Nottingham City Council

Health and Adult Social Care Scrutiny Committee

Minutes of the meeting held in the Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 16 November 2023 from 10:02am to 11:50am

Membership

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

Colleagues, partners and others in attendance:

Emma Coleman	-	Nottingham City Safeguarding Adults Board Manager
Rebecca Gray	-	Head of Midwifery, Nottingham University Hospitals NHS Trust
Lesley Hutchison	-	Independent Chair of the Nottingham City Safeguarding Adults Board
Dr Gemma Malin	-	Head of Maternity Services, Nottingham University Hospitals NHS Trust
Adrian Mann	-	Scrutiny and Audit Support Officer
Anthony May	-	Chief Executive, Nottingham University Hospitals NHS Trust
Kate Morris	-	Scrutiny and Audit Support Officer
Michelle Rhodes	-	Chief Nurse, Nottingham University Hospitals NHS Trust
Julie Sanderson	-	Head of Adult Safeguarding and Quality Assurance
Rosa Waddingham	-	Chief Nurse, NHS Nottingham and Nottinghamshire Integrated Care Board
Councillor Linda Woodings	-	Portfolio Holder for Adult Social Care and Health

18 Apologies for Absence

Sarah Collis – Healthwatch Nottingham and Nottinghamshire

19 Declarations of Interests

In the interests of transparency, Councillor Saj Ahmad stated that she is an employee of NHS England and the Department of Health and Social Care.

20 Minutes

The minutes of the meeting held on 12 October 2023 were confirmed as an accurate record and signed by the Chair.

21 Nottingham City Safeguarding Adults Board Annual Report 2022/23

Lesley Hutchinson, Independent Chair of the Nottingham City Safeguarding Adults Board, and Emma Coleman, Nottingham City Safeguarding Adults Board Manager introduced the Nottingham City Safeguarding Adults Board Annual Report for 2022/23. Councillor Linda Woodings, Portfolio Holder for Adult Social Care and Health, and Julie Sanderson, Head of Adult Safeguarding and Quality Assurance, were also in attendance. The following points were highlighted:

a) There are three statutory members of the Nottingham City Safeguarding Adults Board: Nottinghamshire Police, the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) and Nottingham City Council. There are also a number of non-statutory partners that form part of the wider membership.

b) This Annual Report focuses on the activity of the Board in 2022/23. Three strategic priorities were identified: Prevention, Assurance and Making Safeguarding Personal (MSP), with a particular focus on the MSP aspect, regularly receiving case studies at Board meetings to maintain partner focus and hearing the voice of adults with lived experience.

c) There were two Safeguarding Adults Reviews (SARs) carried out in the period covered by this report, both of which were approved by the Board in June 2022. Both reviews resulted in a number of recommendations with action plans in place to ensure that the resulting leaning is embedded across all partner organisations.

d) Looking at data benchmarking, the national trend for Section 42 enquires has increased, whereas in Nottingham it has decreased. The Board and its Training, Learning and Improvement Subgroup have a range of guides and materials available for practitioners around how and when these enquires should be made. The focus on this work continues and will be highlighted during the upcoming National Safeguarding week.

e) Looking at the types of abuse that enquires are made about, the most common nationally and locally is neglect (32% nationally versus 40% locally). The percentage of enquires for physical and psychological abuse have reduced, but have increased for sexual abuse and institutional abuse. Figures for percentages of enquires for modern slavery have remained consistent and figures for enquires on the grounds of domestic abuse have reduced.

f) There was a slight increase in enquires where NHS staff were identified as the perpetrator of abuse. This is potentially related to the recent introduction of the People in Positions of Trust (PiPoT) guidance issued by the Board. The Board is doing further work to understand this and will monitor enquires through 2023/24.

g) The data around demographics of those subject to enquires through Section 42 are not reflective of the demographics of the overall population of the city. The majority of referrals are for white people and analysis of the most recent census data is underway to establish how this corresponds to enquiry data, to establish which communities are underrepresented and to see where further support around enquires may be needed.

h) The Board has set its priorities for 2023/24, including a working group to consider transitional safeguarding from Children's to Adults' services, publication of two SARs, further development of the strategic plan focusing on Prevention, Assurance and MSP themes and the development of a multi-agency data dashboard to ensure that resources are correctly focused.

The following points were raised during discussion:

i) The Committee queried what the reasons for the lower Section 42 enquire rate were compared to the national average, and whether further training or guidance on recognising safeguarding issues was needed. A number of factors could be the reason for why enquiry rates are slightly lower, such as safeguarding issues not been recognised or confidence in reporting issues being low for agencies who do not usually make enquires. Analysis of where enquires are coming from will identify any gaps and support can then be provided to help increase awareness and confidence.

j) Committee members asked for clarification on the "with care and support need" criteria for enquires, and whether that need had to have been formally identified. However, the criteria applies to anyone who is thought to have care and support needs, not just those assessed as in need by the Council. Referrals to safeguarding do not necessarily result in a safeguarding intervention as this may not be the required response, but further referrals will be made to various partners for the needed support services. For example, a domestic abuse survivor may not have an adult safeguarding need, but is still vulnerable, so does require support from other services. Members commented that terms such as 'vulnerable' need to be standardised in meaning across partner agencies to ensure consistent support.

k) The percentage of Section 42 enquires for neglect in Nottingham is higher than the national average. Members asked whether there was a correlation between this statistic and the high level of deprivation in Nottingham City. A disproportionate number of regulated services in Nottingham are rated as inadequate or as requiring improvement, often due to instances of neglect – through this can apply to wide range of incidents. More qualitative analysis is needed to understand this and the potential link to deprivation, but lower standards in care both at home and in residential homes could lead to a greater risk of incidents of abuse.

l) Members asked why Section 42 enquires for the Black, Asian and Minority Ethnic (BAME) community were so low. Work has begun to look at census data to establish how the level of enquiries compares to the demographic of the population. Work is also underway to look at how to better engage with BAME communities and community groups to ensure that referrals are being made where necessary and that there is confidence in the system.

m) Members asked for more information about the increase in numbers of NHS staff being identified as perpetrators of abuse. The PiPoT guidance was finalised and released by the Board in March 2023. There is no suggestion that the local figures are outliers relative to the rest of the care sector, but this will be monitored and further updates provided to the Committee. The role of the Board is to seek

assurance that practices and frameworks are in place to ensure safeguarding can take place effectively and efficiently across partner organisations. After the introduction of the PiPoT guidance, and any new guidance, all organisations are required to confirm that they have received it and are acting on it to bring policies and procedures into alignment.

n) Councillors asked what piece of work had given the most satisfaction within the period of the report. The improvement work around governance and the implications across the Board membership for improved service delivery and safety was highlighted as successful, as had been engagement across the whole partnership. The level and quality of information being fed into the Board by partners in a timely manner was very positive. More work is planned around the MSP agenda, with a commitment from partners to bring forward case studies to ensure that the voice of those with lived experience is heard. There are no partners where it is considered that the information they provide is inadequate or of low quality.

o) Committee members asked for more information about the work on preventing 'closed cultures' that could develop in healthcare settings and the position regarding private inpatient mental health settings. The Board seeks and gains assurance from partners on the ongoing work to ensure that potential 'closed cultures' where vulnerable people access support are addressed. There is a joint piece of work underway between the ICB and both the City and the County Councils looking at inpatient mental health settings and the Board awaits the outcome of this assurance work from the ICB.

p) Councillors asked what the reasons behind the decrease in domestic abuse referrals compared to the national average may be. Multi-Agency Risk Assessment Conferences (MARAC) are seeing higher numbers of referrals and services are seeing higher demand, but those seeking support do not necessarily have safeguarding care or support needs. This extra pressure on services by higher demand and limited capacity has been highlighted at a national level through the MARAC arrangements.

q) One of the SARs completed during the period of this report included issues with housing. As the City Council's Social Housing function has recently been bought back in-house, Committee members sought assurance that the information provided by Nottingham City Homes on potential adult safeguarding issues was sufficient and timely. There are good working relationships between Nottingham City Homes and the Nottingham City Safeguarding Board, with work being undertaken around hoarding and early intervention and prevention when needed. Following recommendations from the SAR, more detailed information sharing procedures have been put in place to help support and protect vulnerable individuals.

The Committee resolved:

1) **To request sight of the Nottingham City Safeguarding Adults Board's (SAB) new resources for partners to support them in raising safeguarding concerns.**

2) **To request to be kept informed of the SAB's oversight of People in Positions of Trust reporting.**

3) **To request a future progress update on:**
   a) **how engagement has been increased with under-represented communities and how their feedback on services has been used to improve outcomes; and**
   b) **the impact that strengthening the involvement of service users in safeguarding arrangements is having.**

4) **To recommend that close partnership working across the system is vital so that victims of domestic abuse do not fall between services, and it should be ensured that:**
   a) **the service pathways for support are fully clear to the people who need them; and**
   b) **all partners are able to signpost people to the right service pathway from wherever in the system they first make contact.**

5) **To recommend that partners across the system should be as consistent and clear as possible in the ways in which they define categories of vulnerability and abuse, so that communities are supported in identifying potential victims and vulnerable people at risk effectively.**

22 Nottingham University Hospitals NHS Trust - Maternity Services and Well-Led

Antony May, Chief Executive of Nottingham University Hospitals NHS Trust (NUH), Michelle Rhodes, Chief Nurse (NUH), Rebecca Gray, Head of Midwifery (NUH) and Dr Gemma Malin, Head of Maternity Services (NUH), attended the meeting to introduce a report updating the Committee on the outcomes of two recent inspections around Maternity Services and the Well-Led theme. Rosa Waddingham, Chief Nurse at the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) was also in attendance. The following points were highlighted:

a) The Care Quality Commission (CQC) conducted two inspections of NUH earlier in 2023, one unannounced inspection of Maternity Services in April 2023 and a planned inspection of the Well-Led theme in June 2023. The report on both inspections was published on the CQC's website in September 2023. It found that both services, previously rated as 'Inadequate', had improved to an overall rating of 'Requires Improvement'.

b) The inspection found a number of positive improvements across both sites. There were improved numbers of midwifery staff, staff spoke positively about their jobs and the Trust and felt that positive changes were being made to the work culture. Women felt involved in their care, listened to by staff and were positive about their care. Cardiotocography monitoring had been improved, and almost all women were seen by triage within 15 minutes of attending.

c) These changes mean that Maternity Services at the City Hospital site moved to a 'Good' rating and those at the Queens Medical Centre (QMC) moved to a 'Requires Improvement' rating, with an overall rating of 'Requires Improvement'.

d) Across both sites, some issues were identified, including the safe storage of breast milk and medications, and further work around governance requiring action. At the QMC additional issues were a problem with a call bell system, disposable curtains with the wrong date on them, outdated electrical equipment testing and, in some cases, women did not have an up-to-date risk assessment in place.

e) Action has already taken place to resolve the cross-site issues and the call bell system on the ward at QMC has been addressed. Work has been undertaken to ensure that risk assessments for all antenatal and postnatal women are in place. The CQC have been notified of these actions and were satisfied.

f) The inspection found a number of positive improvements in leadership and culture across the Trust. Inspectors noted that the leadership had strengthened and those on the leadership team had capacity and capability to drive change. The Executive worked collectively and had a core of aligned priorities, and the People First strategy was well considered. The CQC did, however, highlight that the strategy must be implemented effectively and that it would be monitoring the Trust to ensure that this took place. Corporate and Clinical Governance had been brought together well and was resulting in better oversight. Families and patients gave good feedback around their experiences with NUH, as did staff.

g) There are still some issues that need to be addressed - the inspection found that the Duty of Candour work needed to be improved and was included as a 'must do' action. Although the work around Duty of Candour in Maternity Services was now much improved, work needs to be done across the rest of the Trust to bring it up to a good standard. There was still work to be done in some areas of the hospital where culture needed more focused improvement and where staff were less positive about the changes in culture seen across the rest of the Trust.

h) The ICB confirmed that it continued to work with the Trust and was satisfied that systems of oversight were in place. The improvements described in the report are a positive step in the improvement journey, but with more work still to be done.

The following points were raised during discussion:

i) Committee members questioned the issues raised around the Duty of Candour and raised concerns that this is still an outstanding issue as it was initially raised in 2019. The Trust has a statutory duty to openness and transparency in the event that something goes wrong. The Trust has been found to be good at the first step in their process, verbally acknowledging that something has gone wrong and apologising. The second and third steps in the process (a written apology and an outline of the investigation, followed by a written update on the outcome of the investigation) have not been delivered as well as the first stage, or have not recorded accurately across the Trust.

j) There are a number of reasons why this is still an issue, including staff capacity to complete the letters, prioritisation of the task, and record keeping processes. To tackle this, there is direct oversight of performance around this issue at the director level, there are monthly performance meetings looking at where

resources and effort need to be focused to drive up compliance, and lessons learned from the changes within Maternity Services are being rolled out across the Trust to encourage best practice.

k) Councillors asked whether the positive changes in culture highlighted in both inspections had led to better staff retention rates. Retention had improved as had the time between recruitment and employment commencing. Work had been done around improving the workplace environment to keep staff motivated, and a refreshed staff support offer had been launched. Supervision and appraisal processes have been updated and refined to encourage a conversation between managers and staff about all aspects of work, not just performance. Senior managers are more accessible to staff and where issues are raised a response direct from senior managers is given. In Maternity Services specifically, a review into culture was undertaken and with specific appointments to roles to help tackle issues that were identified.

l) More information was requested about work being done with Black, Asian and Minority Ethnic (BAME) staff to improve reports of bullying, and with BAME families to ensure that they felt listened to. The Director for Corporate Governance is leading on effective inclusion and is currently leading work to develop the new Workforce Inclusion Strategy due to be finalised in January 2024. Within Maternity Services specifically two roles have been created: a Nurse Consultant for Health and Equalities and a Matron for Inclusion. Both roles are focusing on feedback from the ongoing Ockendon Review around different ways of working to change the culture and ensure the voice of all families is heard.

m) Committee members expressed concern at some of the basic faults that the most recent inspection had found and asked whether NUH had been aware of them prior to their being highlighted. The issue with the call bell was known and a temporary fix was in place at the time of the inspection, with a permanent fix recently completed. The issues around the storage of breast milk related to the security of the fridges - locks have been added to the fridges and women now request access where previously it a sign in and out system was used. A programme has been developed to look at the basic operating processes to ensure that required actions, such as changing disposable curtains, are part of staff's everyday awareness.

n) The Committee asked how far through the process of cultural change NUH felt it was and when it hoped to move from a 'Requires Improvement' rating to 'Good'. Given the usual inspection cycle, it is likely to be three years before a rating of 'Good' is achieved. This will allow more time for the changes to embed and for the culture to continue to develop. Work is underway with the Head of Communications to understand the whole patient experience, to ensure that full feedback is being gathered from travelling to the hospital to post-discharge communication. This will help to ensure that the improvement journey is progressing.

o) Councillors enquired how far through the programme of identified actions in Maternity Services NUH was and whether there were any actions that were causing concern. Of the initial 272 actions identified in Phase One, only around 70 remain as the programme moves to Phase Two. Of these remaining actions,

many are cross-cutting and have numerous interdependencies. Many actions have developed and changed since the initial programme was developed and other work has been undertaken. Some actions have been added that were not on the original programme that have come about due to the ongoing work and, for some actions, it has become clear that timescales needed to be updated. The action document is a live document and there will always be improvements to be made. It is likely that most actions originally idented within Phase One will be completed by January 2024, with others being completed over the course of 2024. The ICB noted that good progress is being made, with appropriate oversight still in place as required.

The Committee resolved:

1) **To request that a report on the upcoming Workforce Inclusion Strategy is brought to a Committee meeting following its adoption, to consider its intended outcomes and timelines.**

2) **To request confirmation as to when the 'must-do' action set by the Care Quality Commission for the Nottingham University Hospitals NHS Trust (NUH) to achieve full compliance with its statutory duty of candour responsibilities will be completed, and that NUH confirms to the Committee that the CQC is satisfied that this 'must-do' action has been met effectively within the agreed timescale.**

3) **To request that an appropriate timetable for monitoring and updates is agreed with NUH to provide assurance on:**
   a) **the progress made towards achieving an overall 'Good' rating for maternity services from the CQC within the next 3 years;**
   b) **the outcomes of the planned further improvements to patient experience within maternity services over the next 12 months; and**
   c) **the development of the current Maternity Improvement Plan into a live system of continuous improvement over the next 12 months.**

4) **To recommend that further support is provided to staff to ensure that they have the skills and capacity to engage effectively with patients in writing in relation to any problems or complaints, following their discharge from hospital.**

5) **To recommend that the learning and improvement within maternity services in terms of the duty of candour, addressing complaints, workplace culture, and equality, diversity and inclusion are applied effectively to all other services provided by NUH, as appropriate.**

6) **To recommend that the effectiveness of standard operating processes (such as regular equipment testing and the proper storage of expressed breast milk and medication) should not be overlooked as part of the wider improvement journey.**

7) **To recommend that the cultural improvements achieved in engaging internally with staff must also be replicated in the engagement with patients, to ensure that they feel safe and able to speak out if needed.**

23 Work Programme

The Chair introduced the current work programme, highlighting that space was being allowed for in January and February 2024 to consider the potential impacts of the proposed 2024/25 Budget on Adult Social Care, and that arrangements would be confirmed when more was known about the upcoming Budget proposals.

The Committee noted the Work Programme.

24 Future Meeting Dates

Resolved to meet on Thursday 18 January 2024 at 10:00am instead of on 11 January 2024.