Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 21 February 2023 at 10:30

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

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Noel McMenamin (Tel. 0115 993 2670) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE
Tuesday 10 January 2023 at 10.30am

COUNCILLORS

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

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

SUBSTITUTE MEMBERS

Councillor Mike Pringle for Councillor John 'Maggie' McGrath
Councillor Francis Purdue-Horan for Councillor David Martin

Officers

Martin Elliott - Senior Scrutiny Officer
Noel McMenamin - Democratic Services Officer

Also in attendance

David Ainsworth	-	Sherwood Forest Hospitals NHS Trust
Lucy Dadge	-	Nottingham and Nottinghamshire ICB
Robert Simcox	-	Sherwood Forest Hospitals NHS Trust

1 MINUTES OF THE LAST MEETING HELD ON 15 NOVEMBER 2022

The minutes of the last meeting held on 15 November 2022, having been circulated to all members, were taken as read and signed by the Chairman.

2 APOLOGIES FOR ABSENCE

Councillor David Martin (other council business)
Councillor John 'Maggie' McGrath (other reasons)
Councillor John Willmott (other council business)

Apologies for absence were also received from Sarah Collis of Nottingham and Nottinghamshire Healthwatch.

3 DECLARATIONS OF INTEREST

Councillor Mrs Saddington declared a personal interest in agenda item 4 “Newark Hospital - Expansion of Elective Capacity” 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 4 “Newark Hospital - Expansion of Elective Capacity”, in that her husband was a Community Staff Nurse who had previously worked for Sherwood Forest Hospitals NHS Trust, which did not preclude her from speaking or voting.

4 NEWARK HOSPITAL - EXPANSION OF ELECTIVE CAPACITY

Lucy Dadge, Director Integration at Nottingham and Nottinghamshire ICB and David Ainsworth, Director of Strategy and Partnerships and Robert Simcox, Deputy Director of People of Sherwood Forest Hospitals NHS Foundation Trust attended the meeting to present a report that sought approval for the expansion of elective day-case activity at Newark Hospital.

The report stated that an opportunity had arisen for Sherwood Forest Hospitals NHS Foundation Trust (SFHT) to utilise additional capital investment to expand elective day-case activity at the Newark Hospital site through the construction of a modular theatre and recovery area. It was noted that the expansion of elective capacity at Newark Hospital would support the delivery of significant reductions in elective backlogs in specialities such as Elective Orthopaedics, Urology and Ophthalmology. In introducing the report Lucy Dadge advised that the expansion of capacity would help reduce waiting times, improve the patient experience as well as assisting in the management of future demand.

Lucy Dadge advised that developing the Newark Hospital site would also enable the provision of access to additional services locally for Newark residents and would also help to address health inequalities for those patients. Lucy Dadge further advised that an additional benefit of securing additional elective capacity away from the main hospital site avoided the potential impact on patients of cancelled procedures due to urgent care demand. It was noted that other patients from across the SFHT areas who were facing long waiting times for procedures could also be offered care at Newark Hospital.

In order to progress the proposals during 2023 Lucy Dadge advised that SFHT had secured access to £5.6million of NHS capital funds to provide an additional modular Laminar Flow Theatre (to treat orthopaedic cases) and related recovery area, two ‘Minor Operations’ suites to increase capacity as well as additional capacity that would enable more procedures to be carried out in the outpatient treatment area.

A full briefing note on the proposals was attached as an appendix to the Chairman's report.

The Chairman welcomed the proposals for the expansion of capacity at Newark Hospital, noting that increased service provision at the site had been an area of focus for the Health Scrutiny Committee for some considerable time. The Chairman noted how beneficial this expansion of capacity would be for Newark residents who may have found travelling to Kings Mill Hospital difficult as well as how the expansion would also benefit patients across the wider area covered by the SFHT. The Chairman asked if there were any plans for an MRI Scanner to be provided at Newark Hospital. David Ainsworth stated that there was currently a CT Scanner at Newark and that plans being prepared to make a bid for additional funding for an MRI Scanner also noting the benefits that this would provide for patients.

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

- That the plans to expand elective provision at Newark Hospital were to be welcomed.

- Whether there planned expansion at Newark Hospital would also include paediatric services.

- Whether the current backlogs in the provision of non-urgent services were just the result of the impact of the Covid-19 pandemic or whether longer term pressures on health services were also being felt.

- How confident were the ICB and the SFHT that they would be able to recruit to the new positions that would be needed to deliver the expansion at Newark Hospital?

- How many vacancies were there currently across health services in Nottinghamshire?

- When would patients across the SFHT area start to see the benefits of the expanded provision?

In response to the points raised, Lucy Dadge, David Ainsworth and Robert Simcox advised:

- That the current proposed expansion of elective services at Newark would not include paediatric services.

- That before the pandemic the health service in Nottinghamshire had had a good reputation for managing and providing timely elective services and in meeting targets for their provision. It was also noted that whilst increased demand for emergency care did create additional pressures around the provision of elective procedures that the current situation with elective backlogs was directly related to the impact of the pandemic.

- That 13 FTE positions would be needed to deliver the expanded capacity at Newark Hospital. SFHT colleagues were confident that these posts would be filled due to recent a recent proactive recruitment exercise that had led to 20 roles being successful filled. It was also noted that the opportunity would be provided to staff to work across SFHT sites would also make the new roles more appealing to potential applicants. Lucy Dadge also noted that SFHT's excellent reputation also made roles with the Trust attractive to potential applicants.

- There was a current vacancy rate across SFHT of 7% (around 350 vacancies). Members were advised that information around the number of vacancies across the Nottingham Universities Hospital Trust could be circulated outside of the meeting.

- That the practice of enabling staff to work across a range of sites and roles had the potential to reduce staff turnover as it made roles more varied for staff.

- That as the required investment had already been secured, the new services at Newark Hospital would hopefully be operational by April 2023. It was reaffirmed that the proposed services that would be provided at Newark Hospital would be to provide additional capacity across the SFHT area that would also be of benefit to all patients in the area. It was noted that the expansion of elective capacity would be of particular benefit to patients in the more deprived areas in and around Newark and would also increase patient choice and access across the entire SFHT area.

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

- Whether there would be sufficient parking at Newark Hospital to cope with the increased number of patients accessing services at Newark Hospital. Members noted their concern at the cost of parking at the hospital and the impact of this on patients accessing services. Members noted that improved public transport links to healthcare sites would be beneficial for patient access to healthcare.

- When it would be known if the bids for increased diagnostic equipment across the SFHT had been successful. Members noted that it would be beneficial to patients if a permanent MRI scanner could be provided at Newark Hospital. Members asked what role that they could play in supporting activity to obtain an MRI scanner for Newark Hospital.

- Members welcomed the focus on proactive recruitment activity but noted that the rotation of roles for staff was not always successful in reducing staff turnover.

- What was the current status of waiting lists for elective procedures across Nottinghamshire?

- That the additional funding for expanded service provision at Newark Hospital was to be welcomed. It was noted that hopefully at a time in the future service provision at Newark Hospital could be further expanded in order to provide A&E services that would benefit residents of Newark and surrounding areas.

In response to the points raised, Lucy Dadge, David Ainsworth and Robert Simcox advised:

- Newark Hospital currently had good parking provision. This would be further enhanced by the addition of approximately 80 spaces that would be available for staff and patients to support the increased demand created by the expansion of services provided at Newark Hospital.

- The outcome of bids for funding for diagnostic equipment would be known in approximately six-months' time.

- There was currently a portable MRI scanner at Newark Hospital and patients from Newark could also access other diagnostic services at other SFHT sites. It was noted that it was an ambition to get a permanent MRI scanner at Newark Hospital given the importance of having good patient access to diagnostic services. Lucy Dadge advised that any future bid to fund an MRI scanner at Newark Hospital would benefit from the endorsement of the Health Scrutiny Committee.

- Waiting lists for elective procedures were actively managed and were reviewed daily. Waiting list management was based on patient need in order to deliver as many procedures as possible.

The Chairman thanked Lucy Dadge, David Ainsworth and Robert Simcox for attending the meeting and answering member's questions.

RESOLVED 2023/1

1) That the proposal to utilise new capital investment to expand elective day-case activity at the Newark Hospital site through the construction of a modular theatre and recovery area, be approved.

2) That the proposal to start a public and patient information publicity campaign from early January 2023, be endorsed.

5 WORK PROGRAMME

The Committee considered its Work Programme for 2022/23.

RESOLVED 2023/2

1) That the Work Programme be noted.

2) That the following items be considered at the 21 February meeting of the Health Scrutiny Committee:

    - NUH Chief Executive - Welcome and Introduction
    - Maternity Services – Current Performance Update
    - Health and Care System Winter Planning 2022-23 Update.

3) That the following items be considered at the 28 March meeting of the Health Scrutiny Committee:

    - NHS Dentistry Services, with a focus on access to services
    - Community Diagnostic Centres
    - Diabetes Services Update.

4) That the Democratic Services Officer liaises with the Chairman of the Health Scrutiny Committee and the Nottingham and Nottinghamshire Integrated Care Board to establish if an additional meeting of the Health Scrutiny Committee can be convened in advance of the next scheduled meeting to consider the issue of Access to GP Services.

5) That the Democratic Services Officer liaises with the senior officers and the Senior Scrutiny Officer to establish the most appropriate way for scrutiny to be carried out on the delivery of the provision of Health Visiting for 0–3-year-olds that is part wider Healthy Families Programme.

The meeting closed at 12:15pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

21 February 2023

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NUH CHIEF EXECUTIVE – INTRODUCTION, PRIORITIES AND CHALLENGES

Purpose of the Report

1. To welcome Anthony May, the Nottingham University Hospitals NHS Trust (NUH) Chief Executive, to the Committee for the first time, and to receive a briefing from him on the key priorities for the organisation, and his vision for how they will be delivered.

Information

2. Anthony May became NUH Chief Executive in September 2022 at a time when the organisation and the wider health and social care sector has faced a series of severe pressures and challenges. Several critical incidents have been declared as a result of exceptional pressure on staff and services, maternity services remain rated as inadequate by the Care Quality Commission, and there has been unprecedented industrial action within the health sector. At the same time, plans for the long-term future of service provision at both the Queen's Medical Centre and City Hospital are being progressed under the Tomorrow's NUH Programme.

3. A written briefing from the Chief Executive is attached to this report as Appendix1. In it, Mr May describes his experience since taking up the post of Chief Executive and identifies three overarching areas of focus in order to drive improvement – these are emergency care flow, recruitment and retention and leadership.

4. Members are requested to consider and comment on the information provided and identify requirements for information for future consideration. As maternity services and winter planning are the subject of separate reports elsewhere on this agenda, members are requested to comment on these areas when those reports are being considered.

RECOMMENDATIONS

That the Health Scrutiny Committee:

1) consider and comment on the information provided; and

2) determine whether any further information was required for the Committee's consideration.

Councillor Sue Saddington
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Noel McMenamin – 0115 993 2670

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

NHS
Nottingham
University Hospitals
NHS Trust

People First

Reflection on a 100 day journey and looking towards the next 1,000 days

Anthony May, Chief Executive

February 2023

Contents

Foreword

This report collects my experiences since taking up post on 1 September 2022. Before I joined Nottingham University Hospitals NHS Trust (NUH), I worked in the local health and social care system for 18 years. While that gave me some experience and insight into the challenges and opportunities at NUH, it is not possible to know an organisation until you live and breathe it. That is why I embarked on my 100-day plan – to immerse myself into NUH, to get to know the people who work and volunteer at the Trust, and to see NUH from the perspective of our patients and partners.

Critically, I wanted to answer the question 'what will it take for NUH to achieve its potential and to recover, after the most turbulent period in its history?'.

In this report, I try to answer that question. Although I accept my interpretation will be open to critique from those who know NUH better, I have built a strong evidence base for my findings. I have met over 2,500 colleagues at NUH. I have engaged with our Integrated Care System (ICS) at every opportunity. I have taken soundings from stakeholders from outside health and social care. I have listened to feedback from colleagues in NUH, some of which has been inspirational, and some of which has been stark. I have tried to understand what it is like to receive care at NUH, what it is like to work at NUH, and what it like to be a partner of NUH. The title of this report reflects the fact that NUH depends on people; those who come through the doors every day for their care, those who work and volunteer at our three sites, and those who work for our partners. For that reason, the report is called People First.

Early in my tenure, I gave interviews to the media. During one of these interviews, I was asked for my initial views about NUH. My reply was to say that **NUH is full of remarkable people doing amazing things every day**. In saying that, I was reflecting on the examples of excellent care I had seen, coupled with a deep level of compassion, dedication, and commitment to deliver the best care possible. NUH does so many things so well, it is humbling to be part of it. Many colleagues talk of their pride at being an employee of NUH, despite the challenges.

While my response to the question from the media is sincere and true, it does not tell the whole story. Despite the best efforts of the many thousands of colleagues at NUH and of our partners, patients often wait too long for their care, they are sometimes treated in unsuitable conditions, and a combination of these and many other factors can affect outcomes. Added to that, many colleagues report feelings of fatigue and of not being able to reach their professional standards. They find this debilitating and stressful. It is an unfortunate truth that some colleagues report experiences that do not fit with the values of a modern NHS organisation. I have received reports of bullying, harassment and discrimination. This behaviour must stop.

These circumstances are not unique to NUH, but that does not matter. For our local communities, for our hard working staff and volunteers and for our partners, we must strive to deliver our services to a consistently high standard. We must play our part in delivering the objectives of the NHS, and of our local system. We must seek to understand the factors which drive the health and social care sector. We must devise a plan which tackles our problems, and which optimises opportunities. Those of us in senior positions have a responsibility to lead decisively but with new levels of compassion, inclusion and understanding.

Since joining NUH, the following issues have come up most often:

- Emergency care and its impact on delays and waiting times (flow)
- Recruitment and retention
- Culture and leadership

This report sets out a roadmap for NUH, and a framework through which these issues can be tackled. If we do so, the many excellent services at NUH can thrive, and we will take advantage of opportunities.

While it is important that we tackle these three predominant issues, the single biggest factor to our success is to recruit and retain a well-led and highly motivated workforce. This must be coupled with the engagement of our patients and a renewed commitment to working with our partners. It is people that matter at NUH and across our system, and we must put people first.

Anthony May - CEO

Executive Summary

The ability to focus on and prioritise the things that matter most to our patients, partners and communities is a key strategic capability. As an organisation, NUH struggles to prioritise at times because prioritisation means making choices between competing and equally essential health care services. Agreement on a clearly defined set of priorities will ensure we arrive at fair, transparent and timely decision making which supports the achievements of our most important strategic goals, meet the expectations of our patients and partners and provide confidence to our regulators in our ability to address the challenges we face.

For any organisation to succeed, it must be clear about its purpose. At NUH, a combination of complex internal and external pressures mean that colleagues and stakeholders are no longer clear about our core purpose. Following the pandemic, this may be true for many organisations, but it is particularly the case at NUH, where we face unprecedented pressures and are subject to intense public and regulatory scrutiny.

In fact, NUH has several purposes, and we serve many different communities and stakeholders. For example, for some local people, NUH is their local hospital. For others, it is an important regional national centre, offering highly specialised and complex services, some of which are world leading. In other instances, NUH is the provider of health and care education, training the clinicians of the future. Sometimes, NUH explores new frontiers of clinical research and innovation.

For us to succeed across all these domains, this report argues we must focus on emergency care flow, recruitment and retention, and leadership and culture. These three barriers are constraining many, if not all, of the services and functions at NUH. To focus on these three areas effectively, they must be accepted universally as our top priorities. We must take a strategic approach to key interventions which, if led and managed properly, will make NUH a better place to receive care, a better place to work and a better partner. The change which is necessary must be delivered consistently and transparently, engaging all staff and partners in an inclusive, bottom-up way. In essence, this report makes three key recommendations:

1. To accept that improving emergency care flow (and its consequent impact on all our waiting times), recruitment and retention, and leadership and culture are the top priorities for NUH

This might seem obvious, but if we are to remove these barriers, it is important to name them and to commit to their resolution. Like many complex organisations, NUH suffers from having multiple priorities. While that is understandable and can be acceptable when an organisation is at the top of its game, it is not helpful when an organisation is struggling. Naming and owning these barriers as our top priorities to address, across NUH and with our stakeholders, is the first step to addressing them.

2. To develop and deliver a series of interlocking strategies designed to achieve our three top priorities

The report recommends a series of interlocking clinically led and enabling strategies, which are designed to help us work towards achieving our three priorities. Crucially, there are three clinically led strategies, which will engage our invaluable clinical excellence and experience. Currently, clinicians report feelings of detachment from decision making and the Care Quality Commission (CQC) found too great a distance between the 'ward and the Board'. The best health and care organisations are clinically led and NUH will benefit greatly from harnessing the power of our clinical body. A by-product of this approach will be to secure better engagement from all clinical groups, some of which report feeling undervalued and underused. Similarly, this approach will help determine the future models of clinical leadership, which will help secure better recruitment and retention, across the board.

The clinical strategies will be complemented by enabling strategies. It is true that many of these exist in one form or another, but they are not consistent in their style or level of maturity, and many colleagues report a lack of understanding or awareness of how strategies are formulated, or how decisions are made. If led and managed properly, these strategies will set our short and medium term direction and provide a framework for decision making and resource allocation. Importantly, these strategies will help us to tackle crucial issues such as recruitment and retention, inclusion, patient safety, estates, net zero carbon, digital development and financial planning. They are necessary to take us back to the basics of running a large, complex organisation in a planned and purposeful way.

People First

While all these strategies are important, the development of a Trust-wide inclusion strategy is also vital to the future of NUH. The Trust has been publicly criticised for its approach to equality, diversity and inclusion and there is evidence that problems persist. Since the 2021 CQC inspection, much has been done to tackle this unfair and unacceptable problem – but there is much more to do. The development of an inclusion policy will be led by a dedicated Sub Committee of the Trust Board, to ensure maximum transparency and engagement.

It is easy, in a report such as this, to consider issues in the mid to long term. While the sustainable success of NUH depends on careful planning and a careful consideration of evidence and circumstances, there are compelling reasons to act now. We face mounting pressure across many fronts and some of these are urgent. For this reason, each of the strategies, regardless of their maturity, comes with some actions for 2023.

3. The adoption of a Trust-wide system to lead change and development in an inclusive and transparent way, and which encourages a bottom-up approach to ideas for innovation, efficiency, and effectiveness

The best organisations have a consistent methodology and approach to change and transformation. At NUH, our approach to change is sometimes excellent but too often inconsistent and dependent on the goodwill and ingenuity of individuals. Change is supported in a fragmented way and there is insufficient coordination of activity and pooling of resources.

This report recommends a consistent approach to change, which uses the same methodology and tools across the organisation, and which is supported through a single point of control and resources. To be successful, we must take a rational approach to change to encourage ideas from all parts of the organisation. There are several examples of such approaches and which we chose to use will be based on circumstances and best fit. What is important, is to choose a model urgently and implement it quickly.

This report cannot stand alone. It is not a strategy in its own right, but a set of reflections from my first 100 days and a proposed approach to setting the direction we must take to reach our potential. There is a section at the end which deals with implementation. There are many initiatives and developments underway, and these must be seen in the context of the report's recommendations, and our governance arrangements. If the report is to have impact, its implementation needs to be led and managed properly but it cannot become administrative or bureaucratic in nature and must become business as usual.

People First

NUH in numbers

£1.3bn
our budget

59,155
patients arrived at our Emergency Department via ambulance

1.9m+
meals served to patients

1,677
Beds

80
Wards

408,000
portering movements

297,600
first outpatient appointments

210,524
attendances to our Emergency Department, with a daily average of 577 patients

18,600
members of staff

1.3m
visits to our public website

1,100+
volunteers offering their support to enhance patient care

1,187,590
all outpatient appointments

£28.3m
Research income in 2021/22

152,007
emergency operations

13,952
planned operations

12,795
patients recruited into NIHR sponsored studies

311
hours and 31 visits made by our volunteered Health Ambassadors

10,258
patients recruited into Covid-19 trials

National and Local context

This section sets out the national and local context that impacts many aspects of our agenda and the people we serve.

What we see in the places we serve

The picture we see at NUH reflects the pressures across the NHS in England. As with most cities, our population is growing. Our city is diverse and multicultural, but it also suffers from high levels of deprivation, especially in inner-city areas. We deliver district general services to 2.5m residents of Nottingham, Nottinghamshire, and its surrounding communities. Our local partners are also under pressure. The City Council, for example, remains under intervention following a review[1] which has placed significant challenges on their financial situation and freedoms. While they and we are committed to partnership working, these issues within the organisation place real constraints on our ability to realise benefits from improved partnership working.

The worsening health inequalities between different sections of our community pose a significant challenge for both NUH and our wider integrated care system. For example, people in the three cities, Derby, Leicester, and Nottingham, have a significantly lower life expectancy than the national average. There is a disproportionate number of people likely to experience poor health affecting their everyday life before they turn 60, meaning over 15 'unhealthy' years. There are higher than national levels of obesity, smoking and alcohol related admissions to hospital.

Our services continue to operate under sustained pressure, with high numbers of patients and staff still testing positive for Covid-19, flu and other respiratory illnesses, which has resulted in three critical incidents in the last six months. Our emergency department is regularly overcrowded and patients face delays and treatment. Additionally, certain NUH services have come under intense scrutiny in recent years, with the CQC raising concerns about our leadership in 2021 and rating our maternity services as inadequate following an inspection in October 2020.

It is in this context that we set out our roadmap for how our organisation should design its plans and priorities.

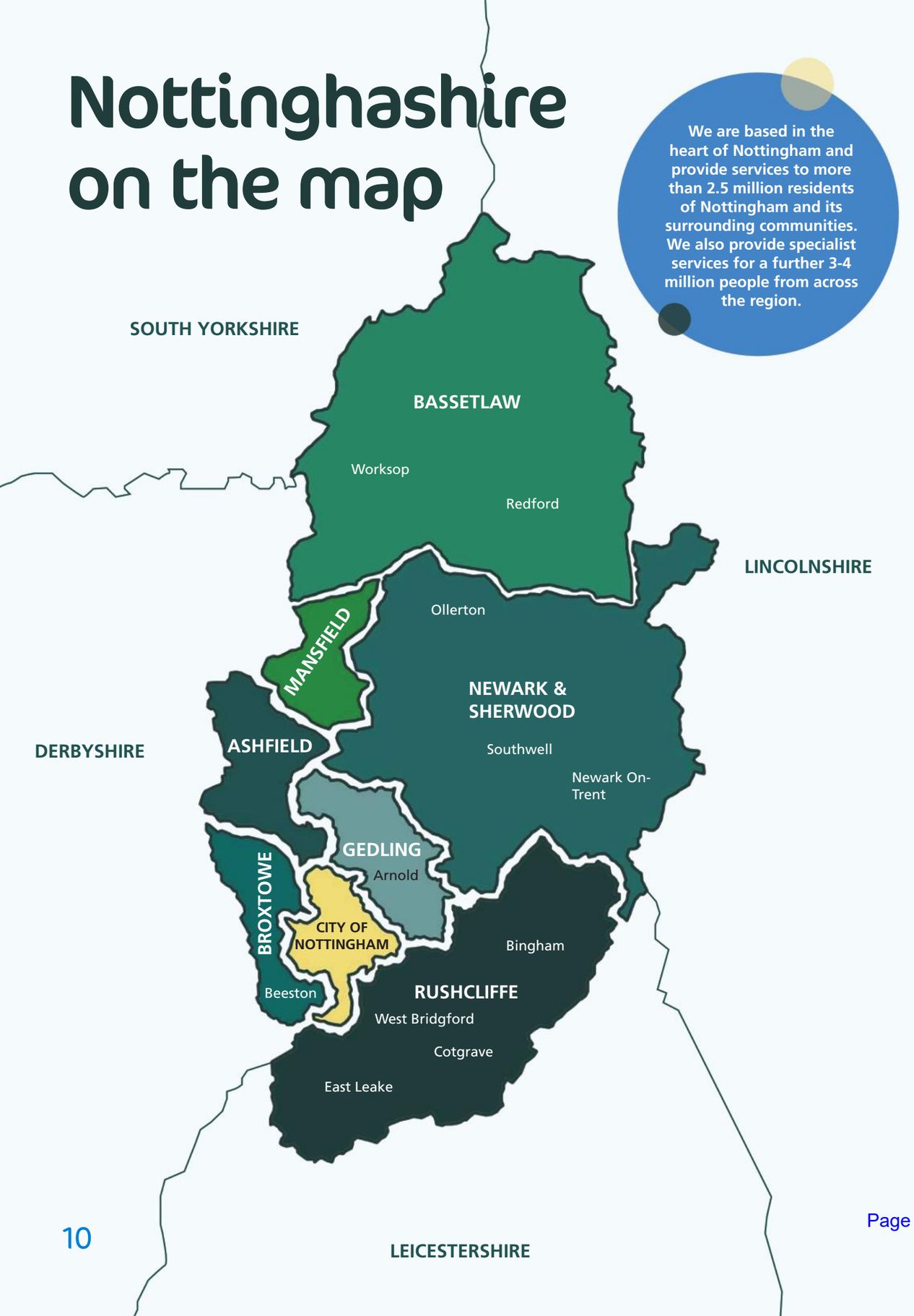
1. Non-statutory review Nottingham City Council
2. Demography: future trends | The King's Fund (kingsfund.org.uk)
3. Poorest get worse quality of NHS care in England, new research finds | The Nuffield Trust
4. NHS Workforce Statistics, September 2022 - GOV.UK (www.gov.uk)

National Context

Legislation	The Health and Care Act 2022 created new statutory bodies in Integrated Care Systems and brought an expectation of more collaborative working.
Demographics	Greater demand for services due to a growing and ageing local population with complex health and social care needs (65-84-year-olds will increase by over 30% and 85+ year olds by over 90% over the next 15 years)[1].
Disease Burden	An increasing number of people with multiple long-term conditions. Links between social status and health i.e. people living in deprived areas have worse outcomes[2 and 3].
Technological Advances	Increasing availability of digital and emerging technologies e.g., data analysis, genomics, artificial intelligence, surgical robotics, and new treatments
Workforce Availability	National workforce scarcity in key groups e.g., nursing, anaesthetics, radiology, neurology, and others. NHS organisations reported 133,400 staff vacancies across all staff groups in Sept 2022[4].
Covid-19 Pandemic	Ongoing effects of the pandemic e.g., Long-Covid, increase in mental health illness, capacity constraints, longer waiting times for treatment.
Patient Expectations	With increasing waiting times, patients are concerned that the NHS is no longer readily available when they need it.

Nottinghashire on the map

We are based in the heart of Nottingham and provide services to more than 2.5 million residents of Nottingham and its surrounding communities. We also provide specialist services for a further 3-4 million people from across the region.



Nottingham City, Mansfield and Ashfield have some of the highest levels of deprivation in England. The proportion of people from the most deprived quintile attending the NUH emergency department is 36.4% compared to England Average of 27.1%[5]

5. https://tabanalytics.data.england.nhs.uk/ /views/SEDIT/Launch?:iid=1

The barriers to achieving success

Every day our dedicated workforce strives to provide quality care and make things better, but individual, organisational, and system-wide barriers often get in the way.

Based on conversations with patients, partners, and colleagues, we have identified the three key areas that are currently preventing us from being able to harness their passion and dedication and, ultimately, are stopping us from achieving success. If we can get these three things right, we will be in a much stronger position to address our other challenges and restore faith in our ability to deliver, both for patients and colleagues. These three challenges are far reaching, as they affect all of our services, teams and ultimately our patients. This report presents the case that we require a step change in these three areas if we are to realise our potential. Without this, whatever our endeavors, we are likely to fail.

The three barriers to overcome are:

1. Flow

(Emergency care flow and its consequent impact on delays and all our waiting times)

2. Recruitment and Retention

3. Leadership and Culture

To illustrate the scale of our challenges and the barrier they represent, the tables below provide some key statistics that influence our current thinking. The next section discusses each of the barriers in more detail.

1. Flow

- 200,000 patients come through the doors of our emergency department each year.
- The proportion of patients handed over to the trust from our colleagues in the ambulance service within 15 minutes has declined from 70% (Oct 2019) to 40% (Jan 2023)
- The average time a patient spends in our emergency department has increased from 240 minutes (Oct 2019) to 430 minutes (Jan 2023)
- The time a patients spend in our emergency department has increased from 240 minutes (Oct 2019) to 430 minutes (Jan 2023)
- The total average number of patients who are medically safe for discharge but still occupy a hospital bed has increased from 58 (April 2020) to 238 (Jan 2023)
- The proportion of patients receiving their first cancer treatment within 62 days of being referred to our hospitals has declined from 80% (Oct 2019) to 61.3% (Nov 2022)

2. Recruitment and Retention

- We have approximately 2,300 vacancies across our Trust
- Our sickness levels have increased from 4.5% (April 2020) to 5.4% (Nov 2022)
- The average time it takes to hire a new employee is 69 days compared to 35 days at the best performing trust in the East Midland
- We currently employ over 18,600 staff at NUH
- In the 2021 staff survey:
  - 54.4% of staff would recommend NUH as a place to work compared to the national average of 58.4%
  - 49.4% of NUH staff say that they have access to the right learning and development opportunities compared to the national average of 54.4%
  - 36.2% of NUH staff feel that their work is valued compared to the national average of 40.7%

3. Leadership and Culture

- From the 2021 national staff survey:
  - 48.5% of staff say that they look forward to coming to work compared to the national average of 52%
  - 41% of staff felt confident that if they raised a concern that it would be addressed compared to the national average of 47.9%
  - 44% of our staff feel that communication between staff is not effective
- The CQC well led review 2021 described a disconnect between the Board and the wider organisation

Barrier 1: Flow

(Emergency Care and its impact on waiting times)

The efficient movement of emergency patients through our hospitals is key to how effectively we can deploy our resources, particularly staff and beds. Poor patient flow results in patients staying longer in hospital than is necessary, overcrowding on our wards and in our emergency department, and delays in the handover of patients from the ambulance service. It also reduces the beds and resources normally reserved for patients on our waiting lists, as these are instead used for emergencies. Ultimately, these conditions result in poor patient experience, delays to care, and frustration for staff who cannot make best use of their valuable skills. The pressure on our emergency pathway has been increasing for many years and dominates our agenda.

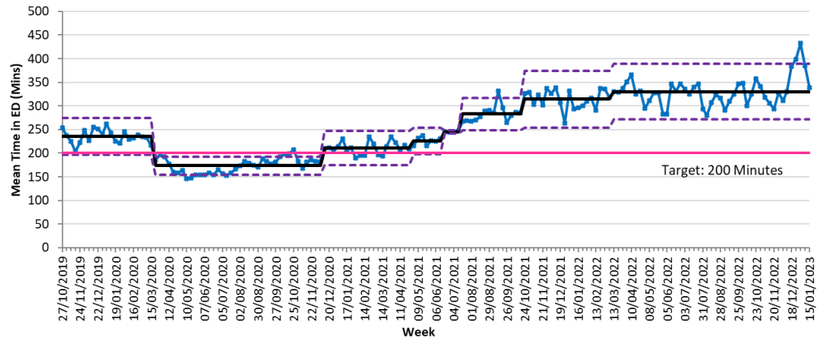
The challenges facing emergency care within the NHS in the recent past have been well documented[6]. The impact of this situation can be seen across all parts of the NHS. The issues are complex, and it will require input from all parts of the health and care sector to create services that our local people deserve. In the current year, national plans have asked ICSs to create plans that cover 10 key areas, such as supporting 999 services, improving primary and community health services, as well as improving hospital flow and discharge[7]. More recently, all emergency care systems in the NHS have been asked to reduce the time it takes for ambulances to handover patients to hospitals to maintain safe emergency services[8].

We have been working within our ICS across Nottingham and Nottinghamshire to improve the local situation. We have held several summits to bring together health and care partners to develop plans for improvement, including working with primary care in our Accident and Emergency (A&E) department, improving the volume of same-day emergency care and creating an integrated discharge hub to move patients promptly from the hospital when their medical treatment is complete. We are also working with our partners in the ICS to ensure that the recently announced increases to social care funding can be applied to maximum benefit for our population[9].

Despite this work, the impact of an overly pressurised emergency care system can be seen throughout the organisation, with its impacts reaching far beyond our overcrowded emergency department (fig 1). The number of patients whose care is complete but are awaiting discharge is at unsustainably high levels and peaked this autumn in excess of 200 patients (the equivalent of eight hospital wards (fig 2). While the numbers of patients attending our emergency department are broadly similar to the levels seen before the pandemic, the length of time patients are staying within our hospitals is increasing, creating further bed pressures. This compromises our ability to run the A&E department efficiently, with longer times to admit patients, longer times to offload ambulances, increased pressure on staff, and reduced capacity for our planned services, which also have growing waiting lists (fig 3). There is more to do to understand the full complexity of this situation.

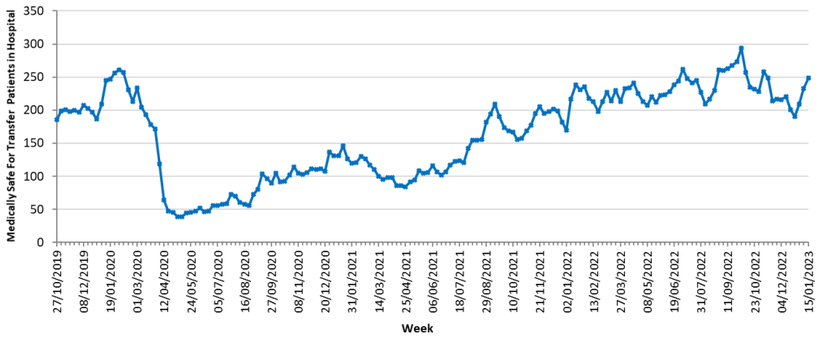
6. www.england.nhs.uk/publication/going-further-on-our-winter-resilience-plans/
7. www.england.nhs.uk/long-read/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/
8. www.england.nhs.uk/long-read/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/
9. commonslibrary.parliament.uk/research-briefings/cbp-9315/

Fig 1: Average length of time in ED



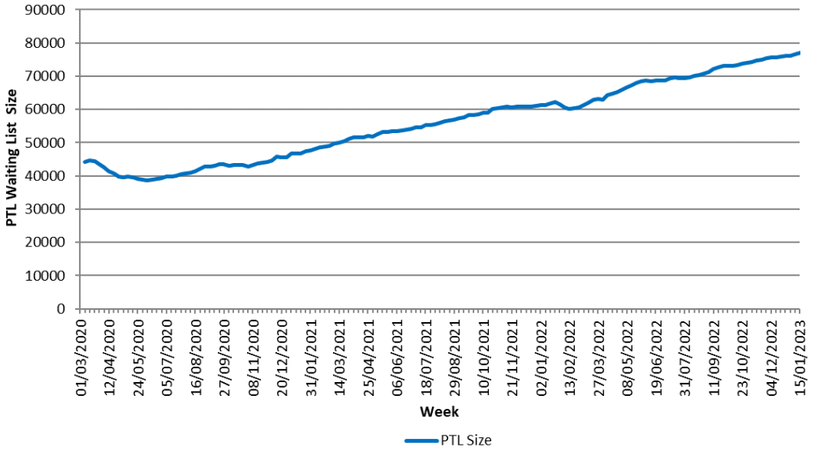
Patients are waiting longer in our Emergency Department

Fig 2: Number of Medically Safe for Transfer patients (MSFT)



The number of patients who are fit for discharge, but are still occupying a hospital bed has been increasing since the pandemic.

Fig 3: Elective Pathway - Total patients waiting list



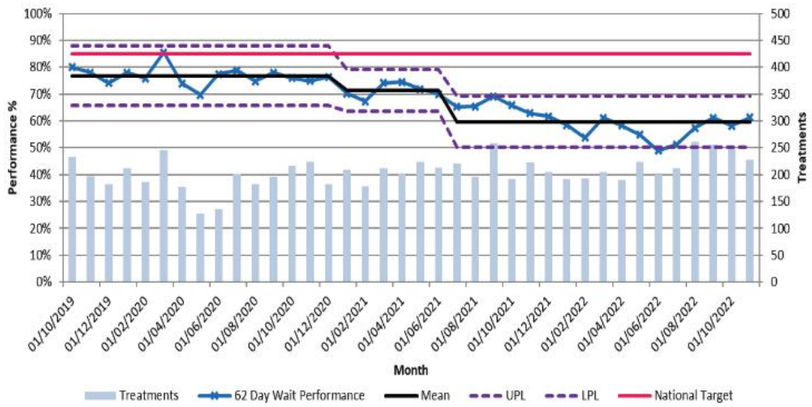
Our waiting lists have been growing since the pandemic

Although we have increased our bed capacity and introduced successful approaches to same-day emergency care, patients who require longer stays in hospital are remaining within our beds for even longer. From our patients' perspective, they often face long waiting times before they are assessed (at the very time they are at their most anxious), and then wait a long time often in an overcrowded accident and emergency department before admission to our wards. As result, while our patients are waiting to be either assessed or moved onto a ward, they are not in the right environment, and we know that this is not the level of care or experience that our that staff want to deliver.

We know that we need to continue to work as a system to ensure that patients access the treatment they need at the right time and at the right place to enable our accident and emergency department to be responsive. We know achieving this will enable us to deliver timely planned care to our patients as well. We must remember that emergency care and planned care are intrinsically linked, and both must be working at their optimum potential to achieve the best service for our patients.

The need to address these issues has been highlighted by the NHS's national planning guidance[10] for the 2023/24 financial year. Within it there is a clear focus on the need to recover core services and productivity, such as improving both the ambulance response time and accident and emergency waiting times, as well as reducing the time patients wait for planned care, cancer care or diagnostic care (fig 4). By focusing on flow through our hospitals, we know we can have an impact on all these issues, emphasising its importance in our plan for the next year and beyond. At NUH we are creating an emergency care strategy based around three key streams of work, the acute front door, acute patient flow, and discharge (see Appendx 1). This will form part of a wider plan to improve emergency care alongside our partners in the ICS. We will deliver our part of the emergency care strategy and report through our normal performance management mechanisms. We will continue to develop our partnerships within the ICS, who have also made emergency care one of its priorities[10], playing our part to ensure that the wider health and care system can deliver the improvements set out in the NHS planning guidance and meet the needs of emergency care patients. Nonetheless, the key to our success will be improving patient flow throughout our hospitals.

Fig 4: Performance against cancer waiting times standard



Fewer patients are being treated for cancer within the expected time of 62 days from the time they were referred by their GP

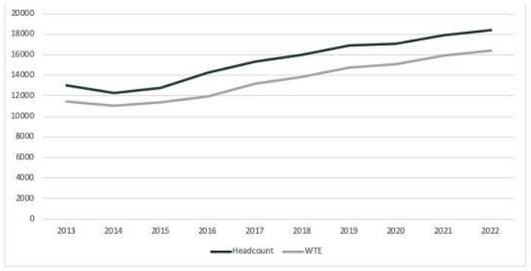
10. www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/
11. https://healthandcarenotts.co.uk/plans-and-priorities/

Barrier 2: Recruitment and retention

Without a well-supported, trained, educated, healthy, and motivated workforce, any NHS organisation would struggle to deliver services that are of the highest quality. Our workforce challenges closely reflect the national NHS picture of high vacancies, hard to recruit to posts, increased levels of sickness and staff turnover, and staff survey results that show a drop in morale and engagement.

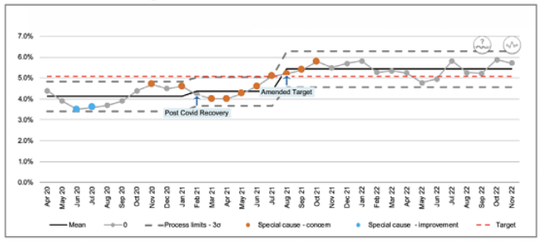
NUH is one of the largest employers in the East Midlands with more than 18,600 staff, a number that has grown year-on-year (fig 5). Our turnover levels have exceeded 12% and we are currently reporting approximately 2,300 vacancies.

Fig 5: Number of staff employed



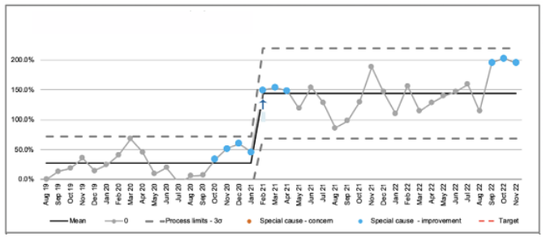
We have also seen increasing sickness absence levels since the beginning of the pandemic (fig 6).

Fig 6: Sickness Absence Rate



Consequently, we are seeing higher use of bank and agency staff, driving increased costs, and impacting on the continuity of care offered across our services (fig 7).

Fig 7: Agency spend



There are several factors driving the trend of increasing vacancy levels and high sickness. These include an increasingly competitive marketplace for employees within the NHS and across the wider economy, and increased staff pressures post-pandemic. Our staff survey results in 2021 show that our staff remain committed to NUH, are proud of the organisation and their colleagues, and report good working relationships and cooperation. However, there are also areas of concern. From the staff survey and our staff engagement exercise, The Big Conversation, we have identified three main areas to focus our improvement on: the behaviour of managers and leaders, the physical environment and systems and having the right number of people at the right time in the right place. Our action plan in response to these concerns has developed 12 key priorities (fig 8), several aimed at improving recruitment and the working lives of staff so that they want to stay with us and realise their full potential. Delivering these priorities in 2020/23, and creating our next set of priorities for 2023/24, will be key to improving staff confidence in the Trust.

Another issue we face around recruitment and retention is that our recruitment processes and workforce management systems are outdated and depend on high levels of manual intervention. The average time to recruit into a vacant post at NUH is currently 69 days, compared to the best within the East Midlands at 35 days. In response, we approved a business case to expand our recruitment team and invested in automated processes. For example, applicants can now scan and electronically send us their identity documentation which we use to complete the necessary employment checks. We have also approved a business case to implement an update to the national electronic staff records system where managers can directly update aspects of their team's employment record. To boost recruitment opportunities, we have started taking innovative approaches to recruitment such as holding an admin and clerical open day which resulted in 40 interviews and 14 job offers on the day. In addition, we are working with a recruitment and marketing firm to support recruitment into our maternity services where competition for midwives is particularly intense.

The NHS planning guidance for 2023/24 has also placed emphasis on the need to improve retention and staff absence through a focus on all elements of the NHS People Promise. It describes a need to focus on the productivity of our workforce, invest in our maternity and neonatal services (with an additional £165 million being made available nationally) and a target to reduce agency spend to a maximum of 3.7% of the NHS pay bill.

These initiatives are all underway. Success needs to be measured over the coming year in terms of the time it takes to hire staff, the number of vacancies, and our reliance on agency staff. These factors will form part of our regular performance management processes reported through the organisation and to the Trust Board. Fundamentally, if we can make substantial inroads into the level of vacancies that we currently hold, then we can meet the requirements set for the 2023/24 NHS plan and provide the level and consistency of care our patients need.

Fig 8: Big Conversation priorities

Big Conversations Theme	Priority action number	Key deliverables
Becoming your best self Developing people and their careers	**Priority 12**	Training and Leadership for staff
Appreciation and Recognition Recognising, appreciating and rewarding our people for their contributions	**Priority 11**	Appreciation and Recognition
Part of a team Creating a stronger sense of connection, with visible leaders and an environment that helps us recruit and keep the best people	**Priority 10**	Visibility of Leaders
	Priority 9	Flexible/Agile working
	Priority 8	Support for staff
	Priority 7	More efficient recruitment process
Working safely and improving our environment Creating a place where people feel safe to come to an inclusive workplace, free of racism, bullying & harassment	**Priority 6**	Kindness and Civility
	Priority 5	Tackling racism and bullying
Sorting the basics Ensuring people have access to water coolers, a place to take a break, healthy, affordable food and an improved travel to work offer	**Priority 4**	Car parking and transportation
	Priority 3	Somewhere to take a break
	Priority 2	Access to water
	Priority 1	Minor new works

Barrier 3: Leadership and culture

Recent years have been difficult for NUH. We have faced criticism from regulators, in particular the CQC, about our maternity services and leadership, which were both rated as inadequate. Our staff also questioned the way the Trust has been led and feel that our reputation has been negatively impacted by these reports. NUH has also been given the lowest rating in NHS England's oversight framework which is designed to identify organisations in need of additional support.

Our maternity services are subject to an independent review, chaired by Donna Ockenden. We have given our commitment to engage fully with this review and to ensure that recommendations to improve our services will be implemented.

Meanwhile, public criticism of our culture and approach to equality, diversity and inclusion has caused us reputational damage as an employer. Black and ethnic minority colleagues have reported negative experiences, such as racism. Understandably, this has had a knock-on effect on staff morale, and in turn could affect, their ability to deliver an excellent patient experience. Associated with this issue, patient feedback consistently shows dissatisfaction with the way we communicate, from the letters we send to the way we speak to patients in our care. Staff feedback also tends to back this view up.

It is fair to say these concerns are a symptom of weaknesses in both our culture and leadership, but also a sign of the pressure our staff work under. We have responded quickly and positively to the criticisms from our regulators and patients alike, putting forward plans to improve our maternity services and our leadership. These plans are regularly reviewed at our Board meetings and presented to NHS England to ensure we are making the progress we promised we would.

What is it like to work at NUH?

Colleagues across NUH reported good relationships despite the challenges we face, but also told me that sometimes we aren't kind under pressure. In 2021, the Trust's leadership was publicly criticised for allowing a culture of bullying, harassment, racism and discrimination to develop. Staff spoke about feeling unable to speak up about concerns, be that about their working conditions, treatment by managers, or, indeed, the safety of our patients. Culture change is necessary and there need to be improvements in behaviour, civility and professionalism going forward.

Anthony May - Reflections on my first 100 days

12. http://nuhnet/newsdesk/Pages/Statement-from-Anthony-May-about-becoming-a-zero-tolerance-organisation.aspx
13. Health and social care review: leadership for a collaborative and inclusive future - GOV.UK (www.gov.uk)

These plans include:

- Weekly Executive team visits to different areas of the Trust and monthly Ask the Executive Q&A sessions for staff to ask questions and have access to the Executive team on a regular basis
- A revised serious incident management process, including a new complex case review panel which looks at incidents, complaints, and inquests to ensure a proactive coordinated response
- A strengthened complaints review process to ensure responses are compassionate
- Issuing a zero-tolerance statement relating to racism and discrimination[12]
- A monthly equality, diversity, and inclusion (EDI) committee chaired by a non-executive director
- Our maternity improvement programme (MIP) is supporting continuous improvement towards our aim of ensuring that women and their babies always receive safe, effective, and evidence-based care
- Improvements to our performance reporting methodologies, including monthly performance management meetings between the executive and divisional leadership with a clear problem-solving approach. This will strengthen our link from ward to Board.

While this is a good start, there is more to do. It is important that we make best use of our staff in determining how NUH is led and run, and we must maximise the clinical voice in leading our organisation. Some revised proposals on how our leadership structures are arranged will be considered in the early part of 2023. They will be specifically designed to amplify the clinical voice in decision-making and should be implemented on first of April 2023. Over the coming year, we will take the opportunity, using the 'better together' staff engagement approach, to reconsider our values and our vision. We can also go a lot further to engage with patients to help us better understand and meet their needs, understand areas where we can improve and ensure we design improvements to our services in partnership with the public. We will also pay attention to the recommendations in the Messenger Review[13] in relation to leadership development, promotion of collaborative behaviours and a greater commitment to promoting EDI in leadership roles.

We will continue to deliver on our commitments within the Maternity improvement programme, monitored by our dedicated maternity oversight committee chaired by one of our non-executive directors. We will progress our well-led improvement programme overseen by our regulators. Our EDI programme is overseen by a new committee reporting directly to the Trust Board. Similarly, we will continue to monitor the outputs of our staff survey to understand if we are making progress in creating the culture and leadership our organisation needs and which our patients deserve.

Staff scores

In the 2021 NHS staff survey, NUH scored below average in several areas – a significant decrease from the previous year. Feedback, however, did show that staff remain committed to NUH and proud of the organisation and their colleagues, with working relationships and cooperation being reported as positives of working at NUH

- Staff engagement score 6.7 vs national average of 6.8 (national staff survey)
- 33.1% of staff say they often think about leaving the organisation (source: national staff survey) vs national average of 31.3%
- 48.5% of staff say they look forward to coming to work (source: national staff survey) vs national average of 52%

Patient scores

the % of people who would recommend us to friends and family if they needed similar care or treatment

- Friends and Family score (Inpatients & Daycases) (Apr 22 – Nov 22) 97%
- Friends and Family score (Accident and Emergency) (Apr 22 – Nov 22) 76%
- Friends and Family score (Outpatients) (Apr 22 – Nov 22) 97%
- Friends and Family score (Maternity) (Apr 22 – Nov 22) 95%

Our response to overcoming the challenges we face

The ability to focus on and prioritise the things that matter most to our patients, partners and our communities is a key strategic capability. As an organisation, NUH struggles to prioritise at times because prioritisation means making choices between competing and equally essential health care services. However without a well-defined set of priorities, it is impossible for us to build the bridge between what we are doing today with what we need to achieve tomorrow.

The three key barriers we believe we must focus on were identified following extensive discussions with our staff, our patients and our partners in a number of settings. However, simply naming them will not be enough to provide the clarity and purpose our organisation needs. We have several clinical strategies and crosscutting enabling strategies that bring together our plans. They are, however, in need of refreshing. At the time of writing, some are more advanced than others, there are differing styles, and they all need aligning to our three priorities of improving flow, recruitment and retention, and leadership and culture. By taking time over the next year to engage with our staff, partners and patients, we can create a plan for NUH and clarify our core purpose and priorities.

We are also keen to review our overarching approach to change management. We already have several successful approaches to engaging our teams in implementing change, but they are neither comprehensive nor consistent. If we are to truly transform NUH, we will need to review our approach to change, using evidence from across the NHS, so that we can harness the wealth of expertise within our staff, our patient groups, and other local groups. In doing this we can sustain our approach to continually improving our organisation and ensuring future success.

Considering all this, this report makes three recommendations which are described in more detail in the next sections. They are:

- To accept that improving emergency care flow (and its consequent impact on all of our waiting times), recruitment and retention, and leadership and culture are the top priorities for NUH
- To update and implement a series of interlocking strategies designed to achieve our three top priorities
- The adoption of a Trust-wide system to lead change and development in an inclusive and transparent way, and which encourages a bottom-up approach to ideas for innovation, efficiency, and effectiveness

By moving forward on these three recommendations, we can create clarity of purpose for our organisation, focus on the most pressing issues, develop plans to be the best we can be, and define a way of running our organisation that drives high performance for the long term.

Our approach is purposefully ambitious. We will expect to see improvement against the three barriers in the next year, have a set of aligned strategies over the next year and to have begun a procurement for a change management partner within six months. To implement this, we will need to work closely with our staff, our partners, and our patients over the coming years. However, we are committed to starting this journey now and have some clearly defined deliverables for the year ahead. By supporting staff in introducing and sustaining these changes we are confident that their implementation will have a positive impact on our ability to focus on our core purpose and deliver better care for patients.

Recommendation 1:
Focus on overcoming our three barriers

- Flow
- Leadership and culture
- Recruitment and retention

Recommendation 2
Develop and deliver interlocking strategies

Including what actions will be taken in 2023

Recommendation 3
New management system

Recommendation 1:

To accept that improving emergency care flow (and its consequent impact on all our waiting times), recruitment and retention, and leadership and culture are the top priorities for NUH

The proposal to focus on flow, recruitment and retention, and leadership and culture has come following extensive engagement within our organisation, particularly with our staff, but also patients and our partners. It is important that we have specific areas of focus, given the vast array of issues our teams could look to prioritise. These three issues are those that have been named most consistently and, will have the biggest impact in releasing staff to focus on their core roles and enable the whole organisation to realise its potential.

The emergency care pathway is vital for our patients, dealing with those in the most urgent need. Yet it is blighted with delays and areas where demand exceeds capacity. This is not unique to NUH, and the 2023/4 NHS operational planning guidance[14] also has a key focus on urgent and emergency care. If, in conjunction with our health and care partners, we can improve flow through this pathway, we will be able to direct our resources of staff and beds to those patients where our teams' skills are best used, including releasing capacity for patients who face long delays on our planned care waiting lists.

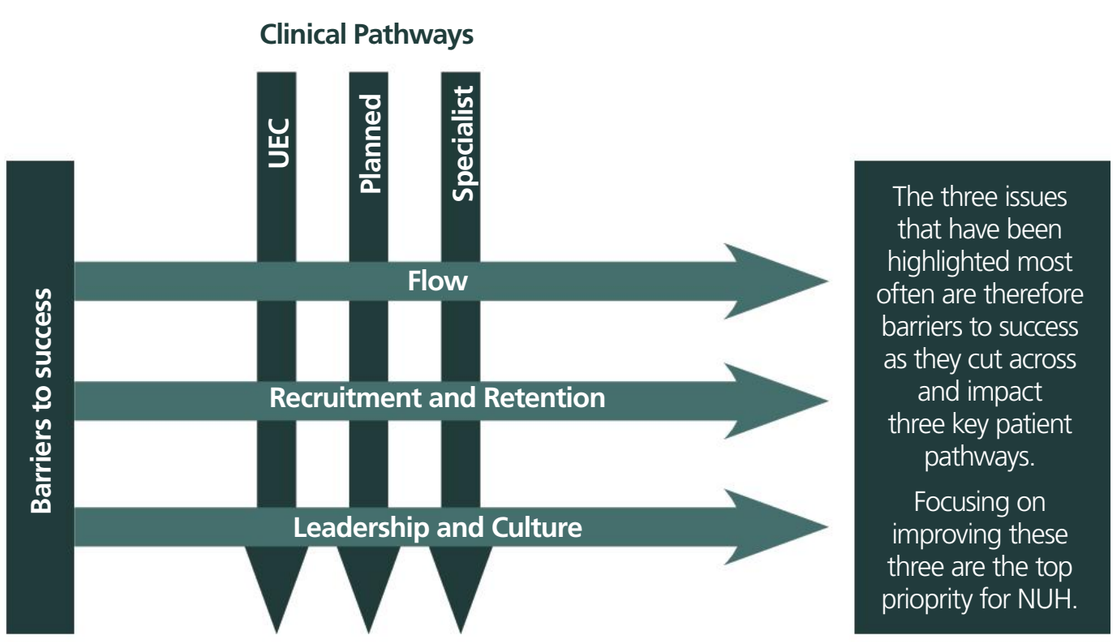
Given the scale of vacancies we currently hold (approximately 2300), it is inevitable that we will not achieve all we want to. This situation also puts additional pressure on our remaining staff and means we have an increasing reliance on agency staff. Trying to ensure we have sufficient people to care for our patients consumes time and effort every day. We are also aware from staff consultations, including the Big Conversation, that our own processes are manually intensive and slow, causing further frustration. There is much we can do to improve staff morale and, subsequently, retention. By focusing on recruitment and retention, we can build the necessary body of staff, who feel valued by their organisation, and can more clearly focus on doing their best for our patients.

Culture and leadership are important for all successful organisations and particularly for large organisations such as NUH. The review into leadership[15] across health and social care, led by General Sir Gordon Messenger, highlights the impact that good leadership and management can make, and also the need to develop staff. Comments from our staff and reports from regulators tell us that we can do more to improve leadership and culture. These regulatory comments are felt heavily by our organisation, along with those made about our maternity service. We must meet these challenges head-on and implement the improvement programmes we have committed to.

All three of these priorities are fundamentally about releasing the potential of our organisation so that it can be the best embodiment of NUH to the benefit of our patients and our community. We believe that focusing on these priorities can be a cornerstone to rebuilding trust and confidence in NUH as the leading organisation we all wish it to be. We should commit to making a step change in how we manage these three issues. This is our first recommendation.

However, focusing on these three issues alone will be insufficient. We know that flow, recruitment and retention, culture and leadership are barriers to how we want our clinical pathways to function (Fig 9). We should therefore commit to updating our strategies so that they align to the improvements required. This is discussed further in the next recommendation.

Fig 9: Alignment of clinical pathway strategies to overcome barriers to success



Patient Story

A 49-year-old father of two was admitted to critical care at Queen's Medical Centre with severe pancreatitis – a condition where the pancreas becomes swollen over a short period of time. He developed breathing difficulties and a blood clot which he received treatment for during his stay with us.

He spent a total of 180 days with us and required specialist critical care treatment including antibiotics and a tracheostomy – an opening created at the front of the neck so a tube could be inserted into the windpipe to help him breath. As part of his rehabilitation, the physiotherapy team encouraged him to stay as mobile as possible and our and language therapists saw him to help him with strategies to communicate with the tracheostomy. Occupational therapists and the therapy support workers worked closely with the nursing and physio teams to promote independence. To help keep his spirits up staff took him for trips outside, either on his bed or in a chair. He was also encouraged to visit the ward before being discharged from critical care to help with the transition from a higher ratio nursing care to a lower level.

It's important to us that we listen to patients and use their feedback to improve patient care. For example, we appreciate that being nursed in critical care can be a challenging time for patients, so we now offer them the opportunity to visit critical care after they have been discharged. These visits are one of the ways we can provide answers to any questions patients may have about their time with us. This helps us to fill in gaps in memory often caused by the medicines we use or confusion. This patient did take up the offer and returned to critical care to look around. He thanked the team for his care and was grateful for the opportunity. He felt it helped with his psychological recovery and to progress his rehabilitation. He has also gifted two televisions and other rehabilitation equipment, which were gratefully received.

Nine months after discharge, he was walking independently, had returned to work part time and celebrated his 50th birthday with a family holiday to Cyprus.

14. 2023/4 NHS operational planning guidance
15. www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future

Recommendation 2:

Develop and deliver interlocking strategies designed to achieve our top 3 priorities (Flow, recruitment and retention and culture and leadership)

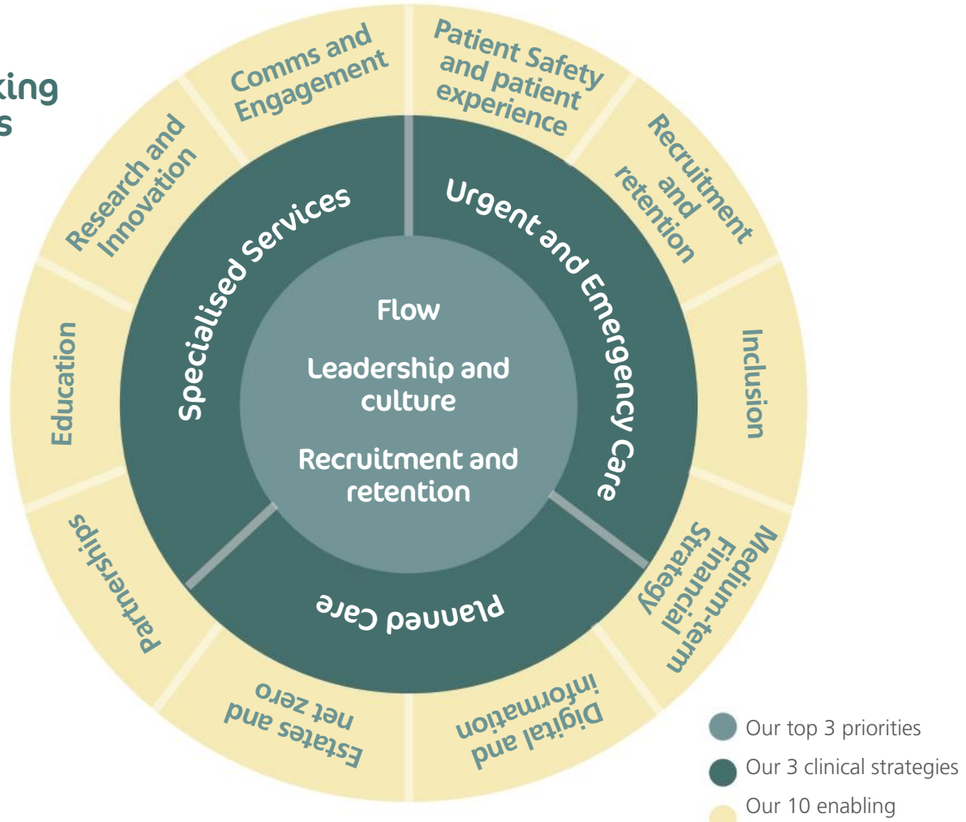
Our proposal is to take a framework approach to create a strengthened and re-aligned series of strategic delivery plans which set out our vision and medium-term goals across three patient pathways: urgent and emergency care (UEC), planned care, and specialised services. These are identified as clinically led strategies and are underpinned by 10 Trust-wide enabling plans. These interlocking strategies clarify our direction, align to our three top priorities, and describe the progress we can make in 2023, as well as subsequent years.

We already have some longer-term strategies relating to Tomorrow's NUH, which we must use as a marker for our service direction. Nonetheless, we must continue, in the short term, to reduce the time our patients wait for care, improve our facilities and technology, keep up with best practice, such as getting it right first time (GIRFT)[16], and other clinical publications.

We should also be developing our services following review of our outcomes and patient feedback. There are many important projects at different stages of development that should be described within our strategies, for example the National Rehabilitation Centre, Jubilee facility, expansion of our neonatal and maternity service, mechanical thrombectomy, and consolidation of our burns and plastic surgery service.

Fig 10:

Interlocking Srategies



These plans, among others, should help us to continue to improve our clinical services before the implementation of Tomorrow's NUH, which brings a greater ambition to improve facilities such as a dedicated Children's Hospital and bringing together emergency care at Queens Medical Centre.

The diagram shows the strategies falling into one of two categories: clinical and enabling.

Patient Story

After beginning to feel unwell and struggling with respiratory difficulties, a gentleman in his late 90s was brought into Queen's Medical Centre and admitted onto ward B49. Initially his condition deteriorated after he contracted an infection in hospital, followed by Covid-19. However, after recovering under the care of our teams, he was finally discharged to a local care home for assessment.

His family expressed their appreciation for the care he received during his stay with us. They specifically mentioned clear communication from our team and support with the patient's next steps, which they appreciated during a distressing time.

16. https://gettingitrightfirsttime.co.uk/

a) Clinically led strategies

There are many ways to describe the range of clinical services provided at NUH, from patient pathways to clinical divisions to individual services. Whatever the definition, it is important we invest time in considering how we organise and deliver care to our patients.

We will be developing three clinically led strategies to respond to the barriers we have identified, for example considering how new service strategies and partnerships can reduce the impact that our lack of "flow" has across all our services. They will focus on the next three years and more to create direction beyond the regular annual planning round to define the services our hospital will provide.

Our people first approach will ensure the key components of these strategies include:

- Tackling the overarching issues behind access and performance problems and improving the responsiveness of services. This will include integrated working with partners on new service models and streamlining the delivery of care to increase quality, efficiency, productivity, and delivery of proposed investments.
- Clarifying and consolidating our vision for specialised services, aligned to commissioning strategies[17], to ensure equitable access and support clinical best practice and clinical and financial sustainability.
- Putting in place plans to support continuous improvement in the quality and safety of our services.

The development of these strategies will need clinical engagement and support. They will also be developed in partnership with our patients and colleagues in primary care, community care, mental health, specialist, and social care. We will be guided by data in relation to local population changes and influenced by the NHS Long Term Plan[18] which embraces the development of local integrated care systems, the strengthening of capacity and capability in primary and community care, and delivery of world-class care for major health problems. We will ensure that these strategies are underpinned by better use of technology, with new roles and ways of working to support new models of care. For example, we will include more integrated working with partners to reduce unnecessary hospital visits and admissions, allowing us to focus on our core purpose.

A high-level summary of each of the three clinical strategies is set out below, with more information including priorities for delivery in 2023 in Appendix 1.

Together this set of interlocking strategies can lay out more clearly and consistently how we expect NUH to develop over the coming years.

The three clinical strategies and the high level mission are described below. More information can be found in Appendix 1

Urgent and emergency care	Working with our partners in health, social care and the voluntary sector. We will: • Resolve the barriers to flow. • Create and support new models of care that provide timely access, good outcomes and high-quality experience for our patients. • Including same-day emergency care and virtual wards
Planned Care	We aim to: • Meet our part of the national ambition to recover waiting times including timelines to eliminate long waits for planned care with a specific focus on reducing the time between referral and treatment for cancer. • Deliver expansion of our facilities and services. Improve our service efficiency
Specialist Services	We will: • Raise the profile and understanding of our specialised services. • Better understand population need and design and deliver sustainable pathways which lead to outstanding health outcomes for the populations we serve.

17. www.england.nhs.uk/commissioning/spec-services/
18. www.longtermplan.nhs.uk/

b) Enabling strategies

The 10 enabling strategies are defined as those that not only support the delivery of organisational infrastructures, systems and processes but are also essential to removing the barriers identified and the efficient delivery of the three clinically led strategies. These will be guided by the people first philosophy and aligned to the existing Trust-wide strategy.

A high-level vision of what each strategy aims to deliver is set out below. More information, including priorities for delivery in 2023, can be found in Appendix 2. Updating our strategies and aligning them to our three key priorities can provide us with a clear direction over the next three years.

Patient Safety and Patient experience	Deliver continuous improvements to the quality and safety of care provided to patients and empower staff to make ongoing improvements in their everyday wok, including embedding a safety culture from Board to ward.
Recruitment and retention	Become the employer of choice by creating an environment that supports the recruitment and retention of the most talented staff. Develop a highly skilled, compassionate, and flexible workforce that is equipped to deliver sustainable and resilient services to meet the needs of patients.
Inclusion	Reaffirm our values of equity, inclusion, and justice by becoming a great and inclusive place to work, where discrimination, bullying and harassment are not tolerated and opportunities to develop and progress are open to all. Invest in our staff so that they thrive at work and feel valued for their contribution to patient care.
Medium-term Financial Strategy	Look after our resources as effectively and efficiently as possible over time to allow us to continue to invest in our people, buildings and the equipment we need to be financially sustainable.
Digital and information	Optimising the use of technology and science to support patient care, patient experience and to support innovation. Use digital, data and technology to allow all of our people to be excellent in their roles.
Estates and net zero	Reinforce our commitment to sustainability and green issues, providing hospital services in a fit for purpose and flexible estate that enables the delivery of high-quality care, while maximising efficiency, productivity and environmental sustainability.
Partnerships	Strengthen partnership and community connections to ensure we are working collaboratively with public, private and voluntary sector colleagues to most effectively add value to the populations we serve and deliver our core purpose.
Education	Provide excellent, high-quality training and leadership programmes that inspire, challenge, and prepare our staff to deliver high-quality care which drives excellent clinical outcomes and research studies.
Research and Innovation	Increase opportunities for our patients and staff to participate in high-quality research and development. Drive our ambition to become an outstanding clinical partner to academia, industry and local government and make NUH a centre for cutting edge research and innovation
Comms and Engagement	Ensure that patients, carers and all our communities are at the centre of our plans and proposals. Create a culture of cooperation, coproduction and coordination with our patients, partners, and staff.

Recommendation 3:

The adoption of a Trust-wide system to lead change and development

Develop a consistent NUH approach to managing change to move us to excellence and ensure we have a sustainable long-term approach to continuous improvement.

The scale of change and development required at NUH demands a long-term and organisation wide approach. The recently published report from The Health Foundation on building an organisational culture of continuous improvement[19] analysed the partnerships of five NHS Trusts with the Virginia Mason Institute and how this could inform the implementation of a system for change within an NHS organisation. There were several key characteristics emerging from these collaborations, including developing strong peer learning, leading to better CQC ratings where staff have greater involvement in sharing ideas and learning. Crucially, the report also highlights the importance of aligning improvement priorities with organisational and national objectives.

We already have several nationally recognised models of improvement operating within NUH, including capability building (Quality Service Improvement Redesign), empowering our staff (Shared Governance), significant expertise within human factors, and service review approaches (Working to Achieve Value and Excellence – WAVE programme). These are supported by teams from strategic planning, information and insight, and organisational development. What we now need to do is bring these components together in a deliberate and purposeful way to create a consistent approach that will ensure that we have the best chance for sustained improvement to the benefit of ourselves and our patients.

We intend to scope and potentially procure outside assistance with this programme of work in the first half of 2023.

This has drawn on the learning from the recent publication of the report by Warwick Business School into the 5-year Virginia Mason Institute (VMI) and NHS partnership programme which has set out six key learnings that were derived through the development and adoption of management systems in five NHS provider organisations. (Table 1)

Table 1 - development and adoption of management systems in five NHS provider organisations - six key learning [20 21]	
1	Build cultural readiness as the foundation for better QI outcomes
2	Embed QI routines and practices into everyday practice
3	Leaders show the way and light the path for others
4	Relationships aren't a priority, they're a prerequisite
5	Holding each other to account for behaviours, not just outcomes
6	The rule of the golden thread: not all improvement matters in the same way

19. www.health.org.uk/publications/long-reads/building-an-organisational-culture-of-continuous-improvement
20. www.wbs.ac.uk/news/six-key-lessons-from-the-nhs-and-the-virginia-mason-institute-partnership
21. https://warwick.ac.uk/fac/soc/wbs/research/vmi-nhs/reports/

People First

Implementation

To monitor the implementation of our plans against the report's recommendations, we must establish an appropriate governance process, making use of our existing committee structures and their onward reports to the Trust Board.

Our proposal is to make as much use of our existing reporting and monitoring mechanisms as possible throughout the year and to bring an overarching report on progress to the Board in a year's time. We have argued that there is much to do and that priority actions have and will be identified. By defining the appropriate measurements for monitoring progress, we can use two existing formal Trust Board reports to describe progress rather than delay while we create a new governance mechanism. We will use the annual planning process to incorporate some key objectives and measures into our 2023/24 plan.

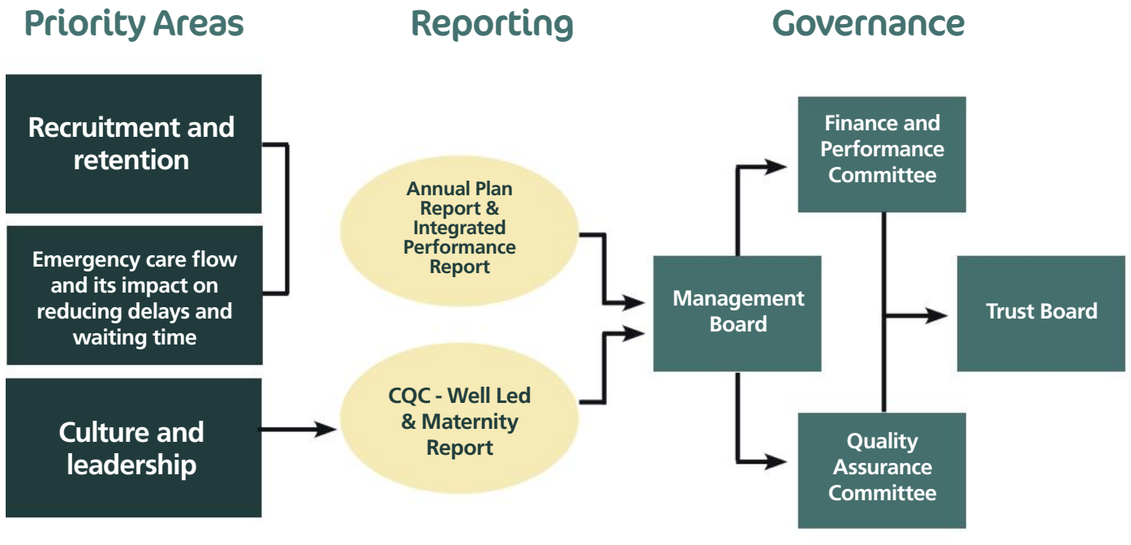
- Recruitment and retention and emergency care flow can be monitored within the quarterly Annual Plan and Integrated Performance Reports (IPR).
- Culture and leadership measures can be incorporated and monitored within the existing CQC well-led and maternity reports.
- External assurance processes involving our integrated care system and NHS England will continue in their present form.

Each of these reports will be examined at the appropriate executive and Board committee meetings in line with the diagram below, fig 11.

We will complete a full review in 12 months' time through our Annual Report 'look back' assessment, which will be produced for April 2024 Trust Board.

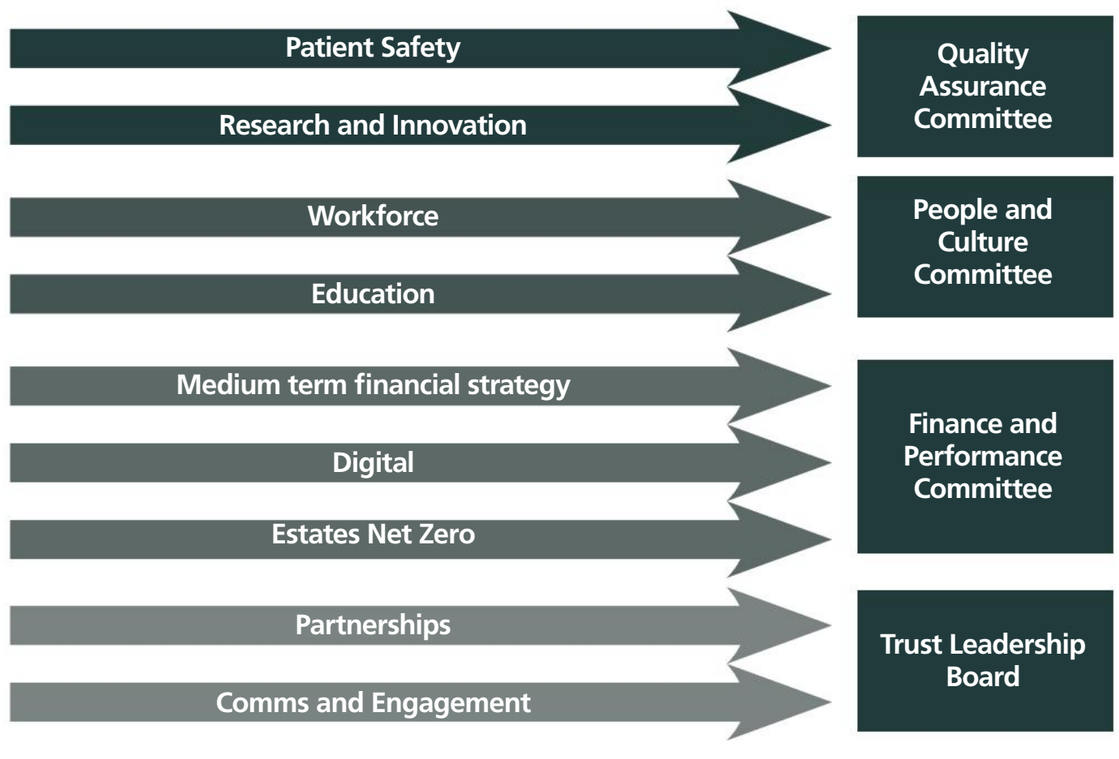
Our next step will be to pull together the actions from this report and the associated strategies and incorporate them into the 2023/24 annual plan as well as creating the appropriate reports for scrutiny.

Fig 11: Governance arrangements



Further monitoring of the framework approach for the clinical strategies and enabling strategies and plans will be undertaken through the Trust Board sub-committee structure as follows, fig 12.

Fig 12: Committees reporting and monitoring arrangements



Summary and next steps

This report considers in some detail the barriers which currently prevent NUH from achieving its full potential. Alongside the nation's entire health and care system, we face unprecedented pressure but are also additionally subject to intense public and regulatory scrutiny. The report is based on Anthony May's experiences during his first 100 days in post and takes into account the issues and concerns raised by patients, staff, and our partners during the many conversations he has had.

The report acknowledges and appreciates our highly skilled and dedicated workforce, whose efforts deliver quality care to thousand of people every day. However, it also makes the case for fundamental change, including a collective focus on the key barriers to success, a refresh and realignment of our clinical and supporting strategies and the development of a consistent and effectively approach to change management.

The report gives three recommendations that will enable us to move forward, gain clarity of purpose and direction, and deliver the services that our population need and deserve. They are:

1. To accept that improving emergency care flow (and its consequent impact on all of our waiting times), recruitment and retention, and leadership and culture are the top priorities for NUH

Based on conversations with patients, partners, and colleagues, the report identifies these three barriers as those which are preventing us from being able to harness the passion and dedication of our workforce and, ultimately, from achieving success. If we can improve in these three areas, we will be in a much stronger position to address our other challenges and restore faith in our ability to deliver, for both patients and colleagues.

2. To develop and deliver a series of interlocking strategies designed to achieve our three top priorities.

Using the breadth of expertise across the organisation, the report recommends the refresh or development of a series of clinical and enabling strategies, which set out our plans for the next three to five years and provide the clarity of purpose our staff require. They will give us a framework to support high quality decision making and resource allocation and help us to get back to the basics of running a large, complex organisation in a planned and purposeful way.

3. The adoption of a Trust-wide system to lead change and development

The most successful organisations have a consistent methodology and approach to change and transformation. The report recognises that our approach to change is sometimes excellent but too often inconsistent and dependent on the goodwill and ingenuity of individuals. It recommends a consistent approach to change, which uses the same methodology and tools across the organisation.

However, the report's findings cannot stand-alone and, for implementation of the recommendations to succeed, the whole organisation must recognise and accept that:

- This is a team effort, and everyone will need to contribute to ensure our collective success
- Implementation must be led and managed properly, but it will need to become business as usual rather than an additional administrative burden
- Given both the clinical and enabling strategies require investment and transformational changes over several years, full implementation will span over more than one planning round

While it is vital that we give everything we have to implementing these recommendations, the single biggest factor influencing the success of the organisation will be our ability to harness the skills and retain our own workforce and the expert contribution of our partners. It is for this reason that the report is titled people first.

Next steps

To move forward, the recommended next steps are:

- Roll out the communication and engagement plan following approval from the Trust Board.
  - I. Presentation of the 100-day plan to the partners and public
- Establish the monitoring and reporting mechanisms described in this report using our existing governance structure
- Bring forward to the Trust Board some recommendations on changing management arrangements for the Trust, enhancing clinical involvement in our decision-making
- Begin the delivery of key actions described to support:
  - i. A step change in solving our three key challenges (flow, recruitment and retention, leadership and culture)
  - ii. Refreshing our clinical and enabling strategies along with delivering the key actions described for the 2023/24 financial year
  - iii. Start the procurement process for a new change management process
- Create an overarching plan to implement the actions for 2023 laid out in each of the strategies

Urgent and Emergency Care Clinical Strategy 1

Appendix 1

Why do we need a strategy

Our ability to move patients through from the emergency department and into the hospital has an impact on many aspects of our clinical services, operational performance, and priorities. Getting UEC services running optimally is key to unlocking the ambitions of our organisation to deliver timely and quality care.

NUH is one of the largest providers of UEC within the NHS and our major trauma centre serves the whole of the East Midlands. We have a growing and ageing population, and we are seeing more complex issues among those we are treating, including both the elderly and frail and more recently children and young people's mental health. We are seeing a rise in the number of cases of extremely vulnerable patients with particularly complex medical needs who remain in the emergency department for a long period as there is simply nowhere else for them to go.

The UEC landscape also has several complex issues which contribute to the current challenges. The whole health and care system will need to continue to work together to support improvements across our hospital, and our partners.

Our main drivers for improvement are:

1. Our A&E department is over crowded with specialty patients waiting for specialist opinions and interventions; High numbers of patients waiting more than 12 hours due to our inability to find a vacant bed within the hospital.
2. A very high bed occupancy level
3. Delays for patients can lead to suboptimal care and outcomes
4. There are not currently many alternatives to admission
5. Planned and emergency care demand compete for limited capacity (e.g. beds, theatres and staff)
6. A high number of patients who are medically fit for discharge, impacting on bed availability (sometimes in excess of 200 patients)
7. Ambulance handover delays
8. Staffing issues, including absence due to Covid-19 and seasonal illness
9. Out of hospital capacity such as home care is often undersized and therefore compromises discharge principles such as "home first" principle [22]
10. New 'front doors' to the hospital are improving care for some but putting new demands on our resources with more care hours being delivered than ever before

The 2023/24 NHS operational planning guidance set a priority of improving the responsiveness of UEC care[23] and building additional community capacity – keeping patients safe and offering the right care, at the right time, in the right setting. This now also includes the expectation that we will return to reporting against the 4hr target from 1 April 2023. Expansion of virtual ward models, eliminating 12-hour waits in A&E departments and minimising ambulance handover delays are all key priorities over the 2023/24 financial year.

There has been a programme of continuous improvement across the urgent and emergency care pathways at NUH. The next phase is to move away from a 'winter plan' and develop a longer-term strategy that takes in to account all seasonal variations.

22. www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/reducing-long-term-stays/home-first
23. www.england.nhs.uk/publication/going-further-on-our-winter-resilience-plans/

Director Responsible: Chief Operating Officer - Lisa Kelly

What is the scope

- Acute front door
- Acute patient flow
- Discharge
- Preparing and planning for seasonal variation of UEC pathways
- Partnership arrangements across health and social care and voluntary sector

What does success look like

- Right care, right place, right time
- Hospital care and discharge practice from the point of admission
- Clinically safe alternatives to admission to hospital
- Better patient experience
- Improved access to care for all to address health inequalities
- Development of an integrated 24/7 urgent care service

Timescale

The Strategy will be produced by April 2023

What we will do in 2023

- Work with our partners as part of the system wide UEC programme
- Engage with multi-disciplinary teams to help our understanding of total patient demand
- Develop a programme of work to focus on patient safety and reducing delay related harm
- Reduce demand on our services including maximising Same Day Emergency Care (SDEC) and increase our virtual ward offering
- Enhance our bed reconfiguration including opening the Jubilee unit in January 2023
- Enhance our processes and improve patient flow including internal and external mitigations to reduce the backlog of medically safe patients in our hospitals
- Make strategic enhancements in staffing, including a temporary transfer team for paediatric emergency and CAU and enhanced support of flow matrons to support discharge capacity in the CAS division
- Develop the model for a co-located Urgent Treatment Centre

Planned Care
Clinical Strategy 2

Appendix 1

Why do we need a strategy

During the Covid 19 pandemic waiting lists nationally have increased, with people waiting longer and longer for planned surgeries and procedures. The NHS has more patients waiting for planned care now than it has had at any point in its history and NUH is no exception. Reductions in planned health care activity seen in 2020 were associated with increases in health inequalities[24].

In February 2022, NHS England published its plan for tackling the COVID-19 backlog of elective care[25] which sets out an ambitious plan to recover planned care over the next three years with specific focus on the time between referral and confirmation of diagnosis for cancer and eliminating waits of over two years for any planned care. NHS England have reaffirmed many of these priorities for 2023/24 within the priorities and operational planning guidance[26].

At NUH, and across the NHS, the level of planned care activity currently being delivered is below pre-pandemic levels. Many of the reasons for this are clear and understandable. Our performance and activity levels are compromised due to the overflow of emergency care, high number of patients who are medically safe to be discharged, and workforce challenges, including vacancy rates and staff absences. This constrains effective hospital flow, theatre capacity, and efficient use of our bed base. Other challenges in delivering our recovery include timely access to diagnostics and delays in reporting, including complex endoscopies and histology reporting due to the significant workforce challenges within pathology services.

Waiting lists are now large and traditional methods of working will not deliver what we need to for our patients. At NUH we are tackling this by:

- Expanding our capacity: We are developing new facilities - a new ward in early 2023 and three theatres by April 2023. This will be followed by the development of an elective hub in quarter four 2023/24 providing three additional theatres, admission/discharge facilities, and a short stay ward.
- The elective hub will focus on high volume, low complexity patients.
- Developing our workforce capacity and capability to meet the needs of our patients.
- Having a specific focus on the productivity of our elective pathway in line with planning guidance and best practice.
- Working with the independent sector: Early in the COVID-19 pandemic, we worked closely with colleagues in the independent sector to make best use of any unused capacity. At that time this was vital in protecting the most at-risk patients, including those with cancer and patients who needed a high level of post-operative care. We will now explore opportunities to work with the independent sector to see how we can develop partnership arrangements to support our ability to reduce waiting lists and waiting times.

In addition, we will need to continue to innovate and develop our workforce, our practice, and our partnerships to enable patients to access care in a timely and effective way. We will need to make best use of technology and harness the potential of data and digital opportunities such as more virtual wards, moving care out of hospital to in different settings, and virtual care and remote consultations supporting care in patients' homes. In terms of cancer, two-week wait referrals continue to increase. As with elective patients, cancer patients are currently being treated in order of clinical priority, rather than based on the length of their wait, wherever possible.

We also need the public to understand their role in helping us manage demand for our services and making sure we make best use of our available resources. For example, we have high numbers of patients who do not attend their appointments, leading to wasted resource and other patients missing out as a result.

24. www.midlandsdecisionsupport.nhs.uk/wp-content/uploads/2022/05/Strategies-to-reduce-inequalities-in-access-to-planned-hospital-procedures_20220429iv.pdf
25. Coronavirus » Delivery plan for tackling the COVID-19 backlog of elective care (england.nhs.uk)
26. www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/

Director Responsible:
Chief Operating Officer - Lisa Kelly

What is the scope

- Outpatients
- Diagnostics
- Cancer
- Elective surgical procedures and theatres
- Maternity

What does success look like

- Effectively use our capacity to ensure everyone can access services in a timely fashion
- Work with ICS partners to address health inequalities on our waiting lists and ensure our services are responsive, fair and inclusive
- Develop our workforce to ensure we have the right staff with the right skills to meet the needs of patients
- Use data and technology to improve our services and ensure we deliver high quality care and the best possible outcomes and experience for patients in a timely way

Timescale

The planned care and cancer strategies will be produced by April 2023.

What we will do in 2023

- Work with our partners as part of the system wide planned care programme
- Engage with our teams to develop capacity and demand modelling to clarify requirements and support needed to deliver key milestones
- Work with clinical services to understand service needs and explore opportunities to meet these with partners in the independent sector
- Continue to expand our patient initiated follow up offer (PIFU)
- Develop our virtual care capacity to improve patient choice, access and experience
- Enhance our elective bed and theatre capacity opening the Jubilee unit in January 2023 and 3 modular theatres in April 2023
- Develop the NUH strategy for robotic operating.
- Continue to deliver our theatre workforce strategy
- Implement the Nottingham and Nottinghamshire mutual aid hub (hosted by NUH) to maximise opportunities to safely and effectively treat patients other organisations where capacity exists reducing waiting times
- Through a focus on GIRFT High volume low complexity (HVLC) programme, work maximise our day case and short stay planned care activity
- Deliver our Targeted Investment Fund (TIF) capital investment programme to expand our elective care capacity focusing on high volume low complexity work
- Through our diagnostic improvement programme deliver the capacity required to meet our DM01 performance targets for 2023/24

Specialised Services Clinical Strategy 3

Appendix 1

Why do we need a strategy

Specialised services are delivered in regional centres and are vital to the local and wider regional population. NUH is currently one of the leading specialised service providers in the Midlands. We have developed expertise in a significant range of specialised services, including major trauma and neurosciences, as well as many other adult and children's specialised services. We recognise that the regional population does not have equal access to these vital services at the current time. Working and collaborating with our partners we are seeking to understand population need, design and deliver sustainable pathways, and deliver outstanding health outcomes for the populations we serve.

Specialised services are hugely varied in nature, with services that cover a range of complexities (medical and surgical), types of condition, forms of treatment (e.g. various cancers), and size of patient treatment groups. For this reason, they tend to be provided in relatively few hospitals to maximise the clinical skills for patients with those complex and less common conditions, and with catchment populations of more than one million. This also means some of these services have small numbers of clincians, making the service 'fragile'. One of the solutions to this is improved collaborative working with other centres.

We are recognised as the East Midlands centre for major trauma and neurosciences due to the breadth and quality of the specialised services we provide. For example, NUH is only able to be the East Midlands major trauma centre because of the number of related services we provide, including neurosurgery, cardiac surgery, orthopaedics, vascular surgery and critical care. Our specialised services are supported by the largest number of critical care beds across the East Midlands region.

Specialised services enable us to harness technology to deliver cutting-edge care and drive further research and innovation to improve outcomes for patients with uncommon and complex conditions. NUH is commissioned to provide these services by NHS England and they play a considerable part in attracting and retaining high quality staff and providing teaching, training and research opportunities. We continue to work with our commissioners to make sure our services meet national standards and costs, and that the most up-to-date treatments are available for patients within our region.

Thanks to our status as a specialised services provider, when local patients need to access these servives their pathway and treatment is seamless, with the specialised element just part of the pathway. Integrated specialised services means our patients benefit from:

- Care closer to home
- Continuity of care/ seamless pathways
- Improved outcomes

However, evidence suggests that there is not currently equal access to specialised services across the region because they are delivered in such low volumes at a small number of geographically dispersed sites. We recogise our regional responsibility for patient care with these vital services and want to ensure the whole population has full access.

We also know there is more we can do in specialised cancer service provision, as more and more people are impacted by cancer. In 2016, cancer was the largest cause of death in Nottingham, accounting for 27% of all deaths. There are 4,484 new diagnoses of cancer in Nottinghamshire every year and, in 2014, 28,000 people in Nottinghamshire were known to be living with cancer – a number that is forecast to increase to 69,200 by 2030.

We are committed to working with our partners across the region to:

- Investigate and address the causes of disparities and ensure all patients have equal access to specialised services
- Gain a wider understanding of population health need
- Identify those specialised services that are fragile and support these services
- Design and deliver sustainable pathways
- Understand the impact of the upcoming commissioning delegation arrangements, from services being commissioned by NHS England to being commissioned by ICBs instead
- Gain full benefit from our specialised services operational delivery networks

24. www.midlandsdecisionsupport.nhs.uk/wp-content/uploads/2022/05/Strategies-to-reduce-inequalities-in-access-to-planned-hospitalprocedures_20220429iv.pdf
25. Coronavirus » Delivery plan for tackling the COVID-19 backlog of elective care (england.nhs.uk)
26. www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/

Director Responsible: Medical Director - Dr Keith Girling

What is the scope

Specialised services are not always easily separated out from our pathways. Therefore, we recognise a need to closely link any new plans to the UEC and planned care strategies that are being developed.

The specialised services strategy aims to raise the profile and understanding of all our specialised services and ensure full visibility and engagement across the organisation.

It will also support us to establish annual planning links, identify those specialised services that are fragile and need some support, and create the appropriate governance arrangements to enable us to optimise the benefits associated with:

- Recruitment and retention
- Private patients
- Research and innovation
- Financial benefits
- Teaching and Training

What does success look like

Developing visibility and understanding of our specialised services will enable us to work and collaborate with our partners in a more informed way to deliver outstanding health outcomes for the populations we serve.

- Reduce the number of fragile services in the East Midlands
- Integrate pathways to improve access and reduce health inequalities for patients across the East Midlands
- Better understanding of population need
- Improved clinical outcomes

Timescale

The draft strategy will be produced by Summer 2023, with full board sign off completed Autumn 2023.

What we will do in 2023

- Develop a specialised services clinical strategy by summer 2023, focusing on our specialised cancer services
- Continue to work with NHS England and ICBs to fully understand the impact of the delegation arrangements
- Collaborate and influence development of the East Midlands Acute Providers Network (EMAP)
- Lead the development of a definition and processes for fragile services, working with NHS England before wider collaboration across the East Midlands through EMAP

Patient Safety and Patient Experience

Enabling Strategy 1

Appendix 2

Why do we need a strategy

Delivering healthcare is a hazardous business carrying risks to the patient and to the caregiver. Providing care safely is everyone's business, aiming to deliver timely, cost effective care for patients with the best outcomes whilst keeping staff safe in the work they undertake. Patient Safety is best delivered by staff, patients and carers working together to identify hazards, and continuously improve the standards of care. This requires a clear strategic direction and ambition to embed safety throughout the organisation. Patient Safety is an intrinsic part of 'Quality' and the domains of effectiveness and patient experience need equal consideration and together are considered in the Trust's Quality Strategy.

Create a learning culture,

- To deliver high standards of patient safety we want to create a just and safe culture. This requires a genuine and compassionate engagement with patients, families, and staff – to both listen to their experience and to say sorry when things go wrong.
- Our staff must feel able to share their experiences and not be afraid to speak up if something has gone wrong. This means nurturing an open culture where we talk about the factors, such as processes and environment, which have led to something going wrong, rather than focusing on individual blame. We also need to recognise and celebrate when things have gone well.

Develop A skilled workforce

- Increasing the competency and capability of all staff and ensuring we provide staff with the tools they need to work safely is essential to patient safety.
- Training to recognise and respond appropriately to patient safety incidents and for each person to understand and play their part in promoting and overseeing quality.
- Everyone in the Trust needs to understand and value their role in relation to quality and patient safety, from Board to ward. We are therefore focusing on strengthening understanding of the role of the quality and patient safety team, creating the right environment and supporting staff to take a proactive approach to improvement.

Ensure our approach is in line with national requirements

- We will align our strategy to the new NHS Patient Safety Strategy[27]. This will include adopting a new approach to investigating and learning from incidents (the Patient Safety Incident Response Framework - PSIRF) and a greater focus on identification of opportunities for learning and sustained improvement.

Develop a Human Factors based approach

- To support us as we transition to PSIRF and drive a change in culture, focused on learning and improvement, we are adopting a 'Human Factors' approach to investigating and learning from incidents. This is set out in our new Human Factors Strategy.
- The Quality and Patient Safety Team are working closely with the Trent Simulation and Clinical Skills Centre, who are experts in this field, to deliver a joint response to embedding a Human Factors approach to learning across the organisation.

Patient safety incidents

- Incidents of harm, or potential harm (near misses) are inevitable. It is vital staff are supported and encouraged to report all incidents, – it is well known that a strong reporting culture leads to improvements in patient safety.
- We have a good reporting culture, but we need to ensure we take action to address the issues raised so that we do not repeat the same incident again.
- In preparation for implementing PSIRF, we must address our backlog of 'Serious Incidents'. Each Incident requires a comprehensive investigation to understand what went wrong and what we need to do differently to ensure the same thing doesn't happen again

Patient experience and engagement:

- We are committed to delivering continuous improvement in patient, family and carer experiences. We have robust systems and processes in place for measuring and monitoring feedback including: compliments, complaints, concerns, and comments. The complaint process can be daunting for our patients, and we know that responses are not always the best they can be. The wait for a response can be lengthy. Working with patients and the Complaints team, steps are being taken to improve this.
- We must move forward on both patient safety and patient experience, this includes ensuring patients are represented throughout the organisation as demonstrated by the Patient Partnership Group. It is vital that we put people with lived experience, including carers, at the heart of all we do by valuing their skills, knowledge and interests and giving them an equal voice.
- A review of the Patient Experience and Engagement Strategy is required to reflect experience and engagement in the current Healthcare climate developing a strategy which reflects National and local needs

27. www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

People First

Director Responsible:

Medical Director - Dr Keith Girling
Chief Nurse and Director of Infection Prevention and Control - Michelle Rhodes

What is the scope

The strategy will cover the range of issues identified above

What does success look like

- High levels of reporting of incidents and near misses but ongoing reduction in incidents of harm.
- Evidence that we are learning from when things go wrong – changes in practice lead to reduction in repeat incidents.
- Staff are not afraid to speak up and share their experience when things go wrong.
- Patients report a positive experience of care, and our outcomes are among the best in the country.

Timescale

Our new Patient Safety Strategy will be developed and published by the end of Q3 2023/24

What we will do in 2023

- Focus on embedding learning though different mediums and initiatives including: safety learning events, internal and external speakers, newsletters, champion roles
- Implement PSIRF approach to investigating and learning from incidents by end Q3 2023/24
- Relaunch the Learning Academy from January 2023. A revised approach will be adopted to make use of expertise from a range of disciplines, including quality improvement (QI) and transformation, human factors, patient safety, data analytics, shared governance, as well as clinical and patient representatives. It will help us to tackle some of our biggest quality and patient safety challenges in a unified way
- Map training requirements and deliver required training across the organisation by end Q4 2023/24.
- Launch tender process to replace or upgrade the system we use to capture incidents and other quality related data, such as risks and complaints. We aim to complete this by end Q3 2023/24
- Review of the Patient Experience and Engagement Strategy and ensure co-production with patients and the ICS by September 2023

Workforce (R&R) Enabling Strategy 2

Appendix 2

Why do we need a strategy

We aim to be the employer of choice within the NHS by creating environment that supports the recruitment and retention of the most talented staff. We need to develop a highly skilled, compassionate and flexible workforce that is equipped to deliver sustainable and resilient services to meet the needs of patients, both now and in the future.

- Rebuild our employer brand: The CQC reports, as well as negative publicity relating to maternity care, are feeding some of the challenges we face, particularly in terms of recruitment.
- Address our capacity, resourcing, and recruitment challenges: External factors, such as labour market shortages, play a significant part in the large number of vacancies we are trying to fill (approx. 2,300). This is a wider problem affecting the NHS, with an estimated 110,000 vacancies nationally.
- Improve staff experience: Staff are often working in incredibly challenging circumstances due to workforce shortages and increased demand and pressure. This leads to high turnover and sickness levels. Staff sickness is running at over 5%.
- Tackle prominent EDI challenges: We need to address and eliminate bullying, harassment, and treatment of staff from minority backgrounds as referenced in the CQC report and staff surveys. Work has started, initially focused on ethnicity as the immediate priority. This now needs to extend to all protected characteristics.
- Instigate the changes needed to improve organisational culture: Agreeing and adopting a set of values that all staff can buy into and an improvement in behaviour, civility, and professionalism by recruiting people who meet our value set.
- Improve systems and data: Inadequate systems to record and report workforce data have led to frustration and inconsistency. While there are efforts underway to digitally transform several processes, the admin load remains mostly on staff.
- Maternity care: This is an area under particular scrutiny at NUH , but also with recruitment expectations set out in the NHS planning priorities.

Director Responsible: Chief People Officer - Dr Neil Pease

What is the scope

A People Strategy was approved in November 2022. This contains our ambition to be the employer of choice in the NHS. There is a clear focus on the brand of the organisation and how we promote ourselves within what is a very competitive marketplace.

It is recognised that a significant area to be considered within the strategy is culture, leadership, and the impact this has on reputation the quality of care and ultimately recruitment and retention. The strategy talks about improving transactional processes with recruitment being a major process for improvement. The strategy also refers to staff wellbeing and how embracing the digital agenda can support our workforce in many different ways, from speeding up transactional processes to accessing educational and support opportunities.

What does success look like

When:

- The number of permanent staff increases as we close the vacancy gap
- Turnover will reduce to within accepted levels and staff experience improves year on year as reported in the NSS
- We will have created a modern workplace through our facilities, agile working practices and technology, to meet the aspirations and needs of all staff
- We employ a workforce that is truly representative of the communities we serve
- Being able to grow our own workforce by working with our partners in local authorities, schools and universities to develop and grow our own workforce supply
- We consider workforce inequalities and the role NUH can play as an Anchor organisation improving employment and educational opportunities
- Reducing the time of investigations and acting on concerns both of which impact staff experience and reputation
- We further develop and promote our health and wellbeing offer
- We will have comprehensively delivered against the 12 priorities agreed through the Big Conversation exercise
- Just Culture is embedded across the organisation which will catalyse improvements in organisational culture

Timescale

Refresh by September 2023

What we will do in 2023

- Expand and right size the recruitment team having agreed an investment package which will also reduce time to hire to 45 days
- Develop an approach, which focuses on Trust-wide recruitment by staff group
- Develop marketing to promote NUH, its opportunities and the region as a place to live and work
- Continue work on improving organisational culture
- Establish ourselves as an Anchor organisation, as part of the health and care system and contribute to the improvement of health inequalities

Workforce (Inclusion) Enabling Strategy 3

Appendix 2

Why do we need a strategy

In 2021, we were criticised publicly for allowing a culture of bullying, harassment, racism and discrimination to develop. We know that our black and minority ethnic colleagues find it harder to progress in their roles and feel less supported than their white colleagues. People with a disability report a similar experience. We also face widespread inequalities in our communities that directly affect residents and their ability to lead happy and healthy lives.

We are making progress, but there is more to do. We serve some of the most diverse communities within areas of huge deprivation. We need to ensure that our workforce reflects our communities at all levels. We need to develop a culture and atmosphere that is nurturing for everyone, regardless of background, ensuring that we provide the best outcomes and experience possible for everyone in our employment or care. Both statistics and the voice of our staff have shown us that, although we are making progress, we have much more work to do.

We have a BAME strategy which has eight aims, including increasing representation within senior posts, improving the recruitment and HR processes for staff, creating local metrics to monitor progress and a staff health and wellbeing programme for BAME staff.

The BAME strategy will continue to be advanced but there is a recognition that we must move to a position of inclusion where all staff are considered. With this in mind, we aim to develop a broader inclusion strategy to support us becoming a zero-tolerance organisation and drive the cultural changes needed to make this happen.

Director Responsible: Chief People Officer - Dr Neil Pease

What is the scope

- To tackle underrepresentation in senior positions for staff from minority backgrounds as established in the latest Workforce Disability and Race Equality Standards
- The achievement of delivering the national targets as per the Midlands EDI strategy (six high impact actions)
- To develop a comprehensive approach to equality, diversity and inclusion especially in addressing health inequalities
- Bring together EDI work across the whole organisation and create the golden thread that will improve our performance and outcomes from community, healthcare and workforce perspectives

What does success look like

- Improved staff survey engagement scores against benchmark comparator
- Higher levels of staff retention and lower rates of sickness absence
- The number of formal disciplinary cases of bullying, harassment and discrimination may increase by more confidence in reporting
- Will have embedded a cultural ambassador programme to support investigation processes
- The Scope for Growth strength-based approach to talent management will be delivered and linked to progression and study leave policy
- We will use value-based recruitment with specific questions related to race, equality and inclusion
- Our workforce will better reflect the diversity of the community we serve
- We will have embedded a systemic leadership development intervention designed to create transformational change and enable a culture of diversity, equality and inclusion, where the power of difference is valued
- Freedom to Speak Up (FTSU) will work closely with EDI leads and staff network leads (while maintaining confidentiality) to identify patterns of bullying, harassment and discrimination concerning specific protected characteristics
- Include inclusion issues in Second Big Conversation programme
- Staff survey results will demonstrate improvement

Timescale

The Inclusion strategy will be developed by December 2023

What we will do in 2023

- Launch the EDI Oversight group led by an non-executive director.
- Appoint a new Director of EDI – a new role for NUH
- Review the current EDI provisions in the Trust
- Launch the new inclusion strategy and align our objectives to the new national EDI strategy to be launch in April 2023

Medium-term financial strategy
Enabling Strategy 4

Appendix 2

Why do we need a strategy

All NHS organisations are required to break even as a statutory duty. Achieving financial sustainability requires a strategic approach to ensure we use our resources as effectively and efficiently as possible over time. This will allow us to continue to invest in our people, buildings, and equipment we need to be financially sustainable.

- The NHS financial model is returning to one where elective care funding is linked to activity whilst emergency care is largely funded through a fixed payment. In addition separate Covid payments are mostly being withdrawn with ongoing costs re-inbursed through normal payment mechanism. This reflects the priorities of the NHS as it faces the challenges of emerging from the pandemic and associated elective backlogs while returning to delivery of the objectives set out in the Long-Term Plan
- This will require a paradigm shift in approach as we seek to return to a sustainable financial position, while managing flow and workforce challenges at a time when the efficiency challenge set to the NHS is expected to be a minimum of 2.7%
- Deliver a Quality improvement and waste reduction programme (QIWR) in excess of 3% will be required. Our award winning Patient Level information and coding system (PLICs) and WAVE teams will identify opportunities and how to achieve them.
- In the short term, our ICS has been set the challenge of ending the 2022/23 financial year a deficit of no greater than £25m (with our deficit limited to £20m)
- Like many Trusts across England, comparing the current year to the 2019/20 pre-pandemic year, we have invested in more staff and more technology, but the volume of treatment we are providing has not increased. This is putting pressure on public finances and more importantly on our ability to address waiting lists
  - Our staff numbers have grown by 1,772 (12%) since April 2020
  - Spending on agency, bank and locum staff has increased by £54.4m (115%)
  - Overtime, waiting list initiatives and extra duty payments have increased by £9.7m (91%)
- A credible financial strategy provides assurances that our spending plans are affordable over the medium term (five years) and supports our reputation nationally, helping us avoid further intervention and placing us in the best position to obtain national capital investment and encourage recruitment
  - Supports us in the journey of "well led" organisation

1. Enables us to invest to improve our ageing buildings, our underpinning technology and our major medical equipment, as well as obtaining approval for our major capital schemes such as Tomorrow's NUH (TNUH) [28], Maternity and Neonatal redesign (MNR), National Rehabilitation Centre (NRC) and the Targeted Investment Fund (TIF) bid
- Ensuring our financial plans are fully aligned to the organisation's priorities

28. www.nuh.nhs.uk/tomorrows-nuh/

Director Responsible:
Chief Finance Officer - Duncan Orme

What is the scope

- Ensure that NUH is financially resilient, stable and sustainable for the future.
  - Maintaining a strong control environment
  - Address reliance on agency use
  - Delivery of QIWR programme and elimination of waste
- To ensure that effective financial planning contributes to the delivery of the Trust strategy and priorities.
  - Activity and workforce planning in particular recruitment and retention
  - QIWR and transformation planning
  - Focus on productivity
  - Capital planning aligned to site master plan and reconfiguration plan
  - Approval and delivery of new hospital programme schemes
- To plan for future resources and maximise income opportunities.

What does success look like

- Developing a credible plan to achieve break-even position (over two to three years) while meeting short-term expectations.
- Our objective is to be the most effective and efficient provider of secondary and tertiary care.
- Key to this is improved flow through our emergency pathway resulting in lower reliance on agency spend and increased elective productivity, resulting in greater income earned.
- An effective recruitment and retention strategy should result in reduced reliance on agency spend and higher productivity.
- Supporting our ambition to invest in technology, our patient environment and high-quality equipment.
- Delivering on our major capital schemes (TIF, MNR, NRC, TNUH).
- Achieving One NHS level 3 accreditation.

Timescale

The draft strategy will be produced by Spring 2023, with full board sign off completed Summer 2023.

What we will do in 2023

- Deliver a financial plan that is acceptable to the ICB and NHSEI and supports elective recovery.
- Enhance the control environment.
- Enable a QIWR programme which addresses agency spend, MSFT and elective productivity
- Deliver on capital programme that delivers an elective hub at City, carbon reduction and supports major schemes.

Digital and Information Enabling Strategy 5

Appendix 2

Why do we need a strategy

Digital, technological and scientific expertise, alongside the use of data will increasingly continue to have a material impact on the delivery of care, increasing safety, improving population health outcomes, and reducing costs in the future. A refreshed holistic digital technology and data strategy to achieve this will be critical to our success, empowering our people using technology and business intelligence to develop together in line with opportunities available as a leading hospital in a digital world.

- We have state-of-the-art equipment in some areas, yet in others we have outdated technology.
- Paper based recording also exists alongside state-of-the-art electronic systems. Staff, patients, and the public have higher expectations in line with technology elsewhere in their daily lives.
- Resource constraints have created a lack of sustainable technology re-fresh programme, resulting in often unreliable, slow to access, multiple, disconnected applications and data in fixed locations and in some cases not adequately supported.
- We must move from data rich, often looking backwards to information rich and looking forwards. Covid-19 showed we can make better, more informed decisions through better data collection, reporting and data modelling. Data quality limits our current use.
- Increased patient expectations demand our interactions could be more convenient with digital solutions so that access to and collaboration on their own patient records is supported by technology, as well as safer care and patient experience improvements.
- Our WAVE programme that looks at how data can inform waste reduction and the development of efficient pathways need to be supported by efficient flow of information.
- We have a fragmented analytic structure with issues with key person dependency, lack of standardisation and no coherent set of priorities across all the analyst teams which leads to gaps in knowledge, conflicting information, and low business continuity.
- We want to work with our people across the organisation to improve their use of information.
- Currently our data warehouse is a constraint, requiring investment.
- Our New Hospital Programme will provide a catalyst to enable staff and patients to fully benefit from technology improvements. Smart hospitals will accompany the investment in new skills to exploit the potential.
- Historically, many of our 'departmental' systems including Human Resource systems and data reporting have sat outside of digital and data teams, this limits our ability to support the workforce strategy, needing resolution

Director Responsible: Chief Digital and Information Officer - Andy Callow

What is the scope

- A central, organisation-wide, real-time electronic patient record (EPR): a shared electronic patient record along patient pathways ensures all parties can in real-time contribute to care delivery and planning.
- Increased clinical functionality and links to diagnostic systems, across multiple patient pathways will remove the need to ask the patient for information repeatedly and also for staff to re-key data.
- Where appropriate we will use mobile capture and input at the bedside.
- Business Intelligence to support all of our initiatives: develop population health management capability in collaboration with system partners. Using artificial intelligence and human skills in designing care services as part of a regional 'Ecosystem', exploitation of our Digital Twin technologies to support prediction, inform decisions and increase productivity.
- Single version of the truth across the ICS, supporting workflows of health and care data and systems, enabling system wide efficiencies and planning fit for our population.
- Digital and Data across the organisation will have a holistic strategy enabling the development of our people, improving recruitment and retention. Ensuring we have world class technology and business intelligence enabling excellent care.

What does success look like

- A single Digital and Data Strategy, in line with the ICS strategic goals.
- Ongoing investment in our infrastructure, will mean reliable, safe and resilient foundations.
- Our workforce is digitally literate and empowered to work with data and systems, at NUH and across our ICS.
- We are an excellent employer; we attract good quality candidates, and we retain staff.
- Patient Experience is improved through the visibility of data to support Discharge and Flow, improving care by making the best use of technology and business intelligence.
- Citizens access and contribute to their own health and care record, promoting self-care and improving the experience of our patients.
- Our solutions interact seamlessly and are easy to use.
- A single version of data is available, enabling productivity, proactive planning, and informed decisions.
- Our people can work from anywhere, we have sufficient Digital tools including mobile technology for data capture and review.
- Good quality data allows consistent use of data to support scheduling and predictive analytics for proactive and informed decision making.
- Our people have confidence in Digital and our Data.

Timescale

A combined Digital and Informatics strategy will be designed and approved by December 2023.

What we will do in 2023

- Invest in our Digital and Data workforce, benchmarking to ensure we have the appropriate resource levels and skill mix, enabling improved recruitment and retention.
- Improve ward to board reporting implementing a standardised approach.
- Harmonise analytical roles across NUH working to a professionalised standard and to a unified strategy, invest in Divisional Insight managers
- Strengthening and working closely with external partners including the University to enhance our local skills and increase innovation opportunities
- Delivery of the priorities identified in our Digital Roadmap, including: commencement of the replacement of our core Patient Administration System (PAS); a single solution within our Emergency Department (Digital Front Door); Electronic Prescribing and Medicines Administration across all adult Inpatient wards; Digitisation of care plans and clinical case notes. Pathology; a single LIMs (Laboratory Information System) solution at NUH and SFH. Continue to develop our Maternity solution, including our people held record.

Estate and carbon Enabling Strategy 6

Appendix 2

Why do we need a strategy

Our estate should offer safe, clean, and fit for purpose facilities, allowing our staff to provide the best care for our patients. The estate is integral to our overall mission, with our plans for improvement and development described in our estate strategy and site master plans. Additionally, the size and scale of our estate impacts upon the global environment and we must look to minimise our direct and indirect emissions.

The following are the drivers behind the need for a refreshed estate strategy in 2023:

- Backlog Maintenance. Our estate is old, and we have the fourth highest backlog maintenance level in the NHS, valued at £407 million. Our approach to dealing with this has several components. We have increased our budget to tackle the most critical backlog maintenance issues, but we will only make serious inroads into an issue of this magnitude through a strategic programme of investment. Significant backlog maintenance will be addressed by virtue of Tomorrow's NUH, however not all buildings are included. Therefore, our estate strategy is being refreshed to address current and emerging risks around condition, compliance, and capacity of our estate.
- Respond to priorities from staff. Staff feedback has highlighted the need for improvements in facilities, such as staff restrooms and ready access to chilled drinking water, as well as improvements to processes including the minor new works request and delivery models.
- Reconfiguration Programme and major schemes. The reconfiguration programme is in development to take a 5-year view on critical clinical reconfiguration before and alongside our plans with Tomorrow's NUH. For example, the new maternity and neonatal facility on the Queen's Medical Centre site will provide a high quality environment for some of our most vulnerable babies, and will be sized to the capacity that our regional role requires. This scheme is about to be presented for final approval to NHSE and we will look to deliver the building programme to the scheduled completion date of December 2024.
- Green plan. As one of the largest organisations in Nottinghamshire, we are inevitably one of the biggest polluters, emitting 48,390 tonnes of carbon dioxide each year. We need to reduce our carbon emissions to contribute to the NHS ambition of achieving carbon net zero by 2040. We are doing this through our work with the Carbon Energy Fund (CEF) to deliver the public sector de-carbonisation schemes (PSDS) and travel to hospital/work schemes.
- Tomorrow's NUH. The program is part of the new hospital programme[29] aiming to deliver 40 new hospitals across England. Tomorrow's NUH aims to achieve a hot and cold site split with Queen's Medical Centre being our hot site for urgent care and the City campus our main cold site for planned care
- NRC. The National Rehabilitation Centre (£104m), also part of the new hospitals programme, will be the first of its kind within the UK, providing a dedicated NHS patient rehabilitation centre to transform rehabilitation services with integrated research and educational facilities.

29. New hospital building programme announced - GOV.UK (www.gov.uk)

People First

Director Responsible: Director of Estates and Facilities - Andrew Chatten

What is the scope

Our Estates Strategy was last agreed in March 2018 and will be refreshed to bring it up to date with current circumstances. It set out a two-phase programme to improve the built environment and engineering infrastructure. During the first five years we committed to investing capital and revenue resources to address our highest risk backlog and enhance our maintenance regimes to extend the lifecycle of critical plant. The second five years of this strategy was predicated on national funding through the Health Infrastructure Plan, which would be used to transform clinical pathways with estate investment as an enabler.

We published our Board-approved "Green Plan" in line with NHS England guidance in January 2022 which set out the scope of our carbon reduction activities.

- NHS target reduction to net zero by 2040 (for controllable emissions)
- Reduction in impact of energy, water, waste, transport, and procurement
- Delivery of the PSDS schemes at the Queen's Medical Centre and City Hospitals

What does success look like

- Refreshing our Estates strategy to take into account Tomorrow'a NUH, the current critical infrastructure condition and the Reconfiguration Programme describing key service developments over the next five years.
- The development of a NUH Estates master plan as a "live" roadmap for each site to guide the execution of operational plans within the estate, strategy.

Timescale

The draft strategy refresh will be produced by Spring 2023, with full Board sign off completed by Summer 2023.

TNUH - the pre-consultation business case for consultation with the public in the Summer 2023

NRC - final approvals is expected by spring 2023 and open the buildings to patients by the end of 2024

What we will do in 2023

- Deliver a refresh of the Estate Strategy that supports the Trust's reconfiguration programme
- Prepare and maintain site masterplans for each site
- To deliver improvements in staff facilities including travel to work
- Deliver on capital programme that delivers an elective hub at City, PSDS and supports major schemes

Partnerships
Enabling Strategy 7

Appendix 2

Why do we need a strategy

We have a history of working in partnership with several different partners across the public, education, and private sectors over many years. We know that we cannot achieve our vision, purpose, and strategic objectives without working closely with our partners and, therefore, we are reviewing and strengthening our approach to partnership working.

As our population demographics change, we will need to adapt and evolve to continue to provide the breadth and quality of services that are needed by the people that we serve. Working with our partners will be fundamentally important if we are to:

- Meet the health and care needs of our populations
- Support our workforce
- Achieve our strategic objectives

Our hospitals and health and care system are under extreme pressure and have been for some time now. With an ageing population and the healthcare backlog resulting from the Covid-19 pandemic, these pressures will not resolve themselves if we deliver healthcare in the traditional way. We recognise that we have a role in working with our partners to support:

- Our populations to stay healthy
- Our patients to manage their illnesses and health conditions
- Our staff by ensuring there is a sustainable workforce for the future

Partnerships are important to us. They are fundamental to us being a successful hospital and organisation. We need strong partnerships because:

- Many of our end-to-end pathways are delivered in collaboration with other partners. We need to work closely with other health and social care providers to ensure that patients can effectively navigate our system and receive the best care possible
- We are a large teaching hospital and have a responsibility for delivering our core services, training new colleagues, researching new treatments and technologies, and delivering specialised services. We have partners who have skills and expertise we do not possess, who we need to work with to deliver our core purpose and responsibilities
- We are also the largest employer in Nottinghamshire and are classed as an anchor organisation. As such, we play a vital role as a key partner to our wider population in the health and vitality of our local communities and economy.

We have many long-standing partnerships that we will continue to build upon. Legislative changes passed in 2022 also give us an opportunity to develop new partnerships that will support us to address the challenges we currently face, to deliver our strategic objectives, and meet the needs of our population. In refreshing our approach to partnership working we want to ensure:

- We continue to be a strong advocate for the development of place-based integrated models of care that reflect the needs of our local population and offer seamless service provision across partners
- We focus on partnerships, through adopting an "Anchor Institution" approach, which improves life for our patients as well as the communities in which we operate
- We strengthen our relationships with our two local Universities, University of Nottingham and Nottingham Trent University, to create sustainable healthcare models and maximise our civic contributions
- We strengthen our collaboration with Primary Care and General Practice to be an effective partner and play our role in alleviating current pressures and creating sustainable services
- We work with provider colleagues locally and regionally to establish sustainable services, design pathways that meet population need, and address inequalities

Director Responsible:
Assistant Chief Executive and Director of Integration - Tim Guyler

What is the scope

- We are reviewing our current Partnership Framework to ensure it appropriately interfaces with strengthened partnership working following the implementation of Integrated Care Systems
- There are several strategies that underpin partnership work through the ICS. Some of these are new (i.e., the ICP Strategy), while others already exist but are being reviewed to ensure we are delivering effectively through strengthened partnership arrangements(i.e. Joint Health & Wellbeing Strategy)
- Over the next 12 months, it will be important for us to be clear on the actions we can take to support the delivery of ICS agreed strategies and that our own internal strategies demonstrate aligned ambitions and actions
- As part of this, individual bi-lateral partnership agreements for key Trust partnerships within the ICS are being reviewed. These currently include our partnership arrangements with Primary Care, University of Nottingham, Nottingham Trent University and University Hospitals of Leicester.

What does success look like

- Refreshed Partnership Framework
- Developed Social Value Strategy
- Embedded partnership working across the Trust's objectives.
- Clearly defined partnerships with agreed objectives.
- Established provider collaborations; including East Midlands acute collaboration, Nottingham & Nottinghamshire provider collaboration, South Notts and Nottingham City Place Based Partnerships (PBP), Primary Care and General Practice

Timescale

We will review our current approach to partnerships and create a draft refreshed Partnership Strategy by 31 July 2023.

What we will do in 2023

- Refresh our Partnership Strategy and underpinning governance.
- Review, agree and implement refreshed MOUs with UoN, NTU and UHL
- Strengthen our partnership working with Primary Care and General Practice
- Continue to support the development of provider collaborative arrangements via: EMAP, ICS, Nottingham & Nottinghamshire provider collaborative, South Notts & Nottingham City PBPs
- Agree a Social Value Strategy progress related work programme

Education
Enabling Strategy 8

Appendix 2

Why do we need a strategy

NUH has a strong history as a teaching trust. Longstanding and successful relationships with our local Universities have helped us train many incredible healthcare professionals. Changes in our patient population, workforce diversity, funding pathways, technological developments, and the shift to more collaborative working across the system, present many opportunities to enhance our learning and education offer and be more ambitious about our role as a training provider.

However, the education function at NUH is fragmented across multiple portfolios which leads to:

- A lack of understanding of the true scale of investment in education and training.
- Professional silos and limited shared learning and good practice.
- A lack of robust governance and risk management and the management of performance and progress.

Furthermore, there are a number of drivers:

- We want to become the employer of choice in the region
- The changing nature of patient needs requires a skilled and flexible workforce capable of providing healthcare across traditional boundaries
- Generational differences within the workforce mean we need to think about roles and how they are delivered differently. Some roles may not even currently exist
- As we increasingly work at a system level, we need an educational strategy that optimises our teaching status.
- There are currently opportunities for growth which are not being fully optimised, for example the national apprenticeship levy

Director Responsible:
Chief People Officer - Dr Neil Pease

What is the scope

- Provide excellent education, training, leadership and practice development to support the current and future workforce in delivering the best care for our patients
- Improve and increase leadership capability and capacity
- Promote and support the personal and career development aspirations of our staff and the communities we serve
- Better education and training opportunities will drive improvements in staff recruitment and retention
- We will be able to optimise the use of emergent technology and simultaneously creating both education and employment opportunities

What does success look like

Establish our Trust as a nationally and internationally recognised centre of excellence in the provision of high quality healthcare education and training;

- Support improvements to staff recruitment and retention
- Clarity around governance and direction for all our educational activity
- Deliver education and training which directly benefits quality and safety of our patients
- Support and develop leadership capability and capacity and at all levels but with a specific focus on those with the most responsibility, such as mid-band leaders
- Promote and support the personal and career development aspirations of our staff
- Optimise the use of emergent technology and innovative ways of working
- Effective use of the apprenticeship levy which will result in increased opportunities and a broader portfolio
- Ability to collaborate with other organisations as part of the health and care system
- Provide improved governance and assurance surrounding this key agenda

Timescale

The Education strategy will be developed in 2023 following the appointment of Director of Education

What we will do in 2023

- Appoint a Director of Education to drive forward the coordination of all the different educational programmes we are involved in
- Work increasingly with our partner educational providers through agreed memorandum of understanding
- Restructure the education and development functions at NUH to align behind this direction of travel
- Create an Education Strategy for NUH

Research and Innovation Enabling Strategy 9

Appendix 2

Why do we need a strategy

We are a centre of excellence for research, innovation, education, and specialist services. We aim to significantly increase opportunities for our patients and staff to participate in high-quality research studies. Our ambition is to become an outstanding clinical partner to academia, industry, and local government and make NUH a centre for cutting edge research and innovation.

- We must maximise the benefits that R&I activity brings in addressing our three strategic challenges. This includes improving health outcomes and patient experience through early access to innovative therapies. In addition, there is evidence that recruitment, retention, and staff satisfaction are better in research active areas. Finally, a thriving R&I function will encourage a culture of challenge to the clinical status quo and drive the necessary service improvement.
- We must align research and innovation investment and activity with both local health priorities and the burden of disease, to help address health inequalities. We will enable clinical-academic collaboration by supporting regular events between our clinical staff and our academic partners to discuss and design solutions for unmet clinical need and service pressures.
- We must maximise potential sources of income from outputs of R&I activity, including but not limited to contract commercial research, exploitation of intellectual property, and research education provision.
- We are in the process of forming a regional NHS-academia-industry partnership. We will lead the 2024 accreditation bid to NHS England and will recruit and employ the managing director and delivery team.
- Our strong partnerships with local universities are one of the reasons NUH was chosen as the host for the new National Rehabilitation Centre (NRC) at Stamford Hall. The NRC will lead national and international trials involving service and product innovation for patients with rehabilitation needs.

People First

Director Responsible:
Managing Director - Research and Innovation - Maria Koufa-li

What is the scope

- The development of an Academic Health Science Centre
- In partnership with University of Nottingham and Nottingham Trent University develop strategy and new themes for the next Biomedical Research Centre and Clinical Research Facilities competition (expected in 2026)
- The curation and analysis of healthcare data to accelerate research and service development
- Supporting a culture of innovation across NUH and enabling the Tomorrow's NUH vision
- Plan for the Research Futures School as the main research education provider across the East Midlands
- Impact and translation of research evidence to practice plan

What does success look like

By April 2026, we will:

- We will have established Nottingham-wide NHS-academia-industry partnership. This will help to identify and address the greatest challenges facing the wider Nottingham health and care system and generate more collaborative and interdisciplinary research and faster development and adoption of innovation at scale
- Help NUH become a learning organisation and system leader in research, innovation, and quality improvement
- Recruit a minimum of 10% of our yearly admissions into trials
- Embed innovation labs in key clinical areas to maximise staff and patient participation
- Grow our contract commercial research income from £3 million to a minimum of £6 million

Timescale

The 3-year strategy and delivery plan will be presented to Trust Board for approval in May 2023.

What we will do in 2023

- Develop joint operational plan for health research with the University of Nottingham, Nottingham Trent University and the ICB
- Lead the 2024 accreditation bid to NHS England for the health science network and recruit and employ the managing director and delivery team
- Consultation with staff to refresh strategy by May 23

Communications and Engagement Enabling Strategy 10

Appendix 2

Why do we need a strategy

Good communication saves lives. From public health campaigns that increase the awareness of cancer symptoms to supporting the delivery of the Covid-19 vaccination programme, communications and engagement in the NHS plays a vital role in helping to save hundreds of thousands of people from serious illness and death.

As a national service funded through national taxation, the NHS is accountable to the public, communities and patients that it serves (The NHS Constitution). As an organisation committed to making the necessary improvements, we must ensure that the system of responsibility and accountability for taking decisions is transparent and clear to the public, our patients and our staff.

As the largest employer in Nottinghamshire, we must also ensure that there is authentic and effective internal communication and engagement with colleagues across our hospitals and community sites. This approach will ensure staff know what is happening across NUH, how their work contributes towards our objectives and how they can have their say. The pandemic saw Trusts across the country increase the amount of time spent communicating with staff (The Rapidly Changing NHS, 2020) and this will be an area of focus for our communications and engagement strategy.

There is an overwhelming body of evidence to show that engaged staff really do deliver better health care. NHS providers with high levels of staff engagement (as measured in the annual NHS Staff Survey) tend to have lower levels of patient mortality, make better use of resources and deliver stronger financial performance (West and Dawson, 2012).

Timely and effective communications is fundamental to how we engage with all our diverse audiences and, in particular, plays a vital role in improving both patient and staff experience. Similarly, communications that do not meet the needs of the audience, can have a detrimental impact on staff morale, public confidence and the trusts and confidence placed in an organisation. Effective communications and engagement ensures that patients, staff and the public know what their NHS is trying to achieve and how we're doing it, to help people believe in what we're doing and to bring them with us.

Director Responsible:
Acting Director of Communications and Engagement - Jack Ad-lam

What is the scope

The communications and engagement strategy will be informed by extensive engagement with staff, patients, the public and our stakeholders

It will set out a clear and consistent approach to external and internal communications with all our audiences to support our vision, our aims and our overall strategic objectives.

What does success look like

The success of the strategy and the work we do will ultimately be judged on the contribution made to overcoming the challenges identified in this report (flow, recruitment and retention and leadership and culture). In addition we hope to achieve:

- Improvement in staff engagement scores (as measured by the NHS Staff Survey)
- An effective and impactful approach to internal communications
- Consistent key messages and a brand identity that can be communicated to all audiences
- Effective communications and engagement which support the delivery of NUH's strategic objectives
- Build and maintain confidence in our services, through effective media and stakeholder engagement
- Develop consistent, measurable, high-quality communication channels suitable for our diverse audiences

Timescale

Engagement on the strategy will begin in quarter one with the final strategy agreed by September 2023.

What we will do in 2023

- Develop and deliver a comprehensive internal communications audit, the findings of which will inform the communications and engagement strategy.
- Invest in and create a dedicated internal communications function to take forward the finding and recommendations of the audit and ensure there is authentic and effective communication with colleagues across the Trust.
- Work in partnership with our patient and public groups to identify improvement opportunities for patient and public communications.
- Work with colleagues in HR to agree an improved approach to staff engagement.
- Work with others to deliver another Big Conversation to engage staff on our vision and values.

Glossary

Accident and Emergency (A&E)

Black, Asian and Minority Ethnic (BAME)

Care Quality Commission (CQC)

Cancer and Associated Specialties (CAS)

Clinical Assessment Unit (CAU)

Chief Executive Officer (CEO)

East Midlands Acute Providers Network - EMAP

Emergency Department (ED)

Equality, Diversity and Inclusion (EDI)

Integrated Care Board (ICB)

General Practitioner (GP)

Integrated Care System (ICS)

Integrated Care Partnership (ICP)

Joint Health & Wellbeing Strategy (JHWS)

Maternity Improvement Programme (MIP)

Maternity Neonatal Reconfiguration (MNR)

Memorandum of understanding (MoU)

National Health Service (NHS)

National Rehabilitation Centre (NRC)

NHS England (NHSE)

Nottingham University Hospitals (NUH)

Nottingham Trent University (NTU)

Patient Level Information and Coding System (PLIC)

Patient Safety Incident Response Framework (PSIRF)

Placed Based Partnerships (PBP)

Public Sector Decarbonisation Scheme (PSDS)

Quality Improvement Waste Reduction (QWIR)

Quality Service Improvement Redesign (QSIR)

Question and Answer (Q&A)

Queen's Medical Centre (QMC)

Research and Innovation (R&I)

Sherwood Forest Hospitals (SFH)

Targeted Investment Fund (TIF)

Tomorrow's NUH (TNUH)

Urgent and Emergency Care (UEC)

University Hospitals of Leicester (UHL)

University of Nottingham (UoN)

Virginia Mason Institute (VMI)

Whole Time Equivalent (WTE)

Working to Achieve Value and Excellence (WAVE)

Year to date (YTD)

Nottinghamshire County Council

Report to Health Scrutiny Committee

21 February 2023

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NUH CHIEF EXECUTIVE - MATERNITY SERVICES – CURRENT PERFORMANCE AND ONGOING IMPROVEMENT WORK

Purpose of the Report

1. To consider the latest information and the new Nottingham University Hospital (NUH) Chief Executive's perspective on current performance and ongoing improvement work in respect of maternity services.

Information

2. At the Committee's meeting on 14 June 2022, it was reported that NHS England and NHS Improvement had drawn an Independent Thematic Review of maternity services to a close, and that a new national review, led by Donna Ockenden would be undertaken. As a result, the Committee agreed that it was appropriate to step back and let the national Review get on with its vital work.

3. It was also agreed that the Committee would no longer consider the Care Quality Commission's report on its re-inspection of maternity services, published in May 2022, as the report would help inform the national Review. The Committee will have the opportunity to consider the national Review, once published.

4. The new NUH Chief Executive Anthony May is attending the Committee for the first time to provide his perspective on the key priorities and challenges facing the Trust. At its January 2023 meeting, the Committee requested that updates and perspectives on maternity services and winter planning should be the subject of discrete reports, rather than being included as a single wide-ranging report.

5. Mr May will be accompanied by Lisa Kelly, Chief Operating Officer, Michelle Rhodes, Chief Nurse and Sharon Wallis, Director of Midwifery to brief members and answer questions.

6. Further to the Committee's decision of June 2022 in relation to the Ockenden Review, the focus of the Committee' scrutiny for this agenda item will be on current performance and the ongoing improvement work (including those improvements that have been implemented as a result of interim feedback and engagement arising from the Ockenden Review).

RECOMMENDATION

That the Health Scrutiny Committee:

1) Notes the update information about the Ockenden Review.

2) Considers and comments on the information provided about the current performance and ongoing improvement work.

Councillor Sue Saddington
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Noel McMenamin – 0115 993 2670

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Title: Maternity update from Nottingham University Hospitals NHS Trust

Report for: Nottinghamshire County Council Health Scrutiny Committee

Date: 21 February 2023

Report prepared by: Michelle Rhodes, Chief Nurse, Nottingham University Hospitals NHS Trust

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1. Purpose of this report

This report provides an update of maternity performance and ongoing improvement work at Nottingham University Hospitals NHS Trust (NUH).

2. Introduction

In March 2022, the Care Quality Commission (CQC) carried out an inspection of maternity services at Nottingham City Hospital and the Queen's Medical Centre. Following this inspection, the maternity services at NUH were rated as inadequate overall.

Since then, the Trust has developed a comprehensive Maternity Improvement Programme (MIP) to address the findings identified in the CQC report. The MIP is now well established to support the delivery of sustained and continuous improvement.

3. Maternity Improvement Programme - overview and governance

The MIP is a comprehensive programme of improvement that includes actions we are taking in response to:

- Findings and recommendations from CQC inspections
- Feedback from women and families using our services, as well as staff working in maternity services
- Local learning gathered from investigations and coronial inquests
- Ongoing assessment of local needs
- Savings Babies' Lives standards (a care bundle for reducing perinatal mortality)
- Better Births (a five year forward view for maternity care)
- Recommendations and learning from maternity reviews carried out elsewhere (Morecambe Bay, Shrewsbury and Telford Hospital and East Kent)

Progress of the MIP is overseen by the Maternity Oversight Committee (MOC), which is chaired by a Non-Executive Director who is the Trust's Maternity Safety Champion.

The purpose of the MOC is to provide assurance to the Trust Board, through monthly reporting to the Quality Assurance Committee (QuAC), that the objective and aims of the MIP and the actions are being delivered and relevant recommendations from

national maternity reviews are actioned. NHS England's Director of Intensive Support and Maternity Improvement Adviser (National Maternity Safety Support Programme) are standing invitees. The Chair of the Maternity Voices Partnership attended the Committee in February 2023 and will be a member going forward.

4. Maternity Improvement Programme – progress to date

The MIP action plan is a well-established programme and has driven key changes across the service, helping to improve outcomes for women and babies. These include:

- Triage service (urgent care in pregnancy) - further to the separation of the triage service from the Day Assessment Unit in April 2022, the service has maintained an improved position against the 90% target of 'attendees seen within 15 minutes of arrival' to the triage area.
- Implementation of Birmingham Symptom Specific Triage System (BSOTS) - the service has implemented BSOTS, which ensures women are now seen in order of clinical urgency.
- Structured Handover of Care Review (SBAR approach - Situation, Background, Assessment and Recommendation) - we have implemented the SBAR approach, with October 2022 audit results showing 100% compliance across labour ward, sanctuary and maternity triage. SBAR supports clinicians to make effective escalation and efficient handover by providing a framework for communicating critical information that requires attention and action, thereby improving patient safety.
- Clinical risk assessment at booking appointment and every contact - audits demonstrate 100% compliance with risk assessments at the booking contact and continual assessment of risk throughout pregnancy.
- Investment in jaundice meters across the community – these meters test the level of bilirubin in blood to identify jaundice, which has resulted in babies being more accurately identified and treated. We have seen a reduction in serious incidents where jaundice is a theme.
- Enhanced Cardiotocography (CTG) equipment and training - improved training rates has resulted in fewer serious incidents, related to issues with CTG monitoring.
- Introduction of a maternity advice line - this provides 24 hour access to a midwife via a dedicated phone lines before or after birth
- A range of additional actions have been delivered, which include:
    - The opening of the Rainbow Clinic, to support those who have lost a baby
    - Expanded the infant feeding team
    - Improved access to clinical guidelines with the introduction of the Pocket Pal app for maternity staff and aligned Trust guidelines with national recommendations where available
    - Implemented BadgerNet, a maternity digital clinical system to support seamless care across all parts of the pregnancy pathway

- Investment in staff training for obstetric emergencies, foetal heartbeat monitoring and human factors
- Introduced foetal monitoring leads for midwifery and obstetrics, tasked with supporting the team to follow best practice
- Strengthened the senior clinical team, appointing more consultant obstetricians and providing better cover across our two hospitals
- Ongoing recruitment of midwives, including from overseas and the appointment of two heads of midwifery
- Focus on retaining midwives, offering the option to work flexibly to suit their needs
- Introduced a flow coordinator role to support the maternity service 24 hours a day, seven days a week
- Ongoing improvement of our staff feedback service and encouraging colleagues to raise any concerns through our Freedom to Speak Up Guardians and through other channels
- Improving record-keeping, including the assessment of risks and handovers between midwives and medical staff
- Developed a maternity dashboard to identify themes and trends in activity, clinical incidents and staffing to ensure better oversight of the service

5. Maternity Improvement Programme – next steps

Proposals have been developed for a new 'Accelerated Development' phase of the MIP during January-March 2023. A dedicated focus is being given to four priority areas of work, which will collectively deliver on 17 objectives within the improvement programme, by the end of March 2023. A sprint approach, is being applied to underpin the four priority areas:

1. Governance
2. Communications and engagement
3. Clinical pathways (postnatal care)
4. BadgerNet implementation (a maternity clinical digital system to record care from booking to discharge)

A recognised quality improvement approach has been adopted across the programme, using the five-step methodology of:

1. Set up and plan
2. Discovery
3. Design and trail
4. Implementation and roll out
5. Embed and sustain

The QI methodology is dovetailing with a strengthened project and programme management function and tighter reporting processes, to underpin monitoring and assurance mechanisms with greater oversight at divisional and executive level.

A programme management office (PMO) is in place to provide project and programme support, alongside dedicated leadership from transformation midwives and organisational development specialists. We also have some 'enabling work streams', such as staffing and culture and leadership, which continue to progress key aspects of the programme.

The remaining actions have been reviewed to form a matrix based on risk to enable prioritisation for the next quarter's actions. Actions have been reviewed to provide an overview of timescales for completion, resource required and outcome measures with an aim to complete by March 2024.

6. **Maternity Improvement Programme - accelerated development phase**

Governance: A sustainable, robust maternity governance system and process

- Robust framework for maternity QRS Governance Processes
- Serious Incident Reporting and Learning
- Risk Management Process
- Up-to-date Maternity Clinical Guidelines, SOPs and Pathways

The focus of this workstream will be to ensure robust governance processes and structures are in place to deliver safe services, including increased accountability at all levels. This focus will underpin the whole of the MIP and enable more effective and measurable progress across all of the work streams. The workstream will also oversee the delivery of our ongoing recovery work to eliminate any over-due serious incident (SI) investigations, open incidents and guidelines.

We monitor the total number of open SI's on the Strategic Executive Information System (StEIS) each week, with our ICB partners. The aim is to eliminate all outstanding SI investigations (for those which occurred pre 14 September 2022) by the end of March 2023. As of 6 February 2023, the backlog of open serious incidents is 29 (down from 61).

A trajectory for completion has been developed and is reviewed weekly, so any required mitigations can be identified. This is monitored via a weekly Incident Management Cell Structure, to give additional oversight to the recovery work.

Additional support to complete the investigations has been provided by a range of internal and external sources. Families have been contacted where there have been delays. The Local Maternity and Neonatal System (LMNS) which is part of the ICB, review and sign off the SI reports as part of the process. They have commented on the improved quality of the investigations and action plans. Additional processes for senior sign off have been implemented and will continue.

The Quality, Risk & Safety (QRS) team are led by a new Head of Midwifery and have recently undertaken a process-mapping exercise to strengthen and embed lessons learned from incidents, including measuring outcomes. The QRS team will lead on family liaison and engagement throughout the enhanced investigation process, with the support of a matron for engagement role, which is out to advert currently.

Communication: More effective communications and engagement

We have committed to:

- Improving communication with colleagues in maternity, including gaining feedback, through a baseline 'temperature check' to understand how we can better communicate and engage colleagues on the work of the MIP
- Using data and insight to inform our communications and engagement activity to ensure that our audiences receive the information most useful for them in a format that is suitable and accessible.
- Engaging proactively and openly with women, families and our communities, including through local media and stakeholders, and provide updates on the work of the Maternity Improvement Plan, including where we have more work to do.

In addition:

- The Director of Midwifery leads monthly engagement sessions with staff - the entire Maternity workforce is invited to each session, to communicate updates on progress within the Maternity Improvement plan and contribute to the ongoing improvement work
- Over the last year, the service has worked hard to improve the response rate to the Friends and Family Test (FFT), to ensure feedback from our families is received and acted upon. In December the service received 243 responses to the FFT, 93% of all responses were positive.
- The service has responded to the feedback from the national maternity survey, much of the postnatal pathway work combines pre-exiting actions as part of the MIP, as well as additional actions that are in response to the survey feedback.
- In January 2023, the service held a system wide event called 'Who's Shoes', to plan the future of the homebirth service.
- In March 2023, the Chief Executive and Maternity Safety Champion (Non-Executive Director) will hold a series of staff focus groups to listen and engage with colleagues in maternity

Postnatal Pathway: Clinical Pathway improvement focusing on the postnatal pathway

This workstream will focus on streamlining the postnatal pathway, with a view to the discharge process, and flow and efficiency. This is a key area of service user and staff feedback, and links to existing medicines management actions. Followed by continued improvements to the induction of labour and elective Caesarean section pathways already underway.

The planned benefits of this work will reduce the incidents associated with capacity and flow, such as diverts and the temporary closure of the service. The outcome of this priority will promote timely discharge for women, reduce waiting to be seen, and where appropriate women will experience midwifery led discharge. We hope to see a reduction in complaints and negative feedback on surveys in relation to elements of the postnatal pathway.

Digital Development: Continued development of the Badgernet information system

This workstream will work to ensure the delivery of the system into business as usual, addressing emerging data quality issues as part of the ongoing rollout. The launch of electronic capture of time stamps for the triage service and electronic assessment will form a part of this, supporting the improvement of key metrics aligned to practice improvements.

Successful implementation of Badgernet took place in November 2022. In the first month, 424 babies were born and added to Badgernet, with 681 bookings completed on Badgernet in Community. A full benefits evaluation exercise is being completed and the initial estimate indicates a positive return on investment. One of the key safety element of Badgernet is the 'break-glass' function. This was used 66 times in the first month alone, meaning clinical staff were able to access 66 electronic patient records that have been referred from out of area, that otherwise wouldn't be accessible.

7. National CQC Maternity Picker Survey Results (2022)

The National CQC Maternity Picker Survey 2022, was published on 11 January 2023. Picker is commissioned by 65 Trusts to undertake this survey, and results show our benchmarking position in relation to these trusts.

For this survey, the data for NUH was collected from all eligible maternity service users aged 16 and over, at the time of delivery, who had a live birth in February 2022. Our response rate to the survey was 41%, which is lower than the Picker Average of 48%. (Our response rate for the 2021 National Maternity survey was 58%).

In comparison with the National Picker Average (65 Trusts), the service has done significantly better in five questions (choice of where to have a baby, given help by antenatal midwives, involved in decisions during labour, personalised care after birth and feeding help and advice), about the same in 45 questions and significantly worse in three questions (able to get help when needed after the birth, partner able to stay in hospital and midwives input with feeding).

8. Workforce and staffing

Our most important asset is our people. Within a national context of workforce challenges in both midwifery and medical staffing, it is vital that NUH invests in people to reduce attrition and become an employer of choice. The following actions support this aim.

- Birthrate plus is a national workforce tool for midwifery staffing, reflecting the complexity and care needs of women, versus safe staffing levels and additional roles such as specialist midwives and managers. The Birthrate plus workforce report was received in December 2022 and a separate report has been produced to outline the findings. Based on current midwives in post, the gap is 32 whole time equivalents (WTE), which consists of 23 WTE clinical midwives across acute, and community midwifery services and nine WTE specialist roles. The NUH Trust Board has supported an over-establishment to provide an enhanced skill mix, above Birthrate plus recommendations. The business case for this is being developed for approval in March 2023.
- A recruitment and retention strategy and action plan for 2023 is currently out for consultation. In addition, a Local Maternity and Neonatal System (LMNS) workforce strategy was approved in December 2022 and will be presented to the System People and Culture Group.
- Maternity services are progressing a longer term workforce strategy for the next 3-5 years, aligning to LMNS strategy to include a review of models of care, innovative roles and skill mix reviews.
- A designated recruitment and retention matron is currently being advertised to provide additional capacity.
- Midwifery leadership capacity has been increased, with the recruitment of two heads of midwifery.
- Three new substantive Obstetric Consultants commenced in post in January 2023
- The proactive use of agency and bank colleagues to mitigate staffing gaps continues.
- Recruitment of international midwives, in consortium with other East Midlands Trusts also continues, with one midwife commenced in post and three joining in January 2023. A trip to South Africa took place in January 2023 to recruit international midwives, 18 posts offered for a summer 2023 start date.
- Following successful recruitment activity, in January we welcomed three international midwives plus ten newly qualified midwives, with offers to another twenty six people.
- An external company, supported by NHS England, has reviewed adverts for midwives at bands 5 and 6. The Trust is also liaising with regional peers to benchmark people metrics (vacancy, sickness and turnover).
- Enhanced rates in place for NUH contracted staff and competitive rates of pay for NHS Professionals (bank) staff.
- Recruitment incentives for newly qualified midwives in place since July 2021 and remain in place until December 2023 following recent review by the Executive and Divisional Leadership Team.

- A bespoke shortened ‘Nurse to Midwife’ course (MSc) commenced at Derby University in January, with all 10 places filled.
- Recruitment open day took place on 4 February 2023 for midwifery vacancies (band 5 and band 6) with further dates planned in March, May, July and November 2023.

9. Continued engagement with the Independent Review of Maternity Services (Ockenden Review)

We are committed to making the necessary and sustainable improvements to our maternity services and continue to engage fully and openly with Donna Ockenden and her team on their independent review.

On Thursday 2 February, NUH and NHS England colleagues met with Donna Ockenden and her team to receive early feedback. Donna provided feedback about where communication with women and families, written and spoken, should have been better.

Women and families can be assured that the feedback and learning that Donna shared us at the meeting, and throughout the review, will be used to make improvements to our maternity services immediately.

We are not waiting for the review to conclude before making changes and our staff have been working hard to make the necessary improvements now. Crucial to these improvements is ensuring that family voices are heard and we are encouraging people who have significant or serious concerns about their maternity care to contact the review team. We are also encouraging current and former staff who work directly in or closely with our maternity services, to come forward and engage with the review.

Nottinghamshire County Council

Report to Health Scrutiny Committee

21 February 2023

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NUH CHIEF EXECUTIVE - HEALTH AND CARE SYSTEM WINTER PLANNING 2022-2023 PROGRESS - NUH PERSPECTIVE

Purpose of the Report

1. To consider the latest information in respect of winter planning arrangements for 2022-2023, specifically from the NUH perspective.

Information

2. At its September and November 2022 meetings, the Committee considered and discussed in detail reports and presentations on the health and adult social care winter planning arrangements in place for 2022-2023.

3. Overall responsibility for these arrangements falls to the Nottingham and Nottinghamshire ICB, and an ICB representative, Rosa Waddingham, will be in attendance. However, the NUH Chief Executive Anthony May's attendance at this meeting provides the opportunity to hear from him how these arrangements are working specifically from the NUH perspective.

4. Mr May will be accompanied by Lisa Kelly, Chief Operating Officer, Michelle Rhodes, Chief Nurse and Sharon Wallis, Director of Midwifery to brief members and answer questions, as necessary.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Considers and comments on the information provided.

Councillor Sue Saddington
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Noel McMenamin – 0115 993 2670

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Title: Winter update from Nottingham University Hospitals NHS Trust

Report for: Nottinghamshire County Council Health Scrutiny Committee

Date: 21 February 2023

Report prepared by: Lisa Kelly, Chief Operating Officer, Nottingham University Hospitals NHS Trust

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1. Purpose of this report

This report provides a brief overview and update of winter planning, what has happened in terms of demand and the response to this by Nottingham University Hospitals NHS Trust (NUH).

2. Introduction

How did we prepare for winter?

NUH strives to deliver accessible, high quality services throughout the year. Winter is one of the nationally recognised pressure points where additional planning is required in order to maintain resilient services.

The aim of the NUH winter plan (appendix a) is to ensure NUH capacity, processes and systems are fit for purpose and resilient to meet the anticipated level of demand throughout winter and maintain and optimise patient safety. Our vision is to deliver a caring, safe and productive winter.

The NUH winter plan is underpinned by the following principles:

- Appropriate services are available for patients requiring care in the acute setting
- Patient safety is optimised and quality of care is maintained. Patients are not exposed to unnecessary clinical risk (including Covid-19, influenza and norovirus)
- The health and wellbeing of staff is maintained
- Any adverse impact on elective activity and associated patient experience, income and performance is minimised. Cancer and clinically urgent activity is preserved
- An agile approach is adopted with plans in place to respond to a potentially rapidly changing environment as a result of the Covid-19 pandemic and influenza
- Health and care partners across the Integrated Care System (ICS) will work together to offer appropriates services to our population in the right place at the right time

The winter plan was designed to:

- **Anticipate and assess** issues in maintaining resilient services
- **Prevent** the likelihood of occurrence and effects of any such issues
- **Prepare** by having appropriate mitigating actions, plans and management structures in place
- **Respond and recover** by enacting plans and contingencies as required

Key highlights from the winter plan included:

- There was uncertainty in winter 2022/23 as a result of the continued impact of the pandemic and learnings from the Southern Hemisphere relating to influenza. As a result, an agile approach was needed to respond to a potentially rapidly changing environment
- A nominal state bed model was developed based on elevated activity rates experienced in the first half of 2022/23 continuing with additional winter demand phased in
- The adult base ward bed modelling for the remaining months of 2022/23 showed a mitigated position against the nominal state and a peak bed deficit in Jan-23 of 18 beds against the 'challenging winter' scenario. It is important to note that residual, forecast bed position was based on the successful delivery of the mitigating actions to the intended level of impact
- Given the uncertainty and changes in non-elective demand, hospital length of stay and Covid-19 and influenza epidemiology; the modelling may not be as informative as in pre-Covid-19 years. We track the input parameters alongside the delivery status of our schemes. The delivery status of system schemes has been tracked within the ICS team
- The pressure from the modelled medically safe patient cohort provided significant scope for improvement. System plans were developed to significantly reduce the number of medically safe patients in hospital; it was of utmost importance that these schemes deliver
- Internal actions are in place to:
    - Reduce demand on our services;
    - Have the highest number of hospital beds open and enhance our bed configuration;
    - Enhance our processes and improve patient flow;
    - Make strategic enhancements in staffing.
- Escalation triggers for the Trust are monitored throughout the day (365 days a year), with corresponding actions cards in place to support de-escalation.
- 24/7 rotas are in place for site management Duty Matrons and clinical staff for all 24/7 services. On-call senior staff are in place throughout the year 24/7 (gold on-call and two silver on-call at all times).

The Nottingham and Nottinghamshire Integrated Care System has also produced a system winter plan (appendix b) providing an overview of how local organisations are working together to meet anticipated urgent and emergency care needs this winter. It

assimilates projections for healthcare demand, organisational actions to increase capacity and activity and shows the overall impact on the systems hospital beds.

3. Current situation

The bed model is based on two scenarios:

- **Scenario 1 (Nominal State):** This is based on elevated run rates experienced in the first half of 2022/23 continuing, with additional winter demand phased in the second half.
- **Scenario 2 (Challenging Winter):** This is based on an extremely challenging winter with additional demand pressures from cases of Covid-19 and Flu.

The demand over the winter period has seen the system as a whole move to track Scenario 2 in terms of Covid-19 and Flu admissions. In addition ED respiratory attendances surged significantly during the last fortnight of December across all age groups, but particularly in the 30-40-year olds who are not eligible for routine winter vaccinations. A corresponding increase in respiratory admissions during second half of December was observed, coupled with longer lengths of stay, caused NUH and the wider system to move into critical incident on 29 December, this is the second critical incident for NUH in December with a previous one being declared between 19 and 23 December for capacity and flow constraints.

Furthermore, Paediatrics ED attendances and admissions remained very high during this period; Covid-19 admissions peaked during the last two weeks of December and RCN industrial action took place on the 15 and 20 December, and EMAS industrial action took place on the 21 December some of which would have contributed to an increase in demand after the Christmas period.

4. Mitigations

A system critical incident was declared on 29 December. NUH came out of critical incident on the 6 January. In response to the increased demand, NUH repurposed three surgical wards to accommodate the high emergency admissions described above (79 beds) and further repurposed three bays to create 12 medical beds.

The impact of the above changes whilst essential for emergency flow have negatively affected planned care capacity. This was minimised through the festive period and also through admission via Barclay ward and the treatment centre. However, the continued use of the elective bed base to support non-elective surge has led to a significant loss of elective activity. Average elective admissions over the period from August to 28 November 2022 were 106, this dropped to 14 over the five days from 4-9 January 2023. Towards the end of January 2023 the number of patients in the NUH bed base who have tested positive for flu has started to reduce in a sustained way and the Trust is now in a position to re-establish our elective bed base and associated planned care activities and begin to increase our activity toward pre-winter volumes.

The total system planned mitigations for December 2022 were behind plan by 49 due to late funding approval. Funding for the additional UEC mitigations was confirmed by NHSE as part of the BCF funds on 21 November 2022 with local financial sign off on 16 December 2022. These large schemes are crucial as they are expected to save 50 acute beds (as assumed in the bed model).

NUH has also responded to the winter pressures experienced through:

- The introduction of NUH@Home, commencing on 1 November act as a bridge to allow early discharge whilst patients wait for either the start of a new package of care or a restart. By late January 15 patients have completed their NUH@H package, saving 82 bed days in total
- The establishment of the QMC Transfer Of Care Unit on ward A24 to support Medically Fit For Discharge (MFFD) patients with planned discharge dates, allowing specialist beds on base wards to be released
- Targeted increase in the use of the Discharge lounge, increasing numbers of patients through the unit
- In-reach of Gastroenterology into ED from April 2022 has yielded a 7% average avoidance of Gastroenterology specialty tags. It is anticipated that this will further improve from January 2023 due to the increase presence of Gastroenterology consultants on the QMC site due to winter investment
- Running a fourth emergency list twice a week from December 2022, early indications show a reduction in preoperative length of stay.

Further funding has been approved nationally to increase discharges during week commencing 9 January in addition to the BCF funds to create further system capacity. The system has thus bid for £1.67m to create additional p1/p2/p3 and interim bedded capacity together with wrap around assessment, therapy and nursing support which the system is currently in the process of mobilising.

The three taskforces (Acute Front Door, Acute Patient Flow and Discharge) within the Urgent and Emergency Care Programme have continued to deliver improvements. Highlights from December 2022 and January 2023 include:

- Successful embedding of “straight to specialty” process for patients arriving at ED with GP letters
- Increase in % of primary care patients streamed from ED between Nov and Dec (up from 15% to 18%)
- NUH Integrated Discharge Team (IDT) have appointed six new band four roles and have designed a new working model to be tested w/c 16 January
- There have been 316 patients admitted to a Virtual Ward between 1 December to 23 December
- Positive signs of reduction in EMAS conveyances, ED attends and NEL activity for Cohort 1 of High Intensity Service User patients
- Criteria for discharge now identified for emergency surgery pathways

- Virtual wards have been established for Paediatric Oncology, Surgical Triage Unit, Respiratory, Paediatric Jaundice, Maternity and Heart Failure cumulatively saving 67 beds since September 2022 to January 2023
- Introduction of PDSA trails of the reverse bed chain model to rapidly transfer patients from ED commenced on 16 January with plans to build upon the trials to inform the sustainability and viability long term of the reverse bed chain quality management operating model.

5. Conclusion

The NUH winter plan document presents a summary of planned activities based upon underlying demand and capacity assumptions. It is clear that the nominal state scenario underestimated the actual demand that was observed in the early months of winter and that the system began to track against the challenging winter scenario. NUH and system partners reacted to increase capacity and mitigate demand increases in response, which whilst effective for the emergency pathway also had a consequential negative impact on planned care capacity. Furthermore, unanticipated variables such as critical incidents, strike action and non-seasonal Strep A demand have increased pressure on NUH capacity that was not built into the initial winter plan.

Learning has been taken around how we forecast the impact of influenza and unforeseen variables such as Strep A and strike action. Further action is also needed around how we predict future demand trends, currently this is based on historical trends being representative of the future demand which therefore will miss these unforeseen variables. A forum will begin in March at NUH to better determine how we will plan for, respond to and manage future influenza and COVID surges.

Urgent and emergency services have experienced a combination of pressures impacting the whole system but most visibly at the front door. NUH and the system prepared extensively for winter, putting in place multiple mitigations and adding further when it was apparent winter demand pressure was higher than anticipated.

As described in the NHS England and The Department for Health and Social Care's Delivery Plan for Recovering Urgent and Emergency Care Services the NHS faced problems discharging patients to the most appropriate care settings, alongside the demands of flu and COVID peaking together, has seen hospital occupancy reach record levels. This means patient 'flow' through hospitals has been slower.

Building on this national guidance and NUH's recently published 'People First: Reflection on a 100 day journey and looking towards the next 1,000 days' identifies improving emergency care flow (and its consequent impact on all our waiting times), recruitment and retention, and leadership and culture are the top priorities for NUH. The next phase of our continuous improvement journey is to move away from a 'winter plan' and develop a longer-term urgent

and emergency care strategy that takes in to account all seasonal variations, due for completion in April 2023.

The NUH Trust Board recognise the significant input and contribution of our clinical divisions, corporate teams and system colleagues that continue to work tirelessly to plan service provision to provide the best care possible to our local population and patients using the resources available.

Appendices

Appendix A

Nottingham University Hospitals NHS Trust winter plan

Appendix B

Nottingham and Nottinghamshire ICB winter plan

Appendix C

Incidents declared since September 2022:

1. 27 September - 5 October: Capacity and flow – high medically safe numbers in the Trust, with pressure felt at the front door. Long wait times for beds out of ED. Difficulties to discharge into the community.
2. 11 October: ICT issues – Network connectivity lost across all NUH sites. Unknown fault initially, but systems restored after 3 hours 40 min.
3. 23 November: ICT issues – failure of a pathology IT system (WINPATH) plus wider ICT issues across the Trust. Caused by a planned upgrade that developed a fault in the system. WINPATH issues affect our ability to process bloods, which created a backlog of test and disrupted flow through the Trust, including discharge.
4. 19-23 December: Capacity and flow - Severe pressures in ED with lots of respiratory patients. High number of closed beds due to infection. The Trust concurrently managed RCN and EMAS strikes, and a supply issue affecting oxygen cylinders.
5. 29 December - 5 January: Capacity and flow – continuation of pre-Christmas pressures. Impact mostly felt in admission areas.

NHS
Nottingham
University Hospitals
NHS Trust

Winter Plan

We Listen
We Care

2022/23

Contents

1. Executive summary

- There is uncertainty in winter 2022/23 as a result of the continued impact of the pandemic and learnings from the Southern Hemisphere relating to influenza. As a result, an agile approach will need to be adopted to respond to a potentially rapidly changing environment.
- Adult base ward bed modelling for the remaining months of 2022/23 show a mitigated position against the nominal state and a peak bed deficit in Jan-23 of 18 beds against the challenging winter scenario. It is important to note that residual, forecast bed position is based on the successful delivery of the mitigating actions to the intended level of impact. Given the uncertainty and changes in non-elective demand, hospital length of stay and Covid-19 and influenza epidemiology; the modelling may not be as informative as in pre-Covid-19 years.
- The pressure from the modelled medically safe patient cohort provides significant scope for improvement. System plans are in place to significantly reduce the number of medically safe patients in hospital; it is of utmost importance that these schemes deliver.
- Internal actions are in place to: (1) reduce demand on our services; (2) have the highest number of hospital beds open and enhance our bed configuration; (3) enhance our processes and improve patient flow; and (4) make strategic enhancements in staffing.
- Specific Christmas and New Year plans will be created in November and embedded in this plan.
- Escalation triggers for the Trust are monitored throughout the day (365 days a year), with corresponding actions cards in place to support de-escalation. A full capacity protocol is in place.
- 24/7 rotas are in place for site management Duty Matrons and clinical staff for all 24/7 services. On-call senior staff are in place throughout the year 24/7 (gold on-call and two silver on-call at all times).
- Key risks have been documented with work continuing on mitigations.

2. Context

Nottingham University Hospitals NHS Trust (NUH) strives to deliver accessible, high quality services throughout the year. Winter is one of the nationally recognised pressure points where additional planning is required in order to maintain resilient services.

The aim of the NUH winter plan is to ensure NUH capacity, processes and systems are fit for purpose and resilient to meet the anticipated level of demand throughout winter and maintain and optimise patient safety. Our vision is to deliver a caring, safe and productive winter.

The NUH winter plan is underpinned by the following principles:

- Health and care partners across the Integrated Care System (ICS) will work together to offer appropriates services to our population in the right place at the right time
- Appropriate services are available for patients requiring care in the acute setting
- Patient safety is optimised and quality of care is maintained. Patients are not exposed to unnecessary clinical risk (including Covid-19, influenza and norovirus)
- The health and wellbeing of staff is maintained
- Any adverse impact on elective activity and associated patient experience, income and performance is minimised. Cancer and clinically urgent activity is preserved
- An agile approach is adopted with plans in place to respond to a potentially rapidly changing environment as a result of the Covid-19 pandemic and influenza.

This plan is to be read in conjunction with and is supported by the following documents:

- Nottinghamshire ICS System-wide Winter Plan 2022/23 – recognising the need for a whole-system accountability and responsibility framework that span health and social care to effectively manage patient safety.
- NHS England Cold Weather Plan.
- Management of Adult and Children Patient Flow Policy (includes escalation triggers and actions) (CL/CGP/087).
- Trust Emergency Preparedness, Resilience and Response (EPRR) policy (GG/CM/050).
- Major incident plan (GG/CM/052 Parts A, B & C).
- Business continuity planning policy (GG/CM/054).
- Discharge Policy for Greater Nottingham (CL/CGP/096).
- All usual clinical and operational policies which remain active throughout winter.
- National 'next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter' letter.
- National 'going further on our winter resilience plans' letter.

This document is structured as follows:

- **Anticipate and assess** issues in maintaining resilient services
- **Prevent** the likelihood of occurrence and effects of any such issues
- **Prepare** by having appropriate mitigating actions, plans and management structures in place
- **Respond and recover** by enacting plans and contingencies as required.

The embedded slide pack below is a summary document of 2022/23 winter planning (including some reflections on winter 2021/22) that was considered by our Operational Leadership Team on 5 Sep-22*
*NM slide pack attached as appendix to report.

This winter follows an unprecedented 30 months with the Covid-19 pandemic. There have been staffing pressures throughout the system which has been limiting some services and derogating staffing levels in others. Although a wellbeing offer is in place at both Trust and system-level, our workforce is entering the winter period tired and in some areas fragile.

The table below provide context on some key indicator changes we have seen when comparing the month of September with previous years.

Indicator	Change between Sep-21 and Sep-22	Change between Sep-19 and Sep-22
Emergency Department attends	Reduced by 11% (61 patients per day)	Reduced by 7% (40 patients per day)
Average discharge length of stay	Increased by 12% (0.7 days)	Increased by 8% (0.4 days)
Average number of General and Acute beds open	Increased by 89 beds to 1,542	Increased by 32 beds
Average number of medically safe for transfer patients requiring a supported discharge	Increased by 46% (increase of 54 patients waiting)	Increased by 27% (increase of 37 patients waiting)

3. Anticipate and assess

3.1 Reflecting on winter 2021/22

Winter 2021/22 was once again dominated by Covid-19 with surging demand pre-Christmas as the Omicron wave peaked in early Jan-22. Community infection levels were high and with no national lockdowns; demand on many hospital services remained high. However, the demand on critical care due to Covid-19 was significantly lower than the previous winter period with many patients being in hospital 'with Covid-19' as opposed to being in hospital 'due to Covid-19'.

Pathway segregation remained in place across our hospitals all winter which adversely impacted on patient and staff flows between areas. Staff sickness levels were high in line with high prevalence of Covid-19 in the community; this placed significant pressure on an already tired workforce.

In many regards the pressures from winter did not ease with the change in seasons in 2022. We have continued to have significant delays in admitting patients with long 'fit for ward' times and an associated extended mean time in our Emergency Department (ED). The number of patients in our hospitals whilst medically safe to leave was high over the winter period and grew further during the summer (at odds with usual seasonal trends) placing significant pressure on effective patient flow through our bed base.

Over the winter period of 2021/22 elective activity was curtailed as bed capacity was required to support non-elective demand (including Covid-19 and medically safe patients). Theatre availability has also been constrained throughout 2022 due to staffing pressures; this has adversely impacted on the volume of elective surgical activity as we have been working hard to recovery and restore our elective programme.

3.2 Modelling winter demand - bed model

On an annual basis, detailed modelling is undertaken in order to forecast capacity required in terms of our acute adult base-ward bed capacity. This is our largest cohort of beds and recognised as being the most challenged in terms of provision of effective patient flow. In terms of demand and capacity planning, the bed model is considered an important driver to inform operational plans as bed pressures are often a key driver to: (1) patient delays; or (2) restrict the volume of patients that we are able to treat resulting in increased elective backlogs and increased risk of delay-related harm across all our pathways. There are a variety of risks recorded on Datix with a number considered as significant risks scoring 20 and above.

Bed modelling in the context of annual planning has a long history. The core modelling approach remains largely unchanged, although it has been refined continuously over time. The key focus remains on the adult general and acute base-wards with a percentile-based modelling approach calculating demand projections at specialty group level. The key modelling parameters include: the planning percentile (typically 85th i.e. the forth busiest day in the month); a target bed occupancy rate; medically safe bed occupancy levels and capacity assumptions and mitigations (the mitigations include physical capacity alongside efficiency savings). The inputs relating to historical bed occupancy, demand modelling assumptions and capacity assumptions are used to produce bed demand projections and resulting views of any residual 'bed gaps'.

A variety of planning scenarios have been modelled including one to align to the national planning guidance. The scenario in alignment with planning guidance (low Covid-19 demand, pre-pandemic levels of non-elective demand, 104% elective demand, pre-pandemic length of stay and reduced levels of discharge delays) created a relatively balanced bed position. However, the planning guidance assumptions and the operational reality of the year-to-date position at the end of the first quarter of 22/23 were very different. Broadly speaking the key changes can be summarised as:

- Covid-19 demand continued to present 'waves' with significant numbers of positive patients. Recent trends are that the majority of patients are in hospital 'with' Covid-19, rather than 'due to Covid-19'. The Covid-19 status of patients does impact on patient placement, length of stay and also the ability to discharge the patient in a timely manner (particularly if transferring into a community service). Covid-19 prevalence not only impacts on hospital capacity from a patient perspective, it also places constraints on our workforce affecting our ability to maintain our services at the level we would wish (for example: offer the planned number of theatre sessions).
- One day plus non-elective demand has remained below pre-pandemic levels. This, in part, is likely to be due to increased levels of Same Day Emergency Care (SDEC) activity and other system demand avoidance schemes/initiatives.
- Length of stay for patients on our base wards has remained above pre-pandemic levels. This partly will be due to increased SDEC; however, will more fundamentally link to ongoing Covid-19 demands and the following point.
- The number of patients medically safe and awaiting a pathway 1, 2 or 3 discharge (formerly known as a 'supported' discharge) have been exceptionally high and have not followed usual seasonal trends (reduced levels in the summer period).

The net result of the above factors has been significant hospital flow challenges (adversely impacting on a number of our performance metrics) and difficulties to increase elective activity at the pace we would have wished and in alignment with our operational plan.

Due to the variance in our lived reality, we created further scenarios. Our 'nominal' state was further refreshed at the end of quarter one based on our year-to-date experience. The key parameters/ assumptions included:

- Non-elective demand: 94% (based on Jun-22) at 85th percentile (includes influenza demand as per 2019/20)
- Elective demand: 104% (based on activity plan)
- Length of stay: Based on 21/22 H2 out-turn
- Medically safe: Uplifted levels based on elevated numbers seen in first six months of 2022
- Bed occupancy target: 90%
- Core bed base: 1,283 adult G&A beds with 2.95% closed bed factor applied
- Variable capacity: Peak total of 98 beds in Jan-23 to Mar-23
- Efficiencies: Peak total of the equivalent of 132 beds.

In additional to the above 'nominal' state, a 'challenging winter' scenario was created at system level. The challenging winter scenario added additional demand pressure due to Covid-19 and influenza alongside additional capacity constraints due to a likely increase in bed closures/pathway segregation due to infection. In developing the 'challenging winter' scenario evidence from Australia was used, based on their influenza experiences, together with University College London forecasts around future Covid-19 waves.

The latest Trust-wide view of the adult base ward bed model outputs is shown in section five below.

3.3 Modelling winter demand - bank holiday pressure points

In order to understand specific pressure points throughout the year (i.e. bank holidays), analysis is undertaken considering historical data normalised around the New Year bank holiday (day zero).

For the Christmas and New Year period, Emergency Department (ED) attends and admissions, emergency admissions (all routes) and discharges have been considered for the two weeks running up to Christmas and the two weeks following New Year. The outputs can be found in the embedded Excel files below.


Christmas New Year Emergency Trends.xls


Christmas Holiday Analysis 2019-21.xlsx

Key messages include:

- Ambulance arrivals tend to remain at stable levels during Christmas. 2019 and 2020 saw reductions in arrivals after the end of the Christmas holiday period.
- Daily average ED attendances on average drop by circa 45 patients per day during the Christmas holiday. They tend to remain at a lower level in the two weeks after the Christmas period.
- Daily average non-elective admissions and discharges on average drop by circa 20 patients over the Christmas period, with net outflow (more discharges than admissions) in the first week and net inflow (more admissions than discharges) in the second week of the holiday period.
- Daily average elective admissions reduce by circa 40% during the Christmas period.
- Daily average supported discharges typically reduce during the second week of the Christmas period.
- Medically safe patient numbers typically accumulate across all pathways during the Christmas period.

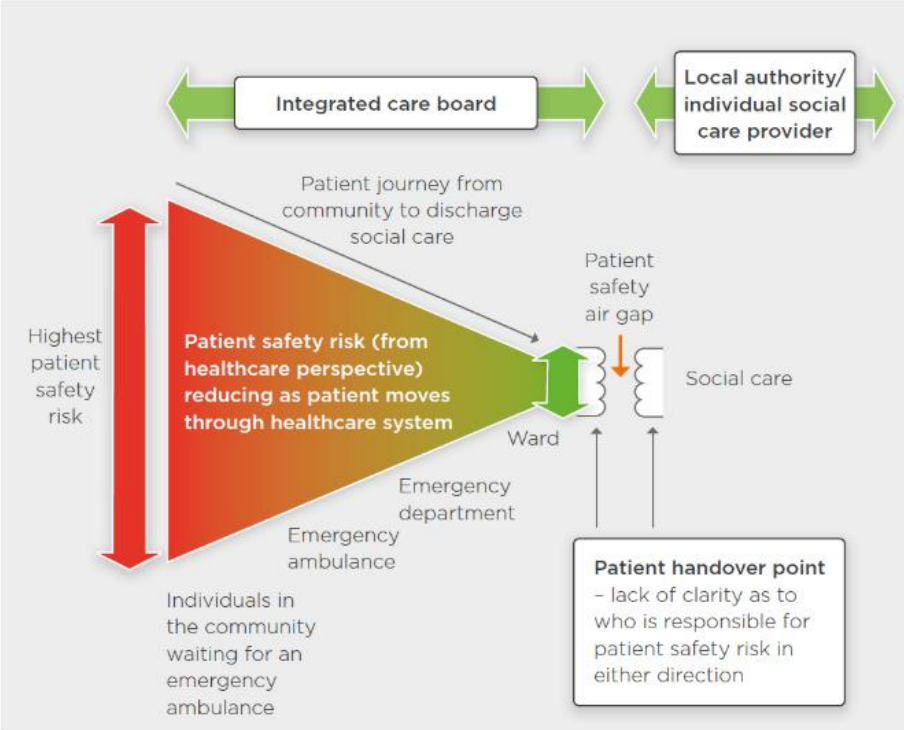
The embedded outputs are shared with divisional teams as part of the specific Christmas and New Year planning exercise that takes place in November each year. This exercise is completed in November once staff rotas are clearer (typically set 6-weeks in advance at all times) due to the relationship between service plans and staff rotas.

3.4 Risks

The Trust risks associated with capacity-related winter pressures can be summarised as:

IF	THEN	RESULTING IN
▪ Physical space is insufficient to meet demand. ▪ Unable to provide sufficient medical and nursing staff to meet demand. ▪ Unable to maintain a resilient workforce. ▪ Insufficient equipment to meet demand. ▪ Insufficient number of hospital beds to meet demand. ▪ Insufficient system capacity to maintain system flow and the timely transfer of medically safe patients. ▪ Experience a influenza pandemic or significant norovirus or CRE outbreaks. ▪ Experience any significant issues with the fabric of our buildings or other infrastructure (e.g. ICT).	May not deliver resilient services over winter.	▪ Adverse impact on patient safety. ▪ Inability to deliver appropriate services to our patients (particularly on elective pathways). ▪ Adversely impact on our reputation causing undesirable media coverage and a loss in confidence from the population we serve. ▪ Reduced staff morale, resilience and retention. ▪ Lack of compliance with national standards causing undesirable regulatory action.

The diagram below is extracted from a Nov-22 Healthcare Safety Investigation Branch interim bulletin titled ‘harm caused by delay in transferring patients to the right place of care’; it provides a simplified diagram of risk to patient safety as a patient is moved through the healthcare system to social care.



Key controls and areas of mitigation include:

- Deliver the actions detailed in this winter plan and our ICS system winter plan.
- Maintain a healthy workforce to maximise the ability of the acute to be able to respond to urgent and emergency care pressures (including encouraging the uptake of the flu and Covid-19 vaccines and promotion of existing health and wellbeing offer).
- Flexible use of staff to cover areas experiencing shortages with the use of bank, agency and locum staff where necessary and offering overtime.
- Timely completion of maintenance to keep estate in good condition.
- Enact the management of patient flow policy, full capacity protocol and surge plans as required including continuing to off-load ambulances as promptly as possible; even when this results in crowding in our Emergency Department recognising the patient safety risks detailed above.

4. Prevent

4.1 Preventing and managing infection

The Trust has in place a series of guidance and policies that are followed throughout the year to avoid, manage and contain infections including any cases of diarrhoea and vomiting (D&V), influenza and norovirus. These include:

- Infection preventions and control policy (CL/CGP/031)
- Outbreak of infection policy (CL/CGP/014)
- Viral gastroenteritis policy (CL/CGP/032)
- Isolation policy (CL/CGP/033)
- Respiratory viruses policy (CL/CGP/058)
- Pandemic influenza policy and procedure (GG/CM/020)

Planning for the annual influenza fighter campaign is underway with a nurse in place leading the vaccination process across the Trust. Peer vaccinators are identified with training underway in Sep-22. Influenza vaccines are expected to be delivered early Oct-22 at which point clinics will commence. In liaison with community partners we also plan to opportunistically vaccinate eligible unvaccinated patients attending our outpatient clinics. There is a 90% frontline staff vaccination CQUIN target in place for 2022/23. The influenza vaccine programme is operating alongside the Covid-19 immunisation programme which commenced in Sep-22 with staff uptake closely monitored and all staff encouraged to get vaccinated. Encouraging high staff uptake in both vaccine programmes is important to protect each other, our patients and support a resilient workforce over the winter period. As of 4-Nov the staff vaccination rates were 23% for influenza and 26% for the Covid-19 booster.

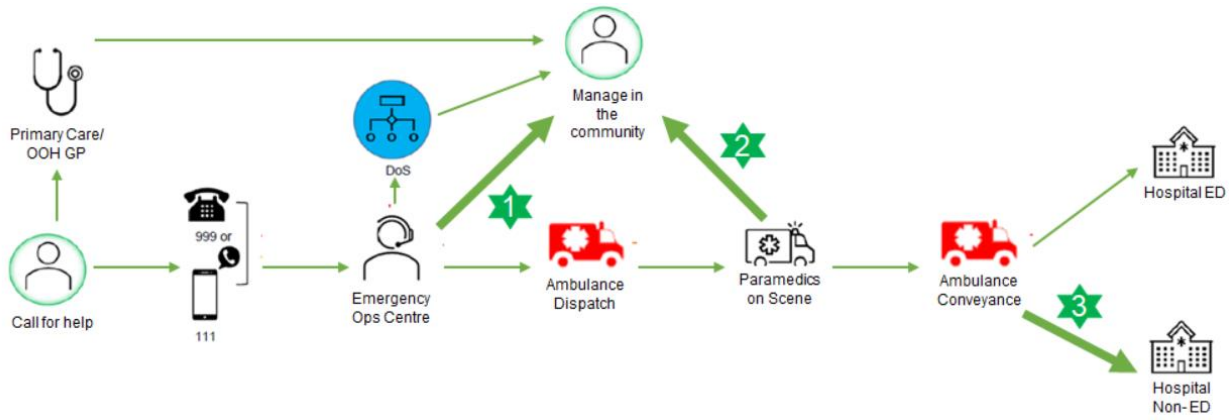
4.2 Communications

The system winter communications plan sets out the approach to delivering proactive and reactive communications across the NHS Nottingham and Nottinghamshire ICB to support the ICS wide plan for winter resilience in 2022/23. As with previous years, the focus locally continues to be on adult and staff flu and Covid-19 vaccination campaigns, the childhood flu campaign and supporting people to get the help they need at the right time, in the right place. In addition, this year, there is a focus on 111, discharge and virtual wards.

The Trust will continue to work with system partners to deploy a consistent message. For further details on system communication, please see the system winter plan.

4.3 Demand avoidance

The system-led changes and investment to reduce demand on the acute setting can be summarised in the visual below:



The priority system admission avoidance areas are:

1. Two hour urgent community response.
2. Promotion or existing alternative pathways, access to GPs and training and education.
3. Access to Same Day Emergency Care (SDEC) services and specialty triage lines. In recent years, NUH has invested heavily to increase the SDEC offer across our clinical services.
4. Additional capacity in the acute community Integrated Respiratory Service (IRS).

In addition there are system activities which identify vulnerable people at risk of hospitalisation and help people to stay well; initiatives include annual health checks; personalised care plans and social prescribing.

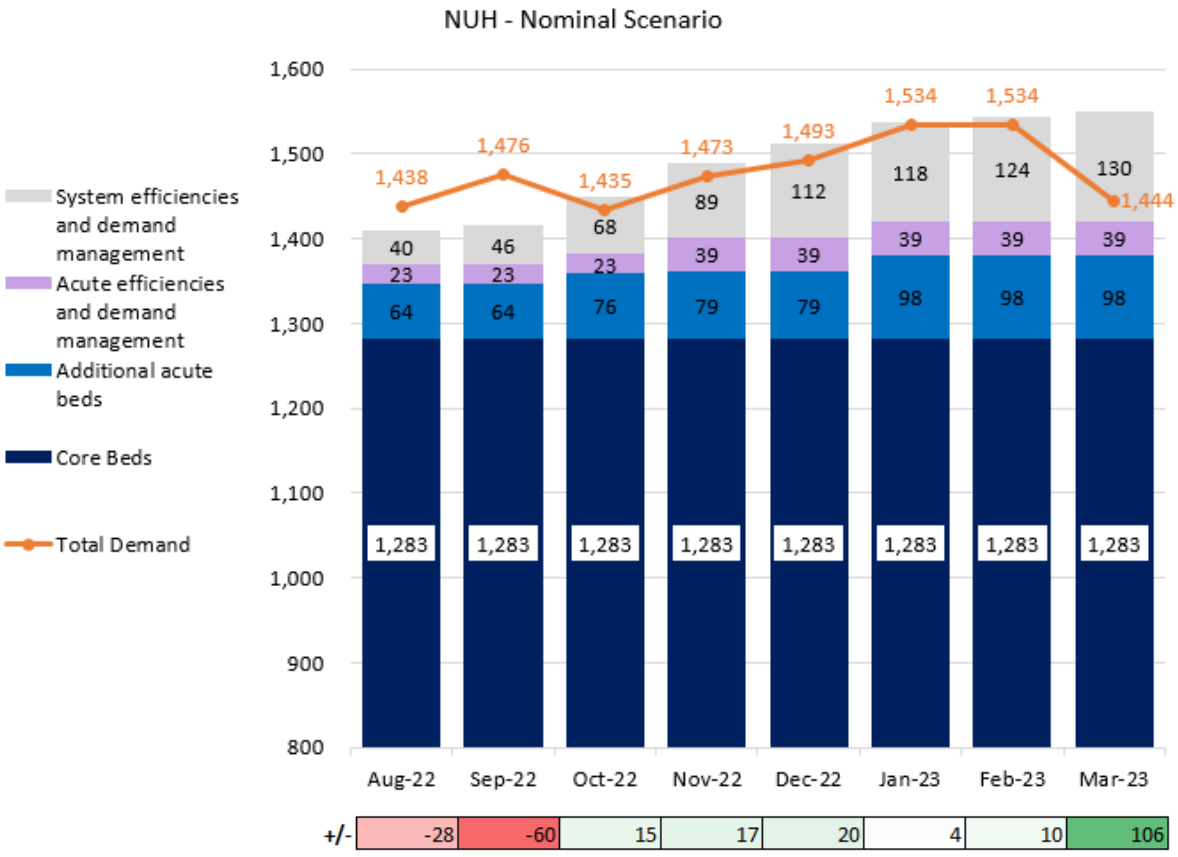
5. Prepare

5.1. Hospital capacity - mitigations for predicted bed deficit

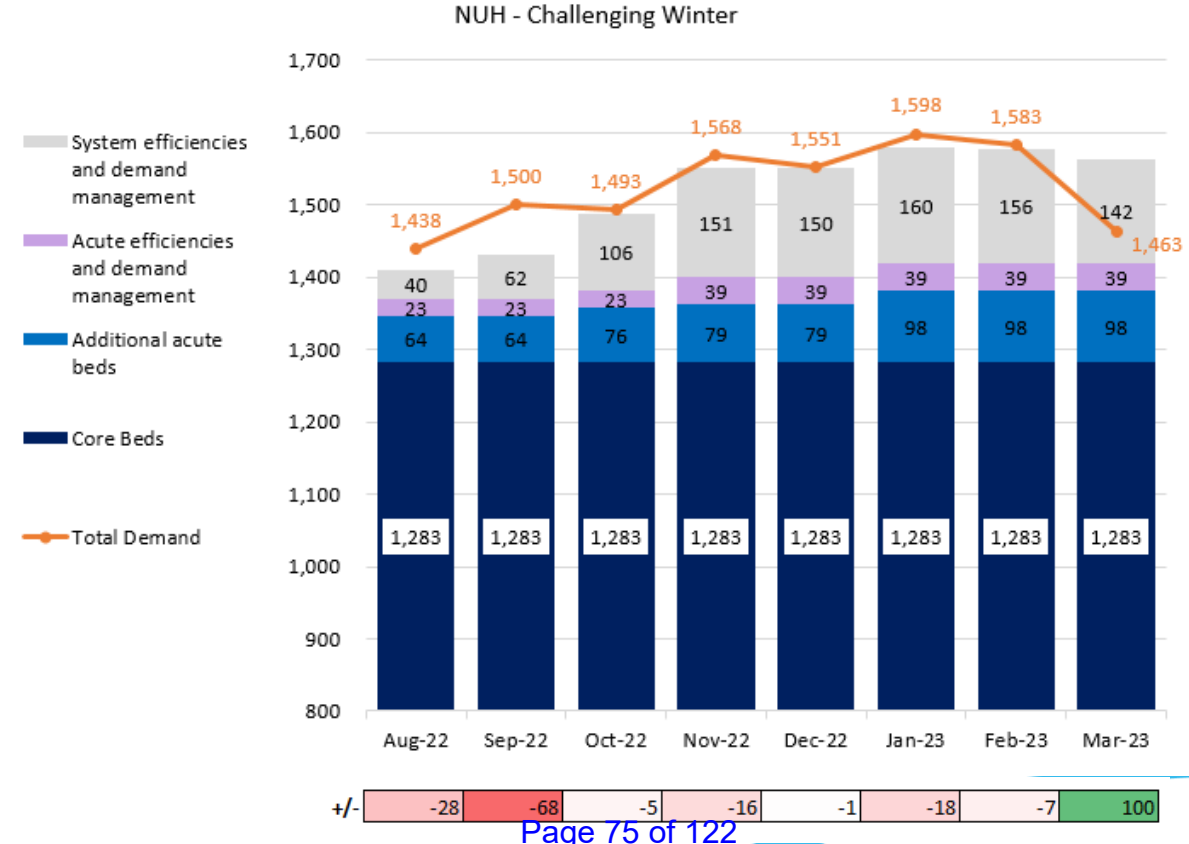
The Trust has kept open year-round in 2022/23 many of the beds that would usually be opened on a seasonal basis to support elective recovery and deal with times of heightened non-elective (including Covid-19) demand. As a result there is very limited additional capacity that can be opened over the winter period. The increases in acute bedded capacity since the summer period primarily relate to the opening of Berman 2 ward (brought forward due to Critical Incident in Sep-22), the opening of three additional beds on our Cystic Fibrosis Unit and the opening of the new modular ward (Jubilee unit) in Jan-23.

Efficiency and system mitigations have been applied to our model; further details are included on the following pages and in appendix A.

As the graph below presents the position against the 'nominal' scenario going forwards is a mitigated position on the basis of the successful delivery of all schemes to the intended level of impact. The Mar-23 position in both scenarios is underestimating the likely demand due to the baseline period being Mar-20 (the start of the Covid-19 pandemic).

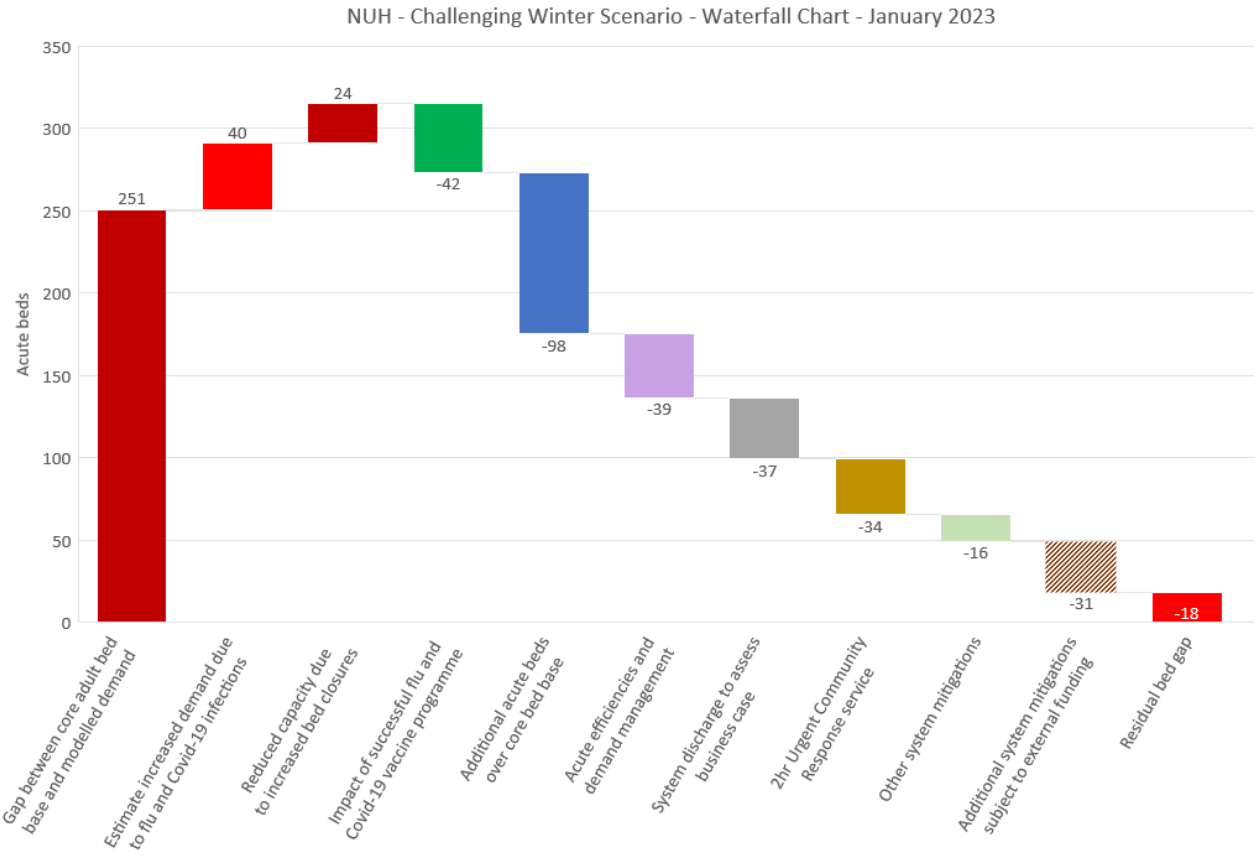


The graph below considers the forecast adult base ward bed position against the 'challenging winter' scenario. Within this scenario additional mitigations are included relating to the successful delivery of the Covid-19 and influenza vaccination programmes. In this scenario the peak residual bed gap going forwards is 18 beds in Jan-23 (again based on successful delivery of all schemes to the intended level of impact).



Please note: Both mitigation charts above include 31 beds of system mitigations from mid-Nov-22 that are subject to social care winter funding.

A waterfall chart is included below for the forecast 'challenging winter' Jan-23 position (the month with the largest residual bed gap going forwards).



Appendix A provides a breakdown of the schemes that form part of the above bridge chart.

Whilst some of the mitigations are easy to evidence once implemented e.g. opening additional beds; others are more challenging to evidence and quantify the impact. As such, there might be areas where the assurance level in terms of delivery is less clearly understood.

Within NUH we have further mitigating actions agreed and either in place or being delivered to support an improved position that it is difficult to quantify the bedded impact (or that deliver alternative benefits). The key actions have been grouped in themes and are summarised as follows:

Reduce demand on our services

- Maximising Same Day Emergency Care (SDEC) services with focus on increased use of our SDEC service in our Cancer and Associated Services (CAS) division and delivering paediatric SDEC. Gastroenterology SDEC has also commenced in two beds on ward C24 that cannot be used for inpatient care due to evacuation routes.
- Creation of a QMC admissions and discharge unit following the merger of QMC Daycase Unit, QMC Discharge Lounge and the Elective Admissions Lounge admissions and discharge areas to create an integrated service offer and sustainable workforce. This is being delivered in a phased manner and we plan pre-winter to increase the number of patients returning to the unit post-surgery to release inpatient beds. It has not yet been possible to quantify the potential bed impact for this scheme yet.

Enhance our bed configuration

- Berman 2 (12 beds) opened as a 'fit for home' unit. This unit opened early in Sep-22 during the Critical Incident.
- Jubilee Unit (20 beds) opening as a new elective ward in Jan-23 to support the transfer of elective activity from QMC to City to enable reconfiguration and expansion of Gastroenterology and Emergency General Surgery at QMC.
- Reconfigure Surgery Division Bed Capacity, utilising the opportunity presented by the Elective Colorectal/HPB move to City to create additional bed capacity for Gastroenterology at QMC.
- Increase surge capacity across our children's wards D33 and E37 from Dec-22.
- Expansion of Elective Admissions Lounge/Theatres Admission Lounge capacity at City to enable increase volume and specialty mix of patients to utilise this Daycase pathway, reducing use of inpatient beds by daycase patients.
- Maximum utilisation and flexible use of the Short Stay Unit (SSU) in the Treatment Centre.
- Improve ability to use any Linden Lodge capacity if there are no patients waiting elsewhere in the hospital for rehabilitation.
- De-medicalisation of a Healthcare of Older People (HCOP) ward to support specialty in-reach.
- Utilise ward A24 (Lyn Jarrett Unit) as a medically safe for transfer ward. This is dependent on securing sufficient staff and is presently high risk (so not yet reflected in our bed model).
- Create a four cubicle Trauma and Orthopaedic frailty unit at the end of ward F18 to provide additional capacity during the day shift in order to support early pull from ED (dependent on capital works).

Enhance our processes and improve patient flow

- Deliver symptomatic point of care testing in key arrival areas using the 4-plex Cepheid test (Covid-19, influenza A, influenza B and Respiratory Syncytial Virus) to support effective management of infected patients.
- Home care reablement trial provided by a third party for an initial 12-week period from Sep-22 to Dec-22 to bridge the gap before the system discharge to assess programme delivers impact. Scheme extended to the end of Mar-23.
- NUH care in the community scheme to start in a stage manner from Nov-22 as a 'provider collaborative' to provide up to twice daily packages of care to bridge the gap between the end of the patients hospital stay and the start of the social care commissioned package of care.
- Opening of the new expanded and developed paediatric ED estate from early Oct-22.
- Delivery of the NUH element of the ICS virtual ward business case. Potential being explored for further expansion into other specialties (see appendix A).
- Continued delivery of the microbiology 24/7 case approve and implemented in 2021/22.
- Continued delivery of our Enhanced Peri-Operative Care (EPOC) unit at QMC with the service expanding to an extra two patients per week from Oct-22. Deliver a City Hospital EPOC service with new processes in place for booking elective higher care beds from Nov-22.
- Work to increase utilisation of our Discharge Lounges across QMC and City Hospital with a proactive 'pull' of patients, maximising early moves and increasing use of the City Hospital discharge lounge for surgical specialties (for patient's post-operative care).
- Delivery of criteria-led discharge in our respiratory service.

Strategic enhancements in staffing

- Social prescribers in ED to ensure appropriate use of services and check and challenge.
- Work to establish a temporary transfer team for patient moves between our paediatric Emergency Department and the Childrens Assessment Unit (CAU).
- Pharmacist cover at City Hospital until 3pm at weekends.
- Additional morning phlebotomist at City Hospital to support the availability of earlier blood tests for blood dependent discharges.
- Enhance flow matron support and discharge co-ordinator capacity in our CAS division.

5.2. System medically safe for transfer mitigations

As mentioned above the system has committed to reducing the number of supported medically safe for transfer patients (MSFT) in hospital with a number of schemes identified, quantified and risk adjusted. Full details of these schemes are held by system partners with tracking taking place via the ICS.

The schemes identified for this winter have been identified in conjunction with all system partners, reviewed through multi agency discussion, considering the dual goals of positive impact on capacity and flow for the system, and being deliverable for this winter. The agreed list of proposals also went through an ICB assurance process with representation from ICB quality, finance, contracting and the urgent care teams to scrutinise the proposals and agree the schemes that offered the best return on investment for the system. The alternative to bed capacity – home based schemes were assessed as high priority.

These proposed schemes have been worked up by the SAIU using methodology from previous winter scheme models to produce a predicted impact on the bed gap, both at system and individual acute levels. Each scheme has the totality of the impact calculated, and then an assurance percentage applied to it to give the impact expected for this winter. For example if a scheme is only 60% assured, only 60% of its projected total impact would be taken into account as affecting the bed gap position.

The schemes can be summarised as follows:

Additional home care & fast track capacity

- Sciensus pathway 1 capacity.
- Homecare block (City and County Local Authorities).
- Utilisation of smaller homecare providers.
- Third sector support including the use by community providers of the British Red Cross.

Maintain spot purchased community beds

- Circa 140 interim beds, many of which have been in place since last winter, at a system cost pressure.

Community virtual wards

- Nottinghamshire Healthcare and CityCare service will deliver a community led offer which will deliver a consistent approach to virtual ward across the Nottinghamshire system. The priority of the service will be frailty and respiratory patients, although this clinical offer will not be confined at the expense of other conditions. The service will deliver a wraparound offer supporting other conditions and complexities which demand an intensive level of support and monitoring

All system schemes have been quantified, risk adjusted and, where appropriate, reflected in our bed model mitigations.

5.3. Elective activity over winter

As we enter the winter period we face staffing constraints that are impacting on our theatre offer. At the time of writing the theatre constraints are the rate limiting factor to the delivery of elective inpatient and daycase activity. It has been agreed that the theatre timetables for Dec-22 to Mar-23, once published, will be used to inform the volume of elective beds required to maximise the available theatre capacity. This volume of beds will then be protected to support the delivery of elective care over the winter period.

We will work towards maximising the use of the Treatment Centre theatres and beds over the winter period as a dedicated elective environment.

Elective activity would normally naturally reduce over the Christmas and New Year holiday period in line with patient choice – this is reflected in our bed modelling. This normally provides a degree of outlier capacity during one of the peak periods for non-elective demand.

5.4. Specific pressure points (Christmas and New Year)

Divisional Christmas and New Year staffing and service plans will be collated in November to align with staffing rotas. A cross-divisional review session will be completed. The Christmas and New Year plans will span from Monday 19 December 2022 to Sunday 8 January 2022. A copy of the plan will be embedded below in Dec-22.

The Christmas and New Year plan master version will be held by the site management team.

6. Respond and recover

All plans will be enacted in order to respond to winter demand and maintain and optimise patient safety.

6.1. Escalation triggers and actions

The Trust has in place escalation triggers that are routinely monitored by the site management team. Corresponding escalation actions detailed in the Trust Management of Adult and Children Patient Flow Policy (CL/CGP/087) are followed in order to respond to issues affecting our ability to maintain resilient services and de-escalate the position. The Trust Management of Adult and Children Patient Flow Policy has been reviewed in 2021 prior to entering the winter period.

The hospital has a full capacity protocol that will be followed during times of peak pressure when patient flow is compromised. The full capacity protocol includes actions such as going 'one-over' on suitable wards where there is an identified discharge.

The use of the escalation triggers and actions and full capacity protocol are business as usual activities.

6.2. Business continuity plans

Business continuity plans are in place across key Trust services. They will be enacted as needed during winter (in the same way they would be at any other time of the year) and kept in place until normal services can resume.

6.3. Governance

The normal Gold and Silver on-call rotas continue 24 hours a day throughout the year. The rota for staff on-call can be found here on the Trust intranet. Details of on-call staff together with the site management team Duty Matrons are included in the specific Christmas and New Year plans referred to above.

The executive operational lead for winter for the Trust is Lisa Kelly, Chief Operating Officer.

A system control centre will be in place seven day a week throughout winter. The centre has had a 'soft' launch in early Nov-22 and will be refined with discussions with acute Trusts to ensure processes are aligned.

6.4. System documents

The local ICS has in place system-level winter plan (that this plan should be considered in conjunction with) alongside system-wide OPEL framework and escalation processes.

7. Appendices

7.1. Appendix A: Bed mitigation scheme breakdown

Theme	Scheme	Impact	Timescale	Delivery Status
Additional acute bed capacity over core bed base				
	Daybrook	3 additional beds	Year-round	In place
	Harvey 2	4 additional beds	Year-round	In place
	Loxley	4 additional beds	Year-round	In place
	Southwell	5 additional beds	Year-round	In place
	Winifred 2	4 additional beds	Year-round	In place
	C4	6 additional beds	Year-round	In place
	Nightingale 2	12 beds	May-22 onwards	In place
	D55	12 beds	May-22 onwards	In place
	Berman 1	16 beds	Jun-22 onwards	In place
	Berman 2	12 beds	Nov-22 onwards	In place
	Cystic Fibrosis Unit	3 additional beds	Nov-22 onwards	In place
	Jubilee Unit (Modular ward)	20 beds	Jan-23 onwards	Build underway
	Lyn Jarrett Unit (20 beds) (as a medically safe ward)	0 beds	Not currently in model. Subject to staff availability.	
Sub-total		**Peak of 101 beds.** **Adjusted to 98 beds to include a 3% closed bed factor**		
Internal Trust efficiencies				
	CHS home care trial	3 beds worth of savings	Sep-22 to Mar-23	In place
	Provider collaborative	15 beds of savings	Nov-22	Commenced in Nov-22
	Microbiology 24 hour (carried forward scheme from 21/22)	7 beds of savings	Year-round	In place
	Virtual wards (VW) ○ Circulatory heart failure (in place for over 1-year) ○ Digestive (Aug-22) ○ Max Fac (Nov-22) ○ Neurosurgery (Nov-22) ○ Vascular (Dec-22)	13 beds of savings	Oct-22 onwards	Impact currently averaging 3 beds in Oct-22 for circulatory and digestive. Activities ramping up.
	Gastroenterology SDEC	1 bed saving	Nov-22	Commenced in Nov-22
Sub-total		**Peak of 39 beds.**		

Theme	Scheme	Impact	Timescale	Delivery Status
Discharge to Assess (D2A) business case		**Peak of 49 beds of savings (37 in Jan-23)**	Impact ramping up throughout the winter period	Variable, some over and some under. Schemes ramp up over winter.
2 hour urgent community response service		**34 beds of savings**	Year-round with set up in Oct-22	In place and over delivering against activity plan.
Other system mitigations				
	CityCare additional beds at Connect Heritage	14 beds	Nov-22 onwards	In place
	Virtual wards ran by Nottinghamshire Healthcare Trust	2 beds of savings	Nov-22 onwards	Commenced in Nov-22
Sub-total		**16 beds/savings**		
Additional system mitigations subject to social care winter funding				
	County local authority homecare block (up to 105 additional packages of care per week)	14 beds of savings	Subject to external funding.	
	Respiratory, cardiac and palliative in-reach	9 beds of savings		
	Additional capacity in IRS.	2 beds of savings		
	Block home care extension (400 hours of additional homecare)	3 beds of savings		
	Other schemes (including Asthma Biologics and IDT care home nurse)	3 beds of savings		
Sub-total		**31 beds of savings**		
Grand total		**266 (251 in Jan-22)**		

Urgent and Emergency Care

System Winter Plan 2022

1. Our approach

This paper provides an overview of how local organisations are working together to meet anticipated urgent and emergency care needs this winter. It assimilates projections for healthcare demand, organisational actions to increase capacity and activity and shows the overall impact on our hospital beds. Our winter plan prepares us to respond effectively when people need to access urgent and emergency care. We are also working to increasingly prevent ill health and to anticipate care needs, shifting our focus to prevention as well as response. In future years, our plan will include more measures to prevent illness and crises happening in the first place, working alongside communities and primary care services.

Typically, pressures increase over the winter period because people are more likely to need admission to hospital or suffer winter illnesses. However, the level of pressure has been sustained and extreme in recent months, with many people working as if they were in the middle of a difficult winter for more than two years. This plan takes into account the current situation that front line teams are facing and builds in anticipated further mitigations for added service demands over the winter.

Organisations have put in place detailed plans to manage increased demand for their services and these have been brought together as a whole system plan[1]. Additionally, our system-wide Demand and Capacity Group has developed scenarios of demand for services over the winter period; founded on current activity, previous winter demand increases, influenza levels in the southern hemisphere this year and likely COVID-19 infection rates[2].

Based on our projections of what will be required, we are putting additional capacity into many of our services, including hospital and community-based beds and increased care in home settings. We are also undertaking the Autumn vaccination programme for influenza and COVID-19 to prevent as many infections as possible. We are expanding services that can safely care for people outside of hospital and we are improving our ability to discharge people from hospital in a timely manner.

The ability of services to respond to demand levels is partly dependent on hospital / community bed and home support capacity. It also depends on the availability and skill levels of the workforce and operational processes within each organisation. A further factor is the ability of services to complete their care interventions and then work together so that people can move from one care setting to another as their needs change (known as flow). System flow is a key contributor to current service pressures, with delays and backlogs in accessing care at each point of care. The system winter plan combines actions in relation to each of these factors. All are inter-dependent in terms of overall impact and effectiveness of the plan. The table below shows the schemes that have been put in place or enhanced, over and above current services in 111, 999, general practice, community and mental health services, social care and hospitals[3].

[1] Mitigation impacts will continue to be iterated in the coming weeks, as organisational positions change. The assumptions include all current plan schemes, but more are likely to be quantified and added to the model.

[2] This scenario is termed a challenging winter, as it has addition COVID-19 and influenza projections, with the potential for a 'twindemic'

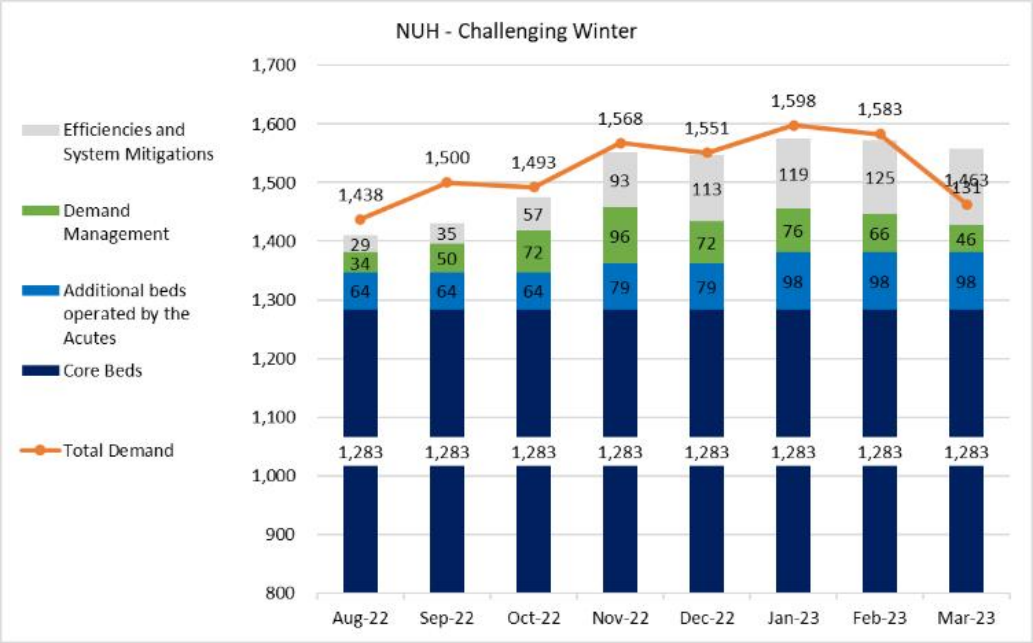
[3] Each organisation has detailed plans, with many operational actions within them.

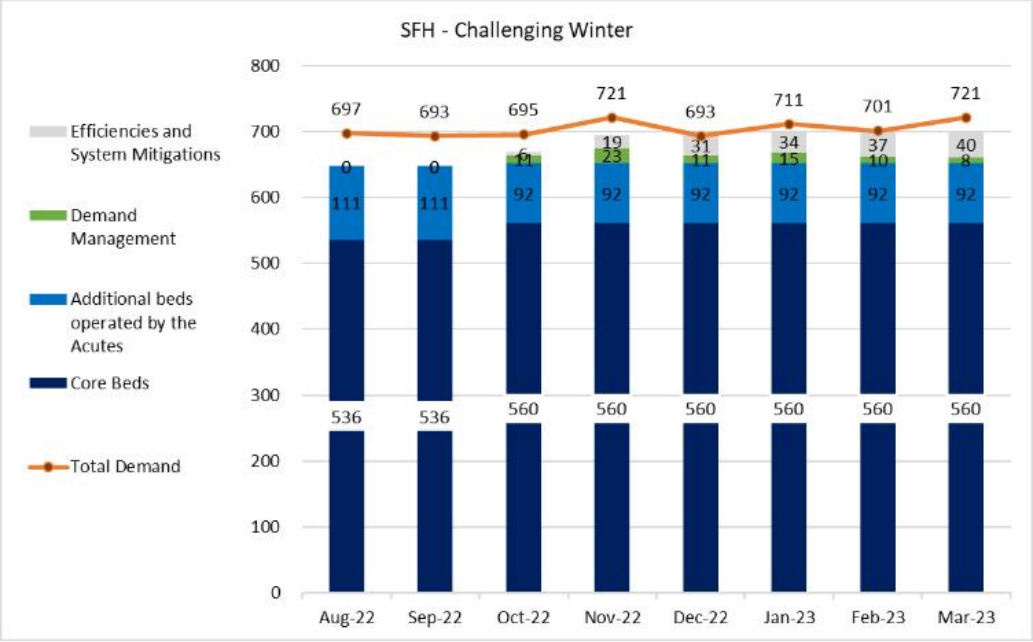
2. Our schemes

Preventing admission to hospital	In hospital assessment and treatment	Discharge from hospital and ongoing care
• Autumn COVID-19 and influenza vaccination programmes • Revised mental health crisis sanctuary model, with voluntary sector capacity to support statutory provision • Mental health expertise for 999 ambulance calls • Diversion of 111 ED dispositions through a Clinical Assessment Service and prevention of ED attendances • 111 direct bookings into primary care appointments, mental health helpline and text messaging • Alternative ambulance pathways, avoiding ED and going straight to relevant services • 2-hour urgent community response • Falls prevention, non-injury falls pathway and care homes pilots to reduce ambulance conveyances • Same day emergency care (SDEC) expansion • Hot clinics • High intensity user services and social prescribers in ED • Expansion of pulmonary rehabilitation services • Hydration in care homes	• New acute mental health inpatient unit with additional 14 beds • Opening additional acute hospital bed capacity • Rolling deep clean programme to reduce healthcare associated infections • Maintain high standards for ambulance handover times • Review of internal triggers and protocols • Reverse bed chains to improve flow from ED into the hospital • Timely clinical decision making / eliminating delays • Review of support services cover for additional capacity / weekend discharges • Staffing level reviews • Direct commissioning of additional ‘step down’ capacity • Ward one over processes	• Embed discharge to assess – discharge from a hospital bed with funded support and longer-term care assessments made at a more appropriate time • Development of discharge hubs to speed up discharge processes • Virtual wards with remote monitoring to reduce hospital admission / length of stay (frailty and respiratory) • Increased care home and home care capacity • 100 - day discharge challenge to improve processes across organisations • Maximise community bed utilisation and flow • Criteria led discharge • Fee uplift for homecare providers

3. Overall impact of the projected demand for hospital beds and our winter plans

Our demand and capacity hospital bed modelling shows projected demand and the system mitigations that are planned to bridge projected increases in demand and activity. The baseline assumes that delayed discharges will follow current trends, with some additional seasonal increases. The grey and green bars show the impact of confirmed winter schemes; based on activity trends, implementation phases and risk. The model also includes a risk-adjusted assessment of the impact of discharge and internal hospital schemes on length of stay. This is reviewed on a weekly basis at our system bed modelling group and will be a dynamic tool, with a report produced fortnightly for review by the Demand and Capacity Group. It will be regularly tracked against actual data points, as well as projected values as we go through the winter. Individual schemes will also be tracked in terms of their progress and impact through our ICS Urgent and Emergency Care Board.





Any shortfalls in terms of demand versus capacity would result in hospital occupancy increasing above the planned 90-92% levels within the model and / or reduced capacity to reduce elective care treatment backlogs. There was a national announcement of further winter social care funding over the summer and associated schemes are scheduled to come into effect in line with the model from the end of November, pending clarity on national funding mechanisms. Should these funding assumptions change, there could be up to a 2% increase in bed occupancy in later winter months if all other factors remain constant.

Our experience shows us that mismatches in capacity and demand can arise because of peaks in demand (such as COVID-19 waves), flow issues, process issues and workforce shortages preventing timely interventions at points of care. Frequently, a combination of these factors cause increased pressure at points of care, often manifested as overcrowding and delays in our emergency departments. For example, length of hospital stay has increased locally and nationally in recent months and this has an impact on the overall availability of hospital beds. These issues are monitored closely within organisations and across the system and relate to both patient and hospital factors. Escalation and trigger actions are under review to strengthen flow and the use of our capacity further.

4. Discharge and flow from hospital into community settings when people require ongoing support and rehabilitation

Flow through our system is a key priority, since this is a significant contributor to overcrowding in our emergency departments, ambulance delays and delays getting onto the relevant ward when admission to hospital is required. Delayed discharges into home environments with supportive care result in people being less likely to maintain their independence in the longer-term and are a significant cause of system flow issues. Our analysis shows that a key constraint is the availability of home care and this has a knock-on impact on hospital and community service flow. This is a common problem across the country. Further detail on this aspect of the winter plan is therefore described in more detail.

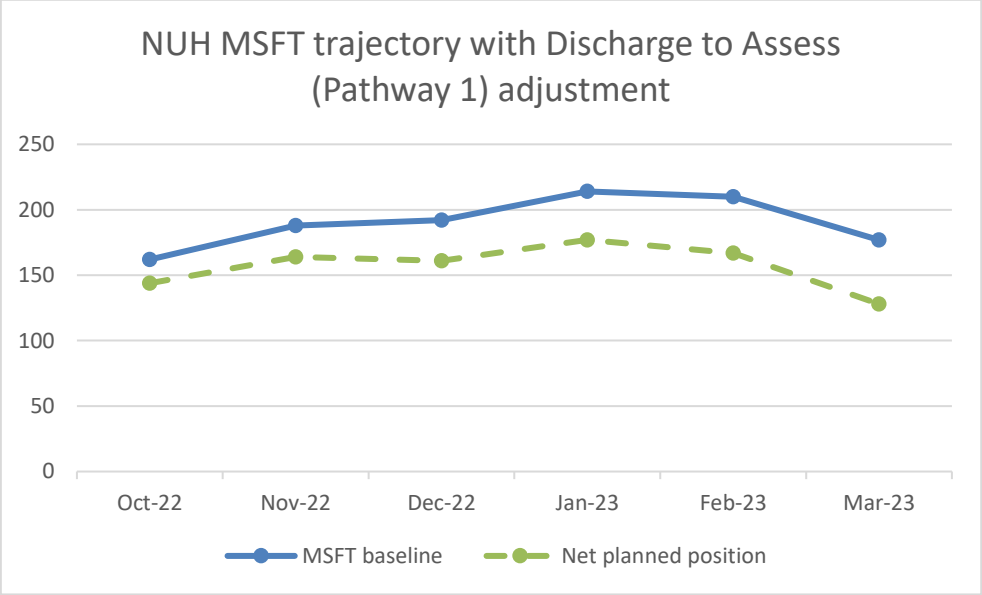
We have been working together to understand what level of home care capacity is required to enable acute hospital discharges and recovery at home, enhance hospital flow and reduce risks and harm at all points of care. A discharge to assess business case has been approved, which builds a new model of care and the required capacity in pathway 1 (hospital to home with support). This increases capacity for hospital discharges from 214 per week to 302 per week by March 2023. We are now starting to see increases in activity levels as new capacity comes into effect.

Summary	Weekly Demand being met met today (inclusive of temporary arrangements)	Demand met by proposal per week
Nottinghamshire Healthcare Trust	48	103
Nottingham City Council	21	40
Nottinghamshire County Council	81	90
CityCare	51	57
CCG / ICB	8	8
Total	209	297
Nottm County Council - EDASS	5	5
Total	214	302

Weekly Activity Trajectory Shown Per Month								
Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
48	55	62	68	75	82	89	96	103
21	23	26	28	30	33	35	38	40
81	82	83	84	85	87	88	89	90
51	52	53	53	54	55	56	56	57
8	8	8	8	8	8	8	8	8
209	220	231	242	253	264	275	286	297
5	5	5	5	5	5	5	5	5
214	225	236	247	258	269	280	291	302
	11	22	33	44	55	66	77	88

The business case calculated the direct impact of increased pathway 1 capacity on delayed discharges from hospital, with increasing impact as more capacity takes effect. However, there isn't a standalone cause and effect relationship between pathway 1 capacity and reductions in delayed discharges from hospital because there are lots of different causes of delayed discharges. Capacity for home care following discharge is one key cause of delayed hospital discharges, but other internal and external factors and processes come into play and are significant. Discharges for people with ongoing care needs are in the minority in terms of overall hospital discharges, so a greater impact on overall flow will be achieved by looking at all discharge processes. We have therefore brought teams together to reduce all causes of discharge delays and have introduced hospital discharge hubs to streamline processes between different services and settings.

Taking all of this into account, our organisations have worked together to forecast the likely impact of the additional pathway 1 capacity on the levels of delayed hospital discharges (over 1 day). We will monitor this on a weekly basis and additional actions will continue to be taken to reduce delayed discharges further. Estimated impacts for NUH are shown below. Similar calculations are also in progress for SFH.



5. Plan impact and delivery

Our plan brings together the efforts and expertise of all parts of our local NHS and care system. It includes a broad range of actions in many different care settings. There are no single solutions that will resolve the level of pressure on our urgent and emergency care services. Great care has been taken to make our assumptions as robust as possible, but they are plans rather than predictions and there are many interdependencies that could affect how the system works together over the winter. We will monitor impact and progress very regularly.

National and local evidence and metrics are emerging concerning delay-related patient harm. We have analysed the impacts of serious incidents across the system and will introduce

clinical delay-related harm measures into our plan monitoring processes. We will also track impacts on staff and will continue staff wellbeing offers.

Risks to delivery of the plan include workforce availability, ongoing support needs at home (reducing outflow from the additional pathway 1 capacity into step down services), infection outbreaks requiring beds to be closed to new admissions, impacts on reducing elective care backlogs, inclement weather, industrial action and health impacts associated with the increased cost of living.

However, we can take additional steps to monitor and manage risks as they arise. We will put in place a System Control Centre to ensure a consistent and collective approach to managing system capacity, demand and clinical risk. This will work closely with organisational operational controls to coordinate and mitigate pressures across the system. We also have defined escalation levels, with additional triggers as levels of pressure and delays increase. We have interim care home placements that we use to support flow from hospitals when people need somewhere to recuperate from the acute phase of their illness.

We have also learnt from previous critical incidents and have adapted operational processes as a result. We work closely together to understand and escalate actions when organisations experience high levels of pressure. We have daily operational calls, whereby partners can take supportive actions to pre-empt further pressure building up. Examples include ambulance diverts and staff redeployment. There is a high level of commitment to work across organisations to respond to increased winter demand and a strong spirit of collaboration.

Our plan is based on robust analysis and a comprehensive set of actions across all organisations. We will closely monitor implementation and impacts of the plan for the population that we serve, recognising that all elements are important and all have a part to play in the overall effectiveness of our plan.

Amanda Sullivan

ICB Chief Executive

2022/23 Winter Planning

5 September 2022

Key Principles for Winter Planning

Winter planning at NUH is underpinned by the following principles:

- Health and care partners across the Integrated Care System (ICS) will work together to offer appropriates services to our population in the right place at the right time
- Appropriate services are available for patients requiring care in the acute setting
- Patient safety is optimised and quality of care is maintained. Patients are not exposed to unnecessary clinical risk (inc. Covid-19)
- The health and wellbeing of staff is maintained
- Any adverse impact on elective activity and associated patient experience, income and performance is minimised. Cancer and clinically urgent activity is preserved
- An agile approach is adopted with plans in place to respond to a potentially rapidly changing environment as a result of the Covid-19 pandemic.

Approach to Winter Planning

1. **Anticipate and assess** issues in maintaining resilient services:
    - Lessons learned from 2021/22
    - Key winter pressure drivers identified – likely epidemiology of winter 22/23
    - Demand modelled
    - Risks identified
2. **Prevent** the likelihood of occurrence and effects of any such issues:
    - Prevent and manage infection inc. vaccination; patient/staff testing
    - Effective patient and staff communications (system approach)
3. **Prepare** by having appropriate mitigating actions, plans and management structures in place:
    - Mitigating actions and flow priorities inc. staff and support service plans; staff well-being
    - NEL surge plans and the extent to which elective activity is protected
    - Specific plans for Christmas and New Year period
4. **Respond and recover** by enacting plans and contingencies as required:
    - Escalation triggers and actions
    - Contingency plans.

2021/22 Winter Reflections

- Covid-19 demand surged pre-Christmas (Omicron wave) peaking in early January (albeit at lower levels than previous year). No national lockdowns. The impact of Covid-19 demand on critical care was significantly lower than the previous Covid-19 winter period
- Pathway segregation remained in place across our hospitals impacting on patient and staff flows between areas
- Staff sickness levels were high in line with high prevalence of Covid-19 in the community; this placed significant pressure on a tired workforce
- Non-elective attendance demand eased a little during Omicron peak; although overall non-elective admissions remained relatively strong
- Significant delays in admitting patients with long 'fit for ward' times and an associated extended mean time in ED
- Medically safe for transfer levels remained high all winter and did not reduce as we entered the Spring/Summer period
- Elective activity was curtailed as bed capacity was required to support non-elective demand. Theatre availability was constrained until late Spring due to staffing pressures.

Key Winter Pressure Drivers

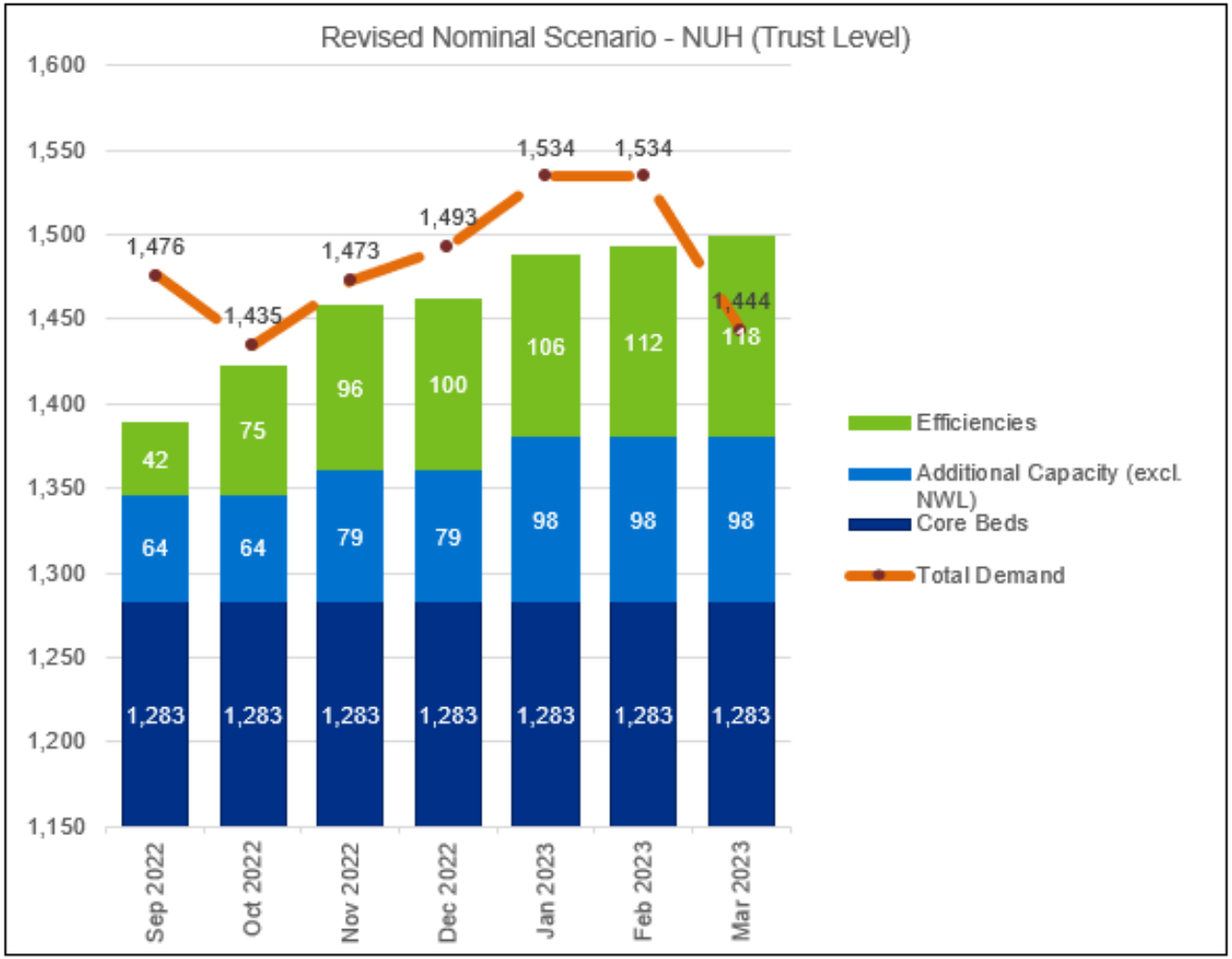
Traditionally, key drivers for our winter pressures relate to:

- Higher acuity
- High prevalence of influenza
- Increase in attendance/admissions in respiratory (inc. RSV) and HCOP
- Increase in beds closed due to infection (norovirus, D&V, CRE etc)
- Increase in number of beds occupied for patients medically safe >24 hours awaiting a P1-3 discharge
- Increased bed occupancy and associated flow challenges out of admission/assessment areas and ED
- Increased competitive locum and agency staffing environment

In the 'living with Covid-19' era there is a degree of uncertainty around what the epidemiology of winter may be like in 22/23. Taking learnings from the Southern Hemisphere.

Adult base ward bed model

- Key focus on the adult general and acute base wards. Scenario-based approach
- Nominal scenario:
  94% NEL demand;
  104% EL;
  85% bed occupancy;
  85th %-tile of demand; and
  MSFT >24 hrs rising from current levels to >200 during Jan/Feb-23
- Chart updated last week to reflect delayed modular ward opening
- System model has additional 14 community beds for Connect Heritage from Oct-22.



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
+/-	-87	-13	-15	-31	-47	-41	55

NUH winter mitigations: In plan

#	Name	Description	Deliverables	Investment required	Timescale	OLT Lead	Proposed Governance
1	Pockets of beds	Open small pockets of beds already accounted for in operational plan year round. Includes: Edward 2 (4 beds); Winifred 2 (4); Harvey 2 (4) and Fleming (6).	Increase bed base by 18	In plan	Aug to Oct-22	Relevant Divisional Nurses	OPG
2	Modular ward	Open modular ward and transfer activity from QMC to City.	Increase bed base by 20	In plan	Jan-23	Neil Ellis	Elective Board
3	Berman 2	Open ward as 'fit for home' unit. Discharge lounge in dayroom area.	Increase bed base 12	No, replacing Newell to deliver equivalent outcomes for investment	End of Oct-22	Lorraine Hourd	Emergency Board
4	NUH Care in the Community	Provider collaborative scheme to provide BD (up to twice daily) packages of care to bridge gap between end of the patients hospital stay and start of social care commissioned package of care.	Reduce P1 discharge delays Impact estimated at 15? beds		Staged from Oct-22	Lorraine Hourd	Emergency Board
5	Homecare reablement service	12-week trial of homecare service provided by a third party.	Reduce P1 discharge delays. Impact estimated at 3 beds	Approved by MB in Aug-22 (£200k)	Sep to Dec-22	Russell Pitchford	Emergency Board
6	Virtual wards	NUH element of the ICS Virtual ward business case.	Reduce LOS. Impact estimated at 13 beds	In plan	Remainder of 22/23	TBC	Emergency Board
7	Microbiology 24/7	Continuation of 21/22 approved case.	Reduce LOS. Impact estimated as 7 beds	In plan	Full year	Amanda Kemp	OPG
8	Paediatric ED opening	Expansion and development of paediatric ED estate.	Reduce LOS / patient turnaround	In plan	Early Oct-22	Russell Pitchford	Emergency Board

Winter mitigations: Further considerations (1/2)

#	Name	Description	Deliverables	Investment required	Timescale	OLT Lead	Proposed Governance
9	Re-locate and expand Gastro bed base	Transfer Gastroenterology beds into South block and expand into a second (Hepatology) ward with associated specialty bed base adjustments.	Productive use of capacity and improved pull from B3	Not significant	TBC – workforce change required. Aim pre-winter	**Surgery** and medicine	Emergency Board
10	HCOP reconfiguration	Reconfigure HCOP (to support Gastro scheme above) including in-reach into Surgical wards. And further potential and opportunities supporting bed access.	Reduce LOS. Impact estimated xx beds			Surgery and **Medicine**	Emergency Board
11	HCOP de-medicalisation	De-medicalisation of some HCOP wards and increased HCOP in-reach into other areas	Improved use of medical resource	No.	Oct/Nov-22	Medicine	Emergency Board
12	C24 move	Reconfigure major trauma and Emergency General Surgery capacity. Develop C24 as a short-stay emergency surgery ward.	Enabler for scheme 13	Not in the short-term. Investment required to expand major trauma	TBC	**Surgery**	Emergency Board
13	Emergency theatre lists	Create optimal number of emergency theatre lists over winter.	Reduce LOS. Impact estimated xx beds	No. Opportunity cost	Oct-22	Surgery and **Clinical Support**	Elective Board
14	Extension of 7 day MDT	Invest in additional resource to deliver LOS improvements inc. senior decision makers, pharmacy and therapies. Would need to be focussed on high impact areas.	Reduce LOS. Impact estimated xx beds	Yes	Staged from late 2022	Medicine (primary lead)	Emergency Board
15	IPC weekend services	IPC support to minimise capacity loss through due to IPC issues, risks and concerns	Reduce closed beds due to infection	Yes – 2x B8A's, 4x B6's. Investment case in draft.	ASAP	TBC	OPG

Winter mitigations: Further considerations (2/2)

#	Name	Description	Deliverables	Investment required	Timescale	OLT Lead	Proposed Governance
16	POC testing	The recommendation is that we implement the 4-plex cepheid test (Covid-19, fluA, fluB, RSV) in ED, SRU and RAU	Reduce closed beds due to infection	Yes. Investment case in draft	Depends on scale	CAS	OPG
17	Virtual ward expansion	Going beyond the deliverables detailed in the ICS business case.	Reduce LOS.	TBC	TBC	TBC	Emergency Board
18	Rehab	Post critical care rehabilitation across medicine and surgery (predominantly medicine?). Initial idea at this stage.	TBC	TBC	TBC	Medicine & Clinical Support	TBC
19	Maximising daycase	Increase the volume of daycase activity. Would link to 7-day services as we would need to invest in weekend resource.	TBC	Yes	TBC	Ambulatory Care	Elective Board
20	Criteria-led discharge	Increase number of specialties where criteria-led discharge is implemented	Reduce LOS. Impact estimated xx beds	TBC	TBC	Divisional Directors and Nurses	Emergency Board
21	Culture and risk appetite – clinical	Pros and cons; review underway following Critical Incident. Would need to consider how we support staff.	Reduced LOS.	No	Staged – cultural change will take time	Divisional Directors	Emergency Board
22	Non-clinical work reduction and risk	Output of further discussions post cold debrief as discussed in Management Board.	TBC	TBC	TBC	TBC	TBC
23	Respiratory winter planning	Mitigate additional complications around respiratory surge options	TBC	TBC	TBC	Medicine	TBC
24	Urgent treatment centre potential	On-site escalation urgent care model	TBC	TBC	TBC	Medicine	TBC
25	7-day site ops	7-day senior site ops cover based at QMC	TBC	Yes	TBC	Duane Mclean	Emergency Board

Risks

IF

- **Physical space** is insufficient to meet demand.
- Unable to provide sufficient **medical and nursing staff** to meet demand
- Unable to maintain a **resilient workforce**
- Insufficient **equipmen**t to meet demand
- Insufficient number of **hospital beds** to meet demand
- Insufficient **system capacity** to maintain system flow and the timely transfer of medically safe patients
- Experience a **influenza pandemic** or significant norovirus or CRE outbreaks
- Experience any significant issues with the **fabric of our buildings** or other infrastructure (e.g. ICT)

THEN

We may not deliver resilient services

RESULTING IN

- Adverse impact on **patient safety and harm**
- **Inability to deliver appropriate services** to our patients (particularly on elective pathways)
- Adversely impact on our **reputation** causing undesirable media coverage and a loss in confidence from the population we serve
- **Reduced staff morale, resilience and retention**
- Lack of compliance with national standards causing **undesirable regulatory action**
- Additional **costs and financial pressures**.

Arguably some of these risks are issues…

Next steps

1. Gather more information about vaccination programme
2. Further liaison with Communications teams re. system and internal approach
3. Agree approach to staff and patient testing (investment required)
4. Deliver mitigations in plan and agree if schemes for further consideration are all going to be progressed
5. Capture any additional Divisional capacity, process and staffing actions planned to support flow over winter
6. Agree non-elective surge plan and extent to which elective capacity is protected
7. Develop the formal Winter Plan word document (in draft)
8. Specific focus on Xmas and New Year plans in November (when staffing rotas are clearer) using similar format to previous years.

Nottinghamshire County Council

Report to Health Scrutiny Committee

21 February 2023

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

ACCESS TO GP SERVICES

Purpose of the Report

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

Information

2. Issues in respect of access to GP services is a recurring issue raised by residents with elected representatives, and one which the Committee has previously considered at its meetings in September and November 2021 and again in January 2022.

3. Previous consideration of GP access issues took place in the context of the then-ongoing Covid-19 pandemic. Now, as the NHS and wider society learns to live with the virus, the focus has shifted to how GP access now functions in a more 'post-pandemic' environment.

4. Lucy Dadge, Director of Integration at the Nottingham and Nottinghamshire Integrated Care Board will be accompanied by Joe Lunn, Associate Director of Primary Care, Lynette Daws, Head of Primary Care, Paul Miller, Head of Primary Care IT, and GPs Dr Stephen Shortt and Dr Thilan Bartholomeusz to brief Members and answer questions.

5. Members are requested to consider and comment on the information provided and identify any future actions arising from consideration of the issue. It is intended that there is a themed focus to discussions, addressing areas such as enhanced access, different appointment types, workforce pressures, telephony and IT initiatives. It is planned to address specific queries and comments on practice level issues outside the meeting.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Consider and comment on the information provided.

2) Identifies any future actions arising from consideration.

Councillor Sue Saddington
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Noel McMenamin – 0115 993 2670

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

NHS
Nottingham and Nottinghamshire

Nottinghamshire County Health Scrutiny Committee

21 February 2023

Access to General Practice Services

Dear Colleagues,

Nottinghamshire County Council Health Scrutiny Committee have asked NHS Nottingham and Nottinghamshire ICB to provide an update for Members at the February 2023 meeting in relation to:

- **Access to General Practice Services**

The brief below provides the update requested.

Joe Lunn
Associate Director of Primary Care

Nottinghamshire County Council Health Scrutiny Committee

Access to General Practice Services

1. Introduction

The Committee has asked the ICB to present on access to general practice services post the COVID-19 pandemic and what the 'new normal' looks like, including what is working well and where the pinch points are. The Committee would also like to see district-level GP access data.

Across Nottingham and Nottinghamshire ICB there are 131 general practices, varying from single handed practices to large practices with multiple branch sites. General practice provides core primary medical services across a population of 1,278,774. Core services include the identification and management of illnesses, providing health advice and referral to other services. Practices are required to provide their essential services during core hours, which are 8.00am–6.30pm Monday to Friday, excluding bank holidays.

Across Nottinghamshire, three practices are currently rated 'Inadequate' overall and one practice is currently rated 'Requires Improvement' overall. No practices are awaiting full inspection outcomes. Seven practices do not have a current rating as they are yet to be inspected following partnership / ownership changes. All other practices (76) have an overall rating of either 'Good' or 'Outstanding'.

2. Access

Following the COVID-19 pandemic, the health and care system has been in recovery, however, there has been a continued high demand for all services across the system. Due to the unprecedented pressures Nottingham & Nottinghamshire health and care system declared critical incidents in July 2022, September 2022 and December 2022 and this has continued into January 2023.

General practice is the backbone of the NHS and has played a pivotal role in supporting system recovery across the ICS. This has meant maintaining services under challenging circumstances as well as responding to emergent needs. For example, our primary care teams have recently responded to a national request by rapidly establishing urgent Acute Respiratory Infection hubs to respond to the increase in Strep A cases. This has been in addition to addressing existing winter pressures such as other respiratory conditions, flu, and COVID-19 infections which remain present.

As a result of the extraordinary demands the ICB has taken steps through a general practice winter support package to offer resilience and help manage winter pressures in general practice. This includes flexibilities for the Quality and Outcomes Framework (QOF) with practices continuing to risk stratify patients, focusing on the most vulnerable patients and carrying out Long Term Condition reviews. This winter support package builds on the letter, published by NHS England in September 2022, to support general practice, primary care networks and teams through winter and beyond.

Since October 2022 Enhanced Access has been included in the Network Contract Directed Enhanced Service (DES), which provides core primary medical services across all 23 Primary Care Networks (PCNs). This replaced the previous Extended Hours (at individual practice

level) and Extended Access (across PCNs) to provide a more cohesive service for patients to access.

The Network Standard Hours for Enhanced Access are 6:30pm until 8:00pm Monday to Friday and 9:00am until 5:00pm on a Saturday. PCNs must deliver additional clinical support to patients for 60 minutes per 1,000 population, a week, at locations which are accessible to all registered patients in the PCN. The total number of hours that are delivered across Nottingham and Nottinghamshire is 1,237.75 per week. During October and November 2022 1,501 hours were delivered a week due to additional flu clinics being provided.

2.1. Appointment data

General Practice Appointment Data (GPAD) is published by NHS Digital. On 24 November 2022 NHS Digital published the first set of individual practice level GPAD for October 2022. This is available via https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

This paper does not provide practice level data due to there currently being wide variation between how practices record appointments within their clinical system appointment rotas. This variation includes how the type of appointment is recorded as well as the health care professional seeing the patient. NHS England have published guidance to support practices with recording appointments to reduce this variation. Bearing in mind these caveats, the data is available at the link above should Committee Members wish to access it.

This experimental data excludes Enhanced Access activity and is not yet consistently recorded across all providers. It is however, designed to provide an insight into the activity and usage of core appointments (GP and health care professionals) and how general practice is impacted by seasonal pressures, such as winter. The latest data available is for November 2022. Table 1 shows a breakdown of the total count of appointments provided in October and November 2022 across the ICB.

The data uses the 'raw[1]' practice list rather than weighted practice list, which is adjusted according to varying workload due to age, sex and deprivation for the registered population.

Table 1 – Appointment Category

Appointment Category	Oct-22	Nov-22	Difference	%
Total count of appointments	653,783	644,260	▼ -9,523	-1.5 %
Appointments seen as face-to-face	466,336	442,201	▼ -24,135	-5.5 %
Appointments on-the-day (same day) booking	246,441	259,245	▲ 12,804	4.9 %
Appointments seen within 2 weeks (days 1 to 14 – excludes same day appointments)	249,397	247,472	▼ -1,925	-0.8 %

Tables 2a and 2b show the number of appointments undertaken over the periods of October and November 2019 to October and November 2022:

The small reduction in total count of appointments between October 2019, 2020 and 2022 and November in 2019, 2020 and 2022 could be attributable to flu vaccination clinics (and autumnal COVID-19 booster clinics in 2022), which are predominately undertaken during

[1] A 'Raw' practice list is all patients registered at the practice and unweighted.

October each year. The pivotal role general practice has had in delivery of these vaccination programmes, whilst maintaining patient care throughout the pandemic, cannot be underestimated. This has also been alongside adapting to new care delivery mechanisms and maintaining patient and staff safety.

Table 2a – Number of Appointments

	Oct-19	Oct-20	Difference Oct 20-Oct 19	%	Oct-21	Difference Oct 21-Oct 20	%	Oct-22	Difference Oct 22-Oct 21	%
Notts ICB total count of appointments	652,181	599,822	▼-52,359	-8.73%	644,092	▲44,270	6.87%	653,783	▲9,691	1.48%

Table 2b – Number of Appointments

	Nov-19	Nov-20	Difference Nov 20-Nov 19	%	Nov-21	Difference Nov 21-Nov 20	%	Nov-22	Difference Nov 22-Nov 21	%
Notts ICB total count of appointments	589,640	539,610	▼-50,030	-9.27%	646,460	▲106,850	16.53%	644,260	▼-2,200	-0.34%

A total of 589,640 appointments were provided in November 2019 compared to 644,260 appointments provided in November 2022. The increase in the total number of appointments provided during this period could be partially attributed to the national introduction of the PCN Additional Roles Reimbursement Scheme (ARRS). This was introduced as part of the Network Contract DES to support PCNs. The ARRS provides funding for additional roles (see section 2.3) to create bespoke multi-disciplinary teams. Primary care networks assess the needs of their local population and, working with local community services, make support available to people where it is most needed.

2.2. Types of appointments available

The way patients see a health care professional continues to evolve with the national direction to have multiple ways to access health care. A priority for NHS England is to ensure that a range of types of appointments are available to patients and practices are required to offer and promote' online consultations and video consultations to their patients. As a result, access to the different types of appointments offered by practices has also increased.

Tables 3a and 3b show comparable breakdown of the appointment types across the ICB during October and November 2021 to October and November 2022.

In October 2022 the number of face-to-face appointments has increased to 466,336 in comparison to 413,115 in October 2021. In November 2022 the number of face-to-face appointments has increased to 442,2001 in comparison to 402,132 in November 2021.

Telephone appointments have decreased from 141,185 in October 2022 compared to 187,849 in October 2021. Telephone appointments have also decreased from 153,498 in November 2022 compared to 197,694 in November 2021

Video/online appointments have increased to 9,640 in October 2022 compared to 5,531 in October 2021. Video/online appointments have also increased to 6,993 in November 2022 compared to 6,008 in November 2021.

This identifies a ratio of 3.11 of face-to-face appointments (includes home visits) to one remote appointment (online and telephone) in October 2022. November 2022 identifies a

ratio of just under 3 (2.78) of face-to-face appointments (includes home visits) to one remote appointment (online and telephone).

Table 3a – Appointment Type

	Oct-21		Oct-22	
	Notts ICB total count of appointments (%)	England Average (%)	Notts ICB total count of appointments (%)	England Average (%)
	644,092	284,973	653,783	301,788
Appointment type:				
Face to face	413,115 (64.1%)	183,619 (64.4%)	466,336 (71.3%)	215,269 (71.3%)
Home visit	1,993 (0.3%)	1,685 (0.6%)	2,764 (0.4%)	2,202 (0.7%)
Telephone	187,849 (29.2%)	88,924 (31.2%)	141,185 (21.6%)	73,615 (24.4%)
Video/online	5,531 (0.9%)	1,505 (0.5%)	9,640 (1.5%)	2,087 (0.7%)
Unknown	35,604 (5.5%)	9,241 (3.2%)	33,858 (5.2%)	8,617 (2.9%)

Table 3b – Appointment Type

	Nov-21		Nov-22	
	Notts ICB total count of appointments (%)	England Average (%)	Notts ICB total count of appointments (%)	England Average (%)
	646,460	286,098	644,260	294,614
Appointment type:				
Face to face	402,132 (62.2%)	179,468 (62.7%)	442,201 (68.6%)	203,655 (69.1%)
Home visit	2,518 (0.4%)	1,918 (0.7%)	3,205 (0.5%)	2,285 (0.8%)
Telephone	197,694 (30.6%)	94,052 (32.9%)	153,498 (23.8%)	77,796 (26.4%)
Video/online	6,008 (0.9%)	1,371 (0.5%)	6,993 (1.1%)	1,803 (0.6%)
Unknown	38,108 (5.9%)	9,289 (3.2%)	38,363 (5.9%)	9,075 (3.1%)

Table 4 breaks this down by the Nottinghamshire Place Based Partnerships for November 2022. Comparable data is not available for November 2021.

Table 4 – Appointment Type (Place Based Partnership): November 2022

	Nottinghamshire Place Based Partnership (Locality areas)					
	Bassetlaw	***%***	***Mid-Notts***	***%***	***South Notts***	***%***
	**Larwood and Bawtry* **Newgate Medical Group* **Retford and Villages*		**Ashfield North* **Ashfield South* **Mansfield North* **Rosewood* **Newark* **Sherwood*		**Arnold and Calverton* **Arrow Health* **Byron* **Nottingham West* **Rushcliffe*	
Total count of appointments per area - November 2022	*70,142*		*178,566*		*207,333*	
Appointment type:						
Face to face	*52,429*	*74.75%*	*126,744*	*70.98%*	*135,225*	*65.22%*
Home visit	*45*	*0.06%*	*207*	*0.12%*	*2,007*	*0.97%*
Telephone	*14,940*	*21.30%*	*36,404*	*20.39%*	*54,512*	*26.29%*
Video/online	*125*	*0.18%*	*1,982*	*1.11%*	*2,594*	*1.25%*
Unknown	*2,603*	*3.71%*	*13,229*	*7.41%*	*12,995*	*6.27%*

The above table shows that in South Nottinghamshire the percentage of patients receiving a face-to-face appointment is lower than Mid Nottinghamshire and Bassetlaw Place Based Partnerships (PBPs). However, the percentage of telephone appointments is higher in South Nottinghamshire than Mid Nottinghamshire and Bassetlaw PBPs. This may reflect patient choice and the demographic makeup of the population. The general practice contract does not specify the number or type of appointments that should be provided by each individual practice; however, practices do have to meet the reasonable needs of their population. This is actively monitored by the ICB through triangulation of data about workforce, appointments, and patient feedback methods alongside other quality markers and practices are offered support, where necessary.

Practices themselves also review patient feedback through several mechanisms, for example, Friends and Family Test, Patient Participation Groups, Complaints, Concerns and Enquiries, and Social Media Platforms.

2.3. Healthcare professionals

Sufficient workforce to meet demand continues to be a challenge across general practice with a number of vacancies and sickness levels contributing. Table 5 shows the General Practice Workforce Data (November 2019 and 2022) for GPs, other clinical roles and non-clinical roles across Nottingham and Nottinghamshire by number and whole time equivalent (WTE). Whilst the overall number of GPs and other clinical staff included in these tables has reduced slightly for headcount, the overall WTE has increased.

Table 5 – Nottingham and Nottinghamshire General Practice Workforce Data

	November 2019		November 2022	
	Headcount	**WTE**	**Headcount**	**WTE**
GPs (includes salaried, partners, registrars and retainers)	1,020	736.77	974	813.20

Other clinical staff (includes practice nurse, advanced nurse practitioner, health care assistant, phlebotomists)	780	528.07	765	532.81
Administration / non-clinical roles	1,964	1,428.43	2,068	1,533.31

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

It should also be noted that the numbers provided in table 5 do not include the ARs staff.

The following ARs are currently employed in PCNs across Nottingham and Nottinghamshire (Appendix A provides a description of the roles):

- Care Coordinators
- Clinical Pharmacists
- Community Paramedics
- Dietitians
- First Contact Physiotherapists
- Health and Wellbeing Coaches
- Mental Health Practitioners
- Nursing Associates and Trainee Nursing Associates
- Occupational Therapists
- Pharmacy Technicians
- Physician Associates
- Social Prescribing Link Workers

Two new roles were introduced in September 2022, these are:

- General Practice Assistant
- Digital transformation Lead

Across Nottingham and Nottinghamshire there are currently 481 ARs in post (30 November 2022), this equates to 433.68 WTE. For Nottinghamshire PCNs this equates to 336 ARs, 307.33 WTE.

2.4. Booking to appointment

GPAD data includes the patient wait from booking to appointment. Table 6 shows that fewer patients were seen on the same day in November 2022 compared to November 2021. Data for both November 2022 and 2021 is significantly higher than the England average for same day appointments.

Table 6 also shows that fewer patients are waiting 2-14 days from booking to appointment in November 2022 compared to November 2021, with more patients waiting longer than 15

days from booking to appointment. However, it should be noted that many patients choose to wait to see a GP / a GP of their choice. The nature of some appointments means that they can be booked in advance by mutual agreement with the patient.

Table 6 – Booking to Appointment

	Nov-21		Nov-22	
	Notts ICB total count of appointments (%)	England Average (%)	Notts ICB total count of appointments (%)	England Average (%)
	646,460	286,098	644,260	294,614
From booking to appointment:				
Same Day	265,809 (41.1%)	120,944 (42.3%)	259,245 (40.2%)	122,515 (41.6%)
1 Day	40,586 (6.3%)	23,491 (8.2%)	41,172 (6.4%)	24,296 (8.2%)
2 to 7 Days	122,606 (19.0%)	59,533 (20.8%)	115,474 (17.9%)	56,825 (19.3%)
8 to 14 Days	95,880 (14.8%)	40,006 (14%)	90,826 (14.1%)	40,169 (13.6%)
15 to 21 Days	56,255 (8.7%)	21,246 (7.4%)	58,245 (9.0%)	23,440 (8.0%)
22 to 28 Days	35,553 (5.5%)	11,575 (4.0%)	39,848 (6.2%)	14,256 (4.8%)
More Than 28 Days	29,478 (4.6%)	9,121 (3.2%)	39,195 (6.1%)	12,838 (4.4%)
Unknown	293 (0.1%)	183 (0.1%)	255 (0.1%)	276 (0.1%)

Table 7 shows the wait time for patients booking to appointment across the Nottinghamshire Place Based Partnerships for November 2022. Comparable data is not available for November 2021.

Table 7– Booking to Appointment (Place Based Partnership)

	Nottinghamshire Place Based Partnership (Locality areas)					
	Bassetlaw	%	Mid-Notts	%	South Notts	%
	*Larwood and Bawtry *Newgate Medical Group *Retford and Villages		*Ashfield North *Ashfield South *Mansfield North *Rosewood *Newark *Sherwood		*Arnold and Calverton *Arrow Health *Byron *Nottingham West *Rushcliffe	
Total count of appointments per area	70,142		178,566		207,333	
From booking to appointment:						
Same Day	27,776	39.60%	68,270	38.23%	84,243	40.63%
1 Day	4,600	6.56%	11,235	6.29%	12,151	5.86%
2 to 7 Days	13,057	18.62%	30,268	16.95%	35,813	17.27%
8 to 14 Days	9,016	12.85%	24,364	13.64%	31,048	14.97%
15 to 21 Days	6,044	8.62%	16,730	9.37%	18,220	8.79%
22 to 28 Days	4,865	6.94%	13,731	7.69%	12,681	6.12%

More Than 28 Days	*4,764*	*6.79%*	*13,884*	*7.78%*	*13,127*	*6.33%*
Unknown	*20*	*0.03%*	*84*	*0.05%*	*50*	*0.02%*

3. Summary

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

There are no specific contractual requirements in relation to the levels of access for general practice services, however access and quality is monitored through both national and local platforms and intelligence. Patient reporting of difficulties in accessing services is not unique to Nottingham and Nottinghamshire, this has increased for the majority of general practices across England and has received significant national media coverage.

Through the recruitment of Additional Roles, general practice is providing services utilising a range of multi-disciplinary professionals to best meet the needs of individual patients, in line with national policy to build a broader workforce across general practice. This supports the key role for general practice in ensuring that patients access the right care, in the right place and at the right time. In the right place also means remote access e.g. telephone, video or online consultations if deemed appropriate by the clinician and is acceptable to the patient.

Due to the unprecedented demand, the Nottingham and Nottinghamshire health and care system declared several critical incidents during 2022. General practice has played a pivotal role and prioritised needs to focus on vulnerable patients and those most at risk of hospitalisation to support the health and care system. The ICB has provided a general practice winter support package to continue to support general practice resilience through the remaining winter months.

As well as the unprecedent pressures across the system, general practice is facing a number of additional challenges, including:

- Workforce challenges (recruitment, vacancies and sickness, particularly ongoing COVID-19 related)
- Recruitment and integration of Additional Roles
- Post COVID-19 recovery, long-term condition work versus urgent treatment needs
- Implementation of new initiatives (e.g. Enhanced Access and ARI hubs)
- Challenges that are brought as a result of patient frustration and violent and aggressive behaviour towards practice staff

Despite all the challenges an increase in the number of appointments, delivered by general practice, has been demonstrated. Whilst the appointment data is experimental it shows there has also been a growth in all types of appointments. Our PCNs also continue to explore and implement a range of initiatives to address growing patient demand – looking to the future as well as tackling current needs of patients. This has been demonstrated in the wide range of transformational initiatives being undertaken at a Place level for example, development of on-line tools to increase information flows and reviewing pathways of care for vulnerable and frail patients.

Appendix A

Description of PCN Additional Roles

Care Coordinators
Care coordinators provide extra time, capacity, and expertise to support patients in preparing for clinical conversations or in following up discussions with primary care professionals. They work closely with the GPs and other primary care colleagues within the primary care network (PCN) to identify and manage a caseload of identified patients, making sure that appropriate support is made available to them and their carers (if appropriate), and ensuring that their changing needs are addressed.

Clinical Pharmacists
Clinical pharmacists work in primary care as part of a multidisciplinary team in a patient facing role to clinically assess and treat patients using expert knowledge of medicines for specific disease areas. They work with and alongside the general practice team, taking responsibility for patients with chronic diseases and undertaking clinical medication reviews to proactively manage people with complex medication use, especially for the elderly, people in care homes and those with multiple conditions.

Community Paramedic
A paramedic in primary care can recognise and manage the deteriorating patient and can manage patients with long term conditions, minor injuries, and minor illness. They can also support patients who require wound care, have fallen, have MSK problems, and have urinary tract or respiratory infections. Paramedics can supply a range of medicines through PGDs, including antibiotics and analgesics.

Dietitians
Dietitians are healthcare professionals that diagnose and treat diet and nutritional problems, both at an individual patient and wider public health level. Working in a variety of settings, including primary care, with patients of all ages, dietitians support changes to food intake to address diabetes, food allergies, coeliac disease, and metabolic diseases. Dietitians also translate public health and scientific research on food, health, and disease into practical guidance to enable people to make appropriate lifestyle and food choices.

First Contact Physiotherapists
First Contact Physiotherapists (FCP) are qualified independent clinical practitioners who can assess, diagnose, treat, and manage musculoskeletal (MSK) problems and undifferentiated conditions and, where appropriate, discharge a person without a medical referral. FCPs working in this role can be accessed directly by patients, or staff in GP practices can refer patients to them to establish a rapid and accurate diagnosis and management plan to streamline pathways of care.

Health and Wellbeing Coaches
Health and wellbeing coaches (HWBCs) will predominately use health coaching skills to support people to develop the knowledge, skills, and confidence to become active participants in their care so that they can reach their own health and wellbeing goals. They may also provide access to self-management education, peer support and social prescribing. Health coaches will support people to self-identify existing issues and encourage proactive prevention of new and existing illnesses.

Nursing Associates and Trainee Nursing Associates
The nursing associate is a new support role in England that bridges the gap between healthcare support workers and registered nurses to deliver hands-on, person-centred care. Nursing associates work with people of all ages in a variety of settings in health and social care, including general practice.

Occupational Therapists
Occupational therapists (OTs) support people of all ages with problems resulting from physical, mental, social, or development difficulties. OTs provide interventions that help people find ways to continue with everyday activities that are important to them. This could involve learning new ways to do things or making changes to their environment to make things easier. As patients' needs are so varied, OTs help GPs to support patients who are frail, with complex needs, live with chronic physical or mental health conditions, manage anxiety or depression, require advice to return or remain in work and need rehabilitation so they can continue with daily activities.

Pharmacy Technicians
Pharmacy technicians play an important role within general practice and complement the more clinical work of clinical pharmacists, through utilisation of their technical skillset. Working within primary care settings allows the pharmacy technician to apply their acquired pharmaceutical knowledge in tasks such as audits, discharge management, prescription issuing, and where appropriate, informing patients and other members of the primary care network (PCN) workforce. Work is often under the direction of clinical pharmacists as part of the PCN pharmacy team.

Physician Associates
Physician associates are healthcare professionals with a generalist medical education, who work alongside doctors providing medical care as an integral part of the multidisciplinary team. Physician associates are dependent practitioners who work under the supervision of a fully trained and experienced doctor. They bring new talent and add to the skill mix within teams, providing a stable, generalist section of the workforce which can help ease the workforce pressures that primary care currently faces.

Podiatrists
Podiatrists are healthcare professionals that have been trained to diagnose and treat foot and lower limb conditions. Podiatrists provide assessment, evaluation, and foot care for a wide range of patients, which range from low risk to long-term acute conditions. Many patients fall into high risk categories such as those with diabetes, rheumatism, cerebral palsy, peripheral arterial disease, and peripheral nerve damage.

Social Prescribing Link Workers
Social Prescribing Link Workers give people time and focus on what matters to the person as identified in their care and support plan. They connect people to community groups and agencies for practical and emotional support and offer a holistic approach to health and wellbeing, hence the name 'social prescribing'. Social prescribing enables patients to get the right care for them.

Nottinghamshire County Council

Report to Health Scrutiny Committee

21 February 2023

Agenda Item: 8

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations, and reviewing other issues impacting on services provided by trusts which are accessed by County residents.

3. The 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 new 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 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. At its January 2023 Committee meeting, officers agreed to explore further the most appropriate way for scrutiny to be carried out on the delivery of the provision of Health Visiting for 0–3-year-olds, which is part of the wider Healthy Families Programme. Following discussion and further representations, it is proposed to consider this item at the Health Scrutiny Committee's March 2023 meeting.

RECOMMENDATION

That the Health Scrutiny Committee:

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

Councillor Sue Saddington
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Noel McMenamin – 0115 993 2670

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2022/23

Subject Title	Brief Summary of agenda item	Scrutiny/Briefing /Update	External Contact/Organisation	Follow-up/Next Steps
14 June 2022				
Review of Maternity Services at NUH – Update and Implications		Scrutiny	None	
Tomorrow's NUH		Scrutiny	Mark Wightman and Alex Ball Nottingham and Nottinghamshire CCG	
Temporary Service Changes - Extension		Scrutiny	Mark Wightman and Alex Ball Nottingham and Nottinghamshire CCG	
26 July 2022				
Integrated Care System and Implications of Health and Care Act	Further update on the Health and Care Act and its implications for services and residents	Briefing	Dr Amanda Sullivan, ICB	
Proposed Transfer of Elective Services at Nottingham University Hospitals	Endorsement of proposals to move colorectal and hepatobiliary services from QMC to City Hospital	Scrutiny	Lucy Dadge and Alex Ball, Nottingham and Nottinghamshire ICB Ayan Banerjea, Colorectal Surgeon	
20 September 2022				
East Midlands Ambulance Service Performance	The latest information on key performance indicators from EMAS.	Scrutiny	Richard Henderson, Chief Executive, Greg Cox, Operations Manager (Nottinghamshire)	

Integrated Care System Preparation for Winter 2022/23	Lessons learned from experiences of last winter and preparations for the forthcoming winter	Scrutiny/briefing	tbc	
Update on Dementia Services	Further briefing/update of the Dementia Strategy		Proposed Action: Request briefing and liaise ASC/PH Select Committee on next steps	
15 November 2022				
Health and Care System Critical Incident and Winter Plan	Update from September 2022 meeting on winter pressure challenges	Scrutiny	ICB/NUH	
Update on Expansion of Neonatal Capacity at NUH	Update on Expansion Programme	Scrutiny	ICB	
Update on Acute Stroke Service	Update on relocation of services to QMC	Scrutiny	ICB	
10 January 2023				
Newark Hospital – Increased Capacity	Briefing on expansion of operating theatre facilities at Newark Hospital.	Scrutiny	TBC	
21 February 2023				
NUH Chief Executive – Priorities and Challenges	Briefing from NUH Chief Executive on key areas of focus to deliver improvement	Scrutiny		
Maternity Services Progress	Briefing from NUH Chief Executive on Maternity services	Scrutiny		

Health and Care System Winter Planning 2022-23 – NUH Perspective	Briefing from NUH Chief Executive on delivery of winter planning from the NUH perspective	Scrutiny			
Access to GP Services	Refresh of information considered to date, and update on post-pandemic access	Scrutiny	ICB/GP representatives		
28 March 2023					
Dentistry Services	Briefing on service provision and barriers to access, including registration of infants and young children	Scrutiny	NHS England		
Health Visiting	Service delivery of health visiting for 0-3 year olds. Focus on cohort affected by lack of face-to-face contact during pandemic	Scrutiny	To be determined		
Community Diagnostic Centres	Briefing on the roll-out of Community Diagnostic Centres in Nottinghamshire				
9 May 2023					
Diabetes Services Update	Further information on diabetes services	Scrutiny	Senior officers of Nottingham/Nottinghamshire CCG/successor organisation (ICB)		
Colorectal and Hepatobiliary Services to City Hospital - Update	Update on relocation of elective services from QMC	Briefing (from July 2022 meeting)	ICB/NUH		

20 June 2023				
25 July 2023				
Integrated Care Partnership - Update	Update from July 2022 meeting on implications for services and residents	Briefing	TBC	
East Midlands Ambulance Service Performance	The latest information on key performance indicators from EMAS.	Scrutiny	Richard Henderson, Chief Executive, Greg Cox, Operations Manager (Nottinghamshire)	
To be scheduled and potential alternative actions				
Discharge to Assess (From Hospital)	To be discussed with Chair/V-Chair Adult Social Care and PH Select Committee to consider how the committees can work together to look at this item			
Mental Health Services and Support	Last considered Feb 2022 - To be discussed with Chair/V-Chair Adult Social Care and PH Select Committee to consider how the committees can work together to look at this item			

Tomorrow's NUH	Proposal to have all-member briefing sessions as required, rather than as regular agenda item	Scrutiny	For consideration	
Newark Hospital – Future Strategy	Update on future provision	Scrutiny	Mark Wightman and Alex Ball Nottingham and Nottinghamshire ICB	
Early Diagnosis Pathways	To consider access/timeliness of early diagnosis for cancer, CPOD etc, and to explore where disparities lie	Scrutiny		
Non-emergency Transport Services (TBC)	An update on key performance.	Scrutiny	Senior CCG/ICB officers.	
NHS Property Services	Update on NHS property issues in Nottinghamshire	Scrutiny	TBC	
Frail Elderly at Home and Isolation	TBC –	Scrutiny	Proposed Action: Initial Focus on GP use of Frailty Index. Possible link in with Overview of Public Health Outcomes	
Performance of NHS 111 Service	Briefing on performance			
Long Covid	Initial briefing on how commissioners and providers are responding to the challenges of Long Covid			
Also:				
Visit to Bassetlaw Hospital late 2022				
Visit to QMC Emergency Department	Chair scheduled to visit on 20 March			