Nottinghamshire County Council

Health Scrutiny Committee

Monday, 23 January 2017 at 14:00

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

AGENDA

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 Alison Fawley (Tel. 0115 993 2534) 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 28 November 2016 at 2pm

Membership

Councillors

Yvonne Woodhead
Muriel Weisz
Kate Foale
Bruce Laughton
David Martinter
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

Victoria Bagshawe	Sherwood Forest Hospitals NHS Foundation Trust
Andrew Haynes	Sherwood Forest Hospitals NHS Foundation Trust
Michelle Livingston	Healthwatch Nottinghamshire
Sally Dore	Mansfield & Ashfield CCG
Amanda Sullivan	Mansfield & Ashfield CCG
Liz Gundel	Contracts Manager, NHS England
Nick Hunter	Chair, Pharmacy Local Professional Network
Sam Travis	Clinical Leadership Adviser / Controlled Drugs Accountable Officer, NHS England

CHAIR

In the absence of Councillors Colleen Harwood and John Allin, it was agreed that Councillor Kate Foale take the Chair for this meeting.

MINUTES

The minutes of the last meeting held on 11 July 2016, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES

Apologies were received from Councillor Brian Lohan.

MEMBERSHIP

It was reported that Councillor Yvonne Woodhead had been appointed in place of Councillor Colleen Harwood and Councillor Muriel Weisz had been appointed in place of Councillor John Allin, for this meeting only.

DECLARATIONS OF INTEREST

None.

FINANCIAL CHALLENGES – CLINICAL COMMISSIONING GROUP (CCG)

Dr Amanda Sullivan and Sally Dore introduced a briefing to inform Members of the financial challenges facing Newark and Sherwood and Mansfield and Ashfield Clinical Commissioning Groups including the reprioritisation of how NHS resources were deployed.

Dr Sullivan explained that the demands on resources were increasing at a faster rate than funding came in and highlighted the need to reprioritise or refocus the services provided so that maximum health benefits could be achieved. There were significant financial pressures across the NHS and potential financial shortfalls for Newark and Sherwood and Mansfield and Ashfield CCGs. Efficiencies had already been made and work through the Better Together Programme had put the CCGs in a good position financially and in terms of service delivery. A Financial Recovery Plan had been developed to mitigate emerging financial risks and a series of eight engagement events for stakeholders had been undertaken to assess views on the priorities for NHS funding. An online survey had also been used. A list of services and how they were ranked was included in the appendix to the report.

Members were concerned that there may be risks to some patients if the prescribing of over the counter medicines was stopped as they may not show on their GP's record and may not be appropriate. Dr Sullivan said that certain medicines were checked by the Pharmacist with the GP and that it mostly related to one off prescriptions rather than regular medication.

There was surprise that Osteopathy was in the low priority category but Dr Sullivan explained that in the consultation some items only applied to small groups of patients and that there was a need to balance priorities as the NHS was a service for all but the consultation exercise had been undertaken to assess opinion.

Work would be done on helping people learn about NHS services so that they used them effectively and awareness training would be incorporated in to mandatory staff training.

The next steps were outlined and it was explained how each service had been categorised depending on the impact on potential service users, whether further

engagement was required or if a public consultation was required. A public consultation for IVF services was proposed between 14 November 2016 and 13 January 2017.

The chair thanked Dr Sullivan and Sally Dore for their briefing.

IN-VITRO FERTILISATION (IVF) – VARIATION OF SERVICE

Dr Sullivan explained that a formal consultation on the eligibility for IVF treatment on the NHS would take place from 14 November 2016 to 13 January 2017 and views would be sought on a range of options as detailed in the appendix to the report.

In response to Members concerns that NICE offered up to three cycles, Dr Sullivan said that this was guidance and that this was unlikely to be the case in many areas. Members discussed the financial cost of the service and Dr Sullivan advised that there was very little difference between the cost of privately funded IVF and NHS funded IVF. Members were also concerned that a reduction in the service may have a psychological impact on couples who could not conceive which could also be a cost to the NHS.

The Chair thanked Dr Sullivan for her briefing and requested that an interim update be added to the agenda for the next meeting.

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

Update

Andy Haynes and Victoria Bagshawe introduced a briefing which updated Members on the current position of Sherwood Forest Hospitals NHS Foundation Trust (the Trust) following the Care Quality Commission (CQC) inspection.

The significant improvements made at the Trust were acknowledged by the CQC and an overall rating of requires improvement had been given. Several areas of outstanding practice were identified including sepsis, mortality and performance against the ED 4 hour target and were detailed in the report.

Financial performance was on track and in roads were being made in to the £42.1m deficit. Andy Haynes explained that savings had been made through a reduction in agency costs and the focus would be to sustain this position.

Victoria Bagshawe assured Members that quality had been maintained and outlined the measures in place to ensure that this continued.

Andy Haynes explained that there would be an ongoing strategic link with Nottingham University Hospitals rather than a formal legal partnership as had been discussed at previous meetings.

End of Life Care

Andy Haynes gave a briefing which informed Members of the significant progress that had been made on end of life care since the CQC inspection in 2015. He highlighted that end of life care had been flagged as an issue by CQC reports in

2014 & 2015 and was an issue regionally and not just for individual trusts.

Significant progress had been made with End of Life care and that clear and effective governance procedures were now in place and audits were undertaken regularly. He outlined the targets for 2016/17 and the measures that would need to be in place to enable the Trust to work toward achieving good status. This included visiting other Trusts to see examples of best practice, working collaboratively to enable more patients to dye in their preferred place of care, developing specific end of life training and ensuring patients are discharged safely and effectively.

The Chair congratulated the Trust on their achievements and asked for an update to be scheduled in the work programme for the March 2017 meeting.

COMMUNITY PHARMACY BRIEFING

In response to a request from Members, Liz Gundel, Samantha Travis and Nick Hunter presented a briefing that informed Members about community pharmacies and the issues that they faced.

Members were given background information on how pharmacies were commissioned and described the services that must be provided. It was explained that there was a national process for annual monitoring which could include a contract review visit from NHS England. An action plan would be put in place if non-compliance was identified. The General Pharmaceutical Council was the regulatory body for all pharmacy professionals and pharmacy premises.

It was noted that in comparison to other primary care contractor groups, there were only a small number of complaints which related to community pharmacies. There were two pathways for formal NHS complaints and these were outlined to Members. During discussion Members felt that there was a lack of awareness of the complaints procedures and that the information about how to make a complaint should be publicised more widely. Ms Travis said that an information leaflet for complaints should be available at each practice.

The changes to pharmacy funding and the anticipated impact that the two year funding package would have, were outlined to Members. Members were concerned that this would inevitably lead to pharmacies having to reduce operating costs and possibly even the closure of some pharmacies which may impact on the community they served.

NHS England had recently announced a £42m Pharmacy Integration Fund which would support the transformation of pharmacy and how it operated across the NHS over the next two years. The fund would support the development of new clinical services, working practices and digital platforms to provide a modern NHS community pharmacy service.

The Chair thanked Ms Gundel, Ms Travis & Mr Hunter for their informative briefing and requested that an update be scheduled for the March 2017 meeting.

WORK PROGRAMME

The work programme was discussed. It was agreed to add the following items to the programme;

- Bassetlaw hospitals – financial update
- Obesity Services
- IVF update – January 2017
- Community Pharmacy – March 2017

The meeting closed at 4.35 pm

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 January 2017

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

DONCASTER AND BASSETLAW HOSPITALS FINANCIAL POSITION UPDATE

Purpose of the Report

1. To introduce the latest information on Doncaster and Bassetlaw Hospital (DBH) Trust's financial position.

Information and Advice

2. Members will recall that they previously received briefing on the Trust's financial position in July 2016. The Health Scrutiny Committee heard that it was discovered in October 2015 that there had been significant misreporting to the Board of Directors. The financial year had ended with a deficit of £46.7m (of which £10.3m related to a revaluation of the Trust's land and buildings). KPMG had undertaken an independent investigation, with recommendations for action. The Trust had appointed a director with responsibility for financial turnaround, supported by a dedicated internal delivery team, and overseen by a Financial Oversight Committee. The regulator, NHS Improvement, supported the Trust's response, and the Trust was already delivering savings.

3. A written briefing from the Trust on the current financial position is attached as an appendix to this report. Mr Mike Pinkerton will again attend the committee to present the briefing and answer questions.

4. Members will see from the briefing that the financial position is considerably improved, and that the Trust anticipates receiving several million pounds from the NHS Improvement incentive scheme for Sustainability and Transformation funding. Members may wish to ask when these funds will be made available to the Trust.

5. Members will need to determine if any further information is required.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.
2) Determine what further information is required, and schedule as necessary.

Councillor Colleen Harwood
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

Briefing

January 2017

Financial position update

I am pleased to report very encouraging progress in our financial recovery since the last briefing in June 2016.

You may recall that at the end of the last financial year (March 2016) we shared with NHS Improvement a clear and achievable plan, delivering an £11m Cost Improvement Plan (CIP) which formed an integral part of our financial recovery plan for 2016/17. The plan forecast a deficit position of £27.1m for the year.

In order to deliver our CIP, and achieve our year end forecast we set up a small, internal Project Management Office under the Director of Turnaround with 13 work streams incorporating all work to reduce and control costs. The work streams all had a Work Stream Lead and a Senior Responsible Officer from the Board of Directors. Fortnightly management meetings for each work stream took place early on in the recovery process to ensure delivery was on track.

In terms of money we have saved, up to the end of November we have delivered £6.51m CIP against a target of £5.89m. This represents an overachievement of savings of £628k. As a result of our continued over performance we have recently reforecast our year-end position from a planned deficit of approximately £17mand we hope to improve on that further still.

We now understand that we will strongly qualify for the NHS Improvement incentive scheme for Sustainability and Transformation funding, which will reward over-performance against Control Totals with a £-for-£ revenue reward. Current projections show this scheme will allocate several millions of pounds to the Trust, in reward for the financial progress made.

While delivering the CIP still represents a huge challenge, the savings we have delivered are a good indicator of how far we have come. Throughout the Turnaround process we have received positive feedback and support from NHS Improvement about our approach and progress.

To have achieved this whilst also maintaining, and in many cases improving our quality, safety and performance, is a great accomplishment and is a credit to our hard-working, dedicated staff.

For the fourth year in a row we have seen reductions in pressure ulcers, falls and hospital acquired infections, the latter of which dropping by over 27% in 15/16. Similarly, our mortality rate continues to be low and well within the expected range.

We are achieving referral to treatment waiting times for our patients and although our emergency pathways are under constant pressure, we continue to be one of the best performing Trusts in the country for treating patients within four hours.

It is incredibly important that alongside delivering financial performance we also remain focussed on providing safe and effective care to our patients.

As I have said before, it's not finance or quality, it has to be both, and many of the measures we will continue to take to improve efficiency will also positively impact on quality overall, and/or individual patient experience. Equally, we will continue to ensure that relevant efficiency business cases are carefully assessed for impacts to quality and risks eliminated, or mitigated to the maximum extent possible. Our Quality Impact assessments are signed off by Medical and Nursing Directors and shared with our local CCGs, now formally part of the Turnaround programme arrangements and on an annualised basis with the Accountable Care Board at Bassetlaw, which has wide organisational representation.

Paediatric Admissions at Bassetlaw Hospital

Due to staffing shortages in December we had to close our Paediatric Ward to admissions after 7pm at Bassetlaw Hospital, and close the ward itself after 10pm.

Caring for children requires specialist skills and at Bassetlaw Hospital there is a shortage of staff with the required skills, despite a number of recent recruitment drives. As a result we have taken this measure to guarantee that we have the right staff in place to run a safe service for our patients.

Despite some of the claims made in the media this is not about cutting back on our services to Bassetlaw. Our highest priority at the hospital is providing the safest care and treatment to our young patients. Due to national shortages of staff, we cannot currently guarantee that these services will be safe overnight and we cannot take that risk with the life of a child.

The change to admissions means that children attending Bassetlaw Emergency Department after 7pm will be assessed and:

- children requiring admission will be transferred (via East Midlands Ambulance Service dependant on condition) to the Children's Ward at Doncaster Royal Infirmary for their immediate care and treatment
- discharged home or referred to a dedicated Review Clinic on the Children's Assessment Unit the next morning.

We anticipate that this will only affect a small number of patients in our care and we have taken steps to enhance our day service which we expect to bring down admissions. A paediatric consultant will be on site 24 hours a day, meaning that any children coming to the Emergency Department will continue to be seen and offered necessary treatment.

We expect approximately 3 admissions per week after 7pm to be transferred to DRI, and that may reduce further depending on the impact of consultant paediatricians providing the planned on site presence late in the evening.

Patients who require prolonged observation or inpatient admission will be transferred to the Children's Ward at Doncaster Royal Infirmary (DRI) as early as possible.

Paediatric services will remain at Bassetlaw Hospital and we are working to improve and redesign the current day service, maximising opening times, hosting special clinics with senior paediatricians each morning to support children's care and avoid unnecessary admissions.

Elective children's day surgery will continue as well as children's outpatients in the newly built facility following a £ 250,000 investment completed this December.

Teaching Hospital Status

Following formal recognition of the quality and volume of our teaching and training and R&D, and an overwhelmingly positive consultation, the Trust will shortly be licenced as Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust. There will be a formal launch event in January 2017.

Mike Pinkerton
Chief Executive
Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 January 2017

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

PAEDIATRIC ADMISSIONS AT BASSETLAW HOSPITAL

Purpose of the Report

1. To introduce briefing on the alteration to paediatric admissions at Bassetlaw Hospital.

Information and Advice

2. Due to staffing shortages the paediatric ward at Bassetlaw Hospital is now closed to admissions at 7:00 pm with the ward itself closing at 10:00 pm. This service only comprises six beds with 80% of patients discharged within 24 hours. The sorts of conditions treated in the unit are typically upper respiratory or long term conditions. It is not a facility for children who are very acutely unwell e.g. suffering from meningitis. The Trust has made strenuous efforts to address the issue of staff shortages, but now faces a shortages of nurses as well as one of doctors. It is anticipated that the ward will transition to be an assessment centre.

3. A written briefing from the Bassetlaw Clinical Commissioning Group is attached as an appendix to this report. Denise Nightingale, Chief Nurse and Executive Lead for Quality and Safety at the CCG will attend the committee to present the briefing and answer questions, accompanied by David Purdue, Chief Operating Officer, Doncaster & Bassetlaw Hospital.

4. Members will see from the briefing that this alteration to services is a result of the recruitment issues facing the commissioners and Trust and is made for safety reasons. On that basis, this matter is not presented to the Health Scrutiny Committee as a potential substantial variation of service.

5. Members will need to determine if any further information is required.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.
2) Determine what further information is required, and schedule as necessary.

Councillor Colleen Harwood
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

Paediatric In-Patient Services at Bassetlaw Hospital

Briefing for the Nottinghamshire Overview and Scrutiny Panel

Aim

This paper outlines the imminent changes to the paediatric unit on ward A3 at Bassetlaw District General Hospital (BDGH) and the proposed paediatric service model as a result of this. These changes are as a result of the significant medical and nursing workforce shortages and as such are required on safety grounds. Any changes to the service are also designed to protect the level of service provided by the Emergency Department at Bassetlaw Hospital by ensuring continuing paediatric registrar cover on site available to support the ED department.

Changes to Children's Wards over the Last Decades

Paediatric units in small district general hospitals have changed over the last 20 years resulting in lower bed occupancy rates and quicker turnaround from admission to discharge. This is due to a number of changes both to population health, medical advances and specialisation which has centralised some elements of paediatric services. For example:

- Childhood immunisation has reduced the number of children who may have died or had complications from common diseases.
- Best practice standards from the Royal Colleges recognise the importance of seeing senior medical staff as early as possible in a child's illness. This has to some extent reduced the time parents and children wait to see the Consultant for their opinion and are then discharged. This has also reduced the length of stay.
- A reduced length of stay has reduced the impact on families trying to care for children at home whilst a child is in hospital. The exception to this is children needing to be cared for in specialised centres where the level of clinical expertise is crucial.
- Advances in the medicine available to support very pre-term babies has meant that these children generally need to be transferred to specialised special care baby or neonatal intensive care units in bigger hospitals where they are cared for by paediatric teams.
- Children's Surgery is no longer advocated to be undertaken by generalists but by surgeons who operate frequently on small children and by anaesthetists who regularly anaesthetise children and have the necessary experience and competencies.
- Major trauma reviews have centralised this type of injury in units with major trauma unit status.
- Acutely unwell children should be cared for within units that meet the national standards and are often transferred using EMBRACE which is a specialised medically led retrieval and transport service to take children to designated units.

In general there has been a National recognition of the link between volume of patients and outcomes of care and the development of clinical skills is often furthered by frequency of practice. As a result staffing and training models have changed.

Paediatric Services Review 2011

A clinical services review was undertaken on the maternity and paediatric services in Bassetlaw Hospital in 2011 which highlighted the fragility of the medical workforce in terms of the numbers of clinicians and skills, with concerns regarding the sustainability of a safe high quality paediatric service. The findings of the review resulted in the immediate introduction of measures being put in place along with additional funding provided by the commissioner Bassetlaw PCT (now CCG) in order to stabilise the situation and secure local services for the future.

In 2011 Bassetlaw Children's Ward had 20 beds open, reduced in 2013 to 14 and in 2016 the beds were reduced again to 12. The majority of the admissions were for a one-day or less than one-day length of stay.

In 2013 the Doncaster and Bassetlaw Hospitals Foundation Trust (DBHFT) instituted a cross site paediatric consultant rota to deal with the potential deskilling of consultants exposed only to Bassetlaw hospitals limited clinical workload. Whilst that has been successful and allowed the continuation of safe services to be provided to the present day, the workload and relative lack of senior cover at Bassetlaw makes the Junior posts unattractive to both permanent and locum recruitment, as candidates will often prefer to work in larger, busier centres.

Paediatric Activity Now at Bassetlaw Hospital

Children who required assessment and clinical observation over a few hours have been managed in the ward alongside children who needed a slightly longer time to recover in hospital. National clinical standards do exist which relate to the care of the acutely unwell child. Based on these standards, acutely unwell children, for example those with sepsis or meningitis should not remain in the small paediatric unit at Bassetlaw due to there being no paediatric high dependency and intensive care facilities. Pathways exist to transfer such children to Sheffield Children's Hospital or Doncaster Royal infirmary.

The high number of admissions for one-day stays on the ward had already instigated the CCG to request the development of a Consultant led Paediatric Assessment Unit for introduction in April 2017. This unit would have been co-located with the overnight stay paediatric beds on the ward and would run concurrently. This would have enabled safe clinical observation and assessment of children by paediatricians and paediatric nurses over a period of around 8 hours who may then have been discharged home or alternatively if they had required further observation would be offered a bed on the paediatric ward. Due to staffing restraints this model has been revised and has an earlier implementation date.

In a District General Hospital the paediatric service and medical workforce would be expected to provide assessment and management for children in: A&E; babies in the special care baby unit (SCBU); attendance at all emergency caesarean section procedures plus cover for an in-patient paediatric unit, an observation /assessment facility, clinic work and community paediatrics.

The Special Care Baby Unit at Bassetlaw Hospital provides a valuable service and is differentiated from a Neonatal Intensive Care unit (at Sheffield Children's Trust and Doncaster Royal Infirmary) by the level of medical and nursing intensity the baby requires. It is supported by the paediatricians and the proposals in this paper do not impact on the SCBU.

Breakdown of Paediatric Activity

Number of Admissions

Non Elective Admissions to ward A3

	15/16	Apr-Sept 16/17
Bassetlaw CCG	1756	759
Other Commissioner	643	301

Reason for Admission

The most common reasons for paediatric admissions to ward A3 at Bassetlaw hospital include for example viral infections, upper respiratory infections and gastro enteritis without complications.

There is correlation between admission cause for both Bassetlaw and other commissioners.

Length of Stay of Admissions

Admissions with a short length of stay make up the biggest percentage of admissions to A3 (84% stay 1 day or less) In 2015/16 49.5% of children stayed less than 1 day and a further 34.5% stayed 1 day only. A further 7.5% stay 2 days and 7.7% between 3 and 7 days.

This trend continued in the first half of 2016/17.

Paediatric Medical Staffing Model (Bassetlaw Hospital)

There are traditionally three tiers of medical staffing on the rota. These are 'junior doctors' who can either be on a training rota and allocated by the deanery or on a GP training scheme and undertaking a placement in a hospital setting. The middle grades of doctors are from a training scheme supporting them to become a Paediatric Consultant or non-training middle grade (doctors who have chosen or not been able to progress further through the hospital medical careers structure). In addition there is a Consultant Paediatrician available 24/7 should they be called.

There are 13 consultants currently employed to support the rotas across DRI and BDGH. There are 5 consultants with a base at BDGH.

Paediatric Nursing Staffing Model (Bassetlaw Hospital)

Registered children's nurses are deemed by the CQC to be 'properly qualified' to support children in hospital and there should be enough staff to keep people safe and meet their health and welfare needs. A workforce model called PANDA (Paediatric Acuity and Nurse Dependency Assessment tool) is used to identify the number of staff required for the dependency of the

patients in a paediatric ward. These nurses are supported by Health Care Assistants who are used to working with ill children.

Current Shortages of Medical Staffing and Impact

In August last year the Royal College of Paediatrics and Child Health published a workforce survey that showed that more than one in four paediatric medical posts are vacant nationally. In addition, up to 77% of junior doctors rotas have been unable to attract the full complement of staff required to support the rotas.

DBHFT and Bassetlaw CCG have been working together since September in an attempt to manage an increasing number of workforce shortages for both paediatric medical and nursing staff. Despite mitigating actions agreed by the trust and the CCG these shortages are now operationally impacting on the paediatric ward.

There is currently a three person gap on the junior doctor rotation which would have been traditionally filled by GP trainees but due to difficulties recruiting to the GP training scheme, these posts remain unfilled. The Trust has been using locum doctors to cover the gaps but due to national shortages of paediatric doctors, locums are in short supply. Locums for paediatrics are difficult to recruit to and difficult to retain once hired particularly if offered better rates elsewhere or placements nearer to home. The Trust has tried to retain locums by offering attractive rates which are in excess of the national agency rates but this has not proved that successful in keeping locums for the longer term at BDGH where often locums do not turn up for shifts in the evenings if they can get a better paid shift elsewhere. This has meant that 11 night shifts that have been agreed and pre-booked but have not been actually worked due to cancellations. In addition 28 shifts have not been able to be covered.

The situation with workforce and the unpredictability of the locum doctor cover situation has resulted in the ward being temporarily closed at night to new admissions on many occasions. Communication has been sent to local GPs around cover arrangements for children who are already an in-patient on the ward, new admissions and clinician reviews in A&E for that evening (and subsequent nights in the week if necessary.)

The impact of this has been that when only one paediatric middle grade has been on duty overnight and the junior doctor shift is not filled, the ward has closed to new child admissions but children admitted earlier in the day who are stable have remained on the ward overnight. The middle grade doctor is then able to attend any obstetric emergencies and undertakes reviews for children on the ward and supports the special care baby unit. Accident and emergency teams are supported by this middle grade doctor or the Consultant on call.

It is apparent that the unpredictability of the service due to workforce issues is unsatisfactory and the number of shifts being filled by locums not substantive doctors is a potential safety concern particularly when they may be the only doctor or one of two on site at night.

In addition the Trust has undertaken an overseas recruitment drive for medical staffing through an agency. There is a rolling advert for both junior and middle-grade staff but these have not been successful.

Current Shortages of Registered Children's Nurses and Impact

In December it became clear that there was an emerging children's nursing workforce problem with gaps of 6 whole time equivalents and only 1 new applicant. Children's nursing is also a national shortage profession and is unlikely to improve significantly before 2019 due to the numbers of nurses in training. The nursing degree only has one graduation in September, of which newly qualified staff were offered posts but with minimal success.

The Trust has attempted to source children's nurses through locum agencies but has only been able to fill 3 shifts. NHS professionals who provide the agency staff only have 3 children's nurses on their books and those are already internal staff employed by the Trust.

The Trust have approached Sheffield Children's Hospital for help with both nursing and medical staff but they are also having staffing difficulties and are unable to help.

Trust Paediatric Services Position for January 2017

Doncaster and Bassetlaw Hospitals NHS Trust consider the situation with medical and nursing staff shortages and the impact of this overnight for BDGH paediatric ward to be unsafe. Commissioners support their concerns and have asked the Trust to consider what paediatric services can be delivered safely at Bassetlaw Hospital which minimises immediate risk and the impact on our local population. The Trust has proposed an extended day Children's Assessment Unit at Bassetlaw and a 'hot' 7 day a week consultant led outpatient clinic in order to maximise the number of children who can continue to be managed locally.

Proposed Changes to Paediatric Services at BDGH

The proposed model is at this time, an urgent response to the workforce difficulties outlined earlier in the paper. These staffing issues are now critical and it is not anticipated that they will improve in the foreseeable future and as such a temporary closure of the overnight paediatric beds at Bassetlaw Hospital is necessary from no later than the 31/01/2017. An alternative model of care which aims to reduce the impact on our local population and enhance senior clinical decision making is outlined below. This model and supporting arrangements will be monitored to ensure they are safe and effective prior to any decision in October 2017 being made about the service going forward.

This proposed model is a consultant-led paediatric assessment unit, seven days a week running 8am to 10pm with a time cut-off for the last admitted child for assessment of 8pm each day. Having a consultant delivering urgent assessment and care should result in many of the less than 1 day stay children being managed within the assessment unit. Children who require admission will be able to be transferred for overnight stay to DRI.

Having a Consultant leading the initial review of unwell children will help determine quickly those who may be deemed or may progress to be 'acutely unwell children.' Rapid transfer to a centre such as DRI or Sheffield's Children's Hospital, to achieve the best clinical outcomes can then take place.

This model of care is consistent with Royal College of Paediatric and Child Health guidance. Transfers will take place using best practice guidance from other areas that have already had to reduce their in-patient bases. Urgent transport will be available and jointly commissioned by the CCG and the Trust.

It is envisaged that an average of 3 children a week may need to be transferred in this manner.

The new model will be enhanced by the Trust providing a seven day 'hot clinic' service for ill children who need to be seen quickly for clinical diagnosis but are unlikely to need an admission for assessment. This clinic allows same day access to a specialist opinion for GPs, Out of Hours providers and A&E to get a rapid assessment by a consultant where they feel some urgency is required. The clinic will also invite children discharged from the assessment unit on the previous day for a consultant review if clinically necessary. This will offer parents confidence about their child's progress if they have been on the assessment unit the day before.

The assessment unit and the hot clinics will offer an improved service that better meets the needs of the majority of the children currently attending Bassetlaw A&E and the Children's Ward as shown by the data earlier in the paper. Consultants providing initial assessment for those children who present urgently with subsequent rapid treatment and discharge whilst screening early for those who are emergencies provides a strong platform to build the paediatric presence at Bassetlaw Hospital.

Capital investment by the Trust into the paediatric unit at Bassetlaw Hospital (circa £250k) has been provided by the Trust to build the assessment unit and new children's out patients area both of which are co-located on the A3 ward. The CCG and Trust are also investigating a telemedicine link to Sheffield Children's Hospital to facilitate better communication and help to speed up clinical decision making between clinicians at the different hospitals.

This revised model will also protect the level of service provided by the Emergency Department at Bassetlaw Hospital by ensuring continuing paediatric registrar cover on site available to support the ED department.

Service Evaluation

The Trust will also continually review the service model put in place to understand the effectiveness of the changes and the impact of the local population.

Patient feedback will be collected via the Friends and Family Test for all discharges from the Emergency Department and the in-patient facilities at BDGH and DRI.

The numbers of children requiring transfer will be monitored weekly to ensure transfers are appropriate and have not increased against the estimate.

Sheffield Children's Hospital will be involved in the service evaluation. The Trust will also continue to work with the Children's Services across South Yorkshire to ensure a robust recruitment drive to meet the standards in the Facing the Future, National Guidelines for Paediatric Care.

Recommendations

Overview and Scrutiny are asked to note the temporary changes and their urgency to the paediatric model at Bassetlaw Hospital whilst recognising the national workforce situation may require such a model to be the longer term solution.

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 January 2017

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

CONTRACEPTIVE AND SEXUAL HEALTH SERVICES

Purpose of the Report

1. To introduce an update on Contraceptive and Sexual Health Services.

Information and Advice

2. Members will recall that a new sexual health service contract commenced in April 2016. The Health Scrutiny Committee requested an update on the progress of this service along with the latest data on the prevalence of sexually transmitted infections.

3. A written briefing from Nottinghamshire County Council's Public Health Department is attached as an appendix to this covering report. Mr Jonathan Gribbin, Consultant in Public Health will attend the committee to present the information and answer questions.

4. Members will need to determine if any further information is required.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.
2) Determine what further information is required, and schedule as necessary.

Councillor Colleen Harwood
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

Nottinghamshire County Council

Briefing to
Health Scrutiny Committee
23 January 2017

SEXUAL HEALTH SERVICES IN NOTTINGHAMSHIRE COUNTY

Purpose of the Report

1. The purpose of this report is to:

   a. Advise the Committee of the needs of the population in regard to sexual health and the Council's statutory responsibility for commissioning comprehensive open sexual health services.

   b. Describe how the Integrated Sexual Health Service (ISHS) addresses these needs, highlighting changes to the arrangements which existed formerly and evidence about its early performance.

   c. Identify other issues in the local sexual health system which require attention.

Information and Advice

Public health significance of good sexual health

2. Good sexual health is an important part of physical, mental and social well-being, requiring a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences which are free of coercion, discrimination and violence[i].

3. The burden of poor sexual health falls most heavily on disadvantaged groups and there is a clear link between sexual ill health, poverty and social exclusion in Nottinghamshire County. The consequential costs of poor sexual health are borne by society at large as well as the individuals.

4. The public health significance of the overall sexual health agenda is underlined by the inclusion of several indicators in the Public Health Outcomes Framework:

   a. **Under 18 conceptions** (Domain 2, Health Improvement): children born to teenage mothers are much more likely to experience a range of negative outcomes in later life, such as developmental disabilities, behavioural issues and poor academic performance.

   b. **Chlamydia diagnoses in people aged 15-24 years** (Domain 3, Health Protection): if untreated, between 10-20% of chlamydia cases result in infertility due to pelvic inflammatory disease.

   c. **People presenting with HIV at a late stage of diagnosis** (Domain 3, Health Protection): These individuals carry a tenfold increased risk of dying within a year of

diagnosis, compared to those diagnosed early. In addition to the significant, dismal and unnecessary health outcomes for the individuals concerned, late diagnosis also yields significant treatment, clinical and social care costs.

5. In recognition of the extent to which good sexual health contributes to health and wellbeing, the Nottinghamshire County Health and Wellbeing Strategy includes the priority to reduce the rates of STIs and unplanned pregnancy.

Commissioning context & responsibilities

6. Following the Health and Social Care Act 2012, responsibilities for commissioning comprehensive sexual health, reproductive health and HIV services have been divided across local government, Clinical Commissioning Groups (CCGs) and NHS England (NHSE). The promotion of good sexual health and protection of residents depends on all parties fulfilling their responsibilities.

7. Local Authorities Regulations mandate that unitary and upper tier local authorities commission confidential, open access services for STIs and contraception, as well as reasonable access to all methods of contraception[ii]. Appendix 1 provides a summary of the system wide commissioning responsibilities for sexual health, reproductive health and HIV services.

8. In addition to the increased burden of ill-health which results for individuals and communities, there are consequential financial costs of poor access to timely testing for STIs, prompt treatment and a full range of contraception which are borne by CCGs, NHSE, Nottinghamshire County Council, neighbouring local authorities and other public service budgets. Some of these costs are considerable. For example, the average lifetime cost of HIV treatment for one person is £380,000[iii].

9. There are also close dependencies between sexual health and other local authority agendas. For example, the availability and accessibility of effective sexual health and reproductive health services makes a critical contribution to Nottinghamshire's ambition to continue to lower teenage conceptions across the whole of Nottinghamshire and to a greater degree in more deprived areas. Similarly there are close dependencies with Sex and Relationships Education (SRE) and the Child Sexual Exploitation (CSE) agenda.

10. Nottinghamshire County's Joint Strategic Needs Assessment (JSNA) highlighted significant variation across the county in both the prevalence of STIs and the number of teenage conceptions[iv]. It identified that addressing sexual ill-health and promoting sexual wellbeing is a key step to reducing overall health inequalities, e.g. to young people in teenage hot spot areas across the county, to people who have higher sexual health risks (MSM - Men who have sex with men and sex workers), groups at risk of late diagnosis of HIV.

11. The JSNA also identified the need to commission an integrated sexual health service (ISHS) to provide an improved service offering to residents in which the provider undertakes to make appropriate changes to clinic times and venues to best meet the evolving needs of residents.

12. Following consultation, the Public Health Committee approved a service model describing the scope and function of the ISHS, a tiered model of care, and delivery through a hub and

spoke configuration of clinics (see Appendix 2). It meets the quality standards set by national regulatory and professional organisations (e.g. National Institute for Health and Care Excellence, British Association for Sexual Health and HIV) and locally determined standards which have been drawn up to mitigate against serious problems encountered by commissioners in other local authorities.

13. The Committee also endorsed a funding envelope for the new service in order to release savings in the order of £680,000 per year over the duration of a five year contract.

14. The subsequent procurement process resulted in a recommendation to the Public Health Committee to award contracts to three NHS organisations to deliver an ISHS across Nottinghamshire County.

Performance of the Integrated Sexual Health Service

15. The new ISHS was launched in April 2016. The difference which the ISHS is now making to the lives of residents is that (compared to former arrangements) it provides services across the County in which contraception and STI-related needs can be addressed safely and effectively in a single visit.

16. Prior to April 2016, recording of service activity was incomplete and inconsistent which means that it is problematic to make a direct "before/after" comparison. Since April 2016, the precision and completeness with which activity is recorded has improved significantly which will provide a good basis for tracking future trends in service usage.

17. The location of the clinics in which residents can access the service is published by the providers[v] and, for convenience, is also listed in Appendix 3. There is a gap in provision in the Eastwood locality where, following the loss of use of a general practice building, the provider has been unable to identify a suitable alternative clinic setting. Whilst routine activity data indicates that utilisation of sexual health services by residents of Eastwood remains high (through attendance at ISHS clinics elsewhere), the current lack of a locally accessible clinic remains a concern to commissioners. Therefore the authority has written to the Chief Officer of Nottingham West Clinical Commissioning Group to ask for the assistance of NHS partners in identifying suitable premises for a clinic.

18. Further intelligence is needed to monitor the extent to which the new service is meeting the needs of all residents, including groups with the greatest levels of unmet need. This will be addressed through an annual programme of health equity audits, to which the providers are contractually obliged to contribute and which are designed to highlight opportunities for further service improvement. These audits form a part of the overall regime for quality assurance and represent good practice in the commissioning of health services. The results of the first audits will be available to commissioners in summer 2017.

19. Performance management of the providers has highlighted a problem with the accuracy of the service information published on the internet. Whereas the providers themselves are responsible for ensuring the information on their own websites remains current, it has proved difficult to update the information published within the NHS Choices website. As a consequence, it is possible that our residents may be misled and inconvenienced concerning local clinic times and venues. This appears to be a national problem with the administrators of the NHS Choices website and falls outside the immediate control of our

providers. Public health commissioners are exploring an appropriate route for escalating the issue.

20. Other arrangements for underpinning the safety, effectiveness and service user experience of the ISHS includes a programme of quality assurance visits. During the first half year of the new contract, the three providers have participated in a total of five QA visits. Observations and actions arising from these visits included:

    a. There is positive feedback from service users consulted during the visits about access to the service, availability of choice of a staff member of same gender, and the non-judgemental approach of staff.
    b. Staff experience of "dual training" (which underpins the integration of the contraceptive and STI aspects of the ISHS) has been positive
    c. Specific recommendations about enhancements and refinements to the centralised booking arrangements for each provider, e.g. requirements upgraded telephone line access and for a provider to monitor call "drop-off"

21. In regard to risks about which stakeholders expressed serious concerns at the start of the procurement process, NHSE have highlighted no concerns to us about integration with local pathways for HIV treatment (which became a major problem for some Councils), and lead clinicians in the ISHS and in Health Education England confirm to us their satisfaction that local providers remain able to fulfil their role in sustaining high quality training of the next generation of specialist medical and nursing staff.

22. Neither the authority nor our providers have received any formal complaints regarding the ISHS.

Other issues in the local sexual health system requiring attention

23. The ISHS represents an important part of the local sexual health system. A range of other services and organisations play significant roles in securing good outcomes and arrangements for the population. These include but are not restricted to: schools (provision of good quality sex and relationships education), primary care (e.g. referrals for testing and treatment of patients who are symptomatic, contraceptive advice including long acting reversible contraception, cervical screening), HIV treatment (NHS England), termination of pregnancy services (commissioned by CCGs).

24. Public health colleagues convene the Sexual Health Strategic Advisory Group (SHSAG) to secure expert clinical and commissioning advice about outcomes and arrangements for sexual health. SHSAG oversees a work programme whose scope extends beyond the commissioning responsibility of the local authorities and addresses the following issues (amongst others):

    a. **Chlamydia rates (15-24 year olds).** Nottinghamshire has the lowest testing and detection rate in the East Midlands. This is likely to contribute to a higher avoidable burden of ill-health and complications for our residents arising from untreated STIs.

    b. **Unplanned pregnancy.** Local rates are similar to national rates but nevertheless indicate considerable unmet need and consequential costs for the local authority and other public services.

c. **Resources for mounting an effective response to a local increase in STI s.** There is no longer budgeted capacity to fund measures which may be recommended in the event of an increase of STIs (e.g. Gonorrhoea, Syphilis, Hepatitis A).

d. **Teenage Conception Rates.** Maintenance of the comprehensive measures previously implemented through the National Teenage Pregnancy Strategy (2000 -2010) and targeted prevention through the Family Nurse Partnership (FNP) Programme.

e. **Long acting reversible contraception (LARC)** represents a highly effective and cost effective method of contraception. As part of its responsibility to provide access to all methods of contraception, the authority commissions LARC from most general practices. Further work is required to ensure that women across Nottinghamshire have ready access to LARC.

f. **System pressures**. Pressures in one part of the local health system have consequences elsewhere. Unmet need relating to prevention and early treatment lead to additional treatment costs for the NHS. Similarly, there is anecdotal evidence that some patients have found the length of time they have to wait for a GP appointment unacceptable and have chosen instead to access the more specialist sexual health service for contraception, resulting in additional activity and cost pressure for the Council.

Wider considerations

25. The chief risk to the local sexual health system relates to the future funding of the ISHS. Reduction in funding would result in the curtailment of a statutory service and loss of the associated health and wellbeing and economic benefits. More specifically:

a. Firstly, any reduction in budget would be likely to result in some kind of restriction in access to mandatory open services and/or curtailment of services targeted to address underlying causes in areas with the worst sexual health outcomes. This is because there is limited scope within our mandated sexual health services for containing all of the existing cost pressures.

b. Secondly, reductions in access to mandatory open sexual health services are likely to impact outcomes at individual and population levels. For example, reductions in the proximity of services or opening hours will impact on their accessibility to some people in need of contraceptive services or STI testing.

c. Thirdly, the scale of impact at an individual level is potentially very serious including, for example, unplanned pregnancies in teenagers and adults, onward transmission of untreated STIs, infertility arising from delay in or lack of treatment for Chlamydia infection, and additional complications or early death associated with delayed diagnosis of HIV. At a population level, these outcomes are likely to be reflected in terms of increased health and social inequalities with their long term implications.

d. Fourthly, in addition to the potentially serious impact for individuals and their communities, these impacts also entail adverse financial consequences for public service budgets in Nottinghamshire County. For example, a recent study based on national-level modelling found that modest restrictions to sexual health services would negatively

impact outcomes and that the consequential costs of this to public service budgets across the whole UK would be in the order of £100 billion over an 8 year period[vi]. Accurately quantifying what the scale or timing of these impacts would be in Nottinghamshire is problematic and sensitive to underlying assumptions and local conditions. Nevertheless, it indicates the general scale and adverse nature of the likely impact.

e. Fifthly, notional savings in the Council's sexual health budget would be offset by increased demand and consequential costs for other interventions. Some of these will represent additional pressures on other Council budgets (e.g. increased demand for Early Years interventions). In other instances, the impact will be felt in Council commissioned services funded by some form of capitated grant (e.g. nursery provision), for which it is already very challenging to identify sufficient adequate capacity in the market. After this, any net saving realisable by the Council, would be paid for in part by CCGs who will have to divert funds to meet the costs associated with additional demand for termination of pregnancy, ante- and perinatal services, treatment for infertility and other complications arising from delayed diagnosis and treatment. NHS England and other parties will bear additional costs associated with the local authority's failure to secure timely diagnoses of HIV.

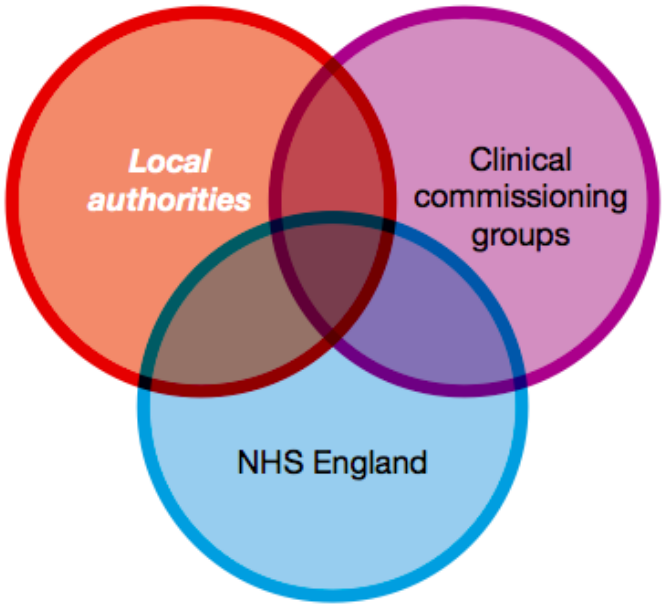
For any enquiries about this report please contact:
Jonathan Gribbin, Consultant in Public Health (jonathan.gribbin@nottscc.gov.uk)

Appendix 1

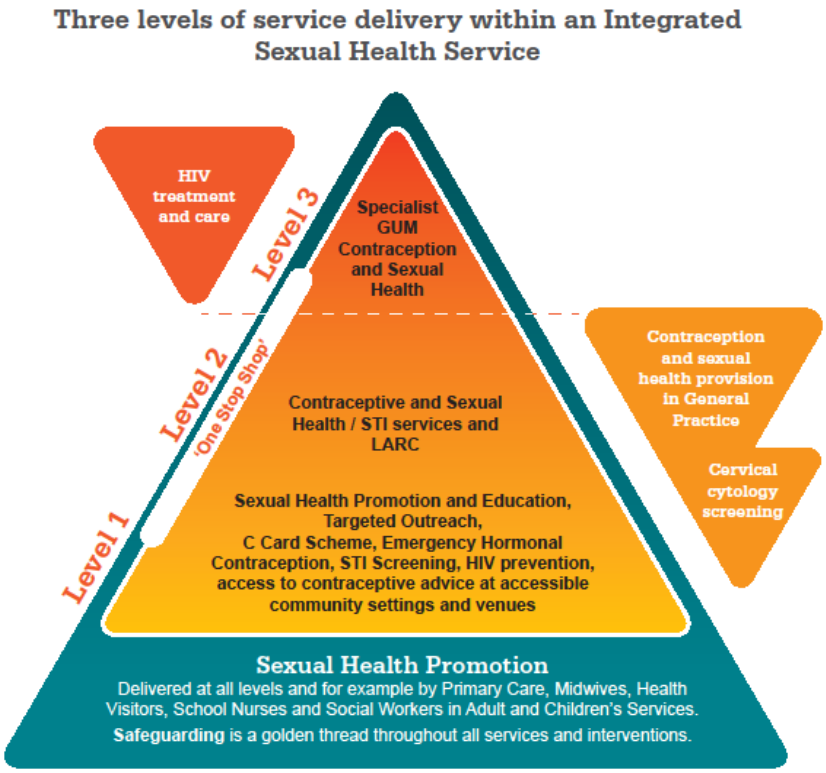
Commissioning Responsibility for sexual health, reproductive health and HIV [vii]

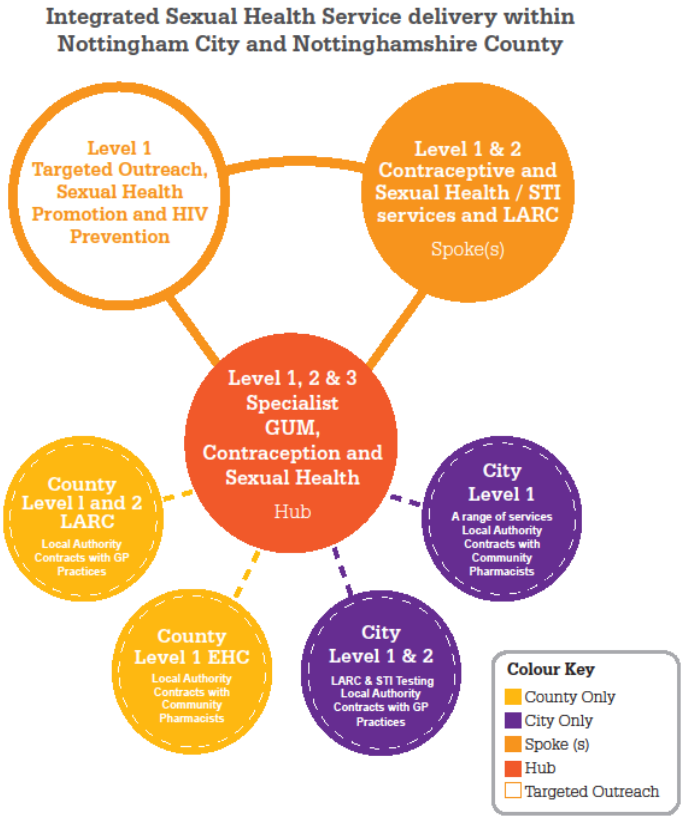
Local Authorities	CCGs	NHS England
• Contraception • STI testing and treatment • Chlamydia testing as part of the National Chlamydia Screening Programme • HIV testing • Sexual health aspects of psychosexual counselling • Sexual services including young people's sexual health, teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies	• Abortion services • Vasectomy • Non sexual health elements of psychosexual health services • Gynaecology including use of contraception for non-contraception purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care including post-exposure prophylaxis after sexual exposure • Promotion of opportunistic testing and treatment for STIs • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening • Specialist fetal medicine
Original Source: Department of Health Commissioning Sexual Health services and interventions: Best Practice guidance for local authorities, 2013		

The Venn diagram illustrates the interface and co-dependency of commissioning sexual health, reproductive health and HIV services.



Appendix 2 – Tiered service model for the Integrated Sexual Health Service





Appendix 3 – Locations of clinics for the Integrated Sexual Health Service (all clinics are open to County residents; those located in County localities are shown in bold)

1. **TriHealth Bassetlaw serving North Nottinghamshire**

Worksop clinic The Ryton Street Centre Worksop Nottinghamshire S80 2AU

Retford clinic Retford Hospital, North Road Retford Nottinghamshire DN22 7XF

Harworth clinic Harworth Primary Care Centre Scrooby Road Harworth DN11 8JT

2. **SFHT My Sexual Health serving Mid Nottinghamshire Mansfield, Ashfield, Newark and Sherwood**

The Hub, Kings Mill Hospital Level 5, Pink Tower Mansfield Road Sutton in Ashfield NG17 4JL

Ashfield Health Clinic Ashfield Health Village Portland Street Kirkby in Ashfield, NG17 7AE

Bull Farm Primary Care Centre Concorde Way Millennium Business Park Mansfield NG19 7JZ

Mansfield Community Hospital Stockwell Gate Mansfield NG18 5QJ

Mansfield Woodhouse Health Centre Church Street Mansfield Woodhouse NG19 8BL

Oak Tree Lane Health Centre Jubilee Way South Mansfield NG18 3SF

Oates Hill Health Centre 2 Forest Street Sutton in Ashfield NG17 1BE

Warsop Primary Care Centre Church Street Warsop NG20 0BP

Eastwood Centre Newark Hospital Bowbridge Road Newark NG24 4DE

Ollerton Health Centre Church Circle Ollerton, NG22 9SZ

3. **NUH Sexual Health serving South Nottinghamshire Gedling, Broxtowe and Rushcliffe and Nottingham City**

Hub - GU Medicine

City Hospital, Hucknall Road, Nottingham NG5 1PB

Hub - Victoria Health Centre

The Victoria Health Centre, Glasshouse Street, Nottingham NG1 3LW

Community clinics (County clinics in bold)

Mary Potter Centre, Gregory Boulevard, Hyson Green, NG7 5HY

Clifton Cornerstone, Southchurch Drive, Clifton, NG11 8EW

Radford Health Centre, Highurst Street, Radford, NG7 3GW

Bulwell Riverside Centre, Main Street, Bulwell, NG6 8QJ

Park House Health & Social Care Centre, 61 Burton Road, Carlton, NG4 3DQ

Hucknall Health Centre, Curtis Street, Hucknall, NG15 7JE

Stapleford Care Centre, Church Street, Stapleford, NG9 8DB

Kimberley Health Clinic, Newdigate Street, Kimberley, NG16 2NJ

Strelley Health Centre, 116 Strelley Road, Strelley, NG8 6LN

City Care Health Clinic, Lower Parliament Street, Nottingham, NG1 3QS

Beeston Clinic, 38 Wollaton Road, Beeston, NG9 2NR

Arnold Health Centre, High Street, Arnold, NG5 7BQ

Melbourne Park Medical Centre, Melbourne Road, Aspley, NG8 5HL

West Bridgford Health Centre, 97 Musters Road, West Bridgford, NG2 7PX

References

[i] WHO Health Topics Sexual Health. Accessed on line on 24.10.2014 at: http://www.who.int/topics/sexual_health/en/

[ii] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Accessed on line on 24.10.2014 at: http://www.legislation.gov.uk/ukdsi/2012/9780111531679/contents

[iii] Nakagawa et al 2015. Projected lifetime healthcare costs associated with HIV infection. PLoS ONE 10(4): e0125018. doi:10.1371/journal.pone.0125018. Accessed 23/12/16.

[iv] Nottinghamshire County JSNA (2014) Teenage Pregnancy Chapter (including health and wellbeing for young families) 2014

[v] North Nottinghamshire (Bassetlaw): Bassetlaw TriHealth http://bassetlawtrihealth.dbh.nhs.uk ; Mid Notts (Mansfield, Ashfield, Newark and Sherwood): My Sexual Health http://www.sfh-tr.nhs.uk/index.php/my-sexual-health ;
South Nottinghamshire (Broxtowe, Gedling, Rushcliffe) and Nottingham City: NUH Sexual Health Service https://www.nuh.nhs.uk/our-services/services/sexual-health-service

[vi] Development Economics (2013) Unprotected Nation. The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services. A report by Development Economics

[vii] PHE (2014) Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 January 2017

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

IN-VITRO FERTILISATION – VARIATION OF SERVICE

Purpose of the Report

1. To allow further consideration by the Health Scrutiny Committee of the consultation on variations in the In-Vitro Fertilisation (IVF) Service.

Information and Advice

2. Members will recall having previously received briefing on potential changes to the IVF service. The Health Scrutiny Committee requested an interim update with progress on the consultation at this meeting.

3. Dr Amanda Sullivan, Chief Officer, Mansfield and Ashfield CCG and Newark and Sherwood CCG and Sally Dore Pathway Redesign Manager at NHS Arden & Greater East Midlands Commissioning Support Unit will attend this meeting to make a presentation on the outcomes of the consultation. Since, at the time of writing, the consultation has not yet concluded, the presentation is not available for inclusion within these papers.

4. Health Scrutiny Committees have a particular role in examining how health service changes are consulted on and if the proposed changes are in the interests of the local health service. Members are invited to give their views on how this change is being consulted on, and to schedule further consideration of the consultation response, with a view to determining if the proposed change is in the interests of the local health service.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the IVF treatment consultation

2) Schedule further consideration of the results of the consultation, as necessary

Councillor Colleen Harwood
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

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 January 2017

Agenda Item: 8

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 which impact 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 Colleen Harwood
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 2016/17

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
11 July 2016				
Sherwood Forest Hospitals Trust – Updates on Improvement	Examination of the latest position on improvements within the Trust (with focus on Emergency Department and End of Life Care)	Scrutiny	Martin Gately	Ben Owens, Clinical Director, Urgent and Emergency Care, Paul Moore SFHT and Newark and Sherwood CCG
Doncaster and Bassetlaw Hospitals – Cancelled Emergency Operations and Financial Position	Examination of the current position in relation to cancelled emergency operations, as well as the Trust's financial position.	Scrutiny	Martin Gately	Mike Pinkerton, Chief Exce DBH Trust .
26 September 2016 (Cancelled)				
Sherwood Forest Hospitals Trust – Updates on Improvement	Examination of the latest position on improvements within the Trust with a focus on End of Life Care	Scrutiny	Martin Gately	TBC
28 November 2016				
Community Pharmacy Issues	To examine commissioning, regulation and complaints handling in relation to community pharmacies.	Scrutiny	Martin Gately	Joe Lunn, Head of Primary Care NHS, England TBC
Financial Challenges –	To examine the consultation on financial challenges run by Mansfield &	Scrutiny	Martin Gately	Amanda Sullivan

Mansfield and Ashfield/Newark and Sherwood Engagement	Ashfield/Newark & Sherwood CCG.			
Sherwood Forest Hospitals Update on Improvement	Examination of the latest position on improvements within the Trust with a focus on End of Life Care	Scrutiny	Martin Gately	TBC
23 January 2017				
Doncaster and Bassetlaw Hospitals – Financial Position Update	Further to the briefing in July 2015 from Mike Pinkerton, the committee will receive an update on the Trust's financial position.	Scrutiny	Martin Gately	Mike Pinkerton, Chief Executive of DBH Trust (TBC).
Paediatric Admissions at Bassetlaw Hospital	Briefing on the closure of Bassetlaw Paediatric Hospital to admissions after 7:00 pm due to staffing shortages and associated issues.	Scrutiny	Martin Gately	Denise Nightingale, Bassetlaw CCG & David Purdue, Bassetlaw Hospital
Contraceptive and Sexual Health Services	Update on Contraceptive and Sexual Health Services commissioned by the County Council	Scrutiny	Martin Gately	Jonathan Gribbin, Consultant in Public Health
IVF Variation of Service (2)	Second consideration of variation of service relating to In-Vitro Fertilisation.	Scrutiny	Martin Gately	Dr Amanda Sullivan, Newark and Sherwood CCG
27 March 2017				
Discharge Issues	Examination of work to prevent unsafe discharge.	Scrutiny	Martin Gately	Dawn Atkinson, Head of Business Change and Implementation, Mansfield and Ashfield CCG
Improving IT Links	Examination of ongoing work	Scrutiny	Martin	Dawn Atkinson,

between GP services and Hospitals			Gately	Head of Business Change and Implementation, Mansfield and Ashfield CCG
Health Inequalities	Update on ongoing work to address health inequalities in the County TBC	Scrutiny	Martin Gately	Public Health NCC TBC
Sherwood Forest Hospitals Performance Update	Examination of the latest performance information (Including A&E, single front door and winter pressures)	Scrutiny	Martin Gately	Sherwood Forest Hospitals Trust (TBC)
Sherwood Forest Hospitals – Pharmacy Delay	Examination of pharmacy issues which cause delayed discharge	Scrutiny	Martin Gately	Sherwood Forest Hospitals (TBC)
Community Pharmacy Issues Update (2)(TBC)	Update on Community Pharmacy issues	Scrutiny	Martin Gately	Liz Gundel, Pharmacy Lead, NHS England
26 June 2017				
24 July 2017				
To Be Scheduled				
Obesity Services				

Potential Topics for Scrutiny:
Never Events
Health Inequalities
Substance Misuse

Suggested Topics

Improving IT links between GP services and Hospitals (CCGs) – Cllr Lohan
Unsafe Discharge/Assess Team/Discharge Team – Cllr Harwood & Cllr Lohan
Recruitment (especially GPs)
Rushcliffe CCG Pilots Update