Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 13 June 2017 at 10:30

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

AGENDA

1 To note:

a) the appointment by the County Council on 25 May 2017 of Councillor Keith Girling as Chairman and Councillor Martin Wright as Vice Chairman

b) the membership of the committee as:
Chairman – Councillor Keith Girling
Vice-Chairman – Councillor Martin Wright
Councillor Richard Butler
Councillor Dr John Doddy
Councillor Kevin Greaves
Councillor David Martin
Councillor Michael Payne
Councillor Liz Plant
Councillor Kevin Rostance
Councillor Steve Vickers
Councillor Muriel Weisz

2 Minutes of the last meeting held on 27 March 2017 3 - 6

3 Apologies for Absence

4 Declarations of Interests by Members and Officers:- (see note below)
(a) Disclosable Pecuniary Interests
(b) Private Interests (pecuniary and non-pecuniary)

5	Introduction to Health Scrutiny	7 - 10
6	Introduction to Health Inequalities	11 - 30
7	Work Programme	31 - 36

Notes

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

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

Customer Services Centre 0300 500 80 80

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

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

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

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

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Monday 27 March 2017 at 2pm

Membership

Councillors

	Collen Harwood
	John Allin
	Kate Foale
A	Bruce Laughton
	David Martin
	John Ogle

District Members

	Helen Hollis	Ashfield District Council
A	Brian Lohan	Mansfield District Council
	David Staples	Newark and Sherwood District Council
	Susan Shaw	Bassetlaw District Council

Officers

Paul Davies	Nottinghamshire County Council
Alison Fawley	Nottinghamshire County Council

Also in attendance

Roz Howie	Chief Operating Officer, Sherwood Forest Hospitals Trust
Ben Owens	Clinical Director, Sherwood Forest Hospitals Trust
Michelle Livingston	Healthwatch, Nottinghamshire
Dawn Atkinson	Mansfield & Ashfield CCG

MINUTES

The minutes of the last meeting held on 16 March 2017, having been circulated to all Members, were taken as read and were signed by the Chair.

APOLOGIES

Apologies were received from Councillor Bruce Laughton and Councillor Bruce Laughton.

DECLARATIONS OF INTEREST

None.

The Committee agreed to take Item 6 on the Agenda – Sherwood Forest Hospitals Performance Update (including pharmacy delay) - earlier in the agenda

SHERWOOD FOREST HOSPITALS PERFORMANCE UPDATE (INCLUDING PHARMACY DELAY)

Ben Owens and Roz Howie presented a briefing to update Members of the significant improvements that had been made further to the Care Quality Commission (CQC) inspection. Particular focus was given to emergency care transformation and pharmacy delay.

During the presentation, the following points were highlighted:

- Significant progress with the 4hour emergency standard had been made and in 2016/17 the Trust continued to be the best performer in the region and in the top 10 in the country.
- Length of stay had reduced from 8.3 days to 6.5 days and had been static at this level for over 8 months. However January had seen an increase but this was felt to be expected in winter.
- Mr Owens explained the risks that poor flow could bring which included higher mortality, more bed moves, higher cost and failure to meet targets.
- Steps taken to improve flow included maximising the co-located Primary Care facility, agreeing Emergency Care Standards, hot clinics, short stay ward, Frailty Intervention Team.
- Very few elective procedures had been cancelled.
- Savings of circa £6m by reducing the bed base by 60.
- The CQC rating for the Emergency Department was now good.

During discussions the following points were raised:

- Readmission rates were monitored to ensure that patients had not been discharged too early and deaths in the community were reported via the Coroner's Court. Care was taken that the wishes of people at the end of life were considered as hospital was not always the appropriate place to die.
- Treatment in the community was a more cost effective option and by working with community alliances it would free up funding to be spent more effectively. This would be measured by the Commissioners through joint working. However hospital would always be an option if it was in the patient's best interests.
- The Better Together Alliance were looking at a number of streams of work which would help with the efficiency of the Emergency Department.
- Procedures were in place for patients presenting with mental health problems. Issues regarding availability of beds across the country would be referred to the Joint City/County Health Scrutiny Committee although Members requested data for north Nottinghamshire be made available.

Pharmacy delay

Roz Howie briefed members regarding the ongoing work to expedite discharge from hospital.

She highlighted the following points:

- A stock of pre packed medicines are held on the ward to allow dispensing at the patient's bedside
- There is a 9am - 5.30pm ward based service and a dedicated service via Vocera (bleep system) between 11am-1pm and 2pm-5pm.
- The Trust worked closely with community pharmacies to ensure continuation of medication after discharge.

During discussions the following points were raised:

- Recruitment and retention of Pharmacists was an issue for the Trust as more attractive conditions could be found in the Community, for example, no weekend working.
- Investment is required in technology.
- Work was ongoing with the Better Together Alliance to address some of the issues.

The Chair thanked Mr Owens and Ms Howie for their reports**.**

DISCHARGE ISSUES

Dawn Atkinson gave a presentation which informed Members about the work being undertaken to prevent unsafe discharge.

During her presentation Ms Atkinson highlighted the following points:

- The overall impact of implementing a fully integrated discharge system would support a reduction in the following areas: non elective admissions and readmissions, length of stay, excess bed days and demand for long term residential care.
- There was no short term solution to addressing the issues but there was shared commitment to developing a whole system plan which included redesign of the service to establish appropriate pathways which would inform future commissioning plans.
- Progress to date included preliminary mapping of services, stakeholder workshops and development of pathways for complex discharges.
- A transformational integrated model had been developed by the Project Team as a result of engagement events and the next steps would be to translate this in to an operational delivery model.
- Aspects of good practice had been identified and built into the model.

During discussions the following points were raised:

- Traditional measures to determine outcomes did not completely reflect patient/carer feedback and it was hoped to include both quantitative and qualitative measures in future.
- Workforce issues were a challenge and this was reflected in the workforce stream of the STP.
- A robust information sharing protocol was in place.
- Cultural change was thought to be the greatest challenge and was about different services accepting that they can manage patient care.
- Strategic commissioning would ensure the best use of funds.

IMPROVING IT LINKS BETWEEN GP SERVICES AND HOSPITALS

Dawn Atkinson introduced a presentation which informed Members about the work being undertaken to improve information technology (IT) links.

The presentation described the infrastructure and developments implemented which provided a more reliable and faster system and the preparations for allowing public access in GP sites.

The following developments were highlighted:

- Electronic Prescribing software
- Electronic transfer of patient records between practices
- Patient online access
- Availability of GP records to support direct care
- Tools to alert GPs and multidisciplinary teams to gaps in care and care planning
- Best practice templates

During discussions the following points were raised:

- Engagement with patient representative groups would be needed to encourage use of online systems and to understand the challenges and barriers to using such a system. The option to telephone or call in to a surgery would not be removed.
- Timeliness of data being entered on to the system was key for information sharing and that the workforce needed to be confident regarding the protocols for sharing information.
- New ways of working were a cultural shift and would be a challenge to be embraced by some staff for example, use of Skype.

The Chair thanked Ms Atkinson for her presentation and requested that an update be brought to the November meeting.

WORK PROGRAMME

The work programme was discussed and it was agreed to add the following items to the work programme:

- NHS England trajectory
- Notts HCT – mental health provision
- Winter pressures

The meeting closed at 4.05pm

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

13 June 2017

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

INTRODUCTION TO HEALTH SCRUTINY

Purpose of the Report

1. To introduce initial briefing on the principles of Health Scrutiny from a representative of the Centre for Public Scrutiny.

Information and Advice

2. Brenda Cook, an associate of the Centre for Public Scrutiny (CfPS) will attend the Health Scrutiny Committee to brief Members on health service issues and the operation and principles of health scrutiny.

3. Brenda Cook is the CfPS' Regional Advocate for the East Midlands and East of England. She is an expert on health overview and scrutiny legislation and practice – and also one the main authors of the early guide to health scrutiny "Substantial Variations and Developments of Health Services" (2005).

4. Government guidance states that the primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration – and in making recommendations and how it could be improved.

5. At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service, and in testing this information by drawing on different sources of intelligence. Health scrutiny is part of the accountability of the whole system, and needs involvement of all parts of the system.

6. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

7. Effective health scrutiny also requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local Healthwatch.

8. In the light of the Francis Report (the findings of the public inquiry into poor care at Mid Staffordshire Foundation trust published in 2013) local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although health scrutiny functions are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends.

9. Furthermore, health scrutiny committees will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

10. Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well **health inequalities** are being addressed, as well as specific treatment services.

11. Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible. If external support is needed, informal help is freely available from the Independent Reconfiguration Panel (IRP) and/or the Centre for Public Scrutiny. If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals.

12. In considering substantial reconfiguration proposals health scrutiny needs to recognise the *resource envelope* within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.

13. Health scrutiny is a fundamental way by which democratically elected local councillors are able to voice the views of their constituents, and hold relevant NHS bodies and relevant service providers to account. Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny. Health scrutiny should be held in an **open forum** and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings. This will be in line with the new transparency measure in the Local Audit and Accountability Act 2014 and will allow local people, particularly those who are not present at scrutiny hearing-meetings, to have the opportunity to see or hear the proceedings.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing on health scrutiny and asks questions, as necessary

2) Indicates requirements for further information, as required

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers
None

Electoral Division(s) and Member(s) Affected
All

Nottinghamshire County Council

Report to Health Scrutiny Committee

13 June 2017

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

HEALTH INEQUALITIES

Purpose of the Report

1. To provide information on the work being undertaken by Nottinghamshire County Council to address health inequalities.

Information and Advice

2. Barbara Brady, Acting Director or Public Health, Nottinghamshire County Council will attend the Health Scrutiny Committee to brief Members on the latest measures to address health inequalities.

3. Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.

4. Local authorities are uniquely placed to tackle health inequalities, as many of the social and economic determinants of health, and the services or activities which can make a difference, fall within their remit. The challenge is to reduce the difference in mortality and morbidity rates between rich and poor and to increase the quality of life and sense of wellbeing of the whole local community.

5. A presentation from the Public Health Department is attached as an appendix to this report.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing on health inequalities and asks questions, as necessary

2) Indicates requirements for further information, as required

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers
None

Electoral Division(s) and Member(s) Affected
All

Health Inequalities

Barbara Brady

Interim Director of Public Health

By the end of the session

- What are they
- What causes them
- Who is affected
- The position in Nottinghamshire
- Implications for NHS
- Implications for wider system

What are Health Inequalities

They are avoidable differences in health status experienced by certain population groups.

They run counter to our aspiration that ‘everyone should have the opportunity to makes the choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background’

The Causes

They arise because of inequalities in the conditions in which people are born, grow, live, work, and age. These also affect the way people look after their own health and use services throughout their life.

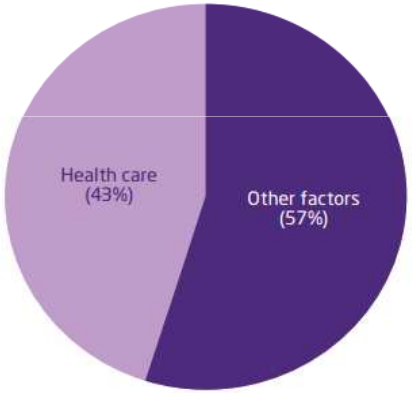
The lower a person's position in society (in terms of employment, income and education), the worse their health.

The Determinants of Health

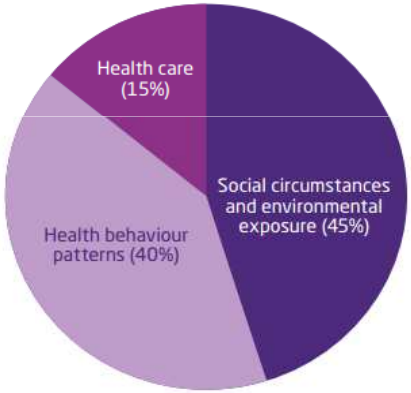
The importance of public health

Our health is determined by our genetics, lifestyle, the health care we receive and our wider economic, physical and social environment. Although estimates vary, the wider environment has the largest impact.

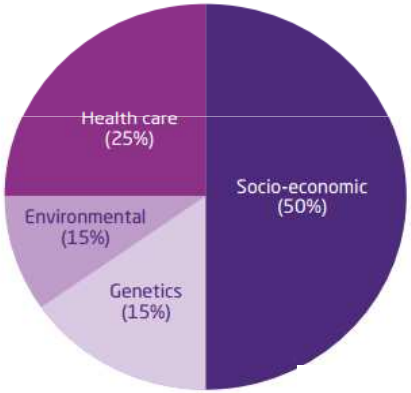
Bunker et al (1995)



McGiniss et al (2002)



Canadian Institute of Advanced Research (2012)

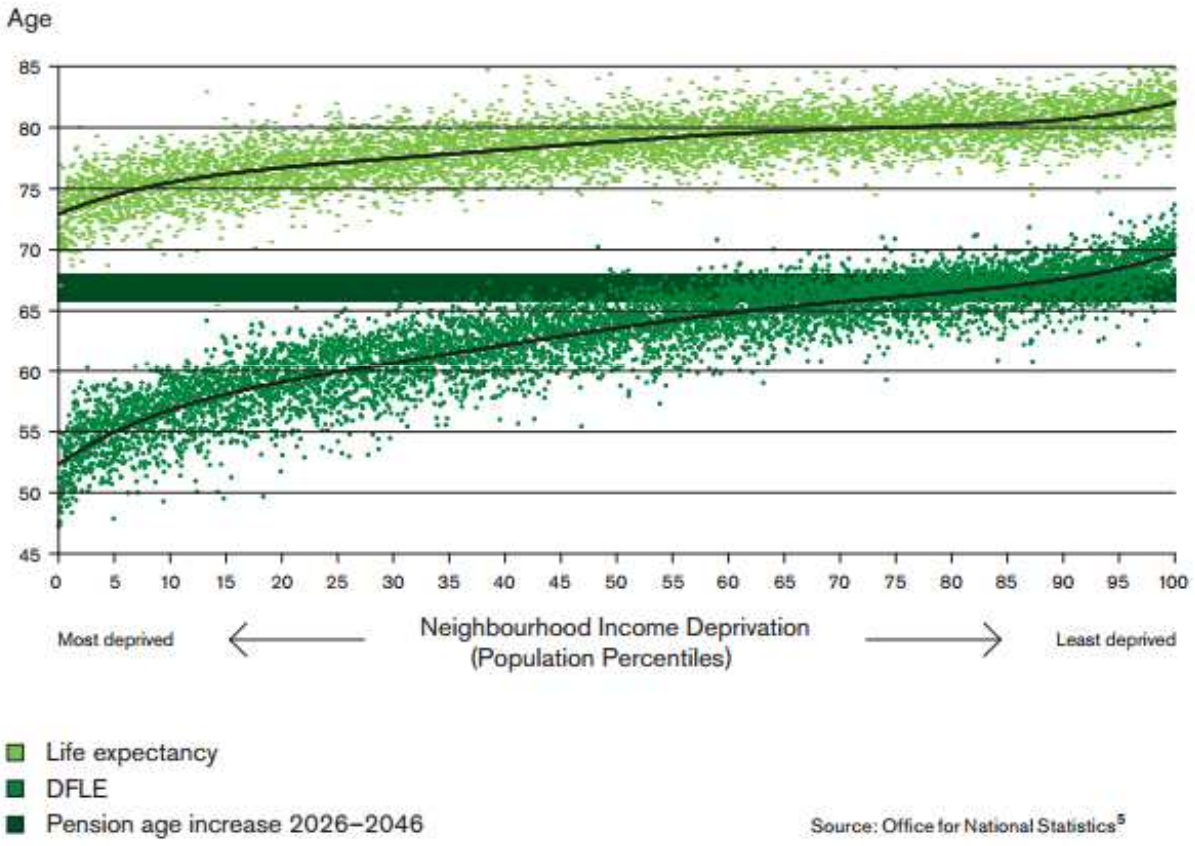


TheKingsFund

Health Care explains between 15 – 43%

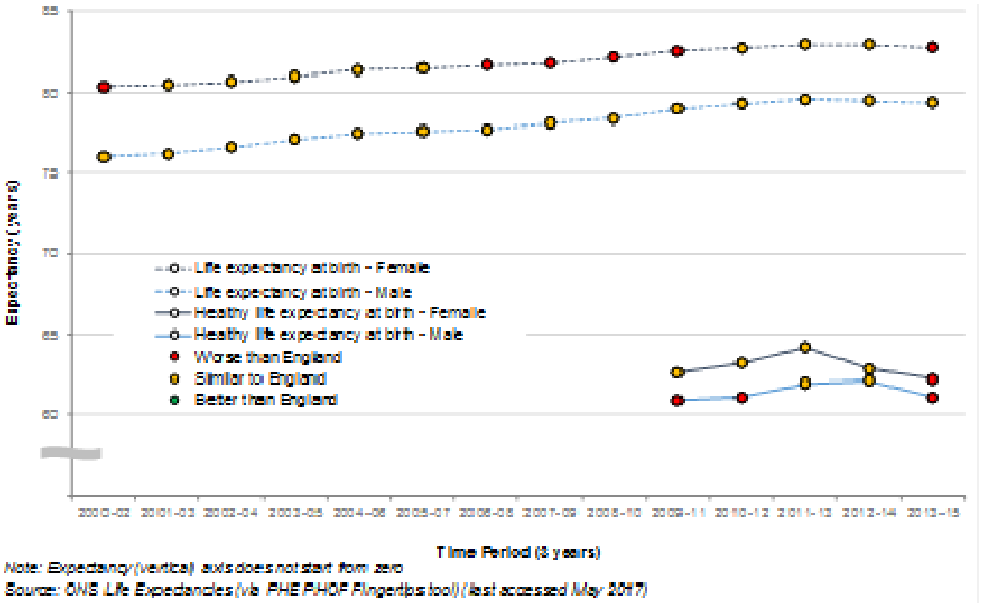
The ‘Marmot Curve’

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



Source: Office for National Statistics[5]

Nottinghamshire Trends in Life & Healthy Life Expectancy

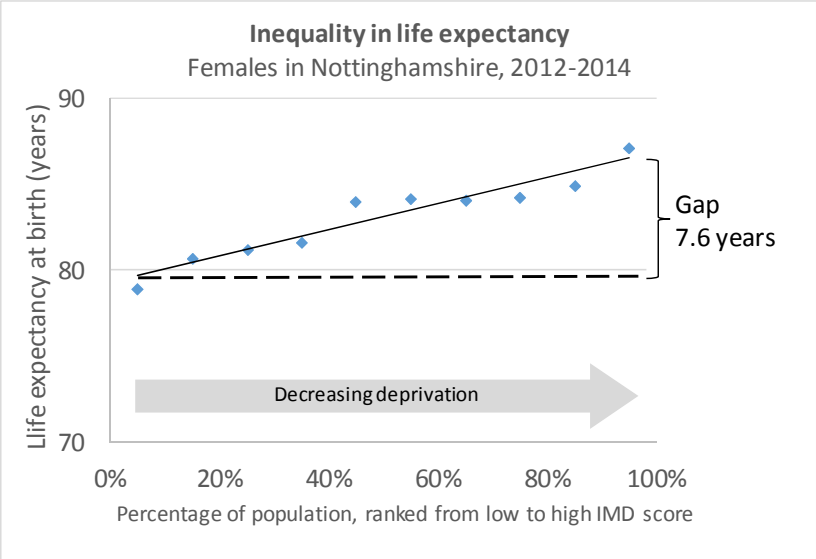


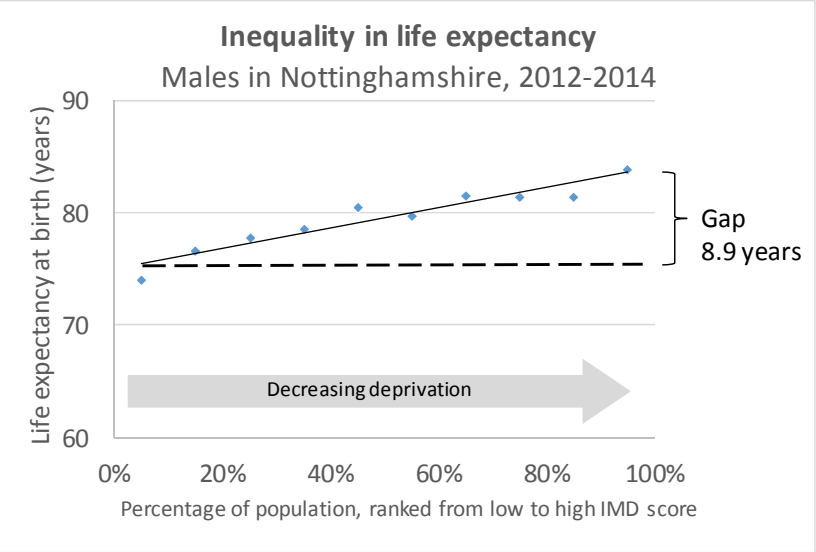
Note: Expectancy (vertical) axis does not start from zero
Source: ONS Life Expectancies (via PHE PHOF Fingertips tool) (last accessed May 2017)

This is the gap between Life Expectancy & Healthy life Expectancy

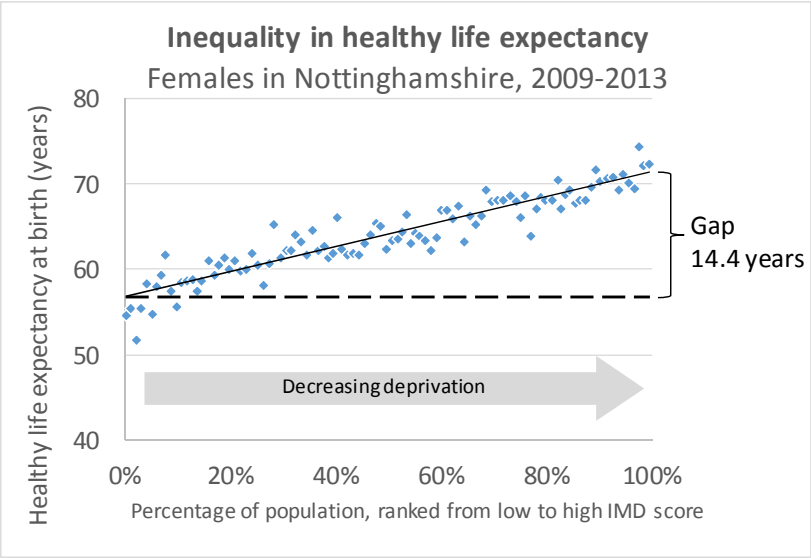
HLE is based on survey data in which individuals describe themselves as being unhealthy this includes physical and mental health

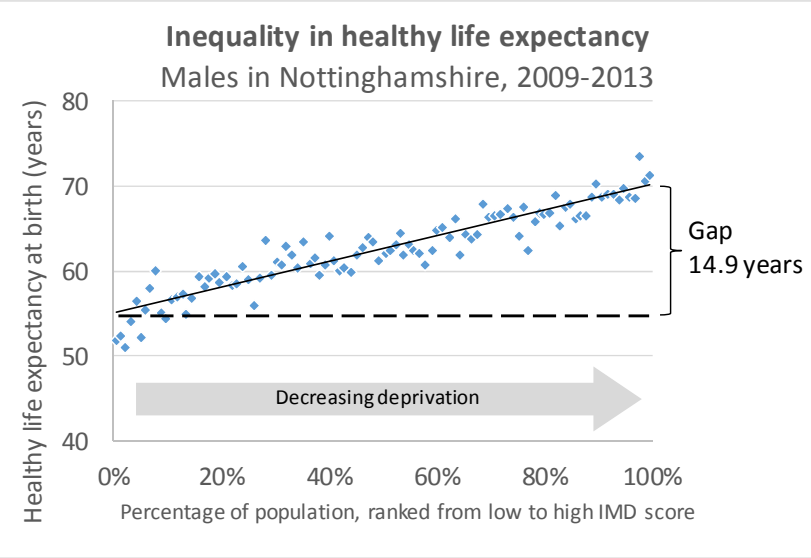
Inequality in Life Expectancy





Inequality in Healthy Life Expectancy





Implications for the NHS

Health Service Act 2006 (as amended by the **Health** and Social Care Act 2012), introduced for the first time legal **duties** to reduce **health inequalities**, with specific **duties** on CCGs and NHS England.

https://www.england.nhs.uk/wp-content/uploads/2015/12/hlth-inqual-guid-comms-dec15.pdf

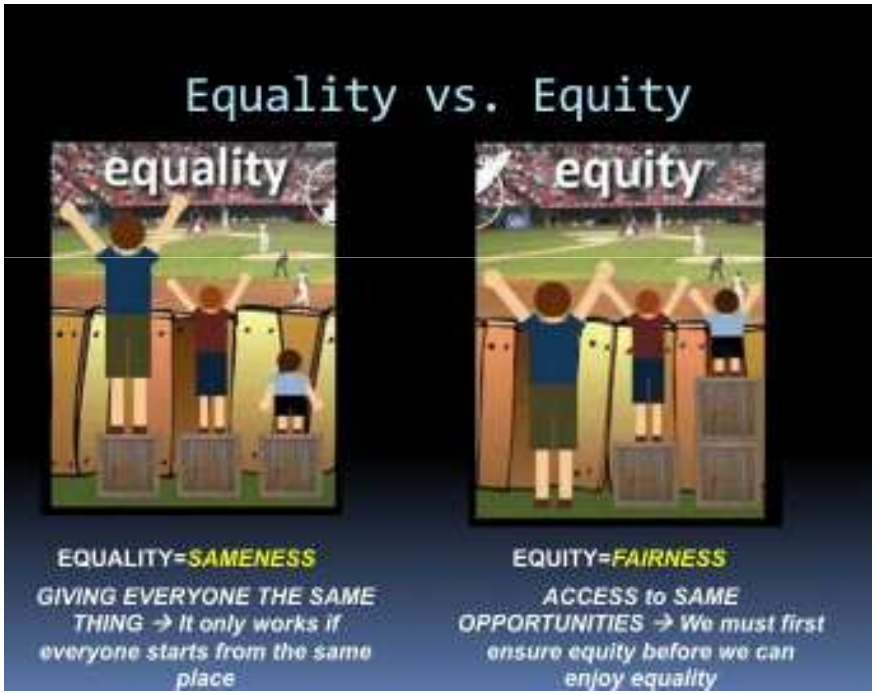
CCGs have duties to:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved
- Exercise their functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where they consider that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved
- Include in an annual commissioning plan an explanation of how they propose to discharge their duty to have regard to the need to reduce inequalities
- Include in an annual report an assessment of how effectively they discharged their duty to have regard to the need to reduce inequalities

NHS England has duties to:

- Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved
- Exercise its functions with a view to securing that health services are provided in an integrated way, and are integrated with health-related and social care services, where it considers that this would improve quality, reduce inequalities in access to those services or reduce inequalities in the outcomes achieved
- Include in an annual business plan an explanation of how it proposes to discharge its duty to have regard to the need to reduce inequalities
- Include in an annual report an assessment of how effectively it discharged its duty to have regard to the need to reduce inequalities
- Conduct an annual assessment of CCGs, including an assessment of how well each CCG has discharged their duty to have regard to the need to reduce inequalities, and publish a summary of the result

The difference between Equality and Equity



This Council

- The council currently receives a Public Health ring fenced grant which is to support the authority in carrying out its public health duties.
- The grant has some nationally set conditions which includes reducing health inequalities across the life course, including within hard to reach groups.

Implications for Health & Wellbeing Boards

Health and Social Care Act 2012 established Health & Wellbeing Boards as statutory committees of all upper tier local authorities to act as a forum for key leaders from the local health and care system to improve the health and wellbeing of the people in their area; reduce health inequalities and promote the integration of services.

In Summary

- Reducing health inequalities requires action on the factors that shape our health and will not be achieved by focusing only on improving the health of individuals alone
- So, health and social inequalities must be considered in the planning stages of services and programmes in order to maximise their potential for contributing to reducing health inequalities.

Nottinghamshire County Council

Report to Health Scrutiny Committee

13 June 2017

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

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

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

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

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

RECOMMENDATION

1) That the Health Scrutiny Committee considers and agrees the content of the draft work programme.

2) That the Health Scrutiny Committee suggests and considers possible subjects for review.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2017/18

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
13 June 2017				
Health Inequalities	Update on ongoing work to address health inequalities in the County	Scrutiny	Martin Gately	Barbara Brady, Public Health NCC
Introduction to Health Scrutiny	An introduction to health service issues and the operation of health scrutiny	Scrutiny	Martin Gately	Brenda Cook Health Scrutiny Expert (Centre for Public Scrutiny)
25 July 2017				
Public Health Briefing	Introduction to Public Health issues	Scrutiny	Martin Gately	Barbara Brady, Public Health NCC
Sherwood Forest Hospitals Performance Update	The latest performance information from Sherwood Forest Hospitals Trust.	Scrutiny	Martin Gately	TBC
IVF Substantial Variation	Update on re-consultation/Further action taken by the commissioners	Scrutiny	Martin Gately	Dr Amanda Sullivan, Sherwood Forest CCG
10 October 2017				
Bassetlaw Hospital (Including Children's Services)	Update on the latest position	Scrutiny	Martin Gately	TBC
Primary Care 24 [TBC]	Latest performance information	Scrutiny	Martin Gately	TBC
21 November 2017				

9 January 2018				
13 February 2018				
27 March 2018				
8 May 2018				
24 July 2018				
To be Scheduled				
Obesity Services				
Suicide Prevention Plans – Public Health	New role for Health Scrutiny – further to suggestion from Health Parliamentary Select Committee			
Community Pharmacy Issues Update				Liz Gundel, Pharmacy Lead, NHS England
Healthcare Trust Mid and North Notts Services				
Never Events				
Substance Misuse				

Potential Topics for Scrutiny:

TBC

Recruitment (especially GPs)

Rushcliffe CCG Pilots Update

Former Joint Health Committee Issues

STP
Implementation and Evaluation of services decommissioned from NUH (TBC)
Community CAMHS
Transforming care for people with learning disabilities/autism
Emergency Care
Winter Pressures
Congenital Heart Disease Services
Progress/Evaluation of implementation changes to mental health services
Defence National Rehabilitation Centre
East Midlands Ambulance Service