MINUTES OF A MEETING OF THE
HEALTH & WELLBEING BOARD
Commitee Room 2 - Town Hall
14 August 2013 (1.30 - 3.30 pm)

Present

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Dr Atul Aggarwal, Chair, Havering CCG
John Atherton, NHS England
Dr Mary Black, Director of Public Health, LBH
Cheryl Coppell, Chief Executive, LBH
Anne-Marie Dean, Chair, Health Watch
Joy Hollister, Group Director, Social Care and Learning, LBH
Cllr Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Alan Steward, Chief Operating Officer (non- voting) Havering CCG
Dr Gurdev Saini, Board Member, Havering CCG

In Attendance

Sir Peter Dixon, Chairman, BHRUT
Dame Professor Donna Kinnair, Clinical Director for Emergency Medicine, BHRUT
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Observers from Public Health and Havering CCG

Apologies

Conor Burke, Accountable Officer, Havering CCG
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH

36 APOLOGIES FOR ABSENCE & SUBSTITUTE MEMBERS

Apologies were noted and no substitute members were received.

37 DISCLOSURE OF PECUNIARY INTERESTS

None disclosed.

38 MINUTES

The Board considered and agreed the minutes of the meeting held on 10 July which were signed by the Chairman.

39 BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS TRUST PRESENTATION

Following quality and performance issues at Queen's Hospital A & E, and in particular, two recent Care Quality Commission (CQC) inspections, the Health and Wellbeing Board had invited representatives of BHRUT to discuss the following:

- In the light of the CQC reports, what the key issues were for the Trust and how it was planning to make further improvements in patient care and safety
- Effective patient flow through the hospital, particularly A&E, and compliance towards the 95% 4-hour A&E waiting time target
- How the Trust planned to improve its staffing capacity in the hospital, with particular reference to A&E
- What were the process issues to ensure effective and timely discharge of patients
- What the Trust's plans were in relation to winter pressures and how it intended to work with relevant partners to effect integrated care
- An update on the three work streams that the Urgent Care Board (UCB) had given BHRUT to lead on:
  - i) A&E recruitment
  - ii) Urgent Care Centre (UCC) at Queens (including redirection to primary care)
  - iii) Seven day working
- Further explanation of the BHRUT Chief Executive's letter of 18 July in relation to:
  - i) The strategic drivers, including risk assessments, underpinning the proposals outlined in the letter
  - ii) The approval process for the letter
- Whether BHRUT had any issues or concerns that it would like to raise with the Board.

The Chairman of BHRUT gave a presentation to the Board covering the following points. During the course of the presentation, various issues were raised by HWB Board members, the Chairman of BHRUT welcomed this interactive approach.

<u>Accident & Emergency – Queens Hospital</u>

It was acknowledged by BHRUT that there had been long standing concerns about the emergency care pathway and that BHRUT's performance was among the poorest in London for patients completing their care within 4 hours. The target performance

percentage for the year was 95% however the first quarter of 2013/14 was 88.59%. Performance had increased over the last four weeks to 93% although this was usual during the summer months. In summary, BHRUT stated that too many patients were waiting too long in the Emergency Department which was undesirable and could become clinically unsafe. The main reasons for this were assessment delays, bed waits and specialty response delays.

Care Quality Commission (CQC) Inspection

The result of the CQC inspection in May came as no surprise as the Trust had been aware of their shortcomings. The CQC had concerns about shortage of permanent medical staff and delays in the Emergency Department affecting the care and welfare of patients. Some improvements were noted in the report such as the provision of hot meals for patients awaiting hospital admission. The CQC had recommended radical thinking in order to tackle the reasons behind the poor performance and the Trust would have to submit revised plans to the CQC by September 2013.

It was brought to the attention of the Board that attendances at Queens's A & E had remained fairly consistent although there had been some change in severity of clinical condition. There had, however, been a 15% increase in patients arriving by ambulance – the average being 110 per day which made Queen's the busiest A & E department in London. A & E attendances had also risen from 90,000 to 132,000 last year.

BHRUT were also looking at patterns of attendance which were increasing over the weekend period as well as staffing to cover Saturday evening to Monday morning. There was limited consultant cover during this period and BHRUT were looking to address this.

Recruitment

The BHRUT officers also cited difficulty in recruiting staff as another reason for the poor performance and asked the Board to note that there was currently a national shortage of A&E doctors. Queens A&E should be staffed by a full complement of 21 doctors but there were only 7 permanent Accident & Emergency Consultants currently employed. The shortfall was being filled by locums and agency staff however this was not in the patient's interests and was also very expensive for the Trust. BHRUT was suffering from a lack of critical mass of senior consultants and without a critical mass of permanently employed doctors, it was difficult to recruit additional doctors. BHRUT asked the Board to note that the Trust had to compete with the London Teaching Trusts as well as the Helicopter Emergency Services in trying to attract staff and that recruitment to a full complement would take some time. A member of the Board

felt that these recruitment difficulties had been an issue at the Trust for many years.

BHRUT asked the Board to note that measures were being taken to improve the A & E experience at Queens such as:

- Possible specialty ward moves
- Introduction of longer periods of specialist cover so that the patient pathway flowed better through hospital care.
- Major staff recruitment efforts were on-going including five new joint appointments with Barts Health which allowed doctors to choose their speciality
- An international recruitment drive

The Board expressed concern about these recruitment challenges and reinforced the fact they believed overcoming these recruitment needs was essential and that BHRUT's reputation was key to solving this challenge.

Urgent Care Centre and Primary Care Referral

In meeting the challenges as presented, the Trust was working with their partners at NELFT and at the Clinical Commissioning Group trying to get patients treated in other environments as opposed to arriving at Accident & Emergency. The BHRUT officers thought that the public were confused about the various options for obtaining healthcare (e.g. 999, 111, Out of Hours clinics, Walk-in centres etc.) or picked up the phone too readily to send a person to A&E, particularly in the case of elderly care homes, and that there needed to be a clearer set of entry points.

With regards to the Urgent Care Centre, BHRUT stated that they were currently referring 12% of patients and acknowledged that this percentage needed to improve, however, they advised that patients will always go for the most accessible treatment. Moreover, it was not possible to force patients to leave A & E and go elsewhere and vital that they had the correct information. The CCG had requested further information on this practice and BHRUT was working with them to advise on their processes for redirecting to Urgent Care, GP streaming and navigation of administrative support. A new model for referral to the Urgent Care Centre was in the process of implementation.

The Board asked BHRUT to note that there were currently 200 GP slots available every weekday for Primary Care referral of which there had only been 10% uptake.

It was noted that the issue regarding redirection of patients through to Urgent Care/Primary Care be discussed at a future Health and Wellbeing Board meeting.

Urgent Care Board (UCB) Projects

Reference was made by Board members to the six major Urgent Care Board projects and the two further work streams led by the Integrated Care Coalition. BHRUT stated that it was difficult to assess at the current time as to whether they were working. The Board expressed concern that it was essential that BHRUT engaged fully with the whole health economy on projects that had been agreed. The Chairman of BHRUT gave his undertaking on this and asked that he be alerted if this did not happen.

Patients' waiting time in Accident & Emergency

BHRUT stated that waiting times on any two days can vary. The CQC report stated that on the first day of the inspection, the average waiting time was 3 hours 15 minutes. Officers explained that on the first day of the CQC inspection, there were two patients waiting for many hours, one of which was a Mental Health patient, which significantly increased the average waiting time for this day and was an anomaly. The average waiting time to see a specialist on day 2 of the CQC inspection was 15 minutes

Seven Day Working

BHRUT stated that a lot of preparation had been done on the seven day working initiative and that this would commence in Medicine on September 1st.

The Board expressed surprise that BHRUT could implement 7 day working without discussion and negotiation with the rest of the health economy and a challenge to BHRUT was laid down by the Board in this respect.

Discharge Procedures

BHRUT had been working on implementing a new discharge system to streamline the process and explained that the new Patient Administration System should be on-line soon. The Discharge Plan commenced when the patient entered hospital but there could be delays in the system around long stay wards, discharge medicine and externally through delay in social care assessments or rehabilitation bed availability.

The Board challenged the need for this to be a system wide response, not just BHRUT, and it was noted that a joint discharge process was one of the Urgent Care Board's priorities and that it was essential that BHRUT fully engage with this. The Chairman of BHRUT confirmed that he believed BHRUT would fully engage.

It was noted that the recommendations made regarding discharge procedures in the clinical review for BHRUT by McKinseys had not been implemented as yet.

Chief Executive's Letter – King George Hospital Proposed Night-time Closure of A & E

BHRUT apologised for the confusion caused by the correspondence relating to this matter. It was noted that no decision had yet been taken and that a Clinical Review was currently on-going of the BHRUT proposals. BHRUT's reason for the proposal was due to more blue light emergencies at Queens and that there were not enough staff grades/consultants to cover both sites. The closure of King George at night was only one option that was being looked at and the Board were asked to note that an Urgent Care Centre would remain at King George. The Clinical Review would be exploring all issues, in particular, clinical safety. BHRUT noted they had a duty of care to patients and insufficient staff in one site may present a clinical risk, which was unacceptable. BHRUT believed the review may suggest that combining the two resources into one would be a safer option even though it was acknowledged this would have some impact on patients – ie displacement.

The Board members challenged the proposal, whilst recognising and welcoming that an urgent and independent Clinical Review would resolve the matter. Board members questioned why more immediate measures such as the enhanced use of the Urgent Care Centre at Queens was not being prioritised if the clinical position at Queens was considered by its Board and management to be unsafe.

After some discussion, a conflict of view between the CCG and BHRUT emerged about the contractual position with regard to the Urgent Care Centre. This was of concern to the Board and the Chairman of BHRUT agreed it should be resolved urgently.

It was noted that if the review advised for closure of King George's A & E at night, there would be a need to work together in order to send the right message as it was a possibility that surrounding boroughs may disagree. It was also noted that the UCB would not oppose this option if proven that it was a safe move.

In summary, it was agreed that there needed to be more joint communication between the Trust and the Local Authority. In terms of Queen's Hospital's reputation, this was going to take a long time to turn around, however, it was agreed to try to find a way to publicise the Trust's excellent work in Cancer and Neurology.

It was noted that the NHS England representative would forward the results of the Clinical Review (site visits and desk top exercises) to the Health and Wellbeing Board as soon as it was available

The Chairman on behalf of the Board thanked Sir Peter Dixon and Dame Professor Donna Kinnair for their presence and contribution to the meeting.

40 DATE OF NEXT MEETING

The Board was asked to note that the date of the next meeting was scheduled for 11 September 2013.

Chairman