Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 08 October 2024 at 10:00

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

AGENDA

1	Minutes of last meeting held on 16 July 2024	3 - 14
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below)	
4	Nottinghamshire Healthcare NHS Foundation Trust Integrated Improvement Plan Update	15 - 22
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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 James Lavender (Tel. 0115 854 6408) 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 16 July 2024 at 10.00am

COUNCILLORS

Roger Jackson (Chairman) - apologies (medical reasons)
Nigel Turner (Vice-Chairman)

Mike Adams	Johno Lee
Sinead Anderson (apologies)	David Martin
Robert Corden	John 'Maggie' McGrath
Steve Carr	Michelle Welsh (apologies)
Bethan Eddy	John Wilmott (items 1-7)

SUBSTITUTE MEMBERS

Councillor Keith Girling for Councillor Roger Jackson
Councillor Richard Butler for Councillor Sinead Anderson
Councillor Mike Pringle for Councillor Michelle Welsh

OTHER COUNCILLORS IN ATTENDANCE

None

OFFICERS

Martin Elliott – Senior Scrutiny Officer
Katherine Harclerode – Democratic Services Officer
Noel McMenamin – Democratic Services Officer

ALSO IN ATTENDANCE

Lucy Dadge - Director of Integration, NHS Nottingham and Nottinghamshire ICB
Alex Ball - Director of Communications and Engagement, NHS Nottingham and Nottinghamshire ICB
Anthony May - Chief Executive, Nottingham University Hospitals NHS Trust (NUH)
Dr Manjeet Shehmar - Medical Director, Nottingham University Hospitals NHS Trust (NUH)
Gemma Malin - Consultant Obstetrician, Nottingham University Hospitals NHS Trust (NUH)
Sharon Wallis - Director of Midwifery, Nottingham University Hospitals NHS Trust (NUH)

1 TO NOTE THE APPOINTMENT AT COUNCIL ON 16 MAY OF COUNCILLOR ROGER JACKSON AS CHAIRMAN AND COUNCILLOR BETHAN EDDY AS VICE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE FOR THE 2024-2025 MUNICIPAL YEAR

2 TO NOTE THE MEMBERSHIP OF THE COMMITTEE FOR THE 2024-25 MUNICIPAL YEAR AS FOLLOWS: COUNCILLORS MIKE ADAMS, SINEAD ANDERSON, STEVE CARR, JOHNO LEE, DAVID MARTIN, JOHN MAGGIE MCGRATH, NIGEL TURNER, MICHELLE WELSH, JOHN WILMOTT

3 APOLOGIES FOR ABSENCE

4 DECLARATIONS OF INTEREST

None.

5 MINUTES OF THE LAST MEETING HELD ON 14 May 2024

The minutes of the last meeting held on 14 May 2024, having been circulated to all members, were taken as read and signed by the Chairman.

Councillor Roger Jackson– Other reasons
Councillor John 'Maggie' McGrath – Other reasons

6 NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST – MATERNITY SERVICES UPDATE

Consideration was given to a report in respect of Maternity Services which was introduced by Anthony May, Chief Executive of Nottingham University Hospitals NHS Trust (NUHT), who joined the meeting remotely due to having tested positive for COVID-19. Also presenting were Dr Manjeet Shehmar, NUH Medical Director; Gemma Malin, NUH Consultant Obstetrician; and Sharon Wallis, NUH Director of Midwifery. The report included information regarding developments and progress in respect of Service improvement. The following points were highlighted:

- Donna Ockenden provided feedback to the Trust every other month, and the report included this information up to the beginning of the summer.
- Early feedback had been received for July which had been consistent with feedback from the CQC. This feedback had been high-level and had not yet been finalised for publication.
- Five strands of feedback were described, including concerns in respect of communication with families, hygiene and cleanliness, kindness and civility in responses to women and families.
- In response to concerns that the service relied too heavily on newly qualified nurses and midwives, evidence had been provided to the CQC of the training and support that the Trust provided to newly qualified midwifery nurses.

- Work done to improve inclusivity was described, including interpreter services to improve communications and translation, pilot of an antenatal class, and specific work with patient groups. The addition of regular sessions with staff had been well received.
- Some of the women that the service had not heard from had been identified as an area of focus; therefore, actions had been taken to work with Muslim women in particular. Further work was scheduled with Portuguese -speaking women.
- It had been recognised that recruiting from internationally educated midwives had improved the diversity of backgrounds within the workforce.
- Transactional issues were quicker to resolve and had been done, but transformation involved larger projects that were more difficult to achieve such as cultural change and improvement culture.
- There was buy-in from staff to lead on changes, such as translation of postnatal materials into additional languages.
- The approach to the ongoing improvement journey had been chosen by the Trust's Board.
- By the end of November, it was estimated that the Service would be fully staffed. There was very little movement from qualified staff.
- Preceptorship midwives provided support to newly qualified midwives. Professional support was also provided through a monthly engagement team.
- Recognising that at this stage, the skill mix was in development, roll out of training and support for senior team members had been introduced. This enabled feedback to be given to people in real time that had been seen to be effective.
- The home birth team, which had been suspended previously, was now almost fully established, with birth plans for mothers who wished to have a birth outside of guidance.
- Consideration was given to Friends and family feedback to ensure understanding.
- Recruitment work had also been done at the Senior Registrar level. Staffing levels were expected to improve at this grade in August.
- A separate rota for gynaecology had also been put in place to provide extra support.
- The Improvement Plan also called for an additional 13 consultants.
- Additional challenges in rota gaps had been experienced due to sickness and career breaks.
- Staff were not working above their grade, although staff supported at lower levels as needed.
- Staffing requirements for obstetrics and maternity involved some differences that were being worked out.
- The support that was being provided to address any issues raised by Donna Ockenden or by patients was noted.

In the discussion that followed, members raised the following points and questions:

- It was encouraging to see that the response from people wanting to work at the trust had generated a waiting list.

- More information was requested regarding any impact of the Ockenden Reivew on staff.
- Further assurances were requested regarding continued staff concerns.
- The Service had been observed to be re-energised and it was hoped that the improvements had not stalled and that additional improvements would be reported to scrutiny in future updates.
- Improvement from inadequate to requires improvement was seen to be a step forward.
- More details were requested in respect of how the Service responds to early signs of issues.
- Additional details were sought regarding the reasons staff were not redeployed from other areas to complete Freedom of Information requests at a faster rate.
- Further information was requested regarding the impact of any reorganisation on services.
- Further detail was requested regarding how staff had been supported in the areas that were most in need of improvement.
- Additional details were sought regarding utilisation of the Pocket Talk app by staff.
- More information was requested regarding how the next phase of improvement would achieve consistency once the review was complete.
- Members welcomed the plans for car parking and requested assurances that the efficient heating system would lead to cost savings.
- Staffing levels of management had been implemented and further information was requested regarding how this had made a difference.
- Additional details were requested regarding step taken to ensure parents and families feel safe and that women are being heard.
- The 37 outstanding actions were requested to be shared with members at an appropriate time for the purposes of benchmarking performance.

In relation to the points raised, the representatives of NUHT provided the following responses:

- Applicants who had applied for posts had understood that the Service was under pressure and was in the spotlight.
- The CQC had fed back that staff were engaging and positive, and acknowledged the pressure on the Service. Therefore, the Director of Midwifery had put a package of wellbeing support around staff. This included wellbeing advocates, who were experienced midwifes who speak to staff and doctors to offer support. There was also counselling service for psychological support. The staffing in terms of numbers and clinical expertise were very strong; however, the context creates a challenge. It was understood that maternity services throughout the country were under pressure.
- The Medical Director noted the waiting list for applicants to work in the Service which meant that the Service was able to attract applicants and that staff were not leaving. The last 12 months had maintained 100% retention of new staff.
- To support staff well, leadership must be easily accessible, when women attend for an appointment to deal with a health issue, this could require significant additional time to answer the questions, and the necessary

resources must be in place. Staff understood the issues and made a positive decision to come to NUH.

- The Chief Executive also noted that the staff and unit were under pressure. The staff surveys conducted across the trust had been positive across the last few years. As part of the current review, Donna Ockenden met with staff which added valuable feedback and showed that communication was good. It was important to engage with staff on a regular basis, keeping them up to date not just on matters relating to the service but also to give support.
- Arrangements were in place with a flow chart given to colleagues of the various ways to raise concerns. Fulfilment at work was considered to be important, and to feel that this was a rewarding profession.
- The workforce race equality data had been published for the Trust, showing an improving picture. Earlier this year, the workforce diversity strategy was published. NUH had a diverse workforce. New values had been launched. Over 4000 colleagues engaged. These elements worked together to enable the right support. With the right support and training, staff enjoyed coming to work, which was very much a focus.
- It was not acceptable that women and families were not treated with civility. Calling this out was important, and staff were becoming empowered to call out these behaviours as they did with racist behaviours.
- A lack of diligence in checking of equipment had not caused any harm but had led to changes from a monthly assurance to a daily one. The cleaning service support doing the checks were not midwives, so evidence had been provided back to the CQC regarding this, and the processes had been tightened up.
- Specific changes had been made such as more frequent visits from the infection control team and more protocols and scheduling around cleaning.
- As a result of ongoing work, an increase had been seen in staff confidence and empowerment to speak up. Whereas previously this would not have happened, this was a positive sign of culture change.
- During peaks in activity, the Service moved staff from clinical activity to support. Peaks in activity could sometimes be for four hours. The staffing had never been better. There were still some agency and bank staff, who were fantastic staff, but introduced certain challenges. Therefore, the reduction was very positive.
- The Medical Director affirmed the transition that had been made and the improvement journey that was signalled in staff culture changes and willingness to speak up. Positive numbers showed the service was being staffed well and feedback from staff showed that staff were receiving additional support. This involved local accountability, leadership and professionalism of the staff on the floor to make sure that jobs were done to the best of their ability.
- The new hospitals programme had received support from the new government, and NUH was a big part of this programme which had been delayed to 2030 due to costs associated with failing concrete. The new programme relied on modular building, and this was expected to involve a less time intensive construction period.
- Permission had been given by NUH England to replace all windows in QMC in the meantime. This would help with noise attenuation and increase heat

retention in the winter. New theatres and wards would be opened at City Hospital next year, including a rehabilitation centre.

- Although the major refurbishment and rebuilding project had been delayed a few years, several other projects were going forward, with investments and improvements being made.
- Alongside other training, targeted induction programmes were delivered to new staff joining the service. The support introduced within medical teams involved a consultant with junior doctors attached to that consultant. This model was more difficult to achieve during the pandemic when there was a need to work differently. Working in a team was very important for support. There was a designated team of the shift and a safety huddle format so that staff knew the other team members they would work with on a shift.
- Staff all had mobile devices to record observations. Scripts in multiple languages were available on these devices. The Pocket Talk app enabled staff to speak into the app for real time translation into another language. translates in real time into another language.
- Staff had been sharing learning with others. For example, the antepartum haemorrhage leaflet had been commended. The Service had been sharing learning with other Trusts as well.
- The Trust's was one of the biggest carbon reduction schemes in the NHS. In order to obtain funding, a return on investment had to be shown. By changing to ground source heating and replacing windows, the return on investment was demonstrated.
- The issue with car parking was understood; therefore, there were two multistorey car parks in the Tomorrow's NUH programme.
- Staff must be trained to respond to information requests. The decision was taken to restructure the Service and recruit permanent staff to respond to the requests. Something that slowed down the timeliness of responses, was that there were many systems involved. Once the information was brought together, the information received a clinical review before being sent. There was work being done to look at supplementing the resource for clinical review, these were completed by the same staff that run the Service.
- There had been a significant response from staff and training to recognise unconscious bias, to respect others' perspectives and views. Awareness work included using culturally appropriate dolls, as 47 percent of the population was not white. The training did cause staff to reflect, as they realised there had been some unconscious bias.
- Issues were reported regularly through listening to our staff and being visible as part of the team with a view to communicating openly with staff. There were 37 actions within the improvement plan, with a continuum for work in areas of cultural awareness. More national reports were felt to be needed to promote wider understanding.
- The behavioural framework was described, with the next step of holding people to account. Racism was not tolerated and would be dealt with as a professional standards issue.
- Structures around senior leadership within maternity were felt to have worked well as there was a Head of Midwifery for Quality Risk, and Safety and a Head of Midwifery for workforce. These roles did not work by site as was usual practice. This structure was also important for succession planning.

- To ensure parents and families felt safe and women were being heard, appointments took longer than scheduled if needed to ensure questions were answered. A 20-minute appointment could take 40 minutes.
- There had been an increase in referrals to the birth planning programme, and more women spoke to the Service about their experiences of giving birth. There was complex care planning for women who had complex care needs.
- Community midwifery services were being reviewed according to outcomes rather than population. Consideration was given to the variation in connectivity among populations, as it was important to maintain communications and engagement.

The Chairman thanked the representatives of NUHT for attending to provide additional context. It was understood that the CQC report would not be available until early autumn. Once this was published, an update would be scheduled.

RESOLVED 2024/12

1) That the report be noted.

2) That a further update be received at an appropriate time.

7 ACHIEVING FINANCIAL STABILITY IN THE NHS

Consideration was given to a report in respect of achieving financial stability in the NHS, presented by Lucy Dadge, Director of Integration NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), Alex Ball, ICB Director of Communications and Engagement and Sarah Fleming, Programme Director for System Development (ICB) The report provided a high-level summary of all of the proposed changes relating to identified efficiencies and the associated prospective financial savings. The presentation highlighted the following points:

- The review to identify areas of additional funding and expense within the NHS had been done in a desire to be in the best position to deliver the best care over the winter when there is greater need for healthcare services.
- It was felt that plans would benefit from public scrutiny, as any formal decision-making would follow due process.
- The paper provides a high-level summary of all the proposed changes with members invited to identify any items for which further detail would be requested for scrutiny.
- The projections were based on a commissioning approach for the next two years, for example, for acute services and primary care. Multiple approaches were considered for each of the proposed changes, and considerations included best practice and benchmarking.
- Proposals such as the end of life community model rather than the specialist palliative care model involved contract negotiations and controls.
- In respect of primary care psychological medicine, the view had been taken that the benefits could be provided through psychological services already available, reducing duplication.

- Section 117 Aftercare could be delivered in community following an inpatient stay, reviewed on a case-by-case basis to ensure care continues to be needed and appropriate.
- Proposals included direct commissioning of joint funded care packages, and reviewing existing packages to ensure a need was still existing. This would involve liaison reviews, one-to-one reviews in care homes and eligibility reviews.
- A Fast Track single service was proposed for people who were in what was often the last year of life so that families could work with one service rather than two services.
- Transport would be withdrawn where there was not a health care statutory need; where there was a statutory need, transport would still be provided.
- Prospective savings would be made from a phased exit from the South Notts Fracture Liaison Service.
- The details would continue to be developed, as the impact of pressure on services required services to change and evolve.
- Subject Matter Experts could be brought together in a workshop format in any areas that members felt would benefit from a deep dive.

In the discussion that followed, members raised the following points and questions:

- The importance of community engagement was emphasised in relation to communicating the changes to the wider public.
- Members expressed interest in the practical implementation of the prescribing changes to high cost medicines, and whether any challenges were encountered in explaining the changes to prescribers and patients. This was noted to be a high-value change with proposed savings of 6 million.
- Assurances were requested that the change to patient transport had been proposed following a thorough review. Concerns were expressed that transport responsibilities would go to family members who may encounter significant challenges.
- Additional information was requested regarding the changes to continuing health care, which would affect many people including patients and partner providers.
- More information was sought regarding how slippage on staffing would impact efforts to address backlogs and whether this would have a negative impact on future funding.
- Members requested that units be clearly designated for all figures and calculations in reports.
- More details were requested regarding how virtual wards were being utilised, with more people at home using assistive technologies.
- Members sought additional information regarding waiting times for elective surgery and how these would be affected by changes.
- Assurances were requested that the Pharmacy Council was aware of the changes and monitoring the impact.

- Further assurances were sought regarding recruitment challenges and how the changes would affect system-wide staffing.
- Additional clarification was requested regarding how all of the psychological services would be delivered by mental health when these services were pressured.
- Members sought additional assurances that there was a resilience plan for primary care to help promote retention going forward.
- Additional assurances were sought that the new community diagnostic centre had not been delayed in order to make savings.
- Further elucidation was sought regarding the rationale for not re-investing savings into service delivery.
- Concerns were expressed regarding the cuts to care packages.
- Assurances were sought regarding mental health that the care coverage would be available despite less involvement from police.
- Concerns were raised regarding the prioritisation of pharmaceutical-oriented solutions and assurances were requested that preventable illnesses were being prevented.
- Greater understanding of how the impact of changes was being measured.

In relation to the points raised in discussion, the representatives of the ICB provided the following responses:

- Medicines management teams were extremely specialised, and they had drafted the proposals, working with GPS and pharmacists to understand how these medicines would feel different to people although having the same therapeutic efficacy.
- Following much discussion on discharge transport, there was a new transport provider delivering the patient transport service to take people home after an inpatient stay or taking them to a hospital appointment. Dedicated staff looked at cases on a case by case basis and coordinated communications that would benefit families. Sometimes families did need the Service to intervene, and these families were heard. The ICB was willing to come back to update scrutiny on how the transport service changes were embedding.
- The proposed change was very specific regarding transport. There was an obligation if the criteria are met for transport to an outpatient appointment or home from an inpatient. For those where there was not an obligation, the intention was to protect the transport service. It was not the intention to continue to provide the kind of transport for day care and other types of respite health care where other benefits could continue to provide that transport.
- The responsive transport service would respond in times of extreme pressure. Efforts were made to ensure people who were very frail did not have to go home at night, for example. If someone who was very frail was being discharged, this was a clinical decision about what was best for them. If someone was nearing end of life, their wishes were respected wherever possible, in conjunction with relatives, but it was understood that the pressure can build.

- GPs and Pharmacists worked together with individuals to learn if a medicine was still really needed, and if the prescriber agreed that it was still needed. The expert medicine management team had the role of coordinating the communications around this.
- It was understood that the roving service needed to sustain providers, but it was also foremost about the impact on the individuals. Therefore the new commissioning model was proposed.
- If a patient had been assessed as having a social care and health care need, the nurse and social worker would assess the case review the needs together to ensure an appropriate package was around the person for these needs and that the needs were reviewed to ensure the treatment was delivered as part of their ongoing recovery.
- Sometimes elements remained in place longer than needed when health needs changed. Local government colleagues participated in the joint assessment of what was needed and no longer providing what was no longer needed.
- The allocated funding could not be spent regarding the community diagnostic centre. Therefore, the money would be slipped to next year, and this would not have a negative effect on future funding. Had the new building been possible, this would have enabled the delivery of more services, and later than planned this would catch up to allow more community-based care.
- ICB colleagues worked with NHS colleagues to avoid creating imbalances in the market.
- Clarification was provided that the figures within the tables were in thousands.
- Members were encouraged to escalate any pharmacy performance concerns to the ICB to be referred to specialist commissioners working within regulatory contexts.
- Across all providers, inroads were being made in recruiting substantive workforce, not relying on agency staff. Some providers had to change the way they train staff to ensure a full complement of specialist skills across the location. Many things were changing in the way services are delivered, and this requires ongoing training.
- The intention was for Nottinghamshire healthcare to ensure people experiencing mental health issues for the first time receive support. The ICB also was trying to improve the crisis service for those who experienced an unforeseen mental health difficulty. For some people there was no choice but to detain them under a Section, and these people should be seen earlier. These were not health services, as some of them are recreational or social services. They must be reviewed regularly because they would not be appropriate at a later time. This was a case management approach rather than a reduction in provision of care. The proposal was that the services follow people through their journey.
- It was believed that there was some duplication in mental health care which allowed the service to be provided without spending the money twice. The ICB had invested cost pressure and then received additional funding from government. This was enough funding to do what was planned.
- There was ringfenced funding for investment in mental health services, as this was considered a very important prevention area. There was work with

providers to ensure there were enough mental health beds, and the savings made would not impact on this provision.

- The ICB would continue to invest in treatments to prevent more costly care. There were some areas where it was believed that sufficient inroads could not be made to deliver savings this year. Plans were predicated on prevention being better than cure.
- Prevention funding had grown year on year, and the ICB strove to ensure this funding delivered the best possible outcome, with evidence that investment in prevention delivered better outcomes. A strong example was around diabetes. There were other case studies in areas such as social prescribing to support people before their mental health reached clinical levels to help them maintain their wellbeing.
- Equity meant equity of outcomes not equity of services, and it was important to seek to bring Bassetlaw into this. There were 19 quality measures of potential impact on outcomes. For any measures over the threshold at the screening, a full risk assessment was done. This was taken to a panel which develops the screening tools. The assessments were not done on an individual basis. As the equality impact assessments were developed, these could be shared.
- The number of people affected by changes to joint funding packages would be provided in a future update.
- The primary care workforce comes to Nottinghamshire to be trained and it is desirable for the trained workforce to stay. Retention was currently better than average. Across approximately 125 practices and 800 GPs across the county there was variation in the arrangements that were desired such as salary and flexible working.
- Efforts to sustain good general practice was not all about GPs anymore. This now involved clinical pharmacists who were much better at doing medication reviews. Physiotherapy was better in a GP setting rather than a hospital setting. The intention was to enable GPs to do more of what they do best which was same day urgent care and complex conditions management.
- The intention was to come back to scrutiny to share more context in a future meeting. The decisions would be made now through the ICB Board with understanding of the feelings of members about the proposed changes.
- There was an opportunity individually and corporately to help communicate the changes and to provide an opportunity for communities to comment on schemes.

The Chairman thanked the representatives of the ICB for attending the meeting and noted the opportunity for members to help communicate the changes within the communities in which members work.

RESOLVED 2024/13

1) That the content of the briefing be noted.

2) That further information be received regarding the changes of greatest importance to Nottinghamshire residents.

5 WORK PROGRAMME

Consideration was given to an outline programme of scrutiny work. This was the first work programme for the municipal year 2024-20205. Each year the work programme was revisited to set the priorities for scrutiny work. A further discussion would be planned in respect of the Lung Health Pathways and the Healthcare Trust's Improvement Plan. Further consultation with members would be done regarding prioritisation of the work programme for the year.

During the discussion, members made the following comments:

- Clarification was requested regarding timescales for receiving the additional information requested earlier in the meeting.
- It was hoped that additional items could be added to the work programme.

Assurances were provided that updates would be arranged in a timely way that maximised the use of the time available for discussion of the important issues.

RESOLVED 2024/14

1) That the Work Programme be noted.

2) That consideration be given to how best to receive additional information regarding the issues raised by members.

The Chairman thanked Members for attending the meeting and closed the meeting at 13.15 pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

8 October 2024

Agenda Item: 4

NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST INTEGRATED IMPROVEMENT PLAN UPDATE

Purpose of the Report

1. To consider a briefing paper from the Nottinghamshire Healthcare NHS Foundation Trust in respect of progress taking place on their Integrated Improvement Plan (IIP) to address the issues identified in the recent Care Quality Commission (CQC) reports, including the report on Rampton, Adult Inpatient Services, and Older Adult Inpatient Services as well as the Section 48 review commissioned by the Secretary of State for Health and Social Care.

Information

2. Following the recommendations from the Section 48 report, the CQC reports and the financial situation within the Trust the Integrated Improvement Plan has been phased to ensure the Trust can deliver targeted, timely and sustainable improvements. The IIP consists of five significant programmes of work:

   - Patient Safety & Quality Improvement
   - Leading for the Future
   - Finance & Productivity
   - People & Culture
   - Governance

3. In August, part 2 of the Section 48 report was published focussing specifically on the Valdo Calocane case. This report produced additional recommendations for the Trust on risk assessment and record keeping, care planning and engagement, medicines management and optimisation and discharge planning.

4. The briefing provides detailed updates regarding key actions, achievements, challenges and risks, and outcomes of recent CQC inspections of Trust services. The briefing also outlines next steps and describes the work of the Patient and Carer Reference Group and Colleague Reference Group which are being introduced to provide advice, insight and oversight on the Trust's future improvement work.

RECOMMENDATION

Nottinghamshire Health Scrutiny Committee is asked to:

1) Note the contents of this report.

2) Provide feedback on the progress taking place in respect of the Trust's Integrated Improvement Plan.

3) Discuss how the Committee would like to receive further updates.

Councillor Roger Jackson
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Katherine Harclerode – 0115 854 6047

Background Papers

None

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire Healthcare NHS FT: Integrated Improvement Plan update

Briefing for Nottinghamshire County Health and Adult Social Care Scrutiny Committee

October 2024

Introduction

This briefing provides an update on the progress taking place in Nottinghamshire Healthcare NHS FT on their Integrated Improvement Plan (IIP) which has been developed to address the issues identified in the recent Care Quality Commission (CQC) reports, including the reports on Rampton, Adult Inpatient Services and Older Adult Inpatient Services as well as the Section 48 review commissioned by the Secretary of State for Health and Social Care.

Background

Following the recommendations from the Section 48 report, the CQC reports and the financial situation within the Trust the Integrated Improvement Plan has been phased to ensure the Trust can deliver targeted, timely and sustainable improvements. The IIP consists of five significant programmes of work:

- Patient Safety & Quality Improvement
- Leading for the Future
- Finance & Productivity
- People & Culture
- Governance

In August part 2 of the Section 48 report was published focussing specifically on the Valdo Calocane case. This report produced additional recommendations for the Trust on risk assessment and record keeping, care planning and engagement, medicines management and optimisation and discharge planning.

Updates

- The Trust accepted entry into NOF4 and recognised the unusual high-profile circumstances we are in. To support the ongoing delivery of the IIP buddying arrangements have been put in place with the high secure hospitals Broadmoor and Ashworth as well as with Northamptonshire Trusts. Support is also in place from the national and regional Recovery Support Programme (RSP) teams, regional and national provider groups and other specialist expertise.

- Part 2 of the Section 48 report has been received and the recommendations from this have been included as part of the reporting through the Patient Safety & Quality Improvement Programme.

- The IIP has an established governance process with each of the five programmes having a Programme Board that reports into the monthly Integrated Improvement

Portfolio Board. This reports into a Board level committee and externally to the regional Integrated Oversight and Assurance Group which is chaired by Dr Jess Sokolov and Amanda Sullivan from the ICB.

- Support to the IIP is being received externally from the NHSE regional and national Recovery Support Programme (RSP) Teams across the Programmes, in particular Finance & Productivity, Patient Safety & Quality Improvement and People & Culture. The RSP are also providing some targeted support to the Local Mental Health Teams.

- Transition Criteria for exit from NOF 4 have been produced and agreed by the IIP Board and have been aligned to each of the five Programmes under the IIP. Progress and pace against the transition criteria will be monitored internally at the IIP Board and at the Trust Board and externally at the regional and national NRST meetings with the first quarterly monitoring report produced in October.

- An Evidence and Assurance Group is being set up and will be responsible for signing off completed recommendations and transition criteria for the IIP once they are satisfied, they have been actioned and there is clear evidence of achievement and sustainability. This group will be chaired externally by the Improvement Director at Northamptonshire NHS FT.

Key achievements

- A Safe Now dashboard has been developed, with the ICB supporting clinical and operational engagement, to monitor and measure safety and improvement. Weekly meetings between the ICB and the Trust review Safe Now data

- The CQC Assurance Group has closed a number of actions for Rampton Hospital as evidence of continued and sustained improvement:

    - Hospital Life Support Training
    - Physical Health checks following rapid tranquilisation
    - Completion of seclusion care plans
    - Clinical/managerial supervision
    - Recording patient observations (caveat – performance dropped in July for late observations)
    - Safe staffing levels

- Waiting lists for each Adult Community Mental Health Team have been validated including numbers and duration, wait for assessment and Wait for Treatment.

- The target of 85% completion of the Oliver McGowan e-Learning by 31st July was met by Trust staff.

- There has been a significant increase in closed IR2s due to patient safety systems that identify areas for concerns, from 64.4% to 84.93%.

- Good progress has been made to reduce the number of patients waiting over 18 weeks for assessments in Community Mental Health across localities. A Capacity and Demand exercise has highlighted opportunities to improve efficiency within teams and these are being developed into a plan.

- Clinical Lead role has commenced in Adult Mental Health to support Flow with a focus on transition plans for Out of Area patient and purposeful admission.

- Care Group Nurse Directors have been recruited and will take a lead on areas of improvement across the Trust ensuring our care pathways have a strong clinical voice and will be part of the triumvirate leadership team at Care Group level.

- Through an organisational change process all Psychological Therapists have been brought together into one team to enable deployment in a way that reduces variation.

- Additional funding has been secured to increase the recruitment of new Psychological Therapist posts in the Integrated Team.

- "Big Conversation" events have taken place across the Trust sites since June with our Executives taking the lead and sharing the details of the IIP with colleagues in order to have open discussions on how people can become more involved, sharing ideas on how improvements can be taken forward. The feedback from these conversations has been aligned to the five IIP programmes and will be addressed through the Phase 3 process.

Key challenges and risks

- Both male and female Length of Stay in Adult Mental Health are below the required target which is to be at mean of 39 days by the end of December 2024, a pilot will be in place over September and October to flex ward capacity to respond to male/female demand.

- The Crisis Line performance is currently off track however a short and medium term recovery plan is being progressed to improve this through a working group.

- Progress against reducing OOA beds is off target and reductions in private beds has plateaued, purposeful admission reviews were started in August via the Medical Optimal Care Leads with a target of 100% OOA patients to have transition plans in place and admission prevention actions are being worked up with the Crisis Team to support timely and appropriate access to beds.

Recent CQC inspection outcomes

Following the S48 review, the CQC notified the Trust that it would be adopting a different approach to inspecting Trust services. Rather than large, comprehensive inspections taking place over a defined period, the Commission will carry out smaller scale rolling inspections into Trust services focusing on one or two specific Quality Statements. A number of these inspections have taken place over the past few

months, with several outcomes published, and more in draft and awaiting finalisation. Of the published outcomes (full inspection reports not yet publicly available), the table below sets out the CQC findings:

CQC Domain	CAHMS In-patient 14/8	Mother and Baby Unit 13/8	Orion Learning Disability Unit 9/8	Adult Eating Disorder Unit 9/8	Rampton Hospital 17/6
Safe	Good	Good	Good* (Breach also identified re risk assessments following incidents which is being actioned)	Good	Inadequate
Effective	Requires Improvement	n/a	n/a	n/a	n/a
Caring	Good	n/a	Good	Good	Requires Improvement
Responsive	Good	n/a	n/a	n/a	n/a
Well-led	n/a	n/a	n/a	n/a	Requires Improvement

Whilst it is pleasing to see the progress particularly in the Quality Statement regarding Safe, the Trust is fully aware that there is much more to do and will continue to work with the CQC to make improvements.

Next Steps

- The IIP Programmes are in the process of transitioning to Phase 3 of the plan to look at tackling the underlying root causes by reviewing some fundamental issues such as:

    - Reviewing priority clinical pathways, working with patients and carers to understand how we can improve our clinical models and therefore patient experience;
    - How we recruit, train and support our staff to provide consistent levels of patient care and service;
    - Improving the clinical voice and listening to and working with patients in everything we do.

- A Patient and Carer Reference Group and a Colleague Reference Group are to be implemented to ensure the patient voice is at the centre of any improvement work going forward.

- “Big Conversation” events will continue to take place at Trust sites, led by the Executive Team and these will also be held for patients and carers.

- Staff Engagement events have been set up at various sites across the Trust to share what support services are in place for our staff.

Patient and Carer Reference Group

- A Patient and Carer Reference Group is being set up and the Trust is working with Healthwatch Nottingham/Nottinghamshire to take the group forward and embed the patient voice in every part of the IIP Programmes.

- The aim of this group is to give advice, ideas and insight on the Trust's plans, challenges and opportunities to improve the safety, quality and value for money of its services from a patient, carer and community perspective. It will also provide oversight with a check and challenge process on the progress of plans developed for the IIP to ensure they are based on what matters to patients and carers.

- This group will build on the feedback the Trust has received to carry out some rapid pathway redesign work with patients at the centre.

- Two initial co-production sessions have been held with patients, carers and voluntary sector and community groups – their feedback is being used to shape how we take this and the wider plan forward.

Colleague Reference Group

- A Colleague Reference Group has been set up with more than 25 staff members initially expressing an interest in being part of it. This group will work with colleagues across the Trust to help shape and design the improvements outlined in the IIP.

- The group will provide insight from a colleague point of view on the work the Trust is doing to improve the safety, quality and value for money of its services, identify areas of improvement that should be focussed on, advise how the Trust can strengthen the colleague voice in all its services and develop a culture of listening and co-production with colleagues.

- Colleagues will also be asked to identify specific areas or projects they can contribute to as part of the IIP.

Appendix 1
Safe Now Metrics:

Inpatient Care	
Code	**Metric**
1.1	Number of patients waiting for a bed
1.2	Number of patients in a 136 Suite Step Up for over 24 hours
1.3	Number of readmissions within 28 days
1.4	Wards with staffing under 85%
1.5	Wards with staffing over 125%
1.6	Patient risk assessments up to date (%)
1.7	Compliance with physical health assessment on admission process
1.8	Compliance with NEWS2 escalation policy
1.9	Number and proportion of NottsHC patients requiring enhanced observations (1:1 or greater)
1.10	Number and proportion of observations where no issues were found
1.11	IR1s submitted on falsified observations
1.12	Number of patients secluded
1.13	Episodes of seclusion
1.14	Compliance with seclusion Code of Practice (developmental)
1.15	Number of patients prone restrained for anything other than intramuscular tranquilisation
1.16	Number of patients prone restrained for more than 10 mins
1.17	Episodes of rapid tranquilisation
1.18	Number of incidents where patients went AWOL and come to harm
1.20	Number of total incidents of moderate harm and above
1.21	Number of patients clinically ready for discharge
1.22	Quality of discharge
1.23	Deaths within 30 days post discharge
Community Services (Local Mental Health Teams – LMHT, EIP & MHSOP CMHT)	
2.1	Compliance with 72 hour follow up standard
2.2	Compliance with 18 weeks wait standard for assessment
2.3	Compliance with Waiting Well Policy
2.4	Compliance with 18 weeks wait standard for treatment
2.5	Number of patients awaiting CCO allocation not on the active caseload of another NHT team
2.6	Disengaged patients
2.7	Patients declined for service and death within 6 months
2.8	Patient risk assessments up to date
2.8a	CCO patient risk assessments up to date (Community, developmental)
2.9	Clinical Vacancy Rate in Community Teams
AMH & MHSOP – Crisis & Home Treatment Team	
3.1	Clinical vacancy rate in Crisis Response Service
3.2	Patient risk assessments up to date
3.3	Proportion of very urgent patients seen within 4 hours
3.4	Proportion of very urgent patients see within 4 hours face to face
3.5	Proportion of urgent patients sees within 24 hours
3.6	Proportion of urgent patients seen within 24 hours face to face

Nottinghamshire County Council

Report to Health Scrutiny Committee

8 October 2024

Agenda Item: 5

ACHIEVING FINANCIAL SUSTAINABILITY IN THE NHS

Purpose of the Report

1. To consider a briefing paper from the Nottingham and Nottinghamshire Integrated Care Board (ICB) providing a summary of the financial position of the NHS in Nottingham and Nottinghamshire, and providing additional detail regarding a series of planned service changes and adjustments over the next two years to deliver financial sustainability.

Information

2. While overall NHS expenditure in Nottingham and |Nottinghamshire will increase in 2024-25, this comes against a backdrop of increasing national and local pressures on resources. These pressures, which include increased and more complex demand for services, inflationary pressures, increased staffing and the impact of industrial action, make it more difficult to deliver service priorities and requirements identified by NHS England within existing available resources.

3. The ICB has therefore drawn up a set of proposals designed to address patient need, best value and financial sustainability over the next two years. The proposed actions include rationalising and consolidating contracts in line with value-based commissioning principles, increased use of digital technology, more cost-efficient prescribing practices and a review of health and social care packages. It is anticipated these changes will deliver savings of £64 million over the two-year period of financial adjustment.

4. Lucy Dadge and Alex Ball attended the July meeting to brief members and answer questions. Following discussion, an update with additional detail around the key changes was requested.

RECOMMENDATION

Nottinghamshire Health Scrutiny Committee is asked to:

1) Note the contents of this report.

2) Indicate which proposed changes require further consideration.

3) Discuss how the Committee would like to receive further updates.

Councillor Roger Jackson
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Katherine Harclerode – 0115 854 6047

Background Papers

None

Electoral Division(s) and Member(s) Affected

All

NHS
Nottingham and Nottinghamshire

Achieving Financial Sustainability in the NHS

Briefing for Nottinghamshire Health Scrutiny Committee

October 2024

1. Introduction

In July 2024, Nottingham and Nottinghamshire Integrated Care Board (ICB) briefed the Nottinghamshire Health Scrutiny Committee on the current financial position of the NHS in Nottingham and Nottinghamshire and initial ICB plans to achieve financial stability over the next two years. The main goal is to make the best use of the NHS funding available to us, operating within the level of national funding that has been allocated.

We have increased levels of funding this year for our local NHS, but our cost pressures have also increased, meaning that we have a 6% savings requirement across our local NHS. We have an agreed £100m deficit with NHS England for 2024/25, so we still have a considerable planned overspend for this financial year. We have a regulatory requirement to be in a balanced financial position by the end of 2025/26, so our savings programme will be phased over a two year period.

We are committed to meeting our financial duties in a manner that minimises (but cannot entirely rule out) the need for front line service changes and maximises efficiency, productivity, strong financial governance and control. This initial phase of work is primarily focused on achieving best value for money in our services and comprises the majority of the schemes presented to the Committee to date.

Previously, a number of high-level scheme descriptors were shared to give the committee visibility of the scope of our work and for transparency purposes. This paper builds on previous discussions and provides more information about the nature and likely levels of impact for our population, benefiting from additional work done on the schemes over the summer. We will do as much as we can to improve value for money in our services, without materially changing the service offer and therefore most of the presented schemes are not considered to meet significant service change thresholds. We will continue to monitor overall impacts of efficiencies, with a view to enhancing and spreading best practice, as well as mitigating unforeseen negative impacts as far as possible within our available resources. This oversight will include the impact on organisations, or particular cohorts of our population.

Additional areas of focus are being explored with system partners to support our ambition to provide the best possible health and wellbeing for our communities, creating a health and care system that is fit for the future. These may be more transformative in nature than this first phase and may be areas that require longer-term work for engagement and potential consultation in the future. It is too early in our work to be able to predict this with a level of certainty.

The purpose of this paper, therefore, is to:

- Provide information on the nature and scale of likely impact in relation to the proposal descriptors that the Committee received in July.
- Indicate some further areas of focus for the ICB and system partners, about which we will bring more detail on in the future.
- Describe the process being used by Nottingham and Nottinghamshire ICB to assess the likely impacts of proposals on Nottinghamshire citizens.

2. Our approach

Our approach is focussed on working within our resources to minimise any negative impact on patients and therefore takes the following approach:

- Prioritising schemes that enhance efficiency and productivity, as well as reviewing contractual arrangements and value for money in the services that are currently provided.
- Maximising efficiencies in non-patient-facing areas and enhancing financial controls across the system.
- Ensuring compliance with existing NHS funding policies, particularly where thresholds are not being applied in line with policy. This may include clinical procedures or situations where clinical intervention has limited proven benefit. It may also include the application of eligibility criteria for NHS funding, in line with national funding frameworks for the NHS.
- Deferring some investments in services, so that we don't increase operating costs and can therefore protect existing services within affordable levels.
- Conclude pilot activities where clear benefits have not been demonstrated.

3. Assessing impact

There is an established process to assess the impact on quality and equality of our savings plans where services are proposed to be changed or ceased. In order to ensure consistency across all proposals we will complete an Equality and Quality Impact Assessment (EQIA) screening tool for all schemes to identify whether a full EQIA is required. It is acknowledged that proposals will have both positive and negative impacts, depending on individual circumstances, and these assessments will ensure that the impacts are understood and acknowledged in decision making. Consideration of these impacts supports our process for efficient decision-making (see process map at Appendix 1).

The ICB and other organisation must complete the tool for all proposals that are being considered as part of achieving financial sustainability across in the NHS in Nottingham and Nottinghamshire. Whilst the consideration of equity impact is a statutory duty the addition of quality and population health considerations give a far greater oversight of the impact of decision making. This risk matrix approach to determine impact also considers:

1. Whether there is alternative service provision.

2. Risks that may result in in unfair or unavoidable differences in health across different groups in society.
3. Risks that may result in poor or worsening health outcomes for individuals or populations.

Proposals that are identified as having a high or medium impact are reviewed at two internal ICB Panels:

1. EQIA Consultation Panel
2. EQIA Endorsement Panel

To date no decisions have been made through our process that demonstrate an overall negative impact on health, noting that most decisions have a variety of mixed impacts. We recognise that there is the potential for this to change and ICB Board members are currently considering how we develop a formal approach to such decisions.

We have also implemented a system review group so that the impacts of decision making are also considered collectively to ensure that interdependencies are identified and managed, and in particular to consider if any population group will be impacted by the collective changes made by NHS providers and commissioners. The ICB, along with Public Health colleagues from both Local Authorities, have supported the development of this approach, and the first meeting took place in August. This System Impact Panel does not take away from the statutory responsibilities of organisations to consider impact, but adds an addition lens to view the impacts of our collective decision making.

At this stage it is too early to provide any emerging themes or trends regarding the potential system-wide impact of NHS, local authority and wider proposals but we are committed to sharing these with the Committee in due course.

4. Update on proposals

In July 2024, a number of scheme descriptors were shared with the Committee, and they have been categorised into three groups to facilitate easier identification of areas where ongoing scrutiny may be most applicable. The categorisation of schemes has evolved since July 2024, benefiting from the additional work conducted over the summer.

a) Group 1

Group 1 includes proposals that do not affect Nottinghamshire citizens, including:

- Review of ICB corporate administration costs and estates.
- Those that may impact on Nottingham citizens only.

b) Group 2

Group 2 includes proposals that maintain existing services with minimal impacts on how people access care. A summary can be found in the table below:

Activity Type	Service Areas
Business As Usual Efficiencies This is routine ICB activity and tasks that is performed on a daily basis to maintain its standard functioning. It includes efficiency, productivity, and value for money improvements within services.	• Prescribing (e.g. switching from expensive branded medication to cheaper generic alternatives). • Savings on the administrative services provided to GPs by the ICB including IT updates, SMS software and training support. • Ending of pilot activity where the activity transitioned into regular operation.
Contract Consolidation and Administration This includes: Combining multiple smaller contracts into a single, larger contract to reduce administrative costs. Ongoing management and oversight of contracts. Review of contracts across service lines – enhancing value for money without changing services.	• Primary Care. • Planned Care including musculoskeletal and gynaecology referral pathways. • Mental Health to ensure spread of growth funding across hospital and community services and to ensure no duplication from prior year investments. • Urgent and emergency care, including Pathway 1 funding to be reviewed in line with historical activity, funding to be reduced where activity has under-delivered and ensuring all eligible patients included in provision (including non-weightbearing). • Independent Sector Providers. • Urgent Community Response (consolidate different service models to provide one consistent offer, reducing management and administrative overheads and duplication).
Deferred Investment This represents a savings opportunity to not provide additional investment or where funding has been received for activity not yet delivered. It is not a reduction in business as usual spend. The services that patients will be used to receiving will remain the same. Service Development Funding (SDF) is annual non-recurrent funding received by the ICB to support specific transformation areas.	• Community Diagnostic Centres. • Better Care Fund (review of growth application and existing funding to remove duplication in funding areas). • Prevention and long-term conditions. • Service Development Funding (SDF).

Adherence to Eligibility Policies Compliance with the existing ICB Value Based Commissioning Policy (including restricted procedures and eligibility criteria) and other policies which set out thresholds for receiving care. Patients will be able to access the care and treatment that they are eligible for, but not over and above those levels.	• Planned care. • Continuing Health Care (joint care package funding and eligibility reviews of health needs in joint packages and in line with national policy frameworks, NHS requirement to meet health needs and health tasks still met). Some individuals may have changes to their care packages and these will be assessed in relation to specific individual needs. Regular reviews of health needs and changes to care packages are business as usual and best practice. Financial processes regarding funding splits between the NHS and councils for jointly funded packages are being jointly developed through refining operational processes and financial mechanisms. The NHS funding element of joint packages is now based on individual health needs assessments rather than pre-determined % splits between the NHS and councils. This work is in parallel to ongoing assessment of health and care needs for individuals, which remains in line with national requirements.
Maximising National Income Ensuring national income is received for all applicable planned care procedures.	• Reporting of planned care activity to ensure we are paid for all services delivered.

c) Group 3

Group 3 includes proposals that may change services, and this is likely to require ongoing information and monitoring by the Committee.

In some circumstances, NHS commissioners pay providers for healthcare services determined locally rather than nationally. In Nottingham and Nottinghamshire, the arrangements in place are historic and may now be out of date or be duplicating services. It is proposed that a local price service review is undertaken.

When we have more details of proposals which will require statutory scrutiny by the Committee and may require public consultation then we will highlight those in the usual way.

5. Further areas of focus

Since July 2024, work has continued with system partners to identify further areas/services that can support the ICB to operate within the level of national funding that has been allocated. These include:

- Community crisis response services, developing an integrated community offer alongside Urgent Community response coordination and navigation services.
- Other Community services including hospice services, podiatry and dietetics and other service areas.
- Interpretation and Translation Services, in line with other NHS services.
- Informatics system support.

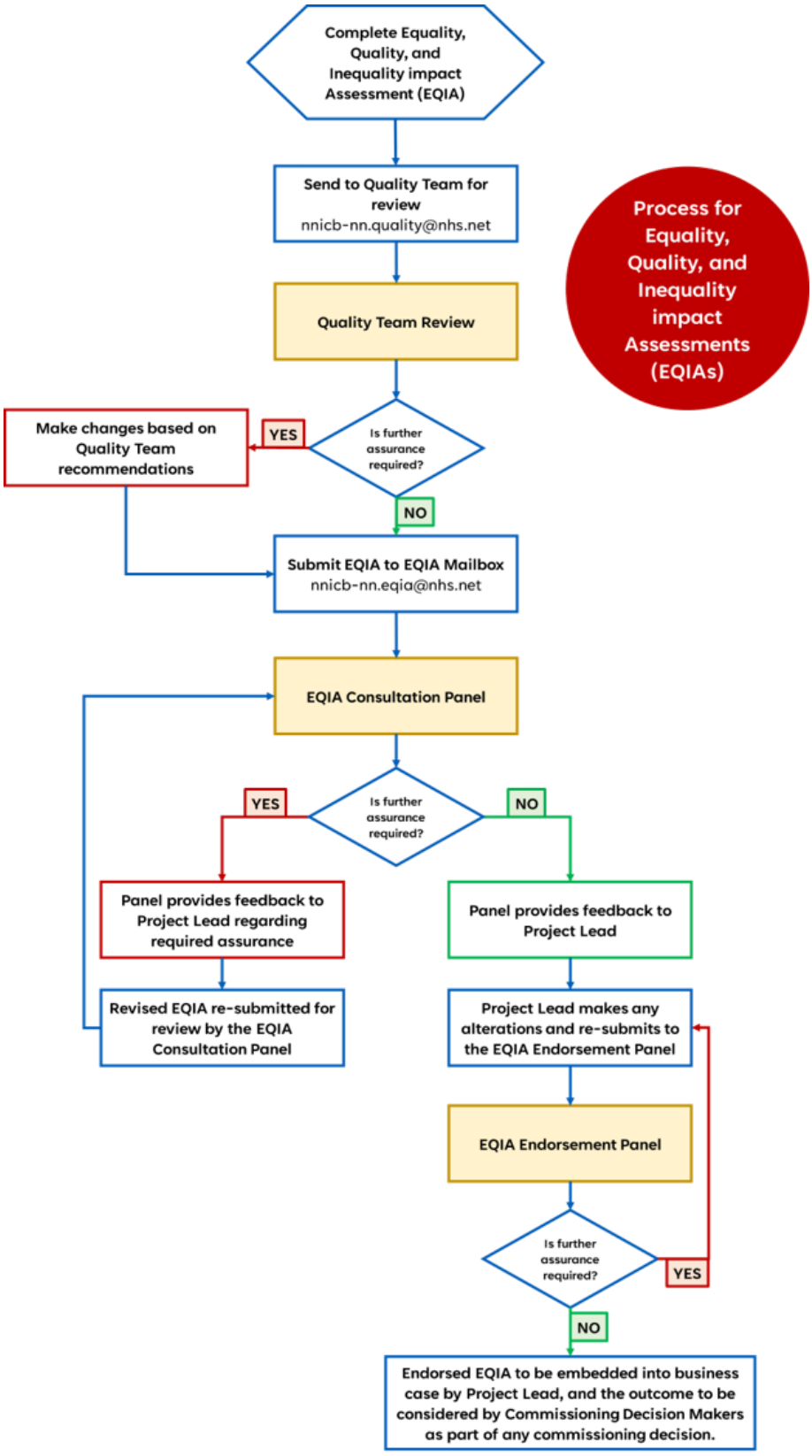
These services will be reviewed over the coming months and proposals brought forward for scrutiny as appropriate. Since our programme extends over two years, additional schemes will be identified and developed on an ongoing basis. NHS providers are also considering potential areas for service change and the ICB will work with them to undertake service reviews and impact assessments where appropriate and again will share with the committee for scrutiny and discussion at the appropriate time.

6. Recommendations

Nottinghamshire Health Scrutiny Committee is asked to:

- Note the contents of this report.
- Discuss how the Committee would like to receive further updates.

Appendix 1 – ICB process for EQIA



Nottinghamshire County Council

Report to Health Scrutiny Committee

8 October 2024

Agenda Item: 6

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 Council's adoption of the Leader and Cabinet/Executive system means that there is now an Overview and Scrutiny function, with Select Committees covering areas including Children and Young People and Adult Social Care and Public Health. While the statutory health scrutiny function sits outside the new Overview and Scrutiny structure, it is appropriate to keep this Committee's work programme under review in conjunction with those of the Select Committees. This is to ensure that we work in partnership with the wider scrutiny function, that work is not duplicated, and that we don't dedicate Committee time unduly to receiving updates on topics.

4. The latest work programme as available at the time of agenda publication is attached at Appendix 1 for the Committee's consideration. The work programme will continue to develop, responding to emerging health service changes and issues (such as substantial variations and developments of service), and these will be included as they arise.

5. The work programme has been revisited for 2024-25 to map out both outstanding and emerging issues for the Committee's consideration.

RECOMMENDATION

That the Health Scrutiny Committee:

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

Councillor Roger Jackson
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Katherine Harclerode – 0115 854 6047

Background Papers
Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2024/25

Subject Title	Brief Summary of agenda item	Format	External Contact/Organisation	Follow-up/Next Steps
16 July 2024				
NUH briefing – Update on Maternity Service provision.	Update on current performance in respect of delivery of maternity services by NUH		NUH	
Achieving Financial Sustainability in the NHS	Report outlining proposed actions to address ICB financial sustainability		ICB	
08 October 2024				
Nottinghamshire Healthcare Trust – Improvement Plan	To consider progress against the NHFT improvement plan		NHFT	
Achieving Financial Sustainability in the NHS - Update	Report providing additional detail regarding proposed actions to address ICB financial sustainability		ICB	
19 November 2024				
Mental Health in Bassetlaw and Update on A&E Village Development STC	To update the Committee on the development and delivery of mental health services in Bassetlaw		ICB	

Winter Plan 2024	To consider how learning from last winter has informed strategic approach to winter planning for 2024.		ICB	
07 January 2025				
Lung Health Pathways (non-Cancer) in Nottinghamshire	To consider non-cancer pathways as a follow up to the Targeted Lung Health programme item considered at the March 2024 meeting		ICB	
Achieving Financial Sustainability in the NHS	To consider the impact of proposed actions to address ICB financial sustainability		ICB	
11 February 2025				
Newark Urgent Treatment Centre - Update	To consider an update regarding opening hours implementation		ICB	
25 March 2025				
NUH Briefing – Update on Maternity Service provision	To consider an update on current performance in respect of delivery of maternity services by NUH		NUH	
01 July 2025				

To be scheduled and potential alternative actions				
Health and Wellbeing Provision in Hucknall – Cavell Centre	Pause in development of Cavell Centres at national level in June/July 2023		Holding position agreed at January 2024 meeting to consider when revised proposals from ICB/NHS England emerged	
Walk-in Centres				
NHS 111 Service	To consider performance data as requested at the January 2024 meeting		Briefing paper as requested at May 2024 meeting	
Enhanced Clinical Role for Pharmacies – Impact on Pharmacies and GP Services	To consider how the delivery of services by pharmacies which were formerly the preserve of GP practices has impacted both sectors		Integrated Care Board	
Sherwood Forest Hospitals Trust	To discuss any potential areas where scrutiny could add value		Sherwood Forest Hospitals Trust	