MINUTES OF THE MEETING OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON Friday, 31st May, 2024, 10.00 am - 1.00 pm

PRESENT:

Councillors: Pippa Connor (Chair), Tricia Clarke (Vice-Chair) and Matt White

ATTENDING ONLINE:

Councillors: Kemi Atolagbe, Rishikesh Chakraborty, Jilani Chowdhury and Andy Milne

7. FILMING AT MEETINGS

The Chair referred Members present to agenda Item 1 as shown on the agenda in respect of filming at this meeting, and Members noted the information contained therein'.

8. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Cohen, Cllr James and Cllr Revah.

It was noted that four Councillors (Cllrs Atolagbe, Chakraborty, Chowdhury & Milne) had joined the meeting online. As only Councillors attending the meeting in-person could be considered towards the quorum requirements (which was a minimum requirement of four Members required, with one Member from at least four of the five boroughs), the meeting was technically not quorate. The meeting therefore continued as an informal briefing and it was noted that any formal decisions would need to be deferred to a future quorate meeting.

9. URGENT BUSINESS

The Committee noted the pre-election guidance which indicated that, during the current pre-election period, Councillors should exercise caution to avoid any potentially controversial statements/decisions that could be associated with a particular party.

10. DECLARATIONS OF INTEREST

Cllr Pippa Connor declared an interest by virtue of her membership of the Royal College of Nursing.

Cllr Pippa Connor declared an interest by virtue of her sister working as a GP in Tottenham.

11. DEPUTATIONS / PETITIONS / PRESENTATIONS / QUESTIONS

None.

12. SCRUTINY OF NHS QUALITY ACCOUNTS

Gillian Smith, Chief Medical Officer at the Royal Free London NHS Foundation Trust, introduced the draft quality accounts report for the Trust, noting that its main hospital sites were Barnet Hospital, Chase Farm Hospital and Royal Free Hospital with a range of services also delivered across other sites such as community hospitals and community-based clinics.

Gillian Smith explained that the theme of this year's quality account report was equality issues with the progress in these areas highlighted in the report, including through the quality priorities. It was also recognised that there was more to do on equality, diversity & inclusion and on addressing health inequalities.

Other developments included:

- The launch of a new Quality Strategy and the implementation of a new Patient Safety Incident Response Framework.
- There had been an increase in demand for services including urgent and emergency care and cancer diagnosis/treatment with further increases expected in the coming years. This challenge was reflected in the level of cancer performance against national targets and the Trust had moved into an enhanced support framework with NHS England to recover that position.
- In terms of elective care, there had been a huge impact from the industrial action which had impacted on the ability to reduce waiting lists, although a good position had been maintained against the longer waiting times.
- Good progress had been made against the quality priorities set out the previous year, including on patient involvement and the establishment of an involvement framework.

Gillian Smith then responded to questions from the Committee:

- Cllr Clarke asked about maternity services at the Royal Free Hospital in the context of the expected changes to services in North Central London (NCL) that had recently been consulted upon. Gillian Smith explained that the birth rate in NCL was falling and that, while the quality of services and patient feedback was good, it would not be possible to sustain services at the number of units currently in place in the longer term with the declining number of births.
- Cllr Connor referred to page 4 of the report, which stated that the CQC had carried out a focused inspection of maternity services at Edgware Community Hospital and had rated the service as 'Good' for the safe and well-led domains and requested further details on the ratings for the other domains. Gillian Smith

clarified that these were the only domains that had been inspected and that this had been the only CQC inspection of maternity services within the past year. The actions relating to previous CQC inspections had been covered in previous quality accounts reports and had now been closed.

- Asked by Cllr Connor about other CQC inspections relating to the Royal Free, Gillian Smith said that they were at an early stage of understanding what the inspection schedule would be under the new CQC framework, but that no announced inspections were anticipated at present. She confirmed that the most recent inspection of the whole Trust took place in 2018 and that the report was published in 2019 with an overall rating of 'Requires Improvement' with a variety of ratings across specific services. All of the actions from this inspection had been carried out with an ongoing process of self-assessment to identify where new issues or actions arose. Cllr Connor suggested that future quality accounts reports should include an explanation of the latest position with the Trust's CQC inspections, including the use of clear terminology. **(ACTION)**
- Cllr Clarke requested an update on the outcome of the Never Events framework referred to on page 28 of the report. Gillian Smith said that the output from the consultation had not yet been made available but that there had been a lot of learning from the implementation of the framework which had been in place for some years and that the approach to safety had moved on in some areas, as reflected in the new Patient Safety Incident Response Framework. She added that the Trust would be very interested and engaged with the outcomes from the consultation when this was made available.
- Referring to page 7 of the report on equality, diversity & inclusion, Cllr Connor requested further details on the 'Barnet Flow' programme. Gillian Smith explained that this programme focused on the processes for admission and discharge from hospital in order to keep the flow of patients going by ensuring that beds were available when required (including emergency admissions) and that patients were going home as early as possible when appropriate to do so. In terms of the equalities aspect of this, they were still at the stage of understanding the position before developing actions.
- Cllr Connor referred to the Maternity Equality, Diversity and Inclusion Working Group, described on page 7 of the report, and asked what changes had been achieved from this group. Gillian Smith said that actions had included specific antenatal classes for black women, translating some patient information into a wider range of languages and piloting some sessions with patients in language other than English. She added that the service, working with the Maternity and Neonatal Voices Partnership (MNVP), was doing a lot of listening work and reaching out across all areas of the community which would lead to further actions.
- Cllr White referred to Priority 1c (improving communications on waiting times and cancellations of appointments) and described the experiences of some residents with appointments being cancelled late and then having to try and rebook through a booking system that often did not have any available appointments for months and did not take clinical need into account. Gillian Smith acknowledged that there had been a large number of short notice cancellations in the previous year, including because of industrial action. She

added that the cancellations were done with clinical oversight with more urgent patients prioritised. The rebooking was also closely monitored but some patients were having to wait longer that the Trust would like and this was reflected in the current waiting times and waiting list. The Trust aimed to be as systematic as possible about the communications with patients and making sure that all available capacity was being used. Cllr White observed that the report appeared to be tracking the reduction in people who didn't attend their appointments but not how people's care was being negatively affected. Gillian Smith responded that this wasn't specifically the focus of this priority but that patients with very long waiting times were subject to clinical harm review. She also clarified that the process did not involve the patient going to the back of the queue if a rebooking was required. Cllr Connor suggested that a note to the Committee on how the process worked would be helpful. **(ACTION)**

- Cllr Atolagbe asked for further details on how the communications process worked after a cancellation. Gillian Smith reiterated that this was clinically led and prioritised and that the staff contacting patients were provided with the appropriate information and training to resolve the rebookings. Cllr Atolagbe commented that it was important to be mindful that non-urgent cases could become more urgent cases if not rebooked in time.
- Cllr Connor referred to Cancer Patients Missed Diagnosis under Priority 3c on page 27 of the report and asked if this was improving. Gillian Smith responded that the new Patient Safety Incident Response Framework provided some national parameters which defined the type of incidents and recommended that the organisation looks at previous incidents to ensure that themes are identified. Similar types of incidents then underwent the patient safety incident investigation under the new methodology. These considerations contributed to the list on page 27 which remained areas of focus.
- Asked by Cllr Connor about the implementation of 'Martha's Rule', Gillian Smith confirmed that the Royal Free was one of the Trusts participating in the first wave of pilot programme launched by NHS England and that Barnet Hospital and the Royal Free Hospital would be pilot sites. This would involve patients knowing how to access a second opinion and a more formalised process by which the clinical teams checked in with patients and a quality improvement approach to develop actions on delivering Martha's Rule.
- Cllr Connor referred to Priority 1b (fundamentals of care: nutrition) and noted that the Committee had previously expressed concerns about responsibility on the wards for ensuring that patients were assisted to eat properly. Gillian Smith said that this required a multi-professional approach including therapy input and medical assessment. Each hospital site had a group chaired by the Director of Nursing to oversee aspects of nutrition and hydration on the wards. This was an ongoing area of focus as reflected by quality priorities. Cllr Connor commented that future quality accounts should explain how problems in this area are flagged up and actioned, for example if a tray of food is left untouched by a patient.
- Asked by Cllr Clarke for further explanation on Never Events, the 'learning from deaths' section on page 58 and the 'patient safety incidents' section on page 66, Gillian Smith acknowledged that these were linked and required

comprehensive oversight. Never Events were a specific list of events that should always be prevented by processes in place. Learning from deaths was part of a national framework aimed at ensuring that deaths were scrutinised and that there was learning on care, safety and communication where appropriate. The Patient Safety Incident Response Framework covered any incident, however it was identified, the vast majority of which did not involve serious harm or death. Those that did involve serious harm or death were then investigated through the patient safety investigation process.

- Cllr Atolagbe requested further details on the proposed crisis hub for CAMHS assessment. Gillian Smith explained that this was a rapid assessment process aimed at preventing patients from needing to come to the Emergency Department out of hours by providing a more direct route into the professional support that they required.
- Referring to the waiting list statistics on page 70 of the report, Cllr Connor asked how this was being addressed, noting that there were 102,000 patients on the waiting list, up from 92,000 at the start of the year and that 5,000 of these patients had waited for more than a year. Gillian Smith explained that additional capacity had been added, including on weekends, to deliver increased activity. All options were continuing to be assessed with a clinical focus on treating the most urgent patients first. She added that the main setback in this area in the past year had been the impact of the industrial action.

Cllr Connor thanked Gillian Smith for attending the meeting and also acknowledged the positive developments in the report which the Committee had not had time to cover.

Whittington Health NHS Trust

Sarah Wilding, Chief Nursing Director, and Anne O'Connor, Associate Director of Quality Governance at the Whittington Health NHS Trust took questions from the Committee on the draft quality accounts report for the Trust:

- Cllr Connor noted that the previous year's quality accounts report had included details of a proposed CQUIN for 2023/24 on Compliance with Timed Diagnostic Pathways for Cancer Services and asked about progress in this area since then. Sarah Wilding said that there had been a huge focus on diagnostics and the partnership with UCLH to make sure that patients were diagnosed and treated as quickly as possible and this was predominantly an area of improvement.
- Cllr Clarke raised concerns about the standards of the estate at parts of the Whittington Hospital, noting faulty lifts as an example. Sarah Wilding acknowledged that some of the environment and maintenance was not at the standard they would like and so there had been a focus on some of these priority areas over the past 6-9 months, including lift maintenance. However, there was a challenge with capital spend in NCL. Cllr Clarke asked for further details to be provided about the lift maintenance at the Whittington. **(ACTION)**

- Asked by Cllr Clarke about the rate of ‘C.diff’ (clostridioides difficile infection), Sarah Wilding noted that there had been 23 cases in 2023/24 against a trajectory of 13. The response to this had included a huge drive on hand hygiene and antibiotics compliance as well an environmental focus on cleanliness. She also noted that, across the 23 cases, only one area of exact transmission between patients had been identified.
- Cllr Connor queried the use of the term “damage to organisational reputation” in a paragraph on page 108 of the agenda pack which related to the potential risks associated with failing to provide outstanding care because openness was an important factor in dealing with any issues of concern. Sarah Wilding said that this was not the intention of the terminology used but that this was a helpful reflection which she would feed back to colleagues. She also felt that the Whittington was known for being open and transparent and also had a strong relationship with the CQC.
- Cllr Connor referred to the target on page 116 of the agenda pack to reduce waiting times for first appointments across CAMHS, OT (occupational therapist) and SLT (speech and language therapy) by at least 20% by the end of March 2025 and asked how realistically this could be achieved. Sarah Wilding acknowledged that this could be seen a ‘stretch target’ but said that it was ambitious because CAMHS was an area of focus for the Whittington and that there was a drive for improvement in waiting times for children’s autism, ADHD assessments and access to speech and language therapists.
- Cllr Connor referred to the action on page 118 of the agenda pack to further develop the intranet page for people with autism and learning difficulties and asked about service user input to the format. Sarah Wilding said that there was an active learning difficulties patient group and so the content and accessibility work had been developed in partnership with this group. There was strong partnership working in this area and an ambition to develop this further with adults with autism.
- With regards to neonatal services, Cllr Clarke welcomed the progress on delayed cord clamping and the acquisition of the Concord Birth Trolley. Sarah Wilding noted that delayed cord clamping was looked at as part of the quality improvements last year and this was why it had been brought forward as outlined in the report. In response to a point from Cllr Atolagbe about the requirements for improvement at the neonatal unit, as set out on page 124 of the agenda pack, Sarah Wilding acknowledged that delayed cord clamping had been a negative outlier at the Whittington so there had been a drive for improvement.
- Referring to the section on the Perinatal Mortality Review Tool (PMRT) on page 164 of the agenda pack, Cllr Connor noted that 12 cases met the eligibility criteria for PMRT review and asked for further details on the learning from this. It was agreed that further details would be provided in writing. **(ACTION)**
- Asked by Cllr Clarke about the progress on the Start Well consultation, Sarah Wilding said that the ICB would be reviewing the results from this but the decision on next steps was not expected until next year.
- Cllr White referred to the staff survey described on page 145 of the agenda pack and highlighted the importance of staff morale in delivering good quality

care. He questioned whether comparing figures to other Trusts was the right way to assess this and asked whether there were any targets in place. Sarah Wilding explained that the staff survey was looked at by the CQC in a comparative way which is why the data was set out in this manner. Comparisons were also made to the data from previous years to understand which areas were improving and declining. Actions resulting from the survey included a drive to ensure that staff had the right equipment they needed.

- Cllr Connor referred to Q20a of the staff survey on feeling secure to raise concerns about unsafe clinical practice, to which 70% had answered yes. She asked what more was being done to raise this figure. Sarah Wilding said that actions included publicising to staff the multiple ways of reporting unsafe practice, formally or informally, and this had been done successfully in maternity services. She added that a low proportion of staff reporting concerns did so anonymously which was a positive sign about the culture of accountability and also noted that the Board was very visible. Anne O'Connor commented that there was oversight of any trends that emerged through the reports received.
- Cllr Connor noted that, according to the section on the Freedom to Speak Up Guardian on page 167 of the agenda pack, there had been an increase in concerns raised by administrative and clinical staff. Sarah Wilding observed that there had been various rounds of staff engagement which may have increased the confidence of staff to report issues. There had also been some gaps in some of the administrative teams about six months previously which had caused pressures that may have resulted in more concerns being raised.
- Asked by Cllr Atolagbe about actions to improve the indicators on staff morale and well-being set out on page 149 of the agenda pack, Sarah Wilding said that valuing staff was essential and there had recently been various staff awards to recognise contributions to quality care. A new Head of Well-being had recently been appointed who was leading on some new initiatives in this area and there were also more resources to support staff when circumstances were challenging. The Chief People officer now worked between the Whittington and the UCLH which provided opportunities to share best practice.
- Cllr Atolagbe asked for an update on the closure of Simmons House, as described on page 133 of the agenda pack. Sarah Wilding said that Simmons House had been temporarily closed with the staff redeployed to support children and young people elsewhere in the system and that work was ongoing with the provider collaborative to establish interim arrangements. She also confirmed that there was not yet an agreed date for the reopening of Simmons House.
- Asked by Cllr Atolagbe about the 'Requires Improvement' CQC ratings in certain areas, Sarah Wilding noted that the inspection had taken place in 2019 and there had been no further CQC visits in these areas since. However, quality visits were carried out and she also chaired a committee that looked at learning and improving across the organisation.
- Cllr Connor requested further details on compliance with the Data Security and Protection (DSP) toolkit referred to on page 135 of the agenda pack. Sarah

Wilding explained that there had been a drive to improve mandatory training in relation to this which was monitored through performance meetings.

- Cllr Connor referred to page 173 of the agenda pack which explained that the target for the Urgent Response and Recovery Care Group to ensure that patients were seen within certain times had been only partially met. Sarah Wilding confirmed that there had been a drive to treat more patients through virtual wards but that there had been some challenges with staffing in those areas so there was ongoing work to improve recruitment. This was all monitored through performance meetings. Cllr Connor asked whether the virtual ward capacity would be reduced because of the lack of staffing. Sarah Wilding explained that virtual ward capacity was reviewed at daily meetings each morning in terms of capacity, staffing and safety with patients then triaged accordingly.

Cllr Connor thanked Sarah Wilding and Anne O'Connor for attending the meeting and noted the follow up actions that had been agreed.

North Middlesex University Hospital NHS Trust

Lenny Byrne, Chief Nurse, and Vicky Jones, Medical Director for the North Middlesex University Hospital NHS Trust, introduced the draft quality accounts report for the Trust highlighting:

- the recent work on patient experience and patient voice;
- the response to the CQC review of maternity services in May 2023;
- the work on the patient safety incident response framework, including a focus on deteriorating patients;
- the implementation of 'Martha's Rule' which had included some funding as part of a national programme;
- procedural safety work in theatres which had contributed to there being no Never Events in the past year;
- a paediatric diabetes audit which had positive results on the screening and support for managing sugar levels in young people and patients in the most disadvantaged groups.

Lenny Byrne and Vicky Jones then responded to questions from the Committee:

- Cllr Connor requested further details on the recent CQC inspection which had rated the Trust overall as "Requires Improvement" and had rated maternity services as "Inadequate". Lenny Byrne said that the main inspection had highlighted a number of key issues including:
    - The management of grievance cases. An improvement plan had been introduced with HR processes to ensure that reviews were undertaken in a more timely manner.

    - Responsiveness to patient complaints and closing them in a timely manner. A Trust-wide plan had been established on the timely management and best resolution of complaints.
    - Closing down serious incidents. Further information about the management of serious incidents and how learning was shared across the organisation had been included in the report.
    - Leadership and development opportunities for a wider group of staff. The number and type of leadership courses had been extended.
    - The CQC raised concerns about the potential merger with the Royal Free and the impact on the capacity of the executive team. There was a plan to manage the capacity constraints with some additional consultancy to support the executive team.
- With regard to the CQC review of maternity services, Lenny Byrne explained that the review had identified 26 compulsory or 'must do' actions, including on safety issues and the management of the triage service. There was therefore not a single fix and so incremental improvements and continuous monitoring and oversight would be required. The final report had been published in December 2023 and some actions had already been put in place prior to this based on provisional feedback from the CQC. Specific issues included:
    - It was considered that the Trust did not have a best practice standardised national tool for the monitoring, management and oversight of patients. There were also issues around staffing, equipment and the culture of the department.
    - A key priority was patient safety and, on triage, the 'BSOTS' system was now being used which was a standardised national best practice system.
    - Due to the CQC rating, the service had been automatically stepped onto a national support programme, which included a midwifery expert being on site three days per week providing additional support, oversight and scrutiny.
    - On staffing, there had been a vacancy rate at the time of the inspection which was now in the process of being filled with 27 new midwives recently recruited. The Trust was also waiting for a national standardised skill mix review of maternity services which was an assessment tool that would specify the staff required to safety manage the population.
    - On culture, a programme of listening events and culture improvement measures had been put in place across maternity services.
- Cllr Atolagbe observed that there did not appear to be feedback from staff in the report. Lenny Byrne responded that, although this had not been included in the report, there had been significant contact with the teams in maternity and monthly executive listening events. There were also executive visits to different parts of the organisation every morning between 9am and 10am. Further information on staff feedback could be included in the final version of the report. Cllr Connor commented that it would be useful to see that evidence and data in the report to be able to demonstrate that things were changing in a positive direction. **(ACTION)** Vicky Jones added that the NHS staff survey had been reviewed since the CQC visit and that each department was developing action plans in response to this. In particular, the maternity team had picked up an

issue of making sure that communications reached everybody and so this needed to be done through various formal and informal channels.

- Cllr Clarke welcomed that there had been zero Never Events at NMUH in the past year but noted that, according to page 45 of the report, 25 deaths (just under 2%) were judged to have been likely to have been caused by problems in the care provided to the patient and there also appeared to be a high number of stillbirths. Vicky Jones explained that there was a very low threshold for scrutinising deaths and therefore about 25% of deaths were scrutinised. The NMUH also had a higher proportion of deaths that occurred in the hospital, as opposed to the patient home or hospice care, which further increased these figures. This data was used to drive improvements around deaths and there had been a focus this year on detecting and managing deterioration. Vicky Jones also emphasised the importance of preventing stillbirths and explained that it was difficult to judge crude numbers. It was better to use an adjusted ratio which took into account deprivation and birth numbers and, on that basis, NMUH was in line with their peers. However, there was a strong focus on the improvement plan which included risk assessments at every part of a patient's journey through maternity care.
- Cllr Connor queried why, according to page 46 & 47 of the report, there had been 12 patient safety incidents resulting in severe harm or death in the reporting period for September 2019 but 126 incidents in May 2024. It was agreed that these figures would be checked and an explanation provided in writing to the Committee. **(ACTION)**
- Cllr Connor requested further details on improvements to the support provided to patients in maternity care. Vicky Jones cited the example of triage when a patient had been in touch to explain worrying symptoms, had been advised to come in for assessment and then not done so, but there were now processes to follow up with that person. Improvements had also been made to interpretation services.
- Cllr Clarke referred to the work on deferred cord clamping at the Whittington which the Committee had heard about in the previous session and asked if the hospital Trusts were working together on this. Vicky Jones confirmed that this had been a real area of focus over the past two years as the NMUH previously had a low rate of deferred cord clamping. 100% of babies were now considered for delayed cord clamping and, as this was not clinically appropriate for all babies, delayed cord clamping was carried out in over 70% of cases.
- Referring to page 25 of the report about patient experience, Cllr Connor asked what was being done to ensure patient nutrition and hydration on the wards in cases where patients were not eating the meals provided. Lenny Byrne said that he had recently reviewed the fundamentals of care including protected mealtimes. This involved reducing the activity on the ward at breakfast and lunch times to allow patients to have their meals in peace and quiet and also to allow the nursing staff to focus on drug rounds and the provision of the meals. There was ongoing work to ensure that protected mealtimes were consistent across the hospital. There was also a 'red tray' system in place which identified patients who required additional support with nutritional needs. The evidence from the nutritional steering group was that this was working well. A hot meal

service had also been added to the Emergency Department for patients who required this. Asked by Cllr Connor about the data on patient nutrition and hydration, Lenny Byrne acknowledged that there could be further detail provided in the final report about the actions that were being taken in this area. **(ACTION)**

- Cllr Connor asked about conditional discharge patients including information about who there should contact for support in order to reduce the risk of readmissions. Lenny Byrne reported that there had been work on information packs for patients upon discharge from various services including contact information and follow up instructions. There was also an ongoing review of clinical nurse specialists which would include ensuring that clear discharge planning was part of their remit.
- Cllr Atolagbe referred to the 'North Mid Loves Our Patients' initiative on page 29 of the report and suggested that further data should be made available on this. **(ACTION)**
- Referring to CT head and spine scanning on pages 32 & 33 of the report, Cllr Connor noted that these had declined in the past year due to the volume of patients and inability to fully assess trauma patients in the space within the Emergency Department. Vicky Jones explained that one change was that older patients having a CT head scan also now had a CT spine scan at the same time as they had a higher risk of spine injury so this was a positive change. In addition, there was an external provider for the night time reporting of CT scans and there had been work on the agreement to ensure that they were feeding back those reports in a timely way. There had been positive progress on reporting times.
- Asked by Cllr Connor about the CQUIN funding, Vicky Jones confirmed that the national funding programme had ended and so there were no payments that came with achieving these targets in the future. The national recommendation was to continue to work on the areas most relevant to the organisation and so NMUH would be working on the ones that fit with the organisation's safety priorities.
- Cllr Connor observed that the reassurances given on the various questions asked had been clear from the answers provided but had not necessarily been made clear in the draft report itself. Lenny Byrne said that this was helpful feedback which would be considered in the development of the final report. He added that there had been an internal conversation about the right amount of information to provide in the report as there was a large amount of data accumulated on improvement work which could not all be included. He also noted that any additional information required by the Committee on maternity services or any other aspect of NMUH services could be provided.
- Asked by Cllr Connor to highlight one issue that could improve services for residents, Vicky Jones said that her priority would addressing the small pockets of poor culture that had been identified. This did not reflect the vast majority of NMUH staff, but it was important to ensure that local residents could feel confident that they would always be treated with kindness, respect and by staff who have the appropriate training to deliver the best care. Lenny Byrne said

that he had two areas which were improving maternity services and setting up the Patient Partnership Council to help enable a patient voice representative of the diverse populations served by the Trust.

Cllr Connor thanked Vicky Jones and Lenny Byrne for attending the meeting and noted the follow up actions that had been agreed.

CHAIR: Councillor Pippa Connor

Signed by Chair ……..

Date ……