MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
9 September 2014 (7.30 - 9.50 pm)

Present:

Councillors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Patricia Rumble, Gillian Ford, Joshua Chapman and Jason Frost.

Officers present:

Matthew Hopkins, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS trust (BHRUT)
Rachael Royall, BHRUT
Dr Gurdev Saini, Director, Havering Clinical Commissioning Group (CCG)
Alan Steward, Chief Operating Officer, Havering CCG
Ilse Mogensen, North East London Commissioning Support Unit
Ian Buckmaster, Director, Healthwatch Havering (part of meeting)
Carole Howard, Healthwatch Havering
Mark Ansell, Consultant in Public Health, London Borough of Havering

One member of the public was also present.

11 ANNOUNCEMENTS

The Chairman gave details of action in the event of fire or other event requiring evacuation of the meeting room.

12 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

There were no apologies for absence.

13 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

14 MINUTES

The minutes of the meeting held on 24 June 2014 were agreed as a correct record subject to an amendment submitted by the Chief Operating Officer of Havering Clinical Commissioning Group and were signed by the Chairman.

15 HEALTHWATCH ANNUAL REPORT

A Director of Healthwatch Havering presented the first annual report of the group to the Committee.

The Committee was informed that Healthwatch Havering was part of a new national concept which gave every individual in every community their own local independent consumer champion for health and care. The umbrella body for the organisation was Healthwatch England, a part of the Care Quality Commission. During its first year Healthwatch Havering had made a difference working with local partner organisations to improve services.

The Director of Healthwatch Havering explained that Queen's Hospital had been placed in special measures. Although not directly involved in that decision, Healthwatch Havering had submitted preliminary evidence to the inspection team and were also present by invitation at the meeting at which the CQC announced the findings of the inspection team.

It was also noted that the Healthwatch Havering social care team had been paying close attention to the borough's care homes and, in particular, those identified by the CQC as being in need of significant improvement.

Although Healthwatch Havering had no direct remit to represent, or act as advocate for, individuals or to investigate individual complaints, people in distress did not always understand exactly who to approach for help and contacted Healthwatch Havering "because we are here". Healthwatch Havering had taken the view that they had a general duty of care to help those in distress and carried out that duty by referring people on to those best placed to help them.

The Chairman of Healthwatch Havering explained how it was making a difference influencing official bodies and others by being formally represented at meetings of the Council's Health, Individuals and Children's Services Overview & Scrutiny Committees and at a wide range of other relevant bodies, both local and regional to North East London**.**

Healthwatch Havering had developed an ambitious work programme for 2014/15, which would include an investigation of patient-related activity at GP practices

The Director of Healthwatch Havering added that Healthwatch Havering was making a difference in developing a role in public consultation and encouraging participation in health and social care issues.

In September, Healthwatch Havering had commissioned the Film Unit of the Media Studies Group of Sixth Formers of a local school - the Coopers' Company & Coborn School, Upminster, to produce a short film of local peoples' thoughts about local health services. This film was available on the

Youtube website. Some Healthwatch Havering volunteers also provided a stand at Havering's National Women's Day in March, at Havering College and were represented at Havering's Over-Fifties Forum on a regular basis.

Healthwatch Havering was making a difference by participating actively at all meetings of the Health & Wellbeing Board which was a key provision of the Health and Social Care Act 2012. The Committee was informed that Healthwatch Havering had presented an end of year report on its progress to the Board which included their work plan for 2014/15.

Following the presentation Members of the Committee received the following answers to their questions:

- Healthwatch Havering gave care homes a two weeks warning before a visit. The Committee was also informed that Healthwatch Havering reserved the right to make an unannounced visit if there was a concern. Healthwatch Havering viewed its role as working closely with the CCG as a critical friend.
- Healthwatch Havering was working closely with its partners to identify and understand why young people who were supposed to attend a GP surgery instead turned up at Accident & Emergency.
- The organisation had a forward plan to consider issues around mental health provision for young people who were moving to Adult Health Care.
- Healthwatch Havering was working with St Francis Hospice to provide its volunteers with Gold Standard training on end of life care.

The Committee **noted** the annual report.

16 BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST IMPROVEMENT PLAN

The Committee received a presentation from the chief executive of BHRUT on the Improvement Plan for 2014/15 at the Trust.

The Committee was informed that following Queen's Hospital being placed in special measures the Trust had taken various steps to address the issues.

The Trust had an Improvement Director allocated by the Trust Development Authority (TDA) to oversee and support the Trust's improvement plan. The Trust had to produce a plan and deliver improvements over a period of time whilst receiving support to make improvements. The Trust also had to report progress monthly which was overseen by the TDA.

The Committee was informed that the improvement plan for the hospital had five key themes to address the findings of the Chief Inspector of Hospitals'

review. Each theme had important objectives and supporting improvement actions:

- **Workforce**: recruiting, retaining, developing and deploying the right numbers of permanent staff needed to provide high quality care 24/7.
- **Emergency Care Pathway**: making sure patients were assessed and treated promptly and were supported to return home as soon as they were medically fit to leave hospital, and to ensure that patients were cared for in the right place with the right follow up care.
- **Clinical Governance**: supporting all care with effective management of patient notes and information, and systems which quickly alerted to problems.
- **Outpatients**: ensuring effective management of outpatient services so appointments ran on time, every time.
- **Leadership and Organisational Development**: putting the right systems, structures, checks and balances in place to make sure the Trust was properly managed from board to ward.

The Trust's hotel services were being retendered in order to improve the quality of hospital food.

The new BHRUT IT system had the flexibility to meet hospital needs. Work was in progress with suppliers in order to get the system working for patients and it was agreed that the chief executive should report back in two months' time on progress with the IT system.

The chief executive felt that there were not enough trainee doctors nationally. This was also an issue with emergency consultants due to the competitive nature of recruitment and it was emphasised that the Trust wanted to recruit more doctors.

There were already some outpatient services that ran from non-hospital sites such as the Victoria Centre in Romford. The chief executive was mindful of clinic capacities with for example ophthalmology outpatients being very busy.

There were a number of reasons why clinics might be cancelled. These included their not being set up properly on the system or the relevant doctors being on other duties or on leave. Action was being taken to enforce the Trust policy that no clinics could be cancelled within six weeks of their scheduled date.

The JONAH computer system for patient discharge was followed by some wards but not by others and the chief executive accepted that this needed to

be addressed. It was felt that, in order to have an effective patient flow, 10 patients at each hospital should be discharged before 10 am with 20 discharged from each site by 12 pm. 85.5% of patients had met the four hour treatment rule in A&E in August, some 4.5% short of the Trust's target in this area.

Shifts had been altered at the Trust's call centre to match demand levels which had allowed more calls to be answered. More modern phone technology was also being introduced. The chief executive would look into why the ear, nose and throat department only had an answerphone and was unable to be contacted via the switchboard.

All tablets to take home could be dispatched from the hospital pharmacy within four hours but this required doctors to transcribe medication forms earlier. Funding had been allocated for extra staff to ensure this was done.

Trainee doctors were expected to undertake clinical audits and there was a programme of monitoring of this. This would produce changes in the way the hospital worked. Named management staff would follow up on changes and the chief executive felt there was a need to employ more clinical governance staff.

It was felt that more GP appointments should be made available via NHS 111 as this would reduce pressures on A&E. It was important to make alternatives to A&E more accessible but the chef executive accepted there was a challenge in this as people were often used to going to A&E.

It was noted that urgent care services were due to be retendered and that both money and the quality of service would be considered equally during the tendering process.

The chief executive wished to implement the Trust improvement plan before expanding A&E at Queen's. The A&E would however be expanded in order to create space for the Urgent Care Centre. A target date for the A&E works would be set once progress on the improvement plan had been achieved.

As regards the Francis Report, the chief executive felt that this had shown a tolerance by staff in mid-Staffordshire of poor standards. There had been a lack of accountability and little use of clinical audit etc. The report had said that people needed to understand a Trust's values. Non-compliance should be tackled and a culture of openness and transparency should be developed.

The response to the Francis Report from BHRUT had been to understand the current quality of care and create a culture where staff could report problems. The focus would be on putting patients first.

The director of quality and safety at the Trust wanted clinical services to check if patients were safe and that care was effective. There were also priorities to improve the patient's experience and ensure that the workforce

was engaged. Trust complaints and compliments were analysed and the chief executive signed off all responses to complaints. The Trust also had an Independent Patient Experience Group which included representatives from Healthwatch.

The Trust whistle blowing and raising of staff concerns policy had been updated. 'Meet the chief executive' sessions were held for staff who were encouraged to have a duty of candour. The Trust vision had been refreshed and it was accepted that the Trust needed to be financially viable in order to improve care for patients.

A PRIDE programme – passion, responsibility, innovation, drive, empowerment had been introduced for staff and the chief executive agreed that staff training and development were very important.

Other initiatives included walkabouts by Trust directors who completed a template about wards they had visited. Walkabouts were held at least once a week. The next steps for the Trust were to seek to improve public confidence in their services.

The chief executive wished to promote a culture where staff believed it was safe to speak up. He wanted staff to take ownership of processes but accepted this was a culture shift that would take time to implement. Progress had been seen with for example the friends and family test for in-patients which had recorded a 71% approval rate in August and 73% in July.

The Trust's guardian services scheme to allow staff to discuss concerns confidentially had been working well and had been used by approximately 110 staff thus far. Junior managers needed to follow through on these commitments however in order for the programme to work fully.

The Trust was keen for staff to resolve complaints on the spot and to focus more on the patient experience. Matrons were expected to be visible on wards and photographs of staff were displayed at ward entrances. It was also important that board members talked to patients direct. It was felt essential that nursing staff adopted themes such as care and compassion in their work.

The Committee **NOTED** the position.

17 BREAST CARE SERVICES

The Committee had been asked by the Joint Health Overview and Scrutiny Committee to consider whether the proposed changes to breast cancer services required formal consultation.

BHRUT officers explained that they wished to move breast cancer services from the Victoria Centre in Romford to King George Hospital. Some of the Victoria site was already vacant and NHS Property had earmarked the site

for disposal. It was explained that breast screening was carried out at a number of centres and that all breast surgery was now done at King George Hospital. The proposals were therefore consistent with the development of specialist women's services at King George.

The Trust was working with Transport for London on improving public transport to King George. It was uncertain if taxi fares to or from the hospital could be reimbursed or if patient transport covered screening services.

A quality assurance group had overseen the process of developing the breast services proposals and engagement had taken place on the plans with service users. It was hoped to open the new unit at King George in June 2015. BHRUT officers were happy to report back on progress both before and after the opening of the new unit.

Members felt effective communication of the changes was important, both to the Havering and joint overview and scrutiny committees and to the public as a whole. It was noted that a local representative panel was also being set up.

The chief executive agreed to look into the lack of parking at breast care facilities at both King George Hospital and the Harold Wood polyclinic.

The Committee **AGREED** that the proposals to relocate breast cancer services did not require formal consultation.

18 INTERMEDIATE CARE CONSULTATION

A director of Havering CCG explained that intermediate care referred to specialised services to avoid or reduce stays in hospital. Two new services had recently started. A community treatment team (CTT) consisting of doctors, nurses, social workers and other professionals and an intensive rehabilitation service (IRS) where therapists visited people in their homes up to four times a day.

Both services were available seven days a week and the maximum wait to commence treatment would be five days for the IRS and two hours for the CTT. Feedback for both services had been good. Four thousand patients had been seen from Havering compared with only seven hundred in a similar timescale under the old system.

There were currently 104 rehabilitation beds across Havering, Barking & Dagenham and Redbridge but 49 were not used. As such, it was considered that a total of only 40-60 beds was now needed. The proposal was that these beds would be based at King George Hospital.

Officers reported that the proposals had been well received in Havering and Barking & Dagenham while some concerns had been expressed in the Wanstead area of Redbridge.

Members felt there was a lack of awareness of the new services and officers explained that leaflets giving details of the new services were being sent to GPs and community groups. A pilot scheme was also in operation where members of the CTT went out with ambulance crews as this could reduce the number of visits needed to hospital.

A social worker did work on the CTT and risk assessment of home conditions could be carried prior to discharge from hospital. The CTT aimed however to keep people out of hospital. Patients could access the CTT direct or be referred via the NHS 111 service.

A Member observed that the proposals were in line with the national focus on moving funding and services from acute to primary settings. Extra staff had been employed in anticipation of winter pressures and this was reviewed on a regular basis. Agency or locum staff could also be used if necessary although efforts were being made to reduce this.

The Committee **NOTED** the presentation and **AGREED** that the clerk to the committee should draft a letter for the Chairman giving the Committee's response to the consultation, based on the discussions at the meeting.

19 ST GEORGE'S HOSPITAL UPDATE

The CCG chief operating officer confirmed that the CCG was committed to having services on the St George's site such as a GP, pharmacy and possibly a community treatment base. There would be a probable focus on older people at the site. It was also possible that a voluntary sector facility could go on the site.

Approval had now been received from NHS England to develop a business case for St George's. A delivery board would therefore be re-established including NHS Property and NHS England. There would also be a steering group with wider representation. It was planned to submit an outline business case to NHS England in February or March 2015. It was confirmed that any medical facilities would be at the front of the site.

It was hoped to put forward a strong case to use the St George's site for the new facilities although it was noted that NHS Property could decide that other local facilities should be used instead.

An update on the position could be given following a meeting of stakeholders in October and monthly written updates would be given to the Committee where possible. It was noted that local residents were unhappy that the site remained empty after two years and at the annual £0.5 million cost of keeping the site secure.

The Committee **NOTED** the update.

20 URGENT BUSINESS

There was no urgent business.

Chairman