Public Document Pack

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

3.30 pm	Tuesday 7 January 2014	Redbridge Town Hall, Council Chamber

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Sanchia Alasia
Councillor Syed Ahammad
Councillor Tariq Saeed

LONDON BOROUGH OF WALTHAM FOREST

Councillor Khevyn Limbajee
Councillor Sheree Rackham
Councillor Richard Sweden

LONDON BOROUGH OF HAVERING

Councillor Wendy Brice-Thompson
Councillor Nic Dodin
Councillor Pam Light

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor Hugh Cleaver/
Councillor Filly Maravala
Councillor Joyce Ryan (Chairman)

CO-OPTED MEMBERS:

Mike New, Healthwatch Redbridge
Jamie Walsh, Healthwatch Waltham Forest
Ian Buckmaster, Healthwatch Havering
Richard Vann, Healthwatch Barking & Dagenham

For information about the meeting please contact:
Anthony Clements
Anthony.clements@havering.gov.uk
Tel: 01708 433065


Waltham Forest


London Borough of
Redbridge


LIBERTY
Havering
LONDON BOROUGH


The London Borough of
Barking & Dagenham

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. MOBILE COMMUNICATIONS DEVICES

Although mobile phones, pagers and other such devices are an essential part of many people's lives, their use during a meeting can be disruptive and a nuisance. Everyone attending is asked therefore to ensure that any device is switched to silent operation or switched off completely.

3. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS (Pages 1 - 2)

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

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

3 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any point prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETINGS (Pages 3 - 18)

To agree as a correct record the minutes of the meetings held on 8 October and 20 November 2013 (attached).

5 ACUTE TRUST EMERGENCY PLANNING

To receive presentations from emergency planning officers at Barts Health NHS Trust and Barking, Havering and Redbridge University Hospitals NHS Trust on how local hospitals would deal with major emergency incidents.

6 CHANGES TO CANCER AND CARSDIOVASCULAR SERVICES (Pages 19 - 22)

To receive an update from Neil Kennett-Brown, Programme Director, Transformational Change, North and East London Commissioning Support Unit on proposals for changes to cancer and cardiovascular services.

Note: A draft response letter from the Joint Committee is attached for discussion and agreement by Members.

7 PATIENT EXPERIENCE - BARTS HEALTH (Pages 23 - 32)

To receive a presentation from Tracey Carter, Deputy Chief Nurse and Lyn Hinton, Associate Chief Nurse, Barts Health on patient experience at the Trust.

Report and appendix attached.

8 NHS 111 UPDATE

To receive an update on performance of the NHS 111 service in this region from Jacqui Niner, Head of Services, Partnership of East London Cooperatives Ltd.

9 URGENT BUSINESS

To consider any other item of which the Chairman is of the opinion, by means of specific circumstances which shall be specified in the minutes, that the item shall be considered as a matter of urgency.

Anthony Clements
Clerk to the Joint Committee

This page is intentionally left blank

Map of LB Redbridge Town Hall
128-142 High Road, Ilford, Essex 1G1 2DD

Meeting rooms
Please report to reception on arrival
The Council Chamber and Committee Rooms 1 & 2 are on the 1st Floor
Rooms 42, 43 and 49 are on the 2nd Floor

Travel directions

Walking
The Town Hall is 5 minutes walk from Ilford Station, which is in zone 4. Trains run every 10 minutes from Liverpool Street and you can also join the train at Stratford. Journey time is 15 mins by train from Liverpool Street and 7 mins from Stratford. When you come out at Ilford station turn right and cross at the lights. Walk through the Town Centre (passing an Iceland on your right and The Mall on your left) until you come to the Town Hall on your right. For evening meetings please use the side entrance (near the Abbey National Bank). A bus may can be found via the www.tfl.gov.uk.

Driving
If you intend to drive**, parking spaces at the Town Hall are limited and will need to be booked in advance through the Scrutiny Team on 0208 708 2375/ 2739. A pay and display system is operational between 6.30 – 9.30pm. If a place has been reserved in advance for these times, a permit needs to be obtained from Security at the side entrance in Oakfield Road and displayed in the windscreen**. Alternative car parking facilities are available in Clements Road or in The Exchange Mall. The nearest motorways are the A12 (alight at Gants Hill for Cranbrook Road and proceed toward Winston Way) or the A406 (alight at Ilford for Winston Way). From the Winston Way dual carriageway, take the first left near Cineworld and **proceed straight ahead** for the Town Hall car park in Chadwick Road. **Do not turn right towards the library, as only buses can turn right and you may incur a penalty fine.**

This page is intentionally left blank

MINUTES OF A MEETING OF THE OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Council Chamber - Town Hall
8 October 2013 (3.30 - 5.15 pm)

Present:

COUNCILLORS

London Borough of Barking and Dagenham	Sanchia Alasia
London Borough of Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light (Chairman)
London Borough of Redbridge	Stuart Bellwood, Filly Maravala and Joyce Ryan
London Borough of Waltham Forest	Richard Sweden
Essex County Council	Chris Pond

Healthwatch co-optees:

Ian Buckmaster, Havering
Mike New, Redbridge
Richard Vann, Barking & Dagenham
Jaime Walsh, Waltham Forest

Councillor Winston Vaughan, London Borough of Newham was also present.

Officers present:

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT):
Mike Gill, Medical Director

Barts Health:
Len Richards, Chief Operating Officer
Alastair Chesser, Group Director, Emergency Care and Medicine CAG
Sandra Reading, Deputy Director, Women's and Children's CAG
Jo Carter, Stakeholder Relations and Engagement Manager

Care Quality Commission (CQC):
Seaton Giles, Compliance Officer
Margaret McGlynn, Compliance Officer

Commissioning Support Unit:
Neil Kennett-Brown, Programme Director – Transformational Change

Scrutiny Officers present:
Barking & Dagenham: Glen Oldfield, Michael Tyson
Havering: Anthony Clements (clerk to the Committee)
Newham: Luke Byron-Davies
Redbridge: Jilly Szymanski, John Owen
Waltham Forest: Corrina Young

All decisions were taken with no votes against.

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

11 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of arrangements in case of fire or other events that may require the evacuation of the meeting room. The Chairman also explained that, whilst the meeting was being held in public, only Members and nominated Healthwatch co-optees would be able to ask questions. On this occasion any Members present from Councils outside the region covered by the Committee would also be allowed to ask questions.

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

Apologies were received from Councillors Syed Ahammad (Barking & Dagenham) Hugh Cleaver (Redbridge) Khevyn Limbajee (Waltham Forest and Sheree Rackham (Waltham Forest).

13 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

14 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 2 July 2013 were agreed as a correct record and signed by the Chairman.

15 CARE QUALITY COMMISSION INSPECTIONS OF LOCAL HOSPITALS

Care Quality Commission (CQC) compliance officers explained that the A&E at Queen's Hospital had been inspected in May 2013 by a team consisting of A&E consultants and Experts by Experience who were trained members of the public. The main concerns identified had been over patient care and welfare and over staffing issues. Similar concerns had been raised in the CQC's previous inspection in December 2012.

It was accepted that staff now gave more time and attention to people waiting in A&E. Nursing staff levels were acceptable but there were not enough permanent consultants in A&E and this had been the position for the last two years. Patient feedback about A&E staff was now more positive and a recent inspection of five elderly care wards at King George Hospital had found that staff there knew the patients and their needs.

A series of inspections had also recently been carried out across Barts Health looking at areas including A&E, outpatients and maternity. This had found that the Trust was not meeting ten of sixteen essential standards. Poor staff attitudes had been found in Whipps Cross maternity and warning notices had been issued over areas such as baby resuscitation units not being ready for use.

Inspectors had also found that elderly patients were not always getting pain relief and that handover of patients from ambulances at the Whipps Cross A&E and Urgent Care Centre was not good enough. A lack of equipment had been noted on elderly wards and warning notices issued concerning a lack of staff appraisals and supervision.

The Chairman noted that there was now a new maternity unit at Whipps Cross and this had recently been visited by members of the Committee.

Following the Francis Report, the CQC recognised that hospital inspections had to be more in-depth. As such, larger inspections teams were being formed that would be on site at a hospital for 5-7 days. Listening events would be held with the public and the CQC would publish performance ratings for hospitals from April 2014. Failing Trusts could be referred to the Trust Development Authority for the implementation of a failure regime. A new inspection of BHRUT was due to commence on 14 October with a listening event in Ilford scheduled for 15 October.

Response from Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

The BHRUT officer was pleased that elderly care at King George had recently received a good assessment from the CQC. It was accepted that there remained a lot of challenges in the Emergency Department and this was a long-standing issue. Current performance on the four-hour rule at Queen's A&E was only 88%.

Overall attendance numbers at Queen's A&E were about the same but cases received had got more serious. There had been an increase of 15% in the number of ambulances coming to A&E and a total of 32 ambulances had been received at Queen's in a 2 hour period the previous Saturday.

There was a national shortage of A&E doctors and BHRUT had lost four further consultants from A&E in the last three months. Recruitment was currently in progress to a series joint appointments with Barts Health but only 7 of 21 A&E consultants across both sites were filled by permanent

staff. Work was also in underway with UCL partners to increase recruitment options.

Plans had been drawn up to improve the A&E department at Queen's which was now seeing in excess of 130,000 patients per year despite having been built for only 90,000 patients. Seven day working had commenced from September 2013 for the frail elderly, gastroenterology, and chest medicine departments. Care planning and discharge procedures had also improved.

The CQC had raised concerns about staffing on both sites and it was confirmed that the London Clinical Senate had advised against the proposed night closure of A&E at King George. Staffing levels in A&E were reviewed by senior officers on a weekly basis.

Response from Barts Health NHS Trust

Following criticism of cleanliness by the CQC, all senior staff in maternity had received enhanced training on how to inspect cleaning. All midwives and support staff had also received enhanced training in infection control. Maternity equipment was now replaced in a more timely fashion and Whipps Cross now had two brand new maternity operating theatres and new high dependency beds. Two bereavement suites had also recently been opened. Officers agreed that poor staff attitudes reported by the CQC had not been acceptable and action plans had been drawn up to address this.

More doctors and nurses had been recruited to the A&E department at Whipps Cross and a new Acute Assessment Unit had been opened ten days previously. It was also planned to improve the hospital discharge process.

Whipps Cross had received good scores on patient satisfaction and on the friends and family test. Officers felt it was also important to ensure staff felt valued by Barts Health.

A lot of work was being undertaken on the hospital cleaning contract. Work was done in partnership with commissioners, the Trust Development Authority and Healthwatch. This also meant there were regular peer review inspections across the Barts Health sites. A new Care Campaign at Whipps Cross ensured team meetings were in place and appraisal rates had been raised.

Questions and discussion

CQC officers were disappointed that some Members had not received details of the planned listening event and agreed to circulate details of this. Members did feel that some local hospital services e.g. maternity at Queen's had improved and that there should be more media coverage of positive developments in the NHS.

Members also reported very mixed feedback of other services such as the elderly care wards at Whipps Cross. Issues such as a lack of timely administering of pain relief had been addressed some years previously but were now reoccurring. The CQC representative agreed, having found that patients were not appropriately cared for at the Urgent Care Centre at Queen's and that, in some cases, patients should have been referred to A&E sooner.

Barts Health officers emphasised that they were not trying to defend bad behaviour on wards. While most staff were good, it was also important to eliminate bad behaviour. The Barts Health merger had created challenges for staff but it was not correct to suggest that Whipps Cross was not a major focus for Barts Health. Members felt that not giving pain relief or taking patients to the toilet was simply bad practice. Barts Health officers accepted that some wards were better organised than others and did take these sort of incidents seriously when they occurred.

Officers accepted Members' reports of staff attitudes being variable at best. It was also agreed that it was sometimes unclear who was in charge of a ward etc. Staff should introduce themselves and phones should be answered. It was also accepted that delayed discharge was a problem at Whipps Cross, particularly as Waltham Forest was an elderly borough. This was a shared responsibility across partners.

Smoking cessation was a key priority for both staff and patients at Whipps Cross and offices were disappointed at reports that hospital staff were leaving discarded cigarette butts on the path between the bus stops and the main hospital entrance. Officers would confirm whether Barts Health had spoken to TfL re helping patients or relatives from Redbridge to get to Whipps Cross.

A Member suggested that the CQC should publish advice for Councillors on what to look out for when they visit hospitals and the CQC officers agreed to take this back. Information on what the CQC looked for during its inspections was available on the organisation's website. It was noted that Healthwatch also had the power to undertake enter and view visits to hospitals. It was also suggested that the CQC programme of inspections should be more widely publicised.

The Committee **NOTED** the presentation and responses.

16 CHANGES TO CANCER SERVICES

The officer from the Commissioning Support Unit explained that a reconfiguration of cancer and cardiac services was being proposed across Central, North and East London as well as part of Essex. It would however only be specialist services that would be affected. The launch of the public engagement process had been delayed slightly so it was not possible to discuss the proposals in detail at this stage. The engagement process would run until the end of November at which point views would be sought from the Committee (as well as the equivalent bodies for Inner North East and North Central London) on whether the changes were considered to be substantial and hence whether formal consultation would be needed. Initial letters to the Chairmen of all the affected borough Health OSCs would be sent shortly after the case for change had been signed off.

If formal consultation was required, a super-JOSC covering all effected boroughs and counties would need to be formed in order to give the final response. Work would be undertaken with the existing JOSCs initially but the final response would need to be submitted by the super-JOSC.

NHS England had taken the decision to combine consultation on the cancer and cardiac proposals. The views of the JOSC that had been previously expressed on the cardiac proposals had been noted.

The Committee NOTED the situation and AGREED to hold an additional meeting in order to be briefed on the proposals and to seek to reach a view on whether they constituted a substantial variation.

Note: The meeting has since been confirmed for Wednesday 20 November at 3.30 pm in Redbridge Town Hall, Ilford.

17 STROKE REORGANISATION AT WHIPPS CROSS HOSPITAL

Officers explained they were proud of the stroke services at Whipps Cross but that patients with stroke now generally spent less time in hospital and length of stay was predicted to continue to fall further. For this reason, the number of stroke beds at Whipps Cross had been reduced from 26 to 19 as there was no longer sufficient demand in the system.

It was accepted that this development could have been publicised better and more positively by the Trust. Approximately one third of stroke admissions now went home within 48 hours although the average length of stay was around 14 days.

Rehab services such as physiotherapy were better in some boroughs than others and officers felt that the provision of community services was vital. It was clarified that stroke patients had not lost the use of the gym at Whipps Cross although this was now considered less important for the recovery of stroke patients in any case.

The Committee **NOTED** the update.

18 PROPOSED AMENDMENT TO COMMITTEE'S TERMS OF REFERENCE

The Committee considered a report suggesting an amendment to clause 5 of its Terms of Reference in order to make it clearer that each constituent borough Health Overview and Scrutiny Committee (OSC) had the right to nominate Members the JOSC as it saw fit and that the requirement to reflect political balance could be waived by a borough OSC, provided this was agreed by the rest of the Committee.

The recommendation of the report was **AGREED** unanimously as follows:

> That the Committee adopt the revised wording of clause 5 of its Terms of Reference as follows:
>
> **Appointments made to the JHOSC by each participating London borough OSC will reflect the political balance of the borough Council, unless a participating borough OSC agrees to waive the requirement and this is approved by the JHOSC.**

In light of this, the Committee also **APPROVED** that the requirement for the Redbridge representatives on the Joint Committee to reflect political balance be waived as agreed by the Redbridge Health Overview and Scrutiny Committee on 23 September 2013.

19 URGENT BUSINESS

There was no urgent business.

_____

Chairman

This page is intentionally left blank

MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Council Chamber, Redbridge Town Hall
20 November 2013 (3.30 - 5.20 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Sanchia Alasia
London Borough of Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light
London Borough of Redbridge	Stuart Bellwood, Hugh Cleaver, Filly Maravala and Joyce Ryan (Chairman)
London Borough of Waltham Forest	Richard Sweden
Essex County Council	Chris Pond

Healthwatch Representatives:
Barking & Dagenham – Frances Carroll (substituting for Richard Vann)
Havering – Ian Buckmaster
Redbridge – Mike New
Waltham Forest – Jaime Walsh

Scrutiny officers present:
Barking & Dagenham – Glen Oldfield, Mark Tyson
Havering – Anthony Clements (clerk to the committee)
Redbridge – Jilly Szymanski, Jon Owen
Waltham Forest - Corrina Young

NHS officers present:
David Fish, NHS England
Ian Grant, Haematologist, BHRUT
Neil Kennet-Brown, NHS England
John King, Barts Oncology Pathway Director
Charles Knight, Barts Health
Mansoor Mughal, UCLH
Hilary Ross, UCL Partners

Approximately five members of the public were in attendance.

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

20 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of arrangements in the case of fire or other event that should require the evacuation of the meeting room.

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

Apologies were received from Councillors Syed Ahammad (Barking & Dagenham) and Khevyn Limbajee (Waltham Forest). Apologies were also received from Richard Vann, Healthwatch Barking & Dagenham (Frances Carroll substituting).

22 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

23 MINUTES OF PREVIOUS MEETING

Members made the following comments:

On page 3M, the date of the first Care Quality Commission listening event had not been known to the Joint Committee at the time of the meeting and health officers were in fact unable to give these details during the meeting itself.

On page 5M, officers had been asked to confirm whether Barts Health had spoken to TfL re helping patient and relatives from outlying districts to get to Whipps Cross, rather than solely those from the Redbridge area.

The Chairman also asked if it could be fed back to the Care Quality Commission that, as mentioned at the meeting, a guide for what Councillors should look out for when visiting hospitals etc would be very useful.

Subject to the comments above, the minutes of the meeting held on 8 October 2013 were **AGREED** as a correct record and signed by the Chairman.

24 REVISED COMMITTEE MEMBERSHIP

The Committee noted that Malcolm Wilders had recently resigned from the Committee due to ill health. The Committee **AGREED** that it should record its thanks to Mr Wilders for his contribution whilst a member of the Committee.

25 CHANGES TO CANCER AND CARDIOVASCULAR SERVICES

Presentation from NHS Officers

NHS officers explained that cancer and cardiovascular disease were the two biggest reasons for early mortality. It was felt that current services were not coordinated enough and that specialist centres such as the Hyper Acute Stroke Unit at Queen's Hospital led to better outcomes for patients. Centres such as these would also give a better patient experience.

There were proposals affecting several different types of cancer including bladder, prostate, kidney, leukaemia, brain, head & neck and stomach. It was emphasised that the strongest drivers for change were improving patient outcomes and improving the patient experience.

Many cancer services in the region were not meeting national guidelines and it was wished to have specialist care available on a 24:7 basis. This would include better technology such as the use of robotic surgery for prostate cancer, specialist nursing and access to clinical trials.

All pre and post operation services would continue to be delivered on a local basis. BHRUT would see a rise in some operations such as those for brain cancer and upper oesophago-gastric (OG) cancers, although the latter was planned to eventually move to one site at UCLH. There would be fewer bladder, prostate and renal cancer operations at BHRUT under the proposals. Overall, BHRUT would see a 3% reduction in episodes of care under the proposals.

Feedback to date had shown overall support for the proposals to consolidate specialist services but people had also indicated that services should be kept local where possible. In Outer North East London, there had been support to move from 3 to 2 OG centres but concerns had been raised over the plan to move to a single centre eventually and this proposal was still being considered. There had also been feedback that a second centre for prostate cancer should be located at BHRUT in order to reduce travel difficulties. It was accepted by NHS officers that travel issues were very important although patients had stated they would be willing to travel further for better outcomes.

UCLH would provide a number of travel support initiatives for patients including procuring more disabled parking bays, giving better information on travel options and, in some cases, supplying hotel accommodation for patients and their families. Similar support would be available from the Royal Free Hospital for kidney cancer patients.

It was not anticipated that there would be much impact of the cardiovascular proposals on Outer North East London as patients from this area already travelled to the London Chest Hospital which would transfer to the Barts site at Farringdon from 2014. As with the cancer services, officers explained that there would be a concentration of very specialist services with no change to

local services which would continue to be provided at BHRUT and Basildon Hospitals.

The heart unit at Barts would be the largest in the UK and it was expected this could save 1,000 extra lives per year if even the average outcomes for England could be reached. 24:7 specialist care could however only be provided by having a larger unit such as that on the Barts site. There had been strong support overall for the Cardiovascular proposals. The Chairman asked if it would be possible to visit the Farringdon Barts site once it was receiving patients.

Address by PHASE

The Committee were addressed by representatives of PHASE – a prostate cancer support group covering the BHRUT area. The representatives explained that prostate cancer was the most common form of male cancer and that late diagnosis was a major issue due to the lack of a cancer screening system.

The main provider of prostate operations was BHRUT and NHS England wished to transfer these operations from BHRUT to UCLH. PHASE felt that the current service provided by BHRUT was centrally located within the ONEL area. The service was also cheaper with a cost per operation 12% lower than at UCLH and, in PHASE's view, the change was not supported by local clinicians.

PHASE had not seen any specific evidence that a transfer to UCLH would give better outcomes for patients and therefore wished to keep services at BHRUT. PHASE also considered that there should be a full public consultation on the proposals.

Questions and Discussion

NHS officers clarified that the figure of 1,000 lives saved was based on the current death rates for the local area and the annual average figures for England.

A travel analysis of the proposals was being carried out and it was anticipated that approximately 20-30 patients per borough would be affected. Most cancer services at Queen's Hospital would be unchanged although a small number of patents would be affected.

Officers emphasised that there had been no final decisions as yet. The proposals were recommendations to NHS England. The number of patients affected by the urological changes i.e. those men having radical prostatectomies, was a very small proportion of the overall number of patients. It was also thought that the numbers of patients requiring surgery of this type may reduce in the coming years. It was also planned to offer enhanced diagnostic services for prostate cancer at all hospitals including King George.

Services such as Hifu Unltasound were a very significant treatment for prostate cancer and it was probable that a new centre for this treatment would be established at Queen's Hospital. The work proposed to transfer to UCLH was therefore a very small proportion of the total number of prostate treatments.

A PHASE representative stated that the group had spoken to clinicians at BHRUT who did not support the changes but the Chairman felt that the Committee needed to see evidence of this.

The NHS officers agreed that they did not currently know how many prostate cancer cases are diagnosed too late to have surgery. Early detection would mean more cases could be treated by surgery and hence fewer deaths. Tumours were more aggressive in late diagnosed cases. 63% of BHRUT prostate patients had less aggressive tumours which indicated that early diagnosis had been taking place.

Officers would supply for the Committee details of the travel impact assessment that had taken place. Alternative centres to UCLH for patients outside Greater London would be Addenbrokes Hospital in Cambridge and Basildon Hospital although formal discussions on where surgery for Essex NHS patients would be located had not taken place as yet.

Officers were not aware of any charges for the UCLH patient hotel although they would confirm if this was the case. Centralisation was the preferred option due to the small numbers of operations taking place currently in each hospital. It was emphasised however that 97% of current cancer care would remain local. Thus brain cancer surgery was planned to cease at the Royal London Hospital and this would lead to a corresponding increase in activity at Queen's. Reducing oesophago-gastric surgery from three to two sites would also bring numbers of operations per site up to national guidelines. As regards prostate surgery, it was hoped that commissioners could provide more accurate figures for the number of radical prostatectomies carried out.

Given new NICE guidance that prostate conditions should be treated more with active surveillance rather than operations, officers felt this could mean the number of prostate patients from this region having to travel into London would reduce to as low as 3-4 per month. Members felt that data on complication rates etc was also required.

Members were concerned at the lack of data with which to make a decision on the proposals. The NHS officers confirmed that they were committed to getting this information and would also supply to the Committee borough data that had been given to Health and Wellbeing Boards and Clinical Commissioning Groups. Prostate outcomes in the BHRUT area compared to the rest of London were currently being investigated.

Clinicians had been involved in the development of the cancer services case for change and officers reiterated that the priority was to improve

patient outcomes and experience. Clinicians felt that there was clear evidence that the more operations a clinician carried out, the higher their skills level would become. Officers also accepted that prevention and early diagnosis needed to improve. There were projects running on patient pathways and work was in progress with primary care physicians on e.g. avoiding heart attacks in patients. It was felt that specialist centres would drive improvements across the whole system. Members asked for further information to be provided on this work.

No diagnostic services would be lost from Whipps Cross and it was planned to make procedures such as gastroscopies more available to people. Work was also under way to investigate why some patients are only diagnosed with cancer when they present at A&E. A report on this work would be publicly available from early December.

Whipps Cross would lose some renal activity to the Royal Free Hospital. Officers would confirm the numbers involved but it was thought this would be in the region of 10-20 operations per year. There would also be a movement from Whipps Cross to UCLH for robotic pelvic cancer surgery but it was noted that most patients were already choosing to have surgery of this type at UCLH rather than Whipps Cross. Dialysis would continue to be delivered locally as would other existing kidney services. The proposed changes only related to kidney cancer surgery.

A representative of Healthwatch Redbridge was unhappy with the current engagement arrangements and NHS officers confirmed they were happy to discuss this. NHS England had also confirmed that they were committed to a period of formal engagement once the clinical preferred option had been established.

It was planned that a summary of the feedback received would be presented to the Chairmen of the JOSCs for ONEL, INEL and North Central London at a meeting to be held in the week commencing 9 December. This meeting would also seek to establish which, if any, of the proposals the JOSCs felt required formal consultation.

The Committee discussed the proposals and felt overall that, whilst there were some significant changes, that a formal consultation process was unlikely to be necessary. Members did feel that there should have been more public engagement and that much of the data and information requested would need to be provided by NHS officers before a final decision on whether consultation would be necessary could be taken.

It was **AGREED** that an item be taken at the next meeting giving an update on the position with the cancer and cardiovascular services proposals.

Chairman

This page is intentionally left blank

Anthony Clements
Principal Committee Officer

COMMITTEE ADMINISTRATION
London Borough of Havering
Town Hall Main Road
Romford RM1 3BD

Please contact: Anthony Clements
Telephone: 01708 433065
Fax: 01708 432424
email: anthony.clements@havering.gov.uk

TO:

Neil Kennet-Brown
Programme Director – Transformational Change
North East London Commissioning Support Unit
Third Floor
Clifton House
75-77 Worship Street
London
EC2A 2DU

Date: 19 December 2013

Your Reference:
Our Reference: **AC**

Dear Neil

Views of Outer North East London Joint Health Overview and Scrutiny Committee (JHOSC) on Proposals to Change Specialist Cancer and Cardiovascular Services

As the current Chairman of the Outer North East London JHOSC, I am writing to confirm the overall views of the Committee on the above proposals. Having undertaken scrutiny of the proposals during the recent engagement process, the Committee is of the view that these proposals do not require formal consultation under section 242 of the National Health Service Act 2006. The Committee therefore feels that the changes should proceed, subject to the comments shown below.

As you are aware, The NHS has a duty under section 242 of the above Act to promote involvement and consultation in any service change. This involvement has to be proportionate to the extent of the proposed service changes. The NHS also has a duty under section 244 of the Act and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 to consult with local authorities on any proposal it considers is a substantial development or variation in the provision of health services.

The Joint Health Overview and Scrutiny Committee is exercising its powers as conferred under the NHS Act 2006, section 245 (as amended by the Health and Social Care Act 2012). This is distinct from and separate to those powers exercised by the Executive of the constituent Councils.

The JHOSC has considered the engagement exercise that NHS England and UCL Partners have conducted regarding the proposed changes to cancer and cardiac services in North Central and North East London. The Committee wishes to place on record its view that, while it does not consider the proposed changes to constitute a substantial variation in service, it considers it essential that engagement on the service alterations continues with the JHOSC and all other relevant stakeholders as the proposals are developed and implemented.

The Committee has considered the outputs from the engagement process and notes in particular that:

- Many patients and members of the public expressed their strong support for the majority of services to be kept local where possible.
- Travel implications were highlighted by nearly all respondents, particularly among cancer patients and their families in Outer North East London and West Essex. Strong concerns were expressed about the inconvenience and difficulty for patients and their families travelling to central London, lack and cost of car parking, and the difficulty and discomfort of travelling when undergoing treatment.
- The urology proposals, affecting Outer North East London and West Essex in particular will have an external review, by NHS England (London) clinical senate, to provide further evidence before commissioners finalise their decision making on the model. The Joint Committee would support any proposed retention of urological cancer services at either Queen's or King George Hospitals (in conjunction with the centre to be developed at UCLH).
- Many respondents felt that more information was needed as to how proposed specialist centres would work to increase early diagnosis and prevention.
- There is a need for outcome data from the proposed specialist centres to be frequently and publicly available to help inform patient choice and ensure standards are being met.
- Integration with the rest of the pathway and continuity of care is essential. There needs to be mechanisms in place to ensure patients, their records and their treatment plans are managed appropriately as they leave and re-enter a non-specialist part of the pathway.

The Committee is pleased that the NHS has agreed to send stakeholders a final report on the proposed changes in February/March in order to provide a final opportunity for comments. The JHOSC would also like the NHS to address the issues raised in the engagement and provide responses. This would however be in order to ensure any unforeseen challenges are mitigated against (and benefits realised) rather than to reconsider the key decisions to move services.

In conclusion, the Committee wishes to reiterate its view that it is essential that robust engagement continue not just with itself but with all relevant parties and stakeholders. The JHOSC would also like to be able to scrutinise the project business case when it becomes available, the independent prostate report, the full engagement report and the equalities impact assessment.

Yours sincerely

Councillor Joyce Ryan
Chairman, Outer North East London Joint Health Overview and Scrutiny

This letter has been copied to:

All Members and Supporting Officers, Outer North East London Joint Health Overview and Scrutiny Committee
Luke Byron-Davies, Clerk, Inner North East London Joint Health Overview and Scrutiny Committee
Rob Mack, Clerk, North Central London Joint Health Overview and Scrutiny Committee

The Joint Health Overview and Scrutiny Committee is exercising its powers as conferred under the NHS Act 2006 section 245 (as amended by the Health and Social Care Act 2012). This is distinct from and separate to those powers exercised by the Executive of the constituent Councils.

This page is intentionally left blank

Barts Health NHS
NHS Trust

Progress update on patient experience
December 2013

1. Overview

Barts Health is committed to using patient feedback and patient experiences to continuously improve our services. This report provides an update to the outer north east London Joint Overview and Scrutiny Committee on how the Trust involves patients in improving the delivery of our care. Tracey Carter, Deputy Chief Nurse, and Lyn Hinton, Associate Chief Nurse will attend the meeting of the committee on the 7 January to answer any questions on this paper.

2. Patient stories at Trust Board

The Trust Board meetings begin with a story from a patient's experience. The patient story is an account of one event or episode of care, given directly to the Board so that we can understand what happened and why. By actively listening to real experiences the Board will see our organisation through the patients' eyes and be able to maintain a focus on continually improving patient safety and experience from the patients' perspective. The story is discussed in detail with the patient and recorded in the public minutes with relevant actions. The story is also discussed within the Clinical Academic Group and action plans are implemented and monitored at quality and safety meetings.

The Board has agreed that each CAG will support a patient and a staff story from their services to Trust Board each year, and members may also request stories that relate to a specific Trust objective or that highlights a prominent theme from complaints. An annual event will also be held where all patients who have told their story to the Trust Board, will be invited to meet with members, hear how their story has made a difference and to review any changes made as a result. The first event will be held in spring 2014.

3. Patient forums and representatives

Although the development of the original patient engagement forums was slowed down earlier this year, the Trust continues to support and nurture all the volunteers recruited and use their valuable expertise and knowledge. In addition, the Whipps Cross patient panel has continued to give robust support and commitment to the site.

The patient panels and representatives currently in place provide support and are involved in the CAG Boards and service line activities and formal peer review inspections. We have also strengthened involvement in key areas of work – for example in our dedicated excellence in older people's care programme we are working closely with an external assurance panel and Age UK London, and members of the Whipps Cross Patient panel and other local patient representatives are working with us to support ward managers and speak to patients to help influence decisions and improve patient experience. Individuals recruited to CAG Boards also continue to work closely with clinical leaders to ensure patient feedback is directly used in service improvement.

The development of revised patient panels will be picking up pace in the New Year and will be linked to the improvements we are making in site based leadership and support. We will work with patient representatives and Healthwatch to develop a model which is sustainable and suitable to local needs. This may include exploring communities of interest and for task and finish groups. It is expected that this work will begin in January next year and we would be happy to attend a future meeting of the committee to update on progress.

4. Working with Healthwatch

Senior nursing and communications colleagues regularly meet with City, Hackney, Tower Hamlets, Newham, Redbridge and Waltham Forest Healthwatch leads to discuss patient experience and share ideas for improvement. As part of this partnership, a new process to share detailed information from our PALS and complaints services has been agreed. The raw data which will be provided consistently on a monthly basis will be anonymised to enable Healthwatch analysts to manipulate the data into reports they require. An overview report of PALs and complaints data including the top three themes and issues, the cases by site, the initial contact method, PALS data by CAG and the top 10 themes will also be provided to Healthwatch every six months. A copy of this report is provided as an appendix to this paper.

We have also agreed a more robust and efficient process to consider recommendations and agree actions as a result of Healthwatch enter and views. The new process will be led by Hospital Directors and CAGs, with appropriate action plans monitored at service quality and safety meetings and reported to the Quality Assurance Committee.

Healthwatch continue to receive written briefings, request to support structured, formal Peer Reviews and other engagement opportunities in the Trust, and we expect relationships will be further strengthened with the introduction of Hospital Directors and lead site nurses. Healthwatch are also keen to work with the Trust in the New Year on developing local communities of interest and patient forums and we welcome their support.

In addition to the above, and in partnership with the CCGs, Healthwatch managers attend on a quarterly basis the WELC and Barts Health strategy meeting to support discussions around local health services.

5. Listening to patient feedback

The Trust is committed to improving patient experience by actively responding to the results received from national patient surveys. On 1 October, we also introduced real time feedback questions that we scored poorly on in the inpatient survey, the Care Quality Care Commission (CQC) indicators and the commissioning for quality innovation (CQUIN) questions.

- Did you have confidence and trust in the Doctors treating you?
- Did you have confidence and trust in the Nurse's treating you?

- Overall, did you feel you were treated with respect and dignity while you were in the hospital?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you involved in decisions about your discharge from hospital

The questions are on the reverse of the Friends and Family (FFT) cards and in all inpatient adult wards.

The Trust has also implemented the Friends and Family Test (FFT) in adult inpatient and emergency departments since April 2013. The FFT is a temperature check for the organisation measured by how likely they are to recommend the service to a loved one. The percentage of patients taking part has increased at Barts Health and is average when compared nationally. The wards have responded well to the task of engaging patients with the initiative and the Emergency Department have made good progress, including securing funding for a counter system in the department. This will enable patients to rate their experience by dropping a coloured counter into a box thereby reducing barriers such as not having a pen, insufficient literacy or English language. Patients can still write comments on a card if they wish to clarify their rating choice.

The introduction of FFT across our maternity departments in October this year will also help further improve the service for patients. Feedback for maternity is sought at the 36 week antenatal appointment, at the end of the delivery/hospital episode and 10 days after, when the mother and baby's care is handed over to the health visitor and GP.

We expect FFT will be implemented in outpatients and day-care across all our hospitals in 2014 and all areas by April 2015.

6. Improvements to our PALS service

A change to the way that the PALS operate was introduced as a pilot on 1 July 2013.

The purpose of providing a centralised PALS Hub is to achieve the timely and effective triage of patients who call to request information; raise a concern; provide feedback or to make a complaint and thereby facilitate the earliest possible resolution. Contact is available through fax, email and telephone. There are 3 lines available and a voicemail facility for people to leave a message should the lines be engaged.

This page is intentionally left blank

Barts Health NHS
NHS Trust

Appendix 1

PALS & Complaints Data report

PALS (April 2013 – Oct 2013)

Bart Health PALS registered 3372 cases between April 2013 to October 2013. Chart 1 demonstrates the breakdown per legacy site.

PALS Contacts are split into two types, Information & advice and issues and concerns. Cases registered under issues and concerns are typically the more complex cases where there has been PALS intervention and local resolution work.

As chart 4 confirms the top three themes under our issues and concerns activity continues to focus on;

- Problems with appointments (21%)
- Poor communication between patients and staff (20%)
- Concerns about diagnosis and treatment (15%)

Chart 2 indicates that the main method of contact with the service continues to be via telephone and email. A change to the way that the PALS operates was introduced as a pilot on 1 July 2013. The aim was to create a centralised call HUB in order that all calls to PALS were managed in an efficient, effective and timely way. Service systems were fully integrated and a Barts Health PALS centralised telephone phone number and email address was introduced in October 2013 to help improve access to the service.

Chart 1

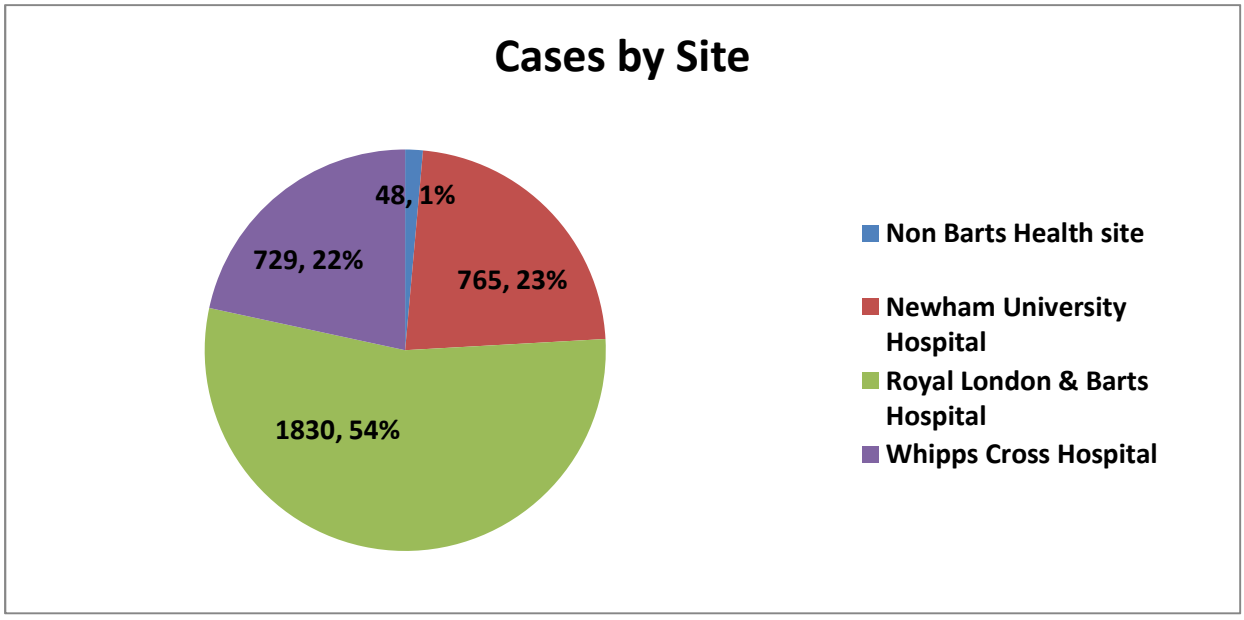


Chart 2

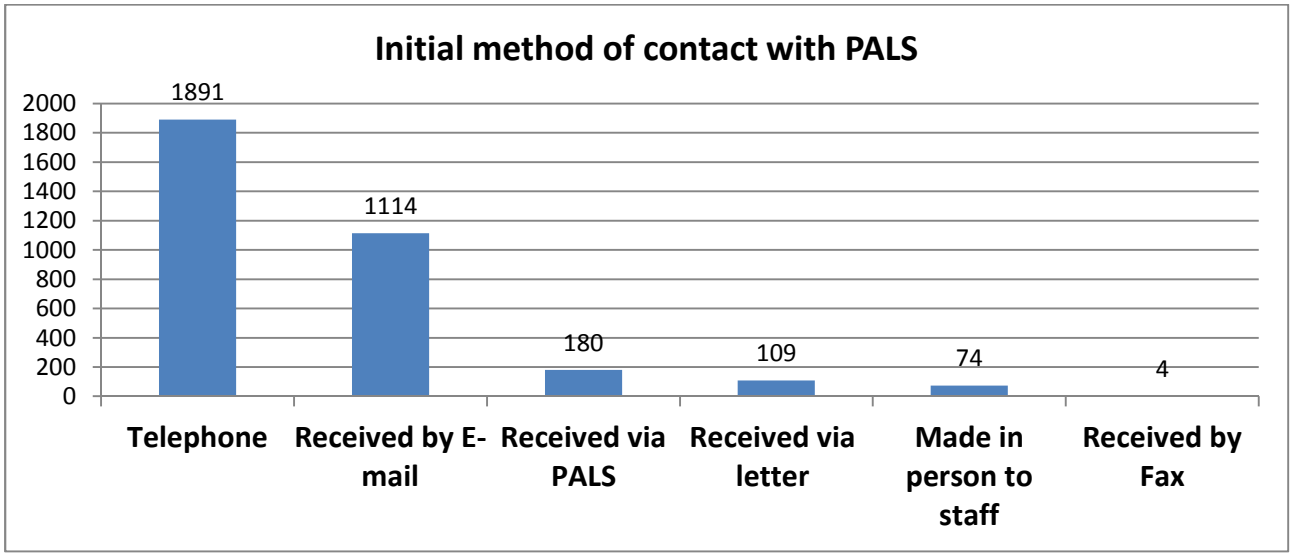


Chart 3

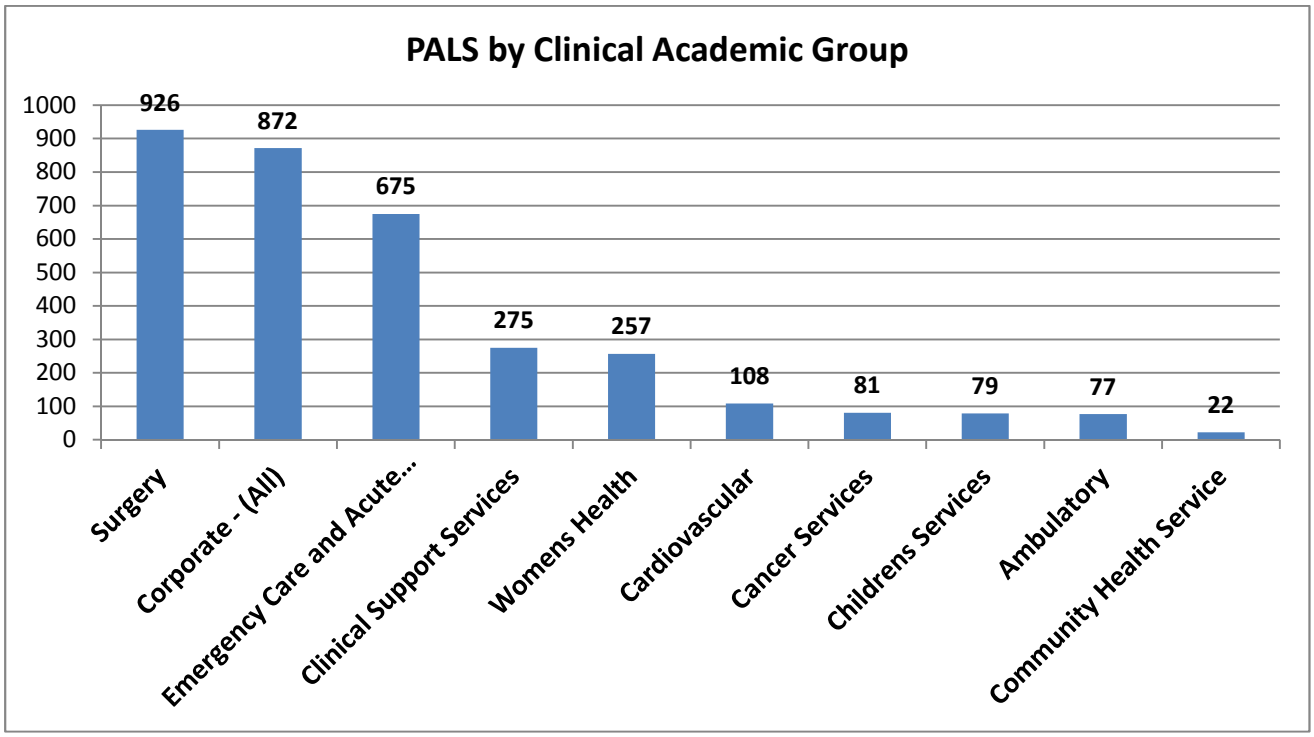
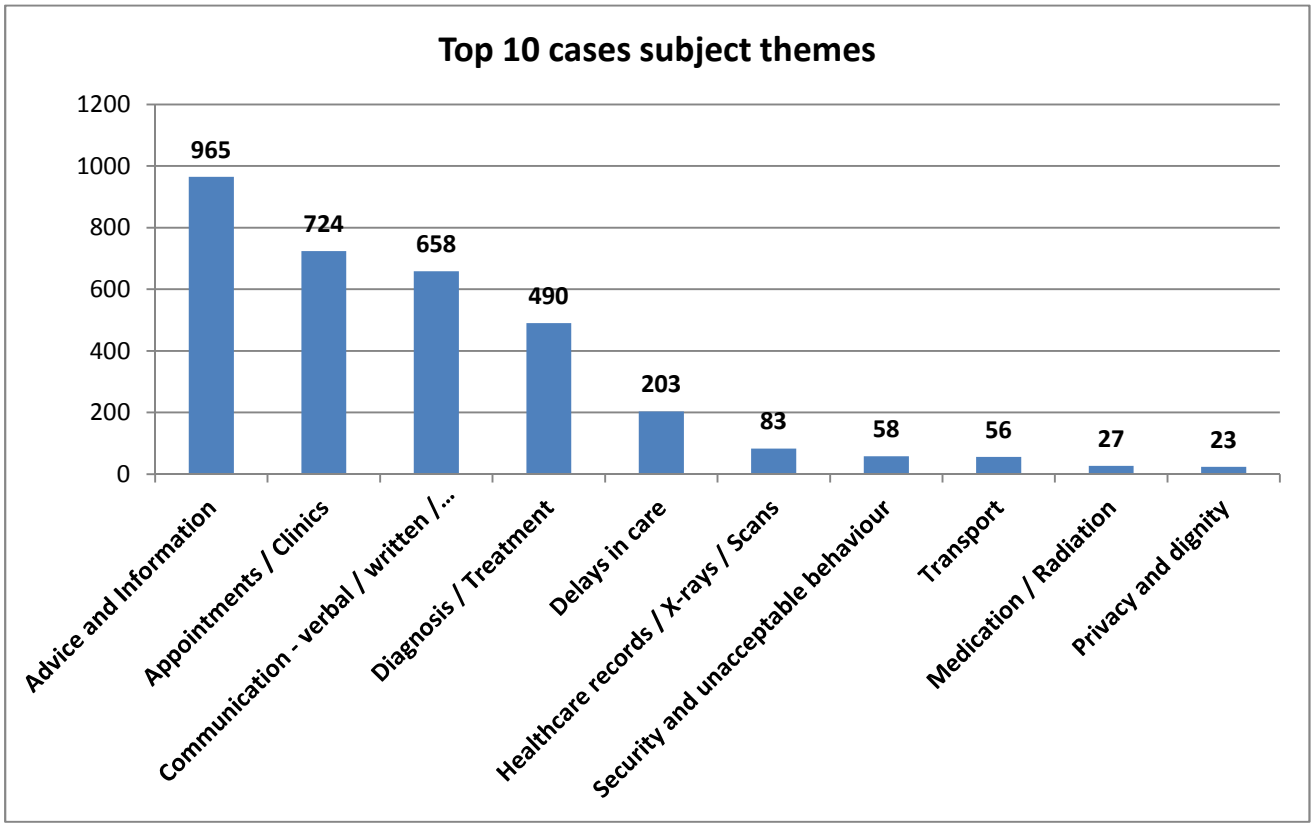


Chart 4

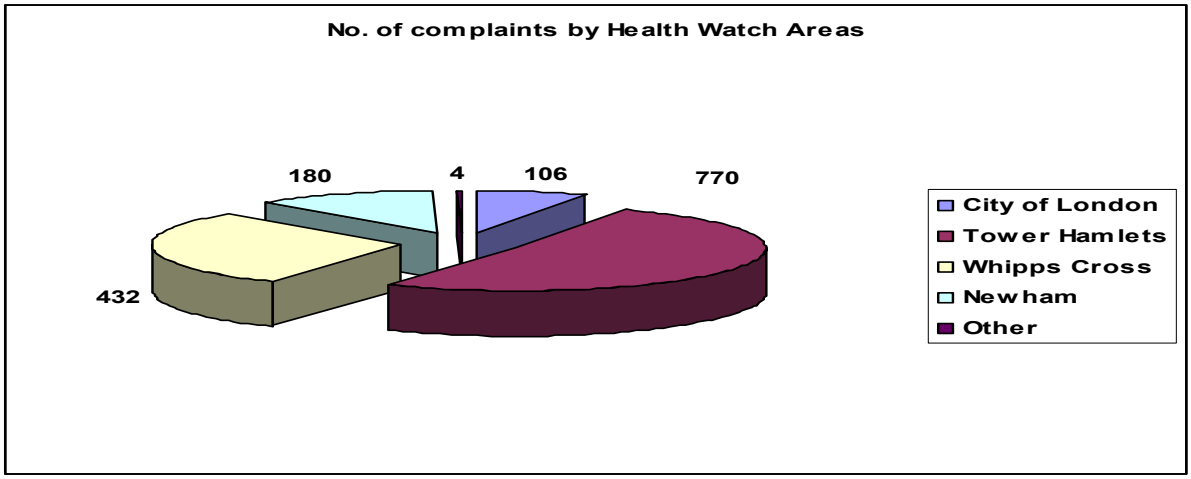


Complaints (April 2013 – November 2013)

Between April 2013 to November 2013, the Trust received a total of 1492 complaints. Majority of the issues raised related to services provided across the Tower Hamlets area 770 (52%), with the second highest number of complaints being about services provided in the Waltham Forest area 432(29%) and the third highest being about services provided across the Newham area 180 (12%).

Chart 5 below gives an outline of the number of complaints received by all the sites the Trust provides services from.

Chart 5



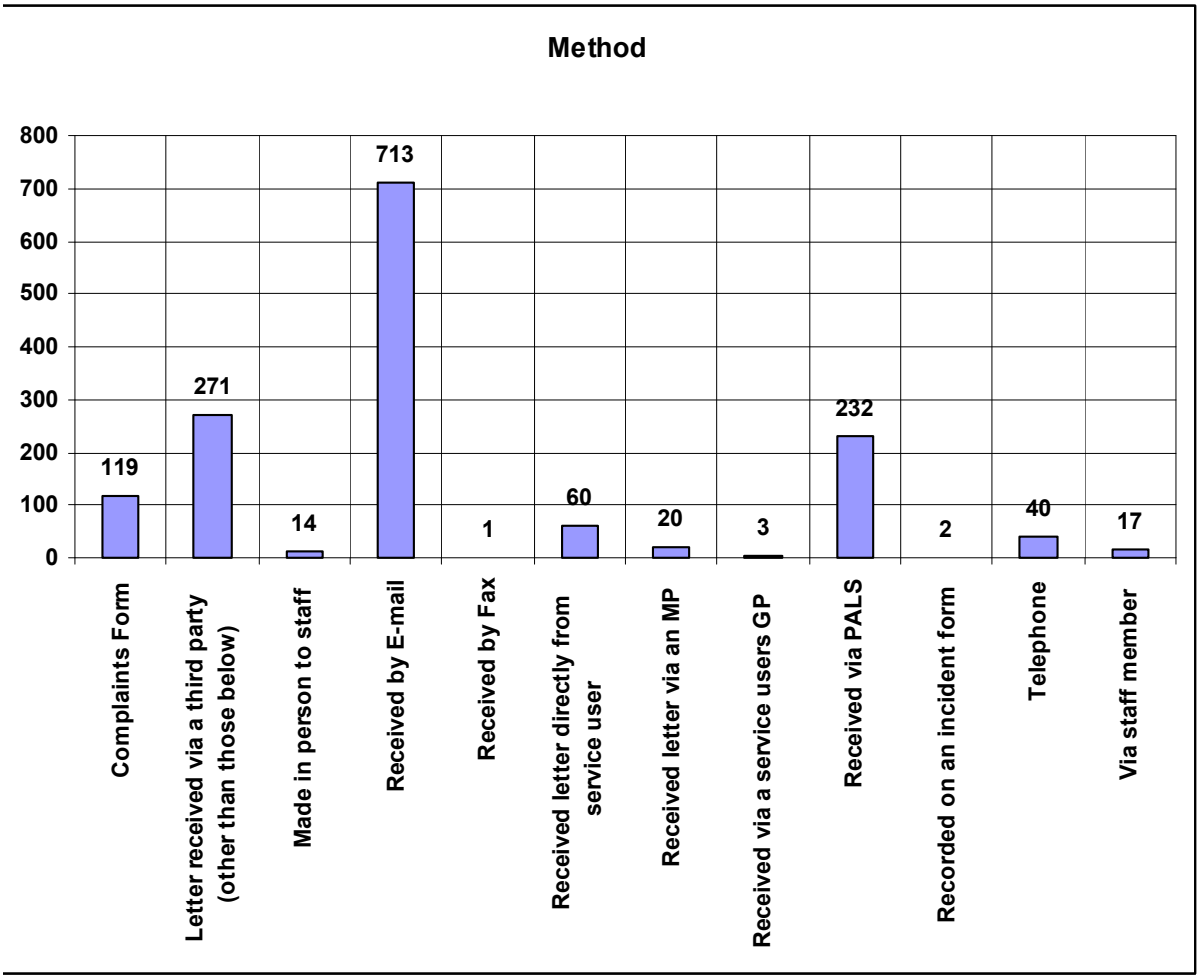
Access methods

The Trust aims to provide an accessible complaints handling service across all hospital sites, enabling the diverse range of patients we provide services for to be able to make a complaint if they feel it is necessary to do so.

Chart 6 below indicates that a high number, 713 (48%), of complainants preferred to access the complaints process via email. The Trust's Central Complaints email address provides an opportunity for complainants to either email the Central Complaints Team directly, or to complete an online form, via the Trust's website.

Once the online form is completed and submitted, the complaint form arrives in the Central Complaints inbox where the team receive and triage cases, then disseminate them to the appropriate Clinical Academic Group (CAG) in the Trust.

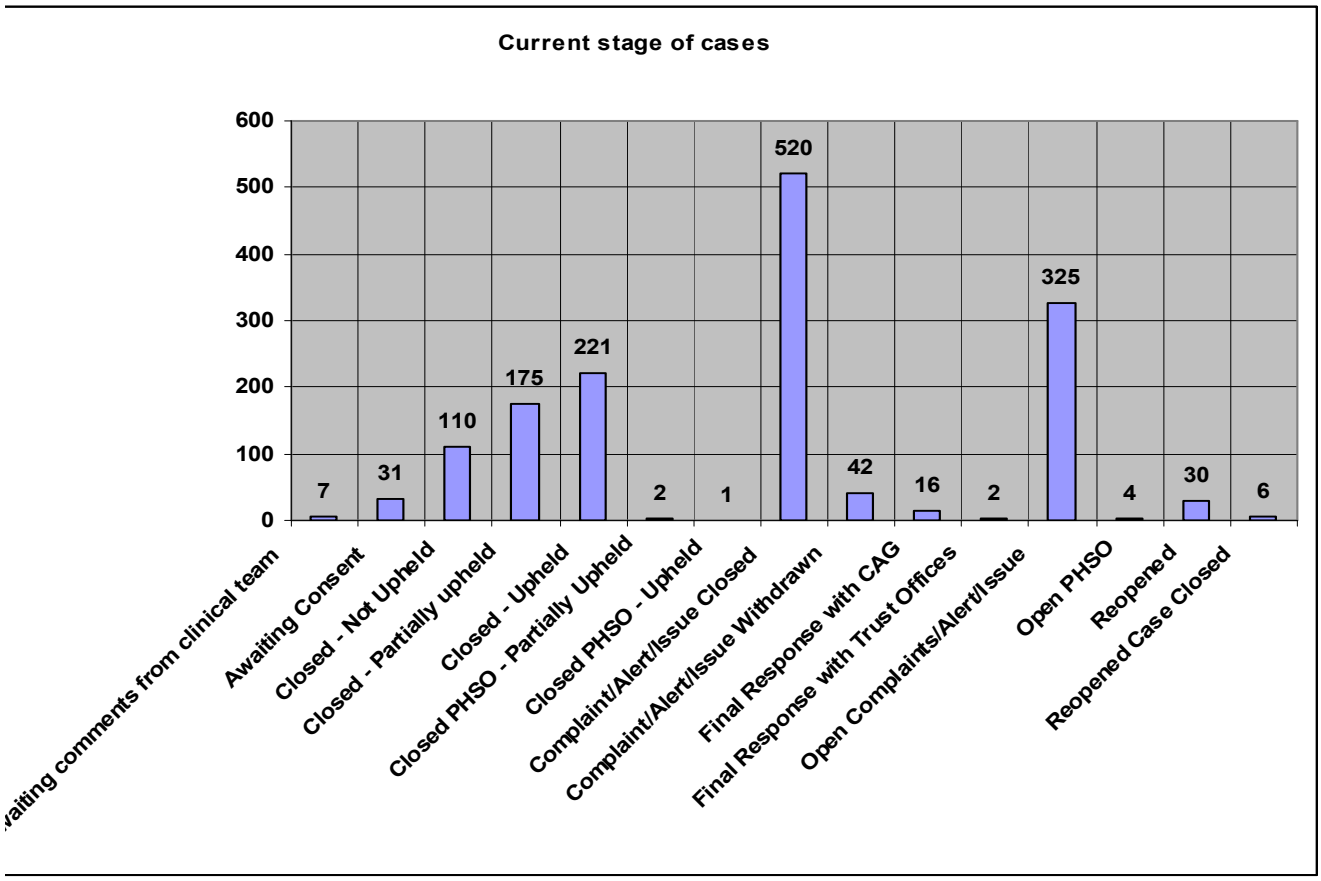
Chart 6



Current stage

The chart below indicates that during this period, a total of 1113 (75%) of complaints have been closed. Included in this number are all case which have been upheld, partially upheld, not upheld or withdrawn. Chart 3 below gives an outline of the current position of all cases received during the year to date.

Chart 7



Samantha Rashid – Patient Experience Lead
Bumi Akinmutande - Complaints Lead
Oct 2013