MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
2 October 2013 (7.00 - 9.10 pm)

Present:

Councillors Pam Light (Chairman), Nic Dodin (Vice-Chair), Ray Morgon, Ted Eden, Wendy Brice-Thompson and Peter Gardner

Ian Buckmaster, Healthwatch Havering was present.

Councillor Paul McGeary was also present.

Health officers present:
Caroline O'Donnell, North East London NHS Foundation Trust (NELFT)
Jacqui van Rossum, NELFT
Alan Steward, Havering Clinical Commissioning Group (CCG)
Dorothy Hosein, Barking, Havering and Redbridge NHS Hospitals Trust (BHRUT)

13 ANNOUNCEMENTS

The Chairman reminded those present of action to be taken in the event of fire or other event that may require the evacuation of the building.

14 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

There were no apologies for absence.

15 DISCLOSURE OF PECUNIARY INTERESTS

There were no interests disclosed.

16 MINUTES

The minutes of the meeting held on 25 June 2013 were agreed as a correct record and signed by the Chairman.

17 NORTH EAST LONDON COMMUNITY SERVICES

Officers explained that there had been a number of service developments at North East London Community Services (NELCS) that impacted on Havering. A major recent innovation had been the establishment of a Community Treatment Team that supplied crisis intervention for patients with health needs in their own home or if they had presented at Queen's

Hospital. The team of multi-disciplinary health professionals had begun operating in April 2013 and was available 8 am – 8 pm, 7 days per week. A Havering social worker was also on the team.

The team had received approximately 1,300 referrals so far which was in excess of the planned demand. NELCS officers agreed that referrals were increasing but were confident that the Community Treatment Team currently had sufficient capacity. The peak times for demand were 10 am to 12 pm and 4 pm to 8 pm. Demand levels were reviewed weekly and it was aimed to have less activity in acute settings and more treatment carried out in the community.

The Community Treatment Team had been developed in conjunction with the BHRUT Hospitals' Trust and was available to all adult patients. The most common reasons for referral to the team were falls, respiratory conditions and urinary tract infections. The team had also targeted those nursing homes with the highest number of referrals to A&E.

A system of integrated case management had been introduced where NELFT worked in partnership with both primary care and social care. This sought to manage patients at the highest risk of needing a hospital admission. This service had also seen increased activity with more than 900 patients using the service in the last 6 months. This team also worked with St Francis Hospital to assist patients at the end of their life. This work was led by the Clinical Commissioning Group and aimed to deliver services such as pain relief at home.

NELCS were also working on more proactive discharge planning with patients, families and carers. The butterfly scheme to identify patients with memory problems had been implemented as had a more proactive system to deal with any peaks in demand. The continence service had also been redesigned with a new service specification and pathways for both children and adults. This service could be accessed via GPs using the Choose and Book system. It was clarified that the service was not means tested and was based on clinical need.

Community Services had recently scored highly on the Friends and Family rating as well as on the Patient Safety Thermometer – a quality test assessing management of pressure ulcers, catheters etc.

The Chairman was pleased that there was now a dedicated mental health and community services lead for Havering – Caroline O'Donnell.

The Committee **NOTED** the presentation.

18 **QUEEN'S HOSPITAL - COMMISSIONERS' PERSPECTIVE**

The Clinical Commissioning Group (CCG) chief operating officer explained that the CCG wished to have services in the community that would reduce the numbers of people attending A&E. It was accepted that there were difficulties in A&E at Queen's Hospital in particular. This was partly due to high numbers of ambulances attending Queen's A&E and to people not being able to be seen in primary care. Other reasons for the A&E problems included slow responses from other parts of the hospital and slow discharge of patients from wards.

In response to these problems, an improvement plan had been developed with stakeholders including the community treatment and integrated case management teams. This also covered issues such as increasing the use of the Urgent Care Centres and having more GPs assigned to care homes. Primary care had also been piloting weekend GP opening and ensuring that correct advice was given via the NHS 111 service.

BHRUT had also developed its own improvement plan concentrating on recruitment and retention issues as well as areas such as improved pathways to avoid people having to go to A&E, improving patient experience and implementing seven-day working at Queen's. Patient discharge was also being considered with the joint assessment and discharge team having gone fully live from 1 April. The BHRUT improvement plan had been agreed with the CCG, CQC, NHS England and the Trust Development Authority.

The CCG had a contract with BHRUT based on meeting the A&E four-hour rule for 95% of patients. The BHRUT chief operating officer accepted that this target had not been met by August 2013. The Trust met with the CCG weekly to review progress on the improvement plan.

The local CCGs had recently commissioned an independent clinical review of the proposed overnight closure of A&E at King George Hospital. This had concluded that there was no immediate safety risk from retaining A&E at both King George and Queen's and had hence found that A&E at King George did not need to be closed overnight. The review had found that BHRUT should look at recruitment and retention and be clearer about the overall plan to close A&E at King George.

System-wide efforts to improve A&E included the establishment by the CCG of an Urgent Care Board. This met monthly (in private) and covered all stakeholders including the Council and Healthwatch.

BHRUT was leading on introducing seven-day working at the hospital although this would also impact on NELFT and on social care issues. The use of Urgent Care Centres was being investigated and the CCGs were also looking at services for the frail elderly and how the demand on the hospital could be reduced. A communications campaign that aimed to reduce use of A&E was being planned by the CCG, NELFT and BHRUT

and the CCG chief operating officer confirmed that Councillors would also be involved in this.

In response, the chief operating officer at BHRUT felt that the biggest challenge was recruiting senior A&E consultants. This was a problem nationally, not just at BHRUT. Only 8.8 of 21 senior A&E consultant posts at BHRUT were currently filled permanently and two more members of staff were due to leave over the next two months. The remaining posts were filled by locums etc. Queen's A&E was very busy with in excess of 500 patients seen each day and this made it difficult to recruit. Advertising had been taken out in the Evening Standard and also overseas but there was a lot of competition nationally to fill A&E vacancies.

Five joint posts had been advertised with Barts Health but no applications had been received and the posts would be readvertised. Staff shortages were covered by putting in more senior registrars and using more specialist cover. The chief operating officer emphasised that Queen's A&E was safe and added that the medical and nursing directors signed off staffing rotas on a daily basis.

The Trust had made progress with initiatives such as the new surgical assessment unit at Queen's and improvements to pathways for care of the elderly. There were also now more nurses applying to work in A&E and it was important to retain these.

Queen's was seeing up to 150 ambulance patients a day – a 15% increase. The main reasons for attending A&E were falls and trauma but more detailed information was available. The CCG felt that the rise in number of ambulances at Queen's A&E was partly due to the high number of care homes in the area. It was important to stop care homes automatically referring residents to hospital. It was also important to be clearer about where people can go as an alternative to A&E.

It was felt that many people still chose to attend A&E particularly if they perceived that they would be unable to get an appointment with their GP. It was essential to change people's mindsets re this. The BHRUT officer confirmed that there were GPs assessing people at the front of Queen's A&E but agreed that the current layout of A&E meant this was not obvious for patients. BHRUT was working with the CCG to redesign the A&E estate over the next 12 months. An outline business case for the redevelopment of Queen's A&E was due to be submitted to the Trust Development Authority by the end of December.

It was clarified that weekend GP opening would consist of one surgery per cluster, giving a total of six practices open at weekends across Havering. The CCG was also talking with NHS England about issues such as the lack of a GP to see walk-in patients at Harold Wood clinic.

It was noted that the NHS 111 service did not give advice in the way the previous NHS Direct had done. The CCG was working through with NHS

111 how their ranking strategy worked as regards suggesting alternatives to A&E.

As regards the Department of Health winter money, a list of initiatives had been submitted via the urgent care board to the Department Health. £10 million of projects had been proposed but only £7 million had been received. This meant that items with less priority had been dropped in order to prioritise areas such as extending the opening hours of the urgent care centres. A list of what projects the winter monies would be used for could be supplied to the Committee. The overall aim was to use the winter monies in both A&E and in the community to reduce the numbers of people attending A&E.

The CCG chief operating officer was happy to bring the plans for A&E redesign at Queen's to the Committee once the business case had been published.

The Committee **NOTED** the presentation.

19 COMMITTEE MEMBERSHIP

Recent changes to the membership of the Committee were noted and the Chairman welcomed Councillors Eden and Gardner to their first meeting. The Chairman also explained that she had invited Councillor McGeary to attend meetings of the Committee and this was supported by the Committee.

20 ST GEORGE'S HOSPITAL UPDATE

The CCG chief operating officer reported that significant progress had been made in the plans for St George's Hospital. It had been suggested that a GP surgery and a centre of excellence for older people could be located on the site. It was emphasised however that the CCG did not own or develop the site and that this was the responsibility of NHS Property Services.

There had been broad support in the recent consultation for the GP surgery and centre of excellence proposals and the CCG had asked several local GP practices if they would be interested in moving onto the St George's site. The next step would be to make a case for services that could be located on the site. This could include phlebotomy, ultrasound facilities as well as possibly rehabilitation and step up beds. These proposals were currently being worked through with stakeholders.

The CCG was keen to avoid having any unused space in the new buildings on the site. It was aimed to put the outline business case to NHS England in January 2014 and then to NHS Property Services. The CCG were happy to bring this to the Committee once it was available.

It was accepted that the consultation had only received 126 responses but this had been a higher level of response than in some similar consultations held elsewhere. Local residents would be consulted on moving GPs onto the site and the CCG officer noted that local Councillors had received very little consultation thus far on plans for the site.

It was estimated that 10-15% of the St George's site would be used for new medical facilities. The overall strategy on what services were proposed would be included in the CCG's review of commissioning intentions of which more details would be available towards the end of 2013. The outline business case for St George's would match up with this.

It was likely that some urgent or unplanned care would be provided at St George's. This could potentially include a walk-in centre for minor illnesses. It was confirmed that the Urgent Care Centre at Queen's was sub-contracted to the Hurley Group while that at King George was provided by the PELC organisation and the CCG was keen to increase the percentage of A&E patients going through the Urgent Care Centre.

There were no immediate plans to move the beds at Greys Court or Foxglove ward at King George back into Havering. There would however be consultation on these services in January or February 2014. It was hoped that sale of parts of the St George's site would fund development of the medical facilities on the remainder although this would need to be via NHS Property Services.

It was unlikely any clinic on the St George site would beoin the scale of the polyclinic at Harold Wood. The chief operating officer agreed to seek a breakdown of attendance figures at Queen's for majors, minors and the Urgent Care Centre. The reports of the urgent care centre running down and staff transferring over to majors from 7 pm would also be investigated.

The Committee **NOTED** the update.

21 HEALTH AND WELLBEING BOARD MINUTES

The Committee **NOTED** the minutes of the meeting of the Health and wellbeing Board held on 14 August 2013 and Members agreed that it was extremely helpful for the Committee to see these.

22 CHAIRMAN'S UPDATE

The Chairman reported that she and other Members had visited St George's Hospital in order to view the current condition of the site with NHS Property Services officers and this had given a useful understanding of current security arrangements etc.

Successful topic group meetings had been held looking at patient discharge and at the complaints process at BHRUT. AS part of the Joint Committee, several Members had also recently visited the NHS 111 call centre in order to discuss in more detail how calls to the number were handled.

A list of the memorials at St George's Hospital and where these were now located was available should Members require it.

The Committee **NOTED** the Chairman's update.

23 URGENT BUSINESS

The committee officer explained that the case for change for cancer and cardiac services had been delayed but this was likely to be approved and made publicly available shortly. While the majority of any consultation could be dealt with using the existing Joint Committee for Outer North East London, any final response would need to be on behalf of all affected boroughs in North and East London as well as any neighbouring counties impacted by the proposals.

The Committee **NOTED** the position and that updates on the situation would be given by the committee officer via e-mail. The Committee also **NOTED** its existing decision that the Chairman would lead on behalf of the Committee on any pan-regional scrutiny work of this nature that may be required.

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Chairman