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