MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
3 October 2012 (7.00 - 9.45 pm)

Present:

Councillors Pam Light (Chairman), Wendy Brice-Thompson, Nic Dodin (Vice-Chair), Linda Trew, Ray Morgon and Frederick Thompson (substituting for Councillor Fred Osborne).

16 **ANNOUNCEMENTS**

The Chairman advised all present of the action to be taken in the event of fire or other emergency requiring evacuation of the building.

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

Apologies were received from Councillor Fred Osborne (Councillor Frederick Thompson substituting).

Councillor Steven Kelly was also present.

Officers present:

Lorna Payne, Group Director – Adults and Health, LBH
Neill Moloney, Director of Planning and Performance, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Jackie Doyle, BHRUT
Heather Mullin, NHS North East London and the City (NHS NELC)
Stephanie Dawe, Chief Operating Officer, North East London NHS Foundation Trust (NELFT)

Havering Local Involvement Network (LINk) members present:
Emma Lexton, Vice-Chair
Susan Fey
Joan Smith, Coordinator

18 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of interest.

19 MINUTES

In the minutes of the 4 July 2012 meeting, it was noted that the reference to "The Mayor" in item 1 should in fact read "The Chairman". The minutes were otherwise agreed as a correct record and signed by the Chairman.

The minutes of the meeting held on 6 September 2012 were also agreed as a correct record and signed by the Chairman.

20 CHAIRMAN'S UPDATE

The Chairman advised the Committee that she had held a lot of discussions with the Clinical Commissioning Group and Heather Mullin at NHS NELC regarding the future of NHS services in Havering and plans for St. George's Hospital. She had also recently attended a Havering LINK event with local pharmacists which had been very productive and wished to take a presentation from a local pharmacist at a future meeting.

It was hoped to visit the new beds at King George Hospital that would take over from those at St. George's. An invitation had also been received to see the JONAH discharge system in operation at Queen's Hospital. It was also planned to meet with the new director of midwifery at the hospital.

21 HEALTH AND WELLBEING BOARD

The Chairman of the Health and Wellbeing Board (Cllr. Kelly) explained that the Board's overall aim was to ensure an across the borough approach to both health and social care. The Board membership numbered twelve people including four Councillors, the Group Director for Social Services and the Director of Public Health. A representative of the Local Healthwatch for Havering would also join in April. This representative would be appointed by Local Healthwatch themselves and not by the Council. The Clinical Commissioning Group (CCG) was also represented.

No Government funding had been received to set up the Health and Wellbeing Board and other funding had been used to run 19 projects for the Board. These covered areas such as the number of rehab beds, falls, telecare, strokes and COPD. Each project was run jointly between the Council and health partners.

The Board also wished to have GP surgeries open, on a rota basis, on Saturdays and Sundays. The CCG would check that savings generated by the projects were reinvested into the borough. Another role of the Health and Wellbeing Board would be to agree the final budget of the CCG although this would be undertaken in partnership with the CCG itself.

The Health and Wellbeing Board also produced the Joint Strategic Needs Assessment and it was hoped to produce local health statistics as this would allow effective pre-emption of health problems in Havering. It was

hoped this would reduce both numbers of people going into hospital and rates of readmission.

There were seven priorities for the Health and Wellbeing Board:

1. Early help for vulnerable people to live independently. The Board felt that more work on long-term conditions of the elderly could reduce their need to attend or be admitted to hospital. The development of telehealth would reduce hospital admission and the Board also wished to tackle the isolation of elderly people.

   There would be more community based provision of reablement. Fifteen more beds were opening in Royal Jubilee Court. There would also be a move to allow more initial reablement to take place in people's homes.

2. Dementia identification and support – It was agreed that this was a growing problem in Havering and the Board wished to change attitudes and ensure that dementia was seen as an acceptable illness. An aim was to reduce the number of people on anti-depressants as this may increase dementia. The Health and Wellbeing Board could direct strategy on this. Better recognition of dementia was also needed by professionals to reduce instances of e.g. urinary tract infections being mistaken for dementia. The Board had also agreed to adapt some allotment units to be used by people with dementia.

3. Early detection of cancer – Early cancer detection rates in Havering were very low. If diagnosed early, survival rates were good but there was a need to have doctors better recognise the symptoms. The cancer department at Queen's was good but the Board felt the screening programme needed to be better.

4. Tackling obesity – A priority was to increase support levels such as exercise programmes in order to reduce levels of obesity, particularly in children.

5. Better integrated care for the frail and elderly – A new Integrated Care Coalition had been developed which would allow all major stakeholders to look at patient discharge. Issues such as doctors having to give a new prescription to allow drugs to be dispensed in care homes could be considered by this new body. A further aim of the Coalition was to increase the numbers of people able to die at home rather than in hospital etc. The Coalition was chaired by Cheryl Coppell.

6. Better integrated care for vulnerable children – A total of 470 cases were now specifically targeted by Children's Services with targeted social work support and other assistance.

7. Reducing avoidable hospital admissions – The Board felt it was essential to decide who needed to go into hospital. One option was to use a consultant stationed on the door of A&E to reduce admissions but opening GP surgeries at weekends would reduce A&E attendees. The Board also wanted to reduce waiting times for GP appointments and introduce more safeguarding controls for care agencies to stop people being admitted to hospital. It was also important to find out about the quality of service and patient experience received.

Enter and view visits would be undertaken by Healthwatch. The Chairman of the Health and Wellbeing Board felt that it was important that such visits were undertaken by skilled and trained people something that, in his view, had not always been the case under Havering LINk. A LINk representative responded that all LINk members were required to undergo a full day's training course and have a Criminal Records Bureau check before they were allowed to undertake any visits. Quality assurance of enter and view visits would be the responsibility of the Healthwatch board.

Communication of the health strategy would, in some instances, be the responsibility of bodies such as the NHS Commissioning Board or the Public Health Board. Locally, Living Magazine etc. could also be used.

The Health and Wellbeing Board Chairman felt that the capacity of GPs would need to be considered. There was no obligation on the CCG to fund Queen's Hospital and more money should be retained to be put into local primary care.

The Data Protection Act was a problem in attempts to help vulnerable older people as it was not possible to obtain information on local people above certain ages. Work was in progress with the NHS to try and improve this. The numbers of people in non-acute beds who lived alone was monitored and people on over 65 medical checks were also signposted to Council activities.

The Board chairman agreed that it was important that all potentially vulnerable older people were seen. The Activate Havering project aimed to contact isolated people and it was also being investigated how people not on benefits or funded social care could be contacted.

The Committee **noted** the update on the Health and Wellbeing Board.

22 BHRUT UPDATE

A number of new appointments had been made to the BHRUT management team. This included a new Director of Nursing – Flo Pannell-Coates who had started with the Trust that week. A number of new clinical directors had also been recruited.

Targets had been met by BHRUT for cancer waiting times and infection control. Complaint response times had also improved. Other achievements included receiving good or excellent ratings in recent PEAT inspections and lobbying for extra bus links to Queen's Hospital. Further work was underway on areas including the emergency care pathway, ensuring a better patient experience, staff culture, attitudes and behaviour.

The Trust was undertaking a large programme of staff engagement and had recently joined UCL partners with the aim of strengthening areas such as training and innovation. Several Clinical Fellows had also recently been recruited to BHRUT as had a new Director of Infection Control.

All but eight of the recommendations made in the Care Quality Commission (CQC) report had now been met or partly met by the Trust. A follow up inspection was held in September 2012 and all conditions imposed by the CQC on BHRUT's registration had now been lifted. As regards cancer services, 99.5% of patients were seen within two weeks with even many of the remaining 0.5% being offered appointments within this period but being unable to attend. The hospital mortality ratio at the Trust had improved to 94 against a London benchmark of 100.

The Trust had the best midwife to births ratio in London and also offered a high level of senior doctor cover in maternity. Building of the Queen's birth centre was due to be completed in October 2012 and the unit would comprise eight delivery rooms and four post-natal beds. Figures for numbers of births at BHRUT in the coming years were as follows:

2011-12 10,300 births across Queen's and King George
2012-13 9,200 births at Queen's, 1,900 at King George
2013-14 8,000 births at Queen's obstetrics and midwife-led unit only (this would include approximately 500 births from the Essex area).

Havering mothers would normally be allowed to have their deliveries at Queen's. Births that were expected to be more straightforward would be handled at the Midwife-Led Unit but this would still be on site at Queen's.

There were now four new emergency consultants at Queen's and the Deanery had also agreed the provision of additional junior doctor cover in A&E. The RESET programme was looking at discharge issues and the provision of additional capacity at Queen's A&E and the Critical Care Unit.

The Trust had recorded a £49 million deficit last year and planned to improve this by £10 million this year. A £40 million deficit control target had been agreed for 2012-13. Patient activity had shown a shift between elective and day cases and the BHRUT officer agreed to separate out activity figures for Queen's Hospital alone.

Approximately £15 million had been invested in the last year in facilities such as the Midwife-Led Unit at Queen's and the endoscopy and renal units at King George. An upgrade of pathology services was also being planned.

As regards hospital food, new menus were reviewed with Havering LINk and the Independent Patient Experience Group who had also been invited to attend during mealtimes. Any pre-chilled meals used at the hospital were required to follow nutritional guidelines.

Most cardiac arrest cases were taken straight to the London Chest Hospital as this was felt to be the best clinical outcome. Cardiac arrest cases presenting at Queen's would however only be transferred once they had been assessed and stabilised.

A range of BHRUT performance information was available in Board papers and also on the Trust's website. This included benchmarking information.

The Committee **noted** the update.

23 HOSPITAL RECONFIGURATION AND INTEGRATED CARE

The NHS NELC officer thanked the Committee Chairman, Cabinet portfolio holder and Group Director for their assistance with the options appraisal process in relation to St. George's Hospital. It was emphasised that there was no immediate problem with the hospital boiler and heating for the building would continue. There were however breaches of health and safety rules that would be addressed.

The officer felt that St. George's was not suitable as a rehab facility due to a lack of toilets, showers, laundry facilities and space on the wards. Immediate action needed to be taken due to the service being isolated and vulnerable. The provider board (NELFT) therefore had to decide if it could continue to run services safely from the site and had concluded that it could not. The changes were considered to be temporary and so could be implemented without public consultation. Four options for the relocation of rehab beds had been considered and Foxgolve ward at King George had been assessed as the best temporary option for the frail elderly beds at St. George's.

All other facilities would be staying on the St. George's site for the present and 24:7 security and boiler cover had been brought in. In the longer term, future plans for care were being considered as part of the Health and Wellbeing Strategy. Options for the longer term future of services would be brought both to the Committee and the Health and Wellbeing Board.

The ten stroke beds at St. George's would be replaced by seven beds at Greys Court in Dagenham – a centre of excellence for stroke services. This would allow NELFT to invest more in temporary community services. What services would be based at St. George's in the future was currently being considered. A new GP surgery was one possibility.

The Chief Operating Officer at NELFT added that an unannounced enter and view visit by Havering LINk had found the standard of care at St. George's to be of high quality. This would continue at King George and it

was likely many of the same staff would continue to deliver the service. Staff had been briefed on the location change and it was accepted that some staff may not wish to move to King George. Any surplus travel expenses incurred by staff would be covered by NELFT.

There were current 35 frail/elderly beds and 10 stroke beds at St. George's and these would be replaced by 30 frail/elderly beds at King George and 7 stroke beds at Greys Court. It was felt that greater flexibility in how the service was provided would mean these lower bed numbers would be sufficient.

As regards the longer term plans for St. George's, a business case was scheduled to be completed by the end of November 2012. This would detail which services would remain on site and include an outline time line for the changes. It was emphasised that NHS NELC was committed to keeping a health presence on the St. George's site. It was hoped to conclude the plans before responsibility for the site was handed to NHS Property Services at the end of March 2013. Urgency provisions could be used if necessary. Plans for the nursery on the St. George's site were uncertain at this stage.

Members emphasised that, in some cases, they had been approached by St. George's staff wanting to know what was happening. They felt that there was a need to communicate to people more clearly what was happening and the reasons for the changes. The NHS officers responded that the recent briefing note from NHS NELC did cover these points. The process of engagement on St. George's would include links with the local community. The process would be led by the current NHS NELC borough director who would report directly to Heather Mullin. It was agreed that the NHS NELC officer should give a weekly update to Members giving the latest position regarding St. George's. It was accepted that NELFT staff morale had lowered due to people not being engaged previously but this would be addressed.

A representative of Havering LINk felt it was essential for developments with St. George's to be communicated as soon as they were known. The key message to convey to residents was that only part of the site would be sold and that the money gained would be reinvested in local services. The NHS NELC officer responded that some of the capital receipts would cover the upgrade work at Queen's Hospital. The previous plans for St. George's had only gone to pre-engagement consultation although this was questioned by the LINk representative (a former NHS Havering director) who stated that the PCT had approved previous initial plans for St. George's.

The Chairman had been assured that facilities at King George would be better than the equivalent at St. George's with greater availability of showers, toilets etc. There would be a day room in the unit where patients could have meals if they wished and patients would be able to go to physiotherapy on site at King George. Being located on the King George site would also allow easier access to diagnostics.

The quality of the estate at Brentwood Community Hospital was an aspiration for rehab facilities in Havering but NHS officers felt the hospital's location was too inaccessible from Havering. The Chairman added that access from Havering to King George Hospital was also difficult and she would be asking the Council's transport planners to make representations on this. It was noted that there was now a direct bus route from Barkingside to Queen's Hospital.

Efforts would be made to move any staff not relocating to King George Hospital into community services and there would not be any redundancies as a result of the move. Further details would be given in the business case.

The Committee **noted** the updates.

24 HAVERING CLINICAL COMMISSIONING GROUP

The NHS officer explained that people were at the centre of the new healthcare system. The Havering Clinical Commissioning Group (CCG) was working under an interim operating model from 1 October. Lay members of the CCG were currently being recruited as was a nursing representative.

A dummy run for the CCG authorisation process would take place on 24 October with final authorisation in mid-December. The formal decision on CCG authorisation would be received in early 2013. The process would include challenging the CCG on areas in which it appeared to be non-compliant.

The transfer of public health functions to the council was underway and Alwen Williams, chief executive of NHS NELC was leading on the process of closing down the cluster Primary Care Trust on 31 March 2013. Attempts were being made to treat staff sensitively but this was a very large reorganisation.

The suggestion from a Member that a simple guide to the NHS be put in the spring issue of Living magazine would be taken forward by the NHS bodies.

The Committee **noted** the update.

25 HAVERING LINK ANNUAL REPORT

The LINK coordinator introduced the report and gave apologies from the LINK Chairman – Med Buck. The LINk had worked productively during the year with the Committee itself, NHS Havering, the Council's adult social care section and other providers.

An enter and view visit (undertaken, like all such LINk visits by fully trained staff) had been carried out at Queen's maternity. The LINk representatives

had received a good overall impression of the unit although staff morale had been found to be low.

At the request of the Committee Chairman, the LINK had also visited Sunrise ward at Queen's Hospital and had found that the red tray system to denote people needing assistance at meal times was not working properly. The LINk had therefore made a number of recommendations to ensure the red tray system was working properly and also covering areas such as the prompt removal of dirty crockery and increasing the number of healthcare assistants.

A follow up visit in April 2012 found that the red tray system was now working better. A meal manager had been appointed and dirty crockery was now removed as a priority. The number of healthcare assistants had doubled and an administrator was now employed on the ward.

Two topic group meetings had been held in conjunction with the Committee looking at the issue of patient discharge from hospital. The report produced by the LINk had been discussed at senior levels during meetings between the Council's Adult Social Care section and BHRUT. The LINk's report had also led to improved working between Social Care and NELFT.

During the year the LINK had also arranged for improvement to the 'quiet room' at Queen's Hospital with the installation of e.g. non-denominational pictures. A Care Quality Commission compliance inspector had also recently praised the work of the LINk.

The LINk looked forward to the forthcoming introduction of Healthwatch and thanks were also recorded to the Council's Principal Committee Officer for his support of the LINk's work.

The Committee **noted** the annual report of Havering LINk.

26 AGEING WELL - PROSPECTIVE AGENDA ITEMS

It was agreed that a meeting of Overview and Scrutiny Committee Chairmen and Vice-Chairmen be held in the new year to consider the work in this area that had been undertaken and what further issues concerning the ageing population could be scrutinised. One suggestion was for the relevant committee to consider the impact of housing and associated issues on older people.

27 URGENT BUSINESS

There was no urgent business.

Chairman