Nottingham City Council

Health and Adult Social Care Scrutiny Committee

Minutes of the meeting held at Ground Floor Committee Room, Loxley House, Station Street, Nottingham, NG2 3NG on 11 November 2021 from 10am – 1:15pm

Membership

Present	**Absent**
Councillor Georgia Power (Chair)	Councillor Anne Peach
Councillor Cate Woodward (Vice Chair)	
Councillor Michael Edwards	
Councillor Samuel Gardiner	
Councillor Maria Joannou	
Councillor Kirsty Jones	
Councillor Angela Kandola	

Colleagues, partners and others in attendance:

Ajanta Biswas	-	Healthwatch Nottingham and Nottinghamshire
Lucy Dadge	-	Chief Commissioning Officer, Nottingham and Nottinghamshire Clinical Commissioning Group
Rupert Egginton	-	Acting Chief Executive, Nottingham University Hospitals NHS Trust
Michelle Rhodes	-	Chief Nurse, Nottingham University Hospitals NHS Trust
Dr Ian Trimble	-	GP, Nottingham and Nottinghamshire Clinical Commissioning Group
Rosa Waddingham	-	Chief Nurse, Nottingham and Nottinghamshire Clinical Commissioning Group
Sharon Wallis	-	Director of Midwifery, Nottingham University Hospitals NHS Trust
Councillor Adele Williams	-	Portfolio Holder for Adults and Health
Jane Garrard	-	Senior Governance Officer
Kate Morris	-	Governance Officer

37 Apologies for absence

Councillor Anne Peach (personal)

38 Declarations of interest

None

39 Minutes

The minutes were considered by the Committee. Ajanta Biswas, Healthwatch Nottingham and Nottinghamshire highlighted that she was in attendance at the last meeting, but that her name was missing from the attendees list. She also requested

that she be invited to the informal meeting discussed at minute 34 Adult Eating Disorder Service, resolution 2.

Subject to these amendments, the minutes were confirmed as a true record of the meeting and were signed by the Chair.

40 Nottingham University Hospitals NHS Trust - CQC Inspection

The Chair introduced the item to scrutinise action being taken in relation to the findings of the recent of the recent Care Quality Commission (CQC) inspection of Nottingham University Hospitals NHS Trust, with a focus on the aspects relating to leadership of the organisation. She informed the Committee that NHS England/ NHS Improvement had been invited to attend the meeting but was unable to do so. Instead she will be meeting separately with the Regional Medical Director and will feedback to the rest of the Committee on that meeting.

Rupert Eggington, Acting Chief Executive of Nottingham University Hospital NHS Trust, introduced a report by the Trust setting out how it has responded to the issues raised by the CQC. Michelle Rhodes, Chief Nurse, and Sharon Willis, Director of Midwifery, both from Nottingham University Hospitals added additional information and the following points were highlighted:

(a) The CQC inspected Nottingham University Hospitals Trust (NUH) in July 2021. In August it issued a warning notice under section 29a, requiring the Trust to demonstrate improvements by the end of January 2022. The full report was issued in September 2021 and can be read online;

(b) During this period, NUH has established four key areas to focus on:
- delivering safe and effective winter care;
- workforce;
- addressing the concerns of the regulators; and
- investment.

(c) In response to the concerns of regulators, including the CQC, the first phase of action was to present a summary of the report to staff and engage in a period of listening. A range of methods to engage with staff of all levels were used including direct contact events, staff meetings and a survey;

(d) The Senior Leadership Team has worked with teams from across the Trust to develop, and take forward a plan in order to respond to the recommendations made by the CQC, respond to the common themes brought up by staff, and to points raised in previous clinical and corporate governance reviews;

(e) The Trust acknowledges that it hasn't always lived up to its stated values and commitment to invest in people. Work is already underway to tackle issues around culture, in particular issues relating to bullying and inclusion. This includes programmes for Executive members and senior management;

(f) An engagement programme has been developed to bring staff together to think of new and innovative ways to work together, to design strategies

particularly around culture, to enable staff to speak up and to feel that they are heard when they do so;

(g) The Trust has engaged with the Arbinger Institute and is developing a programme around leadership with an open mind. It has been received positively by senior management and will be running again with managers across the Trust from early December;

(h) An external review of the Black and Minority Ethnic Strategy has taken place through with involvement from NHS Improvement, and there has been an increase in resource provision to tackle bullying;

(i) The development of the Executive is focusing on a number of key areas, such as risk and team building. When it has been safe and practical to do so Executive members have been on visits to a variety of teams and departments across the Trust, either as individuals, small groups or as part of a Board meeting;

(j) The governance arrangements for a Quality Assurance Group, chaired by NHS England, are being finalised. Beneath the Group will sit three sub-groups specifically looking at the key themes of:
- Maternity;
- emergency care; and
- governance.

Rosa Waddington, Chief Nurse, Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) spoke about the CCG's oversight role. In addition to the written report about the CCG's role and activity, she highlighted the following information:

(k) The CCG is looking at the local improvement and quality statement in partnership with the CQC and NHS England. In terms of the oversight and review of maternity services, the CCG has set up a focused quality assurance group to see how best to work with NUH to improve these services, and a number of issues have been found around the safety and care provided;

(l) In May 2021, care more widely across the Trust was reviewed with view to considering active recovery from the Covid pandemic. Collaborative action has been taking place to address key issues and risks identified as part of this review;

(m) As a result of the review recommendations were made to the CQC and Integrated Care System to escalate the Trust to higher levels of surveillance. A shared system action plan was put into place, predating the CQC inspection, which has proved to be a good platform for working at pace;

(n) The action plan in place is aligned to the existing plans but has a wider scope. An overview group, chaired by NHS England and the CCG, has been established in order to understand what actions need to be put in place in order to make rapid improvements. These changes need to be built on with

proportionate scrutiny, in an environment that is supportive as well as challenging.

In response to questions and comments from Committee members the following points were made:

(o) The Trust confirmed that, in order to help support and deliver the programme of improvement necessary, external expertise is being used. The programme also relies on internal resources, and partnership resource from NHS England who is helping to source and fund national expertise. Organisations identified for involvement have a proven track record of supporting change, particularly around change in culture. There is an issue around capacity internally, and so by engaging external organisations, the Trust is able to dedicate more resource to delivery of the action plan. The intention is for external organisation to develop the skills and knowledge of NUH staff so that they can build on progress once external organisations are no longer directly involved;

(p) The CCG has always been keen to support change and Rosa Waddington highlighted the need to work at pace, but to do so in a supportive, yet challenging, way;

(q) Gathering feedback from frontline staff on these changes is an active process. The CCG is talking with frontline staff, as well as holding insight visits. NUH is also actively engaging with staff with a “bottom up” focus. Citizens, patients, and Healthwatch Nottingham and Nottinghamshire are also being consulted;

(r) NUH recognises that it can be difficult for frontline staff to speak up. Staff are able to speak to HR directly, and chose to do so regularly, but there are also strong relationships with trade unions across the Trust. There are monthly meetings where trade unions and HR discuss issues raised and there is also the professions advocacy resource;

(s) There is a BAME Shared Governance Group that has been established by the Trust to help BAME colleagues’ voices be heard better. The Trust acknowledges that there is still a lot of work to be done, and better relationships with staff need to be built, but people are starting to speak out. Although it has been difficult to hear, the Trust confirmed that it is committed to addressing the issues being raised;

(t) When questioned Rupert Egginton confirmed that there were a number of BAME Trust Board members with extensive and diverse experience of NHS Management;

(u) Concerns were raised by Committee members that the impact on mental health of staff of the culture of bullying had not been taken into account so far within action plans, and that staff may still feel uncomfortable or unable to come forward for fear of reprisals. Both councillors and the Healthwatch representative called for visible evidence that clear progress is being made around culture change;

(v) The Trust advised the Committee that there is a large well-being programme offering staff practical and emotional support with specialist BAME and cultural elements. This programme also includes specialist trauma care for staff as a result of the pressures of working though the pandemic. This well-being support has been in place previously but has been bolstered and extended over the last year to deal with the pandemic;

(w) As an example of how the Trust is listening to staff, it was reported to the Committee that staff have fed back that bank shift payments within NUH are lower than for other Trusts, and therefore less attractive to work. In response to this, bank shift rates have been aligned with those of neighbouring Trusts;

(x) Staff have been asked to tell the Trust what would work for them in terms of shifts. There have been a number of suggestions through staff feedback and these are being explored further the outcome of the will be shared;

(y) Following on from questions around patient feedback, the Trust confirmed it is clear the biggest issue is around communication and how NUH has communicated with patients. Questionnaires around care and experiences in maternity services have been distributed to families through the Small Steps Big Changes programme, for example, to assess how patients have felt about care throughout the pandemic. These responses come to the Neonatal Board for review and the Quality Assurance Group also reviews the feedback offering check and challenge;

(z) Rupert Egginton, Acting Chief Executive of the Trust, was invited to tell the Committee about his experience and leadership within the NHS. He responded that he has worked for the NHS for 34 years in total, 20 years within Director level role, mainly in Chief Financial Officer roles. When the previous Chief Executive stood down the Trust Board asked if he would act as Chief Executive whilst the recruitment process takes place. He has had experience in developing culture change within the Trust. He is supported by Michelle Rhodes who is the Chief Nurse and other Directors who have a wide breadth of knowledge and experience;

(aa) Rupert Egginton confirmed that the Trust Board had issued an apology to staff within the Trust. He also reiterated the apology made to the public, apologising for the impact on confidence that the report will have had on people and patients, and to staff for their experiences;

(bb) The Trust acknowledges that it has gone through a difficult period over the last 18 months with the Covid pandemic, the CCG review and then the CQC Inspection. It has not always done as well as it could have done, despite the feedback being given by staff and patients. The Trust accepts the points highlighted in the Inspection and review reports;

(cc) Until recently there have not been the active programmes challenging the culture and bullying experienced by some staff. The Trust recognises that the processes in place were neither sufficient nor efficient at the time and there is now a greater emphasis on listening to staff;

(dd) The Trust agreed that it needs to address how middle management handle frontline staff. Some Committee members suggested that this management level of the Trust has been under-invested for years and as a result some managers have workloads that allow for less time for people management than ideal. It was suggested that this level of management needs to feel supported in order for the Trust to improve;

(ee) In reference to the review of Maternity Services, the Trust confirmed that it had categorised a number of incidents as not needing formal reporting when they should have done. The Trust stated that it thought it was reporting appropriately and had done so consistently since national guidance was introduced. However, the guidance can be interpreted in a number of different ways and incidents that should have reported under an alternative interpretation were not. It is recognised that this has a significant impact on a number of lives and families and the Trust has reviewed, and changed its approach;

(ff) The Trust highlighted that it has established new internal guidance on how these types of incident are dealt with and reported. This guidance has now been in place for a number of months and the process is far more robust than previously. The Trust continues to work alongside the Independent Review Team looking at Maternity Services, fully cooperating and providing information required.

(gg) The Trust reiterated its apology to all of the families significantly affected by this error and its impact on care. Trust representatives stated that there was no malicious intent and no indication of an attempt to 'cover up'. All cases show that the framework put in place by the Trust was used, however that framework misinterpreted the national guidance. For all cases there was local investigation by the Maternity Team that took place to identify learning, however the formal reporting was not completed as the national guidance required. Now all maternity serious incidents are reported through to the Trust Board and the CCG;

(hh) Following a snapshot review of other services the Trust does not believe that there is a similar scale of issues with reporting of incidents as for maternity services, however a deep dive review is ongoing. Committee members expressed concerns that failings could be more widespread across the Trust and not isolated to maternity services. When questioned, the Trust indicated that an area of potential concern being reviewed closely is falls, particularly non-witnessed falls, and the reporting of those incidents. The Trust agreed to keep the Committee updated on this;

(ii) A Committee member commented that the Trust appears to have a very structured framework around risk, reporting, providing check and challenge and reporting but these issues have still occurred and cultural issues have not been identified within the Risk Register.

The Chair thanked everyone for their attendance. She advised that she feedback on her forthcoming meeting with the NHS England Midlands Regional Medical Director and noted that the Committee would be reviewing progress with improvements to

maternity services specifically at its meeting in February 2022. In addition, the Committee asked NUH to present the findings of its review of Serious Incident reporting, including any lessons learnt and action taken in response to a future meeting of the Committee. Noting comments made by NUH representatives about the reporting of falls, the Chair commented that it will be interesting to see if the review identifies any other departments with a similar scale of issues to that of Maternity Services. The Committee also expressed an interest in hearing directly from frontline staff and agreed to explore options for doing this.

The Committee noted that, while the CQC identified areas of significant concern, it had rated the quality of care provided as 'Outstanding'. The Committee thanked frontline staff for their continued hard work and dedication through some very difficult times recently.

Resolved to:

(1) request that Nottingham University Hospitals NHS Trust present the findings of its current review of Serious Incident reporting, including lessons learnt and action taken in response to the Committee;

(2) explore ways of hearing directly from frontline staff working at Nottingham University Hospitals NHS Trust;

41 GP Services

Before the start of this item the Chair asked that her thanks to GPs across the City, who have worked tirelessly throughout the Covid pandemic to continue serving citizens at a time when resources and funding is stretched be put on record.

Joe Lunn, Associate Director of Primary Care Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) introduced the item reviewing the provision of GP services across Nottingham City. Along with Lucy Dadge, Chief Commissioning Officer Nottingham and Nottingham Clinical Commissioning Group, and Dr Ian GP Nottingham and Nottinghamshire Clinical Commissioning Group she highlighted the following information:

(a) There are three different types of contract for provision of primary care services:
- General Medical Services (GMS) – the national standard GP contract. Terms are determined nationally.
- Personal Medical Services (PMS) – allows some local flexibility with similar to the GMS but the historic financial premium attached to this contract has eroded and there is a shift to the GMS.
- Alternative Provider Medical Services (APMS) – allows for procurement of services to meet the local need, for a fixed contract term, usually 5 years;

(b) Each practice receives a nationally negotiated sum of money for each patient, with capitation adjusted for age, sex, and patient need;

(c) Alongside these contracts is the Quality and Outcome Framework, a voluntary system offering rewards and incentives based around four components and delivering a range of clinical targets. There is no specific target around access;

(d) Practices can choose to offer an extended range of services through nationally and locally commissioned Enhanced Services contracts. The Network Contract for Directed Enhanced services is the basis for Primary Care Networks, providing structure for services developed on local need;

(e) There have been a number of significant changes to the way primary care is contracted and delivered, particularly with the introduction of Primary Care Networks. This has particularly impacted on staffing, which is reported monthly, and allows for links into national workforce planning and recruitment and retention schemes and allows greater flexibility locally;

(f) As part of offering Enhanced Services a network of practices will receive funding for additional clinical staff roles. This further allows the development of a network that caters specifically to the needs of the community. Across Nottingham and Nottinghamshire CCG there are currently 226 Additional Role staff in post adding to the professional support for GPs;

(g) Following on from the initial stages of the Covid pandemic and the lockdown periods, face to face appointment rates at GPs are increasing again and the demand for same day appointments is also increasing steadily. Practices are offering more appointments than previously, and demand is higher than pre-pandemic levels. Practice level data is not available routinely, data shown within the report is CCG level only;

(h) This access is monitored nationally, and although the Nottingham and Nottinghamshire CCG regularly scores better than the national average, there is a wide range of results between individual practices;

(i) Along with the contract requirements for practices, the CCG also has a Primary Care Quality Dashboard, recording a variety of data including CQC inspection outcomes, clinical outcomes, patient experience and patient safety including safeguarding and relevant policies;

(j) The CCG also regularly monitors the outcomes from CQC inspections. There are a number currently uninspected as new providers, but it is anticipated that these will be inspected imminently.

In response to questions from the Committee, and in the subsequent discussion, the following points were made:

(k) The pressures on access to GP services has been exacerbated by the Covid pandemic, and this has forced GPs to look at new ways by which patients can access services, including an increase in online, virtual appointments to help mitigate this pressure. Some Committee members highlighted that not all patients are able to, or feel comfortable with online appointments;

(l) Concerns were raised by Ajanta Biswas, Healthwatch Nottingham and Nottinghamshire, and echoed by Committee members that the traditional contracts for GP services do little to help practices in areas of deprivation or to tackle the health inequalities experienced by communities in areas of social deprivation. There is a mechanism, applied nationally, to take into account deprivation, however it doesn't take into account health inequalities caused by other factors. Inequalities need to be addressed through the additional funding available. Some GP services have been set up with a short to medium term approach to address a need in a particular area, for example the Platform One practice. This allows the establishment of services in areas with more challenging need, and then allows them to stabilise before looking to the longer term;

(m) GP patient participation groups can be well attended but there is significant variation between practices. Some continued to meet virtually during the pandemic, and some are actually more active now than before the pandemic. These groups are important, but resource to support them is limited;

(n) Representatives of the CCG advised the Committee that once the Integrated Care System has been formally established in April 2022, it will be possible to shift more investment into primary care. This will be the opportunity to address health inequalities, allowing local practices to do more. In pilots this more local approach has worked well for patients and individual services designed around population need has shown to be better for patients;

(o) The CCG is required to produce a GP Strategy by March 2022 to demonstrate how funding will be distributed. One of the medium term aims is to look at the grouping of practices within the Primary Care Networks and ensure each one can serve a locality as a whole;

(p) In response to a question about whether the issue of non-attendance for appointments is still an issue, as reported to the Committee some years ago, Dr Ian Trimble stated that it can still be an issue for GPs and it impacts on their availability for other patients. Levels of non-attendance fell during the Covid pandemic but this may be due to the more rigorous triaging of patients prior to an appointment being made;

(q) Dr Ian Trimble confirmed that it is now standard practice for GPs to make referrals to secondary care electronically. This has sped up the referral process and allows patients to be seen by specialist services initially much quicker;

(r) One challenge for GPs is patients who have been referred to specialist services but who do not meet the threshold for immediate access and put onto a waiting list and whilst on the waiting list, these patients continue to access GP services in relation to the condition they were been referred for. The clinical management of these patients sits with the specialist services, and the patient continuing to access GP services adds additional pressure that should be met by specialist services.

(s) A pilot is being run to try and address this additional pressure, including the use of a community anaesthetist to help manage pain, and a clinical team to help prepare patients for surgery with physiotherapy, and keeping them healthy prior to their operation. It is essential that the length of waiting lists is reduced to help relieve pressure on primary care;

(t) There is also a need to manage patient expectations around GP services. It is often not possible to be seen face to face on the same day. Alternative ways to access services have been made more available, and virtual appointments continue to be rolled out;

The Chair thanked everyone for their contribution to the discussion. She asked that the draft GP Strategy be presented to the Committee for consideration prior to approval.

42 Proposed changes to Neonatal Services

The Chair introduced the report from Nottingham and Nottinghamshire Clinical Commissioning Group detailing proposed changes to neonatal services provided by Nottingham University Hospitals NHS Trust. She noted that the proposals included an increase in cot capacity at the Trust and, based on the information provided, overall they appeared to represent a positive improvement in service.

The Committee considered the proposals and concluded that it had no concerns with regards to either the proposals or arrangements for engagement on the proposals.

43 Work Programme

Jane Garrard, Senior Governance Officer, introduced the Committee's work programme for the remainder of the year. She highlighted that, in agreement with the Chair, the update on transition of patients from the Platform One Practice in December would be a written report only. Ajanta Biswas, Healthwatch Nottingham and Nottinghamshire, agreed to collate feedback from the Stakeholder Task Group and report that to the Committee as part of its consideration of the issues.

The Committee noted its work programme for the remainder of the year.