MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Redbridge Town Hall, Ilford
19 January 2016 (2.00 - 3.57 pm)

Present:

COUNCILLORS

Havering	Nic Dodin, Gillian Ford and Dilip Patel
Redbridge	Stuart Bellwood, John Howard (Chairman) and Karen Packer
Waltham Forest	Richard Sweden
Essex	Chris Pond

Co-opted Members
Ian Buckmaster,
Healthwatch Havering
Mike New, Healthwatch
Redbridge

Also present:
Cathy Turland, Healthwatch Redbridge
Matthew Hopkins, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Kathryn Halford, Chief Nurse, BHRUT
Rachel Royall, BHRUT
Jan Stevens, Interim Chief Nurse, Barth Health NHS Trust
Jo Carter, Barts HealthNHS Trust
Dr Russell Razzaque, Consultant Psychiatrist and Associate Medical Director, North East London NHS Foundation Trust (NELFT)
Zoe Anderson, Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs)
Dr Sarah Hayes, Barking & Dagenham, Havering and Redbridge CCGs

Anthony Clements, Havering (minutes)
James Holden, Waltham Forest
Paul Umfreville, Redbridge

One member of the public was also present.

All decisions were taken with no votes against.

19 CHAIRMAN'S ANNOUNCEMENTS

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

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

Apologies were received from Councillors Peter Chand and Eileen Keller (Barking & Dagenham) and Gavin Chambers (Epping Forest).

21 DISCLOSURE OF PECUNIARY INTERESTS

There were no interests disclosed.

22 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Committee held on 20 October 2015 were agreed as a correct record and signed by the Chairman.

23 NURSING SHIFTS

The Chief Nurse at BHRUT explained that nurses at the Trust worked a variety of shifts and a system of long days with 12.5 hour shifts was available. This included one hour of breaks, split throughout the day. Around 20% of nurses sometimes worked this shift pattern but there was a mixed model available to staff.

Staff were only allowed to work two long days or four long nights in succession and the Chief Nurse felt this was a safe level. Two successive days off were required to be taken each week and staff got at least one weekend in every four off work.

Family commitments meant that some staff often preferred to work 2-3 long days each week and this could also reduce costs of childcare and commuting. Full-time employees at BHRUT worked 37.5 hours per week and were not permitted to work in excess of 48 hours per week unless they had signed a special opt out clause. These cases were also monitored by the Trust.

The Barts Health Interim Chief Nurse explained that offering a variety of shifts was the recognised norm across the NHS. The large numbers of nursing vacancies was also a challenge. The Trust was also aware of the risks of staff making mistakes if they were too tired and had similar controls in place to prevent people working excessive hours. Approximately 20-25% of staff at BHRUT had signed to work in excess of 48 hours per week although no staff were permitted to work more than 56 hours at the Trust in one week.

Both Trusts used e-rostering systems which ensured that staff had the required breaks of at least 11 hours built in. Continuity of care needed to be established across shifts and it was felt that this was the responsibility of the Sister in charge of the ward and how they built the nursing team. Officers agreed that it was important that the handover between shifts was robust enough to ensure that all key information was shared. Ward teams comprised 35-50 people and it was felt the availability of longer shifts encouraged the recruitment and retention of permanent staff and hence better continuity of care.

It was confirmed that the shift patterns were available to all grades of ward staff. Clinical nurse specialist working in clinics were likely to work more of a Monday – Friday, 9 am to 5 pm pattern. Senior nurses above Sister level tended to work a longer shift pattern.

It had been proposed by the Secretary of State to remove bursaries from nurses entering training although this had not been finally agreed as yet and would not impact on the two Trusts until at least 2017. Both Trusts had their own schemes to support nurses to train. The Royal College of Nursing had recently launched its own consultation on this issue and officers would obtain further details. It was noted that universities had in fact supported the ending of bursaries as there were 5-10 applications for each nursing place. Officers agreed however that proper discussion was needed before any changes were made. The BHRUT Chief Executive added that he would welcome further discussion on this issue and suggested this be considered by the Trust's Local Representative Panel.

The Portuguese nurses recruited to BHRUT had been settling in well and further recruitment exercises in Europe were planned by the Trust. Recruitment from the Philippines was also being considered. Barts Health had also recruited a lot of international nurses for whom there was dedicated support available. BHRUT held interviews face to face (in English) and insisted that nurses recruited could both speak and understand English. Barts Health also required nurses to sit an exam in English. Support at both Trusts was given to foreign nurses not just in understanding medical terminology and general orientation but also in practical issues such as opening a bank account.

All newly qualified nurses underwent an 18 month induction programme at Barts Health and spent two weeks on training and development before being counted as part of the ward staff. New staff were also supported by the Ward Sister and via a buddy system.

The option of long shifts was also available in training and a balance of experience was sought on ward rosters. There were not specific figures kept of the ratio of trained to training nurses on wards. The number of nurses and Health Care Assistants on wards was however monitored twice a year and this information was published on the NHS Choices website. These audits looked at professional judgements of what constituted an appropriate

nursing level and had recently led to an agreement to recruit 500 further nurses across Barts Health. Daily Safety Huddle meetings also allowed for a response if staffing levels were down.

The number of nursing training places had already gone up following a national review of workforce planning. The rising age of the nursing workforce was also an issue and it was noted that a new grade of Associate Nurse (above Health Care Assistant) was also being introduced.

It was suggested that if Members had further concerns re the number of training places, representation could be made on this matter to Health Education England. A Member added that she could raise this matter with colleagues on the Community Wellbeing Board of the Local Government Association.

The Committee **NOTED** the presentations and thanked officers for their input to the meeting.

24 OPEN DIALOGUE TREATMENT

The Associate Medical Director at NELFT explained that the cost of mental ill health to society was likely to double over the next 10 years. Funding for services was also reducing so it was necessary to look at more cost effective ways of providing services.

NELFT managed most people in the community and hence had the second lowest bed base in the UK. Studies had shown that people who had better social and family networks had better mental health outcomes in the long run. The National Institute of Clinical Excellence had therefore recommended that more family therapy should be provided but there were cost implications to this. A survey by the Care Quality Commission had shown that only 58% of service users had family or friends involved in their care.

The Open Dialogue technique had started in Finland where staff had been trained in family therapy and related skills. A patient's family was at the heart of the care provided and this led to better outcomes. 74% of people treated under Open Dialogue were discharged within two years. The system was now used throughout Scandinavia and also in Germany and the USA.

The core principles of Open Dialogue included the provision of immediate help and the involvement of social or family networks. It was also important to ensure psychological continuity with the same team responsible for a person's treatment. Therapists were also trained to use the dialogism technique whereby everyone's voice was able to be heard.

Open Dialogue also allowed the flexibility and mobility for a user to take charge of their own care. Clinicians were also trained in the Mindfulness technique and made use of peer support whereby people with experience of mental health issues joined the team.

A proportion of mental health teams in Havering and Waltham Forest had now been trained in Open Dialogue and it was proposed to roll out the service to the rest of the NELFT area over the next year. NELFT training in Open Dialogue comprised a four week residential course which trained its first cohort of students in October 2015. Approximately 90 further members of staff were due to be trained this year. A post-graduate diploma in this area was also being developed with London South Bank University.

Initial feedback from service users had been very positive with patients becoming advocates for the service and considerable positive press coverage being generated. Staff reaction had also been very positive. The Department of Health had also shown interest and full roll out of Open Dialogue in trial areas would take place by January 2017.

Referrals would be made to the Open Dialogue staff instead of to a mental health crisis team. It was noted that in other countries communities had successfully developed of people with similar mental health issues. Similar communities were also now seen in Nottingham and Somerset. The Open Dialogue Technique was supported by the Care Act and officers agreed that it was important that service users received continuity of care.
Costs of the Open dialogue technique would be monitored and it was accepted that costs at the outset may be higher than alternative treatments. The Associate Medical Director felt however that the technique would reduce the costs of services in the long term. It was emphasised that the same team would be able to continue to treat people as in-patients.

It was **AGREED** that open dialogue be scrutinised again by the Committee at its meeting in January 2017 in order to consider the results of the trial of the service.

25 PROPOSED CHANGES TO STROKE REHABILITATION SERVICES

The clinical director for the project explained that current stroke services were variable and resulted in a ‘postcode lottery’. There were for example in-patient units at Beech ward, King George Hospital and Grays Court in Dagenham, with different providers, which was a confusing situation for patients. This was a factor explaining why patients in this sector spent longer periods in hospital and had longer recovery times.

Commissioners wished to see a gold standard quality of care across Outer North East London but national standards were not currently being met consistently. There was also not sufficient capacity in the system to meet future demand for stroke services. This demand was likely to rise by around 35% in the future.

A case for change for stroke services had been developed and a workshop held with stakeholders. This had established a preferred option based on improved patient outcomes. This would combine early supported discharge

with community rehabilitation services across all three affected boroughs, together with an in-patient unit at King George Hospital. These services would all be supplied by a single provider. It was felt that this model would allow for improved patient outcomes and also allow the best value for money.

There was currently in progress a 12 week consultation period which would include on-line questionnaires and hard copies of documents being available in GP surgeries. There would also be drop-in sessions arranged for each borough and work was also being undertaken with the relevant Healthwatch organisations. The consultation was due to close on 1 April 2016. All responses would be considered and the final decision would be made by the three CCG governing bodies.

The impact of the preferred option on Barking & Dagenham would mean more patients receiving care at home and any in-patients being treated at King George Hospital. The future of the Grays Court facility would be decided in conjunction with London Borough of Barking & Dagenham. The impact on Redbridge would be similar with Wanstead residents receiving support from the Early Supported Discharge service which would provide services such as speech and language therapy and psychotherapy. The new arrangements would operate in a similar way within Havering. It was noted that Redbridge stood to gain the most under the new arrangements, particularly in the Wanstead and Woodford areas.

A representative of Healthwatch Redbridge confirmed that the organisation had been fully involved and had worked on producing an accessible version of the consultation documents. Healthwatch Redbridge was happy with the methods used in the consultation and pre-consultation exercises.

Officers were currently establishing what was considered best practice around staffing levels, bed numbers etc but were confident that sufficient staff could be attracted to make the model function successfully.

It was confirmed that the former Heronwood & Galleon inpatient unit for intermediate care in Wanstead had now closed.

Councillor Pond explained that the Essex Health Overview and Scrutiny Committee had supported the move of first stage stroke treatment from Harlow to Queen's Hospital. In-patient treatment would also move from Epping to Harlow. Officers admitted that there was some uncertainty around cross-border issues and would check if Essex residents living near the site would be able to use the stroke in-patient beds at King George Hospital. The outcome of this could be reported back to the Essex Health Overview and Scrutiny Committee.

The Committee **AGREED** their support for the proposals to change stroke rehabilitation services subject to the outcome of the consultation and confirmation of the situation regarding Essex residents.

26 HEALTHWATCH REDBRIDGE - ENTER AND VIEW VISITS

The Chief Executive Officer of Healthwatch Redbridge explained that the organisation currently had a total of 61 enter and view reports, 46 of which looked at the issue of GP complaints systems. Other issues covered included access for deaf people in A & E departments, intermediate care and promoting dignity in health and care.

All GP practices in Redbridge had been visited regarding their complaints procedures. Two thirds of practices had been found to have information on their complaints procedures on display but a lot of information such as phone numbers or references to the now closed Primary Care Trusts was out of date. A number of practice staff had been found to have little knowledge of the relevant practice's complaints system and other practices' systems were too complex with for example only written complaints being responded to.

Healthwatch had made recommendations that all GP practices should update and simplify their complaints processes and also make complaints information accessible in alternative formats. Healthwatch Redbridge was also assisting Healthwatch England and the Ombudsman with national work on complaints handling and had been invited to present at a national conference on this subject.

Deaf inclusion work had covered 13 London boroughs and been funded by Health Education England. Healthwatch Redbridge had therefore trained 17 deaf volunteers to undertake enter and view visits. Accessible videos had been produced and Healthwatch Redbridge had led a stakeholder conference on this area. A & E departments at Queen's, Newham and University College Hospitals had been visited to look at barriers for deaf people. Queen's had been ranked the best in this regard.

Outcomes from the enter and view work had included that further funding had been secured from Health Education England. Healthwatch Redbridge now wished to work with other groups with sensory difficulties such as visual, brain injuries and stroke sufferers. Engagement work was also in progress with the Vanguard sites re disabled access and Healthwatch Redbridge had won three national awards for this work.

On intermediate care, the profile of this area had been raised through scrutiny work and Healthwatch Redbridge had made recommendations regarding more carer and patient involvement. It was accepted that there was further work to be undertaken on this area.

A total of ten enter and view visits had been undertaken looking at dignity in health and care. Healthwatch Redbridge had run a conference on the outcomes of this work and was planning a day event on 1 February 2016. A

public event re the consultation on stroke rehabilitation services was also being planned.

27 **URGENT BUSINESS**

There was no urgent business raised.

Chairman