacts on patients. In response it was stated that communication was on a continual basis with relationships developing, enabled by background work to get appropriate communications and systems in place. Care pathways had been changed to address patients' needs – for example, in Urology, patients no longer needed to travel to Derby for secondary care and in Neurology, consultants from NUH were now providing care at SFH to reduce the amount of patient travel;

- Members recognised that the success of the collaboration was dependent upon the staff involved. They queried whether the formal merger had been more worrying to staff than increased collaboration and how the new ways of working (such as increased travel) were impacting upon staff. They also queried whether recruitment and retention had been affected. In response, the Trusts felt that it had been welcomed positively by staff, with teams from 31 specialisms having come together, as part of the proposed merger discussion, to look at building specialisms together rather than offering competing services. There had been a lot of discussions in the last few months about how staff perceived the Integrated Care System and it was recognised that the approach with this could only be sustained with real staff engagement. SFH's Urology department had previously struggled with recruitment and retention but the shared service had seen this improve significantly with the previous vacancy rate of 30% now reduced to 8-9%. SFH's proportion of staffing costs spent on agency staff had also been reduced from 15% to 7.5%;

- Healthwatch Nottinghamshire welcomed the partnership approach in terms of benefits for patients. With reference to the NHS England Planning Guidance 2018, Healthwatch was keen to see an increase in pace, although the difficulties in trying to achieve that over the next year were recognised. In response it was acknowledged that the last year had been difficult and the next year would also be challenging with the increase in demand seen in recent years likely to continue. The current progress needed to develop further, with due consideration given to the future hospital clinical model and what level of investment was needed in primary care in respect of access to services, the prevention agenda and addressing people's lifestyle choices to ensure a sustainable and appropriate offer. Part of the Clinical Services Strategy would involve ensuring an integrated approach with more significant work to consider how and where people access health care. There was a new willingness to take ownership of the whole health agenda, with the acute trusts taking responsibility for out of hospital care as well. The need to build a shared purpose and vision with Nottingham Health Care and Healthwatch and other relevant groups was understood;

- Members queried whether finances were the real reason for the merger not going ahead, with reference to the financial deficit which SFH was facing at the time of inspection. In response it was underlined that although money had been one of the issues considered, there were wider reasons for not pursuing the

merger, including the need to improve quality and the potential negative impact on patient care from a merger (with the level of risk changing during the life of the merger discussions). It was also underlined that wider NHS financial issues were less clear at the point when a potential merger was first being considered;

- with regard to out of hospital care and the reduction in the number of District Nurses and Health Visitors, Members queried how the challenge in funding such community services could be addressed. In response it was stated that the STP was committed to developing the right models of care in all services, both in and out of hospital. Concerns about reductions in these services were recognised and the overall expectation is that people should be cared for closer to home or at home. A pilot scheme was running in South Notts. & Rushcliffe and Mid-Notts areas whereby six nurses were working with nine care homes. This had already had a drastic impact on ambulances and other services and had saved 900 nursing hours as a result. The challenge would be to implement this as quickly as possible across the piece.

The Chairman thanked Tracy Taylor, Dr Keith Girling, Richard Mitchell and Andy Haynes for their attendance.

EAST MIDLANDS AMBULANCE SERVICE

Annette McFarlane, Service Delivery Manager, Keith Underwood, Ambulance Operations Manager and Emily Dunn, Communications Officer, attended the meeting.

Annette McFarlane outlined the key points from the briefing for Members, including contrasting the usual levels of demand with the increases seen over December and January.

Keith Underwood highlighted various issues relating to addressing seasonal pressures, including:-

- the planning stages, which commenced in late Summer;

- the use of a triage vehicle in Mansfield Town Centre;

- the utilisation of a triage unit in Nottingham City Centre on key dates such as New Year's Eve;

- the use of alternative staff (including a mini preparatory team to deal with the vehicles at the hospitals);

- the use of a Clinical Assessment Team (CAT) car;

- the identification of specific managers to respond to delays with handovers;

- the changed response to patients who did not have life-threatening injuries, ensuring each patient received the most appropriate response. The NHS recognised that a period of readjustment was required and therefore the service was not being measured against the time standards in that respect currently;

- the Trust Board's belief that funding levels were not sufficient to address demand.

During discussions the following issues were raised:-

- in terms of comparisons with regional neighbours, it was clarified that the level of calls was comparable with Leicestershire;

- with reference to the 500 hours lost due to handovers in hospital, Members queried the usual handover time on a typical Saturday night. The officers agreed to provide comparison figures to the Members on that issue. Members queried what further steps could be taken to address this issue. In response it was highlighted that meetings were taking place with relevant colleagues in the hospitals to see what could be done to improve the flow;

- with regard to the 20-30% of calls not included in the overall breakdown of calls, it was explained that these would relate to face to face incidents, calls from the CAT team seeking advice and duplicate calls (it was possible to receive numerous calls about the same incident);

- in relation to the previously mentioned funding gap, Members queried what level of additional funding was required for the service to operate at optimum levels. In response, it was explained that there was an ongoing capacity and demand review to consider existing resources (staff, skills and vehicles) and current demand. It was underlined that the gap had now changed as a result of the national response programme and work was underway to clarify the extent of the funding gap via an independent report. Officers agreed to share this report with Members when finalised;

- Members queried what work was being done to manage expectations and demand. The 'Make the Right Call' initiative aimed to educate people against ringing for an ambulance in cases that were not emergencies. The local media and social media helped to promote this message, focussing on real life examples of inappropriate calls. Members offered to help promote this initiative and asked for details to be shared with them. Members also felt that the message needed to focus on the fact that ambulances contained increasingly sophisticated equipment that could help to administer life-saving care. It was hoped that these sorts of messages message may help dispel the notion of ambulances being seen primarily as a transport service;

- Members recognised that a paramedic's role was difficult and felt that morale within the service was suffering as a result of the demand pressures and a 'crisis of confidence' in the service. Members requested an action plan to come back to the Committee to highlight what was being done to address the demand pressures and develop new approaches. It was clarified that an Improvement Plan had been developed at a regional level;

- Members requested further information about the number of calls that were alcohol-related (in terms of all year round rather than just in the Winter months). They also referred to specific incidents they had experienced involving incidents in the street and lengthy delays in an ambulance arriving and queried how many such delays may have contributed to deaths. Comparisons with other areas within the Region and neighbouring areas such as South Yorkshire were also

requested. In response it was underlined that ambulance crews were paramedics who do care strongly about the service they provide and the patients they serve, and who do not want to keep patients waiting. The difficulties in serving rural areas was underlined and a call-out to a rural area could result in a knock-on delay for the subsequent call whilst the vehicle returned. It was acknowledged that EMAS compared well in some areas pf practice but not in others. It was particularly successful on the Clinical Assessment Team front and managing demand in that way. With regard to accidents in the street it was recognised that such incidents were emotive to the public and the service and whilst data was reviewed to forecast activity there was a finite amount of resources available. Consultation was currently being undertaken on a new rota system which would be in place by 9 April 2018. In terms of responding to emergencies, EMAS was developing a new level of response termed Urgent Care Transport which could send trained professionals in non-blue light vehicles to deal with incidents that were urgent but not life-threatening. This was an example of the Service thinking differently to try and provide the best possible care for patients. The officers agreed to share a fact sheet about this with Members;

- Healthwatch Nottinghamshire recognised the pressures which the Service was under but would welcome more detailed breakdowns of data, to help clarify which issues were specific to Nottinghamshire and which ones were broader issues affecting the region. By receiving a more detailed breakdown, Healthwatch would be able to be of greater use in helping the service to improve. Healthwatch also sought assurances that the families of patients who had passed away after not getting to hospital on time received an appropriately dignified and respectful response from the Service. In response it was clarified that a dedicated team dealt with the 'patient experience' process and such cases were obviously very difficult. Responses could range from explaining how the prioritisation systems worked to offering a formal apology depending on the circumstances. It was underlined that more compliments were received than complaints;

- In response to a query as to what support was in place for Community First Responders (CFR), it was clarified that the Service meets with CFR Managers to provide feedback on particular jobs. They were also invited to join ambulance crews as observers to help them better understand the process.

The Chairman thanked Annette McFarlane, Keith Underwood and Emily Dunn for attending the meeting and Members underlined their gratitude for the difficult jobs being undertaken.

The Chairman stated that it would be helpful to hear from Trust Board Executives and for the Improvement Plan to be shared as part of the next update to the Committee.

NEURO-REHABILITATION UPDATE (CHATSWORTH WARD)

The Chairman of the Committee agreed that Councillor Diana Meale could attend the meeting and speak on this matter which affected her electoral division.

Lucy Dadge, Chief Commissioning Officer, Mansfield & Ashfield Clinical Commissioning Group (CCG) / Newark & Sherwood CCG, Peter Wosencroft, Sherwood Forest Hospitals and Nigel Marshall, GP Clinician attended the meeting

and gave a presentation on progress with the redesigned provision which included engagement with staff and the public and the decision-making processes. The next steps in this process included a further public engagement session in April 2018.

A meeting had taken place with staff yesterday which had been well-attended and offered some useful insights. The headline messages from that meeting were:-

- there was overall support for a Level 3 non-specialist service to be commissioned from Chatsworth Ward;

- staff were very keen that patients were not moved without good reason;

- there was a strong desire to ensure that when local patients were ready to step down from a Level 2 service then they should be able to come to Chatsworth Ward to be dealt with in their own community;

- staff were interested to know the number of beds to be commissioned;

- staff were keen to recognise community services currently being offered;

- staff requested that outcomes be patient-centred. They were interested to know what impact it would have on current team configuration and wanted to be fully involved in the design of the service and new roles. They asked for assurance that the change would enable a better tie-in with the Sustainable Transformation Partnership;

- staff reiterated that there had been uncertainty about the changes since July 2017 which had not been helpful. Work was ongoing to finalise the specification with the providers over the next month.

During discussions, the following points were made:-

- Members felt that the feedback from the staff meeting echoed their own understanding from having visited the Ward. With regard to the number of places and any plans to use other beds for complementary means, it was clarified that 8 of the 16 current patients had neurological needs. Although the final number of beds had yet to be agreed it would be less than 16 in future. Retrospective analysis had been undertaken to clarify demand and ensure viability of the Ward. The development of a community based service would ensure some demand for beds, along with the earlier ‘stepping down’ of people. With regard to the rest of the beds, Chatsworth would remain as a service for this care cohort but there was a desire to use the faculty as flexibly and as appropriately as possible. Other service offers, aside from the provision of beds, would be explored, and staff were keen to offer therapies such as neurological rehabilitation. The actual bed requirement would be clearer once the service was embedded and it was too early to work out the entire reconfiguration at this point. Members welcomed the proposed diversification of the service offer (as a means of protection against fluctuation of demand), the redefining of the name of the service and retraining of staff as appropriate;

- Healthwatch Nottinghamshire underlined the need for a range of treatments and sought assurances that community recovery services would be able to deliver from the most appropriate place. The CCG and Trust were keen to ensure

greater consistency of pathways and to ensure patients were cared for in the right place at the right time, without 'bouncing' between service provision. Staff had highlighted the existence of community services which GPs were not necessarily referring patients to and better alignment of provision was needed. The biggest challenge at the moment was to capture the community services offer succinctly;

- Councillor Meale highlighted the concerns amongst staff and the local community, welcomed the time and attention taken to review this issue and underlined the need for a clear message to be developed by the time of the next Health Scrutiny meeting (27 March 2018) so that this could be shared with staff and local people. In response, it was clarified that the next steps would involve clearly defining the service, seeking Governing Body approval and undertaking further engagement with staff and the public.

It was agreed that the finalised implementation plan should be submitted to the next meeting of Health Scrutiny Committee.

The Chairman thanked Lucy Dadge, Peter Wosencroft, and Nigel Marshall for attending the meeting and for considering the views of the Committee in the development of these proposals.

WORK PROGRAMME

The Chairman introduced the report. As part of his introduction, he highlighted his regular meetings with the Chairman of the Nottingham City Council Health Scrutiny Committee to consider any issues across boundaries that both Committees needed to be considering. He underlined that he would welcome any suggestion of such cross-boundary issues from Committee Members. He was arranging for the dates and agendas of the City Committee meetings to be shared with the County Health Scrutiny Committee's Members and underlined that these were public meetings which the County's Members were welcome to attend (with permission to speak a possibility if requested).

In response, Members suggested that the issue of Integrated Care Services would be an appropriate topic to consider in a joint Health Scrutiny, involving both the City and County Members. The Chairman agreed to give that suggestion further consideration.

Members also requested that the Chief Executives of the three Care Commissioning Groups be requested to attend a future meeting to discuss their financial strategies (as previously discussed at the Committee). It was agreed that this issue be added to the work programme.

The current work programme was noted

The meeting closed at 12.56 pm

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

27 March 2018

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP GOVERNANCE

Purpose of the Report

1. To consider issues associated with the governance of the Sustainability and Transformation Partnership (STP).

Information

2. The NHS and local authorities have come together in 44 areas of the country to develop proposals that will support improvements to health and care. This is being done as part of the Five Year Forward View – a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services. These proposals, originally called sustainability and transformation plans, have been created across geographic locations and built around the needs of local people.

3. David Pearson, Nottinghamshire County Council's Lead Officer for the STP will attend the Health Scrutiny to brief Members and answer questions as necessary. A written briefing is attached as an appendix to this report.

4. Members may wish to focus on the role of the Health Scrutiny Committee within the governance arrangements.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration, as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Sustainability and Transformation Partnership Governance
February 2018

1. Introduction

1.1 Sustainability and Transformation Partnerships (STPs) each have an STP plan. The Nottinghamshire Health and Care Sustainability and Transformation Partnership is one of 44 STP planning footprints across the country – this is not just happening in Nottingham and Nottinghamshire. There are 10 areas in the Country who have been described as advanced in their development, including Nottingham and Nottinghamshire. These are to be called Integrated Care Systems.

1.2 STP plans describes how we are implementing the NHS England Five Year Forward view locally with the aim of delivering improvements in the three key areas:

- The health and wellbeing of the population
- The care provided and quality of services
- The management of finance and efficiency

1.3 To deliver these improvements, health and care organisations have come together to plan how services are transforming over five years (2016 – 2021) to meet increased demand and the needs of their local population.

1.4 The STP footprint for Nottingham and Nottinghamshire covers six Clinical Commissioning Group areas, eight local authorities and a population of slightly more than one million people. There is a combined budget of around £3 billion. Bassetlaw is part of the South Yorkshire and Bassetlaw Sustainability and Transformation Partnership with close links between the two STPs.

1.5 As well as strengthening local relationships through joint planning and working, STPs provide partner organisations with a shared understanding of the current challenges, a joint ambition and the steps needed to achieve the sustainability of local health and care services for the future.

1.6 This paper sets out the governance arrangements for the STP. The STP has no statutory basis - all the responsibilities are retained within the individual organisations that make up the partnership. These individual organisations will continue to be governed by their own governing boards or accountability frameworks. The basis for the partnership is that each organisation has a duty to maximise the benefits for the public through taking a broader perspective than just that of their own individual organisation.

1.7 The STP proposals are therefore recommendations that will need to be approved by the board of each partner. As a member of the partnership it is expected that organisations align their decision making with other STP members so proposals can be implemented consistently and coherently.

2. Aims of the STP

2.1 The STP partners agreed to use the following principles to underpin and guide ongoing planning and the delivery of our Plan:

- We will support both adults and children to develop the confidence and skills to be as independent as possible and look after themselves.
- We will organise care around individuals and their carers, delivering personalised care based on people's needs.
- We will work in multi-disciplinary teams across organisations to deliver joined-up care as simply as and effectively as possible, reducing duplication.
- We will work together to shift resources to the most appropriate setting. This may mean spending more on prevention and proactive care in the community and less on services in hospitals.
- We will learn from what works well to spread good practice across the STP area so people can expect eth same quality of care and support irrespective of where they live.
- We will deliver care and support as efficiently as possible so we can spend more on improving people's health, wellbeing and quality of life.
- We will place as much value on a person's mental health as we do their physical health.
- We will maximise the positive impact that health and social care services can add to our local communities through the contracting for products and services (known as "social value").

3. Citizens

3.1 We must be clear with citizens how we will engage with them to deliver the plan and what it means for them. Citizens want to know that they can get high quality health and social care at the right time and in the right place to meet their needs.

3.2 The STP will *assure* citizens that we are driving standards and consistency in outcomes across our whole area, that we are listening to their needs, and delivering best practice and efficiency. The programmes within the STP will *involve* citizens in the local design and delivery of the plans to meet their needs. Services will be delivered in a way that best meet local community needs.

4. Core principles for governance

4.1 Through the STP governance arrangements we want to:

4.1.1 *Establish a mutually accountable system with independent challenge*
4.1.2 *Be clear on where risk is owned and managed*
4.1.3 *Transform care through leaders working together*

a) Establish a mutually accountable system with independent challenge

4.2 At the STP level, organisational leaders need to ensure they are mutually accountable to each other as well as being mutually supportive. They need to learn, share and provide independent challenge to each other. Leaders need to be the interface between the STP Leadership Board and their own organisations and governing boards.

4.3 This requires strong leadership – these key individuals have responsibility for managing the public purse across the area, for meeting key national targets, and for ensuring their own organisational strategies and plans align to the STP objectives of improving people's health and wellbeing, care and quality of services, and finance and efficiency.

b) Be clear on where risk is owned and managed

4.4 Individual organisations and the two 'transformation boards' (areas of local health and care delivery covering Mid Nottinghamshire and Greater Nottingham including the city) will continue to manage their own individual risks. Some of these risks may be managed at the STP level if that is in the best interests of the overall system. The STP Leadership Board keeps track of risks, key metrics and milestones.

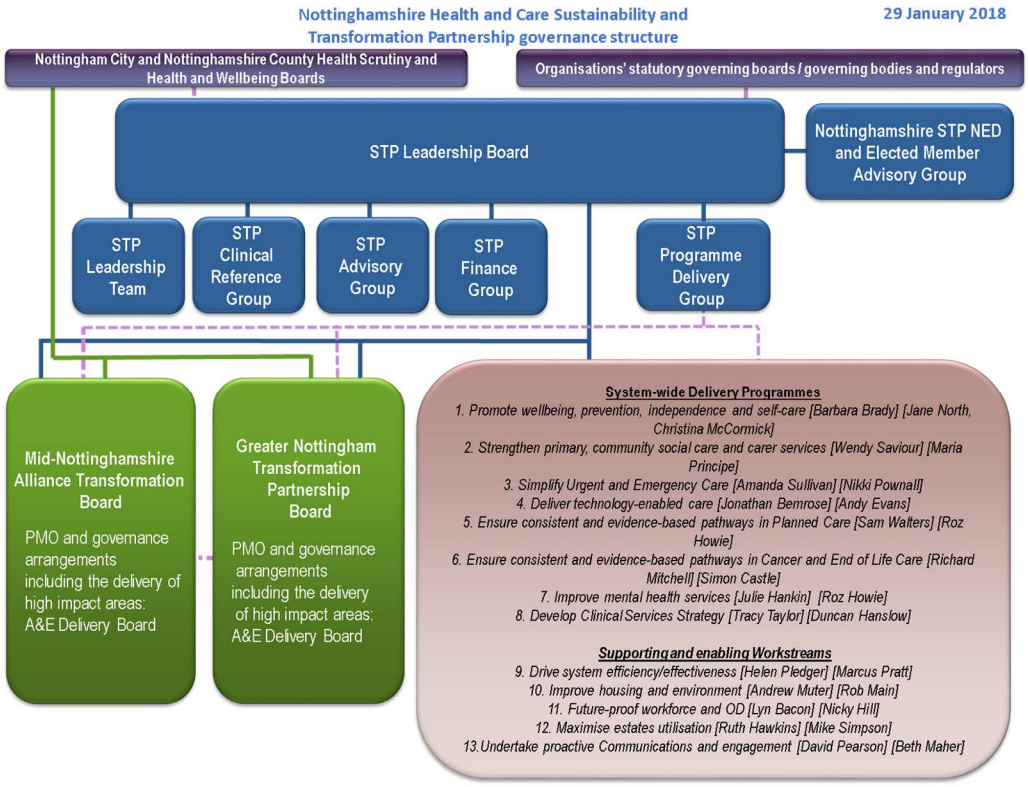
c) Transform care through leaders working together

4.5 The STP seeks to ensure that the location of where a citizen lives should not dictate the quality of service received or the impact on that citizen's health and wellbeing. We have to act as one system for our population, providing evidence-based services and ensuring consistent outcomes. Leaders have to work together within this one system for the greater good. Our governance will underpin this approach.

5. Governance structure

5.1 The STP governance structure is set out in figure one.

Figure 1: Overall Nottingham and Nottinghamshire STP governance structure



5.2 Key features of this approach are:

5.2.1 The STP Leadership Board is where chief executives and accountable officers will hold the implementation teams to account, challenge each other to put system before organisation, ensure services are of a similar high standard across the area, and share best practice across Nottingham and Nottinghamshire. STP Leadership Board membership includes the STP

accountable lead, accountable officers from all clinical commissioning group (CCGs) areas, chief executives from NHS trusts and foundation trusts, chief executives of Nottinghamshire County Council, Nottingham City Council, a clinical representative from each of the Transformation Boards, the Chair of the Clinical Reference Group, and leads of high impact and supporting themes and enablers not otherwise on the Leadership Board. In the event of not being able to attend a meeting, a substitute will be sent.

5.2.2 Within Nottingham and Nottinghamshire local work has been overseen by the Mid Notts Alliance Transformation Board and the Greater Nottingham Transformation Board. These two partnerships host a number of 'vanguard' sites chosen by NHS England to find innovative solutions to health and care challenges; they commission the majority of services in their area. The transformation boards will be held to account directly by the STP Leadership Board on all aspects of their work. This work involves all organisations working together to transform services.

5.2.3 Programme management support will be provided within the programmes rather than at STP Leadership Board level.

5.2.4 Individual organisations will contribute to and approve a range of matters relating to their organisation's contribution to the STP. They retain the powers and responsibilities for delivering the STP.

5.2.5 Local democratic oversight is through the councils, primarily through Lead Members and relevant Committees. Overview and Scrutiny arrangements will be undertaken through established committees.

5.2.6 Health and Wellbeing Boards will receive regular updates on progress in delivering the STP and will contribute to and challenge the work of the ICS.

5.2.7 Citizen involvement is a key aspect of the two transformation programmes and also takes places within various projects/programmes of the STP. A separate Citizen Advisory Group at STP Leadership Board level is being considered for the future but is not currently in the governance arrangements.

5.2.8 An STP Clinical Reference Group is represented on the STP Leadership Board to provide senior clinical/ social care advice and to ensure on-going clinical/social care contribution and leadership to STP strategy development and implementation. An STP Group of senior Elected Members and Chairs of Health Board has been established to provide advice and oversight of the STP.

5.2.9 An STP Advisory Group ensures that wider stakeholders are kept engaged and involved in the development of the STP and can provide advice and recommendations to the STP Leadership Board. The group includes representatives of key partner organisations and associates and representatives from Healthwatch, and key professional bodies.

5.2.10 An STP Finance Group provides financial expertise and assistance to support the STP Leadership Board in delivering their objectives and ensure alignment with organisational financial plans.

5.2.11 An STP Programme Delivery Group supports the STP Leadership Board in the delivery of a viable and deliverable plan which meets the health and care needs of the citizens of Nottingham and Nottinghamshire and best utilises the system resources.

5.3 The STP Leadership Team has been established to support the role and responsibilities of the STP Leadership Board. The role of this function is to:

- Co-ordinate production of documents to support national STP submission requirements
- Support the STP Leadership Board in preparing papers and ensuring that Board actions are followed through in accordance with Board expectations
- Work with programmes to develop an annual STP performance and outcomes framework summarising key objectives, deliverables and performance
- Monitor delivery and provide routine performance reports to the STP Leadership Board evidencing progress against the performance and outcomes framework including exception reports
- Investigate issues highlighted by performance monitoring
- Undertake support activities as instructed by the STP Leadership Board to ensure that system-wide programmes are delivered
- Monitor system risks and hold the system risk log
- Support system leadership development
- Provide support to the Clinical Reference Group to develop their annual work plan
- Maintain and develop the wider communications and engagement plan for stakeholders
- Ensure financial monitoring of delivery against plan and alignment with contract assumptions.

6. Review of governance arrangements

6.1 The role and full expectations of STPs is still under national development - the governance structure will be reviewed at six-monthly intervals or where necessary to reflect any changes to functions.

Nottinghamshire County Council

Report to Health Scrutiny Committee

27 March 2018

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

GP ACCESS (MANSFIELD AND ASHFIELD & NEWARK AND SHERWOOD)

Purpose of the Report

1. To allow Members to consider issues relating to access to GP services in Mansfield and Ashfield & Newark and Sherwood.

Information

2. Members will find attached as an appendix to this report a written briefing from the Clinical Commissioning Group (CCG) which details the commissioning of GP services, the core services offered by GPs, as well as the enhanced services.

3. Waiting times for GP appointments have often been a source of concern to the Health Scrutiny Committee. Members may therefore wish to focus on identifying ways in which the access to GPs can be improved for patients, particularly in rural areas.

4. David Ainsworth, Director of Primary Care will attend the Health Scrutiny Committee to brief Members and answer questions as necessary.

5. Members will be aware that consideration will be given to the commissioning of GP services across the whole county at a special meeting of the Health Scrutiny Committee on 26 April 2018.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration as necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

NHS
Mansfield and Ashfield
Clinical Commissioning Group

NHS
Newark and Sherwood
Clinical Commissioning Group

Paper Title	**GP Access**
Status	**Briefing Paper**
Audience	**Councillor Girling, Chair of Health Scrutiny Committee, Nottinghamshire County Council**
Date	**26 February 2018**
Prepared by	**Kerrie Woods and Paula Longden**

Background

General practice services are commissioned through one of three types of contracts; General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS). Access is governed as follows:

- Core GMS services.
- Extended access enhanced service.
- GP Forward View extended access.

The Public Accounts Committee (PAC) report into GP Access, March 2017, set out a number of recommendations. One was to ensure that no practice that was closed weekly for half a day should be in receipt of additional funds to provide 'extended hours' i.e. outside 'core hours' and secondly that patients should know what they can 'reasonably' expect of their GP practice during core hours.

NHS England is developing a more specific definition of what services patients at all practices can expect during core hours to meet the reasonable needs of patients. NHS England has tested this definition with patient groups and representatives.

Core GP Services

The General Medical Services (GMS) and Personal Medical Services (PMS) Regulations require general practice contractors to provide essential and additional services at such times within core hours, "as are appropriate to meet the reasonable needs of patients," and require the contractor to have in place arrangements for its patients to access those services throughout core hours in case of emergency.

Core hours for GMS and PMS practices locally are 08:00 to 18:30, Monday to Friday, excluding weekends and Bank Holidays. Opening hours for APMS practices are set out in their contract and largely mirror GMS opening hours or longer.

Core services are supplemented by the Extended Access Enhanced Service and the GP Forward View Extended Access.

Extended Access Enhances Service (ES)

The ES became available in 2011 and was designed to secure access to routine appointments at times outside of practices core contracted hours to allow patients to attend the practice at a time when it is more convenient for them (e.g. at weekends, early mornings and evening). All practices are invited to participate in the ES. And as such is not mandated.

Thirty practices across NHS Mansfield and Ashfield and NHS Newark and Sherwood CCG area provide the ES. This provides an additional 120 hours per week of routine pre-booked appointments at a range of early mornings, late evenings and Saturday mornings.

Opening hours for providing those routine appointments must be in line with patient-expressed preferences, which can be through the GP Patient Survey or preferences expressed through Patient Participation Groups (PPGs), the Friends and Family Test (FFT) or other recorded feedback.

GP Forward View Extended Access

The GP Forward View, published in April 2016, set out a commitment to further enhance access to general practice widening it to evenings and weekends by March 2019. Mid Nottinghamshire has made significant progress in gradually implementing this from April 2017. The National requirement on CCGs to commission this is October 2018.

To date 100% of NHS Mansfield and Ashfield CCG's population and 53% of NHS Newark and Sherwood CCG's population are able to access evening and weekend appointments. Practices in Newark are in the final phase with extended access available from March. In total, practices have provided over 10,000 additional appointment slots between 18.30 and 20.00 Monday to Friday and on Saturdays and Sundays.

Access to Appointments and Waiting Times

The CCGs monitor access and waiting times through the GP Patient Survey and, in future, workload data.

GP Patient Survey

The GP Patient Survey (GPPS) is an England-wide survey, providing practice-level data about patients' experiences of their GP practices; it is undertaken by Ipsos MORI on behalf of NHS England.

The latest published data is based on the July 2017 GPPS publication; the survey is carried out annually from January to March.

- In NHS Mansfield and Ashfield CCG, 7,363 questionnaires were sent out, and 3,007 were returned completed. This represents a response rate of 41%.

- In NHS Newark and Sherwood CCG, 3,612 questionnaires were sent out, and 1,665 were returned completed. This represents a response rate of 46%.

Results from the July 2017 National Patient Survey show that NHS Mansfield and Ashfield and NHS Newark and Sherwood CCGs have an 85% satisfaction rate with access which has been consistent for the past four years and is in line with the national average.

GP Workload Data

NHS England has commissioned NHS Digital, under the Health and Social Care Information Centre Directions 2017 to collect a suite of data on GP Workload. NHS Digital is collecting the GP Workload Collection which will result in NHS Digital collecting an increased amount of data from general practices specifically around appointments.

This GP Workload Collection will comprise the collection of the following:

- Appointments - demographics, status and dates to calculate the TNA (Third Next Available Appointment).
- Electronic Prescriptions - orders and repeats.
- Functionality of GP systems - access for patients to their medical records and test results.

The four principal general practice system suppliers will provide non-identifiable data to NHS Digital on a monthly basis.

This data collection will enable the NHS to better articulate general practice workload, understand appointment activity and utilisation and demonstrate the use of general practice across the month.

To date, there has been a partial collection but not all system suppliers have been able to provide full data. Analysis on this data is currently pending.

Practice Mergers and GP at Scale

NHS England's Five Year Forward View (5YFV) sets out a clear direction for the NHS looking at new models of care that encourages practices to come together to explore new, innovative ways of delivering Primary Care at scale.

Larger practices typically benefit from economies of scale, improved resilience, job enrichment with the ability for clinical and non-clinical staff to specialise and often larger, better equipped premises. This has direct benefits for patients.

To access these benefits practices have traditionally merged. Mergers traditionally involve two or more neighbouring practices that were confronted with similar limitations and the CCGs have a formal process for consideration and approval. (See Appendix 1). The CCGs have no formal mergers currently in train.

Although no formal mergers are being considered all 41 practices are working more closely together through the development of a single provider infrastructure. This will enable all practices to access the benefits of working at scale while retaining local ownership, clinical leadership, decision making and back office functions.

Mid Nottinghamshire practices have started to take this concept forward and started to deliver services as localities during 2017/18. There are six localities in mid Nottinghamshire; each serving circa 30-50K populations. A significant example of this is the GP Forward View extended access where locality working has made it possible to roll out the evening and weekend appointments for all patients in the locality whatever the size of the practice. This contrasts with the old ES, which practices provided individually putting a significant burden on smaller practices, and creating inequity across the patch. Locality working provides universal population coverage.

In 2018/19, our practices will continue to work together in developing new ways of providing care outside of hospital. Linking better with community and mental health teams to deliver more care closer to people's homes. Working in localities will mean patients have fewer hospital journeys and will be able to access services within their locality.

Appendix 1: Practice Merger Process

NHS England's Primary Medical Care Policy and Guidance Manual (PGM) provides a framework for CCGs to consider applications for practice mergers. NHS England has recognised four different models for practice undertaking a practice merger, which require differing levels of contractual approval and engagement with patients. None of the identified models are prescriptive on the future proposed models and do not mandate a closure of premises.

Where practices propose a merger of contracts that includes a closure of a premise, this will be considered by the CCG Joint Primary Care Commissioning Committee which is responsible for decision-making surrounding primary care in the future, under delegated authority from NHS England.

On considering such a request, the Committee, as directed by the Policy and Guidance Manual, will consider:

1. The benefits to patients including how patients would access a single service (if so proposed).
2. What the proposed practice boundary changes being proposed are; including geographical changes to location if applicable.
3. The proposed premises arrangements and accessibility of those premises to patients.
4. The proposed arrangements for consulting patients about the proposed changes.
5. The proposed communication to registered patients including how they will support patient choice.

The Committee will also seek assurances that all patients of the newly merged practice will experience consistency across provision, i.e. home visits, booking appointments, essential and additional services, opening hours, extended hours, and so on.

Each merger application is considered on its individual merits.

Nottinghamshire County Council

Report to Health Scrutiny Committee

27 March 2018

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations, and reviewing other issues impacting on services provided by trusts which are accessed by County residents.

3. The work programme is attached at Appendix 1 for the Committee to consider, amend if necessary, and agree.

4. The work programme of the Committee continues to be developed. Emerging health service changes (such as substantial variations and developments of service) will be included as they arise.

5. Members may also wish to suggest and consider subjects which might be appropriate for scrutiny review by way of a study group or for inclusion on the agenda of the committee.

Quality Account Study Groups

6. Quality Account Study Group meetings have been set up as follows:

   Nottingham Treatment Centre (Circle) 3:30 PM (TBC) 17 May 2018 – meeting venue, County Hall

   Membership: City Councillors Carole Jones and Eunice Campbell, County Councillors Muriel Weisz and Keith Girling.

   Nottingham University Hospitals (NUH) TBC – meeting venue County Hall (TBC)

   Membership: City Councillors Ginny Klein and Adele Williams, County Councillors Martin Wright and Keith Girling

East Midlands Ambulance Service (EMAS) 9:30 AM 16th April – meeting venue, Loxley House

Membership: City Councillors – TBC, County Councillors Kevin Greaves and Keith Girling

Nottinghamshire Healthcare Trust (NHCT) 10:00 am 18 April – meeting venue, Loxley House

Membership: City Councillors – TBC, County Councillor Keith Girling

Sherwood Forest Hospitals Trust – TBC – Meeting Venue – County Hall

Membership: County Councillors Martin Wright and Keith Girling

Doncaster and Bassetlaw Hospitals Trust – TBC – Meeting Venue – County Hall

Membership: County Councillors Steve Vickers and Keith Girling

RECOMMENDATION

That the Health Scrutiny Committee:

1) Considers and agrees the content of the draft work programme.

2) Suggests and considers possible subjects for review.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2017/18

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
13 June 2017				
Health Inequalities	Update on ongoing work to address health inequalities in the County	Scrutiny	Martin Gately	Barbara Brady, Public Health NCC
Introduction to Health Scrutiny	An introduction to health service issues and the operation of health scrutiny	Scrutiny	Martin Gately	Brenda Cook Health Scrutiny Expert (Centre for Public Scrutiny)
25 July 2017				
Public Health Briefing	Introduction to Public Health issues	Initial Briefing	Martin Gately	Barbara Brady, Public Health NCC
Bassetlaw Hospital Services (Update)	An update on children's services and recruitment issues.	Scrutiny	Martin Gately	TBC
Sherwood Forest Hospitals Performance Update	The latest performance information from Sherwood Forest Hospitals Trust.	Scrutiny	Martin Gately	Dr Andy Haynes, Medical Director, Richard Mitchell, Chief Executive
IVF Substantial Variation	Update on re-consultation/Further action taken by the commissioners	Scrutiny	Martin Gately	Dr Amanda Sullivan, Sherwood Forest CCG/Lucy Dadge
10 October 2017				
Bassetlaw Hospital (Including Children's Services)	Update on the latest position	Scrutiny	Martin Gately	TBC
Chatsworth Ward, Mansfield Community	Initial briefing on changes at Chatsworth Ward which provides specialised neuro-rehabilitation services	Scrutiny	Martin Gately	Lucy Dadge/Sally Dore Mansfield and Ashfield CCG

Hospital variation of service				
East Midlands Ambulance Service	Latest Performance Information (Particularly in relation to ambulances delayed when dropping patients off at A&E).	Scrutiny	Martin Gately	Annette McFarlane, Service Delivery Manager (Nottingham Division)
Nottingham University Hospitals – Winter Planning	Initial briefing on winter pressures and winter plans.	Scrutiny	Martin Gately	TBC
Sherwood Forest Hospitals – Winter Planning	Initial briefing on winter pressures and winter planning	Scrutiny	Martin Gately	TBC
21 November 2017				
Bassetlaw Hospitals – Winter Planning	Initial briefing on winter pressures and winter planning	Scrutiny	Martin Gately	TBC
Primary Care 24	Latest performance information	Scrutiny	Martin Gately	Dr Amanda Sullivan, Chief Officer, Mansfield and Ashfield/Newark and Sherwood CCG
Chatsworth Ward Neuro-Rehabilitation Ward	Further consideration of this service change.	Scrutiny	Martin Gately	Lucy Dadge, Chief Commissioning Officer, Ashfield/Newark and Sherwood CCG
Newark Hospital Urgent Treatment Centre	Briefing on the transition to Urgent Treatment Centre taking place from early 2018, with the intention that Newark Hospital becomes a centre of excellence across a broad range of diagnostics.	Scrutiny	Martin Gately	Lucy Dadge, Chief Commissioning Officer, Ashfield/Newark and Sherwood CCG

9 January 2018				
Local Pharmaceutical Council	Initial Briefing on the work of the LPC.	Scrutiny	Martin Gately	Nick Hunter, Local Pharmaceutical Council.
Obesity Services	Initial Briefing	Scrutiny	Martin Gately	TBC
Suicide Prevention Plans	A preliminary examination of Suicide Prevention Plans further to a general request from the Parliamentary Health Select Committee.	Scrutiny	Martin Gately	Susan March, Senior Public Health and Commissioning Manager
13 February 2018				
Sherwood Forest Hospitals/NUH Partnership	Update on the working relationship between Sherwood Forest Hospitals and NUH	Scrutiny	Martin Gately	Tracy Taylor, Chief Exec NUH, Richard Mitchell, Chief Exec SFH
East Midlands Ambulance Service – Response to Winter Pressures	Initial briefing on the severe pressure placed on the NHS emergency ambulance service during late December 2017 and early January 2018.	Scrutiny	Martin Gately	Keith Underwood and Annette MacFarlane, EMAS
Neuro-Rehabilitation Update	Further update on proposed changes to Neuro-Rehabilitation services at Sherwood Forest Hospitals Trust.	Scrutiny	Martin Gately	Lucy Dadge, Chief Commissioning Officer Mansfield and Ashfield/Newark and Sherwood CCG
27 March 2018				
STP Governance	Initial briefing on STP governance issues	Scrutiny	Martin Gately	David Pearson, NCC Lead Officer for the STP
GP Services Access	Initial briefing on issues with accessing GP services (particularly in rural areas)	Scrutiny	Martin Gately	TBC

26 April 2018				
Primary Care Commissioning – GP Forward View	An initial briefing on Primary Care Commissioning, specifically the GP Forward View across the whole of Nottinghamshire.	Scrutiny	Martin Gately	Idris Griffiths, Bassetlaw CCG, Gary Thompson, Chief Operating Officer, Nicole Atkinson and Sharon Pickett, Nottingham North and East, Dr David Ainsworth, Mansfield and Ashfield and Newark and Sherwood.
8 May 2018				
Bassetlaw Children's Ward	Further consideration	Scrutiny	Martin Gately	TBC
Suicide and Self Harm Prevention – Rampton Hospital	An initial briefing on suicide and self-harm prevention at Rampton Hospital as part of the committee's ongoing look at suicide prevention.	Scrutiny	Martin Gately	Dr John Wallace, Clinical Director, Rampton Hospital (Nottinghamshire Healthcare Trust).
Nottingham Treatment Centre Procurement	Progress Report on the results of the procurement	Scrutiny	Martin Gately	Maxine Bunn, Director of Contracting TBC
East Midlands Ambulance Service	Further update on actions arising from last winter.	Scrutiny	Martin Gately	East Midlands Ambulance Service
4 July 2018				
Hospital Meals	Initial briefing	Scrutiny	Martin Gately	TBC
Dementia in Hospital	Initial briefing/commencement of a review	Scrutiny	Martin Gately	TBC

NUH Maternity Services	Initial Briefing	Scrutiny	Martin Gately	TBC
To be scheduled				
Community Pharmacy Issues Update				Liz Gundel, Pharmacy Lead, NHS England
Healthcare Trust Mid and North Notts Services				
Never Events				
Substance Misuse				

Potential Topics for Scrutiny:

CCG Finances TBC

Recruitment (especially GPs)

Rushcliffe CCG Pilots Update

Former Joint Health Committee Issues

STP
Implementation and Evaluation of services decommissioned from NUH (TBC)
Community CAMHS
Transforming care for people with learning disabilities/autism

Emergency Care
Winter Pressures
Congenital Heart Disease Services
Progress/Evaluation of implementation changes to mental health services
Defence National Rehabilitation Centre
East Midlands Ambulance Service

Overview Sessions (To be confirmed)

Bassetlaw CCG – June

Nottinghamshire Healthcare Trust – July

Nottingham University Hospitals (NUH) – autumn