MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall, Council Chamber
14 September 2021 (4.30 - 6.13 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Paul Robinson
London Borough of Havering	Nisha Patel (Chairman) and Ciaran White
London Borough of Redbridge	Bert Jones and Neil Zammett
London Borough of Waltham Forest	Richard Sweden
Essex County Council	Marshall Vance

Co-opted Members

Emma Friddin,
Healthwatch Redbridge
Richard Vann,
Healthwatch Barking &
Dagenham

NHS officers present (selected):

Matthew Trainer, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust
Marie Gabriel, Accountable Officer, North East London Clinical Commissioning Groups (CCGs)
Martin Cunnington, Senior Vaccination Lead for North East London
Hannah Coffey, Director of Strategy and Partnerships, BHRUT
Henry Black, Clinical Commissioning Group
Melissa Hoskins, Clinical Commissioning Group
Magda Smith, Medical Director, BHRUT
Cathy Turland, Healthwatch Redbridge

All decisions were taken with no votes against.

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

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

Apologies were received from Councillors Umar Alli, Waltham Forest (Richard Sweden substituting) Beverley Brewer, Redbridge, Donna Lumsden, Barking and Dagenham and Adegboyega Oluwole, Barking and Dagenham. Apologies were also received from Ian Buckmaster, Healthwatch Havering.

Councillor Brewer was present via videoconference.

10 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

11 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Joint Committee held on 15 June 2021 were agreed as a correct record and signed by the Chairman.

12 COVID-19 UPDATE

The senior vaccination lead for North East London advised that almost 2 million vaccines had been given in North East London. More than 80% of people over 65 had been vaccinated as had in excess of 75% of people over 50. A campaign of booster injections would be starting shortly.

Work had been undertaken with the voluntary sector and faith groups to increase vaccine numbers and the outreach team had been put forward for a national award. Increasing numbers of vaccine sites were now available in community pharmacies and local primary care facilities. Vaccination centres and hospital hubs were also continuing.

A universal offer of vaccines for 12-15 year olds was being worked on and was due to start in the next week. Vaccines were already being given to 12-15 year olds who were considered vulnerable. Officers were aware of the communications sent by anti-vaccine groups to schools and this had been escalated to NHS England and the Department for Education. Guidance on this matter would be provided to schools. A third primary vaccine dose was also being considered for people with a compromised immune system.

Work was also in progress with Councils on completing the vaccination programme in care homes. The vaccination rate for care home and ancillary staff was improving and NHS clinicians were available to give additional assurance to staff.

Different approaches such as drop-in clinics were used with younger age groups. Whilst there were still some issues with younger people, the

vaccination for these age groups was improving. Barking & Dagenham vaccination rates were lower, partly due to the younger and more diverse population of the borough. Work had been undertaken with faith groups and a vaccine information bus was used to visit different parts of the borough. Other approaches included webinars with a local boxing club and local businesses in order to give reassurances on the safety of vaccines. Work in Barking & Dagenham was ongoing and it was noted that 90% of Covid patients in the Barts ITU were unvaccinated.

The Joint Committee noted the update.

13 SYSTEM-WIDE SERVICE CHANGES

The Accountable Officer for the North East London CCG stated that the pandemic period had meant a number of necessary changes to services. Some changes had now been reversed but others would remain in the long term as they had been found to give benefits to patients. Work had been undertaken recently to reduce waiting in areas such gastric conditions and orthopaedics.

A Member felt that there were issues about the way in which both Trusts communicated changes. He felt that the Committee should see the proposals for the redesign of surgical services and that it was important to get the mechanics of communication with Members right. The Chief Executive of BHRUT confirmed that the list of wards and their usage that had been requested by the Committee would be available shortly.

It was accepted there was a lot of pressure on primary care at present. Officers agreed that the availability of face to face GP appointments remained important. There was high demand for primary care with for example Havering GPs doing 24% more appointments than previously. Phone triage was often used but patients were then given face to face appointments if appropriate. It was noted that many younger people did prefer remote consultations.

Additional practice staff such as paramedics or pharmacists could often give effective treatment without patients needing to see a GP. Primary care systems were working flat out and fatigue of the GP workforce was a major factor. The number of Covid vaccinations given by primary care was also a factor in excessive workloads etc.

It was accepted that some complaints were received about GP reception staff but this was a very pressured environment. Many GPs were working 7 am – 9.30 pm to clear backlogs. Officers were however happy to look at specific complaints.

There was also a shortage of GPs in the area and many GPs were not willing to work in Outer North East London. There were also significant vacancies across the whole health system. Many members of the public were also given GP appointments via NHS 111. It was felt that people may need to be re-educated about the role of the NHS 111 service.

A member of Healthwatch Redbridge asked for details of the patient engagement process around service changes. Officers responded that this depended on which provider ran the service. It was accepted that the NHS should be better at communicating such changes. The BHRUT Chief Executive added that the NHS should accept that it needed to get better at explaining the clinical rationale for changes to service. It was accepted that people wanted BHRUT to explain changes and involve patients. The Chief Executive was happy to have discussions with Members and Healthwatch re service changes.

Service changes were shown in the agenda papers and on Trust websites. Newsletters were produced for stakeholders and the public but it was accepted that communication could be more effective. Regular meetings were held with Healthwatch in order to discuss service improvements.

A representative of Healthwatch Barking & Dagenham stated that he appreciated the Covid pressures but a lack of communication re service changes had been taking place prior to the pandemic. It was felt that many NHS communications with the public were not clear enough. NHS officers agreed, feeling that the public were often confused about where to go for medical treatment. Any advice patients received from a pharmacy would not replace their relationship with a GP. Officers were happy to work with Healthwatch on guidance on this.

Other issues raised included the difficult patient access at Mile End Hospital and the lack of a plan for hospice services in North East London. Plans for renal services would be shared with stakeholders shortly.

14 BHRUT CLINICAL STRATEGY

The Director of Strategy and Partnerships at BHRUT explained that change was needed to services due to demographic change in Outer North East London and the need to eliminate health inequalities. An appropriate workforce and hospital estate was required to achieve this and the collaboration work with Barts Health would assist with this aim.

The clinical strategy would consider the wider determinants of health and where services are located. There would be a collaborative approach to the strategy with the justification for proposals being shown. Whilst discussions were at an early stage, interviews and surveys were being held with residents, patients and stakeholders. A clear plan would be developed for the oversight and accountability of the clinical strategy.

The Trust Medical Director agreed that BHRUT must engage with the community in the development of its services. There remained Covid-related constraints on services however which meant it was challenging to deliver the clinical strategy in the current period.

Members felt that the Trust should be flexible about processes and outcomes but it was important short term changes did not conflict with long term plans. Concern was raised however about the very low response rate to the residents' survey. It was suggested that, if available, the draft Clinical Strategy should be brought to the next meeting of the Trust.

Officers responded that there had now been in excess of 1,000 responses to the survey but they were happy to share the Trust's communication and engagement strategy. Work would take place with Healthwatch to respond to concerns and challenges raised around engagement on short term system changes. Officers were happy to hold further discussions with Healthwatch outside of the meeting.

It was agreed that, if the Clinical Strategy was available by the time of the Committee's December 2021 meeting, it should be brought to that meeting for scrutiny.

15 BHRUT/BARTS COLLABORATION

The Committee was advised that the collaboration between BHRUT and Barts Health was in line with recent legislation covering areas such as the role of Integrated Care Systems. This encouraged providers to work more in collaboration than competition. The primary motivation for the closer collaboration was to achieve better outcomes for residents. Officers added that Trusts often collaborated and this partnership presented an opportunity to see what could be done better together.

Closer working would help BHRUT to deal better with the challenges of population growth in the sector. Local hospitals were being made more resilient by for example the opening of a new ED at King George Hospital in November. Collaborative work was also undertaken with the London Ambulance Service and for example the Royal London Hospital on emergency care pathways at Queens Hospital.

A Member suggested the new Chair of the two Trusts be invited to the next meeting of the Joint Committee. Concerns were raised however over whether BHRUT would remain independent and whether the Trust Chief Executive would remain as the accountable officer for the Trust. The Trust Chief Executive confirmed there was no plan for a merger and that he would remain as the accountable officer. It would be for the Chair to decide on the make-up of the Trust boards. The joint arrangements were only scheduled

to April 2022 at present. Joint appointments could not be ruled out if they were felt to deliver better outcomes for all residents in North East London.

Members raised concerns that many services were being centralised to Inner North East London and officers responded that they wished to use their assets better to give better accessibility of services to all residents. Consideration was being given to what additional services could be introduced at Barking Community Hospital. It was hoped to reduce variation in services across the whole of North East London.

The Joint Committee noted the position.

16 **COMMITTEE'S WORK PROGRAMME**

As discussed, the Committee agreed to scrutinise the BHRUT clinical strategy at its December meeting, should this be available. It was also agreed to invite the new Chair in Common of BHRUT and Barts Health to the next meeting of the Joint Committee.

17 **DATES OF FUTURE MEETNGS**

The next meeting of the Joint Committee was scheduled for Tuesday 14 December, venue to be confirmed.

Chairman