MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
7 December 2011 (7.30 - 10.10 pm)

Present:

Councillors Pam Light (Chairman), Nic Dodin, Frederick Osborne, Gillian Ford, Eric Munday and Garry Pain.

10 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

Apologies were received from Councillor Wendy Brice-Thompson (Councillor Garry Pain substituting) Councillor Brian Eagling (Councillor Gillian Ford substituting) and Councillor Linda Trew (Councillor Eric Munday substituting).

Apologies were also received from Jacqui Himbury, Borough Director, NHS Outer North East London, Stephanie Dawe, Chief Operating Officer, North East London NHS Foundation Trust and from Joan Smith, Coordinator, Havering LINk.

Councillor Paul McGeary was also present.

A representative from Havering Local Involvement Network (LINk) was also present.

11 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

12 **MINUTES**

The minutes of the meeting held on 13 October 2011 were agreed as a correct record and signed by the Chairman.

13 **ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH**

The Director of Public Health explained that the main focus of the annual report was on cancer outcomes in Havering. Whilst the overall number of cancer cases in Havering was broadly in line with average figures, survival rates one year after diagnosis were lower then the national average. The main reason for this, in the view of the Director of Public Health, was a lack

of awareness locally of the signs and symptoms of cancer. Risk factors such as weight and a lack of physical activity were not so widely known.

The report had made a number of recommendations including the development of campaigns to raise awareness of the signs and symptoms of cancer, more training of GPs in identifying these, ensuring that GPs had access to diagnostic tests for cancer and better access to more modern surgical techniques such as laparoscopic surgery for bowel cancer.

Officers explained that an earlier stage of diagnosis and the provision of effective treatment were key to higher cancer survival rates. It was felt that local cancer treatment was as good as any similar service nationally. The emphasis would be on getting the best value for existing spending on cancer services locally.

Particularly poor rates of presentation were seen with bowel cancer in Havering – a type of cancer where early diagnosis was especially important. Some Members were unaware of the bowel cancer campaign although others had seen the advertisements which had also been presented at a previous meeting of the Committee.

Bowel cancer screening was offered in Havering on a five-year programme. There was approximately a 60% uptake with more women than men likely to complete the test. Screening was offered to people in Havering aged 60-69. Information about testing was given to GPs by a health promotion officer who visited surgeries. Other areas such as Westminster had been running bowel cancer screening for a longer period and were hence able to offer the service to a wider age range. An increased age range for screening would commence once a certain level of coverage had been achieved. The Director of Public Health would confirm the timescale for the age range offered in Havering. The Group Director – Adults and Health felt it was important to establish when the service would be offered to younger patients and also to consider best practice elsewhere.

Officers confirmed that no financial incentives were offered to Havering GPs to provide testing for bowel cancer. The Director of Public Health felt that there was a need for additional local campaigns to raise awareness of cancer. Areas prioritised in campaigns would be those where it was thought most difference could be made – bowel, breast and lung cancer. Focus would also be concentrated on the areas where survival rates were lowest – Gooshays, Heaton and Upminster wards.

A total of £300,000 would be spent on the campaign across three local PCT areas with £100,000 in Havering. Health officers were keen to engage the voluntary sector in order to ensure these funds went as far as possible. Members felt the awareness campaigns could be effective if used at the Havering Show and also if disseminated via social networks.

The Committee **noted** the presentation.

14 BHRUT UPDATE

The Director of Planning and Performance at Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT) updated the Committee on a number of issues that had been raised by Members. Clinicians had firstly confirmed that it was necessary to transport patients by ambulance the short distance from the hospital helipad to A&E.

The total number of beds available did vary slightly but there were a total of 746 beds at Queen's and 389 beds at King George. In addition, there were 75 observation beds and 25 well baby cots at Queen's and 41 further beds at King George. The reported problem with seating in bays 2 and 3 of the cardiovascular unit at Queen's would be attended to by the Trust Estates department.

The four hour rule was still a performance indicator for A&E but other local measures were available on the Trust website. These included numbers of unplanned reattendances with seven days, patients leaving the department without being seen and the time until treatment was administered. The Trust was meeting its target of delivering three of five indicators at King George but had only met one indicator (numbers who left the department without being seen) at Queen's.

Officers accepted that there was a major challenge to speed up the process of patient discharge. The JONAH computer system was used to identify the main constraints to discharge. Efforts were ongoing to improve issues such as access to diagnostic tests and results, clinical decision making and arranging medication to be available on discharge. A discharge partnership board of all relevant stakeholders had been established, chaired by Alison Brown. The final Care Quality Commission report on the Trust had also focussed on relationships with partners.

BHRUT shared concerns over nursing home quality and wished to work with each of the local boroughs on this. The Group Director added that the Council's safeguarding team needed intelligence from BHRUT on concerns the Trust may have. The adult safeguarding team would also look to pick up where apparent symptoms of dementia were in fact due to residents' dehydration.

As regards measuring patients' experiences, BHRUT officers were aware that many survey kiosks in the hospital were not working and gave an assurance that these would be repaired and extended. Patient experience data was not yet available on the Trust's website.

A new process of patient assessment had been introduced at A&E which included arranging for appropriate patients to be seen by their own GP, on the same day if possible, as appointment slots had been reserved. Members were sceptical of this scheme feeling that it would not be possible

to obtain GP appointments at such short notice. Officers emphasised however that GPs were now taking responsibility for managing the emergency care pathway and had suggested this system themselves. The Director of Public Health added that she would include comments about difficulties accessing GPs as part of the response to the current consultation on the Primary Care Strategy. Members were not convinced that this related purely to single handed practices feeling that it was often equally as difficult to access GP appointments at larger practices. Members were also welcome, during the consultation process, to feed back specific examples of difficulties in obtaining GP appointments.

BHRUT had developed an action plan in response to the Care Quality Commission report which had included a number of measures relating to maternity. Separate short-term changes implemented had included the transfer of caesarean sections to Homerton Hospital, not taking Essex based births at Queen's and capping numbers of maternity cases at 20 for Queen's and 7 for King George. Following concerns raised by local women about the transfer of services to Homerton, the Royal College of Obstetricians had been invited to validate the existing process. The plan was now to arrange a short-term increase in capacity at King George in order that planned c-sections could be undertaken there until the proposed midwife-led unit opened at Queen's. It was expected that c-sections from the Havering area would cease being carried out at the Homerton from mid-December. BHRUT officers would supply details of the numbers of extra beds that would be needed at King George to accommodate low risk births.

It was reiterated that BHRUT was taking all aspects of the CQC report seriously and had already made progress against many of the recommendations. The Trust has one of the best midwives to mothers ratios in London and Queen's also had one of the highest levels of obstetric cover in London.

Staff attitude problems in maternity were also being addressed and the Group Director agreed that the current Trust chief executive was committed to personally dealing with staff attitude and performance issues. In response to a Member enquiry, Trust officers agreed to supply figures for staff assaults at Queen's. It was confirmed that assault cases were reported to the Police unless for example patients were not aware of their actions. It was also suggested that the Committee could consider the effect of alcohol in A&E.

The Chair of Havering LINk reported that an enter and view visit to maternity in November 2011 had found a lack of ECG and blood pressure apparatus in the labour room. Trust officers agreed to investigate this.

It was also confirmed that the business case for the proposed midwife led unit was currently with NHS London. If capital funds were secured, it was hoped work would start in March or April and the unit would open in late summer 2012. A business case was also being developed to redesign and

increase the capacity of A&E. Trust officers would supply indicative figures for this project.

The Committee **noted** the update from BHRUT.

15 **NHS ONEL UPDATE**

The Director of public health confirmed that breast screening would start shortly at Harold Wood polyclinic. Screening would be extended to ages 47-73. Appointments would be available 8am – 8pm Monday to Friday. It was unclear at this stage if appointments would also be available on Saturdays.

The breast screening service would be provided by BHRUT but the precise timescale for starting the service at the polyclinic remained uncertain at this stage. NHS ONEL officers would supply details of the date when services were due to start. Screening would also continue at the Victoria Clinic which would be a digital screening system for women needing further investigation. Women were called for breast screening on a three-year programme and the take-up in Havering was approximately 70%, meeting the target for this. The new detection model had not been quality assured as yet and the current evidence indicated that digital mammography gave the best chance of cancer detection.

GP practices would open on the three working days over the holiday period (28-30 December). A guide for practices over the holiday period would be issued to Havering surgeries shortly. Information would also be available on the NHS ONEL website and the Director of Public Health would check how else information on health services over the Christmas period would be disseminated. Members suggested using the local press, libraries and pharmacies to assist with this. The 111 telephone advice service was not available yet and was likely to start in Havering in February 2012.

Members raised concerns that Harold Hill health centre remained underused with a lack of the proposed minor surgery and x-ray services. The Director of Public Health responded that NHS ONEL was currently considering what additional services could be moved into the health centre. It was agreed that the Committee would arrange a site visit to Harold Hill health centre in order that concerns and issues could be discussed on site with the borough director. Members felt similar problems of underuse existed at South Hornchurch health centre and perhaps a visit could be arranged in the future. It was confirmed that chiropody services were now at Cranham health centre. Diabetic chiropody services were based at South Hornchurch clinic.

A GP was based at the polyclinic throughout the day as were a nurse practitioner and health care assistant for part of the day. Nurses were also

available at the polyclinic each day. Extra staff could also be put in according to need.

Changes on an NHS ONEL basis were being led by Alwen Williams and Heather Mullin. Elections were being held that evening for the GP consortia joint board which would lead to the establishment of a single consortium for Havering. Members were keen to establish what would be the priorities of the new Clinical Commissioning Group. The Director of Public Health added that one of the current consortia was working on the Gold Standard framework for end of life care.

The Director of Public Health was aware of rumours concerning the future of St. George’s Hospital but confirmed that there were no plans to sell the site to Newham. It was planned to close some of the buildings on the site but details were still being discussed with GPs who would make the final decision. No part of the land at St. George’s had been sold at this stage. The Director of Public Health would check if the land would be sold as one site or as individual plots. The Director of Public Health would also check the situation as regards land near the site currently being for sale on the internet. A representative of Havering LINk felt that excellent care of the elderly was provided at St. George’s and that people became anxious if the future of the hospital was uncertain. The Chairman felt it was essential that Members were kept up to date as regards developments with St. George’s.

The Committee **noted** the update from NHS ONEL.

16 HAVERING LOCAL INVOLVEMENT NETWORK (LINK) - PATIENT DISCHARGE REPORT

A representative of Havering LINk explained that the issue of patient discharge had been repeatedly raised as a problem by both LINK members themselves and the general public. The report had identified a number of factors contributing to delays in discharge of patients from Queen’s Hospital. A major reason related to problems with prescriptions for medication needed to go home with patients. It was often unclear to the hospital pharmacy where prescriptions had originated from and as many as 50% contained errors of various kinds.

Other factors delaying discharge included a lack of the required training for care home staff and the reluctance of many GPs to visit older people in care homes. The Committee Chairman added that care homes often reported that clients were often discharged without their discharge letters or other information relating to their treatment.

The report had made a total of 32 recommendations to the stakeholders involved in the discharge process including the need for an independent discharge coordinator to speed up the process.

The Group Director welcomed the report and felt the recommendations were helpful. Clinical commissioners and relevant Council heads of service could be involved further work on this area.

It was **agreed** to arrange a topic group meeting to consider the issues raised by the patient discharge report in more detail. Commissioners and other stakeholders would be invited to the meeting in order to that the views of all stakeholders could be considered.

The Committee thanked the LINk representatives for producing an excellent report on the issue of patient discharge.

17 HAVERING LINK - ENTER AND VIEW REPORT BACK

The Chair of Havering LINk reported that an enter and view visit to Sunrise ward at Queen's Hospital had been undertaken on 24 October. This had been requested by the Committee Chairman in order to ascertain principally if the red tray system at mealtimes was working effectively.

The LINk representatives had observed the ward as being very clean and calm but had seen some patients not receiving the required help at mealtimes. A particular problem was the overfilling by ward staff of water jugs meaning these were too heavy for elderly patients to lift. Shortages of staff on the ward had restricted how much assistance could be given to patients.

Standing orders were suspended at this point in the meeting in order that all agenda items could be concluded.

There was also a lack of signage identifying blind patients on the ward who may need help. The LINk observers also felt there was a lack of appropriate training for staff in dealing with patients with dementia or mental health needs. One female patient had fallen on the ward and damaged her eye as a result.

The LINK had made ten recommendations as a result of the visit covering red trays, signage for patients with disabilities, use of water jugs and choice of vegetarian meals etc. The LINK representatives had spent a total of two hours on the ward and the NELFT borough director added that a NELFT team was now based near the elderly wards in Queen's Hospital. The LINk report would be passed on to the relevant NELFT staff who wished to give appropriate training to BHRUT staff.

Members thanked the LINk for their report and asked that the report be forwarded for information to the Outer North East London Joint Health Overview and Scrutiny Committee.

Chairman