**MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
20 March 2014 (7.00 - 9.45 pm)**

Present:

Councillors Pam Light (Chairman), Ray Morgon, Wendy Brice-Thompson and Peter Gardner

Apologies for absence were received from Councillor Nic Dodin and Councillor Ted Eden

Also present:
Ian Buckmaster, Healthwatch Havering
Stephen Burgess, Barking, Havering and Redbridge University Hospitals NHS Trust
Ilse Mogensen, North East London Commissioning Support Unit
Caroline O'Donnell. North East London NHS Foundation Trust
Alan Steward, Havering Clinical Commissioning Group

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

44 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of interest.

45 **MINUTES**

The minutes of the meetings held on 23 January 2014 (joint meeting re Council budget) and 6 February 2014 were agreed as a correct record and signed by the Chairman.

46 **BARKING HAVERING AND REDBRIDGE UNIVERSITY HOSPITAL NHS TRUST (BHRUT)**

The BHRUT medical director explained that a wide ranging Care Quality Commission (CQC) inspection of both Queens and King George Hospitals had taken place in October 2013. The CQC report, received in December 2013, had recognised some improvements in e.g. nursing care. Issues concerning the emergency pathway and reconfiguration etc had however led to the Trust being put in special measures. The Medical Director accepted that more needed to be done concerning A&E, outpatients and Trust governance etc.

A capability review of the Trust had been undertaken, the report from which would be submitted to the National Trust Development Authority (NTDA). An Improvement Director had been appointed who had worked in a special measures Trust in South London, as had the new Director of Finance. A Buddy Trust – a well performing Trust of similar size to BHRUT, was also due to be announced.

The Medical Director emphasised that work was underway with staff and partners to move the Trust forward. A reinspection by the CQC was expected in the next 18 months. The NTDA would also expect to see progress over this period.

The Trust improvement plan was due to be submitted to the NTDA within the next week and an overview document could also be produced. As regards workforce issues, it was accepted that there were major staffing problems in A&E as well as in acute medicine and gastroenterology. This applied to both consultants and middle grade staff. Some recruitment problems were due to perceptions of the Trust and local area being poor.

The Medical Director felt that the entire emergency system was a problem including the wards and discharge procedures. He felt however that the major issues related to patient flows and finance. The maternity department had however improved significantly.

There remained a number of issues regarding transferring patients and notes and the Trust was seeking to institute a better system of governance. It was accepted that there had also been a lot of complaints about outpatient appointments and waiting times although these were issues in many hospitals. The Trust executive team wished to be more visible but there was often not enough time for this.

The Trust improvement plan was expected to be finalised by the end of March and would be published on the BHRUT and NHS Choices websites.

There were now some text reminders of outpatient appointments but the Trust needed to do more of this. There had been some problems with the installation at the Trust of the new Medway computer system. There was also a working group looking at outpatient issues.

It was not expected that the Trust would receive any further resources for this work other than perhaps a small amount of transition money. The Trust overspend was predicted to be £38 million for the next year. Five per cent efficiency savings were also required which would be in the region of £20 million.

It was confirmed that the Trust improvement plan would contain a section on health records. This would also cover issues around keeping records up to date. The Trust saw 648,000 outpatients per year with over a million patient contacts and the Medical Director felt there would always be occasional problems sue to human error etc.

The Medical Director agreed that the layout of outpatients needed to be improved and this would also be covered in the improvement plan. Queen's Hospital generally was also not easy to navigate. Some signage had been improved but the new Trust Chairman remained unhappy with this. Hospital volunteers would in future be more pro-active and wear tabards in order that they were identified more easily. Feeding buddies on wards were also being introduced.

The alteration work in Queen's A&E was currently being reconsidered but this would still need to be carried out in the summer. Changes to areas such as critical care and the moving of the renal dialysis unit were still being negotiated. The Medical Director accepted that A&E had been poorly designed originally.

As regards reconfiguration of the Trust, the outline business case was still being reworked. It was still planned to close the A&E at King George Hospital to blue light ambulances by December 2015. All Queens and King George activity was however being remodelled as the information used in the Health for North East London exercise was now too old. The new data was expected to be available in the next 4-5 weeks.

The current A&E target was to deal with attendances within 4 hours on 90.5% of occasions by the end of March. The current figure was 89% across both sites. There was poorer A&E performance seen in the evenings and at night due to a lot of locum staff having to be used. The Queen's Urgent Care Centre was now open 24:7 on some days and it was a priority to implement 24:7 working at the Urgent Care Centre throughout the week.

Assessment units were being extended and altered to create more short stay beds. This would allow suitable patients to bypass A&E and go straight to an assessment area. An observation area was also being opened at Queen's.

A new paediatric A&E consultant had recently started work with a second consultant starting in April 2014. A total of 17 doctors and 8 anaesthetists had also recently been recruited from India. It was accepted that retaining staff was also a problem. A package including retention premiums was in place for the staff recruited from India and the Trust was trying to be inventive with this issue. It was hoped to move to having a more regular recruitment cycle.

The recent NHS staff survey had shown improved overall results for BHRUT. Motivation and communication with managers had improved and staff also felt they could raise concerns. The CQC placed emphasis on the importance of the staff survey results.

A new Chairman had recently been appointed to the Trust – Dr Maureen Dalziel. Dr Dalziel was a public health doctor and had also previously been a Trust Chief Executive. With effect from 1 April, the new BHRUT Chief

Executive would be Matthew Hopkins – a nurse by background who had previously worked at Barts and Guys and St Thomas' Hospital Trusts. The Medical Director also confirmed that there would definitely not be any victimisation of whistle blowers at the Trust.

Smoking, drinking and hard drug use were harmful and costly to the NHS. The Medical Director felt that there was less evidence of harm from use of recreational drugs. The Trust saw more A&E attendances through misuse of alcohol than drugs.

It was emphasised that the original Health for North East London plans were still being used and it was not therefore necessary to consult on the current proposals. A&E activity had not gone down as predicted in the Health for North East London plans. Additionally, population growth had increased and activity levels had not gone down as anticipated in the original proposals. As such, a refresh of the relevant activity data was currently being undertaken.

The Medical Director emphasised that services would not be fully pulled out of King George Hospital until Queen's was fit for purpose. The special care baby unit would be moved from King George once money was made available to expand the equivalent unit at Queen's.

The Committee **recommended** that the BHRUT improvement plan be an agenda item at the Committee's first meeting after the Council election.

It was explained that the improvement plan was designed to get BHRUT out of special measures and reconfiguration of the hospital would be the second phase of improvement. If improvement were not delivered then the Trust was likely to enter Special Administration.

The Committee **noted** the update.

47 CHAIRMAN'S UPDATE

The Chairman confirmed that a letter had been sent on behalf of the Outer North East London Joint Health Overview and Scrutiny Committee giving the Committee's support for the planned move by Moorfields Eye Hospital to a new location.

Members had recently undertaken a useful site visit to Harold Wood walk-in centre. The Chief Operating Officer for Havering Clinical Commissioning Group (CCG) explained that the current contract for the centre, running until April 2016, was held by NHS England. The CCG would however be looking to manage the services it had responsibility for from April 2015.

Members were pleased that a number of issues previously raised by the Committee had been rectified by the walk-in centre provider – Hurley Group. The car park at the centre was due to be repaired following damage caused by the breast cancer screening wagon. The Chairman was also pleased that more of the building was now being used for clinical purposes. It was however disappointing that the scanning machine in the building was not being used. The CCG Chief Operating Officer agreed to investigate this.

The patient discharge topic group had recently met and considerable improvements had been made to discharge processes. There was however still some confusion over medication and gaps seen in some communications. Duplication of medicine for care homes remained a problem as well as delays in receiving medication from the hospital. The Chairman felt that patients could be sent home with prescriptions, given that many pharmacies were now open longer hours. It was confirmed that discharge issues were covered in the BHRUT improvement plan. The Committee **recommended** that scrutiny of discharge issues should continue in the new Council term.

The Joint Committee had also recently written to the Commissioning Support Unit giving its views on the cancer and cardiac proposals. The Committee broadly supported the proposals although felt it was essential that scrutiny should continue as the plans were implemented.

The Chairman expressed a wish that the CCG would continue to keep the Committee updated on developments.

Work on scrutinising children's health issues had been in progress and the Committee **recommended** that this should continue in the new Council term.

48 NORTH EAST LONDON NHS FOUNDATION TRUST

The Integrated Care Director at North East London NHS Foundation Trust explained that, following the closure of the child development centre at St George's Hospital, services for children with complex needs were currently being provided from 13 different locations. The London Road site was originally planned to be used for corporate services but, following the closure of St George's, had to be used as clinical space.

Other child development centres had been visited in order to inform the design of the London Road site. Stakeholder engagement sessions were planned for March and April and meetings had been held with the Council Lead Member and local groups such as ADD Up. Work would start on the building in May and it was planned to open for clients in December 2014.

Children's services were also being redesigned. Complex disability and mental health services would be integrated and co-located in London Road. It was emphasised however that there were no plans to close the mental health services currently provided at Raphael House in Romford. Neuro-

developmental pathways and services for conditions such as ADHD would also be brought together at the London Road site.

The London Road building would have 950 square metres of space but services would continue to be provided from Harold Wood Health Centre and NELFT would also look for a third location within Havering. The changes proposed would provide a more effective and efficient pathway for children. NELFT officers were happy to bring further updates to the Committee and for Members to visit the London Road site.

While the NELFT Director could not say that all the needs of the ADD Up support group had been met, it was felt that London Road was the best location at the time. NELFT were keen to involve stakeholders in the design aspects of the building.

It was confirmed that NELFT were seeing an increasing number of children with mental health needs. The current overall service caseload was approximately 5,300 children and this had gone up by 4-5% over the last two years.

The Committee **noted** the update and that the children's health topic group had recently visited Raphael House.

49 HAVERING CLINICAL COMMISSIONING GROUP (CCG) FUTURE STRATEGIC PLANS

The CCG Chief Operating Officer explained that the plans of the CCG over the next 2-5 years were driven by the Joint Strategic Needs Assessment which formed the basis for commissioning decisions. Havering had an older population, many of whom had multiple long-term conditions. Ninety per cent of patients with the most complex health problems accounted for 40% of emergency admissions.

There was poor satisfaction with services including access to primary care. There were also lifestyle problems in Havering such as alcohol, smoking and lack of physical activity. Dealing with the most complex problems would make the whole healthcare system function better.

The CCG felt that improving urgent care was not just about BHRUT but that the rest of the health economy should contribute to this. Improving the urgent care pathway was therefore a priority of the CCG over the next year. The CCG was looking to undertake a reprocurement of some of the key services within the urgent care pathway including NHS 111, GP Out of Hours and Urgent Care Centres. The aim was to encourage providers to innovate and work in a more integrated way. The aim was for services to start in 2015/16.

Use of the weekend GP opening service had increased but had still only reached 50-60% of capacity thus far. Open access to weekend GPs could

be operated on a trial basis rather than having referrals solely via the NHS 111 service.

As regards integrated care, the CCG wished to expand the number of conditions covered by the integrated case management system to include dementia and end of life care. More integrated health teams would allow integrated care at a local level. A collect and settle scheme was also being developed for people discharged home from hospital.

The CCG wished to see more care delivered closer to home and to have more outpatient appointments take place locally rather than in a hospital setting. More muscular-skeletal, urology and diabetes outpatient appointments would be delivered in the community from July 2014.

In primary care, the CCG was supporting GPs coming together to share services such as stitch removal within a GP cluster. Havering and Barking & Dagenham GP practices had submitted a bid to the Prime Minister's Challenge Fund for further investment in local primary care services. A Primary Care Improvement Director had also been appointed to the CCG.

The Committee **recommended** that further details of the integrated care work should be brought to a future meeting of the Committee.

The Better Care Fund submission and the CCG operating plan could be shared with the Committee. The operating plan would also be available on the CCG website. The CCG was also working with other CCGs, Councils and providers to submit a five-year strategic plan by the start of June 2014.

Members requested more details on the issues considered by the Urgent Care Board and the Chief Operating Officer responded that a summary of the Board's decisions may be produced. It was noted that the CCG governing body held its meetings in public and that papers were available on the CCG website. The governing body met approximately 5 times a year.

A map of health services in Havering could be provided and the Chairman wished to clarify the location of services that had moved from Queen's Hospital into community locations.

The Chief Operating Officer felt that the directory of services used by the NHS 111 telephone service was the key issue impacting on the effectiveness of the service. He felt there should be more stages of advice offered according to how serious the condition was. He wished to include NHS 111 as part of the urgent care pathway.

The CCG was working with the Red Cross on the out of hospital scheme to consider what was and wasn't working in the existing scheme. The Chief Operating Officer would forward details of which GP practices were in each Havering cluster. Two new clinical directors had been elected by all practices from 1 April – Dr Adur and Dr Anne Baldwin.

The CCG was currently holding discussions with pharmacists, particularly on how the medicines management service could be improved. The CCG was also discussing with BHRUT how information about options for stitches removal could be given out at Queen's Hospital.

The Chief Operating Officer confirmed that there were no new developments concerning the St George's Hospital plans, the bid for which remained with NHS England at present.

The Committee **noted** the update.

50 COUNCIL CONTINUOUS IMPROVEMENT MODEL

The Committee agreed that an update on the transition of public health into the Council should be taken at the next meeting of the Committee, since this issue was now due for review under the Council Continuous Improvement Model.

51 HEALTH AND WELLBEING BOARD MINUTES

There were no comments on the minutes of the meeting of the Health and Wellbeing Board held on 8 January 2014.

52 URGENT BUSINESS

The Committee considered the response by the North East London Public Pharmacy Partnership to the NHS England Community Pharmacy Call to Action. While the were no specific comments on the document at this stage, it was felt that people should make more use of pharmacies which could prescribe as well as offer medication reviews and health prevention advice. The proposed sale of pharmacies run by the Co-Operative organisation was a potential cause for concern.

As this was the Committee's final meeting of the Council term, the Chairman thanked her fellow Members and also the representative from Healthwatch Havering with which the Committee had built a good relationship. The Chairman also thanked the health officers present and the clerk to the Committee for their assistance.

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Chairman

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