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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

7.00 pm	Thursday 6 February 2014	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

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

For information about the meeting please contact:
Anthony Clements 01708 433065
anthony.clements@havering.gov.uk

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 - 10)

To agree as a correct record the minutes of the meeting held on 12 December 2013 and to authorise the Chairman to sign them (attached).

5 CHAIRMAN'S UPDATE

6 UPDATE ON HEALTH AND WELLBEING STRATEGY 2012-14 (Pages 11 - 24)

As part of the Council Continuous Improvement Model, to receive an update from officers on the Health and Wellbeing Strategy 2012-14 (report attached).

7 HAROLD WOOD WALK-IN CLINIC

Discussion with officers from Havering Clinical Commissioning Group and the service provider on issues concerning the Harold Wood walk-in clinic.

8 UPDATE ON PLANS FOR ST GEORGE'S HOSPITAL

To receive an update from representatives of Havering Clinical Commissioning Group on plans for St George's Hospital.

9 MINUTES OF HEALTH AND WELLBEING BOARD (Pages 25 - 32)

Minutes of the meeting of the Health and Wellbeing Board held on 13 November 2013 are attached for noting by the Committee.

10 URGENT BUSINESS

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

Andrew Beesley
Committee Administration Manager

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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.

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Chairman

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Subject Heading:	**Update on the Health and Wellbeing Strategy 2012-14**
CMT Lead:	Joy Hollister, Group Director for Children, Adults and Housing
Report Author and contact details:	Alaine Clarke, Corporate Policy & Diversity Team Leader, ext. 2963
Policy context:	The Health and Wellbeing Strategy relates to all five Goals of the Corporate Plan 2011-14

SUMMARY

The Health and Wellbeing Strategy, published in 2012, is the responsibility of the Health and Wellbeing Board and sets out how those partner organisations will work together to improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services. It provides the overarching direction for the commissioning of health and social care services in Havering. Within the Strategy are eight priorities for action, each with a jointly agreed plan for how improved outcomes will be delivered for local people.

Over the course of 2013, the Health and Wellbeing Board has been monitoring progress on delivery of the Strategy and received updates from partners on four of the eight priorities, and an additional report on the future delivery of one priority. **This monitoring has satisfied the Health and Wellbeing Board that the Strategy continues to reflect the needs of Havering's population, supported by evidence developed as part of the Joint Strategic Needs Assessment and, as such, it has no current plans to revise the eight priorities.**

This report provides the Health Overview and Scrutiny Committee with an overview of the updates received by the Health and Wellbeing Board.

RECOMMENDATIONS

Members of the Health Overview and Scrutiny Committee are asked to review the report and note its content.

REPORT DETAIL

The Health and Wellbeing Strategy, published in 2012, is the responsibility of the Health and Wellbeing Board and sets out how those partner organisations will work together to improve the health and wellbeing of local people and improve the quality of, and access to, local healthcare services. It provides the overarching direction for the commissioning of health and social care services in Havering. Within the Strategy are eight priorities for action, each with a jointly agreed plan for how improved outcomes will be delivered for local people. The eight priorities contribute to three overarching themes:

- Prevention, keeping people healthy, early identification, early intervention and improving wellbeing
- Integrated support for people most at risk
- Quality of services and patient experience

Themes	Priority
Prevention, keeping people healthy, early identification, early intervention and improving wellbeing	1. Early help for vulnerable people to live independently for longer
	2. Improved identification and support for people with dementia
	3. Earlier detection of cancer
	4. Tackling obesity
Integrated support for people most at risk	5. Better integrated care for the 'frail elderly' population
	6. Better integrated care for vulnerable children
	7. Reducing avoidable hospital admissions
Quality of services and patient experience	8. Improving the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be

Over the course of 2013, the Health and Wellbeing Board has been monitoring progress on delivery of the Strategy and received updates from partners on four of the eight priorities, and an additional report on the future delivery of one priority:

- Priority 1: Early help for vulnerable people to live independently for longer
- Priority 2: Improved identification and support for people with dementia
- Priority 5: Better integrated care for the 'frail elderly' population
- Priority 8: Improving the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be

- Priority 4: Tackling obesity (additional report)

This monitoring has satisfied the Health and Wellbeing Board that the Strategy continues to reflect the needs of Havering's population, supported by evidence developed as part of the Joint Strategic Needs Assessment and, as such, it has no current plans to revise the eight priorities.

This report provides the Health Overview and Scrutiny Committee with an overview of the updates received by the Health and Wellbeing Board.

Updates

- **Priority 1: Early help for vulnerable people to live independently for longer**

Priority 1 focuses on the provision of healthcare support for older and vulnerable people through prevention and early intervention. An update on this priority was provided by Joy Hollister, Group Director for Children, Adults and Housing, London Borough of Havering to the Health and Wellbeing Board in July 2013.

Objectives	Progress
To help more vulnerable people maintain independence in the community and reduce use of acute/complex services	Assistive technology, falls prevention and the Community Treatment Team are helping more vulnerable people maintain their independence and reducing acute admissions. There are four Assistive Technology Projects, including Telehealth and Telecare. Telecare enables emergency services to respond following an alert from a personal trigger. At the time of the report, there were 881 Adult Social Care funded users of the Telecare service, of which 90% stated they felt better and that the technology prevented escalation to hospital or residential care. At the time of the update, the Falls Prevention Service reported a reduction in the number of falls (from 1,915 to 1,342); reduction of £2.6m hospital admission costs (from £6,993,020 to £4,368,668); reduction in falls admissions from residential and nursing homes (from 254 to 183); and a reduction in social care costs (from £2,300,000 to £1,225,000) since 2011/12. The Community Treatment Team is a multi-agency team that provides a rapid response to prevent admission to hospital (see Priority 5 on frail elderly'). They are focusing on interventions such as occupational health, COPD and urinary tract infections.

<table>
<tr><td>To tackle isolation and support vulnerable people to help maintain independent living</td><td>The Help Not Hospital project supports low level needs and prevents early need for acute health and social care services. The contract was awarded in September 2012, with service delivery from mid-October 2012. The project aims to support 250 non-FACS eligible people by increasing their independence, ability to self-manage and use established support systems. Volunteers have been recruited to support service users. The range of support includes:
• Essential nutritional needs (shopping, preparing light snacks, providing drinks – provision or prompting through reablement)
• Help with household management (light cleaning/ironing/washing clothes or prompting)
• Emotional support and confidence building
• Providing companionship (respite or befriending)
• Supporting existing treatment plans (e.g. prompting exercises/escorting on local walks/public transport)
• Maximising income (screening benefits/entitlements, help with household administration)
• Escorting (to appointments/other venues)
• Providing information and signposting (on other services/community resources/statutory services)
• Safe and well checks (heating/safety and security)</td></tr>
<tr><td>To improve choice and control over the health and social care people receive</td><td>Choice and control is being expanded through the use of personal budgets, outpatient access, integrated case management, gold standards framework and reablement.

Integrated Case Management (ICM) provides joined-up and co-ordinated care for patients at high risk of hospital admissions or those with Long Term Conditions. The service was reconfigured in April 2013, and consists of six teams comprising a District Nurse, GP, Social Worker, Community Matron and Case Co-ordinator have been established. The teams identify high risk patients and support them on co-ordinated care plans. At the time of the update, the project had produced benefits in reduced emergency admissions by 10%, as well as improving patient service and experience.</td></tr>
<tr><td>To deliver more community based support, including volunteer-led services for people recently discharged from hospital and provision of</td><td>The Joint Assessment and Discharge Service is taking a more joined-up/integrated approach to discharge from hospital to improve the quality of care. A recent change to seven day working is beginning to shift culture and already showing an improvement in patient experience.</td></tr>
</table>

reablement service to help them readjust to independent living	

- **Priority 2: Improved identification and support for people with dementia**

Dementia is a clinical syndrome characterised by a widespread loss of cognitive function. It is a priority for Havering due to its large and growing older population. Updates on this priority were provided by the London Borough of Havering and Havering Clinical Commissioning Group (CCG) to the Health and Wellbeing Board in April and September 2013.

The Dementia Partnership Board is a multi-agency partnership established to develop and deliver Havering's Strategic Dementia Plan, which is aligned to the National Dementia Strategy and seeks to improve the quality of life and services available for people with dementia and their carers. The Board reports into the Health and Wellbeing Board and is chaired by a CCG Board Member and the Clinical Director for Mental Health. It has access to £200,000 for dementia projects. A 1-year fixed term Dementia Programme Manager is being funded to oversee the Strategic Dementia Plan.

Objectives	Progress
To de-stigmatise dementia and ensure sufferers and carers receive best support in managing the condition	There have been a number of local public awareness campaigns about dementia and priority was currently being placed on establishing the true level of prevalence of dementia, and to understand the 'gap' in people receiving a diagnosis. Regular liaison with GP practices and the Havering Memory Service, provided by NELFT, is helping to improve a diagnosis, assessment and follow-up care and support. A pilot Vega "watch-style" assistive technology project involving 51 people has been running for approx. 18 months. An interim evaluation report has indicated positive outcomes such as delay in entering residential care and increased peace of mind and quality of life for users and their carers.
To ensure high quality care and accessible dementia information	A resource within the Commissioning Support Unit has been secured by the CCG to help review current patterns of referrals and activity against prevalence, scoring (dementia severity) etc. The CCG's Clinical Director leading on dementia and Practice Improvement Leads are working with GP practices to share information around dementia and to target improvement activity. A User Engagement sub-group is ensuring that the voices and views of people with dementia and their carers

	are heard and used to inform the development and implementation of services and initiatives.
To clinically train professional to recognise symptoms of dementia leading to earlier diagnosis	A Training and Education sub-group is overseeing the delivery of the Havering Dementia and Training Programme, which will ensure that all staff working with older people in the health, social care and voluntary sectors have access to dementia care training.
To deliver more universal services and better quality of care	A rapid response service is provided by NELFT and the CCG is using contract negotiations with NELFT around the inclusion of dementia services to improve urgent care for people with dementia and to increase the numbers of people with dementia remaining in their own homes with appropriate support. In 2013/14, peer support services facilitated 991 opportunities for Havering residents to receive peer support; the 'Singing for the Brain' sessions were operating weekly at full capacity and further weekly sessions agreed; and 'Information and Advice Outreach' was improving knowledge and awareness of dementia and local services amongst residents through travelling information 'surgeries' across the borough.

- **Priority 5: Better integrated care for the 'frail elderly' population**

Priority 5 focuses on the complex needs of the 'frail elderly' population, which provides one of the greatest challenges to our healthcare economy. An update was provided by Jacqui Van Rossum, Executive Director Integrated Care London & Transformation and Dr Steve Feast, Executive Medical Director, North East London Foundation Trust (NELFT) to the Health and Wellbeing Board in November 2013.

NELFT provides mental and community health services for Waltham Forest, Redbridge, Barking and Dagenham, South West Essex and Havering.

Objectives	Progress
To ensure seamless, integrated and efficient care pathways for 'frail elderly' people with care needs	The Community Treatment Team provides crisis intervention for patients in the community or as an alternative pathway on attendance at A&E. The service was fully launched in April 2013 to Havering patients and works with the CCG, Queens Hospital and the A&E interface, as well as the Integrated Care Coalition. It is a multi-disciplinary team consisting of medical, nursing, therapy and support staff. At the time of the update, the service had received 1,370 referrals for Havering patients and achieved a 14% reduction in admissions into acute care. A communications plan was in place to raise

	awareness of the service with GPs, residential and nursing homes, social care and the voluntary sector. The service operates 7 days per week 8am to 8pm.
To improve pathways into and through community based health services and general practice by working closely with the hospital and GPs	NELFT are building new relationships with the Integrated Care Coalition, Urgent Care Coalition and the provision of community mental health services to Barking Havering Redbridge University Trust (BHRUT) and Barts Health. The changes within the NHS and the inspection regime make for challenging times ahead. Following the Francis Report, NELFT staff are on 7-day working. However, the Trust needs to recruit more staff and are finding it difficult competing with the inner London Trusts. In response to the Francis Report, a number of initiatives have been organised, including the setting up of communication campaigns, conferences, focus groups and the promotion of relevant policies. NELFT have doubled their focus on quality and moved to borough based quality care. NELFT is looking to replicate the model for mental health, where only 3% of patients attend an inpatient unit, for the care of 'frail elderly' patients.
To reduce the incidence and impact of falls and improve the efficiency of care following injury as a result of a fall	NELFT has been providing a falls community exercise programme since February 2012, which incorporates exercise classes in various venues across the borough. Classes are run by a physiotherapist who provides evidence based falls management exercise classes (3 x 12 week programme) to residents over 65 who have suffered a fall or who suffer from balance impairment. There is also an outreach service into care homes, which provides cognition and environmental screening by an occupational therapist for patients at high risk of falls. Furthermore, an independent provider has been commissioned to deliver falls prevention and management training in care homes.
To enhance the independence and capability of individuals to manage their conditions at home	Havering's award winning service in dementia care has resulted in zero acute admissions for two years. As a result, wards had been closed and funds moved into the community. Rapid Assessment Interface and Discharge (RAID) teams have saved 2,600 bed days resulting in £1.4m in savings. There are now 2,200 staff in partner hospitals who have received training in working with people with mental illness in addition to a 24/7 helpline. There are close links with GPs/practice nurses, care homes and Community Mental Health teams with a consultant mobile number available, same day responses, clinic

	emergency slots for patients in crisis and contact with all patients who fail to attend clinic appointments. Patients are also encouraged to call the clinic if there are any problems. Stimulation and reminiscence therapy is available. As a result, care home admissions have dropped. Average waiting times have been reduced for Memory clinics, Havering has a three week waiting list, which compared to the national average is very positive. With regards to acute services, Havering has a new facility at Sunflowers Court and the number of acute admissions has fallen owing to the development of home treatment.
To provide support to people within the community who have recently been discharged from hospital or who are at risk of admission/ readmission	A new collaborative care team has been introduced at Queens Hospital to facilitate early discharge and admission avoidance.

- **Priority 8: Improving the quality of services to ensure that patient experience and long-term health outcomes are the best they can be**

Barking, Havering and Redbridge University Hospital Trust (BHRUT) and North East London Foundation Trust (NELFT) are the two main service providers for acute hospital and community services in Havering. The quality of care provided at Queens Hospital (BHRUT) has been a major concern over the past few years. The Chief Operating Officer of Havering CCG gave a presentation on progress on Priority 8 to the Health and Wellbeing Board in June 2013.

Objectives	Progress
To bring about big improvements in quality of care and patient safety, especially maternity services at Queens Hospital	Improvements in maternity services have been made - patient satisfaction; staffing levels and quality; maternity conditions and facilities - and the cap on the number of maternity patients has been lifted. There have been key issues, namely pressure ulcers, falls, Urinary Tract Infections (UTIs) and Venus Thromboembolism (VTE). These are to be closely monitored in 2013/14, as well as Accident and Emergency, with key performance indicators embedded within the contract. Serious incident management has significantly improved at BHRUT, with the number of cases overdue down from 143 in May 2012 to 11 in May 2013. Those overdue for 6

	months have fallen from 41 to 1 over same period.
To ensure patient experience in A&E is improved by reducing waiting times and diverting people away from A&E where appropriate	A&E quality and performance is still to improve and subject to further discussion with CQC, Trust Development Agency and CCG. It was acknowledged that the Trust has to achieve a significantly higher performance level on the national standard of patient waiting times – 95% of patients should wait no longer than 4 hours for treatment. As at 26 May 2013, BHRUT achieved 84.12% - although attendances remained relatively static. King George Hospital had met the target but has recently dipped and Queens Hospital has rarely met the target since April 2013. An improvement plan has been implemented, which comprises of the following: • An Integrated Care Plan to reduce attendances and support discharged patients at home. • Community Treatment Teams to provide a rapid response type service, so as to reduce attendances and admissions. • To promote use of Urgent Care Centres from 30% patient usage to 50%. • GP alignment to care homes in the borough, so as to reduce reliance on A&E. • Directory of services to increase use of community alternatives to A&E. Following CQCs visit to BHRUT, the Trust has submitted an updated improvement plan taking account of acute reconfiguration, plans for each workstream, leads, actions and key performance indicators, as well as the focus on patient experience and best practice suggestions itemised in the Department of Health checklist. The plan has been signed off and the Trust will be held to account.
To improve quality of care in community residential settings and increase primary medical care in nursing homes	The CCG nursing home scheme went live in March 2013. The scheme matches named GP practices with each of Havering's nursing and residential care homes ensuring regular visits are made to all residents: • 55 UTIs have been treated in the care homes; in addition only 8 UTIs has resulted in unplanned hospital admissions. • 2011/12 London Ambulance Service data showed an average of 108 call outs from care homes in Havering per month. In March 2013, this was down to 71 ambulance call outs. • 5 less admissions for Chronic Obstructive Pulmonary Disease (COPD) than the same month last year. • Intensive medicines management, including better

	utilisation of medicines and stock control.
To ensure sound financial management of the NHS budget for Havering so that quality of service is not compromised	Financial management practices include: • Monthly management of major providers through contractual arrangements. • Detailed financial information shared with practices to allow monitoring. • Quality Innovation, Productivity and Prevention (QIPP) plans agreed to deliver £11m financial savings. • Working closely with the Council to develop community budgets for 2014/15.
To manage risk systematically and accurately and reduce likelihood of occurrence of serious incidents	Monthly Clinical Quality Review Meetings consider the risks to quality and patient safety, as well as the CQC's Quality Risk profile around care and welfare of service users, staff support and service quality. Overall risks are considered by the CCG's Quality and Safety Committee Audits for 2013/14 - includes A&E, integrated care pathways and consultant-to-consultant referrals.
To commission and performance manage Healthwatch to high levels and ensure patient and public engagement	A joint appointment exercise was undertaken by the Council and CCG. Healthwatch is now fully established and a member of the Health and Wellbeing Board.

Future delivery

- **Priority 4: Tackling obesity**

Obesity is a complex issue that can be lead to a myriad of health problems such as diabetes, cancer and cardiovascular disease. Elaine Greenway, Acting Consultant in Public Health, provided a presentation to the Health and Wellbeing Board on the future work programme for Priority 4 in January 2014.

<table>
<tr><th>Objectives</th><th>Progress</th></tr>
<tr><td>To intervene early to slow down the rise in obesity level in adults and children</td><td rowspan="2">Havering has a significant number of assets that contribute to tackling obesity. However, much more needs to be done. These assets include:
• Leadership (Health and Wellbeing Board)
• Sports infrastructure (parks/facilities/gyms)
• Physical activity strategy
• Schools support for healthy lifestyles (e.g. Schools Sports Partnership, free breakfasts)</td></tr>
<tr><td>To promote healthier lifestyles and increase levels of physical activity to</td></tr>
</table>

maintain healthy weight To raise awareness of health risks associated with being overweight and obese	• Voluntary sector (Havering Sports Council, Havering Circle) • School meals and Meals on Wheels • Healthy walks and Havering Active • Active travel: walk to school programme/cycling • Love Food/Hate Waste • Library services (on-line resources/newsletters/volunteers) • Primary care (GPs (Health Checks)/pharmacists) • School nurses, health visitors, midwives • Data: National Child Measurement Programme and Active People • Breastfeeding friendly environment A comprehensive needs assessment in underway to investigate how existing assets can be improved and developed and new innovative programmes introduced to halt the rise in obesity.

Progress reports on the outstanding three priorities will be provided to the Health and Wellbeing Board in 2014.

- **Priority 3: Earlier detection of cancer**

Cancer is a common disease, with one in 200 people in Havering being diagnosed with some form of cancer each year. Research has shown that more than 40% of cancers are attributable to avoidable risk factors such as smoking, alcohol, poor diet and lack of exercise and, as such, many people could significantly reduce their risk of developing cancer by living more healthily. The Health and Wellbeing Strategy sets out how partners will work together to:

- Maximise participation in cancer screening
- Raise public awareness of the signs and symptoms of cancer
- Further improve the identification and investigation of patients with the signs/ symptoms of cancer in primary care settings
- Improve the quality of cancer care

- **Priority 6: Better integrated care for vulnerable children**

Healthy, happy and educated children are more likely to become healthy, happy and productive members of society. Priority 6 focuses on improving the integration of care for our most vulnerable children in Havering by targeting those most at risk as part of our 'early help' offer. The Health and Wellbeing Strategy sets out how partners will work together to:

- Provide intensive, bespoke support to families with multiple complex needs
- Improve the stability of care placements
- Improve health outcomes for children and young people, particularly those in care

- Improve the transition from children's to adults care packages for young people with disabilities
- Reduce teenage conceptions and improve sexual health
- Reduce numbers of children experiencing poverty in Havering
- Provide access to high quality therapies for vulnerable children and young people

- **Priority 7: Reducing avoidable hospital admissions**

Avoidable hospital admissions are extremely costly to the NHS and cause disruption not only to the lives of those affected but friends and family as well. Long or frequent spells in hospital can increase dependency and reduce people's confidence in managing at home, particularly older people. Avoidable admissions include conditions that can be managed in the community. The Health and Wellbeing Strategy sets out how partners will work together to better integrate community services and avoid unnecessary admissions:

- Manage the care of patients proactively in the community through ICM
- Increase independence skills of people within the community who have been recently discharged from hospital or at risk of admission/readmission
- Reduce inappropriate and unplanned discharges, which lead to readmission
- Safeguard vulnerable people from neglect and abuse in care homes
- Ensure high quality prescribing of medications to reduce unnecessary admission

IMPLICATIONS AND RISKS

Financial implications and risks:

The partners of the Health and Wellbeing Board are working together to better integrate services and achieve the best possible healthcare outcomes for the residents of Havering. Any decisions, working practices or arrangements that may have financial implications or risks will be considered as part of service planning.

Legal implications and risks:

The partners of the Health and Wellbeing Board are working together to better integrate services and achieve the best possible healthcare outcomes for the residents of Havering. Any decisions, working practices or arrangements that may have legal implications or risks will be considered as part of service planning.

Human Resources implications and risks:

The partners of the Health and Wellbeing Board are working together to better integrate services and achieve the best possible healthcare outcomes for the residents of Havering. Any working arrangements that may have human resources implications or risks will be considered as part of service planning.

Equalities implications and risks:

The partners of the Health and Wellbeing Board are working together to better integrate services and achieve the best possible healthcare outcomes for the residents of Havering. Any decisions, working practices or arrangements that may have equalities implications or risks will be considered as part of service planning. The Strategy is focused on reducing the health inequalities that exist in Havering. With particular interventions, particularly in public health, health equity audits are carried out to ensure interventions designed to reduce inequalities are having the desired effect.

BACKGROUND PAPERS

- Health and Wellbeing Strategy 2012-14

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MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD

Committee Room 1 Town Hall
13 November 2013 (1.30 pm – 4.15pm)

Present

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

In Attendance

Dr Steve Feast, Executive Medical Director, NELFT
Jacqui Van Rossum, Executive Director, Integrated Care London & Integration, NELFT
Dr Afifa Qazi, Consultant Psychiatrist, NELFT
Caroline O'Donnell, Managing Director, North East London Community Services, NELFT
Neil Kennett-Brown, Programme Director, NHS England
Prof. Kathy Pritchard, Chief Medical Officer, London Cancer
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Apologies

Joy Hollister, Group Director, Social Care and Learning, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH

62 **APOLOGIES FOR ABSENCE**

Apologies were received and noted.

63 **DISCLOSURE OF PECUNIARY INTERESTS**

None disclosed.

64 **MINUTES**

The Board considered and agreed the minutes of the meeting held on 9 October 2013 which were signed by the Chairman.

65 **MATTERS ARISING/REVIEW OF ACTION LOG**

A review of teenage pregnancies/emergency hormonal contraception (EHC) had commenced and that a report would be presented to the Board in the New Year.

The JSNA had been deferred however discussions were progressing

66 **FRAIL ELDERLY AND THE INTEGRATED CARE STRATEGY**

The Chairman welcomed Dr Steve Feast, Jacqui Van Rossum, Dr Afifa Qazi and Caroline O'Donnell from the North East London Foundation Trust (NELFT). Members of the Board were asked to note the following:

The Trust had been through many changes, originally a mental health trust, (NELFT) now provided mental and community health services for Waltham Forest, Redbridge, Barking and Dagenham, South West Essex and Havering.

The area of North East London increasingly presented many challenges and the NELFT team welcomed the opportunity to engage with the Health and Wellbeing Board acknowledging the importance of holding cross borough dialogue and working together.

New relationships were being built with the Integrated Care Coalition, Urgent Care Coalition and the provision of community mental health services to Barking Havering Redbridge University Trust and Barts Health. The changes within the NHS and the inspection regime made for challenging times ahead.

Following the Francis Report, NELFT staff were on 7 day working, however, the Trust needed to recruit more staff and were finding it difficult competing with the inner London Trusts. In response to the Francis Report, a number of initiatives were organised including the setting up of communication campaigns, conferences, focus groups and the promotion of relevant policies. Whistleblowing was also available as a last but open resort. NELFT had doubled their focus on quality and moved to borough based quality care.

In past years, mental health services had been transformed following the closure of asylums. In addition, there had been a change in approach to medication use and consolidation of community beds into a single high quality unit. A similar pattern had been seen in the care of the frail elderly although it was noted that these patients often have very complex drug

regimes. The model on which only 3% of mental health patients attend an inpatient unit needed to be replicated with the frail elderly.

Members were informed that Havering's award winning service in dementia care had resulted in zero acute admissions for two years. As a result, wards had been closed and funds moved into the community. RAID (Rapid Assessment Interface and Discharge) teams had also saved 2,600 bed days resulting in £1.4M in savings. There were now 2200 staff in partner hospitals who had received training in working with people with mental illness in addition to a 24/7 helpline.

There are now close links with GPs/practice nurses, care homes and Community Mental Health Teams with a consultant mobile number available, same day responses, clinic emergency slots for patients in crisis and contact with all patients who fail to attend clinic appointments. Patients are also encouraged to call the clinic if there are any problems. Stimulation therapy is also available as well as Reminiscence therapy. As a result, care home admissions have dropped.

Average waiting times have been reduced for Memory clinics, Havering has a three week waiting list which compared to the national average is very positive. With regards to acute services, Havering has a new facility at Sunflowers Court and the number of acute admissions has fallen owing to the development of home treatment.

The Community Care Treatment Team was launched in April 2013 and was working with the CCGs, Queens Hospital and the A&E interface as well as the ICC resulting in a 14% reduction in admissions into acute services. The savings in funding has been returned to the Commissioners.

NELFT acknowledged that winter was a challenging period and that contingency plans were in place.

The Chairman thanked the NELFT team for their presentation. It was agreed that it was useful to know that any concerns about services in Havering could be discussed with the Managing Director of Community Services responsible for area. Members of the Board underlined the need to ensure that people in Havering were getting the best care and that mental health services required further development. It was agreed that there was further to work to do in developing projects around prevention linking in with Public Health and the CCG.

67 INTEGRATION WITH HEALTH

a) Joint Report from Adult Social Care and Havering CCG on section 256 monies.

The Board noted the report on the provision of section 256 money to local authorities from the NHS for 2013/2014 which required discussion by the Board prior to formal sign off. The report outlined what the money

would be used for, measurable outcomes that the initiatives would achieve together with linkage to the Joint Strategic Needs Assessment (JSNA) and the CCG as well as monitoring arrangements to ensure delivery.

The funding for 2013/2014 for Havering is £3,599.507 and the release of the monies was subject to the following criteria:

- That the money should support adult social care services, which also have a health benefit. Beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.
- To respond to the JSNA and the existing commissioning plans for both health and social care.
- To provide a positive difference to social care services and outcomes for service users.

The Board were asked to approve the use of the S256 money as outlined in the attached matrix.

Several Board members were of the view that the matrix was not detailed enough and it was agreed that this should be refined next year giving more information on cost improvements, cost savings and outcomes.

A request was made for further discussion on the prevention of falls programme and that this should transfer from being a project to a mainstream health issue. In addition, further discussion and review was requested on mental health needs in the borough.

The Board noted the report and agreed to approve the use of the S256 money as outlined in Appendix 2.

b) Future Work on Integrated Transformation Fund

This report informed the Board about the new Integration Transformation Fund which replaces some previous funding streams, including the s.256 money and adds new requirements for partnership working. The fund is contingent upon agreement between the CCG and the Local Authority on areas for joint commissioning to deliver preventative services and reduce pressure on acute services. The proposals would be subject to the Board's approval in February 2014.

The Board noted the report and that the proposals are to be finalised before February 2014.

68 **CANCER AND CARDIOVASCULAR PROGRAMME**

The Board received a report entitled **Improving Specialist Cancer and Cardiovascular Services in North and East London and West Essex**

produced by the North and East London Commissioning Support Unit. The report was presented by Professor Kathy Pritchard-Jones, Chief Medical Officer, London Cancer Academic Health Science Network. Neil Kennett-Brown, London Cancer and the Programme Director, NHS England was also in attendance to offer additional comments.

This report was presented as part of a wide consultation about configuration of cancer services and members of the Board were asked to note the following:

North and East London have expert cancer and cardiovascular doctors but these specialist services were not organised in a way that gave patients the best outcomes with specialists, technology and research being spread across too many hospitals. Evidence gathered by the London Cancer Academic Health Science Network suggested that focused specialist centres would lead to better outcomes. With 15 different pathways in London, a London wide review was underway. Formal engagement, if appropriate, would commence at the beginning of 2014 with NHS England and the CCGs to make decisions by mid-2014.

<u>Cancer</u>

Clinicians had reviewed specialist services for five rare or complex types of cancer:

Brain cancer
Head and neck cancer
Urological cancer (bladder, prostate and kidney)
Blood cancer (treatment of acute myeloid leukaemia and stem cell transplants)
Oesophago-Gastric cancer (stomach or gullet cancer)

The proposal was to create an integrated system of care. It was outlined that there would be a small amount of change within BHRUT as Queens Hospital had provided a range of cancer services for some years, however, it was envisaged that there would be a 3% decrease in Upper Gastro-Intestinal Bladder and Prostrate and Renal activities.

Professor Pritchard-Jones advised Board members that London cancer patients did not always report good experiences with their care and that specialist teams were fragmented and unable to provide a 7 day service. Specialist centres would work with local hospitals and GPs to improve the patient journey and follow up care and would also attract innovation and investment for research as well as attracting the best trainees. Patients would have a better chance of survival, quicker recovery and better quality of life, support from specialist care teams, joined up sustainable 24/7 care and more access to clinical trials with access to the latest treatments. Local services would be more robust and resilient as part of a system, with access to 24/7 specialist teams, better support to introduce innovation and

clinical trials, better training opportunities and more precise outcomes, measurement and benchmarking.

Cardiovascular

A similar review was underway for Cardiovascular services due to patients waiting too long for treatment, surgery cancellations and hospitals unable to deliver 24/7 care by specialist teams.

It was proposed to create a world class integrated Cardiovascular Centre and develop a joined up network of care covering prevention and earlier diagnosis through to treatment of which a majority would be provided closer to people's homes. Patients would have improved experience and outcomes, prompt access to treatment and state of the art equipment, specialist 24/7 care as well as shorter waiting times.

A period of engagement with the public to discuss the above proposals was currently underway. A number of public meetings had been arranged within the inner and greater London areas to obtain feedback and further engagement with Public Health authorities was planned.

Members of the Board raised concerns about the following:

- At times it was not clear that the exercise was actually a consultation and not the presentation of a decision that had already been made.
- The demographic changes within the borough in terms of overall population size and the aging population should be considered in future planning of services. The centralisation of services to London did not make good sense when looking at future population growth across London.
- Survival rates were presented and the proposals aimed at improving survival rates. As survival rates reflect both quality of care and early diagnosis, the need to address lower survival rates without working out how much those rates relate to late diagnosis was not a robust argument.
- The impact of patients having to travel into London to UCL should be assessed as this could have an effect on overall outcomes. This would also have an impact on the elderly, the poor and those who need family support.
- Quality of care is a key factor in decision making about what services configuration is likely to be best and this was not brought out fully in the report. Some of the relevant units in BHRUT have higher quality indicators on a range of measurements than the same units in UCL. It was noted though that there was no standardisation of quality indicators so it was difficult to draw conclusions on quality.
- Why were cancers with the minimum number of cases being centralised?
- It was not clear to what extent consultants agreed with these the proposals.

- Overall there appeared to be a lack of ambition for outer London with specialism being concentrated in inner London hospitals. This has been the pattern for many years and could become a self-fulfilling prophecy.

Professor Pritchard-Jones thanked the Board for their comments and said that their concerns would be noted.

The Chairman thanked both Professor Pritchard-Jones and Neil Kennett-Brown for a frank and open discussion.

69 ANY OTHER BUSINESS

None.

70 DATE OF NEXT MEETING

Members of the Board were asked to note that the next meeting would be held on 11 December 2013 at 1.30 pm.

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Chairman

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