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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

7.00 pm	Wednesday 2 October 2013	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative (3)	Residents' (2)	UKIP (1)
Pam Light (Chairman) Wendy Brice-Thompson Peter Gardner	Nic Dodin (Vice-Chair) Ray Morgon	Ted Eden

Andrew Beesley
Committee Administration Manager

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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 DISCLOSURE OF PECUNIARY INTERESTS

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

4 MINUTES (Pages 1 - 6)

To agree as a correct record the minutes of the meeting held on 25 June 2013 (attached).

5 COMMITTEE MEMBERSHIP

To note recent changes to the membership of the Committee.

6 QUEEN'S HOSPITAL - COMMISSIONERS' PERSPECTIVE

To receive a presentation on recent issues at Queen's Hospital from Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG).

A response will also be received from Dorothy Hosein, Chief Operating Officer, Barking, Havering and Redbridge University Hospitals NHS Trust.

7 ST GEORGE'S HOSPITAL UPDATE

To receive an update on the current position at St George's Hospital from Alan Steward, Chief Operating Officer, Havering CCG.

8 NORTH EAST LONDON COMMUNITY SERVICES

To receive a presentation on the work in Havering of North East London Community Services from Jacqui van Rossum, Executive Director Integrated Care (London) and Transformation.

9 HEALTH AND WELLBEING BOARD MINUTES (Pages 7 - 14)

Minutes of the meeting of the Health and Wellbeing Board held on 14 August 2013 attached for noting.

10 URGENT BUSINESS

To consider any other item 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
25 June 2013 (7.00 PM – 8.35 PM)

Present:

Councillors Pam Light (Chairman) Sandra Binion, Wendy Brice-Thompson, Nic Dodin (Vice-Chair) Ray Morgon and Lynden Thorpe.

Also present:

Dr Mary E Black, Director of Public Health, London Borough of Havering
Neil Moloney, Director of Planning and Performance, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Fiona Weir, Mental Health Service Director, North East London NHS Foundation Trust (NELFT)
Ian Buckmaster, Healthwatch Havering

1 **ANNOUNCEMENTS**

The Chairman gave details of the action to be taken in case of fire or other event that would cause the evacuation of the meeting room.

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

Apologies were received from Councillor Fred Osborne, Councillor Lynden Thorpe substituting.

3 **DISCLOSURE OF PECUNIARY INTERESTS**

Councillor Binion declared an interest as a family member was on the Board of Barking, Havering and Redbridge University Hospitals NHS Trust.

4 **MINUTES**

The minutes of the meeting held on 18 April 2013 were agreed as a correct record and signed by the Chairman.

5 **CHAIRMAN'S UPDATE**

The Chairman explained that Members had recently visited South Hornchurch Clinic and were disappointed to note that a number of areas

that could be used for clinical purposes were in fact being used as offices and other administrative areas.

Members had also recently visited the new Sunflowers chemotherapy unit at Queen's Hospital and the Chairman recorded her congratulations to BHRUT staff on developing this new facility.

The Chairman and Vice-Chairman had also recently met with the Chief Operating Officer of Havering Clinical Commissioning Group (CCG) and discussed a number of issues including the condition of the estate at Victoria Hospital in Romford. These buildings were now under the control of NHS Property Services (formerly Propco) and it had been confirmed that crittall windows on the site would be replaced as well as other maintenance work including resurfacing of the car park.

The CCG planned to operate more services in the community as well as introduce more integrated care involving GPs, community nurses, consultants and other care professionals. The Chief Operating Officer had also confirmed he would investigate the underuse of facilities such as South Hornchurch Clinic.

Discussions with the CCG Chief Operating Officer had also covered the lack of a GP for walk-in patients at Harold Wood Polyclinic and reports that walk-in patients needing to see a doctor were being requested to attend Loxford Polyclinic instead.

It was **AGREED** that minutes of recent meetings of the CCG Board should be put on the agenda for future meetings of the Committee, for Members' information.

6 **BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST**

The Director of Planning and Performance at BHRUT explained that the Trust had admitted liability and apologised to the patient's family following the recent highly publicised case of a woman who had died during an operation to remove her appendix. The Trust had implemented a 30-point plan in response to the incident which included having a named consultant and clinical lead for all in-patients, ensuring that only a consultant surgeon and anaesthetist were allowed to operate on pregnant women and using the World Health Organisation surgical safety checklist at all times. All abnormal test results were now reported immediately and steps had also been taken to support and develop clinical leadership in practice.

The current performance of the Emergency Department showed that the four hour target for completing treatment in the department was being met on 88.59% of occasions. This compared to a target of 95% and the Trust was on target deliver this figure by the end of August. It was also noted that there had been a rise in the number of more complex patients received in the department with 9% more ambulances now arriving at Queen's.

The main reasons for breaches recorded in the four hour rule had been delays in assessments, bed waits and delays in specialised responses where e.g. consultants needed to carry out an assessment in the emergency department. A further report on Queen's A&E was expected from the Care Quality Commission in July 2013. The Director of Planning and Performance recognised that the Trust had made improvements in the operation of A&E but also accepted that there remained a long way to go.

If patients were delayed in the Emergency Department for a long time, arrangements were now being put in place to ensure these patients received a hot meal. The Trust was also gradually implementing seven day working in order to improve patient flow. Senior consultant input on wards would be made available on a seven day basis in order to improve the continuity of care.

The Trust aimed to reduce the number of patients having to be referred via A&E and it was clarified that GPs could refer directly to the surgical assessment unit at Queen's.

While A&E performance at King George Hospital was now operating ahead of target, Queen's remained some way below target. It was noted that record attendance numbers had been seen at Queen's A&E in the last few months but the Trust director felt that performance was gradually improving. The Rapid Assessment and Treatment (RAT-ing) system had now been extended in order to speed up the handover of patients from ambulances. The number of patients held in ambulances for more than an hour had reduced and the focus was now on those ambulance patients waiting in excess of 30 minutes. The Trust was also working with the London Ambulance Service to find out why more ambulances were arriving at Queen's.

Discussions were also under way with Barts Health who managed the renal dialysis unit at Queen's about moving this unit to another site which could potentially allow for an expanded A&E assessment unit.

The level of consultant input on the elderly care ward had been enhanced which had resulted in a reduction of two days in the average length of stay on the ward. Discussions were also being held with partners in an attempt to streamline the hospital discharge process. It was **AGREED** that the Trust Director should send to the Committee Officer the A&E action plan in order that it could be distributed to the Committee.

The business case for capital improvements in A&E had now been split into several smaller documents. These included the move of the cardiac catheterisation unit from King George to an unused ward at Queen's and works to the front entrance of A&E including separate entrances for paediatrics and adults.

The Director of Public Health confirmed that the Council was working with BHRUT and Havering CCG on developing a data dashboard for A&E. She felt that about 80% of the problems in A&E were issues the Trust could address internally while around 20% related to other partners. The Urgent Care Board, set up under the Integrated Care Coalition would also produce data regarding issues such as winter pressures. The Director of Public Health pointed out however that Queen's A&E remained one of the worst in the country. The BHRUT director agreed but felt that there was now more clinical engagement in the department.

The Director of Public Health felt it was good that BHRUT was bringing specialists from other areas into A&E but was concerned that A&E was still 50% understaffed at consultant level. The Trust Director of Planning and Performance agreed that it was a challenge to recruit and retain A&E clinicians and the Trust was therefore looking at the possibility of some joint appointments with a major trauma centre such as Barts Health. There was also a new senior nurse and clinical director in A&E as well as improved signage and chairs.

It was explained that the Trust was investigating a list of 20 high intensity users of A&E and seeing if these people could be treated elsewhere. Some A&E users exhibited mental health problems although the NELFT representative explained that this only applied to 6 of the 20 people on the BHRUT list. The NELFT care plan for patients of this type could also be shared with the Committee. A joint working protocol had been agreed between NELFT and BHRUT on dealing with mental health problems in A&E. The BHRUT director agreed to investigate how appointment letters were dealt with if for example they were for a family member suffering from dementia who could hide the letters. More funding had been received from commissioners this year to support Queen's patients with dementia. NELFT dementia specialists were also delivering training across acute sites. It was also pointed out that people with mental health issues often also presented with physical ailments.

Since the King George Hospital maternity unit had been closed in March, the revised services had been operating well. BHRUT met regularly with local CCGs and it was confirmed that population growth had been built into maternity capacity through, for example, use of the birthing centre at Queen's Hospital. Regular surveys of maternity patients had been undertaken showing a predominantly good experience for mothers. The Care Quality Commission cap and warning notice on BHRUT maternity had been removed for some time.

The new oncology day unit – Sunflowers Suite had recently opened and included a teenage and young adult area.

The Committee **NOTED** the update and the Chairman thanked the BHRUT officer for his input to the Committee and wished him luck in his new role.

7 HEALTH AND WELLBEING BOARD MINUTES

The Committee noted the minutes of the Health and Wellbeing Board and felt it was important that the Committee was aware of what the Board was working on. Members were pleased at the work to introduce discharge plans for people with learning disabilities.

8 COMPLAINTS INFORMATION

The Chairman thanked the Director of Public Health and her team for producing a diagram detailing where complaints about the various health services should be directed. This had been sent to all Councillors and the Chairman considered this a very useful document.

The Director of Public Health suggested that announcements could be made to Councillors when public health campaigns etc were being launched.

9 ANNUAL REPORT OF COMMITTEE

The Committee **AGREED** its annual report 2012/13 and that this should be referred to full Council.

10 NOMINATIONS TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEES

It was **AGREED** that Councillors Pam Light, Wendy Brice-Thompson and Nic Dodin should be the Committee's representatives on the Outer North East London Joint Health Overview and Scrutiny Committee.

It was further **AGREED** that Councillor Light should be the Committee's representative on any pan-London joint scrutiny work that may be needed during the year.

11 COMMITTEE'S WORK PROGRAMME 2013/14

In addition to the suggestions shown in the report before the Committee, it was **AGREED** that a standing joint topic group be set up with the Children and Learning Overview and Scrutiny Committee to scrutinise issues relating to Children's Health. Councillor Light and Councillor Binion, as Chairmen of the two Committees, would meet informally to draw up a list of potential subjects for scrutiny. It was suggested that this could include health issues for children with special educational needs. Details of the topic group meetings would also be passed to Healthwatch Havering once these had been agreed.

It was agreed that representatives of NHS Property Services and the North East London Commissioning Support Unit be asked to address the Committee during the year on the roles of their respective organisations. It

was also suggested that statistical and performance information from the CCG and local Health Trusts could be scrutinised by the Committee.

Members wished to scrutinise the plans for St. George's Hospital but it was pointed out that regular updates to the Committee from the CCG had been scheduled which would also give an opportunity to scrutinise the latest position with St. George's.

Other suggestions for the work programme included the treatment in hospital of people with learning disabilities, oral health and NHS dentistry (the responsibility of NHS England) and, for 2014/15, physical accessibility issues at Queen's Hospital.

It was **AGREED** that the Committee Officer would circulate a revised version of the work programme for further discussion.

12 **URGENT BUSINESS**

There was no urgent business.

Chairman

MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Commitee Room 2 - Town Hall
14 August 2013 (1.30 - 3.30 pm)

Present

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
John Atherton, NHS England
Dr Mary Black, Director of Public Health, LBH
Cheryl Coppell, Chief Executive, LBH
Anne-Marie Dean, Chair, Health Watch
Joy Hollister, Group Director, Social Care and Learning, LBH
Cllr Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Alan Steward, Chief Operating Officer (non- voting) Havering CCG
Dr Gurdev Saini, Board Member, Havering CCG

In Attendance

Sir Peter Dixon, Chairman, BHRUT
Dame Professor Donna Kinnair, Clinical Director for Emergency Medicine, BHRUT
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Observers from Public Health and Havering CCG

Apologies

Conor Burke, Accountable Officer, Havering CCG
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH

36 **APOLOGIES FOR ABSENCE & SUBSTITUTE MEMBERS**

Apologies were noted and no substitute members were received.

37 **DISCLOSURE OF PECUNIARY INTERESTS**

None disclosed.

38 **MINUTES**

The Board considered and agreed the minutes of the meeting held on 10 July which were signed by the Chairman.

39 BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS TRUST PRESENTATION

Following quality and performance issues at Queen's Hospital A & E, and in particular, two recent Care Quality Commission (CQC) inspections, the Health and Wellbeing Board had invited representatives of BHRUT to discuss the following:

- In the light of the CQC reports, what the key issues were for the Trust and how it was planning to make further improvements in patient care and safety
- Effective patient flow through the hospital, particularly A&E, and compliance towards the 95% 4-hour A&E waiting time target
- How the Trust planned to improve its staffing capacity in the hospital, with particular reference to A&E
- What were the process issues to ensure effective and timely discharge of patients
- What the Trust's plans were in relation to winter pressures and how it intended to work with relevant partners to effect integrated care
- An update on the three work streams that the Urgent Care Board (UCB) had given BHRUT to lead on:
  - i) A&E recruitment
  - ii) Urgent Care Centre (UCC) at Queens (including redirection to primary care)
  - iii) Seven day working
- Further explanation of the BHRUT Chief Executive's letter of 18 July in relation to:
  - i) The strategic drivers, including risk assessments, underpinning the proposals outlined in the letter
  - ii) The approval process for the letter
- Whether BHRUT had any issues or concerns that it would like to raise with the Board.

The Chairman of BHRUT gave a presentation to the Board covering the following points. During the course of the presentation, various issues were raised by HWB Board members, the Chairman of BHRUT welcomed this interactive approach.

Accident & Emergency – Queens Hospital

It was acknowledged by BHRUT that there had been long standing concerns about the emergency care pathway and that BHRUT's performance was among the poorest in London for patients completing their care within 4 hours. The target performance

percentage for the year was 95% however the first quarter of 2013/14 was 88.59%. Performance had increased over the last four weeks to 93% although this was usual during the summer months. In summary, BHRUT stated that too many patients were waiting too long in the Emergency Department which was undesirable and could become clinically unsafe. The main reasons for this were assessment delays, bed waits and specialty response delays.

Care Quality Commission (CQC) Inspection

The result of the CQC inspection in May came as no surprise as the Trust had been aware of their shortcomings. The CQC had concerns about shortage of permanent medical staff and delays in the Emergency Department affecting the care and welfare of patients. Some improvements were noted in the report such as the provision of hot meals for patients awaiting hospital admission. The CQC had recommended radical thinking in order to tackle the reasons behind the poor performance and the Trust would have to submit revised plans to the CQC by September 2013.

It was brought to the attention of the Board that attendances at Queens's A & E had remained fairly consistent although there had been some change in severity of clinical condition. There had, however, been a 15% increase in patients arriving by ambulance – the average being 110 per day which made Queen's the busiest A & E department in London. A & E attendances had also risen from 90,000 to 132,000 last year.

BHRUT were also looking at patterns of attendance which were increasing over the weekend period as well as staffing to cover Saturday evening to Monday morning. There was limited consultant cover during this period and BHRUT were looking to address this.

Recruitment

The BHRUT officers also cited difficulty in recruiting staff as another reason for the poor performance and asked the Board to note that there was currently a national shortage of A&E doctors. Queens A&E should be staffed by a full complement of 21 doctors but there were only 7 permanent Accident & Emergency Consultants currently employed. The shortfall was being filled by locums and agency staff however this was not in the patient's interests and was also very expensive for the Trust. BHRUT was suffering from a lack of critical mass of senior consultants and without a critical mass of permanently employed doctors, it was difficult to recruit additional doctors. BHRUT asked the Board to note that the Trust had to compete with the London Teaching Trusts as well as the Helicopter Emergency Services in trying to attract staff and that recruitment to a full complement would take some time. A member of the Board

felt that these recruitment difficulties had been an issue at the Trust for many years.

BHRUT asked the Board to note that measures were being taken to improve the A & E experience at Queens such as:

- Possible specialty ward moves
- Introduction of longer periods of specialist cover so that the patient pathway flowed better through hospital care.
- Major staff recruitment efforts were on-going including five new joint appointments with Barts Health which allowed doctors to choose their speciality
- An international recruitment drive

The Board expressed concern about these recruitment challenges and reinforced the fact they believed overcoming these recruitment needs was essential and that BHRUT's reputation was key to solving this challenge.

Urgent Care Centre and Primary Care Referral

In meeting the challenges as presented, the Trust was working with their partners at NELFT and at the Clinical Commissioning Group trying to get patients treated in other environments as opposed to arriving at Accident & Emergency. The BHRUT officers thought that the public were confused about the various options for obtaining healthcare (e.g. 999, 111, Out of Hours clinics, Walk-in centres etc.) or picked up the phone too readily to send a person to A&E, particularly in the case of elderly care homes, and that there needed to be a clearer set of entry points.

With regards to the Urgent Care Centre, BHRUT stated that they were currently referring 12% of patients and acknowledged that this percentage needed to improve, however, they advised that patients will always go for the most accessible treatment. Moreover, it was not possible to force patients to leave A & E and go elsewhere and vital that they had the correct information. The CCG had requested further information on this practice and BHRUT was working with them to advise on their processes for redirecting to Urgent Care, GP streaming and navigation of administrative support. A new model for referral to the Urgent Care Centre was in the process of implementation.

The Board asked BHRUT to note that there were currently 200 GP slots available every weekday for Primary Care referral of which there had only been 10% uptake.

It was noted that the issue regarding redirection of patients through to Urgent Care/Primary Care be discussed at a future Health and Wellbeing Board meeting.

Urgent Care Board (UCB) Projects

Reference was made by Board members to the six major Urgent Care Board projects and the two further work streams led by the Integrated Care Coalition. BHRUT stated that it was difficult to assess at the current time as to whether they were working. The Board expressed concern that it was essential that BHRUT engaged fully with the whole health economy on projects that had been agreed. The Chairman of BHRUT gave his undertaking on this and asked that he be alerted if this did not happen.

Patients' waiting time in Accident & Emergency

BHRUT stated that waiting times on any two days can vary. The CQC report stated that on the first day of the inspection, the average waiting time was 3 hours 15 minutes. Officers explained that on the first day of the CQC inspection, there were two patients waiting for many hours, one of which was a Mental Health patient, which significantly increased the average waiting time for this day and was an anomaly. The average waiting time to see a specialist on day 2 of the CQC inspection was 15 minutes

Seven Day Working

BHRUT stated that a lot of preparation had been done on the seven day working initiative and that this would commence in Medicine on September 1st.

The Board expressed surprise that BHRUT could implement 7 day working without discussion and negotiation with the rest of the health economy and a challenge to BHRUT was laid down by the Board in this respect.

Discharge Procedures

BHRUT had been working on implementing a new discharge system to streamline the process and explained that the new Patient Administration System should be on-line soon. The Discharge Plan commenced when the patient entered hospital but there could be delays in the system around long stay wards, discharge medicine and externally through delay in social care assessments or rehabilitation bed availability.

The Board challenged the need for this to be a system wide response, not just BHRUT, and it was noted that a joint discharge process was one of the Urgent Care Board's priorities and that it was essential that BHRUT fully engage with this. The Chairman of BHRUT confirmed that he believed BHRUT would fully engage.

It was noted that the recommendations made regarding discharge procedures in the clinical review for BHRUT by McKinseys had not been implemented as yet.

Chief Executive's Letter – King George Hospital Proposed Night-time Closure of A & E

BHRUT apologised for the confusion caused by the correspondence relating to this matter. It was noted that no decision had yet been taken and that a Clinical Review was currently on-going of the BHRUT proposals. BHRUT's reason for the proposal was due to more blue light emergencies at Queens and that there were not enough staff grades/consultants to cover both sites. The closure of King George at night was only one option that was being looked at and the Board were asked to note that an Urgent Care Centre would remain at King George. The Clinical Review would be exploring all issues, in particular, clinical safety. BHRUT noted they had a duty of care to patients and insufficient staff in one site may present a clinical risk, which was unacceptable. BHRUT believed the review may suggest that combining the two resources into one would be a safer option even though it was acknowledged this would have some impact on patients – ie displacement.

The Board members challenged the proposal, whilst recognising and welcoming that an urgent and independent Clinical Review would resolve the matter. Board members questioned why more immediate measures such as the enhanced use of the Urgent Care Centre at Queens was not being prioritised if the clinical position at Queens was considered by its Board and management to be unsafe.

After some discussion, a conflict of view between the CCG and BHRUT emerged about the contractual position with regard to the Urgent Care Centre. This was of concern to the Board and the Chairman of BHRUT agreed it should be resolved urgently.

It was noted that if the review advised for closure of King George's A & E at night, there would be a need to work together in order to send the right message as it was a possibility that surrounding boroughs may disagree. It was also noted that the UCB would not oppose this option if proven that it was a safe move.

In summary, it was agreed that there needed to be more joint communication between the Trust and the Local Authority. In terms of Queen's Hospital's reputation, this was going to take a long time to turn around, however, it was agreed to try to find a way to publicise the Trust's excellent work in Cancer and Neurology.

It was noted that the NHS England representative would forward the results of the Clinical Review (site visits and desk top exercises) to the Health and Wellbeing Board as soon as it was available

The Chairman on behalf of the Board thanked Sir Peter Dixon and Dame Professor Donna Kinnair for their presence and contribution to the meeting.

40 DATE OF NEXT MEETING

The Board was asked to note that the date of the next meeting was scheduled for 11 September 2013.

Chairman

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