THE LONDON BOROUGH OF CAMDEN

At a meeting of the **NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE** held on **FRIDAY, 4TH SEPTEMBER, 2020** at 10.00 am in Remote meeting via Microsoft Teams

MEMBERS OF THE COMMITTEE PRESENT

Councillors Pippa Connor (Chair), Tricia Clarke, Alison Cornelius, Linda Freedman Larraine Revah (Substitute member) and Edward Smith

MEMBERS OF THE COMMITTEE ABSENT

Councillors Lucia das Neves, Osh Gantly, Alison Kelly and Samata Khatoon

The minutes should be read in conjunction with the agenda for the meeting. They are subject to approval and signature at the next meeting of the North Central London Joint Health Overview and Scrutiny Committee and any corrections approved at that meeting will be recorded in those minutes.

MINUTES

1. ELECTION OF CHAIR

Councillor Pippa Connor (LB Haringey) was nominated to Chair the meeting and this nomination was seconded. There were no other nominations.

RESOLVED –

(i) THAT Councillor Pippa Connor be elected chair for the duration of this meeting.

2. GUIDANCE ON REMOTE MEETINGS HELD DURING THE CORONAVIRUS NATIONAL EMERGENCY

The Guidance was noted.

3. APOLOGIES

Apologies were received from Councillor Lucia das Neves (LB Haringey) and Councillor Samata Khatoon (LB Camden). Councillor Khatoon was substituted by Councillor Larraine Revah.

Councillor Edward Smith informed the Committee that Enfield had appointed Councillor Christine Hamilton as its second member on the Committee, she had given her apologies for this meeting.

4. DECLARATIONS BY MEMBERS OF PECUNIARY, NON-PECUNIARY AND ANY OTHER INTERESTS IN RESPECT OF ITEMS ON THIS AGENDA

There were none.

5. ANNOUNCEMENTS

Webcasting

The Chair announced that the meeting was being broadcast live to the internet and would be capable of repeated viewing and copies of the recording could be made available to those that requested them. Those participating in the meeting were deemed to be consenting to being recorded and broadcast.

Deputation
The deputation received from Professor Sue Richards representing North Central London NHS Watch would be considered at the meeting on 25th September.

6. NOTIFICATION OF ANY ITEMS OF BUSINESS THAT THE CHAIR CONSIDERS URGENT

There were no notifications of urgent business.

7. ORTHOPAEDIC SERVICES REVIEW

Consideration was given to a report from North London Partners in Health and Care.

The report provided a summary of the adult elective orthopaedic services review with a timeline of activities completed so far. It also summarised the consultation proposals, findings from the consultation and the final stage of the integrated Health Inequalities and Equalities Impact Assessment detailing the contents of the review and highlighting the next steps.

The Committee was asked to consider and give views on the proposals put forward for consultation, and the consultation process undertaken.

Professor Fares Haddad, (Orthopaedic Clinical Network Chair) Will Huxter (Director of Strategy NCL CCG and Joint SRO for the work on Orthopaedics) Anna Stewart, (Programme Director for the review of Adult Elective Orthopaedics) and Helen

Andrews (Patient Representative Orthopaedics Review representing Healthwatch Barnet) were at the meeting to present the report and respond to Committee members questions.

Helen Andrews (Healthwatch Barnet) informed the Committee that she was one of two patient representatives on the Orthopaedic Services review. She had been a patient representative throughout the whole process since March 2018 and continued to have an active role on the Network Board to ensure continuity of the patient's voice throughout the implementation process. This helped to improve patient experience.

Ms Andrews commented that she had found the process to be fully inclusive at all times, had been invited by the North London Partners to speak at meetings including the London Clinical Senate, ask questions, clarify issues and raise concerns. She had been able to contribute at workshops on issues of patients' pathways, transport and network provision, had made comments on the literature used in the consultation process and also visited a Centre of Excellence which had provided her with further insight into the proposed model of care. She had been a Panel member on the Options Appraisal Process and recently been able to review the decision making business case, attending briefing meetings with the Programme Director, Programme Manager and Network Manager providing her with a better understanding of the whole process.

Will Huxter, Professor Farres Haddad and Anna Stewart informed the Committee that:

- The Adult Elective Orthopaedic Proposals had been worked on for a long time going through a long process.
- Regular updates had been provided to this Committee (NCL JHOSC), local borough Overview Scrutiny Committees (OSC) to discuss the proposals.
- Productive discussions had occurred at the various Scrutiny Committees they had attended, about what was required and the key issues of concern such as transport which regularly came up.
- The fundamental aim was to improve the experience and outcomes for people requiring Adult Elective Orthopaedic surgery in NCL.
- It was a key opportunity to improve outcomes, improve experience, and reduce cancellations and to make the journey of an increasing large number of patients with orthopaedic problems smoother.
- The whole idea of co-locating surgery in centres of excellence where there was expertise, both surgical and associated health professionals to provide streamlined care and deliver associated outcomes was something that was well evidenced internationally and nationally and was a good model to try to follow.
- The intention was to deliver a model that would provide excellent care for patients in NCL, improve equality, would be cost efficient, effective, improve retention of staff, reduce cancellations and would be where patients would look to in getting their care.

- A process of public engagement had occurred whereby, large numbers of people had been reached across the 5 boroughs.
- The North London Partners approach to public consultation had been influenced by NCL JHOSC's views including 'Good Practice Principles'.
- The consultation sought explicitly to look at inequalities, the impact assessment of change, where this would be and how this could be mitigated where required.
- There had been strong levels of support for the proposals that went out to public consultation which was evidenced in the more detailed report.
- The public consultation had taken place from 13th January - 6th April, the last few weeks of the consultation a lot of the activity had transferred on-line so that the shut down around Covid-19 could be complied with.
- Numerous amount of people had been talked too, there had been 3 deliberative events, 66 meetings across the 5 boroughs attended by about 1200 people, 12 outreach sessions across NHS trusts, libraries, Community Centres and community events.
- There had been just under 600 responses to the surveys, which included letters and email responses from other stakeholders, professionals and groups of people.
- The majority of people talked too supported the proposals, with three quarters of those spoken too expressed the view that the proposals would lead to improvements in elective care.
- There was an understanding of the rationale behind the service developments such as the Care Coordinator role, the need to separate emergency and planned care in the way that was being done.
- There were concerns raised around travel, accessibility and staff moving around between sites. These concerns were also picked up in the integrated health inequalities impact assessment.
- A workshop was held to look at mitigations to address these concerns and this was included in the pack.
- In respect of transport, this would be looked at in the decision making business case with the CCG towards the end of September.
- There had been renewed contact with Transport for London (TfL) with a positive response received from them about getting into some of the detail, particularly with staff at Chase Farm Hospital where lots of the concerns were centred.
- The pandemic had changed some of the arrangements around transport with the pool of people eligible for transport to hospital widening.
- The intention was subject to the CCG Governing Body signing off the proposals, to commission a suite of literature on the proposals for GPs to talk to patients about how they made choices concerning which of the partnerships they would want to attend for their care.

Ms Stewart highlighted that the next steps following consultation, response and engagement would include:

Going to the CCG Governing Body on 24th September for a full decision making business case, indicating that this would be shared with NCL JHOSC once the decision had been made public.

ACTION: Programme Director for the review of Adult Elective Orthopaedics

Over the next few months, subject to the CCG signing off the proposals, it could then move to the implementation phase stage. This included, ensuring that the plans in both of the partnerships met both of the commitments made, that they met the model of care and the vision set out and aspirations, and both partnerships were safe to operate in that way. The implementation process would then start early in the next calendar year from the end of December beginning of January in both sites.

The Chair reminded members that the Committee was required to make comments on the proposals put forward and the consultation process. At the end of the meeting a written response from the Committee on the proposals and consultation process would go to the CCG. The CCG Governing body decision making business case was due on 25th September. The actual reality of what the offer was, would be part of the next stage of the process and the Chair requested that this should come back to NCL JHOSC.

Answering Committee members questions the Orthopaedic Clinical Network Chair, Director of Strategy NCL CCG and Joint SRO for the work on Orthopaedics and the Programme Director for the review of Adult Elective Orthopaedics commented that:

- In relation to the deputation coming to JHOSC on 25th September, it concerned an entirely different set of issues. The deputation related to emergency service changes due to Covid-19. The proposals being considered today were stand-alone consultations about service changes that had been discussed since 2018, had been to this Committee 6 times and pre-dated Covid-19.
- Concerning travel, the system was being designed so patients could access their care locally as they always had done, except for major surgical interventions so it would not be a case of frequent trips away.
- Transport was always going to be an issue but this was countered by the fact that patients would be at a place where all the expertise would be located in one place with ring fenced beds, with a very low likelihood of cancellations and much lower likelihood of infection much more streamlined care across a multi-disciplinary team of staff used to doing the procedure at high volume.
- In terms of Covid-19 and potential outbreaks, this was one of a number of reasons for the change. Reducing infection rates by re-locating elective surgery away from emergency pathways was part of the process so that these hubs would be green sites, effectively Covid free sites. Elective surgery should be able to continue in the face of outbreaks.
- In relation to staff testing, there was lots of asymptomatic testing on staff, including temperature checks, with masks worn everywhere. Everybody was

working to infection control practices and guidelines. Patients coming into hospital depending on risk factors were advised to isolate for 2 weeks or social distance and then have a Covid test.

- In relation to capacity, the model would be that the Northern and Southern hubs would work in partnership, with Royal North Orthopaedic Hospital (RNOH) as a super specialist centre. All three hubs would be slightly different not designed to be identical and should be able, if all the theatres were run to their full capacity and fully staffed to catch up with the backlog and essentially have the capacity do more than was needed. There was enough slack in the system and this was believed to be the right model.
- Also a big benefit of the Clinical Network which met fortnightly, was it looked at recovery planning across all of the Trust and where there were long waiters/backlogs work went into how this could be mitigated. There was a good flow of information between the various departments to understand what was going on.
- The whole model was designed not to outsource to smaller lower volume institutions.
- The model being proposed was the most efficient way of getting through large numbers of cases with dedicated beds and teams. It was considered to be the best way of tackling this because it streamlined patients through in the quickest way possible with the available facilities.

A Committee member suggested that it would be useful at an appropriate time in about 12-18 months for the issue of capacity to be looked at again to determine whether the hubs had been able to cope with the increased patient capacity. Ms Stewart agreed to report back to the Committee on the issue of capacity.

ACTION: Programme Director for the review of Adult Elective Orthopaedics

Responding to further questions from Committee members the Orthopaedic Clinical Network Chair, Director of Strategy NCL CCG and Joint SRO for the work on Orthopaedics and the Programme Director for the review of Adult Elective Orthopaedics highlighted that:

- In terms of how elective surgery would keep going were a second wave of the pandemic to occur, this was the very issue that was being looked at, the perception at the moment was that a second surge would not look like the first surge which occurred in March, in terms of hospital impact and the partners should be able to maintain some kind of green pathway through the hospital but if the same situation occurred as the at the end of March some of the local sites would be paralysed. This would be a disastrous scenario and Elective Orthopaedic surgery would not be a priority at the heart of the green sites.
- Green sites would still be able to work through some of the backlog if they were still up and running though.

A Committee member highlighted that the figures on pages 49 and 51 of the agenda relating to, 'Access to Healthcare Information' and 'Preferred Methods for Follow Up' were incorrect. On page 46 of the agenda in relation to '*Will the Proposals Address the Challenges*' there was no key to what the different shadings meant. Mr Huxter and Ms Stewart agreed to correct the information and re-circulate to the Committee. **ACTION: Director of Strategy NCL CCG and Programme Director for the review of Adult Elective Orthopaedics**

Answering further questions, it was noted that:

- In terms of communicating with patients in a way they would understand, the consultation had included practical questions to get a steer from patients on how they preferred to be communicated with.
- Also built into the proposals was the Care Coordinator model role who would be able to talk to patients' right from the start of their journey and provide signposting to specialist services.
- The Patient representative informed the Committee that the patient had been put at the heart of the whole process involving patients in the process all along.
- Care Coordinators were for everybody, the basic principle was that they were well informed and solved some of the issues highlighted.
- Clinicians were involved intrinsically in the process, Care Co-ordinators were a really valuable part of these pathways for everybody and would identify preferred means of communication for the patients.
- Subject to the proposals being signed off by the CCG Governing Body, the proposals were that implementation would be run through the Clinical Network chaired by Professor Haddad and which other patient representatives sat on, so there would be Clinical led oversight. This was a powerful way of ensuring clinical voices were at the height of ensuring delivery was being made on the aspirations.
- In relation to having Care Coordinators feeding into the Clinical network, this would be something for the NHS Partners to consider.

Commenting on the consultation process, the Chair noted:

- that out of the group of 800 members of the Residents Health Panel consulted only 15 appeared to have been Carers (Caring for people with a disability whether an adult or child), and further work was required on a wider basis on how to engage with carers of people with disabilities.
- Although from the mitigations there was reference to older people, there however appeared not to be specific engagement with older people.
- There were a long list of mitigations captured, and queried how realistically those mitigations were going to be addressed in the final business case;
- When reviewing the process in 18 months' time, consideration would not only be given to clinical effectiveness but also patient engagement and patients' ability to get access to the right information at the right time.

- The Committee would want to know what was going to be measured, how it was going to be measured and who was going to be accountable for that.

In response Ms Stewart informed the Committee that:

- A large number of older people were spoken too as part of the consultation process of which there several parts. There was a survey which was completed by about 600 people, there were groups in the community that were spoken too, this included 66 meetings and a total of 1205 people, lots of those were older peoples groups such as Enfield Age Concern.
- In terms of Carer groups, Health Equality Impact Assessment findings highlighted that carers were one of the groups spoken to. This was a separate piece of work commissioned and paid for Market Researchers to call and speak to carers and target different groups. This had just been set up and would look to capture the views of vulnerable people. The next step would be how to ensure more people were engaged with. The mitigations had been grouped into themes, each theme had been taken in turn and built into the model to address
- Subject to the CCG signing off the business case, the Programme Team would look to commission a suite of literature, including patient and GP leaflets which would be made available on the website and also provide virtual tours of the building. The Team would also use performance metrics which tracked achievements and performance. Ms Stewart informed the Committee that she would come back at a future date to report back on how they had managed to deliver on the aspirations.

ACTION: Director of Strategy NCL CCG and Programme Director for the review of Adult Elective Orthopaedics

The Committee also requested that when the update report came back that it also included views from Care Co-ordinators as well as the Patient Representatives.

ACTION: Director of Strategy NCL CCG and Programme Director for the review of Adult Elective Orthopaedics

A Committee member commented that Enfield had a larger response to the survey compared to the other 4 boroughs, in response Ms Stewart pointed out that Enfield had an active Healthwatch organisation and this was what had been incorporated into the survey responses. The Committee asked for a breakdown of the survey responses separating out how many of the survey responses were from Enfield Healthwatch surveys because Healthwatch surveys were not included from the other boroughs.

ACTION: Director of Strategy NCL CCG and Programme Director for the review of Adult Elective Orthopaedics

Commenting further on the consultation process Committee members commented that they had been impressed with the process as it had been thoroughly and professionally done.

The Chair noted that it had been a very full consultation process and North London Partners had done as much as they could have done despite the pandemic. She noted further that in relation to the elderly, it would have been helpful to have had a clear document of their views as a separate group to look at.

In terms of the proposals:

- The views of the carer and vulnerable groups had been captured and fed into the business process, the issue was balancing the trade-off between a more efficient system and people having to travel more and this was an issue that could not be avoided and was quite difficult to address. On balance it would result in better and faster treatment for patients.
- On reflecting back there were similar concerns relating to Stroke hubs around London, and transport was also raised as an issue. In the end it worked very well and proved the right decision to have sectors of excellence.
- The Committee understood the proposals, there was clarity about the aims and aspirations, members had the opportunity to raise concerns, understanding that not all concerns could be mitigated, particularly around Green sites. The proposals had received widespread support particularly amongst clinical staff.

- The Committee would look at the next stage of the process how well it worked and how well the mitigation worked. The Committee requested that a report be brought back in 12-18months on how well it was going and how the mitigations had been addressed.

RESOLVED-

(i) THAT the report and comments above be noted;
(ii) THAT a report come to a future meeting in of this Committee on how well the Orthopaedic Service changes are going and how the mitigations highlighted have been addressed to include the Care Co-ordinator and Patient representative perspective.

8. ANY OTHER BUSINESS THAT THE CHAIR CONSIDERS URGENT

There was none.

The meeting ended at 11.50 am.

CHAIR

Contact Officer: **Sola Odusina**
Telephone No: **020 7974 6884**
E-Mail: **sola.odusina@camden.gov.uk**

MINUTES END