Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 23 November 2021 at 10:30

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 Noel McMenamin (Tel. 0115 993 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 12 October 2021 at 10.30am

COUNCILLORS

Sue Saddington (Chairman)
Matt Barney (Vice-Chairman)

Mike Adams **A**	David Martin
Callum Bailey **A**	John 'Maggie' McGrath
Robert Corden	Michelle Welsh
Eddie Cubley	John Wilmott
Penny Gowland	

SUBSTITUTE MEMBERS

Bethan Eddy
Johno Lee.

Councillors in attendance

Glynn Gilfoyle

Officers

Martin Gately	Nottinghamshire County Council
Noel McMenamin	Nottinghamshire County Council

Also in attendance

Chris Ashwell	-	Nottinghamshire Healthcare Trust
Kazia Foster	-	Nottinghamshire Healthcare Trust
Idris Griffiths	-	Bassetlaw CCG
Michelle Rhodes	-	Nottingham University Hospitals Trust
Rosa Waddingham	-	NHS Nottingham & Nottinghamshire CCG

1. MINUTES OF LAST MEETING HELD ON 7 SEPTEMBER 2021

The minutes of the last meeting held on 7 September 2021, having been circulated to all Members, were taken as read and were signed by the Chairman.

2. APOLOGIES FOR ABSENCE

Mike Adams – Other County Council business

Callum Bailey – Other reasons
Ajanta Biswas – Healthwatch Nottingham and Nottinghamshire

3. DECLARATIONS OF INTERESTS

Councillor Barney declared a personal interest in published agenda item 4 -'Mental Health Crisis Services' as a family member worked closely with mental health services as a clinical psychotherapist, which didn't preclude him from speaking or voting.

Councillor Barney also declared personal interests in published agenda items 6 and 7 – 'Nottingham University Hospital Maternity Improvement Plan' and 'Clinical Commissioning Group Maternity Improvement' - as a family member received ongoing health care and support through NUH services, which didn't preclude him from speaking or voting.

Councillor McGrath declared personal interests in published agenda items 6 and 7 – 'Nottingham University Hospital Maternity Improvement Plan' and 'Clinical Commissioning Group Maternity Improvement' - as a family member worked for the NUH Trust, which didn't preclude him from speaking or voting.

Councillor Gowland declared personal interests in published agenda items 6 and 7 – 'Nottingham University Hospital Maternity Improvement Plan' and 'Clinical Commissioning Group Maternity Improvement' – as she worked closely with the Obstetrics Department at NUH, which didn't preclude her from speaking or voting.

Councillor Lee declared personal interests in published agenda items 6 and 7 – 'Nottingham University Hospital Maternity Improvement Plan' and 'Clinical Commissioning Group Maternity Improvement' – as he was in receipt of ongoing health care and support from NUH, which didn't preclude him from speaking or voting.

Councillor Eddy declared a personal interest in published agenda item 4 -'Mental Health Crisis Services' as she was a Director of the mental health awareness charity Head High, which didn't preclude her from speaking or voting.

Councillor Eddy also declared personal interests in published agenda items 6 and 7 – 'Nottingham University Hospital Maternity Improvement Plan' and 'Clinical Commissioning Group Maternity Improvement' - as a family member worked as a community staff nurse, which didn't preclude her from speaking or voting.

Councillor Saddington declared personal interests in published agenda items 6 and 7 – 'Nottingham University Hospital Maternity Improvement Plan' and 'Clinical Commissioning Group Maternity Improvement' - as a family member worked for the NUH Trust, which didn't preclude her from speaking or voting.

At this point, it was agreed to amend the agenda order, taking items 6 and 7 in succession.

6. NOTTINGHAM UNIVERSITY HOSPITALS MATERNITY IMPROVEMENT PLAN

Michelle Rhodes, Nottingham University Hospitals Trust Chief Nurse, introduced the item, giving apologies for absence from Dr Keith Girling, Medical Director (unwell) and Sharon Wallis, Director of Midwifery (attending an inquest).

Ms Rhodes drew the Committee's attention to the 14 core 'bellweather' indicators of performance, detailed in the report and contained in the NUH Maternity Improvement Plan, which had been drawn up in response to the Care Quality Commission's 'inadequate' rating of the Trust's Maternity Services.

Ms Rhodes highlighted recent improvements and innovations as follows:

- The NUH continued to work closely with the CCG and Healthwatch to inform improvements, and had recently launched a 24/7 Maternity Advice Line, which was staffed by midwives and had been well-received by service users;

- A Family and Friends Test initiative had received positive feedback, and QR Codes had been made available for ease of use to boost response rates;

- Video training material was now in place which used the testimony of a mother who had lost an infant to reinforce key health, messages for midwives and wider staff on patient safety and duty of candour;

- Parents who had poor levels of maternity service had attended the most recent meeting of the NUH Trust Broad, providing powerful witness statements directly to the Trust's decision makers;

- Women's stories were now an integral part of staff training.

Ms Rhodes indicated that staffing recruitment and retention remained the most pressing challenge to the service. While 38 additional midwives had been appointed, difficulties remained with ongoing vacancies arising from experienced Level 6 midwives leaving the service. The Trust was working to rebuild staff morale and address wellbeing concerns

The Committee Vice-Chairman, Councillor Matt Barney, opened the discussion, making a number of points:

- It was unacceptable that the Committee had still not seen the Maternity Improvement Plan or the Provider Maternity Dashboard, and it was clear from the CCG's assessment that there was no clear triangulation between these and the challenges faced by the service;

- The lack of a common digital platform, necessitating repeated entry of the same data was concerning, as was what appeared to be an ongoing culture of bullying and intimidation that he was not convinced had been resolved. He undertook to speak to Ms Rhodes on the bullying and intimidation element outside the meeting

- He expressed the view that staff retention was a more pressing issue that of recruitment, given that the service was haemorrhaging experienced staff;

- He thanked the staff he met during a recent visit to NUH for their candour and honesty in describing their experience within the service. He welcomed their ongoing commitment to improving the service, and the pledge of the new Director of Midwifery, Sharon Wallis, both to work actively with the Committee and to see through plans for improvement;

- During his visit, it was explained that the triage escalation system in place, where cases were rated green, yellow and purple in order of severity, had had an additional 'purple plus' rating added, better to reflect the acute nature of the cases involved;

- He acknowledged that there were grounds for optimism with the recent appointments to the positions of Chief Nurse and Director of Midwifery, but he expressed the view that the rest of the current leadership did not have the ability or credibility to turn performance around.

Ms Rhodes gave responses as follows:

- The Action Plan had been rewritten and would shared imminently;

- The 'Dashboard' was not formally named within the presentation but was captured within the core 'bellweather' indicators. Work was being carried out on compiling national comparators, but this was a complex process as not all trusts held information on all indicators;

- A common digital platform was being developed, and work on the roll-out of new data entry equipment was back on track;

- Issues with the triage system were acknowledged, but it was pointed out that the Trust was far from unique in having to ask other organisations within the region to help with service provision;

- It was fully accepted that staff retention was central to efforts to improve the service, and the new Director of Midwifery was personally committed to addressing the issue.

The Committee Chairman, Councillor Sue Saddington, made the following points:

- Information previously provided to the Committee on serious incidents was at odds with information subsequently reported, and both local and national press coverage quoted a significant number of infant deaths and infants born with life-changing conditions which had not been reported directly to the Committee;

- The Trust's Senior leadership, excepting the recently appointed Chief Nurse and Director of Midwifery, was responsible, in her view, for allowing the service

to deteriorate and then had not taken decisive action to address the shortcomings identified by the Care Quality Commission;

- She therefore intended to write to the Secretary of State for Health and Social Care on behalf of the Committee to highlight the Committee's grave concerns on the issue, and to request that the relevant members of the Trust's Senior Leadership step aside and be replaced.

During wider discussion, a number of issues was raised and points made:

- The point was made that the CCG had previously conducted a review of maternity services in 2018 but that the outcomes and actions were not publicly available. Similarly, the Trust's Board papers on the Improvement Plan were not publicly available on its website;

- An explanation was requested about the threshold criteria for referral of serious incidents, as it was alleged that a number of still births were not considered to have met those criteria. This left mothers feeling responsible for the loss of their babies, in the absence of the NUH recognising these cases as serious incidents;

- It was reported that provision for fathers to remain with mothers following a still birth was wholly inadequate;

- A councillor spoke of their personal experience in respect of a difficult family birth several years previously where, in their experience, the Trust had been focussed on avoiding or minimising litigation rather than on providing appropriate care to their family;

- Several members requested definitive information on numbers of infant deaths and infants born with life-changing conditions. Definitive information on the value of historic insurance claims related to NUH maternity services was also requested;

- There was general consensus in respect of the proposed action by Chairman. In response to requests to instigate a public inquiry into maternity services, the Chairman advised that she would take further advice from officers on the formal process, but that she was supportive in principle of taking further action.

The Chairman thanked Ms Rhodes for her attendance at the meeting.

7. CLINICAL COMMISSIONING GROUP MATERNITY IMPROVEMENT

Rosa Waddingham, the Chief Nurse at Nottingham and Nottinghamshire CCG, introduced the report, which provided an overview of the current maternity improvement oversight arrangements as well as highlighting progress specifically in relation to NUH maternity service provision. being taken to improve maternity provision.

The report detailed the roles, functions and collaborative work undertaken through the Local Maternity and Neonatal System, the actions identified following the Ockenden Review, and specifically a range of maternity quality and safety assurance actions identified to address significant concerns about NUH maternity services.

Ms Waddingham highlighted a lack of pace and ambition in addressing issues identified in the CQC report into NUH maternity services, and confirmed that an Independent Review of NUH Maternity Services had been commissioned to drive rapid improvements where change was most needed. The review was to start by end October 2021, was expected to last a year, and would involve families closely from the outset. An experienced Programme Director, Catherine Purt, had already been appointed, and Terms of Reference would be shared with the Committee as soon as they were available.

The following points were made during discussion:

- The report was welcomed and had helped inform detailed consideration of the previous agenda item;

- Concern was expressed that a previous CCG review had not been published and that it would be preferable to have a 'third party' independent review conducted to ensure full transparency. An assurance was requested that the Health Scrutiny Committee would be kept informed regularly on the review's progress;

- In response, Ms Waddingham advised that it was not in her gift to provide the assurance requested, as the review was wholly independent of the CCG. However, the Health Scrutiny Committee was a key stakeholder, and arrangements would be put in place to ensure that the Programme Director met the Chairman and Vice-Chairman at an early stage.

The Chairman thanked Ms Waddingham for her attendance at the meeting.

At this point, the meeting reverted to the original published running order, and considered agenda item 4.

4. MENTAL HEALTH CRISIS SERVICES

Nottinghamshire Healthcare Trust representatives Chris Ashwell, Deputy Director of Mental Health, and Kazia Foster, Service Improvement and Development Manager, introduced the report and presentation, which provided an initial briefing on local mental health provision, including key performance measures, the impact of the Covid pandemic and an update on local Mental Health transformation plans.

Specific points raised included:

- There had been an increase in referrals to the Children and Young People Eating Disorder, Step 4 Psychology and Adult Crisis services during the pandemic, with extra funding required. Over the same period, local Mental Health teams had seen a more steady referral rate;

- Staffing challenges had been significant during the pandemic, with absence levels averaging at 8%. Recruitment nationally was an issue, with a shortage of suitably trained health professionals, particularly around the treatment of eating disorders;

- The roll-out of self-referral had seen an increase in demand, and while no further action by mental health services was required in a majority of cases, services were instrumental in signposting to other sources of support;

- An enhanced 24/7 crisis service was now in place, with 30 additional posts in place. Street triage services had also been enhanced, with multi-agency teams working with regular service users.

The following points were raised during discussion:

- It was confirmed that the Trust had signed up to the Veteran's Charter, and had received no additional funding from the Ministry of Defence for work specifically with veterans;

- It was acknowledged that that there was a reticence to diagnose children and young people at too early a stage in assessment, but it was important to get accurate diagnoses in order both to provide the correct treatment and to avoid labelling children and young people inappropriately;

- Lots of work was ongoing in schools to help identify and address future need. Mr Ashwell undertook to take forward a specific case referred to during discussion in respect of signposting for Obsessive Compulsive Disorder;

- Analysis of demand was being carried out by Primary Care Network and the information was available on the Nottinghamshire Healthcare Trust website;

- It was confirmed that self-referral had been place for over 12 months, and that more detailed information on crisis sanctuaries could be made available to share.

In summing up, the Committee Chairman advised that this marked the start point of a more detailed scrutiny process for mental health services, and that further work was needed to plot the specific services for children and young people, as well as older age groups and specific cohorts. She also thanked Mr Ashwell and Ms Foster for their attendance at the meeting.

5. BASSETLAW MENTAL HEALTH ENGAGEMENT AND PROPOSALS – FAMILY TRAVEL PLAN

Further to its detailed consideration at the Committee's September 2021 meeting, Idris Griffiths, Chief Officer of Bassetlaw CCG introduced the item, which provided information on a draft family travel plan scheme in respect of the relocation of services from Bassetlaw Hospital to the new Sherwood Oaks facility in Mansfield.

Mr Griffiths advised that the proposals had been drawn up following consultation with the public, service users and carers and wider family members. The proposed scheme was simple, flexible and grounded in equity and fairness, and took into account both financial and non-financial considerations. While focussing on patients and relatives, consultation had also taken place with existing staff, and it was confirmed that the proposals were entirely separate to transport arrangements when being admitted to the service.

A number of points were made during discussion:

- Several Committee members expressed disappointment that a 'cost-claim' approach had been adopted, and considered that the proposed scheme was complex and could potentially disadvantage service users;

- Members were instead supportive of a fixed link bus service, similar to that already available for the paediatrician service in North Nottinghamshire;

- In response, Mr Griffith expressed the view that a fixed service would be inappropriate for service users' needs, and would not represent a good use of public funding in view of the low numbers involved. However, there was a community transport presence in Bassetlaw and that could be an option worth further consideration;

- it was considered appropriate that funding of the travel scheme should last for the length of investment, and not be time-limited to 2 years. It was explained that the proposal was to review arrangements after 2 years, but not necessarily to bring them to an end.

On the wider issue of the proposed change being in the interest of the local health service, the following was:

RESOLVED 2021/03
That:

1) the Committee's comments on the proposed Family Travel Plan scheme be agreed and reported to the Bassetlaw CCG's Governing Body meeting on 19 October 2021;

2) the Committee's final determination was that the proposed change was not in the interests of the local health service; and

3) a further update be brought to Committee once the inpatient care provision had been transferred, it being noted that the Bassetlaw CCG might not be in existence after March 2022.

8. WORK PROGRAMME

The Committee work programme was approved as published but it was noted that it was a live document and would be revisited before the next meeting.

The meeting closed at 2:17pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 November 2021

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

EXPANSION OF NEONATAL CAPACITY AT NOTTINGHAM UNIVERSITY HOSPITALS

Purpose of the Report

1. To provide an initial briefing on the expansion of neonatal capacity at Nottingham University Hospitals (NUH).

Information

2. Lucy Dadge, Chief Commissioning Officer will attend the Health Scrutiny Committee to provide an initial briefing on this development of service at NUH.

3. A briefing from the Clinical Commissioning Group on this proposed change is attached as an appendix to this report.

4. Members are requested to determine whether they are content for the CCG to proceed with a targeted engagement, as planned, or whether they would consider it necessary to undertake a fuller public consultation.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Determine whether a targeted engagement is sufficient in relation to this proposed change.

Councillor Sue Saddington
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 Health Scrutiny Committee

Case for Change for Expansion of Neonatal Capacity at Nottingham University Hospitals

1. Overview and Summary of Proposal

Nottingham University Hospitals are proposing to access NHS capital funds to increase the number of neonatal cots at the Queens Medical Centre (QMC) from 17 to 38. It is planned that this development is completed by 2023.

Current Neonatal Configuration in Nottingham

At the QMC campus there are currently 17 cots (11 Intensive care/high dependency and six special care) along with six transitional care cots on the postnatal ward (C29) which are co-located with maternity services on B Floor of the East Block. Clinically adjacent to and supporting the Neonatal service is specialised paediatric surgery within Nottingham Children's Hospital and the other paediatric tertiary specialists.

At the City Hospital campus, there are 24 cots (12 Intensive care/high dependency, 12 special care) along with six transitional care cots. The Neonatal Unit is co-located with maternity services in the maternity building. There are no other children's inpatient services at the City Hospital, and there is limited access to specialised radiology. Babies requiring specialised imaging, surgical care or other sub-speciality input are currently transferred from the City to the QMC campus. From April 2019 to April 2020, there were 147 transfers between sites.

In the same period, 116 babies could not be accommodated on either Nottingham sites and had to be transferred to other units, not just in the East Midlands, but much further afield. Destinations for these babies in 2019 included Burnley, Luton, Scunthorpe, Bradford and Birmingham.

Total Additional Neonatal Cots required

In order to address all of the Neonatal capacity issues identified and meet future demand the following additional cots are required at the QMC:

- Activity sent out of network = 6 Cots
- Reducing the QMC Neonatal Unit occupancy to 80% = 5 cots
- Activity that could no longer take place at the City Hospital Neonatal Unit if it is re-designated as a Local Neonatal Unit = 10

This is a total of 21 additional cots increasing the total number at the QMC from 17 to 38. The overall impact is shown in the table below including the reduction at City and the overall increase for the system.

Cot Type	Current			Proposed (Change)		
	QMC	City	**Total**	QMC	City	**Total**
Intensive Care	6	6	**12**	13 (+7)	2 (-4)	**15 (+3)**
High Dependency	5	6	**11**	12 (+7)	2 (-4)	**14 (+3)**
Special Care	6	12	**18**	13 (+7)	12 (-)	**25 (+7)**
TOTAL	**17**	**24**	**41**	**38 (+21)**	**16 (-8)**	**54 (+13)**

2. National Context

National Neonatal Critical Care Transformation Review

The National Neonatal Critical Care Transformation Review (NCCR) was published in December 2019. It was structured across 5 key work areas; Capacity, Workforce, Pricing, Education and Models of Care.

The aim of the Review was to make recommendations that will support the delivery of high quality, safe, sustainable and equitable models of neonatal care across England. The proposal to expand neonatal capacity in Nottingham responds to the findings of this national review as follows:

Mortality

- Local Maternity Networks (LMNs) must ensure that, where possible, all women at less than 27 weeks gestation are able to give birth in centres with a Neonatal Intensive Care Unit (NICU)
- LMNs and Operational Delivery Networks (ODNs) should aim to ensure that at least 85% of all births at 23-26 weeks' gestation are in a maternity service with an on-site NICU

Neonatal Care Capacity

- Neonatal services should have the capacity to provide all neonatal care for at least 95% of babies requiring admission for neonatal intensive care, and born to women booked for delivery within the network (i.e. the target of 95% was set to allow for the occasional woman who gives birth whilst on holiday or visiting the area)
- Neonatal services should not operate above 80% occupancy averaged over the year
- Babies requiring neonatal services should receive that care from a unit with the appropriate level of care as close as possible to the family home

The Nottingham Neonatal Service does not currently have the capacity to fulfil its service specification and provide intensive care for all Nottingham-booked and North Hub East Midlands Network (EMN) ODN babies who require it. The Neonatal Unit at the QMC usually operates at a level that is on average greater than 95% occupancy far exceeding the 80% average occupancy prescribed.

Neonatal Unit Designation:

- All neonatal units designated as NICUs must provide more than 2,000 intensive care days per year.

The proposal to increase neonatal capacity in Nottingham in the short term needs to be seen in the context of the ambition of the New Hospital's Programme (Tomorrow's NUH) when – amongst other developments – it is proposed that Neonatal Services will be delivered on a single site. The clinical case shows beyond doubt that prolonging the current situation until such time as the larger scheme is delivered, is not a realistic option, given the mortality and morbidity impacts of not having sufficient Neonatal capacity in Nottingham, combined with the issues related to patient (and families') experience as described above.

The Neonatal service is small numerically in terms of patients, but is regionally commissioned, and the current capacity shortfalls have significant long term detrimental impacts on the babies, not just in the immediate period of care, but also going forward into childhood and indeed full maturity.

3. The Local Case for Change - Why is this Investment and Change Needed?

There are four key drivers for change for this proposal:

1. Insufficient capacity within the Nottingham Neonatal Service to meet local demand resulting in babies being sent out of network for their care. This has a serious impact on mortality and morbidity as highlighted in the December 2020 Getting it Right First Time (GIRFT) Report.
2. The need to respond to the NNCR Report and in particular the requirement for NICUs to provide more than 2,000 critical care cots days per year.
3. The environment and space available on the Neonatal unit at the QMC is not fit for purpose, leading to increased risk of cross-infection and mortality.
4. Insufficient obstetric theatre space with only one full sized obstetric theatre.

The NHS Outcomes Framework 2019/20 includes the following domains specific to Maternity and Neonatal Services:

- Preventing babies from dying prematurely
- Ensuring that people have a positive experience of care (women's experience of maternity services)
- Treating and caring for people in a safe environment and protecting them from avoidable harm

This proposal aligns with the NHS Outcomes Framework 2019/20 by creating a larger, neonatal intensive care service at QMC campus, supported by Special Care Baby Unit at City campus, which will improve outcomes for pre-term infants in terms of mortality, as the number of babies needing to be transferred out of area will be significantly reduce. Prematurity and congenital abnormalities are the single largest causes of deaths among babies less than one year in age. Also, the proposal aims to improve families' experience of neonatal intensive care by ensuring they are cared for in a safe suitable environment, again aligning to the NHS Outcomes Framework.

The Getting It Right First Time (GIRFT) report identified serious concerns in the EMN ODN as follows:

- Major capacity issues in the three NICUs (two in Nottingham and one in Leicester) are causing excess deaths and poorer quality of care for babies in the EMN ODN.
- The proportion of high-risk babies (extremely premature babies and babies requiring intensive care) dying in local neonatal units and special care baby units in the first week of life is more than twice the national average and is higher than any other network.
- The mortality rates in the NICUs in EMN ODN are low/ average (i.e. NICU performance is not an issue)
- Critically unwell babies are not being transferred from Local Neonatal Units (LNUs) and Special Care Units (SCUs), due to lack of capacity in the NICUs

The GIRFT report also cited serious concerns regarding capacity at Nottingham, including that the capacity gap is the greatest in any NICU nationally. Local data from NUH shows that:

- Occupancy levels across all cot types at the QMC are the highest in the country at nearly 100%. Combined special and transitional care cots at the QMC are insufficient for the number of live births (lowest decile) and special care occupancy is consequently well above recommended levels at nearly 125%.
- Total cot occupancy at City is just under the recommended 80% with special care cot occupancy greater than 80%.
- Capacity transfers for non-clinical reasons are five times higher than the NICU average for the QMC, and in the upper quartile at City
- Both hospitals are in the lowest performing decile in relation to the percentage of pre-term infants born in the NICU

- There are significant numbers of 'out born' babies who need to be transferred back into the NICU having received care out of network

Patient/Family Experience

Whilst the clinical benefits to the families of neonates in terms of the significant reduction in the risk of pre-term babies being transferred out of Nottingham (as well as the improved environment in the new, expanded unit) are clear, there are other practical considerations in relation to access, travel and car parking.

Commissioners will work closely with NUH to ensure that for those families who will in future be able to access this expanded local NICU capacity, access and travel concerns are addressed during in-patient and subsequent family visiting periods. We will also analyse feedback from families who have used the current service, some of whom will have seen first-hand the shortfall in resource, and the consequence of having neonatal care provided far from home.

4. Conclusions

This is a major quality improvement for a small number of pre-term babies and their families. The expansion of neonatal intensive care cots at QMC campus will reduce significantly the number of babies needing to be transferred to other hospitals, and the realignment of neonatal care between City and QMC will provide better resources – numbers of staff, expertise, equipment and physical space – for those patients. By way of context the total births at NUH per annum is. circa 8500, albeit that this key clinical development will only apply to approximately 250 babies. The benefits to these families are significant but numerically this development represents an adjustment to a clinical pathway rather than a major service redesign.

Commissioners will work alongside NUH to engage widely with citizens who will access services at both QMC and City to ensure that the development meets user requirements.

The proposed targeted engagement approach comprises three main strands:

1. Review of existing patient experience data. Working with NUH and the CCG Quality team, available patient experience data covering the period of April 2019 to date will be collated and analysed, with a focus on understanding both positive and negative experiences of individuals who have accessed Neonatal services at both QMC and City. Existing research/engagement publications in this area will also be scoped and reviewed to provide a broad evidence base for change.
2. Engagement with patients. This will be focused on previous/current service use, the proposed change and asking for feedback. Methods will include an online survey and/or paper survey, which will include questions about previous/current use of the service, what went well, and what could be improved. There will also be the opportunity to take part in focus groups and workshops to allow patients to provide detailed information about their experiences. Working in partnership with NUH, the Nottingham and Nottinghamshire Maternity Voices Partnership, the CCG's Patient and Public Engagement Committee, Healthwatch Nottingham and Nottinghamshire and other relevant community groups (including organisations such as Zephyr's) will ensure that the voices of those who may be disproportionately impacted are heard, and that the engagement exercise reaches the right people.
3. Ongoing patient and public assurance. The survey, its responses and a "You Said, We Did" summary will be published on the CCG website and disseminated through partners engagement channels.

Commissioners and providers are keen to proceed expeditiously to access the capital funding available to support this major development for Nottingham and Nottinghamshire.

To this end, the CCG wishes to consult with the Health Scrutiny Committee on this proposal, and in parallel, approval is requested from the Health Scrutiny Committee to proceed with a targeted engagement approach (rather than public consultation), the findings of which will be reported back as required. The consideration of the decision to proceed with this work is imminent and therefore a formal response to this request is required before 7th December 2021.

Lucy Dadge
Chief Commissioning Officer
NHS Nottingham and Nottinghamshire CCG

Appendix – Key Drivers

Insufficient capacity within the Nottingham Neonatal Service to meet local demand:

- The Nottingham Neonatal Service does not have sufficient capacity to provide care for all of the sickest and most vulnerable babies it is expected to care for. An average of 116 babies per year (average for 2018-2020) was transferred out of Nottingham and to elsewhere in the UK for their care (in-utero and ex-utero). This has a significant impact on outcomes (as demonstrated within the recent GIRFT report) and detrimentally impacts upon parents and families.
- The GIRFT report showed that the Nottingham Neonatal Unit has the most serious capacity issues of any NICU nationally, and this is having a demonstrably negative impact on both quality of care and mortality for high risk babies born elsewhere in the network who are unable to access the service when they need it. The capacity gap is very significant, and there is currently no agreed plan to resolve this issue which the MNRr business case being put forward seeks to address. Of particular concern within the GIRFT report are:
    - Occupancy levels across all cot types at the QMC which are the highest in the country at nearly 100%.
    - Capacity transfers for non-clinical reasons are five times higher than the NICU average for the QMC, and in the upper quartile at City
    - There are significant numbers of 'out born' babies who need to be transferred back into the NICU having received care out of network (this is the 116 babies noted above).
    - Transfers out of Nottingham affect surrounding neonatal and transport services, creating a ripple effect on hospitals throughout the UK as demand and capacity issues are passed on.
    - This is currently a risk score of 15 within the Family Health risk register (Datix reference: 5507).

The need to respond to the Neonatal Critical Care Transformation Review report:

- The NCCR sets some standards for Neonatal Units which are not currently achieved within the Nottingham Neonatal units. In particular:
    - All neonatal units designated as NICU must provide more than 2,000 intensive care days per year. The neonatal unit at the QMC does not consistently provide more than 2,000 intensive care days per year and the neonatal unit at the City Hospital does come close to meeting this threshold. As neither of the Nottingham neonatal unit currently meets the requirements to be designated a NICU there is a risk that they could both be re-designated as LNUs. If NICU status were lost and the units were both re-designated as LNUs, it is unlikely that neonatal surgery could continue at the QMC. Other important services would also be affected, such as supra-regional neonatal neurosurgery, some neonatal nephrology and foetal medicine services. This would have major consequences for Neonatal and Maternity Services in Nottingham.
    - Neonatal services should not operate above 80% occupancy averaged over the year. The Neonatal Unit at the QMC usually operates at a level that is on average greater than 95% occupancy far exceeding the 80% average occupancy prescribed.

The environment and space available on the Neonatal unit at the QMC is not fit for purpose, leading to increased risk of cross-infection and mortality.

- This impacts on the quality of care, infection control and patient, parent and staff experience.
- Lack of space is an incredibly significant risk for cross-infection between patients and the ultimate harm from this is death. There have been documented outbreaks on the neonatal units within the period 2016-2021 with documented evidence of harm in babies.

- Isolation of babies when an infection occurs is not possible due to lack of suitable spaces.
- Based on Health Building Note (HBN) regulations, the current space is 2-2.5 times too small per cot space.
- This risk is recorded on the Family Health risk register with a score of 20 (Datix reference: 9300).

Insufficient obstetric theatre space with only one full sized obstetric theatre

- Providing two complex cases simultaneous is difficult (is this due to the size of the theatre and or other reasons)? When looking at the performance of complex elective and emergency operations.
- The existing theatres will not be able to provide sufficient capacity to meet increased needs arising from an increase in Neonatal Activity at the QMC. Specific to the small theatre is the fact that any complex case involving a premature baby and a complex delivery will be difficult to manage in the small theatre with equipment and staff needed. Is there a clinical risk to mother and baby with the current size.

Based on the local, regional and national strategies, existing arrangements and the case for change, the investment objectives for this project are as follows:

- To redevelop the environment and space on the Neonatal Unit at the QMC and to be closer to national recommendations (HBN 09-03)
- To increase the NICU capacity on the QMC campus from 17 to 38 cots
- To improve the experience of the mothers and families of babies needing Neonatal Care
- To increase Obstetric theatre space and improve the Obstetric theatres environment at the QMC.
- To achieve balance of service configuration across Obstetric theatres, Obstetric beds and Neonatal

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 November 2021

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

ACCESS TO PRIMARY CARE

Purpose of the Report

1. To provide a further briefing on issues of concern to Members in relation to access to primary care services.

Information

2. Lucy Dadge, Chief Commissioning Officer, Joe Lunn, Associate Director of Primary Care, Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) and Dr Stephen Shortt, Clinical Chair will attend the Health Scrutiny Committee to provide a further briefing on access to primary care issues.

3. A further briefing from the Clinical Commissioning Group on access to primary care is attached as an appendix to this report.

4. Councillor Dr John Doddy, Chairman of the Health and Wellbeing Board will also participate in this meeting in order to give his views on access to primary care issues.

5. Members are requested to consider and comment on the information provided and identify requirements for information for future consideration as part of this ongoing review.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Identifies requirements for information for future consideration.

Councillor Sue Saddington
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 Health Scrutiny Committee

Meeting 23 November 2021

Access to Primary Care

Dear Colleagues,

Nottinghamshire County Council Health Scrutiny Committee have asked NHS Nottingham and Nottinghamshire CCG to provide an update for Members at the November 2021 meeting in relation to:

- **Access to Primary Care**

The brief below provides the update requested.

Joe Lunn

Associate Director of Primary Care

Joe.lunn@nhs.net

Nottinghamshire County Council Health Scrutiny Committee – Access to Primary Care

1. Introduction

Across Nottingham and Nottinghamshire CCG there are 124 GP practices, varying from single handed GP practices to large practices with multiple branch sites.

This paper follows the 'Primary Care Access' presentation to the Nottinghamshire County Council Health Scrutiny Committee at its September 2021 meeting.

The Committee asked the CCG to return to present more detailed figures relating to primary care workforce, practice population and GP survey results. This request was for information to be presented by practice in Nottinghamshire.

The Committee also asked for funding levels per patient by practices and number of appointments delivered.

2. Workforce

Practices are contractually required to report workforce numbers monthly, this includes full-time equivalent (FTE) and headcount figures, with breakdowns of individual job roles. This is for the following staff groups: GPs, Nurses, Direct Patient Care (DPC), and Administrative staff.

Further information about the National Workforce Reporting System (NWRS) can be found via the below link:

https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services#summary

Appendix 1 provides details of the following for all Nottinghamshire practices (excludes Nottingham City):

- Primary Care Network (PCN)
- Practice Name
- Practice List Size (raw) [1]
- Practice List Size (weighted) [2]
- GPs FTE (excluding Locums and Registrars) [3]
- GPs FTE (excluding Locums and Registrars) Rate per 1,000 weighted population
- Nurse FTE
- Nurse FTE Rate per 1,000 weighted population
- Admin FTE
- Admin FTE Rate per 1,000 weighted population

A 'Weighted' practice list is adjusted according to varying workload due to age, sex and deprivation for the registered population. A 'Raw' practice list is all patients registered at the practice and unweighted.

[1] Practice list (raw) is taken from 2021-22 Quarter 2 data
[2] Practice list (weighted) is taken from 2021-22 Quarter 2 data
[3] Workforce (FTE) and England/CCG averages is taken from August 2021 National Workforce Reporting System (NWRS) data

2.1. GP workforce

The NWRS data shows that there are 37 practices in Nottinghamshire and Nottingham CCG that have below the England/CCG average of 0.4 GP FTE per 1,000 weighted population.

This is split by:

- 21/78 Nottinghamshire County practices (17% of 124 practices)
- 16/46 Nottingham City practices (13% of 124 practices)

87 practices (70%) have or are above the England/CCG average of 0.4 GP FTE per 1,000 weighted population.

2.2. Nurse Workforce

The NWRS data shows that there are 52 practices in Nottinghamshire and Nottingham CCG that have below the England/CCG average of 0.3 Nurse FTE per 1,000 weighted population.

This is split by:

- 27/78 Nottinghamshire County practices (22% of 124 practices)
- 25/46 Nottingham City practices (20% of 124 practices)

72 practices (58%) have or above the England/CCG average of 0.3 Nurse FTE per 1,000 weighted population.

2.3. Admin Workforce

The NWRS data shows that there are 46 practices in Nottinghamshire and Nottingham CCG that have below the England/CCG average of 1.1 Admin FTE per 1,000 weighted population.

This is split by:

- 29/78 Nottinghamshire County practices (23% of 124 practices)
- 17/46 Nottingham City practices (14% of 124 practices)

78 practices (63%) have or above England/CCG average of 1.1 Admin FTE per 1,000 weighted population.

As independent businesses practices carry out their own recruitment to ensure delivery of services to their registered population, in accordance with the national contract.

The CCG has an established Primary Care Workforce Group who support practices to access national and local initiatives to attract, support and retain a workforce with the right skills to meet population health needs. This is achieved through increasing training numbers, reducing the attrition of qualified staff by keeping them in Nottinghamshire, offering attractive roles that allow work life balance, career and personal development as well as flexibility of portfolio - with senior practice staff supporting the next

generation. The established Primary Care Training Hub supports the training and education of our workforce, embeds new roles and supports workforce planning.

The introduction of Primary Care Networks (PCNs) builds on core primary care services with an aim to improve the ability of general practice to recruit and retain staff by providing integrated health and care services to the local population. The recruitment of Additional Roles (ARs) staff e.g. Clinical Pharmacist, Physician Associate, Occupational Therapist, enables a greater provision of proactive, personalised care delivered by an increasing workforce with a diverse skill set. This creates a bespoke multi-disciplinary team to ensure that individual patient needs are met by the most appropriate professional to support their care, in line with national policy to build a broader workforce in primary care.

Across Nottingham and Nottinghamshire CCG there are currently 226.8 WTE ARs staff in post. For Nottinghamshire PCNs this equates to:

PCN	Total ARs	Total WTE
Mid Nottinghamshire Locality		
Ashfield North	14	12.03
Ashfield South	10	9.83
Mansfield North	14	13.2
Newark	16	15.92
Rosewood	9	8.27
Sherwood	12	10.71
South Locality		
Arnold & Calverton	12	9.56
Arrow Health	13	10.38
Byron	15	12.08
Nottingham West	36	32.99
Rushcliffe	29	27.81
Synergy Health	8	6.23

Appendix 2 provides all the Additional Roles staff recruited to each PCN (includes Nottingham City).

3. GP Survey

Patients' views on access to GP appointments are captured annually via the national GP Patient survey. The latest results were published on 8 July 2021 and are available via the below link:

https://www.england.nhs.uk/statistics/2021/07/08/gp-patient-survey-2021

It is possible to view and compare practice level data. In terms of access data, the Nottingham and Nottinghamshire CCG results are higher overall than the national average but there is variation between practices:

3.1. Nottingham and Nottinghamshire CCG GP Survey Results 2021

	CCG Average	National Average	Highest Practice	Lowest Practice
How easy is it to get through to someone at your GP practice on the phone	72%	68%	98%	21%
How often do you see or speak to your preferred GP when you would like to	45%	45%	85%	7%
How would you describe your experience of making an appointment	73%	70%	95%	28%
How would you describe your experience of your GP practice	84%	83%	99%	55%

3.1.1. How easy is it to get through to someone at your GP practice on the phone?

Response: Very easy + Fairly easy

The CCG average (72%) is higher than the national average for this question (68%). The GP Survey data shows that there are 48 practices in Nottinghamshire and Nottingham that are below the CCG average for this question:

- 27/77 Nottinghamshire County practices (22% of 122 practices)
- 21/45 Nottingham City practices (17% of 122 practices)

74 practices (61%) are or above the CCG average for this question. 84 practices (68%) are or higher than the national average for this question.

GP Survey data for 2 practices is not available for this question (1 Nottinghamshire and 1 Nottingham City).

3.1.2. How often do you see or speak to your preferred GP when you would like to?

Response: Always or Almost Always/A lot of the time

The CCG average is the same as the national average for this question (45%). The GP Survey data shows that there are 60 practices in Nottinghamshire and Nottingham that are below the CCG and national average for this question:

- 35/76 Nottinghamshire County practices (29% of 121 practices)
- 25/45 Nottingham City practices (21% of 121 practices)

61 practices (50%) are or higher than the CCG and national average for this question.

GP Survey data for 3 practices is not available for this question (2 Nottinghamshire and 1 Nottingham City).

3.1.3. How would you describe your experience of making an appointment?
Response: Very good + Fairly good

The CCG average (73%) is higher than the national average for this question (70%). The GP Survey data shows that there are 50 practices in Nottinghamshire and Nottingham that are below the CCG average for this question:

- 27/76 Nottinghamshire County practices (22% of 121 practices)
- 23/45 Nottingham City practices (18% of 121 practices)

71 practices (60%) are or higher than the CCG average for this question. 83 practices (69%) are or above the national average for this question.

GP Survey data for 3 practices is not available for this question (2 Nottinghamshire and 1 Nottingham City).

3.1.4. How would you describe your experience of your GP practice?
Response: Very good + Fairly good

The CCG average (84%) is higher than the national average for this question (83%). The GP Survey data shows that there are 57 practices in Nottinghamshire and Nottingham that are below the CCG average for this question:

- 28/77 Nottinghamshire County practices (23% of 122 practices)
- 29/45 Nottingham City practices (24% of 122 practices)

65 practices (53%) are or higher than the CCG average for this question. 69 practices (57%) are on above the national average for this question.

GP Survey data for 2 practices is not available for this question (1 Nottinghamshire and 1 Nottingham City).

Appendix 3 shows a breakdown of practice level data for the above questions for Nottinghamshire practices (excludes Nottingham City).

4. Practice Funding

4.1. Contract

Practices receive a nationally negotiated price (global sum) for providing 'core primary care' on the basis of a £ per weighted registered patient. The capitation fee is adjusted according to varying workload due to age, sex and patient need using the Carr-Hill formula to weight the patient list size. Further information about GP contracts is set out via the below link:

https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained

The global sum is £97.28 per weighted registered patient (April 2021).

The CCG has awarded 9 new APMS contracts over the last year and the value per weighted registered patient is higher than global sum for 7 of these contracts. This reflects the new contracts have a shorter contract term (not contracts in perpetuity). The contract values range from £97.28 (global sum) to £110.00 per weighted registered patient, in line with the procurements undertaken. The contract value will reduce annually and by year 5 will be in line with global sum. The APMS contracts are listed below:

- Balderton Primary Care Centre
- Bilborough Medical Centre
- Broad Oak Medical Practice
- Grange Farm Medical Centre
- Kirkby Community Primary Care Centre
- Parliament Street Medical Centre
- Peacock Healthcare
- Southglade Medical Practice
- Whyburn Medical Practice

4.2. Practice appointment data

Practices have a contractual requirement to allow the extraction of anonymised and aggregated data about appointments offered.

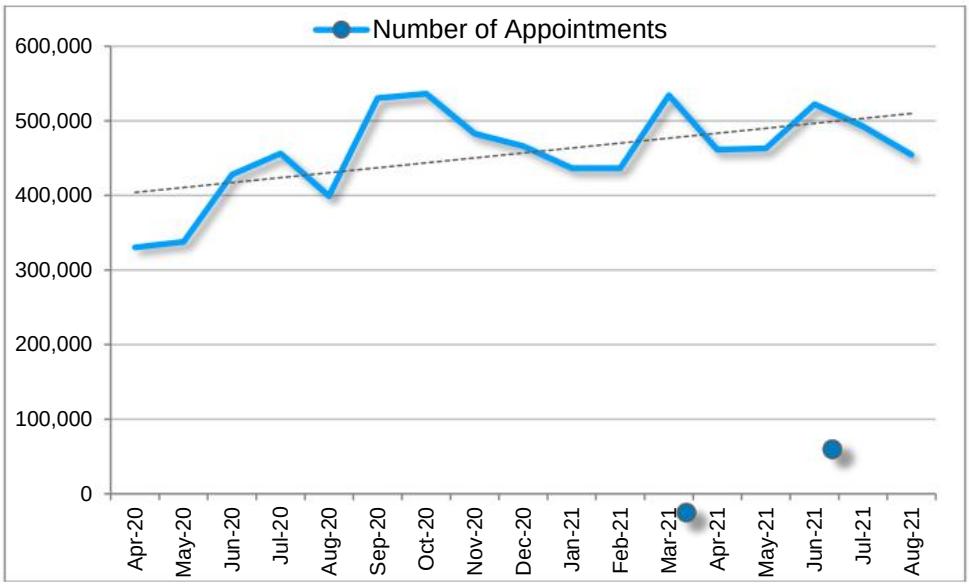
This appointment information is published by NHS Digital but only gives CCG aggregated data, not practice specific data. This can be viewed via the below link:

https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

The latest access data available is for August 2021. The figures for Nottingham and Nottinghamshire CCG are provided below (this table also shows data for August 2020 as a comparison):

	August 2021	*August 2020*
Number of appointments:	454,315	*399,056*
Appointment type:		
Face to face	263,103	*211,162*
Home visit	1,629	*1,328*
Telephone	164,427	*164,253*
Video/online	2,418	*1,984*
Unknown	22,738	*20,329*
From booking to appointment:		
Same Day	206,755	*182,822*
1 Day	29,227	*31,667*
2 to 7 Days	85,337	*81,754*
8 to 14 Days	56,688	*49,993*
15 to 21 Days	34,092	*24,158*
22 to 28 Days	22,084	*13,724*
More Than 28 Days	20,048	*14,854*

The graph below shows the number of appointments undertaken over the period April 2020 to August 2021.



Appendix 4 shows access data for Nottingham and Nottinghamshire CCG from April 2020 to August 2021, this highlights a significant increase in September 2020 when lockdown restrictions eased. However, the introduction of a second lockdown shows a decrease in access from November 2020. The reduction in access for August 2021 reflects the traditional summer holiday period for the population, which is also shown in August 2020 (albeit during lockdown), the data shows an increase in access in comparison.

5. Summary

The CCG is responsible for commissioning general practice medical services, on behalf of NHS England, and monitors delivery of services through the nationally negotiated GP contract.

Practices have a contractual requirement to report their workforce numbers monthly via the National Workforce Reporting System (NWRS). The data published for August 2021 indicates that nearly 60% of practices are above the CCG and National average of GP, Nurse and Admin FTE for 1,000 population. Recruitment remains challenging in primary care, further compounded by the COVID outbreak. The CCG uses national and local initiatives to support a range of recruitment and retention schemes and training to core clinical delivery.

Practices report Operational Pressures Escalation Levels (OPEL) daily, introduced during the early stages of the COVID outbreak, this includes the challenges they are facing in terms of staffing levels and patient demand. Challenges are primarily due to clinical and non-clinical staff self-isolating due to COVID, non COVID illness, annual leave and vacancies.

The GP Survey questions included in this paper are good indicators of patient satisfaction showing that the CCG average score is higher than the national average score. However, the GP Survey results published July 2021 are only one indicator of patient satisfaction. Practices obtain feedback from the Friends and Family Test (paused nationally during COVID), and through their own feedback

mechanisms. Nottingham and Nottinghamshire CCG has a registered population of circa. 1.1 million, the maximum number of responses for a GP survey question was 15,500 which is 1.4% of the registered population.

There are no specific contractual requirements in relation to the levels of access for primary care services, however access and quality is monitored through both national and local platforms. Patient reporting of difficulties in accessing services (particularly during the pandemic) isn't unique to Nottingham and Nottinghamshire, this has increased for practices across England.

NHS England published guidance on 14 October 2021; 'Our plan for improving access for patients and supporting general practice' which set out details of support to practices to help improve access and specifically face to face appointments over the winter period. Initial plans will be submitted to NHS England regional colleagues by 28 October 2021.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/10/BW999-our-plan-for-improving-access-and-supporting-general-practice-oct-21.pdf

PCNs are leading the work of appointing and supporting Additional Roles staff to work in general practice to supplement the work of practice GPs and nurses, further improving access. This supports the key role for practices in ensuring that patients access the right care, in the right place and at the right time. This means that practices are providing services utilising a range of multi-disciplinary professionals to best meet the needs of individual patients, in line with national policy to build a broader workforce in primary care.

PCN	Practice	Practice List Size Qtr. 2 2021- 22	Practice List Size Qtr. 2 2021- 22	GP FTE (excl. L&R)	GP FTE (excl. L&R) Rate per 1,000	Nurse FTE	Nurse FTE Rate per 1,000	Admin FTE	Admin FTE Rate per 1,000
					England Avg. 0.4		England Avg. 0.3		England Avg. 1.1
					Notts CCG Avg. 0.4		Notts CCG Avg. 0.3		Notts CCG Avg. 1.1
PCN	**Practice**	**Raw**	**Weighted**						
Arnold & Calverton	Stenhouse Medical Centre	12,103	12,099	7.36	0.6	4.29	0.4	10.50	0.9
Arnold & Calverton	Calverton Practice	9,688	10,734	5.42	0.6	2.85	0.3	14.74	1.5
Arnold & Calverton	Highcroft Surgery	11,567	10,914	4.18	0.4	3.78	0.3	15.40	1.3
Arrow Health	Westdale Lane Surgery	8,349	8,535	3.28	0.4	2.48	0.3	6.42	0.8
Arrow Health	Daybrook Medical Practice	9,704	9,545	5.92	0.6	2.33	0.2	10.14	1.0
Arrow Health	Plains View Surgery	7,661	7,293	2.24	0.3	2.56	0.3	9.30	1.2
Arrow Health	Unity Surgery	4,075	3,978	1.30	0.3	0.77	0.2	4.37	1.1
Arrow Health	Ivy Medical Group	7,105	7,873	2.75	0.4	2.17	0.3	8.90	1.3
Arrow Health	Peacock Healthcare	5,558	5,563	2.57	0.5	1.26	0.2	9.48	1.7
Ashfield North	Willowbrook Medical Practice	13,755	15,208	3.81	0.3	4.20	0.3	19.01	1.4
Ashfield North	Woodlands Medical Practice	10,219	11,056	6.29	0.6	2.60	0.3	12.00	1.2
Ashfield North	Kings Medical Centre	8,846	8,811	3.77	0.4	3.17	0.4	8.46	1.0
Ashfield North	Brierley Park Medical Centre	9,367	9,968	5.21	0.6	2.68	0.3	10.12	1.1
Ashfield North	Skegby Family Medical Centre	9,076	9,946	4.77	0.5	4.66	0.5	13.25	1.5
Ashfield South	Ashfield House	6,085	7,156	1.00	0.2	1.92	0.3	9.08	1.5
Ashfield South	Kirkby Family Medical Centre	4,344	4,976	1.06	0.2	0.53	0.1	4.38	1.0
Ashfield South	Kirkby Health Centre	4,022	4,421	2.16	0.5	1.58	0.4	3.34	0.8
Ashfield South	Lowmoor Road Surgery	5,061	5,856	2.00	0.4	0.50	0.1	5.96	1.2
Ashfield South	Selston Surgery	5,028	5,227	2.05	0.4	0.50	0.1	6.08	1.2
Ashfield South	Kirkby Health Care Complex	4,298	4,608	0.93	0.2	2.00	0.5	2.93	0.7
Ashfield South	Jacksdale Medical Centre	4,191	4,195	0.87	0.2	1.28	0.3	4.65	1.1
Ashfield South	Kirkby Community PCC	6,849	6,853	1.49	0.2	1.49	0.2	3.96	0.6
Byron	Torkard Hill Medical Centre	15,851	16,717	6.40	0.4	4.02	0.3	19.38	1.2
Byron	Oakenhall Medical Practice	7,142	7,812	2.63	0.4	2.80	0.4	6.82	1.0
Byron	Om Surgery	2,144	2,119	0.93	0.4	0.50	0.2	3.49	1.6
Byron	Whyburn Medical Practice	12,246	13,203	3.49	0.3	0.00	0.0	0.00	0.0

Mansfield North	Oakwood Surgery	15,784	17,501	7.54	0.5	4.16	0.3	19.66	1.2
Mansfield North	St Peters Medical Practice	2,781	2,886	0.42	0.2	0.85	0.3	3.76	1.4
Mansfield North	Orchard Medical Practice	19,538	19,630	9.18	0.5	6.05	0.3	21.37	1.1
Mansfield North	Pleasley Surgery	3,817	4,514	1.28	0.3	0.53	0.1	4.96	1.3
Mansfield North	Riverbank Medical Services	4,625	5,425	1.13	0.2	0.69	0.1	2.64	0.6
Mansfield North	Sandy Lane Surgery	6,194	6,502	2.21	0.4	1.85	0.3	6.56	1.1
Mansfield North	Meden Medical Services	6,027	7,068	2.72	0.5	1.97	0.3	8.52	1.4
Newark	Barnby Gate Surgery	13,888	13,728	5.72	0.4	4.41	0.3	10.04	0.7
Newark	Fountain Medical Centre	13,369	13,637	6.70	0.5	4.70	0.4	14.02	1.0
Newark	Lombard Medical Centre	19,788	19,323	17.12	0.9	5.54	0.3	25.59	1.3
Newark	Collingham Medical Centre	7,398	8,906	6.13	0.8	3.06	0.4	13.26	1.8
Newark	Southwell Medical Centre	12,374	12,184	8.82	0.7	2.25	0.2	13.56	1.1
Newark	Hounsfield Surgery	4,352	5,177	2.13	0.5	0.56	0.1	7.27	1.7
Newark	Balderton PCC	6,225	5,843	1.70	0.3	0.80	0.1	3.69	0.6
Beeston	Oaks Medical Centre	10,569	9,598	6.06	0.6	2.16	0.2	8.41	0.8
Beeston	Abbey Medical Centre	5,401	4,992	2.66	0.5	2.70	0.5	8.00	1.5
Beeston	Manor Surgery	12,939	12,597	6.93	0.5	3.38	0.3	13.14	1.0
Beeston	Bramcote Surgery	3,679	3,432	1.73	0.5	1.46	0.4	5.73	1.6
Beeston	Chilwell Valley And Meadows Practice	15,272	14,455	9.58	0.6	4.94	0.3	17.37	1.1
Eastwood/Kimberley	Eastwood PCC	19,111	21,643	8.38	0.4	3.93	0.2	35.93	1.9
Eastwood/Kimberley	Newthorpe Medical Centre	7,623	7,968	3.20	0.4	1.90	0.2	9.73	1.3
Eastwood/Kimberley	Hama Medical Centre	5,235	5,228	1.28	0.2	1.28	0.2	0.34	0.1
Eastwood/Kimberley	Giltbrook Surgery	4,961	5,133	1.84	0.4	1.84	0.4	1.44	0.3
Stapleford	Saxon Cross Surgery	7,379	7,315	2.71	0.4	2.88	0.4	6.40	0.9
Stapleford	Linden Medical Group	7,703	8,111	5.54	0.7	1.54	0.2	8.57	1.1
Stapleford	Hickings Lane Medical Centre	6,395	6,108	1.49	0.2	1.64	0.3	2.10	0.3
Rosewood	Churchside Medical Practice	6,849	7,019	4.26	0.6	1.73	0.3	8.36	1.2
Rosewood	Forest Medical	16,414	16,949	4.19	0.3	6.89	0.4	19.09	1.2
Rosewood	Roundwood Surgery	13,519	14,122	5.73	0.4	3.80	0.3	17.49	1.3
Rosewood	Mill View Surgery	8,353	8,999	4.30	0.5	2.38	0.3	11.97	1.4
Rosewood	Acorn Medical Practice	3,583	3,341	1.36	0.4	0.60	0.2	4.98	1.4
Rushcliffe Central	St Georges Medical Practice	12,795	11,666	8.29	0.6	3.96	0.3	8.70	0.7
Rushcliffe Central	Musters Medical Practice	9,848	9,038	6.58	0.7	3.02	0.3	7.46	0.8
Rushcliffe Central	Castle Healthcare Practice	17,043	16,263	9.98	0.6	3.09	0.2	17.50	1.0
Rushcliffe Central	West Bridgford Medical Centre	4,481	3,676	2.13	0.5	1.41	0.3	4.08	0.9
Rushcliffe Central	Gamston Medical Centre	6,180	5,33	2.66	0.4	2.06	0.3	5.40	0.9

Rushcliffe North	Belvoir Health Group	25,046	26,477	13.94	0.6	5.74	0.2	30.36	1.2
Rushcliffe North	East Bridgford Medical Centre	7,269	7,926	3.57	0.5	6.46	0.9	10.17	1.4
Rushcliffe North	Radcliffe On Trent Health Centre	8,216	8,830	4.98	0.6	1.80	0.2	7.37	0.9
Rushcliffe South	Orchard Surgery	8,624	8,493	4.01	0.5	2.30	0.3	9.94	1.2
Rushcliffe South	East Leake Medical Group	25,668	26,464	19.37	0.8	7.04	0.3	36.82	1.4
Rushcliffe South	Ruddington Medical Centre	6,961	6,816	4.00	0.6	2.24	0.3	7.69	1.1
Sherwood	Middleton Lodge Practice	12,917	15,006	5.20	0.4	4.36	0.3	12.86	1.0
Sherwood	Abbey Medical Group	12,330	14,390	13.25	1.1	6.00	0.5	17.98	1.5
Sherwood	Sherwood Medical Partnership	11,773	12,784	4.62	0.4	6.08	0.5	25.76	2.2
Sherwood	Rainworth Health Centre	6,067	6,970	1.92	0.3	0.90	0.1	8.33	1.4
Sherwood	Major Oak Medical Practice	6,864	8,330	2.00	0.3	1.00	0.1	7.08	1.0
Sherwood	Bilsthorpe Surgery	3,653	4,744	1.70	0.5	1.98	0.5	7.14	2.0
Sherwood	Hill View Surgery	7,757	8,579	2.06	0.3	1.33	0.2	9.92	1.3
Synergy Health	Trentside Medical Group	12,058	11,952	4.08	0.3	4.40	0.4	13.53	1.1
Synergy Health	Jubilee Park Medical Partnership	12,602	12,327	2.69	0.2	3.82	0.3	12.97	1.0
Synergy Health	West Oak Surgery	5,484	4,989	2.56	0.5	1.22	0.2	6.18	1.1

Appendix 2 – Additional Roles employed by the PCN (as at August 2021)

PCN	Clinical Pharmacist		Social Prescribing Link Worker		First Contact Physiotherapists		Pharmacy Technician		Physician Associate		Care Coordinator		Occupational Therapist		Health & Wellbeing Coach		Dietitian		Advanced Practitioner		Community Paramedic	
	No	WTE	No	WTE	No	WTE	No	WTE	No	WTE	No	WTE	No	WTE	No	WTE	No	WTE	No	WTE	No	WTE
Mid Notts Locality																						
Ashfield North	6	5.16	3	2.60	3	2.27	1	1.00											1	1.00		
Ashfield South	3	3.00	1	1.00	2	1.83	2	2.00			1	1.00									1	1.00
Mansfield North	5	4.49	2	1.80	1	1.07	1	1.00			1	1.00			2	2.00			1	0.84	1	1.00
Newark	9	8.85	3	3.00	2	2.07					1	1.00					1	1.00				
Rosewood	2	2.00	3	2.80	1	1.07	1	0.60			1	1.00							1	0.80		
Sherwood	4	3.60	4	3.60	2	2.07	1	0.80	1	0.64												
City Locality																						
Bulwell & Top Valley	4	2.83	2	1.98	2	2.00																
BACHS	6	4.94	4	3.48	1	1.00																
Radford & Mary Potter	3	2.48			2	2.00	1	1.00														
Bestwood & Sherwood	6	5.05	2	1.79					1	1.00												
Nottingham City East	3	2.83	2	1.98	2	2.00	1	1.00	2	2.00	1	1.00			2	2.00						
Nottingham City South	3	2.71	1	0.99			1	0.99														
Clifton & Meadows	2	1.99	1	0.99	2	2.00																
Unity (Nottingham)	2	1.99			1	1.00							1	1.00	1	1.00	1	0.05				
South Locality																						
Arnold & Calverton	4	3.43	3	1.73	2	2.00					1	1.00					1	0.40			1	1.00
Arrow Health	6	4.72	3	1.73	1	1.00					1	0.93									2	2.00
Byron	3	2.50	3	1.73	3	2.25	3	3.00									1	0.60			2	2.00
Nottingham West	7	5.96	5	5.00	5	4.53	2	1.70			6	5.60	4	3.60	1	1.00	1	1.00			5	4.60
Rushcliffe	9	8.85	8	7.80	5	5.00	2	1.80	1	1.00	2	1.53	1	1.00					1	0.83		
Synergy Health	1	1.00	4	2.59	2	1.64					1	1.00										
	88	**78.38**	**54**	**46.59**	**39**	**36.8**	**16**	**14.89**	**5**	**4.64**	**16**	**15.06**	**6**	**5.60**	**6**	**6.00**	**5**	**3.05**	**4**	**3.47**	**12**	**11.60**

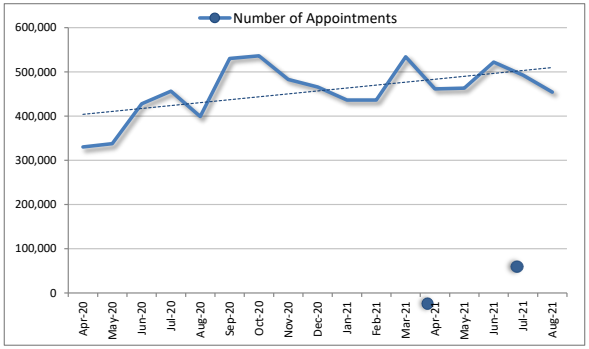
PCN	Practice	Practice List Size Qtr. 2 2021- 22	Practice List Size Qtr. 2 2021- 22	How easy is it to get through to someone at your GP practice on the phone	How often do you see or speak to your preferred GP when you would like to	How would you describe your experience of making an appointment	How would you describe your experience of your GP practice
				National Avg. 68%	National Avg. 45%	National Avg. 70%	National Avg. 83%
				CCG Avg. 72%	CCG Avg. 45%	CCG Avg. 73%	CCG Avg. 84%
				Highest Practice 98%	Highest Practice 85%	Highest Practice 95%	Highest Practice 99%
				Lowest Practice 21%	Lowest Practice 7%	Lowest Practice 28%	Lowest Practice 55%
PCN	**Practice**	**Raw**	**Weighted**				
Arnold & Calverton	Stenhouse Medical Centre	12,103	12,099	78%	35%	79%	93%
Arnold & Calverton	Calverton Practice	9,688	10,734	93%	45%	83%	95%
Arnold & Calverton	Highcroft Surgery	11,567	10,914	30%	24%	35%	58%
Arrow Health	Westdale Lane Surgery	8,349	8,535	91%	27%	79%	88%
Arrow Health	Daybrook Medical Practice	9,704	9,545	48%	39%	62%	81%
Arrow Health	Plains View Surgery	7,661	7,293	83%	69%	83%	86%
Arrow Health	Unity Surgery	4,075	3,978	79%	54%	77%	76%
Arrow Health	Ivy Medical Group	7,105	7,873	71%	33%	71%	84%
Arrow Health	Peacock Healthcare	5,558	5,563	54%	36%	68%	83%
Ashfield North	Willowbrook Medical Practice	13,755	15,208	41%	26%	56%	77%
Ashfield North	Woodlands Medical Practice	10,219	11,056	79%	47%	80%	87%
Ashfield North	Kings Medical Centre	8,846	8,811	64%	32%	65%	86%
Ashfield North	Brierley Park Medical Centre	9,367	9,968	88%	27%	71%	88%
Ashfield North	Skegby Family Medical Centre	9,076	9,946	68%	48%	67%	78%
Ashfield South	Ashfield House	6,085	7,156	50%	60%	69%	80%
Ashfield South	Kirkby Family Medical Centre	4,344	4,976	85%	64%	79%	91%
Ashfield South	Kirkby Health Centre	4,022	4,421	75%	65%	65%	77%
Ashfield South	Lowmoor Road Surgery	5,061	5,856	64%	46%	68%	78%
Ashfield South	Selston Surgery	5,028	5,227	97%	71%	87%	92%
Ashfield South	Kirkby Health Care Complex	4,298	4,608	74%	67%	87%	94%
Ashfield South	Jacksdale Medical Centre	4,191	4,195	87%	69%	75%	90%
Ashfield South	Kirkby Community PCC	6,849	6,853	89%	43%	81%	89%
Byron	Torkard Hill Medical Centre	15,851	16,717	67%	35%	59%	78%

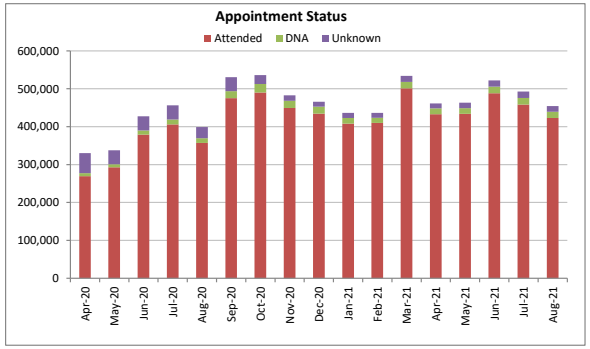
Byron	Oakenhall Medical Practice	7,142	7,812	48%	17%	52%	68%
Byron	Om Surgery	2,144	2,119	82%	Not Available	Not Available	75%
Byron	Whyburn Medical Practice	12,246	13,203	43%	25%	56%	81%
Mansfield North	Oakwood Surgery	15,784	17,501	52%	13%	73%	80%
Mansfield North	St Peters Medical Practice	2,781	2,886	89%	60%	83%	92%
Mansfield North	Orchard Medical Practice	19,538	19,630	66%	45%	75%	90%
Mansfield North	Pleasley Surgery	3,817	4,514	84%	48%	79%	80%
Mansfield North	Riverbank Medical Services	4,625	5,425	65%	64%	81%	84%
Mansfield North	Sandy Lane Surgery	6,194	6,502	58%	67%	70%	79%
Mansfield North	Meden Medical Services	6,027	7,068	73%	25%	68%	76%
Newark	Barnby Gate Surgery	13,888	13,728	40%	35%	60%	80%
Newark	Fountain Medical Centre	13,369	13,637	38%	28%	48%	68%
Newark	Lombard Medical Centre	19,788	19,323	73%	16%	77%	84%
Newark	Collingham Medical Centre	7,398	8,906	88%	43%	83%	86%
Newark	Southwell Medical Centre	12,374	12,184	70%	48%	71%	83%
Newark	Hounsfield Surgery	4,352	5,177	95%	66%	87%	96%
Newark	Balderton PCC	6,225	5,843	76%	30%	64%	76%
Beeston	Oaks Medical Centre	10,569	9,598	98%	54%	84%	90%
Beeston	Abbey Medical Centre	5,401	4,992	75%	42%	77%	86%
Beeston	Manor Surgery	12,939	12,597	97%	72%	87%	94%
Beeston	Bramcote Surgery	3,679	3,432	95%	38%	78%	82%
Beeston	Chilwell Valley And Meadows Practice	15,272	14,455	94%	71%	89%	95%
Eastwood/Kimberley	Eastwood PCC	19,111	21,643	75%	40%	82%	92%
Eastwood/Kimberley	Newthorpe Medical Centre	7,623	7,968	94%	59%	89%	95%
Eastwood/Kimberley	Hama Medical Centre	5,235	5,228	95%	69%	83%	83%
Eastwood/Kimberley	Giltbrook Surgery	4,961	5,133	96%	69%	93%	92%
Stapleford	Saxon Cross Surgery	7,379	7,315	90%	43%	77%	94%
Stapleford	Linden Medical Group	7,703	8,111	75%	48%	77%	87%
Stapleford	Hickings Lane Medical Centre	6,395	6,108	94%	43%	84%	89%
Rosewood	Churchside Medical Practice	6,849	7,019	69%	59%	88%	96%
Rosewood	Forest Medical	16,414	16,949	51%	9%	64%	80%
Rosewood	Roundwood Surgery	13,519	14,122	37%	12%	62%	85%
Rosewood	Mill View Surgery	8,353	8,999	78%	44%	71%	92%
Rosewood	Acorn Medical Practice	3,583	3,341	88%	57%	86%	91%

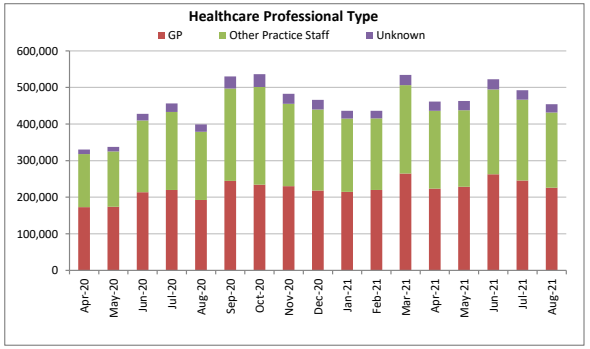
Rushcliffe Central	St Georges Medical Practice	12,795	11,666	98%	64%	95%	99%
Rushcliffe Central	Musters Medical Practice	9,848	9,038	89%	51%	88%	91%
Rushcliffe Central	Castle Healthcare Practice	17,043	16,263	93%	54%	83%	94%
Rushcliffe Central	West Bridgford Medical Centre	4,481	3,676	90%	76%	82%	86%
Rushcliffe Central	Gamston Medical Centre	6,180	5,336	88%	48%	82%	87%
Rushcliffe North	Belvoir Health Group	25,046	26,477	83%	41%	76%	87%
Rushcliffe North	East Bridgford Medical Centre	7,269	7,926	95%	59%	93%	97%
Rushcliffe North	Radcliffe On Trent Health Centre	8,216	8,830	80%	42%	74%	86%
Rushcliffe South	Orchard Surgery	8,624	8,493	Not Available	Not Available	Not Available	Not Available
Rushcliffe South	East Leake Medical Group	25,668	26,464	84%	27%	75%	88%
Rushcliffe South	Ruddington Medical Centre	6,961	6,816	92%	46%	89%	93%
Sherwood	Middleton Lodge Practice	12,917	15,006	92%	39%	79%	92%
Sherwood	Abbey Medical Group	12,330	14,390	68%	31%	77%	84%
Sherwood	Sherwood Medical Partnership	11,773	12,784	21%	7%	28%	55%
Sherwood	Rainworth Health Centre	6,067	6,970	77%	50%	81%	93%
Sherwood	Major Oak Medical Practice	6,864	8,330	68%	55%	74%	77%
Sherwood	Bilsthorpe Surgery	3,653	4,744	79%	60%	83%	93%
Sherwood	Hill View Surgery	7,757	8,579	95%	85%	89%	89%
Synergy Health	Trentside Medical Group	12,058	11,952	49%	31%	62%	78%
Synergy Health	Jubilee Park Medical Partnership	12,602	12,327	50%	51%	59%	77%
Synergy Health	West Oak Surgery	5,484	4,989	81%	49%	72%	87%

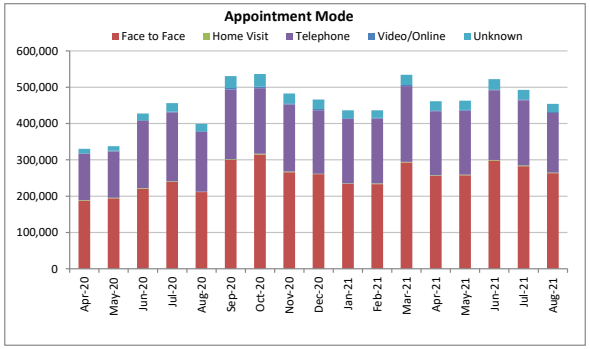
Appointments In General Practice

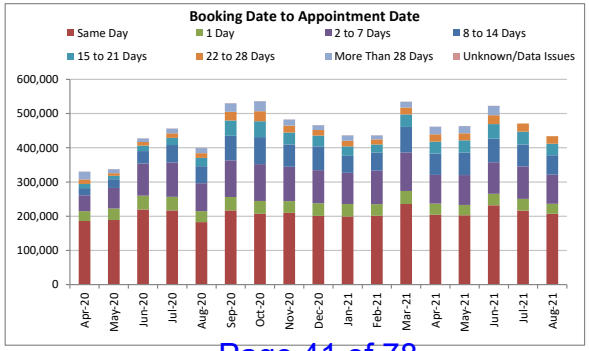
		NHS Nottingham and Nottinghamshire CCG	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
		Number of Appointments	330,249	337,543	427,688	456,346	399,056	530,413	536,306	482,905	465,913	436,384	436,409	534,353	461,437	463,174	522,336	492,711	454,315
Table 3a	Appointment Status	Attended	269,591	292,854	378,900	406,186	357,365	475,077	490,193	449,412	434,667	408,210	409,925	501,091	432,908	434,056	488,173	458,457	423,209
		DNA	7,951	7,836	10,968	12,902	12,374	18,870	22,569	19,027	18,088	14,719	13,386	16,993	15,549	14,662	17,482	17,374	16,240
		Unknown	52,707	36,853	37,820	37,258	29,317	36,466	23,544	14,466	13,158	13,455	13,098	16,269	12,980	14,456	16,681	16,880	14,866
Table 3b	Healthcare Professional Type	GP	172,622	173,716	213,441	220,039	192,564	244,749	234,383	230,090	218,379	214,815	219,728	264,522	223,444	228,628	262,514	245,746	226,158
		Other Practice Staff	145,417	151,486	196,179	212,981	186,140	252,378	266,852	225,124	221,426	199,999	195,925	241,898	212,815	209,068	231,904	220,960	205,359
		Unknown	12,210	12,341	18,068	23,326	20,352	33,286	35,071	27,691	26,108	21,570	20,756	27,933	25,178	25,478	27,918	26,005	22,798
Table 3c	Appointment Mode	Face to Face	187,490	194,213	220,524	239,216	211,162	300,351	314,964	265,936	260,417	233,626	233,275	292,699	256,009	257,770	298,001	282,719	263,103
		Home Visit	1,292	1,530	1,882	1,812	1,328	1,434	1,823	1,792	1,523	1,431	1,882	1,850	1,604	1,481	1,677	1,735	1,629
		Telephone	127,299	127,252	185,005	189,660	164,253	192,002	180,765	184,371	174,665	177,305	178,216	208,767	176,151	175,964	191,704	179,429	164,427
		Video/Online	1,953	2,183	2,012	2,360	1,984	4,240	3,978	3,429	3,362	2,492	2,311	3,132	2,466	2,521	3,071	2,877	2,418
		Unknown	12,215	12,365	18,265	23,298	20,329	32,386	34,776	27,377	25,946	21,530	20,725	27,905	25,207	25,438	27,883	25,951	22,738
Table 3d	Time From Booking Date to Appointment Date	Same Day	185,928	188,789	219,654	216,985	182,822	217,179	206,866	209,577	200,912	199,083	201,437	235,593	204,398	202,290	231,702	216,590	206,755
		1 Day	28,549	33,535	40,242	39,932	31,667	38,799	37,408	34,397	36,894	36,822	33,665	37,987	32,288	30,864	33,567	34,116	29,227
		2 to 7 Days	46,398	60,185	93,707	100,374	81,754	107,185	107,682	100,784	96,619	91,045	97,663	112,666	84,179	86,832	92,595	94,782	85,337
		8 to 14 Days	20,932	25,525	36,960	50,666	49,993	71,909	79,127	64,765	69,868	49,542	53,015	74,716	62,550	65,792	68,753	64,408	56,688
		15 to 21 Days	12,678	10,212	15,881	21,216	24,158	44,847	46,554	34,988	31,244	27,773	23,942	36,759	34,577	36,228	42,522	37,518	34,092
		22 to 28 Days	13,034	7,497	10,460	12,833	13,724	25,222	29,204	20,134	16,624	16,631	14,871	20,403	21,265	20,506	26,153	23,394	22,084
		More Than 28 Days	22,652	11,714	10,696	14,237	14,854	25,185	29,354	18,182	13,702	15,431	11,683	16,135	22,060	20,550	26,906	21,814	20,048
		Unknown/Data Issues	78	86	88	103	84	87	111	78	50	57	133	94	120	112	138	89	84











Nottinghamshire County Council

Report to Health Scrutiny Committee

23 November 2021

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

HEALTH AND CARE BILL 2021

Purpose of the Report

1. To provide an initial briefing on issues arising from the Health and Care Bill 2021.

Information

2. Rebecca Larder, Nottingham and Nottinghamshire ICS Programme Director will attend the Health Scrutiny Committee to provide an initial briefing on the Health and Care Bill 2021.

3. A briefing from the ICS Programme Director is attached as an appendix to this report.

4. Members are requested to consider and comment on the information provided and schedule further consideration, if necessary.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Schedules further consideration, if necessary.

Councillor Sue Saddington
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 Health Scrutiny Committee

Briefing on the Health and Care Bill 2021

Introduction

1. This paper provides Nottinghamshire County Health Scrutiny Committee with an overview of the Health and Care Bill 2021. The paper also confirms opportunities, arising from this Bill, for local citizens.

Background

2. Health and care systems need to continually develop and evolve to remain fit for purpose in an ever-changing landscape. As NHS and Social Care services in England look to recover from the Covid-19 global pandemic, national policy centres on Integrated Care Systems (ICSs) as providing the best route to improving population health and wellbeing, quality of service provision and achieving the most effective use of resources.

3. An ICS brings together citizens, NHS, Local Authority and wider partners to meet the health and care needs in a geographical area, to co-ordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

4. Integrated care is not new but rather has a long history. Over recent years, Nottinghamshire County residents have benefitted from tangible improvements brought about by an Integrated Care Pioneer programme; a Rushcliffe Vanguard; and collective endeavours across the Nottingham and Nottinghamshire ICS in responding to Covid-19.

5. To date, the NHS and Social Care system has not been fully configured to accommodate the development of ICSs. The Health and Care Bill 2021 aims to address this. Subject to the passage of the Bill through Parliament, ICSs will be established on a statutory footing across England from 1st April 2022, bringing partners together to support integration of health and social care.

6. Strengthened decision making and accountability for system performance will be embedded into the NHS accountability structure through an NHS Integrated Care Board. An Integrated Care Partnership will also come into being.

7. This dual structure recognises that there are two forms of integration which will be underpinned by legislation: integration within the NHS to remove some of the cumbersome barriers to collaboration and to make working together across the NHS an organising principle; and integration between the NHS and principally local authorities to deliver improved outcomes to health and wellbeing for local people.

The Integrated Care Partnership

8. The Integrated Care Partnership (ICP) will bring together the NHS, local government, and wider partners such as those in the voluntary sector. The ICP will operate at whole system level and will be responsible for developing an integrated care strategy to improve health and care outcomes and experiences for their populations – the NHS Integrated Care Board (ICB) will have due regard to this strategy when making decisions.

9. ICPs are expected to provide opportunity to align purpose and ambitions with plans to integrate care and improve health wellbeing outcomes for local populations. ICPs will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. Such joined-up, inclusive working is central to ensuring that ICS partners are targeting their collective action and resources at the areas which will have the greatest impact on outcomes and inequalities as England recovers from the pandemic.

10. Integrated care strategies should be developed for the whole population using best available evidence and data, covering health and social care and addressing the wider determinants of health and wellbeing. This should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments (JSNAs).

11. The expectation is for the integrated care strategy to be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities. The ICP will champion inclusion and transparency and will challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place and neighbourhood level engagement, ensuring the system is connected to the needs of every community it includes.

12. Planning is underway locally, led by the Local Authorities and NHS, to establish an ICP by April 2022 subject to legislation. It is proposed that the local ICP forms ‘the guiding mind,’ across the Nottingham and Nottinghamshire health and care system, in creating an integrated care strategy.

13. Local stakeholders have confirmed the ICP provides opportunity to build a broader approach to planning based on population need, particularly across the NHS, putting JSNA insights front and centre. It also provides opportunity to strengthen accountability to local people; to focus on healthy life expectancy and addressing inequalities and inclusion; to build on collaborative approaches developed during Covid19; and to maximise collective endeavours including as anchor organisations and in the use of the one ‘public purse.’

14. Care is being taken with the local design to ensure that the Nottingham and Nottinghamshire ICP will complement, not duplicate, the work of the Health and Wellbeing Boards and will strengthen alignment of the ICS with Health and Wellbeing Boards. Current legislation does not change the role or duties

of Health and Wellbeing Boards nor does it change Local Authority structures or commissioning arrangements.

15. Specifically, the Nottingham and Nottinghamshire ICP will have an important role in synthesising both the Nottingham and the Nottinghamshire Health and Wellbeing Strategies into one integrated care strategy. The new NHS ICB will pay due regard to this integrated care strategy in commissioning services including from Place Based Partnerships and Neighbourhood teams (Primary Care Networks) going forward.

16. The ICP will be established by Nottingham City Council, Nottinghamshire County Council and the Nottingham and Nottinghamshire NHS ICB. In keeping with the Health and Care Bill it will take the form of a joint committee between these three statutory bodies (i.e. it is a partnership not a corporate body). Beyond this members' may be from a wide range of partners working to improve health and care in their communities and may change overtime as the ICP matures and to take account of the areas of priority focus. Chairing is for local determination and a range of options are being considered.

17. Thought is being given to how the full range of stakeholders, particularly local communities and those who rely on care and support are engaged in the work of the local ICP and, specifically, the co-production of the integrated care strategy. The ambition is for all stakeholders to have a point of influence with the ICP. It is expected that, in part, the ICP will build on the expertise, relationships and engagement forums that already exist across local areas, building priorities from the bottom up and ensuring that these priorities resonate with people across the ICS.

18. The recommended arrangements for the ICP will be presented, for approval, to Local Authority and NHS governance structures in early 2022. It is expected that these recommendations will enable the ICP to be flexible, able to develop and evolve to take account of best practice.

19. The transition path focuses on:

- Approving the ICP scope, purpose and operating arrangements.
- Establishing the ICP in shadow/interim form by April 2022.
- Aligning JSNA development across our health and care system and embedding into planning processes across health and care.
- Operationalising mechanisms for the integrated care strategy to be developed with, and reflective of, all the communities served.
- Aligning public health and ICB data and intelligence to determine health needs, population health management and inform system priority setting processes.
- Developing and agreeing the first integrated care strategy by September 2022, enabling operational planning to have due regard for overall population health needs and priorities.

The NHS Integrated Care Board (ICB)

20. Subject to legislation, NHS ICBs will be established on 1st April 2022 as a new statutory organisation. This will include a Nottingham and Nottinghamshire ICB covering the whole Nottingham and Nottinghamshire population, including Bassetlaw following an ICS boundary change.

21. ICBs will allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system level. There will be a duty placed on the ICB to meet system financial objectives supplemented by a new duty to compel providers to have regard to the system financial objectives. The ICB will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged.

22. The allocative functions of CCGs will be held by the ICB. The ICB will take on the commissioning functions of the CCGs and some of those of NHS England within its boundaries, as well as CCGs' responsibilities in relation to Oversight and Scrutiny Committees. The Chief Executive will become the Accounting Officer for the NHS money allocated to the ICB. New functions and duties and new ways of working through integration, collaboration and shared responsibility will come into being.

23. There will be increasing collaboration between ICBs and with NHS England on commissioning to make decisions, pool funds and facilitate services to be arranged for their combined populations. This will include primary care services (e.g. dentistry, community optometry, pharmaceutical services) as well as public health and specialised services.

24. The ICB will, as a minimum, include a chair, a chief executive officer, and representatives from NHS Trusts, General Practice, and Local Authorities, non-executives and others determined locally. ICSs will also need to ensure they have appropriate clinical advice when making decisions.

25. Locally, work is underway to agree the Nottingham and Nottinghamshire ICB Constitution through a range of engagement activities including with Local Authorities and HealthWatch. The ICB will be a unitary board where all board members are collectively and corporately accountable for the performance of the organisation, making decisions as a single group and sharing the same responsibility and corporate liability for the delivery of functions and duties.

26. In addition to the Chair, independent Non-Executives, the Chief Executive, and Executive Directors with portfolios covering the entirety of the duties and functions of the ICB, locally it is proposed that Partner Members are drawn from both Local Authorities (i.e. two members), one GP and one NHS Provider member. A number of advisors, to the ICB board, are also proposed including Public Health.

Additional Measures

27. A duty to collaborate will be introduced for NHS and Local Authorities to support collaboration across the health and care system and a triple aim duty placed on health bodies, including ICSs covering: better health and wellbeing for everyone; better quality of health services for all individuals; and sustainable use of NHS resources.

28. Barriers to integration will be removed through making provisions for joint committees, collaborative commissioning approaches and guidance on joint appointments. The legislation will also ensure more effective data sharing across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways.

29. Requirements for Place will not be set in legislation with the recognition that Places vary by population and geography. However, there is an expectation that the statutory ICSs' will also work to support places within its boundaries to integrate services and improve outcomes – recognising that different places will be at different stages of development and face different issues. Health and Wellbeing Boards will remain in place and will continue to have a role at Place level. From April 2022, Bassetlaw will become a Place within the Nottingham and Nottinghamshire ICS. Work is underway to integrate Bassetlaw into local arrangements whilst patient pathways/flows will remain unchanged.

30. A key responsibility for an ICS will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector. Place level commissioning within an integrated care system will most likely align geographically to a local authority boundary, and the Better Care Fund (BCF) plan will provide a tool for agreeing priorities.

31. To support patient choice, section 75 of the Health and Social Care Act 2012 (including the Procurement, Patient Choice and Competition Regulations 2013) will be repealed and replaced with a new procurement regime, alongside a bolstered process for Any Qualified Provider (AQP).

32. The Health and Care Bill also sets out plans:

    - To merge Monitor and the Trust Development Authority (NHS Improvement) and NHS England. Complemented by enhanced powers of direction for the government to support greater collaboration, information sharing and aligned responsibility and accountability.
    - Provide new powers for the Secretary of State for Health and Social Care over the NHS and other arm's-length bodies (ALBs). Under the proposals, the Secretary of State will be able to intervene in service reconfiguration changes at any point without need for a referral from a local authority. The Department of Health and Social Care will also be able to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation.

- For additional new duties on the Secretary of State to be introduced. This will include a statutory duty to publish a report in each parliament on workforce planning responsibilities across primary, secondary and community care, as well as sections of the workforce shared between health and social care.
- Strengthen quality and safety including through enshrining the Healthcare Safety Investigations Branch (HSSIB) into law as a statutory Body to reduce risk and improve safety.

33. Reforms to social care, public health and mental health are being dealt with outside the Health and Care Bill, with some minor exceptions.

Citizen Involvement in the ICS

34. National guidance has been received on how people and communities should be involved in the work of the ICS going forward. Nottingham and Nottinghamshire plans to deliver in line with national requirements but also aims to be a beacon of best practice in this area. The proposed local approach has been co-designed with key stakeholders and centres on:

a) Governance and structures: This includes establishing an Advisory Group to champion working with people and communities in all locations and levels of the ICS; and agreeing that the ICP should receive regular reports summarising the Citizen Intelligence and Insights gathered over the preceding period in order to inform the ICP's role as the 'guiding mind' of the system.

b) Embedding Community Engagement: This includes refreshing the ICS Outcomes Framework to reflect how community engagement will feature in the metrics used.

c) Generating and Utilising Intelligence from Communities: This includes continuing and strengthening work with elected members in generating meaningful insights; establishing a Citizens Panel to complement other engagement activities ensuring the work is representative and has a broad base that can be drilled-down into Places and Neighbourhoods; and continuing to deepen work with Healthwatch and the VCSE, including agreeing specific roles within our governance structures (at both Place and System) and transformation programmes.

d) Integrating Community Involvement Work and Resources: This includes establishing an Engagement Practitioners Forum to bring together and coordinate all the work being delivered across the system – ensuring that it is complementary and maximises resources.

e) Culture Development: This includes developing a community engagement training and development programme for all relevant staff across the system including supporting Places to grow and develop their expertise in this work area; ensuring that there is a championing of the importance of listening and involving citizens and communities at the ICB.

Opportunities for Local Citizens

35. The Nottingham and Nottinghamshire ICS is working to the shared purpose of every citizen enjoying their best possible health and wellbeing.

36. The ICS creates the conditions in which health and care professionals – working at neighbourhood, place and whole system level – are able to come together maximising the use of our energies and resources; seeking out and implementing the types of change that deliver enduring improvements in population health and wellbeing across:

    - Primary and secondary care.
    - Physical and mental health services.
    - Health, social care and wider public and community services.

37. To date, the NHS and Social Care system has not been fully configured to accommodate the development of ICSs. Policy, delivery and assurance mechanisms have not been fully aligned, which has resulted in barriers to improvement.

38. The removal of many barriers, as set out in the Health and Care Bill 2022, provides renewed impetus for collaborative working. Whilst the move to put ICSs onto a statutory footing from April 2022, subject to legislation, is a step forward, recognition is given to the fact that structural change alone is no guarantee of success in bringing about a high performing system that is agile, adaptive and therefore best able to serve its population needs.

39. The local health and care system therefore continues to build on work to date, including learning from joint working in response to Covid19, to ensure maximum benefit for the population served from integrated care.

Rebecca Larder
Nottingham and Nottinghamshire ICS Programme Director
October 2021

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 November 2021

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

IMPROVING CHILDREN'S AND EMERGENCY SERVICES AT BASSETLAW HOSPITAL

Purpose of the Report

1. To alert the committee to a proposed development of service at Bassetlaw Hospital.

Information

2. In 2017, Bassetlaw Hospital closed its children's ward to overnight admissions for safety reasons linked to staffing. Now, significant capital investment is proposed for the Bassetlaw Hospital site in order to create an 'Emergency Village' which would meet the needs of the community now and in the future.

3. A briefing from the Bassetlaw Clinical Commissioning Group on this proposed change is attached as an appendix to this report.

4. Senior representatives of the commissioners will attend the committee to present this information and answer questions.

5. Members are requested to indicate whether they consider this change to be a substantial variation of service. There is no legal definition of what comprises a substantial variation of service. It is a matter for the Health Scrutiny Committee to determine. If Members determine that the matter is substantial it will trigger consultation – rather than just engagement - not only with the Local Authority but with the wider public.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Determine if the proposed change represents a substantial variation of service.

Councillor Sue Saddington
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

Blyth and Harworth (Councillor Sheila Place)
Misterton (Councillor Tracey Taylor)
Retford East (Councillor Mike Introna)
Retford West (Councillor Mike Quigley)
Tuxford (Councillor John Ogle)
Worksop East (Councillor Glynn Gilfoyle)
Worksop North (Councillor Callum Bailey)
Worksop South (Councillor Nigel Turner)
Worksop West (Councillor Sybil Fielding)

Health Scrutiny Committee Briefing
November 2021

Improving Children's Urgent and Emergency services at Bassetlaw Hospital

1. Introduction

A temporary change to the children's urgent and emergency pathway was introduced in January 2017 as a result of workforce pressures being experienced by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH). As a result of the need to maintain safe services, children who require overnight observation and those with more complex support needs continue to be transferred to Doncaster Royal Infirmary (DRI).

In late 2019, the Government announced £17.6 million capital funding for DBTH to create an 'Emergency Village' at Bassetlaw Hospital. The funding aims to ensure that Emergency Department (ED) facilities meet the demands on the emergency care services for the communities of Bassetlaw now and in the future.

2. Background

This significant and unprecedented capital development creates an opportunity to ensure a resilient model for urgent and emergency care services at Bassetlaw Hospital for both adults and children. In respect to children's services it specifically offers the opportunity to address the challenges to service provision which saw the overnight children's inpatient service close.

The CCG and Trust are committed to providing accessible services locally, wherever it is safe to do so. The development of the Emergency Village at Bassetlaw Hospital offers possibilities to extend current same day emergency care provision for ambulatory care, easier access to rapid diagnostics, integrated service delivery with primary and community teams and mental health. The new capital development could also ensure emergency and short stay services are provided on a permanent basis at Bassetlaw for children. This includes providing direct access for referrals from primary care.

This positive change in the care pathway for children to ensure a permanent provision for overnight stays is possible due to the co-location of ED and children's observation ward (currently some distance apart). This will mean fewer staff will be required which mitigates the risk of a shortage of paediatric nurses. The new development of a children's 'hub' within the Emergency Village will potentially also increase the attractiveness of working at Bassetlaw Hospital to new recruits. Furthermore, DBTH have developed close working relationships with Sheffield Children's Foundation Trust with the intention to explore possible rotational posts to add further resilience to its workforce.

3. Making the case for change

Given this opportunity to confirm a permanent safe solution we wish to engage more extensively to ensure any changes implemented are developed with our wider community and that we are guided by feedback from Governing Body, clinicians, patients and their families, local people, the Health Scrutiny Committee, local politicians and community leaders.

We want to engage with our local community at the earliest opportunity, ensuring local people have the opportunity to share their views and that we facilitate appropriate levels of conversation across all our stakeholder groups. As such, we are preparing an engagement plan, outlining our approach to working with key stakeholder groups and informed by existing knowledge and feedback. We are recommending a 12 week period of consultation and engagement (Appendix 1).

In developing the potential service change we will also work closely with NHS England and Improvement (NHSE/I), ensuring that any changes meet the requirements of the NHSE/I assurance process. We will also work with the Yorkshire and Humber Clinical Senate to ensure any new service meets the highest clinical standards and is in line with good clinical practice.

To support the engagement, a Case for Change is also being developed (Appendix 2). This will include potential options which have been co-designed through pre-engagement work with clinical teams from the hospital, clinical colleagues in the Children's Hosted Network, patients and their families and other relevant stakeholder groups. The Case for Change outlines the criteria being used to evaluate the options as well as a proposed consultation and engagement plan for the public and impacted patients.

4. Assurance and next steps

The CCG and Trust are discussing the draft Case for Change and proposed consultation plan with NHS E/I as part of their Stage 2 assurance process on 9 November 2021.

Whilst there is no legal definition of 'substantial development or variation', we are seeking the views of HSC with regards to whether they believe the proposed changes to increase the opportunity to provide Children's urgent and emergency services for longer at the Bassetlaw site is substantial and would therefore trigger the duty to consult with the local authority under the s.244 Regulations.

Given the proposed development of the Emergency Village on the Bassetlaw Hospital site, and the opportunity this presents for reviewing the current provision of both adult and children's urgent and emergency care, both the CCG and Trust will endorse HSC's decision for formal consultation if deemed appropriate and are committed to continued engagement with the HSC throughout the forthcoming process.

HSC is asked to:

- Note and support the intention to progress with seeking a permanent solution to meeting urgent and emergency needs for children in Bassetlaw following the introduction of a temporary change to the pathway introduced in January 2017
- Note and support the significant additional investment of £17.6m in urgent and emergency services at Bassetlaw Hospital.
- Decide whether they believe the proposed changes to Children's urgent and emergency services is substantial and would therefore trigger the duty to consult with the local authority under the s.244 Regulations.

Appendix 1

Improving Children's Urgent and Emergency services at Bassetlaw Hospital

Engagement and consultation plan

1. Introduction

This plan details the activities for the engagement around the proposed service changes to Children's Urgent and Emergency services at Bassetlaw Hospital.

The engagement plan is built upon the following core elements:

- Stakeholder identification and mapping
- Developing the narrative on the proposed potential service changes for the local community and stakeholders
- Seeking early views from key stakeholder groups

Engagement at an early stage in the process is essential in ensuring that people have the opportunity to have a say in developing the future service model for Children's Urgent and Emergency services at Bassetlaw Hospital. We know that any change to health services can be emotive, high profile and have a wide-reaching impact. It is important, from both a statutory and good practice perspective, to develop a transparent process which can help to maintain trust between the health authorities involved, the communities they serve and stakeholders.

Engaging within the context of COVID restrictions presents both opportunities and challenges. Whilst many existing groups and networks will now be familiar a range of digital platforms, we must ensure that the process in inclusive for those who are not familiar and cannot access these.

2. Pre-engagement

The key lines of enquiry for the pre-engagement phase have been to explore the views on what principles and potential options should be considered when developing the future clinical model of Children's Urgent and Emergency services. Engagement with key stakeholders and patient and carer representatives at this stage has also identified priorities, groups who may be impacted and areas of concern.

The insight gathered from this phase will be fed back to inform the development of any future public engagement.

In developing these options in-depth engagement has taken place with the Paediatric, Emergency Department and support services staffing teams at Bassetlaw Hospital as well as wider stakeholders, within informal sessions on the wards and in departments. More formally engagement has taken place at the Bassetlaw Emergency Village (BEV) Steering Group, Task and Finish groups and the Bassetlaw Emergency Village Project Board.

All options have been developed by lead Paediatric Clinicians at DBTH including Divisional Director of Nursing, Clinical Director for Paediatrics and Divisional Director and General Manager for Children and Families directorate, Paediatric Hosted Network colleagues and Primary care representation/Bassetlaw CCG nursing as well as Senior Management from the trust including Chief Nurse/Deputy Chief Executive, Director of Strategy and Improvement.

The options have been scrutinised at DBTH Clinical Governance Committee and Paediatric Consultants meetings, as well as external peer review from The Children's Hosted Network and presented to Bassetlaw CCG Governing Body.

Also, a quality improvement event was held in July 2021 where the Paediatric option for the master floor layout and colocation of services, designed by the Paediatric team and presented by the Paediatric Clinical Director, was voted the most preferred option chosen by a wide list of stakeholders including Bassetlaw CCG, EMAS, Mental Health services and Community Service representation as well as DBTH service leads.

The DBTH Children and Families Board reviews Bassetlaw Emergency Village plan development at its monthly meeting and a dedicated Clinical working group has been in place since January 2021 developing plans for relevant pathways of care and supporting the design of options.

We have also sought out and considered the views expressed by families who have recent experience of being transferred from the Children's Assessment Unit at Bassetlaw to DRI for observations lasting less than 24 hours.

3. Consultation preparation

It is envisaged that since the outcome of any future service change will be a 'substantial development or variation' of current service provision that a formal public consultation will be required.

In order to be meaningful and effective, the consultation will require the preparation of the following elements: stakeholder identification and mapping; engagement delivery plan; engagement tools and resources; and a timeline and key milestones. These are detailed below.

It should be noted that there are a number of interdependencies between these elements being prepared, which include the following being developed by the programme board:

- A narrative for the case for change (supported by appropriate background information)
- An agreed mandate for the consultation and engagement (addressing who is leading the engagement; whose views are being sought; the scope of the engagement and key lines of enquiry; what decisions are being influenced and what the wider aim is)
- Identification of key spokespeople and clinicians for the consultation and engagement process

3.1 Stakeholder identification and mapping

Stakeholder identification and mapping is a key part of any engagement process. Not all stakeholders will want, or need, the same level of engagement all of the time. Allowing time for mapping at the outset – and using this alongside impact assessments - enables effective prioritisation and can direct resources accordingly where gaps are highlighted.

Whilst mapping and analysis will help direct the initial engagement, ongoing research into existing networks and groups will continue to allow the engagement approach to constantly evolve and develop an understanding of the conversations they are having.

3.2 Consultation delivery plan

A forward plan of consultation delivery will be developed following the initial stakeholder mapping. So that resources can be used effectively, the plan will make use of existing networks and routes to communicate and engage stakeholder groups across the partnership organisations as well as preparing additional engagement routes where there are gaps or communities of particular interest.

The plan will cover key stakeholders who can help direct and influence the engagement process as well as the wider engagement with statutory bodies, service users and other stakeholders and will remain under constant review.

3.3 Consultation tools and resources

A suite of engagement tools and resources will be required to ensure that there is high quality, accessible information available for stakeholders. These will also ensure that the feedback and views are captured in as consistent a manner as possible to aid analysis and inform future decision making.

At this time we expect the engagement tools and resources required will be:

- Consultation document (clearly explaining the need for change and the options under consideration)
- FAQs (to address related issues and specific questions as they arise)

- Discussion guide and survey (to ensure alignment of key questions across all engagement)
- Reporting template and data monitoring form (to include key characteristics, demographic information and option for contact details to be provided for future engagement)

3.4 Timeline and key milestones

The timeline for the consultation phase will capture key milestones and opportunities for engagement as well as providing a reference for the next steps.

4 Outline approach to consultation

Consultation will take place via a combination of established communications channels and bespoke opportunities set up for the purposes of this engagement.

The guiding principles of utilising communications channels should be:
- Using trusted and established channels where possible
- A digital first approach where possible
- Going to where people are at – attending existing networks and meetings in the first instance

We will offer a range of methods for people to have their say throughout the engagement period, including: online surveys; meetings; discussion groups; and social media. The following is a list of the existing communications channels available to reach stakeholders. It is not designed to be exhaustive but rather added to throughout the engagement phase.

Written (digital or printed)	Face to face (or virtual)
Internal Social media Intranet Email – all staff Email – targeted	*Internal* Briefings – including targeted meetings with managers and clinicians Existing meetings
External Email Website Social media	*External* Partnership meetings Briefings

Our approach to engagement with specific stakeholder groups will be informed by our research into the most effective routes and mechanisms in light of any COVID restrictions.

To facilitate the engagement effectively, Doncaster and Bassetlaw Teaching Hospitals NHS Trust and NHS Bassetlaw CCG will:

- Have copies of the engagement documentation available on the CCG's website throughout the process
- Details of the engagement and the documents will be distributed via email to key stakeholders including but not limited to:
    - MPs
    - CVS
    - Health Scrutiny Committee
    - Health and Wellbeing Board
    - Patient Reference Group
    - Healthwatch
    - Doncaster and Bassetlaw Teaching Hospitals NHS Trust
    - NHS England/Improvement
    - South Yorkshire and Bassetlaw ICS
    - Nottingham and Nottinghamshire ICS
    - Local Trusts with Children's services including Sheffield Children's NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Sherwood Forest Hospitals NHS Foundation Trust, The Rotherham NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust.
- Send media release to all local media outlets at the start of the consultation and at key points in the engagement process
- Use Facebook and Twitter, and other social media resources, to raise awareness of the engagement
- Ensure that translations are made available on request in key community languages and made available on the CCG website when requested
- Log all calls received with regards to the engagement
- Collate all letters and emails received as part of the engagement
- Ensure that there are records of all meetings, virtual or otherwise
- Attend meetings with the following key stakeholder and representative groups during the engagement

Following the consultation, an independent analysis of all responses to the engagement will be undertaken by TCC and a report will be produced.

NHS Bassetlaw CCG will review the report and findings before making any decision. Feedback will then be provided via stakeholder briefings, meetings and media release.

Case for Change

Children's Urgent and Emergency Services at Bassetlaw Hospital

Introduction

£17.6m has been announced in support of a proposal by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) to create an 'emergency village' at Bassetlaw Hospital.

This funding aims to ensure that the Emergency Department (ED) facilities at Bassetlaw Hospital meet the urgent and emergency needs of the communities of Bassetlaw, now and into the future.

*Image shown is an initial artist's impression and may be subject to change

This new development creates an opportunity to confirm the future model of urgent and emergency children's services at Bassetlaw Hospital and address the challenges to service provision which resulted in the temporary closure of overnight children's inpatient service in January 2017 due to safety issues.

A new configuration of how children's urgent and emergency services are located within the Emergency Village plan could mean that children presenting at Bassetlaw ED with conditions requiring observation would be able to stay for longer at Bassetlaw Hospital, including overnight, regardless of the time (night or day) before being safely discharged home. This would be an improvement on the existing temporary arrangement and mean more patients would remain at Bassetlaw without the need for a transfer to Doncaster Royal Infirmary (DRI).

Background to the temporary changes made in 2017

Prior to 2017, the Children's services provided on the Bassetlaw hospital site included:

- Care in the Emergency Department;
- A ward with an ambulatory area and 14 beds to accommodate inpatients (also supporting same day attendance on the ward and a small number of planned day case lists)
- Dedicated children's outpatient clinic facilities.

In January 2017, temporary changes had to be made to the inpatient (ward) provision for children at Bassetlaw. The changes meant that the overnight children's inpatient service was temporarily transferred to DRI to address the safety issues created by shortfalls in specialist children's nursing staffing at night.
This happened because there weren't enough nurses with the specialist skills in children's nursing to cover both the Emergency Department and to provide care on the ward as the Children's' Ward is not located near any other overnight services. The number of paediatric nurses available within the department (as required by Royal College of Paediatrics and Child Health Recommendations (April 2018)) was specifically highlighted in the December 2018 Care Quality Commission (CQC) inspection which rated DBTH as 'requires Improvement' overall. The subsequent CQC inspection in February 2020 rated the overall assessment as "good" and at this point overnight services were still being temporarily transferred to DRI.
The temporary model meant that the ward changed into a 10 bedded Children's Assessment Unit, open until 9pm and only accepting referrals until 7pm. All children requiring overnight care (including observation) continue to be transferred to DRI, a 20-mile journey which on average is a 35–40 minute drive. If patients are assessed as being well enough, they can travel in the family's own transport if available, if not transport is provided. (See Appendix 1)

Impact of the temporary changes on our communities
Since the temporary changes were introduced in 2017:

- Paediatric ED attendance remained stable prior to the COVID pandemic. In line with national data different patterns of all ED attendances have been noted since 2020/21 reflecting the impact of the Covid-I9 pandemic. (*Please note data from 2021 is from 1 April 2021 to 30 September 2021, which doesn't include the busier winter period).

Site	2015	2016	2017	2018	2019	2020	2021 *	Grand Total
DRI	16786	18288	18192	18714	20744	14505	14635	121864
Bassetlaw	9206	9913	8858	9082	10091	6834	7207	61191
Montagu	5965	5966	6021	5597	5629	4699	4318	38195
Grand Total	31957	34167	33071	33393	36464	26038	26160	221250

- The planned outpatient clinics and Orthopaedic day case theatre list for Children provided on site have been unaffected and remain unchanged.
- Access to Urgent Children's service via ED has also been unaffected.
- In 2016/7 the average length of stay (LOS) for Bassetlaw paediatric patients (0-17yrs) admitted as a non-elective patient to Bassetlaw Hospital was 1.40. In 2017/18 (post the implementation of the temporary arrangement) the LOS was 1.36. The LOS has continued to decline with current LOS (year to date) of 0.80. There has been a similar reduction in LOS for elective admissions reducing from 0.76 in 2016/7 to 0.42 in 2021/22 (year to date).
- To date, the average number of transfers from Bassetlaw CAU for overnight admission to DRI is 25 patients per month (from Feb 2017 to Sept 2021). This equates to approx. 2% of the average number of paediatric patients attending ED per month (1st April-30th September 2021). The actual activity ranges from 13 to 57 children transferred per

month (which is not unexpected as there is usually significant seasonal variation). However, we numbers were disproportionately lower during the pandemic.

- Over the past 12 months 208 children have been transferred to DRI who could have remained at Bassetlaw for overnight observation and would therefore benefit from an extension to the service currently in place.
- In the last year only 88 children who were transferred to Doncaster remained on the Children's Ward at Doncaster for over 24hrs.
- When the CAU closes at 10pm, under current arrangements children continue to be transferred if ongoing care is required.
- In the Bassetlaw area, an average of approx. 200 children access Sheffield Children's Emergency Department directly each year. Most of these families self-present and some will have established links with Sheffield Children's for ongoing care for long term conditions and complex case management.
- Children needing emergency surgery, care on a high dependency unit (HDU) or specialist care are transferred directly from ED to both Sheffield Children's and Doncaster Royal Infirmary. 48 patients went to either DRI HDU or the Sheffield Children's in the past 12 months.
- The CAU at Bassetlaw currently supports the flow of patients from the Emergency Department, direct referrals from GPs or outpatients and phlebotomy requested by primary care and community paediatric services. Activity for the unit can be seen below:

Total CAU Activity

Average	Non-Elective	Day case	Elective
< Feb 2017	204	13	6
> Feb 2017	126	8	7
Total	162	11	7

Monthly average data from January 2013 to July 2021

Service feedback

- Overall feedback from families and patients is very good, though a small number of complaints were received when the service initially changed. However, feedback does indicate the desire from patient carers to stay at Bassetlaw overnight when safe to do so. Comments are attached in Appendix 2

Many attempts have been made to recruit to paediatric nursing staff since the temporary changes came into place in January 2017, some of which have been successful. However, due to natural attrition overall staffing numbers remain severely challenged. Therefore, despite considerable and sustained recruitment and retention initiatives the overall number of paediatric nursing staff remains unable to support a return to a pre-January 2017 model.
The prospect for an improving position for recruitment continues to be concerning. There is only one paediatric nursing cohort intake per year from Sheffield Hallam University. Adverts are routinely placed three times a year by DBTH to attract new starters. We also rotate staff to support their professional development. Nurse staffing continues to be a national challenge as there remains a shortage of qualified

nurses generally. Whilst there has been significant investment nationally into overseas recruitment for adult nursing, this has not yet been undertaken for children's nursing. NHS England and Improvement are now working with Trusts and recruitment agencies to bring Children's nurses to the UK. In addition to this the local Higher Education Institutes have increased the placements for children's nursing by 40. This will potentially be beneficial for DBTH, but not until 2023 even if we can attract and retain these newly qualified nurses within the local geography.

Case for Change

The Trust, and the CCG, are committed to providing accessible services locally, wherever it is safe to do so. The development of the "Emergency Village" at Bassetlaw Hospital offers possibilities for co-location of the Children's CAU with the Emergency Department and Children's outpatient department to make best use of specialist nursing and medical staff capacity within the hospital and potentially across children's community services. Consequently co-location will support meeting an anticipated increase in demand for same day/urgent services as a result of the pandemic and existing patient need.

Nearly 3,000 of 25,745 Bassetlaw children (aged 0-19) have one or more long term conditions with the highest numbers managing asthma and neurodevelopment disorders. 16.2% (3,205) of Bassetlaw children are also within low-income families which has a strong association with poorer health outcomes.

Emergency activity at Bassetlaw Hospital continues to rise, especially since the end of lockdown. Combined with significant new building developments, having the correct model of care in place is essential for system recovery and sustainability. Co-location will mean less staff will be required, which mitigates the risk of a shortage of paediatric nurses. A new development may attract staff and we are working with Sheffield Children's Foundation Trust to look at possible rotational posts.

Development of options

In developing potential options for Children's Urgent and Emergency Services at Bassetlaw Hospital the five key criteria outlined in The Green Book (central government guidance on appraisal and evaluation) have been applied. They are:

- Strategic fit and meets business needs
- Potential value for money
- Supplier capacity and capability
- Potential affordability
- Potential achievability

Pre-engagement work with clinical teams from the hospital, clinical colleagues in the Integrated Care Systems (ICS)Children's Hosted Network and the clinical commissioning group has taken place to identify and appraise that the options are viable against the five criteria. We have also sought out and considered the views expressed by families who have recent experience of being transferred from the Children's Assessment Unit at Bassetlaw to DRI for observations lasting less than 24 hours.

During this process further options have been considered and discounted against those criteria. This included specific consideration of re-opening the ward to provide the pre-2017 model. This option was discounted since it does not meet the achievability criteria. An option to discontinue providing Children's Urgent and Emergency Services at Bassetlaw Hospital has also been discounted since this

conflicts with patient feedback and the expressed desire of local parents to access care closer to home. This option also fails to meet the criteria of strategic fit and business needs (as we are committed to providing accessible services locally, wherever it is safe to do so).
In all options, as has always been the case, children will be transferred directly from ED to both Sheffield Children's and Doncaster Royal Infirmary when clinically indicated. We remain committed to ensuring all our children are provided care in an appropriate environment where their needs can best be met. DRI will therefore continue to provide care for more complex patient needs for example emergency surgery and high dependency or specialist care.
The options in development are described below.

- **Option 1 (continue current temporary model on a permanent basis)** – The existing Children's Assessment Unit (CAU) stays where it is (not near the Emergency Department) and closes at 9pm each evening with no further admissions from 7pm and patients requiring overnight stay are transferred to the Doncaster Royal Infirmary site from 4pm.
    - **Benefits:** Maintains stable position, model well established, maintains resilience of clinical oversight and delivery for paediatric nurse input
    - **Risks:** Fails to consider opportunity for more patients to remain locally in Bassetlaw; patients might be transferred due to transient need for observations and hence potentially poor patient experience

- **Option 2** – A dedicated Children's Assessment Unit (CAU) is built next to the Emergency Department but still closes at 9pm each evening with no further admissions from 7pm and patients requiring overnight stay are transferred to the Doncaster Royal Infirmary site from 4pm. This allows for better use of specialist children's nurses.
    - **Benefits:** Creates improved resilience as a result of co-location
    - **Risks:** Fails to consider opportunity for more patients to remain locally in Bassetlaw; patients might be transferred due to transient need for observations and hence potentially poor patient experience

- **Option 3** – A dedicated Children's Assessment Unit (CAU) is built next to the Emergency Department, which will allow children to remain on Bassetlaw Hospital site when they require a short stay for observation, which can be overnight. Children who require a longer length of stay will continue to be transferred to the Doncaster Royal Infirmary site. This allows for better use of specialist children's nurses and means children who require a short stay would be cared for at Bassetlaw overnight.
    - **Benefits:** Creates improved resilience as a result of co-location; supports more children staying for longer at Bassetlaw with reduced need for patients to transfer to DRI site without compromising patient safety/quality
    - **Risks:** Transition of service from current temporary arrangements dependent upon building works completion and ongoing recruitment and retention of paediatric nursing staff. Latter risk to be mitigated

through increase in training places for nursing with phased implementation.

With each of these options the Children's outpatients remains on site at Bassetlaw and the outpatient services provided will remain unchanged.

Next steps

We want to engage with our local community at the earliest opportunity, ensuring local people have the opportunity to share their views and that we facilitate appropriate levels of conversation across all our stakeholder groups. As such, we have prepared an engagement plan - Appendix 3 of this document, outlining our approach to working with key stakeholder groups, informed by existing knowledge and feedback.

In developing the potential service change we will also work closely with NHS England and Improvement (NHSE/I), ensuring that any changes meet the requirements of the NHSE/I assurance process. We will also work with the Yorkshire and Humber Clinical Senate to ensure any new service meets the highest clinical standards and are in line with good clinical practice.

While there is no legal definition of 'substantial development or variation', we are seeking the views of HSC with regards to whether they believe the proposed changes to increase the opportunity to provide Children's urgent and emergency services for longer at the Bassetlaw site is substantial and would therefore trigger the duty to consult with the local authority under the s.244 Regulations.

Given the proposed development of the Emergency Village on the Bassetlaw Hospital site, and the opportunity this presents for reviewing the current provision of Children's urgent and emergency care, both the CCG and Trust will endorse HSC decision for formal consultation if deemed appropriate and are committed to continued engagement with the HSC throughout the forthcoming process.

Whilst there are no plans to consult on the development of the Emergency Village, as it is a reprovision of services in line with national standards, we will seek community involvement in the look, style and feel of the Emergency Village.

Appendix 1

Paediatric Transport Checklist to Doncaster Royal Infirmary (DRI)

This document is to be completed by the Doctor that has assessed the patient and identified a need to transfer to DRI. Re-assess in the event of a change in clinical condition whilst awaiting transfer.

Complete the following:-

Yes	**No**	GCS less than 15
Yes	**No**	PAWS >3 prior to transfer
Yes	**No**	Has ABCD ever been abnormal since arrival?
Yes	**No**	Have they received oxygen or fluid bolus?
Yes	**No**	Have they received opiate or other sedative medication?
Yes	**No**	Is the condition progressive?
Yes	**No**	Do they have any i/v infusion (secure cannula are permitted)?
Yes	**No**	Have they received drugs to which they could have an allergic response within the previous hour?
Yes	**No**	Are there any child protection issues?
Yes	**No**	Has a Middle Grade or above doctor any concerns?

Any "Yes"

ALL

Patient suitable for own transport.
Ensure the parents are given the following prior to transfer:-

- Copies of Medical Notes / Letter
- Direction to receiving hospital
- Contact number of current hospital
- Contact number of receiving hospital
- Completed and signed Transport Checklist

Patient will require ambulance transport.
Identify "Urgency" and "Crew" required

Parents unable to transport

Booking Ambulance

Consider the following when deciding on the urgency and ambulance crew accompanying the transfer:-

- Have you optimised & stabilised the patient as best as you can in your current site?
- How long can your patient wait in your current site before they will be too sick to be transferred?
- How likely will the patient deteriorate en route to the receiving site?
- Do we need a Nurse / Doctor / Anaesthetist to accompany the patient (Any patient with syringe driver or infusion pump running will require transport via paramedic crew)?

Date: …… Time of assessment:……

Designation:……..

Signature:…… Name:……..

Appendix 2

Parent's Feedback - Care for children requiring transfer to DRI from BDGH

Staff all caring and compassionate, training staff are a credit to the team, I felt reassured throughout our stay from being admitted at Bassetlaw and transition to Doncaster, it's a shame resources had to be wasted and my child was unsettled due to the move however that is not the fault of either hospital and all staff have been amazing.

Transfer from BDGH excellent transition with a lovely professional nurse waiting for us, a side room available straight away. Nurses explained everything and did absolute best to make (named child) and I as comfortable as possible and explained clearly in a way I understood. Drs very competent and kind in there delivery and making it clear that not only would (named child) be treated now but also followed up in clinic which has put my mind at ease, a big thank you from (named child) and I.

Outstanding care from every single member of staff at Doncaster and Bassetlaw you saved our baby's life through quick thinking and excellent staff members and care.

Brilliant hospital, transferred from Bassetlaw at 21.30 and nothing was too much trouble, also lovely that there is a parents room to make a much needed cuppa, very good of staff to make toast for parents at breakfast time.

We were transferred from Bassetlaw and we were made to feel very welcome (named child) was very well looked after.
(Named child) received the best possible care at Doncaster children's hospital the team took no chances and were very thorough. We have been considered ok to transfer back to Bassetlaw for the blood tests of which we are very grateful.

Fabulous staff, nothing was a problem. It's a shame my son couldn't stay here overnight rather than having to travel to Doncaster.
The staff members in this department are second to none. The nurses were friendly and accommodating, going above and beyond to attend to our needs. The doctors were excellent, approachable, friendly and caring. How privileged and blessed we are to have such an excellent facility in North Nottinghamshire. Thank you also for the gifts for our child who was in all day on Christmas Eve and transferred to Doncaster for Christmas day. Thank you for helping to soothe our two year old son who was extremely distressed and upset with being so poorly. This service and level of care is amazing. Thank you!!!

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 November 2021

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

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 Sue Saddington
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 2021/22

Subject Title	**Brief Summary of agenda item**	**Scrutiny/Briefing/Update**	External Contact/Organisation
8 June 2021			
NUH Maternity Services Improvement Plan	Further briefing on NUH's improvement plan for maternity	Scrutiny	Dr Keith Girling and Sarah Moppett (NUH)
Diabetes Services/Public Health	Initial briefing on diabetes and public health services	Scrutiny	Lewis Etoria & Laura Stokes, Nottingham & Nottinghamshire CCG
13 July 2021			
East Midlands Ambulance Service Performance	The latest information on key performance indicators from EMAS.	Scrutiny	Richard Henderson, Chief Executive, Greg Cox, Operations Manager (Nottinghamshire)
Bassetlaw Mental Health Proposals	The latest position on engagement and decision making in relation to mental health in Bassetlaw	Scrutiny	Idris Griffiths, Chief Officer, Bassetlaw CCG and Julie Attfield, Executive Director, Local Mental Health Services,
Tomorrow's NUH	Further briefing on development of services at NUH	Scrutiny	Lucy Dadge, Chief Commissioning Officer, Lewis Etoria, Head of Insights and Engagement Nottinghamshire CCG (and other senior officers TBC).
7 September 2021			

Access to Primary Care	An initial briefing on patient access to primary care as part of an ongoing review.	Scrutiny	Lucy Dadge, Chief Commissioning Officer, Joe Lunn, Associate Director of Primary Care and other senior Nottinghamshire CCG officers
Bassetlaw Mental Health Proposals	The latest position on engagement and decision making in relation to mental health in Bassetlaw	Scrutiny	Idris Griffiths, Chief Officer, Bassetlaw CCG and Julie Attfield, Executive Director, Local Mental Health Services,
12 October 2021			
Mental Health Crisis Services	An initial briefing on the state of mental health crisis services as part of an ongoing review	Scrutiny	Julie Attfield Nottinghamshire Healthcare Trust
Bassetlaw Mental Health Proposals – Travel Plan	Consideration of the draft travel plan	Scrutiny	Julie Attfield, Nottinghamshire Healthcare Trust and Dr Victoria McGregor Riley, Bassetlaw CCG
Nottingham University Hospitals Maternity Improvement Plan	Update on NUH's actions in relation to its CQC inspection improvement plan	Scrutiny	Dr Keith Girling, Medical Director and other senior NUH officers.
Public Health and Commissioner Maternity Improvement	An initial briefing on wider maternity improvement issues.	Scrutiny	Rosa Waddingham, Chief Nurse, Nottinghamshire CCG, Louise Lester,

			Public Health Nottinghamshire County Council
23 November 2021			
Health and Social Care Bill	An initial briefing on the implications of the Health and Social Care Bill	Briefing	Alex Ball, Director Communications and Engagement, Nottinghamshire ICS/CCG TBC
NUH Neo-natal proposals	Initial briefing on new proposals at NUH	Scrutiny	Lucy Dadge, Chief Commissioning Officer and other senior Nottinghamshire CCG
Access to Primary Care	Further consideration of information as part of an ongoing review	Scrutiny	Lucy Dadge, Chief Commissioning Officer and other senior Nottinghamshire CCG officers TBC
4 January 2022			
Tomorrow's NUH	Further consideration of the proposals	Scrutiny	Lucy Dadge, Nottinghamshire CCG
NUH Maternity Services Improvement Plan	Consideration of the Improvement Plan	Scrutiny	Michelle Rhodes, Chief Nurse, NUH
22 February 2022			
Access to Primary Care	Further consideration of Information as part of an ongoing review	Scrutiny	
29 March 2022			

10 May 2022			
To be scheduled			
Public Health Issues			
Integrated Care System – Ten Year Plan (TBC)	An initial briefing on the ICS – ten-year plan.	Scrutiny	TBC
NHS Property Services	Update on NHS property issues in Nottinghamshire	Scrutiny	TBC
Operation of the Multi-agency Safeguarding Hub	Initial briefing on the	Scrutiny	TBC
Frail Elderly at Home and Isolation (TBC)	TBC	Scrutiny	TBC
Winter Planning (NUH)	Lessons learned from experiences of last winter	Scrutiny	TBC
Tomorrow's NUH (January 2022)	Further briefing on development of services at NUH	Scrutiny	TBC
EMAS (July 2022)	Key Performance Indicators	Scrutiny	TBC

Potential Topics for Scrutiny:

Recruitment (especially GPs)

Air Quality (NCC Public Health Dept)

CAMHS – Mental Health Support

Mental Health – Young People and COVID