Nottingham City Council

Health and Adult Social Care Scrutiny Committee

Minutes of the meeting held in the Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 16 May 2024 from 9:31am to 11:56am

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Saj Ahmad
Councillor Maria Joannou (Vice Chair)	Councillor Kirsty Jones
Councillor Michael Edwards	Councillor Farzanna Mahmood
Councillor Eunice Regan	Councillor Sarita-Marie Rehman-Wall

Colleagues, partners and others in attendance:

Lucy Anderson	-	Head of Mental Health Commissioning, Contracting and Performance, NHS Nottingham and Nottinghamshire Integrated Care Board
Kate Burley	-	Deputy Head of Mental Health Commissioning, NHS Nottingham and Nottinghamshire Integrated Care Board
Sarah Collis	-	Chair, Healthwatch Nottingham and Nottinghamshire
Melissa Edwards	-	Principal Clinical Lead, Vita Health Group
Dr Susan Elcock	-	Executive Medical Director and Deputy Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust
Adrian Mann	-	Scrutiny and Audit Support Officer
Kate Morris	-	Scrutiny and Audit Support Officer
Claire Pearson	-	Associate Director for Psychological Professions, Nottinghamshire Healthcare NHS Foundation Trust
Jan Sensier	-	Executive Director for Partnerships and Strategy, Nottinghamshire Healthcare NHS Foundation Trust
Andy Sirrs	-	Clinical and Strategic Lead for Serious Mental Illness, Nottinghamshire Healthcare NHS Foundation Trust

54 Apologies for Absence

Councillor Kirsty Jones	-	unwell
Councillor Farzanna Mahmood	-	work commitments
Councillor Sarita-Marie Rehman-Wall	-	personal reasons

55 Declarations of Interests

None

56 Minutes

The Committee confirmed the minutes of the meeting held on 11 April 2024 as a correct record and they were signed by the Chair.

57 Nottinghamshire Healthcare NHS Foundation Trust - Integrated Improvement Plan

Dr Susan Elcock and Jan Sensier, Executive Medical Director and Deputy Chief Executive and Executive Director for Partnerships and Strategy at the Nottinghamshire Healthcare NHS Foundation Trust (NHT), presented a report on the development of an Integrated Improvement Plan to address the significant issues highlighted in the recent assessments carried out by the Care Quality Commission (CQC). Ifti Majid, Chief Executive of NHT, sent his apologies as he had been called away on an urgent family matter at short notice. The following points were raised:

a) Following the outcomes of the CQC's reports, NHT acted immediately to create improvements for patients in waiting well, with support available whilst waiting to access services and processes in place for NHT to better keep in touch with patients through this period. Work has also been done to ensure that needs assessments are carried out more quickly, to also help reducing waiting times.

b) The development of an Integrated Improvement Plan is now underway but, following an initial review by colleagues from NHS England, the Plan (although mostly developed) is now in the process of being phased to enable its more effective implementation over a period of time. As a result, the Plan remains in a draft form and has not yet been completed for adoption. Nevertheless, action to address the issues raised in the CQC report will continue to take place whilst the Plan is being finalised.

c) There are five key areas to the Plan, with the first phase to focus on addressing the Section 48 review recommendations. The Plan can also be categorised into three themes: community mental health services, Rampton Hospital and NHT as an organisation. The first key area is Patient Safety and Quality Improvement. This stream has a number of different projects including waiting well, crisis service delivery and proactive risk management. This stream's initial focus will be on the immediate action needed to address the Section 48 review recommendations.

d) The second key area of the Plan is Leading for the Future, looking at the capability and capacity of leadership across NHT. The Plan highlights the need for a strong clinical voice in leadership and at every level to ensure a balance between operational and clinical requirements. There is also a need to standardise operational processes across the organisation. The third key area looks at Finance and Productivity, and a work programme has been designed to tackle an underlying operational deficit that has been mitigated by one-off funding for a number of years. Work planned includes optimising the estate and improving financial management and controls. The Finance Recovery Plan also sits within this area.

e) The fourth key area of the Plan is People and Culture, with a focus on investing in people within NHT, improving engagement with staff, retention of staff and the workplace culture of NHT. An emphasis of this area is around listening to patients and staff and acting on the feedback. The final key area is Governance, and describes how NHT will be held to account for improvement, the development of systematic processes for monitoring and delivering change, and listening – particularly to external partners and external organisations working with NHT. This

area also includes the development of the existing electronic patient records system, using systems in a better way to allow clinicians more time to provide care and enable improved information sharing with Primary Care settings.

f) The internal governance structure for monitoring and reporting progress has been agreed and established. Individual programme boards covering each area of the Plan feed into the newly established Integrated Improvement Portfolio Board, which then reports into the higher leadership structure with the Board of Directors getting regular updates on progress. The Executive Leadership Team includes members from the NHS Nottingham and Nottinghamshire Integrated Care Board and NHS England, as well as executive and non-executive directors. Programme boards also include representation from the Staff Reference Group and the Patient/Carer Reference Group, and work is being done to develop these groups so that they reach more staff, patients and carers, and a more diverse range of people. NHT has also liaised with Healthwatch around the development of these groups, and an Evidence and Assurance Board has been established to ensure that the correct metrics are in place to reflect performance and improvement.

g) Additional staff have been recruited to improve the capacity available to receive and process feedback from patients and carers, as well as from staff. NHT recognises that changing the culture in such a large and fragmented organisation is a significant challenge. An external review of the Local Mental Health and Crisis teams has been undertaken to provide insight into ways to drive improvements. There has been a 30% reduction in the use of ‘out of area’ beds, and more robust communications are in place for those still placed in out of area beds. Work has been done to improve the carrying out of risk assessments, with additional training now in place. Further resources rolled out include co-produced training around interaction with patients with learning difficulties. This training is delivered by both patients and trainers and is mandatory for staff, with 66% of staff now having completed it.

h) The new telephone line for the Crisis team went live on 29 April 2024. Unlike the old telephone line, the new service offers the option to connect to NHS 111 and addresses issues such as dropped calls, messages and other features where the previous system was less effective. NHT is working on a new suite of publicity for the new telephone system.

The Committee raised the following points in discussion:

i) The Committee noted that NHT sometimes had to make in-area placements for people in mental health crisis within private mental health settings such as the Priory Hospital, Arnold that had itself been rated as ‘inadequate’ by the CQC, and asked what checks are done by NHT to ensure its patients’ safety in these settings. It was reported that NHT recognises that there are serios issues at the Priory Hospital, but that there is a robust regime of checks by a dedicated team that is in place for all private sector beds. However, the Priory Hospital offers specific specialist care and support, so a balance needs to be struck between the risk of placing someone here, or at an alternative potentially a significant distance out of area.

j) The Committee asked how effective NHT was at gathering feedback from patients, and whether people in its care had the proper freedom to speak out about their experiences. It was explained that the current systems to collect feedback from patients and carers could be significantly improved, as they do not fully enable NHT to identify patterns in complaints or concerns in a holistic way. In the past, responses to individual complaints have not been used to address wider issues, and have not always been expressed well or offered proper apology. Going forward, all letters in response to complaints are being reviewed by senior staff to ensure a proper focus on care. A large section of the Integrated Improvement Plan is focused on developing how feedback is gathered and then used.

k) The Committee asked how much the Integrated Improvement Plan had changed recently following the feedback from NHS England. It was set out that the content of the draft Plan has not changed substantially, but a phased approach is now being introduced following external advice, so the overall structure of the Plan needs to be changed significantly. Full timelines for the anticipated improvement journey will be included within the finalised Plan, which is aimed to be completed during June.

l) The Committee asked how many other similar mental healthcare providers were in a comparable position, and whether NHT was in touch with those that had been through a transformation process successfully. It was explained that there are other providers currently working within a transformation framework, at different stages of their improvement journeys. NHT has taken steps to liaise with these providers with a view to taking as much learning as possible.

m) The Committee questioned why it has taken such a long time for NHT to be able to recognise there were significant issues within the organisation, and what elements of the organisational culture had enabled problems to continue for so long. It was explained that, previously, NHT had operated a top-down approach, so more engagement is needed from staff and patients for it to be more effective as an organisation. Embedded ways of doing things are challenging to alter, particularly in the context of NHT's fragmented structure due to the use of different operating models across different services. The Integrated Improvement Plan aims to introduce more standardised operating models across all services, returning to a focus on getting the very basics right to help achieve a shift in culture. It is aimed to empower staff to improve the culture of the organisation, within a framework to support that change.

n) The Committee sought assurance that resourcing the delivery of improvement at the national Rampton Hospital was not being done at the expense of improving local mental health services in Nottingham. It was stated that local mental health services were not being given a lesser priority to Rampton Hospital. The Integrated Improvement Plan has specific actions designed for improving the situation at Rampton, but also for improving the local services for Nottingham – many of which are similar and cross-cutting. Separate capacity has been engaged for implementation of the parts of the Plan concerning Rampton so that an equal focus can be given to all areas.

o) The Committee asked whether senior staff regularly reviewed individual patient case files to ensure that proper processes were embedded and working well to drive improvements in quality. It was reported that clinical managers still also work shifts and review patient files. A newly implemented quality assurance audit is taking random samples of case files every month to understand where issues with quality may be. There has not been sufficient senior clinic oversight in the past, so steps are being implemented to rectify this.

p) The Committee asked what work NHT was doing to ensure that the key performance indicators and metrics that had been developed were the correct measures to give an accurate picture of the work towards improvement and its outcomes. It was set out that NHT has been in touch with other similar providers across the country to establish what effective key indicators look like. The priority is to find the right balance between qualitative and quantative metrics to get an accurate measure of improvement across a large range of services, and there is a process in place to regularly review measures to ensure that they remain appropriate, effective and relevant. There is also a focus on more patient-measured outcomes and the triangulation of feedback, metrics and performance indicators.

q) The Committee asked for more information around performance in relation to service waiting times. It was reported that both referrals to and acceptance rates for services have remained fairly stable and work has taken place to better understand where patients already access other services or no longer wish to be on the waiting list. The rejections of referrals has not increased, so the decrease in waiting lists does represent a reduction in the time that people have to wait for the assessment and access. Work continues to ensure that the waiting well policy is implemented to support patients on waiting lists.

r) The Committee queried how an equity of access to services would be ensured across all Local Mental Health Teams, particularly in terms of the specialist staff available. It was explained that work has begun to understand from clinical staff the issues that NHT experiences with recruitment and retention, particularly in the context of psychologists. Issues around the professional development offer have been identified, so work is taking place to address these and make a career in NHT more appealing. However, further work is needed to recruit more psychologists, as the standardisation of the offer provided by all teams is dependant on growing capacity.

s) The Committee asked how the report commissioned from Healthwatch on patient experience had supported the drafting of the Integrated Improvement Plan. It was set out that the Healthwatch report had been fundamental to the production of the Plan. The recommendations that the Healthwatch report made have been woven through the Plan and feature in all areas. NHT has been working with Healthwatch to develop strategies for listening to the patient voice and increasing the reach of communications with patients.

The Chair thanked the representatives of NHT for attending the meeting to present the report and answer the Committee’s questions.

Resolved:

1) **To request that the finalised Integrated Improvement Plan and its associated timetable are shared with the Committee as soon as they are available.**

2) **To request that further details are provided on the current referral and rejection rates for Local Mental Health Teams and how this has impacted on the waiting list for assessment, and the wait times for service access following assessment.**

3) **To recommend that the Nottinghamshire Healthcare NHS Foundation Trust considers the provision of a local women-only ward for acute mental health emergency care with the NHS Nottingham and Nottinghamshire Integrated Care Board, as the current provision options are either private or out of area.**

4) **To recommend that effective key performance indicators are developed, fed into by both quantitative data and direct input from patients on their experiences of care, to ensure that the planned improvement outcomes are specific, relevant and measurable.**

5) **To recommend that feedback from patients on their experiences of care is fully publicised to demonstrate how it has informed improvement planning and delivery.**

58 Talking Therapies and Step 4 Psychotherapy Services

Lucy Anderson and Kate Burley, Head of Mental Health Commissioning, Contracting and Performance and Deputy Head of Mental Health Commissioning at the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB); Claire Pearson and Andy Sirrs, Associate Director for Psychological Professions and Clinical and Strategic Lead for Serious Mental Illness at the Nottinghamshire Healthcare NHS Foundation Trust (NHT); and Melissa Edwards, Principal Clinical Lead at the Vita Health Group, presented a report on the mental healthcare support available through the Talking Therapies and Step 4 services. The following points were raised:

a) Talking Therapies was commissioned in 2023 and is delivered by the Vita Health Group. The service specifically aims to work towards reducing health inequalities, so provision has been increased with additional roles in place, increasing mental health practitioners and psychologists in community mental health teams and integrating community mental health practitioners into Step 4 services. Integrated working with Primary Care has increased, with community mental health workers based within Primary Care settings offering short-term interventions and onward referral for more specialist services where required.

b) Talking Therapies provides Step 2 and Step 3 mental health services, working mostly with patients who have self-referred. Referrals can be made directly from Talking Therapies to Step 4 for more complex cases requiring additional support, rather than referring back to Primary Care or signposting on. These referrals to Step 4 include prior consultation with clinical staff to ensure the suitability of

onward referral, and regular multi-disciplinary team discussions take place around referrals. Each referral to Step 4 is triaged by senior clinical staff, who have access to full records for each patient. Where Step 4 services are not appropriate, alternative provision is developed. Rejection rates form Step 4 services are low, due to the multi-disciplinary approach to referral and the collaborative working. Step 4 waiting times for assessment and treatment can vary, with currently waits for treatment being around 9 months. Work is being undertaken to ensure that waiting lists are reduced and, in the interim, people on the waiting list are contacted and helped to 'wait well'.

c) The Talking Therapies Community Engagement team operate across the city to work to understand the needs of the local population. There are a number of different programmes targeting specific audiences: in particular, under-represented communities, those with long-term health conditions, students and the wide-ranging, ethnically diverse populations – with clinical leads assigned to each programme. Targeted advertising of services is produced to reach a wide range of audiences within their communities. Moving forward, a focus for the ongoing community engagement work will be on increasing opportunities for the co-production of services.

The Committee raised the following points in discussion:

d) The Committee asked what steps were being taken to ensure equality of access to services – particularly for those people with limited experience or access to technology, as face-to-face provision was limited. It was explained that referrals into Talking Therapies can be made through a number of routes including online, telephone and by post. There is also a programme that enables referrals through advocacy. Services have been mostly online, particularly through the Coronavirus pandemic – however, face-to-face sessions are available alongside the remote delivery. Services can be provided with interpreters, including British Sign Language. However, specialist interpretation services are required due to the complex nature of some of the discussion, so this can cause a longer waiting time for some patients. All materials are available in a variety of different languages, in large print and in easy-read formats. The Community Engagement team works hard to gather feedback that is used to make improvements to each programme and improve access for all communities.

e) The Committee observed that there was detailed information online about Talking Therapies, but that details concerning Step 4 services were much more limited. It was acknowledged that there less information online from NHT around Step 4 services and that this could be improved. However, Step 4 services are tailored to the individual and are formulated with the patient, so it is not possible to publish a specific protocol for the care and services provided as they are unique to each patient. However, work will be done on the website to improve the information available.

f) The Committee asked what was being done to help improve the capacity and resilience of services. It was reported that work is being done to upskill workers within Step 2 and Step 3 to offer a broader range of therapy-based services. There is investment being made in more phycologists, and in upskilling community practitioners and the wider workforce (such as social workers) to

deliver some of the more standard phycological interventions. The aim is to create a network of support to reduce the need for further intervention and to alleviate some pressure on waiting times.

g) The Committee asked what care a patient could expect to receive from Step 4, and how they would be involved in the development of their care and in deciding when treatment would end. It was reported that Step 4 services offer a range of therapy for the most serious and complex cases. Phycologists are each trained in a range of therapies and offer support for patients over a longer period of time that Steps 2 and 3, using a broader range of therapies to tackle the more complex nature of each case and to personalise treatment. The length of each programme varies for each individual, but can go up to thirty sessions. At the end of the programme of treatment, each patient is invited to give feedback. Outcomes are measured using patient satisfaction and whether the patient feels that they can progress with their day-to-day lives more confidently. There is a challenge to balancing the demand for services with the continued benefit of therapy beyond a certain point. If patients have not fully recovered within the programme time, work is done on what additional services may be able to offer further support and help. Recovery rates are around the same levels as for Steps 2 and 3 which, for addressing complex trauma, are considered to be good by national measures.

h) The Committee asked what happened to patients who did not feel recovered or able to manage daily life at the end of a Step 4 programme, and raised concerns that some patients would have to be re-referred – and so re-enter a lengthy waiting period and have to establish a relationship with a different therapist. It was explained that it is possible to re-refer patients back into Step 4 to explore other forms of therapy. Currently, a longer-term therapy offer is not commissioned within the NHS mental healthcare provision, and there are challenges in balancing demand for services with delivery capacity.

i) The Committee considered that, as such, there is a clear service gap for people who are in need of long-term therapy. The Committee noted that the Centre for Trauma, Resilience and Growth had offered therapies for a period of two years before it was closed in May 2023 on the grounds that the services it provided could be moved into the wider Secondary Care Psychological Therapies Pathway for delivery in substantively the same way. The Committee raised a substantial concern that the longer-term therapeutic support that had been delivered by the Trauma Centre was now not replicated via the thirty sessions available through Step 4. The Committee was also deeply concerned that, if services had been reduced to a significant degree (or even decommissioned), it did not appear to have been consulted by the ICB on this service change, as is required.

j) The Committee considered that it is of serious concern that the national recovery rate expectation for patients with mental health needs is as low as 50%, as this appears to demonstrate a clear lack of parity of esteem between mental and physical health services in what is considered a good outcome for patients.

The Chair thanked the representatives of the ICB, NHT and the Vita Health Group for attending the meeting to present the report and answer the Committee’s questions.

Resolved:

1) **To request that further information is provided on the closure of the Centre for Trauma, Resilience and Growth and the extent to which the services provided by the Centre are now delivered through Step 4 services.**

2) **To recommend that more information is published on the Step 4 service offer and the pathways to it, particularly on the Nottinghamshire Healthcare NHS Foundation Trust's website.**

3) **To recommend that the service need for longer-term psychological therapy beyond the current Step 4 offer is assessed and considered for further support provision within existing services where possible, or through additional services commissioned by the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB).**

4) **To recommend that the ICB gives very careful consideration to how a parity of esteem between the resourcing of physical and mental healthcare needs can be achieved, and that it pursues this issue further at the national level.**

59 Work Programme

The Chair presented the Committee's completed work programme for the 2023/24 municipal year.

The Committee noted the completed work programme.