**MINUTES OF A MEETING OF THE**
**HEALTH OVERVIEW & SCRUTINY COMMITTEE**
**Havering Town Hall**
**28 February 2012 (7.30 pm – 10.05 pm)**

**Present:**

Councillors Pam Light (Chairman), Wendy Brice-Thompson, Nic Dodin, Frederick Osborne, Linda Trew and Barbara Matthews (substituting for Councillor Brian Eagling).

Councillor Paul McGeary was also present.

Apologies for absence were received from Councillor Brian Eagling

Also present:

Andrew Atack, Heartstart Havering
Neill Moloney, Director of Planning and Performance, Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT)
Jacqui Himbury, Borough Director, NHS Outer North East London (NHS ONEL)

Stephanie Dawe, North East London NHS Foundation Trust (NELFT)
Fiona Weir (NELFT)

Three members of Havering Local Involvement Network (LINk) were also present.

18 **ANNOUNCEMENTS**

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

19 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

20 **MINUTES**

The minutes of the meeting held on 7 December 2011 were agreed as a correct record and signed by the Chairman.

21 **HEARTSTART HAVERING**

The officer from Heartstart Havering explained that the organisation had been set up in 1992 by the British Heart Foundation to spread knowledge of Cardiac Pulmonary Resuscitation techniques in the general population. Free courses of approximately 2.5 hours in length were offered by the organisation covering essential information regarding how to save a person's life. Heartstart Havering ran its first course in 2002 and had run a total of 247 courses, training 3,360 people since 2003. A further 25 adults and 55 children had been trained so far in 2012.

The organisation had no budget for publicity and a bid for funding from the Community Chest had been unsuccessful. Course dates had however been set to the end of 2012 and an on-line booking system had been set up. A text information system was also on trial.

Heartstart Havering was keen to ensure that defibrillators got to people as quickly as possible. The AED defibrillator read the level of electrical activity in a person's heart and gave an electric shock to the heart if necessary. The use of the defibrillator was demonstrated to the Committee who felt that it was easy to use with clear, audible instructions. AEDs were already available on all platforms at Romford station as well as in shopping centres and libraries. The aim was now to try and put AEDs on streets in residential areas.

Each AED unit cost £1,000-£1,500 and would be maintenance free for 5-7 years. Several pilot areas to have an AED located had been identified in Havering in order that several hundred houses could be within as little as a three minute walk of an AED machine. Outdoor cabinets for the AED machines were available at a cost of £400 - £1,000. As a measure against vandalism, the cabinets included a photograph of each person that opened the cabinet, which could also be e-mailed to the Police if necessary. Emergency 999 calls could also be made from the cabinet. Heartstart Havering wished for the Committee's support for future applications for funding for the scheme.

Members felt the scheme was a good idea but remained concerned about the risk of vandalism of the equipment. Perhaps the machines could be sited inside tower blocks or at petrol stations and supermarkets where there was less risk of vandalism etc. The AED machines self-checked on a daily and weekly basis but it was also envisaged that local people would do weekly checks of the equipment. It was accepted the spraying of graffiti on the equipment could probably not be prevented.

The representatives from BHRUT and NHS ONEL supported the AED idea. The borough director from NHS ONEL felt the locating of the machines in residential areas could be given a trial and the strategy reassessed if necessary.

The Committee **agreed** that, while not controlling any funding itself, it was otherwise happy to support the Heartstart Havering project. This would include written support of the plans if required.

## 22 BHRUT UPDATE

The Director of Planning and Performance at BHRUT explained that additional beds were being put in at King George Hospital to cater for in the region of seven births per day. A small amount of maternity activity had also been shifted to Essex (20-30 births per month). The Essex arrangements had been due to continue until April but this had now been relaxed due to capacity issues in Essex. Planned caesarean section deliveries would continue to take place at Homerton Hospital until the end of March at which point this arrangement would cease as the cap on numbers of deliveries at Queen's would be lifted from 1 April. It was accepted by the Trust that transferring caesarean sections to the Homerton was not ideal but it was felt that it was now acceptable to bring these deliveries (approximately 3-5 per week) back to Queen's. The Care Quality Commission was also supportive of this change starting from 1 April.

The capital funding of approximately £1.5 million for improvements to maternity funding at Queen's had now been agreed. It was anticipated that works would be completed by November 2012 at which point A&E activity would begin to transfer from King George to Queen's. Capacity issues at Whipps Cross and Newham hospitals would also be considered as part of the Health for North East London programme. Members were anxious that services at King George were not reduced until the new facilities were in place.

There were a range of options to accommodate the extra demand for A&E services at Queen's including converting the current renal or sexual health units. The BHRUT officer would update the Committee further on these plans in due course.

Tenders had been released for the operating of the Barking Birthing Centre and the formal contract would be awarded shortly. More detailed work on this would also be needed.

Figures for staff assaults at BHRUT were as follows:

Calendar year 2011 – 149 incidents of verbal abuse and 113 of physical abuse.
April 2010 – March 2011 – 175 verbal abuse and 144 physical abuse.
April 2011 – December 2011 – 114 verbal and 80 physical

The Committee agreed unanimously that such amounts of abuse of staff were unacceptable and officers agreed to ascertain if figures for the proportion of assaults relating to drink or drug abuse could be provided. It was also noted that funding had been received for the installation of mobile A&E tents in Ilford and Romford town centres in order to deal with alcohol-related incidents.

£5-7 million funding was available for reablement and other local schemes to reduce readmission to hospital.

The incidence in the recent LINK report concerning a lack of ECG and blood pressure apparatus had been investigated by the Director of Nursing but such equipment was not considered necessary in low risk births (one third of the total). There was sufficient equipment available to cover all high risk births. Any broken machines were repaired by the contractor – Catalyst within a set turnaround time. Equipment was checked by the supervisory midwife for each shift as well as via the Trust's Visible Leadership programme.

There were approximately 11,000 births per annum in the Trust area although this would be approximately 9,500 – 9,800 this year due to the effects of capping of delivery numbers. Mothers were given a choice of venues at which to give birth. The Health for North East London plans would also mean that it would be more convenient for some women to give birth at Whipps Cross once the maternity unit at King George was removed. Officers agreed that Whipps Cross was currently operating at full maternity capacity and plans for how the hospital would cope with this extra demand would be brought to the Committee once they had been finalised.

A Member raised the issue of people smoking outside the entrance to the maternity unit, the smoke from which then came on to the unit via the open windows. The BHRUT officer agreed to investigate this. Signs were put up and people smoking outside of designated areas were challenged but staff often received considerable verbal abuse when doing this. A member felt that the Trust's expenditure on smoking shelters outside the hospital had been a waste of resources and that the main hospital entrance area was in a very poor condition.

A&E consultants were currently on call but BHRUT was looking to move to 24 hour consultant cover on site at A&E. A further 8-10 consultants would have to be recruited in order to achieve this.

It was clarified that Heather Mullin would lead the work on the transfer of services from King George to Queen's but the final decision on when the move took place would be a decision for the relevant Clinical Commissioning Groups (CCGs).

The NHS ONEL borough director explained that midwives remained legally responsible for the care of a baby for 28 days up to birth. A Member explained that a haemorrhaging new mother had recently returned to maternity where staff had simply referred her to A&E. BHRUT officers agreed that this should not have happened and would investigate this further.

The norovirus was an issue at the Trust and it was accepted that there would always be some outbreaks at the hospital. The virus was of a sudden onset with a short duration (usually 2-3 days) but was not usually that

serious. There was a comprehensive programme of staff training in place regarding norovirus in place at the Trust. Investigations were undertaken in all cases where there were two or more cases of diarrhoea or vomiting on a ward but results could take up to a week to be received. Affected wards were closed to admissions and discharges for 72 hours. Posters advising of the closure were also displayed at the ward entrance, the main hospital entrance and in A&E. Visitor numbers were limited and children were also discouraged from visiting affected wards.

A detailed cleaning schedule including steam cleaning was implemented for all wards affected by the norovirus. The ward was also "blitz cleaned" prior to reopening. BHRUT officers would e-mail to the committee officer information leaflets available for patients and visitors in order that these could be distributed to the Committee.

In 2010, 16 wards across Queen's and King George Hospitals were at one point shut simultaneously due to the norovirus. In 2011, no more than four wards had been shut at once and this was only for a short period. At the time of the meeting, only one ward, the stroke unit, was currently closed. There had been no incidents of norovirus reinfection since the ward closure period had been lengthened to 48 hours.

It was **agreed** that a standing item on the Health for North East London work should added to the Committee's agendas with effect from the next meeting.

## 23 HAVERING CLINICAL COMMISSIONING GROUP

The borough director explained that the Clinical Commissioning Group (CCG) was headed by a board of seven experienced clinicians, each leading on a particular area. The CCG would have to deal with a number of issues specific to Havering including a growing population and pockets of deprivation. Other challenges included issues regarding Queen's Hospital, introducing improvements to primary care and the rising demand for health services.

The CCG was already planning clinical improvements including the introduction of seven outpatient clinics in community settings and undertaking peer reviews of how individual practices were performing. Corporate successes included the merger of the previous two Havering CCGs into one organisation and a draft constitution being developed. The CCG board would operate as a shadow CCG from 1 April with delegated authority from NHS ONEL for the community budget. Overall responsibility for the budget would however remain with NHS ONEL for another year.

As regards engaging with partners, the CCG had undertaken a lot of work with patients, Councillors and the Local Involvement Network. Work was also in progress with the Health and Wellbeing Board. The borough director

accepted that there was a very challenging year ahead but was confident that the CCG would rise to the challenge.

Members were anxious to ensure that patients would not see any reductions in services but the borough director emphasised the CCG would have patients at its centre with the implications for patients of any changes being considered at the CCG board. The overall NHS budget had been uplifted by 2% but outpatient clinics located in the community as planned by the CCG would also be cheaper to operate than those in acute settings.

All GP surgeries would be required to have patient participation groups of which there were currently 12 in total. Lesley Buckland, NHS ONEL vice-chairman, was leading on patient engagement for the CCG.

A representative of Havering LINk was concerned about any possible loss of contact between patient and doctor as a result of these changes. The borough director responded that the GPs involved were funded to employ locums whilst they were engaged in CCG work. It was a matter for each practice to manage continuity of care. Two of the members of the CCG board were semi-retired and hence did less clinical work in any case. It was emphasised that overall GP consulting hours were not expected to reduce as a result of the CCG being set up.

The salaries paid to GPs were confidential but funding to set up the CCG equated to £2 per head of resident population and so totalled approximately £500,000. This was also expected to cover the costs of clinical backfill and engagement work. The budget was expected to be underspent at the end of the year.

The borough director was certain that the CCG would lead to an improvement on the existing healthcare system as the performance management framework introduced would address quality and financial issues.

The Committee was concerned that there were no female doctors on the CCG board but the borough director responded that there were a lot of women on the wider management team and that the transition year would see further changes.

**Chairman**