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JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

2.00 pm	Tuesday 21 July 2015	Dagenham Civic Centre, Rainham Road North, RM10 7BN

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Peter Chand
Councillor Eileen Keller (Chairman)
Councillor Adegboyega Oluwole

LONDON BOROUGH OF WALTHAM FOREST

Councillor Tim James
Councillor Gerry Lyons
Councillor Richard Sweden

LONDON BOROUGH OF HAVERING

Councillor Nic Dodin
Councillor Gillian Ford
Councillor Dilip Patel

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor John Howard
Councillor Karen Packer

EPPING FOREST DISTRICT COUNCIL

Councillor Gavin Chambers (Observer Member)

CO-OPTED MEMBERS:

Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge
Richard Vann, Healthwatch Barking & Dagenham
Alli Anthony, Healthwatch Waltham Forest

For information about the meeting please contact:
Anthony Clements, anthony.clements@oneSource.co.uk 01708 433065

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies have been received from Councillor Dilip Patel (London Borough of Havering).

3 COMMITTEE'S MEMBERSHIP

To note the revised membership of the Committee.

4 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 point prior to the consideration of the matter.

5 MINUTES OF PREVIOUS MEETING (Pages 1 - 10)

To agree as a correct record the minutes of the meeting held on 14 April 2015 (attached) and to authorise the Chairman to sign them.

6 HEALTHWATCH BARKING & DAGENHAM - REPORT ON VISIT TO FERN WARD, KING GEORGE HOSPITAL (Pages 11 - 28)

To consider a report of Healthwach Barking & Dagenham on an Enter & View visit to Fern Ward, King George Hospital (report of visit and BHRUT action plan attached).

7 BHRUT IMPROVEMENT PLAN

Senior officers from Barking, Havering and Redbridge University Hospitals' Trust will present on the development of the Trust's improvement plan following the recent reports on the Trust's hospitals by the Care Quality Commission.

8 COMMITTEE'S TERMS OF REFERENCE (Pages 29 - 34)

1. To note the current terms of reference of the Outer North East London Joint Health Overview and Scrutiny Committee (attached).

2. To confirm, where possible, which boroughs have delegated to the Joint Committee the power to refer matters to the Secretary of State.

9 URGENT BUSINESS

To consider any 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.

Anthony Clements
Clerk to the Joint Committee

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MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Waltham Forest Town Hall
14 April 2015 (2.00 – 5.05 pm)

Present:

Barking & Dagenham
Councillor Eileen Keller

Havering
Councillor June Alexander (substituting for Councillor Nic Dodin)
Councillor Gillian Ford

Redbridge
Councillor Stuart Bellwood
Councillor Mark Santos
Councillor Tom Sharpe

Waltham Forest
Councillor Gerry Lyons (substituting for Councillor Stuart Emmerson)
Councillor Richard Sweden (Chairman)

Essex
Councillor Chris Pond

Co-opted Members present:
Alli Anthony, Healthwatch Waltham Forest
Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge
Manisha Modhvadia, Healthwatch Waltham Forest

Also present:
Councillors Kastriot Berberi and Yemi Osho, Waltham Forest

Health officers present:
Peter Morris, Chief Exective, Barts Health
Jo Carter, Barts Health Communications
Lynne Hill-Tout, Interim Managing Director, Whipps Cross Hospital
Deborah Kelly, Barts Health
Mike Roberts, Barts Health

Dr Steve Ryan, Chief Medical Officer, Barts Health

Lucy Hamer, Care Quality Commission
Hatley Marle, Care Quality Commission

Alan Steward, Chief Operating Officer, Havering CCG
Ilse Mogensen, North East London Commissioning Support Unit

Council officers present:
Masuma Ahmed, Barking & Dagenham
Bill Brittain, Group Manager, Intensive Support, Barking & Dagenham
Anthony Clements, Havering (clerk to the Joint Committee)
Jilly Szymanski, Redbridge
Dan Fryd, Waltham Forest
James Holden, Waltham Forest
John Savage, Waltham Forest
Ramzi Suleiman, Waltham Forest

Approximately 15 members of the public were also present.

All decisions were taken with no votes against.

35 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman gave details of arrangements to be followed in case of fire or other event requiring the evacuation of the meeting room or building.

36 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.**

Apologies were received from the following Councillors:

Barking & Dagenham:
Sanchia Alasia
Danielle Lawrence

Havering:
Nic Dodin (Councillor June Alexander substituting)
Dilip Patel

Waltham Forest:
Stuart Emmerson (Councillor Gerry Lyons substituting)

37 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of pecuniary interest.

38 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 13 January 2015 were agreed as a correct record and signed by the Chairman.

39 BARTS HEALTH - RESPONSE TO WHIPPS CROSS HOSPITAL CQC INSPECTION

The Barts Health NHS Trust chief executive explained that an inspection of Whipps Cross Hospital by the Care Quality Commission (CQC) had taken place in November 2014 and had revealed significant concerns in a number of areas including A&E patient flow, staffing and bullying. Following the inspection, a risk summit was organised with stakeholders in March 2015 and Barts Health wished to be inclusive with other organisations as part of its improvement plan.

Significant concerns raised by the CQC included issues of staffing, morale & culture, the routine delivery of standards such as keeping to timetables for treatment and the lack of safety policies and embedding of safety etc. The Trust management believed that the public would still get good outcomes and care at Whipps Cross but accepted that patients had been let down. While there were good aspects of care at Whipps Cross, improvements were also required.

The Trust Medical Director explained that immediate recovery action was agreed with the Trust Development Agency, local Clinical Commissioning Group (CCGs) and Healthwatch Waltham Forest. Significant progress had been made around improving the quality and safety of clinical care. Daily meetings were held where nurses could share any concerns around patient care. The number of medical patients treated on surgical wards had been reduced and the seven-day site presence of senior management had also been improved.

As regards staffing levels, improvements had been made but there was still a reliance on use of agency staff on some wards. The budgeting process for the nursing establishment was currently in progress and the Trust aimed to reduce its need for agency staff. On safeguarding, the introduction of a babytracking system at Whipps Cross maternity had not been concluded and the Trust accepted that this needed to be actioned. Recruitment had taken place to the senior leadership team whose visibility had improved, making it easier for staff to escalate issues if necessary.

The Trust and hospital leadership were keen that staff understood and engaged with the hospital improvement plan. On outpatient issues, the Trust wished to meet waiting time targets, avoid duplication of appointment letters and ensure patient records were available at appointments. In A & E, the objectives were to ensure patients were seen and assessed promptly, admitted to the correct ward and discharged safely.

Trust officers felt that recruitment had improved with the ratio of permanent, agency and bank staff being looked at. A new eight-bed High Dependency Unit was due to open at Whipps Cross by December. It was accepted that communication around the hospital improvement plan had to be improved both with stakeholders and the general public and also with the hospital's own staff.

It was also important that staff were engaged in delivering better care and a clinical senate had been established to manage the hospital at a local level. A quality and safety committee would also be set up to allow safety issues and complaints to be dealt with on site at Whipps Cross.

The final area of the hospital improvement plan covered compassion in care – an area of good practice referenced in the CQC report. A compassion in practice working group dealt with key areas of concern such as care of the elderly and dementia. It was aimed to make the hospital estate more dementia friendly. End of life care – an area criticised in the CQC report was also being worked on. Work was being undertaken with the Patients Association and the hospital was keen to work with both local and national patient groups.

Questions and discussion

The Trust chief executive agreed that the raising of concerns by staff should be encouraged and felt that it was people's duty to do this. Staff would not be penalised for raising concerns and the Trust had a private means for staff to raise concerns about issues such as bullying. This had been reinforced in the values of the organisation and 1,500 staff leaders were being trained in the Trust's values.

The hospital areas with the highest amount of reliance on agency staff were children's in-patients wards, surgical wards and A & E. Whipps Cross now had a full complement of ED consultants but struggled to recruit ED nurses. The recruitment situation on the children's wards had improved recently although there remained large numbers of new staff in this area.

The new leadership at Whipps Cross did have the authority to tackle problems at the hospital. The post of managing director at the hospital was currently on an interim basis but would be advertised permanently in due course. This would allow a higher level voice to represent Whipps Cross to the Trust Board.

Recruitment in paediatrics was a national issue. Specialist recruitment agencies and incentive packages were therefore employed to aid recruitment to these areas at Whipps Cross. It was hoped to reach almost full establishment for children's staffing at Whipps Cross by the end of March. Elderly wards were now almost at full establishment and the new staff were of high calibre and enjoying working at Whipps Cross. Recruitment difficulties for surgical wards were also seen in other areas rather than just Whipps Cross. The Trust wished to use their own staff bank

to fill vacancies rather than external temporary staff. Other incentives to attract staff being considered included rotation across sites, clear career pathways and education & training opportunities.

The private finance initiative (PFI) did not impact on the quality of care at Whipps Cross. The PFI cost did total £28-30 million and the Trust wished to address the long-term issues around this. The estate at Barts and the Royal London hospitals was in a good condition. The remainder of the Trust's estate required an upgrade however and there was a maintenance backlog across the Trust of approximately £80 million. Around £16 million had been invested in the estate in 2014/15 although much of this investment was not visible to the public. The four oldest operating theatres at Whipps Cross were being replaced at a cost of £9.2 million.

The communications strategy around Whipps Cross would include the local press and local residents. The Trust wished to improve patients' experiences and then make these improvements clear to the wider public. It was suggested that the annual Barts Health awards could be hosted at a venue closer to Whipps Cross in order to boost the profile of the hospital.

Hospital management accepted that most media stories about Whipps Cross (both positive and negative) were true but there were also some areas of very good practice at the hospital. These included endoscopy and the new heart service at the hospital. The induction of labour had been improved at Whipps Cross maternity and this had been praised in the CQC report.

The Trust respected equal pay obligations and the requirements of safe staffing. London weighting issues were also taken into account. As regards falls prevention and frailty of patients, the Trust was prioritising this and wished to adopt national best practice on frailty. More senior geriatricians needed to be employed by the Trust and more weekend working would be introduced in order to develop the elderly pathway. A falls strategy had been operating at the Trust for the last two years and all wards were required to report incidents of patient falls. The number of falls across the Trust as a whole had been reduced but further improvement was needed.

The Trust wished to extend the opening hours of its Patient Advice and Liaison Service (PALS) in order that the service was available out of hours. Recruitment to a more dynamic PALS model was currently under way.

As regards end of life care, a compassionate care plan for the dying had been produced but its implementation had been delayed. Staff training on this policy was expected to start shortly. It was accepted that more work needed to be done at the Trust on end of life care. The Trust was not aware of any issues around screening programmes being raised by the CQC.

The Trust chief executive felt that Barts Health did have a fully committed and dynamic management team. A new Trust Chairman was due to be appointed in early June and further senior appointments would follow.

A lot of partnership working was included in the improvement plan and the overall nursing strategy and care model. Regular use was made of national networks such as the Health Education Network. The robustness of patient panels at Barts Health needed to improve and the Trust also wished panels to be more representative of their local communities with e.g. better youth representation. The Trust had obtained funding in order to develop this work.

Further details would be supplied of the Trust's work with people with dementia. A Member felt that the needs of people with dementia should be considered in all areas of the hospital and had established that this had not been done in the design of the new heart hospital at Barts. It was noted that there was a Trust-wide dementia strategy group in operation.

It was **AGREED** that progress at Whipps Cross be considered again by the Joint Committee in approximately six months and that in the meantime, a site visit should be arranged for Members in order to gain more of an understanding of the challenges and issues facing the hospital. The outcomes of the current Waltham Forest scrutiny review of end of life care would also be shared with the Joint Committee.

It was further **AGREED** that it be established with the Joint Health Overview and Scrutiny Committee for Inner North East London what scrutiny that committee was undertaking of the issues at Whipps Cross. It was noted that scrutiny of the Whipps Cross improvement plan was already being conducted by Waltham Forest, Redbridge and Essex health scrutiny committees. Any relevant outcomes from this work could also be brought back to the Joint Committee.

40 CARE QUALITY COMMISSION HOSPITAL INSPECTION PROCESS

Officers from the Care Quality Commission (CQC) explained that the CQC strategy committed the organisation to working closely with scrutiny. The CQC wished to strengthen this relationship further following issues such as those raised by the Francis Report. The CQC had recently produced a new guide for scrutiny committees on working with it. The CQC teams that inspected facilities for health, social care and primary & integrated care each wished to strengthen their relationships with scrutiny.

A new set of CQC standards for care had been introduced with effect from 1 April 2015. If the CQC found that services provided were not good, it needed to decide if the services provided required improvement of if they should be rated as inadequate. Services were also now required to put their

CQC rating on public display. Guidance for providers had now been updated and was available on the CQC website.

It was noted that the CQC was responsible for inspecting hospitals, GPs, dentists, mental health facilities, care homes, home care services, children's care facilities and healthcare within the criminal justice system.

Officers reiterated that the relationship with scrutiny was important to the CQC. The CQC inspection schedule was announced to scrutiny and a representative of the most local scrutiny committee was invited to the quality summit arranged by the CQC following an inspection. Inspection reports were also notified to scrutiny.

The CQC inspection of Whipps Cross had been undertaken in direct response to concerns raised by local stakeholders. Evidence was collected from stakeholders before each inspection and a team of 45 people had been involved in the inspection at Whipps Cross.

Inspections of Newham and the Royal London Hospitals had been undertaken in January 2015 and these reports were currently with the respective Trusts who were allowed to check matters of factual accuracy. The inspection at BHRUT had been dealt with supportively by the Trust and the report on this was due to be compiled by the end of April.

The CQC had the remit to look at how integrated services were and information was shared between the different sector CQC teams. The CQC also undertook thematic reviews looking at for example care and services for older people.

Members expressed disappointment at the lack of an invitation to Redbridge to the quality summit re Whipps Cross and the CQC officers accepted that it was important to identify correctly which overview and scrutiny sub-committee should be invited. This was also a challenge where hospitals treated patients from across several different Local Authority areas. Members also recorded their thanks to the CQC for an excellent report on Whipps Cross.

A member of the public asked why the CQC had not picked up concerns about Whipps Cross at an earlier stage. Officers responded that the CQC did have a database of evidence on Whipps Cross. Barts Health had been inspected in December 2013 by a team of 90. When it became clear that action plans were not being worked towards, the CQC announced a new inspection in November 2014.

A new power granted to the CQC was the authority to review end of life care. The CQC could also look at if there were clear responsibilities for care planning and further information could be provided on this.

The Committee **NOTED** the presentation from the CQC.

41 CCG/NHS ENGLAND CO-COMMISSIONING

The chief operating officer of Havering Clinical Commissioning Group (CCG) explained that NHS England wished for the commissioning of GP practices to be decided at a more local level. All four CCGs in ONEL wished to have full delegation in this area as this would allow the CCGs to drive integrated care. Delegation would relate to CCGs commissioning GP practices, performance managing practices as a whole and being involved when deciding on closures of practices.

It was hoped that delegation would allow improved care by GPs for people with long-term conditions. It was accepted that there were also risks to delegation such as to the reputation of CCGs as well as a potential conflict of interest as GP practices were themselves members of CCGs.

The CCGs were currently consulting their members on this issue. Full delegated commissioning responsibility had been approved for the four ONEL CCGs with effect from 1 April 2015. Governance arrangements were currently being considered and a primary care committee was being established to take on these responsibilities. The local Healthwatch organisations, Health and Wellbeing Boards and Councils would be non-voting members of the committee, which would meet in public. There would also be a wider reference group including BHRUT and other providers.

It was planned that the primary care committee would be established over the next two months and an update could be given to a future meeting of the Joint Committee. The position would be checked as regards whether non-voting members would be able to remain present during confidential part 2 discussions at the primary care committee.

The Joint Committee **AGREED** to recommend that non-voting members of the primary care committee should be present at discussions regarding the distribution of resources.

The CCG officer accepted that GP recruitment and retirement was a major issue and felt that workforce issues would be a key work stream of the primary care improvement programme. NHS England would continue to performance manage individual clinicians but the CCGs would undertake wider performance management on issues such as access to GPs. Funding received in Barking & Dagenham, Havering and Redbridge from the Prime Minister's Challenge Fund had been used to establish GP access hubs.

The Committee **NOTED** the position.

42 URGENT CARE REPROCUREMENT

The Committee was addressed briefly by a Waltham Forest resident and member of the Waltham Forest CCG steering group. The member of the public noted that the urgent care procurement process was now paused but felt there had not been sufficient involvement of patients and the public in the process. If there was to be a single provider of services such as NHS 111 and the out of hours GP service across the four boroughs, the member of the public wished to establish how the different demographics of the four boroughs would be taken into account and also what risk assessment had been undertaken.

The Havering CCG chief operating officer, on behalf of the four ONEL CCGs explained that the original competitive dialogue evaluation had left only one viable provider and the CCGs had therefore decided not to continue with that process. It was accepted that patient and public involvement could have been better and the new procurement process would commence with an urgent care conference in June 2015. This would involve the Joint Committee, Healthwatch, local Health and Wellbeing Boards as well as other stakeholders. The conference would aim to develop a high level specification for an urgent care pathway.

The CCGs wished to generate more interest in the urgent care procurement from a range of different providers. Next steps in the procurement would be considered after the urgent care conference had been held. It was uncertain at this stage if any potential change of Government following the General Election would have any impact on the process.

The Committee **NOTED** the position.

43 HEALTHWATCH BARKING AND DAGENHAM - REPORT OF ENTER AND VIEW VISIT

In view of the length of the meeting, it was **AGREED** that this item be deferred to the next meeting of the Joint Committee.

44 URGENT BUSINESS

The schedule of meetings for the joint Committee for 2015/16 was **AGREED** as follows:

Tuesday 21 July 2015, 2 pm, Barking & Dagenham
Tuesday 20 October 2015, 2 pm, Havering
Tuesday 19 January 2016, 2 pm, Redbridge
Tuesday 19 April 2016, 2 pm, Waltham Forest

Chairman

Enter & View Visit
Fern Ward
Medicine and Elderly Care Ward
King George Hospital

For further copies of this report, please contact

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Telephone: 020 8526 8200

www.healthwatchbarkinganddagenham.co.uk

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Introduction

Healthwatch Barking and Dagenham is the local independent consumer champion for health and social care. We aim to give our citizens and communities a stronger voice to influence and challenge how health and social care services are provided for people in the borough.

Enter & View is carried out under the Health & Social Care Act 2012. It imposes duties on certain health and social care providers to allow authorised representatives of local Healthwatch organisations to enter premises and carry out observations for the purposes of Healthwatch activity.

Authorised representatives observe and gather information through the experiences of service users, their relatives/friends and staff to collect evidence of the quality and standard of the services being provided.

To do this we:

- Enable people to share their views and experiences and to understand that their contribution will help build a picture of where services are doing well and where they can be improved.

- Give authoritative, evidenced based feedback to organisations responsible for delivering and commissioning services.

- Are able to alert Healthwatch England or the Care Quality Commission, where appropriate, to concerns about specific service providers of health or social care.

Summary

Healthwatch Barking and Dagenham authorised representatives undertook the visit to speak with patients about three areas of care during their hospital stay: nutrition, personal hygiene and interaction between staff and patients. We spoke to 10 patients on the day of the visit.

Overall patients were satisfied with the meals provided and felt that they were given a choice of what they would like to eat. In terms of drinks, all patients were not aware that soup or a milk drink was available. There were concerns raised about catering staff asking if people want a drink only from the entrance of the bay. This was a problem for those who had hearing impairments and also for those who were in the bathroom or asleep at the time.

Patients highlighted that staff had a lot to do but do try their best to provide the care they can.

Although patients were satisfied with their bedding being changed and staff helping them with bathing, issues were raised by relatives about incontinence items not being changed overnight.

All patients have an information board placed behind the bed. Relatives indicated that these are not always updated to reflect the correct information.

Details of the Visit:

Date:

8th October 2014

Premises Visited:

Fern Ward, King George Hospital

Enter & View Authorised Representatives:

Barbara Sawyer
Val Shaw
Manisha Modhvadia (Healthwatch Officer)

Specific Areas Identified for Observation:

- Nutrition
- Personal Hygiene
- Interaction between Staff and Patients

Reasons for the Visit:

To visit wards that provide in-patient hospital services for older people - to gather the views and experiences of patients about the services being provided to them. This Enter & View visit is part of a wider programme being undertaken by Healthwatch Barking and Dagenham around issues concerning health and social care services for older people and is as a consequence of findings from the Francis Report. Healthwatch have undertaken a visit previously to Queens Hospital as part of this work programme and wanted to determine parity of care across the Trust.

Purpose of the Visit:

To ascertain patients' views on the choice and quality of the food and drink they receive; to ask patients and their visitors about the staff interaction with them and to get views and comments about the quality of personal hygiene support that patients receive.

Healthwatch authorised representatives spoke to 10 patients on the day of the visit.

The Wards' Services:

The ward has 30 beds: split into 4 units with 6 bays each, set up as single sex units. There are 4 side rooms.

It is a medicine ward for elderly care.

Visiting times start at 10.30am till 7.30pm and patients are provided with 2 cooked meals a day.

Staffing arrangements:

Morning: 6 Qualified Nurses and 3 Health Care Assistants

Afternoon: 4 Qualified Nurses and 3 Health Care Assistants

Evening/Overnight: 3 Qualified Nurses and 3 Health Care Assistants

During the weekend the staff numbers drop by 1, in all categories.

During the visit, the staff from the ward were very helpful and assisted by providing all information that was requested.

Healthwatch Barking and Dagenham would like to thank the staff for their assistance and co-operation during our visit.

On entering the wards, each one has a sink near the entrance to encourage visitors to wash their hands as well as use the alcohol hand rubs.

Information boards were observed on the wards' reception areas.

We saw a system of red trays and water jugs with red lids being used to identify patients that required help with feeding and drinking.

Patients' Experiences:

Nutrition:

Healthwatch representatives were not looking at nutrition on the wards from a Dietician's perspective, but from the point of view of the patients.

The questions asked centred on the help patients get to eat and drink, whether they can choose the food they eat and if they feel it is of good quality.

On the day of the visit Healthwatch representatives spoke to ten patients.

Generally, patients found the quality of food to be satisfactory. Healthwatch Representatives observed a red tray and lid system being used. Every patient had a red tray and lid. A staff member told Healthwatch Representatives that all the patients in the ward had them as it's an elderly ward.

Patients were asked if they are helped with food and drink, four patients told Healthwatch representatives that they did not need any help but were sure a member of staff would help them if they did. Five patients out of the ten said they received help.

Eight patients said they were happy with the size of food portions provided and two said they were not.

Patients' opinions varied on the choices of food.

Comments included:

"I was given what the patient before ordered; there was no other alternative choice for me".

"I am given a menu to choose from and the choices are good"

"Yes I am given choices by the menu".

"I have had sandwiches the bread is too thick, Its needs to be thin bread"

In discussion with patients and relatives it came to light that some patients are not being helped with the menu options, the menu is left on their table to complete by themselves.

Comments included:

"Don't always get what you want, not much help to fill out the menu option, there are a lot of the elderly people in here who are confused and are left to fill in the options."

" I cannot read very well, as my sight is very poor, the staff do not always do the menu with me."

Relatives highlighted that patients were not aware that they can ask for a milk drink or a cup of soup. It's only when a patient or a relative ask staff that they become aware of this.

Healthwatch representatives spoke to patients about drinks. Out of the ten patients 5 mentioned that catering staff only came to the doorway and ask patients if they wanted a drink. One patient on the ward, who was hard of hearing, told us that she has missed out on drinks due to this.

Patients also told us that catering staff do come back to ask if they would like a drink. Patients who are asleep or in the bathroom miss out on having a drink.

One relative spoke about his mother's care on the ward. His mother, he explained, his mother is a stroke victim and unable to use one side of her body. No staff member had helped her to have a drink and her jug was left on the side of the table where she was unable to reach it. No beaker was provided to the stroke patient until a relative asked for one.

Comments from patients

"You have a menu that you can choose from. I am happy with the choices, sometimes if I don't like something, the staff will give me something else but it depends on if there is anything left"

"Not aware that soup is an option, unless you ask, you would not know that's its available, it's only a packet of soup, but people still need to know it's an option"

"Yes food is hot enough for me"

"Two hot meals a day, but when I have had sandwiches the bread is too thick, it needs to be thin bread"

"Plenty of water in the jug"

"Always enough water and drinks"

Personal Hygiene:

Patients were asked for their views and experiences of personal care support: was it meeting their needs and was it being carried out in a way that preserved their dignity?.

Overall, patients were satisfied with the way they were being cared for and said that they were treated with dignity and respect. All patients that were asked said that their bed linen was changed every day.

Patients and relatives commented on the call button: highlighting that it took a while for staff to attend to patients once they had buzzed.

One relative spoke to Healthwatch Representatives about his mother's experience within the ward. He felt that the staff seem to be very busy but try their best. His concern was over the call buttons "I told the nurse that the call button does not work: the nurse told me that the button would be fixed the following day. I felt uncomfortable leaving my elderly mother without having a way to call for help overnight. The nurse then got some sellotape as a temporary measure. My mother has been here over two weeks and the problem has not been dealt with."

Relatives were concerned that patients were not being asked about changing incontinence pads overnight. A relative commented, "One morning I came in my mother was drenched, although the nurses changed her and gave her a bed bath, this would not have happened if someone asked if she needed a change."

Two patients told us that when they use a bedpan, they are left with the bedpan and the nurse goes to deal with something else and then they are left waiting until she comes back. The patients said the position is uncomfortable.

Comments from patients

"I wash everyday"

"I can use the toilets, wash every day, I do wear continence items."

"Would help if asked, but can wash myself"

"Overnight no one asks if you need a change."

"I had to wait a while before anyone came to take the bedpan"

"After using the buzzer there was no response and therefore her daughter had to go to the desk"

"It does take staff a while to come I know they have a lot to do"

Staff interaction

Healthwatch representatives wanted to explore the experiences that patients and relatives had when interacting with hospital staff.

We spoke with patients; we wanted to know if they had been treated with respect and dignity during their stay: that the staff responded to requests for assistance in a timely way and whether patients understood why they were in hospital and the treatments they were being given.

Overall patients were generally happy with their experience of the staff.

Patients felt that sometimes staff had a lot to do but tried their best. Feedback from some patients showed that staff treat them with respect and are approachable.

Comments from patients included
"Staff do treat me well",
"Very pleasant"
"Yes staff are very nice".
"Patients are put at the end of the queue".

Comments from other patients and relatives however, were less favourable:

"I had to wait one and a half hours for them to set up a commode".

Two relatives who were spoken to on the day felt that if they were not there, their relative would be left alone all day, they felt a befriending service of some sort would be of great help.

Some patients said they are given an explanation about their treatment and medication, whilst others said they were not told what was going on.

Relatives who were present on the day said doctors had explained what medication their relative was taking. One relative said "I am glad I know what is going on, as a carer I need to know what is happening with my mother or it will make things a lot worse when she comes home and I have no idea."

Additional information

Representatives observed information boards above each bed, they consisted of patient information, including the patients name, the date, the nurse and consultant who were treating the patient.

Three relatives indicated issues with incorrect information being displayed on the boards.

One relative told Healthwatch Representatives that staff had swapped their relative and other patient between bays. However once this was done the information on the boards were left with incorrect details of the patient. Another relative said that although the boards are a good idea, at times the details of the nurse who is treating the patient are incorrect.

The third relative told us that there is vital information that nurses keep missing out such as their mother only being able to drink with a beaker. The relative felt this information should be on the board so that all staff are aware and catering staff know that the patient needs her water in the beaker.

Incorrect or incomplete information on these boards is inconvenient at the best, and could possibly be dangerous. This is particularly the case if the wrong name and details are mistakenly left over a bed when patients are moved.

Conclusion and Recommendations:

Overall feedback indicates that majority of patients were happy with the portions of food they receive. However issues were raised about catering staff and the communication with the patient when distributing drinks and the food menu.

Information boards were an issue raised by relatives in particular. Their feedback indicated that incorrect information was being displayed. Healthwatch Representatives felt that incorrect information could have serious implications, especially in terms of the wrong medication being given to the patient.

Patients did not have issues with bathing. However feedback that was received about the management of incontinence items show that improvements need to be made.

Taking into consideration the views of patients and relatives Healthwatch recommend:

- Catering staff distributing tea and coffee need to each individual patient and ask if they would like a drink. This is essential on an elderly ward, where patients could be confused and for those with hearing impairments.
- Before leaving the ward, catering staff should ask those who may have been having a wash/gone to the toilet if they would like a drink.
- All patients should be asked if they need help filling in the menus.
- Staff need to double check that patient information boards display the correct information at the beginning of their shift.
- Where patients are using a bedpan, staff need to wait for the individual to finish using the bedpan so they are not left waiting in a uncomfortable position longer then they need to.
- All call buttons on the ward need to be checked to ensure they are in working order. If a call button is not working an alternative method needs to be provided to ensure the patient has a way of calling staff when they need to.

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Enter & View Visit by Healthwatch Barking & Dagenham

Action Plan

Healthwatch Barking & Dagenham carried out an Enter & View Visit on Fern Ward at King George Hospital on the 8th October 2014. The action plan below includes the recommendations that were made following the visit.

Recommendation	Lead	Timescale	Actions Taken
Catering staff distributing tea and coffee need to go to each individual patient and ask if they would like a drink. This is essential on an elderly ward, where patients could be confused and for those with hearing impairments.	Mary Etchells, Senior Sister	With immediate effect	Recommendation discussed with Karen Burroughs from Sodexo. Ward Sisters to oversee that this is carried out for each patient in each bay daily. Sodexo Supervisors to monitor that the housekeeper is going into the bays and offering drinks to every patient, using the correct cup, beaker. Escalation to Matron Hughes in the event this is not being maintained.
Before leaving the ward, catering staff should ask those who may have been having a wash/gone to the toilet if they would like a drink.	Mary Etchells, Senior Sister	With immediate effect	Recommendation discussed with Karen Burroughs from Sodexo. Ward staff to ensure all patients receive appropriate drinks daily and escalation to Matron Hughes if housekeepers fail to deliver this action.
All patients should be asked if they need help filling in the menus.	Mary Etchells, Senior Sister	With immediate effect	Volunteers currently assist patients when on the wards with the support and guidance from the nursing and care staff on the ward.

Recommendation	Lead	Timescale	Actions Taken
			Health Care Workers need to ensure patients are supported to complete their menus daily and to ensure they are collected and given to the kitchen staff daily. To be monitored by Registered Nurses.
Staff need to double check that patient information boards display the correct information at the beginning of their shift.	Mary Etchells, Senior Sister	With immediate effect	Daily checks of patient boards to be undertaken by the Nurse in Charge. Matron to check compliance daily.
Where patients are using a bedpan, staff need to wait for the individual to finish using the bedpan so they are not left waiting in a uncomfortable position longer then they need to.	Mary Etchells, Senior Sister	With immediate effect	All staff are aware of the issues and have been instructed to remain by the patients when they are using bedpans, but far enough to ensure privacy. Call buzzers to be in easy reach of all patients.
All call buttons on the ward need to be checked to ensure they are in working order. If a call button is not working an alternative method needs to be provided to ensure the patient has a way of calling staff when they need to.	Mary Etchells, Senior sister	With immediate effect	The patient's Named Nurse to ensure that they have call buzzers in easy reach. Matron to check on ward rounds Faulty equipment to be reported to the works department on 5702 and checked daily for completion. Concerns of continued faulty equipment to be escalated to Matron Hughes.

Action Plan developed by: Matron Connie Hughes, January 2015

Action Plan to be reviewed monthly

TERMS OF REFERENCE FOR
OUTER NORTH EAST LONDON
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Establishment of the JHOSC

1. The Outer North East London Joint Health Overview and Scrutiny Committee (the JHOSC) is established by the Overview and Scrutiny Committees having health responsibilities of the London Borough Councils of Barking & Dagenham, Havering, Redbridge and Waltham Forest ("the borough OSCs") in accordance with s.190-191 of the Health and Social Care Act 2012 and consequential amendments and the Local Authority (Overview and Scrutiny Committees Healthy Scrutiny Functions) Regulations 2002.

Membership

2. The JHOSC will consist of three Members appointed of each of the Borough OSCs.

3. In accordance with section 21(9) of the Local Government Act 2000, Executive Members may not be members of an Overview and Scrutiny Committee.

4. The Essex County Council Health Overview and Scrutiny Committee may nominate one full Member for the Joint Health Overview and Scrutiny Committee. Thurrock Borough Council Health Overview and Scrutiny Committee may nominate an observing Member of the Joint Health Overview and Scrutiny Committee. The Councils of the Borough of Brentwood and District of Epping Forest may also each nominate an observing Member.

5. Appointments made to the JHOSC by each participating London borough OSC will reflect the political balance of the borough Council, unless a participating borough OSC agrees to waive the requirement and this is approved by the JHOSC.

Attendance of Substitute Members

6. If a Member is unable to attend a particular meeting, he or she may arrange for another Member of the borough OSC to attend as substitute, provided that a Member having executive responsibilities may not act as a substitute. Notice of substitution shall be given to the clerk before the commencement of the meeting.

Role and Function of the JHOSC

7. The JHOSC shall have the remit to review and scrutinise any matter, including substantial variations, relating to the planning, provision and operation of health services that affect two or more boroughs in Outer North East London. The JHOSC will have the right to respond in its own right to all consultations on such matters, both formal and informal.

8. In fulfilling its defined role, as well as reviewing documentation, the JHOSC will have the right to do any or all of the following:

    a. Request information or to hold direct discussions with appropriate officers from each of the following organisations or their successor bodies:

        Barking and Dagenham Clinical Commissioning Group (CCG)
        Havering CCG
        Redbridge CCG
        Waltham Forest CCG
        NHS England
        North East London Commissioning Support Unit
        Barking, Havering and Redbridge University Hospitals NHS Trust
        Barts Health NHS Trust
        North East London NHS Foundation Trust
        North East London Community Services
        London Ambulance Service NHS Trust

        as well as any other NHS Trust or other body whose actions impact on the residents of two or more Outer North East London Boroughs;

    b. Co-operate with any other Joint Health Overview and Scrutiny Committee or Committees established by two or more other local authorities, whether within or without the Greater London area;

    c. Make reports or recommendations to any of the NHS bodies listed above and expect full, written responses to these;

    d. Require an NHS or relevant officer to attend before it, under regulation 6 of the Regulations, to answer such questions as appear to it to be necessary for the discharge of its functions in connection with a consultation;

    e. Such other functions, ancillary to those listed in a to d above, as the JHOSC considers necessary and appropriate in order to fully perform its role.

    Although efforts will be made to avoid duplication, any work undertaken by the JHOSC does not preclude any individual constituent borough Overview and Scrutiny Committee from undertaking work on the same or similar subjects

Co-optees

9. The JHOSC shall be entitled to co-opt any non-voting person as it thinks fit or appropriate to assist in its debate on any relevant topic. Each borough Healthwatch organisation for Barking & Dagenham, Havering, Redbridge and Waltham Forest shall be entitled to nominate one co-opted (non-voting) member of the JHOSC.The power to co-opt shall also be available to any Working Groups formed by the JHOSC.

Formation of Working Groups

10. The JHOSC may form such Working Groups of its membership as it may think fit to consider any aspect or aspects of its work. The role of such Groups will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the JHOSC. The precise terms of reference and procedural rules of operation of any such Groups (including number of members, chairmanship, frequency of meetings, quorum etc) will be considered by the JHOSC at the time of the establishment of each such Group; these may differ in each case if the JHOSC considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business from which the press and public could legitimately be excluded under the Access to Information legislation.

Meetings of the JHOSC

11. The JHOSC shall meet formally at such times, at such places and on such dates as may be mutually agreed, provided that five clear days' notice is given of the meeting. The Committee may also meet informally as and when necessary for purposes including, but not limited to, visiting appropriate sites within the boroughs or elsewhere.

12. Meeting venues will normally rotate between the four Outer North East London boroughs.

13. Meetings shall be open to the public and press in accordance with the Access to Information requirements. No tape or video recorders, transmitters, microphones, cameras or any other video recording equipment shall be brought into or operated by any person at a meeting of the JHOSC unless the Chair of the meeting gives permission before the meeting (this exclusion will not apply to the taping of the proceedings by officers responsible for producing the minutes). When permission is given, a copy of any tape made must be supplied to the London Borough of Havering, in its role as Administrator.

Attendance at Meetings

14. Where any NHS officer is required to attend the JHOSC, the officer shall be given reasonable notice in advance of the meeting at which he/she is required to attend. The notice will state the nature of the item on which he/she is required to attend to give account and whether any papers are required to be produced for the JHOSC. Where the account to be given to the JHOSC will require the production of a report, then the officer concerned will be given reasonable notice to allow for preparation of that documentation.

15. Where, in exceptional circumstances, the officer is unable to attend on the required date, and is unable to provide a substitute acceptable to the JHOSC, the JHOSC shall in consultation with the officer arrange an alternative date for attendance.

16. The JHOSC and any Working Group formed by the JHOSC may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

17. The JHOSC shall permit a representative of any other authority or organisation to attend meetings as an observer.

Quorum

18. The quorum for the JHOSC shall be four, provided there is present at least one Member from at least three of the London borough OSCs. For meetings involving the writing or agreeing of a final report of the Committee, the quorum shall comprise at least one representative from each of the four London borough OSCs.

Chair and Vice Chair

19. Each meeting will be chaired by a Member from the host borough on that occasion.

Agenda items

20. Any member of the JHOSC shall be entitled to give notice to the Clerk of the Joint Committee that he/she wishes an item relevant to the functions of the JHOSC to be included on the agenda for the next available meeting. On receipt of such a request (which shall be made not less than five clear working days before the date for despatch of the agenda) the relevant officer will ensure that it is included on the next available agenda.

Notice and Summons to Meetings

21. The Clerk of the Joint Committee will give notice of meetings to all members. At least five clear working days before a meeting the relevant officer will send an agenda to every member specifying the date, time and place of each meeting and the business to be transacted, and this will be accompanied by such reports as are available.

22. Any such notice may be given validity by e-mail.

23. The proper officer of each Council shall ensure that public notice of the meeting is displayed in accordance with the customary arrangements of that Council for giving notice of Committee etc. meetings.

Reports from the JHOSC

24. Once it has formed recommendations the JHOSC will prepare a formal report and submit it to the relevant bodies. In accordance with the Department of Health Guidance on the Overview and Scrutiny of Health dated July 2003, the JHOSC should aim to produce a report representing a consensus of the views of its members. If consensus is not reached within the JHOSC, minority views will be included in the report.

25. In undertaking its role the JHOSC should do this from the perspective of all those affected or potentially affected by any particular proposal, plan, decision or other action under consideration.

Formal Consultations and Referrals to Secretary of State

26. Under guidance on Local Authority Health Scrutiny issued by the Department of Health in June 2014, only the JHOSC may respond to a formal consultation on substantial variation proposals covering health services in more than one constituent Council area. This power also extends to the provision of information or the requirement of relevant NHS officers to attend before the JHOSC in connection with the consultation.

27. The JHOSC may only refer matters directly to the Secretary of State on behalf of Councils who have formally agreed to delegate this power to it.

Procedure at JHOSC meetings

28. The JHOSC shall consider the following items of business:

(a) minutes of the last meeting;
(b) matters arising;
(c) declarations of interest;
(d) any urgent item of business which is not included on an agenda but the Chair, after consultation with the relevant officer, agrees should be raised;
(e) the business otherwise set out on the agenda for the meeting.

Conduct of Meetings

29. The conduct of JHOSC meetings shall be regulated by the Chair (or other person chairing the meeting) in accordance with the general principles and conventions which apply to the conduct of local authority committee meetings.

30. In particular, however, where any person other than a full or co-opted member of the JHOSC has been allowed or invited to address the meeting the Chair (or other person chairing the meeting) may specify a time limit for their contribution, in advance of its commencement which shall not be less than five minutes. If someone making such a contribution exceeds the time limit given the Chair (or other person chairing the meeting) may stop him or her.

31. The Chair (or other person chairing the meeting) may also structure a discussion and limit the time allowed for questioning by members of the JHOSC.

Officer Administration of the JHOSC

32. The London Borough of Havering will be the Lead Authority for clerking and administering the JHOSC. The Clerk of the Committee will be the Principal Committee Officer, London Borough of Havering. Costs of supporting the JHOSC will be shared, in proportion to their representation on the Committee, by the London Boroughs of Barking and Dagenham, Havering, Redbridge, Waltham Forest and by Essex County Council, in cash or in kind.

Voting

33. Members may request a formal vote on any agenda item by informing the Clerk of the Joint Committee at least five working days before a meeting. If it is not possible to give this notice, Members have the right to request a vote at a meeting itself, provided they explain to the meeting why it has not been possible to give the standard notice of this request. The decision on whether to allow a vote, if the standard notice has not been given, will rest with the Chairman of that meeting.

34. Any matter will be decided by a simple majority of those members voting and present in the room at the time the motion was put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote. Co-opted members will not have a vote.

Public and Press

35. All meetings of the JHOSC shall be open to the public and press unless an appropriate resolution is passed in accordance with the provisions of Schedule 17 of the National Health Service Act 2006.

36. All agendas and papers considered by the JHOSC shall be made available for inspection at all the constituent authority offices, libraries and web sites.

Code of Conduct

37. Members of the JHOSC must comply with the Code of Conduct or equivalent applicable to Councillors of each constituent Local Authority.

General

38. These terms of reference incorporate and supersede all previous terms of reference pertaining to the JHOSC.