MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
6 February 2014 (7.00 - 9.25 pm)

Present:

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

Apologies for absence were received from Councillor Peter Gardner.

Councillors Paul McGeary and Lynden Thorpe were also present.

Ian Buckmaster, Healthwatch Havering was also present.

Officers present:
Joy Hollister – Group Director, Children, Adults and Housing
Mark Ansell – Acting Director of Public Health

NHS England – Rylla Baker, Deputy Head, Primary Care Commissioning and Lorna Hutchinson, Senior Commissioning Manager
Havering Clinical Commissioning Group – Alan Steward, Chief Operating Officer
Hurley Group/Harold Wood Walk-in Centre – Sue Shepherd, Centre Manager, Mabli Jones, Director of Operations and Organisational Development, Dr Eugene Lewis, Walk-in Centre GP

37 MINUTES

The minutes of the meeting of the Committee held on 12 December 2013 were agreed as a correct record and signed by the Chairman.

38 CHAIRMAN'S UPDATE

The Chairman confirmed that the Joint Committee had concluded that the proposed changes to cancer and cardiac services did not warrant formal consultation. The Committee's views had been given in a letter to the North East London Commissioning Support Unit which had been circulated to all Members.

The Children's Health topic group had recently met to scrutinise the introduction of personal health budgets and would be meeting again later in February to consider the provisioning work on the contract for Child and Adolescent Mental Health services.

Several Members were due to undertake a site visit with other Members of the Joint Committee to Moorfields to scrutinise the reasons for hospital's planned move of location.

The patient discharge topic group would be meeting next on 4 March.

39 UPDATE ON HEALTH AND WELLBEING STRATEGY 2012-14

Under the Council Continuous Improvement Model, the Council's Health and Wellbeing Strategy was due for review by the Committee at this point. The Group Director – Children, Adults and Housing explained that the Health and Wellbeing Board, chaired by the Leader of the Council, was quite a different model for Havering as it gave voting rights to officers as well as Members.

The strategy featured eight priority areas based on the Joint Strategic Needs Assessment and overall themes included prevention, integration of care via pooled budgets etc and improving the quality of the patient or service user experience. The Health and Wellbeing Board received an update on a different theme at each meeting.

A lot of work under the strategy was undertaken with NHS bodies such as the Clinical Commissioning Group (CCG) and North East London NHS Foundation Trust (NELFT). Work was also undertaken with the Council's Housing Services and with the third sector such as the 'Help not Hospital' project.

There had been a number of successes under the strategy such as the development of Community Treatment Teams which were multi-disciplinary teams supported by assistive technology such as telehealth which for example allowed a GP to monitor a patient's oxygen levels remotely.

Another success had been the introduction of the Integrated Case Management Team which was also multi-disciplinary and dealt with people with the highest risk of hospital admission. A Joint Assessment and Discharge Team was also about to be launched in Queen's Hospital that would apply across Barking & Dagenham and Redbridge as well as Havering.

There had been considerable success with dementia services but officers accepted that a lot more needed to be done. Waiting times at memory clinics had reduced and work was ongoing with clinicians to ensure innovative treatments etc were employed for dementia. A Health and Wellbeing Board sub-group was taking forward work on dementia with providers and commissioners. A lot of work was also taking place on obesity which was an increasingly important issue both locally and nationally. More work was also being carried out to increase the early detection of cancer.

Officers confirmed that Havering had a low rate of delayed transfer of care but it was important not to compromise quality. Complaints about hospital discharge were considered by the Adult Safeguarding Board. The Group Director at the Council also met with the Director of Nursing at BHRUT to look at serious case alerts. It was accepted that some problems with discharge remained but the overall situation was improving. The CCG Chief Operating Officer also held quarterly meetings with BHRUT to discuss patient discharge issues. Liaison also took place with the PALS service, Healthwatch, GPs and Councillors.

The CCG was discussing with NHS England the reasons for late discharge of cancer locally and it was important that there were sufficient services available if awareness of the possible signs of early cancer was to be raised. A further proposal was to base MacMillan cancer nurses in some GP practices. Pancreatic cancer was suggested as an issue that would benefit from an awareness raising campaign although officers explained that the symptoms of this type of cancer were not clear cut. Diet, alcohol intake and smoking were all factors in pancreatic cancer.

A reported case of a six month delay in a patient receiving cancer treatment should not have taken place as officers confirmed that there were specific standards for treatment of this kind such as a two-week pathway.

Work on improving communication between GPs and the new Joint Assessment and Discharge Team was continuing and the Health and Wellbeing Board would shortly be asked to approve measures to produce a greater integration of IT systems between the Council and the NHS. The CCG would also continue to pursue improved IT integration with BHRUT. Data protection was an issue in IT work but the Government was addressing this. Further details of the specific case would be supplied to the CCG Chief Operating Officer in order that he could investigate further.

Further details of work in all these areas were contained in the Health and Wellbeing Strategy which was available on the Council's website. It was also planned to use existing staff (both Council and those of partner organisations) in new ways of working with an emphasis on being more locality-based. The overall lead on this work at the Council was the Leader of the Council - Councillor Steven Kelly.

The Committee **NOTED** the update.

40 HAROLD WOOD WALK-IN CLINIC

The CCG Chief Operating Officer explained that the contract for the walk-in centre (formerly polyclinic) covered the walk-in service, wound care and phlebotomy. The contract had started with the former Havering Primary Care Trust but some parts of the contract including for the walk-in centre were now with the CCG. The primary care part of the contract was held by NHS England. Responsibility for the contract could not be changed until the contract expired in December 2015.

Wound care such as stitches removal could be provided at the walk-in centre or at some GP surgeries. Officers accepted that this was confusing for people and so wished to develop a cluster model to ensure treatment closer to people's homes.

The clinic was open 8 am to 8 pm seven days a week and 52% of Havering patients attended during the morning. Officers explained that patients presenting in the evening would be redirected if it was felt that they could not complete their treatment by 8 pm. Of 2,620 patients seen at the walk-in clinic after 6 pm in the last two weeks, only 90 had been redirected elsewhere. A decision to redirect would always be made a clinical member of staff.

It was confirmed that there was a doctor on duty for walk-in patients throughout the centre's opening hours i.e. from 8 am to 8 pm. Most patients presenting with injuries would however be seen by a Nurse Practitioner while those presenting with illnesses would be seen by a GP. This was because Nurse Practitioners were A&E trained although an A&E GP also worked at the walk-in clinic for five sessions a week. The Nurse Practitioners at the walk-in clinic were also able to prescribe.

There was a defined waiting area for the GP practice and the rest of the waiting area was allocated to the walk-in centre. If patients needed a referral for tests etc they would, after being examined, be referred back to their own GP for this. Patients presenting in a serious condition would be stabilised as far as possible (an IV drip could be inserted if needed) and then referred to A&E if necessary. There were agreed pathways between the walk-in clinic and Queen's Hospital A&E. It was accepted that the Harold Wood centre saw more patients needing to go to A&E than other walk-in clinics elsewhere.

Officers accepted that reported cases of walk-in centre staff refusing to remove stitches should not have taken place. It was thought this may be related to difficulties in people obtaining GP appointments. This service was available at the clinic and such reports could be followed up. The CCG would also look at the clarity of information re stitches removal that was given to patients at Queen's Hospital. Post-op clinics (booked by appointment) were run at the walk-in clinic by nurses.

A representative of the Patient Participation Group for the walk-in centre felt that the centre offered a very good service. Officers confirmed that the waiting time at the walk-in clinic was normally two hours and at 6.30 pm that evening there had been 22 patients waiting to be seen. Children or people presenting with urgent conditions would always be seen even if they arrived a few minutes before the closing time. The CCG was also looking at extending urgent care generally in Havering next year with for example some GPs opening later at night. It was also noted that the Patient Participation Group would shortly allow patients to submit comments on the walk-in centre via e-mail.

Officers agreed to implement a suggestion that the name of the doctor and nurse on duty be put on a display board at the walk-in centre entrance. The CCG Chief Operating Officer would bring to a future meeting of the Committee the outcome of work on why patients presented at the centre as more ill compared to other similar walk-in centres. It was accepted that there were issues around access to GPs and this had led to a bid for funding from the Challenge Fund. Members felt that services should be made more widely known to the public. The 'Don't Go To A&E' campaign had been effective but this had led to an increase in people attending the walk-in clinic.

The Committee **NOTED** the update and **AGREED** to arrange a visit to the walk-in centre.

41 UPDATE ON PLANS FOR ST GEORGE'S HOSPITAL

The CCG Chief Operating Officer explained that the CCG had a number of priorities including moving services from hospital into the community, improving urgent services and primary care and ensuring better integrated working with the Council. The population of Havering was increasing in age and there were also many new communities arriving in the borough.

The above factors had led to a wish to introduce a new, innovative development on the St George's Hospital site. This could include services such as a GP-led primary care centre, assessment and diagnostics, planned and unplanned care for older people as well as flexible working space.

The proposed primary care facility could bring existing GPs together and offer extended hours with greater access. Four local GP practices had expressed an interest in moving onto the St George's size which, if this took place, would give a practice size of at least 10,000 patients.

The Outline Business Case for the project had not been finalised as yet and the CCG would work with local people on the plans. The expansion of community treatment teams also needed to be taken into account in the St George's plans.

The decision making process had now changed and the CCG had to submit a case for change to NHS England. It was also clarified that the CCG did not own the St George's site as ownership had been transferred to NHS Property Services. The current annual maintenance costs for St George's were approximately £500,000 per year.

The new development would use around 15% of the St George's site and be located at the front of the site with good access. There had already been engagement with the Havering Health and Wellbeing Board, Over-50s

forum etc and further engagement would follow once approval had been granted for the next stage of the project. The CCG would receive a final decision on their submission from NHS England but timescales would need to be confirmed.

It was hoped to submit the CCG documents to NHS England in February and to get feedback from NHS England on the proposals by early summer. The preferred option for the site had not been decided on at this stage. The Chief Operating Officer confirmed that there would not be a polyclinic-style facility on the site. It was also not definite that there would be any beds in the new development but the CCG would like some integrated care beds to be put on the site.

Members emphasised that local residents had asked for more specific information on what would be on the site but the Chief Operating Officer responded that it was essential to demonstrate a need for and value for money of any services put on the St George's site. Beds on the site were likely to be very short stay for older people requiring monitoring or stabilisation. It was also possible that there may be some urgent care on the site for example the Out of Hours service.

Members felt that they needed a more strategic overview of the CCG's plans for health services in Havering as a whole. It was therefore **AGREED** that the CCG should explain its overall future strategy at the Committee's next meeting.

Mapping of current health facilities was mainly held by NHS Property Services although the CCG would have to cover this in the outline business case for St George's. NHS Property passed the cost of any empty health service buildings in Havering onto the CCG. The Chief Operating Officer accepted that parts of some buildings were unused although this was less common in Havering than it was in Barking & Dagenham or Redbridge.

It was uncertain at this stage if rehabilitation beds, currently located outside the borough, would return to Havering. It was possible that services of this kind may be better located outside the Havering area.

NHS Property Services would decide on how building work could be funded and this could potentially include a Private Finance Initiative. There had however been no decision on this as yet.

The Committee **NOTED** the update.

42 MINUTES OF HEALTH AND WELLBEING BOARD

The Committee felt that the minutes were quite minimal but did give the main points discussed by the Health and Wellbeing Board. There were no specific issues raised.

The Committee **NOTED** the minutes.

43 URGENT BUSINESS

A representative of NHS England briefed the Committee on proposals to close a GP surgery in Branfill Road, Upminster. The surgery was staffed by only one GP who had expressed a wish to retire from full-time work and whose current contract expired in June 2014.

The surgery's list was relatively small at around 1,700 patients which meant it may not be viable to procure a new contract. Patients could be encouraged to register with other local GPs of which there were a number in the nearby area. The surgery's list size was decreasing and it could only offer four hours of nursing per week.

The surgery's current GP was proposing to work part-time for another local practice so patients would have the option of continuing to see their existing doctor if they wished. The surgery premises were also not considered fit for purpose.

For all the reasons outlined above, NHS England felt that the surgery should be closed and patients registered with other local practices. The CCG Chief Operating Officer confirmed that the CCG supported the proposals as there were a lot of other practices in the local area.

It was anticipated that there would be more such cluster models in the future, particularly as cluster models of GPs became more prevalent. The NHS England officers confirmed that there were currently seven applications in progress from Havering GPs who wished to move premises. It was important for GPs to work together and GPs should not purchase premises until the move had been approved by NHS England.

Given the situation as explained by the NHS England and CCG officers, and in view of the large number of alternative surgeries in the local area, the Committee **AGREED** to support the closure proposal.

It was **AGREED** to ask NELFT officers to attend the next meeting to give an update on the position with their new site in London Road and to invite BHRUT to attend to give a general update on issues at Queen's Hospital, with particular emphasis on the proposed extension of the Urgent Care Centre at the hospital.

Chairman