MINUTES OF
HEALTH SCRUTINY COMMITTEE

Wednesday, 29 November 2023
(7:02 - 9:02 pm)

Present: Cllr Paul Robinson (Chair), Cllr Michel Pongo (Deputy Chair), Cllr Muhib Chowdhury, Cllr Irma Freeborn and Cllr Chris Rice

Also Present: Cllr Maureen Worby

Apologies: Cllr Manzoor Hussain

21. Declaration of Members' Interests

There were no declarations of interest.

22. Minutes (18 September 2023)

The minutes of the meeting held 18 September 2023 were confirmed as correct.

23. Appointment of Tony Chambers as Interim Chief Executive

The Chief Executive (CE) of Barking, Havering and Redbridge University Trust (BHRUT) provided a verbal update on the appointment of Tony Chambers as Interim Chief Executive BHRUT following the investigation and subsequent sentencing of Lucy Letby.

The CE advised that throughout the multi-stage recruitment process for Tony Chambers, all measures were followed regarding the interview and pre-employment procedures, however there were no findings in relation to misconduct during his time at Chester Hospital (CH). Amongst the 11 applicants for the post, four applicants were shortlisted and interviewed, including Tony Chambers who briefly mentioned his experience and some of the challenges he faced at CH.

Tony Chambers' experience at BHRUT was dominated by Covid-19, with him being only ten weeks in-post when the pandemic began. There had been an external review on the key decisions regarding safety and equality during the time of his appointment, for which there had been a clear governance process and there were no concerns raised. In April 2020, a whistleblowing measure was put in place as an independent guardian policy for staff who were potentially concerned that their issues were not dealt with effectively. Issues raised in relation to management, safety, work and bullying increased between April to October 2020, which signified a positive trend as staff openly proceeded with complaints without anonymisation. This worked to support a changing BHRUT workplace culture as staff could attempt to resolve issues before escalation.

The appointment of CE and Directors was also discussed. In line with the Fit and Proper Persons framework, there was transparency across an individual's career at BHRUT. From pre-employment checks, appraisals, references, exit interviews, enhanced DBS checks and a formal completion of assessment, all senior staff experienced the same procedures. A leader competency framework was also in

place; also based on transparency, the CE commented that Tony Chambers would have met the Trust standards today, although based on the media, his image was flawed.

The criminal trial focussed on the actions of Lucy Letby and did not analyse the conduct of the NHS Trust and therefore, media coverage on the topic of conduct was highly speculative.

A series of questions were asked to the CE BHRUT regarding their responses and reflections on the Letby case. On a question on the Trust's plans for prevention of such cases in the future, the CE suggested that the Letby case was considered an isolated case which was not ideal to inform policy changes. He also ensured that there were no characteristics which would have indicated that Letby was involved in such criminal activity, where it was further noted that the potential role of race could have misinformed the response of the Senior Leadership Team at CH.

The CE outlined the progress of policy change in response to a question on rebuilding trust from the perspective of the public. A focus on behavioural characteristics alongside seeking external critical reviews and independent bodies of scrutiny would be used to improve transparency and responses to future cases. It was highlighted again that there was no concern surrounding the Trust's decision at the time of Lucy Letby's employment at CH.

The CE stressed the importance of the clinical voice in leadership especially where data is involved. It was noted that the public board published positive information on factors such as mortality rates in both Queen's Hospital (QH) and King George's Hospital (KG), both of which performed well. Other trends regarding pressures on the Emergency Department in hospitals had been address and there were several positive changes made, which in turn contributed to reducing waiting times at KG. Such improvements represented BHRUT's ongoing progress following policy changes.

A question was asked regarding the NHS England Fit and Proper Persons Framework for board members, and whether issues around bullying were considered on the risk register. The CE mentioned that as part of the NHS open environment principle, all staff were actively involved in a training programme to manage situations should concerns arise. Following this, a Member raised a question regarding the increase in staff raising concerns using the existing guardian policy and grievance policy in place. It was noted that in consideration of the large scale of the organisation, the number of cases was not problematic, nor should actions be taken to reduce it at the time. All staff were encouraged to follow the implemented procedures should they raise any concerns about the workplace, although staff were also given active bystander training which dealt with issues without engaging in the formal procedure.

A further question was asked in relation to staff wellbeing at BHRUT, and the support measures in place to maintain a standard of welfare amongst staff. With increases in staff raising concerns about the workplace, the CE mentioned that staff were less willing to so do if bullying was experienced with senior staff. The CE explained that whilst it was difficult to change the culture in an organisation, it continued to be a work in progress. Interventions included dismissals for inappropriate behaviour; targeted action for some areas; and improving the staff

survey response rate which displayed improvements more recently. Other support services included formal therapy for staff, as well as supervision and more security staff to support staff, especially on the frontline. Examples included an increase in security staff at KG from two to four staff for frailty services in the Emergency Department and reductions in abusive interactions between sonographers and the public in the Maternity ward as a result.

The CE was asked for information on further areas for improvement at BHRUT. Improvements at both QH and KG were outlined; changes to specialist services, a virtual ward for care and support for the elderly and reduced waiting and admission times at KG were highlighted. Following the previous Care Quality Commission inspection which rated KG as 'inadequate', the interventions placed contributed to the most recent inspection which suggested significant improvement had been made with a high standard of clinical care and outstanding patient feedback. Other interventions such as reducing agency staff had aided the retention of staff, thus improving productivity and efficiency among the workforce. This allowed for the progression of staff instead of having restricted roles on certain pathways at the Trust.

The CE also encouraged the idea that more services should be introduced in Barking Community Hospital or shopping centre facilities for better accessibility amongst the wider community. This would consequently reduce the strain on hospitals as the pressure on services resulting from higher cancer rates being identified post-pandemic, for example, would require staff to work harder and longer hours.

The Committee noted the update.

24. Community Diagnostic Centre

The Chief Operating Officer (COE), BHRUT, the Clinical Cancer Lead (CLL) and the Programme and Service Development Lead – Community Diagnostics (PSDL), presented a report on the progress of the new Community Diagnostics Centre (CDC) at Barking Community Hospital (BCH).

As part of a national programme since the beginning of the pandemic, CDCs were to be introduced as a means to increase the capacity for patient investigations. By working with community providers for staff and facilities, alongside gaining funding to carry out the project, the development of this innovative service would work to reduce delays for patient services. Especially as a Borough which does not have an acute hospital to support its growing population would contribute to a 21% increase in demand for services, this would reduce deprivation levels overall, by contributing to the reduction of health inequalities in the Borough.

The PSDL highlighted the importance of engagement with the local population who supported the development of the CDC. Their suggestions were considered throughout the development and reflected the needs of service users in the Borough.

As a result of service user feedback, the BCH CDC would include:

- Free parking for patients;
- Calm pastel and pale colours throughout to make it more relaxing for all

patients;
- Floor to ceiling windows;
- Ramps, lifts and accessible changing rooms run throughout, and all patient services available on ground floor;
- Landscaped outdoor space;
- Increasing ways to book appointments;
- Staff to be trained on how to communicate with all patients; and
- Continuous improvement of care and experience gathered through patient and staff survey before and after the CDC opens

With various facilities at the CDC, the PSDL explained that an extra 72,000 scans would be possible every year. Scanning equipment such as MRI, CT and ultrasound would be housed at the CDC alongside consultation rooms for a range of other tests. Early diagnoses for some cancer types would also be available as well as innovative tests such as cystosponge, colon capsules, transnasal endoscopy and a rapid asynchronous triage clinic for oral lesions. Included with this were public facilities for waiting and changing and hearing induction loops for patients with hearing impairments. Such advancements would also provide job opportunities amongst the local population, for example, where nursing staff would benefit from an expanded scope of practise when the CDC opened.

The progress of the CDC for 2024 was then outlined. Whilst the BCH CDC would open in Spring 2024, there would be ongoing engagement with stakeholders, patients and staff including site visits and a patient trial run in order to understand their first-hand experience at the centre. Furthermore, there would be collaboration with Healthwatch on accessible information standards training for staff to further improve patient care. The opening of a new CDC in St George's (Hornchurch) embedded in the St George's Health and Wellbeing Hub was proposed.

On a question regarding staff communication with patients of differing abilities, the PSDL explained that all staff would be trained to communicate effectively with patients to give them the best experience during their visits. The use of accessible information with posters, portable hearing booths for deaf patients and interpreting services would be available for patients who faced a language barrier due to not speaking English. A question following up on communication services was brought forward, regarding whether frontline staff were trained in interpreting skills or British Sign Language (BSL), for example. It was highlighted that external providers would provide services, for both BSL and telephone interpreting for referral patients with language barriers due to the short appointment times that the CDC would enable. A member suggested that staff demographic based on diversity and equality would be beneficial, not only for the staff but also as a cost-effective means for interpreting services for patients facing a language barrier.

In consideration of patients with learning disabilities, it was noted that one-and-a-half years ago, a system was put in place to identify such patients to ensure they received proper care in collaboration with the learning disabilities team as a means to reduce health inequalities.

In response to questions regarding the appointment booking system, specifically for groups such as the elderly who may be technologically excluded, the PSDL explained that various methods of communication were available for patient use; these included already existing e-referrals, a patient call service, email system and an online booking system which would be introduced in the future. It was

recognised that in order to create connections and maximise engagement with patients, Do Not Attends (DNAs) were monitored frequently and a need to push for telephone communications to discuss appointments instead of automatic text messages was desirable.

The CLL was asked about the range of cancer diagnoses that were tested at the CDC, and whether these were inclusive of factors such as age, cancer type or gender.. The CLL outlined that breast, prostate and lung cancers were increasingly identified at Stage 1 and Stage 2 from patient screening services. Contributory to this was the targeted lung health checks within the Borough which promoted screening for a quicker diagnosis. The CDC enabled a secondary preventive measure which focused on the top five cancers in the Borough. The importance of world-class technology was indeed costly, however effective where the CDC could provide a cancer diagnosis within 7-10 days in comparison to the standard 28-day time frame. In relation to this, a Member asked why only some cancer types were detectable at the CDC. The CLL explained that some cancer types were commonly detectable at a later stage, such as pancreatic cancer, so the CDC as a means of early diagnosis was not applicable. On the other hand, blood cancer was diagnosed with blood tests, so patients would be diverted to haematology clinics at acute hospital sites. Other cancers would require sedation or other interventions which may not be facilitated at the CDC.

Further, the CDC's proposed for an extra 72,000 scans per year was raised. In consideration of the pressure on staff, the COE suggested that selective staff would be recruited to deliver services, where a phased roll out of additional staff would improve efficiency for the CDC. Throughout the CDC, the COE and PDSL stressed the value of recruiting local staff to further develop the Borough. However, a question was then raised on the available staff training to meet the expectations of the increased capacity for services across old and new CDCs. The CLL highlighted that a radiology academy would be in place to improve training for junior staff; by encouraging staff to rotate between sites and use different facilities, these experiences helped to create better patient services as staff are well-developed on programmes which provide a breadth of insight into various departments. This would also help to generate a new workforce amongst the local population.

The Committee noted the report.

(Standing Order 7.1 (Chapter 3, Part 2 of the Council Constitution) was suspended at this juncture to enable the meeting to continue beyond the two-hour threshold).

25. Joint Health Overview and Scrutiny Committee - 19th October 2023

The minutes of the last Joint Health Overview and Scrutiny Committee (JHOSC) were noted.

26. Minutes of the last HWBB/ICB (Committees in Common) meeting - 12 September 2023

The minutes of the last Health & Wellbeing Board and ICB Sub-Committee were

noted.

27. Work Programme

The Committee requested that a report on the impact of the financial savings due to be considered by the ICB be presented to the next meeting of the Committee.

The work programme was noted.