# MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
**Havering Town Hall**
**26 January 2017 (7.00 - 8.40 pm)**

**Present:**

Councillors Dilip Patel (Vice-Chair), Denis O'Flynn, Alex Donald, Carol Smith and June Alexander

Dr Susan Milner, Interim Director of Public Health
Barbara Nicholls, Director of Adult Services
Carol White, Integrated Care Director – Havering Integrated Care Directorate, North East London NHS Foundation Trust (NELFT)
Sarah Tedford, Chief Operating Officer, Barking, Having and Redbridge University Hospitals' NHS Trust (BHRUT)
Dr Remi Odejinmi, Divisional Director for Anaesthetics, BHRUT

## 25 ANNOUNCEMENTS

The Chairman gave details of the arrangements in case of fire or other event that might require the evacuation of the meeting room or building.

## 26 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

Apologies were received from Councillor Michael White.

## 27 DISCLOSURES OF INTERESTS

There were no disclosures of interest.

## 28 MINUTES

The minutes of the meeting of the Sub-Committee held on 26 October 2016 were agreed as a correct record and signed by the Chairman.

## 29 HEALTH SERVICE WINTER PRESSURES

BHRUT had recently seen a marked increase in patients presenting at the Emergency Department (ED). The winter peak period had begun in November 2016 and was still ongoing. The department saw up to 550 patients per day and the lack of a substantive workforce in the ED was also a problem. A lot of bank and agency staff were used in the ED which was a financial pressure for the Trust.

More patients with respiratory problems were seen during cold weather although the Trust had not seen any Major outbreaks of Influenza or the Norovirus as yet.

Other impacts on the Trust of winter conditions included icy conditions leading to an increase of fractures etc, potential problems with electricity and gas supplies and schools closing due to snow which impacted on nursing staff etc with families. This meant it was important to communicate effectively with the public in order to direct them to the most appropriate place for their care.

Staffing across both hospital sites was reviewed three times a day and staff were moved between sites if necessary. There was 24:7 consultant cover at Queens ED and this was available four days per week at King George. Conference calls were also held on a daily basis with health and social care partners to discuss how pressures could be alleviated. Across the Christmas period, these conference calls were held on a London-wide basis.

The most challenging weeks for the Hospitals' Trust had been 2-8 January where additional beds had been opened in the community and it was felt that all organisations involved has worked well together over this period. Most ambulance patients were now handed over to a clinical member of staff in the ED within 30 minutes. The winter pressures work undertaken by BHRUT had recently received praise in the Health Service Journal.

Compared to two years ago, there had been a 23% rise in the number of patients attending the ED and a 19% rise in the numbers arriving by ambulance. Fewer patients were however being admitted to hospital via the ED. The rise in ED patients was due to a range of reasons including a lack of GP appointments in some cases and in others, people having seen their GP and wanting a second opinion. Other sections of the diverse population locally were unused to the GP system.

A redirection process had been established as many people who arrived in the ED could be more effectively treated in a pharmacist, walk-in centre or could wait to see their GP. This had allowed around 120 patients per day to be redirected from the ED, approximately 25% of the total. Details of the NHS 111 service were also given to patients attending the ED but officers agreed that consideration also needed to be given to how the NHS 111 service worked.

The redirection service did not run overnight and during this period all patients were assessed in the ED with the sickest patients treated first. There was normally only one ED consultant available overnight and it was therefore necessary to manage demand in this way.

The Sub-Committee **NOTED** the position.

## 30 HEALTH TOURISM

BHRUT officers explained that there was a legal obligation on Health Trusts to establish if a patient was an overseas visitor. As of April 2016, BHRUT was owed a total of £2.5 million for treatment of non-UK residents. In the succeeding six months, some 487 BHRUT patients had been identified as not eligible for free NHS care. Paperwork to identify these patients was distributed in each of outpatients, the ED and the ante-natal department. Officers would forward an example of the forms used.

These patients were seen by the Trust's overseas team and would be billed if they were not eligible for free care. It was accepted however that it became difficult for the Trust to obtain payment once the patient had left hospital. Many overseas patients did not have credit cards and it was also difficult for doctors or nurses to ask patients for their payment details. Officers felt that, to ask for payment details whilst a patient was in the ED would take time away from the clinical teams. National Insurance numbers were not asked for from patients as this would cause too much administration for the Trust. If possible, treatment would not be given until payment had been made and the Trust also passed relevant details to the Home Office.

Approximately £400,000 of the charges for overseas treatment had been recovered by the Trust but the Clinical Commissioning Groups underwrote around half the £2.5 million total figure. Under the Trust's improvement plan, overseas patients would be asked to pay a deposit for elective care prior to treatment. The Trust did take the issue of health tourism seriously but officers accepted that it was very difficult for BHRUT to recover this money. There had not been a major increase noted in the numbers of health tourists in either hospital or community services.

The Sub-Committee **NOTED** the update.

## 31 JSNA ANNUAL REPORT

The Interim Director of Public Health explained that the Joint Strategic Needs Assessment (JSNA) was the statutory responsibility of the Health and Wellbeing Board but that Council Leads and the Clinical Commissioning Group (CCG) were also obliged to input into the document. The JSNA allowed members of the Health and Wellbeing Board to understand the health needs of the local population.

Core products of the JSNA included the quarterly 'This is Havering' document which gave a breakdown of the Havering population and an annual overview of Health and Social Care needs in the borough. Interactive ward health profiles were also now produced. Other in depth work included the obesity needs assessment and work to develop the business case for

the Accountable Care Organisation. Borough level profiles were also produced in an accessible format covering areas such as cardio-vascular disease, smoking etc.

In addition to the existing work, locality profiles would be established under the JSNA in the coming year and the Pharmaceutical Needs Assessment – a legal requirement for the Council, would also be rewritten. The Needs Assessment was mainly used by NHS England to control the entry of new pharmacists into the local market and guidance was currently awaited on this.

It was clarified that pharmacists were paid by the NHS. It was possible that the number of community pharmacists could reduce but it was also planned to expand the role of pharmacies. Officers explained that pharmacists wished to stay in High Street locations but there were not currently any Council funds available to commission further services from pharmacists. Services such as blood tests in pharmacies would need to be commissioned by the CCG but the logistics of collecting blood samples may make this difficult.

Most targets for flu jabs had been met and officers would provide current figures. Flu levels in Havering were monitored and were low currently.

It was confirmed that the Stop Smoking service had been decommissioned although the service for pregnant women had been recommissioned. There had however been a low take up for this. The service was advertised in maternity services.

## 32 ACCOUNTABLE CARE ORGANISATION

The Director of Adult Services explained that the Accountable Care Organisation was now called the Integrated Care Partnership (ICP) and agreed that progress on this work had slowed recently. Officers were however now working more closely with patients themselves.

Borough Health and Wellbeing Boards had oversight of the ICP and the ICP Partnership Board was chaired by the relevant Lead Member from Barking & Dagenham. Havering's Leader and Lead Member also attended the Partnership Board as did Chief Executives and Chairs of the Councils, CCGs and providers involved.

Consideration was currently being given to which areas the ICP would look at first. The ICP Board also had representation on the board of the Sustainability and Transformation Plan for North East London which covered seven CCGs and 8 Local Authorities across the sector. It was suggested that an update on governance of the Sustainability and Transformation Plan could be given at a future meeting of the Sub-Committee.

Locality models were being developed as part of the ICP work. The areas of the three localities for Havering were almost confirmed and the localities would be population based as research had shown that the best health outcomes were seen with localities of 70-90,000 population size. Areas such as Romford or Rainham where there were likely to be considerable rises in population had also been mapped as part of this work.

The key priorities for locality models were children's health, referral to treatment issues and urgent care pathways. A recent workshop on the locality models had been held successfully with representation from GPs, other clinicians and a urology consultant from BHRUT. An officer from NELFT added that it was wished to have discussions with people at any contact point, not just health and social care. Contacts promoting health could therefore take place in housing offices, libraries, leisure centres etc. A client with for example difficulties paying their rent could well have issues with anxiety and could therefore be referred from the housing service direct to talking therapies available in the locality. This would represent better value for public money.

The ICP also aimed to make services more efficient and to avoid any repetition between health and social care. The Havering Locality Design Group included representatives from Healthwatch, the Local Pharmaceutical Committee, the voluntary sector as well as the Council's Directors of Adults and Children's Services. A workshop with the community and voluntary sector was also planned for March 2017.

The locality model had been designed in conjunction with staff and patients and would be a small programme initially. The ICP wished to improve self-care as many people did not need any other support in order to stay healthy. More intensive interventions would be as planned as possible under the new model.

The Locality Design Group would continue to meet fortnightly until April to develop the proposals and engagement would also continue with key stakeholders including the Local Medical Committee and the community & voluntary sector.

Members welcomed the proposals, feeling that early intervention was the best policy for improving local health outcomes. It was confirmed that GPs were involved in the design of the model although there remained workforce issues with many GPs approaching retirement age. The role of community pharmacies also needed to be determined.

Officers felt that there was now more appetite from GPs to look at how they could work differently. The Director of NELFT added that there were variations in how people accessed health services across the UK. In London, GPs had been somewhat deskilled and other areas such as hospitals had been overskilled. There was an image that a hospital was the best place for health care but this was not necessarily the case.

The Sub-Committee **NOTED** the position.

## 33 CARE BEDS POLICY

The Director of Adult Services confirmed that the Council would pay care home fees for the first four weeks of a resident's hospital stay. Beyond this period, 60% of fees would be paid for by the Council. The social work process would be used to ascertain how long beyond the four weeks fees would continue to be paid.

The maximum fees the Council would pay per week for a patient in a residential home had a lower rate of £471.51 with a nursing higher rate of £528.21. Fees for dementia care ranged £518.60 to £545.46 and all fees paid were currently under review.

## 34 CORPORATE PERFORMANCE INFORMATION (Q3)

Performance had improved on the successful completion of drug treatments target and the new provider was now working with commissioners.

It was suggested that a performance report for the public health service plan could be taken as an agenda item for the next meeting of the Sub-Committee. Information on Delayed Transfers of Care that had recently been presented at the Individuals Sub-Committee could also be brought to this Sub-Committee.

## 35 URGENT BUSINESS

There was no urgent business raised. The next meeting of the Sub-Committee was scheduled for Wednesday 19 April at 7 pm in the town hall.

**Chairman**