MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Redbridge Town Hall
13 January 2015 (2.00 - 5.05 pm)

Present:

COUNCILLORS

Essex	Chris Pond
Havering	Nic Dodin and Gillian Ford
Redbridge	Stuart Bellwood, Mark Santos (Chairman) and Tom Sharpe
Waltham Forest	Richard Sweden

Healthwatch representatives present:

Ian Buckmaster (Havering)
Mike New (Redbridge)

Officers present

Nilesh Mistry, Community Pharmacist
Rob Burns, Director of Planning and Information, Great Ormond Street Hospital for Children NHS Foundation Trust
Wendy Matthews, Director of Midwifery, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Denise McInnerny, Head of Midwifery, Whipps Cross Hospital
Jacqui Niner, Partnership of East London Cooperatives (PELC)
John Light , PELC
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Ilse Mogensen, Commissioning Support Unit

Scrutiny officers present

Masuma Ahmed, Barking & Dagenham
Anthony Clements, Havering (clerk to the Committee)
Jilly Szymanski, Redbridge

All decisions were taken with no votes against.

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

25 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of the action to be taken in case of fire or other event requiring the evacuation of the meeting room.

26 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillors Sanchia Alasia and Eileen Keller (Barking & Dagenham) and Dilip Patel (Havering). Apologies were also received from Alli Anthony (Healthwatch Waltham Forest) and Richard Vann (Healthwatch Barking & Dagenham).

27 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of interest.

28 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 14 October 2014 were agreed as a correct record and signed by the Chairman.

29 PHARMACY ARRANGEMENTS

The Committee was addressed by a community pharmacist from the Loughton area. The pharmacist had created a template to allow more effective communication between pharmacists and GPs. It was felt that advice given by pharmacists was not currently communicated directly to GPs. Equally, pharmacists were not currently able to access GP patient records. The template had therefore been created to show on patient records what interventions a pharmacist had undertaken with patients.

The pharmacist stated that 95% of patients he had assisted would otherwise have gone to the GP and his pharmacy alone had therefore produced a £62,000 saving to the NHS. He felt however that the template project needed funding in order to maximise the benefits of interventions by pharmacists.

The project had been discussed with the pharmacist's local Clinical Commissioning Group – West Essex CCG, NHS England and the Royal Pharmaceutical Society. While most pharmacies currently operated a paper-based system, the form that had been developed could be completed on a Tablet device. Patients using the pharmacy system had to consent to their information being transmitted to their GP. The pharmacy form had been

developed in cooperation with stakeholders over a three year period. It was hoped to also develop an I-phone based system with different levels of security.

It was noted that a co-director of Healthwatch Havering was the secretary of the North East London Local Pharmaceutical Committee.

It was emphasised that the template could be used by any pharmacies, whether independent or part of a large chain.

The Committee felt that any initiative that reduces pressure on A&E and GPs should be supported and it was **AGREED** that the local CCGs should be asked to support the project.

30 GREAT ORMOND STREET HOSPITAL

The Director of Planning and Information at Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) explained that GOSH was a specialist children's hospital, founded in 1885. The hospital had a small number of beds (350) but high staff numbers (approximately 4,000) and turnover. Nearly half of the hospital's beds dealt with complex care and there had been an 80% increase in the number of patients seen over the last 8 years. The hospital also ran the second largest private hospital service in the UK.

GOSH offered all children's services except burns treatment. GOSH dealt with 25% of children's heart surgery in the UK as well as 33% of bone marrow transplants and 75% of children's epilepsy surgery. There were a total of 19 specialist children's services offered by the hospital and these were not commissioned by CCGs but by NHS England in most cases. Forty-eight per cent of GOSH patients were from London with a further 24% from Hertfordshire, Essex and Bedfordshire. 11.5% of admissions were from Essex with the ONEL boroughs each accounting for 1.6 – 3.2%. Redbridge for example had seen 1,210 admissions in the last year. One per cent were overseas patients funded by the NHS under reciprocal agreements.

There was no A & E department at GOSH and the hospital did not generally take referrals from GPs. Referrals were usually made by consultants in other hospitals. The Trust's vision was for GOSH to be the leading children's hospital in the world for patient experience, outcomes and research.

A major challenge for GOSH was the planned change in NHS commissioning arrangements for specialist services which could have an impact of £20 million on the Trust's finances, The ability to recruit and retain key staff was also a challenge. The Trust also wished to make patient records digital and transferrable.

Opportunities for the Trust included the hospital's strong brand name which allowed it to diversify its income base. The hospital's new clinical building was due to open in 2017. GOSH was also at the forefront of genomic medicine such as the development of a non-invasive pregnancy testing service.

The greatest clinical pressures at GOSH related to end of life care. GOSH was often the hospital of last resort and families were often reluctant to agree to the ceasing of intervention. Some patients incurred extremely high treatment costs with the 125 most complex cases seeing £12.5 million more being spent on treatment than GOSH had received from commissioners for these patients.

The private patient wing at GOSH was operated separately from the rest of the hospital and funds from this were being used to support NHS services and research.

The Liverpool Care Pathway had never been used at GOSH and the UK's only dedicated paediatric palliative care team was based at GOSH. Digital records were in the process of being rolled out to different departments at GOSH. It was hoped to also develop a portal system to be used by other hospitals around the UK.

GOSH did make use of premiums for groups of staff that were difficult to recruit to although the Trust had not moved outside of national pay scales. Staff recruitment and retention at GOSH had improved in the last year and a lot of nurses had been recruited from countries including Ireland, Portugal and Spain.

A service level agreement was in place to allow the GOSH palliative care team to visit hospices. This team also administered care in people's homes.

Lobbying and risk assessment work was in progress in relation to the impact of specialised commissioning changes. GOSH was also seeking to increase efficiencies and derive more income from private patients. The GOSH officer accepted however that the planned changes in commissioning arrangements were likely to lead to fewer NHS beds and theatre sessions at GOSH.

The Committee **NOTED** the update and thanked the GOSH officer for his attendance and input to the meeting.

The Committee **AGREED** that GOSH should not be penalised by any forthcoming changes in the arrangements for specialised NHS commissioning and that a letter communicating the Committee's view should be sent to NHS England.

31 MATERNITY SERVICES

A. Whipps Cross

The head of midwifery for Whipps Cross advised that 4,800 babies had been born at the hospital in 2013/14. Services available through Barts Health included community midwives for home births and other specialist services including bereavement services. There were also specialist teams available for e.g. pregnant women with mental health needs.

Whipps Cross offered the full range of maternity services. Specialist scans could now be done at the Royal London Hospital meaning it was no longer necessary to travel to Great Ormond Street for these. There were a total of 158 midwives at Whipps Cross. There were not any vacancies for midwives at the hospital currently but this situation did vary. A consultant midwife had been appointed to give clinical leadership and a clinical education lead was in the process of being recruited. An infant feeding coordinator was also now in post.

Women's experiences of maternity were very important and the Trust was working with its Maternity Services Liaison Committee. The friends and family test was used and the Trust sought to learn from complaints received. Clinical skills of midwives had been assessed and feedback from local women was also sought via the Trust's 'Mum to Mum' programme.

Improvements implemented at Whipps Cross over the last 18 months included opening a new theatre suite in HDU, standardising maternity services and developing a home birth team across Barts Health. A new programme of labour induction had reduced the number of caesarean section required and 1:1 care for maternity was now at 97% - a good safety indicator.

The report from the latest CQC inspection of Whipps Cross had not yet been shared but warning notices issued from the previous inspection had since been lifted.

B. BHRUT

While all hospital births at BHRUT now took place at Queen's Hospital, maternity outpatient appointments were still provided at King George. Community midwifery and home birth teams were also available.

There were a total of around 350 midwives at BHRUT including 70 community midwives. A total of 15 midwives including two senior midwives were present on each shift. Electronic patient records were used in maternity and all birthing rooms were en suite, There were approximately 20 births per day at Queen's, making it one of the busiest maternity units in the UK. Consultants were present on the wards from 8 am to midnight and the Trust's current rate of caesarean sections was 24.8%.

BHRUT now had low rates of use of epidurals and of labour induction, both of which were positive indicators. There were also now very low admissions of mothers to ITU and a very low level of brain damaged babies. There had not been any intra partum still births at BHRUT in the last two years.

Maternity HDU was staffed by midwives and trained nurses. This meant there had only been one admission needed to the hospital's main intensive care unit so far this year. There had also been fewer post partum hysterectomies needed so far this year.

Maternity triage was open 24 hours a day for pregnant women. The antenatal ward had 16 beds and there were two post-natal wards for high risk and low risk cases. The obstetrics assessment unit was midwifery-led and open 7 days per week, 8 am to 6 pm.

Maternity clinics were held at Queen's and King George as well as at the Fanshawe Community Clinic in Barking. The life study project had been set up to conduct research on babies over a 20 year pathway. The project was centred at King George and was currently recruiting women.

Other services provided included parenting sessions, clinics for women who had previously undergone caesarean sections and birth reflection sessions. The Queen's birthing centre had opened in January 2013 and only 25% of deliveries had required any transfer to the main labour ward. Neo-natal services were available at Queen's up to level two.

BHRUT was commissioned for an annual total of 8,000 births and was projecting 7,957 deliveries for 2014/15. When the Care Quality Commission had last visited in October 2013 it had found significant improvements in maternity services at Queen's. The Trust had been compliant with all maternity standards inspected.

Service user feedback was collected and there had been a fall in the number of formal complaints received. There were also around 240 compliments received by the service each month which scored 96-98% on the Friends and Family Test. A lot of service user surveys were also collected.

The workforce was funded at a 1:29 midwife to birth ratio and there were approximately 10% of posts vacant at present. There was a recruitment and retention plan and the Trust was also looking at training maternity care assistants as midwives. Staff were rotated through the different maternity services in order to build up their skills. The Trust was proud of the 1:1 care it could offer in labour and that its maternity services had been transformed. Moving forward, the Trust wished to increase rates of home births and to lower rates of caesarean sections and of still births.

C. Comments from Healthwatch Havering

Healthwatch Havering had undertaken an enter and view visit to maternity at Queen's in April 2014. The visit had been undertaken by Healthwatch representatives including a senior commissioning manager from another area. This had found that a number of improvements had been made and were being built into the system. BHRUT did respond to the recommendations made by Healthwatch and included these within the Trust's action plan. It was planned that Healthwatch would revisit maternity in order to check on progress.

Officers could provide figures for the number of births commissioned at Whipps Cross split by each borough. Around 1,400 women in the Whipps Cross catchment area also gave birth elsewhere. Work was in progress to investigate where these women gave birth. A representative of Healthwatch Redbridge added that 30-50% of Redbridge mothers delivered at Whipps Cross and that the new facilities at the hospital were very good. It was noted that the business plan for the next phase of work at Whipps Cross was awaiting approval.

D. Further Discussion

It was confirmed that BHRUT had a consultant midwife in public health who focussed on issues relating to female genital mutilation and could refer women to appropriate agencies if necessary.

BHRUT was aiming to achieve baby friendly accreditation over the next 4-5 years and needed the boroughs to work together to give breast feeding advice to new mothers. Funding was needed to support mothers in the community with breast feeding. The Committee **AGREED** that better joint working should be encouraged to develop breast feeding.

BHRUT officers accepted that services needed to be strengthened at the Barking Birthing Centre. The service would continue for the present but needed to be reviewed.

A Member congratulated BHRUT on how the closure of in-patient maternity services at King George had been dealt with. Figures on where maternity service users came from would also be useful as there was a lot of mobility in choice of where to give birth. Officers had not seen any change in the ratio of male: female terminations carried out at the Trusts but it was noted that terminations could also be carried out in the private sector.

Consultant cover at Whipps Cross was available for 74 hours per week but this was not sufficient in the delivery suite. It was hoped to increase consultant numbers but this would cost Barts Health in the region of £1.4 million per year. It was **AGREED** that a letter should be sent on behalf of the Committee to Barts Health supporting Whipps Cross maternity in their bid for funding to increase consultant cover.

HIV screening was offered to all women giving birth at both Trusts. A specialist HIV midwife was available at Whipps Cross to develop appropriate care plans etc.

There was also a consultant psychiatrist and psychiatric nurse available at Whipps Cross who worked with the midwives. Mothers thought to be suffering from e.g. depression would be referred back to their GP; those who were e.g. bipolar would be treated by the specialist service team.

It was confirmed that a maternity dashboard of 50 indicators was used at BHRUT and that a pan-London dashboard was also being developed. Figures from the BHRUT dashboard could be supplied to the Committee.

Home births currently accounted for 0.7% of BHRUT births with figures for home births across London being slightly higher at 1-2%. It was emphasised however that many women were not suitable for home births. Women's choice of where to give birth was accommodated where this was possible and safe to do so. Home births at Barts Health were approximately 2% of the total deliveries at the Trust and it was hoped to expand this. Patient experience questions used by Barts Health were nationally available on the internet.

Whipps Cross would also offer, at the point of GP referral, a choice of place of birth and antenatal care, within the Trust provision. Barts Health was funded to a midwife: birth ratio of 1:32 but the current figures were in fact 1:30.4. As regards still births, audits and process reviews were undertaken for all such cases at Whipps Cross.

It was confirmed that both Trusts were happy for Members to visit their maternity services if they wished. The Committee **NOTED** the update and thanked the officers and Healthwatch representatives for their input.

32 **NHS 111**

It was explained that the service provider for NHS 111 as well as of the out of hours GP service for ONEL and Essex was PELC – the Partnership of East London Cooperatives. PELC also operated GP walk-in centres at King George and Whipps Cross Hospitals.

The NHS 111 service allowed easier access to urgent care and access to on-site advisers for complex care issues. Ambulances could be dispatched if the telephone assessment deemed this to be necessary and the NHS 111 software had an automated link to the NHS 111 service. NHS 111 would otherwise give a time frame and clinical outcomes to e.g. see a patient's GP within three working days.

NHS 111 used the NHS Pathways system that had been developed by GPs and other clinicians. Around 30% of calls received were transferred to clinical advisers such as nurses or paramedics if they were thought to be sufficiently complex. Nationally, there were around 500,000 calls to NHS 111 each month.

The service used a directory of services that listed all NHS services within England. NHS 111 was also able to send patient details electronically. Training for health advisers on the services lasted for five weeks including a two weeks initial course that was required to be passed. Ongoing training and support was also available. Updates were added to the system for new issues such as the Ebola outbreak.

As regards clinical governance, NHS 111 met on a monthly basis with commissioners and also with patient representatives. Feedback was received via surveys and end to end audits with patients. All complaints and incidents were also logged. There had been approximately 21,000 calls to NHS 111 from the ONEL area in December 2014. Around 62% of calls were referred to primary care though it was accepted that access for patients to GPs remained a problem.

The directory of services used by NHS 111 allowed the identification for commissioners of gaps in services and it was felt that NHS 111 had made the NHS as a whole more cost effective. NHS 111 had its own dashboard that it used for performance indicators.

If calls were referred incorrectly, this was fed back to NHS 111 by the services concerned on occasions but did not always happen. The profile of a service could also be changed on the directory of services if necessary. NHS 111 was keen to receive more feedback on calls that had been misdirected. Feedback could be given via the PELC website and PELC officers would supply the links to this. There were also mechanisms via the PELC website for health professionals to give feedback. PELC also worked with the local Healthwatch organisations for example in planning resilience. NHS 111 also conducted their own patient surveys.

The response time target for the service was to answer 95% of calls within 60 seconds. This indicator had reached 97% over the Christmas period. Targets to limit the number of abandoned calls were also being met. It was noted that around 40% of calls to the ONEL NHS 111 service originated from other geographical areas.

There had not as yet been much national publicity for NHS 111 due to provider problems in other regions. It was clarified that NHS 111 staff had the same ability to assess calls as did operators on the 999 emergency service. The recent establishment of GP Federation Hubs in two of the ONEL boroughs would be reflected in the NHS 111 directory of services. The local ‘Not Just A&E’ campaign also promoted NHS 111.

Officers indicated they were happy for the Committee to visit the NHS 111 offices in order to learn more about the service and the work it undertook.

The Committee **NOTED** the update.

33 URGENT CARE PROCUREMENT

The chief operating officer of Havering CCG explained that the four local CCGs were working together to reprocure urgent care. This covered non - A & E services such as NHS 111, walk-in centres (other than at Barking Hospital) and urgent care centres. The CCGs were keen to engage with patients and the public on this process and had identified key elements for the public such as quick assessments by doctors and good transfer of patient records.

The reprocurement process was currently at the stage of 'competitive dialogue' and it was planned to award the contract for urgent care services at the end of June 2015. The new service was hoped to start in September 2015.

Outline solutions from bidders were currently being evaluated and further engagement sessions with patients and the public were being planned. Officers were happy to give an update on the position at the next meeting of the Committee.

Sessions were planned whereby each of the bidders could hold discussions with patient and public engagement representatives. These would not be open sessions due to the confidential nature of the procurement process.

The Committee **NOTED** the update.

34 URGENT BUSINESS

There was no urgent business raised.

Chairman