LONDON BOROUGH OF HARROW

# Health and Social Care Scrutiny Sub-Committee

# Minutes

# 20 June 2023

| | | |
|---|---|---|
| **Present:** | | |
| **Chair:** | Councillor Chetna Halai | |
| **Councillors:** | Govind Bharadia<br>Maxine Henson | Kuha Kumaran<br>Rekha Shah |
| **Advisers:** | Julian Maw | |
| **In attendance (Councillors):** | Phillip O'Dell | For Minute 37 |
| **Apologies received:** | Councillor Vipin Mithani | |

## 31. Attendance by Reserve Members

**RESOLVED:** To note the attendance at this meeting of the following duly appointed Reserve Members:-

| Ordinary Member | Reserve Member |
|---|---|
| Councillor Vipin Mithani | Councillor Kuha Kumaran |

## 32. Declarations of Interest

**RESOLVED:** To note that the following declaration of interest was made at the meeting:

Councillor Philip O'Dell declared a non-pecuniary interest in Item 7, Royal National Orthopedic Hospital NHS Trust - Quality Accounts, in that he was presently a volunteer at Royal National Orthopedic Stanmore.

## 33. Minutes

**RESOLVED**: That the minutes of the meeting held on 21 February 2022, be taken as read and signed as a correct record.

The Chair varied the order of business and items 40 and 41 were considered before other items on the agenda.

## 34. Public Questions

**RESOLVED:** To note that no public questions had been received.

## 35. Petitions

**RESOLVED:** To note that no petitions had been received.

## 36. References from Council and Other Committees/Panels

**RESOLVED:** To note that no references from Council or other committees/Panels had been received.

## 37. Royal National Orthopaedic Hospital NHS Trust - Quality Accounts

The Sub-Committee received the report of Louise Morton, the Chief Nurse of Royal National Orthopaedics Hospital NHS Trust (RNOH). She informed the Sub-Committee that all NHS Trusts, were required to produce an annual account of the quality of their services. This was an important way to share information with the public about the quality of care provided at RNOH and to demonstrate works being undertaken to improve services. The report and account detailed the performance of RNOH against national quality indicators for patient safety, clinical effectiveness, and patient experience. It also reviewed progress against last year's priorities and outlined its quality improvement priorities for 2023/24.

Other highlights included that RNOH:

- was recognised as the 9th best orthopaedic provider in the world, the best in the UK and the only UK orthopaedic hospital in the top 50 (Newsweek 2022).

- was recognised in the top 9 NHS performers nationally for patient experience.

- scored highly for involvement of patients in care decisions, quality of patient care after discharge and excellent communication skills of the Doctors.

- was committed to providing its staff with the very best staff experience in the NHS and the fact that patients had received some of the best care in the NHS in England was down to the staff dedication and

- staff survey continued to be amongst the best in London and nationally. and scored:

    - above the NHS national averaged across all areas of the staff survey
    - ranked number one across London Acute Specialist Trusts
    - ranked number one across London Trusts for staff engagement, morale and safe and healthy
    - ranked number one across North Central London, in all but one category –
    - placed third on recognition & reward (recognition & reward scores were a concerning theme across the NHS alongside burnout scores).

She highlighted the following Priorities for RNOH:

- Audit programme
- Access to care
- Staff Support and welfare
- Industrial action and living crisis.

- Launching organisation restructure
- Developing digital infrastructure
- Theatre building

The Chair commended the report, the excellence of the reporting standards and the great contribution that volunteers had made to the NHS. She acknowledged RHOH's co-production partners and Harrow residents were very happy to have RNOH and its dedicated staff. She encouraged them to continue to provide a good service and improve the service accordingly. There were similar commendations from other Members on the quality of the report and survey results.

Members asked the following Questions:

A Member lauded the efficiency and introduction of electronic systems, integrated system for patient care and asked what impact the new electronic system would have in the future, The officer explained that the electronic prescription systems would reduce human error, enable immediate tracking of progress and enhance learning.

The Member asked who the partners mentioned in the report were and if volunteer groups were involved. The officer explained that partners included patient groups, volunteer health groups and other health care organisations.

A Member asked in reference to the 38% reduction in medically reported incidents, what the forecast was for next year. The officer explained that there was no particular target but efforts would be made to look at trends and maintain that percentage or make further improvements.

A Member asked for more information about the effective elective surgery programme. The officer explained that the officers were awaiting the outcomes of the national data and did not know when it would become available.

A Member asked if there was any update on the required improvement in medical care surgery service for children. The officer explained that this was the last CPC inspection, and RNOH had not been inspected subsequently, but obviously the criteria that are underpin the safe domain was being constantly considered.

A Member asked what the actual number of days was in terms of reduction of stay. The officer explained that she did not know as it was a target set by RNOH and the number of days was dependent on specialty and procedure. There was an expected length of stay benchmarked as safe for various procedures.

The Chair asked how RNOH ensured that all discharges were safe. The officer explained that discharges were planned according to a patient's individual needs and a care plan. There was a multidisciplinary assessment though most times after orthopaedic surgery, many patients were safe to go down the stairs, safe to go home use the facilities and look after themselves. An assessment would determine the multidisciplinary care plan and discharge checklist for every patient alongside discussions with relatives about their needs and expectations.

The Chair asked about data on readmissions on the pain on the patients that have been discharged. The officer explained that patients were likely to be readmitted to the local area hospital should they experience complications after surgery rather than back at RNOH.

A Member asked about artificial intelligence and what anticipated impact on systems like EPS and other record systems available to patients. The officer explained that RNOH was some way from full digital maturity, it was one the priorities, but could not be achieved overnight and that was the position of other NHS organisations and RHOH was part of a national programme to explore this resource to some extent but there could be limitations due to infrastructure in RNOH’s specialty area.

A Member asked for further information about the type of incidents referred to on page 69 as about 60% that resulted in severe harm and resulted in death. The officer explained that it could be potentially postoperative complications or a pressure care area but efforts were being made to look at all incidents to understand the level of harm that had occurred to any patient.

The Chair asked about the quality plan, the clinical incidents relating to patient safety and the priorities to maintain between 30 to 80 incidents per thousand bed days and the officer offered further explanations.

The Chair asked about waiting lists… how long was the wait? The officer explained that there was a target to reduce 68 week waits by March 2024,

and RNOH was on target to deliver this. Also, as the service was by referral, some patients had already been on the waiting list at another hospital before their referral to RNOH. There was a clinical harms review process for people on waiting lists. Checks were conducted to ensure that their circumstances do not change for the worse during that waiting period and GPs or secondary care provider were also consulted if needed, there was the opportunity to change the clinical decision.

The Chair asked why the number of non-clinical incidents, was a lot higher in 2021/22 than in 2022/23. The officer explained that some of the incidents were around environmental issues and security, as the height of the pandemic, the Trust had a lot of restrictions like many other hospitals about what could be done and who could visit and what people were asked to do if they came into the outpatient areas and a number of incidents were reported around some of those issues probably relating to medical equipment.

The Chair asked if there were plans for redevelopment or modernisation of the site as some of the buildings were quite old. The officer agreed some of the buildings were old. She explained that the theatre was the latest addition to the estate and there were plans to modernise some areas of the site to help alleviate the lack of space issue.

Councillor Philip O' Dell commended the professionalism of the volunteer staff at RNOH especially in the face of recent industrial actions and staff shortages. He asked why the target for staff flu vaccinations for last year or up to Quarter 4th 2023 could not be achieved. The officer explained that the Covid pandemic switched the focus from flu to COVID and in the last flu campaign people were keener to have a covid vaccine than they were a flu vaccine, flu was no longer seen as a challenge and people felt perhaps, they have had enough of vaccines.

Councillor Philip O' Dell asked if the officer had any comments about why the number of complaints per patient has increased from 10 per 1000 to about 16 per 1000. The officer explained that this was being monitored very closely and there had been a spike but it was beginning to reduce again. She said that most organisations had fewer complaints during the earlier parts of the pandemic. It looked like people waited through the pandemic, as they understood the different priorities. Some of the complaints related to waiting lists which were clogged after the pandemic hence the introduction of The Waiting Well Initiative which had helped to keep in touch with patients despite the challenges around the communication systems. Efforts were being made to understand what was happening to people to resolve the complaints and this had led to a good early rate conversion by the Trust's Panel which managed concerns as pal's concerns resulting in fewer formed complaints and very few escalated complaints to the ombudsman.

**RESOLVED:** That the assurance statement be provided that the quality account was shared with the Sub-Committee and had been reviewed to its satisfaction.

## 38. Immunisation Services in Harrow

The Sub-Committee received an introduction to the report by the head of public health Commissioning for NHS England, London region. The report outlined the current arrangements for childhood immunisation and scrutinised the effectiveness of the commission.
She said that what the data detailed in the report revealed was that on average, across the programmes, Harrow, like many of the London boroughs, had a lower uptake rate by about 4% to 6% compared with the national average of about 2% to 3%.

She pointed out that on page 8, some of the graphs were not accurate as the graphs were the same for all four for instances. She said that they would be corrected and resubmitted.

The report identified some of the actions that had been undertaken regionally and nationally to improve vaccination uptake and coverage, and most relevant, the significant activities that Harrow Council had undertaken to improve uptake locally.

She said that at some point soon, the impact of the work and activities would be evaluated so that those that worked could be replicated to maintain an ongoing impact on increasing vaccination uptake rates in Harrow.

Members asked the following questions:

A Member commented that it was difficult to understand what could improve vaccination uptake rates perhaps short, medium and long term goals were needed and asked whether any of the suggestions made at the previous meeting of the Sub-Committee had been implemented.

An officer explained that only one intervention was not going to help with the uptake rather a system and partnership approach to doing this was needed. There was a referral management scheme last year which was repurposed to focus on improving vaccination and that entailed each of the PC in the primary care networks, groups of GP practices coming together. They were required to have a nominated immunisation coordinator and part of their role was to analyse and understand the data, about those parents and children who were declining vaccinations to really understand what the barriers were and to support them into making a much more informed decision around whether to get their child immunised or not. She said that part of the data analysis showed a group of practices and communities where there was really low uptake. It helped highlight the low uptake within the Polish and Somalian communities in the borough. Engagement exercises were being considered which would involve the coordinators, together with some of the clinical staff, looking at, perhaps having face to face meetings at food banks, children's centres and even virtual consultations to address any concerns or issues they may have as part of the role that the coordinators have also been doing. Also a robust call and recall system in practices was being explored.

A Member suggested recruiting members of the communities with low uptakes to help with engagement and communication. The officer explained

that the Council had been successful in achieving a bid of £26,000 from North-West London ICS to work with particular community groups and work was being done by identifying and working with community champions to reach low uptake communities. They would be moving forward to understand what were the blockages and the barriers to people, making that decision to take up the offer of vaccination and to being able to do so as well, as understanding how accessing vaccinations could be supported and made easier for people.

The Chair asked what the arrangements were for monitoring, auditing and performance management of each GP with regards to childhood immunisations, and how was NHS England supporting GP practices to actually reach their targets. The officer explained that GP primary care had a delegated commissioning function within the system, and so both the ICB and NHS England had a part to play in that the IMF's coordinators also worked with the GPs supporting them and helping them with the day-to-day understanding of how to implement some of the immunisation programmes. There was also support for the GP practices in terms of one-off payments, an incentive scheme to reward practices who were able to achieve certain uptake levels and there was also a process of performance management in terms of conversations with practices through the primary care teams and GP contracts.

The Chair asked if a risk assessment had been carried out on shifting the commissioning responsibility from NHS England to north-west London ICS, particularly in terms of levels of resources. The officer explained that there was a national process of delegated commissioning whereby vaccination programmes were the responsibility of the commissioning function or vaccination programmes in their entirety. The national perspective was that transfer to ICB was likely to happen over the next couple of years and a risk assessment would be undertaken as part of that process, both at a national level and then at a regional, local and ICB level.

A Member expressed concern about the recent outbreak of measles and mumps in Harrow. The officer responded that yes there were eight reported cases of measles in Harrow, but data had shown it was contained in a geographical location so local teams had been engaging with practices where patients were most at risk or where they had identified cases.

**RESOLVED**: That the purpose and NHSE approach to the provision of childhood immunisation in Harrow be noted.

## 39. Harrow Community Services Position statement

Members received the report of the Harrow Borough Director, North West London Integrated Care Board. The report described the purpose and the approach to the North West London Integrated Care Board's review of community outpatient services within the context of all outpatient services in Harrow and across North West London Boroughs.

This was part of an ongoing engagement activity that would lead to a procurement strategy in June 2023. Harrow had a number of community services which were only provided in Harrow, the contracts would end in September 2023 and Harrow was engaging as part of a programme to determine future arrangements. EHIAs were being completed for each service and would be finalised when the engagement process had been completed.

The officer explained that the engagement would close on 22 June 2023, the feedback from Harrow residents would be considered along with a number of data points to decide about the future commissioning of services going forward in the meantime, services would be provided by the existing provider in line with their contracts.

A Member asked that as the report stated that for most children, 60%, could be seen by a GP and would get help within one or two weeks, whether this too long to wait and how was this performance in comparison to the national average and other London Boroughs. The officer explained that the longest patients were anticipated to wait in terms of new guidelines from NHS England was a maximum of two weeks appointment, but the system was, if you requested an appointment online or by telephone, there would be a clinical triage of that condition and if the GP thought that the child needed to be seen that day, they would either see the child that day or refer them to neighbouring hubs if there was no capacity. The problem was whether the child could be seen in a neighbouring hub, if not, then as a last resort they would advise the child to go to the Urgent Treatment Centre (UTC). This would be decided by clinical need at the point of triage.

A Member asked if any features of artificial intelligence could be used to speed up seeing patients to improve patient care. The officer explained that she was not certain but the idea was being explored at a very low level with advice and guidelines in terms of AI for paediatric services rather than senior appointments.

A Member raised concerns that it was still difficult to get appointments and it was a big issue. The officer explained that all services were very challenging. The officer explained that it was not specific to Harrow but this was a national issue. NHS England had published a plan around improving access in general practice. Each practice PCM had to come up with plans as to how they were going to improve same day care to their patients how they were going to make sure that patients could contact them easily through the telephone. Huge investments have been made in the telephony structure and a huge amount of work was going to be done in Harrow and across NHS North West London to improve access.

The Chair asked how many patients were served in a year across the services, what the results were. The officer gave the following details:

- Community neurology service saw about 600 referrals a year. 7.9% of those referrals were triaged straight to secondary care, the rest of patients were seen in the clinic and either followed up or discharged back home.

- Gastroenterology saw about 612 referrals, 21% of those patients were triaged directly to acute hospitals.

- The paediatric service saw about 1943 referrals a year, 29% of those were triaged in acute hospital care settings.

- ENT Service saw approximately 2,900 referrals, a year of which approximately 9% of those referrals were transferred to secondary care.

The Chair asked as these four areas services were going to be closed, how many patients would be affected and if they were going to be referred to other services. The officer explained that the service would be provided by another provider. The officer explained that as the services would be provided by another provider.

The Chair asked what the annual contract amount for the current provider of the four local services was and as changes were being made to the service, how much savings would be made via the proposal to use existing primary and secondary care services for these specific services and if they would be channelled back to the provision of primary and secondary care in Harrow. The officer explained that there would be no efficiency savings as the services would be provided by another provider. Also, some of the funds would be invested in upskilling primary care clinicians and service conditions so from the ICB level, savings were not anticipated.

The Chair requested that the committee be updated on the engagement and roll out for patients including potential challenges and if possible, any update on the contract negotiation with the current provider for the four services and if any efficiency savings had eventually been identified.

**RESOLVED:** That the report be noted.

## 40. Appointment of Vice-Chair

**RESOLVED:** That Councillor Rekha Shah be appointed as Vice-Chair of the Health and Social Care Scrutiny Sub-Committee for the 2023/2024 Municipal Year.

## 41. Appointment of (Non-Voting) Adviser of the Sub-Committee 2023/24

**RESOLVED:** That Julian Maw be appointed as Non-Voting Adviser to the Sub-Committee for the 2023/24 Municipal Year:

(Note: The meeting, having commenced at 6.30 pm, closed at 8.08 pm).

(Signed) Councillor Chetna Halai
Chair