37. Declaration of Members' Interests

There were no declarations of interest.

38. Minutes - To confirm as correct the minutes of the meeting held on 10 January 2018

The minutes of the meeting held on 10 January 2018 were confirmed as correct.

39. Winter Pressures

Matthew Hopkins, Chief Executive of Barking, Havering and Redbridge University Trust delivered a presentation headed “This Winter in Our Hospitals”.

Key points were as follows:

- Headlines
- A&E Delivery Board (AEDB)
- Performance against four-hour access standard
- Challenges
- Meeting the challenge
- Positive feedback
- In summary

Members asked about the current workforce and what steps were being taken to deal with any staff shortages and retention. Mr Hopkins responded that the Trust were actively seeking to recruit where there were vacancies. He advised that there was a national shortage of consultants although one Paediatric Consultant had recently been recruited in the Trust but if they had transferred from other trusts this then depleted resources at other hospitals. In terms of nursing vacancies, he was aware that retention was a problem and advised that one in four nurses were leaving in their first year of service. In the last financial year however there had been a new model of nursing supervision introduced and this included re-employing retired nurses who would support and mentor new nurse recruits.

Members were concerned about disabled parking bays being regularly blocked at Queens Hospital. Mr Hopkins was aware that this was a problem however the Trust were working with the London Borough of Havering in seeking planning permission to build another multi-storey car park at the Hospital in the medium to
long term which should help alleviate the severe parking problems at the Hospital.

In answer to a question, Mr Hopkins stated that there was a cap on the total spend on agency staff in the Trust and acknowledged that the amount spent on agency staff was unlikely to change in the short term, which was currently £23m. The cost of agency staff went up as demand went up and there was a need to work towards permanent staff retention where possible.

Members referred to the special measures in the Trust which had been introduced by the Care Quality Commission (CQC). Mr Hopkins advised that the Trust had been taken out of special measures at the end of March 2017 however in September and October 2017, it was noted that the financial position of the Trust was not as it had been reported previously and the CQC had introduced further special measures to deal with the £20m deficit. There were cash flow issues evident and investigations were ongoing, which would be completed in due course and Mr Hopkins was keen to ensure that this process was as transparent as possible. He would update the HAASC successor body in the next three months on the progress with these investigations. Although this was disappointing, there was a clear need for the Trust to put in place good cost controls and be more cost effective but not at the cost of good quality improvement as had been the case in recent years.

Members were concerned about the recent flu epidemic and whether it had been contained and also asked whether the flu vaccine had been effective for staff. They also asked if the vaccination process had been a success. Mr Hopkins responded that the flu vaccine was necessary in order to improve health and protecting patients. The uptake for staff taking the vaccine in the Trust was 63% last year and this had now gone up to 70%. Dr Magda Smith added that in Australia and New Zealand there had been significant cases of young people dying from flu and the best flu vaccine was used in the Trust with a very high uptake. She noted that some staff in the Trust had declined to take the vaccine as they had some side effects, however the Trust was keen to promote the vaccine for staff in line with good practice and the General Medical Council’s view that patients needed to be protected.

Members were concerned about early discharges from wards and patients waiting to go home (called a TTA). They considered that the TTA’s should be on the wards and sought a reduction in the delays. There had also been cases of late bookings for transport and escorts. Mr Hopkins responded that in terms of TTA, the time taken to get tablets from the pharmacy to the ward had taken two hours which had then reduced to 22 minutes. A lot of patients were at Queen’s Hospital for less than a day.

Members were pleased about the appointment of a Paediatric Consultant in the Trust but concerned about 11% increase in admissions. Mr Hopkins acknowledged the increased and discussions were on-going to create a GP hub, with specific capacity to take children which would ease the pressure on admissions to A&E. The Trust was doing what it could to ensure that pressure was reduced at A&E departments by signposting patients to the right services. For example, GP’s would be able to deal with matters such as minor injuries rather than patients needing to go to A&E.
The Cabinet Member for Health and Social Care stated that she was pleased that there was a business case for the remodelling of A&E and although there was the provider alliance, more needed to be done to integrate services. She added that patients needed greater information when they go to A&E and were confused with the information given. Mr Hopkins agreed that greater integration was needed at primary and hospital levels and key messages to patients needed improvement. Access to services needed to be quicker and although there had been some successes, improvements were needed.

The Director of Public Health referred to emergency admissions and the challenges of those regarded as being “sicker”. He asked if the plans were sustainable. Matthew Hopkins advised that the rate of admission had been stable at 16% but emergency admissions had risen by 11%. There was a need for more critical bed capacity. The challenge was to free up more bed space and there had been a very large increase in stroke admissions. Critical care beds were completely full. There were also cases where those having been discharged were re-admitted to hospital. Queens Hospital were also seeking to transfer some patients to hospices.

40. Update from BHRUT on Sepsis performance and referral to treatment times

Dr Magda Smith, Associate Medical Director & Trust Sepsis Lead and Claire Mullaly, Lead Nurse for Sepsis & Nursing Projects provided a presentation on Sepsis performance and key points were as follows:

- Recognising Sepsis
- Sepsis 6 Pathway- give 3/take 3
- How we REAct
- Sepsis Trolleys
- Sepsis Death by Month
- Emergency Department Sepsis Screening by Quarter 2015-17
- Inpatient Screening by Quarter 2016-17
- Education Awareness
- Sepsis in Children (Paediatric Sepsis)
- Positive Recognition from NHS England
- Plans for the future
- Sepsis is everybody’s business

Members were concerned about detecting the symptoms of sepsis in children. Dr Smith advised that children can become ill very quickly and this was a challenge as they can be overtreated as to comparisons with adults. Some patients may have contracted sepsis after contracting cancer.

Members asked about public awareness and publicity of Sepsis at hospitals and GP practices. Dr Smith stated that leaflets and cards had been produced by the Sepsis Trust at these centres and a lot of work had been undertaken to raise awareness and recognise the symptoms of sepsis.

Members asked about immunity against sepsis and recognising the symptoms and blood cultures. Dr Smith advised that sepsis was a condition in which the body and organs struggled with infection and the use of antibiotics varied which was laid down in a protocol. The use of antibiotics was used wisely along with blood
Piers Young, Deputy Chief Operating Officer provided a presentation on Referral to Treatment (RTT) and the key points were as follows:

- Historical context
- Improving Care
- Clinical Harm Programme
- Current RTT performance
- On-going assurance

Piers Young advised that the NHS has a standard tariff for costs of referral to treatment and the service remains free for NHS patients.

Members asked for clarification for those attending referral appointments and also for those who did not attend their appointments (known as DNA). Piers Young advised that patients were referred to treatment within an eighteen-week period and the diagnostic decision by clinicians was whether patients may or may not need surgery or be treated. In such cases, patients were regarded as “waiters”. In terms of the DNA issue, there was an access policy in the Trust, to be more patient friendly. When patients did not turn up for appointments, a clinical review is undertaken to determine if the patient should be re-booked for another appointment and not discharged from referral to treatment. The DNA rate in the Trust was approximately 10% which is slightly higher than it should be and it was of concern that the DNA situation did not free up appointments for other patients. Piers Young added that in the future, there would be dates for referral agreed with patients at GP practices as well as text message reminders sent to patients.

Members asked whether a triage facility could be introduced for referral to treatment. Piers Young responded with the example of the Urology department where the new clinics started the Triage facility in January 2018 and this had included progress in working with GP’s to ensure the right information was needed and patients signposted to the right areas. He accepted that improvements were needed and this included the introduction of an “Advice Guidance Patient Service”.

Members were concerned about the backlog in surgery appointments owing to the winter pressures in A&E departments. Piers Young advised that the Trust had done a lot of forward planning for winter pressures and this included priority for A&E resources and pre-planned reductions in numbers attending. He added that the backlog in A&E surgery was only 15% per day as most of the patients were day care and not inpatient. The Trust had been able to release resources for A&E priority.

Members asked how many complaints had been received by the Patients’ Advice and Liaison Service (PALS) regarding DNA (did not attend) appointments and rescheduling of appointments concerning RTT (referral to treatment) and this response would be forwarded to Members.

(At the conclusion of this item, the Select Committee agreed that, in accordance with Part 2, Chapter 3, paragraph 7.1 of the Council Constitution, the meeting be extended for a reasonable period beyond the two-hour threshold to enable matters to be concluded.)
41. Progress report - The Cancer Prevention, Awareness, and Early Detection Scrutiny Review

At the start of the 2015/16 municipal year, the Select Committee had agreed to undertake an in-depth scrutiny review into cancer prevention, awareness, and early detection.

The scrutiny review addressed 3 questions:

1. Why are residents of Barking and Dagenham more likely to develop cancer and less likely to survive cancer than residents in other London boroughs?

2. What is the reason that residents are less likely to respond to requests to screen for cancer than in other London boroughs?

3. What is the reason that residents are not as aware of the signs and symptoms of cancer as residents in other London Boroughs?

Twelve recommendations for action in LBBD were made. HASSC was consulted on the draft report at its meeting in March 2017 and Councillor Worby, the Cabinet Member for Health and Adult Social Care, and Chair of the Health and Wellbeing Board, also had an opportunity to view the recommendations.

The scrutiny report made 12 recommendations:

1. The Health and Wellbeing Board (HWB) acts to reduce the prevalence of smokers in the borough, to levels comparable with London;

2. The HWB sets out to the HASSC what action it is taking to reduce the number of overweight and obese individuals in the borough, to levels comparable with London;

3. The HWB acts to increase residents’ awareness of how lifestyle, including exposure to the sun, can affect the likelihood of developing cancer, the signs and symptoms of cancer and the importance of early diagnosis, and screening;

4. The National Awareness and Early Detection Initiative informs the commissioners on what action it is taking to target specific ‘at risk’ groups;

5. The Barking & Dagenham Clinical Commissioning Group (BDCCG) ensures that GPs are auditing and acting on audit information to ensure that patients enter the cancer pathway appropriately, and cancer is diagnosed at as early a stage as possible;

6. The BDCCG, in partnership with Macmillan and Cancer Research UK, acts to increase the proportion of residents returning bowel cancer screening kits, within the next year;

7. The HWB, along with MacMillan and Cancer Research UK, acts to
raise awareness of the importance of screening and to increase uptake of breast and bowel screening in the borough to a level comparable with England within the next year;

8 The HWB, along with MacMillan and Cancer Research UK, acts to raise awareness of the importance of screening and reduce the variation in cervical screening uptake between GP practices within the next year;

9 The Committee urges NHS England to make the Cancer Dashboard available within one year;

10 The HWB acts to raise awareness of the importance of the Health Check and reduce the variation in Health Check uptake between GP practices;

11 NHS England provides assurance to it that residents will continue to have in-borough access to breast screening; and

12 The BDCCG, working through the North-East London Cancer Commissioning Board, assures the Committee of the action it is taking to increase awareness of the signs and symptoms of cancer.

The progress plan against these 12 actions was attached at Appendix 1 to the report.

The Cabinet Member for Health and Social Care introduced the report and action plan and stated that a great deal of this work on public awareness had been done and she would come back to the successor body for HAASC in due course with an update.

Members asked whether mental health and depression might be included in this review. The Director of Public Health responded that there was a need for these areas to be addressed at primary care level and for a better range of support to be provided in these areas.

In answer to a question about cancer detection, the Director of Public Health stated that if patients visited their GP were concerned about issues such as weight loss and if the GP considers there may be a potential cancer diagnosis, the patient will be seen by a consultant within a two-week period. He added that too many patients were diagnosed with cancer whilst attending A&E departments. Patients diagnosed at an earlier stage may have a better chance of recovery and survival.

The Select Committee agreed the report and action plan and noted that this would be submitted to the Health and Wellbeing Board on 13 March 2018.

42. Results of Inspections undertaken by the Care Quality Commission on Local Adult Social Care Services- Quarter 3

This report was an overview of CQC inspection reports, published during Quarter 3 of 2017/18: (1 October 2017– 1 December 2018). The report provided an overview of the inspections as well as the actions that had been taken. The report covered CQC inspection reports on providers in the Borough and those providing services to residents outside the Borough.
Members asked how care provider staff were made aware of the issues involved in the CQC reports, however it was advised that it was the responsibility of the care provider to ensure staff were aware and inspectors forewarned providers that an inspection was due to take place.

Links to the CQC inspection reports were found at appendix 1 to the report.

The Select Committee noted the report.

43. The Oral Health in Early Years Scrutiny Review - Final Report and Recommendations

At its meeting on 20 September 2017, the Select Committee agreed that the following three key questions should form the Terms of Reference of the oral health mini-scrutiny review:

i. What are the reasons for young children in Barking and Dagenham having poor oral health?
ii. What is the quality of services that are available to residents and what do they deliver to improve oral health?
iii. What are the best ways of getting the right messages out to parents about looking after their children’s oral health?

This final report presented the findings of the scrutiny review and made eight recommendations to improve the oral health of children in the London Borough of Barking and Dagenham as follows:

1. The Health and Wellbeing Board (HWB) takes action to support an integrated approach to oral health promotion across all children’s services and that contract specifications for all early years’ services include a requirement to promote oral health; this should include very early oral health promotion by health visitors to help prevent tooth decay from sweetened dummies, prolonged use of milk in bottles and other sweet foods.

2. The Committee urges NHS England to actively support the teaming up of dentists with children’s centres to encourage engagement with dental services from an early age, so that dental disease can be detected early and children get used to going to the dentist.

3. The HWB is asked to monitor and report back on the progress of the oral health strategy, including the results of the ‘Teeth for Life’ (tooth-brushing) project.

4. The Committee urges NHS England to implement the initiative proposed by the Chief Dental Officer and increase dental activity by 2%, so that dentists can see children at 1 year of age.

5. The Committee urges NHS England to actively support those dentists who underperform in activity to utilise their spare capacity to target young families to engage with their dental service.
6. The Integrated Commissioning Board look at the impact of dental emergencies on paediatric A & E attendance and challenge the system (Clinical Commissioning Groups) as to what is being done to address this.

7. The HWB, in collaboration with the British Dental Association, takes action to raise awareness of the importance of taking young children to the dentist and that it is a free service. This could include communication through images to help address the need for information in languages other than English.

8. The HWB supports action around food outlets, cafes and restaurants as part of the drive to decrease sugar consumption and improve oral health; for example, the ‘Sugar Smart’ campaign;

The Cabinet Member for Social Care and Health Integration was concerned to ensure that this scrutiny review would not just a ‘tick-box’ exercise and she considered that parts of the review were very concerning.

The Select Committee agreed the report and recommendations and noted that this would be submitted to the Health and Wellbeing Board on 13 March 2018. The Chair advised that he would be attending the Board and introducing the item to them. It was also noted that the Action Plan will be enhanced and it would also have a more robust delivery plan.

44. **Health and Wellbeing Board Forward Plan**

The Forward Plan was noted.