MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
10 March 2016 (7.00 - 9.20 pm)

Present:

Councillors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Jason Frost, Linda Van den Hende, Alex Donald and Garry Pain.

Officers present:
Ian Buckmaster, Healthwatch Havering
Dr Susan Milner, Interim Director of Public Health, London Borough of Havering
Caroline O'Donnell, North East London NHS Foundation Trust (NELFT)
Carol White, NELFT
Sarah See, BHR Clinical Commissioning Groups (CCGs)

One member of the public and one member of the press were also present.

46 WELCOME AND INTRODUCTIONS

The Chairman reminded Members of action to be taken in the event of fire or other event requiring the evacuation of the meeting room.

47 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillor Linda Hawthorn (Councillor Alex Donald substituting) and Councillor Carole Smith (Councillor Garry Pain substituting).

48 CHANGES TO MEMBERSHIP

It was noted that Councillor Gillian Ford had recently left the Sub-Committee. Councillor Linda Van den Hende was welcomed by the Sub-Committee to her first meeting as a Member.

It was also agreed unanimously that Councillor Van den Hende should take the vacant position on the Outer North East London Joint Health Overview and Scrutiny Committee.

49 DISCLOSURE OF INTERESTS

There were no disclosures of interest.

50 MINUTES

The minutes of the meeting of the Sub-Committee held on 12 January 2016 were agreed as a correct record and signed by the Chairman.

51 NORTH EAST LONDON NHS FOUNDATION TRUST (NELFT)

Mental Health Liaison Service

Officers from NELFT explained that, while acute hospitals had always had some mental health liaison services, this was generally patchy and people with mental health issues often fared badly in acute settings, leading to longer lengths of stay etc.

NELFT favoured a model based on rapid access, intervention and discharge (RAID). This was very expensive and funding had been allocated for an enhanced service available 24:7 on site in A & E for over 18s. This had allowed the introduction of parallel assessment whereby BHRUT and NELFT mental health liaison staff assessed patients together. Staff also went into A&E seeking to identify cases with a mental health element.

The target of seeing all patients referred in 60 minutes was met by mental health liaison staff on 94% of occasions. On-ward targets were being met at 100% and the service could have up to 120 referrals per week. Patient satisfaction with the service was high with comments indicating the team was caring and engaged with family members.

Work was also in progress regarding high intensity users – those who attended A & E more than 10 times per year. NELFT wished to reduce this by setting up complex care plans in order that these patients could be better supported in the community.

The new service also sought to ensure people with dementia received appropriate care in hospital. Delirium could often be misdiagnosed as dementia and mental health liaison staff trained A & E colleagues in how to identify this. This had led to fewer breaches of targets at BHRUT. Other training offered to BHRUT staff included case discussions and more specific courses such as working with people with dementia.

Future initiatives planned included a street triage service to reduce the need for the Police to pick up people from the street under s. 136 powers. An under 18 service could also be introduced into A & E, albeit this would involve fewer patients and better IT systems would allow mental health records to be fully accessed from the A & E department.

It was emphasised that the mental health team worked closely with partners such as the Police and London Ambulance Service although more work needed to be undertaken with the Police. If the project was supported going forwards then work on identifying mental health issues could also potentially be undertaken with Police Community Support Officers.

It was confirmed that there were now two s. 136 suites at Goodmayes Hospital which reduced the need for people with mental health issues to be held in police cells. Officers felt there should be parity in A & E between responses for physical and mental health issues.

Patients with mental health issues would still attend the main triage in A & E but mental health liaison service staff would seek to proactively identify these patients and try to offer other community-based routes of crisis support where appropriate.

The Police were able to notify NELFT and the Council of people they had dealt with who had exhibited mental health issues and information sharing was included within this framework. Patients who refused treatment would be proactively contacted by staff but officers confirmed that nobody could be forced to accept treatment unless they were considered a danger to themselves or others.

Intermediate Care

Officers explained that changes to intermediate care were being implemented across Barking & Dagenham, Havering and Redbridge and that most Havering patients requiring intermediate care already accessed Foxglove ward at King George Hospital. The intermediate care beds at Grays Court in Dagenham were due to move to Japonica ward at King George by the end of March 2016.

NELFT officers would respond in due course to feedback from a recent enter and view visit that Healthwatch Havering had carried out to Japonica ward. General patient feedback on the new locations had been positive and any lack of space on the ward was being addressed.

There were a total of 51 intermediate care beds available at King George that could be increased to 57-61 beds if required. It was confirmed that the wards were currently full and that some additional beds were being used for intermediate care at present.

Officers confirmed that the referral of the intermediate care plans by Redbridge health scrutiny to the Secretary of State had not been upheld and implementation would proceed as scheduled.

It was **AGREED** that the Sub-Committee should undertake a site visit to Foxglove and Japonica wards at King George Hospital in late April or early May.

Acorn Centre

The Acorn Centre had begun operating in February 2015 and opened officially in summer 2015. Child and adolescent mental health services (CAMHS) were in the process of being relocated from Raphael House in Romford and it was hoped to complete this by September 2016.

Officers accepted that parking was a problem at the centre and were now looking for new staff parking areas. The installation of new pay and display bays near the centre had helped the situation slightly.

Staff at the centre used hot-desking which was working well overall. Clinicians no longer had dedicated office space in order to make the best use of the facility. A virtual tour of the Acorn Centre was available on the NELFT website and officers would send a link to this.

The Sub-Committee **NOTED** the updates.

52 **PRIMARY CARE STRATEGY (PMS REVIEW)**

Officers explained that the Primary Medical Services (PMS) contract was one of several contracts used for GPs and this was now under review nationally. Fifteen Havering GP practices used the PMS contract which carried a total premium of £1.1 million and equated to additional funding of £10-12 per patient.

The London PMS offer had now been confirmed by NHS England and this included mandatory Key Performance Indicators (KPIs) such as influenza services and cervical screening as well as optional KPIs covering areas such as breast screening and walk-in centres. In addition, premium service specifications in the London offer covered better use of on-line technology for patients, Saturday morning GP openings (as seen at the two hubs in Havering which could now access patients' GP records) and allowing additional hours and appointments capacity at practices. The total premium for Havering practices for these services equated to £11.18 per patient.

In view of these targets, PMS practices would be asked over the next year to increase patient uptake of on-line services. The Local Medical Committee had been receptive to overall commissioning intentions although individual negotiations with practices had not taken place as yet.

Two practices in Havering now provided blood pressure and ECG checks and it was felt more cost effective to commission these types of services

from GP practices. The new services would be monitored by Primary Care Commissioning officers as well as via the Council and Healthwatch.

In line with national trends, there was a shortage of GPs in Havering. Officers had sought to resolve this by working towards more place-based commissioning as well as considering new roles and career opportunities for GPs and other practice staff such as nurses.

It was confirmed that some practices allowed patients to register at the practice address in case of homelessness etc but this did not apply to all Havering GPs. There were also plans to remodel the sexual health service to form a more attractive offer for women. Officers agreed that practice nurses could potentially be used to work on this service.

It was clarified that GPs owned patient records on behalf of the Secretary of State. Each time a patient visited a GP hub, they were required to give consent for their records to be shared.

As regards appointments where patients did not attend (DNAs) these constituted 9-13% of GP appointments in Havering and cost in the region of £1 million a year overall. It was hoped that work to extend access to GPs would result in less DNAs occurring. Officers would confirm which GPs offered phlebotomy services.

The Sub-Committee were pleased that work with NELFT such as the Community Treatment Team had won a number of awards and was seen as a best practice model. Staff morale in the service was felt to be very good.
The new GP practice was at Orchard Village was currently under procurement and was due to open in October 2016. The walk-centre for this area would remain at South Hornchurch Health Centre. The Kings Park surgery contract in Harold Wood was also currently under procurement and the contract with the current providers had been extended until March 2017. Both the walk-in centre and GP contracts for the site would be procured at this point.

It was noted that one Havering GP practice had recently given notice of retirement and officers would provide further details on this.

The Sub-Committee **NOTED** the position and thanked officers for their input to the meeting.

53 PUBLIC HEALTH EXPENDITURE

The Interim Director of Public Health explained that when responsibility for public health transferred to the Council in April 2013, Havering had received one of the smallest grants in the UK. This had been based on the previous low expenditure on public health by the then Primary Care Trust. The Interim Director was required to account for how the Public Health Grant was spent and cuts to funding meant some services had been lost or reduced.

The total grant for public health services in Havering was £9.7 million but this had received a significant in-year cut of £688,000. A further cut of around £1 million was required in 2016/17 and an additional £300,000 in 2017/18. A paper had therefore been taken to Cabinet in February 2016 suggesting disinvestment in some public health services worth a total of £850,000. These cuts did not impact on the Council's mandatory public health services nor on certain non-mandatory services such as school nursing, the drug and alcohol service and health champions.

Services that may be decommissioned included some sexual health and physical activity services as well as the stop smoking service. The final decision on whether to decommission these services was a matter for the relevant Cabinet Member.

The Council's public health team had been cut by one third and offered a corporate support service to other Council departments and partner organisations such as the Clinical Commissioning Group. Services which received the most funding were health visiting, sexual health and drug & alcohol services.

The Interim Director accepted that the most controversial proposal was to decommission the stop smoking service. Some negative feedback on the proposal had been received but it was felt this constituted the 'least worst' option in order to make the required savings. Smoking cessation services for pregnant women would be retained and it was noted that people were making more use of electronic support and obtaining nicotine replacement products from their GP.

The prevalence of smoking had fallen and this had made the stop smoking service less cost effective. Other boroughs were also considering decommissioning of smoking cessation services and it was possible that a pan-London digital platform could be commissioned for this. It was emphasised that non-smoking was the norm in Havering although prevalence of smoking was higher in certain sub-groups that could be targeted via services such as the Healthy Schools programme.

The Interim Director wished to identify the added value provided by the service and there were therefore public health business partners for each area of the Council. The service was able to comment on section business plans and was looking to integrate an assessment of public health into decisions. There was also a target to raise the profile of the Healthy Workplace programme.

The current sexual health service operated on an open access basis whereby people referred themselves to clinics for e.g. sexually transmitted infections. The Council had to pay for all Havering residents who received these services (other than HIV services) even if they were treated in other areas.

The Council was also obliged to commission open access to the family planning service which was managed by GPs from Queen's Hospital and four other sites within Havering. These services would not be changed although a remodelling of the sexual health service was being consulted upon.

It was noted that women tended to go to other sexual health services rather than their GP and could go to the family planning service to obtain the contraceptive pill although this was a more expensive method for public health to fund.

The Sub-Committee **NOTED** the position.

54 HEALTHWATCH HAVERING UPDATE

A director of Healthwatch Havering explained that the Care Quality Commission (CQC) had recently introduced an on-line map of care homes with links to their ratings and further details. The Healthwatch Havering website also now included links to the reports for facilities at which Healthwatch had conducted an Enter and View visit.

Healthwatch had received some complaints that patients registered at the North Street and Rosewood Medical Centres received inferior service compared to the GP hub surgeries at those sites. Healthwatch would be undertaking a review of the hubs in due course and would update the Sub-Committee on this work.

The three local Healthwatch organisations had been commissioned by the Clinical Commissioning Groups to consult the public on how they viewed Urgent Care Centres, Walk-in Centres and similar facilities. As such, a questionnaire on these and related issues had been distributed by Healthwatch. The results of this research project would be reported to the Clinical Commissioning Groups and an update given to the Sub-Committee.

55 URGENT BUSINESS

The Clerk to the Sub-Committee advised that preparations were continuing for the topic group review of delays to treatment at the Hospitals' Trust. The Director of Healthwatch Havering added that the Trust had been very supportive of the review thus far. It was noted that an initial briefing for the review would be held on 6 April and the Sub-Committee agreed some minor amendments to the scope of the review that had been suggested by Healthwatch Havering.

A Member reported staff from a local care home had complained that residents were at times being discharged from Queen's Hospital with cannulas left in their hands and without discharge letters or medication being provided. The Director of Healthwatch Havering agreed that the organisation would investigate this.

Chairman