MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
12 December 2013 (7.00 - 10.00 pm)

Present:

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

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)
Mike Brace CBE, Havering Low Vision Strategy
Gary Etheridge, Deputy Director of Nursing, BHRUT
Apologies were received from Alan Steward, Havering CCG , Dorothy Hosein, BHRUT and Victoria Wallen, Head of Complaints and PALS, BHRUT

LBH Officers present:
Annette Froud, Service Manager – Adults with Learning Disabilities, London Borough of Havering
Barbara Nicholls, Head of Adult Services
Lorraine Hunter-Brown, Committee Administration

24 ANNOUNCEMENTS

The Chairman reminded those present of action to be taken in the event of fire or other events that might require the meeting room or building's evacuation.

25 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

Apologies for absence were noted and the Chairman welcomed Councillor Frederick Thompson as substitute Committee member for Councillor Wendy Brice-Thompson.

26 DISCLOSURE OF PECUNIARY INTERESTS

There were no interests disclosed.

27 MINUTES

The minutes of the meeting held on 2 October 2013 were agreed as a correct record and signed by the Chairman.

28 CHAIRMAN'S UPDATE

The Chairman requested that the Committee receive future plans for the St. Georges Hospital site once approved by NHS England. It was agreed that a representative from the CCG be invited to present to the Committee on what services will be provided in the borough.

Following consultations about future Cancer and Cardiovascular services at BHRUT, it was advised that the proposals concerning prostate cancer had been put out to independent assessment. Queens Hospital did not want the services removed whereas concerns had been expressed about the Trauma Unit in London and the loss of expertise. There was also a query over the placement of neurological cancer services. It was proposed that a letter of intent be requested to confirm that all other cancer services would remain at the Trust. The Committee agreed that in the event of services being moved, that assistance with transport should be provided for patients travelling to London from the BHRUT areas to receive treatment, and that this should be a requisite in any future policy.

The Chairman advised that information on the number of deaths in BHRUT was awaited. A letter had been received and that she would be responding.

The Chairman requested that Children's Health be discussed at the next meeting, in particular, the white paper on the Children's and Family Bill and issues around direct payments to parents.

The Chairman proposed that the NHS 111 service be discussed at the next meeting following reports that a GP had advised that 70% of his patients had been told by the phone line to attend Queens Hospital instead of his surgery. It was agreed that PELC be invited to answer any questions the Committee may have.

The Chairman commented on the provision of GP services at the Harold Wood Polyclinic stating that it was inadequate and closure times unsatisfactory. It was noted that the Chairman would write to NHS England regarding the matter.

The Committee received an update on the Community Treatment Team working with adults in the community with an acute physical need who

potentially can be treated at home rather than attend A & E. In the last reporting phase, there had been 1600 calls of which 8-10% required admission to acute beds. Response times were within 2 hours of contact. Referrals to the service came from GPs, family or the patients themselves. During the last two months, there had been a number of public engagement events to promote awareness. The intensive rehabilitation service had been launched providing visits four or five times a day for high need patients. Extra community beds had also been provided to alleviate winter pressures. A full report was due to go to the CCG at the end of January 2014 in time for further commissioning in 2014 which would be presented to the Health Overview and Scrutiny Committee later in 2014.

29 HAVERING LOW VISION STRATEGY

The Committee received a presentation from Mike Brace representing the Havering Low Vision Strategy with an accompanying document tabled at the meeting.

Members were advised that sight loss was a little known disability and that there was no strategy in place at national level for people undergoing sight loss, which in most cases, were age progressive or caused by disease. The Department of Health acknowledges the significant increases in aging populations and yet there are no clauses in the Health Bill relating to sight loss. At a local level no reference is made in the Havering Health and Wellbeing Strategy nor was there any reference to sight loss within the Joint Strategic Needs Assessment.

Sight loss was linked to many health issues which could be diagnosed through early intervention or preventative measures. It was noted that people with learning difficulties were ten times more likely to suffer sight loss and that 40% to 50% of cases went undiagnosed. A recent study showed that out of 700 school pupils, 253 had sight loss in some form which would be identified by routine sight testing. Loss of sight also occurs in 60% of stroke cases with no provision made for sight health tests during recovery. Sight loss could also be a main factor in elderly people having falls.

It was suggested to the Committee that sight tests should form part of the admissions programme and falls programme as well as stroke patients being sight tested before discharge.

Members were advised of the overall lack of ownership and the level of services available for the disability. The Sensory Team provided only 20 hours in clinic with linking to services patchy or non-existent. Services had ceased at the Yewtree Centre and the Havering Low Vision Clinic had ceased in June 2013. It was noted that a strategy had been drawn up but this now required implementation and support. There had been a lot of voluntary sector assistance, however, a proper level of service was now required. The presenter confirmed that he made contact with the Director of Public Health.

The Chairman thanked the presenter for a most informative report and was surprised that the matter had not been discussed either by Equality and Diversity or by the Health and Wellbeing Board. It was noted that NELFT provided an eye screening programme for diabetes, however, the Committee agreed that there was a need for a more rounded service linked to the community, Learning Disabilities and other health services. The Chairman stated that the matter should be referred to the Commissioners and urged the Committee to think how to raise the profile of the disability with the

30 **HOSPITAL PATIENTS WITH LEARNING DISABILTIES**

The Committee received a presentation from Gary Etheridge, Deputy Director of Nursing at BHRUT on facilities and policies for patients with learning disabilities. Members were asked to note the following:

Following several alarming government reports, a number of new initiatives were being put into place within BHRUT in order to improve the patient experience for people with learning disabilities (LD). During the six months between 1 April 2013 and 31 October 2013, 17 LD patients had been admitted to BHRUT and 223 LD patients had attended A & E. An initiative called Pride had been launched that would focus on the patient's needs and improve communications and fundamentals of care. A referral was made to the recent CQC inspection where BHRUT were complimented on their safeguarding strategies and delivery of care to patients.

A safeguarding structure had been established with safeguarding children and adult groups reporting to the Trust Board and the appointment of a specialist Learning Disabilities Nurse who would be commencing in March 2014. All staff had a responsibility to report their concerns through "Voice" :

- **V**erbalise
- **O**penness & transparency
- **I**nterests of patients come first
- **C**onfidentiality for staff will always be maintained
- **E**xcellence in care at BHRUT

In addition, a Patient Champion/Guardian had been appointed to promote a culture of trust, vision, values and mission.

Resources currently being made available were Easy-Read information about complaints and the supply of the PALS leaflet, a Learning Disability Folder available in wards for audit purposes as well as 43 link workers on both hospital sites. There was also a Patient Passport Health Action Plan, the PAS IT system would alert staff by identifying LD patients as well as the provision of training for staff.

In order to ensure that the policies and initiatives were working the following had been implemented:

- Learning Lessons (Mystery Shopper, Patient Stories)
- Easy-read Documents
- Being Open & Transparent
- Patient Experience & Involvement Strategy
- 3 Million Investment - Nursing
- Launch of Mencap Charter
- Appointment of LD Nurse
- DOLs/MCA Authorisation database
- Safeguarding Annual Report
- Learning Disabilities Progress Report
- Learning Disability Action Plan
- Annual Audit Plan (e.g. Safer Recruitment)
- Learning Disability Patient Survey
- Reasonable Adjustments Audit
- Development of Policies & Pathways
- Triangulation of Complaints, PALS & Real-Time Patient Surveys

A number of initiatives had been introduced for LD patients admitted to wards. A link worker would be available for each ward and the Matron would screen and review the patient daily. In addition, a LD pathway would be put in place alongside nursing risk assessments. Relatives and carers could visit out of hours and there would be the provision of overnight facilities. A Discharge Team would oversee transfer of care arrangements.

For LD patients attending A&E, an LD Champion will be available and specialist LD triage will make initial risk assessments. The patient will be checked regularly to ensure their comfort and the Matron or Shift Co-ordinator would monitor the patient in the department. If an LD patient attends Outpatients, prior planning would ensure the appointment runs smoothly particularly for complex cases. Appointment times could also be brought forward if necessary with the provision of a quiet area and link worker to advise.

The Committee were asked to note the future initiatives being planned were as follows:

- Safeguarding Strategy 2013-2016
- Restructuring the team - Safeguarding Lead
  Evaluating LD pathway to ensure effective on the job training for staff/Mandatory Training
- Re - launching Learning Lessons Group
- Ratification of a Transitional Policy
- Reinvigorating the LD Champion Role
- Meeting with HAVCare

The Committee enquired about care pathways for Dementia patients and were advised that BHRUT had appointed three Dementia Nurse Specialists so far and that 25%-30% of the workforce had received Dementia training. This was a necessary strategy as it was known that people with learning

difficulties develop Dementia quickly in later years and require specialist nursing and end of life care. Further comment was made by members about patients' nutrition whilst in hospital and it was advised that the Patient Health Passport would highlight any feeding anomalies and that nurses would be available to assist patients. In response to a query regarding complex LD cases, the Committee were advised that this was generally not an issue and that no-one could be an expert as LD patients are very different, however, BHRUT had implemented certain recommendations and the LD nurse followed good practice. Additional nursing would be provided and the patient would be put into a side ward if necessary.

In processing information about LD patients coming into A&E, alerts are created and the Deputy Director of Nursing has access to all alerts and outcomes.

The Committee noted the report which was in response to the Committee having voiced their concerns about how adults with LD were being treated in hospital. Members were further advised that the Health Passport initiative would ensure that there was feedback from clients and carers about their standard of care.

31 BHRUT PATIENT EXPERIENCE REPORT

The Committee noted the BHRUT Patient Experience Report for the quarter July to September 2013. The report drew from a number of sources including PALS, Compliments and Complaints, the Health Service Ombudsman Referrals, NHS Choices, Real Time Survey results and a Patient Story. Members were advised of the key points:

PALS had received and dealt with 731 concerns of which 87% had been resolved. 274 of the concerns related to appointment issues. A separate work stream headed by the Head of Outpatients was looking into these in more depth.

Comment cards had been issued and 80 had been completed. There was positive feedback related to quality of care and treatment provided. These compliments had been passed onto the relevant departments and staff.

Within NHS Choices, 45 comments had been received of which 29 related to Queens Hospital. The Committee were advised that the data was used to provide feedback to the clinical areas.

A total of 198 complaints had been received which the largest number (45) pertaining to the Acute Medicine Directorate and 28 by the Emergency Department.

Real Time Patient Surveys (paper based) had been introduced across the Trust which also encompassed the Friends and Family Test. A RAG rating scoring system based on the London average of 65 had been agreed by the Trust and would be reviewed regularly. BHRUT had achieved 47% survey coverage within Adult Inpatients and scored 46 in the Family and Friends Test and it was confirmed that the feedback received would be acted upon. The Trust were looking to improve patient communication by implementing "Welcome Boards" for patients providing information about food, uniforms, chaplaincy and PALS in addition to providing the "Message to Matron" service where patients, carers and relatives can advise Matron of any concerns.

A number of initiatives would be introduced or explored in the third and fourth reporting quarters including easy-read leaflets, Learning Lessons from Complaints, Mystery Shopper and Complaints Workshops.

With regards to End of Life Care (EoLC), a bereavement questionnaire had been launched Trust-Wide to obtain data from relatives on care and patients' chosen place to die. An EoLC facilitator would be capturing and presenting data. The Specialist Palliative Care Team were awaiting further national direction on individualised EoLC plans, however, the Gold Standard Framework continued to be progressed on two wards and there were regular EoLC training programmes in place for all health professionals.

The Committee commended the Trust officer for the report and agreed that a lot of good work had been carried out at the Trust.

32 HEALTHWATCH HAVERING UPDATE

The Committee noted the report from Ian Buckmaster of Healthwatch. Healthwatch was launched in April 2013 and since then had dealt with a number of emerging public concerns about standards of care in health and social care settings, namely Winterbourne House and Mid-Staffordshire Hospital. Concerns had also arisen regarding the adverse CQC report about standards in Queens Hospital and several residential care homes. Healthwatch had corresponded with executives at BHRUT expressing their concerns and had in turn received positive responses. Healthwatch had contributed to the last CQC inspection by submitting evidence about various aspects of services that they themselves had inspected in May 2013. In addition, Healthwatch had been working with the CCG in a campaign to persuade people that attending A&E is not always the best option.

Healthwatch was not able to act as advocate for individuals or to investigate individual complaints, people had however approached them for assistance and it was felt by the Board that they had a duty of care towards people in distress and referred complainants onto those best placed to help them.

There had been other issues of concern to the Healthwatch Board about inappropriate discharge from hospital and the closure of Orchard Village Health Centre in Rainham where their intervention led to clearer explanations for the closure and alternative contact details being advertised. Healthwatch had received further communications from patients who had their treatments cancelled, and upon contacting BHRUT, treatments had been reinstated. More recently, the signage to the Polyclinic at Harold Wood was corrected to show the new access route following representation from Healthwatch.

It was noted that Healthwatch was a statutory member of the Havering Health and Wellbeing Board and was formally represented at Havering's Overview and Scrutiny meetings for Individuals and Children's Services. In addition, Healthwatch Havering was represented on:

- St George's Hospital Site Steering Group (currently in abeyance)
- Urgent Care Board for Barking & Dagenham, Havering and Redbridge (which also includes the three CCGs, Boroughs, BHRUT and NHS England)
- CQC Dementia Advisory Group
- North East London Quality Surveillance Group
- Local Government Association (LGA) HW Local Peers meetings
- St Francis Hospice Clinical Governance Group and the "Dying Matters Week" St Francis Hospice Steering Group
- Children with Disabilities and Special Needs Strategy Group

Informal meetings were regularly held with senior managers of the Adult Social Care Quality & Assessment Team, BHRUT and the CCG and Healthwatch had also been invited to attend a CQC Quality Summit at Queen's Hospital, prior to the publication of the CQC report on their latest inspection of BHRUT.

The Healthwatch Social Care team visited a large care home that shared 8 or 9 GPs. Upon contacting the CCG, it had been clarified that this would probably be reduced to fewer designated GPs thus avoiding confusion over which GP was responsible for which resident.

The Hospital team was looking into the discharge pathway at BHRUT after concerns were raised, and was planning to survey waiting times for cancer treatment and end of life pathways.

The Healthwatch website was also being developed to improve its use for feedback and surveys.

A Healthwatch workshop was recently held where the CCG and North East London Foundation Health Trust (NELFHT) were able to give presentations about their plans for improving home care services. Similar events were planned for 2014.

Healthwatch has welcomed many newcomers to assist in its function and a number of volunteers had been recruited. The Committee was referred to the Healthwatch Management Structure and Criteria for Participation. In addition, there was the provision of training for volunteers and a handbook for guidance.

Work had begun on a number of issues outlined in the report and a range of policies had been drafted.

The Council had paid the first year's grant in full. In addition, a supplementary grant (spread over two years) has been made to assist in directing the additional effort mentioned above. Office accommodation had been provided at Morland House in Romford.

The Chairman, on behalf of the Committee, thanked the presenter for a most informative report and asked that the Committee be provided with further updates at alternate meetings.

33 COUNCIL CONTINUOUS IMPROVEMENT MODEL

The Committee noted that the Cabinet report concerning the Council's Health and Wellbeing Strategy 2012-2014 was due for review and agreed that an update should be provided at the next meeting.

34 CHILDREN'S HEALTH TOPIC GROUP - SCOPE

The Committee noted and agreed the Children's Health Topic Group Scope document.

The Chairman requested that the Committee receive an update from Children's Services offices on the White Paper and what provisions are being made around safeguarding.

35 MINUTES OF HEALTH AND WELLBEING BOARD

The Committee noted the minutes of the Health and Wellbeing Board meeting on 9 October 2013. Members agreed that there should be more interaction between the Health Overview and Scrutiny Committee and the Health and Wellbeing Board and therefore proposed that a member of the Health and Wellbeing Board be invited to present to the Committee at a future meeting.

36 URGENT BUSINESS

No urgent matters were raised.

Chairman