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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
AGENDA

7.00 pm	Wednesday 28 June 2017	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative (3)	Residents' (1)	East Havering Residents'(1)	Labour 1
Michael White (Chairman) Dilip Patel (Vice-Chair) Carol Smith	Nic Dodin	Alex Donald	Denis O'Flynn

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

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.

What is Overview & Scrutiny?

Each local authority is required by law to establish an overview and scrutiny function to support and scrutinise the Council's executive arrangements. Each overview and scrutiny sub-committee has its own remit as set out in the terms of reference but they each meet to consider issues of local importance.

The sub-committees have a number of key roles:

1. Providing a critical friend challenge to policy and decision makers.

2. Driving improvement in public services.

3. Holding key local partners to account.

4. Enabling the voice and concerns to the public.

The sub-committees consider issues by receiving information from, and questioning, Cabinet Members, officers and external partners to develop an understanding of proposals, policy and practices. They can then develop recommendations that they believe will improve performance, or as a response to public consultations. These are considered by the Overview and Scrutiny Board and if approved, submitted for a response to Council, Cabinet and other relevant bodies.

Sub-Committees will often establish Topic Groups to examine specific areas in much greater detail. These groups consist of a number of Members and the review period can last for

anything from a few weeks to a year or more to allow the Members to comprehensively examine an issue through interviewing expert witnesses, conducting research or undertaking site visits. Once the topic group has finished its work it will send a report to the Sub-Committee that created it and will often suggest recommendations for the Overview and Scrutiny Board to pass to the Council's Executive.

Terms of Reference:

Scrutiny of NHS Bodies under the Council's Health Scrutiny function

AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – receive.

3 DISCLOSURE OF INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 6)

To agree as a correct record the minutes of the meeting held on 19 April 2017 (attached) and to authorise the Chairman to sign them.

5 DELAYED REFERRALS TO TREATMENT - JOINT TOPIC GROUP REPORT OF HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE AND HEALTHWATCH HAVERING (Pages 7 - 26)

Report of joint topic group with Healthwatch Havering attached.

6 HEALTHWATCH REPORTS (Pages 27 - 64)

Reports by Healthwatch Havering attached.

7 ANNUAL REPORT OF SUB-COMMITTEE 2016-17 (Pages 65 - 72)

Report attached.

8 NOMINATIONS TO JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEES (Pages 73 - 76)

Report attached.

9 SUB-COMMITTEE'S WORK PLAN 2017-18 (Pages 77 - 80)

Report attached.

10 URGENT BUSINESS

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

Andrew Beesley
Head of Democratic Services

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
19 April 2017 (7.00 - 8.20 pm)

Present:

Councilllors Dilip Patel (Vice-Chair), Carol Smith, June Alexander and Linda Van den Hende. The meeting was chaired by Councillor Patel.

Also present:

Barbara Nicholls, Head of Adult Services,
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Andrew Rixom, Consultant in Public Health
Natalie Keefe, Director of Primary Care Transformation, Barking & Dagenham, Havering and Redbridge CCGs
Hannah Murdoch, Communications and Engagement Manager, BHR Clinical Commissioning Groups

36 **ANNOUNCEMENTS**

The Chairman gave details of the arrangements to be followed in the event of fire or other event that may require the evacuation of the meeting room.

37 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

Apologies were received from Councillor Michael White and from Councillor Alex Donald (Councillor Linda Van den Hende substituting).

Apologies were also received from Mark Ansell – Interim Director of Public Health (Andrew Rixom substituting).

38 **DISCLOSURE OF INTERESTS**

There were no declarations of interest.

39 **MINUTES**

The minutes of the meeting held on 26 January 2017 were agreed as a correct record and signed by the Chairman.

40 PMS REVIEW AND PRIMARY CARE UPDATE

Officers explained that the review of the Primary Medical Services (PMS) contracts held by some GP practices had now resumed with only a local rather than London-wide offer to be negotiated. The review aimed to ensure that all patients could expect to receive the same level of care from their GP.

Of 44 GP practices in Havering, 12 operated under a PMS contract. This allowed a total additional investment of around £1 million although this was the third lowest premium in London. The overall contract value would increase by £7.3 million over the next five years due to a combination of population growth and other cost pressures.

The CCG was looking at the transition costs of a new contract with a lower premium. Overall primary care investment was also being looked at as were economy wide solutions where possible. The new contracts were required to be agreed by the start of October 2017.

Any Havering practices that had been rated by the Care Quality Commission (CQC) as 'requires improvement' would be offered additional support. The CCG had also now developed policy and procedure templates for GP practices. Mandatory on line training was also supplied for practice staff in areas such as complaints, health and safety and infection control.

Whilst all Havering GP practices had now been inspected by the CQC, not all the inspection reports had been published as yet. Practices would be supported to develop an action plan based on the relevant CQC findings. It was confirmed that a CQC inspection did assess the quality of the relationship between a GP and patients by speaking to patient representatives.

There were three GP networks now established covering the north, central and southern parts of the borough and network leads had now been recruited.

The Sub-Committee NOTED the position.

41 ICP AND LOCALITIES MODEL

The Integrated Care Partnership (ICP) sought to address issues such as population growth, quality of service and financial issues. The ICP also aimed to allow more decision making to take place at a local level and ensure services were delivered in a more integrated, joined up way. This would avoid instances of, for example, patients having to give their details more than once during their care pathway.

It was accepted that recruitment and retention was a challenge for all partners involved. There was also a significant financial challenge facing the health economy, meaning it was important to encourage people to self-care

where possible. The Partnership sought to join up services offered by the Council, Hospitals' Trust and community service providers but the role of the community and voluntary sector also needed to be considered.

The localities would have a population of around 80,000 each and a locality design group included a broad range of stakeholders such as the Council, Havering CCG and Healthwatch. Stakeholders were keen that people should be involved in this different way of delivering services.

The north locality would focus on children's services initially whilst the central area would investigate how delays in referral to treatment could be avoided and the southern locality would consider access to urgent and emergency care. The work on children's services would focus on emotional health and wellbeing. The difficulties sometimes experienced in accessing child and adolescent mental health services would also be considered. It was planned for example for GPs to work with families and schools to arrange access to counselling. Referral to more formal mental health services would only be made at a later stage, if necessary.

Urgent and emergency care work would be linked to the intermediate care offer. It was aimed to divert people from attending A&E and to ensure that people spent as little time in hospital as possible. In order to improve outcomes, it was preferable to support people to stay at home.

For intermediate care, an integrated rehabilitation and reablement service had recently been launched and officers hoped the benefits of this would be seen within six months. It was hoped that this service would reduce duplication and hence benefit residents.

A joint commissioning board would be established across the 3 local boroughs and CCGs. A system programme delivery board would look at the CCG deficits and how to reduce these. It was emphasised that the localities work also involved other Council functions such as housing, benefits advice and careers advice.

The number of care visits in a person's home depended on their assessment. This could be as many as 4 visits a day when a person was first discharged from hospital. Homecare was currently monitored via a swipe card system and the new service would also have a full monitoring mechanism for the quality of care.

The operational management of the integrated rehabilitation and reablement service would be undertaken by NELFT. Officers clarified that there were not currently any social workers in the service but this would be kept under review.

The Sub-Committee NOTED the report.

42 PUBLIC HEALTH SERVICE PERFORMANCE REPORT

Officers explained the dashboard showing progress against the current service plan for public health. This covered areas such as stronger partnership work (within the Council and elsewhere) and improving quality and cost effectiveness via for example the recommissioning of the Council's sexual health services. Other developments included the establishment of the Health Protection Forum and more representation of public health on safeguarding groups. The Health Champion programme would also be expanded with the aim of improving health knowledge in the workplace.

Members expressed disappointment that a specific health objective would not be included in licensing applications but officers felt that the licensing policy in Havering was influenced by public health issues.

The strategy for childhood obesity covered the need for more exercise and the role of video games etc.

The Sub-Committee NOTED the performance report.

43 Q4 PERFORMANCE INFORMATION

It was noted that the Council's performance on the proportion of service users successfully completing drug treatments had improved and was currently at 52.3% of users undertaking the treatment.

44 HEALTHWATCH REPORTS

A director of Healthwatch Havering explained that the organisation had increased the number of visits to GP practices over the last year. This had been prompted by problems encountered by the Rosewood Practice. It was noted that, following a successful merger, the situation at Rosewood had improved. This practice would be revisited by Healthwatch shortly.

Over the last year, a total of 13 Practices had been visited by Healthwatch, some as part of a review of the GP hub system. Healthwatch had found that the availability of out of hours GP services was not widely known.

Many GP premises were converted houses which could be problematic and other surgeries shared the same premises but failed to work together. A particular issue noted by Healthwatch was the situation at the Harold Hill Health Centre where 4 GP Practices each operated from the site with a separate reception desk and no evidence of any working together etc. Healthwatch felt therefore that the CCG should do more to encourage practices to work together. A site such as the Harold Hill Health Centre should have been a super-practice rather than housing 4 separate practices.

Healthwatch wished to see fewer physical barriers between GP receptionists and patients. A training package for GP receptionists had been

developed by Healthwatch but this had not seen a good take up. It was acknowledged that GP receptions were also often short staffed.

A GP in the Rainham area had recently been placed into special measures and it was confirmed that the CQC did have the power to close practices where necessary – something that had already happened in Barking & Dagenham and Newham. Around 40% of Havering GPs whose inspection reports had been published had been rated as requires improvement or inadequate which was the highest proportion in London. This was felt to also be a regional problem as similar outcomes were being seen in neighbouring boroughs.

It was unclear how many GPs with lower ratings were single-handed although it was agreed that single-handed GPs often received better patient feedback via the Quality Outcomes Framework. Healthwatch had also noted a lack of GP partners due to the added responsibility of running a practice business. There was now a move towards larger companies operating GP practices.

Healthwatch had visited Maylands Surgery in October 2016 in response to the flash flooding at that site and the long period of time it had taken to make repairs. Healthwatch had therefore recommended that the CCG and the practice should look at resilience plans and that the CCG should also ask all its practices to review their resilience plans. It was emphasised that Healthwatch felt that Maylands had done a good job in difficult circumstances.

Healthwatch had also recently inspected the Mungo Park surgery based at South Hornchurch clinic. It had been found that patients were unable to use the surgery car park as this was taken up by local parents and business parking. The building owners had confirmed they were now looking at introducing parking enforcement for the car park – an improvement that had been suggested by Healthwatch.

45 **URGENT BUSINESS**

There was no urgent business raised.

Chairman

Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY SUB-COMMITTEE, 28 JUNE 2017

Subject Heading:	Delayed Referrals to Treatment – Joint Topic Group report of Health Overview and Scrutiny Sub-Committee and Healthwatch Havering
CMT Lead:	Daniel Fenwick
Report Author and contact details:	**Anthony Clements, 01708 433065, Anthony.clements@onesource.co.uk and Ian Buckmaster, 01708 303300 ian.buckmaster@healthwatchavering.co.uk**
Policy context:	**The information presented details a scrutiny review of local health services**
Financial summary:	**No financial implications of the report itself for either the Council or Healthwatch Havering.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

The attached report on Delayed Referrals to Treatment details the outcomes and recommendation of a joint scrutiny review between the Sub-Committee and Healthwatch Havering. The Sub-Committee is asked to approve the report and agree that the recommendations in the report should be referred to the relevant NHS organisation(s) for response.

RECOMMENDATIONS

1. That the Sub-Committee approves the Joint Topic Group report on Delayed Referrals to Treatment.
2. That the Sub-Committee agrees that the recommendations contained within the report should be referred to the relevant NHS organisation(s) for response.

REPORT DETAIL

Officers will present and summarise the main features of the attached Joint Topic Group report on Delayed Referrals to Treatment.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Delayed Referrals to Treatment

Barking, Havering and Redbridge University Hospitals Trust

January 2016 to March 2017

Trust Headquarters, Queen's Hospital, RM7 0AG

Report of a Review by a Joint Topic Group of the Havering Health Overview & Scrutiny Sub-Committee and Healthwatch Havering

Joint Foreword

Councillor Michael White
Chairman
Health Overview & Scrutiny Sub-Committee

Anne-Marie Dean
Chairman
Healthwatch Havering

The Joint Topic Group was formed to enable Healthwatch volunteer members and Councillors the opportunity to explore the issues, regarding the very significant delays in the care of patient at Queen's Hospital and King George Hospital.

A joint review seemed a sensible way forward, given that the two organisations have complementary statutory powers – Healthwatch has the power to enter and view hospital premises[1], while the Overview and Scrutiny Sub-Committee has the power to hold NHS officials to account[2]. In the event, recourse to those powers was not necessary as all relevant NHS and other agencies co-operated fully in the Review.

Using the values of the NHS as the basis for the review the Joint Topic Group asked a series of individuals and organisations to meet with the Group and respond to the questions and concerns.

The NHS values of

- Accountability – everything done by those who work in the NHS must be able to stand the test of public judgements
- Probity – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark

[1] s225, Local Government and Public Involvement in Health Act, 2007, as amended by s182 of the Health and Social Care Act 2012
[2] s21, Local Government Act 2000, as amended by s244 of the NHS Act 2006

of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired during NHS duties.

- Openness – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

The problem became apparent in December 2013 when BHRUT migrated data from one computer data base to another and this exposed a discrepancy. In February 2014, BHRUT undertook a major investigation to identify the cause of the problem and the number of patients affected. In June 2016, legal directions were issued by NHS England to Havering CCG (lead CCG for BHRUT contract) to develop a robust and credible recovery plan; these legal directions were lifted in February 2017.

In autumn 2015, it became apparent that delays had occurred for a significant number of patients in receiving treatment at Queen's Hospital, Romford and King George Hospital, Chadwell Heath, both run by the Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT).

Healthwatch Havering and members of the London Borough of Havering's Health Overview and Scrutiny Sub-Committee became greatly concerned at this and agreed to carry out a joint review of the circumstances that had led to the delays.

The delays breached the NHS Constitution rights of the affected patients – to treatment within 18 weeks of referral – in some case to a considerable degree; delays more than 12 months were not uncommon.

It was acknowledged that the delays had arisen under previous management of the two hospitals but the current managers bore the responsibility of both eliminating (so far as possible) the backlog of treatments and ensuring that current and recent referrals were not themselves delayed by the clearing of that backlog.

The purpose of the review, and of the consequent report, was not to seek to apportion blame for the delays but to examine why they occurred, to be satisfied that adequate steps had been taken both to ameliorate their effects and to ensure that, so far as possible and practicable, appropriate steps had been taken to avoid their recurrence.

The good news is that BHRUT is now expected to be able to deliver the RTT national standard by the end of September 2017. By the end of March 2017, local GPs had redirected a total of 26,000 patients into alternative services, helping ease pressure on BHRUT waiting lists. The Topic Group is generally supportive of the work undertaken by BHRUT and the CCG to resolve this issue and is also pleased at the enhanced monitoring that has been put in place with, for example, the issue of delayed Referrals to Treatment now being a standing item on the agenda at meetings of the Council's Health and Wellbeing Board.

But the concerns remain that the initial cause of the delay – which could well have been devastating for some of the individuals affected – could recur if a migration of data from one ICT system to another went awry and the contract was not robustly monitored both for performance and quality.

Although it happened long after the issues under examination in this report and when most of them had been resolved satisfactorily, the ransomware attack that affected many NHS and other organisations in mid-May 2017 graphically illustrated the need for robust governance of the use of ICT within health service organisations. It is not just a question of care when migrating data but of ensuring that all risks are identified and addressed robustly and in a timely fashion, that security and other inadvertent vulnerabilities are not allowed to develop to be exploited by those with malicious intent, that all software is kept as up to date as possible and that software and system upgrades are applied without avoidable delay.

Acknowledgements

The Topic Group would like to record its appreciation of the assistance of a wide range of senior NHS staff, as well as Council staff, in response to the review.

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TOPIC GROUP MEMBERS

London Borough of Havering

Councillor Michael White, Chairman, Health Overview and Scrutiny Sub-Committee (from May 2016)

Councillor Dilip Patel, Vice-Chair, Health Overview and Scrutiny Sub-Committee

Councillor June Alexander

Councillor Nic Dodin (until May 2016 – Chairman of Health OSSC)

Councillor Jason Frost (until May 2016)

Councillor Linda Hawthorn

Councillor Linda Van den Hende

Healthwatch Havering

Anne-Marie Dean, Chairman and Executive Director

Ian Buckmaster, Executive Director and Company Secretary

Hemant Patel, Non-executive Director

Volunteer Members:

Mary Bell

Carol Dennis

Jenny Gregory

Emma Lexton

Kathleen Meddeman

Diane Meid

Dianne Old

Valerie Perry

Jennifer Smith

WITNESSES WHO APPEARED BEFORE THE TOPIC GROUP

Maureen Blunden, Head of Patient Administration, BHRUT

Niki Eves, Communications Manager, BHRUT

Andrew Hines, Regional Chief Operation Officer, NHSI

Faisal Mangera, Improvement Team, NHSI

Hazel Melnick, Associate Director Communications and Marketing, BHRUT

Louise Mitchell, Senior Responsible Officer – Planned Care, CCGs

Barbara Nicholls, Director of Adult Services, London Borough of Havering

Steve Russell, Deputy Chief Executive, BHRUT

Sarah Tedford, Chief Operating Officer, BHRUT

Carol White, Integrated Care Director – Havering, NELFT

GLOSSARY OF TERMS AND ACRONYMS

BHR -	The area comprising the London Boroughs of Barking & Dagenham, Havering and Redbridge
BHRUT -	Barking, Havering and Redbridge University Hospitals NHS Trust
CCG(s) –	Clinical Commissioning Group(s)
GP -	General Medical Practitioner (Family Doctor)
ISTC -	Independent Sector Treatment Centre[3]
ICT -	Information and Communications Technology
NELFT –	NELFT NHS Foundation Trust (formerly North East London NHS FT)
NHSI -	NHS Improvement
PAS -	Patient Administration System
RTT -	Referral(s) To Treatment
TDA -	NHS Trust Development Authority

[3] A facility that is part of the NHS but is provided by an independent contractor

FINDINGS

Meeting 1: 6 April 2016, BHRUT

1.1 The Topic Group was pleased at the openness displayed by officers from BHRUT – the NHS Trust responsible for running Queen's and King George Hospitals - when discussing these issues. It was openly admitted that a hospital the size of Queen's would expect a waiting list in the region of 30,000 but this had at one point reached 120,000 (based on unaudited data). By the time of the meeting, this figure had reduced to around 57,000 but BHRUT officers accepted that this was still too high.

1.2 The implementation of a new computerised Patient Administration System (PAS) at BHRUT had taken place in December 2013. BHRUT officers felt that, with hindsight, the implementation had been undertaken too rapidly. The new PAS system had shown 110,000 – 115,000 patients on the waiting list compared to the 28,000 that had been reported previously. This had led BHRUT to take the decision, with the approval of NHS England and the former NHS Trust Development Authority (now NHSI), to cease reporting figures for referral to treatment to allow time to investigate fully the issues.

1.3 BHRUT officers accepted that there had previously been insufficient governance and oversight of the RTT issue. They told the Topic Group that, in hindsight, decisions around the issue taken by the previous management appeared to be counter-intuitive. The Topic Group accepted that many of the problems had occurred under previous management and the current BHRUT management advised that the management culture had now changed, with dialogue encouraged between management and frontline staff.

1.4 The BHRUT officers confirmed to the Topic Group that BHRUT was now using the ISTC at King George Hospital, as well as other private sector facilities. Indeed, some 49% of the additional activity required to clear the backlog was likely to be outsourced to the private sector. A total of around 9,000 extra appointments would be needed to clear the backlog with a further 20,000 to cope with the additional demand on BHRUT's services. A further 8,000 appointments would reduce the time to first outpatient appointment to six weeks and 56,000 additional slots would be needed for follow up appointments.

1.5 An additional 760 operations would reduce the backlog while around a further 800 would be needed to cope with additional demand. A further 3,000 operations would arise from patients currently awaiting outpatient appointments. It was not likely that these figures would be impacted by a rise in activity at A & E as other beds were normally ring fenced for emergency admissions from A & E.

1.6 It was noted that, if additional anaesthetists could be recruited to support the extra consultants, this would allow an extra 27,000 slots. Better productivity could produce a further 8,000 slots and more use of clinical nurse specialists a further 5,000.

1.7 The recruitment of the extra consultants would allow 2,000 more operations to be performed and better theatre productivity a further 1,400. Waiting list initiatives such as more weekend use of theatres would also allow 700 more operations to be carried out. Most theatre maintenance was carried out in August and December when demand was lower and other maintenance periods could normally be worked around. Trust officers accepted that recruiting enough consultants to facilitate these

changes remained a challenge. Recruitment initiatives included recruiting from overseas, joint appointments and the establishing of academic consultant posts.

1.8 Trust data on waits for treatment had been reviewed by NHS Intensive Support Team and was also considered weekly by a programme board with representatives from across the local health economy. Monthly updates were also given to a system resilience group. BHRUT officers accepted that, as at April 2016, based on publicly reported data, BHRUT had the most long-waiting patients in the country, with around 850 patients waiting in excess of 52 weeks for treatment.

Meeting 2: BHRUT, 22 July 2016

2.1 BHRUT had changed to a new computerised patient administration system in December 2013. BHRUT officers clarified that the new ICT system had not itself caused the delays to treatment but had made pre-existing delays (not previously known of) visible to BHRUT. Trust officers felt that, as a result of the lessons learned through the present delays, any future change to a new ICT system would be managed better than in 2013.

2.2 There was a dedicated, central team in BHRUT to receive referrals to hospital consultants but many referrals were sent directly by GPs to consultants. BHRUT officers felt it would be far more efficient if all referrals could be sent via the central team. It was suggested that the Health and Wellbeing Board could look at this issue.

2.3 At the meeting, BHRUT officers accepted that BHRUT was not at that point meeting the 18-week target for the time between GP referral and the start of treatment.

2.4 All consultants were required to give six weeks' notice of annual leave. The service manager would then discuss with the consultant which appointments could be booked to the next clinic and which needed to be referred to another consultant.

2.5 At the time of the meeting, the backlog of patients waiting had reduced by around 50% although this still meant that approximately 52,000 people were awaiting an appointment. This was, however, being reduced by approximately 500 patients per week. Extra clinics were being undertaken by BHRUT, and the BHR CCGs were commissioning alternative providers and redirecting patients.

2.6 Readmission rates at BHRUT were at 9% after 30 days compared to a national average of 12%. The readmission rate of patients undergoing elective treatment was only 1%.

2.7 Members of the Topic Group felt that the local health economy lagged behind on some digital systems. In Islington for example, a patient record could be shared, with the patient's consent, between the Hospital Trust, Council and CCG whereas, in Havering, not only was electronic file sharing between GPs and the Hospital difficult, there were different ICT systems operating within the Hospital that made in-house information sharing difficult.

Meeting 3: 5 September 2016, BHR CCGs

3.1 In addition to providing overseeing primary care medical services, the local CCGs commissioned the majority of services provided by BHRUT and hence had the responsibility of overseeing BHRUT's reduction in their backlog of appointments and accounted to NHS England on a weekly basis for this. Legal directions had been issued by NHS England to Havering CCG as the lead commissioner

for BHRUT, requiring the CCG to submit a plan for recovery of the RTT position by September 2016. A demand management programme had therefore been carried out which sought to slow the number of referrals going into BHRUT. The longest waits for treatment were in areas such as gastroenterology, dermatology, urology and general surgery.

3.2 The CCG officer was supportive of any measures that could streamline the process for patients, including all referrals being sent to the appropriate central team at BHRUT rather than to individual consultants. Referral activity from GPs to BHRUT was tracked by the CCG, although incidents of referrals that were not appropriate were not specifically monitored.

3.3 It was felt that a pathway redesign programme being worked on by both GPs and BHRUT clinicians would serve, in due course, to reduce delays to hospital treatment. Whilst there were no known cases of patients coming to clinical harm as a result of delays in receiving treatment, there had been a significant financial impact on the CCGs due to the need to fund additional activity to reduce the backlog of appointments.

3.4 It was agreed that the appropriateness of GP referrals was an important part of the redesign work and the Topic Group noted there had been enhanced engagement from the CCGs on this.

Meeting 4: 31 October 2016, London Borough of Havering Adult Services

4.1 The Council's Director for Adult Social Care confirmed that there was some anecdotal evidence from social care officers of people waiting lengthy periods for treatment. This could result in a danger of deconditioning for the individuals concerned, which could lead to a referral to social care for care at home. There

was, however, no direct evidence that the delayed treatments had actually resulted in this.

4.2 It was assumed that the delays in receiving appropriate treatment could only lead to poor long term health outcomes for patients concerned, and therefore Adult Social Care had been supportive of onward referral to other NHS Hospitals and private sector facilities to ensure appropriate treatment received.

Meeting 5: 23 January 2017, NELFT

5.1 NELFT provided a range of healthcare services in the community as well as being the principal provider of mental health services for the Outer North East London area. The NELFT officer was not aware of any patients who had come to harm specifically due to delays in their receiving treatment at BHRUT. NELFT were unaware of any direct correlation between instances of delay in transferring care (commonly called "bed blocking") and RTT delays.

5.2 A range of treatments were offered by NELFT for people waiting lengthy periods for hospital treatment. These included cardiac nurses, diabetes services, podiatry and audiology. NELFT were unaware of any cases where patients had come to clinical harm due to delays in receiving treatment. It was possible for some conditions to introduce pathways that did not include referral to a consultant but GPs were often not in favour of this approach.

5.3 NELFT monitored referral to treatment times at monthly performance meetings and, at the time of the meeting with the Topic Group, the 18-week target had been breached only rarely.

Meeting 6: 23 January 2017, NHSI

6.1 NHSI provided strategic leadership to hospitals and covered areas such as waiting times, finance, service quality and leadership. NHSI also worked with partners such as the local CCGs and NHS England to work with BHRUT on these issues.

6.2 NHSI and its predecessor – the NHS Trust Development Authority (TDA) - had worked closely with BHRUT on referrals to treatment since September 2015. A support team had been set up and specialist external companies had been brought in to help BHRUT manage its waiting lists. Reporting on waiting lists had been resumed by BHRUT from November 2016.

6.3 The measures of success that NHSI considered key for BHRUT were that BHRUT continued to report on waiting times, cleared the backlog of longest waiting patients and was expected to reach the target of 92% of patients waiting less than 18 weeks for treatment by September 2017. It was felt that the resumption by BHRUT of reporting on waiting times had been a key milestone.

6.4 BHRUT now had more robust processes in place to review patient outcomes and NHSI had seen no evidence of moderate or severe harm to patients resulting from any cases of delayed treatment. Summary data on waiting times was provided by BHRUT to NHSI and NHS England on a weekly and monthly basis.

CONCLUSIONS

C1 As explained at the outset, the Topic Group fully accept that the root cause of the delayed treatments occurred before the management changes that led to the present management team taking charge of BHRUT. It is a matter of concern, however, that no one appears to have noticed that things were going awry until a very late stage. It is clear that the Information Technology Governance arrangements under which the patient data was migrated from the old system to the new were inadequate; indeed, the governance arrangements prior to then may well have been equally inadequate, given that the delays had not previously been "visible" (see paragraph 2.1 above).

Current (and future) management of BHRUT must satisfy themselves that, in any future change of ICT systems, governance is sufficiently robust to ensure, so far as possible, that patient data is properly migrated. Subsequent events in May 2017 amply demonstrated the need for robust governance to ensure that ICT systems are kept at the highest possible level of cybersecurity.

The Trust should also consider what measures need to be taken to ensure that all ICT systems in use within BHRUT's hospitals are capable of exchanging full details about individual patients, both internally and externally with key partners, such as not only individual GPs but also Polyclinics and Walk-in Centres that may refer patients on for treatment, or to which patients may be referred.

C2 Whilst it is understandable that GPs should prefer to refer their patients to specialists whom they know and have confidence in, it is apparent that their doing so is not the most efficient way of

proceeding and can, inadvertently, lead to delays for individuals. GPs cannot know how consultants' workloads stand and direct referral introduces the risk that those workloads, already varied, will be further distorted by acceptance of direct referrals. It is clearly better for all GP referrals to be directed to a central point, from which they can then be allocated to whichever provider or consultant is best placed (in terms of both workload and relevant skill) to deal with that patient.

C3 Topic Group members were surprised to learn that there was no formal follow up process by GPs to find out whether patients had seen a consultant to whom they had been referred, and what had been the outcome. It appeared that, unless a patient returned to the GP to follow up an apparent failure to be offered an appointment, the whole process worked on a "fire and forget" basis: the GP made a referral but did not subsequently seek to discover its outcome.

RECOMMENDATIONS

R1 That BHRUT review its Information Technology Governance arrangements to ensure that, in any future migration of patients' data from one ICT system to another, robust steps are taken to ensure that the "loss" of data that occasioned the delays that have been the subject of this review are so far as possible avoided.

R2 That BHRUT and partners review their ICT systems to ensure that they are sufficiently compatible with each other to permit the free, secure exchange of patient data between them, and (so far as appropriate) to facilitate the secure exchange of patient data with GPs and other points of referral such as Polyclinics and Walk-in Centres

R3 That the CCGs review options in partnership with BHRUT to determine how demand, and in turn capacity, for elective referral activity is best modelled to optimise patient access and experience.

R4 That the CCGs work with GPs to develop procedures whereby, when a referral is made, it is followed up in a timely fashion to ensure that the patient is actually seen by the most relevant health care professional and treatment appropriate to their condition is arranged.

BACKGROUND PAPERS

Presentations given at, and notes of, meetings of the Topic Group:

6 April 2016

27 April 2016

26 May 2016

22 July 2016

5 September 2016

31 October 2016

23 January 2017

APPENDIX – MEETINGS HELD

Meeting no.	Date	Witnesses
1	06/04/16	Niki Eves, Communications Manager, BHRUT Hazel Melnick, Associate Director, Communications and Marketing, BHRUT Steve Russell, Deputy Chief Executive, BHRUT Sarah Tedford, Chief Operating Officer, BHRUT
1A	27/04/16	None – planning meeting only.
1B	26/05/16	None – planning meeting only.
2	22/07/16	Maureen Blunden, Head of Patient Administration, BHRUT Steve Russell, Deputy Chief Executive, BHRUT
3	05/09/16	Louise Mitchell, Senior Responsible Officer – Planned Care, BHR CCGs
4	31/10/16	Barbara Nicholls, Director of Adult Services, London Borough of Havering
5	23/01/17	Carol White, Integrated Care Director, NELFT
6	23/01/17	Andrew Hines, Regional Chief Operating Officer, NHSI Faisal Mangera, NHSI

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 28 JUNE 2017

Subject Heading:	Healthwatch Havering – Reports on Queen's Hospital Inpatient Meals and NELFT Mental Health Street Triage Scheme
CMT Lead:	Barbara Nicholls
Report Author and contact details:	**Ian Buckmaster, 01708 303300 ian.buckmaster@healthwatchavering.co.uk**
Policy context:	**The information presented details two reviews of aspects of local health services undertaken by Healthwatch Havering**
Financial summary:	**No financial implications of the report itself for either the Council or Healthwatch Havering.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

The attached reports on Queen's Hospital in-patient meals and the NELFT Mental Health Street Triage Scheme are presented to the Sub-Committee by Healthwatch Havering. The Sub-Committee is asked to consider the reports and take any action it considers appropriate.

RECOMMENDATIONS

1. That the Sub-Committee considers the attached Healthwatch Havering reports and takes any action it considers appropriate.

REPORT DETAIL

Officers will present and summarise the main features of the attached Healthwatch Havering reports on Queen's Hospital in-patient meals and the NELFT Mental Health Street Triage Scheme.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Enter & View

Queen's Hospital, Romford: In-patient meals

6 October 2016

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

Introduction

The principal purpose of a hospital is to treat the sick and injured. Most patients are seen and dealt with quickly, and most leave the same day.

Inevitably though, many patients stay as in-patients, some for a considerable period, especially elderly patients who need a support package of care

before they can return home. These patients must, of course, be fed and kept hydrated.

No one expects "hospital food" to match home-cooked food, or indeed that which would be served in a multi-star hotel or restaurant; on the other hand, patients have a right to expect food that is:

- nutritious
- able to meet special dietary requirements (whether of a religious nature such as halal or kosher, of a personal/lifestyle-choice nature such as vegetarian or vegan, or of a medically-necessary or non-allergenic nature such as gluten-free or nut-free)
- provided in a quantity sufficing to satisfy their hunger
- complementary to their clinical needs where necessary and
- served to them in a reasonable manner, with assistance to eat if they need it.

Patients also have a right to be – and remain – hydrated, particularly as hospitals are often dry, warm places where it is possible to become dehydrated quite quickly.

Over the years, there have been many humorous references to inadequacies in the quality and quantity of hospital food – many of the "Carry On" films of the 1950s and 1960s drew much comedic effect out of hospital food, and numerous films and TV programmes since have maintained that caricature.

Against that, clearly it is impossible to satisfy completely the expectations of every patient. What to one person is a perfectly-acceptable meal will be to others either too much or too little: food likes and dislikes are highly personal and no two people will agree on what is their "favourite meal". It is particularly difficult to produce a consistent and acceptable offering when catering for many hundreds of patients for two main mealtimes every day, all with different needs and expectations, not only in quality, quantity and nature of food but in terms of the amount of time and assistance they need to eat it.

Healthwatch Havering set this report in hand because of reports from patients and others alleging inadequate dietary arrangements [1] (not necessarily at Queen's Hospital).

As an initial step, several wards in Queen's Hospital were visited on 6 October 2016 at lunchtime to enable Healthwatch members to observe the delivery and presentation of the midday meal, the help available to those patients who needed assistance with feeding and how patients with varying needs coped with their meals. The team comprised of seven Healthwatch members, who visited individual wards in pairs or threes.

Following that visit, members of Healthwatch Havering met senior staff from the hospital and its catering contractor to discuss various issues, emerging from both the Enter & View visit and earlier patient reports.

Nutritional standards

NHS England (NHSE) has identified 10 key characteristics of good nutrition and hydration care [2]. These are:

1. Screen all patients and service-users to identify malnourishment or risk of malnourishment and ensure actions are progressed and monitored.
2. Together with each patient or service user, create a personal care/support plan enabling them to have choice and control over their own nutritional care and fluid needs.
3. Care providers should include specific guidance on food and beverage services and other nutritional & hydration care in their service delivery and accountability arrangements.
4. People using care services are involved in the planning and monitoring arrangements for food service and drinks provision.
5. Food and drinks should be provided alone or with assistance in an environment conducive to patients being able to consume their food (Protected Mealtimes).
6. All health care professionals and volunteers receive regular raining to ensure they have the skills, qualifications and competencies needed to meet the nutritional and fluid requirements of people using their services.

[1] See for example "Fix Dementia Care: Hospitals" – The Alzheimer's Society 2016
[2] NHS England (NHSE) website: https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics

7. Facilities and services providing nutrition and hydration are designed to be flexible and centred on the needs of the people using them, 24 hours a day, every day.
8. All care providers to have a nutrition and hydration policy centred on the needs of users, and is performance-managed in line with local governance, national standards and regulatory frameworks.
9. Food, drinks and other nutritional care are delivered safely.
10. Care providers should take a multi-disciplinary approach to nutrition and hydrational care, valuing the contribution of all staff, people using the service, carers and volunteers working in partnership.

The catering service at Queen's Hospital must be judged against those criteria. In addition, sources of advice and guidance on nutritional standards and guidance used by the hospital include the British Dietetic Association [3], BAPEN (a charitable organisation that seeks to advance the nutritional care of patients as well as the wider community, which has produced a Malnutrition Universal Self-Screening Tool [MUST]) [4] (see later in the report), Public Health England (Healthier and More Sustainable Catering: Nutrition principles) [5] and Government Buying Standards for Food and Catering Services from the Department of the Environment, Food and Rural Affairs (DEFRA) [6].

Catering arrangements

Catering services at Queen's Hospital (and at its sister hospital, King George in Goodmayes) are provided by Sodexo Limited under contract to the Barking, Havering and Redbridge University Hospitals Trust (BHRUT). Sodexo provides a range of non-clinical services at the two hospitals, including canteen/restaurant facilities for staff and public (such as a Costa Coffee outlet). Different arrangements for catering apply at King George Hospital, so the observations in this report are not necessarily relevant to the in-

[3] BDA website: https://www.bda.uk.com/publications/professional/NutritionHydrationDigest.pdf
[4] BAPEN website: http://www.bapen.org.uk/
[5] PHE website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347883/Nutrition_principles.pdf
[6] DEFRA website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347883/Nutrition_principles.pdf

patient service at that hospital (which was, in any event, not included in the study now reported on). Catering is part of a Total Facilities Management contract following a competitive tendering exercise for which the evaluation criteria valued quality 60% and cost 40%. The food is sourced from a major hospital catering supplier, Tillery Foods, based in South Wales [7] but which has a London depot in Croydon.

On average, some 2,200 meals are prepared and served each day, and the average cost of feeding a patient is about £10.50 per day.

Hospital management told Healthwatch that:

> The Trust has monthly patient dining meetings with Dietitians, Speech and Language Therapists, Sodexo Catering Manager and the Trust's soft Facilities Manager Contract Manager, to keep up to date with any new catering developments and ensure food quality and nutritional standards are continued to be met.
>
> Dietitians are involved in meal taste tests which are held on the wards, and the Nutrition and Dietetic Department undertake 'Nutrition - how are we doing' audits to monitor patients' experience of the food and mealtimes. The results of the audits are reported to the Trust's Nutritional Advisory Group for review.

In addition:

> Meal taste tests are carried out monthly by the Trust Facilities Team, Dieticians, Catalyst Quality and Performance Manager Sodexo Management team, Tillery Valley food supplier, Senior Sisters/Charge Nurses, nurses and Healthcare Assistants.

Food is delivered from Tillery Foods frozen and ready to be reheated. It is stored in the hospital's food storage area until required, when it is taken by trolley (called a "food cassette") from the food storage area in the hospital to appropriate ward. On arrival at the ward, the trolley is connected to the electricity supply and the food is prepared for serving hot.

A range of foods is available through a variety of menus. Food for patients who do not have special dietary requirements is varied by rotation of menus over a two-week period; food for patients who have special dietary

[7] Tillery Valley Foods website: http://www.tilleryvalley.com/home.html

requirements is also available – should a patient require a specialised menu not generally catered for, a diet chef is available to discuss their specific needs with that patient.

There is inevitably wastage of food. In 2015/16, 176 tonnes of food waste were recorded, approximately 6% of the total waste tonnage at Queen's Hospital [8]. Food waste is collected separately and recycled.

Serving arrangements

In common with many hospitals, food orders used to be based on choices made by patients the previous day. This inevitably meant that many patients were served food not of their choice but that of the patient who had previously occupied the bed.

To overcome that, and to ensure compliance with a recommendation following the PLACE inspection that food be ordered within five hours of the time it is due to be served, the hospital is introducing the use of Saffron, an electronic, tablet-PC based, ordering system (similar in concept and operation to the ordering system used in an increasing number of restaurants). A "host" (an employee of Sodexo) takes the patient's order which is sent electronically to the food store so that meals can be prepared.

Once the food has arrived at the ward for final preparation and is ready to be served, ward staff report to the ward kitchen area and take the food to the patient.

Mealtimes are "protected", which means that all routine and non-urgent medical and nursing tasks are suspended and all available staff are used to take meals to patients. Where a patient is unable to feed themselves, assistance should be available either from staff or from volunteers to ensure that they are fed. Staff receive regular training in nutrition and food preparation and handling.

[8] Source: Barking, Havering & Redbridge University Hospitals Trust, in response to enquiry from Healthwatch, October 2016

The visit

The visit on 6 October involved three teams of Healthwatch members. As different teams were involved, the following accounts of their observations accordingly reflect their different experiences: two teams had a generally good impression of the arrangements they observed but the third found the experience disappointing.

Bluebell Wards A and B – specialities: medical and respiratory

There are six bays, each with four beds, in each ward (together with four barrier rooms, which the team did not enter), which have mainly elderly people as patients. There are four Consultants responsible for these wards, and nursing staff including a Matron and a Senior Sister.

The team was met by the Duty Manager, who escorted them around, introducing staff whenever possible.

The team visited Bluebell B ward first, where there were three duty stations, all staffed. In addition to the wards (48 beds plus 4 barrier beds), a Friday day clinic is held each week for day patients. The team was told that visiting is from 10.30am to 7.30pm daily.

The team arrived at midday and the heated food trolley arrived on the ward at 12.10pm. Meal times are "protected", which means that no routine work or doctors' rounds take place during them, to ensure both that staff are available to concentrate on feeding and that patients are not avoidably disturbed from their meals; lunch time is noon to 1pm. Coffee or tea is offered at about 2pm hours

The team observed that patients' hands were cleaned with wet wipes prior to their eating. A "red tray" and "red jug" system was in operation (to indicate to staff those patients who needed help with eating and drinking) and all patients had access to plenty of drinks, including water. The team noticed one jug that was nearly empty; it was quickly filled when staff were made aware. Tables

were well positioned.

The food arrived hot, had an acceptable appearance and a pleasant odour. It was vegetarian goulash, beef stew and dumplings with mashed or sautéed potatoes and macedoine of vegetables (obviously from a freezer). Plates were served with covers that were removed at the bedside. The menus had been ordered earlier that morning which the staff told the team was better, with patients usually getting food of their choice, rather than the choice of the patient who had previously occupied the bed. One man was eating tuna salad and one lady had chosen ham sandwiches which had been unwrapped for her.

The team noted, however that, despite the pre-ordering system, the last patients to be served (usually those in the bays) sometimes were given what was left, rather than what they had ordered. For example, one patient told the team that she had been served quiche for both lunch and dinner the day before the visit, which was corroborated by a visitor. Condiments and serviettes were available and help was being given to those who needed it by staff (nurses and health care assistants (HCAs)), and visitors were also helping. Most meals were being eaten and the patients whom the team spoke to were mostly quite happy with their meal. The team noted a lack of fresh vegetables, that hot desserts were served at the same time as the main course, and had thus cooled by the time they came to be eaten, rather than being served separately. They also considered that better quality fruit juice could be offered.

The team was told that dietary requirements were assessed on admission and that notes about such requirements were displayed above the beds; and that requirements seemed to be adhered to. Patients were weighed and the dietitian was involved in that. Some patients were having puréed food, and one liquidised. The patient in question told the team that he did not like having liquidised food as it did not taste nice from a plastic feeder.

Although the staff seemed hard pressed all the time they were very

cheerful and treated their patients kindly and with respect. Almost all patients to whom the team spoke were full of praise for the staff, as were their visitors.

One of the younger patients to whom the team spoke, however, happened to be a dietician by profession and she described the food as "appalling, with little nutritional value at all". She was very critical of the lack of fresh vegetables and fruit.

Dessert on the day of the visit was rice pudding or yoghurt. The whole meal is presented to the patient at the same time so a hot dessert soon gets cold before being eaten. The dietician patient was also very critical of the cartons of fruit juice, which she said had no flavour and was just coloured sugar water. She was, however, the only person to voice criticism. Having professional background knowledge of dietary matters, her comments are noteworthy but it is equally notable that she was the sole critical voice.

Portions were not large but appeared adequate. The team was told that patients could ask for more food and that snacks were available (however, when the team enquired later whether food was available on the wards, they were told there was none). The plates were cleared after a reasonable time and the waste was disposed of in a black plastic sack.

The team noted one elderly lady, bedbound, in Bluebell A who had, unnoticed, fallen asleep with her lunch on her lap, which had gone cold. The team drew her to the attention of a nurse, who woke her up, removed the cold lunch and then helped her eat some cold rice pudding.

No leaflets or information appeared to be available for patients, visitors or staff about time procedures on the wards and no-one appeared to use the anti-bacterial hand wash, despite there being four barrier rooms.

The staff told the team that they were happy with the meal

service. They spoke freely and were generous with their time despite being very busy; they seemed to be a good team working flat out, which the team found impressive.

HCAs and Nurses complete the fluid charts and the nurses monitor them. Comfort rounds are made about every two hours, consisting mainly of toilet needs and drinks. A Sister said she thought it was necessary to have several menus to accommodate the diverse dietary needs and ethnicities on the wards. Patients had a variety of illnesses, although those with respiratory problems were the majority on these wards. All patients are assessed using the Malnutrition Universal Screening Tool (MUST), which takes place on admission.

The team noticed that one bed that was very low, with a mattress on the floor next to the bed. Staff explained that the patient in question tended to fall out of bed so precautions were taken for his protection. For that reason, his table had been placed out of reach at the foot of his bed, as he could have hurt himself if the table was in the usual position. His drinking and toileting needs was checked every two hours, an arrangement that appeared to work well. The team was unable to speak directly to the patient as he was sleeping.

The team was unable to talk every patient, as some were not well enough to be bothered.

Harvest A Ward - speciality: care of the elderly

The team considered that meals were well presented, in reasonable portions and were appetising; they appeared to be nourishing and in accordance with patients' requests. Hot meals were checked for temperature constantly, and cold meals were pre-plated before arriving on the ward. These also appeared appetising and well presented.

Specific conditions and dietary needs were well signed above the beds.

Beds were adjusted at meal times to enable patients to sit in comfortable eating positions, although some tables needed renovation. Tables were

placed in position for meals. Sanitizer hand gel was available for all patients to use before meals, and water jugs were available and within easy reach of all patients, although some appeared over-full.

However, on the day of the visit, the meals were very late arriving at the ward; staff explained that there had been a problem in the kitchen and this had caused the delay. When questioned about effect of the delay in meals on patients, the team was told that snacks and fruit were available for patients if needed.

Although sufficient staff to were available to serve the meals to patients and help was given to those who required assistance with eating their meal, there was only one person dishing the meals onto the plates from the trolley. Both main meal and dessert were served at the same time and this took some time to reach the patients. Patients in single rooms were last to receive their meals and they seemed to have a long wait before being served.

The team was told that a new system of ordering meals was being trialled on this ward. The staff told the team that they were not happy with the system as it required a lot of staff time. The logic of experimenting with a new ordering system on a ward where patients needed assistance to make their choices was not immediately obvious.

The team spoke to many patients, all of whom said they were happy with the meals they were receiving, and with the quality and quantity of the meals. Visitors praised the meals that their relatives and friends had been receiving.

Sunrise B Ward – speciality: care of the elderly

The team arrived on the Ward at approximately 12 noon. They were met by the Matron, who was pleased to see them and very happy for them to be there. She felt mealtimes had improved a lot since she had originally joined the Trust.

The heated food trolley arrived just after 12.15pm and staff, all

of whom were wearing plastic aprons, were ready to serve and feed patients. There were six nurses to feed patients, with two staff serving the meals.

The team walked around the bays observing what was happening. The only food available was meatballs and mashed potato, which the team was told was classed as a "soft food". Dessert was also available on the trays but no patient appeared to eat theirs.

The team concluded that there were not enough staff available to feed every patient their food, which was becoming cooler and less appetising by the minute. One nurse to whom the team spoke appeared exasperated by the situation (her facial expressions said it all).

Meals are ordered during the morning of the day in which they will be served, by a kitchen assistant using a tablet computer app, who must go to up to 100 patients asking them what they want to eat for the day. As many of the patients are frail and elderly, they never seem to get what they order as the assistant guesses what they might eat.

Every patient had their meal served up on a red tray, and all had a water jug with a red lid, denoting they need help. Some jugs were out of patients' reach because they knock them over. The families that were there to help their relatives were not very happy with what was being served and a patient told the team that the food was unappetising and she would have loved something with a bit of flavour. The team spoke to the son of a patient waiting to be discharged after two weeks on the ward and he said that his mother had continually been served chicken, which she did not like, and that she had only had one meal that she had ordered during her entire stay on the ward!

All patients who were being fed had been propped up, although some were clearly very drowsy, which caused considerable problems for the nurses trying to feed them, and was very time consuming. The result was that no desserts were eaten. One patient was given two dinners and desserts as part of a plan to get him to put on

weight. It was also noted that some patients were given gluten-free cake for dessert even though they were not on a special diet.

To illustrate the problems staff had to contend with, some patients were observed with their arms tucked inside the bed sheets and were thus unable to wash their hands or feed themselves. The team was told that one patient in a side ward, who had dementia, tended to throw things and so her hands were permanently tucked down the bed. Her daughter told the team she was exasperated by the situation. Despite that, staff were unable to help all patients with their food as they did not have the time to do so.

Condiments were available on the trolley but not used (and were probably not appropriate for the type of patient on the ward). There was no evidence that indications of dietary requirements were within easy view of staff, such as discrete notices above the beds.

The portions of food served up appeared very small. Basic food is kept in the ward kitchen, such as bread and milk, which is not always brought up to the ward when ordered and staff must go down to get it. They also have Complan-type drinks to try and build patients up.

During the visit, the team saw no evidence of a comfort round being offered, and the levels in the water jugs suggested that not all patients were drinking sufficient water to remain properly hydrated. There appeared to be a very limited choice of food, restricted mainly to meatballs and mashed potato for the main course and rice pudding or Bakewell tart for dessert; small quantities of other foods were in evidence but too little to make any difference, and seemingly indifferently prepared.

The team gained the impression that choice was limited because this is an elderly care ward – but the consequence was that, because patients were not being fed the food of their choice, they were not eating what they were offered and wastage levels were accordingly high. The team was told that one family had complained about the lack of choice of food and were clearly not happy with the new system.

Although staff were enthusiastic about the meal time, there were too few of them to make a difference.

Conclusions

The Healthwatch teams that carried out the visits had a mixed experience. The conduct of the mealtime at both the Bluebell and Harvest wards was satisfactory: food was served in adequate portions, seemingly in accordance with patients' orders and assistance with eating was available to those needing it. In Sunrise B ward, however, the story was very different: the food on offer was limited to "meatballs and potato", there were insufficient staff available to assist all patients with feeding, some patients' ability to move had been restricted for their own safety (but, by doing so, their ability to take food had been likewise restricted), and the food was indifferently served because the nursing and HCA staff were too stretched to attend properly to every patient.

Clearly, the hospital is conscious of the need to improve management of the patients' mealtime experience. The introduction of a new system to manage the ordering of meals is potentially a significant step but the evidence of the visit suggests that there is some way to go yet. More importantly, more needs to be done to address the problem of ensuring that those patients who are unable to feed themselves are helped to do so.

Moreover, whilst it is recognised that some patients lack the ability to order their own food – so some element of choice is unavoidably left to staff – it seems inappropriate simply to order a bland meal of "meatballs and potato" virtually automatically and that perhaps more effort could be made to encourage some at least of the patients to take a more active part in ordering their own food.

That said, it is also recognised that nursing and HCA staff are very busy and may not have time to spare to help every patient who needs it to order food. But good nutrition is a key part of recovery from illness or injury and there is always the possibility not only that some time spent with a patient

to organise the food they want would assist in reducing the amount of time they spend as an in-patient before being discharged, but also in promoting a better quality of life for them once they are discharged.

It is accepted that the food on offer meets all requisite standards for nutrition and hygiene; it is served hot when necessary and cold alternatives are available. But no matter how good the food may be, if the patient cannot or does not eat it for any reason, it will simply go to waste. The teams on the visit reported instances of patients not eating, or being able to eat, because they did not like what they were served or were unable to feed themselves and no one was available to help them.

There is clearly no simple answer. The hospital has used a "feeding buddy" scheme, with volunteers coming in to help patients who cannot feed themselves but such a scheme can only succeed if there is a ready supply of volunteers in sufficient numbers – but at the time of the visit, this did not seem to be the case. Nursing and HCA staff have numerous other tasks and duties to attend to and feeding is too easily overlooked (even though, as noted already, good feeding is one of the keys to prompt recovery).

It would not be feasible for Healthwatch to make specific recommendations about mealtimes. It is hoped, however, that the hospital will encourage staff to engage more with patients during mealtimes and, in particular, encourage patients who are have the ability to do so but for some reason are finding it hard, to feed themselves, and to respond to suggestions that a food is not liked or is not acceptable in a more positive way by taking action to ensure that something more to the patient's liking is made available to them. The greater use of volunteer "feeding buddies" would also help in that respect and the hospital is urged to develop that scheme further, as a matter of urgency.

Finally, since the visits were undertaken, comments have been received to the effect that the new food ordering scheme is not working as envisaged. The difficulties of managing the ordering of food in the quantities required

are obvious and the use of innovative solutions is to be encouraged. But new systems need to be bedded in over a period and closely-monitored to ensure that they are effective and working as expected.

The teams would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 6 October 2016 and is representative only of those patients and staff who participated. It does not seek to be representative of all service users and/or staff.

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ENTER AND VIEW VISIT MEALTIMES – 6TH OCTOBER 2016

1 INTRODUCTION

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2 HEALTHWATCH HAVERING REPORT 6TH OCTOBER 2016

Healthwatch authorised representatives undertook a visit to several wards at Queen's Hospital to enable Healthwatch members to observe the delivery and presentation of the midday meal, the help available to those patients who need assistance with feeding and how patients with varying needs copied with their meals.

Following on from that visit, Healthwatch Havering met with senior staff from the hospital and it's catering contractor to discuss various issues, emerging from both the enter and view visit and earlier patient reports.

3 BACKGROUND

The following wards were visited:

Harvest A & Sunrise B are both 31 bedded acute medicine wards specialising in care of the elderly. There are 4 Consultants responsible for these wards, with nursing staff including a Matron and a Senior Charge Nurse/Senior Sister.

Bluebell A & Bluebell B – are both 28 bedded specialist medicines wards specialising in respiratory. There are four Consultants responsible for these wards, with nursing staff including a Matron and a Senior Sister.

The catering services at Queen's Hospital are provided by Sodexo Limited, on average 2,200 meals are prepared and served each day.

4 BHRUT RESPONSE TO HEALTHWATCH HAVERING REPORT

Although there were no specific recommendations contain within the report we would like to take the opportunity to address any areas of concern where improvements can be made to enhance patient experience during meal service.

4.1 GENERAL FEEDBACK

The 'Feeding buddy' scheme was relaunched and re-branded to 'Mealtime Assistants' in February 2017 to date we have 27 Mealtime Assistants, which consist of 15 volunteers and 13 staff members who volunteer their time during the lunch period. They have attended the awareness program and are now supporting wards during meal times. Further training is scheduled for June 2017 and future dates planned throughout the year.

There are five required standards for NHS hospital food in England as set out in the NHS standard contracts for hospitals. These 5 standards are:

1. The 10 Key Characteristics of good nutrition and hydration care, NHS England
2. Nutrition and Hydration Digest, the British Dietetic Association
3. Malnutrition and Universal Screening Tool, BAPEN
4. Healthier and More Sustainable Catering – Nutrition Principles, Public Health England
5. Government Buying Standards for Food and Catering Services (GBS), the Department for Environment, Food and Rural Affairs.

Dietitians are not involved in weighing patients: Ward staff weigh the patient and calculate the patients MUST score and if necessary, refer the patient to the dietitians.

New meal ordering system is not working - The new meal ordering system has been reviewed on a regular basis and any recommendations/ issues raised by the Trust have been picked up. We believe that the initial issues are resolved, however we are currently working with the patient dining group to explore different ways to order for the care of the elderly wards.

4.2 BLUEBELL A & BLUEBELL B FEEDBACK

Dietary needs and ethnic menus on the wards: There are a large number of menu's available to meets the cultural and medical needs of our patients. Further promotion of the menus was conducted during Nutrition and Hydration week in March 2017. We are also including a list of the various menu options on the main menu that is currently accessible on the wards so that patients and relatives are made aware of what is available.

No fresh vegetables available - The food service at Queen's is cook chill and the majority of the vegetables are cooked from fresh at our suppliers factory and chilled before delivery, however some vegetables such as peas and mixed vegetables are a frozen product. Fresh fruit is available to choose at every meal service.

A patient comment that food was appalling with little nutritional value and juice cartons were coloured sugar water - All menu items are agreed with the Trust dietician for nutritional content during the menu planning and reviews.

4.3 HARVEST A FEEDBACK

The meals were arriving late on the ward - the staff explained that on the day of the visit there was a problem in the kitchen and this caused the delay. When this happens patients are offered fruit and snacks. The time of delivering meals are now very closely monitored by the Matron and any delays are reported to Sodexo Management.

There was only one person dishing the meals onto the plates from the trolley - this has now changed. The ward ensures that at least two members of nursing staff are involved in dishing out the meals alongside Sodexo Hostess. The other members of staff are required to help patients with eating and drinking during Protected Meal Times, the ward has protected meal times between 12:00-13:00 and 17:00-18:00. Staff members are not allowed to have breaks during these times and they are required to assist patients with feeding. The Ward Manager ensures that band 6 nurse takes a lead on serving food to the patients every day.

Both main and desert were served at the same time and this took some time to reach the patients - the ward

has now introduced "meal by meal" serving for the patients. The main meal is always served first and the desert follows as soon as patients finish with the main one.

Patients in the side rooms were last to receive their meals and they seemed to have a long wait before being served - patients in the side rooms are now being served at the same time as patients in the main ward areas

4.4 SUNRISE B FEEDBACK

The only food available was meatballs and mashed potato (classed as a soft food) - the ward is now offering more choice for the patents and this includes soft food. There are currently 3 soft main course choices on the normal menus daily and 2 hot options for dessert and one cold. In addition to this we offer a dysphasic menu which consists of soft choices

It was concluded during the visit that there were not enough staff available to feed every patient their food - the ward follows Protected Meal times and all members of staff are required to be present and assist patients with feeding during these times. Staff members are not allowed to have their breaks during these times and patients do not go for CT scans and others investigations. This is a designated time for the elderly patients to have their meals. Food serving is always lead by the senior nurse (band 6 and above).

There is only one kitchen assistant trying to order food for the patients electronically using tablet - the food ordering is now being done not just one member of Sodexo staff, but nursing staff also assist with this activity. This allowed facilitating food ordering for all patients on the ward. Patient who are able to perform this task themselves are encouraged to do so. When the system was introduced the host was responsible for ordering of 60 patient meals on review this was changed in January 2017 to each host taking 30 orders

One patient was served chicken which she did not like for the entire stay on the ward - food is now ordered in the mornings and if the food does not meet patients' expectations, it is being changed. The Ward Manager was not made aware that patient was served wrong food for the duration of her stay as this had not been escalated to her. The Ward Matron also ensures and randomly checks if the right patient is served the right food he/she ordered.

Gluten-free cake was given to the patient who did not require special diet - issues regarding wrong food being served to the wrong patients were addressed by the Ward Manager Karuna with immediate effect. If this happens as a result of the human error, the wrong food is disposed of and the right food is given to the right patient.

Condiments were available on the trolley but not used - all patients are now being asked if they would like any condiments and they are available to all patients upon request.

There was no evidence that dietary requirements were within easy view of the staff, such as discreet notices above the beds - the Ward Manager and unit Matron now ensure that patients' white boards are being updated at least twice daily with regards to patients' dietary requirements. Night staff also ensures that extra checks are performed in the early hours of the morning to ensure that the patients receive the right diet throughout the course of the day.

Water jugs suggested that not all patients were drinking sufficient water to remain properly hydrated - not all patients require their fluid intake to be closely monitored, however, patients admitted with dehydration and kidney injuries require their fluid intake to be closely monitored. These patients are put on fluid charts and their input and output is closely monitored. The Ward Manager ensures that fluid charts and comfort rounding charts

are filled out properly and accurately.

It was felt that patients were not offered choice of food they had - the ward now ensures that all patients are getting the right food of their choice (whether of religious nature such as halal or kosher or of the personal nature such as vegetarian or vegan). The Ward also offers food of a medically - necessary or non-allergenic nature such as gluten free or nut free diet.

5 CONCLUSION

We would like to take the opportunity to thank Healthwatch Havering for undertaking this Enter and View visit and for the feedback provided in the report. We are aware of some of the issues identified and are managing these as part of the on-going aim to improve patient experience in relation to meal times.

ENTER AND VIEW – MEALTIMES 6TH OCTOBER 2016

ACTION LOG FOR MATTERS ARISING FROM HEALTHWATCH ENTER AND VIEW INSPECTIONS

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
1	Bluebell A & B	We are also including a list of the various menu options on the main menu that is currently accessible on the wards so that patients and relatives are made aware of what is available	Lindsay Newell	T.B.C	Next printing date for menu's to be confirmed	
2	Bluebell A & B	Dessert being served at the same time as the main course	Environment & Catering Manager – Sodexo	Ongoing	This practice is now being closely monitored by the Sodexo supervisors and Housekeepers are being retrained in the correct procedure which is for all courses to be served separately	
Page 53	Bluebell A & B	Patients not being given choice and last patients being served left over food	Environment & Catering Manager – Sodexo	31.05.17	The Sodexo Hosts have been trained to ensure all patients are given a choice. We are in the process of making the menu's more visible so that patients and their relatives will be able to have their choice ready when the host arrives to take their order. The menu's will be placed in a menu holder on the table in the centre of the bays or in side rooms on the bedside table	
4	Harvest A	Meals service late and experimental meal ordering system observed	Environment & Catering Manager – Sodexo	Ongoing	The meal ordering system was introduced in order to ensure patients could order their meals closer to meal service therefore ensuring they get their meal of choice. The system implementation was fazed over a period of 4 months and was closely monitored during implementation with changes made as and when issues were raised .The new service is still being closely monitored	
5	Sunrise B	Dessert being served at the same time as the main course	Environment & Catering Manager – Sodexo	Ongoing	This practice is now being closely monitored by the Sodexo supervisors and Housekeepers are being retrained in the correct procedure which is for all courses to be served separately	
6	Sunrise B	Patient comment that the food was unappetising	Environment & Catering Manager – Sodexo	Ongoing	Regular food tasting is carried out at ward level with a varied range of people attending .We would welcome patients representatives to attend in order that the patient view is represented	

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
7	Sunrise B	Patients relative comment that his mother was not given an opportunity to choose her meal therefore resulting in her being given food she did not like	Environment & Catering Manager – Sodexo	31.05.17	Hopefully now that the new ordering system is in bedded this type of feedback will reduce. The menus as in point 2 will be more readily available for patients to make their choice	
8	Harvest A & Sunrise B	Meeting to be scheduled with Harvest A & Sunrise B Ward Managers and Sodexo to discuss the most recent Healthwatch report and their findings.	W Szarek	31.05.17		

Enter & View

NELFT
Mental Health
Street Triage Scheme

Goodmayes Hospital
Barley Lane, Goodmayes IG3 8XJ

23 November 2016

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What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

The visit that is the subject of this report was arranged through NELFT.

Although the visit was not undertaken as part of Healthwatch Havering's 'Enter and View' programme of visits using statutory powers, its content was similar and this report sets out the findings of Healthwatch participants.

Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

The Scheme

The NELFT Mental Health Street Triage Scheme is operated by NELFT in association with the Metropolitan Police, British Transport Police (BTP) and London Ambulance Service (LAS). Through the scheme, a dedicated team of mental health practitioners (the triage team) is available for call out by police or the LAS to assist with people who appear to have a mental disorder who are causing a disturbance in a public area. The intention is to avoid the unnecessary arrest and potential criminalisation of a person whose problem is essentially one of mental distress and whose care is better left to mental health professionals. Having responded to a call out, the triage team can assess the individual and decide whether the best course of action is to take them to a mental health facility, to the Emergency Department at an acute hospital or leave them for the police to deal with under their statutory powers. The scheme operates across the four Outer North East London boroughs, Havering, Barking & Dagenham, Redbridge and Waltham Forest.

At the invitation of NELFT, a team of Healthwatch Havering members attended one of the regular management meetings for the Scheme. The meeting was also attended by a Police Sergeant from Romford (who is the liaison officer for the scheme), a liaison officer from the BTP and members of the street triage team (the LAS had been invited to attend but did not do so). The discussion focused on the police use of Section 136 of the Mental Health Act, 1983 (which contains the statutory authority for police officers to initiate the “sectioning” of people who have mental disorders and can lead to their compulsory detention in a mental health facility). It was agreed that a police station custody area was not ideal as a place of safety for people showing mental health problems and one of the main objectives of the scheme was to ensure that properly trained police officers and others attended a location and dealt with the matter.

The mental health facility at Goodmayes Hospital has two rooms dedicated for the use of patients detained under Section 136.

Another objective of the team is to stop people being taken to an Emergency Department (A&E) suffering from apparent mental issues unless they need

immediate medical assistance for an injury or illness. The consensus is that an ED/A&E is really not an appropriate place of safety for those suffering from mental health issues, not least because of the pressure that such departments are under currently.

At the time of the visit, the triage team was operating Monday to Friday from 11am until 1am but not at weekends or on public holidays; from December 2016, the team was merged into the Integrated Acute Service Response Team with revised hours of 5pm-1am Monday to Friday, and 8am-12midnight at weekends and bank holidays. Typically, 2 or 3 incidents will be attended each day, with some additional referrals signposted. Outside the scheme's operating hours, police respond to people suffering mental disorder and deal with them as a policing issue. Police officers approach such people as sympathetically as possible but their training, priorities and powers are focussed on "maintaining the peace" rather than handling complex individual mental health problems and so they will take a person either to a police station as a place of safety or to an ED/A&E if that person is injured.

The BTP interest in the scheme stems from the fact that many people with mental health problems seek to end their lives by suicide on the railways, both National Rail and London Underground. The BTP is in the forefront of measures to reduce suicide on the railways and has developed training programmes for their own and railway operating staff to deal sensitively with people who have mental health problems.

Development of the scheme

Public service resources are, of course, heavily constrained. There are funding pressures, not only on the NHS but also on the police service (both Metropolitan and BTP). National policy is, however, moving to favour improvements in services for people in mental health crisis, not least to reduce their dependence on ED/A&E services and it may now be time to promote innovative, multi-agency schemes such as this. In the context of the railways, an incident caused by a person in mental distress can lead to

disruption in the travel arrangements of thousands of people, at enormous overall cost, both public and private.

The scheme clearly has the potential to be cost effective in supporting people in a mental health crisis. At present, outside the times when the triage team operates, police officers (who are largely untrained in mental health issues) are left to cope with people in mental health crisis as best they can; whilst the officers undoubtedly deal with the situation to the best of their ability, their efforts are no substitute for assessment by trained and accredited mental health staff.

Healthwatch Havering would therefore support any move to extend the operating times of the triage team, ideally to provide 24 hour cover all the time. While accepting that this is dependent on the availability of funding, it is surely more cost effective to provide specialist intervention at the earliest opportunity and avoid unnecessarily taking people in mental health crisis to a police station.

In the same vein, Healthwatch Havering believes that consideration should be given to providing the triage team with a dedicated LAS emergency vehicle able to use "Blues and Twos" (two tone siren and blue lights), in a similar way to the service provided by the K466 Rapid Response Car (run jointly by the LAS and NELFT) to attend calls to elderly people who have had a fall. This would enable the rapid deployment of triage team members to an incident – currently, they use ordinary vehicles that, complying with traffic law, can take a considerable time to get to an incident. This will require development with the LAS – but ought not to require much additional expense, given that an ambulance will often attend an incident in any event (and may even lead to some reduced cost, given that attendance by a paramedic in a car is less costly than deploying a crewed ambulance). It would also be possible for the paramedic to deal with minor physical injuries, thus avoiding need for unnecessary hospitalisation.

Ideally, the triage team could be supported by a team of dedicated police officers working from the same hub as the NELFT staff. That may not be practicable but arrangements should be made to provide all police officers in

the three boroughs (including their BTP colleagues) with an understanding of mental health issues and the work of the triage team.

Conclusions and recommendations

The street triage scheme appears to be an excellent idea that will lead to an improved service for people suffering from mental health crises in a public place. It will also ensure that police officers will no longer have to deal unnecessarily with events using their Section 136 powers. It is an innovation that deserves support and development, not least as a cost-effective alternative to dealing with people in mental health crisis by putting them at risk of being dealt with inappropriately through the criminal justice system.

To secure development of the scheme, the following recommendations are made:

To NELFT:

(1) That consideration be given to operating the scheme for longer hours than at present, ideally on a 24-hour basis at all times;

(2) That arrangements be made with the Metropolitan Police and the BTP for all police officers in the BHR area to be given training to enable them to cope confidently with people undergoing a mental health crisis up to the point where a mental health street triage team can intervene, without unnecessarily resorting to their Section 136 powers;

(3) That the scope for use of a dedicated LAS vehicle to convey triage team members to an accident be explored with the LAS and police.

To the LAS:

(4) That effort be made to ensure that a LAS officer of suitable seniority attends future meetings of the Street Triage Team;

(5) That scope for use of a dedicated LAS vehicle to convey triage team members to an accident be explored with NELFT and the police;

To the Metropolitan Police and BTP:

(6) That arrangements be made for officers in the BHR area be given training to enable them to cope confidently with people undergoing a mental health crisis up to the point when a mental health street triage team can intervene, without unnecessarily resorting to their Section 136 powers;

To the BHR and Waltham Forest Clinical Commissioning Groups:

(7) That development of the Street Triage Scheme be supported, and that consideration be given to providing funding for:

(a) training police officers as recommended in (2) and (6) above

(b) further development of the scheme to provide up to 24 hour, all times cover; and

(c) use of an LAS vehicle to convey team members to incidents.

Healthwatch Havering would like to thank all staff who were seen during the visit for their help and co-operation, which is much appreciated.

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 28 JUNE 2017

Subject Heading:	Health Overview and Scrutiny Sub-Committee – Annual Report 2016/17
CMT Lead:	Daniel Fenwick
Report Author and contact details:	**Anthony Clements, 01708 433065, Anthony.clements@onesource.co.uk**
Policy context:	**As required under the Council's constitution, the document attached summarises the work of the Sub-Committee during the 2016/17 municipal year.**
Financial summary:	**No impact of presenting of information itself.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

The annual report of the Sub-Committee is attached for approval and referral to full Council.

RECOMMENDATIONS

1. The Sub-Committee to approve the Annual Report 2016/17 and refer this to Council.

REPORT DETAIL

The attached document summarises the work of the Sub-Committee during the 2016/17 municipal year. It is recommended that the Sub-Committee agree that the report should be referred to full Council for consideration, as required under the Council's constitution.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

Health Overview and Scrutiny Sub-Committee
Annual Report 2016/17

INTRODUCTION

This report is the annual report of the Sub-Committee, summarising the Sub-Committee's activities during its year of operation ended May 2017.

It is planned for this report to stand as a public record of achievement for the year and enable Members and others to have a record of the Sub-Committee's activities and performance.

SUB-COMMITTEE MEMBERSHIP

Councillor Michael White (Chairman)
Councillor Dilip Patel (Vice-Chair)
Councillor June Alexander
Councillor Alex Donald
Councillor Denis O'Flynn
Councillor Carol Smith

During the year under review, the sub-committee met formally on four occasions and dealt with the following issues:

1. Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT) – Improvement Plan and Plan for Winter Pressures

On two occasions during the year, the Sub-Committee held discussions with senior BHRUT officers concerning the Trust's improvement plan and how it proposed to deal with pressures during the winter peak demand period. Improvement work centred on areas such as workforce issues, service improvement and improving learning from incidents and mistakes.

The Sub-Committee also scrutinised the Trust's plans for dealing with winter pressures including assisting patients with transport difficulties to get to appointments. The Trust also explained how expected demand levels were calculated. At its January meeting, the Sub-Committee examined the current situation with winter pressures at the Trust. This included discussion of the reliance on agency and bank staff in the Emergency Department and how staff could be moved between different Trust sites as required. The methods for redirecting patients who did not require treatment in the Emergency Department were also discussed.

2. Care Bed Charges

The Council's Director of Adult Services explained the charges levied by the Council for places in care homes, which were lower than the average rates in both London and Essex. It was noted that, if a care home resident was admitted to hospital, the full care rate was paid for the first four weeks, dropping to 60% of the rate thereafter. Members suggested that the length of time the full rate was being paid could be reviewed as a potential cost saving measure.

3. Integrated Care and Locality Working

Throughout the year under review, the Sub-Committee was kept up to date with work to integrate health services locally as well as to establish a locality model in Havering. The Integrated Care Partnership (formerly Accountable Care Organisation) sought to address challenges of reduced funding for both the Council and Havering Clinical Commissioning Group. The rising population of and demand for health services in North East London also required a different way of working.

Localities would be set up, dividing Havering into three areas with key priorities for the different localities being children's health, referral to treatment issues and urgent care pathways. GPs had been involved in the design of the locality model but there remained workforce issues with many GPs approaching retirement age. At the Sub-Committee's April meeting, it was noted that an integrated rehabilitation and reablement service has recently been launched and it was hoped this service would reduce duplication and hence benefit Havering residents.

4. Corporate Performance Reporting

Throughout the year, relevant performance information was scrutinised by the Sub-Committee. This included discussion of Council performance in areas such as the successful completion of drug treatments, HIV testing and targets for participation in the national child measurement programme. Meeting this latter target allowed the collation of a database of information relating to childhood obesity.

5. Health Tourism

The Sub-Committee held discussions with senior BHRUT officers concerning fees for treatment for non-UK residents. The Sub-Committee scrutinised the amount of outstanding debts for treatment at the Trust and the number of patients this related to. Methods used to recover these debts were also discussed as was the support available for this issue from Havering Clinical Commissioning Group.

6. Public Health Service Performance Report

At its April meeting, the Sub-Committee discussed with a senior Public Health officer the section's performance and priorities. This included scrutiny of the recommissioning of the Council's sexual health services and the increased representation of public health on safeguarding groups. The Council's strategy to deal with childhood obesity was also discussed.

7. Delays in Referral to Treatment

Throughout the year under review, the Sub-Committee has been engaged in a joint, in-depth scrutiny review with Healthwatch Havering. This has covered an investigation of the reasons for delays in referral to treatment at BHRUT together with recommendations for how similar problems could be avoided in the future. This joint review with the local Healthwatch organisation is believed to be one of the first instances of such joint working in the UK and has proven a very positive experience for both sides. It is planned for the final report of the joint review to be published in June 2017.

8. Healthwatch Havering

The Sub-Committee continued to enjoy a productive working relationship with Healthwatch Havering. A director of the organisation attended most meetings of the Sub-Committee and was allowed to ask questions of witnesses. The Healthwatch Havering annual report was presented at the July meeting of the Sub-Committee. The organisation which represented users of local health and care services had conducted a number of 'enter and view' visits to health and care facilities and published reports of these on its website. Healthwatch was also represented on organisations such as the Health and Wellbeing Board and the local Urgent Care Board.

Later in the year, the Sub-Committee was able to discuss in more detail the visits Healthwatch members had undertaken to local GP Practices. Issues discussed included a lack of knowledge of the out of hours GP service amongst local residents and instances of surgeries sharing the same premises but, in the view of Healthwatch, failing to work together. Healthwatch Havering had also recommended that Havering CCG should ask all its Practices to review their resilience plans following problems at one surgery caused by flash flooding in 2016.

9. Outer North East London Joint Health Overview and Scrutiny Committee

Throughout the year under review, the Sub-Committee was represented by Councillors White, Patel and Alexander on the Joint Health Overview and Scrutiny Committee covering Outer North East London. This Committee allows scrutiny of health service issues covering more than one Council area and, in addition to Havering, includes representation from Barking & Dagenham, Redbridge, Waltham Forest, Essex and Epping Forest Councils.

Among the issues scrutinised by the Joint Committee, which met on four occasions during the year, were the following:

Improving Access to Psychological Therapies (IAPT) – This service, run by the North East London NHS Foundation Trust (NELFT) aimed to improve access to psychological therapies at the primary care level. NELFT officers explained the services available which were mainly based on forms of cognitive behavioural therapy. Access to the service was via a person's GP or via self-referral.

NELFT – At the Joint Committee's October meeting, senior NELFT officers explained the issues facing the Trust. This included a nursing shortage leading to a reliance on bank and agency staff (this was a problem seen nationally) and the decision to close and refurbish the Brookside Unit for Child and Adolescent Mental Health, following concerns raised by the Care Quality Commission.

Sustainability and Transformation Plan – The Joint Committee received a detailed briefing on the Sustainability and Transformation Plan (now renamed the East London Health and Care Partnership). This included contributions from several members of the public who were allowed to address the Committee and raise concerns about the proposals. Discussion by the Committee included what services would be retained at King George Hospital, the impact on Queen's Hospital A & E if the department at King George was to close and the accessibility and format of public documents issued in relation to the plans.

Open Dialogue – The Joint Committee was briefed in January by the Associate Medical Director at NELFT on Open Dialogue – a new technique that allowed people with mental health issues to be seen with their family or friends network. Havering, along with Waltham Forest, had been chosen as pilot locations for the project and it was hoped that funding would be received to enable a large-scale trial of the technique to take place.

London Ambulance Service – The Joint Committee has also scrutinised the work of the London Ambulance Service during the year with the rising demand for ambulance services and recruitment issues facing the service being discussed with senior Trust officers. Work with partners such as GPs and NHS 111 was in progress to seek to reduce the level of demand for ambulances.

BHRUT Care Quality Commission Inspection - The recent reinspection of BHRUT by the Care Quality Commission had identified several areas of good practice such as children's services and services for dementia. The Committee was pleased that

the Trust had now exited special measures and agreed to take a further update on progress with the safety of services at the Trust.

IMPLICATIONS AND RISKS

Financial implications and risks:

None – narrative report only.

Legal implications and risks:

None – narrative report only.

Human Resources implications and risks:

None – narrative report only.

Equalities implications and risks:

While the work of the Sub-Committee can impact on all members of the community, there are no implications arising from this specific report which is a narrative of the Sub-Committee's work over the past year.

BACKGROUND PAPERS

None not already in public domain.

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE
28 JUNE 2017

Subject Heading:	Nominations to Joint Health Overview and Scrutiny Committees
CMT Lead:	Daniel Fenwick, Director of Legal and Governance
Report Author and contact details:	Anthony Clements Tel: 01708 433605 Anthony.clements@havering.gov.uk
Policy context:	To agree the Committee's nominations to serve on the Outer North East London Joint Health Overview and Scrutiny Committee and any pan-London Joint Health Overview and Scrutiny Committee.

SUMMARY

Havering has previously played a major role in the Outer North East London Joint Health Overview and Scrutiny Committee (ONEL JOSC) as well as in the pan-London equivalent. The Committee is therefore asked to confirm its nominations to both Committees for the current municipal year.

RECOMMENDATIONS

1. That, in line with political proportionality rules, the Committee nominate three Group Members as its representatives on the Outer North East London Joint Health Overview and Scrutiny Committee for the 2017/18 municipal year.

2. That the Committee nominate the Chairman as its representative at any meetings of the pan-London Joint Health Overview and Scrutiny Committee during the 2017/18 municipal year.

REPORT DETAIL

There are a large number of proposed changes and other health service issues that affect a considerably wider area than Havering alone. Issues related to Queen's Hospital for example impact not just on Havering residents but also those from Barking & Dagenham and Redbridge as well as parts of Essex. Mental health issues, under the remit of the North East London NHS Foundation Trust, impact on all these areas as well as Waltham Forest.

As regards formal consultations, Members should note that it is a requirement (under the NHS Act 2006 and the Health and Social Care Act 2011) that all Councils that are likely to be effected by proposed changes to health services must form a Joint Health Overview and Scrutiny Committee in order to exercise their right to scrutinise these proposals.

In light of these requirements, the boroughs of Barking & Dagenham, Havering, Redbridge and Waltham Forest as well as Essex County Council have formed a standing ONEL JOSC to deal with cross-border issues. Further details of the Committee's work and copies of the reports etc. it has produced can be obtained from officers and are available on the Council's website. It is suggested that the Sub-Committee agree, as in previous years, three representatives to sit on the ONEL JOSC, in line with proportionality rules. It is suggested therefore that Councillors White, Patel and Dodin are nominated as the Sub-Committee's representatives as this will most closely fulfil the political proportionality requirements.

Some issues, such as changes to stroke and trauma services, impact across the whole of Greater London and all boroughs therefore need to be involved in the scrutiny of these areas. As such, arrangements have previously been in place for a pan-London JOSC to meet when such proposals are brought forward. Previous practice has been that the Chairman represents Havering at any pan-London JOSC meetings and the Sub-Committee is requested to agree this for the 2017/18 municipal year.

IMPLICATIONS AND RISKS

Financial implications and risks:

There are none arising directly from the report. The work of the Sub-Committees mentioned is supported by existing staff resources and minor budgets within

Democratic Services. With regard to the Joint OSC, the other four participating Councils make a financial contribution towards the support provided by Havering staff.

Legal implications and risks:

None.

Human Resources implications and risks:

None.

Equalities implications and risks:

None although one outcome of effective health scrutiny will be to reduce health inequalities for Havering residents.

BACKGROUND PAPERS

None.

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Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, 28 JUNE 2017

Subject Heading:	Sub-Committee's Work Plan 2017-18
CMT Lead:	Daniel Fenwick
Report Author and contact details:	**Anthony Clements, 01708 433065, Anthony.clements@onesource.co.uk**
Policy context:	**The document attached outlines a suggested work programme for the work of the Sub-Committee during 2017-18.**
Financial summary:	**No impact of presenting of information itself.**

The subject matter of this report deals with the following Council Objectives

Communities making Havering	[X]
Places making Havering	[]
Opportunities making Havering	[]
Connections making Havering	[]

SUMMARY

A proposed work programme for the Sub-Committee is attached for discussion and adoption by the Sub-Committee.

RECOMMENDATIONS

1. The Sub-Committee review the attached work plan, make any changes that it wishes and adopt the final work plan for the 2017-18 municipal year.

REPORT DETAIL

The attached document suggests an outline work programme for the Sub-Committee during the 2017/18 municipal year. The Sub-Committee is asked to review the work plan and make any amendments that it wishes. The Sub-Committee is then asked to agree the final work plan.

Members may find it useful to leave some capacity spare for future meetings in order to deal with consultations or other urgent issues that may come up during the year.

IMPLICATIONS AND RISKS

Financial implications and risks: None of this covering report.

Legal implications and risks: None of this covering report.

Human Resources implications and risks: None of this covering report.

Equalities implications and risks: None of this covering report.

BACKGROUND PAPERS

None.

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE, WORK PLAN 2017-18

28 JUNE 2017	**7 SEPTEMBER 2017**	**30 NOVEMBER 2017**	**1 MARCH 2017**
ANNUAL REPORT	DIGITAL ROADMAP FOR INTEGRATION BETWEEN HEALTH AND SOCIAL CARE	BHRUT WINTER PRESSURES PLAN	JSNA UPDATE (PUBLIC HEALTH)
DELAYS TO TREATMENT TOPIC GROUP REPORT	PUBLIC HEALTH BUDGET	INTEGRATED CARE PARTNERSHIP UPDATE	GP PRIMARY MEDICAL SERVICES CONTRACT (BHR CCGs)
JHOSC NOMINATIONS	STP UPDATE	HEALTH TOURISM (BHRUT)	
HEALTHWATCH: MEALS AT QUEEN'S HOSPITAL	UPDATE RE CARE HOME CHARGES	NELFT PLANS GOING FORWARD	
HEALTHWATCH: MENTAL HEALTH STREET TRIAGE	HEALTHWATCH ANNUAL REPORT		

Possible topic group reviews:

1. GP surgeries – Are they in the right place and are there enough of them? Or:
2. How is the Health and Wellbeing Board driving the integration of health and social care?

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