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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

7.30 pm	Thursday 10 May 2012	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative Group (4)	Residents' Group (2)	Labour Group (0)	Independent Residents' Group (0)
Pam Light (Chairman) Wendy Brice-Thompson Frederick Osborne Linda Trew	Brian Eagling (Vice-Chair) Nic Dodin		

Ian Buckmaster
Committee Administration & Member Support Manager

For information about the meeting please contact:
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AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – receive.

3 DECLARATIONS OF INTEREST

Members are invited to declare any interests in any of the items on the agenda at this point of the meeting. Members may still declare an interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 6)

To approve as a correct record the minutes of the meeting held on 28 February 2012 (attached) and to authorise the Chairman to sign them.

5 AGEING WELL EVENT (Pages 7 - 16)

Following the recent Ageing Well event considering priorities for older people in the borough, the attached report details some themes arising from the event that could be used as components of the overview and scrutiny committee's work programme.

6 NEW COMMISSIONING ARRANGEMENTS

To receive an update on the new NHS commissioning arrangements from Conor Burke, Director of Clinical Commissioning Group Development, NHS North East London and the City.

7 BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST QUALITY ACCOUNT

To receive a presentation from Pam Strange, BHRUT on the Trust's Quality Account.

8 HEALTH FOR NORTH EAST LONDON UPDATE

To receive an update on implementation of the programme from Heather Mullin, Health for North East London.

9 HAVERING LINK - ENTER AND VIEW (Pages 17 - 24)

To receive an update on a Havering LINk enter and view visit to Queen's Hospital from Cliff, Reynolds, Havering LINk (visit report attached).

10 COMMITTEE'S ANNUAL REPORT, 2011/12 (Pages 25 - 32)

Attached.

11 URGENT BUSINESS

To consider any other item in respect of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item shall be considered at the meeting as a matter of urgency.

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
28 February 2012 (7.30 pm – 10.05 pm)

Present:

Councillors Pam Light (Chairman), Wendy Brice-Thompson, Nic Dodin, Frederick Osborne, Linda Trew and Barbara Matthews (substituting for Councillor Brian Eagling).

Councillor Paul McGeary was also present.

Apologies for absence were received from Councillor Brian Eagling

Also present:

Andrew Atack, Heartstart Havering
Neill Moloney, Director of Planning and Performance, Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT)
Jacqui Himbury, Borough Director, NHS Outer North East London (NHS ONEL)

Stephanie Dawe, North East London NHS Foundation Trust (NELFT)
Fiona Weir (NELFT)

Three members of Havering Local Involvement Network (LINk) were also present.

18 **ANNOUNCEMENTS**

The Chairman reminded everyone present of the action to be taken in an emergency.

19 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

20 **MINUTES**

The minutes of the meeting held on 7 December 2011 were agreed as a correct record and signed by the Chairman.

21 **HEARTSTART HAVERING**

The officer from Heartstart Havering explained that the organisation had been set up in 1992 by the British Heart Foundation to spread knowledge of Cardiac Pulmonary Resuscitation techniques in the general population. Free courses of approximately 2.5 hours in length were offered by the organisation covering essential information regarding how to save a person's life. Heartstart Havering ran its first course in 2002 and had run a total of 247 courses, training 3,360 people since 2003. A further 25 adults and 55 children had been trained so far in 2012.

The organisation had no budget for publicity and a bid for funding from the Community Chest had been unsuccessful. Course dates had however been set to the end of 2012 and an on-line booking system had been set up. A text information system was also on trial.

Heartstart Havering was keen to ensure that defibrillators got to people as quickly as possible. The AED defibrillator read the level of electrical activity in a person's heart and gave an electric shock to the heart if necessary. The use of the defibrillator was demonstrated to the Committee who felt that it was easy to use with clear, audible instructions. AEDs were already available on all platforms at Romford station as well as in shopping centres and libraries. The aim was now to try and put AEDs on streets in residential areas.

Each AED unit cost £1,000-£1,500 and would be maintenance free for 5-7 years. Several pilot areas to have an AED located had been identified in Havering in order that several hundred houses could be within as little as a three minute walk of an AED machine. Outdoor cabinets for the AED machines were available at a cost of £400 - £1,000. As a measure against vandalism, the cabinets included a photograph of each person that opened the cabinet, which could also be e-mailed to the Police if necessary. Emergency 999 calls could also be made from the cabinet. Heartstart Havering wished for the Committee's support for future applications for funding for the scheme.

Members felt the scheme was a good idea but remained concerned about the risk of vandalism of the equipment. Perhaps the machines could be sited inside tower blocks or at petrol stations and supermarkets where there was less risk of vandalism etc. The AED machines self-checked on a daily and weekly basis but it was also envisaged that local people would do weekly checks of the equipment. It was accepted the spraying of graffiti on the equipment could probably not be prevented.

The representatives from BHRUT and NHS ONEL supported the AED idea. The borough director from NHS ONEL felt the locating of the machines in residential areas could be given a trial and the strategy reassessed if necessary.

The Committee **agreed** that, while not controlling any funding itself, it was otherwise happy to support the Heartstart Havering project. This would include written support of the plans if required.

22 BHRUT UPDATE

The Director of Planning and Performance at BHRUT explained that additional beds were being put in at King George Hospital to cater for in the region of seven births per day. A small amount of maternity activity had also been shifted to Essex (20-30 births per month). The Essex arrangements had been due to continue until April but this had now been relaxed due to capacity issues in Essex. Planned caesarean section deliveries would continue to take place at Homerton Hospital until the end of March at which point this arrangement would cease as the cap on numbers of deliveries at Queen's would be lifted from 1 April. It was accepted by the Trust that transferring caesarean sections to the Homerton was not ideal but it was felt that it was now acceptable to bring these deliveries (approximately 3-5 per week) back to Queen's. The Care Quality Commission was also supportive of this change starting from 1 April.

The capital funding of approximately £1.5 million for improvements to maternity funding at Queen's had now been agreed. It was anticipated that works would be completed by November 2012 at which point A&E activity would begin to transfer from King George to Queen's. Capacity issues at Whipps Cross and Newham hospitals would also be considered as part of the Health for North East London programme. Members were anxious that services at King George were not reduced until the new facilities were in place.

There were a range of options to accommodate the extra demand for A&E services at Queen's including converting the current renal or sexual health units. The BHRUT officer would update the Committee further on these plans in due course.

Tenders had been released for the operating of the Barking Birthing Centre and the formal contract would be awarded shortly. More detailed work on this would also be needed.

Figures for staff assaults at BHRUT were as follows:

Calendar year 2011 – 149 incidents of verbal abuse and 113 of physical abuse.
April 2010 – March 2011 – 175 verbal abuse and 144 physical abuse.
April 2011 – December 2011 – 114 verbal and 80 physical

The Committee agreed unanimously that such amounts of abuse of staff were unacceptable and officers agreed to ascertain if figures for the proportion of assaults relating to drink or drug abuse could be provided. It was also noted that funding had been received for the installation of mobile A&E tents in Ilford and Romford town centres in order to deal with alcohol-related incidents.

£5-7 million funding was available for reablement and other local schemes to reduce readmission to hospital.

The incidence in the recent LINK report concerning a lack of ECG and blood pressure apparatus had been investigated by the Director of Nursing but such equipment was not considered necessary in low risk births (one third of the total). There was sufficient equipment available to cover all high risk births. Any broken machines were repaired by the contractor – Catalyst within a set turnaround time. Equipment was checked by the supervisory midwife for each shift as well as via the Trust's Visible Leadership programme.

There were approximately 11,000 births per annum in the Trust area although this would be approximately 9,500 – 9,800 this year due to the effects of capping of delivery numbers. Mothers were given a choice of venues at which to give birth. The Health for North East London plans would also mean that it would be more convenient for some women to give birth at Whipps Cross once the maternity unit at King George was removed. Officers agreed that Whipps Cross was currently operating at full maternity capacity and plans for how the hospital would cope with this extra demand would be brought to the Committee once they had been finalised.

A Member raised the issue of people smoking outside the entrance to the maternity unit, the smoke from which then came on to the unit via the open windows. The BHRUT officer agreed to investigate this. Signs were put up and people smoking outside of designated areas were challenged but staff often received considerable verbal abuse when doing this. A member felt that the Trust's expenditure on smoking shelters outside the hospital had been a waste of resources and that the main hospital entrance area was in a very poor condition.

A&E consultants were currently on call but BHRUT was looking to move to 24 hour consultant cover on site at A&E. A further 8-10 consultants would have to be recruited in order to achieve this.

It was clarified that Heather Mullin would lead the work on the transfer of services from King George to Queen's but the final decision on when the move took place would be a decision for the relevant Clinical Commissioning Groups (CCGs).

The NHS ONEL borough director explained that midwives remained legally responsible for the care of a baby for 28 days up to birth. A Member explained that a haemorrhaging new mother had recently returned to maternity where staff had simply referred her to A&E. BHRUT officers agreed that this should not have happened and would investigate this further.

The norovirus was an issue at the Trust and it was accepted that there would always be some outbreaks at the hospital. The virus was of a sudden onset with a short duration (usually 2-3 days) but was not usually that

serious. There was a comprehensive programme of staff training in place regarding norovirus in place at the Trust. Investigations were undertaken in all cases where there were two or more cases of diarrhoea or vomiting on a ward but results could take up to a week to be received. Affected wards were closed to admissions and discharges for 72 hours. Posters advising of the closure were also displayed at the ward entrance, the main hospital entrance and in A&E. Visitor numbers were limited and children were also discouraged from visiting affected wards.

A detailed cleaning schedule including steam cleaning was implemented for all wards affected by the norovirus. The ward was also "blitz cleaned" prior to reopening. BHRUT officers would e-mail to the committee officer information leaflets available for patients and visitors in order that these could be distributed to the Committee.

In 2010, 16 wards across Queen's and King George Hospitals were at one point shut simultaneously due to the norovirus. In 2011, no more than four wards had been shut at once and this was only for a short period. At the time of the meeting, only one ward, the stroke unit, was currently closed. There had been no incidents of norovirus reinfection since the ward closure period had been lengthened to 48 hours.

It was **agreed** that a standing item on the Health for North East London work should added to the Committee's agendas with effect from the next meeting.

23 HAVERING CLINICAL COMMISSIONING GROUP

The borough director explained that the Clinical Commissioning Group (CCG) was headed by a board of seven experienced clinicians, each leading on a particular area. The CCG would have to deal with a number of issues specific to Havering including a growing population and pockets of deprivation. Other challenges included issues regarding Queen's Hospital, introducing improvements to primary care and the rising demand for health services.

The CCG was already planning clinical improvements including the introduction of seven outpatient clinics in community settings and undertaking peer reviews of how individual practices were performing. Corporate successes included the merger of the previous two Havering CCGs into one organisation and a draft constitution being developed. The CCG board would operate as a shadow CCG from 1 April with delegated authority from NHS ONEL for the community budget. Overall responsibility for the budget would however remain with NHS ONEL for another year.

As regards engaging with partners, the CCG had undertaken a lot of work with patients, Councillors and the Local Involvement Network. Work was also in progress with the Health and Wellbeing Board. The borough director

accepted that there was a very challenging year ahead but was confident that the CCG would rise to the challenge.

Members were anxious to ensure that patients would not see any reductions in services but the borough director emphasised the CCG would have patients at its centre with the implications for patients of any changes being considered at the CCG board. The overall NHS budget had been uplifted by 2% but outpatient clinics located in the community as planned by the CCG would also be cheaper to operate than those in acute settings.

All GP surgeries would be required to have patient participation groups of which there were currently 12 in total. Lesley Buckland, NHS ONEL vice-chairman, was leading on patient engagement for the CCG.

A representative of Havering LINk was concerned about any possible loss of contact between patient and doctor as a result of these changes. The borough director responded that the GPs involved were funded to employ locums whilst they were engaged in CCG work. It was a matter for each practice to manage continuity of care. Two of the members of the CCG board were semi-retired and hence did less clinical work in any case. It was emphasised that overall GP consulting hours were not expected to reduce as a result of the CCG being set up.

The salaries paid to GPs were confidential but funding to set up the CCG equated to £2 per head of resident population and so totalled approximately £500,000. This was also expected to cover the costs of clinical backfill and engagement work. The budget was expected to be underspent at the end of the year.

The borough director was certain that the CCG would lead to an improvement on the existing healthcare system as the performance management framework introduced would address quality and financial issues.

The Committee was concerned that there were no female doctors on the CCG board but the borough director responded that there were a lot of women on the wider management team and that the transition year would see further changes.

Chairman

Havering
LONDON BOROUGH

REPORT TO ALL OVERVIEW AND SCRUTINY COMMITTEES, MARCH-MAY 2012

Subject Heading:	Potential Work Programme Themes Arising From Ageing Well Event
CMT Lead:	Ian Burns, Acting Assistant Chief Executive, Legal and Democratic Services
Report Author and contact details:	Anthony Clements, Principal Committee Officer Tel: 01708 433065 anthony.clements@havering.gov.uk
Policy context:	The Council's overview and scrutiny powers and the need to ensure an effective overview and scrutiny process.
Financial summary:	No implications arising directly from this report.

The subject matter of this report deals with the following Council Objectives

Ensuring a clean, safe and green borough	[]
Championing education and learning for all	[]
Providing economic, social and cultural activity in thriving towns and villages	[X]
Valuing and enhancing the lives of our residents	[X]
Delivering high customer satisfaction and a stable council tax	[]

SUMMARY

Following the recent Ageing Well event considering priorities for older people in the borough, this report details some themes arising from the event that could be used as components of the overview and scrutiny committees' work programmes.

RECOMMENDATION

That Members consider the themes raised by the Ageing Well event and decide which, if any, should be added to the work programme of their Committees.

REPORT DETAIL

1. Members will be aware that, in January 2012, an event was held considering the implications for Havering of the growing elderly population and the Ageing Well agenda generally. The event was well attended with a number of Members and other stakeholders present. Groups and organisations dealing with the elderly who were represented included Age Concern, Havering Police and local NHS organisations.

2. The event produced a great deal of discussion and ideas from the delegates about what were considered the priority areas for older people (a number of members of the Havering Over-50s forum also attended and gave valuable input to the discussions). The results of these sessions are summarised in the appendix to this report.

3. Shortly after the event, several of the Overview and Scrutiny Committee Chairmen, assisted by officers, met informally to consider the outcomes from the event. A number of general themes emerged and these, along with some further suggestions, are listed below. It should be noted that this is not an exhaustive list and Members are welcome to use any of the information below or in the appendix to consider what items could be added to the Committees' work programmes.

   - Security and fear of crime including data protection issues
   - Lifestyle and social inclusion
   - The impact of housing and planning on older people
   - Accessibility and transport
   - Bereavement support
   - The impact on young carers
   - Safeguarding issues

4. Issues affecting older people are often wide ranging and it is likely that many of the issues listed above (or any others chosen by Members) may cover the remit of more than one Overview and Scrutiny Committee. This should not be seen an obstacle to undertaking the work but Members may wish to give consideration to co-opting members from appropriate

other committees onto any topic group set up in response to the Ageing Well work. For example, a review of security and fear of crime led by the Crime & Disorder committee may find it useful to co-opt a member from the Towns & Communities overview and scrutiny committee in order to more fully consider the security aspects of housing design and related areas.

IMPLICATIONS AND RISKS

Financial implications and risks:

None arising directly from this report. Any financial implications arising from individual reviews would need to be considered as part of the report of the specific topic group.

Legal implications and risks:

None.

Human Resources implications and risks:

None, this work would be supported within the existing committee administration team.

Equalities implications and risks:

The ageing well event was specifically focussed on issues affecting older people and hence sought to improve scrutiny of an area (age) that is a protected characteristic under the Equality Act 2010. Further scrutiny work in this area will assist in meeting the Council's equalities obligations.

BACKGROUND PAPERS

Appendix: Feedback from Ageing Well Event Breakout Sessions, 19 January 2012, Havering Town Hall

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Appendix: Feedback from Ageing Well Event Breakout Sessions, 19 January 2012, Havering Town Hall

Lifetime Housing & Health

Contributor's background	What is going well	What is not going well	Priority Areas
Individual	• **Homes in Havering – tenants in need – contains service** • **LA – reablement. Occupational Health** • **Age Concern – partnership** • **Libraries service re info** • **Information – downsizing** • **Referral to chemists** • **Home blood tests** • **Polyclinic** • **Care at Queens** • **Patient choice/ Service Provision**	• Dementia admission to hospital going into care homes and not home on discharge • Lowest survival rate in first year of cancer • Death rate 50% in falls • Unavailability of NHS Dental • Homes in Havering • First point of contact (Housing and Health, customer services, training) • Private sector – unsure where to access advice • Declining membership at libraries amongst older people	- Making sure voices are heard in the CCG - Discharge from hospital
Community and voluntary sector	• **Homes in Havering – good partners** • **Training** • **Handyman service** • **Always someone on end of a phone** • **Gardening service** • **Bowel cancer screening** • **Day hospitals – full clinics** • **Personal budget** • **Age concern being totally independent**	• Cross-related working • Removal of wardens from sheltered housing • Poor communication between partners • Apathy • Outcome of consultation and foregone conclusion • Major issue with discharge from hospital	• Homes in Havering work with older people
Organisation and agency	• **Good liaison/communication with tenants** • **Lunch clubs run by Age Concern** • **Concessionary decoration**	• Homes in Havering in implementation • GP commissioning – have a particular way of looking at things which may preclude other things	• Homes in Havering issues • Oversight of CCG's monitoring

	• **Handyman services (HiH) – gardening etc** • **Health – emphasis on mental health – more awareness** • **Good new initiatives** • **Dementia liaison services** • **Hospital training** • **Housing transfer arrangements**	• Housing provision is not fit for purpose – sheltered • OAP's become isolated • Reduction in in-patient beds • Failure to diagnose serious illness early enough • GPs not aware of symptoms of dementia • Wish Council would leave things alone if it is doing well	• Dementia services, esp. in health service.

Remaining active & healthy

	What is going well	What is not going well	
Individual	• **Parks/open spaces** • **Adult gyms** • **Walking section social** • **Community/pensions clubs, dance clubs, active** • **Culture** • **Transport** • **Facilities for DIP second to none - everything you need** • **Use of allotment sites**	• 2nd largest borough in London • cost of Dial-a-Ride prohibitive • compared to B & D poorer service • need to pay for audio books • Transport • Safety in public • Not enough social activities in Romford	• Culture and Leisure Services • Dial-a-Ride
Community and voluntary sector	• **Libraries/churches** • **Caring** • **Parks** • **Lots of open spaces** • **Concessionary swimming classes** • **Well being classes at centres** • **Walking clubs** • **Informed voluntary group (friends of Parks)** • **Volunteers are 50+**	• Cost to health of stopping free swimming • Poor communication of activities • Integration of Services • People falling through the gaps	• Cost of Dial-a-Ride and poor service • Leisure activities for over 50s

Organisation and agency	• **referrals from GPs to Hornchurch Sports Centre** • **rehabilitation service** • **Freedom Pass – keeps people active** • **Good leisure facilities** • **Good integration between services** • **Good CQC interventions and transformations**	• Lack of coordination between agencies regarding preventative work • Transport access to Queens/St Francis Hospice • Gaps in bus provision (accessing care provision) • Subway access in Romford market • Fear of crime • Nil increase in community support • Sports co-ordinators lost	• Transport issues • Fear of crime amongst over 50s

Financial security & social inclusion

	What is going well	What is not going well	
Individual	• **Age Concern** • **NELFT integrating social care/health** • **Community nurses** • **Willingness to engage with commissioners** • **IT training – access to Financial Services** • **Greater Choice**	• Insurance provision and awareness (home/travel etc) • Increase in suicide rate and dementia • Mental health and separation of services • Parcels of high relative deprivation (unseen poverty) • Poor pension planning • Lack of access/understanding of what benefits and support are available • Power of attorney – lack of awareness • Misunderstanding of LPA • Dementia – putting people back in own homes • Right to choice where to live • Data Protection	• Financial awareness and social accessibility • Role played by putting a charge on housing for people who access services • Mental health services for older people
Community and voluntary sector	• **Borough looking at financial inclusion** • **Work of Age Concern** • **Banking protocol** • **Advisory/signposting Services of Age Concern.**	• People not necessarily aware of rights • Cannot access cash	

Organisation and agency	• **Super neighbourhood team** • **Safeguarding** • **Restructure of Dementia services** • **Community engagement and awareness from London Fire Brigade** • **Community provisions at Queens**	• Safeguarding – care homes in the borough • Relatives abusing parents to retain control	• Safeguarding

Independent Living

	What is going well	What is not going well	
Individual	• **Specialist Dementia Teams in hospitals** • **Staying longer in own home and not forced to leave** • **Home shopping delivery**	• Lack of personal responsibility • Lack of ICT literacy (impact of demographic changes) • Change of family set up • No dementia phone • Susbsidy to people and children – need to look after yourselves	• Domiciliary care
Community and voluntary sector	• **Lots of volunteers in Age Concern** • **Aware of people with Dementia** • **Good local shops and facilities** • **Provision of ICT support from various sectors**	• Risk to local shops/community facilities • Lack of recognition and broader awareness • Lack of practical support for over 65's • Support for carers – not individuals with dementia • Gaps not aware of • No one for single persons	• Role of carers
Organisation and agency	• **Provision of ICT classes at Libraries** • **Re-ablement Services**	• automation of services (telephones) • old equipment used by reablement services, not possible to recycle • cutting funding for Advocacy Project at Age Concern	• Reablement service

Care & community issues

	What is going well	What is not going well	
Individual	• **Emphasis of keeping people in their own homes** • **LINk** • **HUBB and LA very good** • **Churches in the Community** • **CQC value the person** • **Good to have standards thresholds**	• Demise of extended family • Isolation of many individuals • Feelings of vulnerability (media driven) • Services of St Francis Hospice not reaching everybody – focus on education and lifelong learning • Need intergenerational demographic cohesion •	
Community and voluntary sector	• **Work of the Hospice** • **Low level of crime** • **Reablement service is very good** • **Providing improvement in the home** • **Involvement of Older People (over 50s forum)**	• Quality of Home Care variable • Home care – plenty of it • Crimes get missed because of lack of resources • Lack of neighbourliness (public awareness) • Emphasis of Safeguarding • Lots of work goes unseen in the voluntary sector • Churches/ religious groups not being included in some events	• Domiciliary care – quality issues • Safeguarding work • Hard to reach groups
Organisation and agency	• **Voluntary sector provides excellent service** • **People's Housing Choices are respected**	• Unrecorded crime • Lack of referrals to Hospice from GP's (no consistency) • Are there enough people to help the elderly stay at home. • Churches to be involved in all aspects of work • Need to consult with voluntary/ community sector when designing new services (LA/NHS) • Unaware of CQC legal powers	• Role of GPs • Role of churches & community groups

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HAVERING LINk

Unannounced

Enter and View Visit

To

Sunrise A & B Wards

Queen's Hospital

Barking, Havering and Redbridge University Hospitals NHS Trust

On

Sunday 22 April 2012

A report compiled by Havering Local Involvement Network

Introduction

Havering Local Involvement Network (LINk)

Havering LINk was established to help local people influence or change the way their local NHS and social care services are planned and delivered.

Havering LINk's role covers the following areas.

- Promote and support the involvement of people in the commissioning, provision and scrutiny of local health and social care services.
- Enable people to monitor and review the commissioning and provision of local health and social care services relating to the standard of provision.
- Obtain the views of people about their needs and experiences of local health and social care services.
- Make these views known to those responsible for commissioning, providing, managing or scrutinising local care services.

Havering LINk can exercise, its power as conferred under the Local Government and Public Involvement in Health Act (2007) to:

- Carry Enter and View Visit to local services to see whether the services are working well.
- Ask for information from service providers who must give a response within 20 working days.
- Make reports and recommendations to service providers.
- Referring issues to the Havering Council's Health Overview and Scrutiny committee if it seems that action is not being take

Havering LINk is made up of individuals and community groups who work together to improve local health and social care services. The job of a LINk is to find out what people like and dislike about local services, and to work with the people who plan and run them to help make them better. This may involve talking directly to health and social care professionals about a service that is not being offered, or suggesting ways that an existing service could be made better.

Purpose of this Enter & View Visit

Havering LINk conducted an Enter and View visit to Sunrise A & B Wards on Sunday 22 April 2012. This visit was a follow up as Havering LINk had carried out an Enter & View visit on 24 October 2011. That visit had been prompted by a request from Havering Council's Health Overview and & Scrutiny Committee. The main aim of the visit in October was to ascertain if the "Red

Tray System" was being implemented for patients who were vulnerable in the elderly wards.

Following feedback regarding poor experiences of elderly patients admitted to Sunrise A & B wards, Havering LINk had concerns that patients were not being assisted adequately during mealtimes and the red tray system for indicating which patient needed assistance at mealtimes was not working effectively.

After the Enter and View visit in October, Havering LINk identified some issues and made recommendations. This visit was made to ascertain if our recommendations had been implemented as was indicated in the response from BHRUT in January 2012.

Overview of the Service

We visited Sunrise A & B wards which are located on the fourth floor and in the orange zone. Both wards are specialised in the treatment of elderly patients. The wards are under the management of a Matron and a Senior Ward Sister for each Ward. Each ward has 30 beds and both were full on the day of our visit.

Barking, Havering and Redbridge University Hospitals NHS Trust operates across two main sites at Queen's Hospital and King George Hospital serving a population of around 750,000 from a wide range of social and ethnic groups in Essex.

The Visit

The Enter & View team consisted of Co Vice Chairs: Emma Lexton, and Cliff Reynolds, Havering LINk and they were supported administratively by Joan Smith, Co-ordinator Havering LINk.

We carried out the visit on 22nd April 2012 from 11.30am to 1.10pm. We observed the serving of the meals and how patients were being assisted. We talked to patients, staff and visitors.

What is the Red Tray System

The Red Tray System was introduced in many NHS Trusts including Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) to help in reducing nutritional risk in hospitals. It provides a signal that vulnerable patients need help and support from staff, or has a poor dietary intake. This is used to ensure all nutritionally at risk patients are identified, supported and assisted with their feeding to improve their nutritional status.

Red lid on jugs and red tray system has been introduced for people who need assistance with eating or are no longer able to eat or drink normally.

There is now a meal manager on duty every day from 10am to 6pm. The meal manager is a healthcare assistant who has been identified to fulfil this role on the staffing rota. The role incorporates helping patients to complete their menus, identify patients who may need assistance with eating and drinking, ensuring that the red tray and red jug system are being utilised and preparing patients for their meals. They also undertake a "Complan Round" at 10am and 3pm, for those patients with a Malnutrition Universal Screening Tool (MUST) score of "1" and who may not have eaten well at breakfast or lunch time. This is a recent initiative within these areas.

Our findings

- We started our visit at 11.30am on Sunrise B Ward by talking to nursing staff and a tour of the wards just before lunch was served. We observed that both wards were clean and tidy and had a general feeling of calm.
- Sunrise B Wards had 7 staff on duty that day, 3 qualified nurses and 4 support workers, one of them being the Meal Manager.
- We noticed that the water jugs were full, even those with red lids on. All the jugs were accessible and there were drinking cups nearby
- We observed the red tray system and that patients were assisted with feeding
- Patient A had the Complan sign by her bed and said that she had received it that day. She said that the staff were great, the food was ok and if they did not want anything from the menu she is given a sandwich
- Patient B informed us that the food was ok but they were not given a choice. She was not given the option of a baked potato
- Patient C's relatives said that the hospital had improved immeasurably since 4 years ago. They told us that there had been an issue recently where the buzzer was not answered but this had been quickly resolved to their satisfaction. They were confused as to what actions need to be taken when their relative is discharge. They were not sure about the process to follow
- Patient D said that she had Macular Degeneration but we did not see a sign above the bed indicating that the lady had sight problems. We spoke to the Staff Nurse on duty who immediately located such sign and displayed it.
- Patient E had a sign saying "hearing aid" and "to speak to the patient on the left hand side". This patient's relative said that she was very happy with her father's treatment

Sunrise A

- The ward had 6 staff on duty, 3 nurses and 3 care assistants. One member of staff had reported in sick. The Meal Manager was identified
- We noticed that the water jugs were full but once again the patients all had access to the water with drinking cups nearby

- Patient A said that the food was "horrible", she never likes anything on the menu but did not know that she could order something else
- Patent B's relative told us that his mother was on a soft food diet but was given roast potatoes which we observed. The staff did not appear to be aware that the roast potatoes were unacceptable.
- Patient C said that sometimes the food was not good and cited the food given on Friday where the chips stuck to the plate and the fish was poorly steamed
- Patient D had a sign saying "needs feeding" but there was no red lid on their water jug
- We observed one patient having their food cut up for them and she was then able to feed herself
- One relative said that her mother had been in the hospital for 7 to 8 weeks and she is fed by the staff. This relative said that "I cannot fault the staff"
- We observed one charge nurse gently feeding a patient
- We spoke to some of the relatives and they were confused as to what happens when their father was discharged. They said that they had to fight with a social worker who said that their father was well enough to go home. The relatives were confused and felt that the information forthcoming from the social worker was confusing.
- Relatives being able to visit earlier and help with the feeding can only be beneficial to patients and staff.

What the Staff said

- The staff were forthcoming and said that caring for the elderly is a pressurised job both demanding and challenging. They said that recently things had improved; there are more Care Assistants on the wards, now four as compared to two in the past. This has only been implemented on elderly wards as the Trust recognises the need. This need was identified by Havering LINk when the visit took place in October 2011. We would like to enquire whether the expansion of employing more Care Assistants is carried out on other wards where the majority of patients are elderly
- The red tray system is working, the domestic staff will report to a nurse if the patient will not eat. Patients are prompted to eat and one Health Care Assistant on the ward oversees all the patients who refuse to eat
- Training has been given and patients with dementia are easily identified, we were offered sight of the records of training
- The staff now had enough uniforms
- The Ward Sister on Sunrise B ward said that she had been under pressure in the past due to time taken up on the telephone dealing with discharges/ admissions but two weeks ago a new member of staff was employed to co-ordinate the process. This member of staff is a qualified nurse and the Ward Sister said that this helps hugely. The Co-ordinator frees up the time which the Ward Sister used to have to devote to the discharge process. The pressure on the Ward Sister

having to devote their time to paperwork was highlighted when Havering LINk carried out the previous Enter and View visit in October

- The use of volunteer(s) is valued. There is a volunteer on both Sunrise Wards who helps with the feeding and answering the telephone
- The nursing staff now do shorter days as paper work does have to be caught up on, this practice only takes place on Sunrise Wards. Previously staff were unable to take their breaks as they had to catch up on the administration
- They said that they felt engaged with the Trust; there is one representative from each ward who attends meetings and is able to report back to the other members of staff on the wards.
- The staff showed us Fluid Balance Charts and said that after a patient is given a drink the form is updated. During the day, patients are offered a drink every hour
- We were shown the Comfort Record Charts when a patient is asked every two hours if they want to use the toilet, change position in bed or are in pain
- They ask the doctors to write up the prescription forms the day before, when it is known that a patient is going home the next day but admitted that they "had to convince" the doctor to write the prescription
- They agreed that the prescriptions are still not timed
- They reiterated that all dirty crockery was removed quickly
- When questioned on both wards none of the nursing staff were aware of the butterfly system. This system uses a butterfly logo to identify patients who have dementia and Havering LINk was informed by BHRUT that this will be introduced in the future

Our Recommendations

These are actions that we expect the Trust should take to ensure that consistent and continuous care is delivered to meet patients needs and expectations.

1. Water jugs should not be filled to the top; some patients may find them too heavy to lift.
2. The Butterfly Scheme be introduced in the near future
3. Some patients did not have the sensory deprivation signs displayed by their beds when they quite clearly needed them. This should be addressed.
4. Nursing staff should not have to coerce doctors to complete prescription forms. This should be an automatic process.
5. The time the prescription is ordered should be automatically recorded as this will assist the tracking of the prescription
6. Our observations showed that some patients are not aware that they can order something different from the menu, this should be rectified.
7. Patients on "soft food" should not be given roast potatoes and more care should be given when offering such food.

8. Some relatives appeared confused as to what was going to happen when their relative is discharged i.e. going into care homes, the process of a Care Plan. We suggest that a 3rd party be utilised i.e. the Voluntary Sector for advice and signposting.
9. The use of volunteers on the ward to assist in answering the telephone and feeding should be expanded.

What we saw as a result of our recommendations from the Enter and View visit in October 2011.

As a result of Havering LINk carrying out the Enter and View visit in October 2011 we made the following recommendations. Havering LINk is pleased to note that these recommendations have been implemented by BHRUT.

- The Senior Ward Sister and her team should ensure that the Red Tray System is working in practice and staff are ensuring that vulnerable patients are assisted with feeding and benefit from a good diet including sufficient fluids.
    - Havering LINk notes that Fluid Balance Charts are maintained and regularly updated. The Red Tray System appears to be working well with some reservations as we have pointed out i.e. "soft food diet" The employment of a Meal Manager should be acknowledged as beneficial to patients and staff.

- Dirty crockery needs to be removed as soon as the patient finishes their meals to ensure welfare of people admitted.
    - No dirty crockery was in evidence and nursing staff acknowledged that removal of dirty crockery was a priority
- Staffing requirements in Sunrise A & B wards need to be revaluated and should be based on the dependency level of patients admitted. An increase in the number of Health Care Assistants will be helpful to ensure that patients who require assistance with eating are fed in a timely manner.
    - Havering LINk is pleased to note that the number of Health Assistants on the ward has doubled. This has proved to be an efficient tool in streamlining the day to day operation of the ward. Both in assisting patients to eat and to alleviating the time spent by the nursing staff on such practices.
- ..... It is not cost effective for a skilled Senior Ward Sister to perform simple clerical tasks. The Trust should make more effective use of the Ward Sister's time to improve patients' care. The Trust should consider employing a well trained volunteer to assist with paperwork is required.
    - Havering LINk is pleased to note that a Discharge/Admittance Co-ordinator has been

employed who is responsible for the paperwork. This was clearly identified by the Ward Sister on duty as a major improvement, giving her the time to concentrate on her clinical duties.

Acknowledgements

Havering LINk would wish to compliment BHRUT on some of the actions taken as a result of our recommendations in particular the increase of staffing levels of Care Assistants, Meal Managers and the implementation of a Discharge Co-ordinator.

We would like to show our appreciation to all the patients who engaged with us during their visit and we thank them for their valuable feedback. We would like to express our thanks to the Senior Ward Sister, Staff Nurses and all the staff on the wards for their warm welcome and assistance during the enter and view visit.

Emma Lexton
Co Vice Chair
HAVERING LINk

Cliff Reynolds
Co Vice Chair
HAVERING LINk

Joan Smith
Co-ordinator
Havering LINk

24 April 2012

Havering
LONDON BOROUGH

MEETING	DATE	ITEM
HEALTH OVERVIEW AND SCRUTINY COMMITTEE	**10 MAY 2012**	**10**

REPORT OF THE CHIEF EXECUTIVE

SUBJECT: ANNUAL REPORT 2011/12

SUMMARY

This report is the annual report of the Committee, summarising the Committee's activities during its year of operation ended May 2012.

It is planned for this report to stand as a public record of achievement for the year and enable Members and others to have a record of the Committee's activities and performance.

There are no direct equalities or environmental implications attached to this covering report. Any financial implications & risks from reviews and work undertaken will be advised as part of the specific reviews.

RECOMMENDATION

1. That the Committee note the 2011/12 Annual Report and authorise the Chairman to agree the final version for Council.

2. That the Committee agree the report be referred to full Council.

Staff Contact: Anthony Clements
Principal Committee Officer

Telephone: 01708 433065

Cheryl Coppell
Chief Executive

Background Papers - None

OVERVIEW AND SCRUTINY COMMITTEE

Subject Heading:	Annual Report 2011/12
CMT Lead:	Ian Burns Acting Assistant Chief Executive
Report Author and contact details:	Anthony Clements Principal Committee Officer 01708 433065 Anthony.clements@havering.gov.uk
Policy context:	Under the Council's Constitution, each Overview and Scrutiny Committee is required to submit an annual report of its activities to full Council.

SUMMARY

This report is the annual report of the Committee, summarising the Committee's activities during the past Council year.

It is planned for the report to stand as a public record of achievement for the year and enable Members and others to note the Committee's activities and performance.

There are no direct equalities or environment implications attached to this report. Any financial implications from reviews and work undertaken will be advised as part of the specific reviews.

RECOMMENDATIONS

1. That the Committee note the 2011/12 Annual Report and authorise the Chairman to agree the final version for Council.

2. That the Committee agree the report be referred to full Council.

REPORT DETAIL

During the year under review, the Committee met on six occasions and dealt with the following issues:

1. PRIMARY CARE ISSUES

1.1 Clinical Commissioning Groups - Throughout the year, the Committee scrutinised and kept up to date with developments regarding the Clinical Commissioning Group (CCG) or GP Consortium in Havering which will, from April 2013, assume a key role in the commissioning of many health services for local people. The role of the CCG has been explained to the Committee and several Members also attended an initial engagement event held by the CCG itself. The Committee will seek to further develop its relationship with the CCG (over which it will have full scrutiny powers) during the coming year.

1.2 St. George's Hospital – The Committee prioritised throughout the year plans for the development of St. George's Hospital. Proposals for the site were discussed with the NHS ONEL borough director although it was explained that the final decision on the future of St. George's would need to be taken by the CCG. Through the scrutiny process, it was also clarified that an area of land sold adjacent to the hospital was privately-owned by a third party and this did not have any impact on the future of the hospital site itself. In March 2012, Members undertook a site visit to the hospital where they were able to view those services still operating on the site and discuss future plans with representatives from the NHS ONEL estates department.

2. QUEEN'S HOSPITAL ISSUES

2.1 The Committee received throughout the year updates from senior officers at Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT) on the latest position at both Queen's Hospital and the Trust as a whole. The Committee's focus had been principally on those areas particularly criticised by the Care Quality Commission – A & E and maternity. Each meeting of the Committee was attended by the Trust's Director of Planning and Performance (or a suitable substitute) who was able to discuss in detail the problems in these areas and actions the Trust was putting in place to resolve these. In addition, Members undertook site visits during the year to both A & E and maternity at Queen's. The visit to A & E allowed discussion with medical and managerial staff of plans to expand A & E services in light of predicted future demand and of the Trust's new Rapid Assessment and Treatment system. The tour of maternity allowed Members to gain a detailed insight into the issues faced by the department and to have useful discussion with the Sister on duty. In order to avoid duplication, the

Committee was pleased that a Member and officer from Barking & Dagenham were also able to attend the maternity visit.

2.2 Hospital Transport – In light of continuing concern over transport arrangements at Queen's Hospital, the Committee received in October a presentation from the Council's transport planning officer on hospital transport issues. This included work to persuade Transport for London to divert more Romford buses into Queen's Hospital itself and also the current lack of any direct bus between King George and Queen's hospitals. Other issues discussed included the lack of step free access at stations used for accessing the hospital and the need to continue to monitor the use of Blue Badge spaces at Queen's Hospital.

2.3 Norovirus – The Committee received a presentation at its February meeting on the problem of norovirus at Queen's Hospital and steps the Trust had taken to combat this. The BHRUT Director of Planning and Performance also circulated to the Committee copies of information about norovirus given to patients and hospital visitors.

3. NORTH EAST LONDON FOUNDATION TRUST (NELFT) ISSUES

3.1 At the start of the year, the Chairman met with the Chief Executive of NELFT in order to discuss a number of issues including developments at Goodmayes Hospital and the Trust becoming the principal provider of community services for the whole of Outer North East London.

3.2 The Committee also held a successful visit in December to the Brookside Child and Adolescent Mental Health Unit. Members were able to discuss with NELFT staff both the in-patient and day programmes offered in this specialist facility.

4. HEALTH SCRUTINY CORRESPONDENCE

4.1 The Committee has continued, where it feels it appropriate, to use its powers to request specific information and responses from the Health Trusts to matters of concern. Issues scrutinised in this way during the year included the issues of the sale of land near to St. George's Hospital and the use of disabled Blue Badge parking bays at Queen's Hospital. All letters and responses received are copied to all members of the Committee in order that they receive the latest information.

5. TOPIC GROUP WORK

5.1 On several occasions during the year, the Committee called separate, stand alone, topic group meetings in order to scrutinise specific issues in more depth. One such meeting allowed for detailed discussions with a BHRUT Director of the problems facing the A & E department at Queen's Hospital. This allowed for a considerably more detailed scrutiny of these issues which were attracting national attention at the time.

5.2 Patient Discharge – Following the presentation to the Committee of the Havering Link report on patient discharge, the Committee agreed that the breadth of issues raised in the report meant that a topic group meeting should be arranged in order that these areas could be scrutinised in detail. As such, a meeting was arranged in February that was attended by members of Havering Local Involvement Network (LINk) as well as senior representatives of all local Health Trusts involved in the discharge process, the Clinical Commissioning Group and the Council's Adult Social Care section. Each stakeholder gave a detailed verbal response to the LINk's report and this led to a very productive session which gave all parties an insight into the issues preventing timely discharge from hospital. It was agreed that a follow-up meeting should be held in September to consider progress in this area.

6. SITE VISITS

6.1 In addition to the site visits detailed elsewhere on the report, the Committee visited several other local facilities as follows:

6.2 Saint Francis Hospice – In September, Members visited Saint Francis Hospice and toured the facilities. Members also discussed with the Hospice chief executive strategies for end of life care and the Hospice's day patient and outreach services.

6.3 Care Homes – While the Committee has no statutory power to inspect care homes, Members were pleased that several local facilities did invite them to tour their buildings and discuss issues of concern. One issue that was repeatedly raised by care home staff was the difficulty in obtaining full notes for residents who have been released from hospital. This was fed back to Havering LINk as part of their work on patient discharge issues.

6.4 Queen's Hospital Pharmacy - In April, the Committee visited the pharmacy at Queen's Hospital. Members were shown around by the Deputy Chief Pharmacist and gained an insight into the process involved in filling prescriptions for patients both in the hospital and ready to be discharged home.

6.5 Harold Hill Health Centre – Following concerns raised by the Committee that the facility was being underused, Members visited Harold Hill Health Centre and toured the facility in conjunction with senior officers from the then NHS ONEL estates department. While being generally impressed with the quality and size of the facilities at the health centre, Members remained concerned that the building was not being used sufficiently.

7. JOINT HEALTH SCRUTINY

7.1 The Chairman and other Members have played a full part during the year in the Outer North East London Joint Health Overview and Scrutiny Committee

which continues to look at a range of health issues relevant to the sector as a whole. All Members receive agendas and minutes of the Joint Committee as well as updates between meetings. Key issues scrutinised by the Joint Committee during the year have included:

7.2 LINks referral of maternity services. In July, the LINks covering Havering, Redbridge and Barking & Dagenham jointly referred, using their statutory powers, the problems with maternity at Queen's Hospital to the Joint Committee. The Joint Committee arranged for senior maternity officers at BHRUT to attend the meeting where they gave an update on maternity issues and answered detailed questions from both Members and LINk representatives themselves.

7.3 Changes to NELFT services – The NELFT chief operating officer met with the Joint Committee and discussed in detail the reasons for the decommissioning of certain services such as Think Arts and an eco-therapy project in Barking & Dagenham. At its April meeting, the Committee also scrutinised NELFT proposals to reprovide aspects of its psychotherapy services across the sector.

7.4 Cancer model of care – The Committee received a presentation from London Health Programmes on the latest pan-London work on a cancer model of care. It was noted that the proposed model aimed to improve early diagnosis rates and hence overall survival rates.

7.5 Commissioning Support Organisation – The Joint Committee has also scrutinised plans for the local Primary Care Trusts to offer commissioning support in the future to CCGs via a new Commissioning Support Organisation. This model would apply to the whole of North and East London and the Committee was pleased to welcome a Member from London Borough of Newham to the meeting who was also allowed to ask questions on this item.

7.6 Saint Francis Hospice – The Committee also received a presentation from the chief executive of Saint Francis Hospice on their outreach work covering most of Outer North East London. The Committee was given details of the hospice's role and funding arrangements as well as the hospice's at home and telephone services.

8. HEALTH FOR NORTH EAST LONDON

8.1 The Committee has continued to monitor developments with the Health for North East London proposals and will continue to take regular updates on this during the coming year. In June, the Chairman also gave evidence to the Independent Reconfiguration Panel considering the proposals.

9. HAVERING LINk

9.1 The Committee has continued to work effectively with Havering LINk throughout the year. LINk representatives are present at each Committee meeting and are given the opportunity to ask questions of the health officers present. The LINk formally presented its report on patient discharge to the Committee and this led to a full topic group session on the issues raised, as discussed above.

9.2 Queen's Hospital Enter and View – At the request of the Committee Chairman, the LINk undertook an enter and view visit to Sunrise Ward at Queen's Hospital to monitor the effectiveness of the red tray system to indicate those patients requiring assistance at mealtimes. The LINk presented its findings at a meeting of the Committee and, although there were many positive observations noted, the LINk also made a number of recommendations to the Hospitals Trust covering areas such as staff training and the overfilling of patients' water jugs.

10. OTHER AREAS SCRUTINISED

10.1 Annual Report of the Director of Public Health – The Director of Public Health for Havering presented her report to the Committee which this year focussed on cancer outcomes. The Committee was pleased to hear details of the bowel cancer screening programme in Havering but felt that such screening should ideally also be offered to younger patients.

10.2 Heartstart Havering – In February, the Committee received a presentation from an officer of Heartstart Havering, a local group giving free classes in lifesaving techniques such as cardiac massage. The Committee offered its full support to Heartstart Havering's plan to install more defibrillation machines in community areas.

IMPLICATIONS AND RISKS

Financial implications and risks:

None – narrative report only.

Legal implications and risks:

None – narrative report only.

Human Resources implications and risks:

None – narrative report only.

Equalities implications and risks:

While health issues and the work of the Committee can impact on all members of the community, there are no implications arising from this specific report which is a narrative of the Committee's work over the past year.

BACKGROUND PAPERS

None.