MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Waltham Forest Town Hall
8 April 2014 (3.40 - 6.25 pm)

Present:

COUNCILLORS

Barking & Dagenham	Sanchia Alasia
Havering	Wendy Brice-Thompson, Nic Dodin and Pam Light
Redbridge	Stuart Bellwood, Vanessa Cole and Filly Maravala
Waltham Forest	Khevyn Limbajee (Chairman) and Richard Sweden
Essex	Chris Pond

Healthwatch representatives present:
Richard Vann, Barking & Dagenham
Ian Buckmaster, Havering
Mike New, Redbridge

Health scrutiny officers present:
Masuma Ahmed and Glen Oldfield, Barking & Dagenham
Anthony Clements, Havering (clerk to the Committee)
Jilly Szymanski, Redbridge
Corrina Young and Farhana Zia, Waltham Forest

Health officers present:
Victoria Wallen and Emma James, BHRUT
Rylla Baker, NHS England
Dr Russell Razzaque and Fiona Weir, NELFT

45 **CHAIRMAN'S ANNOUNCEMENTS**

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

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

Apologies were received from Councillor Syed Ahammad, Barking & Dagenham and from Jaime Walsh, Healthwatch Waltham Forest.

47 DISCLOSURE OF PECUNIARY INTERESTS

Councillor Richard Sweden disclosed an interest as he was employed by North East London NHS Foundation Trust.

48 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 13 March 2014 were agreed as a correct record and signed by the Chairman.

49 BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST (BHRUT) PATIENT EXPERIENCE

The head of PALS and complaints at BHRUT explained that there had been a large rise in the number of enquiries received by PALS. Many of these were due to issues relating to the new Trust computer system such as appointment letters being duplicated or not being received. IT solutions to address this had now been put in place. There were however still concerns about patients being able to amend appointments etc.

There had been an increase in compliments received compared to the previous quarter. The highest proportion of both compliments and complaints related to A&E. Information could also be provided anonymously on the NHS Choices website which for the first time had seen more positive than negative comments relating to the Trust. The positive comments related mainly to maternity and A&E. Negative comments related mainly to difficulties in telephoning the hospital and all comments were responded to by the BHRUT Interim Medical Director.

The overall number of complaints had risen in the last quarter although the Trust response rate to complaints had also improved in that period. It had been found that patient surveys by kiosk or hand held device had not received a large response so patient surveys were now completed on paper as this generated a larger response rate from patients.

As regards the Friends and Family test, BHRUT was achieving a score of 65 for adult inpatients and 42 for A&E. This was slightly below the target for adult inpatients and well below that for A&E. It was accepted that a lot of work was required to improve patient experience in A&E.

A lot of information for patients had been placed on the BHRUT website. A patient handbook and a bedside handbook of information were also being developed. Patients could also nominate individual staff members for recognition or pass messages and comments direct to the Matron.

Measures to improve patient experience included the appointment of two patient & staff experience facilitators who spoke direct to patients on each ward. Information was reported back to wards monthly and it was wished to increase this. Welcome boards were also being installed in each ward.

Future developments would include the introduction, as part of a national initiative, of patient headboards indicating if for example patients suffered from dementia or needed assistance at mealtimes. More easy read patient literature would also be introduced.

Following a pilot scheme, a bereavement questionnaire was being introduced which would be sent to next of kin eight weeks after a patient's death. Departments were also asked to specify what they had learnt from complaints that had been reported. Patients were also beginning to relate their stories and experiences at staff induction and training and at Trust Board meetings.

A mystery shopper programme using real patients would commence shortly. Monthly patient experience reports were produced and the previous year's survey responses were also analysed.

The BHRUT officer was aware that there continued to be complaints concerning the hospital telephone and computer systems. It was accepted that it was not possible to answer every phone call at present and further information could be provided on plans to deal with this.

It was clarified that the red tray and butterfly schemes to indicate patients who needed help with feeding or had memory difficulties would continue and that the patient headboards would be in addition to these. New methods of changing appointment via the Trust website or the PALS office were also being considered. The instances of people receiving a number of duplicate letters for the same appointment had been caused by the new Trust computer system and these had now reduced.

All enter and view reports submitted by Local Healthwatch were logged and the officer would check where these were presented to although this was believed to be BHRUT's Quality and Safety Committee.

Patients comment cards were collected weekly from the wards. A recent instance of a number of cards completed by the same individual had been brought to the attention of the Ward Sister but it had not been possible to identify the specific patient involved.

The complaints and PALS teams had recently been restructured and there were now 3.8 whole time equivalent PALS officers and 2 PALS administrators. The PALS office at Queen's was open from 10 am–12 pm and 2-4 pm and could also be contacted by phone or e-mail. People with urgent problems could be seen outside those times. The office at King George had been shut due to lack of staff but had now reopened from 10 am – 12 pm and would be open the same hours as the Queen's office within two weeks.

The Committee **noted** the presentation.

50 GP SERVICES IN OUTER NORTH EAST LONDON

It was explained by the Deputy Head of Primary Care (London) at NHS England that this was a national organisation that had commenced in April 2013 with a very broad role. NHS England was responsible for commissioning services directly and for assuring the work of Clinical Commissioning Groups (CCGs).

Core GP services i.e. those operating from 8 am – 6.30 pm were commissioned by NHS England which also commissioned community pharmacies, optometry and dental care. NHS England procured, monitored and performance managed contracts and sought to raise the quality of primary care and poorly performing GPs. NHS England was also responsible for GP premises.

CCGs commissioned secondary care such as hospital care as well as non-core primary care e.g. special GP services. The NHS 111 service was also commissioned by CCGs.

There were however a number of overlaps between the two roles such as the estate strategy which was likely to see more services located on the same sites. NHS England and the CCGs also had to agree the primary care strategy together. The primary care strategy had a number of priorities including empowering patients and the public, publishing clear quality outcomes, and developing the workforce, GP premises and IT.

NHS England expected to see GP practices working together on a bigger scale in order to achieve economies of scale. This would see more extended opening hours and the officer felt that some GP surgeries would be open until 10 pm very shortly. GP practices would also make more use of text messaging and virtual consultations. More hospital-based services would move into the community although the position would be different in each borough.

It was explained that there were a lot of part-time GPs in the sector. As more practice nurses etc were introduced, the size of a practice list normally went up. Appointments at GPs were organised by the individual practice rather than NHS England and there were no targets for numbers of appointments in the current GP contracts. Patients should make complaints initially to the GP practice. NHS England received information annually concerning the number of GP complaints but not on specific issues.

Population information was held by the public health team in each borough and was also contained in the Joint Strategic Needs Assessment for each borough. This was the same for Essex and Epping Forest and it was

agreed that the clerk to the Committee should ask NHS England for the GP statistics for the Essex area.

It was explained that NHS England arranged premises development but that NHS Property Services managed the buildings themselves and associated phone and IT systems. Many GPs had currently bought their own buildings. NHS England's view was that many GPs could not give a full service to patients due to poor premises and it was therefore better to have groups of clinicians working together. The issue should be the quality of care and health outcomes rather than the number of practices. Comments on NHS Choices and reports from Healthwatch were considered but it was difficult to performance manage under the existing GP contracts.

The NHS England representative felt that GP appointments should be able to be obtained in 24-48 hours. There were however large variations in this and it was accepted that delays in appointments had to be addressed. Details of a practice in Havering with a one-month wait for a GP appointment would be passed to NHS England by the Healthwatch Havering representative outside of the meeting. The total list sizes given by NHS England appeared to be larger than relevant borough populations and this may have been due to GPs having incentives to keep patients on their lists if they move out of the area. The list management work undertaken by NHS England was expected to have an impact on this in the next quarter. It was **agreed** that revised figures and a report on GP list sizes should be taken at a future meeting of the Committee.

If an individual GP was exhibiting poor performance, NHS England would seek to address this by drawing up an informal remedial action plan or issuing a breach notice against that contract. Cases of across the board poor performance would be worked on with the General and Local Medical Councils as well as with the Care Quality Commission. Issues such as diabetes and TB targets for GPs would be worked on jointly with the CCGs. GPs working with other practices would also influence this. It remained the choice of the GP whether to employ e.g. practice nurses.

NHS England remained unhappy that practices were not open long enough and CCGs would now commission an extra half hour of appointments for each 1,000 patients. This would aim to save patients from attending A&E if they were unable to get a GP appointment.

The NHS England officer felt that, of the for example 52 GP surgeries in Havering, this should be reduced by one third. She felt that too many Havering practices were open too few hours and that there were too many with less then 3,000 patients on their list.

NHS England hoped that the new GP contract would specify minimum standards. Members were concerned that NHS England should advise the local population of any GP closures and ensure that elderly people had a surgery nearby. There were for example two wards in Redbridge that did not contain a single GP practice. Pharmacies were commissioned by NHS

England and there was sometimes a difficult relationship between pharmacists and GPs. CCGs should be asked why GPs were not using local pharmacies. Essex pharmacies had developed a reporting scheme to improve working with GPs and it was **agreed** that more details of this scheme should be taken at a future meeting of the Committee.

Cases of duplicate registration should not occur although it was noted that, under a new scheme to be introduced from October 2014, patients would be able to register in two places. It was confirmed that primary care services were free to all at the point of contact and that overseas visitors could access primary care services without the need for a visa etc.

Patient Participation Groups were paid for by the respective practices and NHS England felt it was important that these groups continued to have an influence. It was **agreed** that a recent Waltham Forest scrutiny report on GPs would be circulated to the Committee.

The Committee **noted** the presentation.

51 MENTAL HEALTH SERVICES IN OUTER NORTH EAST LONDON

The NELFT representatives explained that access to hospital mental health in-patient services was normally via the NELFT home treatment teams. The establishment of teams had led to a reduction in the number of admissions to hospital. With effect from May 2014, NELFT would also be responsible for adult duty emergency services. There was a rising demand for referral into mental health services.

Mental health assessment opening hours were being extended in Waltham Forest and it was hoped do the same in the other NELFT boroughs. Psychiatric liaison services were accessible from the three local acute hospitals and it was aimed to direct mental health service users away from A&E.

Outpatient clinics were no longer used but community multi-disciplinary teams were used to offer short-term interventions. For older adults, the memory service was in place across the four boroughs. There were also strong links with the Alzheimer's Society and other groups. Work was also in progress with Admiral Nurses in three boroughs and with the third sector with initiatives such as the Alzheimer's Café.

It was explained that the work of the home treatment teams had led to only needing a low bed base in acute wards. There were two female 20-bed wards and three male 20-beds wards as well as a psychiatric intensive care unit. Female intensive care beds were spot purchased as required. Two complex recovery wards covered the four boroughs. Specialist in-patient

services included Moore ward comprising 12 beds for patients with learning disabilities and Brookside – a tier 4 in-patient unit for young people. There remained two female and two male wards for older people.

Emergency mental health admissions via the police were conducted under section 136. There were two suites for this at Sunflowers Court where staff were available to carry out assessments. Once assessments were completed, patients would be moved to wards.

It was the case that there was no statutory requirement under some forms of section for patients to continue to be supervised after their release. There would however normally be some monitoring of these cases by the community recovery teams. The key was to ensure monitoring and stabilising of people in the community.

In-patient detox services were no longer commissioned but each borough had its own substance misuse services. It was confirmed that some psychological services continued to operate at Thorpe Coombe in Waltham Forest. The NELFT officers would supply further information concerning continuing care for older people in Waltham Forest.

The IAPT (Improving Access to Psychological Therapies) team was a primary care service. The team operated by phone or face to face but contacts were mainly by phone and allowed specialised cognitive behavioural therapy for depression or anxiety. The service was accessed by self-referral although information could also be given a person's GP. Details on accessing the service were also available on the NELFT website.

Budgetary information was given in the NELFT annual report and the Trust was required by Monitor to retain a certain level of reserves.

The Committee **noted** the presentation.

52 INFORMATION ITEM: OUTCOME OF REVIEW OF PROSTATE CANCER SERVICES PROPOSALS

The Committee noted that the report of the review by the London Clinical Senate into the proposals for changes to services for prostate cancer had been delayed and was now expected to be available towards the end of April. It was agreed that the clerk to the Committee should circulate this to all Members once it was available.

53 URGENT BUSINESS

The Committee was addressed by a representative of a patients' group in Essex concerning the cancer and cardiac proposals following a recent decision by the Essex Health Overview and Scrutiny Committee to refer the group to the Joint Committee. The representative felt that the views of

Essex residents, particularly as regards access to alternative facilities under the proposals, had not been sufficiently taken into account and that mandatory, full public consultation should take place.

Members noted the address and sympathised with some of the views expressed. It was pointed out however that the Joint Committee had already reached a decision on the proposals and this included a strong recommendation that scrutiny of all aspects of the plans should continue as they were implemented.

The Committee **agreed** to note the continuing discontent with the cancer and cardiac proposals in the Essex area.

It was suggested that the Committee should review GP contract arrangements at a future meeting.

The Chairman stated that the work of the Joint Committee had been very valuable and recorded his thanks to the Committee Chairmen from the different boroughs and to the officers supporting the Committee.

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Chairman