MINUTES OF
HEALTH SCRUTINY COMMITTEE

Wednesday, 29 March 2023
(7:00 - 9:11 pm)

Present: Cllr Paul Robinson (Chair), Cllr Donna Lumsden (Deputy Chair), Cllr Muhib Chowdhury, Cllr Michel Pongo and Cllr Chris Rice

72. Declaration of Members' Interests

There were no declarations of interest.

73. Minutes - To confirm as correct the minutes of the meeting held on 1 February 2023

The minutes of the meeting held on 1 February 2023 were confirmed as correct.

74. NELFT CQC Inspection Update: March 2023

The Associate Director of Nursing and Quality (ADNQ) at the North East London NHS Foundation Trust (NELFT) and the Integrated Care Director (ICD) for Barking & Dagenham at NELFT presented an update on the NELFT Care Quality Commission (CQC) Inspection as of March 2023. This provided context as to:

- The CQC Well-Led inspection of NELFT between April to June 2022, with NELFT subsequently being issued with a new rating of “Good”;
- Overall Well-Led feedback that NELFT had received from the inspection;
- Positive feedback that had been received as to safeguarding at NELFT;
- The Well-Led Improvement Plan, including the nine “Should Do” recommendations that had the CQC had made following the Well-Led review, and the monitoring and progressing of the Improvement Plan; and
- The Quality Support Visit programme at NELFT.

In response to questions from Members, the ICD stated that:

- During the Covid-19 pandemic, complaint response times had decreased, as well as investigations around the most serious incidents; as such, there had been some delays and some increased 90-day responses for complaints and increases around the 45-day response for serious incidents being completed.
- Since the pandemic, this response backlog had improved. NELFT had a very robust process in terms of incidents being reviewed on a daily basis through Datex, which was an electronic system used by NELFT for incident reporting and complaints monitoring. NELFT’s acknowledgement rate of complaints within three days was now at 90%, with the close-down of complaints in terms of the 28-day framework being dependent as to the complexity of the complaints themselves.
- Some of the Inspectorate team that had inspected NELFT in 2022, had also inspected NELFT in 2019. The Lead Inspector had praised NELFT for its cultural and behavioural changes, with many of the challenges previously

identified in the 2019 inspection, such as around senior leadership, having been addressed, such as through different Chief Executive arrangements and embedding a more just and compassionate culture.

- NELFT aspired to become an “Outstanding” Trust; the Trust would use its CQC action plan and the number of quality improvement workstreams within this, to meet the requirements in order to achieve this “Outstanding” rating.
- NELFT faced a number of challenges, such as operating in an area of significant population growth and the continued impact of the Covid-19 pandemic. The new place-based arrangements would present a different opportunity around how NELFT planned and organised health provision to help address some of these challenges.
- NELFT had a number of staff recruitment and retention programmes, with the recruitment process having an induction and speed-dating for new recruits. NELFT also had one of the best staff survey results in London. It had a number of accolades in terms of its work around recruiting staff from Black Asian Minority Ethnic (BAME) backgrounds; in Barking and Dagenham, 60% of its workforce came from a BAME background.
- NELFT’s staff had voiced that they came to work for NELFT due to its inclusivity, agile working and flexibility, having won awards around family friendly practices, workforce race equality standards and disability standards.
- There was a national workforce shortage; whilst some disciplines were harder to recruit to, NELFT was working to recruit in these specialisms. NELFT had also recruited over 240 internally educated nurses this year and was working to nurture this staff group.
- The diversity of NELFT’s senior leadership team was increasing. In terms of the local leadership team of 14 colleagues, 11 were from a BAME background. The NHS was composed of more females than males, with the Senior Leadership team reflective of this.
- There were no 18-week breaches in terms of people accessing community learning disability services in Barking and Dagenham; however, there were 18-week breaches in the Adult’s Autism, Paediatric Autism and Paediatric Speech and Language pathways. During the pandemic, Autism assessments were suspended as the physical assessment had to be completed without a mask; NELFT was currently addressing the backlog through a new pathway around Paediatric Autism, autism assessments and diagnostic services.
- In terms of managing waiting lists, this depended on the service; in some services, staff had been refocused to provide assessment and initial treatment, as opposed to longer-term treatment. The amount of one-to-one service provision had decreased and group provision had been increased, so that more people were able to be seen by NELFT in a shorter time frame. Whilst group treatment worked well for some individuals, it did not for others; digital applications were also being employed to enable people to undertake one-to-one work.
- NELFT had also looked at different skill mix models, such as through utilising Assistant Psychologists to provide lower intensity programmes, to ensure that service users were not left without treatment. Clinical Harm reviews had also been introduced for waits of over 18 weeks, to ensure that service users were not declining whilst waiting for treatment.
- Whilst NELFT had received a small amount of funding to help address

backlog waiting lists due to the pandemic, this funding would not be recurring.
- The Governance structure was to be restructured following a recommendation from the CQC and from Deloitte, who NELFT had commissioned to undertake an internal well-led review; this would enable NELFT to better support the delivery of organisational objectives and to free up more capacity to support the emerging collaborative agenda.
- An area for future improvement was around Quality Improvement (QI) and being able to evidence the involvement of QI and quality improvement projects within the organisation, reviewing data and ensuring that NELFT's projects and improvements made were evidenced in this data. This would help to pinpoint the areas for improvement going forward.
- There was a QI team at NELFT, with a dedicated director for this, and there was also a dedicated QI Advisor for each locality. All staff were also able to undertake QI training.

75. Early Pregnancy Assessment Unit (EPAU)

The Consultant Obstetrician and Gynaecologist (COG) at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) delivered a presentation on the Early Pregnancy Assessment Unit (EPAU), which provided context as to:

- The service itself and how it could be accessed;
- Care and support for people who miscarry;
- How the Trust worked to decrease the risk of repeat miscarriages; and
- How patient feedback was addressed by the Trust.

In response to questions from Members, the COG stated that:

- It was recognised as best practice for an Early Pregnancy Unit to have a quiet room, where patients and their families could receive bad news and where staff could break this bad news. Prior to the pandemic, the Emergency Gynaecology Unit and the Early Pregnancy Unit were located on a different hospital ward; however, during Covid, the use of the wards was changed, with Gynaecology moving to a different ward and the new physical environment not being as bespoke for the service. As such, BHRUT was working to re-establish the quiet room which was present on the previous ward.
- In the new ward, women and families that received bad news would be taken to a quiet area in a side room; however, this was not currently bespoke.
- In regards to the decreased miscarriage rate in 2022/23 in comparison to during the pandemic, the birth rate had also recently dropped, with a direct link between a lower miscarriage rate and lower birth rate.
- There were some staff who were trained in mental health first aid, to support both staff members and patients. The staff that worked within the Early Pregnancy Unit were expected to have communication skills training, including around breaking bad news and in recognising patients who were in mental health distress.
- BHRUT had links with SANDS (a bereavement charity) and its Bereavement midwives did provide close support in terms of links with the Adults and Perinatal mental health services. The vast majority of this staff

also had experience of working within the maternity service; as there were close links with the perinatal mental health service, it was very easy to make a direct referral into these clinics. BHRUT also had the facility for inpatient referral to the Adult mental health services, for mental health crises as a result of an early pregnancy problem.
- There were referral criteria into the Perinatal mental health unit, with all midwives having a certain level of training in looking after patients who did have mental health concerns. There were two levels of the perinatal mental health service, with one being midwife-led and one being for women with more severe mental health illnesses, with these women being eligible to be seen within the joint consultant and perinatal psychiatric service. There was no waiting list to be seen in the joint clinic, with the service also being recognised as being a best practice model.

The Integrated Care Director (ICD) for Barking & Dagenham at NELFT stated that NELFT was the provider of the perinatal infant mental health services (PIMS), which operated across all four London areas in the outer northeast London programme. Delivery was across the community and in the acute service. There was also a maternal mental health specific pathway, known as the Tulip service. The PIMS service was essentially the first point of access into the perinatal mental health remit, with patients either being managed within the PIMS service or through the Tulip service. The Tulip service was commissioned during the pandemic and extended the reach agreement of the perinatal infant mental health service.

In response to further questions from Members, the COG stated that:

- One of the areas of quality improvement work was around flow through the service; the service was well known through social media advertising and BHRUT did not want to delay people's presentation with an early pregnancy problem. The COG also detailed the patient journey and flow through the service and the possible routes that this could take depending on the patient's needs. For those who had experienced a miscarriage, the COG also detailed their patient journey and support received, dependent on the type of miscarriage that they had experienced.
- There was a range of risk factors for early pregnancy problems, with miscarriage being a very common occurrence and arising in 30% of pregnancies. The COG detailed these risk factors, such as having had a previous miscarriage, a previous ectopic pregnancy, predisposing medical conditions, being older in age, smoking and some previous predisposing sexually transmitted infections. The service encouraged women to either see their GP early or to present themselves early to the Early Pregnancy Unit in these instances, or where these women had any concerns, anybody could present themselves to the service through self-referral. The COG also detailed some of the advice and guidance that was provided in these circumstances, as well as reassurance that the vast majority of women who had early pregnancy loss would go on to have a healthy pregnancy in the future. The COG also discussed the criteria around whether somebody was considered to have a recurrent miscarriage and the patient journey and support that would be provided in these cases.
- Ideally, women would present themselves for midwifery care at around nine weeks, in order that there was time for the screening tests that needed to

be undertaken as part of the antenatal service, and in line with national targets for presentation to maternity services. At this point, a woman would be risk assessed, which would also include history of previous pregnancies and pregnancy loss. Unless somebody had been diagnosed with an underlying medical condition, there was usually no additional antenatal treatment or care that was recommended for somebody who had had early pregnancy loss or somebody who had had a pregnancy loss in the second trimester previously. From around 13 weeks to 20 weeks, there was some additional support that would be put in place, but for under 12 weeks, the vast majority of women would not need anything additional in their antenatal care; however, community midwives would discuss this as part of a person's antenatal care and provide tailored advice. People could also approach the Early Pregnancy Unit if they were unsure about anything.

- Individuals who had experienced recurrent miscarriage could be offered genetic testing, to help identify if there were any genetic causes for miscarriage. Screening for other genetic conditions could also be undertaken during first trimester screening, with these women being looked after within the Fetal Medicine Unit; the COG detailed the various means of support provided and diagnostic means through this. The Fetal Medicine Unit worked very closely with King's College and had developed links with the fetal medicine network across the local maternity system, such as with Barts and the Homerton.
- If young people had experienced miscarriages but did not want to present to the service, whilst they should be encouraged to access the service, they could also talk to a trusted adult, or approach their school nurse, GP or wellbeing services within sexual health services. It would also be important to consider safeguarding, as well as their ability to access contraception services, for example, if they had experienced an unplanned pregnancy.
- Caring for staff was essential, particularly as obstetrics and gynaecology as a speciality had a very high attrition rate, with one of the reasons for this being the stress involved in the job. Within the Fetal Medicine Unit, there were regular debriefing sessions led by a Bereavement team; the Trust was looking to extend this into the Early Pregnancy Unit as it was now recognising more and more the emotional burden that could impact staff within this unit.
- The pandemic had brought more recognition of the need for more emotional wellbeing services for staff; BHRUT also had quite extensive psychological support services and if it was recognised that staff were in distress, the Trust could also arrange for events where staff could discuss any concerns that they had. BHRUT had implemented "Schwartz Rounds" during the pandemic, where staff could share their stories and where collective learning could take place. Much support during the pandemic had been modified to take place online and the Trust was now thinking about how it could run this face-to-face. The Trust was rolling out nursing advocates, who were trained in delivering psychological support and who could be accessed by staff for support.
- Compassion fatigue was a very well recognised phenomenon. There were different ways that the Trust could identify this, such as through complaints and incident reports; for example, if an individual was identified on a recurrent basis, this would be flagged up early, or if there was a particularly emotionally difficult complaint, then the COG would intervene directly to find out what was happening and ensure that support could be provided.

- The Trust could also monitor burnout and compassion fatigue, through means such as monitoring staff sickness levels, absenteeism, staff being late and staff cancelling shifts. If an individual had been identified as being particularly at risk, a conversation would be had with their line manager through a supportive route, ensuring that the individual was signposted to the necessary services to support their wellbeing. As a last resort and if the individual needed a break from working in their area, the Trust also had the facility to do this. Teams were also very close knit and were able to identify and provide support to their team members who may be suffering from burnout.

The Committee recommended that more work be undertaken to support fathers and partners during miscarriages and pregnancy loss, as it affected the whole family unit. It also recommended that more work be undertaken to support EPAU access for more vulnerable populations, including teenagers.

76. Proposed Governance for Place-Based Partnerships

The Council's Director of Public Health (DPH) delivered an update on the developing place-based partnership arrangements, which the Council had to agree with the North East London Integrated Care System (NEL ICS) and partners such as BHRUT and NELFT and which would come into place from 1 April 2023. The DPH stated that:

- All had been in discussions and wished to streamline processes; often there were too many meetings, with the same agenda items. As such, it was agreed that a joint Committee of the Health and Wellbeing Board meeting at the same time as the Integrated Care Board Sub-Committee would be a useful approach. This would assist in speeding up the decision-making process and help all partners to address health inequalities issues at a much quicker rate.
- Between now and July 2023, all partners would need to consider how this approach would operate, in terms of aspects such as administration. It may also consider whether membership of the Health and Wellbeing Board (HWB) would need to be refined; for example, Primary Care Networks (PCNs) and the GP Federation were not currently on the HWB or the ICB Sub-Committee.
- A report would be presented to the 13 June 2023 HWB and the June 2023 NEL ICS Board, asking all to agree to these arrangements in shadow-form for the next 12 months.
- Public Health would return to the Committee's 24 May 2023 meeting, to enable the Committee to ask any further questions that it had around the arrangements.
- It was hoped that the arrangements would bring issues closer to local politicians and residents, so that they could have a bigger say in decision-making around resources and how issues were addressed, so that services were more accountable to local people and were more tailored to their needs.

77. Joint Local Health and Wellbeing Strategy 2023-28 Refresh Framework for Delivery - Consultation

The DPH delivered a presentation on the Joint Local Health and Wellbeing Strategy 2023-28 refresh framework for delivery and consultation. This detailed:

- The statutory duty of the Council to produce a Health and Wellbeing Strategy, which sat with the Council's Health and Wellbeing Board. It set out the health and wellbeing needs of residents and mapped out what was needed to be undertaken over the next three to five years to improve health outcomes;
- The context, intended vision and key principles behind the Strategy;
- How the Joint Health and Wellbeing Strategy interlinked with other strategies and delivery plans;
- The consultation dates for the Strategy, which was open for comment between 30 March and 30 April 2023; and
- How it was intended for the Strategy to be monitored in terms of progress.

The Committee requested an informal consultation session between itself, the Cabinet Member for Adult Social Care and Health Integration and Public Health, for Members to provide wider Committee feedback on the Strategy.

In response to questions from Members, the DPH stated that:

- The consultation was available online, for residents and interested partners to provide comment. The consultation was also being complimented with various focus groups, working with specific partners that the Council had networks with. The Council was also engaging with professionals, partners and the wider community through social media, digital media through the website and the Council's newsletter.
- Consultation had also recently being undertaken around the Council's Best Chance in Life Strategy for prenatal conception care through to age 25; the outcomes of which were also being factored into the Health and Wellbeing Strategy.
- The Council was engaging with typically "harder-to-reach" patient groups, such as the homeless, asylum seekers and emerging communities, such as the growing Romanian community, through its existing networks, partners and Healthwatch.
- One of the most difficult aspects of delivering medical and mental health care was communication. There were various barriers to being able to communicate with people, such as where an individual had a learning disability or a language issue, or due to technical medical language. When new communities came to the Borough, there was also often a need to explain how they could access primary care, registering with a GP and what an individual was entitled to through the health system.
- The Council was investing more in interpretation services, as it had found that leaflets were often ineffective in assisting those who were not fluent in English.

The Integrated Care Director at NELFT stated that NELFT had a contract with the Language Shop, which provided interpretation services across a range of London boroughs and health providers, for both sign and spoken languages, in telephone and in-person formats. Whilst it recognised that many families would translate for other family members, it did not rely on this as a source of translation, as it acknowledged that family members could mistranslate information, as well as due to challenges in the Borough around issues such as domestic violence and coercion. If an individual had an access need, they were able to highlight this prior to their appointment, so that NELFT was able to provide interpretation services.

The DPH also stated that in many languages, there was often not a direct translation for some medical diagnoses or conditions, which could prove difficult in explaining certain terms to individuals; the Council was investing in learning and work around this through its Health Inequalities project work, investing in community advocates and by co-locating community hubs within faith community spaces.

In response to further questions from Members, the DPH stated that the Council was engaging well with well-established partners from the LGBTQ+ community and with children and young people. The Borough was also continuously assessing the needs of its children and young people through its annual school health survey, in conjunction with the University of Bristol.

A Member stated that the needs of the Lithuanian community needed to be better considered, with many not understanding where to go when they had speech and language problems. The Member had had to signpost these individuals to services in Newham, as they were able to liaise with services in their native language there. The DPH stated that this would be factored into the consultation, ensuring that further work would target this group to improve their access to services.

78. Joint Health Overview and Scrutiny Committee

It was noted that the minutes of the last meeting of the Joint Health Overview and Scrutiny Committee could be accessed via the link provided on the front sheet of the agenda pack for this meeting.

79. Minutes of Barking and Dagenham Partnership Board

It was noted that the minutes of the last meeting of the Barking and Dagenham Partnership Board were included from pages 69-80 of the agenda pack.

80. Work Programme

The Work Programme was agreed.