MINUTES OF A MEETING OF THE OUTER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE (JOINT MEETING WITH INNER NORTH EAST LONDON HEALTH JOINT OVERVIEW AND SCRUTINY COMMITTEE)

Barking Town Hall
Thursday 21 January 2010 (9.30 am – 12.55 pm)

Present: Councillor Dee Hunt (London Borough of Barking & Dagenham) in the Chair

Councillors representing London Borough of Barking & Dagenham: John Denyer and Marie West

Common Councilman representing City of London: Wendy Mead

Councillors representing London Borough of Hackney: Daniel Kemp and Jonathan McShane

Councillors representing London Borough of Havering: Ted Eden and Fred Osborne

Councillor representing London Borough of Newham: Winston Vaughan

Councillor representing London Borough of Redbridge: Ralph Scott

Councillor representing London Borough of Waltham Forest: Richard Sweden

Councillor representing Essex County Council: Chris Pond (observer status)

Co-opted Members: Malcolm Wilders was in attendance.

Apologies for absence were received from Councillors Maureen Middleton (Hackney), June Alexander (Havering), Ted Sparrowhawk (Newham), Filly Maravala (Redbridge), Tim Archer and Sirajul Islam (Tower Hamlets).

Also present were:

Helen Brown (HB) Programme Director, Health for North East London
Don Neame (DN), Health for North East London (H4NEL)

Several representatives of North East London LINks were also in attendance.

Councillor McShane declared a declared a personal interest, which was not prejudicial, as he was employed by NHS Lambeth.

The Chairman advised those present of action to be taken in the event of emergency evacuation of the Town Hall becoming necessary.

1 MINUTES OF THE PREVIOUS MEETING

1.1 The minutes of the previous meeting of the Joint Committee, held on 26 November 2009, were confirmed as a correct record, subject to the amendments listed below and were signed by the Chairman.

Minute 1, para 1.1, fourth paragraph amended by the addition at the end of the paragraph of the following words 'and other associated services.'

Minute 1, para 1.3, final sentence of fifth paragraph amended by the addition of the following words at the conclusion of the sentence 'and recommend that further evidence be provided.'

Minute 1, para 1.3, final sentence of seventh paragraph be amended to read 'The future of the Forest Medical Centre in Loughton had not, so far, been discussed.'

2. MATTERS ARISING

Referral of H4NEL Proposals to Secretary of State by Redbridge Health Overview and Scrutiny Committee

2.1 Since the last meeting the Redbridge Health Overview and Scrutiny Committee had decided to refer the H4NEL proposals and their consultation to the Secretary of State for Health, with immediate effect. The Chairman clarified the position that Redbridge's decision did not impact on the work of the two Joint Overview and Scrutiny Committees. The Outer and Inner North East London Joint Overview and Scrutiny Committees remained the statutory consultee for these proposals and would report at the end of the consultation period as previously agreed.

2.2 Councillor Scott advised the meeting that there was an overwhelming consensus against and strong opposition to the Health for North East London proposals in so far as they affected Redbridge, especially the closure of A & E at King George Hospital. The London Borough of Redbridge remained committed to the Joint Committee, and it was possible that the Secretary of State may not do anything until the conclusion of the consultation process.

2.3 Councillor Scott informed the meeting that Redbridge were concerned that the proposals had not been properly costed. They also had concerns on the affect of the closure on local maternity services and had no confidence in the ability of Queens Hospital to cover all acute services. A number of issues including travelling time/driving distance, lack of vision for the Redbridge community, the fact that the proposals were devised by clinicians and the timing of the consultation pre-election were all of concern to Redbridge.

2.4 Councillor Denyer advised the meeting that as a local ward councillor he fully supported the position taken by Redbridge.

2.5 Councillor Eden expressed similar views confirming that he felt the timing of the consultation was premature.

3. HEALTH FOR NORTH EAST LONDON - UPDATE

Don Neame, joint Communication and Engagement lead at H4NEL, advised the Committee that all the PCTs in the area were working to deliver the Communication Plan agreed in November. They were working with libraries and G.P. surgeries to ensure information is available and were asking LINks to be their eyes and ears to ensure this was the case.

The first of the roadshows had been held at Homerton Hospital and full details of all the proposed roadshows had been provided to local newspapers. Special arrangements were being made to reach difficult to reach groups with eighty agreeing arrangements for meetings. The dates for all the meetings would be circulated.

Councillor Pond informed the Committee that Essex had asked H4NEL to arrange meetings in Loughton and Brentwood. He was also seeking details of the timetable for what happens after the conclusion of the consultations and what will happen after March.

Helen Brown (HB) explained that it was difficult to be certain as to future timetables but H4NEL expectation that it will take 2 to 3 months to analyse the responses to the consultation. It was likely the next stage would be reported to the PCTs in June/July with the possibility of an Independent Review Panel being arranged to move things forward.

Councillor Denyer asked how many members of the public attended the Homerton Roadshow. H4NEL advised that they had engaged with hundreds of people and others were made aware of the proposals. Councillor Denyer felt they still were not consulting in the right way nor engendering enthusiasm from the general public.

Both Pat Brown (London Borough of Barking and Dagenham) and Councillor Eden made it clear that residents from both Barking and Dagenham and Havering attended King George Hospital and therefore they needed to be reached in the consultation process.

4. EVIDENCE SESSION 1 – LONDON AMBULANCE SERVICE

Kathy Jones KJ), Director of Service Development and Katie Millard (KM), Assistant Director of Operations for the London Ambulance Service attended the meeting to give evidence. Seven questions had been sent to the officers

prior to the meeting. Kathy set the context for the Ambulance Service's response to the consultation. London Ambulance Service had established a set of criteria for supporting PCTs in their aims to rationalise services. These criteria were:

- Criterion 1: proposals must be clinically appropriate for seriously ill or injured patients;
- Criterion 2: London Ambulance Service should have access to facilities for patients with less serious emergency needs; and
- Criterion 3: Proposals should include a commitment to resourcing the ambulance service so that no patient waits longer for an ambulance than they would have done before the change.

The Committee was informed that only approximately 10% of ambulance patients have a life threatening condition, many of the patients are already taken to a specialist hospital (not the nearest hospital) and most of the remainder could be treated in an Urgent Care Centre or even at home. The London Ambulance Service had been consulted on the proposals early in the summer of 2009 and had been a member of the Clinical Reference Group since the start of the process. They were now represented on the Programme Executive Group.

The London Ambulance Service had commissioned modelling with H4NEL on impact of journey times on their operational delivery. The model predicted a 13.8% increase in ambulance activity to Queens (an additional 14 patients a day), an 11.8% increase to Newham (an additional 10 patients per day) and a 10% increase to Whipps Cross (an additional 9 patients a day). These figures also assumed that 39% of current ambulance journeys to King Georges Hospital going to the Urgent Care Centre.

The average journey time for all patients was four minutes. The increase in journey times was 10 minutes or less for around 80% of affected patients, with 31% of patients having similar or shorter journey times because the were not currently accessing their nearest hospital. The maximum impact for an affected patient was predicted to be 19 minutes.

To manage the performance effects in the local area the London Ambulance Service would need additional resources. Extra staff training would also be required to assist in selecting the most appropriate treatment pathways for patients.

However it was pointed out that:

- Most heart attack patients already go to the London Chest Hospital;
- Most stroke patients already go to Queens: and
- As of April 2010 all major trauma cases would go to Royal London.

4.7 Questions and Discussion with the Committee

4.7.1 Councillor Osborne asked where the Urgent Care Centres were based, how many there were and how do the public know where they are. He also asked what had happened regarding the idea of GPs being available 24 hours per day.

KJ informed the Committee that every NEL A & E department would have an Urgent Care Centre at the front. Doctors would be trained to prioritise care. She agreed that GPs should be available 24 hrs per day and the objective of this exercise was to enable H4NEL to invest in suitable services.

HB advised the Committee that there was a complex relationship between Urgent Care Centres (UCC) and A & E, and both services will be available 24 hrs per day. A UCC would be available at King George. PCTs were developing 12-hour services at Polyclinics.

4.7.2 Councillor Osborne then asked when the UCC would be up and running and when would the Polyclinics be available.

HB responded that there were plans for 32 polyclinics in NEL and these would be opened over the next 4 to 5 years. In the meantime every PCT had at least one GP led Health Centre which provided 12 hour care.

4.7.3 Councillor Eden asked who would be providing care at home, and if the changes were to be funded by the PCTs where was the money coming from?

KJ gave examples of the types of treatment it was envisaged would be provided at home. LAS estimated that probably 40% of patients do not need to travel to hospital to receive treatment. In Barking and Dagenham a 24-hour District Nursing Service was available. She reiterated that the idea behind the proposals was to free up funds for community based services.

KJ advised the Committee that it cost the LAS £600,000 to provide an ambulance for a year of the year on a 24 hour basis.

4.7.4. Councillor Sweden asked about the hyper acute services for stroke victims. He accepted the need to concentrate specialisms but were the LAS confident that ambulance crews would be able to recognise a complicated vascular emergency?

KJ accepted that it would be difficult for crews to recognise these. However, the most vulnerable sections of the community were now being screened. It was proposed to carry out a trial somewhere in London. Complicated paediatric problems were easier to identify.

HB informed the Committee that vascular procedures would be provided at two specialist centres rather then four at present.

4.7.5 Councillor Ralph Scott questioned the issue of funding for the London Ambulance Service, as he felt this should be resolved at the time of the annual commissioning process. He also asked if there would be any knock on effect for local authorities, especially in the return of patients after treatment.

KJ responded that the LAS receives annual funding from all 31 London PCTs. What was being asked here was additional funding to cover the cost of the extra impact of any local changes. There were a large number of patients whose needs were social not medical. She felt the proposed changes should not have any impact.

4.7.6 Councillor Sweden felt there had been some uncertainty around what funding local authority social services departments would receive following the OSC meeting at Redbridge. Very little assurance had been forthcoming.

He also felt the new arrangements would put too much pressure on ambulance crews who would need to make more diagnoses.

KJ responded that patient survival rates were in fact higher under this system.

4.7.7 Councillor Pond asked whether the information given on increased activity included patients delivered by the East of England Ambulance Service to Whipps Cross, King George and Queens. He also asked how the London Ambulance Service liaised with the East of England Ambulance Service.

KM informed the Committee that there already existed a working relationship with the East of England Ambulance Service.

HB advised that there had been lots of modelling carried out which included the effect on Essex patients. There had not been any specific discussion with the East of England Ambulance Service but the modelling did include times for East of England patients. She undertook to speak to the East of England Ambulance Service on these issues and agreed to provide Councillor Pond with a copy of the Business case.

4.7.8 Malcolm Wilders (co-opted member) referred to problem of A&E on divert.

KJ advised the Committee that there had been difficulties especially this winter but it was anticipated that the changes would reduce pressure.

4.7.9 Councillor Denyer expressed his support for the London Ambulance Service and asked how many of the passengers LAS transport have their own transport. He also asked what the policy was with regard to charging those who have self inflicted injuries which are drink related.

KJ informed the Committee that there appeared to be a minority of car owners who believe it is their right to call 999. Alcohol accounted for approximately

8% of the ambulance service work. It was difficult for ambulance crews to assess whether those who are drunk are in serious need and a safety first policy was adopted. In London there is a bus which operates on Friday and Saturday nights to pick up drunks and over Christmas a tent was provided at Liverpool Street to assist those who had drunk too much. With regard to charging this was a policy issue for the government.

4.7.10 Common Councilman Mead was concerned that all the figures centred on King George and asked what the effect on Royal London would be. Her perception was that the facilities for ambulances at Royal London were very poor and she was concerned that the Ambulance Service/hospital would not be able to cope adequately with the increased numbers.

KJ advised the Committee that Royal London was not a hospital where the ambulance service had problems. With regard to the increase in numbers this would largely relate to major trauma and would be 1600 to 1800 cases per year. The issue of step down was not the responsibility of the LAS. It was expected that there would be some transfers from Urgent Care Centres to specialist centres.

In response to a question on how hospitals would cope with major incidents without King George, KJ advised the Committee that a number of hospitals would be put on alert with walking wounded being dealt with at the Urgent Care Centres.

4.7.11 Malcolm Wilders informed the Committee that Hackney LINks had concerns that category B response times were not being met.

KJ admitted that the LAS was underperforming on one of its targets; the utilisation rates were too high. The issue of the ambulance service's ability to meet targets would be discussed in the next funding round.

4.7.12 Councillor McShane asked whether ambulances could use bus lanes.

KJ advised the Committee that ambulance drivers were required to follow traffic regulations unless there were on an emergency call (under blue light) when it was acceptable to use the bus lanes.

4.7.13 Lin Lahm from Hackney LINk asked how the hospitals would cope in a major incident.

KJ answered that in even the worst incident the major care units were unlikely to be swamped. All the evidence suggested not more than 4 major trauma units were needed in London.

5 EVIDENCE SESSION 2 – ROYAL COLLEGE OF MIDWIVES (RCM)

5.1 Pat Gould (PG), Team Manager, and Shaun O'Sullivan (SS), Policy Analyst, gave evidence on behalf of the Royal College of Midwives. PG set the policy context for the RCM's response to the consultation.

5.2 Maternity services in north east London faced a particular challenge from the rising birth rate – which had increased in London by 23% since 2001 – the increasing complexity of maternity care and a continuing shortage of midwives. They therefore welcomed the vision set out in the consultation as it recognised that maternity services will have to both support most women to have as normal a pregnancy and birth as possible whilst ensuring women with medical problems have seamless access to high quality medical care.

5.3 Obstetric Services

5.3.1 The RCM welcomed the recommendation to retain obstetric services at the Royal London, Homerton, Newham General, Queens and Whipps Cross Hospitals. Maternity services in all the North East London's Trusts except Whipps Cross were however rated as weak by the Healthcare Commission and staff levels were below the average for England, with the exception of the Royal London. The RCM were therefore urging the Trusts concerned to take action, as a matter of urgency, to improve the quality of care for women and their families.

5.3.2 The RCM's preference would be for the retention of an obstetric unit at King George, provided that the right level of support services, such as 24 hour anaesthetic cover was in place. However, having considered all the arguments they had concluded, reluctantly, that obstetric services may need to be consolidated on five sites, with King George the most logical candidate for closure.

5.3.3 Therefore while not opposed to the closure of the obstetrics unit at King George they were extremely concerned about the impact of transferring the majority of activity to Queen's Hospital. Queen's is already the biggest maternity unit in north east London and the consultation projected that it would deliver almost 10,000 births a year with the transfer of activity from King George. The RCM was against the creation of such a large unit because, in their view, a unit with 10,000 births a year would struggle to support normalcy in pregnancy for the majority of women who are at low risk. They also believed that large, high tech units find it harder to recruit and retain midwives.

5.4 Midwife led care

5.4.1 The RCM welcome the proposal to include antenatal and post natal services as part of the polyclinic that would be established at King George. They would have gone further and recommended the inclusion of a birthing unit also as part of the polyclinic.

5.4.2 The RCM questioned however whether King George, in the south of the London Borough of Redbridge, was the right place to site a birth centre given the close proximity to the standalone midwifery unit that is due to open at Barking Hospital. They accepted that there was an argument for establishing the unit at Barking Hospital first but strongly recommended examining the case for a second birth centre to be located in the northern part of Redbridge.

5.5 Questions and Discussion with the Committee

5.5.1 Councillor Scott felt that the real reason for getting rid of obstetrics from King George was resource driven. There were obvious problems with recruiting sufficient midwives. He was also disheartened with the basis of the RCM's argument.

PG admitted that any reduction in choice was lamentable and she understood his support for King George. The RCM had approached their response on a geographical basis. She accepted that any change cannot be cost neutral; there would have to be investment to improve services.

5.5.2 Councillor Scott said he was encouraged by the idea of continuing antenatal and post natal services at the polyclinic at King George but would like to see a birthing unit also present to maintain continuity of care.

PG said the RCM would recommend a birthing unit at the Redbridge Polyclinic if it met the criteria.

SS stated that if A&E was being retained at King George the RCM would oppose closure of the maternity unit.

5.5.3. Malcolm Wilders expressed concern at the already high incidence of caesarean births in North East London. He was concerned that this would increase with the large increase in births at Queens.

PG felt that the proposals would promote normality and therefore see a reduction in the number of C-sections.

5.5.4. Councillor Eden had four questions:

- The Committee had been lead to believe that Queens would specialise in complex births, was this still the case?
- Were there sufficient midwives available for recruitment?
- Why are there more home births in Europe than the UK? And
- What is the vacancy rate for midwives at Queens?

PG responded that:

- Queens was already specialising in complex births and would continue to do so.
- There was a national shortage of midwives and there were specific issues in London. BHRUT had been very innovative in attempting to

recruit, devising such programmes as the apprenticeship scheme. NHS London was also looking at issues around recruitment.

- The Annual Report for London showed there were just 1.8% of births at home, compared to 3% nationally. None of the PCT's in north east London met the national average. In mainland Europe, hospitals tended to be smaller and therefore home births numbers were higher.
- The vacancy rate across London was 13%, in north east London, other than at Whipps Cross, it was 19%.

5.5.5 Councillor Sweden questioned why there was no mention of Waltham Forest as the closure of King George's would also affect Whipps Cross, which is a very good hospital. SS accepted that Whipps Cross was doing well relative to other PCTs in the region. It is rated as fair. He was unsure how they would deal with the expected increase. The vacancy rate at Whipps Cross was 12% compared to 13% across London and 19% in the region. A formal response would be provided dealing with the effect on Whipps Cross and copied to the JOSC.

5.5.6 Councillor West asked about the level of home births - 1.8% across London and the effect increasing this would have on the number of midwives required.

PG responded that if it is a policy to increase the number of home births, sufficient resources would need to be invested to meet the extra demand on midwives' time.

5.5.7 Councillor Osborne questioned whether Queens could physically cope with 10,000 births per annum.

PG said the RCM do have concerns about the number. They felt low risk births should take place elsewhere. 10,000 was not ideal and they would prefer to see the unit supported by a mid wife led unit any a second doctor led unit capable of dealing with 1,500 births a year, to ensure the midwife led unit was not used as an overflow unit for labour ward activities in the obstetrics unit.

5.5.8 Councillor Osborne asked a further question as to how Queens would cope now as the other facilities are not yet available. SS answered that it was anticipated that the figure of 10,000 would be reached by 2017, by which time the proposed birthing unit at Barking should be available.

5.5.9 Councillor McShane asked how it was envisaged the 10,000 births would be divided how do the RCM intended attracting sufficient midwives and what would be the optimal level of births. Other issues raised included whether an anaesthetist needed to be in attendance to deliver an epidural and if a doctor needed to be present for a suction birth.

5.5.10 Councillor Vaughan asked about the shortage of midwives in Newham, and what was the reason for this, was it due to inadequate accommodation and could midwives be considered for key worker housing?

PG responded to these points as follows:

- The 10,000 births would be divided by categorisation, with some being low risk at the beginning. They would expect 65% to 70% of births to be low risk, with the relatively small number of high risk births being dealt with at Queens. Other births will be dealt with elsewhere.
- An anaesthetist would need to administer an epidural. Therefore those who chose a home birth or birth centre would be advised that an epidural will not be available.
- There was always a risk with a hospital transfer late in labour. There would however be selection criteria applied to ensure births take place at the right place, and there is an on-going risk assessment process with all patients.
- Suction of Von Tuse extraction was usually done by a doctor.
- The information on still births was not available at the meeting.
- Many mothers would still be able to give birth in Redbridge, but across the region it was anticipated there would be approximately 300 home births.
- Accommodation was likely to be a key factor in the difficulty in attracting midwives to the region.

6. HEALTH FOR NORTH EAST LONDON – VASCULAR SURGERY

6.1 Dr Mike Gill (MG), Clinical Director of Health for North East London and Mr Gabriel Sayer (GS), Vascular Consultant, Barking, Havering and Redbridge University Hospitals Trust (BHRUT) delivered a presentation on the proposed changes to the delivery of complex vascular surgery in North East London.

6.2 The presentation described the proposed model and explained how this was currently working in Newham and Homerton. The aim was to improve safety, efficiency and quality of services across North East London.

6.3 The clinical view was that to be good and efficient at vascular surgery (operations on arteries and veins) surgical units needed to perform about 500 complex operations a year. Currently there were 1,000 complex operations in North East London.

6.4 The proposal was to concentrate complex vascular surgery onto two sites – The Royal London and Queens. Currently Newham and Homerton referred all complex vascular surgery to Royal London. This was not the case with Whipps Cross and King George.

6.5 According to Mr Sayer recent European data demonstrated that the UK had an unacceptably high mortality rate for aortic surgery. Also, UK patients are less likely to receive new technology based treatment, had prolonged lengths

of stay and many surgeons did not reach the minimum numbers of cases necessary to maintain competence.

6.6 The evidence was that high volume arterial centres had better outcomes. New technologies e.g. endovascular surgery had better results and the length of stay was related to the volume of procedures. Patients currently died for want of high quality vascular centres.

6.7 Questions and Discussion with the Committee

6.7.1 Councillor Denyer informed the meeting that the case presented was strong. He had however concern at travel times, availability of ambulances and the level of equipment carried by ambulances.

GS stated that travel times were not a significant outcome. The biggest predictor of outcomes was who operated on the patient.

MG asked that the JOSC get the message across that the time of travel was not crucial, the key was who treated a patient you.

6.7.2 Councillor Pond asked that the statistics be resubmitted including details of Essex patients. He was assured that this would be done.

6.7.3 Councillor Osborne asked what was meant by world standard. GS responded that the UK was “the poor man of Europe”. There were six hospitals in London providing complex vascular surgery. World class meant that all operations would be carried out by the very best

6.7.4 Councillor Sweden felt that the case for critical mass and expertise was well made. His concerns were who would make the diagnosis and determine where the patient should go to the specialist centres; were paramedics suitably trained? Secondly how were co-morbidities dealt with?

MG responded that it was fairly likely that these patients would attend A & E and the diagnosis would be carried out there. The Royal London and Queens were already taking more patients with co-morbidities and there was no problem with immediate transfer.

6.7.5 Councillor McShane asked Dr Gill how the JOSC could get the message across. GS said that some areas are more contentious than others, but the initiatives would save lives and improve care.

HB advised the meeting that there were some areas of the consultation they would wish to push ahead with as quickly as possible and those included the proposals for vascular surgery.

6.7.6 Common Councilman Mead referred to the screening process for middle aged men. GS advised the Committee that North East London had missed the first

phase of funding but were applying for funding now. They did not however wish to commence screening before services were centralised.

6.7.7 Councillor Ralph Scott asked whether the officers were confident that as specialist teams were built up, sufficient staff would be able to be recruited. MG advised the Committee that certain models of care such as that being proposed did serve to attract staff.

6.7.8 Malcolm Wilders was concerned that rehab services would become more marginalised, and also asked if less acute patients would suffer.

MG assured the Committee that the Team at Queens felt responsible for rehab and other hospitals would have access to the expertise available at the specialist hospital. In his experience, patients in Newham received a better service since the centralisation of specialist services.

GS advised the Committee that most of the patients come with a Model of Care document to ensure they receive the best possible treatment.

6.7.9 Councillor Kemp asked why it had taken so long to reach this stage. MG responded that it was an indictment on local health services that things hadn't moved sooner. The evidence in the last ten years has encouraged this type of development.

6.7.10 Councillor Sweden asked for further information of the provisions for diagnosis and the number of specialist vascular nurses in the community. GS explained that most A&E departments had the facility to carry out ultra sound scans. Screening needed to be undertaken carefully.

7. ANY OTHER BUSINESS

7.1 Councillor Eden referred to the visit many of the Havering Committee had made to the London Ambulance Service nerve centre. Perhaps a visit to meet ambulance crews could be organised.

7.2 The next meeting of the ONEL JOSC would be held on Tuesday, 2 February 2010 at Havering Town Hall.

7.3 The next meeting of the Joint meeting would be on Thursday, 11 February at Newham Town Hall.