Joint City / County Health Scrutiny Committee

Tuesday, 18 April 2017 at 10:15

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

AGENDA

Notes

(1) 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

(2) 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 Julie Brailsford (Tel. 0115 977 4694) or a colleague in Democratic Services prior to the meeting.

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

(4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.

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

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
14 March 2017 at 10.15am

Nottinghamshire County Councillors

Councillor Parry Tsimbiridis (Chair)
Councillor Roy Allan
Councillor Joyce Bosnjak
Councillor Kay Cutts MBE
Councillor Richard Butler
Councillor John Handley
Councillor Sheila Place
Councillor Jacky Williams

Nottingham City Councillors

Councillor A Peach (Vice-Chair)
Councillor M Bryan
A Councillor E Campbell
Councillor C Jones
Councillor G Klein
A Councillor B Parbutt
A Councillor C Tansley
Councillor M Watson

Officers

David Ebbage - Nottinghamshire County Council
Martin Gately - Nottinghamshire County Council
Jane Garrard - Nottingham City Council

Also in attendance

Officers

Dr Agnes Belenscak - Screening & Immunisation Lead
Dr Aiden Bolger - East Midlands Congenital Heart Centre
Hazel Buchanan - Director of Operations
Peter Homa - Chief Executive, NUH
Dr James Hopkinson - Clinical Lead
David Pearson - STP lead
Sam Walters - Chief Officer, Nottingham North & East CCG
Stephen Ward - Director of Legal and Corporate Affairs
Michael Wilson - Programme Director, NHS England

MINUTES

The minutes of the last meeting held on 14th March 2017, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES

Apologies were received from Councillor Campbell, Councillor Parbutt & Councillor Tansley.

DECLARATIONS OF INTEREST

Councillor Ginny Klein declared a private interest in Item 6 – Nottingham University Hospitals NHS Trust Service Reviews as she uses a number of the services involved.

SUSTAINABILITY AND TRANSFORMATION PLAN – GOVERNANCE ARRANGEMENTS

David Pearson, STP Lead, updated members of the committee on the Nottinghamshire Sustainability and Transformation Plan with a particular focus on the governance arrangements.

He highlighted the following from his report:-

- Through the STP governance arrangements the aim is to Establish a mutually accountable system with independent challenge, be clear on where risk is owned and managed and to transform care through leaders working together.

- 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.

- There are two major transformation partnerships within our area – overseen by the Mid Notts Alliance Transformation Board and the Greater Nottingham 'Accountable Care System' Transformation Board. These boards will lead the implementation of three of the high impact changes and have a lead role in implementing the STP in their areas.

- 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.

During discussion and answering questions, the following points were raised:

- At the age of 18, children with learning disabilities become adults but planning for adulthood starts when they become 13 or 14 years of age.

- The Committee thought the STP could have been more engaged with Members of the Committee with all aspects of the plan and consultation as the communities in which the members represent will all be effected.

CONGENITAL HEART DISEASE

Michael Wilson from NHS England introduced the report to the committee detailing the proposed changes to Congenital Heart Disease services at Leicester.

He highlighted the following from his report:-

- Between January and April 2016 existing providers of CHD services were assessed against key selected standards by a national commissioner led panel. Their role was to assess each hospital's ability to meet selected standards. Services at Leicester were not meeting or likely to meet all the relevant standards within the required timescales. Following the consideration from NHS England's Specialised Services Commissioning Committee, a change in service provision was appropriate. NHS England would only commission CHD services from hospitals that are able to meet the standards within the required timeframes.

- The proposals were announced on 8th July 2016 subject to public consultation Level 1 surgery and interventional cardiology for children and adults should cease at University Hospitals of Leicester NHS Trust.

- Leicester were not meeting the number of surgical cases required, if patients in future required Level 1 services, they would have to travel to either Leeds or Birmingham.

- The level 2 proposal to also remove specialist medical services from Leicester would only affect a small number of patients.

- University Hospitals Leicester provides cardiac and respiratory ECMO (Extracorporeal Membrane Oxygenation) for children and is at present the only provider commissioned to offer mobile ECMO. It also provides cardiac and respiratory ECMO for adults. If the proposals were to be implemented, Leicester would no longer be able to provide cardiac or respiratory ECMO for children or mobile ECMO for children. It would also no longer provide cardiac ECMO for adults with Congenital Heart Disease. NHS England would expect that Leicester could continue to provide adult respiratory ECMO.

During discussion and answering questions, the following points were raised:-

- Not all referrals are directed to Leicester, over a quarter of patients go to a centre which is not their closest available facility. This could be a contributory factor as to why they are unable to meet the number of surgical cases.

- Members were concerned that relocating Level 1 and Level 2 services away from Leicester would leave the East Midlands region without access to CHD services. NHS England did say that the decision has not yet been made and their minds are not made up.

- Discussion has taken place regarding whether there is space for extra patients at Birmingham if the proposals are taken forward. Birmingham has indicated they would be able to increase capacity and funding for the extra patients which arrive at the hospital.

- Concerns were raised over the access to Birmingham from certain parts of the region as it will not be easy for families who do not have access to transport.

Dr Aiden Bolger from East Midlands Congenital Heart Centre gave a short presentation to members and to NHS England on the University Hospitals of Leicester's current situation and their case for keeping the services at UHL, the following points were raised within his presentation:-

- NHS England states with 3 surgeons, each surgeon should perform 125 cases per annum and the unit to achieve 375 cases per year, averaged over three years. If counted from this current year onwards, the hospital is expected to be compliant by March 2019 as required.

- A recent survey from the friends and family test showed 434/436 respondents would recommend the services at Leicester to their family and friends.

- A number of impacts on patients if the proposals are to take place would mean longer travel times to alternative centres, the extra cost involved, ease of access, increased waiting lists, disruption of patient-clinician relationships and increased anxiety.

- Geographical balance of CHD provision is severely threatened by NHS England's plans and specifically to the detriment of the East Midlands population.

- In regards to ECMO at Leicester, it accounts for nearly 50% of UK respiratory paediatric activity.

During discussion and answering questions, the following points were raised:-

- NHS England's proposals are based around the standards not being met, they are ensuring the quality of service being offered is of the highest standard.

- NHS England are not ignoring population growth with their estimations for case numbers by 2021 with 4 surgeons all performing 125 cases each, which totals 500 cases.

The decision has not yet been made and the board of NHS England will make the decision in the autumn.

RESOLVED: A draft response will be prepared and placed on the agenda of the next meeting of the Joint Health Committee for consideration.

NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST SERVICE REVIEWS

Hazel Buchanan, Director of Operations and representatives from CCGs briefed Members on the review of services and service changes at Nottingham University Hospitals (NUH) being undertaken by Nottingham North and East Clinical Commissioning Group.

During her presentation, the following points emerged:

- Reviews are part of CCG responsibilities to commission effectively, efficiently and economically

- Each services was considered in isolation and as part of this, consideration was given as to whether the change was substantial

    - 22 services = clarity on service and financials
    - 4 services = commissioning as a community service
    - 2 services = proposal changed to service with NUH
    - 2 services = ongoing in order to finalise proposal

The governing body's decision and next steps process of each of the 8 services can be seen below:-

Orthoptics

Proposal is to procure as a community service
Proposal included appointments evening and weekends, patients with complex needs will be seen at the hospital.
Governing Bodies for approval

Integrated Dietetics (Acute and Community)

Governing bodies' decision is to procure an integrated service with a specification that requires patients to be seen easily in the most appropriate setting, this includes patients being seen in the acute setting when appropriate.

Motor Neurone Disease (MND) – Home Visiting

Governing bodies' decision is to integrate into existing community services and to produce an annex to the specification to ensure the specific needs of these service users are met.

Next steps are to further engagement will be carried out to inform the annex. Discussions being held between service providers and mobilisation and implementation of service model by community provider.

Pain

Governing bodies' decision is to be commissioned as a community service and the service will be in line with NICE guidance.

Next steps include procurement of new service, mobilisation and clinical review, where appropriate for existing patients.

Chronic Fatigue Syndrome (CFS) Service

Governing bodies' decision is to be commissioned as a community service.

Next steps include procurement of new service, mobilisation and to create a self-help group.

Complex Rehab

Governing bodies' decision is to integrate into existing community service and to include specific reference to services required for patients with Parkinson's.

Next steps are to include the phase 3 engagement, separate appendix for patients with Parkinson's, ensure quality of care and mobilisation and implementation of service model with community provider.

Neuro Services

Governing bodies' decision is for this service to remain at NUH.

Next steps are to agree specifications, finalise costs and review access alongside other rehab services.

Renal Conservative Management

Governing bodies' decision is to continue commission from NUH.

Next steps include finalising specification and agree efficiencies in service provision with NUH.

RESOLVED: A sub-group of the committee would engage with the commissioners to consider the NUH Service Review further.

NOTTINGHAM UNIVERSITY HOSPITALS CLEANING CONTRACT

Peter Homa, Chief Executive at NUH, gave a short presentation on the latest information regarding the cleaning contract at Nottingham University Hospitals (NUH).

He raised the following points in his presentation:-

- In January 2017, NUH and Carillion mutually agreed to a managed exit from the core aspects of the Estate and Facilities contract.

- Core estate and facility services are due to come back under NUH management by 1st April 2017.

- The next steps include cleaning improvements & safe transfer of staff and services.

- Recruitment exercise is underway to address staffing gaps

- Carillion staff will transfer to NUH by April

- Comprehensive improvement plan under development

- Carillion will invest significantly to improve car parking infrastructure and traffic management. Car parking enforcement to be introduced in spring 2017 to tackle inconsiderate parking.

- Dedicated tram entrance will open end of July 2017 in which over 2,200 passengers will use daily.

The chair thanked Peter Homa for his attendance.

WORK PROGRAMME

Members noted the Work Programme

The meeting closed at 1.30pm.

Chairman

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
18 APRIL 2017
GP CAPACITY IN THE CARLTON AREA
REPORT OF CORPORATE DIRECTOR FOR STRATEGY AND RESOURCES (CITY COUNCIL)

ITEM 4

1. Purpose

1.1 To take a strategic overview of GP capacity and any pressures on service provision in the Carlton area and, where appropriate, work taking place to ensure access to good quality GP services for all residents in the area.

2. Action required

2.1 The Committee is asked to identify whether any further scrutiny is required.

3. Background information

3.1 Following an inspection by the Care Quality Commission (CQC), The Willows Medical Centre in Carlton temporarily closed on 10 June 2016 until further notice. The CQC published its report on the inspection findings in August 2016 and the provider's registration was suspended for a period of up to three months and the service was placed in special measures. Subsequently Dr Nyatsuro formally resigned from the GP contract.

3.2 Nottingham North and East Clinical Commissioning Group (CCG) is responsible for commissioning GP services in Gedling (in co-commissioning arrangements with delegated responsibility from NHS England) and the CCG's Primary Care Commissioning Committee considered options for future provision in the area.

3.3 Representatives of Nottingham North and East CCG and Nottingham City CCG (as the area is close to the border and residents in the Nottingham City CCG area were affected) came to the Committee's meeting in October 2016. The Committee was informed that patients at The Willows Medical Centre had been supported to register with an alternative GP practice and that there was sufficient capacity within the local area to accommodate all patients registered at The Willows.

3.4 Some councillors were concerned about future capacity within the Carlton area and the Committee requested that the CCG provide an

overview of GP capacity across the area and work taking place to ensure access to good quality GP services for all residents in that area going forward.

3.5 A paper from Nottingham North and East CCG detailing primary care provision in Carlton, details of patient feedback and next steps is attached and a representative of the CCG will be attending the meeting to answer questions in relation to this.

4. List of attached information

4.1 Report from Nottingham North and East CCG on GP Services in Carlton

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 Report to and minutes of the meeting of the Joint Health Scrutiny Committee held on 11 October 2016.

6.2 Care Quality Commission The Willows Medical Centre Quality Report (25/08/16)

7. Wards affected

7.1 Nottingham City Council - Mapperley and Dales
Nottinghamshire County Council – Carlton West and Carlton East

8. Contact information

Jane Garrard, Senior Governance Officer, Nottingham City Council
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

Nottingham North and East
Clinical Commissioning Group

GP Services in Carlton

Joint Health Scrutiny Committee: 18 April 2017

Hazel Buchanan, Director of Operations and Racheal Rees, Head of Primary Care, Nottingham North and East Clinical Commissioning Group

1) Purpose of the Report

This update has been requested following our last attendance at the Joint Overview and Scrutiny Committee on 11th October 2016 to discuss the closure of the Willows Medical Centre, whereby it was requested that we provide you with an update on the overall provision of Primary Care Services within the Carlton area.

For the purpose of this report we have continued to base the information on the practices that were most significantly impacted by the closure of the Willows Medical Centre on 10th June 2016 following a Care Quality Commission (CQC) inspection.

This paper will summarise:

- Primary care provision in Carlton
- Patient feedback / complaints
- Next steps

2) Primary Care Provision in Carlton

The following practices are located within the Carlton area:

Practice Name	Address	Partners
Park House Medical Centre	61 Burton Road, Carlton, Nottingham NG4 3DQ	Dr Campbell Dr L Louca Dr K Bratt Dr E Pooley Dr A Harrison
Westdale Lane Surgery	20-22 Westdale Lane, Gedling, Nottingham NG4 3JA	Dr Khaliq Dr A Malik Dr H Ahmed
Trentside Medical Group	2a Forester Street, Netherfield, Nottingham NG4 2NJ	Dr C Kennedy Dr H Pathy Dr J Murray
Peacock Practice	428 Carlton Hill, Carlton, Nottingham NG4 1HQ	Dr P Oliver Dr A Subramanian & Dr Zawadzka (both salaried)

Unity Surgery	318 Westdale Lane, Mapperley, Nottingham NG3 6EU	Dr Khan Dr T Coleman & Dr M Jacob (both salaried)
West Oak Surgery	319 Westdale Lane, Mapperley, Nottingham NG3 6EW	Dr M Karpha Dr S Adams & Dr K Bratt (both salaried)
Plains View Surgery	57 Plains Road, Mapperley, Nottingham NG3 5LB	Dr Pillai Dr E Roberts Dr U Ahmad Dr S Adams

The Willows Medical Practice was located on Church Street, Carlton. This practice was suspended on 10th June 2016, following an unannounced inspection by the Care Quality Commission and never re-opened. The Willows Medical Centre was a small practice with a list size of around 3,512 patients, however, following its initial suspension the list size dropped to 2332 patients. The majority of patients have now registered with a new practice (principally the above practices), although 496 patients are yet to register with an alternative practice.

Current Practice List Sizes

Below are the list sizes of the practices up to 1st January 2017, you will see how the list sizes for practices increased as a result of the closure of the Willows Medical Centre.

	01.04.2016	01.07.2016	01.10.2016	01.01.2017
Practice Name	**Raw List**	**Raw List**	**Raw List**	**Raw List**
Trentside Medical Centre	11652	11703	11724	11727
Westdale Lane Surgery	7693	7824	7881	7947
Plains View Surgery	6069	6155	6257	6313
Peacock Practice	5237	5800	5939	5909
Unity Surgery	3773	3780	3751	3729
West Oak Surgery	5406	5482	5526	5563
Park House Medical Centre	7759	8712	9189	9432

Whilst the increase in patient numbers has increased workload for practices, the majority of practices (Trentside Medical Centre, Westdale Lane Surgery, Plains View Surgery, Unity Surgery, West Oak Surgery and Park House Medical Centre) have absorbed this increase and all continue to register new patients. The Peacock Practice was supported to close its patient list with effect from 31st March 2017; the request by the Peacock Practice to close its list was not solely related to the impact of the closure of the Willows Medical Centre.

3) Patient Feedback

The CCG commenced a survey about primary care services in Carlton on 14th September 2016. The results below were extracted 1st February 2017 (the survey has been left open during the period following the closure of the Willows Medical Centre but there has been no direct promotion of the survey since October 2016).

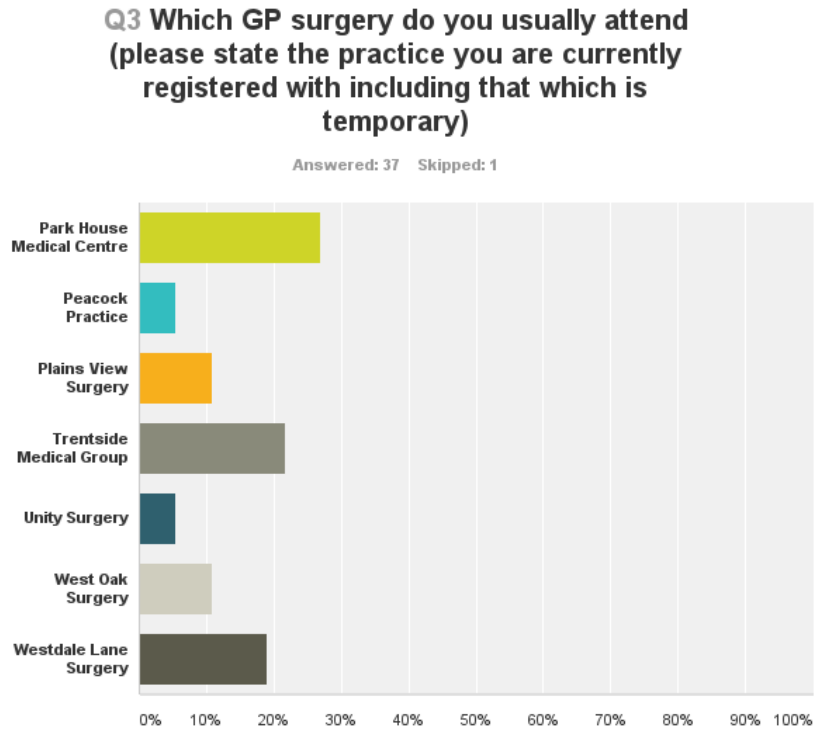
The survey was promoted via:

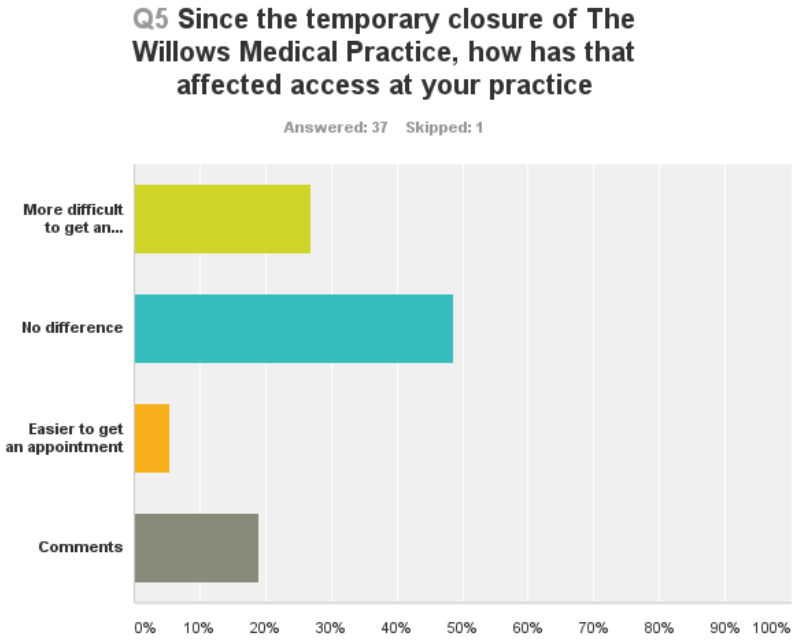
- a questionnaire on survey monkey
- advertising, printed surveys and collection boxes in each GP Practice -
- posters and leaflets were distributed around shops, gyms etc.. around the area, including printed surveys and collection boxes dropped off at Carlton Forum and Richard Herrod
- advertising in Gedling Eye (online publication)
- CCG internet pages
- social media, including paid Facebook adverts targeted at people living in and around Carlton.
- E-mail communication to PPG reps and patient database

The CCG has received 38 responses to the survey:

- 26 web responses
- 11 paper responses from surgeries

A summary of the survey results is provided below:





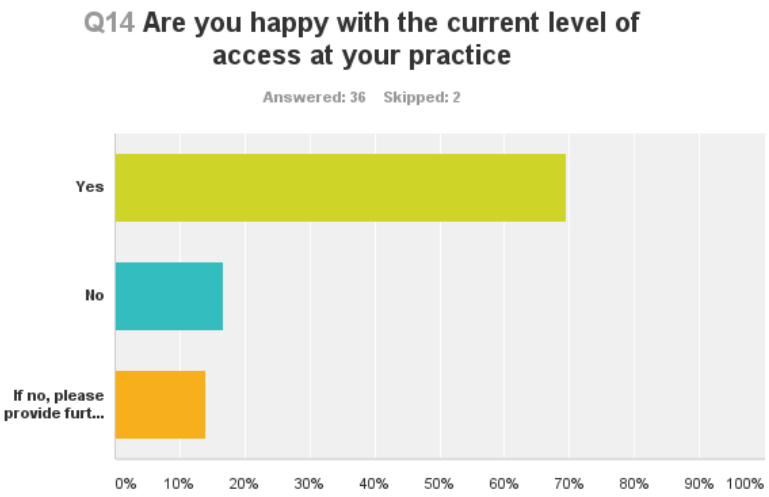
The majority of respondents believed the ease of getting an appointment was no different or had improved following the closure of the Willows Medical Centre. Some of the comments were:

- My new doctors is closer and I prefer it generally
- I have not noticed a significant difference
- I was a patient at The Willows, and have only used my new surgery to get repeat prescriptions (this was done through the Pharmacy service)
- I couldn't get an appointment at the Willows it was usually an online consultation with a prescription being sent to the chemist. However this meant I was overdue my diabetes check-up by 6 months. I have found out since seeing someone at Park clinic I that met firming wasn't working so well and I am now on slow release metformin. I had three new lots of medication and has resulted in having nerve neuropathy in my feet which is very uncomfortable. I was told at the Willows that nothing could be done! This is untrue! Another new medication

In response to a question about whether they felt that their GP Practice was accessible, thirty out of thirty four respondents felt their practice was accessible. The four who didn't commented:

- Parking is a nightmare (Park House)
- Not easy for elderly patients who need to go by car (Peacock)
- Long waits for appointments and slots are not long enough - having to book separate appointments for each complaint or complex complaint (West Oak)
- It is getting more difficult (Park House)

People were also asked if they were happy with the current level of access at their GP practice, the majority of respondents (69.4%) said they were:



The other comments that the CCG received around access are below:

- The emergency walk in service is very good
- Since joining Plains View, now realise how unprofessional the Willows were
- Very happy with Plains View
- Are you going to use the Internet/ Skype consultations?
- Will be good if a female GP is appointed at some stage. And when told to call at 8am better answering system so not engaged all the time when trying to get through for urgent appointments or home visits or telephone conversations
- I have been with this practice since the Willows closed and:
  1. Everyone here treats me as an individual and by my first name.
  2. Staff are friendly, polite and caring at all times.
  3. Would very much promote this practice to friends, relatives and the people of Carlton.
  4. Very relaxed always, no music being played - which is important to relax yourself
  5. Values my choice
- Quicker access to appointments for mental health support / concerns as these are often urgent
- Always a pleasant experience at Trentside Medical Group in Netherfield. Never any issues getting to see a GP or health professional. Keep up the good work of the NHS, we're lucky to have you!
- Receptionists now asks why you wanted to see a doctor / nurse and it feels a bit uncomfortable answering that question as it should be private. Also there are some occasions that I've seen the nurse and then I had to go to the doctor afterwards. It seems that receptionist decide who you can see - doctor or nurse.
- Surgery runs drop in session from 8am so can always access urgent care when needed.
- I feel that the surgery is currently under resourced and needs at least one more nurse and GP.
- Drop in service from 8-10.30 is fantastic. I use it all the time
- If the Colwick Surgery was not closed things maybe slightly easier, we have an empty building that could be used.
- Good service

In summary, there was a low response to the survey which, in itself may be an indication that there are not widespread concerns or issues following the closure of the Willows Medical Centre. As at 1st February 2017, the CCG had received no complaints or concerns about the practices most impacted by the closure of the Willows Medical Centre.

A significant minority of the patients that did respond to the survey felt that it had become harder to make an appointment following the closure of the Willows Medical Centre and around 30% of patients were not happy with the current level of access to their GP practice or wished to make a comment. To provide some context to these figures, the most recent results from the national GP Patient Survey found that around 25% of patients were not satisfied with their GP surgery opening hours and around 30% said it was not easy to get through to their GP surgery on the phone.

The majority of patients have not noticed a significant impact from the Willows Medical Centre closure, concern about access to GP surgeries appears to be at a similar level as is the case nationally and all bar one of the GP practices that have been most impacted by the closure of the Willows Medical Centre continue to register new patients.

Whilst the survey provides assurance that there has not been a significant impact on patients in Carlton's experience of primary care following the closure of the Willows Medical Centre, the CCG intends to re-run the survey again this autumn.

4) Additional Access - Supporting Winter Pressures

The CCG received additional funds in December to provide patients with increased access to support winter pressures. The practices in the Carlton area put in requests for these funds and the practices below were successful:

- West Oak Surgery
- Peacock Practice
- Westdale Lane
- Trentside Medical Practice

Initial data from practices confirmed that there were an additional 1,321 appointments available for patients during December and January. These appointments were a mixture of GP and Nurse Practitioner appointments.

5) Next Steps

The CCG is in the process of commissioning a Care and Quality in General Practice local enhanced service which provides investment to help GP practices to improve access to primary care across a range of indicators, including: telephone access during core hours, physical access to premises during core hours, same day appointments for urgent needs, making progress towards routine appointments within 3 working days and use of technology to book and provide appointments.

In responding to the GP Forward View, the CCG has updated its primary care strategy and action plan and will be working with all of our GP practices to address the issues that they are facing and improve the service they are able to offer to our patients.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

18 April 2017

Agenda Item: 5

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

SYSTEM WORKING TO IMPROVE EMERGENCY CARE

Purpose of the Report

1. To introduce briefing on urgent care resilience from Nottingham University Hospitals (NUH) and Nottingham CCG.

Information and Advice

2. Caroline Shaw, Chief Operating Officer, NUH and Nikki Pownall, Programme Director, Urgent Care, Nottingham City CCG will attend the Joint Health Committee to brief members on performance issues, quality and safety monitoring, winter pressures, the ongoing challenges faced by the commissioner and provider, the Emergency Care Improvement Programme, as well feedback from the Care Quality Commission inspection.

3. A briefing is attached as an appendix to this report.

4. Members may wish to focus their questions on what further improvements can be made to improve Emergency Department capacity, how strengthened system leadership & accountability can serve to improve performance, gaining clarity on the role of the A&E Delivery Board.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee consider and comment on the information provided.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

System working to improve emergency care

Caroline Shaw, Chief Operating Officer, NUH

Nikki Pownall, Programme Director, Urgent Care, Nottingham City CCG

March 2017

- Performance
- Quality & safety monitoring
- Winter
- Ongoing challenges
- Observations by Emergency Care Improvement Programme (ECIP)
- CQC Inspection feedback
- Looking ahead

- Questions

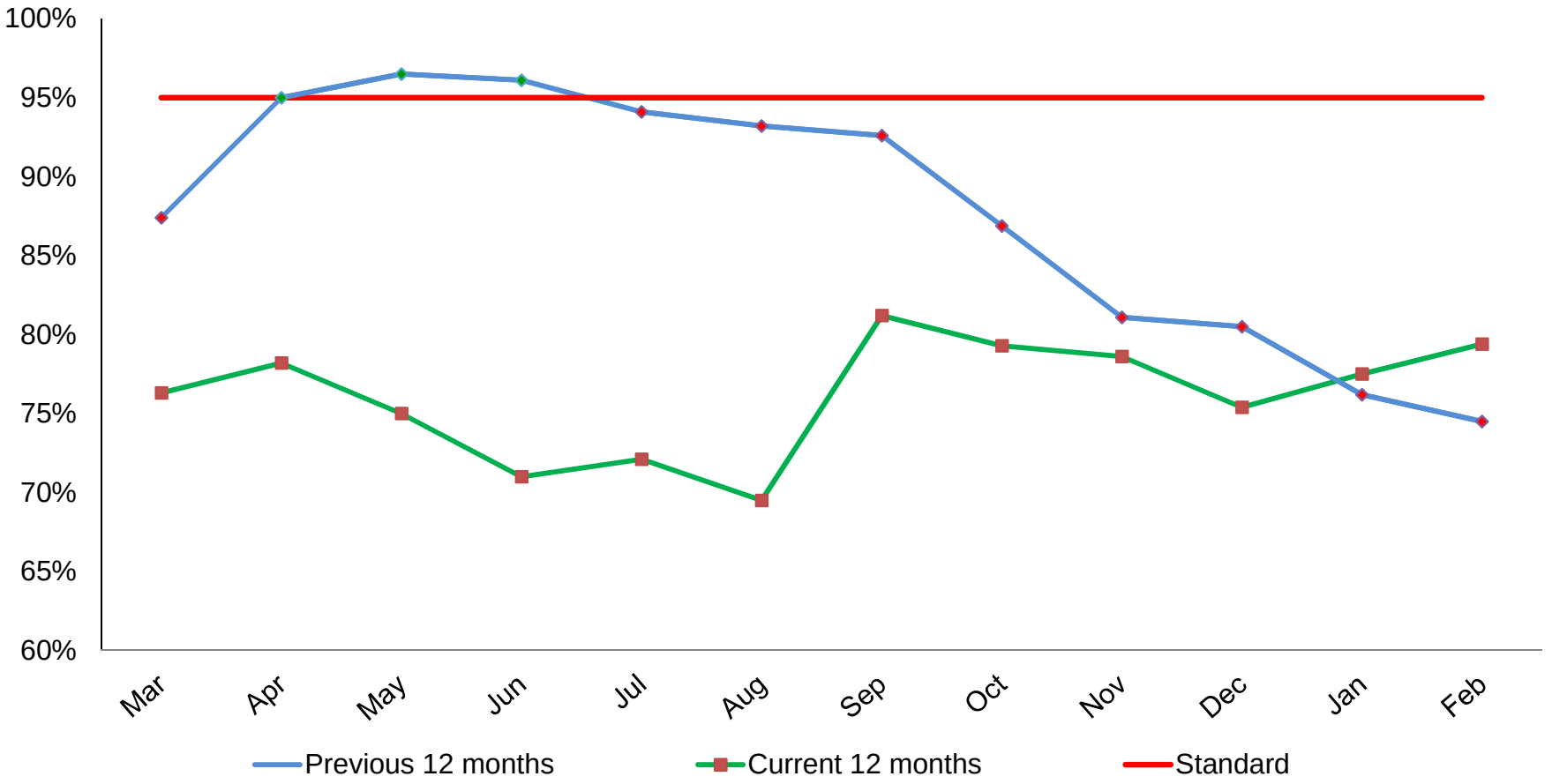
System performance

- Standard: at least 95% through ED in <4hrs
- 2016/17: 76.1% (at 10 March)

  Q1: 74.7%
  Q2: 74.3%
  Q3: 77.8%
  Q4: 78.3% (at 10 March)

- A&E attends up 1.9% (vs 15/16)
  - Average of 535 patients per day (10 more than 15/16)
  - Average of a patient arriving every 2.5 minutes

Through NUH A&E in <4 hrs



Quality, safety & performance monitoring

- 5 x 12 hour trolley waits YTD (9 in 15/16)
- RCA on all waits >8hrs
- Board & Quality Assurance Committee oversight (incl. mortality rates)
- Strong patient experience scores (friends & family test scores remain strong)

Winter: NUH

- 16 additional respiratory beds (Dec-Mar)
- Older Person's Assessment Unit at QMC (trial) – preventing c. 12 admissions weekly
- More primary care clinicians working at front door
- Reduced elective activity over Christmas & New Year: staff and beds used to support flow and discharge of emergency patients

Winter: Community

- Extra home care packages, capacity & reablement
- Healthcare of Older Person in-reach service

Winter: System

- **Flu jabs** (75% target for NUH & community)

NUH staff: 66% (vs 42.9% last year)

Community: Citycare 50%; Notts Healthcare Trust (incl CHP) 31.5%

- **Norovirus – bed/ward closures**

Pressures over Christmas and NY with 34 closed beds

Peak of 102 beds closed on 1 March. Late winter peak vs previous years

Christmas/NY stats

- Challenging December/early January

Christmas Day - 2 January, we admitted a patient every 7 minutes (395 more patients than we discharged)

2 Jan - we had the highest ever number of patients in our ED at one time – 180 patients (vs an average of 60-80 patients)

NUH CQC inspection report

- **CQC urgent & emergency care inspection: ('requires improvement')**

- **December 16' visit, February '17 publication**

- 'Good' for Caring
- Described improvements were required notably:
  - Streaming at front door
  - Named nurses for patients in middle of Blue Area
  - Tackling overcrowding in ED (including a medium/longer-term plan to increase capacity in ED)

Nottingham Citycare CQC Inspection Report

- ‘Outstanding’ overall rating (‘Outstanding for Caring)
- ‘Good’ for Safe & Effective domains
- November & December ‘16 visit, March ‘17 publication
- Included inspection of Urgent Care Centre (improvements identified), improved assessment times recognised

Ongoing challenges

1. Demand vs capacity
2. Staffing (ED)
3. Environmental constraints (overcrowding)
4. Consistency of internal processes
5. Delayed transfers of care for medically fit patients
6. System working

Emergency Care Improvement Programme's 'system diagnosis'

1. Assessment before admission
2. Today's work today
3. Home first/discharge to assess
4. Strengthened system leadership & accountability

Demand
'assessment before admission'

- Integrated urgent care (vanguard) project bringing together '111', mental health, urgent care centre, primary care and ED
- Improving ambulance turnaround
- Primary care at front door reducing admissions
- Older Person's Assessment Unit
- Strengthened streaming

Consistency of NUH processes
'today's work today'

- SAFER focus (incl pre-noon discharges)
- 2 x daily 'Gold' meetings
- Red & green days
- End PJ Paralysis
- Operations Room focus
- New technology for real-time bed/capacity management
- New Operations Director (flow/site management)
- Updated patient flow and escalation policies

Reduce Delayed Transfers of Care
'*home first/discharge to assess*'

- Home is 'default' not hospital
- A shared commitment to ensuring that patients do not go directly to long-term care from an acute bed
- SAFER rolled-out to community settings

  (incl. visibility of waits)
- Leaving hospital policy and associated patient information updated

System working
'*strengthened system leadership & accountability*

- A&E Delivery Board system oversight of performance. Attended by system leaders (Chaired by NUH CEO)
- System winter plan
- System escalation plan
- 1 shared vision for urgent care
- Moving from quick fixes and workarounds to sustainable change

Looking ahead

- It is critical that we have an Emergency Department, critical care and theatre facilities that are fit for purpose for the future

- Over the coming year we will begin important work with our clinical leaders and external partners to develop plans and business cases to create tomorrow's NUH

Questions

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
18 APRIL 2017
INTEGRATED COMMUNITY CHILDREN AND YOUNG PEOPLE'S HEALTH SERVICES PROGRAMME
REPORT OF CORPORATE DIRECTOR FOR STRATEGY AND RESOURCES (CITY COUNCIL)

ITEM 6

1. Purpose

1.1 To review the implementation and impact of the Integrated Community Children and Young People's Health Services Programme.

2. Action required

2.1 The Committee is asked to review the implementation of the Integrated Community Children and Young People's Health Services Programme; and identify if any further scrutiny is required.

3. Background information

3.1 In July 2016 the Committee became aware of concerns raised by some special school leaders about the Integrated Community Children and Young People's Health Services Programme, specifically changes to nursing provision within the new service model. Following discussions with commissioners and the provider, councillors were reassured that the concerns were being addressed directly with the schools concerned but the Committee decided to review implementation and impact of the new service model in due course.

3.2 A joint paper from commissioners and the provider about the implementation of the programme is attached and representatives from both the commissioners and the provider will be attending the meeting to discuss progress with the Committee.

4. List of attached information

4.1 The Integrated Community Children and Young People's Health Services Programme: Update Report for the Joint Health Scrutiny Committee

4.2 Nottinghamshire Children and Young People's Community Services Outcomes and Quality Framework

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

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Nottinghamshire Children and Young People's Community Services

Outcomes and Quality Framework

The vision is to enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met wherever they are. The services will support the child's life choices rather than restrict them and improve the quality of life for children and their families and carers.

This includes children and young people with the following overlapping needs:

- Life limiting and life threatening conditions and illness, including those requiring palliative and end of life care.
- Disabilities and complex conditions including those requiring continuing care and neonates.
- Long term conditions (this excludes the service/s delivered by condition specific Clinical Nurse Specialists based within Acute Trusts).
- Acute and short term conditions (requiring interventions over and above those provided by universal and primary care services, to avoid hospital admission and/or reduce length of stay).

The local outcomes and Quality Framework has been developed to reflect the Nottinghamshire Families' Statement of Expectations developed with young people and families in Phase 1 of the Nottinghamshire Integrated Children and Young People's Healthcare Programme.

The framework:

- Is based on the principle that effective outcomes will be achieved through a culture of shared values and learning, where continual improvement in the quality of work, service delivery and outcomes is everybody's business.
- Will enable goal setting and care delivery to be prioritised according to the needs of the child/young person and their family, rather than on activity targets.
- Describes minimum requirements and enables measurable progression/benchmarking over time which can be incentivised.
- Supports integration within and across organisation and service boundaries.

The ICCYPH service and quality and outcomes framework is underpinned by the domains of NHS outcomes framework and five year ambitions for improving those outcomes and particularly relevant to children and young people the shared ambitions of the "Better health outcomes for children and young people: Our pledge" 2013 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207391/better_health_outcomes_children_young_people_pledge.pdf)

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond ,will be high quality, evidence based and safe, delivered at the right time, in the right place by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be co-ordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

	ICCYPH Service Outcome	**NHS Outcome Domains**	**Applicable NHS 5-yr ambitions for improving outcomes**
1	Parents/carers are able to put being a family first and healthcare provider/s second. They are confident that they have the skills to care and advocate for their child through a genuine partnership with health professionals. Implicit in this is children, young people and their parents/carers are empowered to be involved in all decisions and are informed and supported.	2. Enhancing quality of life for people with long term conditions. 4. Ensuring people have a positive experience of care	2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital. 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
2	Children and young people will maximise their participation in statutory education.	2. Enhancing quality of life for people with long term conditions.	2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

	ICCYPH Service Outcome	NHS Outcome Domains	Applicable NHS 5-yr ambitions for improving outcomes
3	Children, young people and their parents/carers have easy access to quality up to date information in relation to their condition and its impact on everyday life.	4. Ensuring people have a positive experience of care	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
4	Children, young people and their parents/carers have easy access to prescribed supplies and equipment.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm	
5	Everyone involved in supporting the child/young person are involved, empowered and are working towards a continually improving shared plan and seamless care delivery.	4. Ensuring people have a positive experience of care	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
6	Every child/young person who needs care receives the care they need in a timely fashion.	1: Preventing people from dying prematurely	1: Securing additional years of life for the people of England with treatable mental and physical health conditions
7	Children, young people and their parents/carers have access to an appropriately trained, skilled and empathetic workforce who deliver care that meets the demand on the service.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm 4. Ensuring people have a positive experience of care	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
8	Young people and their parents/carers are supported to navigate the transition from childhood to adulthood/adult services and to understand the wider (including legal) implications of this. Implicit in this is that the developmental ability of the young person is taken into account and the NHS Transition Philosophy is adopted.	4. Ensuring people have a positive experience of care 2. Enhancing quality of life for people with long term conditions.	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community 2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

	ICCYPH Service Outcome	NHS Outcome Domains	Applicable NHS 5-yr ambitions for improving outcomes
9	As a result of empowerment of everyone involved in their care children, young people and their parents/carers experience positive changes.	4. Ensuring people have a positive experience of care 2. Enhancing quality of life for people with long term conditions.	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community 2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including
10	Children and young people are admitted to hospital or stay in hospital only when it is unsafe or inappropriate to care for them in the community. Implicit in this is consideration of the child/young person and their parent/carers' choice.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm 3: Helping people to recover from episodes of ill health or following injury	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
11	Children/young people are seen in age appropriate environments furnished and equipped to meet their needs, taking into account chronological and developmental age.	4. Ensuring people have a positive experience of care	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
12	The safety of the child/young person is paramount. This includes: a) Safeguarding b) Moving and handling c) Use of equipment d) Treatment and medications e) Psychological safety f) Relationships and Sexual Health g) Environment	5: Treating and caring for people in a safe environment and protecting them from avoidable harm	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Each outcome will be measured via a number of indicators/outcome measures listed below, which evidence the ICCYPH services contribution to their achievement.

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
1	The outcomes framework and indicators will be robust and meaningful and demonstrate the delivery of the services outcomes.	Annual plan with key milestones that includes engagement with commissioners, partners, CYPF.			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2	Outcomes tools/measures are used to identify outcomes or goals for CYP and measure progress towards these. *(including use of condition/discipline specific measures)*	Number and percentage of children and young people who: • have outcomes/goals identified • demonstrate progress towards outcomes/goals • achieve outcomes/goals within the planned timeframe To be broken down by outcome measure/ condition/discipline as appropriate. Feedback from CYPF, number and % who agree with the following: • 'My support is designed to help me do the things that I want to in life'			Y	Y				Y	Y	Y				Y
3	For CYP on the service caseload and/or those who are discharged to the service, paediatric acute	Provider report of repeat paediatric ED attendances.			Y	Y			Y	Y	Y			Y		Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
	attendances, admissions and length of stay are reduced where possible and appropriate.	Provider report of paediatric admissions. Provider report of length of stay. Number and % of families who have a plan in place to avoid unnecessary admissions.														
4	CYP with complex respiratory conditions have their needs managed in the community wherever possible	Number of avoidable admissions for acute respiratory episodes and infections.			Y	Y			Y	Y	Y			Y		Y
5	Up to date core information about CYPF will be recorded once and shared appropriately between professionals involved in their care..	Provider report or audit on use of information management and technology to support this indicator (in line with service specification) Provider sign up to Nottinghamshire Information sharing protocol Feedback from CYPF, number and % who agree that all professionals involved in the care of the child/young person has access to relevant core information so that they do not have to keep repeating it.			Y				Y	Y						Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
6	CYPF hold person-centred care plans and the workforce supports them to develop, review and amend these.	No and % of CYP with a shared or integrated electronic care plan CYPF feedback: • Proportion of CYP who report that their history and care plan was known and used by all involved in their care • Proportion of CYP who feedback satisfaction with use of the integrated electronic care plan			Y				Y	Y						
7	CYP/parents/carers: a. Have choice about where and when interventions are delivered. b. Have preference, opinions, and priorities taken into account in decision-making. c. Are involved in agreeing, delivering and evaluating the CYPs own outcomes. d. Have care plans which are signed and agreed by all.	Number and percentage measured via multi-disciplinary/multi-agency audit: • Randomised audit of 50 care plans *(detail tbc)* health care records which have been completed within the preceding 6 months • Randomised audit of 50 contributions to EHCP assessments/ requests for information within the preceding 6 months. • Feedback from CYPF			Y	Y			Y			Y		Y	Y	Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
8	Services are easily accessible including by CYP from a diverse range of backgrounds, reflecting local population ethnicity and diversity profiles.	Health equity audit on access to services is conducted by the provider and the findings are shared and acted upon. Implementation of You're Welcome quality criteria CYP feedback using the 15 steps challenge tool					Y	Y	Y					Y	Y	Y
9	Children, young people, parents and carers feel supported to manage their condition.	Number and % of children, young people, parents and carers, reflecting local population ethnicity and diversity profiles, feeling supported to manage their condition: • Who feel informed and have access to advice about their care or condition. • Who feel confident that their treatment or care plan is the best option to meet their needs. • Who feel they have a set of goals/outcomes relevant to them. • Materials are available and			Y	Y	Y		Y			Y		Y		Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
		appropriate for a range of diverse backgrounds and circumstances. • Materials are appropriate to the developmental level, circumstances and communication need of the child, young adult and parents														
10	Self-management strategies are identified within care plans (where appropriate)	Number and percentage measured via: • Randomised audit of 50 care plans *(detail tbc)*) health care records which have been completed within the preceding 6 months and Feedback from CYPF , number and % who agree with the following statement: • We have control over our own care: care is delivered *with* us			Y	Y	Y		Y			Y		Y		Y
11	CYP are assessed and referred for appropriate equipment and once received regular review of equipment takes place.	Number of CYP who are: • Assessed and referred for equipment e.g. equipment, orthotics, wheelchairs • Due for review						Y								Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
		• % review delivered on time														
12	CYPF are supported and trained to safely meet identified care needs.	Proportion of parents and carers (and CYP where appropriate) who report being confident in The interventions they are delivering • The equipment they are using • Moving and handling			Y							Y				Y
13	The needs of parents, carers and siblings are considered in the delivery of services.	Number and percentage of carer's assessments completed. Feedback from CYPF, reflecting local population ethnicity and diversity profiles, number and % who agree with the following: • 'We were supported to access community and family support organisations and activities'			Y							Y	Y			Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
		• 'We understand the process, we know who is involved and we know what is expected of all professionals within what timescales' (PREM from NNPCF)														
14	CYPF have a positive experience as possible at end of life.	Audit of a random sample of end of life care plans. Family feedback (at a time that is appropriate for the family): • Bereaved carer's views on the quality of care in the last 3 months of life (e.g. choice of place of care, standards of care)			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
15	CYPF are supported at the time of transition.	Number and % of families who have a transition plan in place from age 14. Number and % of families who have their transition plan reviewed and frequency of review. CYPF positive feedback on their experience of transition (at an appropriate time for the individual).			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
16	GP Practices have a linked/named ICCYPH worker with whom they have planned or regular contact.	Number and % of GP practices that have an identified named/linked worker. Feedback from stakeholders e.g. web survey: • Number and % of GP practices who know who their named/linked worker is. • Number and % of GP practices that have planned and/or regular contact with their linked/named ICCYPH worker. • Number and % of GP practices who report that ICCYPH services are co-ordinated, efficient and provide a timely response.						Y	Y	Y		Y	Y	Y		Y
17	CYPF have named workers.	Number and percentage of case load who have a named worker. CYPF feedback: Number and percentage of patients and carers who report that they know who the first point of contact or named worker was for all aspects of their care.			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
18	The relevant local authority are notified of CYP with special educational needs or disabilities (SEND).	Number and percentage of all CYP with identified SEND that are notified to local authority.		100%	Y	Y			Y	Y					Y	Y
19	CYP are supported to participate in education	Number and % of half days missed by pupils at Special Schools due to overall absence Feedback from special school staff that health input is delivered in a way that supports participation in educational activities e.g. golden hours			Y	Y		Y							Y	Y
20	CYPs emotional, mental health and wellbeing needs are identified and supported.	Number and % of CYP whose emotional, mental health and wellbeing needs are: • Identified • Supported • Improved/maintained following intervention *Measured by appropriate validated outcome tool/measures (including CYP perspective)*				Y	Y			Y	Y					Y
21	CYPF are supported to live healthier lifestyles	Number and percentage of patients appropriately given advice and			Y	Y	Y				Y		Y			Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
		information, brief interventions or referrals/signposting relating to healthy lifestyles (such as physical activity, healthy eating, smoking cessation/substance misuse, relationships and sexual health). CYPF feedback reflecting the above, including that they have been: • Offered information, advice and support on healthy lifestyles and behaviours. • That they understand the choices they can make to achieve a healthier lifestyle. • They have been supported to make positive changes and/or have increased confidence in making specific lifestyle choices.														
22	There is a proactive and systematic approach to continual improvement with a workforce empowered to suggest and test ideas.	Evidence of • Ideas put forward and tested using validated quality improvement tools and methods e.g. Plan, Do Study, Act (PDSA) cycle • Implementation of change in practice							Y		Y		Y			Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
		• Sharing of learning • Feedback to workforce and CYPF • Feedback from workforce that they are empowered and involved in continual improvement.														
23	Service user feedback is collected, analysed and used to inform service development.	Provider summary report on participation activity including: • Detail of focus groups, forums, public and CYPF participation in all aspect of service delivery • The proportion of patient complaints upheld resolved or acted upon satisfactorily • Demonstration of actions implemented in response to feedback e.g. physical evidence, change in practices/procedures, training and service development. • Evidence of working with commissioners and partners.							Y		Y		Y			Y
24	There is a reduction in the number of adverse experiences for CYPF.	Proportion of CYPF reporting adverse events or complications whilst under							Y		Y		Y			Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
		the care of ICCYPH service. Proportion of serious incident reports submitted within required timescales and to an acceptable standard Evidence of • Implementation of actions • Sharing of lessons learnt • Feedback to workforce CYPF from investigations of incidents Clinical audit programme which evidences learning from national and local audits. Evaluation of the patient safety culture of the organisation														
25	Referral, assessment and care delivery commences within identified timescales, including prioritisation based on clinical need where appropriate.	Number and percentage of referrals acknowledged within one working day of receipt of referral Number and percentage of face to face assessments that take place: • Within two calendar weeks of								Y						Y

			TBA	TBA	Outcomes (Impact weightings TBA)											
Ref	**Indicator/outcome measure**	**Evidence/data source**	**Freq-uency**	**Min**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
		receipt of referral. • Within 24 hours receipt of referral. Number and percentage of total referrals that are repeat referrals for the same child or young person within 12 months														
26	Review of 'Did Not Attends' (DNAs)	DNAs: • Number of DNAs (with reasons) • DNAs as percentage of total appointments								Y						Y
27	Where referrals of CYP are declined at point of referral CYPF are supported to access alternative services or support.	Number and percentage of referrals of CYP that are: • Declined at point of referral • Supported to access alternative service/s or support.								Y						
28	Where referrals of CYP are discharged at point of assessment CYPF are supported to access alternative services or support.	Number and percentage of referrals of CYP that are: • Discharged at point of assessment • Supported to access alternative service/s or support.								Y						

Nottinghamshire Children's Integrated Commissioning Hub

NHS

Nottinghamshire County Council

NHS Nottingham City Clinical Commissioning Group

The Integrated Community Children and Young People's Health Services Programme: Update Report for the Joint Health Scrutiny Committee

April 2017

1. Purpose of the Report

1.1 This report provides an update on the implementation of the Integrated Community Children and Young People's Health Services Transformation Programme, including main achievements and challenges over the first year of operations, and planned priorities for the next year.

2. Introduction and Background

2.1 The vision for the Integrated Community Children and Young People's Services Programme is to enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met wherever they are. The services will support the child's life choices rather than restrict them and improve the quality of life for children and their families

2.2 The programme was borne from a concern that a lack of co-ordinated support for children and young people with complex needs and disability and their families was leading to inequity of access and potential safeguarding risks. There were multiple providers and teams working to different processes, policies and procedures leading to duplication and lack of efficiency and effectiveness, which was having a negative impact on children, young people and families. There were too many acute and

emergency attendances and admissions for conditions that could be treated at home or avoided. Furthermore, children were staying in hospital for too long.

2.3 A joint programme between the Nottinghamshire County and Nottingham City Clinical Commissioning Groups (CCGs) to develop a new, integrated community health service for children and young people with additional needs and disabilities was established. The aim of the programme was ensuring streamlined access and co-ordinated assessment, treatment and review so that families experience a seamless service that is centred around the child / young person and family, promoting independence and quality of life. The programme sought to secure improved safeguarding outcomes, with children and young people and their families enabled to lead as normal a life as possible, with improved access and equity of service provision and with genuine choice for children, young people and their families.

2.4 The programme also sought to secure high quality, cost and clinically effective services with consistent staffing, and satisfied and highly motivated teams ensuring the right skills in the right place at the right time, every time.

2.5 Included within the programme were the following community health services for children with additional needs:

- Physiotherapy;
- Speech and language therapy;
- Occupational therapy;
- Special school and community nursing, including end of life care;
- Phlebotomy.

2.6 Following a full procurement, a contract was awarded to Nottinghamshire Healthcare NHS Foundation Trust, commencing from April 2016. Phase 3 of the programme – mobilisation and transformation commenced in October 2015, with the aim of delivering the following objectives:

- Mobilisation and transformation to an integrated model of care delivery.
- Co-production and collaboration between commissioners, the service provider, partners and children, young people and families.
- Family friendly name for service.
- Test, refine and baseline outcomes framework to effectively support the transformation and outcomes focused care delivery.
- Workforce development.
- Monitoring and continual improvement.
- Improved families' experience.

2.7 This report provides an update on progress against the objectives.

3. Progress update

3.1 Mobilisation and transformation to an integrated model of care delivery

3.1.1 A rapid period of change has enabled the new integrated services to be established early in year 1 of the implementation programme. Staff transferring from their previous employing organisations were supported to their new bases, and multi-disciplinary staff now work in integrated locality teams. All practitioners in the new service are now recording on a single system, which has enabled all children and young people to have an integrated care record and plan.

3.1.2 A single point of access to the service has been established – rather than patients or partners wishing to access community health services for children having to navigate a complex framework of services, this can now be done for all disciplines through a single phone call.

3.1.3 As part of the transformation of community nursing, the model requires that support be needs-led, rather than allocated to particular settings. The advantages of this approach are that the needs of children are met equitably and on the basis of clinical need rather than on the basis of what provision is available in their school or setting, and also enables the upskilling of nursing staff in localities through providing support to a wider range of needs and conditions.

3.1.4 Transitions from nursing services based at the Caudwell House setting has been positive, with colleagues in the service and within children's social care collaborating to ensure all staff within the home are competent to deal with the health needs of the children, that care plans are in place and that the expectations of each service are clearly agreed.

3.1.5 Concerns were raised by some special school leaders in both the County and City special schools regarding changes to nursing provision. Although most of the 14 special schools in Nottinghamshire had previously been supported by a needs-led community nursing service, in 4 schools (3 county and 1 city) nurses had previously been located on the school site. To ensure careful and collaborative resolution of issues emerging from this change, a joint forum between commissioners and providers of the health services and the special school heads was established. This forum now meets termly and has a terms of reference.

3.1.6 Due to specific concerns raised by Oakfield School, health profiling work was undertaken by a Public Health Consultant based in Nottingham City Council. This work is summarised as follows:

Demographics

There are currently[1] 154 pupils on Oakfield School roll which makes Oakfield School the largest special school in Nottinghamshire (including Nottingham City). The number of pupils has increased by 7% since 2010. Oakfield has a ratio of boys to girls of 1:1.5 (95/59).

48% (74/154) of Oakfield pupils are of early years and/or primary school age, 27% (41/154) are of secondary school-age and the remaining 29 pupils are post-16.

50% (77/154) of the pupils at Oakfield School are White British which is broadly in line with the Nottingham City figure of 47.7%. The next most common ethnicity is Pakistani, 12.3% (19/154) slightly higher than the Nottingham City figure of 11.2%.

Diagnoses

45% (70/154) of Oakfield pupils have diagnoses that fit under the broad diagnosis of neurodevelopmental conditions. This is broadly in line with the national picture (any reference to the source of this assertion?). The most common secondary diagnosis in Oakfield pupils is epilepsy with 25% (38/154) of pupils receiving this diagnosis. 62% (96/154) of Oakfield pupils have severe learning disability, see Figure 7, with a further 36% (55/154) having profound and multiple learning disabilities.

Health Needs

81% of Oakfield pupils need some assistance with eating, drinking and/or feeding. This is an increase from the proportion, 72%, identified as needing this assistance in the 2010/11 Special Schools Health Needs Survey (SSHNS).

22% (34/154) pupils require feeding via gastrostomy or NG tube.

The majority (86%) of Oakfield pupils require continence support; 60% (93/154) are doubly incontinent. This is an increase from the proportion, 72%, identified as needing this assistance in the 2010/11 Special Schools Health Needs Survey (SSHNS).

14% (21/154) of Oakfield pupils require suction or oxygen.

32% (50/154) of Oakfield pupils require support with their behaviour and/or emotional health.

59% (89/154) of Oakfield pupils use a wheelchair; a slight increase from the SSHNS figure of 58%.

45% (69/154) of Oakfield pupils need some support to maintain skin health.

[1] October 2016

Therapy Needs

58% (89/154) of Oakfield pupils have identified physiotherapy needs (figure 14). This is a decrease from the proportion, 65%, identified as having physiotherapy in the 2010/11 Special Schools Health Needs Survey (SSHNS). This finding does not reflect local intelligence which suggests pupils therapy needs are increasing and is therefore worth further exploration.

37% (57/154) have 3 or more identified physiotherapy needs.

49% (76/154) of Oakfield pupils have identified occupational therapy needs. This is a decrease from the proportion, 64%, identified as having occupational therapy in the 2010/11 Special Schools Health Needs Survey (SSHNS). Again, this finding does not reflect local intelligence regarding pupils therapy needs and is therefore worth further exploration.

24% (37/154) have an identified sensory need. The SSHNS does not enable an assessment on whether the proportion of pupils with this type of need has increased or decreased.

86% (133/154) of Oakfield pupils have an identified speech and language therapy need. This is a significant increase from the proportion, 71%, identified as having a speech and language therapy need in the 2010/11 SSHNS.

25% (38/154) are identified as having a 1:2:1 session with a speech and language therapist. The SSHNS does not enable an assessment on whether the proportion of pupils with this receiving 1:2:1 support has increased or decreased.

Continuing Care

To be eligible for NHS continuing healthcare, the individual must be assessed as having a "primary health need" and have a complex medical condition and substantial and ongoing care needs. The threshold is based on unpredictability, complexity and severity. When children and young people's complex needs cannot be met by specialist services then they can be considered for continuing healthcare.

5.8% (9/154) of Oakfield pupils have a continuing care package. This question was not asked in the data collection for the SSHNS so no assessment of change in need is possible. In addition, national data sources do not enable an assessment of whether this is higher than the national special school average.

A meeting was held on 31st October2016 to discuss the needs of Oakfield School and it was agreed that a protocol would be developed between the school and the nursing provider. This is due to be completed by the end of February 2017.

3.1.7 The service also provides information prescriptions through 'RECAP'. The e-learning platform, RECAP, enables clinicians to prescribe condition specific materials for

children and young people, such as therapy exercises. The content is audio visual enabling families to see and mirror practice in action, reviewing material as required and reducing clinician needs to retrain families and others. Material is supported by electronic leaflets, fact sheets, media clips and links to relevant websites. This e-platform is now being used by all services.

3.2 Co-production and collaboration

3.2.1 The transformation programme was co-produced with families, and the services are underpinned by the 'Families Statement of Expectations' – a commitment to the values and principles which children and families identified as important to them (attached as Appendix A).

3.2.2 Providers have worked closely with children and young people, families, carers and staff through focus groups and question sessions to rename the service which is now 'Community Children and Young People's Services' since November 2016.

3.2.3 Commissioners and providers have strengthened their collaboration through a monthly Ccollaborative Partnership Meeting, which provides a forum to work through emerging issues together, track progress against the transformation programme, explore performance and operations in detail and jointly agree next priorities. These feed into the contract meetings, and are viewed positively by both provider and commissioning colleagues.

3.3 Test, refine and baseline the outcomes framework

3.3.1 A comprehensive outcomes framework, aligned to the priorities identified by families in their 'Statement of Expectations' underpins the transformation programme, and is attached as Appendix B. To incentivise delivery against the outcomes, a local CQUIN (Commissioning for quality and innovation) has been developed and a process for evidencing progress against the framework to achieve incentive payments has been agreed , with 2.5% of the total contract value linked to achievement of outcomes in year 1, and 4% in year 2.

3.3.2 The payment incentives against the outcomes framework are attached to priorities, such as:

- Reduction in avoidable hospital admissions;
- Patient satisfaction with services;
- % patients with an integrated care plan;
- Timeliness of assessment and treatment;
- Feedback from stakeholders;

- Well planned transition to adulthood.

3.4 Workforce Development

3.4.1 A rapid period of change has resulted in NHFT carrying out organisational development sessions to support staff through this change and enabling staff to shape the new service.

3.4.2 A number of organisational development sessions have been undertaken within the new integrated teams including:

- Communication
- Working in an integrated way;
- Outcome measures.

3.4.3 Feedback from these sessions has resulted in the development of an internal newsletter for all staff. This has resulted in improved and more timely information. These sessions continue to be undertaken.

3.5 Monitoring and continual improvement

3.5.1 In addition to the incentivisation of continual improvement through the outcomes framework and CQUIN payments, performance and outcomes data are analysed and considered each month through routine contract management arrangements. Through this reporting and scrutiny, the following areas of progress and achievement have been identified:

- Excessive waiting lists and times to access speech and language therapy have been addressed, with waiting times for all patients are now within the 13 week target, and for most patients in all services a service specific ambition of 8 weeks is being achieved;
- 100% of patients now have an integrated care record;
- Children are spending less time in hospital;
- Patients have a named professional, whom the family knows;
- The number of referrals which are acknowledged within 1 day has increased.

- Patients who require a routine phlebotomy appointment are seen within 5 days and urgent appointments within 2 days
- Professionals within primary care are able to refer to the service electronically through the SPA.

3.5.2 The accuracy and completeness of data remains an area for development, which the service are prioritising so that plans for future years are based on accurate insights into current service activity.

3.5.3 A quality visit by commissioners was undertaken in November 2016. The visit involved focus groups with staff, home and school visits with practitioners, and interviews with service managers. The visit identified a number of strengths and areas of the service that are going well, including:

- There is plenty of appropriate staff supervision;
- Managers are listening – lots of favourable comments from staff about their managers;
- Managers know the service well, and are reflective – they know what is going well and what isn't;
- Where there are staff performance issues these are being addressed positively and assertively by managers;
- This is a huge transformation programme, and change is being delivered at a pace, with good engagement with both staff and commissioners;
- There have been many successes – locality working and management in place, SPA, growing own staff etc.;
- Nurses are very motivated – recently came from acute Trust and loved being able to share information in community and are relishing having ideas and being able to develop the service. Managers were not sure what they did but came out and watched them so now are appreciative of the role they fulfil;
- Practitioners are finding the new recording system to be beneficial;
- Change has been seamless for families;
- Staff feel listened to, and that managers are taking the time to learn about services;
- Mobile working is working well and enabling improved efficiency;
- The single point of access (SPA) is welcomed.

3.5.4 The quality visit also identified some current challenges for the service, which included:

- The changes have been stressful – initially communications wasn't great and there were problems with technology, however managers have spent time with the staff and listened and things are getting better.
- Some clinical procedures are inconsistent across NHFT and NUH;
- The services are still operating largely separately - as part of mobilisation managers were uncovering work which had been unnoticed, hidden or were creeping developments - these have taken priority to address;
- Physiotherapy vacancies are difficult to recruit to, due to lack of candidates, a national problem;
- Entrenched cultural issues and mindsets in some services are proving difficult to shift, although managers are addressing this robustly.

3.5.4 Commissioners made a number of recommendations which are now being acted upon, as follows:

- More work should be done to integrate functions, process and cultures across professional groups and services, in particular therapies with nurses.
- There are opportunities for services to learn from each other – for example, therapists are experienced in completing Education, Health and Care plans, but nurses less so. Therapists can share templates and approaches to support nurse colleagues.
- Strengthen ongoing communications with staff about how and why things are changing.
- Managers should routinely spend time on the frontline with services – where they currently do this it is appreciated by staff
- Maintaining and developing competency for newly appointed paediatric nurses around enteral feeding/IV care – linked protocols with NUH ideally to enhance seamless care across organisations.
- Clinical supervision of paediatric nurses and access to expertise to aid clinical decision making.
- Acknowledgement by both community staff and commissioners that there were lessons to be learnt around the mobilisation of the new contract – the lessons learned should be logged.

3.6 Improved Families' Experience

3.6.1 There are positive improvements in families experience being evidenced through the routine data collection and monitoring of the service. Some notable achievements are:

- The number of complaints has reduced (there have been none in since October 2016);
- 100% are satisfied with their electronic care plan, are involved in setting their own outcomes and report their history and care plan are well known by those involved in their care;
- 90% of families agreed that they have control over their own care and are involved in decisions about them.

3.6.2 Compliments on the service are also increasing. The following provides some examples of the compliments being received:

Information provision:

'*Thank you so much for the information you have provided. I now feel like I have a starting point!*' (parent mid Notts seeking nursery place for child with additional needs)

'*The information sent was really, really useful, there were lots of things he (child with disabilities) could do*'

Feedback comments on Drop In sessions

'*With regards to the meeting sessions I find them very useful, I think the sensory sessions are good and also the anxiety related ones, eating & sleeping sessions as I feel this affects nearly every parent & child*.'

'*I know not everything will be for myself or my son, but it's nice to go and support other parents and know you have that support as there is quite a lack of it* '

Personal Support with Disability Living Allowance Independence Payments (drop in provided by family action)

'*I had spent weeks on the form - once I saw the advisor the whole form was completed during the appointment - he knew the right boxes to tick*'

'*Good to speak to someone who knew what they were doing, added reassurance that we were doing it right*'

'*Appointment very helpful - I was stuck on a few questions and it made it clear what we needed to write*'

Authors:

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Appendix A ICCYPH Programme Families Statement of Expectations

Our values are…

- Respect
- Collaboration
- Continual improvement

1. “No decision about me without me”.

We are consulted and listened to, heard and treated with respect as experts on our/our own child’s condition and have our views taken into account at all times.

2. Access to information and supplies.

We can easily get information, advice and guidance, and the services and supplies that we need, when we need them, so that our family can enjoy the best possible health and fulfilling lives. This should enable and support our roles, lifestyle choices and aspirations.

3. Whole systems working.

There is collaborative, joined up and timely planning and service delivery, with all parts working as a whole across all organisations and agencies involved in every aspect of our children’s care.

4. Child/young person centred care.

Every child/young person is treated as an individual.

5. Communication and record sharing.

There is timely communication and shared documentation including core essential information about our children, their condition and their support between all those who need to be involved.

6. Capacity, competency and empathy.

We are confident that there are enough staff, who have the right knowledge, skills and expertise for what they are there to do, and they demonstrate this by empathy and understanding in all contacts.

7. Transition.

Children/young people are supported to achieve responsibility for themselves as adults and the family is supported during this period of transition to adulthood and reduced dependence on the family.

8. Continual improvement.

We can see that everyone involved in our children's care is committed to continually improving what they do.

9. Care environment.

Children/young people are seen in age appropriate environments furnished and equipped to meet their needs, taking into account chronological and developmental age.

10. Safety.*

At all times our children are protected from harm.

*Please note this is wider than safeguarding - consider points such as moving and handling training for parents, safe use of equipment etc.

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
18 APRIL 2017
WORKFORCE CHALLENGES – IMPROVING RECRUITMENT OF THE MEDICAL WORKFORCE TO THE EAST MIDLANDS
REPORT OF CORPORATE DIRECTOR FOR STRATEGY AND RESOURCES (CITY COUNCIL)

ITEM 7

1. Purpose

1.1 To receive an update on work being led by Health Education England East Midlands to improve recruitment rates in the region, with a particular focus on Nottingham and Nottinghamshire.

2. Action required

2.1 The Committee is asked to review the effectiveness of work taking place.

3. Background information

3.1 Through its work the Committee frequently hears about challenges in recruiting and retaining sufficient medical, nursing and allied health professionals in health and social care services in Nottingham and Nottinghamshire.

3.2 In January 2016 Health Education England East Midlands spoke to the Committee about what is happening at a national level and locally to address workforce challenges. While many of the pressures are being felt nationally, Health Education England East Midlands reported that students report that the East Midlands isn't attractive to them. The Committee felt that there was potential for City and County Councils work with their partners, for example Marketing Nottingham and Nottinghamshire to support Health Education East Midlands to promote the East Midlands as a place for health professionals and students to train and work. This recommendation was sent to colleagues within the City and County Councils and they were put in touch with representatives of Health Education East Midlands.

3.2 Health Education England East Midlands has been invited back to update the Committee on work that has taken place over the last year to improve recruitment and retention of students and professionals in the East Midlands.

4. List of attached information

4.1 Report on 'Health Education England Working For The East Midlands – Improving Recruitment of the Medical Workforce To The East Midlands'

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 Report to and minutes of meetings of the Joint Health Scrutiny Committee held on 12 January 2016.

7. Wards affected

7.1 All

8. Contact information

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Report on behalf of Dr Jonathan Corne, Head of the Postgraduate School of Medicine and Chair of the East Midlands Heads of Schools, Health Education England - Working Across The East Midlands

Report to	**Nottingham and Nottinghamshire Joint Health Scrutiny Committee**
Date:	**April 2017**
Subject:	**Health Education England Working for the East Midlands – Improving Recruitment of the Medical Workforce to the East Midlands**

Summary:

Health Education England's remit and function across the East Midlands is to:

- Provide national leadership on planning and developing the healthcare workforce
- Promote high quality education and training that is responsive to the changing needs of patients and local communities, including responsibility for ensuring the effective delivery of important national functions such as trainee national recruitment
- Ensure security of supply to the health and public health workforce
- Allocate and account for NHS education and training resources and the outcomes achieved

Health Education England - Working Across the East Midlands (HEE-EM) has been concerned for some time with the difficulties in filling training (junior doctor) posts which is leading to subsequent difficulties in filling consultant and general practitioner posts within the region. HEE-EM has already taken a number of actions that have improved local recruitment rates. HEE-EM realises that a sustainable solution requires interventions at a number of levels and, through a stakeholder group, are working with a number of partners to develop both short and long-term sustainable solutions.

Action Required:

The Health Scrutiny Committee for Nottinghamshire is asked to;

1. Consider and comment on the contents of the report.
2. Encourage local agencies to work with the HEE-EM to facilitate the implementation of its strategy.

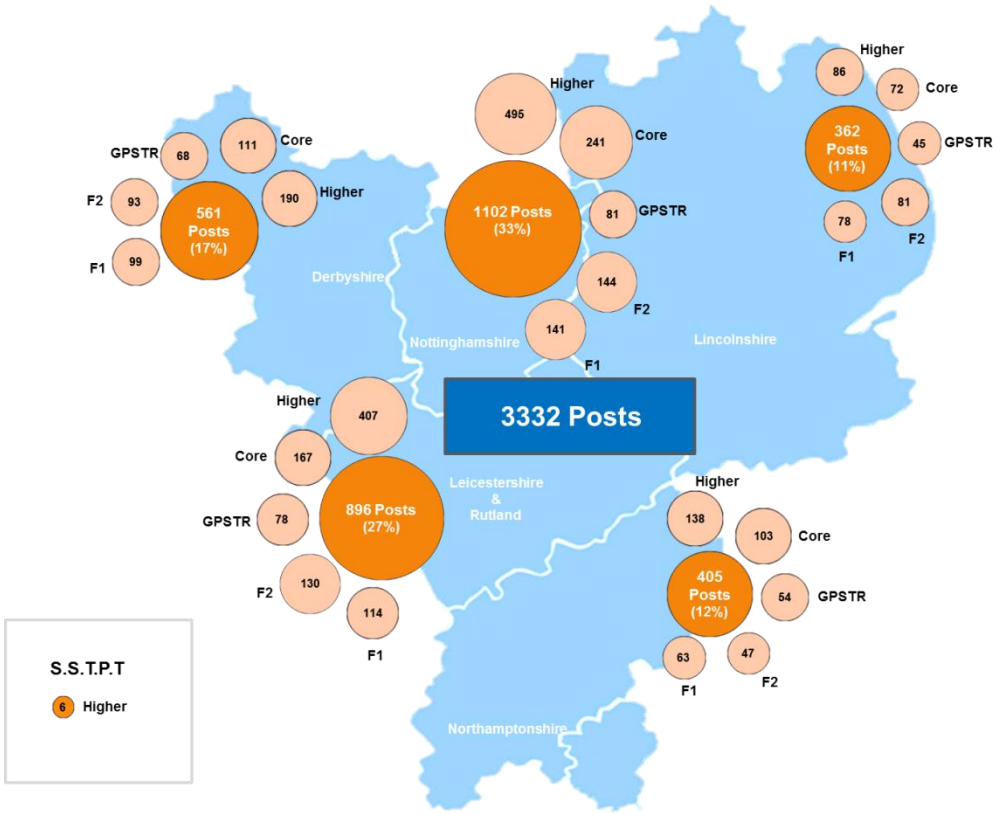
1. Background

Health Education Working for the East Midlands (HEE-EM) is part of Health Education England (HEE), a non-departmental public body constituted to train the future healthcare workforce. This includes non-qualified staff, nurses, associated health professionals (AHPs) and Doctors.

Health Education England receives £5 billion annually to train Healthcare staff across England. From this total, HEE receives approximately £360 million to train staff in the East Midlands.

From the East Midlands total, Nottinghamshire receives £64 million funding via the established learning development agreements negotiated with the County's trusts/providers.

The total number of medical trainees for the East Midlands as a whole, and the numbers designated for Nottinghamshire, are shown in figure 1.



Following graduation, medical graduates enter a two year foundation program, learning generic skills, and then progress to core training (generally two years) and higher specialty training (generally five years) before becoming consultants. In general practice, trainees undertake a three-year program following completion of the foundation program, before becoming partners or salaried GPs. Most of our training programs are East Midlands based, rather than being specific to a general practice or a hospital. In some cases, for example the foundation program, programs are divided into North (Nottinghamshire, Derbyshire and Lincolnshire) and South (Leicester, Northampton and Rutland) rotations. The East Midlands struggles to fill its training places at all levels in both primary and secondary care. For 2015, only 56.4% of primary care training places were filled with fill rates in secondary care varying from 58% for psychiatry and 79% for medicine to 81% for anaesthetics and 92% for obstetrics and gynaecology. This difficulty in filling training posts leads to problems with recruitment at consultant and general practitioner level.

Poor recruitment rates to postgraduate schools within HEE-EM are an ongoing problem and present a risk both to the quality of education and training experienced by our current trainees, and to service provision both now and in the future. The importance of filling all our training posts is obvious, but we should aspire to do more than this and ensure we are also able to attract some of the best trainees from around the country.

Medical trainees provide an important service element. Most on-call rotas in secondary care are staffed by trainees (with consultant supervision), and unfilled posts lead to gaps in the acute rota, impacting on the efficiency and potentially the safety of the service. In addition, a majority of trainees will stay within East Midlands and become consultants or general practitioners within the area. A lack of trainees has

resulted in unfilled consultant and GP posts with a significant impact on service provision and a knock on effect on the quality of training resulting in a vicious cycle – fewer consultants and GPs results in poorer supervision for trainees and reduces further our ability to recruit to the region.

The recruitment of trainees to the East Midlands brings a wider economic benefit. The minimum salary of a core trainee is £31,000 whereas the salary of a higher specialty trainee is between £35,000 and £47,000. Trainees who have established a base in the East Midlands make a significant contribution to the local economy. They are high earners, buying and investing in property, and potentially building local roots through involvement in local and religious groups, sports groups and other activities. Should they take up consultant or GP posts, they will contribute to a pool of economically successful practitioners (the GP and consultant salary ranges between £75,000 and £175,000). This group of fully established and settled practitioners makes additional contributions to the region, for example, as school governors and through voluntary organisations.

Nottingham is successfully developing a profile as a bio-science centre. This is an area where medical trainees and practitioners can make a significant contribution. Pharmaceutical, clinical trial and biotech companies are attracted to areas that have major teaching hospitals with a full complement of well trained, experienced consultants. Postgraduate medical trainees often spend up to three years undertaking medical research – something that has been encouraged by the recent development of the East Midlands Postgraduate School of Academic Medicine. During this period they make a vital contribution to the research portfolio of the medical schools within the region, and significantly enhance the ability of our medical schools to undertake the cutting edge research they are known for, which is a major driver to bio-science investment within the region.

2. The Stakeholder Group

Since most medical graduates will apply to an East Midlands program, rather than one based entirely in Nottingham/Nottinghamshire, an East Midlands approach is needed. Any intervention to improve recruitment will need to be targeted at a number of levels, starting at secondary school/college level, where there is a need to promote medicine as a career to those that may not naturally aspire to it. This focus needs to continue into medical schools, where there is a need to retain graduates within the region, and also concentrate on encouraging those graduates from outside the region to consider East Midlands as a place to live and work.

To facilitate such an approach HEE-EM has set up a stakeholder group with representatives from D2N2, Leicester City Council, Lincolnshire County Council, Leicester and Nottingham Medical Schools, primary and secondary care representatives, industry representative and student and trainee representatives. Full membership of the group is given in appendix one. The group has agreed on an overall strategy that involves intervention at secondary school, medical school and early postgraduate training, as well as a shared approach to promoting the region and our training programs to those currently outside the area. This strategy is partly based on research work commissioned by HEE-EM.

3. Intervention at Secondary School Level

A common theme in both the East Midlands commissioned and national studies is the desire of trainees to work in areas close to family and friends. Medical students who grow up the region of their medical school are more likely to go on to further training locally than their non-local peers, in one study, 34% of doctors were undertaking postgraduate specialty training in the region of their family home. In depth interviews with students from both Leicester and Nottingham showed that being close to family and friends was a predominant factor when choosing a foundation program, and those with family outside the region were far more likely to secure foundation posts elsewhere.

Increasing the number of medical students recruited from the East Midlands would increase the likelihood of graduates remaining in the region for foundation and higher level training, or returning to the region after foundation training elsewhere.

Currently, the majority of medical students in the East Midlands come from family homes outside the region. This is probably a combination of the national and international reputation of the medical schools, attracting applicants from across the country, but also because the demographics of the region make medicine a less obvious career choice for students in secondary school. Nationally, only 1% of medical students come from the most disadvantaged backgrounds and the region has a higher proportion of residents from these backgrounds than the national average.

The overall vision, agreed by the stakeholder group, is to intervene in state and academy schools to pro-actively encourage school students to think about medicine and to further encourage those students by offering work experience in both primary and secondary care. Work experience placements would act as an opportunity to identify those with the necessary promise and aptitude, who can then be mentored by existing medical students and prioritised for inclusion into the relevant additional educational programs provided by the medical schools.

The stakeholder group is working with Futures (the careers advice service), the medical schools and a media company procured by HEE-EM to produce material that can be shown in schools to encourage pupils to aspire to a career in medicine. This will also form part of a social media campaign and be accompanied by the necessary resources for teachers. A focus group for teachers has been arranged, through Futures, for 26th April 2017. HEE-EM has contributed to the production of the D2N2 Health and Social Care Online Handbook and is working closely with the Futures medical ambassador program.

Directors of medical education within secondary care trusts will work with their organisations to change the nature of work experience programs, and target them at state school students recruited through our aspiration campaign. They will also encourage trusts to use these schemes as a way of identifying those students with potential, and we will put in place pathways whereby these students can be flagged up to the medical schools. A similar process will happen in general practice. One barrier to increased provision of work experience in general practice is the need for GP practices to provide the necessary induction, for example basic training in confidentiality and information governance. The stakeholder group is exploring ways in which this can be funded and supported centrally.

Both Nottingham and Leicester medical schools offer a range of initiatives aimed to encourage secondary school students to apply for medicine as part of their widening access scheme. Similar schemes for non-medical professionals are also run in the region. The stakeholder group has agreed to share and build on best practice, promoting across the regions those schemes with the greatest impact. In addition, the medical schools have agreed to work closely together, for example, exploring the sharing of back office costs to increase efficiency and ensure sustainability of the increasing access courses that they run. The group has also secured the support of the medical student societies to widen the provision of mentoring for school students aspiring to medicine.

4. Intervention at Medical School.

A key aim will be to increase the number of Nottingham and Leicester medical students who remain in the region for foundation training. Currently, only 40% of graduates from Nottingham (and 19% from Leicester) stay on to do foundation training in the East Midlands. A study commissioned by HEE-EM identified the combination of quality of clinical rotations, social opportunities, reputation of training hospitals, postgraduate teaching, clinical experience and availability of postgraduate training posts as important factors in determining selection of foundation program.

The East Midlands has in fact a lot to offer with regard to opportunities for city life, the reputation of our training hospitals and the teaching and clinical experience available. Our region includes the vibrant cities of Nottingham and Leicester, many of our hospital departments have national and international reputations, the breadth of clinical experience compares favourably to other programs and teaching is generally well organised. The challenge is to make our medical students fully aware of the opportunities on offer and the benefits of continuing their training in the region.

Traditionally, careers advice within medical school has focussed on which branches of medicine are most suitable for individual students. The stakeholder group has agreed that careers advice should also be an opportunity to promote careers, and the opportunities available, within the East Midlands. Medical school careers fairs will be held at a time when students are contemplating where to undertake the foundation program and include sessions and stalls promoting the East Midlands.

The group has also agreed for HEE-EM to work with pre-clinical and clinical tutors to make them aware of the career opportunities within the region and for tutors to play an active role in promoting the region amongst medical students. In addition, medical schools will ensure that locally based national opinion leaders take an active part in medical student teaching, showcasing the region as playing a leading role in health care delivery, organisation and research.

Our locally commissioned study suggested that student experience was a major influence on students' final choice of destination. Experience during all parts of their rotations was important, since they would be applying to East Midlands-wide foundation programs. Student suggestions for improving this experience included free or discounted membership of health clubs, on-site or free parking, and a comprehensive travel expenses policy for students who have to work in placements outside Nottingham or Leicester.

5. Intervention at Foundation and Core Training

Less than a third of our trainees apply for further training within the East Midlands. Research nationally suggests that the major factors affecting choice of training location are good working conditions, good opportunities for trainees' partners and desirability of location.

A trainee's foundation post will be their first experience of working conditions, and indeed postgraduate training, within the East Midlands. The stakeholder group is working with the providers of training to ensure that the importance of a good working environment is appreciated and hospitals offer not only a good clinical experience and formal teaching but also a good quality of accommodation (available inside and outside the hospital), doctors' mess, and access to IT and other facilities. Previous local research has suggested that trainees are attracted by 'local offers' - for example discounted membership of health clubs.

A key theme at all levels of postgraduate training, in particular at foundation and core training, is embedding our trainee doctors into the community and breaking the bubble that often surrounds them. Trainees need to be aware of the opportunities their region can offer ('a great place to live') but also develop social links that take them outside the medical community and integrate them into the region. The stakeholder group has agreed to explore the free use of local arts venues to host postgraduate medical education events, making trainees aware of the cultural offer of the region. Teaching events can be used to highlight the benefits of the region, using them, for example, to distribute programs of local theatres, concert halls and arts cinemas. The stakeholder group will be exploring wider professional networks that medical trainees could be encouraged to join. There are a number of relatively inexpensive measures that could be taken to make trainees feel welcome to the area, for example discounted membership of health clubs.

We need to encourage trainees to form links with other local professional groups. We have previously explored linking trainee doctors within the region to other professional networks and will be looking to support and encourage the development of these links.

Foundation trainees also need to be aware of the opportunities the region can offer them as they progress through their career. This year, HEE-EM ran for the first time a Foundation Careers Fair which attracted around 300 trainees. This was aimed at encouraging them to stay within the region and involved postgraduate schools and primary, secondary and mental health trusts. In future we would like to work closer with local authorities to use these events to promote the region as a place to live.

Trainees should also be aware of the medically related activities occurring outside the hospital and university. Nottingham, for example, is a core science city with a lot of pioneering medical research – not just within the University. Links with biotech companies, for example Biocity, could be formed and used to enhance training opportunities and widen research opportunities for our trainees.

6. Attracting Graduates from Outside the Region

The East Midlands should aspire to be one of the top places for education and training and to do this, as well as retaining our own graduates, we need to attract medical graduates from outside. This presents a number of challenges; the geography of the East Midlands is poorly understood by those outside the region and the lifestyle advantages, for example good schools, low house prices, not fully appreciated. At the later stages of training (the point at which many would consider moving region) may trainees will have non-medical partners and the opportunities available to them will often not be appreciated.

Last year, HEE-EM took a number of measures to improve its profile with the redesign of our website and the launch of a number of promotional videos. Our introductory video 'let your career start here' has had over 36,000 hits with our more detailed living, working and learning in the East Midlands videos having between 2,100 and 3,800 hits. Early data suggests that this has been effective – applications, for example for Core Medical Training last year increased by 25% compared to a fall nationally of 7%, and there was a similar picture with applications for general practice.

HEE-EM will continue to enhance its profile through further developments of our website. This year we will be extending our range of promotional videos, launching videos on fellowship opportunities and research opportunities. We are also widening our educational remit and producing on-line educational material, with the East Midlands branding, aimed at trainees across the country. This has been adopted by the postgraduate school of surgery, which has produced a number of educational podcasts, some of which have had over 8500 you tube views and over 1000 iTunes downloads. We are also exploring other social media platforms, for example Linkedin, which has recently being promoted by NHS Employers as a platform for recruitment.

National studies have shown that the destination of medical graduates depends, not just on their needs, but on the aspirations of their partners and family. Around half of medical graduates are married to non-medics and the region must serve the needs of both. Any package designed to promote the region to medical graduates must also promote it as an ideal base for other professional groups. HEE-EM has secured funding for the creation of a 'professional prospectus video', which will be hosted on our website, but also form the basis of a social media campaign. The stakeholder group has agreed to support this campaign by facilitating links with key companies and organisations in the various cities and counties within the region. Through the stakeholder group, we will be linking with local place marketing organisations to promote the region as a place to live as well as a place to work.

A number of trainees with an academic interest will be attracted to an area that is known for cutting edge research and technology. We should promote the achievements of our medical schools, but also some of the research being undertaken outside the university sector, for example at Medicity and Biocity in Nottingham as well as some of the clinical trial companies.

Many Nottingham and Leicester graduates who have left the region for foundation and core training could potentially be attracted back, after having gained the experience of life outside the East Midlands. The stakeholder group have secured the agreement of the medical school to explore whether the alumni networks could be used as a way of promoting medical careers opportunities in the region to medical alumni, for example by using well established phone campaigns.

7. Summary

HEE-EM has already taken a number of measures to increase recruitment to the region. These include;

1. Significant improvements to our website
2. The commissioning of a number of promotional videos and an associated social media campaign.
3. Holding a well-attended foundation careers fair.

HEE-EM appreciate that a sustainable solution involves a contribution from a number of stakeholders. We have therefore set up and are leading a stakeholder group that has so far agreed to take the following actions;

1. Implement our agreed overall vision for increasing the recruitment of local school students to medicine.
2. Produce a video and social media campaign aimed at raising the aspirations of local secondary school students.
3. Share resources to allow the most efficient and effective delivery of widening access initiatives, sharing best practice and where appropriate, sharing back office costs.
4. Work with medical student societies to further develop mentoring opportunities for sixth formers.
5. Work with primary care and secondary care trusts to focus work experience to benefit students from the state sector and identify those students with potential.
6. Explore possible funding and support for a centrally delivered induction session for students undertaking work experience in secondary care.
7. Ensure medical schools to use career events to promote career development in the East Midlands and that HEE-EM works with clinical and pre-clinical medical student tutors to enable them to promote opportunities within the region to their students.
8. Work with trusts to improve working and living environments for foundation trainees.
9. Explore the free use of local facilities, such as theatres and arts cinemas, for postgraduate teaching events.
10. Produce a professional video prospectus, involving key professional sectors across the sector.
11. Promote the growing health sciences sector in the East Midlands to potential trainees.
12. Work with place marketing organisations to help promote the region as a place to live, as well as work.
13. Use alumni networks to promote the medical careers opportunities in the region.

This report was written by Dr Jonathan Corne, Head of the East Midlands Postgraduate School of Medicine and Chair, East Midlands Heads of Schools, Health Education Working for the East Midlands, who can be contacted via jonathan.corne@hee.nhs.uk

Appendix One – Membership of the Stakeholder Group

Ashreen Seethal	Careers Inspiration Manager, National Careers Service.
David Browning	Director, MediCity.
Jonathan Corne	Head of School of Medicine, Health Education England (East Midlands).
Justin Brown	Director, Economic Regeneration, Lincolnshire County Council.
Kieran Sharrock	Medical Director, Lincolnshire Local Medical Committee (LMC).
Mandy Hampshire	Clinical Associate Professor, Faculty of Medicine & Health Sciences, University of Nottingham.
Mike Dalzell	Director of Tourism, Culture & Investment, Leicester City Council.
Olivia Macnamara	Student Representative, University of Nottingham.
Owen Harvey	Partnership Manager, N2 Skills and Employment.
Richard Holland	Dean of Leicester Medical School, University of Leicester.
Stuart Young	Executive Director, East Midlands Councils.
Sue Carr	Director of Medical Education, University Hospitals of Leicester.

Appendix Two – Website Links

Health Education England – Working for the East Midlands You Tube Site – This site contains our promotional videos.

https://www.youtube.com/watch?v=gaJ_Z6qXi24&list=PLFgK0eLmts60bUgrWPqpvXiBSAlpuPAiM

Health Education England – Working for the East Midlands Website

https://www.eastmidlandsdeanery.nhs.uk/

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
18 APRIL 2017
CONSULTATION ON PROPOSALS FOR CONGENITAL HEART DISEASE SERVICES – DRAFT RESPONSE
REPORT OF CORPORATE DIRECTOR FOR STRATEGY AND RESOURCES (CITY COUNCIL)

ITEM 8

1. Purpose

1.1 To agree the Committee's response to the NHS England consultation on proposals for congenital heart disease services.

2. Action required

2.1 The Committee is asked to approve its response for submission to the NHS England consultation on proposals for congenital heart disease services.

3. Background information

3.1 In March 2016 the Committee heard from the Congenital Heart Disease Programme Director and the Regional Clinical Director (Midlands and East) Specialised Commissioning from NHS England about NHS England proposals for the future provision on congenital heart disease services, which includes a proposal to cease surgical and interventional cardiology for children and adults at University Hospitals of Leicester NHS Trust (UHL). This is the provider to which the majority of Nottingham and Nottinghamshire patients requiring these services are referred to.

3.2 At that meeting the Committee also received a presentation from Dr Aidan Bolger, Head of Service East Midlands Congenital Heart Centre and Stephen Ward, Director of Legal and Corporate Affairs from University Hospitals of Leicester about UHL's perspective on the proposals.

3.3 The Committee had opportunity to ask questions of the representatives from both NHS England and UHL and consider the written information provided.

3.4 Public consultation on the proposals runs until 5 June 2017. Representatives of NHS England informed the Committee that a decision will be made by the NHS England Board in autumn 2017.

3.5 Based on the information and evidence available to the Committee and discussion at the Committee's meeting on 14 March, a draft response to the consultation has been prepared and is attached. The Committee is asked to agree the response that it wishes to make so that it can be submitted before the consultation closes.

4. List of attached information

4.1 Draft response from the Nottingham and Nottinghamshire Joint Health Scrutiny Committee to the NHS England consultation on proposals to implement standards for congenital heart disease services for children and adults in England

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 Reports to and minutes of meetings of the Joint Health Scrutiny Committee held on 13 September 2016 and 14 March 2016

6.2 Proposals to implement standards for congenital heart disease services for children and adults in England – Consultation Document

6.3 Equalities and Health Inequalities Impact Assessment

6.4 NHS England Provider Impact Assessment Report

7. Wards affected

7.1 All

8. Contact information

Jane Garrard, Senior Governance Officer, Nottingham City Council
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

PROPOSALS TO IMPLEMENT STANDARDS FOR CONGENITAL HEART DISEASE SERVICES FOR CHILDREN AND ADULTS IN ENGLAND

RESPONSE OF THE NOTTINGHAM AND NOTTINGHAMSHIRE JOINT HEALTH SCRUTINY COMMITTEE

Meeting the standards

1. In what capacity are you responding to the consultation?

- ☐ Current CHD patient
- ☐ Parent, family member or carer of a current CHD patient
- ☐ Member of the public
- ☐ CHD patient representative organisation
- ☐ Voluntary organisation / charity
- ☐ Clinician
- ☐ NHS provider organisation
- ☐ NHS commissioner
- ☐ Industry
- ☐ Other public body
- ☑ Other

If other, please specify.

The Nottingham and Nottinghamshire Joint Health Scrutiny Committee is a Health Overview and Scrutiny Committee, constituted in accordance with relevant legislation. Nottingham City Council and Nottinghamshire County Council have delegated their statutory health scrutiny powers to this Committee for matters which impact on both the areas covered by Nottingham City Council and Nottinghamshire County Council. The Committee is made up of councillors from both local authorities.

The Committee considers the proposals to be a substantial variation of service for the residents of Nottingham and Nottinghamshire and is responding to the consultation in accordance with its role, as set out in legislation, in relation to substantial variations or developments of health services.

2. *In which region are you based?*

- [ ] Not applicable/regional/national organisation
- [ ] England – North East
- [ ] England – North West
- [ ] England – Yorkshire and The Humber
- [x] England – East Midlands
- [ ] England – West Midlands
- [ ] England – East of England
- [ ] England - London
- [ ] England – South East
- [ ] England – South West
- [ ] Scotland
- [ ] Wales
- [ ] Northern Ireland

3. NHS England proposes that in future Congenital Heart Disease services will only be commissioned from hospitals that are able to meet the full set of standards within set timeframes. To what extent do you support or oppose this proposal?

- ☐ Strongly support
- ☐ Tend to support
- ☑ Neither support or oppose
- ☐ Tend to oppose
- ☐ Strongly oppose

4. Please explain your response to question 3.

The Committee neither supports nor opposes this statement because it does not consider that this is actually what is being proposed and that the standards are not being applied in a fair or equitable way.

None of the providers who, under the proposals, will be commissioned to provide Level 1 congenital heart disease services currently meet all of the proposed standards and there is an inconsistent approach being taken as to whether they will meet the standards within set timeframes. It is proposed that Level 1 services will continue to be commissioned from Newcastle upon Tyne Hospitals NHS Foundation Trust even though it is acknowledged that it will not meet key standards within the set timeframe. One of the standards that it will not meet is the required caseload which is the same standard that NHS England states that University Hospitals of Leicester will not meet within the set timeframe. Presumably, if NHS England is willing to continue commissioning from Newcastle despite it not reaching the required caseload then it does not consider that this will harm patient safety or have a negative impact on patient outcomes. If a lower caseload will not harm patient safety in Newcastle then it is not clear why NHS England considers that it will do so in Leicester. Alternatively NHS England is willing to commission a service for patients in Newcastle that is inferior to that in other areas of the country. Either way this inconsistency in approach is unfair for patients.

If an exception is being made to allow continued commissioning at Newcastle while NHS England works with them to deliver the standards within a different timeframe it is unfair not to allow a similar exception for Leicester to have additional time and support to meet the required standards.

While NHS England has stated that it does not consider that University Hospitals of Leicester will meet the full standards within the set timescales, it does not provide evidence that other providers will meet those standards. We are not aware of evidence available to Nottingham and Nottinghamshire residents to reassure them that University Hospitals Birmingham NHS

Foundation Trust or Birmingham Children's Hospital NHS Foundation Trust (where the consultation document suggests that most current Leicester patients will be referred to) are more likely to meet the standards than University Hospitals of Leicester. It is not clear what level of scrutiny has been applied to the growth plans of all providers. This evidence may be available within NHS England decision making processes but it is not transparently available within the public consultation process to enable citizens to make an informed view. University Hospitals of Leicester states that it has a growth plan that will enable it to meet the required standards and it seems reasonable that NHS England should work with them, as it has stated it will do with Newcastle, to deliver the standards rather than decommission a well-regarded service, reducing patient choice and requiring patients and their carers to travel further for a service that it is not clear will be significantly better in terms of patient outcomes. The Committee supports the principle of setting standards for services but considers patient outcomes to be the most important measure from a patient's perspective. Surgical survival rates at Leicester are at least as good as expected, in common with most providers, and the most recent Care Quality Commission inspection rated it as Outstanding for effectiveness.

If standards can be applied flexibility, with exceptions allowed, (which is what is being proposed by allowing a different timeframe for implementation by Newcastle) then this calls into question the necessity of those standards in the first place.

5. *Can you think of any viable actions that could be taken to support one or more of the trusts to meet the standards within the set timeframes?*

The standards set expectations for future provision of congenital heart disease services. However for some standards (for example the 3 year period over which the number of operations per surgeon is assessed) the proposals are based on past performance. It is unreasonable to assess a service, and make decisions about its future, based on past performance against a standard that did not exist at the time. Assessment against standards should commence from when the standards came into place not for a period of time before that.

We propose that NHS England should proactively work with University Hospitals of Leicester to support development of its plans to meet the required minimum number of cases (which is the only remaining standard that NHS England states that Leicester will not meet). We understand that its growth plan involves changing usual referral pathways. Representatives of NHS England have told us that referrals are a matter of patient choice and not to be mandated by NHS England. We support the principle of patient choice but believe that most patients make their 'choice' on the basis of their clinician's advice. If a clinician usually refers to one particular provider (perhaps for historical reasons) they will continue to advise patients of this

referral pathway and the length of travel etc. for patients will not be a significant concern for them. Patients will 'choose' on the basis on this advice even though they might actually prefer to be seen closer to home. As councillors we often hear from people that they would rather receive services closer to home and representatives of NHS England acknowledged to us that it is really important for some people to get services locally. The proposals remove this choice for patients in the East Midlands, who will no longer have any Level 1 congenital heart disease services provided in their region. University Hospitals of Leicester has told us that changing referral pathways involves developing new relationships and takes time. Representatives of NHS England told the Committee that they did not consider that they had a role in this – we disagree – and at the very least University Hospitals of Leicester should be allowed time (as Newcastle is) to try and achieve the necessary changes.

Finally, as stated in response to Question 4, the standards should be applied consistently. If one provider is given additional support and a different timeframe that this should be equally applied to all other providers.

Central Manchester University Hospitals NHS Foundation Trust and University Hospitals of Leicester NHS Trust

If Central Manchester and Leicester no longer provide surgical (level 1) services, NHS England will seek to commission specialist medical services (level 2) from them, as long as the hospitals meet the standards for a level 2 service. To what extent do you support or oppose this proposal?

- ☐ Strongly support
- ☐ Tend to support
- ☑ Neither support or oppose
- ☐ Tend to oppose
- ☐ Strongly oppose

Royal Brompton and Harefield NHS Foundation Trust

6. *The Royal Brompton could meet the standards for providing surgical (level 1) services for adults by working in partnership with another hospital that provides surgical (level 1) services for children. As an alternative to decommissioning the adult services, NHS England would like to support this way of working.*

   To what extent do you support or oppose the proposal that the Royal Brompton provide an adult only (level 1) service?

- [ ] Strongly support
- [ ] Tend to support
- [x] Neither support or oppose
- [ ] Tend to oppose
- [ ] Strongly oppose

Newcastle upon Tyne Hospitals NHS Foundation Trust

7. *NHS England is proposing to continue to commission surgical (Level 1) services from Newcastle upon Tyne Hospitals NHS Foundation Trust, whilst working with them to deliver the standards within a different timeframe. To what extent do you support or oppose this proposal?*

- [ ] Strongly support
- [ ] Tend to support
- [x] Neither support or oppose
- [ ] Tend to oppose
- [ ] Strongly oppose

Travel

We know that some patients will have to travel further for the most specialised care including surgery if the proposals to cease to commission surgical (level1) services from Central Manchester University Hospitals NHS Foundation Trust (adult service); Royal Brompton & Harefield NHS Foundation Trust (services for adults and children); and University Hospitals of Leicester NHS Trust (services for adults and children) are implemented.

8. *Do you think our assessment of the impact of our proposals on patient travel is accurate?*

- [ ] Yes
- [x] No

9. *What more might be done to avoid, reduce or compensate for longer journeys where these occur?*

We do not consider the assessment of the impact of the proposals on travel for patients and their carers who live in Nottingham and Nottinghamshire to be accurate.

There are good transport links between Nottinghamshire and Leicester, especially with the recently enhanced A46 road. While Birmingham might look relatively close to Nottingham on a map it is less easy to get to. The assessment suggests that children who currently receive treatment at Leicester will have an increased journey time of 14 minutes while adults will have an increased journey time of 32 minutes. Presumably this is based on where current patients live but since individuals born with congenital heart disease are as likely to live in one area as another it does not make sense as a statistic on which to base commissioning decisions.

The increased length of journey will take longer to complete and cost more for individuals. Locally, our hospitals strongly encourage patients and their carers to use public transport to get to hospitals – presumably this is the same in Birmingham. If Nottinghamshire residents used public transport to get to either of the Birmingham providers then it would take much longer than the increased journey time referred to in the assessment. The train journey between Nottingham and Leicester typically takes approximately. 30 minutes. The train journey between Nottingham and Birmingham New Street typically takes approximately 1 hour 15 minutes (that it without taking into account the ongoing travel at either end). One way of encouraging public transport use is increasing parking charges. Due to the journey, residents from Nottingham and Nottinghamshire would be less likely to be able to avoid parking charges. The increased journey time, especially for those in more remote rural areas may also require overnight accommodation. Consideration could be given to mitigating for these unavoidable costs.

It would not be necessary to mitigate for longer journey times if the standards are applied consistently and services continue to be commissioned at University Hospitals of Leicester.

Equalities and health inequalities

We want to make sure we understand how different people will be affected by our proposals so that CHD services are appropriate and accessible to all and meet different people's needs.

In our report, we have assessed the equality and health inequality impacts of these proposals. Do you think our assessment is accurate?

☐ Yes

☑ No

10. *Please describe any other equality or health inequality impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?*

The assessment does not fully take into account the impact of the levels of deprivation in Nottingham City and some parts of Nottinghamshire County. This impacts on access to transport and the ability of individuals to pay for transport costs to attend medical appointments (which will increase under the proposals). Rural deprivation in parts of the County, such as parts of Bassetlaw, mean that people face challenges in accessing public services and we consider that this will be exacerbated by the proposals.

The assessment does not adequately consider the impact on the existing regional inequity of cardiology services in the UK. The East Midlands already has the least number of cardiologists per head of population of any UK region (Royal College of Physicians census data 2016). If congenital heart surgery and intervention at Leicester closes, it is likely that a proportion of current and future appointments will move away from the East Midlands to Birmingham or Leeds.

Other impacts

We want to make sure that the proposed changes, if they are implemented, happen as smoothly as possible for patients and their families/carers so it is important that we understand other impacts of our proposals.

11. *Do you think our description of the other known impacts is accurate?*

☐ Yes

☑ No

12. *Please describe any other impacts which you think we should consider, and what more might be done to avoid, reduce or compensate for the impacts we have identified and any others?*

The consultation document does not clarify whether University Hospitals of

Leicester will continue to be commissioned as a Level 2 site and what these services will look like, how they will operate, pathways and communication routes to Level 1 services and wider networks. These arrangements should be in place prior to the decommissioning of Level 1 services so that risks to patient care are minimised during the transition period. The consultation document focuses on the impact of patients receiving congenital heart surgery and there has been insufficient regard given to the impact on the larger number of patients requiring specialist medical follow up. We understand that in the adult population in Nottingham, there are approximately 50 patients under specialised follow-up for every one patient going forward for heart surgery. These patients require expertise that is only possible if the cardiologist providing it is regularly working in a centre providing surgery and catheter interventions. Although NHS England has estimated the number of patients requiring surgery who will have to travel out of region, this is not matched by consideration of the sustainability of expertise required to provide appropriate specialist medical adult congenital heart disease services in the East Midlands.

If Level 1 services are decommissioned from University Hospitals of Leicester then consideration needs to be given the service received by patients during the transition period. It is likely that existing staff will look for alternative employment and it is likely to be challenging to recruit to vacancies for a service being decommissioned. The consultation document and our conversation with representatives of NHS England do not demonstrate that sufficient consideration has been given to service provision during this transition period.

The consultation document suggests that most people who currently receive Level 1 services at Leicester will access services at either University Hospitals Birmingham NHS Foundation Trust or Birmingham Children's Hospital NHS Foundation Trust. It reports that University Hospitals Birmingham will require capital investment in order to provide the additional capacity required. The financial pressures facing the NHS are widely reported and, given that context, we are surprised that NHS England is proposing to decommission an existing service only to require significant financial investment to provide an equivalent service elsewhere that also costs patients more to access. The consultation document states that University Hospitals Birmingham has identified sufficient funding. We do not feel that the consultation document demonstrates sufficient consideration has been given to the risks associated with funding being available and able to be spent within required timescales. Greater reassurance is required that the physical changes required will be made prior to the Level 1 services being decommissioned so that existing and new patients at UHB are not negatively impacted upon; and risks identification and mitigation plans in place if not. We are not aware of evidence of assessment of projected waiting times at University Hospitals Birmingham or Birmingham Children's Hospital, have been undertaken.

The consultation document acknowledges that there will be wider impacts as a result of decommissioning Level 1 services at Leicester, including the loss of ECMO services from Leicester – currently the only centre in the UK able to provide mobile ECMO; the provider of all UK ECMO training; and the provider of a significant respiratory ECMO caseload; and paediatric intensive care beds. We feel that insufficient consideration has been given to both the local and national implications of dispersing and diluting the considerable ECMO expertise provided by Leicester. Last year there were national reports of paediatric intensive care bed shortages so it is surprising that NHS England is proposing an option that will reduce bed availability further. Given the close interrelationships between these services and congenital heart disease services it is surprising that a decision is being taken before the national review of PICU and ECMO has reported. The two decisions should dovetail not pre-empt one another. An understanding of future ECMO and PICU needs should be informing this decision not having that review constrained by having options removed by this decision.

Any other comments

13. Do you have any other comments about the proposals?

The consultation document includes an unnumbered question between Question 5 and 6 which groups together proposal to decommission Level 1 congenital heart disease services at Central Manchester and Leicester. The context set out in the consultation document for these two providers is different and the implications of proposals for each is different. Therefore it is surprising that these have been combined together into one question and allow for one response. As a Committee representing Nottingham and Nottinghamshire residents we neither support or oppose the proposal in relation to Manchester but do have a view on the proposal for Leicester. The consultation does not enable us to distinguish between these two different positions. Requiring a combined response is unreasonable. In analysing the responses it will not be possible to tell whether respondents are referring to the proposal for Manchester, Leicester (for which they might have differing views) or both. Therefore it is suggested that this question should be disregarded.

Downgrading the service in Leicester from Level 1 to Level 2 will leave the East Midlands without a Level 1 centre – we do not support this. Based on information provided to us by providers we are also concerned about the viability of Level 2 service in Leicester without Level 1.

We are aware of concerns about the consultation that has been carried out on the proposals. NHS England has included a long list of public meetings being held as part of the consultation. This includes meetings of health overview and scrutiny committees. These are not 'public meetings' in the sense that members of the public can speak and/or ask questions but rather

meetings held in public for the committee to be consulted in accordance with its statutory role. We consider that it is misleading to imply that these meetings form part of the public consultation process. We understand that where public meetings have been arranged by NHS England as part of the consultation process the number of people able to attend has been limited. Nottingham University Hospitals NHS Trust has also informed us that they are concerned that consultation has been poor. We understand that information has been requested from the Trust at short notice and not from relevant clinicians; and that concerns that the Trust has raised specific to Nottingham and the East Midlands have not been addressed by NHS England. This is disappointing and potentially undermines confidence in the consultation process.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

18 April 2017

Agenda Item: 9

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents.

3. The work programme for 2016-17 is attached as an appendix for information.

4. Quality Accounts – this year, due to time constraints, it is anticipated that consideration of Quality Accounts will take place at a single study group meeting for each relevant provider Trust/organisation. Lead officers are currently setting up these meetings.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the work programme for 2016-17 and dates for future meetings.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Joint Health Scrutiny Committee 2016/17 Work Programme

12 July 2016	• **Transforming care for people with learning disabilities and/or autism spectrum disorders in Nottingham and Nottinghamshire – outcomes of consultation and progress against key deliverables** To consider the consultation process and findings and if/how proposals are changing to reflect those findings; and progress against the key deliverables to be completed by June 2016 (Nottingham City CCG lead) • **The Willows Medical Centre, Carlton** To review action taken by Nottingham North and East Clinical Commissioning Group to ensure that all patients in the Carlton area have access to good quality GP services during the temporary closure of The Willows Medical Centre; and in the future. (Nottingham North and East CCG) • **Work Programme** To consider the 2016/17 Work Programme
13 September 2016	• **Environment, Waste and Cleanliness at Nottingham University Hospitals** To review progress in improving the environment, waste management and cleanliness at Nottingham University Hospitals sites (Nottingham University Hospitals) • **Defence and National Rehabilitation Centre (Stanford Hall)** To examine the development of services for trauma rehabilitation (Nottingham University Hospitals)

	• **Future of Congenital Heart Disease Services** To consider NHS England's recent announcement about the future of congenital heart disease services, including changes to the commissioning of services at the East Midlands Congenital Heart Centre at Glenfield Hospital, Leicester. • **Work Programme** To consider the 2016/17 Work Programme
11 October 2016	• **Nottingham University Hospitals and Sherwood Forest Hospitals Trust Merger – Progress Update** (Nottingham University Hospitals) • **Community Child and Adolescent Mental Health Services (CAMHS)** **(**Nottinghamshire Healthcare Trust/ commissioners/ local authority public health) • **Rampton Hospital/Psychologically Informed Planned Environments (PIPES)** To receive information on the operation of PIPES in prisons (NHS England) • **The Willows Medical Centre, Carlton** To consider changes to services following the resignation from Dr Nyatsuro in relation to his GP practice contract (Nottingham North and East CCG) • **Work Programme** To consider the 2016/17 Work Programme

8 November 2016	• **East Midlands Clinical Senate and Strategic Clinical Networks** To receive the EMCSSCN Annual Report and updates on other recent developments (EMCSSCN) • **NUH Emergency Department Targets** To receive briefing on Accident and Emergency performance (NUH) • **NUH Planning for Winter Pressures** To receive briefing on NUH's plans to cope with winter pressures 2016/17 (and also whole system briefing from commissioners and social care partners). (NUH) • **Work Programme** To consider the 2016/17 Work Programme
13 December 2016	• **Environment, Waste and Cleanliness at Nottingham University Hospitals** To review progress in improving the environment, waste management and cleanliness at Nottingham University Hospitals sites (NUH) • **Daybrook Dental Practice Report Findings** An update further to the conclusion of recent proceedings (NHS England) • **Sustainability and Transformation Plan** To receive information about the STP, including an outline of the Plan, governance and plans for delivery, plans

	for consultation and engagement; and information about any anticipated substantial developments or changes to services. (STP Team) • **Work Programme** To consider the 2016/17 Work Programme
10 January 2017	• **Winter Pressures - EMAS** Evidence gathering as part of an ongoing review of winter planning • **NUH – Research and Innovation Update** Briefing on new developments • **NUH – Technology in Care** Briefing on new developments • **Work Programme** To consider the 2016/17 Work Programme
7 February 2017	• **Uptake of Child Immunisation Programmes** To consider the latest performance in uptake and how uptake rates are being improved (NHS England/ Local Authority Public Health) • **Nottingham University Hospitals NHS Trust Service Reviews** To receive information about the local commissioning changes across a variety of services further to service reviews undertaken by the CCG. (Nottingham North and East CCG)

	• **Work Programme** To consider the 2016/17 Work Programme
14 March 2017	• **Congenital Heart Disease** To consider a potential substantial variation of service NHS England • **NUH Service Review** Further details on proposed service changes from Nottingham North and East CCG. • **Sustainability and Transformation Plan Governance Arrangements** To consider proposed governance arrangements for development and delivery of the Sustainability and Transformation Plan and to give consideration to the role for health scrutiny STP Team • **NUH/Carillion Contract** To provide an update on the position with the cleaning services contract at NUH NUH • **Work Programme** To consider the 2016/17 Work Programme
18 April 2017	• **Urgent Care Resilience/System Working to Improve Emergency Care** To review progress in developing resilience within the urgent care system, including the delivery of services during winter 2016/17 and how effectively winter pressures were dealt with. (NUH/Nottingham City CCG) • **GP service capacity in Carlton area**

	To take a strategic overview of GP capacity and any pressures on service provision in the Carlton area and, where appropriate, work taking place to ensure access to good quality GP services for all residents in the area (Nottingham North and East CCG/ Nottingham City CCG) (Nottingham City CCG/ NUH) • **Consultation on Congenital Heart Disease Service Proposals – Draft Response** To agree the draft consultation response. • **Integrated Community Children and Young People's Healthcare Programme** To review the implementation and impact of the new service model. (ICCYPH Programme Manager, commissioners, Nottinghamshire Healthcare Trust) • **Work Programme** To consider the 2016/17 Work Programme

To schedule:

- Progress against JHSC recommendation that "that the City and County Councils work with their partners, for example Marketing Nottingham and Nottinghamshire to support Health Education East Midlands to promote the East Midlands as a place for health professionals and students to train and work"
- Integrated Community Children and Young People's Healthcare Programme – review of implementation and outcomes from service changes
- Procurement of Patient Transport Service, including development of service specification - awaiting confirmation of procurement timings
- Evaluation of Urgent and Emergency Care Vanguard (primary care at the 'front door')
- Integrated Urgent Care
- Strategic Health Plans for the South of the County
- Evaluation of GP Access pilots

- Healthwatch Report – Experiences of Mental Health Crisis
- STP – Consultation and Engagement

Study Groups:
- Quality Accounts

Visits:
- Nottingham University Hospitals sites

Other meetings:
- NUH (Peter Homa)
- NHCT (Ruth Hawkins)
- EMAS (Greg Cox) (informal meeting with East Midlands Health Scrutiny Chairs to consider EMAS response to CQC inspection)

Items for 2017/18 Work Programme:

<u>May/ June</u>
- Nottinghamshire Healthcare Trust Transformational Plans for Children and Young People – CAMHS and Perinatal Mental Health Services update (to include workforce issues, development of Education Centre and financial position)

NHS 111 (align with publication of NHS 111 Annual Report)

Visit to new CAMHS and Perinatal Services Site (spring 2018)