MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Council Chamber - Town Hall
10 July 2012 (3.30 - 5.40 pm)

Present:

COUNCILLORS

Barking & Dagenham	Sanchia Alasia
Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light (Chairman)
Redbridge	Stuart Bellwood and Joyce Ryan
Waltham Forest	Nicholas Russell
Essex	Chris Pond

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

1 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of arrangements in case of fire or other emergency requiring the evacuation of the meeting room.

2 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.**

Apologies for absence were received from:

Councillor Abdus Salam, Barking & Dagenham
Councillor High Cleaver, Redbridge
Councillor Khevyn Limbajee, Waltham Forest

Also present were:

Councillor Paul McGeary, London Borough of Havering

Emma Lexton, Vice-Chair, Havering LINk
Joan Smith, Coordinator, Havering LINk
Richard Vann, Barking & Dagenham LINk

Sue Boon, NELFT
Bob Edwards, NELFT
John Vile, NELFT
Nick Hulme, BHRUT

Scrutiny officers present:

Anthony Clements, Havering (minutes)
Glen Oldfield, Barking & Dagenham
Corrina Young, Waltham Forest

There were three members of the public present.

3 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

4 MINUTES OF PREVIOUS MEETING

It was noted that Councillor Maravala from Redbridge had not in fact been present at this meeting. Subject to this correction, the minutes were agreed as a correct record and signed by the Chairman.

Under matters arising, a Member asked for details of how patient experience could be measured, as mentioned by the Medical Director of NHS ONEL at the previous meeting. It was agreed that the Clerk to the Committee would contact the health officer concerned and ask for further details on this point.

5 BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST (BHRUT)

The Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) officer explained that the Care Quality Commission had recently acknowledged improvements in maternity services at the Trust and had removed the remaining restrictions placed on the service. He felt that the maternity unit at King George would most likely close in mid-2013 but final decisions on timescales had not yet been taken.

A midwife-led unit would be based at King George with more special care and neo-natal beds installed at Queen's. Work was also under way with commissioners to ensure more capacity at other hospitals once the maternity unit at King George was closed. It was confirmed that the cap on maternity cases from other areas being seen at BHRUT had now been lifted. There was no longer any daily limit on numbers of births at BHRUT but an annual cap of 8,000 births per annum was still in place.

Monthly reports of maternity activity would continue to be presented at the BHRUT Board. It was emphasised that it would not be safe for there to be in

excess of 8,000 births per year carried out at BHRUT and that deliveries would have to be carried out elsewhere once this limit was reached. The issue of women's choice had been considered as part of the Health for North East London (H4NEL) consultation but officers were happy to have further discussions around this.

The vacancy rate at BHRUT maternity was now only 2-3% which was considered negligible. The Trust would provide information on where midwives were recruited from as well as retention figures for maternity staff.

It was accepted that BHRUT continued to face a considerable challenge in meeting the four hour target for A&E treatment. Discharge issues were also being considered in order to reduce the average length of stay in hospital. Work on this was under way with community services, social care and other stakeholders. A reduction in length of stay would be required if Queen's was to accommodate the larger A&E department needed in light of the Health for North East London reconfiguration.

Members were sceptical that A&E at Queen's could cope with any further increase in demand, even if other parts of the hospital offered good care. The BHRUT officer responded that he was taking the lead on the outline business case for the extension of A&E. These works would include more resuscitation bays, six more beds in Majors and improvements to the general flow of patients in A&E. The department would be both expanded and redesigned. The BHRUT officer agreed to bring the plans for A&E back to the Committee once they had been considered by the Trust Board in August 2012. He was also happy to take the plans to the individual borough Health Overview and Scrutiny Committees.

It was emphasised that the A&E at King George would not be closed until it had been confirmed that Queen's A&E could cope with the larger number of patients. The date for when A&E was transferred from King George to Queen's depended on establishing that Queen's A&E could cope safely, obtaining the relevant approvals and the building process itself. The officer estimated that the expanded A&E at Queen's was therefore unlikely to open for at least two years (i.e. summer 2014) but this was only an estimate at this stage.

It was anticipated that one third of current patients a King George A&E would not need to attend an alternative facility once the A&E closed. Work was also continuing on keeping people in hospital for less time and on the number of beds that would no longer be required. It was also being considered how King George could be used for rehabilitation facilities. It was accepted that there was a risk of the assumptions made on levels of demand not being correct but the Trust was managing this.

The officer accepted that there was a significant cost impact of the Health for North East London plans. Capital costs would be significantly higher than stated in the Health for North East London business case and precise figures were currently being worked on. Patient flows were also being

looked at to ensure that the Clinical Commissioning Groups understood the revenue implications and that more people would be going through Queen's Hospital. A £30 million reduction in BHRUT's cost base also had to be achieved this year. All areas of work were being looked at in order to safely make savings including procurement and the numbers of temporary staff used.

There would be capital build issues at Queen's in order to accommodate activity displaced from the King George site. The original timescales to take the outline business case to the BHRUT board had been missed but this meant there would now be more information on actual activity expected at Queen's Hospital.

As regards the King George site, 65% of current A&E activity would continue to be treated there, at the Urgent Care Centre. Outpatients would continue to be seen at King George and some elective work would be transferred over from the Queen's site. Clearer plans on the use of King George would be brought to the Committee during autumn 2012.

The BHRUT officer accepted that, if the Trust's financial position did not improve, it would have a deficit over the next five years of in excess of £150 million. In order to reach Foundation Trust status 5-7% cost improvements would need to be made each year and this was not realistic. As such, an integrated business plan was being developed for BHRUT to become a Foundation Trust over the next five years. The plan would require the Department of Health agreeing to an extended Foundation Trust timetable for BHRUT and be the subject of public consultation. Commissioners would also need to sign up to this plan. BHRUT would also have to show a clear strategy for engagement with local people and that it had addressed the issues raised by the Care Quality Commission.

The officer explained that other organisations had successfully and safely reduced their length of stay. He felt that one third of patients in acute hospitals at any one time did not in fact need to be there. Other savings could be made by e.g. reducing the number of cancelled appointments (30-40,000 per year across the Trust). All processes and systems were being looked at that did not add value to the patient experience. One area of saving could be to make patients' next appointments whilst they were still on the premises, as happened in many other Trusts.

The officer accepted that there were significant issues with the sending of duplicate appointment letters etc. He felt that patient confidentiality was not a reason that appointments could not be sent by e-mail and that hospitals should accept patients' e-mail addresses. This would be considered as part of the Trust's systems and process work that was already under way.

The BHRUT officer felt that the Joint and Borough Overview and Scrutiny Committees could help the provision of healthcare by being a critical friend. The relationship between scrutiny and the Health and Wellbeing Board also needed considering. It was inevitable that BHRUT would have to make

unpopular decisions and it was important that scrutiny informed this debate. It was certainly the case that some hospital services may no longer add value or need to be provided elsewhere. The officer also agreed to take issues around the relationship between the Trust, scrutiny and the Health and Wellbeing Board back to the Trust Board for consideration.

Members agreed that they wished to be a critical friend but remained concerned that little real improvement had been seen, particularly at Queen's A&E. The Chairman hoped that the plans the BHRUT officer had outlined would come to fruition.

The Committee **NOTED** the update.

6 NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT) - ACUTE CARE SERVICES

NELFT officers explained that the introduction of home treatment teams had led to fewer in-patient beds being needed for local mental health services. NELFT had a fairly long average length of stay (20-25 days) but someone did have to be quite ill to be admitted. Mascalls Park acute hospital had been shut in recent years and a new but smaller in-patient unit opened at Sunflowers Court, Goodmayes Hospital. Younger adult in-patients were treated at Naseberry Court in Waltham Forest.

Naseberry Court had a total of 41 beds for patients of 16 years and over. The unit was 16 years old but had what was now an outdated design. The Committee was welcome to visit Naseberry Court if it wished. Staff observation was often difficult in the unit and there were sometimes problems with people absconding. Naseberry Court was also at least 25 minutes drive from Goodmayes Hospital which could make it difficult if support was needed from the other unit.

The NELFT officers emphasised that most mental health services were now provided in the community. The total number of hospital beds across the NELFT area was now less than 300, a far lower figure than previously. The NELFT home treatment team also worked on wards in order to assist discharge etc. If Naseberry Court was to be closed, NELFT aimed to commission a home treatment team for older people as well as support people with dementia. The overall effect of the proposed reorganisation would be to reduce total numbers of NELFT adult male beds from 80 to 75 and adult female beds from 58 to 40. Beds in Sunflowers Court at Goodmayes Hospital would rise by 20 male and 5 female beds.

Naseberry Court now only rarely reached 100% occupancy. Its closure would allow NELFT to create additional home treatment teams and increase staffing levels on acute wards. It was emphasised that the closure of Naseberry Court was for clinical reasons and had been driven by clinicians.

The closure would also produce a financial saving which would assist NELFT to make its required efficiency savings.

There would be a three month public consultation starting shortly. This would be led by NHS North East London and the City although NELFT would be partners. This would be followed by a one month staff consultation period. Subject to the results of the consultation, it was possible that Naseberry Court would be closed in February 2013 although this was not definite.

It was felt that locating the inpatient service at Goodmayes would allow more equality of access across the local boroughs. An equalities impact assessment had been carried out on the change and the longer travel distances were being considered by the NELFT carers' reference group.

NELFT was now providing both community and mental health services and this would allow services to be integrated more closely. For example smoking cessation and weight management services could be offered, where appropriate, to mental health service users. It was agreed that the dates for a visit to Naseberry Court being organised by London Borough of Redbridge would be circulated to interested Members of the Joint Committee.

The NELFT officers emphasised that they wished to demonstrate the benefits of the proposals as part of the consultation. Fewer people now needed to stay in hospital for mental health reasons and those that did were usually hospitalised for a shorter period of time.

Members asked if the consultation papers would break down the catchment area of Naseberry Court by electoral ward in order to show the proportion of users from e.g. Redbridge. The NELFT officers responded that this could be provided but Naseberry Court now saw almost entirely patients from Waltham Forest in any case. There would be no major changes to the existing home treatment teams as a result of the proposals but most of the new investment would be in staff on the wards. It was emphasised that NELFT would still have sufficient in-patient beds for those people requiring them. Members also suggested that the consultation papers give details of the numbers of people treated by home treatment teams both before and after the changes and that a copy of the relevant equalities impact assessment be forwarded to the Committee.

The NELFT officers confirmed that they were awaiting approval from NHS North East London and the City to start the consultation which was likely to run during the August-October period at the latest.

The Committee **AGREED** that an update on the plans be given at its meeting in January 2013.

7 COMMITTEE'S WORK PROGRAMME 2012/13

As the representative from Whipps Cross University Hospital NHS Trust had been unable to attend the meeting, it was **AGREED** that this item would be taken at the Committee's October meeting.

It was also **AGREED** that an update from BHRUT should be taken as a standing item at future meetings and that the Care Quality Commission should be invited to give an update on its views on BHRUT's performance, either directly at a future meeting or in writing.

Members remained concerned about transport links to and between local hospitals and asked that the borough engagement officer for Transport for London arrange for colleagues to brief the Committee on hospital transport issues at the next meeting.

Subject to the comments shown above, the Committee **AGREED** its outline work programme as shown in the agenda papers.

8 FUTURE MEETINGS OF THE COMMITTEE

It was **AGREED** that, subject to accommodation being available, the Committee's remaining meetings of the municipal year would be held in Barking & Dagenham, then Redbridge, then Waltham Forest.

Following a discussion, the Committee also **AGREED** to keep meeting start times unchanged at 3.30 pm.

9 URGENT BUSINESS

A representative of Havering Local Involvement Network (LINk) explained that the organisation had recently published its annual report and gave a brief summary of the work the LINk had been doing.

The Chairman congratulated the LINk on its work and on how it had successfully worked together with scrutiny in Havering.

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Chairman