MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Redbridge Town Hall
7 January 2014 (3.30 - 5.50 pm)

Present:

COUNCILLORS

Barking & Dagenham	Sanchia Alasia
Essex	Chris Pond
Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light (Chairman)
Redbridge	Stuart Bellwood and Filly Maravala
Waltham Forest	Richard Sweden

Councillors Mrs Joyce Ryan and Mrs Vanessa Cole (Redbridge) were also present.

Healthwatch representatives present:
Richard Vann, Healthwatch Barking & Dagenham
Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge

Scrutiny officers present:

Glen Oldfield – Barking and Dagenham
Anthony Clements – Havering
Jon Owen and Jilly Szymanski – Redbridge
Corrina Young – Waltham Forest

Health officers present:
North East London Commissioning Support Unit – Neil Kennet-Brown, David Fish, Nadine House, Steve Jupp
Barts Health – Jo Carter, Lynne Hinton, Clare Morrell
BHRUT – James Hebdon
Partnership of East London Cooperatives – Chris Brody, Jacqui Niner, Remi Xander

Four members of the public were present.

All decisions were taken with no votes against.

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

26 CHAIRMAN'S ANNOUNCEMENTS

The Chairman of gave details of action in the event of fire or other event that might require the evacuation of the meeting room.

27 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 Jaime Walsh, Healthwatch Waltham Forest.

28 CHANGE OF COMMITTEE MEMBERSHIP

The Committee noted that Councillor Mrs Joyce Ryan from London Borough of Redbridge had now left the Committee and that, subject to confirmation, Councillor Mrs Ryan would be replaced by Councillor Mrs Vanessa Cole.

It was agreed that Councillor Pam Light from Havering should chair the meeting on this occasion.

29 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of pecuniary interests.

30 MINUTES OF PREVIOUS MEETING

It was noted that the fourth paragraph, second line of page 7M of the minutes of the 8 October meeting should reads ‘offices’ rather than as stated. Some minor amendments to job titles of the NHS officers present were also noted.

Other than the amendments shown above, the minutes of the meetings held on 8 October and 20 November 2013 were agreed as a correct record.

31 ACUTE TRUST EMERGENCY PLANNING

1. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)

   BHRUT covered two acute sites at Queen’s and King George Hospitals. It was noted however that King George was not a receiving hospital for major incidents.

The Trust used a series of emergency manuals and an on-call system that was the same as that used by the Local Authority. There was also an emergency planning and business continuity system in place at Queen's.

In case of a major incident, a series of hospitals (usually four) were nominated by the London Ambulance Service to respond to an incident. A nominated hospital would assess the impact of an incident and decide if this was a major incident that required a more coordinated response. Specific stocks of burns treatments dressings and other equipment were carried in case of a major incident.

If there was a major incident, discharges from Queen's Hospital would be accelerated but this would be done in conjunction with NELFT or North East London Community Services (NELCS). Some existing patients could also be transferred to King George if necessary.

In cases of e.g. severe weather, guidance was sought from the Met Office in the same way as Councils did. There were also plans to deal with industrial action or fuel shortages. Should there be an incident on a hospital site, evacuation plans were available.

Other health links used in emergency planning included NHS England (who would coordinate responses to a major incident) primary care and Council adult social care departments.

2. Barts Health NHS Trust

Barts Health was the largest Hospital Trust in the country, controlling six hospitals including Newham and Whipps Cross. For external incidents, the Trust would be informed by London Ambulance Service or NHS England. In internal incidents, the Trust itself would advise doctors and nurses in the relevant hospital.

Incident response saw staff alerts cascaded down and this covered approximately 250 staff at Barts. Additional doctors could be alerted to come in to assist the discharge of existing patients would also be accelerated. Some elective surgery would also be cancelled in order to free up space for emergency surgery. Arriving relatives would be looked after and hospital staff would also be supported. Support would by Barts and the London Chest Hospital in case of a major incident.

There would also need to be a recovery period following an incident. In the case of the July 2005 London bombings, all casualties were received within a three hour period but the recovery period while victims continued to be treated lasted for around three months.

The Trust also had a number of event-specific plans to cover issues such as the decontamination of patients or an influenza pandemic. There was also a hospital evacuation plan in case of an incident such as the fire at the Royal Marsden Hospital. Plans were also available to deal with fuel disruption, extreme weather etc. Business continuity plans would deal with situations such as the loss of key staff or the non-availability of utilities.

All emergency plans underwent a cycle of audit and review. Barts Health also planned its responses in conjunction with the wider environment such as Local authorities and other emergency services.

A recent incident had seen the trauma centre at the Royal London Hospital put on standby for the building collapse at the Apollo Theatre. The Trust also planned the health response for large scale events such as the Olympic Games and London Marathon.

3. Questions and Discussion

In the case of a major incident occurring in the West Essex area, hospitals would be nominated by the East of England Ambulance service. Notifications would also be received from the Essex or East of England health resilience structure.

If multiple hospitals were required to respond to an incident, NHS England would lead on coordinating the response. Hospitals would advise NHS England if e.g. their emergency department had become full and could not take any further admissions. The grading of incidents was based upon a four-stage scale set up by NHS England:

0 – Incidents affects the Trust only
1 – Incident dealt with within normal major incident procedures
2 – All hospitals in the area respond
3 - All hospitals in the region respond

High levels of A&E patient activity could be managed by the Trusts and A&E departments worked closely on this with the London Ambulance Service. Confirmation had recently been received of funding levels to deal with winter pressures on hospitals.

Barts Health confirmed that accelerated discharge would be planned with Councils and discharge people into community settings would also be supported.

The Committee **NOTED** the presentations.

32 CHANGES TO CANCER AND CARSDIOVASCULAR SERVICES

NHS officers explained that the prostate surgery proposals were now being reviewed externally by the London Clinical Senate. A hybrid option was being considered where bladder cancer surgery would take place at UCLH with radical non-robotic prostatectomies carried out at BHRUT. Findings of the review would be communicated to the Committee. The outcomes of the review were expected to be known by the end of February and it was **AGREED** that these should be scrutinised at a special meeting of the Committee.

A two-site option for stomach and gullet cancer involving BHRUT and UCLH had been recommended for the medium term. Any move to a single site would be subject to a separate review in 3-5 years. There would also be a to clarify the future of the smaller centre undertaking operations of this kind in Chelmsford.

There had been five public drop-in sessions for people to discuss the proposals and the sessions had been run in a similar way to those for other major consultations such as Crossrail or the HS2 rail link. Patients had been involved in an options appraisal workshop and videos and Twitter had also been used as part of the engagement.

Health officers had met with the Chairmen of the three Joint Overview and Scrutiny Committees in December 2013 and felt it would be useful if the Committee could scrutinise planning for the implementation of the proposals such as for example travel issues. Officers were also happy to attend future meetings as required.

A recent issue that had been raised was the impact of the changes on the ocular oncology service but officers felt there was still sufficient capacity for the service at Barts Hospital.

In the new structure, renal surgeons from, for example, BHRUT would also be able to carry out operations at the Royal Free Hospital, thus reaching a sufficient of operations per surgeon to improve skills.

A Member felt that the consultation events had been held in the wrong place and had been too London-centric. Officers pointed out that events had been held at different times of the day. The Commissioning Support Unit officers would have been happy to present in for example Loughton but had not been asked too. The proposals had also been advertised in local newspapers covering Harlow, Epping Forest and surrounding areas.

There were 79 radical prostatectomies that took place in the sector last year and this was less than 20% of all prostate work. This was also less than 3% of cancer in-patient activity. It was emphasised that there were no plans to move any other prostate treatments from BHRUT.

A representative of a local prostate patients support group felt that not enough weight had been given to patients' views during the options appraisal. They also felt that the consultation outside London had been inadequate and that the proposals should be subject to formal s. 244 consultation. Officers responded that the weighting given to patient experience had increased from 20 % to 25% at the expense of clinical outcomes.

It was confirmed that BHRUT would remain a neurology service and continue to offer services for leukaemia and oesophago-gastric cancer. Only partial nephrectomy for renal cancer (approximately 60 patients per year) and prostate cancer surgery (around 80 patients per year) would move from BHRUT.

The Committee considered whether formal s. 244 consultation was required but noted that to do so, a Joint Committee would need to be formed from the three existing Joint OSCs. Members would be free to scrutinise the issues further in the future, even if formal consultation was not invoked. Members felt that it was essential that further engagement took place on the proposals as they were developed, even if formal consultation was not considered necessary. Members also felt that the proposals would improve services overall, even if they did constitute a substantial variation.

The Committee **AGREED** that the draft response letter concerning the cancer and cardiac proposals should be sent to the appropriate health officer, subject to the addition that further engagement and consultation on the proposals should take place. The Committee further **AGREED** that formal consultation under section 244 of the National Health Service Act 2006 was not required on this occasion.

33 PATIENT EXPERIENCE - BARTS HEALTH

Barts Health officers emphasised that the Trust was committed to getting patient experience right. A number of initiatives had recently been introduced in this area including the successful presenting of a patient story at each Trust board meeting.

Patient panels and fora were moving forward and there were hospital directors for each site. The Trust also worked closely with Age UK as regards older people's wards. Reports on Patient Advice and Liaison Service (PALS) contacts and complaints were shared with local Healthwatch organisations. The main concerns reported to PALS related to appointments difficulties, staff attitudes and treatments.

Surveys were carried out with in-patients and the friends and family survey was now also carried in maternity and out-patients with plans to also introduce this for children's services. Improved e-mail and telephone access for PALS had also been introduced.

It was confirmed that the PALS service had closed at Whipps Cross but the Trust was looking to restart services at the Whipps Cross site. Appointments could still be made to meet a PALS officer at the Whipps Cross site. Officers noted that there was no textphone for the PALS service.

The Trust worked very closely with the local advocacy service and could also offer support of for example English was not a patient's first language. Officers were also happy to involve Essex Healthwatch in patient experience work.

Members felt that patient feedback should be standardised across Trusts and that should e.g. be one definition of staff attitude issues. The Committee **AGREED** to recommend that patient experience data should be shared between Barts Health and BHRUT.

34 **NHS 111 UPDATE**

The NHS 111 service had commenced operation in February 2013. Officers were keen to secure more support for the service moving forward from the Commissioning Support Unit. The service was provided by the Partnership of East London Cooperatives (PELC).

In March 2013, the service had received calls from 8,000 patients per month but this had risen to 15,000 per month by November 2013. Approximately 1,200 calls per day had been received over the Christmas period.

There had been no complaints recorded directly against PELC. Complaints were sometimes received by NHS 111 but these mainly related to providers.

The software used by the service was the same across London although officers would take back observations that for example chest pain should be asked about at an earlier stage. While someone saying they could not breathe would be advised appropriately, it was also important to avoid unnecessary referrals to A&E.

It was confirmed that NHS 111 staff were aware of the weekend GP opening service that had recently commenced in Havering. Health facilities were e-mailed by NHS 111 staff if a patient was referred to them but it remained up to providers to ensure that these e-mails were checked regularly.

NHS 111 services were required to be able to meet surges in demand. A staff bank could be called upon to provide additional operatives at times of high demand. Neighbouring NHS 111 services could also assist if required without impacting on the quality of the service. A reserve site in Harlow was

also now available. The facilities at Becketts House had now been expanded and could handle calls from more areas.

Feedback to GPs had now improved and consultation was ongoing with GPs on a revised format for this.

Members thanked the PELC officer for her presentation and for arranging the recent visit to the NHS 111 offices at Becketts House in Ilford. It was felt that it may be useful to arrange another visit for Members after the Council election.

The Committee **NOTED** the update.

35 **URGENT BUSINESS**

It was **AGREED** that a special meeting of the Committee should be held in March to consider the response of Barts Health and BHRUT to the recent CQC reports on the Trusts as well as the outcome of the London Clinical Senate Review of the prostate proposals.

Chairman