1. Nottingham University Hospitals NHS Trust – Quality Account 2023/24

Statement from the Nottingham City Council Health and Adult Social Care Scrutiny Committee

The Health and Adult Social Care Scrutiny Committee welcomed the opportunity to meet with representatives of the Nottingham University Hospitals NHS Trust (NUH) to discuss the draft Quality Account for 2023/24 and is pleased to be able to comment.

The Committee has engaged regularly with NUH since the start of 2021, when published assessments by the Care Quality Commission (CQC) identified serious shortcomings in the provision of NUH's maternity services. Additional work by the CQC identified further problems in relation to NUH not being well-led, and also raised concerns of a workplace culture of bullying and racial discrimination.

During the 2023/24 period of the current Quality Account, the Committee has met with NUH representatives to discuss the improvement delivered to date in relation to maternity services, organisational leadership and workplace culture, and the improvement activity still to be done, and it is hoped that this positive engagement will continue going forward (ahead of the publication of the findings of the independent Ockenden Maternity Review in September 2025).

Given the Committee's serious concerns in previous years about the quality and safety of the care provided by NUH, the improvement planning and progress set out during 2024/24 has been much more positive. The Committee is keen to see the learning and improvement achieved within maternity services in terms of the approach to the duty of candour, addressing complaints, workplace culture, and equality, diversity and inclusion applied effectively to all other services provided by NUH, as appropriate. In addition, the cultural improvements made in engaging internally with staff must also be replicated in the engagement carried out with patients, to ensure that they feel safe and able to speak out if needed – with further support provided to staff to ensure that they have the skills and capacity to communicate effectively with patients in writing in relation to any problems or complaints following discharge from hospital.

The Committee welcomed the launch of NUH's Workforce Inclusion Strategy in early 2024. It considers that it is important that NUH has a clear view to addressing intersectionality and the particular communities from which NUH staff are drawn, and how overcoming barriers to full inclusivity and belonging can be approached on an appropriately individualised basis – particularly in terms of gender identity. It also hopes that appropriate positive action will continue to be developed with disadvantaged communities within Nottingham to show that NUH is an accessible and inclusive local employer, with employment opportunities available across a wide range of areas.

The Committee is glad to see that the current Quality Account acknowledges the challenges that NUH is facing and sets out the action being taken in response, and that a range of outcomes and patient experiences are expressed – with more proactive work now being done by NUH to engage with patients and communities.

The Committee is also pleased to see NUH has reacted positively to its feedback on the 2022/23 Quality Account by including a section about the steps taken to respond to and learn from the reports in the period from the Coroner on the Prevention of Future Death.

The Committee considers that there have been significant system-level pressures on Emergency Departments recently, particularly across the winter, so it is vital that NUH continues to work with its partners across the local Integrated Care System to ensure that there are effective pathways in place for emergency care. That NUH continues to scope and develop appropriate methods for the effective, safe and informed transfer of patients between wards is also important, particularly in the context of people with complex needs. It is also vital that waiting lists continue to be managed actively and efficiently to ensure that patients do not experience avoidable harm while waiting for services, with a particular focus on improving equity of access and addressing health inequalities in the population.

Ultimately, in reflecting on its comments made in relation to NUH's previous Quality Account, the Committee is pleased to be able to reply positively this year as it now feels reassured that the 2023/24 Quality Account represent a fair reflection of the position faced currently by NUH. The Committee notes that there are still significant challenges, but it considers that NUH has moved forward towards a culture of honesty, so it is now able to work constructively with NUH without the barriers that it faced in previous years. NUH will need to continue the work that has been done over the last year to address the longstanding challenges that remain and implement the improvement activity still required, and the Committee will continue to engage with NUH as this transformation journey continues to ensure good, safe and accessible services for Nottingham people.

2. Nottinghamshire Healthcare NHS Foundation Trust – Quality Account 2023/24

Statement from the Nottingham City Council Health and Adult Social Care Scrutiny Committee

The Health and Adult Social Care Scrutiny Committee welcomed the opportunity to meet with representatives of the Nottinghamshire Healthcare NHS Foundation Trust (NHT) to discuss the draft Quality Account for 2023/24 and is pleased to be able to comment.

The Committee has engaged regularly with NHT to focus on the mental healthcare services that it provides for Nottingham people, including psychological therapies, eating disorder services, support for people with co-existing substance misuse and mental healthcare needs, and support for people in mental health crisis.

During the 2023/24 period of the current Quality Accounts, the Committee reviewed the transformation work taking place within NHT's mental health crisis support provision. The Committee welcomed certain developments made in this area, but considered that a whole-system approach to the provision of joined-up mental health services should be established to ensure that a person presenting at any point within the wider system is supported in accessing the help that they need through the most appropriate pathway. An overall approach should also be created to ensure that someone presenting to one service in the system is not directed to another to then be directed on again (which could result in a person in crisis being inadvertently excluded from the system as a whole), and that there is connectivity between different services in delivering the right support centred around the specific needs of the individual.

The Committee notes that, between June and December 2023, the Care Quality Commission (CQC) carried out a series of inspections of NHT's mental healthcare service provision because it had received information that raised concerns about the safety and quality of these services. The resulting reports reduced the rating level for services from the 'requires improvement' assessment given previously by the CQC in 2022 to 'inadequate'. A rapid 'Section 48' review of mental healthcare services was also commissioned by the Secretary of State in January 2024 and, ultimately, NHT was placed within the NHS National Oversight Framework.

The Committee anticipates a great deal of engagement with NHT on the planning and delivery of an integrated improvement process throughout the 2024/25 period and beyond. Ultimately, it is vital that NHT works as closely as possible with partners both regionally and nationally to generate and apply learning in a systematic and planned way to improve the delivery of effective mental healthcare services for people in Nottingham and improve their care outcomes, with clear benchmarking against comparable peers.

The Committee, as it has done for many years, continues to raise concerns around potential 'gatekeeping' in crisis services, which can deny access to crisis care to some patients who are in a mental health crisis, and the standard of care received by some patients. It also still has concerns about capacity within the City Crisis Team

and the difficulty some people experience in reaching them on the telephone. As such, the Committee is pleased to hear that a new telephony system has recently gone live and looks forward to hearing updates over the next year.

However, fundamentally, the Committee considers that access issues will not be resolved until NHT a) invests in and improves the quality of care in Early Help and Prevention services, and b) implements funding for more staff within the Crisis Team to meet the growing need for the service. Most significantly, the Committee remains concerned about the standard of care provided by the Turning Point access line and notes that it has received similar feedback to that reflected in Healthwatch's Specialist Mental Health Services report as commissioned by NHT, and the CQC's Section 48 review.

The Committee must emphasise that a number of issues that it has discussed with NHT in the past (and that have also been raised by the Coroner) were prominent in the findings of the CQC, including families not being properly involved in a patient's care; a lack of information sharing, particularly with GPs; people having to wait too long for or being unable to access crisis and secondary services; a lack of an effective 'waiting well' policy, which put patients at risk of further harm while waiting for services (including self-harm and suicide); the effectiveness of the Turning Point access line; an inequity of access to services in the Nottingham area; the Crisis Team potentially operating as a 'gatekeeper' to inpatient care; and a lack of learning being taken from past events (including patient complaints, Serious Incidents and Prevention of Future Death reports from the Coroner).

The Committee is, therefore, frustrated that over many years of it and, more importantly, patients raising concerns about the standard and availability of care, it appears that NHT did not listen or act on that feedback in an effective way. Whilst the Committee notes that NHT now acknowledges these failings, it must reflect on the missed opportunities and the harm caused as a result.

The Committee considers that it is important for NHT to fully acknowledge the fact that patients have had poor experiences of care and, in some cases, have suffered harm (including abuse) – and that this is set out clearly in the Quality Account. The Quality Account should establish a clear, overall view of the challenges faced by NHT and the reasons behind the CQC's 'inadequate' ratings, balancing achievements and progress in the improvement work being implemented currently against the outstanding challenges and further activity that still needs to be done. It should be clear throughout on how input from the CQC and the Coroner has been used to develop the improvement work being carried out. It is the Committee's view that, at the time of providing this statement and having had the opportunity to meet with NHT and read the draft Quality Account, the document did not reflect the full reality and gravity of the situation that NHT needs to address.

The Committee notes that NHT is now two years into the delivery of a five-year Trust Strategy – but how the outcomes for 2022 to 2024 have been benchmarked and assessed should be reviewed in the context of the CQC's latest findings, and the overall Strategy updated as appropriate considering the developing Integrated Improvement Plan. Tackling health inequalities is a key part of the Strategy, so it is important for there to be full information on the progress, resourcing and outcomes of

this at the locality level, particularly in the context of the most deprived areas of the city. Whilst the Committee notes that NHT has stated an ambition to tackle health inequalities, it questions how effective this will be given the disparities in care offered to city residents. The Committee notes that the city appears to often be the last beneficiary of transformation activity and, in many cases, this work has not yet begun in the city. It also notes the CQC now reflects concerns that it has raised for many years about the sufficiency of staff (notably psychologists) in two city Local Mental Health Teams (LMHTs) and the City Crisis Team. Given the levels of deprivation and multiple disadvantage faced in many parts of the city, the Committee is concerned that NHT will not truly tackle health inequalities if city patients repeatedly face disadvantage.

The Committee considers that NHT must ensure that it seeks feedback (both positive and negative) from representative cohorts of service users and shows clearly how it listens to complaints and implements the arising learning. Very careful consideration must also be given to how people who might be fearful of speaking up are engaged with. Given the issues patients have faced in accessing services, often experiencing being passed around multiple different services, the Committee would like to see how NHT will seek feedback from these patients, who may be at a particular risk of deterioration in their health and wellbeing due to their inability to access healthcare. In addition, it is right that both the range of experiences of staff are reflected, particularly if it is the case that certain staff groups can be subject to racist or misogynistic abuse from patients.

The Committee considers that the further work planned to develop the more effective co-production of care plans is vital, and that they are shared appropriately with other relevant provides of care, including GPs. In terms of effective safeguarding, promises to both patients and their families should be in place, and strong co-production should be employed for the prevention of self-harm and suicide. The Committee notes that delayed (or a lack of) communication with GPs and families has been a theme of the Coroner's Prevention of Future Death reports, and one that the Committee has been raising for many years following feedback from GPs. There must be clear assurance that Duty of Candour processes are working properly in identifying issues and addressing them, both individually and across NHT. Patients should also be involved directly in the work in ensuring an open culture and the 'freedom to speak up'.

The Committee encourages NHT to establish effective key performance indicators and a robust monitoring system that can be used to clearly demonstrate how real improvement has been made to achieve better outcomes for Nottingham people. As a priority, NHT must set out how it intends to effectively hear the views of patients and ensure that concerns are responded to appropriately. The Committee recognises that NHT directors are now taking an oversight role in all complaints via the Patient Advice and Liaison Service, which it welcomes – though this must be done alongside mapping complaints as a whole and not considering at them in isolation.

Fundamentally, the Committee is not reassured that the Quality Account yet represent a full and balanced reflection of the challenges currently faced by NHT, or that the complete range of patient experience is reflected. Whilst the Committee recognises there will have been examples of excellent care provided by NHT, and

these should be celebrated, it is also now widely acknowledged that this is not the universal experience for all patients. It is the Committee's view that for NHT to learn from past mistakes and for patients to begin to rebuild trust, NHT must be honest and transparent about patient experience. It does not consider that this balance is currently reflected.

Nevertheless, the Committee hopes to be able to continue to engage with NHT as it establishes and develops is transformation journey to ensure the delivery of good, safe and accessible mental healthcare services. The Committee notes that, in this context, NHT's Quality Accounts have a particular focus on nationally commissioned services such as Rampton Hospital – but could have a much stronger emphasis on the community and local inpatient mental healthcare services that the majority of Nottingham people use, and whether the extent of local need is fully and effectively resourced in an equitable way. Though there have clearly been very longstanding issues at NHT, the Committee has considered for some time that the rapid decline of services began around the time of the 'inadequate' CQC rating for Rampton Hospital. NHT has assured the Committee that it believes that it has the capacity for rapid improvement of national services, including Rampton Hospital, alongside local services – so the Committee will be keen to maintain a focus on the progress of improvement and will need to be assured that local Nottingham services are not suffering at the cost of higher-profile national services.

Ultimately, going forward, the Committee would like to work with NHT in its improvement journey. It will be a critical friend and will speak out when it feels necessary but it hopes that, unlike previously, NHT will take constructive feedback onboard. The Committee recognises this is the beginning of NHT's improvement journey and hopes that, next year, it will be able to provide a more positive statement to the Quality Account.

3. East Midlands Ambulance Service NHS Trust – Quality Account 2023/24

Statement from the Nottingham City Council Health and Adult Social Care Scrutiny Committee

The Health and Adult Social Care Scrutiny Committee welcomed the opportunity to review the East Midlands Ambulance Service NHS Trust's (EMAS') Quality Account for 2023/24 and is pleased to be able to comments on it. However, the Committee notes that, on this occasion, EMAS asked stakeholders to return their comments within one calendar week – which represented an extremely challenging deadline for the Committee to be able to return a fully considered response.

The Committee has discussed the local performance challenges that affected ambulance waiting times during the 2023/24 winter period and the system-wide approaches being taken to address these with EMAS, the NHS Nottingham and Nottinghamshire Integrated Care Board and the Nottingham University Hospitals NHS Trust (NUH). The Committee was reassured to see that improvements in performance had been achieved, but queried when it would be possible for a projected timeline to be set for when and average wait time for an ambulance of under 30 minutes could again be achieved.

The Committee considers that all possible partnership action should be taken to ensure that patients can be handed over from ambulances to hospital Accident and Emergency Departments as quickly and as safely as possible, and that all appropriate methods are developed in partnership to ensure that people who call for an ambulance gain access to the right pathway for the appropriate urgent and emergency care for their needs from the triage stage – particularly in the context of someone experiencing mental health crisis.

The Committee is aware that there have been some instances reported in Nottingham where EMAS call handlers have reach capacity, so calls have then been diverted to another region. As such, it is important to ensure that there is the right call handling capacity in place to meet the local demand.

The Committee notes that the data on Serious Incidents as set out in the Quality Account is broken down by County area. However, Nottingham and Nottinghamshire are covered by different NHS hospital trusts, so it is difficult to draw conclusions from the data on how the experience of patients taken to Accident and Emergency within the Sherwood Forest Hospitals NHS Foundation Trust in Nottinghamshire may differ from those who are taken for emergency care to NUH in the city – particularly in the context of the Serious Incidents that involved a delay. The Committee is aware that information available elsewhere has shown an appreciable difference in ambulance handover times at NUH and Sherwood Forest hospitals, so a breakdown of data to this level in future Quality Accounts would help the Committee to identify any system performance issues relevant to the city area more easily.

The Committee takes assurance from the fact that EMAS is developing learning from other ambulance services in relation to the Prevention of Future Death reports issued by Coroners. However, the Committee would also encourage EMAS to set out how it has implemented its Duty of Candour and what lessons have arisen that

can be used to improve the patient experience. The Committee would also encourage EMAS to continue to develop its work on the reporting of any breaches of the Minimum Care Safety Standards and consider how clear conclusions can be drawn from the data – for example, does a low level of reporting necessarily mean that the number of breaches is low, or simply that they are not being reported?

Ultimately, the Committee is supportive of the work being carried out by EMAS as established in the current Quality Account, but notes that as the data is set out to reflect performance across Nottingham and Nottinghamshire as a whole, it is difficult to be able to comment directly on the specific service experience of city residents.

4. Nottingham CityCare Partnership Community Interest Company – Quality Account 2023/24

Statement from the Nottingham City Council Health and Adult Social Care Scrutiny Committee

The Health and Adult Social Care Scrutiny Committee welcomed the opportunity to review the Nottingham CityCare Partnership's Quality Account for 2023/24 and is pleased to be able to comment.

The Committee has not met with CityCare directly to discuss its service provision during the 2023/24 period. However, it is supportive of the work being carried out by CityCare as established in the latest Quality Account and takes the following assurance:

- The inclusion of a 'learning from complaints' section is welcome and it is a positive step to see these details set out.
- Setting out the reflections on last year's priorities is positive, as is the highlighting of learning that has been taken from other providers.
- The focus on what is being done to address health inequalities is very welcome.
- It is extremely important that there is a strong focus on 'learning from deaths' – though the assurance given in this area could be enhanced by setting out what learning has arisen from the review of all unexpected deaths by the Holistic Incident Review Panel and the changes made as a result.