MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Council Chamber - Havering Town Hall
18 October 2016 (4.00 - 6.25 pm)

Present:

COUNCILLORS

London Borough of Barking & Dagenham	Jane Jones
London Borough of Havering	Dilip Patel and Michael White (Chairman)
London Borough of Redbridge	Stuart Bellwood, Suzanne Nolan and Dev Sharma
London Borough of Waltham Forest	Richard Sweden
Essex County Council	
Epping Forest District Council	Gagan Mohindra
Co-opted Members	Ian Buckmaster, Healthwatch Havering Cathy Turland, Healthwatch Havering Richard Vann, Healthwatch Barking & Dagenham
NHS Officers	Caroline O'Donnell, North East London NHS Foundation Trust (NELFT) Jacqui van Rossum, NELFT Sarah See, Havering Clinical Commissioning Group
Scrutiny Officers	Masuma Ahmed, Barking & Dagenham Anthony Clements, Havering (Clerk to the Committee) Jilly Szymanski, Redbridge

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

11 CHAIRMAN'S ANNOUNCEMENTS

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

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

Apologies were received from Councillors Peter Chand and Linda Zanitchkhah (Barking & Dagenham) June Alexander (Havering) Tim James (Waltham Forest) and Chris Pond (Essex).

Apologies were also received from Mike New, Healthwatch Redbridge (Cathy Turland substituting) and James Holden, Waltham Forest.

13 **DISCLOSURE OF INTERESTS**

Councillor Sweden disclosed a personal interest in agenda item 7 (North East London NHS Foundation Trust) as he was managed, though not employed by, that Trust.

14 **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting of the Joint Committee held on 12 July 2016 were agreed as a correct record and signed by the Chairman.

15 **PROVISIONAL ITEM: GREAT ORMOND STREET HOSPITAL**

The Clerk to the Committee advised that the Great Ormond Hospital for Children NHS Foundation Trust had offered apologies that a representative had been unable to attend the meeting and that the Trust had requested to attend the next meeting of the Committee.

It was **AGREED** that this item be deferred to the next meeting of the Committee.

16 **WHIPPS CROSS HOSPITAL CARE QUALITY COMMISSION INSPECTION**

The Committee considered the following statement that had been received from Barts Health NHS Trust:

The CQC visited Barts Health at the end of July 2016. They inspected The Royal London Hospital and Whipps Cross University Hospital. The Trust is expecting the reports to be published in the coming weeks although as yet no specific date has been set.

The trust is very keen to update the committee at its next meeting, by which point it is likely that the reports will have been published. This will enable the trust to update the committee thoroughly on its response to the CQC's findings and its next steps. In the meantime, the trust is working to deliver its ambitious improvement plan, published at its annual general meeting in September. The Committee was sent the plan in September and it is available to read at

http://bartshealth.nhs.uk/media/346990/bh6016_safe_and_compassionate2_v6_lr.pdf

It was **AGREED** to defer this item to the next meeting of the Committee.

17 NORTH EAST LONDON NHS FOUNDATION TRUST

North East London NHS Foundation Trust (NELFT) officers explained that the Trust supplied community health and mental health services across Outer North East London and Essex. A portfolio brief summarising the services provided by NELFT could be supplied to the Committee.

The report of the recent inspection of NELFT by the Care Quality Commission (CQC) had been shared with the Trust who had given back to the CQC considerable information around the factual accuracy of the report. The CQC had not however altered the final report which had given the Trust an overall rating of 'requires improvement'.

It was noted that only one psychiatrist had been present on the CQC inspection team. The CQC had visited 62 NELFT wards, teams and clinics and spoken with a total of 265 patients and service users. All boroughs covered by NELFT were inspected.

Officers accepted that there was a nursing shortage at the Trust although this was also a major issue nationally. There were approximately 800 nursing vacancies across the Trust which led to a reliance on the use of agency and bank staff.

The CQC had found that NELFT did not have systems in place for referral times but officers rejected the finding that there were significant waiting times for the district nursing service.

Due to concerns raised by the CQC, NELFT had taken the decision to temporarily close the Brookside adolescent unit. Many problems at the unit were due to staffing issues where a 54% vacancy rate had led to a lot of reliance on agency staff. The CQC had found that the unit wasn't sufficiently clean but officers indicated this was due to a lot of estates work being undertaken at the time of the inspection. Comments by the CQC that the unit was overly restrictive were accepted by the Trust.

Concerns had been raised by the CQC over the number of ligature points (which could potentially be used as a means of strangulation) in the unit but this was being addressed by NELFT to ensure such areas had sloping surfaces etc. It had also been found that care plans should more fully reflect patients' personal preferences. The CQC had found that NELFT had a strong governance structure but had also concluded that the fit and proper person test for directors was not being met in all cases. Officers felt that this was due to a small number of out of date Disclosure and Barring service checks and this was being addressed via the Trust's internal auditors.

Officers were disappointed that the CQC report had not highlighted areas of good practice by NELFT although this had been picked up in the recent Quality Summit where areas such as the good systems in place for safeguarding had been praised by chief nurses for several local Clinical Commissioning Groups. The review had not covered end of life care or community dental services and it was noted that any rating of 'requires improvement' would result in an overall rating of this for the Trust, even though other Trust areas had received the highest 'good' rating.

Officers accepted that the Trust had a lot of work to do and would share the Trust's action plan once it had been approved by the Board. It was expected that the CQC would revisit the Trust prior to the end of 2016 in order to see if the situation had improved.

It was emphasised that the Trust's overall vision remained unchanged and that the Trust would not be complacent or seek to deny the contents of the report.

The decision to close the Brookside unit had been taken internally by the Trust and the Trust was seeking to use a crisis response service more than in-patient settings. The unit had also been extensively refurbished during the closure period and now offered a very different environment with 11 female and 4 male beds. There was also a dedicated parents' wing to allow family support on site. In-patients had their own fobs to allow access to authorised parts of the unit and hence did not need to be escorted. The unit was also now completely open plan.

There were a number of NELFT services which had exhibited good practice. Dementia services in Essex had been nominated for a Health Service Journal award and the CQC had praised the caring attitude displayed by staff. Post-bereavement services run by the Trust had also been praised by the CQC. Officers accepted that more skilled staff needed to be recruited and retained and that the Trust needed to improve its learning from complaints and serious incidents.

Other successes achieved by NELFT included the Trust's acute mental health care pathway being nationally recognised and all NELFT community dementia services being accredited by the Royal College. Work to integrate health and social care in Redbridge was also cited as a success.

Questions and discussion

NELFT officers felt that there were some inaccuracies in the CQC report and that inspectors had misunderstood the process notes but it had been decided not to issue a legal challenge against the report. NELFT had challenged the CQC warning letter re the Brookside unit but the CQC had not accepted this. The refurbished unit had reopened on 29 September.

The service model redesign was staff-led with more emphasis on supporting people in their own homes. Focus groups had been conducted with Brookside service users and their parents.

It was accepted that the NELFT recruitment process had previously been too long and bureaucratic and this had now been streamlined. Training and development opportunities had been promoted in order to seek to increase recruitment but the Trust would not offer 'golden handcuffs' or guaranteed promotions as seen at other Trusts. Exit interviews were also now held to ascertain the reasons people were leaving.

Some 25 nurses had recently been recruited from Ireland and recruitment in areas such as Manchester was taking place in conjunction with other providers. Further international recruitment was also an option though again, this would be in partnership with other Trusts. The NELFT Chief Nurse was also developing training opportunities with the BHRUT Acute Trust. NELFT had also recently been accepted as a national pilot for the Associate Nurse scheme.

As regards commercial strategy, the Trust would continue to look for new business but only if it was felt this complemented NELFT's existing work and would add value to the organisation. It was clarified that the forensic ward at Goodmayes Hospital – Morris ward had received an 'outstanding' rating from the CQC and was commissioned by NHS England.

Excessive use of restraint was being addressed by the new model of care at NELFT which would see more care delivered at home. Information on the numbers and training of therapists at NELFT could be provided. The transformation of the acute care pathway at NELFT, including access teams for initial referral, had led to a reduction in suicide rates.

A lot of work was in progress regarding the Sustainability and Transformation Plan (STP) but NELFT remained a Foundation Trust with an accountable Board. It was agreed that the local Health Economy needed to be sustainable and NELFT was a part of the STP but services were also, as required by law, continuing to be put out to tender.

18 GP PMS CONTRACT

The CCG officer explained that the Personal Medical Services (PMS) contract for GPs was a locally negotiated agreement supported by national regulations. A review of these contracts led by NHS England had begun in September 2015 and had led to the establishing of a London Offer. The London Local Medical Committee (LMC) had been involved in negotiations and the core contract would be the same as that for existing GP services. There would however also be mandatory performance indicators covering areas such as cervical screening and two optional indicators relating to patient response issues.

There was also a premium offer including supplementary payments covering weekend opening and IT services for patients. The new contract had been provisionally agreed but had been paused since April 2016.

Locally, it was proposed to also commission extra GP capacity as part of the contract with the aim of offering 100 appointments per 1,000 GP patients per week. The proposals had now been put by the London LMC to NHS England but no outcomes had been received as yet. The national review of PMS contracts was due to complete by March 2017 and the officer accepted that it would be difficult to complete local negotiations by this date.

It was expected that the responsibility to complete negotiations would be formally handed to CCGs but this had not happened yet. Officers were however happy to discuss the contract with local interested parties.

It was clarified that PMS contract monies were also used by GPs to pay practice members of staff. There was no ratio set for GPs between urban and rural areas. The national standard was one GP for every 1,865 patients. In Redbridge for example, the figure was 1:2,285 meaning a gap of 27 Whole Time Equivalent GPs.

Some GP work could be covered by practice nurses but it was also the case that there was a shortage of clinical staff. This was a national problem as was the rising numbers of younger GPs wishing to leave the NHS. The new PMS contract aimed to give better value for money for commissioners of GP practices.

19 **HEALTHWATCH REDBRIDGE - ACCESSIBLE INFORMATION STANDARDS**

The chief executive of Healthwatch Redbridge explained that accessible information standards had been designed to provide consistent communication support for disabled people and their carers. The standards did not however cover foreign language support needs.

All NHS Trusts and contract providers were covered by the standards as were CCGs and Local Authorities. The standards had a legal basis in the Equality Act 2010, Care Act 2014 and the NHS Constitution. It was therefore mandatory from August 2016 for NHS providers to give information in an understandable way.

The standards covered all service user groups with disabilities or communication difficulties. It was noted that approximately one million NHS appointments had been missed in the last year due to communication difficulties. These were due to a variety of reasons such as patients not hearing their names called in waiting rooms or people with visual impairments not being able to read appointment letters. Some 28% of people with hearing loss had been left uncertain about their diagnosis and 14% had missed hearing their names being called in waiting rooms.

Support that could be given included the use of sign language, visual clues and a texting service but Healthwatch Redbridge had found a lack of working hearing loops in health settings. Support that the NHS could give to patients with visual impairments included more material being available in large print and the use of voice PC software. Advocacy and accessible information for people with learning disabilities should also be encouraged.

Both Healthwatch and the CQC had roles in enforcing this area which was now mandatory for health organisations to provide. It was also open to the Committee and its borough equivalents to scrutinise the provision of accessible information in the local NHS.

Healthwatch Redbridge had completed a programme of work on this area that included visits to all Redbridge GPs, Queens and Whipps Cross Hospitals and several local care homes. A workshop for GPs had also been arranged and a report covering this was available. Stakeholder conferences and a workshop for care homes had also been arranged.

20 HEALTHWATCH HAVERING - DELAYS TO TREATMENT REVIEW

A director of Healthwatch Havering explained that the organisation was working on a joint review with Havering's Health Overview and Scrutiny Sub-Committee of the reasons for the large number of 'lost' appointments and subsequent delays to treatment. Briefing sessions and formal meetings had been held with senior officers from both BHRUT and Havering CCG and the group was now seeking to establish the impact of the delays on Council services.

Havering CCG had received formal legal directions from NHS England to resolve the appointments issue and it was planned to complete the review by early 2017. The final topic group report would be brought to the Joint Committee for consideration.

21 FUTURE MEETING DATES AND START TIMES

It was noted that future meetings of the Joint Committee were scheduled as follows:

Tuesday 17 January (Redbridge)
Tuesday 18 April (Waltham Forest)

It was agreed that the Clerk to the Committee should write to all Members seeking their views on the most convenient start times for meetings.

22 URGENT BUSINESS

There was no urgent business raised.

Chairman