Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 18 June 2019 at 10:30

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

AGENDA

1	To note the appointment by Full Council on 16 May 2019 of Councillor Keith Girling as Chairman and Councillor Martin Wright as Vice-Chairman of the Committee for the 2019-2020 municipal year.	
2	To note the membership of the Committee for the 2019-2020 municipal year as follows: Councillors Richard Butler, Kevin Greaves, David Martin, Liz Plant, Stuart Wallace, Kevin Rostance, Steve Vickers, Muriel Weisz and Yvonne Woodhead	
3	Minutes of last meeting held on 7 May 2019	3 - 8
4	Apologies for Absence	
5	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
6	Clinical Commissioning Group Merger	9 - 36
7	East Midlands Ambulance Service	37 - 42
8	Patient Transport Service	43 - 50
9	Work Programme	51 - 58

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 Noel McMenamin (Tel. 0115 977 2670) or a colleague in Democratic Services prior to the meeting.

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

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

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Tuesday 7 May 2019 at 10.30am

Membership

Councillors

A Keith Girling (Chair)
Richard Butler
A Dr John Doddy
Kevin Greaves
David Martin (Items 5 to 8 inclusive)
Michael Payne
Liz Plant
Kevin Rostance
Steve Vickers
Muriel Weisz

Martin Wright (Vice-Chair)

Officers

Martin Gately	Nottinghamshire County Council
Noel McMenamin	Nottinghamshire County Council

Also in attendance

Laura Burns	NHS England
Anne Crompton	NUH
Rachel Eddie	NUH
Neil Ellis	NUH
Dr Keith Girling	NUH
Caroline Nolan	Greater Nottingham CCG
Alan Reid	Public Health England
Dr Saam Sedehizadeh	NUH
Kirstie Spencer	NUH

1. MINUTES

Subject to recording Councillor Wright's attendance at the meeting, the minutes of the last meeting held on 8 January 2019, having been circulated to all Members, were taken as read and were signed by the Chair.

2. APOLOGIES

Apologies for absence were received from.

Councillor K Girling (Chair) – Council business
Councillor J Doddy – work-related

In the Chair's absence, the Chair was taken by Councillor Martin Wright, the Vice-Chair.

No temporary change of membership requests were received for this meeting.

An apology for absence was also received from Sarah Collis, Healthwatch Nottingham and Nottinghamshire.

3. DECLARATIONS OF INTEREST

None

4. NOTTINGHAM UNIVERSITY HOSPITALS CARE QUALITY INSPECTION AND IMPROVEMENT PLAN

Dr Keith Girling, Medical Director, and Anne Crompton, Associate Director of Quality Governance, Nottingham University Hospitals NHS Trust (NUH), provided a presentation, circulated with the agenda, on the NUH response to the Care Quality Commission's (CQC) report and findings arising from its Inspection between November 2018 and January 2019.

A number of points were made in the presentation:-

- The CQC inspection lasted from November 2018 to January 2019, covered 7 of the 10 key pathways and services and followed 5 key lines of enquiry, providing ratings for 'Caring', 'Effective', Well-led', 'Responsive' and 'Safe';
- Overall, NUH received a 'good' rating, with 'Effective', 'Well-led' and 'Responsive' also rated 'good'. NUH's 'Caring' was rated 'Outstanding', while its 'Safe' rating was 'Requires improvement';
- areas of good or outstanding practice identified by the inspectors included the shared governance model, the supportive approach taken to 'end –of life' care, the impact of Integrated Discharge Teams , the positive use of digital culture and junior doctor liaison protocols;
- NUH was working hard on addressing the shortcomings highlighted in the 'Safe' domain, which included ensuring appropriate staffing levels in the Maternity Unit, making sure Do Not Attempt Resuscitation (DNAR) decisions were fully and consistently documented, inconsistencies with prescribing recording and storing medicines and protocols around clinical waste;
- NUH had not been able to deliver targets in respect of Emergency Department waiting times for some time;

- A comprehensive Improvement Plan was at and advanced stage of development and would be available publicly at the end of May 2019.

During discussions, a number of issues were raised:-

- Training and development had been delivered to relevant staff to secure 100% compliance with DNAR protocols and this was currently being audited to provide an evidence base going forward;
- It was acknowledged that more could be done outside the critical care environment to educate partners and patients' families about DNAR protocols, and the potential impact on patients if these were not in place nor followed consistently;
- It was further acknowledged that it was fundamental to maintain consistency of prescribing and recording of medicines. Digitising patient records was proceeding at pace and this would help reduce inconsistencies in time. Patients sometimes found it distressing to have medication taken from them on entry to hospital, and for changes in medication and timings take place without proper explanation;
- C-Diff and MRSA levels were currently below target levels, in part as a result of revised cleaning regimes;
- It was stated that NUH recruitment and retention levels were satisfactory, but that there was a number of specialisms where there were national skills shortages;
- The Swan initiative, which added quality of life experiences to end-of-life care, was welcomed and strongly supported by the Committee;

The Chair thanked Dr Girling and Ms Crompton for their attendance for their attendance.

5. NOTTINGHAM UNIVERSITY HOSPITALS – WINTER PLANS

Caroline Nolan, System Delivery Director, Greater Nottingham CCGs and Rachel Eddie, Acting Chief Operating Officer, NUH, provided an update on recent performance, ongoing challenges and future areas of focus relating to NUH system winter plans. The following points were made:-

Increased bed capacity had been put in place in several settings, with 113 extra acute beds provided at NUH, 20 more community-based enhance care beds and 35 community-run beds at City Hospital for those no longer needing acute care;

QMC 'front door' built environment improvements had been finalised, providing increased capacity, the Surgical Triage Model was being expanded to wider specialities and frontline staff flu vaccination levels were at an all-time high;

The target of 95% of patients through Emergency department within 4 hours was not met, with the March 2019 performance at 72%. Demand continued to increase with admissions on 1 April 2019 the highest on record;

Good progress had been made with extended GP appointments, the establishment of a Frailty Hub with integrated pathways, integrated discharge systems and ambulance handover times, which were the best in the region;

Challenges remained in respect of keeping pace with increased demand and maintaining staffing levels. NUH was excited to be one of 14 national pilot sites for the development and roll-out of national standards for urgent and emergency care.

During discussions, a number of issues were raised:-

- It was confirmed that work was ongoing to secure long-term funding for the additional acute bed capacity at NUH;
- It was acknowledged that increased numbers of bariatric patients presented a number of additional practical issues to contend with in the hospital environment;
- It was confirmed that Emergency Department (ED) visits were not recorded as 'unnecessary', but treatment was given to those who turned up, irrespective of the severity of illness or injury. New standards will help the provision of treatment in line with priority of illness, while having a primary care stream at ED would also help;
- It was unclear what caused the spike I admissions on 1 April 2019, but it noted that respiratory conditions were often exacerbated as seasons changed;
- It was planned to use the retained acute bed capacity more flexibly next winter;
- A Committee member spoke very positively of her recent experience as an NUH patient during the peak patient intake period.

The Chair thanked Ms Eddie and Ms Nolan for their attendance.

6. NOTTINGHAM UNIVERSITY HOSPITALS – MUSCULAR DYSTROPHY PATHWAY

Dr Saam Sedehizadeh, Consultant Neurologist, Neil Ellis, Pathway General Manager and Kirstie Spencer, Muscular Dystrophy Care Advisor at Nottingham University Hospitals NHS Trust (NUH) introduced a briefing paper on the Muscular Dystrophy pathway, including the physiotherapy service at NUH, making the following points:-

- the Neuromuscular Service at NUH was the only specialist provider of neuro-muscular services in the East Midlands, and was the only hospital in the region providing a diagnostic service;
- the adult neurology service provided a service to 485 adult patients across Nottinghamshire, Lincolnshire, Leicestershire and Derbyshire. While there were some emerging treatments for the condition, the primary focus of the service was on disease management;
- there was no neuro-muscular therapist available to join the specialist neurology clinic, and currently had access to the community neuro team (Nottingham City residents only) and the therapy services based at Linden Lodge. Neither service was available to residents outside the Nottinghamshire area;
- NUH had made funding available to fund a 0.4 full time equivalent physiotherapist post, and the recruitment process for this post was ongoing, with interviews scheduled for end May 2019. NUH had lobbied the NHS

Greater Nottingham Clinical Commissioning Partnership for a full-time post based in both primary and secondary care, but had been unsuccessful.

During discussion, the following points were made:-

- Multi-CCG funding for the service had been attempted but not secured, in part because of the relatively small cohort spread across a wide geographic area;
- It was confirmed that the 0.4 physiotherapist post would be primarily involved in delivering therapeutic rather than diagnostic services;
- The Committee noted that there was a muscular dystrophy Support Centre based in Coventry, with a satellite service based in Loughborough;
- In response to comments that that was unclear whether a physiotherapy treatment 'pathway' was in place, Dr Sedehizadeh expressed the view that he was not convinced that a single pathway could be achieved, given the very heterogeneous nature of the cohort and the difficulty in getting a diagnosis;
- The Committee asked that the Chair of Nottinghamshire Health and Wellbeing Board be requested to write to the NHS Greater Nottingham Clinical Commissioning Group, requesting an explanation for not funding the full-time physiotherapy post, to ask why other CCGs in the region were not requested to support the service and to respond to the view expressed by the Committee that the current service did not appear to be 'joined-up', but was 'patchwork' in nature;
- The Committee request an update on the Muscular Dystrophy Pathway in six months.

The Chair thanked Dr Sedehizadeh, Mr Ellis and Ms Spencer for their attendance.

7. DENTISTRY IN NOTTINGHAMSHIRE

Laura Burns, Contracts Manager Dental and Optometry at NHS England and Alan Reid, Public Heath England introduced a briefing paper, circulated with the agenda, on NHS Dental Services in Nottinghamshire.

The following points were made:-

- Dental contract arrangements underwent major reform in 2006, using a reference point in 2005 under which 'units of dental activity' were allocated;
- Since 2006, new schools, business and housing have been established and dentistry provision has not always kept pace with these changes. Nottinghamshire currently has 78 NHS dental practices;
- Nottinghamshire has levels of tooth decay that are lower than the average for England. However, within Nottinghamshire, there are marked levels of inequality in respect of tooth decay in Mansfield and Ashfield;

- The Joint Strategic Needs Assessment in respect of oral health should be published by the end of 2018, on the basis of which targeted intervention would be commissioned.

During discussion the following points were raised:-

- It was explained that information was not available on the number of people on waiting lists for NHS practices. Information on NHS practices was available on the NHS Choices website;
- The NHS England initiative Starting Well was to be rolled out. This would engage with schools and young families to encourage good oral health habits from an early age. Health visitors carried out oral health checks on babies and young children from age 1. The view was also expressed that young families may not be aware that dental treatment for children was free;
- Healthwatch was the appropriate forum to raise complaints about access to dentistry services in the first instance;
- Mr Reid expressed the view that fluoridation of water did not foster complacency about oral health among the general population, on the basis that very few people were aware of fluoridation levels in their water supply;
- It was accepted that prevention activity, such as gum disease prevent initiatives, could have a positive impact on oral health. However, there were limited resources available, and these needed targeting in areas of greatest need.

The Chair thanked Ms Burns and Mr Reid for their attendance.

8 WORK PROGRAMME

The Committee agreed the following amendments to the work programme:-

NUH Improvement Plan Update
Add to November 2019 meeting

NUH Winter Plans
Add to May 2020 meeting

Muscular Dystrophy Pathway Update
Add to November 2019 meeting

Dentistry in Nottingham Update
Add to November 2019 meeting

Access to School Nurses
Add to a future meeting.

Allergies in Children
Add to a future meeting

The meeting closed at 12.58pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

18 June 2019

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

CLINICAL COMMISSIONING GROUP MERGER

Purpose of the Report

1. To agree a consultation response on the Clinical Commissioning Group merger.

Information

2. The Nottingham and Nottinghamshire Clinical Commissioning Groups (NHS Nottingham West CCG, NHS Newark and Sherwood CCG, NHS Nottingham North and East CCG, NHS Mansfield and Ashfield CCG and NHS Rushcliffe CCG have recently commenced a consultation on merger. Their consultation document is attached as an appendix to this report.

3. Representatives of the Nottinghamshire commissioners will attend the Health Scrutiny Committee meeting to present information and answer questions as necessary.

4. The proposed response from this Health Scrutiny Committee is attached as a further appendix to this report for agreement (the commissioners have kindly agreed to receive the response from the committee even though it will be submitted just after the deadline).

5. Members are invited to discuss the draft response and agree the final wording.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Discuss the draft response

2) Agree the final wording

3) If necessary, delegate the task of amending the draft response to reflect Members' views to the lead officer in association with the Chairman of the committee, as appropriate.

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

Consultation Document

Future arrangements for NHS commissioning across Nottingham and Nottinghamshire

Ensuring everyone in Nottingham and Nottinghamshire has the best possible health and wellbeing

We can provide this document in other languages and formats, such as Braille and large print, on request. Please telephone 0800 028 3693 or email Ncccg.patientexperience@nhs.net for more information.

About this Consultation

This consultation is jointly led by the six NHS Clinical Commissioning Groups (CCGs) across Nottingham and Nottinghamshire. We are collectively considering the future of commissioning arrangements for the area we serve and would like to invite views from key stakeholders on the options available.

This consultation is aimed at stakeholders who work closely with commissioners and would be impacted by the proposed new structure and governance arrangements. However, the consultation paper is a public document and we would welcome feedback from anyone with an interest in the proposals. For the purposes of this consultation, our key stakeholders include:

- Member GP Practices
- Local clinicians
- Healthwatch and other patient representative bodies
- Voluntary and community services
- Local authorities
- Other healthcare partners
- CCG Staff
- Local decision makers

What is not included

This consultation is about commissioning arrangements only. It does not relate to any other NHS organisation or NHS-funded services, such as hospitals, mental health organisations, or primary and community care, and will not affect the funding they receive from us.

This proposal is specifically about the future of the six Nottinghamshire NHS CCGs described on page 4. It does not consider Bassetlaw in the north of Nottinghamshire and so does not include Bassetlaw CCG. This is because this particular area will remain part of the South Yorkshire and Bassetlaw healthcare system.

Contents

Introduction

Dear Colleague,

We are consulting on a proposal to change the future of commissioning for Nottingham and Nottinghamshire.

You will be aware that we have been working in closer alignment since the area became one of the first-wave of Integrated Care Systems (ICSs) nationally in 2017.

Over the past year, we have engaged with member GPs, local clinicians, healthcare partners, patient representative groups and others in exploring how our six CCGs can work more efficiently and effectively across the healthcare system.

We are forming a single joint leadership team and will begin a wider internal reorganisation during the summer this year.

We believe that our natural next step should be to establish one single organisation. We also need to make sure our valuable resources are used in the best way to support people in living longer, happier, healthier and more independently into their old age. We would like to seek your views and opinions about our proposal to merge, before making a formal application.

Whatever our future form, our main focus will remain on ensuring that everyone living in Nottingham and Nottinghamshire has the best health and wellbeing they can. To achieve this we will work together, alongside our health and care partners, to provide people with access to quality healthcare and reduce the health inequalities that exist today.

This decision will have an impact on how we operate as commissioners and how we work together. We ask that you please take the time to consider our proposal and respond to us with your views by 9am Monday 17th June.

We look forward to hearing from you.

Ever-closer collaboration and integration has been a natural progression for our six CCGs since they were established in 2013

Nicole Atkinson
Clinical Chair
NHS Nottingham West CCG

Thilan Bartholomeuz
Clinical Chair
NHS Newark and Sherwood CCG

James Hopkinson
Clinical Chair
NHS Nottingham North and East CCG

Gavin Lunn
Clinical Chair
NHS Mansfield and Ashfield CCG

Hugh Porter
Clinical Chair
NHS Nottingham City CCG

Stephen Shortt
Clinical Chair
NHS Rushcliffe CCG

Amanda Sullivan
Single Accountable Officer for all six CCGs

Existing commissioning arrangements

Our six CCGs are:

NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

NHS Newark and Sherwood Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Nottingham City Clinical Commissioning Group

How we are structured now

All six CCGs are separate statutory organisations with the same healthcare responsibilities and the need to meet legal and NHS duties.

Over the past five years, CCGs have worked more collaboratively, culminating in two geographical areas:

- Mid Nottinghamshire - 2 CCGs (worked jointly from March 2016)
- Greater Nottingham Clinical Commissioning Partnership (formed April 2018) - 4 CCGs

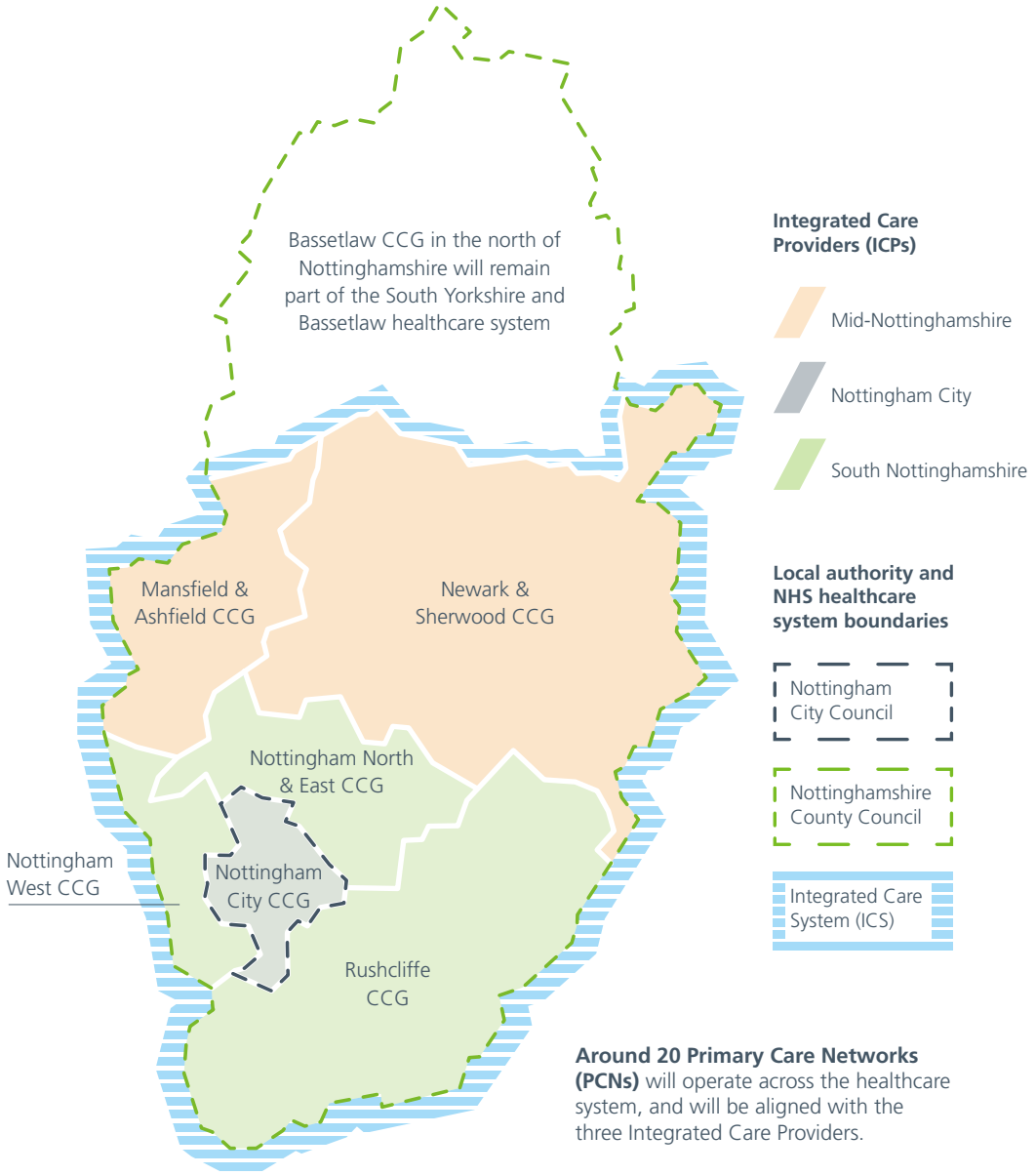
Over the past year, and well before the publication of the NHS Long Term Plan in January 2019, CCGs across Nottingham and Nottinghamshire had already started to consider the potential for a more formal joining up of commissioning arrangements.

In recent months, CCGs have introduced a number of joint arrangements to serve all six CCGs. We now have a single Accountable Officer supported by a single leadership team. Joint committees will soon meet 'in common' and the first joint Governing Body meeting will take place in July 2019. Transitional work is underway both to align wider CCG governance and to bring together staffing structures.

Our boundaries and the areas we serve

The map shows the areas covered by each CCG. It also demonstrates how our boundaries align with those of local authorities and the new Integrated Care System (www.healthandcarenotts.co.uk), which will coordinate healthcare across Nottingham and Nottinghamshire.

Nottingham and Nottinghamshire Integrated Care System (ICS)



Around 20 Primary Care Networks (PCNs) will operate across the healthcare system, and will be aligned with the three Integrated Care Providers.

Introducing our proposal

Each of the Nottingham and Nottinghamshire CCGs has a Governing Body responsible for leading decisions about commissioning with the involvement of member GP practices, local people, partners and other stakeholders. Chaired by a GP, Governing Body members include GPs, lay members, a nurse and a secondary care doctor, as well as non-clinical leaders.

We have discussed the possibilities for future commissioning arrangements openly with many organisations, groups and individuals over the past year, including member GPs, local authorities, voluntary services, hospitals and other healthcare partners.

These conversations have directly helped to shape our thinking, including the preferred proposal to merge. We understand that our stakeholders are supportive of a solution which paves the way for closer integration and better partnership working, enables more strategic commissioning, reduces administration costs, and releases valuable resources to focus on services and initiatives closer to the front-line.

All six CCG Governing Bodies agreed in April 2019 that our preferred way forward would be to fully merge, but no decisions have yet been taken and we remain open to the views of our key stakeholders. This document describes the merger proposal and explains why we have identified this as being the appropriate next step.

Our Proposal: Apply to merge the CCGs

A clear vision

Our overall commissioning aim is to enable people living across Nottingham and Nottinghamshire to have the best health and wellbeing they can.

To achieve this, we must work effectively with all our partners across the entire area to provide people with consistent access to quality healthcare. At the same time, we must also respond to the needs of specific populations and neighbourhoods so that we can reduce the health inequalities that exist today.

We therefore need to be able to operate at a 'system' level across the entire geographical area, as well as maintain our focus on more specific, local healthcare requirements.

The arrangements we put in place for commissioning should be fit for the future and be affordable and sustainable in the longer-term.

Merging to create opportunity

All six CCG Governing Bodies agreed in April 2019 that a merger represents the best opportunity for us to improve health and wellbeing across the areas we serve, as well as redirect clinical and other essential resources closer to the front-line where they are most needed. Delivering better health outcomes, reducing health inequalities, and improving the quality and consistency of local healthcare services are at the heart of our proposal. Whilst changes underway to the NHS around us are important and complement what we are proposing, they are not the primary reason why we feel a merger is the right thing to do.

Duplication ties up valuable resources

At present, the six CCGs do things multiple times – and often differently – across Nottingham and Nottinghamshire. We have the opportunity to reduce duplication, increase our consistency of approach (but not when differences are appropriate) and free up valuable resources, inlcuding clinical time, expertise and development support.

The NHS is changing around us

More widely, the NHS across England is developing to respond to the changing needs of the population. Like elsewhere, across Nottingham and Nottinghamshire we will soon see the creation of new organisations and partnerships. These aim to support health and care organisations in working more effectively together to deliver and improve services, from neighbourhood level all the way up to county-wide.

New Primary Care Networks and Integrated Care Providers will take on some of the existing responsibilities of our six CCGs, for example, leading the transformation of care pathways and creating a more comprehensive, personalised offer for local healthcare. Click here for more information.

Regardless of whether we merge or stay as we are, we believe we must give these new arrangements the best opportunity to succeed in delivering the best health and care services for our local population.

Top 5 benefits of merging

There are many advantages to merging our six CCGs. These will benefit - either directly or indirectly - patients and local people, GPs and other clinicians, health and care partners and many others. Here are the top five reasons why we believe we should combine our CCGs into one single, statutory commissioning organisation.

A full merger would allow us to provide:

1. Better healthcare and health outcomes	Align with health and care partners across the system in order to address health inequalities and ensure consistency of services where appropriate.
2. Better use of clinical and other resource	Save precious clinical time and resources that can be invested into tackling community health priorities via the new Primary Care Networks.
3. Stronger, consistent commissioning voice and leadership	Provide a stronger clinical voice in strategic decisions about health and care services, as well as at neighbourhood level via Primary Care Networks.
4. Greater support for transformation and local innovation	Scale-up the most successful local clinical innovations to rapidly share best practice across a wider area.
5. Significant administrative savings	Reduce duplication in back office functions in order to redirect clinical and other essential resources closer to the front-line where they are needed most.

Other benefits include:

- More control over defining and creating the health system we need and want for the population
- Greater buying power with the ability to deliver better value for money
- Better opportunity to attract, afford and retain staff with the right talent and skills
- Would help achieve a better balance between standardisation and personalisation of care across the area
- Taking forward the best practice from individual CCGs and agreeing common approaches to increase consistency and quality of care
- Making it easier for health and care partners to engage and work with us
- Meets the NHS Long Term Plan requirements
- More affordable so more likely to be sustainable in the longer-term

These benefits are explained in more detail on pages 14-15 in the supporting information section

Why we don't think we can stay as we are

NHS Long Term Plan

The system continues to change around us and we need to adapt. The NHS Long Term Plan sets clear expectations for the next generation of commissioning organisations. These include typically having a single commissioner within each healthcare system and one set of commissioning decisions. Staying as we are would not directly align with the national direction for the NHS.

Duplication and sustainability

We have made some savings by implementing joint arrangements across our CCGs. However, each CCG is a separate legal entity and it costs significantly more to service all six organisations than it would a single body.

Harder to focus on healthcare needs at a local level

The new Primary Care Networks and Integrated Care Providers will take on our existing responsibility to develop personalised care services which meet healthcare needs at neighbourhood level. Their work will directly inform our commissioning plans and activities.

In fact the new arrangements of one single CCG taking strategic decisions across the whole area and smaller PCNs at local level would directly lend themselves to having an even closer local focus, whilst at the same time enabling more effective commissioning of services across the entire geography.

We believe that by supporting, and working with these networks and alliances, we have an opportunity to strengthen our existing approach to commissioning for specific populations and communities.

We already have in place arrangements to engage and involve local people, clinicians, partners and others in the development of our commissioning plans. Over the coming weeks we are creating a new communications and engagement strategy with the aim of building on the good practice of today.

Running costs of six CCGs versus one

If we continue to run multiple CCGs the costs incurred will be much higher than having one streamlined organisation. The time and money spent on governance arrangements and essential statutory duties e.g. annual reports that could be invested in delivering care for patients.

Furthermore, with the shared arrangements we already have for leadership and governance, many of the collaborative arrangements we would need are already in place. Not proceeding to the next logical step of merging would mean that the momentum and progress on delivering better health for the people of Nottingham and Nottinghamshire would be lost.

The new Primary Care Networks and Integrated Care Providers will take on our existing responsibility to develop personalised care services which meet healthcare needs at neighbourhood level.

Why we don't think we can stay as we are

Improving clinical leadership, involvement and engagement

At present, the six CCGs employ clinical leaders and clinical staff, and involve and engage many more GPs and other local clinicians. A single organisation would not require as much clinical resource and would encourage the streamlining of related programmes and activities.

A significant proportion of these clinical resources are tied up in duplicate activity as well as in the administration of the CCG itself.

If the decision to proceed to merger is not taken then this valuable clinical resource will continue to be invested in CCG administrative responsibilities rather than seeing patients on the front line, where they are most needed.

How to share your views

This consultation ends at 9.00am on Monday 17 June 2019. So that we can fully consider your views when we finalise our proposals, your feedback must be received by this time.

Over the next few weeks, senior representatives from the CCG will be meeting with GP member practices and other stakeholders, and we will be involved in a number of other events and activities. For more information, please visit our website:

www.nottinghamnortheastccg.nhs.uk/nhs/ccgs-merger/

Please share your views by:

- Completing our online survey ***www.surveymonkey.com/r/ProposedCCGMerger***
- Responding to the questions on page 11 and sending your answers to us
- Downloading the question and answer sheet from our website and sending the completed document to us by:

  Email: ncccg.patientexperience@nhs.net

  Post (no stamp required):
  Freepost RTGE-CRAT-BABH
  NHS Mansfield & Ashfield CCG
  Birch House
  Mansfield
  NG21 0HJ

If you need help or have any questions about this consultation, you can email us (see left) or call on 0800 028 3693. This includes if you would like to attend an event, require translation services, need us to post information to you or require help with the online questionnaire.

We would encourage you to complete the consultation questions online if you can.

This approach makes it easier to process feedback and compare the views of different groups. The online consultation questionnaire can be accessed from anywhere provided that you have a suitable device with an internet connection.

You will have the opportunity to share your views openly as well as being asked a number of specific questions. You don't need to answer all the questions if you don't want to.

www.surveymonkey.com/r/ProposedCCGMerger

Consultation questions

The questions we are asking in relation to this consultation are:

Q1

To what extent do you support our proposal to merge the six CCGs and create a single commissioning organisation?

Please explain your answer

Q2

To what extent do you support keeping the CCGs as they are now?

Please explain your answer

Q3

Is there anything else you think the CCGs should consider when discussing future arrangements for commissioning?

What happens next

Finalise proposals

We will formally consider the feedback we receive from you during our joint Governing Board meeting on 4 July 2019. Stakeholder views will directly inform our decision as to whether to make a formal application to merge.

NHS England review

If the agreed option is to merge, an application would be made to NHS England for approval. This is the organisation that leads the National Health Service (NHS) in England and is responsible for overseeing our commissioning activities.

NHS England will be particularly interested in the feedback we receive from you. They will want to make sure that our proposed plans are appropriately supported by our key stakeholders, in particular, GP member practices, Healthwatch and healthcare partners. They will also want to make sure that we have effective plans in place to ensure effective clinical leadership as well as ongoing engagement with local people, clinicians and other stakeholders in any new arrangements.

Responding to stakeholder feedback

We have appointed independent parties to evaluate the responses we receive. Their report will summarise what key stakeholders have told us and we will share this on our website. We will discuss feedback in Governing Body meetings and other forums, and will respond formally to the feedback we receive.

Latest news and information

Please visit our website where you will find the latest news and information about this programme of work.

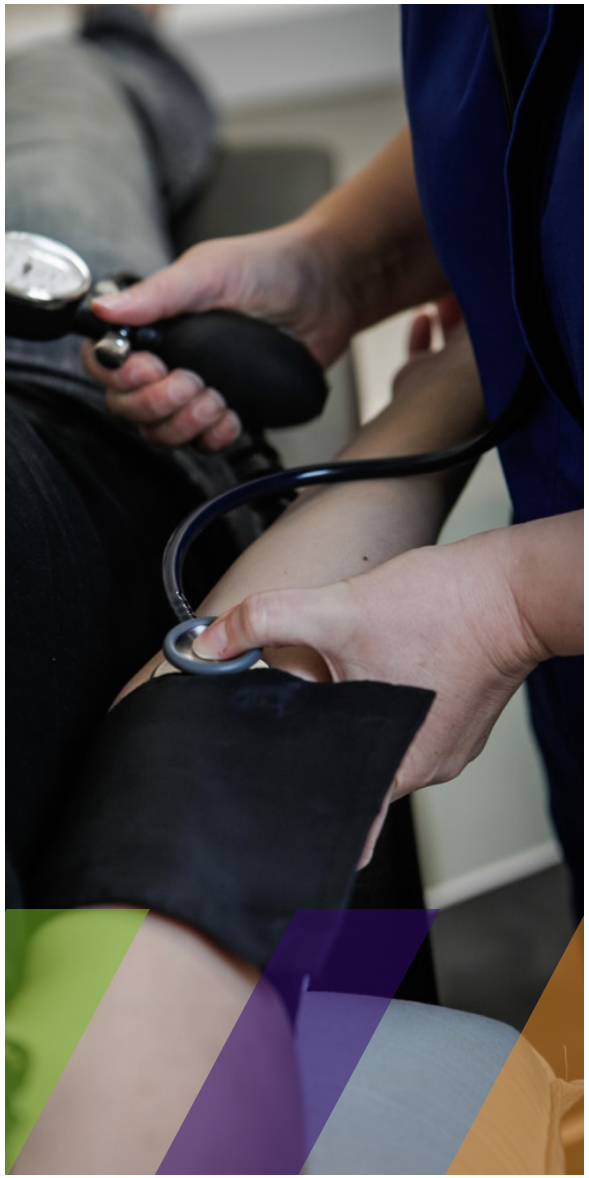
www.nottinghamnortheastccg.nhs.uk/nhs/ccgs-merger/

You can also contact us if you have any queries about the consultation – please see details on page 10.

Timescales

Should we agree to merge and NHS England accepts our proposal, the single CCG organisation would be in place from 1 April 2020. In the meantime, we will make the various organisational changes that need to be made in readiness and will engage with key stakeholders to inform this work.

If we decide not to make an application for merger, we will continue to implement existing plans for closer collaboration between CCGs and will discuss how we can work in the most effective way with the emerging arrangements across the new Integrated Care System.



Supporting Information

The following pages provide further detail about:

- Top 5 merger benefits explained
- The new NHS arrangements and where commissioning will sit
- Plans underway to deliver essential CCG requirements or 'must-haves' in the future

Top 5 benefits of merger explained

There are many advantages to merging our six CCGs. These will benefit - either directly or indirectly - patients and local people, GPs and other clinicians, health and care partners and many others. Here are the top five reasons why we believe we should combine our CCGs into one single, statutory commissioning organisation.

A full merger would enable:

1. Better healthcare and health outcomes

Being a single commissioner would complement emerging developments within the NHS arrangements around us, in particular the Integrated Care System (ICS), Integrated Care Providers and Primary Care Networks (find out more here). Our boundaries would mirror the ICS footprint and align with local authority boundaries (view here).

By structuring ourselves in the best way to enable health and care partners across the system to work more effectively and efficiently together, we would provide the best opportunity to improve healthcare, tackle health inequalities and ensure consistency of services in terms of quality and availability across Nottingham and Nottinghamshire.

2. Better use of clinical and other resource

Through the new Primary Care Networks and Integrated Care Providers, GPs and other healthcare providers will focus on developing and delivering services to meet healthcare needs in their neighbourhoods, whilst still being involved in strategic commissioning through their membership of the CCG.

Duplicating commissioning activities, particularly where clinicians are involved, uses valuable time and resources, which could be freed up to deliver and support front-line services where they are most needed.

3. Stronger, consistent commissioning voice and leadership

As a single body we would provide a stronger, single and more consistent commissioning vision, leadership, voice and approach for the Nottingham and Nottinghamshire health and care system. Clinical leadership would have a greater impact, with consistent decision-making and more clinical efficiency at a system-level, as well as within neighbourhoods through Primary Care Networks.

"A single CCG would remain a clinically-led, GP membership organisation. Strong clinical leadership, together with the involvement of local people, clinicians and partners, remains an absolute priority."

Top 5 benefits of merger explained

4. Greater support for transformation and local innovation

Working across the system to implement a single, cohesive strategy, accompanied by speedier decision-making, would enhance the pace at which transformation can be achieved. We could therefore deliver better patient health outcomes more quickly and effectively, and improve the consistency of services as well as our approach to commissioning.

Front-line clinicians would be able to innovate locally to deliver our strategy consistently within and across neighbourhoods, with best practice properly supported, identified and applied more rapidly across a wider area.

5. Significant administrative savings

Having a single organisation would eliminate duplication of administrative support functions like finance, payroll and procurement. The significant savings made would be better channelled into addressing priority activities which deliver real benefits for local healthcare, rather than serving the CCG organisations themselves.

CCGs have to make a 20% saving in running costs by 2020/21*. At present, this would need to be applied to each of the six CCG budgets. Reducing duplication through merger would make a significant contribution towards this saving. Furthermore, by pooling together, we could collectively address the target in a more innovative and effective way, ensuring ongoing funding for the commissioning activities we need the most.

* The 20% cost savings are to be applied only to CCG administration costs. Patient services, such as hospitals, GPs and community services, are not part of CCG running costs and will NOT be affected.

Other benefits include:

- More control over defining and creating the health system we need and want for the population
- Greater buying power with the ability to deliver better value for money
- Better opportunity to attract, afford and retain staff with the right talent and skills
- Would help achieve a better balance between standardisation and personalisation of care across the area
- Taking forward the best practice from individual CCGs and agreeing common approaches to increase consistency and quality of care
- Making it easier for health and care partners to engage and work with us
- Meets the NHS Long-Term Plan requirements
- More affordable so more likely to be sustainable in the longer-term

‘Must-Haves’

Our ‘Must-Haves’

Regardless of the future arrangements for commissioning, there are a number of ‘must-haves’ that we are committed to delivering. Although they do not form part of this consultation because we need to do them anyway, we recognise that they are likely to be of particular relevance to our GP members.

We must have:

- ✓ The ability to deliver our commissioning ambitions and responsibilities effectively and as quickly as possible, both at neighbourhood level and across the entire geography we serve
- ✓ Strong clinical leadership and involvement in the new arrangements (find out more here)
- ✓ Effective engagement with local people, clinicians, healthcare partners and others to inform commissioning decision making and activities from neighbourhood lto system-wide levels (find out more here)
- ✓ An ongoing focus on the health and care needs of neighbourhoods or specific populations, as well as a strategic focus across Nottingham and Nottinghamshire (find out more here)
- ✓ A single commissioning vision with strategic priorities and health outcome goals at system, place and neighbourhood levels
- ✓ The best opportunity to work effectively with our partners and pave the way for better integration of health and care services
- ✓ The ability to deliver both the 20% savings in CCG running costs* by 2020/21, and restore financial balance across the system in the foreseeable future

* Running costs relate to the administration of the CCG organisation itself, e.g. payroll, finance and procurement. They do not include patient services, which are covered by a separate budget and which will not be affected by this consultation.

‘Must-Haves’

Regardless of the future arrangements for commissioning, there are a number of ‘must-haves’ that we are committed to delivering. As well as asking for your response to this consultation, we welcome views on how we can enable these ‘must-haves’ to happen.

Must-Have 1: Clinical leadership and involvement

Strong clinical leadership and involving clinicians in making healthcare decisions are essential aspects of commissioning. All GP practices are members of a CCG and have a say in what, and how, local NHS services are provided. None of this will change, even if we become a single commissioning organisation.

As well as GPs, we also involve clinicians from hospitals, mental health and community services, and other care settings in our decision-making. Listening to, and learning from, the experiences of front-line clinicians helps us to commission better services for local people in the long-term.

We believe that the good work taking place within CCGs to involve clinicians must not only continue, but be strengthened in any new arrangements. Our GP clinical chairs are developing plans to make sure this happens, and which include:

- CCGs will continue to be clinically-led. Depending on the outcome of this consultation, several GP leaders, a nurse and a secondary care doctor would sit on either an overarching Governing Body, or on a joint committee representing each CCG (as they do now). Our supporting CCG committees will maintain strong clinical involvement, with members including GPs, pharmacists and Allied Health Professionals
- We are working with partners to ensure leadership by, and the involvement of, GPs and other clinicians within the new ICS, ICP and PCN arrangements. Each PCN will be led by a designated Clinical Director
- We will create a specialist clinical group or ‘cabinet’ across Nottingham and Nottinghamshire to provide clinical advice and scrutiny of developments within care pathways and other significant programmes of work
- We will combine similar programmes of clinical work underway across CCGs, e.g. urgent care, cancer or end of life, with each programme led by a senior clinician

If you would like to help shape our thinking around clinical leadership and engagement, including how we can nurture diverse, compassionate and inclusive leadership, please share your views and these will be forwarded to the senior clinical team overseeing this work.

Key question:

How can we ensure ongoing clinical leadership in any future commissioning arrangements, and how can we strengthen what we do already?

Must-Have 2: Effective engagement

Regardless of what our future organisational arrangements look like, we remain committed to engaging and involving our key stakeholders in our commissioning activities.

As happens now, the Governing Body of a single CCG would include patient representatives (lay members) and clinical leads including a GP Clinical Chair, other GPs, a nurse and a secondary care doctor. We would also continue to strengthen and build upon our arrangements for involving and engaging local people, clinicians, CCG staff, partners and others in our everyday activity, which include patient participation groups, patient and public engagement committees, lay member representation and other events and activities.

‘Must-Haves’ (continued)

Effective engagement (continued)

By introducing an Integrated Care System and three Integrated Care Providers which mirror local authority boundaries overall, our partners should find the NHS across Nottingham and Nottinghamshire much more accessible and easier to work with. Furthermore, services delivered by partners at a neighbourhood level, e.g. voluntary services and social care, will be able to work more closely with NHS providers through the Primary Care Networks.

Over the next few weeks we will be refreshing our communications and engagement strategy and will be involving our various stakeholders in doing so. The strategy will include plans for strengthening our approach to engaging with patients, GPs, partners and others, whether as six separate organisations or as a single commissioner. Although not part of this particular consultation, we would welcome your views on how we might achieve this.

Key question:

How can we strengthen our arrangements to involve local people, GPs, other clinicians and healthcare partners in future commissioning activities?

Key Must-Have 3: Ensuring a focus on the health and care needs of neighbourhoods or specific populations, as well a strategic focus across Nottingham and Nottinghamshire

The Primary Care Networks and the three Integrated Care Providers have an essential role to play in understanding, recommending and delivering the services needed at a local level. Based on clinical evidence and experience at a local level, their recommendations will directly inform our commissioning strategy across Nottingham and Nottinghamshire. In turn, PCNs and ICPs will deliver our commissioning aims at a local level, personalising services as required both within and across their neighbourhoods.

Because more clinicians and other healthcare providers will work together to inform services in a specific area, we believe that there will be a far better opportunity to get services right locally.

As a single commissioner with oversight of all these needs, we would also be able to identify where needs are the same across different areas. This means that we can plan and buy unique services for specific neighbourhoods or populations. We can also ensure that consistent services are available across all areas where needed.

As part of our communications and engagement arrangements, we ensure that we listen to, engage and communicate with neighbourhoods and communities across the area we serve. Through patient participation groups, patient and public engagement committees and groups, lay member representation and various events and activities throughout the year, we ensure that patients have a strong voice and are able to help shape our strategies, plans and activities both within neighbourhoods, and across the area we serve.

Regardless of our future organisational form, we remain committed to this type of engagement and will continue to build upon what we do already.

Key question:

What else should a strategic commissioner do to ensure a continuing focus on health and care needs at a local level?

New and emerging NHS arrangements

The NHS is changing around us to meet the developing needs of people living across England, whilst making better use of public funds. These changes are aimed at achieving greater consistency in the quality and availability of healthcare services, and to address health inequalities. They will also streamline healthcare activities, enabling commissioners to do what they do best, e.g. assessing needs and setting meaningful outcomes, whilst supporting providers in doing what *they* do best, e.g. innovating and delivering personalised care solutions to the people they serve.

The new nationwide arrangements will help NHS organisations to take a more strategic view of healthcare across a wider population, to identify common areas of health need and to address them collectively instead of doing things many times and differently. People will find it easier to gain access to healthcare services that both meet their needs and are consistent across the wider area. In turn, this will help address the 'postcode lottery' where some people do not have access to the same services because of where they live.

Our new Integrated Care System (ICS) will bring together NHS organisations, local authorities, voluntary services and other key partners within Nottingham and Nottinghamshire. With a strategic view across the entire geography, the ICS will focus on achieving the best possible health and care services for the entire population, as well as for specific populations and neighbourhoods.

At the same time as enabling a more strategic approach, the changes support a greater clinical focus on healthcare within specific neighbourhoods through the creation of Primary Care Networks (PCNs). The PCNs across Nottingham and Nottinghamshire will in turn be aligned to one of three Integrated Care Providers to collaborate across a wider area in delivering and improving healthcare services.

The changes also aim to make the NHS more efficient and effective by reducing unnecessary duplication and by placing clinical and other valuable resources closer to the front-line.

More about the new arrangements being set up across Nottingham and Nottinghamshire can be found overleaf.

You can find out more about nationwide NHS developments, why they are being made and what they aim to achieve in the *NHS Long Term Plan*, available on the following website: **www.longtermplan.nhs.uk**

Locally, our commissioning priority is to ensure that everyone living in Nottingham and Nottinghamshire has the best possible health and wellbeing they can. We believe the new NHS arrangements being introduced across our area will help us to achieve this. We want to give them every opportunity to succeed and recognise that we will need to adapt the way in which we work if we are to make this happen.

Having explored the various options, we believe that the new arrangements would benefit most from having a single commissioning organisation.

An overview of new NHS arrangements for Nottingham and Nottinghamshire

Primary Care Networks (PCNs) - NEIGHBOURHOODS

As well as having a view of healthcare across the overall area, it is equally essential that we maintain our focus on local needs within a specific neighbourhood or population. Primary Care Networks (PCNs) are being set up to do exactly that. Around 20 new PCNs will be set up across our area so that organisations providing healthcare services at a local level can work even better together.

PCNs will consist of groups of general practices working together with a range of local providers, including primary care and community services, mental health, social care and the voluntary sector. Through these networks, local health and care providers will focus on delivering more personalised, coordinated health and social care to meet the needs of their particular neighbourhood.

PCNs will be led by clinicians and will be appropriately funded, resourced and supported. They will be aligned to one of three Integrated Care Providers (ICPs) according to their geographical location.

Integrated Care Providers (ICPs) - PLACE

All PCNs will belong to one of three Integrated Care Providers (ICPs). These will serve wider populations living within the geographical areas of Nottingham City, Mid-Nottinghamshire* and South Nottinghamshire**. These areas reflect local authority boundaries overall, and build on existing collaborations and alliances which have proven to work well.

ICPs are alliances of health and care providers, including PCNs, that will work together to deliver care by agreeing to collaborate rather than compete. They will be responsible for the cost, quality and consistency of services for the population they oversee. They will develop better pathways of care for patients and more effective ways of working together. Like PCNs at a neighbourhood level, ICPs will inform commissioning decisions relating to the area they serve.

* Mid-Nottinghamshire: Ashfield, Mansfield, Newark and Sherwood
** South Nottinghamshire: Broxtowe, Gedling and Rushcliffe

Our Integrated Care System (ICS) - SYSTEM

The NHS is not the only body that plays a key role in influencing and responding to people's health and wellbeing. For example, local authorities are a major partner because they provide social care, public health and other services which influence the health and wellbeing of the population. Other important partners include voluntary services and the independent sector.

Under the new changes, NHS, local authorities and other key organisations will form a partnership across a designated geography, called an 'Integrated Care System' or 'ICS'. Locally, our ICS covers the geography of Nottingham and Nottinghamshire excluding Bassetlaw, which is historically aligned to services within South Yorkshire. Together, partners within the ICS will focus on ensuring the best possible health and care services both across the entire area, as well as for specific populations and neighbourhoods.

An ICS organisation will provide clinical and administrative expertise to support health and care partners in working together effectively across the area. It will also take the lead on workforce planning and play a regulatory role.

Responsibilities of new organisations and alliances

SYSTEM:
Nottingham and Nottinghamshire Integrated Care System (ICS)

Population: 1 million+

Partner organisations work together to oversee health and care across Nottingham and Nottinghamshire

Key responsibilities:

- Respond to ICP and PCN feedback and recommendations, and set the healthcare strategy for the system to include expected health outcomes
- Improve local health and wellbeing across the entire area and at neighbourhood level
- ***Strategic Commissioning (clinically-led)****
- Manage resources and workforce planning
- Coordinate health and care partnerships
- Regulation

****This is where future commissioning arrangments will fit***

PLACE:
Three Integrated Care Providers (ICPs)

Population: 330,000 - 700,000

Health and care providers collaborate across the geography (place) they serve

Key responsibilities:

- Oversee the cost, quality and consistency of services
- Develop better pathways of care and more effective ways of working together
- Inform commissioning decisions
- Deliver commissioning strategies and plans
- Tailor healthcare where appropriate to meet needs within their place

All PCNs will be aligned to one of the three ICPs

NEIGHBOURHOOD:
Primary Care Networks (PCNs*)

Population: 30,000 - 50,000

GPs work with social care, pharmacists, mental health and other local health and care providers to focus on services within their neighbourhoods

Key responsibilities:

- Deliver coordinated health and care services within their neighbourhood
- Personalise services on their doorstep to meet specific local needs
- Innovate locally to deliver and inform commissioning decisions and plans
- Encourage, represent and respond to the local patient voice

Each PCN will be led by a clinical director

*The number of patients in each PCN is flexible depending on the locality. There will be around 20 PCNs across the area. This is subject to discussion and agreement in May 2019.

How does commissioning fit within new NHS arrangements?

Whether as a single organisation or through joint arrangements, CCGs must both meet the national criteria, and deliver the system requirements as effectively as possible.

We believe that a single, strategic commissioning organisation would have the best opportunity to make this happen. Furthermore, we would be supporting the delivery of care closer to home by reducing duplication and moving valuable resources closer to the front-line, as well as by supporting the collaboration of primary, secondary and community care providers.

The Long Term Plan clearly sets out the expectations for local commissioning, and signals significant changes to the role that commissioners will play within their health and care system.

Key aspects can be summarised as follows:

- Typically, there will be a **single commissioner** within each ICS area
- Every ICS is expected to enable a **single set of commissioning decisions** at system level
- CCGs must become **leaner, more strategic organisations** that support providers in partnering with local government and other community organisations
- Working through the ICS, commissioners will make **shared decisions with providers** about using resources, designing services and improving population health
- Commissioners will be exclusively **responsible for certain decisions,** e.g. procurement and the awarding of contracts
- **Streamlined commissioning** arrangements across the ICS footprint are essential

Although arrangements for the Nottingham and Nottinghamshire ICS are still emerging, a number of requirements have already been agreed for the role of a future strategic commissioner.

These are:

- **Commissioning for outcomes** within and across neighbourhoods through the development of ICP contracts and PCNs
- Commissioning the **transformation of services,** designing and delivering large-scale change in conjunction with partners
- Overseeing and mitigating any **quality and equality impacts** of service change
- Providing **professional leadership** across the system (nursing, therapies, pharmacy, linking general practice with secondary care)
- Driving the **personalisation agenda** whereby services are tailored to specific needs
- Agreeing a long-term system **financial strategy for the system,** including achieving financial balance
- Delivering a 20% **reduction in commissioning running costs** by 2020/21

Glossary

CCG	Clinical Commissioning Group
ICS	Integrated Care System
ICP	Integrated Care Provider (Three within Nottingham and Nottinghamshire healthcare system)
NHS England	The organisation that leads the National Health Service (NHS) in England and is responsible for overseeing our commissioning activities.
PCN	Primary Care Network (there will be around 20 across Nottingham and Nottinghamshire)

Health Scrutiny Committee Response – June 2019

Future Arrangements for NHS commissioning across Nottingham and Nottinghamshire

Question 1: To what extent do you support our proposal to merge the six CCGs and create a single commissioning organisation?

The Health Scrutiny Committee for Nottinghamshire supports the merger of the six Clinical Commissioning Groups into a single body, particularly on the grounds of significant administrative savings and reduction of duplication. The committee is keenly aware of the financial challenges faced by the CCGs, and any reasonable methods of reducing costs are to be welcomed.

The streamlining of management and decision making processes expected to flow from the merger is also to be welcomed. The Committee anticipates greater coherence of purpose and leadership from the merger. It will undoubtedly be easier for the Health Scrutiny Committee to engage with a single organisation rather than six, and that is equally true for other organisations and stakeholders.

The nature of the proposed relationship between Primary Care Networks and CCGs (as well as the expectations of NHS England) is something that the Committee would like to hear about in more detail at some point in the future. NHS England's expectation is that the networks will be geographically based and provide coverage across a whole CCG boundary. It would be informative to hear about networks which cross CCG boundaries or where there are instances of practices belong to more than one Primary Care Network.

Question 2: To what extent do you support keeping the CCGs as they are?

The Health Scrutiny Committee supports the proposal to merge the CCGs.

Question 3: Is there anything else you think the CCGs should consider when discussing the future arrangements for commissioning?

Commissioners should consider more closely involving members of the public (patients and carers) in service design. When commissioners are consulting on substantial variations of service they should always consult fully on the options they are seriously considering. Where 'hybrid-options' emerge as the CCGs preferred way forward during the process of consultation these should trigger further consultation.

Nottinghamshire County Council

Report to Health Scrutiny Committee

18 June 2019

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

EAST MIDLANDS AMBULANCE SERVICE

Purpose of the Report

1. To introduce a briefing from the East Midlands Ambulance Service.

Information

2. The Health Scrutiny Committee receives regular briefings on the work of the East Midlands Ambulance Service (EMAS), particularly in relation to recruitment and performance issues.

3. Representatives of the East Midlands Ambulance Service, Greg Cox, General Manager for Nottinghamshire and Annette MacFarlane, Service Delivery Manager for Nottinghamshire will attend the Health Scrutiny Committee meeting to present information and answer questions as necessary.

4. A written briefing from EMAS is attached as an appendix to this report.

5. Members will wish to indicate when they would like EMAS representatives to return for further scrutiny of their services.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration.

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

17 May 2019

Briefing for Nottinghamshire Health Overview and Scrutiny Committee
Meeting: Tuesday, 18 June, 2019

East Midlands Ambulance Service provides emergency 999 care and telephone clinical assessment services for a population of 4.8 million people.

On average we receive a new 999 call every 32 seconds – around 2,710 calls a day.

Recruitment

As discussed at the last meeting, in May 2018, it was announced that we have agreed new contract terms with Hardwick Clinical Commissioning Group (CCG).

Hardwick CCG – which manages the EMAS contract on behalf of 22 CCGs across the region – has signed off the terms, which will see £9m extra funding for clinical staff, ambulances and other resources being provided in the first year, potentially rising to approximately £19m next year, dependent on performance targets being met and other financial agreements made as part of the contract terms.

The additional funding has been agreed following a jointly commissioned, independent 'demand and capacity review'. The review identified a gap between the resources presently available, and what is needed to deliver national performance standards for ambulance services.

The new funding will directly address this gap, and is expected to result in a stepped improvement in EMAS ambulance response times and consistency of response across all areas of the East Midlands region.

We also introduced our new Urgent Care Service on 2 April 2018. These ambulance crews are specifically mobilised to provide care and transport for patients requiring urgent admission to hospital as determined by their GP or Health Care Professional (HCP). They can also transport patients requiring hospital admission but who do not need ongoing emergency medical treatment, as determined by our Clinical Assessment Team.

In Nottinghamshire, we are in the process of recruiting additional frontline colleagues.

We successfully achieved our recruitment target of 104 frontline colleagues for 2018/2019 financial year. We will be continuing our recruitment Programme and plan to recruit an additional 49 frontline staff 2019/2020.

As a Trust, we have so far recruited 373 new frontline colleagues in the East Midlands, of 484 new frontline colleagues. Of these 373 colleagues, 42 of them are Urgent Care Assistants.

We are also in the process of taking delivery of 4 additional ambulance vehicles in Nottinghamshire.

Current performance against targets

Following the demand and capacity review, a set of performance trajectories were set for each division. This was based on six standards.

Quarter 4-

6 Standards				
Categories	Mean Trajectories	Mean Actual	90th Percentile Trajectories	90th Percentile Actual
Cat 1	00:07:39	00:06:58	00:15:00	00:11:56
Cat 2	00:24:16	00:23:51	00:49:50	00:48:14
Cat 3	Not Included	Not Included	02:48:58	02:33:25
Cat 4	Not Included	Not Included	03:04:39	02:21:42

In Quarter Four, Nottinghamshire division has seen an increase in our response activity of around 6.5% from Quarter Four 2018. Which equates to around 17 additional responses per day and still managed to achieve all six trajectories set by the Commissioner's and achieving the national standards in Category 1, 3 and 4. Category 1 being our highest priority patients.

Overall we have seen improvements in all our standards in 2018/19 from 2017/18.

Issues around transportation of children following closure of A3 ward

This is a matter that concerns Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, rather than EMAS.

We have not had any involvement in the closure of the A3 ward or the transportation of children from the ward.

Nottinghamshire County Council

Report to Health Scrutiny Committee

18 June 2019

Agenda Item: 8

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

PATIENT TRANSPORT SERVICE

Purpose of the Report

1. To introduce a briefing on Patient Transport performance.

Information

2. The Health Scrutiny Committee receives periodic updates on provider achievement against key performance indicators for patient transport.

3. Representatives of the Clinical Commissioning Groups, Lucy Dadge, Director of Commissioning Greater Nottingham CCG and Neil Moore, Associate Director of Procurement & Commercial Development will attend the Health Scrutiny Committee meeting to present information and answer questions as necessary.

4. A written briefing from the Commissioners is attached as an appendix to this report.

5. Members may wish to schedule further consideration, if required.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedule further consideration, if necessary.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Health Scrutiny Committee Update

Nottinghamshire Non-Emergency Patient Transport Service

June 2019

Background

The NHS Non-Emergency Patient Transport Service (NEPTS) in Nottinghamshire and Bassetlaw is currently operated by Arriva Transport Solutions Ltd (ATSL). ATSL have provided the service since July 2012. ATSL have advised Commissioners that they are withdrawing from the Patient Transport Market. They have agreed to operate the Contract until 30th November 2019 when a new Provider will take over.

A full procurement has taken place and a new provider has been identified. There will be a formal announcement, supported by a communication plan, of the new Provider following CCG Governing Body approval in June 2019.

As part of the procurement process, the Commissioners took the opportunity to fully explore the NEPTS market in all regions of England and to identify areas of best practice and innovation. This included two intensive bidder presentation days where 15 different Providers both large and small had very open and frank discussions on an individual basis with Commissioners about the challenges of operating a Patient Transport Service. More detail on some of the interesting points raised is noted below.

The procurement also allowed discussions to take place with Stakeholders such as Nottingham University Hospitals NHS Trust (NUH) and Sherwood Forest Hospitals NHS Foundation Trust (SFHT), as well as patient groups, to identify how the service should be used cost effectively and to inform the groups where improvements in the service had been included in the Contract specification.

Engagement with patient groups has focused on how to apply the eligibility criteria in a fair and robust manner.

These meetings have been well attended to date and include:

- 2nd April 2019 Mid Notts Patient & Public Engagement Committee
- 8th April 2019 Rushcliffe Patient Cabinet
- 24th April 2019 Nottingham City Peoples Council
- 2nd May 2019 Nottingham West Patient Reference Group
- 21st May 2019 Nottingham North & East Patient and Public Involvement Committee
- 19th June 2019 Bassetlaw Patient Partnership Engagement Network

Examples of responses received:

“Training and clear understanding of the criteria and how to apply it for staff taking bookings”

“Eligibility criteria communicated clearly through all channels e.g. hospital clinics. Could information be given to patients with appointment letters?”

“Information to contain eligibility criteria and examples of where people would be eligible and where they wouldn’t against each criteria, in simple and easy to understand terminology. Also that their eligibility may change depending on their current circumstances as some people may think they are ‘registered’ to use it after the first time”

“Ask questions about their circumstances e.g. do you need……can you……. how do you….. things relating to their everyday/usual way of getting about and the mode of transport they use – all related to the criteria. E.g. How do they normally travel, Who assists them?”

Challenges

As discussed above, the bidder event allowed a frank and open discussion between Commissioners and bidders. During these discussions it became clear that throughout England NEPTS providers face a major challenge in dealing with increasing and fluctuating numbers of same day booked journeys. All NEPTS operations have a finite number of vehicles and crews supported by a mixture of additional third party providers who may be other private ambulance companies or approved taxi companies. Once these resources are all used up it proves extremely difficult to find additional resources at short notice to meet the on the day demand.

In all areas the NEPTS Providers pre plan their operation for each day on the day before. This allows for good utilisation of the available resources and highlights any demand issues. They also allocate some of their fleet and crews for same day operations but this will only ever be part of the overall resources.

The fluctuating demands on the acute hospitals in the region can mean that there are often urgent demands to make beds available by discharging patients at short notice. If these patients require NEPTS it can mean that the NEPTS Provider can receive up to 40 requests for transport in less than 2 hours, overwhelming the available resources and leading to delays and system blockages. During the meetings with the acute hospitals there was a clear recognition that they must try and give more notice to the NEPTS Provider to arrange transport and NUH, in particular, have been working closely with ATSL and Commissioners to improve the number of pre booked journeys and reduce the number of same day bookings. It is essential that these improvements continue and the Commissioners have used the opportunity of a new Contract to encourage this change of behaviour using Key Performance Indicators (KPI’s).

The bidders were all very honest about the standard KPI’s being too blunt an instrument and had a ‘cliff edge’ effect where just being one minute over the KPI window would result in failure. These comments have allowed Commissioners to revise the new KPI’s to make them more effective and flexible. The new KPI’s have been designed with a stepped approach which does not have a cliff edge but which encourages the NEPTS Provider to get as many patients within KPI bandings as possible and only penalises those journeys that are excessively late or early.

In addition the discharge departure times KPI’s have been split into Pre Booked and On the day bookings to try and encourage more pre booking of journeys. Information from other NEPTS Contracts that have adopted this standard has shown that there has been a measurable change in the behaviour of the hospitals who move from same day bookings to pre-planned bookings to maintain patient flow.

Current ATSL performance

For the reasons noted above ATSL have not been able to meet the current Key Performance Indicators in a number of areas. Until there is a reduction in the number of same day journeys, the acute hospitals will continue to prioritise same day bookings, particularly discharges, over pre planned journeys such as Outpatients. Despite ongoing challenges in meeting contract KPI's ATSL have continued to work with Commissioners and hospitals to improve service performance. ATSL have been encouraged by Commissioners to explore and present any potential initiatives that they could introduce to improve the KPI's in the short term and support the acute hospitals. Two such innovations have been a great success:

- **Renal shuttle bus service** – This service is in operation at Nottingham City Hospital and Lings Bar renal units. With the cooperation of the units and patient groups a cohort of patients within a defined geographical area were identified and asked if they would all travel together to and from their dialysis on a shuttle bus. Patients had all previously travelled individually in single vehicles. After some initial reticence from patients the service has proved extremely successful with high levels of patient satisfaction and KPI performance regularly above 95% inward and outward. The shuttle buses service operates at both units for morning, afternoon and evening dialysis appointments.

- **NUH dedicated discharge vehicle** – This is the introduction of a dedicated discharge vehicle working with the integrated discharge team at NUH. The vehicle and crew are available to discharge any patients quickly to designated sites within a limited geographical area surrounding the hospital. This ensures that the vehicle is never far from the hospital and also allows a swift response to late care package bookings with a limited acceptance window.

Current Key Performance Indicators

1. **KPI 2 - Appointment arrival time - within 60 minutes prior to appointment time**

KPI Target: 95%

KPI Summary – as reported by Arriva			Std.	Oct	Nov	Dec	Jan	Feb	Mar
KPI 2	**Arrival Times at Point of Care**	Patients shall arrive within 60 minutes prior to their appointment/zone time at the appropriate point of care.	95%	71.7%	71.8%	68.9%	68.6%	68.1%	67%

2. KPI 3 – Departure Times

KPI Target: 90%

KPI Summary – as reported by Arriva			Std.	Oct	Nov	Dec	Jan	Feb	Mar
KPI 3	**Departure Times at Point of Care**	Patients shall arrive within 60 minutes prior to their appointment/zone time at the appropriate point of care.	90%	64.4%	65.7%	64.8%	61.9%	57.8%	59.0%
		Discharge patients shall be collected within 120 minutes of request or agreed transport/or zone time.	90%	57.1%	58.6%	54.0%	52.3%	42.1%	46.5%

Renal KPI's

1. KPI2 - Renal Dialysis inward journeys (by appointment time)

KPI2 targets 95% and 100% respectively

KPI Summary – GEM, Renal only			Std.	Oct	Nov	Dec	Jan	Feb	Mar
KPI 2	**Arrival Time at point of care**	Patients should arrive at the site of their appointment no more than 30 minutes before their appointment time.	95%	74.4%	73.9%	64.8%	67.8%	64.9%	62.6%
		Patient will arrive at the unit before their appointment time.	100%	86.5%	87.4%	83.4%	85.4%	82.8%	87.3%

KPI3 - Renal Dialysis outward time (Collection)

KPI Summary – GEM, Renal only			Std.	Oct	Nov	Dec	Jan	Feb	Mar
KPI 3	**Departure Times at Point of Care**	Patients should leave the dialysis unit no later than 30 minutes after their booked ready time.	95%	77.0%	78.1%	76.5%	74.1%	79.2%	79.1%

As described above the new service will inlcude a new set of Key Performance Indicators, which can be found at Appendix 1.

Conclusion

The Commissioners believe that they have taken the opportunity of re-procuring the NEPTS Contract to provide a more reactive and flexible service that will allow the developments outlined in the NHS Long Term Plan to be accommodated within the Contract and to encourage the new Provider to engage with Stakeholders and Patients to understand, develop and improve the NEPTS Service in Nottinghamshire and Bassetlaw. By also providing realistic and achievable KPI standards it is hoped that the new Provider will achieve performance closer to the KPI standards and have fewer outliers who are late.

Appendix 1

PROPOSED NEPTS KEY PERFORMANCE INDICATORS

KPI No.	KPI Type	Indicator	Threshold %
	ARRIVAL TIMES AT APPOINTMENT		
KPI02	**Outpatient, Day case**	Arrival at the clinic within 75 minutes prior to appointment time - no more than	80%
KPI03	**Outpatient, Day case**	Arrival at the clinic within 60 minutes prior to appointment time - at least	75%
KPI04	**Outpatient, Day case**	Arrival at the clinic within prior to, and no later than 10 minutes after appointment time - at least	85%
KPI05	**Outpatient, Day case**	Arrival at the clinic within prior to, and no later than 20 minutes after appointment time - at least	95%
KPI06	**Outpatient, Day case**	Arrival at the clinic within prior to, and no later than 30 minutes after appointment time - to be	100%
KPI07	**Outpatient, Day case**	Arrival at the clinic more than 60 minutes after appointment time	Never Incident
	ARRIVAL TIMES AT RENAL APPOINTMENT		
KPI02R	**Outpatient, Day case**	Arrival at the clinic within 75 minutes prior to appointment time - no more than	85%
KPI03R	**Outpatient, Day case**	Arrival at the clinic within 60 minutes prior to appointment time - at least	80%
KPI04R	**Outpatient, Day case**	Arrival at the clinic within prior to, and no later than 10 minutes after appointment time - to be	100%
KPI07R	**Outpatient, Day case**	Arrival at the clinic more than 30 minutes after appointment time	Never Incident
	PRE-BOOKED DEPARTURE TIMES		
KPI08	**Outpatient, Day Case, Discharge**	Collected within 60 minutes of patient being 'booked ready' - at least	85%
KPI09	**Outpatient, Day Case, Discharge**	Collected within 75 minutes of patient being 'booked ready' - at least	90%
KPI10	**Outpatient, Day Case, Discharge**	Collected within 90 minutes of patient being 'booked ready' - at least	99%
KPI11	**Outpatient, Day Case, Discharge**	Collected within 120 minutes of patient being 'booked ready' - to be	100%
KPI12	**Outpatient, Day Case, Discharge**	Collected more than 240 minutes of patient being 'booked ready'	Never Incident
	ON THE DAY DEPARTURE TIMES		
KPI08OTD	**Outpatient, Day Case, Discharge**	Collected within 240 minutes of patient being 'booked ready' - at least	90%
KPI09OTD	**Outpatient, Day Case, Discharge**	Collected within 270 minutes of patient being 'booked ready' - at least	95%
KPI10OTD	**Outpatient, Day Case, Discharge**	Collected within 300 minutes of patient being 'booked ready' - at least	99%
KPI11OTD	**Outpatient, Day Case, Discharge**	Collected within 360 minutes of patient being 'booked ready' - to be	100%
KPI12OTD	**Outpatient, Day Case, Discharge**	Collected more than 480 minutes of patient being 'booked ready'	Never Incident
	RENAL DEPARTURE TIMES		
KPI08R	**Outpatient, Day Case, Discharge**	Collected within 30 minutes of patient being 'booked ready' - at least	80%
KPI09R	**Outpatient, Day Case, Discharge**	Collected within 45 minutes of patient being 'booked ready' - at least	90%
KPI10R	**Outpatient, Day Case, Discharge**	Collected within 60 minutes of patient being 'booked ready' - at least	99%
KPI11R	**Outpatient, Day Case, Discharge**	Collected within 90 minutes of patient being 'booked ready' - to be	100%
KPI12R	**Outpatient, Day Case, Discharge**	Collected more than 120 minutes of patient being 'booked ready'	Never Incident

Nottinghamshire County Council

Report to Health Scrutiny Committee

18 June 2019

Agenda Item: 9

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

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

Information

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

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

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

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

RECOMMENDATION

That the Health Scrutiny Committee:

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

2) Suggests and considers possible subjects for review.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2019/20

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
07 May 2019				
NUH CQC Inspection and Improvement Plan	Initial briefing on outcomes and planning following the CQC inspection	Scrutiny	Martin Gately	NUH
NUH Winter Plans	Briefing on lessons learnt from last winter and future plans	Scrutiny	Martin Gately	NUH
Muscular Dystrophy Pathway	Initial briefing on patient experience in the muscular dystrophy pathway, including the physiotherapy service	Scrutiny	Martin Gately	NUH
Dentistry in Nottinghamshire	An initial briefing on the commissioning of dental services in Nottinghamshire.	Scrutiny	Martin Gately	Laura Burns, NHS England
18 June 2019				
CCG Merger Consultation	Agreement of consultation response to CCG merger.	Scrutiny	Martin Gately	TBC
East Midlands Ambulance Service – Performance and Recruitment Update	An update on the progress by EMAS in filling vacant posts and against key performance indicators.	Scrutiny	Martin Gately	Annette McFarlane, Service Delivery Manager and Keith Underwood, Ambulance Operations Manager for EMAS
Patient Transport Service	The latest performance information on patient transport from the commissioners and Arriva.	Scrutiny	Martin Gately	Neil Moore and Lucy Dadge, Greater Nottingham CCG
23 July 2019				
NHS Property Services	An initial briefing on NHS Property Services and its interaction with tenant/providers.	Scrutiny	Martin Gately	TBC

Healthcare Trust CQC Inspection	Briefing on the Trust's improvement plan following recent CQC inspection.	Scrutiny	Martin Gately	Dr John Brewin, Chief Executive (TBC)
Treatment Centre Procurement (TBC)	An update on the latest position with the procurement of the Treatment Centre.	Scrutiny	Martin Gately	Greater Nottingham CCG
Social Prescribing (TBC)	An initial briefing on the benefits of social prescribing.	Scrutiny	Martin Gately	Greater Nottingham CCG
Healthwatch (TBC)	Briefing on the recent work of Healthwatch (including reviews).	Scrutiny	Martin Gately	Sarah Collis, Healthwatch
15 October 2019				
Whyburn Medical Practice Update	Update on contract and service provision.	Scrutiny	Martin Gately	Greater Nottingham CCG
Clinical Services Strategy Update	Further briefing on the strategy.	Scrutiny	Martin Gately	Greater Nottingham CCG
National Rehabilitation Centre	Briefing on service specification	Scrutiny	Martin Gately	Greater Nottingham CCG/NUH TBC
Nottinghamshire Healthcare Trust – Adult Services Update (TBC)	An update on a range of issues in Adult Mental Services, including feedback on additional bed spaces at the Highbury Hospital site.	Scrutiny	Martin Gately	Kazia Foster/Sandra Crawford, Healthcare Trust
3 December 2019				
NUH Improvement Plan Update	Further consideration of improvement plan following CQC inspection.	Scrutiny	Martin Gately	Dr Keith Girling, Medical Director NUH (TBC)
Muscular Dystrophy Pathway Update	Update following the previous consideration of the pathway in May.	Scrutiny	Martin Gately	Dr Saam Sedehizadeh, NUH (TBC)
Dentistry Update	Update further to the previous consideration of this issue in May.	Scrutiny	Martin Gately	Laura Burns, NUH

14 January 2020				
25 February 2020				
31 March 2020				
19 May 2020				
NUH Winter Plans	Annual consideration of winter planning issues.	Scrutiny	Martin Gately	Caroline Nolan/Rachel Eddie, NUH (TBC)
18 June 2019				
To be scheduled				
Public Health Issues				
Integrated Care System –	An initial briefing on the ICS – ten year	Scrutiny	Martin	TBC

Ten Year Plan (TBC)	plan.		Gately	
Ratio of Doctors to Residents in Rushcliffe				
Dementia Care in Hospital				
The administration of GP referrals				
Access to School Nurses				
Wheelchair repair				
Allergies in Children				
Operation of the MASH				
Mental Health issues (e.g. suicide) and GP referrals.				

Potential Topics for Scrutiny:

Recruitment (especially GPs)

Allergies and epi-pens

Diabetes services

Air Quality (NCC Public Health Dept)

Overview Sessions (To be confirmed)

Nottingham University Hospitals (NUH) – July/September 2019

East Midlands Ambulance Service (EMAS) – autumn 2019

VISITS

Urgent Care Pathway (QMC visit) – summer 2019

Medium secure mental hospitals – TBC