THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 7TH SEPTEMBER, 2018** at 10.00 am in Council Chamber - Crowndale Centre, 218 Eversholt Street, London, NW1 1BD

MEMBERS OF THE COMMITTEE PRESENT

Councillors Alison Kelly (Chair), Tricia Clarke (Vice-Chair), Pippa Connor (Vice-Chair), Alison Cornelius, Lucia das Neves, Clare De Silva, Val Duschinsky and Osh Gantly

MEMBERS OF THE COMMITTEE ABSENT

Councillors Huseyin Akpinar and Julian Fulbrook

ALSO PRESENT

Councillor Samata Khatoon

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the North Central London Joint Health Overview and Scrutiny Committee and any corrections approved at that meeting will be recorded in those minutes.

MINUTES

1. APOLOGIES

Apologies for absence were received from Councillor Julian Fulbrook. Apologies for lateness were received from Councillor Clare De Silva.

2. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

For reasons of transparency, Councillor Pippa Connor declared that she was a member of the RCN and that her sister worked as a GP in Tottenham. However, she did not consider this a prejudicial interest and so took part in discussion at the meeting.

Councillor Osh Gantly declared that in her paid employment she had formerly worked with Richard Gourlay (who was in attendance at the meeting as Director of Strategic Development at the North Middlesex) on an Electronic Referral Service. However, she did not consider this a prejudicial interest and so took part in discussion at the meeting.

3. ANNOUNCEMENTS

There were no announcements.

4. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no notifications of any items of urgent business.

5. DEPUTATIONS

Members received a deputation from Alan Morton, Vivian Giraldi and John Lipetz on hospital transport.

The deputees were concerned about the transport difficulties that people who currently received treatment at North Middlesex would face if they had to receive treatment elsewhere. They did not feel a 'community case for change' had been made. They made particular reference to orthopaedic services that were currently delivered at North Middlesex and might take place in Chase Farm in future, following the review of orthopaedic services. They felt that any relocation of services should be paused until transport difficulties for patients travelling by public transport were resolved.

Deputees noted that health officers had said to them when these points were raised that concerns about transport were best directed to TfL. However, they felt that it was not fair to TfL to ask them to make changes solely as a result of a unilateral decision by another public service to relocate its services.

6. MINUTES

Consideration was given to the minutes of the meeting held on 20th July 2018.

Members expressed their disappointment that the information requested on page 3 of the minutes had not been provided. They noted they had received information, as requested on page 5, on the London panels but had not received information on their role and purpose.

Members were concerned that balance sheet information had not been provided, as requested on pages 7 and 8 of the minutes.

RESOLVED –

THAT the minutes be approved as a correct record.

7. JOINT WORKING BETWEEN NORTH MIDDLESEX AND ROYAL FREE HOSPITALS

Consideration was given to the presentation from North Middlesex University Hospital.

Maria Kane, the Chief Executive of the North Middlesex, outlined that – following the CQC inspection which had stated that the hospital needed to improve – there had been joint working with the Royal Free Hospital Group.

The Royal Free was performing well, and so they hoped to learn from their best practice. Clinical practice groups had been formed which included staff from both organisations. There had been improvements in performance flowing from this. Progress had been made against A & E targets – which were that 95% of patients be seen within 4 hours.

Ms Kane acknowledged that the hospital had been in deficit last year. Some of the deficit was due to factors beyond their control, such as PFI charges and the clinical negligence fund. The target was to reduce the deficit to the 'control total' of £19m.

Ms Kane highlighted that there was a need to recruit and retain staff. They had faced high staff turnover, in part due to the fact they did not pay Inner London Weighting on salaries, and there had also been claims of bullying and of rivalries between departments. They were addressing the issue of bullying and these rivalries.

Ms Kane stated that the North Mid would be deciding on whether to become a full member or to move to closer collaboration with the Royal Free at its board meeting on 4th October.

Members asked what consultation had taken place on this, and were told that consultation had taken place with local authorities and CCGs.

Members expressed disappointment at the presentation and felt that it had not laid out a clear case for change.

Members heard from Caroline Clarke (Deputy Chief Executive) and Richard Gourlay (Director of Strategic Development) from the Royal Free. They echoed Ms Kane's comments about improvements in fields like paediatric and maternity care flowing from joint working. They also said that they thought the entry of Chase Farm and Hampstead hospitals into the Royal Free Group had been positive, and that this could be repeated with the North Midds.

Ms Clarke acknowledged that both organisations had deficits, and this would mean that a full merger could not take place soon. However, sharing 'back and middle' office services could deliver savings. She said that she would report back to the JHOSC at a future meeting on the measures being taken to reduce the Royal Free's deficit.

The joint working between the Royal Free and North Mid was at the 'strategic outline' stage and so a case for change had yet to be developed.

Members asked if the case for change would go to public consultation. Health officers said that it would be service alterations which would go out to consultation.

Members expressed the view that what the decision on 'full membership' of the Royal Free Group that the North Midds would be taking on 4th October meant was vague. They wanted to see greater clarity about what "full membership" meant.

The Royal Free had identified one of the main reasons for Full Membership with the North Mid as being based on the back office savings the RFH could make by combining these functions across both trusts. Members commented that it would have been useful to have had a business case and for this to have been presented to the JHOSC so they could scrutinise the actual savings proposed. As there was no business case brought to JHOSC, members said they were unable to identify what if any savings would have been made and any impact on the workforce of any back office systems combining.

Members were concerned about assets and land being sold to cover annual deficits rather than to redeploy funds into capital expenditure which would be beneficial for residents in the long-term. Members noted that Enfield had stated that it wanted land sold to be used for health purposes. Members also noted that the increasing population of the North-Central London sub-region would be likely to add to pressure on health services.

The Committee noted the estimate that 30% of A & E visits resulted from people not being able to access primary care. They welcomed efforts being made to reduce this. They also noted that a physiotherapist had been arranged to assist the 9% of patients who presented with back pain.

Members recommended that the Royal Free and North Midds work with Healthwatch, particularly Healthwatch Enfield and Haringey, in ensuring that good consultation took place.

Members were of the view that the case for change had not currently been demonstrated, given the evidence before them. They asked to see a report on the case for change as soon as it was ready.

Members asked that the briefing note and list of questions provided by the Scrutiny Policy Officer be attached to these minutes and put online.

RESOLVED –

(i) THAT the presentation and comments above be noted;

(ii) THAT the Royal Free and North Midds hospitals work with Heathwatch on ensuring good consultation took place about service changes;

(iii) THAT a report come to the Committee on the case for change underlying North Midds and Royal Free joint working.

8. DATES OF FUTURE MEETINGS

It was noted that dates of future meetings would be:

- Friday, 5th October 2018 (Camden)
- Friday, 30th November 2018 (Enfield)
- Friday, 18th January 2019 (Haringey)
- Friday, 15th March 2019 (Islington)

9. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

The meeting ended at 11:35am.

CHAIR

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MINUTES END

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N.B. This briefing was based on publicly available information to assist members' discussions and questioning. However, it is not intended to be exhaustive, and neither North Middlesex Hospital nor the Royal Free have been involved in its production.

Briefing on Proposed Future Relationship between North Middlesex Hospital and Royal Free

JHOSC meeting – 7 September 2018

Background and Context

Serious failings at North Middlesex University Hospital in 2016

- In April and May 2016, the Care Quality Commission (CQC) undertook unannounced inspections at North Middlesex University Hospital (NUMH) because of concerns raised by patients, commissioners and other stakeholders. This led to the CQC finding that the Emergency Department was "Inadequate" and that Medical Care "Required Improvement".

- In June 2016, the General Medical Council and Health Education England became so concerned about conditions at the NMUH's A&E unit that both threatened to withdraw junior doctors from working there. This would have led to the A&E unit having to close and patients needing to be treated elsewhere. However, both organisations decided against this in a joint statement issued on 30 June 2016, which recognised the major efforts made by all relevant bodies to create a safer environment for patients and for staff in the department.

- In July 2016, following the serious failings noted above, the Royal Free London (RFL) provided support to NMUH to improve its A&E. NMUH's Chief Executive, Julie Lowe, was replaced by Libby McManus on secondment from RFL.

- The most recent CQC report on the NMUH, published in December 2016, found that there had been improvements since its earlier inspections but still rated the hospital as "Requiring Improvement" overall:

Overall **Requires improvement**	
Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Relationship with the RFL Group

- In March 2016, the NMUH's Trust Board decided to explore becoming a founder member of the RFL Group. One of the reasons given was that NMUH's Board recognised that its long-term financial model was not

sustainable and that it was unlikely to generate sufficient revenue to become an NHS Foundation Trust.

- Individual trusts are able to join the RFL group under a range of 'membership models', from full membership (where the member is fully absorbed into the group structure) to other arrangements – such as buddying support and clinical partnerships – where organisations continue to have their own separate governance and reporting structures.

- In September 2017, it was announced that Libby McManus, the Chief Executive of NMUH, would return to work at RFL. It was reported in the national press that she left her role as Chief Executive of NMUH under pressure from ministers over consistently poor A&E performance.

- In September 217, it was announced that NMUH would join the RFL group as its first clinical partner. Unlike other hospitals within the RFL Group, it retained a separate Board of Directors with statutory responsibilities to the Secretary of State.

- Sir David Sloman, Chief Executive of RFL Group, took over as accountable officer at NMUH from September 2017, and in November 2017 Maria Kane was announced as chief executive of NMUH, on secondment from RFL. David Sloman remained as accountable officer at that time.

- David Sloman stepped down as accountable officer at NMUH in May 2018 and in June 2018, Maria Kane moved from being under contract to RFL Group to become fully employed by NMUH.

NMUH's most recent performance

- The CQC undertook further inspections of NMUH in May 2018 but have not yet published their report.

- In May 2018, NMUH achieved 85% against the A&E four-hour target, the same as its recovery trajectory of 85%. It ranked 107 out of 133 trusts.

- In June 2018, NMUH achieved 90% against a recovery trajectory of 86%. NMUH's recovery trajectory target is 90% by September 2018.

Questions the Committee may wish to ask NMUH/RFL about their future relationship

- What RFL group membership models are NMUH's Board considering? Is it a straight choice between remaining as a clinical partner and becoming a full member or are there other options being considered?

- What are the advantages and disadvantages of being a clinical partner as opposed to a full member of the RFL Group?

- What are the financial and value-for-money impacts for RFL Group and NMUH of the different membership options? How would the different membership options affect the two trusts' financial deficits?

- Are there proposals for service reconfigurations and relocations? How would these be impacted by the different group membership models?

- If NMUH's board was disbanded, what measures would be in place to ensure that NMUH's services and performance were accountable to its patients, local stakeholders and local residents?

- What impact will the different membership models have on patient outcomes and patient safety standards?

- What impact would full membership of the RFL Group have on patients' and residents' experience of A&E waiting times, compared to continuing with a clinical partnership?

- What impact might the different membership options have on issues such as car-parking availability and pricing?

- How would residents' and patients' views and experiences be sought and factored in to decision-making under the different membership models?

- What impact might the different membership options have on the catchment area for services?

- What steps would be taken to avoid residents and patients having to make excessive journeys for appointments? How would the availability of public transport be taken into account when assessing travel times?

- What noticeable changes in service would patients and residents experience as a result of the different membership models?

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