Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE
Tuesday 17 October 2023 at 10.30am

COUNCILLORS

Mrs. Sue Saddington (Chairman)
Bethan Eddy (Vice-Chairman)

Mike Adams
Sinead Anderson
Callum Bailey
Steve Carr **– Apologies**
David Martin
John 'Maggie' McGrath
Nigel Turner
Michelle Welsh
John Wilmott

OFFICERS

Noel McMenamin Health Scrutiny Lead
Kate Morris - Democratic Services Officer

ALSO IN ATTENDANCE

Alex Ball	-	Nottingham and Nottinghamshire ICB
Philip Britt	-	Nottingham University Hospitals
Sarah Collis	-	Nottingham and Nottinghamshire Healthwatch
Lucy Dadge	-	Nottingham and Nottinghamshire ICB
Rebecca Gray	-	Nottingham University Hospitals
Dr Gemma Malin	-	Nottingham University Hospitals
Anthony May	-	Nottingham University Hospitals
Michelle Rhodes	-	Nottingham University Hospitals
Mark Wightman	-	Nottingham and Nottinghamshire ICB

1 APOLOGIES FOR ABSENCE

Councillor Steve Carr – Other reasons

2 DECLARATIONS OF INTEREST

Councillor Mrs Saddington declared a personal interest in agenda item four (Nottingham University Hospitals NHS Trust - Care Quality Commission Inspection Report September 2023), in that a family member worked for Nottingham University Hospitals NHS Trust, which did not preclude her from speaking or voting.

Councillor Eddy declared a personal interest in agenda item four (Nottingham University Hospitals NHS Trust - Care Quality Commission Inspection Report September 2023), in that her husband was a Community Staff Nurse, which did not preclude her from speaking or voting.

Councillor McGrath declared a personal interest in agenda item four (Nottingham University Hospitals NHS Trust - Care Quality Commission Inspection Report September 2023) in that a family member worked for Nottingham University Hospitals NHS Trust, which did not preclude him from speaking or voting.

Councillor Michelle Welsh declared a personal interest in agenda item 4 (Nottingham University Hospitals NHS Trust - Care Quality Commission Inspection Report September 2023) in that her case was part of the current Ockenden Inquiry, and that she also worked with bereaved families, NHS England and the NUH on a regular basis.

3 MINUTES OF THE LAST MEETING HELD ON 12 SEPTEMBER 2023

The minutes of the last meeting held on 12 September 2023, having been circulated to all members, were taken as read and signed by the Chairman.

4 NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST - CARE QUALTY COMMISSION INSPECTION REPORT SEPTEMBER 2023

The Chairman advised the Committee that she had been made aware that morning of a letter sent from the Nottingham Maternity Families group for the attention of Committee members. The letter had been circulated to Committee members in advance of the meeting for them to read.

While it was not considered appropriate to read it out in the meeting because of the ongoing Ockenden Inquiry, the Chairman gave an assurance to families that the Committee would continue to hold Nottingham University Hospitals NHS Trust to account for current maternity services performance while that service was arated as 'requiring improvement'. She also indicated that once permission had been gained from the families the letter would be shared with the Trust.

Anthony May, Chief Executive of Nottingham University Hospital Trust introduced the report to the Committee detailing the outcomes of the 'Well Led' and 'Maternity Services' inspections conducted by the Care Quality Commission (CQC) published in September 2023. Michelle Rhodes, Chief Nurse, Dr Gemma Malin, Consultant Obstetrician and Head of Service and Rebecca Gray, Head of Midwifery attended to provide additional information. The CQC report covered the following areas:

- he Maternity Services inspection was unannounced and took place in April 2023, while that for 'Well Led' was pre-announced and took place over 2 days in June 2023. .

- Both inspections saw the overall ratings of the services improve from 'Inadequate' to 'Requires Improvement'. Whilst the Trust was pleased that there had been improvement, they acknowledged that there was still a substantial amount of work to do to move services into the Good and Outstanding ratings . Discussions were under way in respect of the level of ongoing intervention required for the Trust.

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Maternity Services Inspection

- Across both sites (Queens Medical Centre (QMC) and Nottingham City Hospital) the CQC found improved levels of nursing or midwifery staff, that compliance with mandatory training had increased, women felt listened to and staff reported feeling proud and positive of their work.

- Improvements had also been made to the Cardiotocography monitoring and documenting, and work to separate the Triage Unit and Day Assessment unit had created a specific emergency care in pregnancy service. 96% of all pregnant people arriving at the Triage unit were seen within 15 minutes.

- Identified 'Must Do' actions for further improvement includedappropriate storage of breast milk, storage and administration of medication, and ensuring that effective risk and governance systems were in place.

- specific actions required at the QMC site included ensuring call bell systems were in proper working order, proper use of disposable curtains, and ensuring that risk assessments were carried out to keep women and babies safe from domestic violence.

- It was confirmed that work had taken place since the inspection to address all of the areas of deficiency highlighted in the inspection.

Well Led Inspection

- Following the inspection in June 2023 the Trusts rating had improved from Inadequate to Required Improvement. The inspection team had met with range of staff and senior leaders throughout the inspection process through face to face and online focus groups and interviews.

- The CQC had noted a number of improvements, including strengthened leadership capacity and capability, greater collective decision making and shared understanding and responsibility of key challenges, a credible strategy in the "People First" Plan, improving culture with the majority of staff reporting that they felt supported valued and respected, and improvements in governance at different levels of the Trust.

- People who used the services, partners and staff had felt engaged in shaping and improving services and culture.

- Areas of work identified for further improvement included developing of consistency in applying duty of candour and improvements in identifying risk issues, ensuring also that mitigations are embedded across the Trust.

In the discussion that followed, a number of issues were raised and points made:

- Members asked what, if any improvements around recruitment and retention had been made, both across the Trust and specifically in Maternity Services.

- How many serious incidents had been reported in the last 6 months.

- Members asked what steps would be taken to improve Pharmacy services, and in particular to address staffing and better access to Pharmacy Services.

- Members asked for more detail about the following points made in the CQC report:
    - Outcomes for women and babies remained mixed and did not always meet national standards.
    - Electrical equipment with expired electrical testing dates
    - The Service did not always have enough staff with the right skills and experience to keep women and babies safe.

- Would the Trust consider making a public statement about their commitment to their duty of candour?

- Members praised Trust staff for their hard work and the improvements that were starting to be made and asked how the improvements were being communicated back to staff. However they also expressed concern around the length of time it was taking for more significant progress and improvements to be made.

- The report highlighted that although improvements had been made around culture there were still some instances of staff not feeling able to raise concerns without fear of retribution. Members asked how this was being tackled to ensure all staff felt able to speak up.

- Members queried what was being done to tackle waste and maximise productivity within the Trust to make best use of the budget available.

- The CQC report highlighted that further improvements needed to be made around ensuring there was an effective risk and governance system in place that supported safe quality care for all areas in the service, and mitigated risks when identified. Members asked what the Trust had done to address this and how that work could be accelerated.

- Members asked about completion rates for mandatory training and what was being done to improve those figures.

In response to the points raised the following responses were provided:

- A Matron responsible for recruitment and retention had been appointed, since which there had been a marked reduction in staff turnover. Work had been undertaken and more was planned around Flexible working patterns and

ownership of rota-ing had been devolved to individual teams, which had led to a reduction in staff absence. Additional midwives had been recruited and work was being undertaken to ensure more student midwives stayed within the Trust after qualification.

- Since the Committee's previous discussion in February 2023 the large backlog of serious incident reviews reported at that time had been worked through and closed. Within the last 6 months there had been 9 Serious Incident declared, including those automatically reported.

- Outcome data was monitored regularly and division leads were working with an analyst to regularly benchmark against national standards. A new Matron with responsibility for engagement and experience had been recruited to ensure efforts are made to gain feedback from patients of all backgrounds, but in particular from BAME and hard-to-reach communities.

- NUH representatives undertook to provide details of the equipment reported to have had expired electrical testing.

- It was acknowledged that the national shortage of senior doctors impacted service delivery at the Trust. However the Trust mitigated this by reviewing rotas on a regular basis and where necessary prioritising the labour and delivery suites in the event of sickness or staff absence.

- The Trust had been working with a number of other Trusts that had been through similar journey of improvement and those that were considered examples of best practice. Trust executives were due to meet with the Trust Chair and would discuss a public statement around duty of candour.

- A rotational pattern of working was due to be introduced to maternity services to ensure that all staff had the skills and confidence to work in all areas. This would not only ensure flexibility in the workforce but would help staff to feel more empowered and confident in the workplace.

- The further development of the Risk Framework was a key piece of work in the improvement plan for Maternity Services. The Risk Oversight Committee had worked hard to ensure that specialist in risk and risk mitigation were in place and had a sound understanding of the framework. Specialist investigators had been appointed for in depth investigation work to ensure that timely and professional investigations took place.

- Mandatory training numbers were increasing within maternity services thanks to an increase in training budget capacity, which had helped release midwives from day-to-day duties and help them complete mandatory training.

- Significant investment in had led to a reduction in time between recruitment and someone starting in position, an increase in first time recruitment, a significant decrease in drop-out rates from the recruitment process, reduced vacancy rates and reduced use of agency staff. Shift patterns across the Trust were flexible and were not limited to 12 hours. Job share opportunities were

available across the Trust and spaces for Trainee Nurses were filled to capacity.

- The Trust acknowledged that the Pharmacy Service was under significant pressure, a situation which reflected national capacity issues. The Chief Pharmacist was creating a development plan for the Pharmacy services to . address the Service's facilities and accommodation and, assets, in order to deliver improved working conditions.. This workstream had been elevated for executive scrutiny within the Trust. The recent introduction of the electronic prescribing platform had gone some way to improve response times.

- Staff at all levels of the Trust had worked hard to make improvements across all services. The improvement journey well underway but it was acknowledged that there was much more to do. Any changes to current CQC ratings would be dependent on the inspection timetable.

- A new Director of Communication had been appointed and was working hard to ensure both internal and external communication was improved. Online staff focus events had seen significant increase in attendees.

- NUH representatives acknowledged that culture change was key to the long term improvement of the Trust, and work that towards that change had started well. Significant work was underway around leadership development for managers throughout the Trust with a focus on approaching difficult conversations, addressing reports of harassment and bullying and encouraging staff to speak up.

- A network of Freedom to Speak Up Guardians, who were able to access the more difficult services and speak to staff directly with full confidentiality had been established. These Guardians met directly with the Trust Executives and staff confidence levels in the service they offer were increasing.

- Budgets remained challenging nationally for Trusts and it was no different for NUH Trust. A financial recovery plan had been developed in partnership with the ICB, and had been implemented to tackle the current deficit. Programmes to reduce waste were in development and staff were being encouraged to highlight efficiencies where they saw the potential to reduce spend. Work to reduce duplication had been implemented, and local and national initiatives were in place to reduce demand on hospital services.

- The developing work around Risk and Risk mitigation in the Maternity services was being rolled out across the Trust. The newly appointed Director of Corporate Governance was overseeing the Trust-wide risk work to ensure that clinical and corporate risk teams worked more closely.

The Chairman, Committee members and NUH representatives paid tribute to the families affected by this issue, acknowledging that despite their pain and grief they continued to work tirelessly to hold the Trust to account.

The Chairman thanked Anthony May, Michelle Rhodes, Dr Gemma Malin, and Rebecca Gray for their attendance and for answering the. She acknowledged that improvement had been made, and thanked NUH staff for their efforts, but urged them to keep a tight grip on the improvement and to accelerate improvement delivery where possible.

RESOLVED 2023/18

That

(1) The report and the Committee's comments on it be noted;

(2) NUH representatives provide additional information requested by the Chairman of the Committee in respect of serious incidents, the equipment with expired PAT safety certification and the schedule for future Care Quality Commission inspections, when known;

(3) The Committee's ongoing commitment to scrutinise current maternity services performance while the service was rated as requiring improvement be confirmed.

The meeting was adjourned at 12:25 for a short comfort break and reconvened at 12:40

5 TOMORROW'S NUH – PROPOSAL TO CONSULT

Alex Ball Director of Communications and Engagement, ICB introduced the report updating the Committee on the next steps in the Tomorrow's NUH programme. Along with Lucy Dadge, Director of Integration, Integrated Care Board, Mark Wightman, Director Strategy and Reconfiguration, ICB and Philip Britt, Programme Director Tomorrows NUH, NUH Trust he gave a presentation, summarised below:

- In 2019 NHS England announced a programme of investment in new hospital builds, and NUH was one of the selected Trusts to benefit. Over the last 3 years the Trust has worked with the ICB to draw up plans and detailed business cases to ensure proposals were deliverable, affordable and met the needs of the population, both short and long term.

- Following the identification of reinforced autoclaved aerated concrete (RAAC) at a number of the trusts outside Nottinghamshire that were also selected for the scheme and required urgent remedial work, NUH had been moved down the priority list. However, completion of the scheme was still scheduled for 2030.

- Very recently Nottingham University had signalled that it was considering withdrawing the medical school from the buildings sited at the QMC campus. This was still undecided and could lead to alternative opportunities becoming available.

- The broad proposals for investment included the development of a specialised Women's and Childrens hospital, consolidation of emergency care at the QMC site, the development of a Centre of Excellence for elective care at the City Hospital site and enhanced cancer care at both QMC and City sites.

- NHS England had approved the pre-business case and signalled that public consultation could begin. Preliminary public engagement had taken place, and showed an 80% approval rate for the proposed plans. More detailed and extensive public consultation now needed to take place and would be specifically tailored to target groups.

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

- Members were supportive of the idea of a women's and children's hospital and asked that specific consideration should be given to how services for maternity, and for female fertility could be housed in the same building sensitively without impacting patient sensitivities.

- Members noted that specific consultation with communities for whom the City Hospital was seen as the 'go to' location for giving birth should be an area of focus for the consultation.

- Members asked how the ICB would ensure different groups would hear about proposals and have the opportunity to comment

- Given the recent announcement by the University that they were considering moving medical school facilities away from the QMC campus members asked what impact that might have on the financial plans for the proposals

In the response to the points raised the following responses were provided:

- Consultation would ensure that patients were protected and have equitable access to services. There would be extensive work to ensure services and choice were offered patients and the ICB continued promote the Women's Health Strategy.

- Part of the consultation would involve looking at transport links and infrastructure. No new sites were proposed within the business case, but travel to existing sites for residents across Nottingham City and County was an important part of the plans.

- The Consultation was planned to be online, paper based, and in person. Engagement events would take place with translators and interpreters where appropriate, and paper-based information was due to be translated into the top 5 languages in the County. There would also be feedback to the public to demonstrate how their input was being used.

- The University owned both the land and the buildings that the medical school was currently housed in. There would be no impact on revenue from rent reduction so no impact financially on the proposals.

The Chairman thanked the Director of Communications and Engagement, ICB the, Director of Integration, ICB, the Director - Strategy and Reconfiguration, ICB, and the Programme Director Tomorrows NUH, NUH Trust for attending and answering questions put to them by the Committee.

RESOLVED 2023/19

That the Committee:

1) Considered and commented on the report and Appendix;

2) Approved in principle proceeding to Public Consultation, with a view to concluding the exercise before the end of March 2024;

3) Noted that significant elements of the proposed clinical service configuration were fixed;

4) Noted that new estate opportunities detailed at Appendix were not considered to be material by NUH , and would not impact on the proposed clinical model by the time of implementation

6 WORK PROGRAMME

The Committee considered its Work Programme.

RESOLVED 2023/20

That the Work Programme be noted.

The meeting closed at 1:17pm

CHAIRMAN