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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
7 February 2013 (7.00 - 10.20 pm)

Present:

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

Apologies for absence were received from Councillor Ray Morgon (Councillor Barbara Mathews substituting).

42 **ANNOUNCEMENTS**

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

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

Apologies were received from Councillor Ray Morgon (Councillor Barbara Matthews substituting).

Councillor Paul McGeary was also present.

Officers present:

Joy Hollister, Group Director – Social Care and Learning, London Borough of Havering,
Rinaldo Meza, London Borough of Havering, Adult Social Care
Gary Etheridge, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Neill Moloney, BHRUT
Victoria Wallen, BHRUT
Ilse Mogensen, NHS North East London and the City (NHS NELC)
Marie Price, NHS NELC
David Horne, North East London NHS Foundation Trust (NELFT)
Sarah Haider, Havering Clinical Commissioning Group (CCG)
Alan Steward, Havering CCG

44 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

45 MINUTES

The minutes of the meeting held on 20 November 2012 were agreed as a correct record and signed by the Chairman.

46 CHAIRMAN'S UPDATE

The Chairman explained that she, along with Members of the Committee had carried out scrutiny visits to a number of local health facilities. These had included the new Midwife Led Unit at Queen's Hospital with which Members had been very impressed. And Hornchurch Health Centre where it had been felt too much of the building was being used as office space.

A further visit had been made to Foxglove ward at King George Hospital as this was now being used to treat frail or elderly patients from Havering. Members had been disappointed however that there was no day room on the ward for patients and that the small gym areas being used partly for storage.

A visit had also been made to A&E at Queen's Hospital to discuss the Rapid Assessment and Treatment (RAT-ing) system. While the system itself had been viewed very positively, concerns remained that patients were not moving out of the unit sufficiently quickly due primarily to lack of available beds in the rest of the hospital.

The Chairman emphasised that the attitude of staff met throughout the visits had been uniformly excellent.

47 DELAYED TRANSFERS OF CARE OF ADULTS FROM HOSPITAL TO SOCIAL CARE SERVICES

The Council's service manager for preventative care explained that the JONAH system at BHRUT was used to track patients in hospital and should not therefore be used as a reliable tool to measure performance. It was explained that the number of delayed transfers of care for which the Council's Social Care directorate was primarily responsible was 1.8 per 100,000 cases in November 2012. This was slightly above the target of 1 case per 100,000 (which it was expected would be hit in due course) but did represent a considerable improvement on the position in April 2012. This meant that the reimbursement costs to the Council of delayed transfers of care had reduced by 50% compared to last year.

BHRUT officers confirmed that JONAH was not intended to be used as a performance management tool and that the Trust had a very good process in place to sign off delayed transfers of care. Members were also concerned

at the apparent ease with which hospital staff could alter data on the JONAH system. BHRUT looked on a weekly basis at the areas of the Trust that created the most problems as regards patient discharge and it was agreed that there was now good joint working to reduce delayed transfers of care.

Members felt it would be helpful if they could visit Queen's and meet with staff who actually operated the JONAH system. BHRUT officers accepted that nursing staff did not always keep the system fully up to date although this was now more of a priority. Havering social work staff also updated the system on a twice weekly basis.

Officers accepted that the lack of availability of residential placements or of adaptation equipment could sometimes lead to delays in discharge taking place. Delays were also sometimes due to lack of response or contact from patients' families. One solution could be to commence the discharge process earlier in a patient's stay. A planned date of discharge for each patient was identified at the point of admission.

It was explained that the JONAH system reduced the time spent by nurses on administration and hence enhanced patient care. Most nurses at BHRUT favoured using the electronic system.

Adult Social Care officers had been working since mid-November 2012 to increase the numbers of weekend discharges and there was now a team to facilitate this. Officers confirmed that BHRUT supported the principle of moving to a seven day a week service. Members felt however that there currently remained a lack of activity at Queen's Hospital at weekends.

The Committee **NOTED** the report.

48 ST. GEORGE'S HOSPITAL UPDATE

The Clinical Commission Group (CCG) chief operating officer confirmed that the CCG was committed to developing St. George's Hospital as a resource for the local community. The outline business case for the proposals was currently being worked on. The redevelopment process was driven by clinicians but the Council was seen as a key partner.

It was hoped to develop on the site a centre of excellence for older people, a diagnostics unit and an enhanced GP service. The CCG planned to consult on the proposals with stakeholders and local people. This would last for a 12 week period from 18 February. A consultation document would be published and drop in events held. Drafts of the consultation document would be circulated to the Committee and to Havering LINk. A separate consultation would be held at a later stage on the use of rehabilitation events on the St. George's site.

The position if plans for the site were not agreed by the end of March 2013 was still being worked through. Approval to proceed would transfer at that date from NHS London to the Propco organisation. There was however no cut-off date at present and work was proceeding with the aim of retaining within Havering revenue received from the sale of part of the site. It was emphasised that the CCG was absolutely committed to retaining these monies within Havering. Updates on the approval process that would be required would continue to be given to the Committee. It was not necessary for the strategic outline business case to be approved by NHS London. Should the money not be able to be kept for Havering, the CCG would seek to have discussions with the Council, Healthwatch and other stakeholders.

Members suggested that venues such as libraries and church halls be used for consultation events. The consultation documents would also be available on-line and officers would circulate the relevant links. No final decision had been taken as regards how much of the site would be sold. Medical services on the site would also need to be worked through although any GP surgery would be likely to operate for extended hours.

Members felt however that local people wanted as many services as possible on the St. George's site and that purely an enhanced GP surgery would not be sufficient. The proposed closure of A&E at King George Hospital together with problems experienced at Queen's A&E would, Members felt, justify locating a polyclinic-type facility on the St. George's site. This would reduce pressure on Queen's and benefit Havering as a whole. Services that Members felt should be located on the site included diagnostics, minor injuries and clinics for conditions such as diabetes or COPD. Officers agreed that a lot of these ideas were in the proposal. A polyclinic was not being proposed but the aim was to take the pressure off Queen's. Members emphasised that there would not be the opportunity to use this land again and that they wished to see as high a level of facilities as possible on the site.

It was **AGREED** that the Committee would take further updates on the plans for St. George's Hospital at each stage of their development.

49 NORTH EAST LONDON FOUNDATION TRUST (NELFT)

The NELFT service director explained that there were currently 800,000 people with dementia in the UK and this was expected to grow to at least 1 million by 2025. This cost the UK in the region of £20 billion each year.

NELFT ran a number of specialist services for older people as part of the National Dementia Strategy. Identification of younger onset dementia had improved but NELFT was also seeing more referrals of this type. The patient journey for dementia used to be very complex but there was now a

simpler and standard pathway across all the boroughs in which NELFT worked.

A central access and assessment function for the four NELFT boroughs was carried out by nurses based at Goodmayes Hospital. This included nurses going out with doctors to see and assess patients in their own homes. NELFT's memory service also operated across all four boroughs. A new facility was the NELFT community clinics which delivered care closer to home. This utilised GP services and care homes as locations from which to deliver mental health services. It was also noted that the acute sector now screened patients more routinely for dementia.

It was agreed that a high rate of depression was seen amongst older adults in hospital and it was therefore important to have good psychiatric liaison services in order to avoid hospital admission. A recent audit nationally had found that two thirds of anti-psychotic drugs prescribed were found to be unnecessary. NELFT had recently improved its performance with this sort of prescribing and officers would provide further details.

A recent visit by Japanese mental health professionals had looked at how NELFT reduced lengths of stay for older people with mental health problems. There was also now improved accessibility of mental health consultants to local GPs. The Trust's work on cognitive stimulation therapy was led by Professor Martin Orrell and programmes were in progress in both Havering and Barking & Dagenham to train carers to deliver this type of therapy. In Havering this programme was called 'Making a Difference' and officers would supply further details to the Chairman.

Consultants were able to recognise the typology of dementia although brain scans could be used if necessary. Members agreed that it was important to get an official diagnosis. It was accepted that the memory service at the Petersfield clinic had changed and officers would confirm what clinics were now located there.

A representative of Havering CCG reported that local GPs had not seen any problems arising from the NELFT changes. Prescribing of anti-psychotic drugs had indeed reduced and early diagnosis of dementia was also a priority. It was agreed that the relationship with care homes was important and more care homes were now aligned to a GP.

The Committee **NOTED** the presentation.

50 QUEEN'S HOSPITAL UPDATE

The Chairman explained that the Committee was sympathetic to the problems seen at Queen's Hospital and was pleased with the way maternity services had improved. The Committee had however seen no improvement in A&E and wished to help. The BHRUT officer agreed that the Committee had been very supportive and that the Care Quality Commission (CQC) still

had concerns over the performance of A&E. The Trust recognised that there were shortcomings in care and was trying to address the underlying causes for this. Particular issues raised by the CQC included staffing and the level of care offered.

Patients were kept too long in the majors area with, in some cases, waits of over 11 hours to be moved out of the department. In response, the Rapid Assessment and Treatment system had been extended to cover walk-in patients as well as those arriving by ambulance. The CQC was however also concerned about issues such as the dignity of patients, their storage facilities, the availability of washing facilities in A&E and a lack of consultants and junior doctors in the department.

It was noted that Queen's A&E was designed to see 90,000 patients per year but was in fact seeing 134,000 per year. The department was also seeing 73 more patients per day in 2012 compared to 2011. Queen's A&E also received the highest number of blue light ambulances in London. In December 2012, the four hour target for moving patients through A&E had been met on 80.68% of occasions compared to a target of 95%.

The pressure seen in A&E over the Christmas and New Year period was due to poor access to primary care at this time and less consultant presence in the department. Diverts were agreed with the London Ambulance Service when this was clinically necessary. Ambulances would normally be diverted to King George Hospital.

A number of changes had been implemented including the opening of a surgical assessment unit in February 2013. This allowed GPs to refer direct to the unit, bypassing A&E in suitable cases of orthopaedics, abdominal pain etc. Assessments of walk-in patients were not normally expected to take more than an hour. The Queen's sexual health service was being relocated which would allow the creation of extra capacity in the Urgent Care Centre. The new location of the sexual health service was yet to be finalised. The renal dialysis unit (provided by Bats Health) was also being moved from its current location.

Clinics were being piloted in the evenings and at weekends and this had received a good response from clinicians. Steps were also being taken to improve patient flow through the hospital by ensuring access to the same consultant on a ward for a number of consecutive days.

The radiology service was also being extended to weekends although outpatients were not given priority as regards access to scans. Nurse led roles were also being developed to support diabetic patients. It was also confirmed that there were contingency plans in case of a winter epidemic which included stopping elective surgery if necessary. There would also need to be engagement with partners in this type of scenario.

There had not been a discussion as yet with the CQC as regards capping A&E numbers but Members felt that there remained far too many people

going to A&E. The BHRUT officer felt that this feedback was very valuable and emphasised that King George Hospital A&E would not be closed until it was safe to do so.

Members felt that the Urgent Care Centre at Queen's should be used an alternative to A&E rather than being part of the same unit, perhaps with its own entrance. It would also be helpful if the Urgent Care Centre was listed in the recently published "Don't Go To A&E" booklet. The BHRUT officer responded that a lot of primary care patients did attend at A&E and it was wished to direct these patients back to their GPs. Patients with minor injuries would be dealt with at the Urgent Care Centre. Officers agreed that it would be better to make the Urgent Care Centre a separate area.

There were currently 9 A&E consultants in post at Queen's but 18-20 were needed to staff the unit. Agency staff were used but the unit remained short staffed. Additional registrars were also now based in the department. The stroke pathway was now very clear and the good results of a recent audit of this area would be brought to a future meeting of the Committee.

The rapid assessment and treatment process had been used to reduce the number of breaches in receiving patients from ambulances. Officers would provide details of those breaches that had occurred. There was no general policy to redirect ambulances from King George to Queen's.

Detail of the capital improvements across BHRUT was currently being worked on. It was accepted that A&E performance against national indicators had not improved but work was in progress to change the way in which care was delivered. Patient surveys were being carried out at Queen's with a recommendation of level of 90% being seen in maternity and 80-90% in patient wards.

The issue of patients being discharged with incorrect medication from the hospital pharmacy was also raised and the BHRUT officer agreed to take this back.

The Committee **NOTED** the update.

51 HOSPITAL COMPLAINTS

The BHRUT complaints manager explained that the Friends and Family survey had been running for three weeks in A&E. In spite of the problems seen in A&E, there were a lot of positives in the Trust.

In the period from 1 April to 31 December 2012, there were 866 complaints to the Trust of which 772 complaints were formal. It was expected that complaints would rise further due to the recent negative CQC report. Acknowledgement of complaints had improved and there was now a more

focussed procedure for dealing with complaints. This had led to a fall in the number of reactivated complaints.

The complaints backlog at the Trust had significantly improved. The most common subject for complaints was patient discharge followed by diagnosis issues and communication between staff and patients. The need for a high standard of care was now emphasised on all staff inductions and it was suggested that the Trust's patient experience strategy could be discussed at a future meeting.

It was accepted that staff attitudes/behaviour and access to appointments were challenging issues. These areas had improved in maternity and the Trust now wished to do the same in A&E.

Compliments to staff were also acknowledged and staff receiving compliments were written to individually by senior Trust management. It was agreed that patients wanted better communication and the Trust was looking at new ways of working in response.

Issues such as cancellations and lack of access to amend appointments were being addressed by the new outpatients manager. The friends and family survey was also now being extended to paediatrics and outpatients and approximately 2,000 surveys had been received in January 2013. Further details of the survey could be given to the Committee at a future meeting.

Systems had been put in place that helped the complainant and surveys now showed greater satisfaction around the complaints process itself. New complaints managers were being recruited and an easy read complaints leaflet had been introduced for complainants with learning disabilities.

Complaints were monitored weekly but feedback was also received through the PALS service, comment cards and comments left on the NHS Choices website (which were responded to by the Trust). Work was also being undertaken to improve the image of the Trust in the local press. A mystery shopper programme would also be introduced. Senior nurses also conducted care quality audits on a weekly basis.

(Standing orders were suspended at this point in order to conclude the business of the meeting).

Members agreed that Queen's performed excellently in many areas but expressed sadness that criticism of the standard of care in A&E had continued.

The Committee **NOTED** the presentation and **AGREED** that the BHRUT complaints manager should give an update at a future meeting.

52 **URGENT BUSINESS**

The Chairman congratulated Havering LINk on its enter and view work and thanked the organisation's representatives for doing this.

It was noted that the 111 non-emergency telephone service would receive an initial launch in Havering on 5 February 2013.

The Chairman confirmed that the 'Don't go to A&E' leaflets had been distributed to all Councillors. A new promotional campaign was also being launched using the www.notalwaysaande.co.uk website.

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Chairman

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