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Nottingham City Council
Health and Adult Social Care Scrutiny Committee

Date: Thursday, 17 February 2022

Time: 10.00 am (pre-meeting for all Committee members at 9:30am)

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG

Please see information at the bottom of this agenda front sheet about arrangements for ensuring Covid-safety.

Councillors are requested to attend the above meeting to transact the following business

Director for Legal and Governance

Senior Governance Officer: Jane Garrard **Direct Dial:** 0115 876 4315

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enable others to hear you. This does not apply to anyone exempt from wearing a face covering.

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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 13 January 2022 from 10.00 am - 12.10 pm

Membership

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

Colleagues, partners and others in attendance:

Sarah Collis	-	Chair, Healthwatch Nottingham and Nottinghamsire
Rupert Egginton	-	Acting Chief Executive, Nottingham University Hospitals NHS Trust
Dr Keith Girling	-	Medical Director Nottingham University Hospitals NHS Trust
Tiffany Jones	-	Director of Communications and Engagement, Nottingham University Hospitals NHS Trust
Dr Neil Pease	-	Chief People Officer, Nottingham University Hospitals NHS Trust
Julie Sanderson	-	Head of Adult Safeguarding and Quality Assurance
Sara Storey	-	Director of Adult Health and Social Care
Councillor Adele Williams	-	Portfolio Holder for Adults and Health
Jane Garrard	-	Senior Governance Officer
Phil Wye	-	Governance Officer

51 Apologies for absence

None.

52 Declarations of interest

None.

53 Minutes

The minutes of the meeting held on 16 December 2021 were agreed and signed by the Chair.

54 Adult Social Care Workforce and Organisational Development

Sara Storey, Director of Adult Health and Social Care, introduced the report on the proposed content of the Adult Health and Social Care Workforce and Organisational Development Strategy, which is a priority in the Recovery and Improvement Programme for 2022. Councillor Adele Williams, Portfolio Holder for Adults and Health, added that she felt confident that work to address workforce challenges is going in the right direction.

During discussion, and following questions from the Committee, the following points were raised:

a) it is really important to attract and retain suitable staff and make sure that they feel fully supported;

b) a Governance Board will monitor progress against the Strategy, composed of members of the workforce and the community. It will set measures and outcomes for improvement which will be both statistical and anecdotal;

c) the timeframe for the Strategy is three years, although it is hoped that some elements will have an immediate impact and will encourage existing colleagues to remain in post;

d) consultation has taken place with frontline staff via monthly staff engagement, and manager attendance at team meetings. Overwhelmingly the workforce are supportive of each other and talk positively about support they get from each other and managers. The challenges of remote working have been raised, as well as the lack of opportunity for training and progression. Staff are generally most concerned about delivering good outcomes for citizens;

e) the current high staff caseload is unlikely to decrease, but work can be done to decrease bureaucracy and a partner provider of social workers has been commissioned which should ease some pressure. Working more effectively in collaboration with partners also helps to reduce workload;

f) the voice of the service user is also being taken into account and they have been consulted as well as included in panels. Feedback to frontline workers can also be fed into improvement work;

g) the Council has looked at neighbouring authorities for comparison, but this can be difficult as social workers have differing levels of responsibility.

Sarah Collis, Healthwatch Nottingham and Nottinghamshire, offered the support of Healthwatch in listening to, and hearing the voice of service users and carers.

The Committee welcomed the work taking place on workforce issues, particularly the collaborative approach and involvement of stakeholders. It encouraged the continuation of work with staff networks and ongoing work with partners and other local authorities, in recognition that the Council cannot address all of the issues in isolation, and felt that the learning taking place from Children's Social Care was a

sensible approach and should continue. Following the offer from Healthwatch to support activity to involve service users and carers, the Committee supported the Service taking up this opportunity.

The Committee agreed to review progress with implementation of the agreed Strategy at the appropriate point(s).

55 Nottingham University Hospitals NHS Trust Improvement

Rupert Eggington, Acting Chief Executive, Nottingham University Hospitals NHS Trust, introduced the report updating on progress in improvement in response to the findings of the Care Quality Commission (CQC) inspection. He was supported by Dr Keith Girling, Medical Director. Neil Pease, Chief People Officer, and Tiffany Jones, Director of Communications and Engagement, Nottingham University Hospitals NHS Trust spoke about workforce culture, organisational development and communication. They highlighted the following points:

a) A single improvement plan has been developed based on issues identified by the CQC and from the Trust's own investigations with its staff. The aim is to get to the level of a 'Good' rating within 18 months.

b) The Trust is required to report progress against the Section 29a warning notice within six months, which will be the end of January 2022. Evidence on progress will be presented to the Trust Board in January and then submitted to the CQC with a view to the warning notice being lifted.

c) A plan for improvement was approved by the Trust Board in November. This was then discussed with the national NHS England Board which, in a follow-up letter, confirmed that it was supportive of the approach, accepted the plan and confirmed funding to support a programme of improvement.

d) Internal governance arrangements for monitoring improvement activity have been put in place and external governance has been established. This external governance has three strands: leadership and governance; maternity services; other core services inspected. Meetings are chaired by NHS England and there has been a positive assessment of progress to date.

During the discussion which followed, and in response to questions from the Committee, the following points were made:

(a) following criticism of a disconnect between the Board and the wider organisation, work to address this has been put at the front-end of the improvement programme. There is now more visible leadership by the Board and Board members now visit areas across both sites, including visiting wards in advance of weekly Board meetings; Board members attend staff meetings and use technology to hold monthly open staff sessions. An open email account has been established and Freedom to Speak Up arrangements bolstered. Feedback is that Board members are more visible and easier to access, but more work needs to be done on ways for feedback to be given anonymously.

(b) To try and improve the ability for staff to give feedback anonymously, the 'Our NUH' programme of small group meetings is being run by an external organisation and the recently launched 'Big Conversation' can be accessed anonymously. This is important because one of the themes for improvement is 'living our values', which do not tolerate bullying.

(a) Prior to the CQC report, the Board was aware that there were reports of bullying within the workforce, but it was thought to be comparable to that in other NHS Trusts and the level of bullying identified by the CQC was a surprise. The Board was shocked by the findings and took a proactive approach to addressing the issues. Some Committee members questioned why the Board did not think that the levels of bullying were disproportionate when the CQC felt it appropriate to comment on high levels of bullying, and how the CQC could have found that a Board member did not know that there was an issue with bullying if the Trust was doing a lot of work on it, as reported at this meeting. Neil Pease responded that NUH is not an outlier in terms of national statistics, but the CQC looked beyond that and found elements in statistical analysis that should be brought forward for greater focus. Published national staff survey results also show that NUH is not an outlier in comparison to other Trusts, but there are sub-sets of the data which can be interpreted differently. However, he acknowledged that if anyone feels upset enough to speak to the CQC about bullying, and there was a significant number who did, then the Trust has a serious problem. People have said that this is their experience and therefore the Trust needs to act.

(b) Cases of bullying brought forward are being categorised and learning is taking place. An external review of culture in specific areas has been commissioned and it is recognised that bullying needs to be investigated faster and the Trust needs to do better in feeding back on outcomes anonymously. The three staff networks for black and minority ethnic, disability, and LGBTQIA+ staff, along with trade unions have all been engaged in work following the inspection. The Board is trying to proactively address issues of bullying but the Trust is not there yet in terms of having no bullying in the organisation.

(c) The Trust agreed with a Committee member's suggestion that there should be improved monitoring of bullying cases, and confirmed that the Trust is investing in tracking software so that it is better sighted on cases and trends. Monitoring will be both quantitative and qualitative. This will be supported by a more open dialogue with groups across the organisation, including increasing the interface with trade unions and staff networks. To facilitate this, chairs of staff networks have been granted one day a week to dedicate to the work of that network. Further work will be done to bolster Freedom to Speak Up Guardian arrangements. The Trust has engaged Hull University Teaching Hospitals NHS Trust, which has previously dealt with issues of bullying within its own organisation, to act as a critical friend on this issue.

(d) In response to a question about why staff experiencing bullying didn't report this to the Trust before the CQC inspection, Trust representatives acknowledged that the psychological safety of staff had been depressed. The Trust thought that it was doing the right things and therefore it was surprised by the comments made to the CQC. In recognising the importance of psychological safety the Trust has

engaged a third party to support the Trust in understanding why it has not been the case.

(e) Sarah Collis, Healthwatch Nottingham and Nottinghamshire, commented on the parallels with psychological safety for patients in speaking up about their care and the ability of the Trust to learn from patient safety incidents. In response, Trust representatives commented that work on this had started prior to the CQC report and a Family Liaison Co-ordinator was appointed to ensure patients and families have a voice, especially in relation to Serious Incidents. However, it is recognised that more needs to be done on this. The Committee welcomed this recognition and suggested that it would be good to see this articulated in plans so that the Trust can be held to account on that.

(f) Feedback from staff so far has been positive, but it is recognised that there is still a long way to go.

(g) The Trust assured the Committee that there is a structured development programme for the Board in place, including a half-day session on equality, diversity and inclusion training. There will also be reciprocal mentoring to ensure that training is not a standalone event. Increasing black and ethnic minority representation at senior levels is a priority for the Black and Minority Ethnic Strategy and there are a range of activities and interventions in place to support this e.g. interview support.

(h) There are a range of risks to progress, including the latest wave of Covid cases, which will challenge pace of improvement. For example, there are challenges in balancing improvement work and staff training with the need to care for patients and prioritise patient safety at a time of unprecedented staff sickness. Currently it is not possible to maintain all training but risk-based decisions are being taken about what can be supported and what has to be stood down. It is expected that as the current wave of Covid cases recedes, other activity can be built up again. One of the challenges from NHS England/ NHS Improvement has been capacity to undertake the necessary improvement work and that is why it agreed funding for additional support.

(i) Overall the Acting Chief Executive considers that the Trust has made pretty good progress in most areas but more needs to be done to demonstrate evidence of impact.

(j) In relation to the Section 29a warning notice, there are no fixed criteria for its removal. Evidence about what the Trust has done in response and its ongoing the direction of travel is being compiled and will be considered by the Trust Board on 27 January. This evidence will then be submitted to the CQC. It is anticipated that the CQC will visit within a year to triangulate evidence.

The Committee acknowledged the work taking place to address failings and commented that the involvement of Hull University Teaching Hospitals NHS Trust as a critical friend was a positive, but noted that there is still considerable work to do. In particular, the Committee commented on the importance of having arrangements in place for receiving anonymous feedback. Concern was raised that some information provided at this meeting appeared to conflict with content of the CQC inspection

report, and therefore the Committee agreed that it would be appropriate to request a further update from the Trust on progress once the CQC has given its assessment of progress against areas identified for improvement. The Committee encouraged the Trust to be open and acknowledge issues to be addressed to give staff, service users and other stakeholders confidence that those issues are being dealt with.

Resolved to:

(1) thank frontline staff working at Nottingham University Hospitals NHS Trust, whom the Care Quality Commission had recognised for their quality of their care, for their dedication and work particularly during this difficult period;

(2) request that Nottingham University Hospitals NHS Trust provide details of the findings of the national staff survey and Black and Minority Ethnic Workforce Plan; and

(3) request that Nottingham University Hospitals NHS Trust attend a future meeting of the Committee, following the Care Quality Commission's review of progress, to update on its improvement journey and action being taken to address outstanding issues.

56 Nottingham City Safeguarding Adults Board Annual Report 2020 - 2021

The Chair noted that the Committee had received the 2020/21 Annual Report of the Nottingham City Safeguarding Adults Board for information.

Councillor Adele Williams, Portfolio Holder for Adults and Health, informed the Committee that, as the relevant Portfolio Holder, she attends meetings of the Board. She highlighted that 2020/21 had been a very challenging period, and while a number of safeguarding issues had arisen in different ways there were also lots of achievements to note. A Committee member suggested that it would be interesting to explore the Board's work in relation to domestic violence in more detail and this could be an item for inclusion on the Committee's future work programme.

The Committee thanked the Safeguarding Adults Board for its work, particularly during the particularly challenging period of the last couple of years.

57 Work Programme

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

Health and Adult Social Care Scrutiny Committee
17 February 2021

Nottingham University Hospitals NHS Trust Maternity Services

Report of the Head of Legal and Governance

1 Purpose

1.1 To review action to improve maternity services provided by Nottingham University Hospitals NHS Trust following a Care Quality Commission rating of 'Inadequate' in December 2020.

2 Action required

2.1 The Committee is asked to review progress in improvement of maternity services provided by Nottingham University Hospitals NHS Trust and whether:

a) it wishes to make any comments or recommendations; and

b) the focus and timescales for further scrutiny.

3 Background information

3.1 In December 2020, the Care Quality Commission (CQC) published a report which re-rated Nottingham University Hospitals NHS Trust (NUH) maternity services from 'Requires Improvement' to 'Inadequate, along with a warning notice.

3.2 Representatives of NUH attended the Committee's meetings in January and July 2021 to discuss the CQC findings and actions being taken and planned to address the identified failings. At the July meeting the Committee also considered evidence from the Nottingham and Nottinghamshire Maternity Voices Partnership and Healthwatch Nottingham and Nottinghamshire. In addition, the Committee met informally with a parent whose child had died whilst in the care of NUH's maternity services to hear their perspective. The Committee noted the progress that had been made to that point and plans to continue the improvement journey. It acknowledged that it will take time for sustainable change to be made but noted that the issues and concerns about care had already been known about for some years. The Committee also remained concerned about a number of areas including how women are listened to and involved in decisions about their care and when things go wrong; the Service's processes for hearing about when things don't go well, such as complaints from patients and confidence by staff to speak up about concerns, and the extent to which learning takes place as a result; care for women from ethnic minority groups, particularly those who require translation services, as an inability

to communicate with the professionals providing care can affect a woman's engagement in decisions about her care and her ability to raise issues or concerns. The Committee was also concerned about the number of Serious Incidents still being reported.

3.3 In September 2021, the CQC published a report of an inspection it carried out into how well NUH is lead and some specific service areas in July. Following this inspection, the Trust was issued with a Section 29a warning notice under the Health and Social Care Act 2008 and rated as Requires Improvement, with an inadequate rating in relation to whether services are well-led. Some of the failings identified by the CQC in relation to maternity services were also reflected in the findings of how well the Trust as a whole is led. The Acting Chief Executive and Chief Nurse, along with other colleagues, attended meetings of the Committee in November 2021 and January 2022 to discuss action being taken to address identified failings. The CCG has provided information to the Committee in relation to its role in supporting and holding NUH to account for improvement and the Chair has spoken to the NHS England Regional Medical Director for the Midlands about NHS England's role in supporting improvement. The Committee has also held informal evidence gathering sessions with representatives of trade unions representing workers employed by NUH.

3.3 For this meeting, the Trust has submitted a written briefing, which is attached. Michelle Rhodes, Chief Nurse, and Sharon Wallis, Director of Midwifery at NUH will be attending the meeting to discuss the Trust's progress in implementing improvements since the last meeting and ongoing plans to tackle outstanding actions required to improve the quality and standards of maternity services.

3.4 Healthwatch Nottingham and Nottinghamshire will be attending the meeting to provide an update on their latest evidence and engagement with NUH on this issue and also on the work of the Maternity Voices Partnership.

3.5 An independent thematic review of NUH maternity services has now been commissioned jointly by NHS England/ NHS Improvement and Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) with the aim of driving rapid improvements to maternity services. The Committee has welcomed an independent review and, prior to its commencement, sought reassurance from its commissioners regarding the terms of reference, process for carrying out the review and publication of the review. The Chair also held an informal meeting with the Accountable Officer of the CCG about the review.

3.6 An update on the thematic review is attached and the Programme Director and Clinical Lead for Midwifery will be attending the meeting on behalf of the review team to answer questions from the Committee.

4 List of attached information

4.1 Written briefing from Nottingham University Hospitals NHS Trust

4.2 Update on the Independent Thematic Review of Nottingham University Hospitals Maternity Services

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Care Quality Commission Nottingham City Hospital Published 02/12/2020

6.2 Care Quality Commission Queens Medical Centre Published 02/12/2020

6.2 Care Quality Commission Nottingham University Hospitals NHS Trust Inspection Report Published 15/09/2021

6.3 Reports to, and minutes of the Health Scrutiny Committee meetings held on 14 January 2021, 15 July 2021, 11 November 2021 and 13 January 2022.

6.2 Independent Thematic Review into Nottingham University Hospitals Maternity Services Terms of Reference and Published Updates available at https://nottsccg.nhs.uk/get-involved/independent-review-of-nuh-maternity-services/

7 Wards affected

7.1 All

8 Contact information

8.1 Jane Garrard, Senior Governance Officer
jane.garrard@nottinghamcity.gov.uk
0115 8764315

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NHS
Nottingham
University Hospitals
NHS Trust

We Listen
We Care

Maternity OSC Report

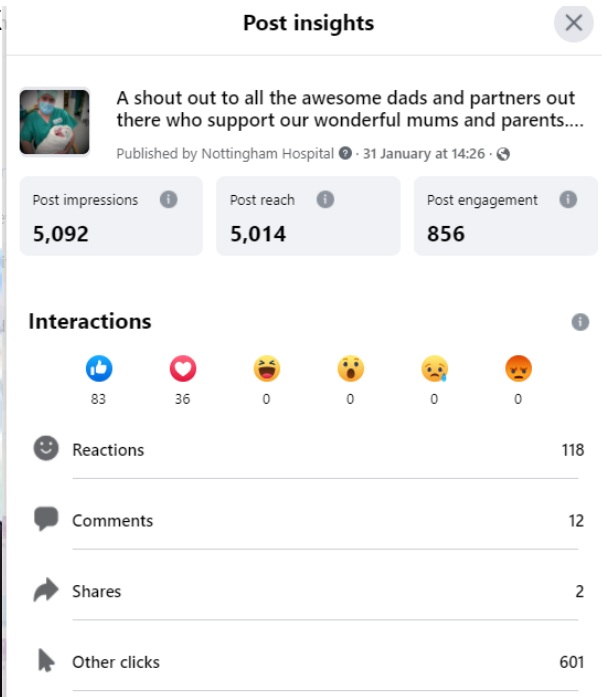
February 2022

Listening to our Families' Voices

We continue to increase our engagement with women and families via different methods – this month we'll focus on social media.

We now have more than 6,000 followers on Facebook. At the end of last year we launched the Maternity Views email address, and encouraged women and families to give themed feedback - in December 52 women contacted us via this method. Our Director of Midwifery also conducts filmed Q&As.

We have a 5* rating on Facebook and a total of 69 reviews to date.



Update of progress in our Maternity Improvement Plan

Engagement and Inclusion

- Our birth reflections service is up and running for women and their partners

Safe Practice

- Our jaundiced baby policy has been finalised and a new pathway is now in place
- Our virtual ward continues to provide safe care for women who have Covid-19

Equipment

- Training on Bilirubinometers for community staff has been completed and the equipment is now in use

Digital

- Supplier engagement and system demonstration event across NUH and SFH

Staffing

- We are managing staffing on a daily basis as well as forward planning
- We are exploring options of different ways to manage capacity to make the best use of our resources
- All four of the new consultants we recruited in summer 2021 are now in post
- We have recruitment and retention specialist support for maternity to help boost recruitment

Update of progress since last meeting

Training and Education

- Additional fetal monitoring training is taking place
- Our project to develop our Maternity Support Workers is progressing
- Training on Human Factors is being rolled out

Culture and Leadership

- We've repeated the Psychological Safety Survey
- Leadership development for senior midwives
- Bespoke interventions on team working
- Cultural change programme stage two has been agreed
- Continued to increase the visibility of leaders

Governance

- We have a new Quality Risk and Safety structure in place
- Funding has been received for Maternity Governance Support

Safe Practice – A Case Study

Women and their babies are protected from avoidable harm

Nottingham University Hospitals NHS Trust

Postpartum Haemorrhage (PPH)

Date	Work done
Jan and Feb 21	Understanding the problem (baseline audit and thematic review of our major PPHs)
Mar 21	4 stage PPH care bundle introduced, including a standardised risk assessment
July 21	Project to optimise antenatal Hb levels
July 21	Project to reduce peripartum blood transfusions
August 21	Project to improve maternal experience. Dissemination of maternal experience survey results with key learning points
September - October	Work to improve uptake of PPH risk assessments and the use of the bundle in women having an ELLSCS

Future priorities:

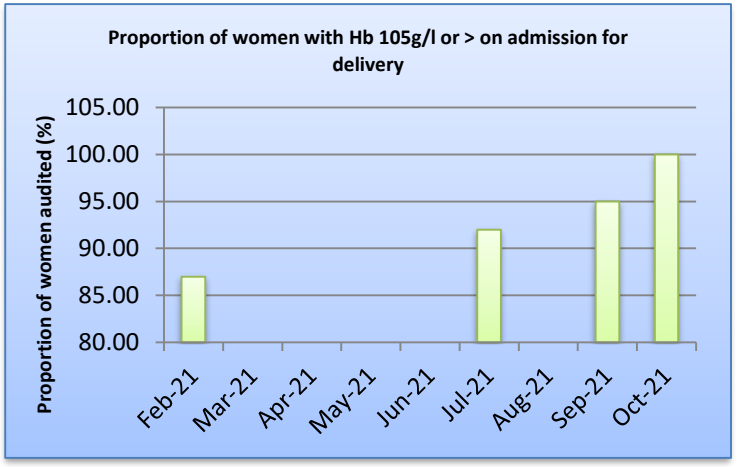
- Continue to promote awareness of PPH management
- Ensure momentum continues with this project

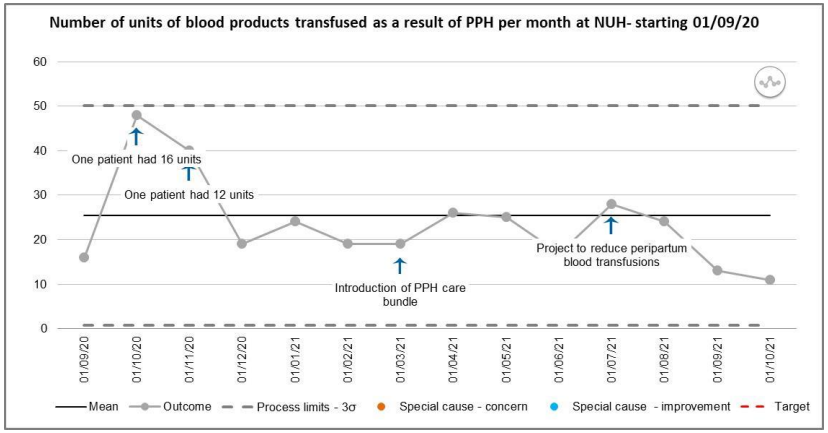
Key risks to delivery – Staffing:

- Project lead due to finish at the end of December
- Because intrapartum notes are paper based there is no way to make PPH risk assessment compulsory therefore approach heavily dependant on engagement and motivation of those delivering care

Results:

- Better use of ferrinject antenatally and peripartum has allowed us to improve the proportion of women with a normal Hb on admission for delivery and has reduced our rate of peripartum blood transfusions secondary to PPH.





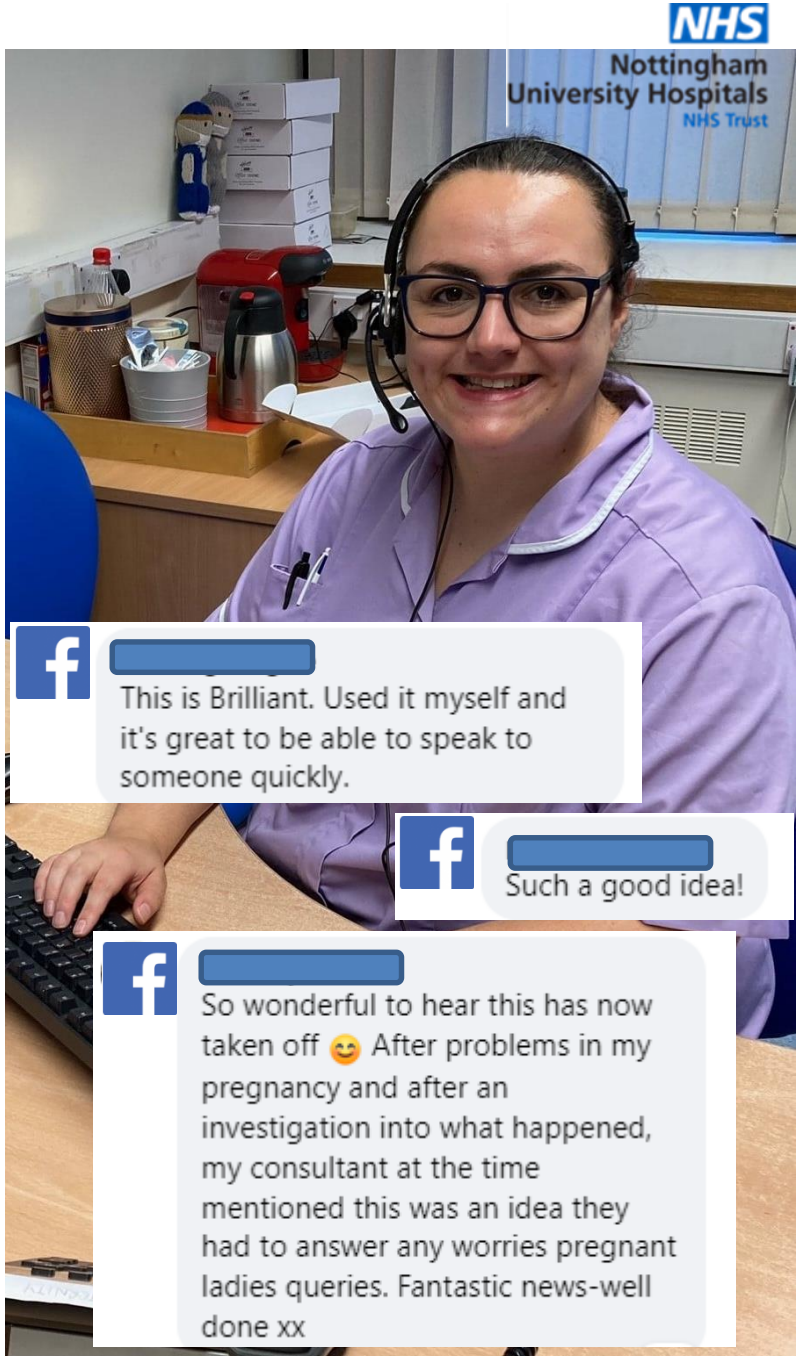
Digital Transformation

Devices:

- 150 new electronic observation devices. Ensuring every member of staff has a dedicated eObs device, plus spares for agency or locum staff
- Every community midwife and support worker now has a laptop and mobile phone

Access:

- We launched the Maternity Advice Line as a single point of contact for women and families looking to get advice. Staffed 24/7 by experts able to escalate problems as required. Data shows us when the key times are that women call, and a triage workflow is in place to help record advice given.



Digital Transformation

System Improvement:

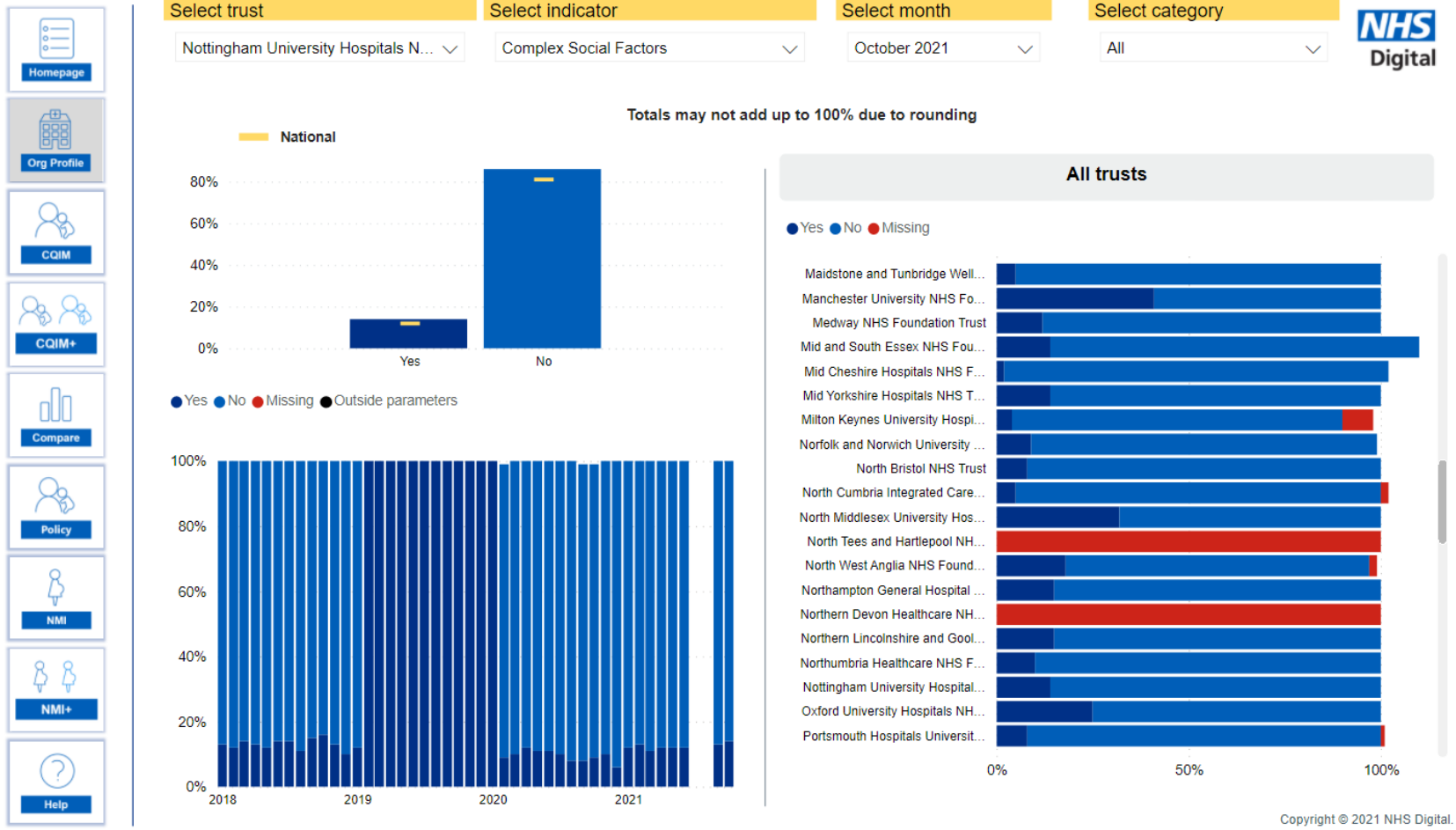
- We've installed new servers for our Maternity Information system so that it works more consistently
- Upgraded to the latest version to ensure compliance with regulation, security and improvements to functionality
- Introduced new workflows that provide better options for women and midwives during the recording of care
- Introduced new mandatory fields within the system to ensure better data quality, more reliable and consistent care and single points of truth for staff to see issues, alerts and comments

Community:

- We've started the transition to use our own Patient Administration System, which will improve accessibility of information, decrease risk to the woman and the Trust, and improve patient experience.

Maternity Dashboard

Nationally comparable maternity data is available here: [Maternity Dashboard]
This is the easiest way to compare our services to units across the country.



Maternity Dashboard – December 2021

Nottingham University Hospitals NHS Trust

Activity :

	Updated to	Target	Set by	Actual		
+ 1 - Mothers Birthed	31-Dec-2021	-	-	646	Neutral	
+ 4 - % Planned Home Births	30-Nov-2021	3 %	NUH	0.2 %		
+ 193 - Total Born Before Arrival (BBA - midwife not in attendance)	30-Nov-2021	-	-	2	No target	
+ 6 - Antenatal Bookings by Booking Date	31-Dec-2021	-	-	714	Neutral	
+ 9 - % Inductions of Labour	31-Dec-2021	-	-	27.6 %	Neutral	
+ 12 - % Spontaneous Vaginal Delivery	31-Dec-2021	-	-	51.9 %	Neutral	
+ 14 - % Forceps & Ventouse Deliveries	31-Dec-2021	-	-	12.1 %	Neutral	
+ 16 - % C-Section Deliveries	31-Dec-2021	-	-	36.1 %	Neutral	
+ 179 - % Elective C-Section Deliveries	31-Dec-2021	-	-	12.2 %	Neutral	
+ 181 - % Emergency C-Section Deliveries	31-Dec-2021	-	-	23.8 %	Neutral	

Maternity Dashboard

NHS
Nottingham University Hospitals
NHS Trust

Maternal Morbidity :

	Updated to	Target	Set by	Actual			
+ 29 - % 3rd and 4th degree tears (Normal Unassisted Deliveries)	31-Dec-2021	2.9 %	NUH	3.9 %			
+ 30 - % 3rd and 4th degree tears (Assisted Deliveries)	31-Dec-2021	6 %	NUH	7.7 %			
+ 32 - % PPH (Post partum haemorrhage) >=1,500ml	31-Dec-2021	2.8 %	NUH	4.3 %			
+ 33 - Maternal ICU admissions in Obstetrics (Number of admissions to intensive/ high dependency care from the maternity unit	31-Dec-2021	1	NUH	0			
+ 34 - % Completed VTE risk assessment at antenatal (full) booking	31-Dec-2021	95 %	NUH	99.1 %			
+ 35 - % of completed VTE risk assessment at delivery	31-Dec-2021	95 %	NUH	98.6 %			
+ 36 - ALL Maternal Deaths (up to 1yr after birth date)	30-Nov-2021	-	-	0		No target	
+ 38 - % Shoulder Dystocia	31-Oct-2021	-	-	2.5 %		No target	
+ 40 - % Puerperal Sepsis	31-Oct-2021	-	-	1.4 %		No target	

Neonatal Outcomes :

	Updated to	Target	Set by	Actual		
+ 43 - Total Stillbirths	31-Dec-2021	-	-	4		No target
+ 44 - Stillbirth rate per 1,000 (Rolling 12 months) ALL NUH	31-Dec-2021	3.8	ONS 2020	5		
+ 48 - Inborn Neonatal deaths within 28 days of birth (24+ weeks gestation)	31-Dec-2021	-	-	0		No target
+ 49 - Neonatal Deaths (born in hospital within 28 days of birth) Rate per 1,000 births	31-Dec-2021	2.8	ONS 2019	2.2		
+ 50 - Inborn Neonatal Deaths, (Liveborn 22-23 weeks gestation within 28 days of birth)	31-Dec-2021	-	-	0		No target
+ 53 - Neonatal Hypoxic-ischemic encephalopathy (Grades 2-3) in Inborn Term Births	31-Dec-2021	-	-	1		No target
+ 54 - Neonatal Hypoxic-ischemic encephalopathy (Grade 2) in Inborn Term Births	31-Dec-2021	-	-	0		No target
+ 55 - Neonatal Hypoxic-ischemic encephalopathy (Grade 3) in Inborn Term Births	31-Dec-2021	-	-	1		No target
+ 57 - % Avoidable Term NNU Admissions	30-Sep-2021	5 %	NUH	18.8 %	Run chart	Run chart
+ 58 - % of inborn term singleton babies with an APGAR score of <7 at 5 minutes	31-Dec-2021	1.2 %	NUH	1.2 %		
+ 59 - Total Babies Birthweight < 3rd centile born at >37 weeks	31-Dec-2021	-	-	7		No target
+ 60 - % Women who have a singleton live birth < 34+0 receiving steroids within seven days prior to birth	31-Dec-2021	-	-	54.5 %		No target
+ 61 - % Women who have a singleton live birth < 32+0 receiving magnesium sulphate for fetal neuro-development prior to delivery	31-Dec-2021	-	-	100 %		No target

Maternity Dashboard

NHS
Nottingham University Hospitals
NHS Trust

Readmissions :

	Updated to	Target	Set by	Actual			
+ 62 - % Maternity (women) re-admissions within 42 days of delivery	31-Oct-2021	3 %	NUH	1.5 %			
+ 63 - Inborn babies readmissions within 28 days of birth	31-Dec-2021	-	-	26		No target	

Quality, Risk, & Safety :

	Updated to	Target	Set by	Actual			
+ 194 - Serious Incidents by date of occurrence	31-Dec-2021	-	-	3		No target	
+ 108 - Serious Incidents by IRM outcome date	31-Dec-2021	-	-	3		No target	
+ 81 - Number of incidents (by reported date)	31-Dec-2021	-	-	210		Neutral	
+ 80 - Number of incidents (moderate harm and above)	31-Dec-2021	-	-	36		Neutral	
+ 79 - Number of incidents (no harm + low harm)	31-Dec-2021	-	-	174		Neutral	
+ 84 - Number of cases reported to HSIB	31-Dec-2021	-	-	1		No target	
+ 85 - Number of NICE Midwifery Staffing Red Flags	-	-	-	-	Run chart	Run chart	
+ 104 - Total medication related incidents	31-Dec-2021	-	-	11		No target	
+ 25 - % 1:1 care in labour	31-Dec-2021	100 %	NUH	98.7 %			

Service Delivery :

	Updated to	Target	Set by	Actual			
+ 75 - Total unit diversions	31-Dec-2021	0	NUH	21			
+ 76 - Total unit closures	31-Dec-2021	-	-	4		No target	
+ 77 - Admission to maternity unit from planned home birth	31-Dec-2021	0	NUH	0			

Patient Experience :

	Updated to	Target	Set by	Actual			
+ 86 - Total complaints	31-Dec-2021	-	-	3		No target	
+ 87 - Total compliments	31-Dec-2021	-	-	2		No target	
+ 88 - Total concerns raised	31-Dec-2021	-	-	5		No target	
+ 89 - FFT Rate – response target 25%	-	-	-	-	Run chart	Run chart	
+ 90 - FFT very good & good	-	-	-	-	Run chart	Run chart	

Public Health :

	Updated to	Target	Set by	Actual			
+ 66 - % Smoking at booking	31-Dec-2021	-	-	9.4 %		No target	
+ 67 - % Smoking at delivery (Delivering Population)	31-Dec-2021	11 %	NUH	12.5 %			
+ 68 - % CO monitoring completed at booking	31-Dec-2021	-	-	49.6 %	Run chart	Run chart	
+ 69 - % of CO reading at 36 weeks	-	-	-	-	Run chart	Run chart	
+ 70 - % women initiating breastfeeding	31-Dec-2021	70 %	NUH	72.1 %			
+ 71 - % Antenatal Bookings by 10 weeks gestation	31-Dec-2021	50 %	NUH	73.5 %			
+ 72 - % Maternity Bookings (by booking date) booked by 12Wks 6 days Gestation (0-12 weeks 6 days)	31-Dec-2021	90 %	NUH	91.3 %			
+ 73 - % Women screened for Sickle Cell/ Thalassaemia by 10 weeks	31-Dec-2020	75 %	NUH	99.9 %	Run chart	Run chart	
+ 74 - % NIPE performed within 72 hours	31-Dec-2021	95 %	NUH	96 %	Run chart	Run chart	

Workforce :

	Updated to	Target	Set by	Actual		
+ 23 - Births per midwife (midwives in funded establishment)	31-Dec-2021	-	-	1.4	Run chart	Run chart
+ 24 - Births per midwife (midwives in post)	31-Dec-2021	-	-	1.6	Run chart	Run chart
+ 113 - Births per midwife (midwives in post, excluding sickness and maternity leave)	31-Dec-2021	-	-	1.7	Run chart	Run chart
+ 114 - % Sickness for midwifery staffing	31-Oct-2021	-	-	7.4 %		No target
+ 115 - % of shifts covered by temporary staffing	-	-	-	-	Run chart	Run chart
+ 116 - No: uncovered shifts	-	-	-	-	Run chart	Run chart
+ 117 - % turnover of staff within maternity	30-Sep-2021	-	-	4.3 %	Run chart	Run chart
+ 118 - No: contacts with Freedom to Speak up Guardian	31-Dec-2021	-	-	3		No target
+ 119 - % Compliance for appraisals	31-Oct-2021	-	-	63.5 %		No target
+ 120 - No: formal HR investigations	31-Dec-2021	-	-	2		No target
+ 121 - New starters survey (Quarterly)	-	-	-	-	Run chart	Run chart
+ 122 - Leavers survey (Quarterly)	-	-	-	-	Run chart	Run chart
+ 123 - Staff survey engagement rate (annual)	31-Jul-2021	-	-	26 %	Run chart	Run chart
+ 124 - % of staff recommending NUH as a place to work	30-Nov-2021	-	-	54 %	Run chart	Run chart

Serious Incident Definition

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

(NHS Serious Incident Framework 2015)

Serious Incidents
Reported January – December 2021

Month	Number of Serious Incidents Reported	Number Reported to HSIB
January 2021	4	3
February 2021	6	1
March 2021	1	0
April 2021	7*	1
May 2021	11**	0
June 2021	5***	2

- * 3 incidents relate to Retrospective Review
- ** 3 incidents relate to Retrospective Review
- *** 2 incidents relate to Retrospective Review

Serious Incidents Reported January – December 2021

Month	Number of Serious Incidents Reported	Number Reported to HSIB
July 2021	4*	2
August 2021	2	0
September 2021	3	1
October 2021	3	1
November 2021	3	0
December 2021	3	0

- * 3 incidents relate to Retrospective Review

Serious Incidents

The Healthcare Safety Investigation Branch (HSIB) Maternity investigation programme is part of a national action plan to make maternity care safer. They undertake approximately 1,000 independent maternity safety investigations a year to identify common themes and influence systemic change.

Criteria are:
All term babies (at least 37 completed weeks of gestation) born following labour, who have one of the below outcomes.

- Intrapartum stillbirth (where the baby was thought to be alive at the start of labour but was born with no signs of life)
- Early neonatal death (when the baby died within the first week of life (0-6 days) of any cause).
- Potential severe brain injury
- Maternal deaths

HSIB top Themes from Final Reports	
2020 analysis	**2021 analysis**
Fetal Monitoring	Practice issues
Escalation	Risk assessment
Triage/ management of telephone calls	Escalation
Diagnosis of labour	Systems and Processes
Documentation and ICT systems	Impacts of COVID19
Safe Discharge	Staffing/ Acuity
	Fetal Monitoring

Ref.	Key Outcome	Measure of Success	Action	Owner
D1	Information Technology systems are used effectively to monitor and improve the quality of care	Patient data will be captured using one single solution.	Ensure all Midwives/clinical teams use a single solution to capture Maternity data (MEDWAY Maternity Improvement). Implement the Digital work plan which includes;	Adam Wisdish
D1.1			Replace the patient management booking system from System One Community Midwifery System to NUH Systems for all women currently under the care of the service	Adam Wisdish
D1.2			Explore Digitised note taking on Medway Maternity by Consultant staff	Adam Wisdish
D1.3			Upgrade Medway Maternity to the current version	Adam Wisdish
D1.4			Complete the K2 server migration	Adam Wisdish
D1.5			Enable an interface for patient alerts between MEDWAY PAS and Maternity	Adam Wisdish
D1.6			Extend the MEDWAY Maternity contract to 2022 to align with MEDWAY PAS	Adam Wisdish
D1.7			Explore an Electronic Document Interface on MEDWAY Maternity	Adam Wisdish
D2	Information Technology systems are used effectively to monitor and improve the quality of care	Clinical teams will have reliable and timely information which is of high quality and readily available.	Improve the quantity, quality and visibility of the data captured for clinical teams (Workbook and Assessment Improvement) through;	Adam Wisdish
D2.1			Review the flow of data capture items to reduce data duplication and reduce the number of systems in use for midwives inputting data.	Adam Wisdish
D2.2			Review the use of the Viewpoint product to determine viability and ensure an upgrade path is identified.	Adam Wisdish
D2.3			Introduce online training packages to assist and enable staff to understand the importance of data capture and to ensure consistent use of application.	Adam Wisdish
D2.4			Develop and implement improvements to all assessments including the Ante-natal Risk Assessment , Antenatal referrals, Smoking referrals and Induction of labour pathway.	Adam Wisdish
D2.5			Implement configuration and set up recommendations for the System C Workbook	Adam Wisdish
D2.6			Develop the use of additional systems to capture data items on the full booking pathway prior to the appointment	Adam Wisdish
D2.7			Explore introducing a Drugs only Discharge Summary	Adam Wisdish
D3			Improve access to systems through appropriate, additional devices (Access and Devices Improvement) through;	Adam Wisdish
D3.1			Increase availability of Computers on Wheels in hospital based clinical areas to allow access to Medway Maternity solution and other applications	Adam Wisdish

D3.2	Information Technology systems are used effectively to monitor and improve the quality of care	Staff working in the maternity service have access to digital equipment in the right place at the right time. The infrastructure is in place to support the use of technology.	Ensure each permanent midwife has a dedicated eObs device	Adam Wisdish
D3.3			Review connectivity availability and speed in additional community locations as identified; improve connection speeds/resilience as appropriate	Adam Wisdish
D3.4			Introduce single Labour Line based in the Community Hub	Adam Wisdish
D3.5			Enable cloud printing in the community	Adam Wisdish
D3.6			NUH Mailboxes	Adam Wisdish
D3.7			Enable community pathology printing	Adam Wisdish
D4	Information Technology systems are used effectively to monitor and improve the quality of care	There is digital leadership across the maternity service. Digital issues are considered and discussed.	SOPs and BCPs involving digital products to be reviewed	Adam Wisdish
D4.1				
D4.2			Complete a Digital Maturity Assessment for Maternity and take action to address the findings.	Adam Wisdish
D5	Information Technology systems are used effectively to monitor and improve the quality of care	All staff working in the maternity service use one single clinical system to capture clinical records for women and babies.	Procure and deploy a replacement clinical solution (Future Systems)	Adam Wisdish
D5.1			Procure a replacement maternity system, ideally integrating with the rest of the LMNS	Adam Wisdish
D5.2			Deploy replacement maternity system across all services	Adam Wisdish

Ref.	Key Outcome	Measure of Success	Action	Owner
E1	Women and babies are protected from avoidable harm because there is adequate equipment available.	Staff have carbon monoxide monitors available to use that are adequately maintained and fit for purpose.	Purchase an additional 20 CO (Carbon Monoxide) monitors to support with CO monitoring. Develop a plan to implement the monitors which includes; training of their use and ongoing maintenance arrangements	Public Health Matron
E2	Women and babies are protected from avoidable harm because there is adequate equipment available.	Staff working in the community have thermometers that are adequately maintained and fit for purpose.	Ensure Welch-Allen thermometers to be rolled out across the community.	Public Health Matron
E3	Women and babies are protected from avoidable harm because there is adequate equipment available.	Staff have CTG monitors available to use that are adequately maintained and fit for purpose.	Secure funding for a CTG replacement programme within 21/22 year. Develop a plan for the roll out of the new machines	Fetal monitoring Midwife
E4	Women and babies are protected from avoidable harm because there is adequate equipment available.	Staff are appropriately trained and skilled to use the CTG monitors.	Deliver training on the Huntleigh T20 replacement / new CTG machines and then roll out the machines.	Fetal monitoring Midwife
E5	Women and babies are protected from avoidable harm because there is adequate equipment available.	Staff have access to equipment in line with national guidance.	Secure funding for the roll out of bilirubinometer across the service. Develop a project plan for the rollout of the meters once funding is secured, to include; training, updating the policy and guideline, and ongoing maintenance of equipment.	Maternity Improvement Midwife
E6	Women and babies are protected from avoidable harm because equipment is safely maintained.	Equipment is regularly serviced and checked in line with manufacturers instructions and electronic testing requirements.	Confirm and communicate the process for clinical equipment servicing and maintenance and ensure staff understand what to do if equipment becomes broken or damaged. Confirm and communicate the arrangements for the maintenance of the asset register for clinical equipment and ensure staff are aware of their responsibility for ensuring this is kept up to date.	Service General Manager -Maternity

Themes
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Actions
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Ref.	Key Outcome	Measure of Success	Action	Owner
S1	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place.	Implement the staffing related actions from "Immediate action plan" that were submitted to CQC in July 2021; Reference 1 and 3	Director of Midwifery and Heads of Service
S2	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Through daily MDT ensure there is senior oversight and documented evidence of non medical staffing levels (Midwives, MSW's, receptionist and administrators) so that risks can be mitigated against in a proactive way.	Director of Midwifery
S3	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Complete a review of the required non medical skill (Midwives and MSW's) mix for the maternity service so the service has a clear workforce strategy that plans for the future.	Director of Midwifery
			Prepare and submit a business case for additional roles to support delivery of the workforce strategy.	
			Explore options to support staffing gaps through additional support from general nursing and healthcare support workers and other members of the MDT as appropriate (for example, to support with post operative care)	
			Develop and implement a plan to implement the MSW workforce reconfiguration. Including:	Head of Midwifery
			1. The introduction of revised job descriptions for band 2 and 3	
			2. update to ESR codes	
			3. Develop Care Certificate 2 training plan	
			4. Implement Care Certificate 2 training plan	
			5. Using the ADKAR model support level 3 MSW's and Midwives to adopt the changes to new Job descriptions	
			Develop career progression routes for Band 2 - 4 MSW's	
S4	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Complete the recruitment of approved non medical maternity posts.	Director of Midwifery
S5	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Implement skills mix templates from E-rostering Paper which will enable the service to make best use of the system for workforce planning.	Assistant HR Business Partner

			Provide guidance and learning to relevant staff to ensure roster system is used effectively on a day to day basis.	
S6	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Ensure the effective use of the NHSP system for booking additional bank and agency staff.	Assistant HR Business Partner
S7	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Ward managers will have the knowledge and skills to be able to successfully manage their budgets and navigate the approvals process in a timely manner	Ensure ward managers and ward leaders have accurate data about their budgeted establishment and the process for replacing posts is efficient and timely.	Director of Midwifery and Divisional General Manager
S8	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Through daily MDT ensure there is senior oversight and documented evidence of medical staffing levels (Obstetricians, doctors in training, Anaesthetists) so that risks can be mitigated against in a proactive way.	Heads of Service
S9	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place.	Develop a proposal for an increased consultant obstetric workforce in line with RCOG recommendations and establish senior medical leads for; • Intrapartum care lead • Patient safety lead/ mat neo collaborative • Patient experience lead • Guidelines lead • Inpatient and CS pathway • PMRT lead Fetal Heart lead Saving Babies Lives	Heads of Service
			Carry out a job planning review to ensure all lead areas are covered.	
			Complete the recruitment of approved medical posts for 2021.	
S10	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place.	Complete a review of the required medical skill mix for the maternity service so the service has a clear workforce strategy that plans for the future.	Heads of Service
S11	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Clarify gaps in non ward based administrative roles across the service.	Divisional General Manager
			Create and submit a business case for additional requirements.	
			Utilise an interim solution until substantive appointments can be made.	
S12	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Staff have access to the necessary education and training and are supported to maintain their skills and competencies.	Review the capacity of the education and training team to ensure there are enough staff to deliver the required education and training programme across the maternity service.	Deputy Director of Midwifery

S13	Women and their babies are treated by the right number of appropriately skilled and competent staff.	The maternity service is supported to manage medicines in line with national guidance.	Review the capacity of the Medicines Management team support to the maternity service to ensure it is fit for purpose and can support with the safe management of medicines. Additional staffing to be secured as required to address any gaps identified.	Chief Pharmacist
S14	Women and their babies are treated by the right number of appropriately skilled and competent staff.	The maternity service areas are adequately cleaned and are compliant with national guidance relating to IPC.	Review the capacity of the domestic cleaning / housekeeping teams across the maternity service to ensure there is adequate hours for cleaning. Additional cleaning time to be secured as required to address any gaps identified.	Director of Estates and Facilities
S15	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Implement the Small Steps Big Change Healthy Pregnancy MSW pilot project	Director of Midwifery
S16	Women and their babies are treated by the right number of appropriately skilled and competent staff.	Women receive care at an appropriate time, by the right person in the right place	Complete recruitment to meet Maternity workforce plan	Director of Midwifery

Ref.	Key Outcome	Measure of Success	Action	Owner
T1	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Mandatory training targets are met.	Establish a process for the service to complete an annual training needs analysis for staff working in the maternity service to include, Midwives, Obstetricians, Maternity Support Workers, Anaesthetists, Neonatologists and paediatricians.	OD Consultant
T2	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Mandatory training targets are met.	Develop a training plan and timetable to meet; 1. annual mandatory training requirements, 2. bespoke training to address any lessons learned and any new developments in practice, 3. any gaps in knowledge of individuals as identified through supervision and PDP 4. Assess the capacity and availability of the Clinical Educator workforce to deliver the identified training needs. 5. Create additional capacity to enable staff to be released for mandatory training. Submit the training plan to the LMNS for validation three times a year.	Deputy Director of Midwifery
T3	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	90% of all maternity staff will have completed all mandatory training	Progress the Business case that enables the training that allows access to venues, training space, training equipment and on line learning packages.	Head of Quality and Safety - Maternity
T4	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Staff report feeling supported to maintain and further develop their professional skills and experience.	Ensure CPD funding for midwives is ring fenced and there is a process in place for applying against the funds available.	Assistant Director of Nursing
T5	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	90% of all maternity staff will have completed all mandatory training.	Develop and implement a process for monitoring compliance with training and escalation of deviation from trajectory.	Deputy Director of Midwifery
T6	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	All relevant staff are able to demonstrate competency in CTG interpretation.	Roll out CTG training and competency assessment to all relevant staff. All new F2's and GPST Doctors who started in Obs & Gynae to have the CTG competency and assessment training as part their induction programme.	Associate Director of Maternity Governance
T7	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Staff report feeling supported to maintain and further develop their professional skills and experience.	Develop and implement a Band 7 handbook and induction programme for midwifery leadership roles. Develop and implement an induction programme for midwifery leadership roles.	Assistant Director of Nursing
T8	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Staff who are new in post feel supported to deliver safe care to women and their babies.	Develop and implement an induction package for all new staff to the maternity units.	OD Consultant

T9	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Staff who are new in post feel supported to deliver safe care to women and their babies	Develop and implement orientation and induction for bank and agency staff.	OD Consultant
T10	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Newly qualified or return to practice midwives report feeling supported and encouraged to gain new skills	Refresh and develop the approach for the midwifery rotation programme to ensure it is fit for purpose and newly qualified or return to practice midwives have access to ongoing support and development.	Maternity Improvement Midwife and Asst HRBP

Themes
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Ref.	Key Outcome	Action	Owner
CL2	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Develop and embed a just culture within all incident and/or never event investigations.	Associate Director of Governance and OD Consultant
CL3	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Develop and implement the initial phases of a cultural transformation programme.	OD Consultant
CL4	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Promote the Freedom to Speak Up Guardian Service within Maternity Services.	Freedom to Speak Up Guardians / DLT
		Ensure the Guardians provide themed feedback to the Service and Divisional leads.	
		Ensure Service and Divisional Leads consider and address the themes.	
CL5	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Complete a development needs analysis of leadership and management capability to promote compassionate leadership. Identify and/or develop and implement compassionate and inclusive leadership development opportunities.	OD Consultant
CL6	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Complete a human factors needs analysis and develop and implement human factors interventions.	OD Consultant and Business Development Manager, Sim Centre
CL7	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Commission mentoring and coaching for the Maternity Matrons and Band 7 ward leaders.	Director of Midwifery
CL8	There is a clear vision and credible strategy to deliver high quality care to women and babies.	Refresh and update the Maternity Service Vision and Strategy (3 - 5 years).	Maternity Service DLT
		Review and align the Midwifery Strategy to Maternity Service Vision and Strategy prior to launch.	
		Ensure progress against the delivery of this Maternity Service Vision and Strategy is monitored through the divisional governance structure	
CL9	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Create an informal “Critical Friends” network across the large North of England teaching hospital maternity units.	Divisional General Manager
		Arrange a programme of opportunities for staff to visit Coventry and Warwick	
CL10	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Ensure the PMA role is utilised appropriately for the development of high quality, safe maternity care, including multi-disciplinary incident debriefs	Director of Midwifery

CL11	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Develop and implement learning forums to provide staff with the opportunity to reflect on any learning identified from incidents, complaints or patient feedback in a safe space.	Associate Director of Governance
CL12	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Develop and implement appropriate actions as a result of the feedback from trainee Doctor survey. Develop process for ongoing review and action	Clinical Director and Heads of Service
CL13	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Implement the actions detailed in the HEE response to improve the student midwife experience.	Director of Midwifery and Deputy Director of Nursing
CL14	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Implement communication tools supporting everyone to have challenging conversations	Clinical Director and Director of Midwifery
CL15	The culture within the maternity service is open and honest, promotes safety, psychological safety, mutual respect and kindness	Identify the barriers to escalation amongst staff groups. Ensure action is taken to address barriers to escalation that are identified. Highlight the importance of everyone listening when someone escalates concerns about care and treatment. Ensure staff know what to do when they don't feel their concerns about care and treatment have been listened to.	Clinical Director and Director of Midwifery
CL16	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Ensure performance is managed in line with the appraisal policy, the capability policy and procedure and the conduct behaviour and disciplinary policy. Revise the approach and implement within the maternity service for supporting and managing staff when their performance is poor or variable.	Director Midwifery/Heads of Service
CL17	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	Ensure there is an effective appraisal process with on going supervision arrangements across the service.	Director of Midwifery/Heads of Service
CL18	Women and their babies are cared for by staff who have the skills, knowledge and experience to deliver effective care, support and treatment	To develop and implement the next phase of cultural transformation.	OD Consultant

Themes
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Actions
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Ref.	Key Outcome	Measure of Success	Action	Owner
G1	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	The arrangements for governance and performance management are clear and are operating effectively. The service receives robust assurance about the quality of care being delivered.	Review the current governance arrangements within maternity and develop an effective governance system. This should take into account the recommendations in the NHSI commissioned Maternity Governance Review and include Ockenden, Saving Babies Lives, HSIB, ATTAIN and NHS Resolution.	Associate Director of Maternity Governance
			Implement revised arrangements ensuring all groups have clear terms of reference and monitor the attendance at meetings.	
			Develop a work plan for maternity governance which ensures that safety, experience and effectiveness are given appropriate coverage and oversight in meetings.	
G2	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	There is an effective and comprehensive process to identify, understand monitor and address current and future risks within the maternity service. Performance issues are escalated through the service, division and trust wide governance processes.	Review the maternity risk register and ensure all risks are updated .	Associate Director of Maternity Governance
			Ensure there is regular oversight of the risk register through the Maternity Governance structure and that risks are escalated to the division in line with the trusts Risk Management policy and procedure.	
G3	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	There is an effective and comprehensive process to identify, understand monitor and address current and future risks within the maternity service. Performance issues are escalated through the service, division and trust wide governance processes.	Develop a maternity risk management framework and policy.	Associate Director of Maternity Governance
			Ensure the policy and framework have been disseminated to risk owners across the service.	
G4	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	The clinical audit processes function well and have a positive impact on the quality of care being delivered to women and babies.	Review and revise the maternity service clinical audit programme to ensure it is fit for purpose.	Associate Director of Maternity Governance
			Devise and implement a process to ensure the full audit cycle is completed.	
			Ensure there is a clear process for the escalation of risks and concerns arising out of audits to the service and the Division.	
G5	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	Women and babies care is consistently planned and delivered in line with current evidence based guidance, standards and best practice.	Ensure all clinical guidelines that are used across the maternity service are fit for purpose and in line with national guidance.	
			Carry out a risk assessment of the clinical guidelines to ensure we prioritise the review of those that will have the greatest benefit for improving patient safety.	Associate Director of Maternity Governance

			Ensure there is a clear process in place for clinical guidelines to be kept under review and up to date.	
			Review the process for cascading guidance out across the service so that staff are clear what clinical guidelines they should follow.	
G6	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	Openness and transparency about safety is encouraged. Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses.	Ensure there is a culture of reporting of all incidents and there is a clear system in place to review all incidents and rapidly identify those which require further investigation and / or investigation so that mitigating actions can be taken quickly.	Associate Director of Maternity Governance
			Develop and implement a process to track moderate harm and above Incidents to ensure there is oversight of all the steps required; for example this should include the appropriate timely review, 72 hours report completion, the duty of candour requirements, reporting to relevant regulators and stakeholders and escalation within through the trusts governance processes.	
			Develop and implement a process to track low and no harm Incidents to ensure there is oversight of timely and effect review and closure	
G7	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	When something goes wrong there is an appropriate thorough review or investigation that involves all relevant staff, partner organisations and women who use the service.	Undertake thematic reviews on open and overdue incidents. Present reports on thematic reviews to agree recommendations on changes in practice required.	Associate Director of Maternity Governance
G8	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	When something goes wrong lessons are learned and communicated widely. Opportunities to learn from external safety events and patient safety alerts are also identified. Improvements to safety are made and the resulting changes are monitored.	Review and refine the approach for how the service learns from incidents, complaints, claims, HSIB investigations, patient safety alerts national safety reviews and inquests.	Associate Director of Maternity Governance
			Ensure there is a process for the monitoring and oversight of actions arising from incident investigations, complaints, claims, HSIB investigations, and inquests.	
			Develop a plan to ensure there are different mechanisms in place to cascade learning throughout the maternity service, the wider trust and other providers where applicable.	
G9	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	Openness and transparency is encouraged and is the norm. The service fulfils the requirements of the Duty of Candour	Carry out a review of Duty of Candour letters for Serious Incidents and HSIB investigations.	Associate Director of Maternity Governance
			Ensure all staff working in the maternity service are aware of the Duty of Candour and how this applies to their role.	

			Ensure there is robust oversight of the compliance with the requirements of Duty of Candour.	
			Liaise with the Trust Corporate function to ensure the service is meeting the requirements of the Duty of Candour.	
G10	The Governance of the maternity service assures the delivery of high quality and person centred care, supports learning and innovation and promotes and open and fair culture	Information is used to support the performance management of the maternity service. Data is accurate, valid, reliable and timely and is used to challenge and improve performance.	Develop and operationalise a maternity dashboard as a mechanism to oversee the quality of the maternity service.	Associate Director of Maternity Governance
			Ensure staff receive relevant information on a daily basis to help them adjust and improve performance as necessary.	Associate Director of Maternity Governance
			Develop a monthly variance report to prompt wider discussion and triangulation of evidence relating to areas of concern.	Improvement Obstetrician
			Develop a process for the indicators in the dashboard to be used to provide assurance on progress against the maternity improvement programme.	Programme Manager

Themes	Actions
10	29

Independent Thematic Review of NUH Maternity Services Update
1 February 2022

This is the latest update on the Independent Thematic Review of NUH Maternity Services which is jointly commissioned by NHS Nottingham and Nottinghamshire CCG and the Midlands Regional team of NHS England and Improvement.

We are committed to ensuring that we provide regular and routine updates to those interested in the review. You can find information on the background of the review and read our previous updates **here**. If you do not wish to receive these updates please contact us on nnccg.nottsmaternityreview@nhs.net

Independent Thematic Review of NUH Maternity Services – latest progress

Lead Neonatologist – we are pleased to announce that Dr Alison Bedford Russell, Consultant Neonatologist at Liverpool Women's Hospital, is joining us as our Lead Neonatologist.

This means that the full review team is now in place and we are actively working within the agreed Terms of Reference. The thematic review approach will follow the 'Windrush' methodology and aims to be complete by November 2022.

Some **useful documents** about how the thematic review is working are now available on our website, please note that these will be reviewed and updated when necessary:

- Governance structure
- Methodology
- Privacy notice

Families – Hilda Yarker, Family Liaison Facilitator has been engaging directly with families since mid-November to build relationships. Dr Teresa Kelly and Debbie Graham also met with families on video calls, at the end of November, to introduce themselves and set out the purpose of the review.

- There are currently 67 families who have contacted us to register on our database. There have been more than 430 individual email exchanges, face-to-face meetings with seven families (national guidance on Covid has impacted this), phone calls with 12 families and 22 video calls.

- The first phase of confidential listening sessions has been taking place since 10th January but we need to hear from many more families to inform the review so please do contact us.

- A dedicated family telephone number has been set up and you can contact us on 07500 940481 to book a listening session or if you have any questions about the review. Alternatively you can book a listening session online.

- All families who have agreed to share their experience have been sent a consent form to complete prior to taking part in a listening session. So far, listening sessions have taken place over video call and we have also received written submissions from some families.

- The review team is collaborating with the mental health commissioner from the CCG to scope out a proposal to commission bespoke, specialist psychological and emotional support for families, siblings and extended family members. The service will be delivered by mental health experts who specialise in dealing with trauma and Post Traumatic Stress Disorder. This is in line with the terms of reference for the review (item 16).

- An Equality Impact Assessment has been put in place to ensure full adherence with the public sector equality duty as defined in the Equality Act 2010, Section 149.

- We are contacting families on our database this week to find out their views around setting up a family group so that this group can be formed in the way that families will find it most useful.

Staff - Dr Teresa Kelly and Debbie Graham, lead clinicians, have met with staff on site at NUH to talk about the purpose of the review. Meetings have also taken place with the Trust Chair, Chief Nurse, Director of Midwifery, and Non-Executive Director and Chair of the Quality and Assurance Committee. Invitations have been sent to all maternity services and neonatal staff, through regular newsletters and Facebook groups, to raise awareness of the confidential listening sessions.

- The first phase of confidential listening sessions have been taking place since 10th January – 4th February 2022. Further sessions will be offered until March as we need to hear from as many members of staff as possible to inform the review. The listening sessions are open to all staff (non clinical and clinical) that work in or with the maternity services and neonatal teams.

Data – Ian Razzell, Data and IG Manager, has been focusing on finalising the platform to house data from the Trust in a secure environment for authorised license holders only. Once this platform, and the necessary data protection policies, assessments and consent are in place, data can be transferred. Other data progress includes:

- Preparation of a deeper engagement portfolio that will allow wider data collection for use in benchmarking and development of themes. This includes Royal Colleges, Coroner's Office, Specialist commissioners and other NHS Trusts.

- Publishing of Nottingham University Hospitals board papers on their website – papers are now available from 2012/13 to 2021/22. We will continue to request that papers dating back to 2006 are also published.

- A specific request has already been submitted to the CCG for information and papers on NUH maternity services, dating back to 2016 - 2018, to support the review. The

CCG have confirmed they will share the information requested and are fully committed to supporting the review.

Raising the profile of the independent thematic review – Meetings have taken place with local MPs and Councillors with a special interest to respond to concerns on behalf of their constituents and residents. We want to raise the profile of the review to ensure that we hear from families and staff who wish to share their experience with us. During the next few weeks we will be:

- Using social media to raise the profile of our website: www.independentmaternityreviewnotts.nhs.uk
- Contacting voluntary groups related to maternity services
- Reaching out to community and faith groups to reach under represented groups
- Briefing local and interested national media
- Visiting Nottingham University Hospital sites to hand out information flyers to staff

The review will start its detailed work this month and is expected to complete by the end of November 2022. We will be making recommendations throughout the review and the commissioners of the review will ensure that these are implemented at pace.

Details on the review process

A reminder of the purpose of the thematic review.

The review will consist of four areas of work, that will interconnect and overlap:

- **Data & Analytics:** a review of all relative data, trends and management information at the Trust since its inception in 2006, in order to assess patterns of incidents over time, correlating themes or trends, and potential causal factors (not limited to clinical activity). External reports and information will also be considered.
- **Detailed Review & Key Lines of Enquiry:** examining current and recent concerns with maternity services at the Trust and investigating specific themes and trends in order to gain insights into practice, culture and processes
- **Listening to Women, People who give Birth and Families:** ensuring that the review incorporates the learning and experience of those with lived experience of maternity services at the Trust
- **Review of the Governance & Oversight of Maternity Services at the Trust:** looking at the levels of assurance to ensure the safety and quality of service provision

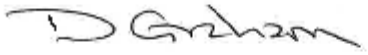
Support Available

We appreciate this must be an extremely difficult time for women and families affected by their experience of maternity services and we have information on our website which can offer support and help. You can find all the details **here**.

To request this information in another language or format please contact the Engagement Team at: nnccg.team.engagement@nhs.net or call or text 07385 360071. If texting or leaving a message, please provide your contact details and a member of the team will get back to you.

Yours faithfully





Cathy Purt
Independent Programme Director

Dr Teresa Kelly
Independent Obstetric Lead

Ms Debbie Graham
Independent Midwifery Lead

Health and Adult Social Care Scrutiny Committee
17 February

Provision of services for adults with learning disabilities

Report of the Head of Legal and Governance

1 Purpose

1.1 To review developments in provision of community services for adults with learning disabilities, with a particular focus on changes for those who previously attended Summerwood Day Centre.

2 Action required

2.1 The Committee is asked to consider whether:

a) it wishes to make any comments or recommendations; and/or

b) whether any further scrutiny is required, and if so the focus and timescales.

3 Background information

3.1 In November 2018 Executive Board approved a new strategy for adult social care 'Better Lives, Better Outcomes' based on the principle of promoting independence and working with citizens and communities to build resilience and independence. Following consultation and engagement with affected citizens and their carers and staff, in April 2021, the Portfolio Holder for Adults and Health took a decision to close Summerwood Day Centre for Adults with Learning Disabilities and reassign citizens using that day centre to a combination of Spring Meadow, Martin Jackaman and Acorn centres as the best approach to help the Council meet aspirations within the strategy of achieving good outcomes within resources available. The new Pathway Service also meets the demands of learning disabled citizens that no longer want to attend traditional-type day services.

3.2 In light of these changes, the Committee wanted to review how services for adults for learning disabilities have developed to meet the needs of users and their carers.

3.3 A briefing on the changes to services, and current provision is attached and the Portfolio Holder for Adults and Health and the Director for Adult Health and Care will be attending the meeting to answer questions from the Committee.

4 List of attached information

4.1 Briefing on provision of services for adults with learning disabilities

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6 Published documents referred to in compiling this report

6.1 Minutes of the meeting of Executive Board held on 20 November 2018

6.2 DD4201 – Summerwood Closure

7 Wards affected

7.1 All

8 Contact information

8.1 Jane Garrard, Senior Governance Officer
jane.garrard@nottinghamcity.gov.uk
0115 8764315

Provision of Services for Adults with Learning Disabilities / Summerwood Day Centre

This report provides the Health and Social Care Scrutiny Committee with an outline of the changes for adults with learning disabilities who previously attended Summerwood Day Centre and an over view of the provision of community services for learning disabled adults.

Background

There are currently 540 learning disabled citizens in Nottingham receiving care and support packages to meet their daytime and evening care needs.

Timeline in relation to changes to day services

March 2021 Nottingham City Council operated 3 day centres for adults with learning disabilities and one for citizens with physical / sensory impairments: Martin Jackaman Centre (72), Spring Meadow Centre (69), Summerwood Centre (17), Acorn Centre (44) supporting a total of 202 Citizens (37%) of the 540.

March 2021 consultation was launched to close 1 internal learning disability day centre.

Consultations with affected stakeholders was conducted for 45 days via Zoom meetings, use of an independent organisation and the “Have Your Say Portal”.

It was proposed that on closing Summerwood day centre, affected citizens currently using that day centre could access a combination of Spring Meadow or Martin Jackaman day centres. These day services would still retain the ability to accept new referrals.

May 2021 consultation closed and the decision was taken to close Summerwood day centre and support the affected citizens to attend Spring Meadow day centre.

September 2021 Summerwood closed. There were 17 citizens attending Summerwood prior to its closure and all 17 citizens transferred to Spring Meadow centre receiving the same level of service as they did when attending Summerwood.

No staff were put at risk of redundancy as there were vacancies across the Adult Provision services and staff were redeployed accordingly. Many of the staff moved to Spring Meadow to enable continuity of care.

January 2022 Despite the ongoing Coronavirus pandemic the internal Learning Disability service provision at Martin Jackaman Centre and Spring Meadow centre are operating at almost pre – pandemic levels.

Citizens and carers of those that moved to Spring Meadow have all reported that they are happy with the new service. No complaints have been received.

Both Spring Meadow and Martin Jackaman day centres services are built on maintaining and improving citizen’s independence, health and well-being, in a supportive and light hearted atmosphere - all of which is done in consultation with the citizens attending and their advocates.

Assessment overview

Assessment colleagues based in the South Whole Life Disability (WLD) Team have reported that since the closure of Summerwood they have received no requests for building based day services from citizens living in Clifton.

The assessment team has received excellent feedback in regard to the 17 citizens who moved to Spring Meadow. Families have reported that they have been surprised at how well their loved ones have adjusted and how impressed they are at the range of activities available at Spring Meadow. Many of the families have said they are building up really positive relationships with the Spring Meadow staff team.

The citizens have commented that moving to Spring Meadow has enabled them to meet up more regularly (sometimes daily) with friends that they previously only saw at certain events, such as the Evergreen drama group. As well as being able to see old friends more regularly citizens have also said that moving to Spring Meadow has meant they have been able to make new friends. A number of citizens have said how they really like the different activities on offer at Spring Meadow.

Supported Living

The Whole Life Disability Team have continued to receive enquiries from families in regard to Supported Living. Supported Living is a more independent option than residential care for citizens who require accommodation with support and is something that Adult Social Care have been developing over the last 4 years. The aspiration in Nottingham is to support people to live as independently as possible and in the least restrictive settings; supported living enables citizens to do that.

This ambitious programme is set to continue for a further 3 years with plans to develop 60 units per year of supported living accommodation across both WLD and Mental Health.

Provision of Community Services for Learning Disabled Adults

Summary

Prior to COVID-19 the provision for adults with learning disabilities and autism and their carers across the City was primarily buildings based for both day and short break services, with some community based opportunities. As a result of the COVID-19 crisis, service provision across the City shifted significantly, with day centres being closed in line with government guidance.

Many of the City's external day centres are now in operation, albeit at a reduced capacity. During the pandemic most services provided outreach support and alternative digital provision.

Market Overview

This information is based on a market intelligence exercise undertaken at the end of 2021, plus information taken from Nottingham City Council's Day and Evening

Services Framework. During October and November 2021 all day centres on the framework were contacted for information about their capacity. There are 27-day centre providers in total, however the information below relates to all day centres who support people with learning disabilities, of which there are 16.

Out of the 16 day centres who operate a day service for people with learning disabilities:

- 14 day centres were open and operating with 2 day centres unknown.
- 10 day centres indicated they supported citizens with all levels of need with 2 day centres indicating they could cater for citizens with low to medium level of need, the remaining day centres are unknown.
- 10 identified they had capacity for taking on more citizens.
- As of Oct 21 there were 183 citizens supported in the external market, and the highest attending day service supports 51 citizens.
- The average cost for a full day, medium rate in the external market is £77.26.

Current Position – External Community Care Market Risks and Pressures

Day centre provision is usually based on a high volume, low cost model, which relies on providers having a volume of citizens accessing the service. During and post-Covid, providers are unable to support the same numbers of citizens they once did at any given time. Should this situation persist it may impact on the business models of some providers. Covid related guidance for day centres has not been recently updated.

Recruitment and retention in the whole care market has been challenging for some time. Analysis by ADASS identified a turnover rate of approximately 30% of workers leaving the market on an annual basis. The issues for staffing have been worsened considerably, particularly during the latter half of 2021. This is due to a multiplicity of factors including;

- Reluctance to work in the care sector following Covid
- High sickness levels due to Covid, particularly in the light of the Omicron variant
- High sickness levels of stress and anxiety
- Reluctance of some staff to be vaccinated - 82% of the wider care market is vaccinated
- Brexit
- Furlough changes
- High employment levels
- Competition from retail and hospitality
- Alongside this, we have also seen significant increase in levels of demand for services linked to the impact of Covid.

The impact of this workforce shortfall is now affecting our ability to provide community based services to meet assessed eligible needs.

Respite Care

Carers have told us that it is often difficult to find pre-bookable respite care for their disabled child/adult with disabilities that they care for. We are working towards commissioning more pre-bookable options for planned respite care in care homes and also options that may support the person in their own home while their carer has a break.

Current Situation

Over recent years respite provision has been secured through short term placements in existing residential services which are made under the existing contract for Residential and Nursing Care. More recently providers have stated that due to the risks associated with Covid, they are now increasingly reluctant to allow short term placements on a regular basis within their homes. Current issues with recruitment have also made this situation more demanding having created a general lack of specialist provision in the local area.

Discussions with regional Local Authority colleagues have further demonstrated that adequate provision of respite is a regional challenge. The majority of Authorities, regionally, are currently unable to meet the need in their area and are also reliant on short term placements in residential care. Those who have been able to meet the demand for respite generally have use of internal provision and / or small block contracts. Although there is internal provision within Nottingham City, it is not able to meet the needs of all citizens requiring respite.

A specification of what the requirement for respite has been developed and is ready share with the market via a soft market test. The purpose of this process is to gauge the interest and feasibility of commissioning a small number of beds to be utilised primarily for respite, but also for short term emergency placements

Next Steps

The soft market testing is due to start imminently and the results of this work will influence next steps in commissioning a respite service

Paul Haigh – Head of Adult Social Care Provision

Amy Groom – Market Intelligence Manager

Oliver Bolam – Head of Mental Health & Whole Life Disability

January 21st 2022

Health and Adult Social Care Scrutiny Committee
17 February 2022

Work Programme

Report of the Head of Legal and Governance

1. Purpose

1.1 To consider the Committee's work programme for 2021/22 based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

2. Action required

1.1 The Committee is asked to note the work that is currently planned for the remainder of the municipal year 2021/22 and make amendments to this programme as appropriate.

3. Background information

3.1 The purpose of the Health Scrutiny Committee is to act as a lever to improve the health of local people. The role includes:

- strengthening the voice of local people in decision making, through democratically elected councillors, to ensure that their needs and experiences are considered as part of the commissioning and delivery of health services;
- taking a strategic overview of the integration of health, including public health, and social care;
- proactively seeking information about the performance of local health services and challenging and testing information provided to it by health service commissioners and providers; and
- being part of the accountability of the whole health system and engaging with the commissioners and providers of health services and other relevant partners such as the Care Quality Commission and Healthwatch.

3.2 As well as the broad powers held by all overview and scrutiny committees, committees carrying out health scrutiny hold the following additional powers and rights:

- to review any matter relating to the planning, provision and operation of health services in the area;
- to require information from certain health bodies[1] about the planning, provision and operation of health services in the area;
- to require attendance at meetings from members and employees working in certain health bodies[1];
- to make reports and recommendations to clinical commissioning groups, NHS England and local authorities as commissioners of NHS and/or public health services about the planning, provision and operation of health services in the area, and expect a response within 28 days (they are not required to accept or implement recommendations);

[1] This applies to clinical commissioning groups; NHS England; local authorities as commissioners and/or providers of NHS or public health services; GP practices and other providers of primary care including pharmacists, opticians and dentists; and private, voluntary sector and third sector bodies commissioned to provide NHS or public health services.

- to be consulted by commissioners of NHS and public health services when there are proposals for substantial developments or variations to services, and to make comment on those proposals. (When providers are considering a substantial development or variation they need to inform commissioners so that they can comply with requirements to consult.)
- in certain circumstances, the power to refer decisions about substantial variations or developments in health services to the Secretary of State for Health.

3.3 While a 'substantial development or variation' of health services is not defined in legislation, a key feature is that there is a major change to services experienced by patients and/ or future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area. Health scrutiny committees have statutory responsibilities in relation to substantial developments and variations in health services. These are to consider the following matters in relation to any substantial development or variation that impacts on those in receipt of services:

- whether, as a statutory body, the relevant overview and scrutiny committee has been properly consulted within the consultation process;
- whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and
- whether the proposal for change is in the interests of the local health service.

Where there are concerns about proposals for substantial developments or variations in health services, scrutiny and the relevant health body should work together to try and resolve these locally if at all possible. Ultimately, if this is not possible and the committee concludes that consultation was not adequate or if it believes the proposals are not in the best interests of local health services then it can refer the decision to the Secretary of State for Health. This referral must be accompanied by an explanation of all steps taken locally to try and reach agreement in relation to the proposals.

3.4 The Committee is responsible for setting and managing its own work programme to fulfil this role.

3.5 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately.

3.6 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.7 The current work programme for the municipal year 2021/22 is attached at Appendix 1.

4. List of attached information

4.1 Appendix 1 – Health and Adult Social Care Scrutiny Committee Work Programme 2021/22

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 None

7. Wards affected

7.1 All

8. Contact information

8.1 Jane Garrard, Senior Governance Officer
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

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Health and Adult Social Care Scrutiny Committee 2021/22 Work Programme

Date	Items
13 May 2021	• **Terms of Reference** To note the terms of reference for the Committee • **Platform One** To assess progress towards the transition date of 1 July 2021, particularly in relation to vulnerable patients to be dispersed to local practices (to include reference to how the EQIA is evolving, being monitored and responded to) • **Nottinghamshire Healthcare NHS Foundation Trust Strategy** To consider the Trust's strategy in order to identify a focus for any further scrutiny of mental health issues in 2021/22 • **Work Programme 2021/22**
17 June 2021	• **Integration and Innovation White Paper** To consider the implications of proposed reforms to health and care and the potential local impact • **Integrated Care System: Community Care Transformation** To consider and comment on this ICS priority which will involve a review of all community services • **Quality Accounts 2020/21** To note the scrutiny comments on each Quality Account (if any submitted) • **Work Programme 2021/22**
15 July 2021	• **Maternity Services** To review the action taken by NUH over the last six months to improve maternity services • **Tomorrow's NUH**[1]

[1] Informal meeting held to do some deep dive consideration of the Tomorrow's NUH programme 30 June 2021 (Phil Britt, Nina Ennis, Lucy Dadge) focused on maternity and cancer services. A further deep dive meeting to be held later in the year to focus on outpatients' care and splitting elective/ emergency services.

Date	Items
	To consider progress to date and plans for consultation and engagement. • **Work Programme 2021/22**
16 September 2021	• **Assessment, Referrals and Waiting Lists for Psychological Support** To consider the Nottinghamshire Healthcare NHS Foundation Trust's plans for managing access to psychological support, particularly in relation to step 4 psychotherapy and psychological therapies. • **Reconfiguration of Acute Stroke Services** To consider proposals for making changes to the configuration of acute stroke services permanent. Changes were made on a temporary basis to support the response to the Covid pandemic. If it is proposed to make the changes permanent, then this is likely to be a substantial variation to services and the Committee will need to carry out its statutory role as a consultee • **Covid 19 Local Vaccination Programme** To assess progress with local delivery of the vaccination against national targets (at 23/03/21 the whole population should have had at least one dose by the end of July 2021) • **Work Programme 2021/22**
14 October 2021	• **Update on Elective Care Recovery** To scrutinise the impact of delays on elective care due to Covid 19, plans to mitigate this impact and the progress with meeting need following delays • **Eating Disorder Services** To assess the impact of expansion to workforce capacity to services, consider the continuing use of BMI as a threshold for access to services and to consider the impact of out of area adult inpatient placements. • **Work Programme 2021/22**
11 November 2021	• **Nottingham University Hospitals NHS Trust – CQC Inspection** To consider the findings of the recent CQC Inspection of NUH and scrutinise action being taken to address areas identified as inadequate and requiring improvement, with a particular focus on the

Date	Items
	Well-Led domain. • **GP Services** To review GP provision and access across the City • **Proposals for changes to Neonatal Services** To consider proposals for changes to neonatal services provided by Nottingham University Hospitals NHS Trust. • **Work Programme 2021/22**
16 December 2021	• **Draft Medium Term Financial Plan (MTFP) - Adult Social Care focus** To consider proposals relating to Adult Social Care in the draft MTFP (as part of the consultation on the MTFP) • **Transformation Programme Adults Portfolio** To receive an overview of the Adults Portfolio of the Council's Transformation Programme • **Platform One** To assess the initial impact of the transition to the new city centre practice and to local practices, with particular reference to the experiences of vulnerable patients. • **Work Programme 2021/22**
13 January 2022	• **Adult Social Care Workforce Development Plan** To review the draft Workforce Development Plan, which forms part of the Council's recovery and improvement activity • **Nottingham University Hospitals NHS Trust Improvement** To review progress in improvement in response to the findings of the CQC inspection, with a particular focus on culture. • **Nottingham City Safeguarding Adults Board Annual Report 2020/21** To receive evidence from the Safeguarding Adults Board regarding work to safeguard adults in the City; scrutinise the work of the Board, including consideration of its 2020/21 Annual Report; and identify any issues or evidence relevant to the Committee's work programme.

Date	Items
	• **Work Programme 2021/22**
17 February 2022	• **Nottingham University Hospitals NHS Trust Maternity Services** To review action being taken by NUH to improve maternity services following CQC rating of 'Inadequate' in December 2020 • **Provision of Services for Adults with Learning Disabilities** To review changes to provision for adults with learning disabilities • **Work Programme 2021/22**
17 March 2022	• **GP Strategy** To review proposals for the draft GP Strategy • **Update on Tomorrow's NUH** (tbc) To receive an update on the latest position in relation to the Tomorrow's NUH programme • **Work Programme 2021/22** • **Developing Work Programme 2022/23**
15 April 2022	• **Reconfiguration of Acute Stroke Services** (tbc) To consider the proposals for making changes to the configuration of acute stroke services permanent, which is a substantial variation of services and therefore the Committee will need to carry out its statutory role as a consultee • **Work Programme 2022/23**

Items to be scheduled

It was agreed at the 13 May HSC meeting that some members would visit the new SMD LES once it is safe to do so, ie post pandemic (liaise with Joe Lunn, CCG)

Item	Focus
1. Discharge and after care (including impact on Social Care)	To consider the effectiveness, including the impact on adult social care, of current plans and practice for the discharge of patients from hospital care -
2. NHS and National Rehabilitation Centre (NRC)	Update on the Decision Making Business Case and implementation plans
3. White Paper	To contribute to discussions about new arrangements, especially in relation to governance, representation on committees and engagement and consultation with the public about local changes
4. Community Care Transformation	CCG to keep HSC informed of progress at Chair/ Vice Chair and CCG monthly meetings.
5. Child and Adolescent Mental Health Services (CAMHS)	(a) To consider the services provided by CAMHS in the light of the need for support as the city recovers from the pandemic; and (b) To consider systems and processes in place to ensure effective transition from CAMHS to Adult Mental Health Services (Recommendation from the Children and Young People Scrutiny Committee)
6. Health Inequalities	To consider how health inequality is measured, how factors which impact on health are established (including barriers to access) and where hot spots identified (geographical and community) and to scrutinise how partners work together to tackle particular aspects of health inequality[2]
7. Dental Services	To review access to dental services during the Covid-19 pandemic, the impact of reduced access and reinstatement of services, future dental provision contracts/ private and public treatment.
8. Nottingham	To consider findings of NUH's review of Serious Incident reporting, any lessons learnt and

[2] Following this to identify an area where scrutiny can add value by more detailed consideration at a future meeting(s), for example: BAME health experiences and access to services/ Poverty and the impact on health and access to services/ Support for those new to the city from other countries to access available NHS services/ Access to PEP medication to prevent HIV (pilot)/ Waiting lists in the context of health inequalities (see notes below funder impact of Covid on elective services from meeting with CCG 03/04/2021)

Item	Focus
University Hospitals NHS Trust review of Serious Incident reporting	action taken in response

Reserve Items

Item	Focus
9. Alcohol dependency/ Alcohol related issues	Potential role of HSC in relation to impact on health when premises are licensed for sale of alcohol
10. Carer Support Services	To review support for carers during the Covid-19 pandemic
11. Gender reassignment services	Need for scrutiny and focus to be identified
12. Impact of Covid-19 on disabled people	Need for scrutiny and focus to be identified
13. 111 First	Changes to the service as a result of Covid

Healthwatch Priorities for 2021/22 – for information

- **Long Term Conditions, primarily diabetes: management, education and support for patients**
- **Primary Care Strategy and Integrated Care Partnership strategy.**