MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
8 September 2015 (7.00 - 8.50 pm)

Present:

Councillors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Jason Frost and Linda Hawthorn

Also present:

Dr Susan Milner, Interim Director of Public Health
Anne-Marie Dean, Chairman, Healthwatch Havering
Caroline O'Donnell, Integrated Care Director – Havering, North East London Foundation NHS Foundation Trust (NELFT)
Carol White, NELFT
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Anthony Clements, Principal Committee Officer

11 **ANNOUNCEMENTS**

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

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

Apologies were received from Councillors Gillian Ford and Carol Smith.

13 **DISCLOSURES OF PECUNIARY INTEREST**

There were no disclosures of interest.

14 **MINUTES**

On minute 6 – Havering Access Hubs and Weekend GP Provision, it was clarified that the Urgent Care Centre at Queen's Hospital was run by the GP Federation and the Urgent Care Federation at King George Hospital was run by the Partnership of East London Cooperatives (PELC).

The minutes of the meeting held on 24 June 2015 were otherwise agreed as a correct record and signed by the Chairman.

15 ST GEORGE'S HOSPITAL

The Chief Operating Officer of Havering CCG explained that the CCG had submitted an outline business case for the development of a health and wellbeing centre on part of the St George's site. Possible facilities that could be incorporated on the site included primary care, NELFT community services, outpatient clinics currently based at Queen's Hospital, voluntary and community sector facilities and a training centre. Given the demographics of the local population, the overall facility would have a focus on frail elderly patients.

NHS England had asked the CCG to provide further detail in their business case on the predicted activity levels at the new facility and on the economic case for the proposals. This was currently in progress and it was planned to resubmit the outline business case to NHS England by early October. It was emphasised that the CCG was committed to making the St George's scheme happen.

It was possible that NHS England could require empty space in existing NHS buildings to be utilised rather than building a new facility but the CCG did not feel there were any existing alternative local health facilities that were not already being fully used.

It was hoped to receive a decision on the Outline Business Case from NHS England by December with a detailed business case to be submitted within six months of approval. Final approval was hoped to be received within a further six months of submission of the final business case. Plans would be brought to the Sub-Committee as the project progressed.

X-ray services would be made available on the St George's site if it was felt these were required. The CCG was aware of the increasing and changing nature of the local population and wished to modernise primary care accordingly. The CCG had noted with interest the results of a survey carried out by the local ward Councillors on what services people wished to see at St George's. The CCG representative felt that the results indicated a wish for a similar group of services to that which the CCG was proposing.

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

16 INTERMEDIATE CARE

It was explained that the CCG wished to move more care closer to home and have less reliance on hospital-based services. To this end, two new services – the Community Treatment Team (CTT) and Intensive Rehabilitation Service (IRS) had been introduced and proven a major success.

The NELFT representative confirmed that the CCT provided a rapid response to patients in crisis or to facilitating discharge. The CCT comprised doctors, nurses, physiotherapists and occupational therapists who provided short-term support to patients in their own homes. The service was available 8 am – 10 pm, 7 days per week.

The IRS offered support from physiotherapists, occupational therapists and nurses in people's homes 7 days per week, 8 am – 8 pm. The service normally responded to a referral within 24 - 48 hours.

The CCT dealt with around 1,600 Havering referrals per quarter. This was approximately 55% of the tri-borough service and reflected the older population within Havering. 93% of referrals to the service were seen in their own homes and patient feedback on the service had been very good. The service had also reduced levels of demand on A & E. It was confirmed that a care plan was established for each patient and this was referred to by staff each time a patient was visited.

The IRS received 280-300 Havering referrals per quarter, around 50% of the total service. 98% of patients had been found to improve during this treatment and length of stay with the service had increased from 7 to 15 days on average. Regular surveys of patient experience were undertaken and patient feedback had been very positive for both services.

As regards system resilience, both services contributed to winter planning. The CCT had established with the London Ambulance Service a falls car whereby a paramedic and CTT nurse visited people who had fallen at home. It was considered that one falls car was currently sufficient to cover the three local boroughs but any increase in the service would be considered by the system resilience group. The service was currently available 7 days per week, 12 hours a day.

The services had received national recognition, being shortlisted for the Health Service Journal awards and requests to view the work undertaken had been received from Finland and the Netherlands. Future plans included the integration of services at the front door of A&E such as older persons' services and ambulatory care. It was planned to co-locate beds at King George Hospital but this was still being finalised with BHRUT and would be brought to the Sub-Committee in due course. Concerns about the change of services that had been raised in Redbridge were being addressed.

Seven per cent of patients seen were not able to be treated at home, often because their conditions were too complex. Patients would be admitted to hospital if this was found to be the situation.

It was noted that the services did not cover the neurological pathway and were for more routine conditions rather than specialist areas e.g. multiple sclerosis. Time spent with patients was not limited and CTT and IRS staff stayed with patients as long as was necessary, depending on a patient's need.

There were approximately 43 WTE staff on each team but officers would confirm this. There were currently four vacancies at the CTT and none at the IRS. While five locums were used overall, there was little staff turnover in either service.

The Chairman of Healthwatch Havering confirmed that the organisation strongly supported both services, feeling they provided excellent treatment and gave a voice to the elderly and most vulnerable people in the community.

The Sub-Committee **NOTED** the update and the work of the two services.

17 CCG UPDATE

Vanguard Programme – It was confirmed that the CCG, with partners, had successfully bid to develop a Vanguard programme, the only such project in London dealing with urgent and emergency care. The CCG had organised a conference on these issues in July 2015 which had concluded that new technology needed to be used more in urgent care. There were too many unnecessary patients at both A & E and GPs and it had also been found that it was necessary to join up relevant pathways and invest in the workforce.

The CCG had jointly bid for the Vanguard programme as part of the System Resilience Group and in conjunction with the GP Federation, NELFT and Barking, Havering and Redbridge University Hospitals NHS Trust. The bid was based around a concept of 'click-call-come in' whereby people could firstly use technology to self-care or to book appointments direct. NHS 111 was seen as a gateway to the system and would have a directory of services available that could be used by its staff and other health professionals. More serious cases would still be asked to attend A & E or an Urgent Care Centre where necessary.

The bid formed a two-year programme for the local health economy. It was planned to develop a new care model by March 2016, involving both residents and local clinicians in this work. Work to move to the new system was planned to begin by October 2016 and new contracts and pricing would be developed by March 2017. Full implementation of the new system was anticipated by October 2017. This work would be funded by the award of a share of a National Transformation Fund.

A local launch of the Vanguard was planned for mid-October 2015 which would be open to stakeholders. It was accepted that more promotion of this area was needed with, for example, use of Facebook to promote the 'Not Always A&E' message. You Tube and mobile phone applications could also be used. The Healthwatch Havering Chairman added that it was important

to ensure that the Vanguard contracts fully reflected what people wanted from services before messages were publicised in the community.

Richmond Fellowship services – It was confirmed that the CCG had decided to reprovide some employment support services provided to mental health services users. Meetings were held quarterly with the new provider – Richmond Fellowship and feedback from service users had been positive. The service target had been to give support to 300 service users in the first year but 254 service users had been assisted in the first six months alone. Officers would supply details of the numbers of service users who had gone on to employment, education, training or volunteering and it was also agreed to seek to set up a visit to the Richmond Fellowship Havering base in order that the Sub-Committee could discuss the services offered directly. More information would also be given on the indicators used to assess the performance of the Richmond Fellowship.

Everyone Counts – The CCG had been encouraging this programme to develop GP services for the over 75s. Sixty schemes had been approved by GPs which would be monitored by the CCG. Examples included schemes introducing health assessments at home by GP practice staff.

Other issues – The CCG and Health & Wellbeing Board had been nominated for an APSE award for their system resilience work and the CCG's work on end of life care had also been recognised. The CCG's work on co-commissioning of GP services was also progressing.

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

18 HEALTHWATCH HAVERING ANNUAL REPORT 2014/15

The Healthwatch Havering chairman explained the organisation was an individual consumer champion for every individual in the community. Healthwatch had a direct line of accountability to Healthwatch England and the Care Quality Commission.

Healthwatch Havering had a team of around 30 volunteers most of whom had a background in either the NHS or social services. Volunteers undertook enter and view visits and determined the selection criteria and priorities for these themselves. Notice was usually given of enter and view visits as Healthwatch was keen to work in partnership with the NHS and social care facilities. All enter and view reports were published on the organisation's website. In 2013/14, nine elderly care homes and seven nursing homes had been visited.

Healthwatch members sat on the Council's Quality and Safeguarding Board, Health & Wellbeing Board and the Primary Care Commissioning Board. Healthwatch had established a positive and supportive relationship with both NELFT and BHRUT.

Views of local residents were collected by Healthwatch Havering via 'have your say' events, meetings with carers and relatives of vulnerable groups and attending meetings of groups such as the Havering Over 50s Forum. The content of the Healthwatch Havering website had also recently been expanded.

Healthwatch's work on learning disabilities had seen a higher number of Havering people with learning disabilities having GP healthchecks and receiving health action plans. Registered patients with learning disabilities were now flagged up on arrival at local hospitals, hospital passports had been introduced for this group and 80 learning disability champions had been trained at the Hospitals Trust.

Healthwatch Havering governance arrangements had been reviewed and the role of volunteer specialist advisor had been introduced to increase the volunteer knowledge base. Enter and view procedures had also been reviewed and benchmarked. All Healthwatch Havering board meeting minutes were now published on the organisation's website.

Funding for Healthwatch from the Council in 2013/14 had been £129,000 and the difficult financial climate had meant that a supplementary grant had been withdrawn, giving total funding for 2015/16 of approximately £117,000. There were a total of 2.31 full time equivalent paid staff at the organisation.

The Healthwatch Chairman clarified that, if patients or residents were felt by enter and view volunteers to be at risk, the Council would be contacted immediately. Officers present stated that both Havering CCG and NELFT had very good relationships with Healthwatch Havering and valued the work undertaken by the organisation.

The Sub-Committee **NOTED** the Healthwatch Havering Annual Report 2014/15.

19 **URGENT BUSINESS**

The Havering CCG Chief Operating Officer reported that the GP hubs service was now being used more frequently at weekends and would supply further details. Increased numbers of children were now being seen at the weekend hubs rather than going to A & E.

A Member suggested that it may prove useful to advertise alternatives to A & E in schools and the CCG officer agreed to consider this.

Chairman

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