Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE
Tuesday 14 May 2024 at 10.00am

COUNCILLORS

Jonathan Wheeler (Chairman)
Bethan Eddy (Vice-Chairman)

Mike Adams
Sinead Anderson – apologies
Callum Bailey
Steve Carr
David Martin
John 'Maggie' McGrath – apologies
Nigel Turner
Michelle Welsh
John Wilmott - items 1-5 only

SUBSTITUTE MEMBERS

Councillor Eric Kerry for Councillor Sinead Anderson
Councillor Pauline Allan for Councillor John 'Maggie' McGrath

OTHER COUNCILLORS IN ATTENDANCE

None

OFFICERS

Martin Elliott – Senior Scrutiny Officer
James Lavender – Democratic Services Officer
Noel McMenamin – Democratic Services Officer

ALSO IN ATTENDANCE

Lucy Dadge – Director of Integration, NHS Nottingham and Nottinghamshire ICB
Diane Hull – Director of Nursing, Nottinghamshire Healthcare NHS Foundation Trust
Lisa Janiec – Head of Elective Care, NHS Nottingham and Nottinghamshire ICB
Ifti Majid – Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust
Jan Sensier – Director of Partnerships and Strategy, Nottinghamshire Healthcare NHS Foundation Trust

1 MINUTES OF THE LAST MEETING HELD ON 16 APRIL 2024

The minutes of the last meeting held on 16 April 2024, having been circulated to all members, were taken as read and signed by the Chairman.

- Item 6: Work Programme

"An update on progress on the medical centre in Warsop was of interest to Members" to be replaced with "An update on progress on the medical centre in Worksop was of interest to Members".

2 APOLOGIES FOR ABSENCE

Councillor Sinead Anderson – Other reasons
Councillor John 'Maggie' McGrath – Other reasons

3 DECLARATIONS OF INTEREST

None.

4 NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST – CARE QUALITY COMMISSION FINDINGS

Representing the Nottinghamshire Health NHS Foundation Trust (NHT), Ifti Majid, Chief Executive, Jan Sensier, Director of Partnerships and Strategy, and Diane Hull, Director of Nursing, presented the report which outlined the background and summary of the Care Quality Commission's (CQC) Section 48 review of their organisation. The following points were raised:

- Following a visit to Rampton Secure Hospital in June and July 2023, the CQC found a number of issues with the running of the hospital which involved insufficient staffing levels, patient care and the state of the buildings. There were also concerns around medicine practice and the hospital's death service with regards to communication. The CQC's report was published in January 2024. Soon after publication, there were reports in the press about Rampton staff not carrying out therapeutic observations correctly and falsifying records. A significant number of staff were suspended because of these incidents. Between July and December 2023, the NHT made improvements to Rampton Secure Hospital by increasing staffing, reducing restrictive practices, and increasing the number of staff trained in British Sign Language, however these improvements were not included in the CQC's report.

- Along with the CQC visit and the press coverage regarding the falsifying of records and failure to carry out therapeutic observations correct, the court hearings regarding Valdo Calocane, the perpetrator of the Nottingham Murders on 13 June 2023, resulted in the Secretary of State for Health requesting a Section 48 review into the NHT.

- As part of the Section 48 review, the CQC was asked to look at what information was available within the public domain regarding Valdo Calocane's care and treatment from all the organisations he was involved with. The second part of the Section 48 review examined the safety of certain services provided by NHT. The third part of the review focused on the improvements which were recommended at Rampton Secure Hospital

and were implemented during the months between the CQC visit and the publication of the report.

- The first two CQC reports were published on 1 March 2024 which related to impatient mental health services for adults and older adults. The findings were disappointing as concerns were raised around medicine management, risk documentation, food and fluid monitoring, environment, leadership, and local management. Serious concerns were raised around the conduct of staff as reports of patients being assaulted by staff were raised. Talks were taking place with the CQC to address these issues. The report about the care of Valdo Calocane was expected to be published by the CQC at the end of June 2024. The reports contained commentary on not just the NHT mental health provision, but on the national mental health sector, as well as recommendations for the NHT, NHS England (NHSE) and the CQC

- As there was a high demand for community services, there was a need to monitor those people on the waiting list and assess whether they needed rapid intervention. Consistency was needed across the organisation in terms of risk assessment and management of patients, as well as engagement with families across the wider organisation. Questions were raised around whether community mental health teams should be commissioned to focus more locally than provide their service across the county.

- The CQC were concerned about staffing levels within NHT mental health services. Whilst the CQC highlighted that NHT responded quickly to their recommendations, they stated that the NHT's leadership were not pro-active enough in addressing issues. Communication between pathways was not effective enough. The CQC recognised that the issues faced by the NHT were also issues faced by all mental health services across the country.

- The CQC had seen improvements at Rampton Secure Hospital such as more staff being trained in BSL, patients feeling safer, and improvements staffing levels. Concerns were raised about therapeutic practices being cancelled, the physical wellbeing of patients was not being addressed, and that staff were being redeployed too regularly. Overall, there was some improvement in the culture of Rampton.

- As a result of the Section 48 review, the wider quality issues identified, and the scrutiny which the NHT were facing at a national level, they were placed into Segment 4 of the NHS National Oversight Framework, and thus enter the Recovery Support Programme. This was used by NHSE to provide mandated supported to NHS Trusts which require it. This support included an allocated Improvement Director, access to extra funding, and priority for national NHS programmes. The NHT will also develop an Integrated Improvement Plan (IIP) which would then allow the Trust to leave Segment 4 support as this plan will be used as the basis for long-term scrutiny of the NHT.

- In terms of mental health service improvements, there was a 9% fall in the number of people awaiting an assessment. This was due to a better understanding what people were waiting for, comprehensive assessment at the triaging stage, and implementing the NHT's Waiting Well policy. The Waiting Well policy involved a person being assessment at triaging. Afterwards, they would receive information and guidance about where they could obtain additional help, and then regular contact takes place between the service and the person to check on them.

- There was a 30% reduction in out of area placements. The NHT recognised that if people needed in-patient care, their recovery would be quicker if they were closer to their families and friends. The Robust Quality Oversight Framework for out of area placements ensured that patients received a quality assessment. The NHT keep in close contact with the out of area patient, and, with the patient's permission, their family, throughout the treatment and care process. An additional two leaders have been recruited into the mental health services to work with the teams to improve the waiting process and the interventions which the service could deliver. There were improvements in the numbers of patients discharged into primary care in a more timely way.

- Regarding in-patient care and support, the work into improving this started before the CQC inspections. There were three levels of therapeutic observation within in-patient care: general, intermittent, and enhanced. This allowed staff to connect with patients, assess their needs, and escalate where appropriate. This policy was reviewed after the CQC inspections. The training in observations was reviewed with over 90% of staff now trained. A robust governance oversight process was in place to review observations through documentation, talking with patients, and CCTV monitoring. There was an over 97% compliance rate with observations.

- There was a new focus on physical healthcare, particularly amongst elderly patients. 96% of staff have received on training on how to recognise the early signs of a deteriorating patient and take action. 'Falls experts' supported and trained staff to identify and reduce the risks of falls among patients. Nursing leadership was strengthened in in-patient areas.

- At Rampton Secure Hospital, there was an increase in nursing recruitment, with newly qualified nurses starting in the summer. This has let to an increase in morale and culture, as well as positive feedback from patients.

- The IIP was design to address not just short-term or medium-terms issues, but the long-term root causes of problems within NHT mental health services. The plan was made up of five key programmes:

    1) Quality and Patient Safety
    2) Leading for the Future
    3) Finance and Productivity Programme
    4) People and Culture

5) Governance

- The final processes of the plan and the metrics were still being developed and would be shared with the Committee in further details.

- In terms of financial performance, the NHT posted a deficit position at the end of 2023/24. Work would be undertaken to bring the deficit down by tackling the causes of financial difficulties, for example, the use of the private sector for extra bed capacity.

- There were three phases of the IPP, with Phase 1 involving meeting the recommendations of the Section 48 review, the improvements at Rampton, and bringing down the deficit.

- The NHT provided wide-ranging services, and those other services would not suffer because of the IPP's focus on mental health services. The organisation was meeting their targets in other areas such as Healthy Families and SEND support.

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

- Members sought assurance from the NHT that patients using their services would get the treatment they needed.

- How would the NHT ensure newly qualified nurses were supported to help them gain experience within their new roles?

- Members raised concerns about the falsifying of records within the service and highlighted the importance of staff coming forward to managers about making sure that the correct processes were being followed.

- Members highlighted the leadership failures at NHT and stated the plans should have been put in place earlier. They also highlighted individual cases of members of the public not getting the mental health support they need.

- Members could be used to provide feedback on the coverage of mental health services within their areas.

- Were staff consulted on the report and was staff training being reviewed?

- Members wanted assurance that these improvements would not divert resources from other areas of the NHT.

- Members highlighted cases where failures of mental health provision have resulted in danger to wider society such as the Nottingham Murders. They also highlighted the danger to frontline public services in dealing with people with severe mental health problems not getting the care and treatment they needed.

- What was being done to change the working culture within NHT?

- Would the NHT see the report into Valdo Calocane before it was published in public and would the Committee see this report?

- Members raised questions around the financial pressures on the NHT such as the deficit, the cost of private healthcare beds and the recruitment of agency staff.

- Members raised questions around the quality of the triaging and risk assessment of patients.

In relation to the points raised by the Committee, the representatives of the NHT provided the following responses:

- The Safe Today Dashboard provided key indicators which would help determine if an area of the service was safe for patients such as staffing, complaints, compliance, observations, restrictive interventions (seclusions and segregations) and waiting lists. The process helped identify early signs of concern, which would allow for early intervention.

- The NHT have discussed with universities about having nursing students interviewed at the end of the second year, be offered a position within a service, then use their third year to prepare for their preceptorship. This would allow them to access in-house training and establish a relationship with their mentors. Training in patient engagement was being commissioned. Newly qualified nurses have also identified training opportunities which the NHT could provide in areas such as shift coordination and delegating to other staff. The creation of Clinical Band 6 and 7 roles would bring experienced practitioners back onto wards to support newly qualified nurses.

- Staff have more confidence to speak up to senior managers if they see unethical and fraudulent activities.

- All the issues highlighted by the NHT were current and ongoing. Some of the routes of the current issues were historical. There was evidence that crisis teams were responding quicker to individuals when needing support when there were in the community. They also had one of the best police liaison teams within the country. The approach outlined demonstrated that the IIP was making a difference, however much more work needed to be done in terms of community support and ensuring people receive mental health support if they don’t meet the requirement for secondary mental health support.

- Staff were consulted and supported through the CQC review process. To make the changes at Rampton sustainable, it was important to make the hospital an attractive place for people to work, retaining staff as well as attracting new staff. 70 new nurses and nursing assistants have been recruited. Patient and staff engagement was being built into the IPP.

- The NHT recognised that the failure of people to receive the right mental health support did have a damaging impact on a person, their family and wider society. Most people with a mental health illness were not violent or aggressive, and lived well in the community.

- There were 'mini-cultures' within the NHT. The Trust recognised that in the past, the organisation had operated in silos, which meant services within the wider organisation did not communicate with one another effectively. Work was undergoing to make services communicate with one another. The culture of learning needed to be improved. The organisation welcomed in people who were recruited externally to give fresh perspectives to change the culture, whilst also promoting people from within the organisation. The shift from a task-based approach to an individual needs-based approach has improved the working culture within the NHT.

- Falsification of records took place during intermittent and general observations by staff who said they had undertaken these observations when they had not. A more robust process was now in place to ensure that all observations took place and were recorded correctly. Staff are more confidence in calling out other members of staff for not carrying out observations. Any falsification was followed by a disciplinary process.

- Two reports were produced into the Nottingham Murders. The first report was undertaken by the CQC as part of the Section 48 review, which reviewed the available evidence and a review of other individuals within the county. There were no interviews with NHT staff regarding this report. It was expected to be published by the end of June. It would be seen by the NHT before publication. After publication, the Committee could scrutinise the report. The second report was an Independent Homicide review, which was normal process for tragic events within the country. This report involved examining wider contributing factors, records and processes, and interviewing staff, clinicians, and leaders. Work had started on this report and it was expected to be published towards the end of the summer, but it might be delayed. Both these reports would be public.

- A staff reorganisation took place at Rampton Secure Hospital. Further staff support was brought in externally to support managers and leaders in the improvement journey and to improve the leadership culture at the hospital and across the wider organisation.

- The financial factors which drove the deficit were the cost of out of area placements, agency staff, and the failure to deliver certain efficiencies within the Trust. The Finance and Productivity Programme within the IIP aimed to address the deficit. When patients are taken on by private healthcare providers both inside and outside of the county, they are responsible for their day-to-day care and treatment based on their own processes and regulations whilst the NHT continued to provide the quality oversight. This was not the ideal for the Trust as sending patients to private health providers was costly and they could provide the kind of quality oversight which they can do internally, and it was preferable to keep patients within the county. The Covid-19 financial support

and non-recurrent funding masked a long-term building up of the deficit. The 'silo working' had resulted in less understanding of the financial pressures of a particular service, so the overall goal was to conduct an overall review of how the organisation delivered its services. The NHT run 10 hospitals. New governors were provided with a briefing on the structure and services provided by the organisation both locally and nationally. This could be shared with Members.

- All the risk assessments were reviewed by the crisis teams and they were now 100% compliant. There was a monthly audit of those risk assessments. The safeguarding team were crucial in the process. Risk assessment management meetings within the local mental health and crisis teams take place. The Nurse Consultant for Suicide Prevention and Self-Harm attending those meetings to triangulate actions for anyone at risk of harm. Risk assessment documents were provided to those patients for them to understand whether they felt that the document accurately reflected their risk. Work has taken place with GPs, local nurses, and the third sector to further understand risks.

The Chairman thanked the representatives of the NHT for attending and the Committee would awaiting a further report into actions of the Improvement Plan in six months' time.

(The Chairman called for a comfort break at 11:45am. The meeting was reconvened at 11:53pm).

RESOLVED 2024/09

1) That the briefing be noted.

2) That a further report be presented to the Committee on the implementation of the Improvement Plan in six months' time.

5 ACCESS TO ELECTIVE SURGERY IN NOTTINGHAMSHIRE

Representing the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), Lucy Dadge, Director of Integration, and Lisa Janiec, Head of Elective Care, delivered the report into the current waiting times for diagnosis and planned care procedures in Nottinghamshire, which outlined the current situation, the actions being taken to reduce waiting times, and how the ICB were maintaining patient safety. The following points were raised:

- The long-term impact of the Covid-19 pandemic and industrial action were the main causes for the lengthening of waiting times for NHS healthcare providers across the country as well as in Nottinghamshire. A surge in demand in emergency care has resulted in cancellations of planned care and less flexibility to reschedule those cancelled appointments.

- The national target for patients being referred to treatment for planned care was 18-weeks. 57.6% of NHS Trusts were meeting that target. Sherwood Forest Hospitals Foundation Trust, which ran King's Mill and Newark

Hospitals, was achieved 60.9% of patients being treated within 18 weeks, whilst the Nottingham University Hospitals NHS Trust, which ran the Queen's Medical Centre and City Hospital, were slightly below the 18-week target at 54.3%, but they were showing signs of improvement.

- The ICB had a target of having no patients waiting over 78 weeks for planned care by the end of May 2024. Some patients on the waiting lists had complex needs which could only be met by a specific service, whilst others chose to wait for planned care due to holiday or family commitments. The next target was having no patients waiting over 65 weeks by the end of September 2024, followed by no patients waiting over 52 weeks by the end of March 2025.

- The waiting lists were impacted by the volume of specialist planned care for ear, nose and throat trauma and orthopaedics. The ICB were meeting the targets for diagnostic waits with 15% waiting no more than 6 weeks by April 2024 and being on track for 5% waiting no more than 6 weeks by April 2025.

- The ICB were creating additional capacity for planned care procedures to meet national targets through weekend appointment and commissioning independent sector providers. Additional community diagnostic spaces have been created in Mansfield and Newark and a mobile MRI service was used in Nottingham, Mansfield and Newark. In the long-term, the ICB needed to increase the number of patients to diagnose and treat by creating extra physical capacity and increase productivity through new ways of working. The first phase of a new Community Diagnostics Facility at Mansfield Community Hospital aimed to be ready by April 2025, with full capacity achieved by July or August 2025. Elective Hubs, which were ringfenced wards and theatres purely used for planned care, were opened at Newark Hospital and were being created at Nottingham City Hospital.

- Productivity was under review and patients were being more supported and prepared for planned care.

- GPs were offered guidance and support to patients who may or may not require planned care.

- The ICB were making sure that waiting lists were not exacerbating local health inequalities. There was no evidence from the waiting lists that those waiting over 56 weeks were no more disadvantaged being from an economically deprived area than from an economically well-off area.

- Patients on waiting lists were reviewed regularly to make sure that they would not be harmed by the wait for their planned care procedure.

- Patients were offered a choice of provider where that was appropriate or clinically beneficial, and it could be outside of the county. Patients were offered this choice at the point of referral and the waiting list was explained to them. Sherwood Forest Hospitals and Nottingham University Hospitals

compared waiting lists to provide mutual aid where possible. The independent sector provided planned care on a weekly basis on NHS rates.

- In October 2023, all patients waiting more than 40 weeks were offered a choice of provider over a 50-mile radius. 277 patients were found that could be offered capacity elsewhere. 70 patients were moved to another provider for planned care.

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

- Members noted that waiting times for planned care were growing for years before the Covid-19 pandemic and the recent wave of NHS staff industrial action.

- Members recognised that surgeons were taking on heavy workloads.

- Members highlighted those early interventions such as changes in lifestyle, accessibility to MRI scans and health screenings would reduce waiting times for planned care.

- Was there a Primary Care Hub in Newark?

- Were the Community Diagnostics Centres mobile?

- What provision was being provided in Bassetlaw?

- Members spoke of their own experiences of surgery being provided at GP surgeries.

- Members also spoke of the need for a campaign around the use of suncream.

- Members were reminded of the health inequalities in areas of the county, for example, the prevalence of people with lung conditions within North Nottinghamshire which contained areas of poverty. There was also the opinion that the waiting list exacerbated health inequality. People who have the option to go for private planned care will do.

In relation to the points raised by the Committee, the representatives of the ICB provided the following responses:

- There was still a focus on prevention. Working was going on around personalised care in which patients would be contacted after referral by their GP onto a waiting list to review whether planned care was the appropriate goal or treatment for them to make them better. GP surgeries were not the appropriate environments for surgery, but improvements in day surgery

operations could free up capacity. Efforts were being made to improve the organisation of work to allow surgeons to manage their patients effectively.

- Ongoing work was taking place on a programme of early health screenings within Primary Community and Secondary Care. Patient information would be provided on how to manage their conditions whilst they were on the waiting lists.

- PC 24 at King's Mill Hospital was open 24 hours a day and patients were able to turn up with an urgent care need and be treated, however it was not a Primary Care Hub.

- The mobile screenings took place where there was a known need for them, for example, mobile lung screenings in areas with a high prevalence of lung cancer. The government funded Community Diagnostic Centres were permanent facilities. Whilst there was one being constructed in Mansfield; one was being planned in the Broadmarsh area of Nottingham city. The ICB did provide care for residents in Bassetlaw, however in-patient care was provided by hospitals ran by different ICBs.

- The mission of the ICB was to close the gap in health outcomes between the richest and poorest areas of Nottinghamshire and to improve overall life expectancy.

- 18 weeks was the longest to wait for surgery a few years ago, so the work of the ICB was to return to that goal.

The Chairman thanked the representatives of the ICB for attending the meeting.

RESOLVED 2024/10

1) That the briefing be noted.

2) That further scrutiny of the issue and the form of that scrutiny be considered.

6 <u>WORK PROGRAMME</u>

Councillor Jonathan Wheeler, the Chairman of Health Scrutiny Committee, and Noel McMenamin, Democratic Services Officer, introduced the Work Programme. For the June meeting, the following reports would be presented:

- Nottingham University Hospitals (NUH) briefing on the maternity service provision.
- Lung Health Pathways (Non-cancer) in Nottinghamshire.

For the July meeting, the following reports would be presented:

- NHS 111 Service – Additional performance data
- Mental Health in Bassetlaw and Update on A&E Village Development (subject to confirmation)

The Newark Hospital Urgent Treatment Centre report would go to a future meeting, however this would be subject to further advice from the ICB about when the proposals would be ready for further consideration.

Whilst the Committee had wished to consider the Council's Suicide Prevention Strategy, the Adult Social Care and Public Health Select Committee would be considering a report into the Suicide Prevention Strategy at their meeting in June, so it was recommended that members of the Committee channel any questions and concerns around the strategy into the Adult Social Care and Public Health Select Committee.

The ICB might bring a report to the June or July meeting of the Committee around the financial pressures from within the ICB, but this was yet to be confirmed.

During the discussion between Members made the following comments:

- The changes of the General Practitioner (GP) contracts should be investigated by the Committee as this could have a wide-ranging impact on the quality of healthcare nationally.

- It would be more beneficial for a briefing note to be circulated to the Committee regarding the NHS 111 Service, and once the additional performance data was released, a further report could be provided at a future meeting.

- The NUH maternity service provision would be a review of the work undertaken by the Ockenden Review into maternity services at NUH so far, as the report was not due until late 2025. The reporting aimed to provide assurance to the public that improvements have been made and that it was safe to use their service.

- The June meeting of the Committee would be the first of the new municipal year, hence there would be a review and a consolidation of the work programme for the following year. The NUH maternity service provision report would be a substantial item.

RESOLVED 2024/11

1) That the Work Programme be noted.

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

The Chairman thanked Members for attending the meeting and for supporting him in his capacity as Chairman of the Health Scrutiny Committee. He closed the meeting at 12:50 pm.

CHAIRMAN