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# Nottingham City Council
# Health and Adult Social Care Scrutiny Committee

**Date:** Thursday, 14 July 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

**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



If you need any advice on declaring an interest in any item on the agenda, please contact the Governance Officer shown above, if possible before the day of the meeting

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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 23 June 2022 from 10.00 am - 12.23 pm**

**Membership**

| **Present** | **Absent** |
|---|---|
| Councillor Georgia Power (Chair) | Councillor Cate Woodward |
| Councillor Maria Joannou (Vice Chair) | |
| Councillor Michael Edwards | |
| Councillor Kirsty Jones | |
| Councillor Nayab Patel | |
| Councillor Anne Peach | |
| Councillor Dave Trimble | |
| Councillor Sam Webster | |

**Colleagues, partners and others in attendance:**

| | | |
|---|---|---|
| Lucy Anderson | - | Nottingham and Nottinghamshire Clinical Commissioning Group |
| Dean Annabelle | - | Change, Grow, Live |
| Jane Bethea | - | Nottinghamshire Healthcare Trust |
| Kate Burley | - | Nottingham and Nottinghamshire Clinical Commissioning Group |
| Sarah Collis | - | Chair, Healthwatch Nottingham and Nottinghamshire |
| Mark Garner | - | Framework |
| Councillor Jay Hayes | - | Executive Assistant for Health and Culture |
| Helen Johnston | - | Public Health Consultant |
| Graham Miller | - | Double Impact |
| Sophie Stone | - | Double Impact |
| Louise Randle | - | Nottinghamshire Healthcare Trust |
| Sara Storey | - | Director of Adult Health and Social Care |
| Councillor Linda Woodings | - | Portfolio Holder for Adults and Health |
| Jane Garrard | - | Senior Governance Officer |
| Phil Wye | - | Governance Officer |

### 8 Apologies for absence

Councillor Cate Woodward – other Council business

### 9 Declarations of interest

None.

### 10 Minutes

The Committee confirmed the minutes of the meeting held on 19 May 2022 as a correct record and they were signed by the Chair.

## 11 Adult Social Care Transformation Programme

Councillor Linda Woodings, Portfolio Holder for Adults and Health, and Sara Storey, Director of Adult Health and Social Care, presented the report providing an overview of the Adult Social Care Transformation Programme and progress to date. They highlighted the following information:

(a) The Programme is building on the Better Lives Better Outcomes Strategy.

(b) The main risk to successful delivery of the Programme is workforce capacity, which is a challenge for the sector nationally.

(c) An extended period of engagement with staff took place as part of development of the programme, in order to hear their views.

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

(d) One of the three key strands of the programme relates to workforce, with career progression strands in the process of being implemented with four levels of progression available for social workers and occupational therapists. This allows for specialism and gives more parity with other local authorities and the NHS in terms of pay.

(e) Adult social care reforms are happening next year, and a lot of focus is on the availability of homecare. A Fair Cost of Care exercise needs to be completed by September/ October and the Council also needs to prepare a market sustainability plan. Internal capacity has been increased over the last year and agreement is in place to continue to fund this. Locally, over 90 homecare workers have been recruited but, due to high levels of turnover, this has only enabled the workforce to be maintained rather than be enhanced. It is anticipated that demand for homecare is likely to increase in the future, including as a result of the reforms. It is estimated that there will be 200-300 additional requests for assessment and support.

(f) National market forces make staff recruitment and retention difficult, with around 4,000 additional social workers needed for the reforms to be a success. Workforce retention in the City is generally quite good but it is relatively easy for people to move to other organisations for better pay, as organisations compete for staff.

(g) Changes to CQC inspections are being made as part of the reforms, which will take preparation and may affect the programme. One of the biggest challenges will be gathering data and evidence.

(h) There is a high degree of confidence that some projects will deliver anticipated savings, but there is more uncertainty for other areas. For example, the

strengths-based review work is about supporting people to do things differently and some of those people have not had a review for some time/ not received preventative work and therefore may actually be in need of more support. The primary focus is on achieving transformational change, which will result in better outcomes. This is the right thing for citizens, better for staff and will ultimately cost less.

(i) The Service is doing everything that it can to make the Transformation Programme a success but some factors are outside its control e.g. workforce capacity and national reforms and it will be necessary to prioritise statutory responsibilities.

(j) The Association of Directors of Adult Social Services collect monthly data on delays in assessment and care. Over the last few years, delays have increased across the country. In Nottingham, there has been a reduction in delays for those accessing through the 'front door' but still challenges for those being discharged from hospital; waits for homecare have started to increase due to recruitment issues but there have been less provider failures in the City compared to some other areas. Overall, Nottingham is not dissimilar to other areas of the country.

(k) Delays in assessment and care are a concern of the wider system including Nottingham and Nottinghamshire Clinical Commissioning Group and Nottingham University Hospitals Trust.

(l) A Governance Board is being established to oversee the Programme, and the intention is to involve frontline staff from different levels. A combination of qualitative and quantitative data will be used to monitor progress.

(m) Lessons learnt so far include the importance of investing in planning time. So far the Programme has had to move at such a fast pace that not as much time has been spent on planning as liked, for example the Strengths Based Review project did not have key data measures in place at the start.

(n) Each project will be considering its own approach to co-design and co-production, but benefits are clear from the Supported Living and Strengths Based projects. The aim is for co-design and co-production to be embedded at all levels.

**Resolved to:**

**(1) recognise the success so far of the Supported Living project;**

**(2) recommend that frontline workers are represented on the Governance Board;**

**(3) support the establishment of co-production panels with citizens and staff; and**

**(4) include in-depth consideration of the Workforce and Organisational Development Strategy and planning to implement national reforms on the Committee's future work programme.**

## 12 Services for people with co-existing substance misuse and mental health issues

Dr Jane Bethea, Consultant in Public Health from Nottinghamshire Healthcare NHS Foundation Trust, introduced the report on behalf of the pathway development group comprising of Nottinghamshire Healthcare NHS Foundation Trust, Nottingham and Nottinghamshire Clinical Commissioning Group, Nottingham City Council, Nottinghamshire County Council, Nottingham Recovery Network, Change Grow Live, Double Impact and Primary Care. She highlighted the following information:

(a) Responding to the needs of people with co-existing mental health and substance misuse requires organisations to work together to make sure people receive care in a timely way and it also requires skills to be shared across sectors, so that staff feel well equipped to work effectively with this client group.

(b) There is a good partnership working between the various partners, both statutory and voluntary sector, with trust and commitment. Progress is on track to have a good service with positive outcomes for this cohort.

(c) Services are now working in a way that means if someone accesses the main substance misuse provider and a mental health issue comes to light, then that provider has the right specialist mental health expertise available to support that person and the staff working with that person. This specialist support will undertake a comprehensive assessment and then act as a trusted assessor for secondary mental health services creating a seamless pathway into services.

(d) If someone is receiving support from a Local Mental Health Team and has a substance misuse issue, then there is peer-support available to that person. The peer-support worker understands their situation and perhaps their fears about accessing support for their substance misuse treatment and helps them engage with local substance misuse services.

(e) An evaluation will look at a number of outcomes, both clinical outcomes around treatment and recovery and also outcomes that are important to the people that are receiving the care and support provided. The evaluation is due to start in September and anticipated to take 6-8 months. The findings will feed directly into plans for ongoing development.

Representatives from other members of the pathway development group shared their experience of the new model, and challenges such as recruitment and funding.

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

(f) It is difficult to know the level of need in the City and it is likely that the prevalence of co-existing conditions indicated by national data is an under-estimation. It is anticipated that demand will increase due to socio-economic factors.

(g) There are some eligibility criteria so it may not be possible for people with addresses elsewhere in the country to access services in the City, but if

somebody does not have a fixed address then they will not be turned away from the pathway.

(h) The Dame Carol Black report outlined how, for many people, mental health problems and trauma lie at the heart of their drug and alcohol dependence. In Nottingham, trauma informed approaches are used to ensure that vulnerable individuals who can sometimes be excluded do not fall through the cracks.

(i) It can sometimes take a number of contacts before somebody with mental health issues or drug dependency will accept a referral to a service, as some have experienced severe trauma or have been let down by services in the past. Flexible working and collaboration is key to helping these people, and services need to work together to ensure that people with mental health issues are quickly and directly referred to the services they require wherever they are approached.

(j) Protected characteristics are being monitored as a part of improvement work, particularly ethnicity. This includes both those receiving services and those delivering services.

(k) Recruitment and retention of staff can be a challenge and services are only now just moving to a position of being fully staffed. It is important that the right people are recruited to roles and this has taken some time.

(l) In addition to paid staff, volunteers are involved in the delivery of services by many of the voluntary sector providers. An increasing number have their own lived experience of mental health issues and/ or substance misuse and many prefer to volunteer rather than be committed to a paid role.

(m) It would be helpful to have a stronger commitment to funding from Government. It is hoped that, following the publication of the Black Report, commissioning guidelines will be issued by Government which could help the transition to joint commissioning.

(n) It is concerning that funding for peer-support workers is currently time-limited. The findings of the evaluation will be important in determining the future of this approach.

(o) The approach will not be totally co-produced but the importance of having the voice of the user as a guide is recognised.

(p) Partners would hope that there would not be another Prevention of Future Death Report raising the same issues as the previous two. A possible gap at the moment relates to primary care. It has been reported that GPs can find it difficult to support people in primary care and access services that are better placed to provide support. Partners are responding to this and are aware of the need to extend the approach into primary care.

(q) It is acknowledged that the model is currently very adult-centric, including older adults, and it is acknowledged that links need to be made with Child and Adolescent Mental Health Services and young people's drug and alcohol services.

**Resolved to:**

**(1) request that contact information for the Street Outreach Team is provided to councillors so that they know how to contact the Team if they become aware of someone who could potentially benefit from its support;**

**(2) recommend that the Partnership develops the model to ensure equivalent support is available for young people, including the development of links with the Child and Adolescent Mental Health Service and young people's drug and alcohol services;**

**(3) recommend that the Partnership extends the model to include primary care to ensure that GPs are equipped to support their patients where appropriate and are able to refer patients to other services when necessary; and**

**(4) request that the findings of the evaluation of the approach are presented to the Committee when it is available.**

## 13 Nottingham University Hospitals NHS Trust Maternity Services

The Chair introduced the report which updated the Committee on information relevant to its scrutiny of maternity services provided by Nottingham University Hospitals NHS Trust.

Sarah Collis reported that Healthwatch Nottingham and Nottinghamshire has written to Donna Ockenden to express concerns about a lack of support for trauma, which could be reignited as a result of the commencement of a new review. Healthwatch has also raised this issue with Nottingham and Nottinghamshire Clinical Commissioning Group.

**Resolved to:**

**(1) note that the Care Quality Commission has published the reports of its inspection of Nottingham University Hospitals NHS Trust Maternity Services;**

**(2) note that the Interim Report of the Independent Thematic Review into Nottingham University Hospitals Maternity Services has been published;**

**(3) note that following the conclusion of the Independent Thematic Review into Nottingham University Hospitals Maternity Services, a new review has been commissioned by NHS England; and**

**(4) invite Nottingham University Hospitals NHS Trust to a meeting of the Committee in autumn 2022 to discuss the Trust's progress in improving maternity services, including addressing the issues raised by the Care Quality Commission in its most recent inspection.**

## 14 Quality Accounts 2021/22

**Resolved to note the comments submitted to provider trusts on behalf of the Committee for inclusion in their Quality Account 2021/22.**

## 15 Work Programme

**Resolved to note the work that is currently planned for the municipal year 2022/23.**

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**Health and Adult Social Care Scrutiny Committee**
**14 July 2022**

# Neurology Services

**Report of the Head of Legal and Governance**

## 1 Purpose

1.1 To consider access to neurology services provided by Nottingham University Hospitals NHS Trust.

## 2 Action required

2.1 The Committee is asked whether:

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

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

## 3 Background information

3.1 In November 2021, the Chair wrote to Nottingham University Hospitals NHS Trust on behalf of the Committee regarding concerns that had been raised with it about access to neurology services provided by the Trust. The concerns related to referrals from GPs being turned down and patients therefore potentially being unable to access the service. A copy of this letter is attached. A copy of the Trust's response is also attached. This set out changes that the service has been making in this regard. The Committee has recently been contacted again about continuing concerns about referrals and therefore decided to invite the Trust to the meeting to discuss access to the service.

3.2 The Trust's Medical Director and the Head of Service for Neurology will be attending the meeting to discuss this with the Committee and answer questions. The Trust has also submitted a written paper, which is attached.

## 4 List of attached information

4.1 Letter to Nottingham University Hospitals dated 29/11/21

4.2 Letter from Nottingham University Hospitals dated 18/01/22

4.3 Neurology Services Update paper from Nottingham University Hospitals NHS Trust

## 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
jane.garrard@nottinghamcity.gov.uk
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Nottingham City Council

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Monday 29th November 2021

Dear Rupert,

I have been contacted by a number of concerned residents and GPs regarding access to the Neurology department at NUH. They are becoming increasingly concerned that in their experience GP referrals are being turned down and patients are unable to access the service they need.

I would be grateful therefore it you could provide the Health and Adult Social Care committee with the following information:

1. How many referrals and/or patients have been made to Neurology?
2. How many referrals and/or patients have been accepted to receive treatment from Neurology?
3. How many referrals have been rejected by Neurology?
4. When a referral is not accepted, does NUH inform, as standard practice, the referrer and/or patient the reasons why the referral was not accepted?
5. For patients whose referrals have not been accepted, what alternative support does NUH offer – does NUH have a system in place to ensure a referral to a more appropriate service is made if applicable?

For points 1-3 I would be grateful if you could provide figures for the past 5 years (or as far back as possible if records are not held for that length of time) to enable to Committee to look at possible trends.

I would also welcome your thoughts on the Neurology service and whether there are any additional comments or relevant issues you would like to make the Committee aware of.

I look forward to hearing from you on this important issue.
Best wishes,

Councillor Georgia Power
Chair of the Health and Adult Social Care Scrutiny Committee, Nottingham City Council

Cc. Nottingham and Nottinghamshire CCG
Best wishes,

Safer, cleaner, ambitious
Nottingham
A city we're all proud of

NHS
Nottingham
University Hospitals
NHS Trust

Via email

Tuesday 18 January 2022

Dear Councillor Power,

Thank you for your letter of the 8th December, which was passed on to me as Head of Service for Neurology at Nottingham University Hospitals. Please accept my apologies that my response to your letter has been delayed.

Our Neurology service serves not only the people of Nottingham and Nottinghamshire, but also those in Mansfield, Leicester, Derbyshire and Lincolnshire accepting primary care referrals from these areas.

Neurology is predominantly an outpatient specialty, and our neurologists provide long term care for patients with neurological conditions which are frequently chronic, incurable and in many cases very debilitating. Fortunately, an increasing number of these conditions are now treatable. The use of modern therapies, many of which have a profound effect upon the nervous system requires specialist knowledge and regular outpatient appointments to ensure their safe and effective delivery and monitoring. This can only be provided by Neurologists, often working in and supervising multi-disciplinary teams. At NUH, we have large cohorts of patients with conditions including Parkinson's disease, Multiple Sclerosis, Epilepsy, Myaesthenia Gravis and Motor Neurone Disease, as well as smaller numbers of patients with chronic nerve or muscular disorders which need regular monitoring. The demands that the care of patients with long term disorders places upon a Neurology department are formidable.

Our service had challenges even before the pandemic with patients frequently waiting more than 18 weeks to receive an outpatient appointment, which often meant a delay in diagnosis for some diseases, such as Parkinson or Motor Neurone Disease. With our current capacity we are able to see patients with Parkinson's disease at a minimum of 7 month intervals, and for epilepsy and multiple sclerosis the figure is closer to 12 months. This is not the service we want to be able to provide for our patients.

New referrals would historically come to the general Neurology clinic through a system called "Choose and Book", which effectively let GPs book patients directly into slots in general Neurology clinics. We are unable to predict the types of new outpatient referrals we might expect to receive, but our Neurology department receives over 150 such referrals a week. With our current complement of Neurology consultants, each of whom will deliver, on average, two general Neurology outpatient clinics per week, we are able to offer in the region of 60-70 appointments per week. As you can see the capacity doesn't quite meet the needs hence the historical (over 18 week) waiting times for a Neurology Outpatient appointment.

In 2019 the National Institute of Health and Care Excellence (NICE) produced some helpful guidance for primary care physicians about when they should, and when they should not, refer patients with "neurological symptoms" (NG127[1]). For example referrals for symptoms such as tremor, speech difficulties or focal muscle wasting would have a high chance of being correlated with an underlying neurological diagnosis, other symptoms, such as headache, fatigue and subjective sensory disturbance (tingling fingers, numb face etc.) have a very low chance of being associated with an underlying neurological disease. Similarly, whilst, historically, conditions like chronic headache, chronic neuralgic pain (conditions which are not caused by structural disease of the nervous system) and e.g. restless legs symptoms might have populated Neurology outpatient clinics, there are now very clear pathways for the treatment of such symptoms, and these can, and indeed should, be instituted in primary care in line with the NICE guidance.

Whilst it is certainly true that all patients are deserving of having their case evaluated, with a proper history and examination, there are some symptoms for which further investigation is not necessary, and others where there are very clear, pre-referral management steps that can and should be undertaken in primary care (simple blood tests, lifestyle measures, initial therapy where this is supported by NICE guidance, monitoring and reassurance).

To take again the example of chronic headaches (that is daily or near-daily headache), the commonest cause is due to the overuse of analgesics. Using the NHS rightcare guidance for headache/migraine[2] in primary care means that we save that 30 minute appointment with a Neurologist for a patient that needs our expertise.

The NHS rightcare guidance for headache/migraine[2] is just one example of a resource which empowers GPs to manage chronic symptoms in primary care, and the advice that we are feeding back to GPs invariably draws upon and makes reference to this and similar guidelines and treatment algorithms. The aim of these guidelines is not to obstruct the path to a Neurologist, but it is to recognise that when Neurologists see patients with such complaints they follow almost to the letter the guidance enshrined in such documents. Thus the "added value" of a Neurologist's input in many cases is negligible. To make our small department run efficiently and well, our goal has therefore been to maximise the "added value" that Neurologists can provide.

At NUH, we have adjusted how we process referrals to the department. Referrals are now triaged by a team of five Consultant Neurologists in rotation. Each referral is read in detail, and any previous correspondence and investigations related to the patient's case reviewed. The Consultant will then triage the referral to either a general Neurology clinic (video or face-to-face depending upon the nature of the presentation), a specialist clinic (for example, the movement disorders clinic in a patient suspected of having Parkinson's disease) or, if they feel that, there are simple management steps that can be undertaken first in primary care, or the referral is otherwise unsuitable for the Neurology outpatient clinic they will respond to the GP with a bespoke letter explaining the reasons, and outlining their recommendations. I would stress that we are not deviating from the guidance laid out by NICE in NG127, and the main difference is that we are now applying these guidelines correctly, when historically we may not have. We do not currently copy these letters to patients, but this is something that we can review in light of the issues that you raise.

We have not made any changes in our service lightly, but have made these changes recognising that we must focus our collective expertise where it is really needed. We have been in contact with senior colleagues in General Practice that have been very supportive of our approach. Dr. Matt Jelpke is a senior GP at the St. George's Medical Centre in West Bridgford, and editor of the clinical design authority of the Nottinghamshire CCGs, and we have been in close liaison with him to ensure we are providing a service geared to the needs of primary care. We continue to work with Primary Care further to develop our network of advice and guidance, and hope in the future to integrate teaching about the pre-hospital management of common "neurological" presentations.

I hope that this, and the data in the charts at the end of this letter, provides you with information about our Neurology service to address the concerns you have raised. To re-iterate, we are not doing less work, and we are not seeing fewer patients. We are, as a department re-aligning what we do to prioritise time for patients with a higher probability of an underlying neurological disease. These patients will be seen, diagnosed and treated far more promptly than they would have otherwise been. Similarly, making these changes has allowed us to continue to see for follow-up our large cohorts of patients with debilitating long term neurological conditions, many of whom are exceedingly vulnerable, on a regular basis.

I will raise your enquiry and concerns with my colleagues and share this response. I will raise the possibility of copying patients in to the advice and guidance letters sent to GPs when an appointment is not offered.

I and my team would be happy to look into any specific complaints that have been raised with you if those individuals consent to your doing so.

Yours sincerely,

**Dr. Jonathan Evans MBBchir MA MRCP PhD**
Consultant Neurologist and Head of Service for Neurology, NUH

**References**

[1]Suspected neurological conditions: recognition and referral
NICE guideline [NG127] Published: 01 May 2019 last updated: 04 July 2019
https://www.nice.org.uk/guidance/ng127. Last accessed 30/12/2021
[2]https://www.england.nhs.uk/rightcare/products/pathways/headache-and-migraine-toolkit/ Last accessed 21/12/2021.

**Additional information:**

Figure 1: Monthly referrals for Neurology OPA from 2017 onwards. Note the reduction in early 2020 coincident with the peak of the Covid-19 pandemic response, and subsequent increase.

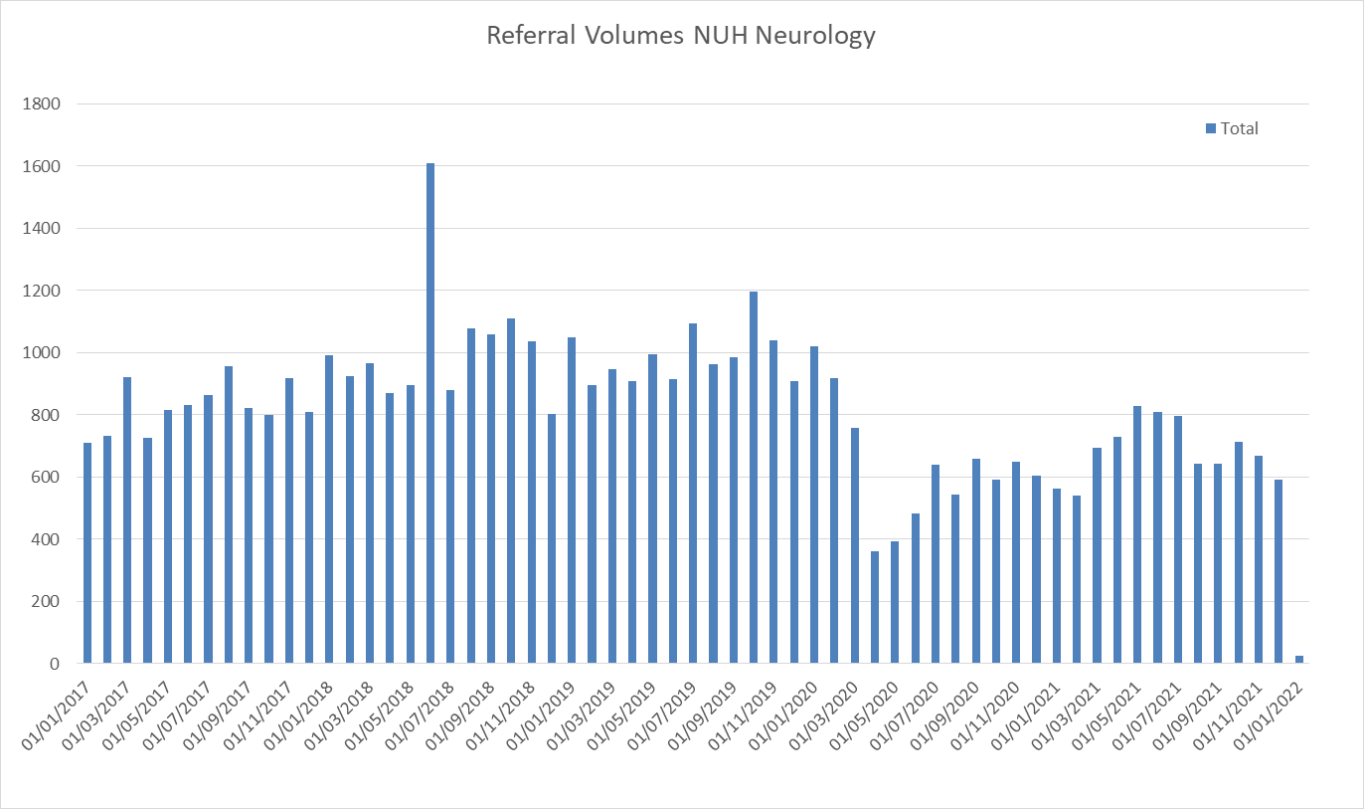



Figure 2 Monthly OPA capacity for NUH Neurology. Note reduction in capacity from April 2020 onwards due to social distancing requirements in clinic spaces, and also reduction in Consultant staffing levels.

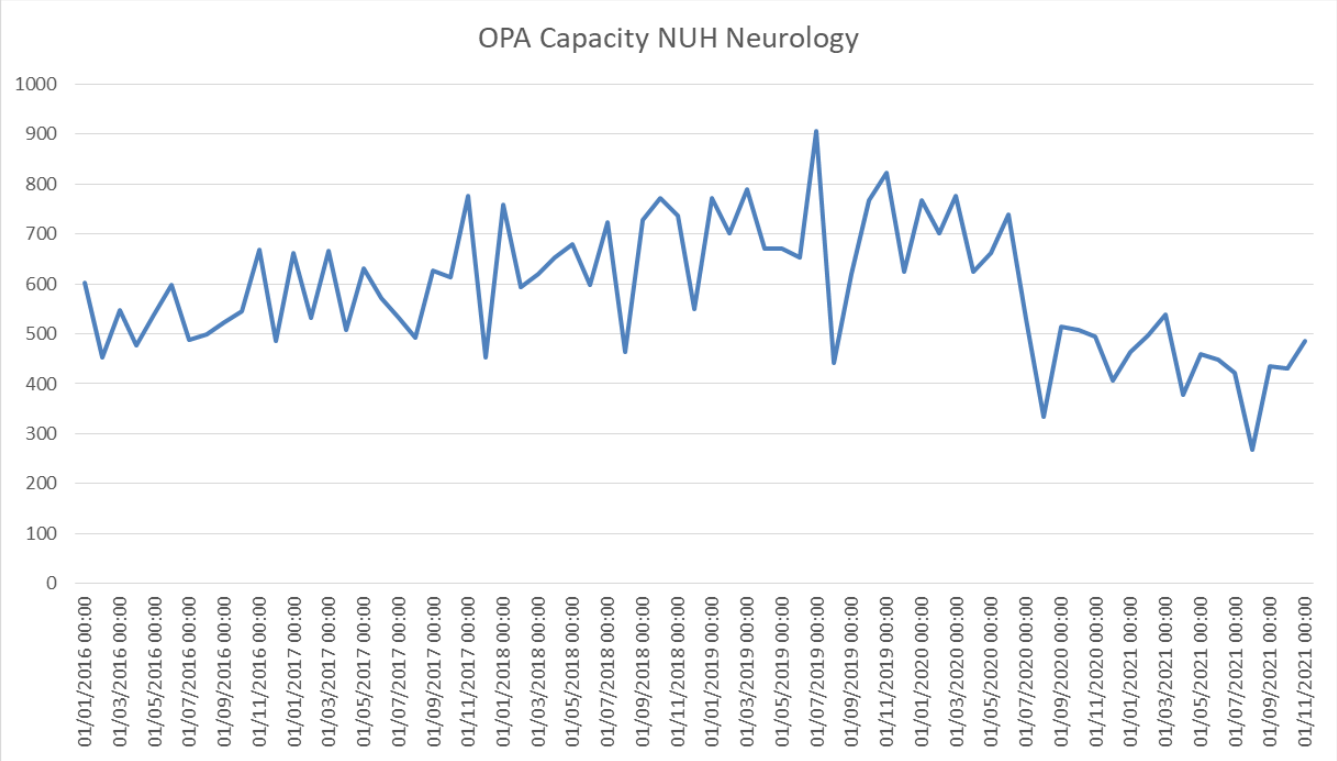


Figure 3: Wait times for Neurology OPA. Regrettably, the initial improvement due to enhanced advice/guidance and improved vetting has been offset in recent months by the loss of Consultants from the workforce. We anticipate that this will be remedied in a further round of recruitment, and our target is to have waits of no longer than 10 weeks for a Neurology OPC.

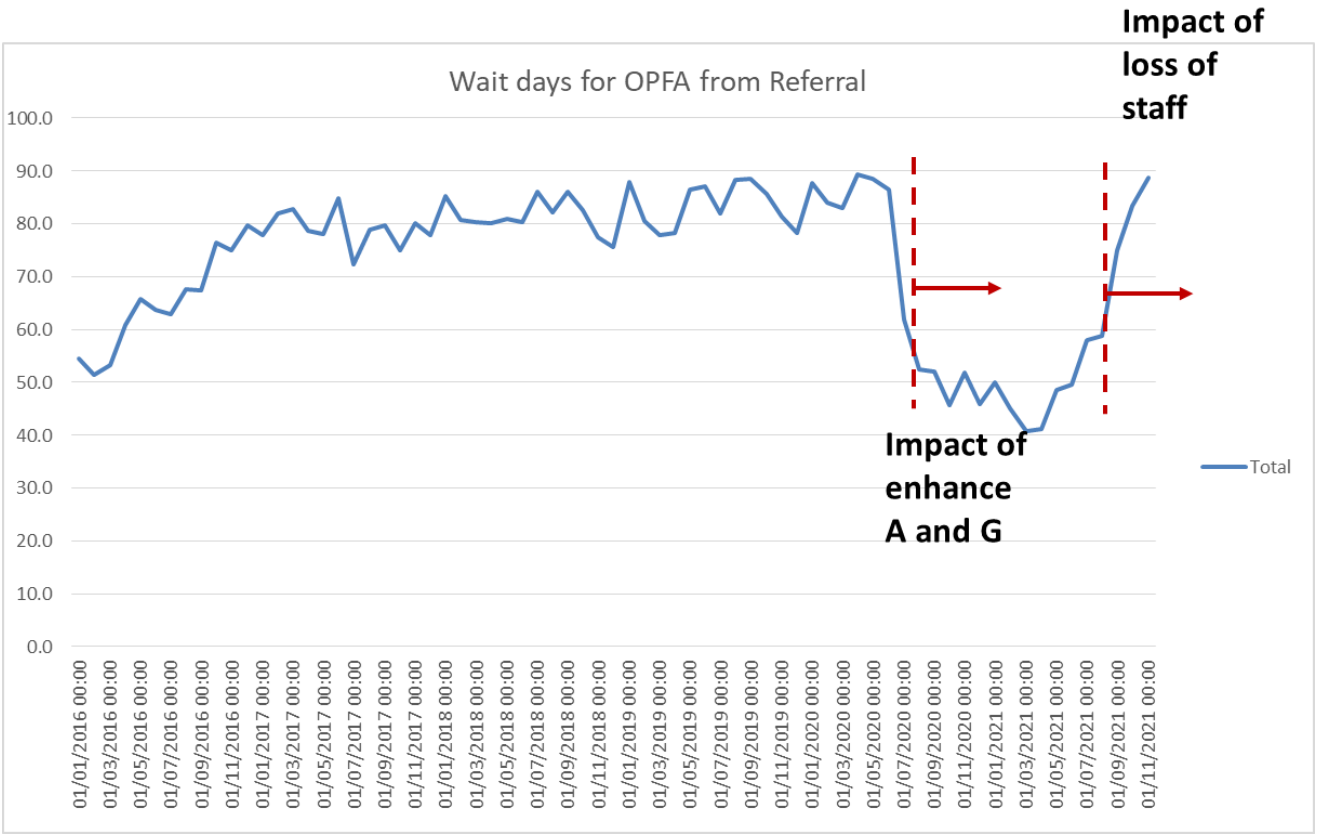
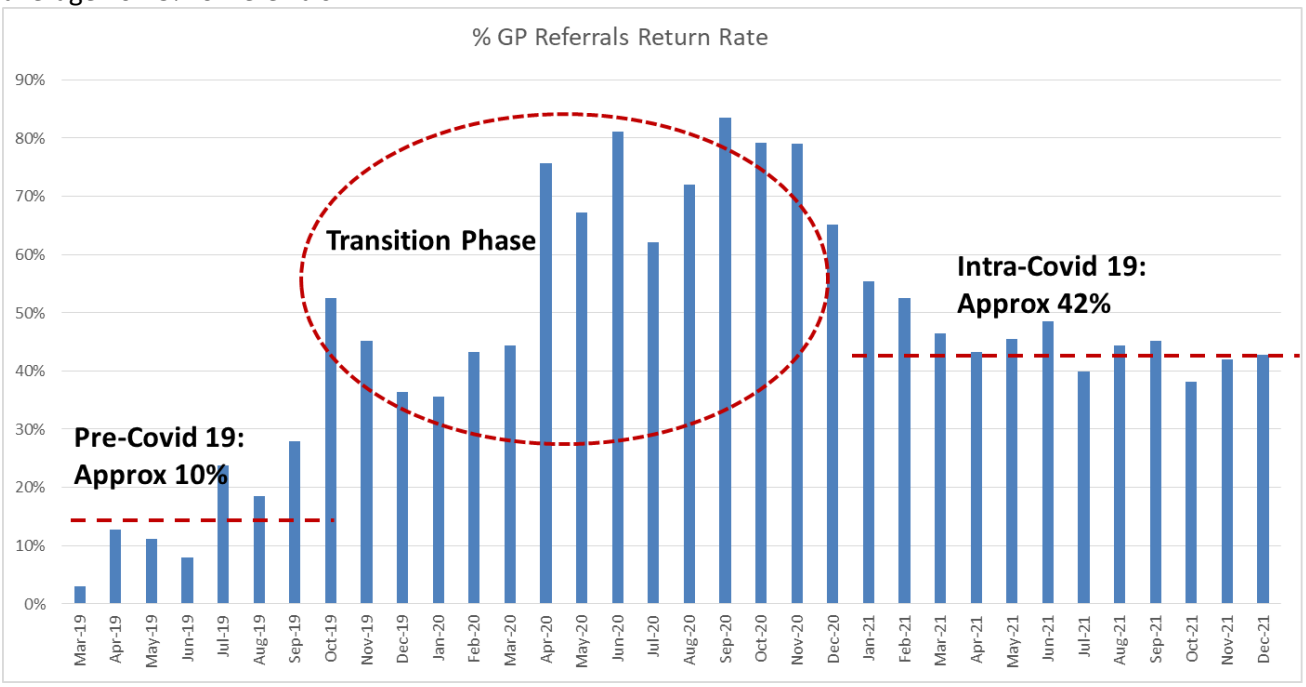



Figure 4: Return of Referral rates. Now that our system of vetting has been established we are returning on average 40-45% of referrals.



# Nottingham University Hospitals NHS Trust Neurology Service, an update

## Background

Our Neurology service comprises of 15 consultants and serves not only the people of Nottingham and Nottinghamshire, but also those in, Leicestershire, Derbyshire and Lincolnshire accepting primary care referrals from these areas.

## Managing referrals

In 2019 the National Institute of Health and Care Excellence (NICE) produced some helpful guidance for primary care physicians about when they should, and when they should not, refer patients with "neurological symptoms" (NG127[1]). For example, referrals for symptoms such as tremor, speech difficulties or focal muscle wasting would have a high chance of being correlated with an underlying neurological diagnosis, other symptoms, such as headache, fatigue and subjective sensory disturbance (tingling fingers, numb face etc.) have a very low chance of being associated with an underlying neurological disease. Similarly, whilst historically, conditions like chronic headache, chronic neuralgic pain (conditions which are not caused by structural disease of the nervous system) and restless legs symptoms might have populated Neurology outpatient clinics, there are now very clear pathways for the treatment of such symptoms, and these can, and indeed should, be instituted in primary care in line with the NICE guidance.

Before implementing the national guidance we saw emerging referrals themes such as

- conditions for which there are clear pre-hospital/ pre-referral steps that had not been followed (example – chronic headache and NHS rightcare guidance);
- patients referred with trivial symptoms not indicative of an underlying neurological disease (e.g. a tingling toe or a numb finger);
- patients re-referred for the same symptoms having been extensively investigated by the department in the past.
- In addition, our Did Not Attend (DNA) rate for follow up appointments was as high as 50% in some clinics

It was quite clear that Neurology outpatient appointments were not being used as productively as they could be. Furthermore, some of the conditions for which NICE recommends referral can be dealt with safety with an advice model, as demonstrated by several authors [Bennett et al, Anderson et al – see attached papers].

For every patient booked in to an appointment that they do not need, and for every DNA, there is a delay in assessment, diagnosis and treatment for a patient with an underlying neurological disorder. This means delay in the diagnosis of Parkinson's disease, Motor Neuron Disease, Multiple Sclerosis and Epilepsy, to name but a few, with the associated worse disease outcomes, distress and worry, as well as the impact upon the quality of life of our patients and their families.

Many patients in our community are suffering because of undiagnosed neurological disorders like Parkinson's disease and Motor Neuron Disease. We make these patients our priority, and it is important that we understand if patients have symptoms of these conditions, we will see them promptly in the neurology clinic.

It is also worth noting our system for returning referrals.

- There are very few referrals that are 'rejected' outright.
- We do return or redirect referrals where we cannot add value - for example, patients that have either been fully and extensively investigated but for whom ongoing health anxiety or a difference in health beliefs is driving the desire for further tests, or patients where neurology is not the correct speciality and the question being asked is outside our expertise.
- We recognise from our local audit that on occasion we should have made an onward referral to other services within NUH and we are already working to improve that process – we cannot do that when the most appropriate service is another provider.

- Other referrals were 'returned' asking for more information from the GP in order to allow us to triage referrals appropriately.
- In other cases, we responded with advice on how to manage the condition in primary care, with pointers for when to refer back, in keeping with NHSE and GIRFT guidance. These patients and GPs receive almost immediate advice on how best to manage their condition, rather than waiting to receive identical information many months later after a clinic appointment.
- Furthermore, having all the information needed, including previous letters from other centres is essential to having an effective consultation when one sees the consultant.

The appropriate use of triage not only allows us to identify and prioritise those patients who need to be seen, it also allows us to see them in the most appropriate setting and by a doctor most able to make a diagnosis and treat their condition. For example, we get many referrals for patients with tremor disorders without obvious features of Parkinson's disease. These patients are now preferentially triaged to a bespoke video movement disorders clinic, where a movement disorder specialist, with a minimal waiting time, will take advantage of modern communication technology, and see them. Using remote/ telephone clinics for follow up has absolutely transformed our outpatient DNA rates, which are now typically running at less than 10%. Patient's also benefit from being seeing directly in speciality clinics rather than moving from general to specialist clinic with the incurred delay in care.

As well as running outpatient clinics, we also manage urgent and emergency patients that present via the Emergency Department and have developed a Hyperacute Neurology Unit (HANU) that runs during the week as a same day assessment service for patients presenting to acute medical areas. Six to ten patients a day are seen on the HANU, and these are patients that would otherwise have been admitted to alternative medical areas, increasing bed pressures. A conservative estimate would be that the HANU prevents 20-25 admissions per week, and shortens length of stay by two or three days for each patient who is seen.

Creating HANU and triaging our referrals both help us create a more robust service, allowing us to see and treat the most appropriate patients.

### Impact of Covid

The effect of the various waves of COVID can be seen in the data on the number of returned referrals at times of COVID peaks where we were redeployed, larger numbers of referrals were returned. See chart at Appendix A.

We began the vetting project in the early months of the COVID pandemic. The pandemic forced us to review what our neurologists were doing in clinic and the value of this when suddenly the demands on our time had dramatically altered.

There were pressing reasons to implement a change; our neurologists were being removed from outpatient clinics to cover COVID wards and stroke medicine, and, in line with national guidance, we were instructed to only see 'face to face' patients where there was absolute necessity. With a smaller number of clinics, and an even smaller number of face to face slots, introducing 'vetting' of referrals to make sure that the right patients were seen and in the right setting was crucial.

The alternative (a model run by most NUH departments, and most neurology departments) was to simply run up a vast waiting list and a legacy backlog of patients, which would harm all and this, is a legacy that has yet to be managed.

However, the vetting also grew from frustrations that over the last decade that the expectations of the neurology general clinic had dramatically altered. Changes in society to some extent in general practice, but certainly with an increase in health anxiety and expectations of the health system meant that large numbers of patients were coming to general neurology clinic in a secondary care setting had little or no medical benefit from being seen.

Even pre-pandemic this change had been noted, and the safety and efficacy of a vetting system such as the one we adopted had been studies [Bennet et al, Journal of the Royal College of Physicians of Edinburgh, 2019 and a further paper from Newcastle also highlights that this approach is far from unique to NUH [Anderson et al. Practical Neurology 2022]

## Audits and safety netting

We have audited our vetting process and this has not identified any safety issues. An alternative approach of “seeing everyone/ seeing all referrals”, is considerably less safe: patients without an underlying neurological diagnosis are preferentially appointed ahead of patients with Parkinson’s disease or epilepsy or motor neuron disease who then experience delay in diagnosis and delay in treatment.

Safety netting is built into the system. Safety-netting is information given to a patient or their carer during a primary care consultation, about actions to take if their condition fails to improve, changes or if they have further concerns about their health in the future

Where a GP writes back and reasonably requests a review after advice, or due to anxiety, we accept referrals that have been re-referred to us (unless it was very clear that the referral was not appropriate for neurology, or the request is for a fourth or fifth opinion with clear futility).

We have started, and we are analysing, an audit of the vetting process. Early results are supportive of the system being safe, and further analysis will allow us to improve the system going forward. In the few cases where patients have accessed emergency care before a returned referral (where advice or more information was sought), none would have been seen prior to admission had the referral been automatically accepted, and there was no avoidable harm to these patients. There are no DATIX incidents of harm, and no harm evident through the eHealth system.

Some GPs have written to commend our vetting approach and how helpful they find the detailed information they receive back. In particular, GPs have expressed the positive impact of detailed advice on how to manage common, but unconcerning neurological symptoms, grateful for the ‘straight to test’ service we offer where appropriate, and happy to have some support in pushing back anxious patients insistent on a referral where the GP feels is of little merit. ICS colleagues have confirmed ahead of this meeting that they find the service very responsive and helpful.

## In summary

A vetting process has been introduced into our neurology service to ensure that patients who will benefit most from the service are seen and receive treatment in a timely way. There is no evidence that this approach has resulted in harm to any individual patient and there have been many positive comments from patients and GPs. The introduction of vetting has also allowed the introduction of an acute neurology service which is delivering high standards of care to patients presenting in an urgent manner.

**Dr Keith Girling**, Medical Director
**Dr Jonathan Evans**, Neurologist and Head of Service for Neurology
Nottingham University Hospitals NHS Trust
July 2022

**Appendix A**

| MONTH | TOTAL REFERRALS RAS + Choose & Book | ACCEPTED | RETURN TO REFERRER WITH A+G | Return rate |
|---|---|---|---|---|
| **Apr-19** | 582 | 567 | 15 | 2.6% |
| **May-19** | 631 | 620 | 11 | 1.7% |
| **Jun-19** | 614 | 605 | 9 | 1.5% |
| **Jul-19** | 740 | 708 | 32 | 4.3% |
| **Aug-19** | 601 | 589 | 12 | 2.0% |
| **Sep-19** | 637 | 588 | 49 | 7.7% |
| **Oct-19** | 722 | 640 | 82 | 11.4% |
| **Nov-19** | 652 | 597 | 55 | 8.4% |
| **Dec-19** | 564 | 520 | 44 | 7.8% |
| **Jan-20** | 572 | 520 | 52 | 9.1% |
| **Feb-20** | 521 | 463 | 58 | 11.1% |
| **Mar-20** | 410 | 355 | 55 | 13.4% |
| **Apr-20** | 258 | 168 | 90 | 34.9% |
| **May-20** | 204 | 161 | 43 | 21.1% |
| **Jun-20** | 312 | 239 | 73 | 23.4% |
| **Jul-20** | 412 | 340 | 72 | 17.5% |
| **Aug-20** | 295 | 164 | 131 | 44.4% |
| **Sep-20** | 339 | 116 | 223 | 65.8% |
| **Oct-20** | 452 | 148 | 304 | 67.3% |
| **Nov-20** | 323 | 71 | 252 | 78.0% |
| **Dec-20** | 503 | 177 | 326 | 64.8% |
| **Jan-21** | 431 | 193 | 238 | 55.2% |
| **Feb-21** | 380 | 186 | 194 | 51.1% |
| **Mar-21** | 431 | 235 | 196 | 45.5% |
| **Apr-21** | 448 | 257 | 191 | 42.6% |
| **May-21** | 477 | 264 | 213 | 44.7% |
| **Jun-21** | 564 | 292 | 272 | 48.2% |
| **Jul-21** | 619 | 376 | 243 | 39.3% |
| **Aug-21** | 525 | 295 | 230 | 43.8% |
| **Sep-21** | 316 | 178 | 138 | 43.7% |
| **Oct-21** | 611 | 383 | 228 | 37.3% |
| **Nov-21** | 478 | 280 | 198 | 41.4% |
| **Dec-21** | 491 | 282 | 209 | 42.6% |
| **Jan-22** | 335 | 209 | 126 | 37.6% |
| **Feb-22** | 418 | 256 | 162 | 38.8% |
| **Mar-22** | 394 | 234 | 160 | 40.6% |
| **Apr-22** | 454 | 272 | 182 | 40.1% |
| **May-22** | 410 | 206 | 204 | 49.8% |

**Health and Adult Social Care Scrutiny Committee**
**14 July 2022**

# Integrated Care System Approach to Health Inequalities

**Report of the Head of Legal and Governance**

## 1 Purpose

1.1 To hear about the approach to improving health inequality being developed across the Integrated Care System.

## 2 Action required

2.1 The Committee is asked whether:

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

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

## 3 Background information

3.1 The Committee is aware that reducing health inequalities is a key focus for the recently adopted Nottingham City Joint Health and Wellbeing Strategy and new Nottingham and Nottinghamshire Integrated Care System (ICS). At a relatively early stage in its development, the Committee wanted to understand the approach that the ICS is developing to try and reduce health inequalities in the City.

3.2 The Director of Public Health and Associate Director of Strategic Programmes and EPRR have submitted information (attached) to inform this understanding, and will be attending the meeting to discuss this with the Committee.

## 4 List of attached information

4.1 'Progress in developing an ICS approach to health equity' report from the Director of Public Health and Associate Director of Strategic Programmes and EPRR

4.2 'Delivering on ICS Outcomes and Reducing Inequalities' report to the ICS Health Inequalities, Prevention and Wider Determinants Group on 9 June 2022

## 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
jane.garrard@nottinghamcity.gov.uk
0115 8764315

**Health and Adult Social Care Scrutiny Committee**

**Progress in Developing an ICS approach to health equity**

**Report of the Director of Public Health and Associate Director of Strategic Programmes & EPRR**

## 1 Purpose

1.1 To brief the Committee on progress and plans to embed an approach to improving health equity across the developing Integrated Care System (ICS)

## 2 Action required

2.1 To note the paper

## 3 Background information

3.1 ICSs aim to bring together the planning, commissioning and delivery of health care services across an area. Integrated Care Boards (ICBs) are a statutory body that replaces Clinical Commissioning Groups (CCGs) and came into force from 1 July 2022.

3.2 ICBs are guided by Integrated Care Partnerships (ICPs), which bring together wider system partners to set the strategic direction for the ICS. ICPs will prepare a strategy, based on JSNAs and joint health and wellbeing strategies (JHWSs) to guide the ICB.

3.3 An important focus of the new ICSs will be to reduce health inequalities. In preparation, the Nottingham and Nottinghamshire ICS has established a Health Inequalities and Prevention Board, chaired by the CEO of Nottingham Healthcare Trust with membership from across a wide range of stakeholders.

3.4 In June 2022, the Board recommended taking a health equity approach to reducing health inequalities. This will provide a strategic focus for the ICP and ICB, as well as informing practice in NHS providers and supported by the implementation of the JHWS.

## 4 List of attached information

4.1 Paper to ICS HIP Board 09/06/2022

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

5.1 N/A

## 6 Published documents referred to in compiling this report

6.1 N/A

## 7 Wards affected

7.1 All

## 8 Contact information

8.1 Lucy Hubber, Director of Public Health
lucy.hubber@nottinghamcity.gov.uk

| | | | |
|---|---|---|---|
| **Item Number:** | 4 | **Enclosure Number:** | Enc B |
| **Meeting:** | ICS Health Inequalities, Prevention and Wider Determinants Group | | |
| **Date of meeting:** | 9 June 2022 | | |
| **Report Title:** | Delivering on ICS Outcomes and Reducing Inequalities | | |
| **Sponsor:** | John Brewin, ICS Health Inequalities Lead, Chief Executive Notts Healthcare | | |
| **Report Author:** | Hazel Buchanan, ICS Programme Director; Lucy Hubber, Director of Public Health | | |
| **Enclosure / Appendices:** | ICS Partnership Board Presentation | | |

**Summary:**


At the last ICS Partnership Board, it was proposed and members agreed for Equity to be adopted as the core organising principle for the ICS. To support this, leadership commitments were also proposed and have been adapted in the presentation attached following discussions in the Board.

In order to demonstrate how equity can be applied across the system, the presentation also provides an overview of the types of actions that can be taken to deliver against the commitments through the different parts of the ICS. A corresponding action from the Board was for the ICS to move into action with plans in organisations as well as across the ICS and it is anticipated that the table and commitments will support this process. To support this it would also be beneficial to consider how equity as a core principle is applied across the different thematic workstreams i.e planned care, urgent care, mental health.

The Group are therefore asked to comment on the descriptors in relation to the commitments and to further develop the detail in the tables on pages 9 and 10 in relation to how the core principle of equity can be applied and delivered across the different thematic priorities of the ICS. This detail will then be used to further inform strategy, present to wider stakeholders and support action against the Health Inequalities plan.


| **Recommendations: Health Inequalities Group are asked to:** | |
|---|---|
| 1. | Provide comment on the characteristics/descriptors of the commitments |
| 2. | Comment and add further context to the tables on how the commitments can be delivered across the different parts of the ICS |
| 3. | Consider priorities for action in order to demonstrate the benefits and impact of equity as a core principles |

**Is the paper confidential?**

☐ Yes

☒ No

☐ Document is in draft form

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Integrated Care System
Nottingham & Nottinghamshire

# Nottingham and Nottinghamshire ICS Partnership Board

## Delivering on ICS Outcomes and Reducing Inequalities



ICS Health Inequalities Lead: John Brewin

Directors of Public Health: Lucy Hubber, Nottingham City Council; Jonathan Gribbin Nottinghamshire County Council

ICS NHS Clinical Lead and Programme Director: Chris Packham

ICS Programme Director: Hazel Buchanan

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Nottingham & Nottinghamshire

# Statutory, Strategic, Operational Objectives

**Statutory** – Duties to improve population outcomes and tackle inequalities is explicitly and implicitly noted in the 12 overarching duties of ICBs and therefore ICSs in the latest Health and Care Bill

**Strategic – Core purpose of an ICS**

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development

**Operational – Aims of the Nottingham & Notts ICS outcomes framework**

- Improving the health and wellbeing of our population
- Improving the overall quality of care and life our people and carers have and receive
- Improving the effective utilisation of our resources.

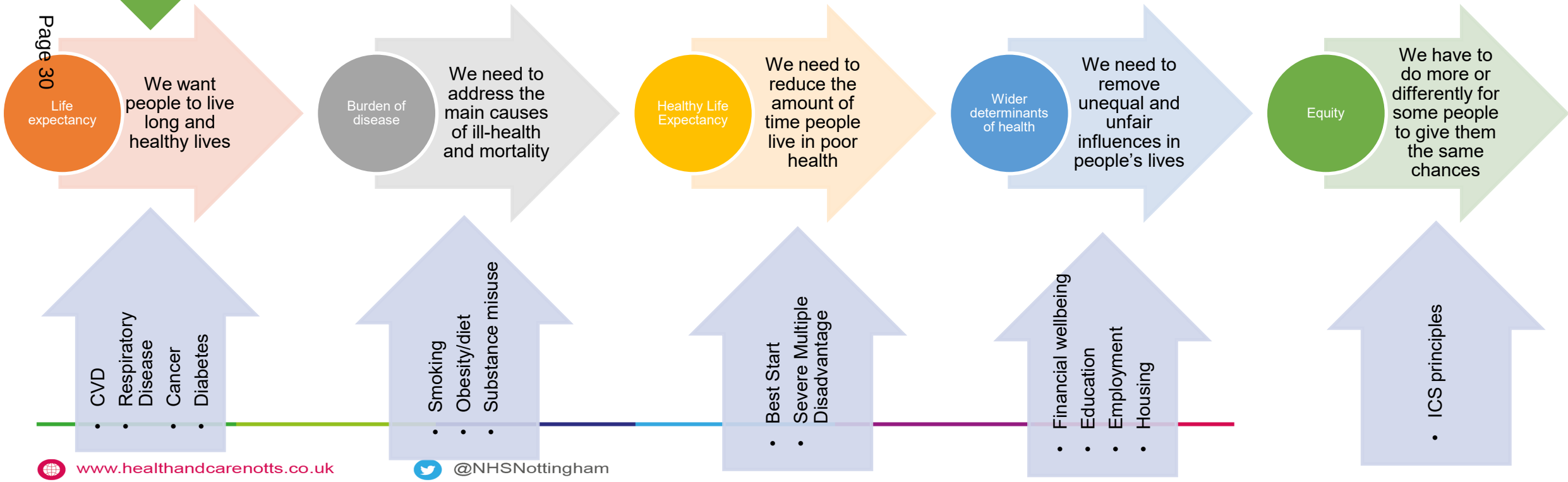
**Nottingham & Notts ICS Shared Vision** - Every citizen enjoying their best possible health and wellbeing

Integrated Care System
Nottingham & Nottinghamshire

# ICS Health Inequalities Strategy, Health and Wellbeing Strategies and Framework for Action

**Primary Outcome**
- ICS priorities
- JHWSs
- PHOF





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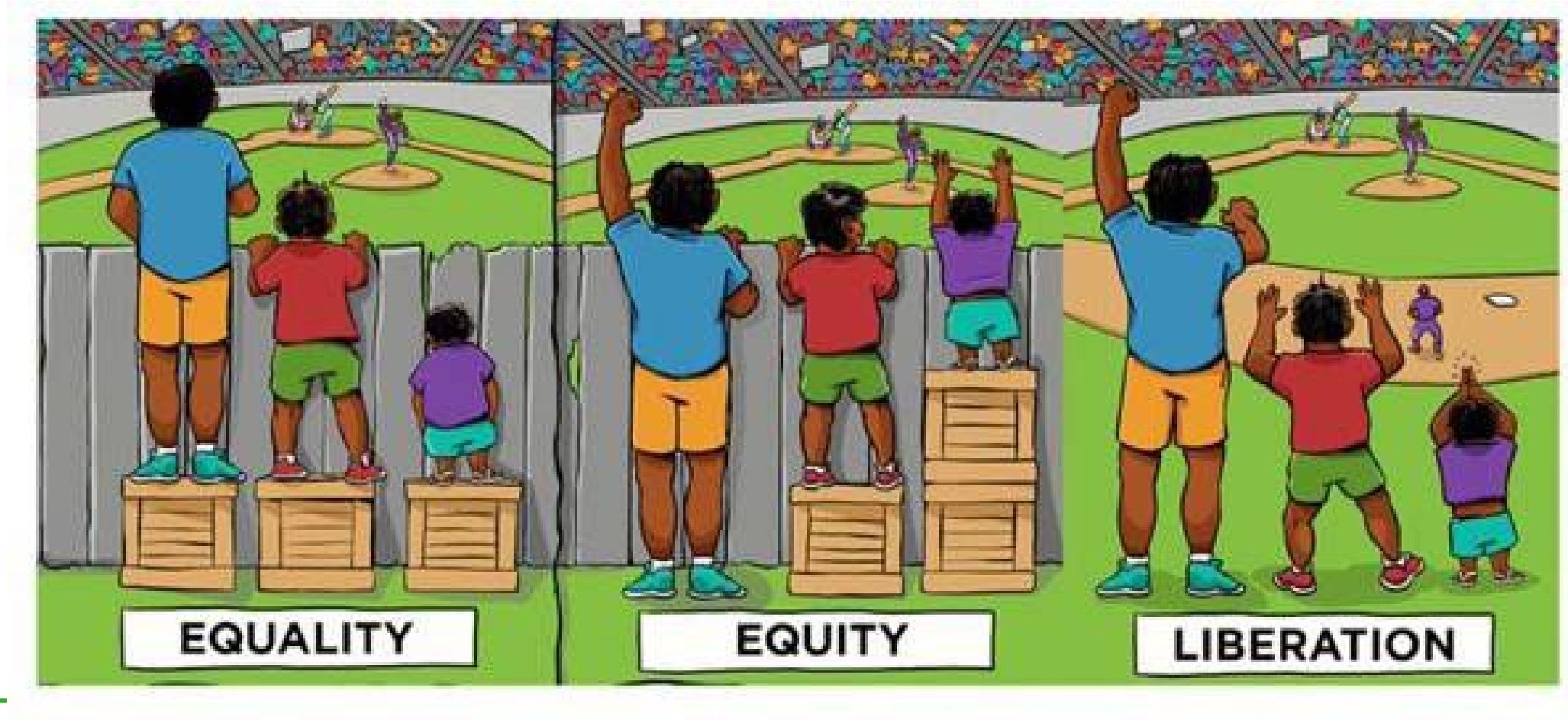
# What is Equity?



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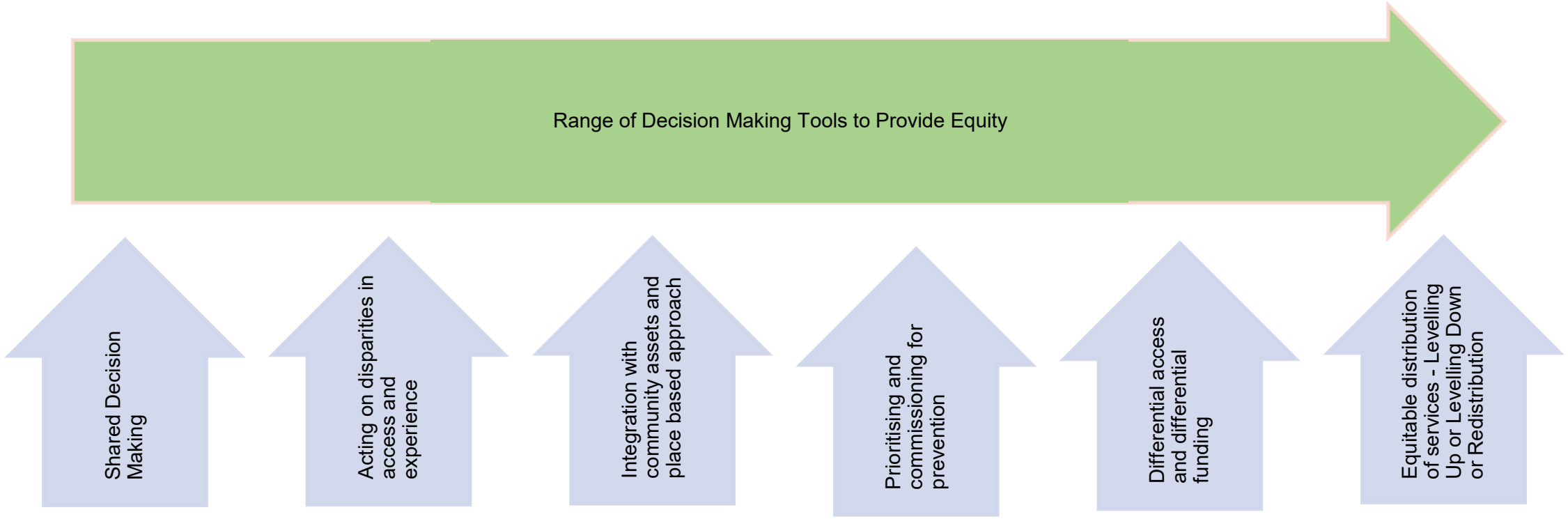
# Applying Equity in Decision Making



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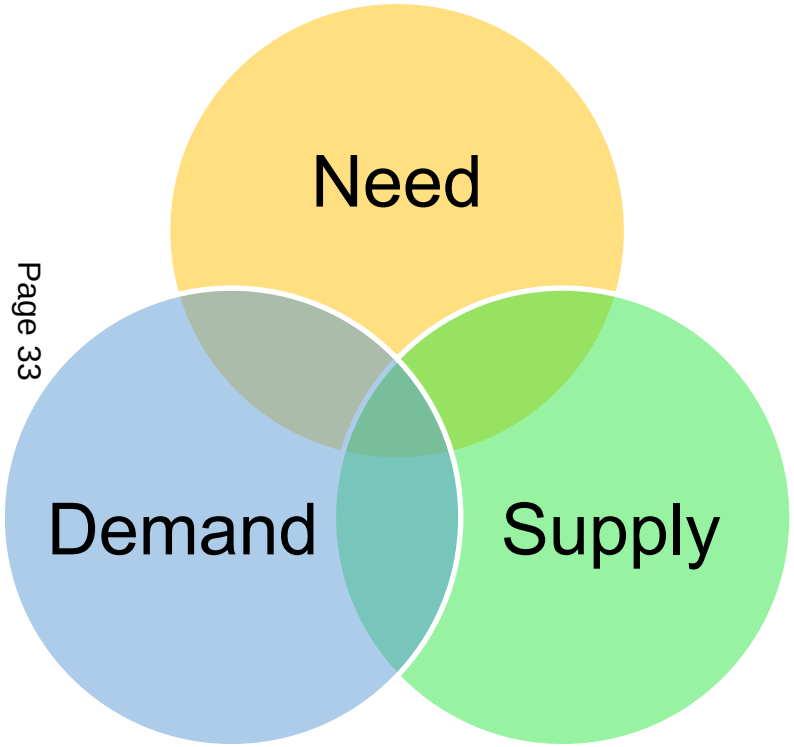


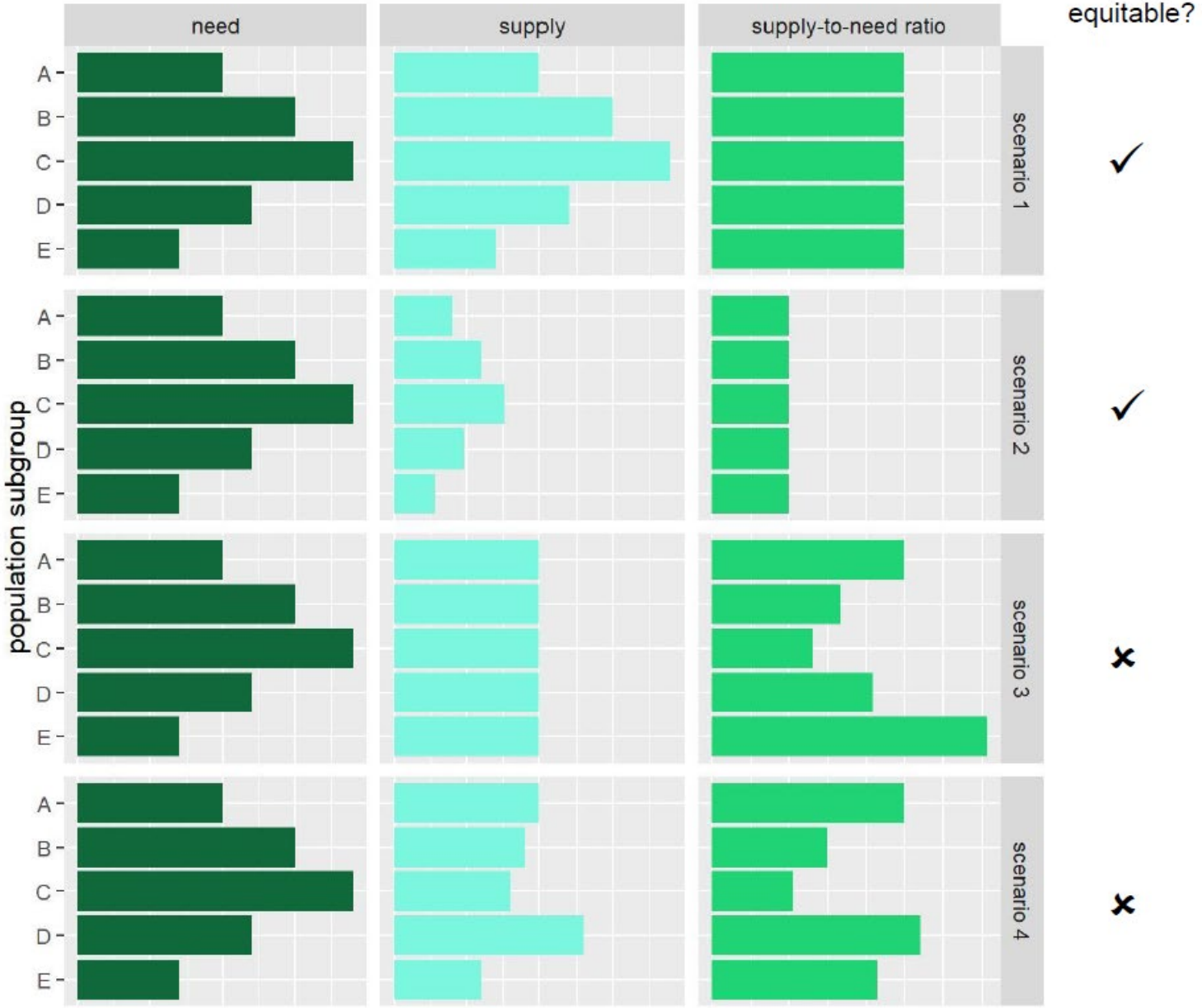

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Nottingham & Nottinghamshire

# Questions to the Board

1. Is the ICS Partnership Board agreed on equity as a means to deliver outcomes and reduce inequalities?
2. Do you recognise how the system can impact on equity?
3. Do you recognise equity as a concept that can be applied within your organisation to deliver outcomes?

Integrated Care System
Nottingham & Nottinghamshire

# ICS Leadership Commitments

## The starting point is always understanding and describing the local population and inequalities in our communities

- Using data and lived experience to create an intelligence-led approach to understanding inequalities
- Describing and understanding our populations for what they are as the starting point – geography, protected characs, inclusion health, socio-economic factors
- Connected communities and co-production

## Targeting solutions and resources based on intelligence

- Using population health tools to design and deliver services based on different needs
- Building intelligence into service/programme planning and delivery – implementing intelligence systems that surface the 'gaps'
- Opportunities and constraints in equitable distributions of services
- Taking an approach that embraces opportunities and constraints in differential investment and differential access
- Being transparent will be central in relation to the management of and shifts in resources

## ICS has a role in addressing wider determinants

- Integrating addressing wider determinants into our service/programme planning and delivery
- Using our role as anchor institutions to impact on local communities, informed by the Local Authorities
- Alignment with the Health And Wellbeing Strategies and delivery of priorities through Place

## Delivering accessible, quality healthcare services

- Informed changes in relation to addressing disparities across access, experience and outcomes and providing equity
- What should we expect and what is happening
- Ensure a strong core service to support all communities whilst recognising the differences and strengths
- Building and maintaining trust and connected communities through place and neighbourhoods is central
- Engendering a key focus and commitment to enabling and supporting our local communities – they don't have issues, they have solutions

## Changing the conversation

- In Boards, meetings, teams and with patients – focusing on building trust and breaking down barriers
- Recognising and valuing the characteristics of local communities across Nottingham & Nottinghamshire
- Jointly planning and commissioning services based on population need
- Providing a mandate to be responsible collectively
- Taking a learning approach – approaching as a journey where failure is a valuable experience for learning

| | Understanding Local Population | Targeted Solutions & Resources | Wider Determinants | Quality Healthcare | Changing the Conversation |
|---|---|---|---|---|---|
| **ICS & ICB**<br><br>Glossary<br>Population Health Management (PHM)<br>Joint Strategic Needs Assessment (JSNA)<br>Systems Analytics Intelligence Unit (SAIU) | Applying PHM at scale through a shared overview of the population, including the JSNA and Core20+ SAIU and system working (alignment with Health and Wellbeing Boards<br>Shared approach to Health Equity Assessments and Equality & Inequality Impact Assessments (including with local communities) | Prioritise smoking, alcohol, weight management<br><br>Process to effectively assess and interpret constraints and opportunities for decision making based on equity<br><br>Applying Core20+5 approach and prioritising action | Anchor Institution priorities aligned to Health and Wellbeing Strategy priorities and system policies i.e. financial wellbeing | Commissioning framework that includes disparities across access, experience, outcomes<br><br>Co-production strategy | ICS and organisational board reporting to include health inequalities relevant to commitments and priorities<br><br>Creating a learning environment including with local citizens– failure as a valuable exercise and sharing the learning |
| **Place Based Partnerships - Place** | Delivering Health and Wellbeing Strategy Priorities<br>Connecting with communities programmes | Health and Wellbeing Strategy priorities Core20+ and targeted partnership approach to design services around need | Health and Wellbeing Strategy Priorities – work programmes in partnership with Public Health | Connected Community Programmes and links with co-production<br>Identifying and informing on Plus in Core20+ - marginalised groups | Partnership working with and building on community assets relevant to population need<br>Building community links |
| **Primary Care Networks (PCN) – Neighbourhood** | Applying impactful interventions as per PHM approach – Targeted action based on local intelligence | PCN Health Inequality Enhanced Service – supporting PCNs as part of wider structure | Social Prescribing<br>Establishing PCN roles and services around local community need | Targeted support based on population need | Shared Decision Making<br>Self-management and LINK workers |

| | Understanding Local Population | Targeted Solutions & Resources | Wider Determinants | Quality Healthcare | Changing the Conversation |
|---|---|---|---|---|---|
| **Provider Collaborative** | Identifying priorities based on PHM and JSNA where can impact on equity across access, experience and outcomes as a collaborative | Effectively assessing and interpreting constraints and opportunities for decision making based on equity | Identifying priorities and opportunities as a collaborative that can be supported by the ICS as an anchor institution and Health and Wellbeing Strategies | Applying co-production Opportunities as a collaborative to impact on disparities across access, experience and outcomes<br>Applying Core20+ approach as a collaborative | Reporting on health inequalities<br>Creating a learning environment across the collaborative in relation to population need<br>Understanding the gap |
| **Organisation** | Applying impactful interventions as per PHM approach - understanding the gap<br><br>Applying system wide EQIA and health inequality assessments | Prioritise smoking, alcohol, weight management<br>Identify points in pathway and prioritise resources where can influence i.e. peri-op, staff health<br>Effectively assessing and interpreting constraints and opportunities for decision making based on equity | Role as an anchor instutions - Procurement Estates<br>Staff (including as provider collaborative | Measure disparities across access, experience, outcomes as a way of working and acting on equity.<br>Personalisation and shared decision making | Reporting on health inequalities as part of standard performance reporting<br>Understanding the “gap” and creating a learning environment on population need |

Integrated Care System
Nottingham & Nottinghamshire

# Questions to the Board

1. Do the leadership commitments serve to represent the approach and galavanise the system ?

**Health and Adult Social Care Scrutiny Committee**
**14 July 2022**

# Proposed change to colorectal and hepatobiliary services

**Report of the Head of Legal and Governance**

## 1 Purpose

1.1 To consider a proposal to transfer the colorectal and hepatobiliary services provided by Nottingham University Hospitals NHS Trust from the Queens Medical Centre to the City Campus.

## 2 Action required

2.1 The Committee is asked to consider the proposed change to provision of colorectal and hepatobiliary services provided by Nottingham University Hospitals NHS Trust and the proposed approach to patient engagement in relation to the change and decide if:

a) it is satisfied with the proposed approach to patient engagement and/or it wishes to make comment or recommendation to the ICB about the proposed approach; and

b) it is satisfied with the proposed transfer of the service to a different site; and/or

i. further information and/or scrutiny is required and if so, the focus and timescales for this; or

ii. it wishes to make comment or recommendation to the ICB about the proposals.

## 3 Background information

3.1 Nottingham and Nottinghamshire Integrated Care Board (ICB) has advised the Committee of proposals for the transfer of colorectal and hepatobiliary services provided by Nottingham University Hospitals (NUH) from the Queens Medical Centre to the City Campus. The ICB has said that this change will support work to clear the backlog of patients waiting for elective care by enabling capacity to be ring-fenced.

3.2 The ICB has submitted a written paper to the Committee outlining details of the proposed change, the context and case for change and proposals for engagement. The ICB was asked to include information about engagement with staff and trade unions and the impact on those with Protected Characteristics. This paper is attached. In agreement with the Chair, this is a written paper only for the Committee's consideration and no one from the ICB will be attending the meeting. Any arising questions, comments or recommendations will be directed to the ICB following the meeting for response.

## 4 List of attached information

4.1 ‘Proposed transfer of elective services at Nottingham University Hospitals’ briefing from Nottingham and Nottinghamshire Integrated Care Board

## 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
jane.garrard@nottinghamcity.gov.uk
0115 8764315

NHS
Nottingham and Nottinghamshire
Integrated Care Board

**Proposed Transfer of Elective Services at Nottingham University Hospitals**

**Briefing for Nottingham Health and Adult Social Care Scrutiny Committee**

**July 2022**

## 1 Introduction

This purpose of this document is to inform the Health and Adult Social Care Scrutiny Committee of an opportunity for Nottingham University Hospitals NHS Trust (NUH) to transfer Colorectal and Hepatobiliary (HPB) services to the City Campus from the Queens Medical Centre. This will enable this capacity to be 'ringfenced' to reduce waiting times for patients and so will support the work to clear the backlog of patients waiting for elective (planned) care.

Currently elective bed and theatre capacity is too often impacted by emergency demand meaning patients have their appointment cancelled. To improve this NUH colleagues have secured access to £15m of NHS capital funds to increase the number of Elective Theatres, ward beds and Enhanced Peri-operative Care Unit on the City hospital site in 2022.

To take full advantage of this opportunity NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) is seeking support from the HSC to proceed with the plans, secure the investment and mobilise the services in time for winter 2022; this would require the Committee to support the NHS to enact the plan with timely and targeted public engagement rather than full public consultation. It is felt that the need to act urgently to secure this additional external capital funding and therefore avoid further long waits for citizens and the associated harm this would entail outweighs the benefits from consulting on this proposal.

## 2 National context

Waiting lists nationally have grown following the Covid-19 pandemic. A challenging winter with increased urgent care demand and Infection Control Procedures requiring segregation of Covid positive patients has meant that elective activity has not yet increased to the levels required to treat current backlogs and manage current demand. Systems are required to develop 'Elective Recovery' plans that deliver activity at 110% of pre-covid levels in 2022/23 increasing to 130% by 2024/25. National planning guidance has a number of key priorities for transformation to inform these plans including the requirement to fully utilise the recommendations of the Getting It Right First Time (GIRFT) programme to increase elective capacity making best use of resources. This includes the creation of ring-fenced elective capacity in 'cold sites' otherwise known as 'Elective Hubs' that separate urgent and elective pathways and patients.

A review by the national GIRFT team has recently been undertaken and our clinical leads have committed to developing plans to:

- Ring fence elective capacity on a site that is away from the main A&E;
- Maximise productivity through better use of theatre and ward areas;
- Focus on six High Volume / Low Complexity procedures in line with national recommendations. This includes general surgery and therefore colorectal and HPB.

## 3 The local case for change

Seasonal pressures this winter and the impact of Omicron have meant further delays in routine elective care as clinically urgent and cancer patients have been prioritised for treatment. The impact of the Omicron variant locally has resulted in continuing emergency demand, lack of interim bed capacity to support discharge and staff absence to a level that is outside of seasonal norms. The Nottingham and Nottinghamshire Integrated Care System (ICS) has developed an 'Elective Recovery Plan' to reduce waiting times and to offer patients personalised care with shared decision making at the centre. In addition, the system has been successful in attracting national capital funding of £35m to be invested on the City Campus at NUH as an 'elective hub' in 2023. This is agreed in principle, pending further approval from NHS England and Improvement (NHSEI) and an outline business case in order to proceed. Whilst this is based in Nottingham City it will be of benefit county wide, and we will be working closely with clinicians and the public as we shape the proposals to meet the needs of our wider population.

However, to reduce the existing backlog of patients waiting for treatment, we also need to maximise and make better use of our elective capacity this year. Our waiting lists for elective care have increased across the ICS and in particular the number of patients waiting longer than 104 weeks at NUH. Routine elective care is vulnerable to cancellation when there are increased emergency pressures and discharge delays.

The aim of this proposal is to protect elective capacity year-round and begin to reduce the backlog. NUH have requested the movement of a small number of services from QMC to City in advance of future wider scale proposals related to TNUH and any further potential changes enabled by the national funding to develop an 'Elective Hub' for the system. The proposal will create additional beds, theatre capacity and will segregate routine elective capacity away from urgent care demand.

The specific services affected in 22/23 would be:

- Colorectal;
- HPB.

The majority of these patients are typically not the most clinically urgent and can therefore experience significant delays. However, a number may also require more complex surgery requiring enhanced perioperative care. Whilst the nature of their condition may not always be life threatening it can have a wider social and economic impact for patients. The proposed move would affect around 900 patients a year accessing Colorectal and simple HPB services and potentially an additional 100 – 150 patients requiring more complex intestinal care.

Capital investment of £15m is available this year to provide:

- Additional 20 bedded ward on the City campus. The ward would be designed to reduce the requirement for critical care;
- Additional 3 Modular Theatres to provide extra capacity and to enable phased refurbishment of existing estate;
- 10 bedded Enhanced Peri-operative Care Unit for surgical patients who cannot be optimally cared for in a general ward environment but can safely avoid Critical care admission.

This would have a number of benefits to patients:

- This would enable Colorectal and HPB patients access to 'ring fenced' elective care on the City Campus reducing the risk of cancellations due to increased urgent care demand;
- It would reduce waiting times for these patients;
- This would release additional capacity (theatres, beds and critical care beds) at the QMC for all other elective services based there.

These proposals will be complimented in future by the development of an 'Elective Hub' which would benefit a wider patient group. This is dependent upon final agreement of additional national funding (as referenced above) but plans will be fully aligned and further detail will follow on this proposal.

## 4 Impact on NUH staff

In late 2021, the trade unions were made aware of the moves, with a formal proposal paper being submitted to the NUH Workforce Change Panel in March 2022. Membership of this Panel includes a number of staff side representatives who approved the plan. The Staff Side Chair has also signed off the formal letter that will be circulated to staff regarding the proposals and continues to work with the Surgery Management team.

Furthermore, staff side health and safety representatives have engaged with the build project to ensure compliance with the relevant workplace guidance for staff.

Staff have been given the option on whether to move with the elective service to City Hospital or remain at QMC. Ward staff including registered and unregistered nurses, therapies and pharmacy are included in this as well as theatre staff. Specialist nurses and medical staff will move with the service.

## 5 Impact on patients

In considering the needs of the population we note that the Nottingham and Nottinghamshire ICB Quality Strategy (2019-2022)[1] identified Nottingham City as the 8th most deprived district in the country. The relocation of these services is proposed in order to protect elective capacity from urgent care demands and to enable safe segregation of patients from an Infection Control Procedures perspective, preventing bed closures due to Covid-19. However, we also recognise that any movement of services has an impact in terms of travel and access, especially when operating in an area of high deprivation.

The proposed move of colorectal surgery and HPB from QMC to City Hospital would affect around 900 patients a year accessing colorectal and HPB services and potentially an additional 100 – 150 patients requiring more complex intestinal care.

The majority of colorectal and HPB patients are typically not the most clinically urgent and can therefore experience significant delays. However, a number may also require more complex surgery requiring enhanced perioperative care. Whilst the nature of their condition may not always be life threatening it can have a wider social and economic impact for patients.

An Equality and Quality Impact Assessment (EQIA) has been undertaken which aims to assess whether proposed changes could have a positive, negative or neutral impact, depending on people's different protected characteristics defined by the Equality Act 2010, identify any direct or indirect discrimination or negative effect on equality for service users, carers and the general public and consider the impacts on people from relevant inclusion health[2] and other disadvantaged groups (e.g. carers, homeless people, people experiencing economic or social deprivation). The EQIA panel, led by our Quality Team, has considered the proposal in line with our commissioning process.

[1] Quality-Strategy-v0.4.pdf (nottsccg.nhs.uk)
[2] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/

The EQIA has determined that the proposals will broadly have a positive impact on patient's different protected characteristics and have a positive impact on people from relevant inclusion health and other disadvantaged groups (see Appendices 1 and 2).

## 6 Conclusions and recommendations

The proposals are fully aligned to the national direction of travel in order to ring fence elective capacity this year. In addition, these changes will complement the additional opportunity for capital investment in 2023 to develop a system wide Elective Hub which would bring significant benefits to our patients and public.

The work can be completed in Summer 2022, and phased service moves could be completed by the October 2022, meaning the ringfenced capacity would be operational for what will certainly be another difficult winter.

It is recommended that the Health and Adult Social Care Scrutiny Committee:

- Approve the proposed plans described above;
- Note that staff and trade unions have been appropriately consulted and have endorsed the proposals;
- Note that the proposals will broadly have a positive impact on patient's different protected characteristics and have a positive impact on people from relevant inclusion health and other disadvantaged groups
- Endorse a targeted approach to patient engagement, in order to deliver the maximum early benefit for patients waiting for Colorectal and HPB surgery.

## 7 Appendices

Appendix 1: Impact of proposals on protected characteristics
Appendix 2: Impact of proposals on people from inclusion health and other disadvantaged groups

## Appendix 1: Impact of proposals on protected characteristics

The EQIA has highlighted that the proposed service change will have a positive impact or no impact on a number of protected characteristics:

*Age:* Patients over 60 years are more likely to need Colorectal/HPB operations than younger age groups and therefore are more likely currently to suffer the consequences of cancellations due to non-elective pressures.

*Disability:* The new facilities at City Hospital are all being developed on the ground floor which will mean any patients who have a physical disability may find it easier to access than the current facilities at QMC. All of the new facilities will meet the current standards for disabled access. The new facilities will have a greater proportion of side rooms than is currently in place in the inpatient wards at QMC enabling the service to better meet the privacy and dignity needs of patients with learning disabilities.

*Gender reassignment:* The new facilities will have a greater proportion of side rooms than is currently in place in the inpatient wards at QMC enabling the service to better meet the privacy and dignity needs of any patients.

*Sex:* NUH provide the services in a manner that ensures that all genders have equal access to them with no one being unfairly disadvantaged.

*Pregnancy and maternity*: It is very rare for pregnant women to have elective surgery procedures of this nature. Where pregnant women do undergo surgery during this time special arrangements are made by the MDT involved to ensure the procedure can be performed safely to ensure maternal and fetal outcomes are not adversely affected.

*Sexual orientation:* The service delivery model currently provides appropriate provision for patients of any sexual orientation. The Trust aim to treat lesbian, gay and bisexual and people of other sexualities with dignity and respect and to provide a culturally appropriate service.

*Religion and race:* The service delivery model currently provides culturally appropriate provision for any patient who has different needs due to their race and/or religion. Service specific information is available in different languages as well as interpreting services being available. This will be maintained in the future.

## Appendix 2: Impact of proposals on people from inclusion health and other disadvantaged groups

The EQIA has highlighted that the proposed service change will have a positive impact on people who fall into inclusion health groups. Proportionately the highest levels of deprivation are in areas located closer to City Hospital. Moving the services from QMC to the City hospital will likely provide easier access to more patients from deprived areas. The majority of patients are typically not the most clinically urgent and can therefore experience significant delays. However, a number may also require more complex surgery requiring enhanced perioperative care. Whilst the nature of their condition may not always be life threatening it can have a wider social and economic impact for patients. Protected elective capacity, available year-round will help ensure patients are treated faster reducing the social and economic impact.

Those people experiencing economic or social deprivation will be able to access the relocated service via reasonably priced public transport, and individuals can also get help with health costs if necessary. The proposal will not affect eligibility for patient transport.

Not all patients will have access to technology for virtual appointments however the fact it is available to those that do is a positive development. Traditional outpatient appointments will continue to be provided at the QMC for patients who don't have access to the technology required for virtual appointments and for those who require this for clinical reasons.

Outpatient and pre-operative assessments will not change from the current provision. Colorectal currently deliver 48.2% of their outpatient activity NF2F which in in line with their national benchmarked peers of 52.1%. HPB deliver 52.4% against a rate of 58.7% for national benchmarked peers. Pre-operative assessments will take place virtually or at QMC initially, as it does now, with the longer term plan to move to City Hospital.

**Health and Adult Social Care Scrutiny Committee**
**14 July 2022**

**Work Programme**

**Report of the Head of Legal and Governance**

## 1. Purpose

1.1 To consider the Committee's work programme for 2022/23 based on areas of work identified by the Committee at previous committee 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 municipal year 2022/23 and make amendments to this programme as appropriate.

## 3. Background information

3.1 The purpose of the Health and Adult Social 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 2022/23 is attached at Appendix 1.

## 4. List of attached information

4.1 Health and Adult Social Care Scrutiny Committee Work Programme 2022/23

## 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
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**Health and Adult Social Care Scrutiny Committee 2022/23 Work Programme**

| Date | Items |
|---|---|
| **12 May 2022** | • **Nottingham University Hospitals NHS Trust Maternity Services**<br>To review progress in improvements to maternity services.<br><br>• **'Tomorrow's NUH'**<br>To consider the findings of pre-consultation engagement.<br><br>• **Work Programme 2022/23** |
| **23 June 2022** | • **Adult Social Care Transformation Programme**<br>To consider an overview of the programme and review progress of the first six projects<br><br>• **Services for individuals with co-existing mental health conditions and addictions**<br>Progress since most recent Prevention of Future Death Notices to seek assurance that what is needed is in place<br><br>• **Quality Account comments**<br>To note the comments submitted to Quality Accounts 2021/22<br><br>• **Work Programme 2022/23** |
| **14 July 2022** | • **Integrated Care System Equalities Approach**<br>To review Equalities Approach of the ICS<br><br>• **Neurology Services**<br>To consider access to neurology services provided by Nottingham University Hospitals Trust<br><br>• **Changes to Colorectal and Hepatobiliary Services**<br>To review proposals to transfer colorectal and hepatobiliary service to City Campus<br><br>• **Work Programme 2022/23** |

| Date | Items |
|---|---|
| **15 September 2022** | • **Step 4 Psychological Therapies**<br>To review progress in reducing waiting times for assessment and treatment for Step 4 Psychological Therapies<br><br>• **Work Programme 2022/23** |
| **13 October 2022** | • **Work Programme 2022/23** |
| **17 November 2022** | • **Adult Eating Disorder Service**<br>To hear about how the Service has developed to improve accessibility and reduce waiting times for treatment<br><br>• **GP Strategy**<br><br>• **Work Programme 2022/23** |
| **15 December 2022** | • **Platform One**<br>To review impact of change, including impact on Emergency Department attendance<br><br>• **Nottingham City Safeguarding Adults Board Annual Report 2021/22** (tbc – dependent on when report is published)<br><br>• **Medium Term Financial Plan**<br><br>• **Work Programme 2022/23** |
| **12 January 2023** | • **Work Programme 2022/23** |
| **16 February 2023** | • **Work Programme 2022/23** |
| **16 March 2023** | • **Work Programme 2021/22** |

| Date | Items |
|---|---|
| | |

To be scheduled:

- Tomorrow's NUH – Proposals for Family Care and Outpatients findings of public consultation and final proposals
- Implementation of Severe Mental Health Transformation Programme in Nottingham
- Improving immunisation rates. Potential areas of focus: lessons learnt from Covid vaccination programme: accessibility of consent for school-age vaccination: effectiveness of new City and County Health Protection Board in providing assurance rates
- Access to dental care – changes to community dental service
- Support for people with co-existing substance misuse and mental health issues
- Adult Social Care Workforce and Organisational Development Strategy

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