MINUTES OF THE MEETING OF THE HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL HELD ON WEDNESDAY, 24TH APRIL, 2024

MEMBERS: Councillors James Hockney (Chair), Andy Milne (Vice Chair), Nicki Adeleke, Chris James, Doris Jiagge, Kate Anolue and Michael Rye OBE

Officers: Doug Wilson (Director of Adult Social Care), Dudu Sher-Arami (Director of Public Health), Mark Tickner (Senior Public Health Strategist), Jane Creer (Governance Officer)

Also Attending:
Dr Nnenna Osuji (Chief Executive North Middlesex University Hospital NHS Trust), Prof Lenny Byrne (Chief Nurse NMUH), Nicole Callender (Divisional Director of Midwifery and Nursing NMUH), and members of the divisional management team for maternity services NMUH
Dr Shakil Alam, NHS NCL ICB
Natalie Fox (Joint Deputy Chief Executive NLMHP), Peppa Aubyn (NHS North Central London ICB – Assistant Director (Enfield)), Adele McCormack (Deputy Chief Operating Officer NLMHP), Ben Mensah (CAMHS Managing Director, BEH MH Trust), Parmjit Rai (Deputy Chief Operating Officer, BEH MH Trust)

1. WELCOME & APOLOGIES

Cllr James Hockney, Chair, welcomed all attendees.

Apologies for absence were received from Cllr Elif Erbil and Cllr Emma Supple. Cllr Supple was substituted by Cllr Michael Rye.

2. DECLARATIONS OF INTEREST

There were no declarations of interest registered in respect of any items on the agenda.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 28 February 2024 were **AGREED**.

4. NORTH MIDDLESEX HOSPITAL MATERNITY SERVICE : CQC RATING AS 'INADEQUATE'

Dr Nnenna Osuji, Chief Executive, North Middlesex University Hospital NHS Trust (North Mid) led the presentation.

She expressed apologies that the CQC rating caused some anxiety to the women the hospital served, and wanted them to know that compassionate, safe and effective care continued to be provided. Each year 3,800 babies were delivered and the vast majority had a positive experience.

One of the elements raised in the CQC report was in respect of perinatal mortality rate, but the definition in the report was inaccurate and gave a cruder rate at a single point in time. This feedback had been passed to the CQC. Women should not make the wrong decision based on that information. The trend in North Mid's data showed an ongoing reduction in perinatal mortality rates, both neonatal and still birth rate, from 2017 to 2022. North Mid was as good or better than the national average for hospitals with a similarly sized maternity unit. Care in the ward after birth was seen as a strongly positive response, with North Mid ranking in the top five trusts according to a recent CQC patient experience survey. It was also ensured that women had the opportunity to see the same team of midwives during the entirety of antenatal and postnatal care.

Maternity services nationally had gone through great changes since 2015's Morecambe Bay incident highlighted failings and the Ockenden report in 2022 highlighted areas of concern nationally, followed by the East Kent report. These informed the CQC framework as the predominant regulatory body and made it more challenging to get good ratings. The CQC had been particularly rigorous with maternity services, and the majority of Trusts inspected had been down-graded.

North Mid had received six CQC inspections within the last two and a half years, with the Maternity inspection taking place in May 2023. NHSE colleagues were invited in during September 2023 prior to the CQC report's publication in December. Additionally, a Maternity Safety Support Programme was commissioned by North Mid: one of 34 trusts in the country with this programme. A Maternity Improvement Advisor commenced March 2024.

In respect of the CQC Maternity inspection, some positives were seen including:
- Clear vision and strategy with stakeholders
- Staff understood how to protect pregnant people from abuse
- Facilities and premises appropriate to keep people safe
- Infection control managed well
- Cleanliness of the unit/areas

Recommendations for areas of improvement were:
- Oversight of leadership
- Improving triage in the maternity unit
- A 'closed culture', speaking up discouraged
- Staff training required improvement
- Women's feedback not always used.

Details were given of progress since the CQC inspection, including a new divisional director of midwifery role and a growing maternity team with

successful recruitment of 28 new midwives in six months. There was continuing investment in recruitment and retention, and nearly 100% of student midwives chose to stay working at North Mid after qualifying. The triaging process had been overhauled to the 'Gold Standard' triage assessment tool. A dedicated Midwifery Advocate would support and improve patient and staff wellbeing. More engagement with the maternity and neonatal voices partnership would help inform improvements. In the National Staff Survey, North Mid was the most improved of 62 other Trusts indicating improvements in staff satisfaction.

The opportunity was being taken to make improvements. It was recognised there were pockets where some more focussed work was needed.

Questions were invited from Members.

The Chair confirmed that the Panel members had requested this issue as an agenda item, and that the CQC report did make for a concerning read, particularly comments in respect of leadership; closed culture; triage, midwifery staff feeling bullied, intimidated and undermined; a higher than average number of still births; staff not receiving adequate training. He asked whether it was believed that all the necessary measures were being put in place. Dr Osuji gave assurance that the maternity services were safe and effective, and all focused areas for improvement were being addressed. Figures in the report were inaccurate, as discussed. Improvement work had been ongoing for most of the last year. The leadership team had been physically visiting services, on the ground with the staff. There was a programme of work across the Trust in respect of addressing bullying and culture.

It was confirmed that feedback had been given to the CQC repeatedly but North Mid had been unable to get them to modify the report. The complexity of cases seen by North Mid was also raised as added context. In response to further questions, it was confirmed that socio-economic factors and ethnicity affected perinatal mortality rates, but over a five year period there had been a consistent downward trend at North Mid. Performance data was carefully monitored and interrogated.

It was considered that the frequency of CQC inspections in the last 2.5 years was prolific and North Mid would be an outlier in such frequency.

It was advised that training was above and beyond what was mandatory. The education offering to staff in maternity services at North Mid and progress was reported up every month. In respect of culture, staff were encouraged to talk in an open way, and a bespoke programme was in place.

It was confirmed that the report's impact on staff had been recognised, and that staff would feel unsettled and sad. Managers spoke to around 300 staff in two sittings within 24 hours of the CQC report publication, where they could also ask questions, and those conversations were ongoing with staff and students.

In response to questions about recruitment of midwives, it was clarified that there was a spike in the vacancy rate post-Covid despite a recruitment drive, but fewer were now leaving, and good training programmes encouraged students to stay. Nationally there had been a drop in numbers taking up midwifery, but North Mid was continually recruiting to its vacancies, and almost 100% of students were staying with them. There was in-house continuing education, secondments and shadowing, and learning and development opportunities. Support had also been put in place to keep North Mid's veteran midwives.

Cllr Rye reported the experience around the recent birth of a grandchild at North Mid; that care before birth had been good, but less so afterwards, and asked about previous ratings, and the staff culture. It was advised that modern medicine encouraged discharge from hospital earlier, and that inspections in 2019 and 2020 gave a rating of good, and the service had never been rated inadequate before. A company had been commissioned to work on staff culture, and numerous opportunities were being provided for staff to speak up, including a walk and talk every day and boxes for staff to put in questions confidentially. Managers walking the shop floor were very visible and available for dialogue with staff. Workshops allowed frustrations to be worked through. A lot was happening in respect of culture and supporting staff.

In response to further Members' queries, it was confirmed that its diversity was one of North Mid's greatest sources of pride. There was around 60% recruitment from the local population and the sense of representation was powerful. The hospital leadership was considered one of the most approachable in any organisation. Staff were listened to and it was understood there were issues to be resolved and those pockets were being actively tackled. It would be wrong to think that issues raised in the report were representative of the whole maternity service.

Cllr Anolue stressed the importance of post-delivery care, and the role of community midwives and a good package of care when new mothers went home. It was advised that North Mid recognised the importance of postnatal care and encouragement of breastfeeding, for which it had a dedicated team. Family and friends were also recognised as playing a crucial role. It was noted that North Central London was working with others and launched new postnatal guidance to be implemented across London for all women to receive the same level of care and documentation and be able to contact a midwife and to get regular updates. A public health midwife had also been recruited. Feedback from councillors in respect of infant feeding would be looked into.

In respect of training, it was confirmed that there had been action on compliance and it was now over 92% and gaps were being addressed. To join, bank staff had to have all training complete. In maternity, any staff not fully compliant with mandatory training were in the pipeline to be trained by a set date.

The Chair thanked all those who attended and requested a further update on progress in six months' time, which was AGREED.

ACTION: Governance Team

5. NORTH CENTRAL LONDON (NCL) MENTAL HEALTH TRANSFORMATION AND CHILDRENS & YOUNG PERSONS MENTAL HEALTH CRISIS RESPONSE UPDATE

RECEIVED the report 'North Central London (NCL) Mental Health Transformation and Childrens & Young Persons Mental Health Crisis Response Update' and attached presentation.

Officers thanked the Panel for inviting them back after a year in respect of the transformation of mental health services across Enfield. The Community Transformation Programme was summarised in a Youtube.com animation which was linked on page 14 of the agenda pack and played to the meeting.

Questions were invited from Members.

In response to Members' queries regarding autism and ADHD waiting times, it was advised that significant waiting times were a national problem, but work continued to reduce these and to have access to care as quickly as possible.

It was clarified that the holistic assessment function related to 'telling once', in response to patients' concerns of having to repeat their story multiple times.

A transition service for 18 to 25 year olds would support those making the transition from children's to adults' services.

In response to queries regarding funding and access across North Central London, it was confirmed that NCL ICB had met its mental health investment standard and had given Enfield additional funding over the baseline in recognition of inequalities and service gaps, and continued investment would ensure delivery in line with the offer. There was recognition that the pathway to services could be difficult. Not everyone went to a GP for referral to CAMHS so there was support in schools and work towards coverage in all schools. It was confirmed that presentation at A&E referred to Barnet as well as North Mid. There were also walk in clinics in libraries and surgeries where a young person could go without a referral. There was currently work with Jubilee Church in respect of providing walk in clinics. Improved communication was being worked on with stakeholders about how to access those services. The engagement and governance structure ensured information was shared on a regular basis.

In response to Members' queries regarding adults in mental health crisis, it was confirmed there were liaison services in all Enfield's acute hospitals; a mental health crisis centre in Highgate; and a 111 call option. With transformation funding, services were being invested in such as crisis cafes.

It was advised that monitoring was done with a sophisticated management system for caseloads. Managers could monitor when a client was last seen, or should have been reallocated, etc. to supervise the service and quality.

More information was also provided in respect of performance, and that an assessment had to have the user at its centre, the care plan must be agreed with the user, and a treatment plan should be started within four weeks.

It was confirmed that following initial assessment of needs, there were four teams which specialised in different treatments, some clinical and some more emotional. At the point of entry there was a determination and allocation to the right place for needs to be best met.

Members asked about what could be done about external factors which could impact mental health. It was advised that officers could for example support clients to keep their tenancy and support them in accommodation, and work was done with the Housing Department and local authority in creative ways. There was also support to keep clients in employment, and enabling people to connect with voluntary sector organisations like MIND. Collaboration with the ICB included homelessness teams coming into hospital wards, and employment services co-located with crisis teams.

The Director of Adult Social Care advised that people wanted a single point of contact, a place to go where someone would listen, and help to navigate the system. It was also acknowledged there was good non medical work done by the third sector, and the Council sought a longer term view in awarding contracts to increase certainty for them.

In response to queries around increased mental health funding, it was advised that the metrics for investment were around case findings and contact, which was increasing by 5% year on year. NCL ICB had met the investment standard and maintained its baseline. Resources were monitored by the ICS Programme Board which met monthly.

In response to Members' concern that 19% of calls to the hub were unanswered, it was clarified this related to a professional line for advice and guidance to the Metropolitan Police. There had been some issues with its roll out but it was aimed for 100% of calls to come through or receive a call back, to ensure that patients went to the right place for their needs.

The Chair thanked all attendees for providing the update and answering Members' questions.

6. WORK PROGRAMME 2023/24

NOTED

1. The completion of the Health and Adult Social Care Scrutiny Panel Work Programme for 2023/24.

2. The work programme item of an update on Enfield Sexual Health Community Services was deferred into 2024/25 until contract negotiations were completed.
3. A requested agenda item for consideration for the 2024/25 work programme had been received from a member of Equalities Board that fits better under the Health and Social Care Scrutiny:

- Reducing HIV transmission rates and ending new transmission by 2030. Local action planning and sexual health service provision.

The Chair was also asked to consider letting Tim Fellows from Enfield LGBT Alliance ask one or two questions if he attends.

7. DATES OF FUTURE MEETINGS

NOTED that meeting dates for 2024/25 would be agreed at Annual Council on 15 May 2024.

The Chair thanked the Vice Chair, Members and substitutes for their attendance and contributions to the Panel this year. The Panel had looked at some very substantive and important items. Thanks were also expressed to the Governance and Scrutiny Team for supporting the meetings.

The meeting ended at 9.21 pm.